NHS
Derby and Derbyshire
Integrated Care Board

NHS Derby and Derbyshire Integrated Care Board Annual Report

1st April 2024 to 31st March 2025








About this report

This document has been prepared, as directed by NHS England, in accordance with the National Health Service Act 2006 (as amended by the Health and Social Care Act 2022). Integrated Care Boards (ICBs) are statutorily required to produce an Annual Report and accounts and to comply with the requirements as laid out in the Department of Health and Social Care Group Accounting Manual.

The structure of this report therefore follows that outlined in the guidance and includes:

- **Performance Report** – this section of the Annual Report includes an overview and a more detailed analysis of our performance during the reporting period, as follows:
    - **Performance Overview**, which describes the structure of our organisation and what we do and summarises our strategies and plans and how we have performed during the reporting period.
    - **Performance Analysis**, which describes our performance measures in more detail and illustrates the level of delivery achieved during the reporting period. It also sets out our risk profile and explains how we have discharged our key statutory duties.
- **Accountability Report** – this section of the Annual Report describes how we have met key accountability requirements and embodied best practice to comply with corporate governance norms and regulations. It comprises three sections:
    - **Corporate Governance Report**, which sets out how we have governed the organisation during the period 1 April 2024 to 31 March 2025 including membership and organisation of our governance structures and how they supported the achievement of our objectives.
    - **Remuneration and Staff Report**, which describes our remuneration policies for Executive and Non-Executive Members, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.
    - **Parliamentary Accountability and Audit Report**, which brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.
- **Annual Accounts** – this section of the Annual Report presents our financial statements for the reporting period.

A glossary is included at Appendix 9 to define any acronyms used within the report. This document can be made available in large print and in other languages by request to the organisation at:

Email: ddicb.enquiries@nhs.net
Website: www.derbyandderbyshireicb.nhs.uk
Registered Address: The Council House, First Floor, Corporation Street, Derby, DE1 2FS

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Foreword by Dr Kathy McLean OBE, Chair

Welcome to the third Annual Report and accounts of NHS Derby and Derbyshire Integrated Care Board (ICB), and my first as Chair, having taken up post in May 2024. The ICB, formed on the 1st July 2022, is responsible for developing plans to meet local health need, managing the NHS budget locally and securing the provision of healthcare services for our population.

Our Board is made up of representatives from our wider NHS family, so that the ICB represents the whole of the NHS in an area, not just the service commissioner. We also collaborate very closely with our Local Authorities, and members from Social Care and Public Health also have voting seats on our Board. Overall, the ICB, our NHS Trusts and our Local Authorities continue to form the core membership of Joined Up Care Derbyshire, our local Integrated Care System (ICS). These partners, collaborating closely with colleagues in the Voluntary, Community and Social Enterprise and Faith sector and Healthwatch, form the Derby and Derbyshire Integrated Care Partnership (ICP) which, in addition to the remit of the ICB, seeks to connect partners and services to change the way health and care provision is integrated for the benefit of citizens. The ICB, ICP and ICS are enshrined in law, with clearly defined strategic outcomes. This is in fact much simpler in practice than it may sound, and this report seeks to explain these inter-relationships.

The landscape in which the NHS operates has seen change in this last year. We have made connections with leaders at the new East Midlands Combined County Authority since its establishment in April 2024, including with the new Mayor, Claire Ward. These have been very productive discussions, and we are committed to understanding how the NHS can support the devolution agenda in addressing the wider determinants of health, especially in the area of employment and skills. The Authority continues to establish itself and it is important that the NHS remains a key partner in its delivery of local priorities.

In July 2024 the General Election resulted in a new Government and ministerial team across the health portfolio. Very early on in its term of office, the Government stated its position on the NHS requiring urgent action to fix existing challenges, and the independent report produced by Lord Ara Darzi in September set out these challenges and recommendations in greater detail. The report was widely received as reflecting the true picture and, along with a range of other issues which require resolution, highlighted three key shifts for the NHS: the shift from analogue to digital; hospital care to community care; and treatment to prevention. These shifts fit well with existing work we are progressing in Derby and Derbyshire, and help to give further focus. A broad engagement exercise took place across the country to seek views on these and other matters, and to help inform the Government's 10 Year Plan for the NHS, which we anticipate will be published early in 2025/26. We conducted our local version of this engagement, which was helpful in confirming early local opinion on our priorities and approach.

A further step from the Government was the publication of the White Paper on devolution, which set out the intended approach to accelerate and standardise the processes by which it passes powers, funding and programmes from Westminster to local areas. This has resulted in a range of discussions on the landscape and boundaries for local government, with the

likelihood of some change for our colleagues in Derbyshire County and Derby City Council. These discussions continue.

