MINUTES OF THE POPULATION HEALTH AND STRATEGIC COMMISSIONING COMMITTEE

STRATEGIC SESSION

HELD ON THURSDAY 8TH AUGUST 2024, 9.00AM – 11:30AM

MS TEAMS

Present:		
Richard Wright **(CHAIR)**	RW	Non Executive Director, NHS Derby and Derbyshire ICB
Michelle Arrowsmith	MA	Chief Strategy & Delivery Officer, Deputy CEO, Executive lead for PHSCC, DDICB
Avi Bhatia	AB	Representative for Clinical and Professional Leadership Group
Craig Cook	CC	Director of Strategy & Planning, DDICB
Robyn Dewis	RD	Director of Public Health, Derby City Council
Wynne Garnett	WG	Programme Lead - Engaging the VCSE sector in the Derbyshire Integrated Care System
Tamsin Hooton	TH	Programme Director, Provider Collaborative
Clive Newman	CN	Director of Primary Care , DDICB
Adedeji Okubadejo	AO	Non-Exec Director & Chair of the Quality & Performance Committee, DDICB
Emma Pizzey	EP	GP representative
Lee Radford	LR	Chief People Officer, DDICB
James Reilly	JR	Non-Executive Director, DCHS
Sardip Sandu	SS	Non-Executive Director, UHDB
Chris Weiner	CW	Executive Medical Director, DDICB
In Attendance:		
Caroline Duckworth	CD	Partnerships Manager
Jane Roberts	JR	Head of Medicines Management – Assurance & Transformation
Sheila Roberts	SR	System Delivery Consultant
Louise Swain	LS	Assistant Director of Partnerships
Minute Taker:		
Victoria Wright	VW	Executive Assistant, DDICB
Apologies:		
Penny Blackwell	PB	Integrated Place Executive Chair, DDICB
Margaret Gildea	MG	Non Executive Member for People & Culture, DDICB
Keith Griffiths	KG	Chief Finance Officer, DDICB
Ellie Houlston	EH	Director of Public Health, Derbyshire County Council
Steve Hulme	SH	Chief Pharmacy Officer, DDICB
Dean Howells	DH	Chief Nursing Officer, DDICB
Mark Powell	MP	CEO, DHcFT
James Reilly	JR	Non-Executive Director, DCHS
Lucy Smith	LS	Lead for Allied Health Professionals, CRH
Suneeta Teckchandani	ST	Consultant Physician in Acute Medicine, Secondary Care Representative

Item No.	Item	Action
PHSCC/2425/53	**Welcome, introductions and apologies** The Chair welcomed everyone to the meeting including new members Tamsin Hooton (TH), who is the new Provider Collaborative representative replacing Mark Powell, and Lee Radford (LR) who is the new ICB Chief People Officer following Linda Garnett's retirement. The above apologies were noted as were the values and purposes of the Committee: Our Values & Purpose: *In delivering their roles and responsibilities, the Committee shall undertake to contribute towards delivery of the following key purposes of an Integrated Care System:* • *Strive to improve the outcomes in population health and healthcare.* • *Tackle inequalities in outcomes, experience, and access.* • *Enhance productivity and value for money; and* • *Assist the NHS in supporting broader social and economic development.* The Chair stated there were some items on the agenda that demonstrate some of the difficult decisions that need to be made. Committee members are here to bring their experience of what they do within the system - rather than represent the organisation that they work for - and to bring that experience to make system wide decisions and support system wide ways of working to ensure finite financial, people and estate resources are used in the best possible way for the population of Derby/shire. The agenda is now set out and grouped based on areas the Committee needs to get assurance of and are linked back to risk. These are: • Strategic Commissioning – are we commissioning strategically to deliver the 5 year plan? • Localised Care and Integration - how we are delivering the Joint Forward Plan and the left shift to localised care and prevention, and reducing the load on the Acutes. • Population Health – is the money that we are investing improving population health and is the Committee getting assurance that we are getting a return on the investment. Adedeji Okubadejo (AO) mentioned that the Board should be advised on how the Integrated Performance Report assurance is received as some of the data comes to this meeting and some of to the Quality and Performance Committee. The Chair confirmed that this meeting is interested in our performance – how we are delivering against the five year plan.	

