Joined Up Care
Derbyshire

Draft

Derby and Derbyshire

Integrated Care Strategy

For consideration by the ICP Board

08 February 2023

NHS
The Derbyshire VCSE sector Alliance
Derby City Council
DERBYSHIRE County Council

Joined Up Care Derbyshire

Contents

Foreword

Integrated care systems provide a positive opportunity for Derby and Derbyshire residents to receive joined up care and support to meet their health and care needs.

Derby City Council and Derbyshire County Council have responsibility for a range of social care and public health functions that support our residents to live well. Our two local authorities are working alongside NHS colleagues, Healthwatch, district and borough councils and the voluntary and community sector to deliver integrated care for our residents.

The Covid pandemic and cost of living pressures have negatively impacted the health of our population in so many ways. Our budgets and services are experiencing challenges and pressures on a regular basis. Our workforce is going the extra mile every day.

Integrated care is not a solution in itself; however it does allow us to develop new ways of working, utilise new technology, maximise the skills of our precious workforce to create new opportunities to collaborate and work together. It will not be easy but there is a shared local commitment to do all we can within the resources available to do our best for Derby and Derbyshire.

Our Integrated Care Strategy summarises the first steps on the journey and describes how we will further grow and develop our shared approaches. There is huge ambition and commitment across the City and County to get this right for our communities. Delivering against the proposals in this strategy has the potential to help us provide a more preventative approach to health, tackle inequality and improve outcomes for local residents.

As Joint Chairs and Vice Chair of the Derby and Derbyshire Integrated Care Partnership we hope that you find the information useful, engaging and that it provides a clear understanding of the journey we are on and what we want to achieve by doing more together for our local populations.

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Chair of the Derbyshire Health and Wellbeing Board

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Chair of the Derby Health and Wellbeing Board

John MacDonald
Chair of Derbyshire Integrated Care Board

1. Introduction

1.1 Purpose of this document

This document has been produced for consideration at the Integrated Care Partnership (ICP) Board on 8 February 2023. It is a first draft of the Derby and Derbyshire Integrated Care Strategy and builds on the Framework Document considered by ICP Board members on 7 December 2022.

The purpose of the Joined Up Care Derbyshire (JUCD) Integrated Care Strategy is to set out how Local Authority, NHS, Healthwatch, and Voluntary Sector organisations will work together to improve the health of Derby and Derbyshire citizens, and further the transformative change needed to tackle system health and care challenges.

The final draft of the Strategy will be produced for consideration by the ICP Board in April 2023. The approved version will then be published in line with national guidance, with a copy provided to each partner local authority and the Integrated Care Board.

A summary of the Strategy will also be produced to accompany the final document. This will be designed to communicate the key elements in a shorter and more simplified manner with the use of infographics and easier to understand language. It will also convey the relationship between this Strategy and other key planning documents and priorities, so that staff and citizens can see how the Integrated Care Strategy and its strategic aims align with health and wellbeing and other key strategies.

The Strategy will not be static, the national guidance requires that *Integrated care partnerships must consider revising the integrated care strategy whenever they receive a joint strategic needs assessment*. Therefore further versions of the Strategy will be produced and published in line with this requirement. To this end the Strategy should be regarded as a starting point for assessing and improving the integration of care.

1.2 Impact of this Strategy

In developing this Strategy a question consistently posed by the team leading its production has been *'what will not happen if we do not have this Strategy, what are the gaps it is seeking to fill'?*

The aim is to develop a document that describes both a high-level strategic intent and the practical steps the Derby and Derbyshire System will take together to provide care that is more integrated, and which provides better outcomes for citizens, in response to population health and care needs.

In response to the question stated above, the Integrated Care Strategy will impact in the following ways:

- **Collaboration and collective working -** The collaborative work to develop the Strategy has helped to strengthen partnership working and engagement between local authorities, the NHS, the VCSE sector and Healthwatch, that will prove beneficial beyond the remit of the Integrated Care Strategy and should act as a springboard for better collective working moving forward. In short, the way in which we are developing this Strategy is just as important as the content.

- **A joined up approach to strategic enablers** - The Strategy captures for the first time the key, enabling actions that are critical to the development of high quality and sustainable integrated care, and identifies key areas of focus to test these actions.

- **Agreement on key areas of focus to test our strategic aims and ambitions for integrated care -** The process for developing the Strategy has resulted in system-wide agreement on three key areas of focus that will help deliver key population health and service delivery outcomes, they are:

  - **Start Well** - To improve outcomes and reduce inequalities in health, social, emotional, and physical development of children in the early years (0-5) via school readiness
  - **Stay Well** - To improve prevention and early intervention of the 3 main clinical causes of ill health and early death in the JUCD population - Circulatory disease, respiratory disease and cancer
  - **Age/ Die Well** - To enable older people to live healthy, independent lives at their normal place of residence for as long as possible. Integrated and strength based services will prioritise health and wellbeing, help people in a crisis to remain at home where possible, and maximize a return to independence following escalations

- **Engagement -** It is critical that the improvements expected as a result of this Strategy are meaningful and impactful to citizens. The strategic approach to engagement developed by JUCD, which includes key principles and frameworks will be key to success. It sets out how we will listen consistently to, and collectively act on, the experience and aspirations of local people and communities. The Integrated Care Strategy provides an ideal opportunity to test and further develop this approach.

1.3 National Guidance on the preparation of Integrated Care Strategies

The guidance currently available on the Gov.UK website is the same as referenced in the December 2022 Framework Document. Please refer to that document or the guidance itself (Guidance on the preparation of integrated care strategies) for further information.

Legal requirements
The legal requirements stated in the guidance are included below along with a statement on the compliance of the Draft Strategy against these requirements.

Legal requirements stated in July 2022 Guidance	Current status for Draft Strategy
The integrated care strategy must set out how the **'assessed needs' from the joint strategic needs** assessments in relation to its area are to be met by the functions of integrated care boards for its area, NHSE, or partner local authorities.	Three key areas of focus emanating from 'assessed needs' have been selected as a focus for the Strategy and to test the strategic aims and ambitions for the development of integrated care, with implementation to be overseen by the ICP. The Joint Forward Plan will describe how other 'assessed needs' will be met.

In preparing the strategy, the ICP must, in particular, consider whether the needs could be more effectively met with an arrangement under **S75** of the NHS Act 2006.	The governance arrangements for the three key areas of focus will consider S75 arrangements.
The ICP **may include a statement on better integration of health or social care services with 'health-related' services in the strategy**.	It is proposed that the wording included in this Strategy document should meet the requirement stated.
The ICP must have regard to the **NHS mandate** in preparing the strategy.	The NHS Mandate is referenced in this draft Strategy, however at the time of writing the 2023/24 Mandate has not been published. The three key areas of focus will incorporate relevant requirements of the Mandate and the Joint Forward Plan is likely to play a more substantive role in responding to the Mandate, given its broader remit and its focus on delivery.
The ICP **must involve in the preparation of the strategy: local Healthwatch organisations** whose areas coincide with or fall wholly or partly within the ICP's area; and people who live and work in the area.	Derby and Derbyshire Healthwatch organisations have been involved through the Communications and Engagement Group for the Strategy (please see **Section 6** for work to date), through their membership of the ICP Board and through separate conversations with the team leading the development of the Strategy. Moving forward Healthwatch will play a key role in the finalisation and delivery of the Strategy, for example by: • Ensuring authentic conversations with citizens help shape and drive work programmes for the key areas of focus and enabling plans • Feeding into evaluation work, ensuring the many different 'voices' of citizens are listened to when assessing progress and the impact of changes made to services.
The **ICP must publish the strategy** and give a copy to each partner local authority and each ICB that is a partner to one of those local authorities.	The final version of the Strategy (April 2023) will be published in line with the guidance.
ICPs must consider **revising the integrated care strategy whenever they receive a joint strategic needs assessment**	This will be done when new JSNAs are received and when new health and wellbeing strategies are agreed.

1.4 Aligning the Integrated Care Strategy

The Strategy will complement joint strategic needs assessments and the joint local health and wellbeing strategies. The health and wellbeing boards remain responsible for producing both of these documents, and these will continue to have a vital role at Place.

The ICP will need to ensure that the Strategy facilitates subsidiarity in decision making, ensuring that it only addresses priorities that are best managed at system-level, and not

replace or supersede the priorities that are best done locally through the joint local health and wellbeing strategies.

References are included in this document to illustrate how the development of the Strategy is being aligned with other system strategies and plans and where further work may be required. Please see **Appendix 1** for a visualisation of how health strategies link together.

Guidance has recently been released (NHS England » Guidance on developing the joint forward plan) to support integrated care boards (ICBs) and partner organisations develop their first 5-year joint forward plans (JFPs) with system partners. The guidance includes the following statement:

*..we encourage systems to **use the JFP to develop a shared delivery plan for the integrated care strategy** (developed by the ICP) and the joint local health and wellbeing strategy (developed by local authorities and their partner ICBs, which may be through HWBs) that is supported by the whole system, including local authorities and voluntary, community and social enterprise partners.*

Conversations are currently being held in the System to discuss the JUCD approach to production of the JFP and the relationship with the implementation of this Strategy.