The notification of the cost reductions required by ICBs and the wider NHS has introduced a different and challenging focus to our work for 2025/26, and it will be important to maintain focus on the issues at hand on performance and population health improvement. Derby and Derbyshire's progress fits well with the emerging national policy agenda and priorities. Our dedicated work in Local Place Alliances continues, where we are seeking to work with a wide range of community partners, including citizens, to understand need and put into place initiatives which seek to meet it. The visits I have undertaken to the community-led work in Barrow Hill, and our excellent work on Team Up, have been invigorating and demonstrate the true value of how partnership working on the ground between and among professionals and community leaders can make a true difference to the lives of local people, to help them stay well and on many occasions help them avoid the need to go to hospital. There are further details on these and many other examples of progress throughout this report.

The ICP, in which the ICB is a key partner, continues its focus on the Start Well, Stay Well and Age/Die Well priorities. The ICP has taken the opportunity to review its approach and role in 2024/25, maintaining focus on the priority areas, but seeking to ensure how the ICP and ICB can set clearer direction, and position ourselves to be better able to mutually commit resources and understand our progress against outcomes. There is no doubt that the work we are doing is of value, and we can have greater confidence that we are focused on the right things through clarity of vision and delivery.

For the NHS, there is further work to do on alleviating service pressure, particularly in our urgent and emergency care system, reducing the waiting lists for operations and care that emerged and have remained since the start of the Covid-19 pandemic in 2020, to improving access to community care including our General Practices and ensuring that we are understanding and working through the health inequalities that exist across and within our communities in Derby and Derbyshire.

This latest ICB Annual Report articulates what we are doing on a range of fronts. I take the opportunity in this foreword to say thank you to everyone who has been involved in the continued planning and delivery of services and the conversations we are having in communities to understand need and help make improvements. What continues to remain consistent is the commitment of health and care staff in working beyond the call of duty to keep our citizens safe and well and to provide the best possible care. I speak on behalf of the ICB Board in expressing our considerable gratitude, and providing assurance to those staff and to our communities that we continue to strive to find solutions and make improvements.

Dr Kathy McLean OBE
Chair
NHS Derby and Derbyshire Integrated Care Board
19th June 2025

PERFORMANCE REPORT

Dr Chris Clayton

Accountable Officer

NHS Derby and Derbyshire Integrated Care Board

19th June 2025

Statement from our Chief Executive

I am proud to be compiling this statement as the Chief Executive Officer of NHS Derby and Derbyshire Integrated Care Board (ICB) at the end of its second full year as an NHS body. Our Annual Report sets out in detail the progress we have made during the year, which once again has been set against the backdrop of significant operational pressure.

The ICB Board continues to reiterate that, in seeking to achieve the longer-term aims of tomorrow, we must set the NHS on a sustainable course today and seek to stabilise the services which provide day-to-day care for our population. Achieving this in a challenging financial landscape and in the context of an NHS which continues to be in recovery from the pandemic, has been the focus of our work and I believe this will remain a focus in the coming year. As we achieve our aims in creating the sustainable NHS our population requires, we must also increasingly give attention to the drivers of poor health and healthcare service demand, by supporting local people to stay healthy for longer and supporting them in the place they call home when they experience an urgent health issue.

The ICB has reached a range of important milestones during the year, at the same time as managing new and emerging challenges that face the NHS and broader health and care system. This report outlines many of these in some detail and provides a snapshot of some of the efforts we are making to improve local health. We continue to work on two fronts; dealing with the operational pressures of today while seeking to set plans that will see longer term sustainable improvements to local health and our health services.

2024/25 has been a year of embedding our work to achieve a recovering and sustainable NHS system for local people, against a backdrop of Government change and refreshed policy position. Alongside the political commentary surrounding a challenged NHS, and acknowledging that locally our NHS continues its journey of improvement following the unprecedented impact of the Covid-19 pandemic, my assessment as we end the financial year is that Derby and Derbyshire has set stable footings to emerge as a successful NHS system. This is apparent in our service performance, our workforce management and the delivery of our financial targets. The details within this report bear this out, and I am very proud and say thank you to everyone who has played a part in these achievements across the NHS family this year.

It remains a fact that patients continue to wait for too long in seeking access to NHS care and services. This is evident in the performance against NHS constitutional targets for urgent and emergency care and waiting times for a range of health services. There is more to do, and we are not complacent in that regard. But we are on the right course, and our delivery of improvement in a wide range of performance areas is testament to the understanding we have of what is required, and our continued focus on a small number of critical areas across the health system.

