Appendix 1

Derby and Derbyshire Integrated Care Board (DDICB)
Engaging with people and communities in commissioning: Assurance Summary 2025/26

1. Ambition and approach: involving people and communities in commissioning

The ICB has a legal duty to involve people who use NHS services, and their carers/representatives, in commissioning decisions - especially where decisions affect how services are planned and delivered. These duties are set out in the National Health Service Act 2006 (as amended by the Health and Care Act 2022).

We use NHS England's statutory guidance on working in partnership with people and communities to inform our approach and assure our practice.

Beyond statutory requirements, we know that commissioning decisions are stronger when they are shaped by lived experience. Our ambition is to ensure that insight from patients, carers, communities and staff meaningfully influences priorities, service specifications, options appraisal, quality improvement and evaluation. How we do this:

- Embed people and communities in commissioning: proactively seek out and use diverse insight to shape priorities, service models and quality improvement - so decisions are better and outcomes improve.
- Build trust through planned, ongoing engagement: invest time and resource in authentic relationships (not one-off consultations), and improve how we feedback what changed as a result.
- Share power and reduce inequalities: involve communities early, remove barriers to participation, and support community-led approaches so that those most affected by decisions can influence them.

Listening well matters because it helps us commission services that work for real lives. We gather feedback from across Derby and Derbyshire about people's experiences of care, what they think needs to change, and the wider things that affect health and wellbeing. Doing this consistently and reaching people who are often missed helps us improve access, tackle health inequalities, and make better use of public money.

In 2025/26 we continued to focus on building relationships, connections and trust rather than only doing one-off engagement. We've supported people to have more say in what matters to them, while also making sure their insight helps shape plans, priorities and day-to-day improvements in services.

To be effective, engagement must go beyond 'transactional' activity where professionals run engagement and communities are asked to react. We focus on partnership, where people help shape the agenda, options and decisions supporting stronger commissioning and more sustainable change.

Our engagement culture aims to create more equal and honest relationships with people and communities, so they feel respected and able to influence decisions. This widens the conversation from individual experiences of services to what matters in everyday life and what would improve outcomes. We continue to use our locally developed Insight Framework and 'development and support tool (co-produced with stakeholders in 2023/24) to plan, deliver and reflect on engagement activity.

There are five areas of the tool, and within each of the five areas, there are three levels. Users of the tool are invited to consider each of the five areas, and reflect on their starting point, to build good practice in all interactions with local communities.

Understanding power	Achieve meaningful relationships with the community.
	Build trust.
	Develop and share the importance of an accurate and deep understanding of community experiences, needs, ideas and ambitions.
Enable social action	So that change can be led by the community.
	To explore what people want to talk about, change and influence.
	To understand how people want to do this.
Building a picture of community experiences, needs, ideas and ambitions	So that accurate and deep community led insights can be understood and shared.
Connecting community and JUCD	So that community led insights can shape solutions and services.
Making a difference together	To address health inequalities.
	To improve services and health outcomes.
	By translating community-led insight into action.

2. Evidence: examples of insight influencing commissioning and service improvement

2.1 Barrow Hill Community Memorial Hall Health Hub

What this was about: Barrow Hill (near Chesterfield) is an ex-mining village with high levels of deprivation and long-standing inequality in access to services. Partners are supporting the Community Trust to develop a Health Hub in the Memorial Hall (phase 1 is due to open in spring).

Who we spoke to: the Barrow Hill Community Trust, local residents, and health and social care partners working together through the Integrated Neighbourhood Team.

How we listened: we used local interviews and ‘deep dive’ conversations and kept the conversation going through fortnightly neighbourhood working so plans stayed led by local insight.

What people told us: people want services that are easy to access, in a space that feels welcoming and non-judgemental. They value informal connection and support, want the Hub to stay community-led, and want a mix of private consultation rooms and open community space.

What we changed: the Hub plans are being shaped around what local people said mattered right down to the balance of spaces and the ‘feel’ of how services show up (for example, trauma-informed and health-literacy aware). Partners are also planning events so residents can explore the building and meet providers early, not after decisions are made.

How this influenced commissioning: the insight is helping shape decisions about the mix of clinical and community space, what we expect from providers using the Hub, and how we align capacity at the community service interface so neighbourhood working stays community-led and sustainable.

How we know: documented themes from interviews and deep dives, regular neighbourhood meetings, and agreed engagement principles for the Hub with local partners.