1.5 Hallmarks for the Strategy

The hallmarks agreed through the Framework Document have been used to help guide the development of this Draft Strategy:

- There is an inclusive approach to developing the content
- The development of the Strategy and its recommended actions is based upon a strong culture of collaboration between JUCD organisations and alliances.
- We will develop a broad and deep engagement approach to inform the further development of the Strategy and relevant implementation plans
- This is a strategy for JUCD, not for regulators, and the process of developing it, should be as important as the content of the Strategy itself
- We will develop content that can be converted into statements which mean the public can easily understand how this Strategy will make a difference to them (*to be done following agreement of the Draft Strategy*).

1.6 Involvement and engagement in the development of this framework document

A range of senior colleagues from the NHS, local authorities, Healthwatch and the VCSE sector have been part of working groups to develop the brief, framework, and approach for the Draft Strategy, following the update on the development of an Integrated Care Strategy provided to the ICP Board in October 2022. This broad involvement has been very helpful in testing the proposed content and whether it is framed in a way that aligns with other system strategies and plans.

1.7 Format and content of the document

References are included in this document to national and system strategies/ plans that are relevant to the development of this Strategy – please see **Section 2**. Minimal content has

been included on these to keep the content of this document focused. The strategic aims for the Strategy are also included in this section**.**

The population health and care needs of Derby and Derbyshire are a fundamental driver for the Strategy. **Section 3** includes a summary of JUCD priority outcomes and indicators. These are based upon joint strategic needs assessments and health and wellbeing strategies and align with outcomes included in Local Authority plans. A section is also included on proposals relating to health protection arrangements.

A main thrust of the Strategy is the need to focus on strategic enablers that are critical to the development of high quality and sustainable integrated care in response to the stated population health and care needs. These enablers are summarised in **Section 4**.

There are three 'key areas of focus' proposed in **Section 5** spanning prevention, early intervention and service delivery. They are not framed as priorities, as they are not necessarily regarded as being more important than other topics. Instead they have been chosen by senior responsible owners from across the System as ideal areas to test our strategic aims and ambitions for integrated care, in response to population health and care needs. They are categorised under the headings of Start Well, Stay Well, and Age/ Die.

The plans for these key areas of focus will include ambitions that span multiple years and for many metrics we may not see attributable improvement until the medium to long term. Delivery plans will need to explain the connections between improvements to be achieved in the short-term (for example in responding to health and care annual operating plan requirements) and ones that will be achieved in the medium to long term, and to also show how they fit together. The Joint Forward Plan will be helpful in this regard.

Other key issues flagged by the ICP and ICB Boards that will be integral to the work arising from this Strategy include addressing health inequalities, the further development of population health management and maximising the NHS contribution to tackling wider determinants of health.

Section 6 summarises the JUCD approach to engagement and the use of insights, and the outline plan for engagement on the Strategy and the key areas of focus.

Section 7 outlines the need and intent to evaluate strategy implementation, including the impact of plan delivery for the three key areas of focus. The content is under development and will be updated for the final version in April 2023.

2. Strategic Context

2.1 National context

<u>The Health and Care Act 2022</u>
The Health and Care Act 2022 put new requirements on NHS and Local Authorities, including the requirements to produce an Integrated Care Strategy, set up an Integrated Care Partnership and establish an Integrated Care Board.

<u>NHS Mandate</u>

The ICP must have regard to the NHS Mandate, alongside guidance from the Secretary of State, when preparing the Integrated Care Strategy. The 2023-24 Mandate and accompanying objectives are awaited.

The NHS Mandate will help inform this Strategy; however it is by its nature NHS centric and some of its content is quite operational, and therefore the primary response to the Mandate will be through the Joint Forward Plan.

National focus on prevention and early intervention

There have been recent calls from national organisations for an increased focus on prevention and early intervention, which echo one of the strategic aims for this Strategy - *Prioritise prevention and early intervention to avoid ill health and improve outcomes.*

The paper published in January 2023 Joint vision for a high quality and sustainable health and care system | Local Government Association provides the views of the Local Government Association, the Association of Directors of Adult Social Services, and the NHS Confederation and endorses the approach outlined in this Strategy:

"Our three national organisations agree that our vision for all partners in the health and care system must focus first and foremost on promoting the health, wellbeing and prosperity of our citizens. This vision is relevant to all of us, whether we need care, support or treatment now or in the future, provide unpaid care for family members, work in social care or health, or run businesses that contribute to health and wellbeing outcomes. It focuses on:

- *maximising health and wellbeing and preventing or delaying people from developing health and social care needs*
- *redirecting resources so that when people need treatment, and short term support they are assisted to make as full a recovery as possible, restoring their health, wellbeing and independence*
- *maximising independence and wellbeing for people with ongoing heath and/or social care needs by working with them to put in place the care and support that works for them."*

2.2 JUCD Strategic context

Introduction

It is recognised that the current environment for health and care is very challenging on a number of fronts including the lived reality of workforce capacity and wellbeing challenges, Covid related backlogs, and financial constraints. And in the context of this Strategy we cannot expect these challenges to diminish in the near future.

There are other System plans that will better describe approaches for dealing with the issues of today and the need for near-term responses, and whilst it is not the intention to downplay or disregard these challenges in developing this Strategy, it is important for the System to also identify what can be done more effectively and efficiently by integrating resources and by working differently, through medium and long-term lens. Therefore through this Strategy we will seek to identify and exploit such opportunities.

It will be important to build on examples of where we do things really well in Derby and Derbyshire and to understand how actions, partnerships and behaviours that have led to successful outcomes, can accelerate our plans for integrated care, and to help build an

appreciative inquiry approach to the development of the Strategy and subsequent implementation plans. In the final version of the Strategy examples of good practice aligned to the key areas of focus and strategic enablers will be incorporated into the document.

The following sub-sections include references to local strategies and plans that need to be considered when developing integrated care. It is not a simple landscape, and at the current time there are multiple, relevant strategies or plans under development, in response to government, NHS and local requirements. A common goal for colleagues working across the System in this space should be to assess other, relevant planning exercises and collectively to try and develop a coherent logic for how the documents align with each other. **Appendix 1** provides an infographic that seeks to help in this regard, and this will be developed further in the final version of the Strategy.

ICS System Development Plan

The ICS System Development Plan is a recent document and includes four strategic priorities (using the NHS stated aims for ICSs). We have agreed that for the Integrated Care Strategy we should build out from the content included in that Plan and have strategic aims for the development of integrated care, that can sit alongside the stated strategic priorities for the ICS, these strategic aims are;

- **Prioritise prevention and early intervention to avoid ill health and improve outcomes**
- **Reduce inequalities in outcomes, experience, and access**
- **Develop care that is strengths based and personalised**
- **Improve connectivity and alignment across Derby and Derbyshire, to ensure people experience joined up care, and to create a sustainable health and care system**

Joint Forward Plan

Section 1 outlined the guidance for Joint Forward Plans, released by NHS England in December 2022, and the initial conversations in relation to the Integrated Care Strategy.

JUCD Operational Plan 2023-2024

Prevention, access and productivity are key themes/ requirements that are driving the 2023-24 operational plan, which responds to guidance released by NHS England. Whilst the Integrated Care Strategy will also focus on other themes (as reflected in the strategic aims), it will also be important that the SROs for the key areas of focus to examine contributions to improvements in access and productivity, as well as prevention.

Local Authority Plans 2022-2025

Please see **Section 3** for an outline of how outcomes, ‘must do’s’ and ‘headline initiatives’ from these plans align with the stated population health and care needs.

Adult social care and children’s strategies

Relevant stated priorities in local strategies covering adult social care and children' services need to align with the aims for the integrated care key areas of focus to support our ambitions for collaboration and integration.

Health and wellbeing strategies
Please see **Section 3** for reference to the Derby City and Derbyshire health and wellbeing plans and the alignment between these, the JSNAs, and current work to develop a Health Inequalities Strategy.

Anchor Institutions
The work of the Derby/ Derbyshire Anchor Partnership needs to be incorporated into the design and delivery plans for this Strategy.

The two local authorities, local NHS organisations and JUCD, Derby County Community Trust and the University of Derby are signatories to an Anchor Charter, and together with Rolls Royce, are members of Derbyshire's founding Anchor Partnership. Together they aim to use their collective influence to help address socio-economic and environmental determinants and enable and facilitate community wealth building, working together through the Derby and Derbyshire Health and Wellbeing Boards and the Integrated Care Board.

The Anchor Partnership has agreed to initially focus its combined influence and actions on the following two impact areas – workforce and access to work, and social value in procurement. Anchor workshops have commenced in recent months with relationships established through communications colleagues in each organisation.