	Sardip Sandu (SS) commented that it was important to note that return on investment may not be immediate and queried whether we should be using the same criteria for measurement as with other projects or whether we should recognise certain things may require a long term view and then agree what that should be. The Chair agreed that this should be recognised, the Committee is often looking forward within a 5 year window, but we do need some assurance on progress. The PHSCC Integrated Performance Report may be different from others as it will be about how we are delivering transformation in the long term and we will have to decide which leading indicators to monitor. Chris Weiner (CW) agreed that there is a need to recognise that some projects and their outcomes are long term and to be able to measure change and have full assurance that things are improving may take a long time. There is a need to identify what the interim process measures are, in which we will have a strong sense of confidence, that we know will deliver the desired health improvement outcome.	
PHSCC/2425/54	**Confirmation of quoracy** The meeting was confirmed as quorate.	
PHSCC/2425/55	**Declarations of Interest** The Chair reminded Committee members of their obligation to declare any interest they may have on any issues arising at Committee meetings which might conflict with the business of the ICB. With reference to business to be discussed at this meeting, James Reilly (JR) declared an interest in Item PHSCC/2425/69 –Tier 3 Weight Management - as he is a NED at DCHS. It was noted that this was not a contractual item and so JR did not need to withdraw from the meeting for this item. JR also declared an interest in Item PHSCC/2425/68 as St Lawrence Road Surgery is a DCHS service. Adedeji Okubadejo (AO) declared that he had an indirect interest in Item PHSCC/2425/69 –Tier 3 Weight Management. This was due to the fact he is clinically and operationally involved with two organisations that provide Tier 4 services and one operates in the local area.	
Minutes & Matters Arising		
PHSCC/2425/56	**Minutes from the meeting held on 13th June** The minutes from the meetings held on 13th June were agreed as a true and accurate record.	
PHSCC/2425/57	**Action log from the meetings held on 13th June** The log was reviewed and updated. It was agreed that going forward the Action log would also show closed actions as well as current actions.	

	JR noted that the PSR item was due to be paper at this meeting not a verbal update. Michelle Arrowsmith (MA) confirmed that there were capacity and expertise issues which prevented a paper being presented but there is a review being undertaken in terms of learning from recent procurements - where there has been some legal challenge - and the ICB have also asked their internal auditors to look at the PSR. MA is keen to bring those pieces of work together as the learning from both will be important.	
Scene Setting		
PHSCC/2425/58	**Updates from Development sessions** Michelle Arrowsmith (MA) confirmed that Risk and the Terms of Reference are already separate agenda items at this meeting and the new Commissioning and Procurement subgroup will play a part in developing Commissioning, Procurement and Contracting plans. The JFP progress report went to Board and they asked for some further work on the JFP. Alongside that, the Board requested an outcomes framework, with both to go back to the November meeting. Some of this work will come via PHSCC. Data insights is on the agenda which is about using the data that is already available to us to be able to have some overview at every meeting. MA confirmed that she is keeping a track of the actions that came out of the Development sessions and there is a lot of work to be done. The Chair responded to say that he is aware of the amount of work required but that we need to ensure that we are making the progress that we want and is hoping by the October meeting that a lot of this work will have come together. MA said she felt there has already been a lot of progress, with the Committee now looking with a forward view and the agenda being in a better position but in terms of capacity, there has been a huge amount of work that has already happened and also going forward with the JFP plus with the Outcomes Framework which is going to monopolise a lot of time. Robyn Dewis (RD) asked, via the meeting chat, if the Health Protection Board will need to programme agenda items for the JFP and MA confirmed they will.	
PHSCC/2425/59	**Terms of Reference** MA presented slides with proposed changes to the Terms of Reference and items for the Committee to note. MA informed the Committee that there is a legal section in the Terms of Reference regarding the delegation of PODs to this Committee but there are now over 50 Spec Comm services and it hasn't been agreed whether they should also come to this	