What’s next: we will continue work with partners, keep neighbourhood working going, and be clear in capturing the specific decisions made as a direct result of what we heard.

2.2 Community Health Alliance: sickle cell newborn screening incident response and co-production

What this was about: after an NHS England Midlands review, we learned that some families may not have been told about carrier status following newborn bloodspot screening. This was linked to the loss of a specialist role and unclear responsibility for communication. Even when the clinical issue was addressed, the impact on trust was significant, and it needed both immediate response and longer-term improvement work.

Who we spoke to: parents/carers and affected communities (including Black African and Caribbean communities), community leaders, and NHS partners including University Hospitals of Derby and Burton (UHDB) and system communications/engagement colleagues.

How we listened: community events in Derby city and Chesterfield (originally set up to explain the new service) became honest listening sessions. We then stayed with the work running further sessions over around 10 months and held co-production sessions with community leaders to agree aims, principles and governance.

What people told us: there was real frustration about not being involved and not being communicated with clearly. People wanted to help shape the new advice and guidance service, wanted improvements to sickle cell services more broadly, and wanted a long-term way to influence and co-produce services with the NHS (not just a one-off conversation).

What we changed: we set up an ongoing programme of engagement and co-production, including the Community Health Alliance (community leaders, members of the public and the NHS) and support to establish a sickle cell patient group. We also shared themes and recommendations with the Trust, and improvements are being taken forward.

How this influenced commissioning: this work created clearer routes for community insight to influence how the service is communicated and experienced and put governance in place so lived experience can continue to shape provider and commissioning decisions over time.

How we know: a themes and recommendations report, an online video explaining the service and safeguards, co-produced aims, principles and governance for the Alliance, and the establishment of a patient group.

What's next: we will support further community-led engagement to agree priorities for the Alliance, with clear routes into commissioning and provider governance, and we will track actions and report back on progress.

More information about the Community Health Alliance can be found on our Involvement Platform.

Information about the sickle cell newborn screening incident can be found on our website including full reports regarding the activities, process and outcomes to date.

2.3 Local Navigation Hubs: using patient and carer stories to evidence value and improve pathways

What this was about: Home Visiting Teams help people to live well at home for longer. Teams told us that it can be hard to explain (and evidence) the value of integrated working in a way that lands in system decision-making.

Who we spoke to: teams in South Derbyshire and High Peak, patients and carers (through quotes and stories), and system partners in the forums where decisions and priorities are discussed.

How we listened: we created safe spaces for structured storytelling, using reflection and learning approaches (Gibbs' Reflective Model and Kolb's Experiential Learning Cycle) and public narrative principles to help teams draw out what changed for people and what could be measured.

What people told us: there was a real appetite for clearer, more human evidence of what integrated neighbourhood working achieves for patients, carers and system capacity, alongside the 'hard' data.

What we changed: teams reworked their stories, so they clearly showed value, backed up with patient and carer quotes. We then took those stories into system spaces, for example, steering groups, neighbourhood teams and Quest sessions, which helped partners spot pathway gaps and improvement opportunities.

How this influenced commissioning: the stories have been used in decision-making spaces to highlight pathway gaps, for example, getting information to carers earlier, to prompt service improvement actions, and to strengthen the case for sustaining local integrated care models.

How we know: written stories that include patient/carer quotes, use of stories in system forums, and the improvement actions identified from them, including earlier information for carers and families.

What's next: we will run a county-wide learning event to share the storytelling approach and make it easier to capture value and track improvement actions in a consistent way.

2.4 Community partnership to address maternity and neonatal health inequalities

What this was about: maternity and neonatal outcomes are not experienced equally across Derby and Derbyshire. Evidence shows poorer outcomes and more negative care experiences for women and babies from Black, Asian and Mixed ethnic backgrounds, and for those living in the most deprived communities. Existing feedback routes have not consistently captured these experiences or enabled them to shape decisions.

Who we spoke to: women from Black, Asian and Mixed ethnic communities and women living in the most deprived areas, alongside partners including Derby Health Inequalities Partnership, Derby City Council and Family Hubs, UHDB, Voluntary, Community and Social Enterprise (VCSE) organisations, community leaders and connectors, and Derbyshire Maternity and Neonatal Voices (DMNV).

How we listened: engagement was community-led and took place in trusted, familiar spaces, using flexible approaches shaped by each community. Community leads were offered training and ethical guidance, with support in place for sensitive conversations and appropriate signposting when needed. This enabled honest discussion and reduced barriers to participation.