As we end the 2024/25 financial year, we can point to stabilisation on many fronts and significant improvements in others. Continuing to sustain our emergency care system will remain a core focus given the secondary impact pressure can have on other areas of performance. Operationally, our health and care system has continued to face challenges

through the year, including the usual winter pressures, which we have once again managed in a consistent, careful and coordinated manner.

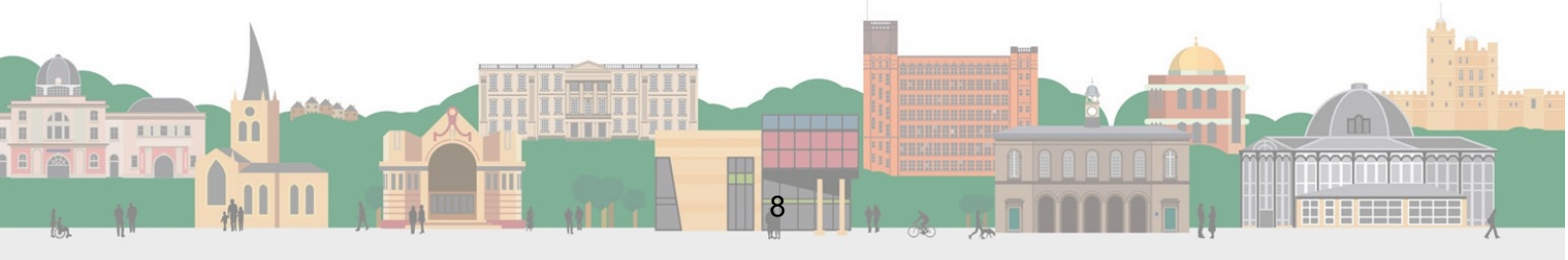
In headline terms, in 2024/25 the local NHS has:

- seen an overall reduction in the waiting lists for surgery at our two acute hospitals and near eradication of patients waiting beyond 65 weeks;
- seen an improvement in the proportion of patients waiting longer than four hours in our Accident and Emergency (A&E) departments;
- seen a greater proportion of patients receiving a cancer diagnosis and cancer treatment within nationally-specified time frames;
- improved performance of ambulance services, including the time taken for ambulance crews to reach patients in the community and the time lost on arrival at hospitals as crews hand over patients;
- begun to evidence the impact of our urgent community response teams, with reduction of emergency department (ED) admissions among our frail and elderly population compared to peers;
- seen our General Practices providing more appointments in comparison to previous years and above and beyond the target set at the start of the year;
- delivered wonderful new inpatient facilities in Derby and Chesterfield to ensure the best possible care for patients with serious mental illness;
- delivered our financial target of a -£50m deficit position, including the delivery of efficiency savings of £170m; and
- delivered our workforce plans, including the stemming of workforce growth and the management of our use of bank and agency workforce.

Alongside evidence of in-year improvement, this performance creates further stability as we head into the next financial year, where the detailed work we have undertaken on our planning highlights that we are forecasting achievement of all key performance targets, against a backdrop of regulatory acknowledgement of improvements.

We are still to see the benefit of other new initiatives which will seek to accelerate our progress and seek to deliver against the three key shifts identified by Government: from analogue to digital; from treatment to prevention; and from hospital to community care. We have clear alignment of our local work against these three areas, notably the opportunities we can unlock through transformation of our community care and General Practice models, to move the NHS increasingly from a 'treatment' service to a 'wellness' service. Our partnership work with local authorities and the Voluntary, Community, Faith and Social Enterprise sector (VCFSE) is crucial in the space, as we seek to balance reduced resources with an ambition for improvement.

Alongside our focus on operational pressures, we have continued to make progress on introducing initiatives and services which can help identify and attend to health issues before they result in a need for hospital care. Through our partnership work in identifying hypertension, in supporting people and identifying others at risk of falls, in establishing our women's health hubs, and our work on care at the end-of-life, we have demonstrated our intent to shift focus from hospital-based care to preventing ill-health and supporting more people in the place they call home. This report sets out the breadth of our work in these and



other areas, as well as important work on service procurements for community care and talking therapies.

From a management and governance perspective, the ICB has now operated for two and a half years since establishment in July 2022. The ICB Executive and Board has been stable through the 2024/25 financial year; the only changes of note have been the retirements of Keith Griffiths as Chief Finance Officer in November 2024, now replaced by Bill Shields in a joint role with Nottingham and Nottinghamshire ICB; and Tracy Allen, Chief Executive of Derbyshire Community Health Services, and a Partner Member of the ICB Board, replaced on an interim basis by Jim Austin.