	Committee and does not know whether there is a legal construct which means they need to be in the PHSCC ToR. MA will be checking this with Helen Dillistone and Kathy McLean. The membership has been revised with both Directors of Public Health now included along with a VCSE representative and Allied Health Professional rep. It has been agreed that Deputies for members can attend but only with agreement from the Chair and Deputies must only attend a couple of times a year. The frequency of the meetings has been amended to currently 6 Business meetings a year and 2 Development sessions. Interdependencies with other groups has been looked at – the Committee needs to ensure that any Quality and Performance concerns discovered here are taken forward and raised at the Quality and Performance Committee and any financial, efficiency and productivity concerns need to be forwarded to the Finance, Estates and Digital Committee. There is also an interdependency with the Integrated Place Executive, Provider Collaborative Leadership Board and Integrated Care Partnership. There are 9 roles and responsibilities in the ToR and MA felt some merged into each other so she has tried to separate them out. MA presented slides with the original wording and provided some explanation as to her changes. 3.1 proposed wording now includes reference to the commissioning strategy, policies, the Committee's intentions and the procurement plan. 3.2's revision has more of a JFP focus. MA's view is that 3.3 is removed due to its crossover with other Committee's responsibilities. 3.4 has been made to be very specific to the Operational Plan with alignment to the JFP. MA suggested that 3.5 is kept as it is as it is aligned to one of the new risks and 3.6 has had 'service change' added to the wording. 3.7 has more focus on Place and Provider Collaborative. With regards to 3.7, TH suggested via the Chat to add about the responsibility to ensure that commissioning strategies and policies are aligned to and support major transformation programmes. For 3.8, MA proposed that the wording is not changed but that there is something added regarding Anchor institutions. MA indicated that in her view, 3.9 should be fully revised to focus on health inequalities, population health and prevention. The suggested revised wording which will be circulated to the group for comment and feedback. Once comments have been received, the final version will be presented at the October meeting.	**MA**

PHSCC/2425/60	**Population Data Insights (ONS/JSNA/Insights Programme)** Craig Cook (CC) explained that this item was about the kind of performance conversation that needs to happen at PHSCC and how different it needs to be from the Quality and Performance Committee. CC said he has approached this topic from the perspective of 'how does PHSCC get a better understanding of the impact that our commissioning action is having on the health of the population' and which aspects of performance matter most. The ICB receives an Integrated Performance Report and work continues to develop this. However, performance in relation to the population health improvement agenda does not feature in a substantial way. PHSCC received no structured information on how the ICS are performing in relation to population health issues and so if the Committee is not receiving the right information, how can it make decisions to further population health. CC listed a number of products which could give the Committee greater insight to how we are performing against the population health improvement agenda including Local Public Health Strategic Health Needs Assessments, Public Health profiles, the NHSE Model Health System and NHSE Population and Person insight which all provide granular level information which is how the Committee could test and understand if interventions are working. The challenge is how to harness all of this information to bring a product to this Committee. The Committee needs an approach that allows assessment of the health and wellbeing of the population, is outcome based, has a sound methodology, can benchmark against other geographical areas and has degree of independence. CC suggested that a possible solution was using ONS Health Index which is published on an annual basis which in his opinion meets all of the criteria and has been used to inform the JFP and inputs into the JSNA. It focuses on 'Healthy People', 'Healthy Lives' and 'Healthy Places' with subdomains and metrics that sit beneath those overarching themes. CC suggested he uses this and works with RD and other interested colleagues to bring back something more structured to the Committee. **Key Discussion Points:** • CW reminded the Committee of the work happening with Operation Periscope – the plan to develop the Integrated Quality and Performance Report for the ICB and ICS - and the timeline of development going through to December. Within this, there is the opportunity to review which population health measures that we want to see in the report and supports Craig's view as these are the public health measures we would want developed into the report. This needs to come together as an integrated report, not a	