It will be important to consider how best to align Anchor Partnership actions with the work emanating from this Strategy on key enabling functions and across the Start Well, Stay Well, and Age/ Die Well areas of focus.

3. Population Health and Care Needs

3.1 Introduction

Work has been undertaken by system colleagues to develop a set of JUCD priority population outcomes and key indicators (known as Turning the Curve) based upon the Derby and Derbyshire Joint Strategic Needs Assessments. These focus on increasing life expectancy, increasing healthy life expectancy, and reducing inequalities. The system outcome priorities/ indicators have been chosen because they are key drivers of the conditions that cause ill health, premature mortality, and inequalities in these, with the biggest causes of death in our population being cancer, respiratory and circulatory disease. This is reflected in emerging work to develop a JUCD health inequalities strategy which reflects the Core20Plus5 NHS England approach to reducing inequalities.

The Derbyshire and Derby Health and Wellbeing Strategies are to be updated during 2023. The content for this document and the needs outlined in this Section are therefore based upon the existing health and wellbeing strategies.

3.2 Life expectancy and healthy life expectancy

The health of a population can be described using healthy life expectancy and life expectancy statistics, and health inequalities can be starkly demonstrated by illustrating the difference in length of life, and how many of those years are spent in good health. Please see **Table 1** below for a summary of the differences in Derby and Derbyshire.

Table 1

	Derby	Derbyshire
Life Expectancy at Birth [inequality gap*], in years		
Female	82.1 [10.1]	83.0 [7.4]
Male	78.6 [10.2]	79.6 [8.3]
Healthy Life Expectancy At birth, 2017-19 [inequality gap, 2009-13*], in years		
Female	62.0 [19.2]	61.3 [13.5]
Male	59.9 [18.7]	61.1 [13.7]

**Life Expectancy at Birth statistical measures estimate the average number of years a new-born baby would survive if they experienced the age-specific mortality rates in this area throughout life. Healthy life expectancy describes reported years in good health. The gap describes the difference between the least and most deprived populations.*

The inequalities illustrated in **Table 1** are distributed differently across the area. Poorer outcomes are linked to areas of socio-economic deprivation and certain groups including, but not limited to, those from Black, Asian, and Minority Ethnic backgrounds, with serious mental illness, living with disabilities, LGBTQ+ people and those currently homeless.

The emerging work to develop a JUCD health inequalities strategy incorporates a review of the drivers of ill-health and mortality, the inequalities which exist between and within communities and sets out desired population outcomes, and priority indictors for affecting outcomes and inequalities – Please see **Section 3.3**.

3.3 Our desired population outcomes

The following statements have been developed locally to describe if the population were living in good health, it would be experienced as follows:

- **Start Well** - Women have a healthy pregnancy, children are born safe and well into a nurturing and secure relationship with care givers, with good nutrition, access to health care, social care, and education. Children thrive and develop positive and healthy relationships.

- **Stay well** - All citizens live a healthy life, can make healthy choices, and are protected from harm. They maintain quality of life and recover well from ill health or injury.

- **Age well and die well** - Citizens thrive and stay fit, safe, and secure into older age. They maintain independence and actively participate in society. They have a personalised, comfortable, and supported end of life.

3.4 System wide population indicators

The following 'Turning the Curve' indicators have been recommended as important 'markers' on the way to improving high-level outcomes. They address direct risk factors for the main causes of death, illness, and inequalities, including mental health:

1. **Reduce smoking prevalence**
2. **Increase the proportion of children and adults who are a healthy weight**
3. **Reduce harmful alcohol consumption**
4. **Improve participation in physical activity**
5. **Reduce the number of children living in low-income households**
6. **Improve air quality**
7. **Improve self-reported wellbeing**
8. **Increase access to suitable, affordable, and safe housing.**

JUCD has also identified additional indicators to reduce specific inequalities in the system drawing on local data and NHS recommendations*. See below for the "Plus 5" indicators (clinical areas of focus which require accelerated improvement).

- **Maternity:** ensuring continuity of care for 75% of people from Black, Asian and minority ethnic communities and from the most deprived groups**.**
- **Severe mental illness (SMI) and Learning Disabilities:** ensuring annual health checks for 60% of those living with SMI or learning disabilities**.**
- **Improving Vaccination uptake:** reducing inequalities in uptake of life course, COVID, flu and pneumonia vaccines
- **Early cancer diagnosis:** 75% of cases diagnosed at stage 1 or 2 by 2028.
- **Hypertension case-finding:** to allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke

* https://www.england.nhs.uk/about/equality/equality-hub/core20plus5/

***Note**: Guidance on Core 20 Plus 5 for CYP has recently been issued nationally and will require consideration. Five clinical areas of focus are asthma, diabetes, epilepsy, oral health, and mental health with specific actions recommended.*

3.5 Derby City Council Plan

A number of the outcomes and 'must do's' under the four focus areas included within the Derby City Council Plan align to and support health and wellbeing plans, and the desired population outcomes and priority health indicators stated above. For example the following are referenced:

- Cleaner air and lower CO2
- Decent, sufficient, and affordable housing with an emphasis on the homes of vulnerable people
- Reducing inequalities and wealthier and healthier residents
- Health and wellbeing strategy with a focus on childhood obesity and public health statutory requirements
- Provide effective strategic leadership to drive stronger integration of health, housing, community, and social care agendas, safeguarding adults that need it
- Establish a citywide Prevention Strategy, focusing on building independence using individual and community assets

3.6 Derbyshire Council Plan

Within the Derbyshire plan one can see how the stated 'headline initiatives' align with health and wellbeing plans, and the desired population outcomes and priority health indicators, examples include:

- Working with partners to benefit the health and wellbeing of people in Derbyshire by better integrating health and social care and developing the Better Lives transformation programme
- Driving forward the ambitious improvements in Children's Services to positively strengthen outcomes for children and young people
- Work with people with learning disabilities, recovering from mental ill health and, or autism to develop Council services to ensure they are tailored to meet individuals needs and help people achieve their personal goals
- Work with partners to enable individuals and communities to lead healthier and happier lives, accessing support when and where they need it to encourage physical activity, help people stop smoking and manage their weight
- Help and empower more young people with disabilities to be independent in their transition to adulthood

In addition the council has published its "Best Life Derbyshire" Strategy in 2023 with a focus on people with lived experience being able to define the outcomes they want from social care.

3.7 Health protection

Integrated care partnerships are asked to consider health protection in their integrated care strategy, with system partners including UKHSA, local authorities and the NHS who, among other bodies, have health protection responsibilities to deliver improved outcomes for the population and communities served. Health protection includes:

- Infection and prevention control (IPC) arrangements within health and social care settings

- Tackling antimicrobial resistance
- Reducing vaccine-preventable diseases through immunisation
- Assurance of national screening programmes
- Prevention activities related to health protection hazards such as needle exchanges for blood-borne viruses (BBVs)
- Commissioning of services for response to health protection hazards (such as testing, vaccination and prophylaxis) and to tackle health protection priorities (such as tuberculosis or BBV services)
- Emergency preparedness, resilience and response (EPRR) across all hazards
- Other health threats determined as priorities

The Directors of Public Health (DsPH) have the duty, under the Health and Social Care Act (2012), to be assured that the local health protection system is working effectively and to ensure that the health of the population is protected. This is sought through the Derby and Derbyshire Health Protection Board, chaired by one of the DsPH and reporting to the Health and Wellbeing Boards; an arrangement that has been in place since 2013. The development of the integrated care system is an opportunity to ensure this is embedded within the local health and care system.

Work is underway to identify key areas of work that require system support, these include:

- Developing the infection prevention and control system
- Ensuring a successful and safe transfer of the responsibility to commission immunisation services
- Ensuring oversight of screening programmes is appropriately linked to the system
- Improved connection for existing strategies e.g. air quality
- Pathway improvements for individuals with complex health protection needs e.g. those with TB who have no recourse to public funds

The following strategic actions have been identified:

- Request a commitment from the ICP to sponsor a review of the governance and architecture for health protection in Derby and Derbyshire.
- Produce a health protection strategy for Derby and Derbyshire to clarify and drive the work of the Health Protection Board and establish agreed outcome measures.
- Review the three key areas of the focus for the Integrated Care Strategy and identify prioritised health protection actions. Secure commitment from the SROs to include these actions as an integral element of their work plans, and to work with Public Health colleagues on their resolution.
- Ensure health protection priorities are included within the appropriate workstreams, and that progress is reported to the Health Protection Board.

4. Strategic Enablers

4.1 Introduction

A key thrust of this Strategy is to focus on enabling actions that are critical to the development of high quality and sustainable integrated care and our response to population health and care needs. These have been grouped as follows:

- System architecture and governance
- System shared purpose, values, principles, and behaviours
- Enabling functions and approaches

4.2 System architecture and governance

Through this Strategy we will strive to ensure there is a 'parity of attention' on health inequalities, population health, and prevention within system reporting and governance arrangements, to ensure clarity and visibility on how we track our ambitions for our Start Well, Stay Well, Age/ Die Well key areas of focus, and wider improvement actions.