What people told us: women shared what mattered most to them across pregnancy, birth and postnatal care, including barriers to accessing services and information, communication needs (language, culture and trust), and experiences of Family Hubs, antenatal settings and maternity spaces. As a partnership we understood that engagement needs to be long term and trusted, and visibly influence decisions, not sit alongside them.

What we changed: we supported the development of a Maternity and Neonatal Health Inequalities Forum – a co-produced partnership bringing communities, commissioners, providers and local authorities together as equal partners. Community insight from this engagement will directly inform the Forum's purpose, priorities and emerging work programme.

How this influenced commissioning: the Forum provides a clear, formal route for lived experience of inequality to inform commissioning, service development and improvement work, aligned with system and national priorities. It strengthens accountability by ensuring communities most affected by inequality are supported to be meaningfully involved and that insight shapes decisions, rather than being only advisory. Commissioners and providers are jointly responsible for responding to what is heard.

How we know: impact is evidenced through community-led engagement activity, the design and function of the Forum, and early learning about what supports effectiveness – including consistent relationships, clarity about what can be influenced, shared ownership, and visible action with feedback to communities.

What's next: we will agree measures for reach, involvement and representativeness, track actions through the Forum and governance structures, and ensure communities can see clear progress and the changes being made as a result of their involvement.

Supporting information for the engagement can be found on our website including the full case for change information and Insight Report.

2.5 Women's Health Hub engagement: turning women's voices into system change

What this was about: we wanted women's voices to shape improvements to women's health services across Derby and Derbyshire.

Who we spoke to: women across Derby and Derbyshire, supported by a Patient and Public Partner who helped co-design the work from the outset. We spoke to around 1700 women, 744 from a local survey and just under 1000 from community engagement events from 39 community groups who ran workshops. The final report was developed into an action plan by the Inclusivity Group, spanning commissioning, public health, patient and public partners, and primary care.

How we listened: a mix of survey and community-led workshops in trusted settings. We funded, trained and supported community groups to lead sessions so we could reduce barriers and reach a wide range of women (including South Asian, Black, Eastern European and refugee communities, LGBTQ+ women, disabled and neurodivergent women, younger women, and women experiencing deprivation).

How we know (reach): we reached 1,730+ women in total (744 survey responses and 986 women taking part in community-led workshops).

What people told us: key themes included access to services, experiences of care, health literacy, barriers to screening and vaccination, and culturally specific needs. A strong message was the importance of primary care reflecting how often women's experiences start (and sometimes stall) in GP and community services.

What we changed: we held feedback events so women and community groups could see what we heard, and we reflected on the findings with community leads and the Patient and Public Partner. The Inclusivity Group then co-produced an action plan and practical outputs to support implementation and improvement.

A Patient Representative who was involved throughout the project said: "This was some of the best community engagement I've ever seen. It wasn't superficial or extractive, it was rooted in connection, respect, listening, and action. The richness and diversity of voices ensured the findings were grounded in truth, rather than assumption. The contributions of lived experience and community partners had a direct and visible impact on project outcomes. My hope is that this project sets the standard for how engagement should be done – with integrity, humility, and a deep commitment to inclusion."

How this influenced commissioning: the insight shaped the overall development approach for Women's Health improvements across the system, such as staff training, and also turned into practical commissioning outputs to support implementation, including a Primary Care Focus Report, a Primary Care Inclusivity Checklist, and an Inclusivity Resource Pack. Work is also underway on a "Talking Heads" video, which will share the experiences of women as a training tool for professionals based on what women have told us.

How we reported back: we used community feedback events and an impact report to show how women's contributions influenced and shaped decisions, actions and changes. One participant said: "For the first time, it feels like what we're saying might actually change something. Not just for me, but for other women too."

What's next: we will keep supporting implementation using the co-produced outputs, track delivery of the action plan and keep the feedback loop going so women can see what is changing.

You can read all about the engagement and view the reports on our website.

2.6 Carers Insight

Case study: Building a carers insight framework to support system working

At a glance: The ICB brought together national and local evidence and lived experience to create a shared, system-wide picture of what unpaid carers need now, and to provide a consistent evidence base to inform commissioning, service improvement and integrated care planning.