	separate piece of work and would like to encourage people to engage in the ongoing work. • JR suggested other sources to consider alongside the ONS Health Index including the National Institute of Healthcare research to see if they have anything of use particularly relating to local population granularity and the framework under health inequalities. In terms of organising the data for PHSCC, we need to be mindful of the framework that the Committee will organise itself around – the Start Well, Stay Well, Age and Die Well and the six core conditions that we continue to target. The plans that the Committee are responsible for highlighted in the Terms of Reference need to contain the information Craig has presented. JR also felt that dashboards with trajectories were required to show we were moving towards the desired outcomes. • AO feels this direction not only would give assurance to the Board but also to the partners in the system with regards to population health. • Emma Pizzey (EP) stated that she likes this idea and thinks it is what the Committee should be doing. It is good to have a baseline to highlight what the key priority areas need to be and check the commissioning agenda fits with that to achieve improvements in population health. • TH supported EP's view and feels the Outcomes framework work needs to be one and the same piece of work. • The Chair wanted to highlight that we need to be mindful of the areas that the ICB are liable for and what other partners are. • CC informed the Committee that there is no intention to get involved in things where responsibility is held elsewhere but we don't have the macro picture mapped out objectively to allow us to think about the NHS contribution and this does that. The Health Index takes 2015 as a baseline and has been tracked every year at a sub Place level on every metric so this could be used now to inform decision making whilst acknowledging it needs to align with the wider Integrated Quality and Performance report. **The Population Health and Strategic Commissioning Committee AGREED for work to progress based on Craig's proposal.**	
Corporate Assurance		
PHSCC/2425/61	**Risk Register update** The new risks were agreed at the last meeting and MA and her team have met with the ICB corporate risk team trying to determine the scoring, mitigations and actions for each risk. This work has highlighted issues that need to be resolved. The risk team were unhappy with some of the wording of the new risks and they felt they were worded as system risks. This Committee is	

	very system focused but corporate risks are ICB risks and system risks are BAF risks. Kathy McLean is also undertaking a piece of work regarding system and ICB risks so there is a lot of work happening with risk at the moment. The Committee risks have since been reworded and sent back to the risk team. It has been agreed that one of the risks is so similar to one of the BAF risks, it will not be added as Committee risk but there will be updates to the BAF. The new risks with full detail will be circulated with the papers for the next meeting so they can be approved at the meeting. JR requested that the original set of risks be brought back with the new risks so that the Committee can see how they have evolved. MA confirmed she would do this.	**MA**
PHSCC/2425/ 62	**Month 3 activity & performance** *TH left the meeting during this item.* CC gave an overview of month 3 activity and performance. CC explained that the focus is on both UEC and Planned Care which are not performing as expected against a whole range of metrics. In UEC, Q1 ended behind the planned trajectory for 4 hour performance, more ambulance hours have been lost on delay and there has been an overall increase in UEC service demand - the majority of the growth of a lower acuity. There is not yet a full understanding of the drivers of that growth but is important to grasp this before winter to be able to develop the right interventions. There has been a reduction in the number of delayed discharges which is encouraging but the test will be whether that improvement can be continued into the rest of the year. Cancer performance is broadly delivering against plan with regards to diagnosis within 28 days and 62 day treatment performance is in line with the plan. The biggest risk with Planned Care is reducing elective long waits which is not on plan. It is unlikely that 65 week waits will be eradicated by the end of September. Insourcing and outsourcing strategies are diluting our ability to understand if productivity is improving. If the end of September target is not met, there is work to be done with both Acutes to determine when the waits will be eradicated and what contribution in-house productivity will have to achieve the aim. **Key discussion points:** • JR raised that performance feedback going forward needs to include all parts of the system not just be focused on the Acutes if we want to see how the system is performing. The Committee should be focused on outliers for each provider group.	

	• AO commented that we are not yet able to answer whether we are getting optimum productivity from the workforce. • MA noted in the chat that NHSE is doing some work on productivity and its definitions as definitions are currently not well defined. • Avi Bhatia (AB) raised that it is likely that there are different definitions of productivity in different areas of the system as each will have unique markers of what productivity looks like which is not recognised in other areas. AB also asked where the semi operational aspects of this are sitting. • MA explained via the meeting chat that an Operational Plan Progress meeting has been established which is an Executive level meeting which looks at Operational Plan delivery and the triangulation between finance, workforce and delivery. • AO stated in the chat that quality of services is something that the Quality and Performance Committee are looking at. • EP highlighted in the chat that there is a need to look at the quality of services being delivered as part of the integrated report as focusing on activity alone is not always helpful.	
Strategic Commissioning		
PHSCC/2425/63	**Commissioning and Procurement Subgroup report** The report was taken as read by the Committee members and CC gave an overview of three areas of work that the group has been focusing on: 1. Agreeing contracts with out of area providers – looking at getting clarity on what we are paying for, and what we need. 2. Ensuring commissioning of current projects is in line with procurement regulations. 3. The change to Choice regulations. CC explained that under the change to Choice regulations, any consultant led provider service delivering an elective service can become accredited and commissioned by an ICB and this is currently an area of substantial growth particularly in the private sector. The Commissioning and Procurement Subgroup has had to create an accreditation process for this and the first request for accreditation that the ICB has dealt with has come from a Provider Community Health and Eye Care (CHEC) who is seeking to become accredited to provide Cataract Surgery. NHS Executives have agreed to award CHEC a contract to provide Cataract Surgery and this Committee is being asked to ratify this decision.	