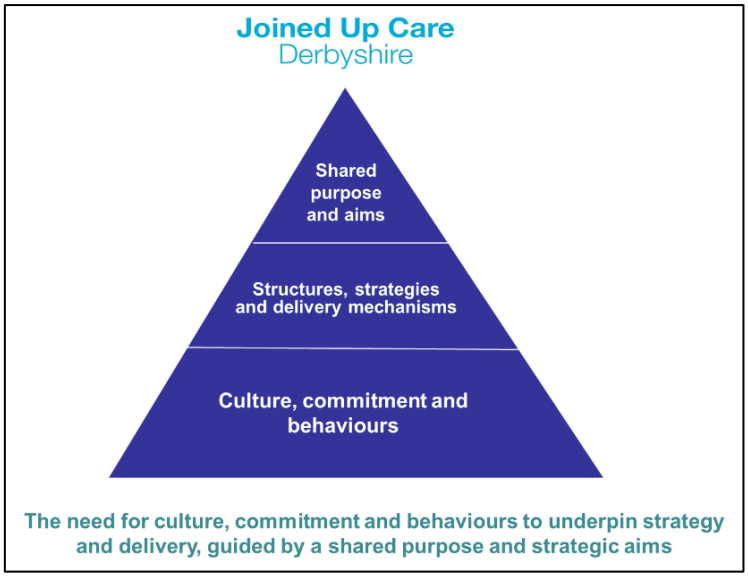
This objective needs to be set in the context of current work taking place to establish a renewed mandate to guide next steps for our collective "Integrated Care" approach, and JUCD governance architecture. A series of guiding questions to the Provider Collaboration at Scale and the Provider Collaboration at Place movements have been asked to help inform the renewed mandate.

Currently the two Place Partnerships and the Integrated Place Executive provide the primary governance arrangements for the Integrated Care Strategy on behalf of the ICP. In this context the role of the ICP in supporting and overseeing the delivery of this Strategy needs to be established, post approval of the final document.

Further consideration is also required in relation to how the Strategy's key areas of focus are governed. All three of the proposal documents described issues with current governance and delivery arrangements that will need to be addressed if benefits are to be maximised. There also needs to be feedback loop processes for how the agreed plans are continually informed by health and wellbeing plans and JSNAs, and vice versa.

4.3 System shared purpose, values, principles, and behaviours

Many of the key strategic enabling actions that are intended to support improvement through practical and transactional solutions, may not succeed, without significant underlying changes in behaviours to support a one-system approach, due to established processes and organisational sovereignty issues. A simple over-arching framework to ensuring a balanced approach is included below.



In the absence of a whole system, shared set of values and principles to underpin the development and delivery of the Integrated Care Strategy then consideration should be given to this, alongside organisational development support that may be required to facilitate the process, to ensure that the Strategy is built on sustainable cultural foundations.

Where success has been achieved in developing integrated care to date, it is important to reflect on the conditions that facilitated the success, both transactional and cultural. Work will take place to gather and review this intelligence to inform further engagement, with leaders, staff, and the public.

Work will now commence to scope how a set of shared values and principles to underpin the development and delivery of the Integrated Care Strategy could be developed.

4.4 Enabling services and approaches

Strategies and improvement plans for enabling functions and approaches should encompass all organisations/ alliances in the System (unless not deemed relevant) and support the achievement of our strategic aims for integrated care.

The content under this Section seeks to summarise current strategies and improvement plans and also flag key constraints that will need to be addressed. The following enabling functions and approaches are included:

- Workforce
- Digital and data
- VCSE sector
- Carers
- Strengths based approaches
- Population health management
- Commissioning
- Quality drivers
- Estate

Primary care is refenced in Section 4.5.

There is already alignment between some of the content in this section and the content in Section 5, where aims and constraints are stated for the key areas of focus selected to test and mobilise this Strategy. This reflects the fact that there is already considerable joint working taking place across the System. The leadership for each of the key areas of focus will be expected to work closely with enabler leads to further this alignment and to develop work programmes that will help to test enabling strategies and improvement plans in real world situations and gather learning to inform continuous improvement.

The content in the following sections (**4.4.1 to 4.4.9**) has been co-produced with JUCD leads for the functions and services covered.

4.4.1 Workforce

Our vision for the JUCD workforce is:
"Anyone working in health and care within Derby and Derbyshire feels part of one workforce which is focused on enabling our population to have the best start in life, to stay well and age well and die well. Our workforce will feel valued, supported and encouraged to be the best they can be and to achieve the goals that matter to them wherever they work in the system."

Key enablers to achieving the vision include:

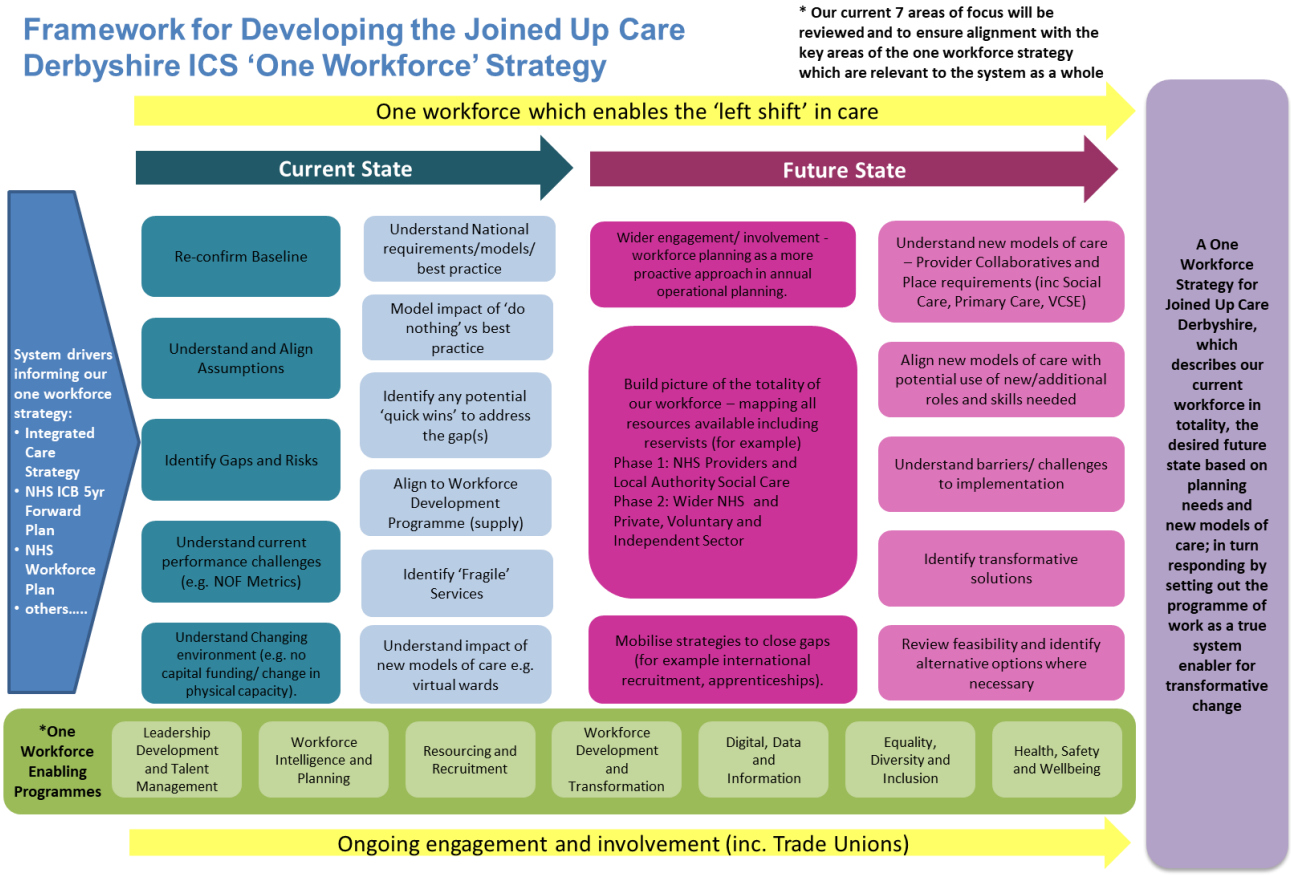
- A single point of access for new recruits, with a "no wrong door" approach to seeing people as a system asset, to be deployed wherever their skills fit best
- An integrated system rather than organisational approach to assessing workforce supply requirements
- Unified approach to leadership and talent development and OD
- An inclusive talent approach as the driver for recruitment and development
- Consistency of People Services offers, regardless of employing organisation - "One People Service across all places"
- Use of technology to enable ease of movement between organisations and reduce non value adding processes
- Clearer sense of common purpose and agreement on priorities for where we can work together, share resources
- Prioritisation of investment in training and development in prevention, personalisation and health inequalities

Some of the key challenges, and constraints to achieving the vision and our integrated care strategic aims include:

- Lack of dedicated workforce expertise to support integration
- Better understanding of the current workforce in the scope of this plan, what the requirement will be in light of the integrated care strategy and a joint approach between service leads and People Services to develop plans to bridge the gap using new approaches to skill mix, expanding/ introducing new roles and deploying staff closer to service users
- High percentage of social care staff who are in the PVI sector and therefore harder to influence in terms of workforce planning and development
- Fragmented and short-term nature of funding streams for workforce transformation and development
- Lack of trust in processes and governance between statutory sector partners and between statutory sector and VSCE

Current areas of focus therefore include delivering the conditions that will enable a JUCD 'one workforce', spanning health and local authority organisations; leadership development at a system level; the Joined Up Careers initiative; and the 'Quality Conversations' training programme which develops a strength based, personalised mindset for health and care staff.