The challenge: Unpaid carers are essential to the sustainability of health and social care, yet many carers remain under-identified, struggle to navigate fragmented pathways, and experience avoidable inequalities (including employment and financial strain, poorer mental and physical health, and barriers linked to language and culture). Locally, evidence also showed inconsistent carer recognition and variable access to carer assessments and support.

Why the ICB did the work:

- To treat caring as a key driver of population health and health inequalities, and to ensure carers are visible within local population health management approaches.
- To create a single, trusted evidence base that could be used consistently across NHS, local authority and VCSE partners.
- To respond to clear signals from carers and local insight that recognition, communication, respite/planning and navigation of systems remained persistent issues (and, in some areas, were worsening).
- To support delivery of statutory duties and good practice expectations (including proactively identifying carers, involving carers in decisions, and enabling access to assessment and support).

What the ICB did:

- Used the 2019 *What Carers Want* summary as a practical framework and "sense-check" against more recent evidence and lived experience.
- Triangulated national research, local population data and local lived-experience insight (listening events, consultations and survey findings) to identify what has stayed the same and what has changed.
- Brought through specific "pressure points" where system processes directly affect carers (for example, early identification, access to information, care planning and discharge, assessment pathways, and contingency planning).
- Made the insight usable for decision-making by grouping it into clear themes and highlighting implications for commissioning and service improvement.

Why this was important: The work strengthened the case for early, proactive support for carers as both a health inequalities issue and a system sustainability issue. Nationally, carers are providing care worth around £184 billion per year, equivalent to the scale of a second NHS, while many experience worsening health and reduced ability to stay in work. Locally, the insight showed that carers can be positive about the care their loved one receives but still miss out on carer identification and support, particularly those providing higher hours of care.

What it highlighted: Core needs have remained consistent since 2019 (recognition, involvement, clear information and support to navigate the system), but the context has become more urgent due to economic pressures and rising care intensity.

- Carer identification is a recurring system weakness – many people do not use the word "carer", and this can be a barrier to accessing help.
- Carers' mental health and wellbeing need to be treated as a core offer, not an add-on, especially for carers providing higher hours of care.
- Employment and finances are major drivers of inequality for carers, with clear links to stress, reduced income and future insecurity.
- Carers from ethnic minority communities can face additional barriers (including language, mistrust and cultural expectations), reinforcing the need for culturally competent approaches and community-based engagement.
- Carers experience the system most sharply at transition points (diagnosis, hospital discharge, crisis, and moving from children's to adult services), where consistent communication and contingency planning are essential.

How the insight is intended to be used (decision-making):

- To underpin the new System Carers Strategy.
- To prioritise system actions that improve early identification (including language and prompts that reflect how people describe caring).
- To inform commissioning and service development (for example, access routes, respite and breaks, peer support, culturally appropriate offers, and improved signposting).

- To strengthen integrated working expectations (information sharing, “no wrong door” approaches, and consistent practice across organisations).
- To provide a baseline for tracking change over time (including future surveys and insight refreshes) and to support ‘You said, we did’ feedback loops with carers.

In addition to the evidence presented above to demonstrate how insight has influenced commissioning and service improvement, we also have further insight that can be viewed on our Insight Library.

The Patient and Public Insight Library is a hub for collating and storing reports from across the Derbyshire health, care, statutory and voluntary organisations, as well as some national reports, which provide invaluable patient and public insight. The library is open to a wide variety of professionals from across the system who access these reports and use the insight to help shape services to the needs of the people of Derby and Derbyshire.

New reports are being uploaded to the library on a regular basis. We feature regular updates about the content on the library in our JUCD Newsletter, which is published monthly and is sent directly to 4000+ subscribers, including members of the public and stakeholder organisations across Derby and Derbyshire.

Our template for the library has been adopted and used by Integrated Care Boards (ICBs) across England.

The library is held on the Futures NHS Platform, so if you are already a member you can access the library.

3. Governance and assurance routes

The ICB’s commitment to embed the voice of people and communities in commissioning and service change is reflected in our governance. These structures provide routes for engagement insight to be considered alongside clinical, quality, finance and equality information when options are developed and decisions are made.

Below are the structures and processes that support working with people and communities, including the responsible leads, and how working with people and communities happens at different layers across the Derby and Derbyshire system. Progress on the delivery of the Working with People and Communities strategy is formally reported to the ICB Board through the Joint Strategic Commissioning Committee (JSCC). Prior to the establishment of the ICB cluster, progress was reported to the NHS Derby and Derbyshire Strategic Commissioning Committee.