	Key discussion points: • JR asked for assurance that in accrediting and awarding contracts of choice, we are not undermining other services, particularly relating to Ophthalmology at CRH. • CC said the Cataract service at CRH is currently delivering but there are other providers who have expressed an interest in being commissioned for services which are deemed as weak at CRH. • CW responded to say that the service at CRH is delivering at the moment but it is important to recognise that it is being entirely staffed through locum agencies and so it is on the official fragile list. There is an ongoing piece of work between CRH and UHDB to look at a potential model to strengthen ophthalmology services across the area. CW also stated that with additional providers, it creates new markets of opportunity and unquantified risks. • JR also said it would be helpful to have a column next to items on the 24/25 operational plan which indicated a financial and activity value against each item to see the materiality of them. The Committee can then understand the significance of each project. • CN stated that Optometrists have raised three issues regarding the change to choice regulations, the first being the additional cost to the system of the additional work. The second issue was the inequity of this with people possibly waiting long times in one area and short times in another, and the third issue was the aggressive marketing from the companies to both Optometrists and patients, with Optometrists feeling bullied into referring into the private providers. • CC responded to the above comments to confirm that there is no evidence that increasing the supply of cataract surgery is worsening health inequalities. Regarding aggressive marketing, this is being picked up with both CHEC and other private providers to set standards on communications. With regards to cost, we spend around £10 million per year on Cataract Surgery and there are very clear specifications and policies on people receiving surgery on one/two eyes which is closely monitored by the team so people are not drawn into the service when they don't need to be. It is not expected that the cost burden will increase but instead the cost be moved elsewhere. The implementation of the service will be key and there are risks regarding the north of the County but it is giving people choice and the opportunity to receive treatment more quickly. **The Population Health and Strategic Commissioning Committee are NOTED the Commissioning and Procurement Subgroup report and RATIFIED the decision of the NHS Derby and Derbyshire Executive, to award a Contract to Community Health & Eye Care (CHEC) to provide Cataract Surgery.**	

PHSCC/2425/64	**Provider Selection Regime** CC explained that a key aspect of the Commissioning and Procurement Subgroup is to provide expert advice to ICB teams who are commissioning services on the best procurement method to use. CC asked the Committee what kind of information they would like to receive on this – in terms of how we use it or the routes we follow. **Key Discussion Points:** • JR said he thought it is about the strategic point and confirming with everyone in the NHS that there is a more strategic approach being taken to procurement which is going to shift the dial on procurement activity. JR feels that for this Committee, it is about how the Executive team identify the opportunities and threats and then present options to the Committee and then the Board about how we're going to shift our contracting activity to maximize the opportunities and benefits that PSR give us and how it shapes our activity going forward. What are the key shifts on how we contract with our suppliers? Procurement needs to be an enabling activity supporting strategy. • Wynne Garnett (WG) commented that he went to some of the early briefings on PSR and that there was a sense that it was seeking to generate improvements around establishing long term relationships, around proportionality of commissioning depending on the amount of money involved and particularly around trying to generate collaborative commissioning approaches. WG would be interested to hear on the degree on how it is going to be able to do that now and how it might be taken forward. WG also asked about how services that do not have CPV codes will be dealt with. • The Chair emphasised that procurement options should be based on value/return and not just cost which is why a longer term strategic approach is required. • CC responded to these points to say all current procurement activity, bar one project, has been initiated under the old regime and that 2024/25 is a transitional year. CC suggested coming back to the Committee with a paper regarding 2025/26, 2026/27 commissions that will be due and the options on procurement for them and this is how the ICB will consider how to make the right decision on what method will be used. The paper will also have a clear description of scope and what it does and what it does not include. • The Chair agreed to CC's suggestion and this will be on the agenda for the October meeting.	**CC**