The following infographic summarises our framework for developing the JUCD 'One Workforce' Strategy. We will need to align and embed this framework as part of the work programmes for the key areas of focus included in **Section 5**. Feedback on the Workforce vision, and the framework, through this Draft Strategy will help to further develop the approach.



4.4.2 Digital and data

The Digital and Data strategic aims and delivery priorities will support and enable the System to work towards the realisation of its strategic priorities and desired population outcomes through:

- **The ability to share citizen/patient information** to support care delivery across health and social care, including;
  - **Derbyshire Shared Care Record (DSCR).** The deployment of the DSCR will be expanded to include hospices, care homes, community pharmacies and other commissioned health and social care providers services. The DSCR provides clinicians and professionals with the most up to date patient/ citizens information to support the delivery of optimal care.

  - **Front Line Digitisation; Electronic Patient Record (ePR**). To enable collaborative working, deliver faster care, pathway redesign, reduced clinical risk and Population Health Management a new ePR will be deployed across our acute hospitals.
  - **Digitising in Social Care (DiSC)** – the implementation of digital social care record for care homes and domiciliary care providers, technology to support falls prevention and other technology evidence to enable citizens to be supported in the place they call home
- **A data architecture to enable population health management to be embedded** across the system to inform service planning and delivery. The ambition is to create a holistic view of citizens that incorporates wider determinants of health to improve physical and mental health outcomes.
- **Digitally enabled care delivery using tools and technology** to improve citizens knowledge and understanding to take greater control of their health and care
- **Digital and data innovation to support technology enabled care pathways** to augment care delivery, efficiency, and citizen/ patient/ staff experience
- **Digitisation of the wider health and social care economy** to improve care and opportunity for future interoperability and data sharing
- **Supporting and developing our citizens and workforce** in the use and adoption of digital services
- **Ensuring an inequity is not created** for those that are impacted. As we push our 'digital by default' vision we must ensure an inequity is not created for those that are impacted by the following barriers:
  - access issues
  - equipment, broadband connectivity, wifi, affordable data packages

This activity will be informed and prioritised through a systemic use of the nationally mandated and benchmarked 'Digital Maturity Assessment' and 'What Good Looks Like' tools.

4.4.3 VCSE sector

Nationally it is recognised that the VCSE sector is a vital cornerstone of a progressive health and care system and is critical in the delivery of integrated and personalised care and helping to reduce health inequalities. The National Development Programme – *Embedding the Voluntary Community and Social Enterprise (VCSE) Sector within Integrated Care Systems (ICS) 2022/2023,* which JUCD is part of, describes how;

"ICSs should ensure their governance and decision-making arrangements support close working with the sector as a strategic partner in shaping, improving and delivering services, as well as developing and delivering plans to tackle the wider determinants of health. VCSE partnership should be embedded as an essential part of how the system operates at all levels. This will include involving the sector in governance structures and system workforce, population health management and service redesign work, leadership and organisational development plans."

Locally, our ambition is for the VCSE sector to be considered as a key enabler for integrated care. It already makes a significant contribution to health and social care through complementary as well as mainstream provision, often supporting people who are under the radar of statutory services. This was particularly evident during the pandemic. VCSE organisations can also support, engage and articulate the needs of both communities of place, interest and condition.

The integrated care strategy provides an opportunity for a less transactional relationship with the VCSE sector where it can contribute at all points of the planning cycle; helping to define needs through soft intelligence, helping to design services so that they meet the needs of communities, as well as offering new and cost-effective approaches to service delivery.

Engaging this contribution will improve services for local people but there are challenges to making this happen that need to be addressed through the implementation of this Strategy and wider system actions. Some of these are listed below and a commitment to tackling these challenges is a key recommendation to the Integrated Care Partnership:

- Building understanding between sectors and changing culture and behaviours
- Supporting and developing the paid and volunteer workforce
- Involving such a large and diverse number of VCSE organisations in a defined ICS structure and communicating with them
- Finding investment, commissioning and support approaches that will make the most of what local VCSE organisations have to offer and develop longer term relationships
- Stimulating greater VCSE sector engagement and delivery in key system initiatives such as hospital discharge
- Enabling communities of place, condition and interest to shape services
- Building the capacity of VCSE organisations

How the VCSE sector will be embedded in the ICS and the processes and culture necessary to make this happen will be captured in a Memorandum of Understanding to be signed off and adopted by ICS partners.

4.4.4 Carers

The Derbyshire Carers Strategy has recently been refreshed (‘2022 Refresh’). The priorities within the Strategy are:

- Improving carer health and wellbeing
- Information and advice
- Carer employment and financial wellbeing
- Early identification and support
- Young carers
- Services and systems that work for carers
- Involving carers as experts
- Recognising and supporting carer in the wider community

System wide adoption of the priorities and pledges set out within the ‘Carers Strategy Refresh’ will ensure its greatest impact in effectively supporting unpaid family carers. Leads for the key areas of focus and relevant enablers (including workforce) for the Integrated Care Strategy will be expected to commit to the pledges within the Carers Strategy and to develop action/ delivery plans to help to realise the significant benefits to carers to improve their health and wellbeing and to support them effectively in their caring role.

4.4.5 Strengths based approaches

Strength based approaches already feature as a facilitative method for catalysing change and improvements in JUCD services. For example, Derby City Council has implemented a strengths based approach based around 8 principles, with the aim of achieving stability and reducing risk for children and young people, and to encourage the involvement of children and young people and their families in decision-making so that they are more in control of

the support they receive and thereby their everyday lives. And a strengths based approach is a key feature of the Team Up approach, and Derbyshire County Council's "Best Life Derbyshire" strategy for social care.

What is a strengths based approach?
Taking a strengths based approach simply means helping people find their own solutions and to create change through their own strengths and the assets available to them. It works at any level, individual, team or system.

Why is it required?
"The dysfunctions of the traditional management system keep many organizations in perpetual fire-fighting mode, with little time or energy for innovation. This frenzy and chaos also undermines the building of values based management cultures."

(Peter Senge – The Fifth Discipline)

Strengths based approaches build resilience, motivation and self-sufficiency. They have been proven to be significantly more effective than traditional deficit based approaches at creating lasting change and continuous quality improvement. This is especially so in complex adaptive systems such as health and care, or in getting the best out of a highly educated workforce.

At the current time when burnout is high amongst the workforce, approaches that build motivation and resilience are essential. Finding a way through this will require a relentless focus on our strengths, supporting people to find their own solutions and trusting them to make their own decisions.

How can it be applied?
There are many successful models and initiatives that use strengths based approaches. These include coaching, appreciative inquiry, human learning systems, quality conversations, local area coordination, Think Local, Act Personal, the 'What Matters to You' movement, personalisation, human learning systems and Team Up Derbyshire. However deficit based approaches still predominate in health and care.

Champions training for a selection of acute, LA, DCHCS, VCSE staff has been arranged from December 2022, with the aim of embedding strength- based approaches in practice, improving communication / understanding across the system and exploring system risk.

It is proposed that we create, implement, and embed strengths based approaches across Joined up Care Derbyshire working as an integral element of a system-level organisational development strategy.

4.4.6 Population health management

Population health management (PHM) uses data and information to understand what factors are driving the physical and mental health in the population and in communities. Better understanding through better use of data then helps to improve the health and wellbeing of people now and into the future. It seeks to reduce health inequalities and addresses the wider determinants of health through collaborative partnership working.

A Derbyshire-wide systematic approach to PHM is being developed and pilot activity to test the different approaches has been undertaken at a local level in four different parts of

Derbyshire. Learning from these pilots will inform next steps and the approach will be developed through the course of 2023, utilising system intelligence and insights, and the adoption of an analyse, plan, do, review approach to all interventions.