1 April 2025 to 30 September 2025

Role	Responsibility
ICB Board	The ICB Board has overall accountability for public involvement and engagement, including the Working with People and Communities Strategy. They also have responsibility for ensuring that the views of the public are appropriately considered in decision making.
Strategic Commissioning Committee	The Strategic Commissioning Committee is responsible for assuring the ICB Board in regard to its statutory duties for patient and public involvement. This is explicit within its Terms of Reference.
Chief People Officer	The Chief People Officer has executive responsibility for sponsoring the ongoing development and implementation of the Working with People and Communities Strategy. They also oversee the teams that support the organisation in its duties and ambitions to work with and hear from people and communities.

1 October 2025 to 31 March 2026
Governance arrangements and board sub-committees were adjusted in year to reflect the move towards cluster working for NHS Derby and Derbyshire ICB, alongside NHS Lincolnshire ICB and NHS Nottingham and Nottinghamshire ICB.

Role	Responsibility
ICB Board	The ICB Board has overall accountability for public involvement and engagement, including the Working with People and Communities Strategy. They also have responsibility for ensuring that the views of the public are appropriately considered in decision making.
Joint Strategic Commissioning Committee	The Joint Strategic Commissioning Committee is responsible for assuring the ICB Board in regard to its statutory duties for patient and public involvement.
Executive Director of Strategy and Citizen Experience	The Executive Directors of Strategy and Citizen Experience, and Quality (Nursing) have joint responsibility for sponsoring the ongoing development and implementation of the Working with People and Communities Strategy. They also oversee the teams that supports the organisation in its duties and ambitions to work with and hear from people and communities.
Executive Director of Quality (Nursing)	

Throughout this period of transition, the Working With People and Communities Strategy continued to be governed and applied through use of established frameworks, which ensured appropriate levels of patient and public involvement in commissioning activity. These frameworks are:

Governance Framework
Engagement Framework
Insight Framework
Co-Production Framework
Evaluation Framework

Patient and Public Involvement Assessment Process

During 2025, 49 potential service changes were assessed through our involvement assessment process. This helps determine the likely impact on patients and the public, the level and type of involvement required, and the appropriate assurance route (including where formal consultation may be needed).

All assessments are logged and shared with local Health Overview and Scrutiny Committees (HOSCs), who can ask questions or request further information about changes of interest or concern.

Our suite of guidance

We have been developing this guidance for a number of years. This comprehensive set of guidance is available to all our commissioner and provider colleagues working within JUCD to help people to navigate the common legal and policy issues from the very start of a service change programme through to the final decision-making. Links through to all our guidance can be found below and outline the systematic way in which we ensure patient and public involvement is factored into all decisions that might have an impact. This year we have added NHSE Assurance Guidance, Clinical Senate Guidance, and Notifying and Requesting a Call-In by the Secretary of State Guidance to highlight the new requirement to notify the Secretary of State of significant changes to health services.

- Guide to working with people and communities / Engagement Model
- PPI Guidance
- PPI Form
- HOSC Guidance
- Case for Change Guidance

- Inform Guidance
- Primary Care PPI Guidance
- Temporary Service Change Guidance
- Notifying and Requesting a Call-In by the of Secretary State
- NHSE Assurance Guidance
- Clinical Senate Guidance

3.1 Evidence: example of implementing our guidance

Case study: demonstrating how the ICB has engaged and listened on same day urgent care in Derbyshire

Case study aim: to show how NHS Derby and Derbyshire Integrated Care Board (DDICB) has engaged and listened to people and partners during the early discovery phase of the Community Same Day Urgent Care (CSDUC) programme, and how what was heard is shaping the programme's direction.

Context: the CSDUC programme sits within a wider urgent and same-day care review across Derby and Derbyshire, focused on how urgent treatment centres, primary care, out-of-hours services, community urgent response and navigation pathways work together and how they are experienced by patients. The programme has been designed as a phased, longer-term piece of work, with early phases focused on listening, understanding local context, reviewing data and building shared understanding before any formal proposals are developed.

What we did to engage and listen: we used a mix of public-facing and partner engagement to test the emerging case for change, understand what matters to people, and surface access and inclusion issues.