PHSCC/2425/65	**Young Adult Service Contract award** *Sheila Roberts (SR) joined the meeting.* The paper was taken as read by the Committee. The only comment received was by AO who queried whether all further information required, indicated in the paper, will be received before the contract is signed. SR confirmed this would be the case. **The Population Health and Strategic Commissioning Committee APPROVED the 'Young Adults Service Supporting those Aged 17 To 24 Years in their Emotional and Mental Health' contract to be conditionally awarded to the preferred bidder, Bidder A.**	
PHSCC/2425/66	**Living Well VCSE Service for Derby City** The paper was taken as read by the Committee. • EP queried which Living Well this related to as there seems to be a lot of things named 'Living Well' and whether it was the 12 week mental health programme being developed by DHFT. • SR replied that this related to a service already in place in Derby with Community Action Derby and believes that it is the mental health Living Well. • RD said that she is assuming this is that programme but that there were conversations before it started that it must not be called Living Well as the name is too close to 'Live Well' which is well known from a City perspective. If it is the service assumed, it is branded as Derby Wellbeing, part of Living Well, Derbyshire and should remain that to avoid confusion. • MA confirmed via the meeting chat that she will ask Bie Grobet to do a one page brief to the Committee on all things Living Well and bring to the next meeting. • JR highlighted the anonymity requirements for this Committee with regards to contracting, which means we can't know the name of the bidder and that it's very likely that the bidder will not be called Living Well. He said that he read the paper to mean that the bid is under the broader Living Well programme. • The Chair suggested an agreement in principle to the recommendation in the paper subject on the points raised above being taken on board. **The Population Health and Strategic Commissioning Committee are APPROVED & AGREED the Contract Award for the Living Well VCSE Derby City Service**	**MA**

Localised Care and Integration		
PHSCC/2425/67	**Dental plan and update on Pharmacy, Optometry and Dental services in Derby and Derbyshire** This was a confidential item so the minutes have been redacted.	
PHSCC/2425/68	**Primary Care Subgroup report** This was a confidential item so the minutes have been redacted.	
Population Health		
PHSCC/2425/69	**Tier 3 Weight Management** This was a confidential item so the minutes have been redacted.	
PHSCC/2425/70	**Seasonal Plan Update** It was agreed that this item would be deferred to the next meeting due to time constraints. *NB: This has been added to the forward planner.*	
PHSCC/2425/71	**Gender Dysphoria** It was agreed that this item would be deferred to the next meeting due to time constraints. *NB: This has been added to the forward planner.*	
PHSCC/2425/72	**Update from the Health Protection Board** This was a confidential item so the minutes have been redacted.	
PHSCC/2425/73	**Research Strategy/Applied Research follow on discussion** It was agreed that this item would be deferred to the next meeting due to time constraints. *NB: This has been added to the forward planner.*	
Items for information		
PHSCC/2425/74	**Monthly updates, minutes & bulletins:** • CPAG updates • Derbyshire Prescribing Group report/minutes • JAPC Bulletin • CPLG minutes • GP Strategy Update	
Closing items		
PHSCC/2425/75	**Forward Planner** The Forward Planner was noted as read.	

PHSCC/2425/76	**Assurance questions** • Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? *Yes* • Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? *Yes* • Has the Committee discussed everything identified under the BAF and/or Risk Register, and are there any changes to be made to these documents as a result of these discussions? *No due to changes to be made.* • Were papers that have already been reported on at another Committee presented to you in a summary form? *Yes* • Was the content of the papers suitable and appropriate for the public domain? *It was identified which were suitable and which were confidential.* • Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? *Yes* • Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? *No* • What recommendations do the Committee want to make to the ICB Board following the assurance process at today's Committee meeting? *All items to be included on the ICB Board Assurance Report.*	
PHSCC/2425/77	**Any other business** None.	
DATE AND TIME OF NEXT STRATEGY MEETING		
Date: Thursday 24th October		
Time: 9am – 11.30am		
Venue: MS Teams		