There are strong links between PHM and the Turning the Curve approaches. The next steps of the PHM work will focus on the Turning the Curve actions to improve the overall health of local populations.

Effective PHM requires data, data sharing agreements and digital enablers to facilitate effective outcomes. Significant development work is required across the system, including linking with digital, information governance and analyst colleagues.

4.4.7 Commissioning

Commissioning and funding allocations are key enablers for achieving our strategic aims and the objectives outlined by leaders for the key areas of focus included in this Strategy. This is likely to result in the System facing difficult decisions, given the current financial context and the expected need for increased resources to be targeted at prevention and early intervention activities.

There are currently extensive collaborative commissioning and joint funding arrangements, but we recognise the need to review and refresh these, seeking opportunities to 'consider whether the needs could be more effectively met with pooled budget arrangements under **S75** of the NHS Act 2006.

Colleagues leading the three key areas of focus will be asked to recommend changes in commissioning and funding arrangements that they have assessed are necessary to achieve the aims and objectives agreed for their areas. and more generally in this Strategy, including the need for an increased focus on prevention and early intervention.

It is indicated that there will be more flexibilities within national guidance for collaborative use of resources and we will review the opportunities that they will present to support delivery of the Strategy.

4.4.8 Quality drivers

Key areas of focus will include:

- Collaborative working between system partner patient experience and patient engagement teams to improve connectivity and alignment
- Bringing together system partners to align quality and equality impact assessments (QEIA) to develop care services that meet the needs of our population
- Bringing together health & social care partners to review and implement learning from LeDeR reviews
- Reducing health inequalities for people with learning difficulties by bringing together system partners to increase the use of annual health checks with their local GP service
- In collaboration with system partners, NHS England, and the Kings Fund, we are a pilot system in leading a project to look at experience of care across an ICS

4.4.9 Estate

NHS and local authority services in Derby and Derbyshire are provided in multiple settings and in multiple buildings. These services and buildings need to be fit for purpose in terms of

being safe and appropriate environments for everyone who uses them. This takes a great deal of forward planning to ensure we are providing the right kind of accommodation to meet the evolving requirements of health and care services. By having the right kind of environments we can help to tackle health inequalities, promote a sense of wellbeing from being in well-designed spaces, reduce the carbon footprint involved in constructing, running and maintaining buildings, and ensure we are meeting our targets on sustainability.

The estate is a key enabler in delivery of the long-term plan; helping the System to transform by optimising the use of the estate, which can adapt to changing service models, and promote co-location and multiple occupancy of buildings with patient, people, places and partnerships as key drivers.

The main priorities of the Estates Strategy are:

- Transform places and services - prioritise & maximise the use of the best quality estate, which is modern, agile and fit for purpose to support patient care
- A smaller better, greener public estate - Create an estate which is more efficient, effective and sustainable through optimisation
- Partnership approach - Work with our partners to strengthen collaboration and benefit from multi agency working

4.5 Primary care

Primary care is at the heart of communities (GPs, HVS, GPs, dentists, pharmacists, opticians, community nursing) and acts as a first point of contact for the people accessing the NHS/ gateway to the system.

Every day, more than a million people nationally benefit from the advice and support of primary care professionals, however; there are real signs of genuine and growing discontent with primary care – both from the public who use it and the professionals who work within it. Access to general practice is at an all-time low, despite record numbers of appointments and primary care teams are stretched beyond capacity, with staff morale at a record low. Primary care as we know it may become unsustainable in a relatively short period of time.

<u>A vision for integrating primary care</u>
The Fuller Stocktake (released May 2022) is a new vision for integrating primary care, improving the access, experience and outcomes for communities, which centres around three essential offers:

- Streamlining access to care and advice for people who get ill but only use health services infrequently: providing them with much more choice about how they access care and ensuring care is always available in their community when they need it
- Providing more proactive, personalised care with support from a multidisciplinary team of professionals to people with more complex needs, including, but not limited to, those with multiple long-term conditions
- Helping people to stay well for longer as part of a more ambitious and joined-up approach to prevention.

The key areas of focus and implementation plans for the Integrated Care Strategy will need to encompass the vision summarised above.

4.6 Difficult questions

A desired output for the final Strategy is to have a consensus on the 'difficult questions' that face the System if our strategic aims and service objectives are to be delivered. Some of these potential questions have already been floated in discussions regarding development of the Strategy and have included the following:

- How ambitious can we be on 'pooled funding'? What is the realistic scope of pooling resources from across constituent organisations?
- What do we collectively think joint commissioning could or should achieve?
- How can our financial planning support a shift to prevention?

Work is also underway to review JUCD examples of good integrated care practice to understand the difficult issues or decisions that have been overcome and to draw out key themes that may be helpful for our key areas of focus to learn from.

It is anticipated that supporting leaders and their teams to overcome generic and high impact challenges will need to be an active role for the governance arrangements described in **Section 4.2**, on the basis that the resolution for at least some of these issues will need to be elevated above local decision-making arrangements.

5. Key Areas of Focus

5.1 Introduction

There are three key areas of focus spanning prevention, early intervention and service delivery. Please see **Sections 5.2 to 5.4** for summary information on each.

They are not framed as priorities, as they are not necessarily regarded as being more important than other topics. Instead they have been chosen by senior responsible owners from across the System as ideal areas to test our strategic aims and ambitions for integrated care, in response to population health and care needs. They are:

- **Start Well** - To improve outcomes and reduce inequalities in health, social, emotional, and physical development of children in the early years (0-5) via school readiness

- **Stay Well** - To improve prevention and early intervention of the 3 main clinical causes of ill health and early death in the JUCD population - Circulatory disease, respiratory disease and cancer

- **Age/ Die Well** - To enable older people to live healthy, independent lives at their normal place of residence for as long as possible. Integrated and strength based services will prioritise health and wellbeing, help people in a crisis to remain at home where possible, and maximize a return to independence following escalations

After the Strategy is approved, the focus will immediately shift to delivery, and the work programmes that will be responsible for realising benefits. A set of common requirements

will be produced to guide the work, and this will support the Integrated Place Executive in managing delivery of the Strategy on behalf of the ICP Board. There is of course significant work already underway across the System within the scope of the three areas of focus and this will be built on as part of the process.

Additional programme resource will be required to drive, support and co-ordinate this work, alongside delivery of the development plans for the enabling functions and services.

5.2 Start Well area of focus

Aim

To improve outcomes and reduce inequalities in health, social, emotional, and physical development of children in the early years (0-5) via school readiness.

Rationale for inclusion as a key area of focus

It is important that children and young people can 'Start Well'. This aim links directly to the JUCD ambition to ensure *People have a healthy pregnancy, children are born safe and well into a nurturing and secure relationship with care givers, with good nutrition, access to health care, social care and education. Children thrive develop positive and healthy relationships.* The overall approach will be preventative.

The Children and Young People's Delivery Board will undertake a pathway approach, incorporating prevention and early intervention that ensures connectivity across the system, and supports the Board's vision to *provide a seamless health, education and social care pathway for children and young people in Derby and Derbyshire - one that enables all children and young people to be healthy and resilient and, if support is needed, enables them to plan their care with people who work together, allowing them to achieve the outcomes that are important to them.*

The work will include a focus on the 20% most deprived population. The emerging 'plus' groups for this priority are teenage parents, homeless families, looked after children, children born at a low birthweight (due to factors during pregnancy), and children with special educational needs.

Derby, Derbyshire Child Health Profiles and benchmarking nationally indicates the need for this priority, and we are engaged with Healthwatch to ensure support for this priority from children, young people and their families. And a recent community consultation undertaken by Derby Health Inequalities Partnership exploring perceptions of health and inequalities, highlighted a key theme of respondents wanting to 'break the cycle 'of poor health in their communities with a focus on children and young people's health.

This priority is supported nationally via the requirements in the NHS Long term plan, 'Core 20 PLUS 5 for CYP' to reduce health inequalities and SEND (special educational needs and disabilities) statutory requirements. It is also aligned locally to the ICS strategy (overarching, in development), Health and Wellbeing Boards priorities (City and County), 'Turning the Curve' Priorities, Children and Family Learners Board priorities (Derby), Childrens Partnerships Priorities (County), Safeguarding Partnership, Healthwatch and local insight.

Key issues that will need to be addressed

- Improving staff retention and development is critical to success
- Service commissioning and provision is currently fragmented, and this priority will provide the momentum for better connectivity across the system and more effective and efficient working
- Existing governance is fragmented by organisation. Giving the CYP Delivery board greater authority and responsibility would ensure decision making is reflective of whole system impact and focus on the long-term vision of both JUCD and the Delivery Board
- Importance of setting behaviours in young children and setting foundations for good health
- A seamless pathway approach to support and care with empowerment given to children, young people and their families from an early age will ensure efficiency is achieved, and the effectiveness of service delivery will be improved
- A review of the current workforce position (including the VCSE sector), the need to map future staffing, describe the shift required, and ensure plans are developed to achieve the shift needed
- Digital and data, particularly the sharing of data across the system will be critical to success, with access to timely and sub-system level data to inform planning. Information governance processes are key to enable effective information sharing across agencies
- Maximising the beneficial impact of communication and engagement

Suggested measures for improvement

- School readiness: the % of children achieving a good level of development at the end of reception.