The ICB delivered the former Secretary of State's requirement to reduce the running cost allowance envelope by 20% during 2024/25. The ICB concluded its period of restructure in year and will deliver a further 10% reduction from April 2025. We have undertaken a wide-ranging organisational development plan in the second half of the financial year, including the introduction of increased focus on staff recognition and detailed work to triangulate workforce data to support local improvements.

However, the Government's announcement of 50% cost reductions for ICBs in March 2025 was unexpected, and as we end the financial year, we await further guidance on how this is expected to be achieved during the calendar year. Despite this, the solid footings we have set on performance improvement will continue to be a focus during the next year, and our successful and collaborative operational planning processes for 2025/26 have ensured that we start the next year with clarity of purpose and achievable ambitions to improve health care for local people.

Dr Chris Clayton
MA MB BChir DRCOG PGCGPE MRCGP
Chief Executive Officer
NHS Derby and Derbyshire Integrated Care Board
19th June 2025

Performance Overview

This overview provides a summary of the purpose and activities of NHS Derby and Derbyshire Integrated Care Board (ICB) and how it performed during the year. It also provides the Chief Executive Officer's perspective on the performance of the ICB.

About Us

The ICB was established by NHS England (NHSE) on the 1st July 2022 under powers in the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 and the Health and Care Act 2022). The ICB is a statutory NHS organisation which serves a population of around 1.4 million and covers the geographic areas of Derbyshire, including the populations of Derby city, Chesterfield, Ilkeston and Long Eaton, Amber Valley, Derbyshire Dales, Bolsover District, High Peak and Glossop.

The ICB has a key role in the delivery of the NHS constitutional standards and statutory duties of the Derby and Derbyshire ICS, which is made up of the ICB and the four NHS providers in Derby and Derbyshire. The ICB brings together local NHS organisations and Local Authorities to plan and help shape local health services.

Our organisational structure comprises six directorates:

Strategy and Delivery	999/111 Commissioning Mental Health, Learning Disabilities and Autism Place and Partnerships Planned Care	Primary Care Strategic Planning and Contracting Urgent and Emergency Care
Nursing and Quality	Continuing Healthcare Infection Prevention and Control Individual Funding Requests Patient Safety/Experience	Maternity and Neonatal Quality and Compliance Safeguarding
Medical	Business Intelligence Clinical Policies Derbyshire Prescription Service Immunisation/Screening	Population Health Management Programme Management Research/Innovation
Finance	Capital Planning and reporting Financial Planning and reporting System planning and reporting	Financial control and governance Cash management Resource Allocation
Corporate	Communications/Engagement Complaints and Patient Advice Liaison Service Corporate Governance Digital Transformation Emergency Planning Environmental Sustainability Equality, Diversity and Inclusion	Estates Freedom of Information Human Resources Information Governance Performance/System Oversight Risk Management
Workforce	System Workforce and Planning	Anchor Development

Purpose and Activities of the ICB

The ICB brings together local NHS organisations and Local Authorities to plan and help shape local health services for the people of Derby and Derbyshire. The ICB has a Board, which is made up of Executive Directors, Non-Executive Members, Partner Members from Foundation Trusts, Local Authorities and Primary Medical Services, and clinical representation. More information on our Board Members can be found on page 117 of this report.

Key issues and risks that could affect the ICB delivering its objectives

The ICB Board uses an assurance framework to test our performance and capability. Part of this annual framework measures performance against what we say we need to deliver and whether these metrics demonstrate improved outcomes for our patients, including how services and quality are delivered and improved. This includes measuring progress in how we delivered the requirements set by the Government in the NHS Mandate, the annual operational plan priorities and the NHS Constitution.

The key issues and risks to the organisation achieving its objectives are described in the Governance Statement section of this report. The ICB's strategic risks identified during 2024/25 can be found on the JUCD website.

Adoption of the Going Concern Approach

The ICB has adopted a 'Going Concern' approach (where a body can show anticipated continuation of the provision of a service in the future) in preparing our annual financial statements. This follows the interpretation in the Government Accounting Manual of Going Concern in the public sector.

Our Relationships

Patients in our area have access to services from a wide range of providers, including Derbyshire Healthcare NHS Foundation Trust (DHcFT), Derbyshire Community Health Services NHS Foundation Trust (DCHSFT) and East Midlands Ambulance Service NHS Trust (EMAS). Our largest contracts are with Chesterfield Royal Hospital NHS Foundation Trust (CRHFT) and University Hospitals of Derby and Burton NHS Foundation Trust (UHDBFT), which account for approximately 65% of our spending.