- **Publishing the CSDUC Case for Change** and a public-facing summary to provide a clear narrative and accessible information to support early dialogue.
- **Holding an online Public Information Session (May 2025)** positioned explicitly as an early information-sharing and listening event.
- **Ongoing system and stakeholder engagement** through existing structures with primary care, community, acute and voluntary sector partners.
- **Early place and neighbourhood-level discovery conversations** in South Derbyshire, North East Derbyshire and Bolsover, and Amber Valley to explore local context, feasibility, workforce and estates considerations, and the shape of future engagement.

Who we heard from: the May 2025 Public Information Session was attended by around 70 people, including members of the public, healthcare professionals and community representatives from across Derby and Derbyshire, with the highest representation from Amber Valley, South Derbyshire and Derby city, and contributions from rural and border areas. In parallel, programme teams have engaged through existing system structures with primary care, community, acute and voluntary sector partners, and through Primary Care Network (PCN), Neighbourhood Alliance and Place-level conversations in priority areas.

What people told us (what we heard): across engagement to date, people consistently highlighted:

- **Confusion about where to go** for urgent care and concerns about being directed to the wrong service.
- **Access and waiting times** including difficulty accessing GP appointments, limited weekend/out-of-hours options, and long waits in some urgent care settings.
- **Transport and travel barriers** including poor public transport, parking issues and long journeys, particularly affecting older people, disabled residents and those in rural/border areas.
- **Digital exclusion and communication needs** including barriers for people who are digitally excluded, deaf or hard of hearing, or who face language barriers, and a need for clearer public information.

- **Workforce and capacity concerns** about staffing levels and whether services can meet rising demand.
- **Service integration and navigation** including clearer referral pathways, better coordination between services (including VCSE support) and clarity on what different parts of the system provide.
- **Equity and inclusion** including concern that pockets of deprivation, people with complex needs and communities near county borders risk being overlooked.

Equality, access and inclusion: engagement has reinforced that future work must actively consider digital exclusion, transport barriers and the needs of people whose voices are often under-represented, including people with disabilities, mental health needs, learning disabilities, carers and those facing language barriers. This will shape the design of future engagement plans, including the use of face-to-face approaches where appropriate and close working with VCSE partners and local participation groups.

Current position and next steps: the programme remains in early engagement and discovery – no formal service change proposals are currently being engaged on.

You can view the case for change on our website.

4. Involvement infrastructure

The ICB has a range of methods and tools to support the involvement of people and communities in work to improve, change and transform the delivery of our health and care provision. These include:

- **Patient and Public Partners (PPPs)** – our JUCD webpage details how patients and public partners can get involved and includes a full suite of guidance, co-produced with current patient and public partners within the ICB, via the Peer Support Network for patient and public partner recruitment.

  In addition, we have developed a range of learning and development resources to support both PPPs and the staff who work with them. For PPPs, these resources aim to build confidence, understanding, and practical skills to support them in their role. For staff, they are designed to support meaningful partnership working and good practice in involving people and communities throughout programmes and service change.

- **JUCD Involvement** – our online engagement platform, designed to facilitate two-way dialogue with residents, and support participation and updates.

- **Readers' Panel** – volunteers made up of members of the public and healthcare professionals have been instrumental in ensuring the information we share with the public, on projects such as Winter Vaccines and Specialist Advice, is easy to read and understand, and contains all the information patients may need.

- **Patient Participation Group network** – this was created to represent the patient population of General Practices in Derby and Derbyshire. The PPG Network meets bi-monthly. You can find out more about PPGs by visiting the JUCD website or by contacting your practice.

  In addition, we have created an online shared space for members of the Derbyshire PPG Network. This space will host agendas, resources and updates from network meetings, as well as a discussion board where members can connect, share learning, and suggest ideas for future sessions. It also includes templates and resources developed or shared by PPG members and the ICB Engagement Team, supporting ongoing learning, collaboration and consistency across PPGs.

- **Derbyshire Dialogue** – a conversation between the residents of Derby and Derbyshire, and those commissioning and providing services. Derbyshire Dialogue is delivered by senior clinicians, or officers in their field, and allows participants to ask questions during the session. Recent subjects have been diverse and have included Improving Women's Health and Building a Carer-Friendly Derby and Derbyshire, and are recorded and uploaded to our Engagement Platform and to our YouTube channel.