This is published nationally and annually in the Public Health Child Health Profile data that is measured at the end of Reception year. It includes several dimensions and is impacted by a range of sub-indicators: those related to the family (maternal mental health, homelessness, family income and parental education), the child (low birth weight, health status and immunisation rates) and services (quality and availability of funded early education) among many others.

5.3 Stay Well area of focus

Aim

To improve prevention and early intervention of the 3 main clinical causes of ill health and early death in the JUCD population - Circulatory disease, respiratory disease and cancer.

Rationale for inclusion as a key area of focus

To prioritise prevention and collectively contribute to ill-health avoidance and improve outcomes for the local population.

The Population Health Management Steering Group has expressed a clear intention to reduce inequalities in outcomes, experience, and access. For example, identifying groups experiencing inequity of access to preventative services, and using this insight to inform subsequent targeted action to redress this.

Reducing morbidity from the three clinical conditions selected through a prevention approach will reduce and manage the demand on resources required for treatment of later stage disease, thus improving the sustainability of the health and care system.

There will be a focus on modifiable behaviours for both mortality and morbidity, across the range of diseases/ conditions, which contribute the most to mortality/ morbidity respectively.

Mortality:

1. Tobacco
2. High systolic blood pressure
3. Dietary risks

Morbidity:

1. High BMI
2. Tobacco
3. High fasting plasma glucose

Preventing ill health is beneficial for population wellbeing and reduces demand for NHS services and was identified in The Marmot Review as a key objective to reducing health inequalities and its associated social and economic costs. Preventative interventions such as cardiac rehabilitation have been shown to reduce non-elective admissions and early cancer diagnosis leads to increased survival and reduces financial impact, both on healthcare resources but also on an individual's ability to work and support their family.

Local insights identify prevention as a priority, for example:

- *"People welcome the move to focusing on the wider determinants of health but feel that priorities still reflect improvements in services, rather than wealth, education, and prevention."*

Key issues that will need to be addressed

- Existing governance and delivery arrangements are currently organisation centred which can inhibit system collaboration and added value of working across organisations to a single, shared aim. In addition, partners (such as the VCSE sector) and those beyond the local organisational system are key to a prevention approach
- Shift of funding, resources, and people towards a preventative focus, where health outcomes are influenced earlier in both clinical and non-clinical pathways
- Coordinated and joined up communications support for health promotion activities
- Strong productive partnerships across JUCD and broader partners, including education, the police and the criminal justice system, transport services, and local employers
- Workforce - the need for effective processes that enable staff to move between organisations and productively function in an organisation other than their employer
- Digital and IT - Flexible IT infrastructure, with shared access to drives, documents, records and data sets
- Simplify referral routes into services and enable effective self-referral to all services which the patient is motivated to engage with
- Population Health Management is a key enabler to this prevention priority
- Exploring the potential to co-locate services, regardless of the providing organisation

- Engagement with carers is key to understand the barriers they experience, for both their own health and wellbeing, along with those they care for

Suggested measures for improvement

Long term outcomes:

- Contribute to reducing the life expectancy gap between the most and least deprived people in Derby and Derbyshire, given that the three clinical conditions selected contribute the most to the local life expectancy gap.

Short-medium term outcomes:

- Identify and subsequently reduce identified inequalities in access to associated services, experience and outcomes from each service, for each condition.

Progress will be monitored against a set of metrics by demographic profile (a draft set has been produced). It is anticipated this will be agreed by System partners, including identifying those directly aligned to a specific partner (e.g. smoking cessation rates), along with those that some/ all partners can contribute to (e.g. referrals to smoking cessation services).

5.4 Age/ Die Well area of focus

Aim

To enable older people to live healthy, independent lives at their normal place of residence for as long as possible. Integrated and strength based services will prioritise health and wellbeing, help people in a crisis to remain at home where possible, and maximize a return to independence following escalations.

Rationale for inclusion as a key area of focus

A key ambition is a 'left shift' of care so that focus is increased on maintaining functioning and independence. Prevention and proactive identification of patients, combined with risk stratification, and effective care planning provides the best approach to supporting those patients and carers who have the most complex needs; this enables them to take an active part in decisions concerning their health and wellbeing and subsequently reducing the demand for health and social care services. When more critical episodes of care occur it is necessary to have responsive integrated community provision available so that acute admissions happen when it is the best option, not because it is the only option.

A fundamental principle of the proposed programme of work (and the leadership and delivery through place based working) to respond to this priority is a strength based approach in terms of the individual, the teams that are supporting and the communities they are part of.

The main vehicle for improving outcomes in this priority area is building integrated local planning, service responses and support in the community (including statutory services, VCSE, independent care providers, individuals and communities). Whilst the value of more integrated, locally delivered care will benefit many (if not all) groups it is particularly evident for those living with frailty and at the end of life.

The selection of this priority builds on engagement with the population over a number of years which has identified themes in terms of what is important to them, to keep them well, and their expectations from services. Derbyshire people have identified being able to stay in their own home for as long as it is safe to do as the most important thing to help them keep their independence and stay healthy as they get older (Healthwatch Report – 2019).

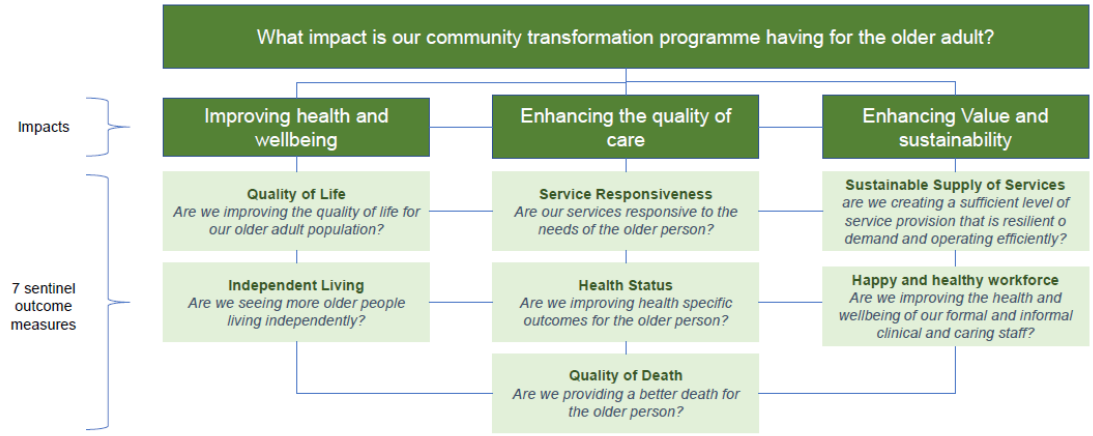
Key issues that will need to be addressed

- Support when navigating health and care – 'no wrong door' - Any point of access to the health and care system should be able to direct the user or carer to the right place
- Joined-up communication – tackle conflicting information, the need to repeat information and inconsistencies, helping staff understand the wider needs of the service user and carer, beyond the condition they are seeking help for
- Working together to reduce the potential tension regarding organisational sovereignty as demonstrated through individual policies, procedures, cultures etc. alongside the need for teams of people to work together with shared processes
- Trust – between groups of staff, and also service users' confidence in staff as advocates. Addressing the impact that existing cultures across organisations and teams have on the ability to make this shift will be an important factor to consider
- Governance mechanisms established through Place and a number of connected programmes of work needs greater ownership, visibility and system backing, if we are to affect the longer term necessary shift to improved population health and slow growth in demand. Our current governance structures don't always effectively support 'distributed responsibility' and working across teams
- The form and pace at which new financial models and mechanisms for collaborative commissioning can be developed and which may need differential allocation. Ensuring commissioning processes are aligned and reward the right things
- Further developments in workforce planning to better meet the needs of the population who are ageing or at the end of their lives
- The ability to access and update a single record to support the care of an individual, and to prevent individuals and their carers having to repeat information to many agencies and staff having to waste time updating multiple systems
- An embedded model for using Population Health Management data to plan and target provision
- The VCSE sector is vital in understanding and meeting the needs of this population
- Co-location of teams that are working together / serving the same cohort
- Ongoing and increasing commitment to ensuring subsidiarity and local determination of delivery

Suggested measures for improvement

It is proposed that 'measurement activities' for this priority are organised under 7 sentinel outcome measures – please see figure below.

There is also a National Integration Index planned to be rolled out in 2023 that will help us understand the level of integration and the impact / benefits experienced by citizens.



6. Engagement

6.1 JUCD approach to engagement

Gathering insight from our diverse population about their experiences of care, their views and suggestions for improvement of services, and their wider needs in order to ensure equality of access, and quality of life is a key component of an effective and high performing Integrated Care System (ICS). These insights, and the diverse thinking of people and communities will be essential to enabling JUCD to tackle health inequalities and the other challenges faced by our health and care system.

As a result, JUCD has developed a strategic approach to engagement, which includes key principles and frameworks that will underpin our ways of working. It sets out how we will listen consistently to, and collectively act on, the experience and aspirations of local people and communities within JUCD. This includes supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services.

Our Ambition is:

- To embed our work with people and communities at the heart of planning, priority setting and decision-making to drive system transformation work, ensuring the voices of patients, service users, communities and staff are sought out, listened to, and utilised resulting in better health and care outcomes for our population
- To recognise that relationship building is important to increase trust and improve involvement and needs to be considered on a planned, systematic, and continuous basis, with the required investment of time
- To ensure continuous engagement that reflects this new relationship with the public, capitalises on those emotional connections and brings people and communities into the discussion rather than talks to them about the decision

In order to ensure a systematic approach, our engagement with people and communities is supported by several frameworks. These frameworks are in different stages of development and co-production with system partners, including people and communities, and are outlined below:

Governance Framework -
This examines the structures that provide the interface between people and communities at all levels of the ICS, allowing insight to feed into the system, to influence decision making. This is also about making sure appropriate assurance frameworks are in place for ensuring we implement the principles outlined in our Engagement Strategy across the system. It includes our Patient and Public Partner Programme, our Guide to Patient and Public Involvement in the ICS, and the development of our Public Partnership Committee.

Engagement Framework – This includes the methods and tools available to all our system partners to support 'continuous conversations' with people and communities in transformational work to improve health and care services. This includes our Citizens' Panel, Online Engagement Platform, PPG network, Readers Panel, Public and Patient Insight Library and Derbyshire Dialogue. The model we use for our Patient and Public Insight Library, has been promoted by NHS England as good practice, and a template has been created to allow other systems to duplicate it.

Co-production Framework - This is our work to embed, support and champion co-production in the culture, behaviour, and relationships of the ICS, including senior leadership level. Drawing together good practice from around the system we plan to co-produce a co-production framework and are in the process of setting up a task group, which will include patient and public partners.

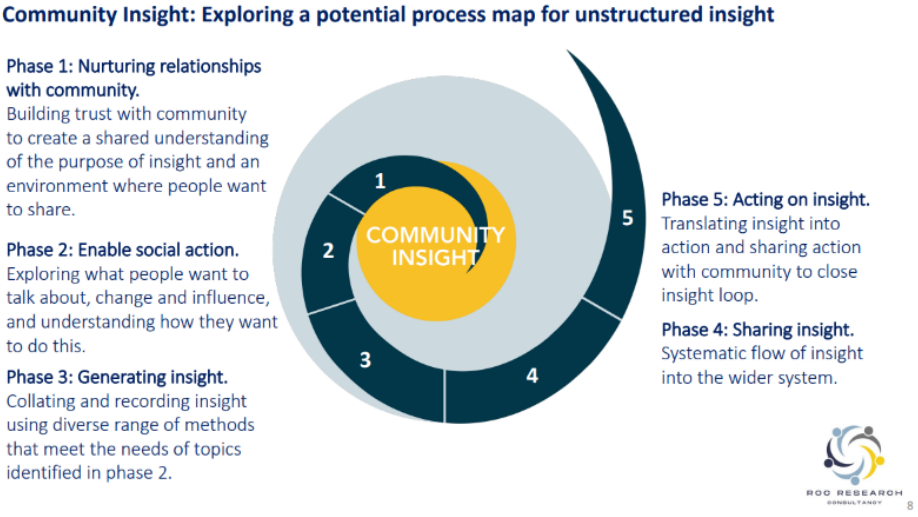
Evaluation Framework – This is being created to allow us to reflect on and examine our public involvement practice and the impact this has both on our work, but on our people and communities. The Evaluation Framework will outline how we will measure and appraise our range of methods, and how this will support ongoing continuous improvement.

Insight Framework - The Insight Framework is the most exciting development so far and looks at how we identify and make better use of insight that is already available in local communities to inform the work of the ICS.

Many communities already have established mechanisms of finding out what's important to people, with regards to their wants, needs and aspirations. We will be seeking to harness and examine that insight and present it in a way that will enable the ICS to listen to and take action, to truly put the voice of people and communities at the heart of decision making.

This approach is about authentic collaboration with communities without a pre-set agenda and will require that we are brave and believe that people know what they need to be well and happy. It will also require us to align our governance structures to support community led action.

A key part of the Insight Framework is our process map outline which outlines 5 phases, please **see figure below**. We plan to co-produce what good looks like in all 5 phases of our model, and then build on strengths-based approaches that are already out there in communities to support them to overcome the barriers that we know they currently encounter. This work will be centred around Place and support the ambition to be a social model that is outcome driven and strength based; focussing on the assets of individuals and communities and developed with them through local leadership.



6.2 Approach undertaken to support the development of the Integrated Care Strategy

An ‘Engagement Workstream for the ICS Strategy’ was created in July last year with representation from health, local authorities, Healthwatch and the VCSE Alliance. This workstream has overseen the development of an 'Insights Document' that has pulled together insight that has been gathered throughout the system over the past 12 months into one place and which highlights high-level themes under the following headings - Integration, Health Inequalities, Quality/Improvement, Strengths Based/ Personalised Care and Health Protection, and Understanding Public Behaviours, Choices, and Attitudes. This was made possible due to the existence of our Patient and Public Insight Library.

This Insight Document has been considered by SROs and teams as part of the evidence base for the selection of key areas of focus for this Strategy under the headings - Start Well, Stay Well and Age Well.

Subject to the agreement of this Draft Strategy the next steps are summarised as follows:

- Present and discuss the Draft Strategy and communicate the selection of the three key areas of focus with the wider public via the Derbyshire Dialogue Forum (15 February 2023), and with local organisations and forums through a series of presentations February – March.
- Co-produce I/ we statements to help communicate the ambitions of the Strategy and the key areas of focus.
- For the three key areas of focus – Hold an initial Derbyshire Dialogue on 15 February to outline the purpose and content of the strategy, and then initiate a process of continuous engagement including the following steps:

    - Hold online engagement events for each of the 3 areas allowing leads to present information in an accessible way and invite comments about what actions are needed to achieve the ambitions set out and capture these to inform plans.
    - Support these conversations through our Online Engagement Platform, with opportunities to continue to ask questions and make suggestions.
    - Create surveys for each area to gather feedback from a wider cohort of people targeted as required.
    - Facilitate and support conversations between programme leads and local community groups who express interest in the key areas of focus, helping to ensure we do not just rely solely on people having digital access, using existing groups and forums where possible, with support from the VCSE sector.
    - Ensure feedback/ insight from these conversations is listened to, considered, and actioned through the implementation plans for the three key areas of focus.

7. Evaluation

7.1 Introduction

Once the ICP has approved and published the Integrated Care Strategy a process for overseeing delivery progress will be required. This could include, if appropriate, identifying, and evaluating the impact that the Strategy has had on commissioning and delivery decisions from multiple perspectives, including providers, citizens, communities, and those engaged in the production of the strategy.

7.2 Measures

In **Section 3** population health and inequalities indicators are referenced. These measures will need to be considered as part of the evaluation process, alongside other measures specific to the key areas of focus, some of which are referenced in **Sections 4 and 5**.

It is noted that there is national work underway by the CQC and by the King's Fund to develop qualitative and quantitative integration measures, through an "Integration Index". JUCD is a pilot site for this work, and this should support evaluation efforts. We will draw on outputs from this work as they emerge and use these to engage local stakeholders.

7.3 Evaluation and impact

It is proposed that evaluation can be considered at two levels:

Evaluation of the Strategy: including a high level consideration of progress against the strategic aims, and an assessment of how successfully other intentions included in the Strategy have progressed, including ambitions for organisational development at a system level and a focus on behaviours and culture to ensure that the Strategy is built on sustainable cultural foundations.

Evaluation of the key areas of focus and key enabling functions: SRO led work on evaluation methodology and measures, to track implementation against objectives.

7.4 Evaluation support

The ICP/ IPE will need to consider whether external input into evaluation would provide additional benefits to those gained via local evaluation routes for evaluation of the Strategy. Options are being explored through fact-finding contacts with The King's Fund, the Social Care Institute for Excellence, and the "Leading Integration Peer Support Programme" run jointly by the NHS Confederation, the Local Government Association and NHS Providers.

The SROs for the three key areas of focus will need to assess existing and potential options for external support. This should include the involvement of Healthwatch and align with the engagement approach and particularly the work on citizen Insights.

Appendix 1 – How our health strategies and the Joint Forward Plan link together