- **Mental Health Together** – 35 volunteer Experts by Experience who bring insights from lived experience of mental health services. The group provides ongoing input into service improvement and has supported system work, including reviewing and challenging service design proposals where lived experience indicates potential unintended impacts. Experts sit in Derbyshire ICB mental health governance groups where they provide the vital patient lens and educate the professionals about minority community concerns. Over this past year, Mental Health Together has grown significantly in numbers of Experts and has collaborated with several professional leads across the system. Amongst their achievements have been:
    - Coproduced with Consultant Psychiatrists a new out-patient leaflet which is supported by the Department of Psychiatry at Oxford University. The aim of this is to empower much more open, honest and effective conversations between patient and psychiatrist.
    - Codesigned the Suicide Prevention Framework for Derbyshire 2026–30.
    - Helped shape an urgent and emergency mental health review carried out by NHSE Improvement team.
    - Coproduced the mandatory risk assessment staff training for Derbyshire Healthcare Foundation Trust.
    - Produced a 'Pearls of Wisdom' brochure, highlighting the value of the voice of lived experience for World Mental Health Day.

  Read a review of Mental Health Together's last 12 months.

Case study: Experts by Experience in Action – NHS 111 (mental health option)

Background: NHS 111 includes a mental health route ("option 2"), available 24/7 for all ages. People can use it for urgent mental health concerns for themselves or someone they know. Calls are transferred to a dedicated member of a local mental health team.

Challenge / issue raised: Mental Health Together (MHT) Experts by Experience raised two issues via the Urgent Mental Health Care Delivery Group, which were agreed for escalation to the NHSE Midlands 111 option 2 Forum.

Insight from lived experience (parity and access): Experts by Experience highlighted that the recorded message ("…if your call is about your physical health press 1, if you are in mental health crisis press 2…") can be interpreted as discouraging people who need mental health information or advice but do not identify as being "in crisis" (for example, self-care advice, support for carers, or condition-related information). This creates a perceived lack of parity between access to mental health advice and physical health advice and may lead people to misrepresent their needs in order to reach support.

Why it matters: access to timely health information and improved health literacy can help people manage their health, support self-care, and potentially prevent deterioration. A message that appears to restrict access to broader mental health advice may represent an inequality and a missed opportunity for early support and crisis avoidance. The current wording is likely to be experienced as an additional barrier by many people especially people who are autistic and people from minority backgrounds where there is still a very strong stigma attached to mental health.

Proposed change: replace the wording with "…if your call is about your physical health press 1, if your call is about your mental health press 2…", so people can access mental health information and support as well as crisis response – without the message being interpreted as filtering out non-crisis mental health calls.

Implementation considerations (process design): any change to the recorded message would require review of the end-to-end call handling process flow. Prior to launch, the NHSE Midlands 111 option 2 Forum completed extensive process design for regional call handling and transfer to local call centres; this would need to be revisited.

Implementation considerations (demand and variation): a broader message could change call volumes and the mix of call types. ICBs vary in how they respond to callers seeking information who are not in a self-defined crisis. The NHSE Midlands 111 option 2 Forum is running a snapshot survey of these variations and estimated call rates. However, the Forum also noted national intent to implement Natural Language Processing for call handling, which may have similar implications regardless of interim wording changes.

Additional insight (call waiting music)

Experts by Experience reported that some call waiting music can be stressful for callers with a propensity to hear voices, where sounds may be interpreted as human voices (sometimes discussed as Musical Ear Syndrome or pareidolia). The recommendation is to review the library of music used for NHS 111 waiting, involving people with lived experience in the selection to minimise potential distress and demonstrate genuine co-authorship of the service experience.

Next steps

The NHSE Midlands 111 option 2 Forum will share the issues and recommended modifications with the NHSE national team to inform ongoing review and improvement of NHS 111 call handling, including future implementation of Natural Language Processing. The Forum has also requested attendance of national NHSE colleagues at a Midlands Forum meeting.

Working together with Experts should be part of everything we do. Their input helps us stay focussed on what local people really need. I'm very thankful for their support and excited to keep working with the.

A big thank you also to Mental Health Together for helping our Experts to make a real difference across Derby and Derbyshire. Having experts in the room has been the best thing that ever happened to these strategic groups.

Jenny Appleby Head of Adult Mental Health Commissioning (DDICB)

Conclusion

Our approach to working with people and communities, our governance arrangements and our involvement infrastructure will continue to provide consistent and authentic routes for the involvement of people in the coming year, supporting a range of people to contribute, in a range of different ways. Providing assurance and accountability that we will keep listening, learning and reporting on what we hear and how it has influenced decisions, so that involvement remains meaningful and results in better experiences, better outcomes and improved wellbeing for the population of Derby and Derbyshire.