Derbyshire Integrated Care System Working and Collaboration

Following the passage of the Health and Care Act 2022, the Derbyshire Integrated Care System (ICS) was formalised as a legal entity with statutory powers and responsibilities. All ICSs comprise two key components:

- Integrated Care Boards; and
- Integrated Care Partnerships.

Our ICS, known as Joined Up Care Derbyshire (JUCD), is the Derby and Derbyshire health and social care partnership for adults and children. JUCD's priority is to make improvements to the Derby and Derbyshire populations' life expectancy and healthy life expectancy levels in comparison to other parts of the country, and reduce the health inequalities that are driving these differences. There are clear health inequalities within Derby and Derbyshire, and working together with partner organisations is part of the whole-system approach to tackling them. JUCD is made up of the following organisations:

Chesterfield Royal Hospital NHS Foundation Trust	Derby City Council	Derby City Health and Wellbeing Board
Derbyshire Community Health Services NHS Foundation Trust	Derbyshire County Council	Derbyshire County Council Health and Wellbeing Board
Derbyshire Health United Community Interest Company	Derbyshire Healthcare NHS Foundation Trust	East Midlands Ambulance Service NHS Trust
NHS Derby and Derbyshire Integrated Care Board	University Hospitals of Derby and Burton NHS Foundation Trust	VCFSE Alliance

Functions of the Integrated Care System

The four key functions and purpose of the ICS is to bring the above partner organisations together to:

1	Improve outcomes in population health and healthcare.
2	Tackle inequalities in outcomes, experience and access.
3	Enhance productivity and value for money.
4	Support broader social and economic development.

Derbyshire Integrated Care Strategy

The Derby and Derbyshire Integrated Care Strategy 2023 is a plan to improve the health of Derbyshire citizens. The purpose of the strategy is to set out how Local Authority, NHS, Healthwatch, and the Voluntary, Community and Social Enterprise and Faith Sector (VCFSE) sector organisations will work together to improve health and further the transformative change needed to tackle system-level health and care challenges. The strategy was endorsed by the ICP in February 2023, and aims to facilitate:

- collaboration and collective working;
- engagement with local people and communities;
- a joined-up approach to strategic enablers that are critical to the development of high quality; and
- agreement of key focus areas to test our strategic aims and ambitions for integrated care.

Strategic Aims

Within the Derbyshire Integrated Care Strategy are a number of strategic aims, which were created to help shape and steer the development of the strategy. They focus on:

- prioritising prevention and early intervention to avoid ill-health and improve outcomes;
- reducing inequalities in outcomes, experience, and access;
- developing care that is strengths-based and personalised; and
- improving connectivity and alignment across Derby and Derbyshire, to ensure people experience joined up care, and to create a sustainable health and care system.

Further detail on the Integrated Care Strategy can be found on the JUCD website.

Joint Forward Plan

The Derby and Derbyshire NHS 5 Year Plan 2023/24 to 2027/28, also known as the Joint Forward Plan, is the ICB and partner NHS Trusts and NHS Foundation Trusts' contribution to meeting the strategic aims of the Integrated Care Strategy. To do this the NHS needs to change its current operating model so that it becomes more preventative in nature, personalised for our population and intelligence-led, with services integrated by design.

The Joint Forward Plan sets out how we intend to meet the physical and mental health needs of the Derby and Derbyshire population through the provision of NHS services, and how universal NHS commitments will be met. This includes the following principles:

- allocating greater resource to activities that will prevent, postpone, or lessen disease complications and reduce inequity of provision;
- giving the teams working in Derbyshire the authority to determine the best ways to deliver improvements in health and care delivery for local people;
- giving people more control over their care;
- identifying and removing activities from the provision of care which result in time and cost being expended but do not materially improve patient outcomes; and
- prioritising the improvement of JUCD's intelligence function and the capacity and capability of its research programme.

The plan was co-produced through engagement with ICP partners, including discussion and review at both Health and Wellbeing Boards, ICB Corporate Committees and public consultation.

Further detail on the Derby and Derbyshire NHS 5 Year Plan 2023/24 to 2027/28 can be found on the JUCD website. The Joint Forward Plan will be refreshed early in 2025/26, in line with the NHS 10 year Plan.

How our strategies link together

Figure 1 below shows how the above strategies link together with other strategic documentation across the System to shape our health in Derby and Derbyshire:

Figure 1 – How our strategies link together

Role of the Integrated Care Board

The ICB brings together all NHS organisations in Derby and Derbyshire as an NHS executive to manage NHS delivery and facilitate the work of JUCD, including supporting the coordination and implementation of our Integrated Care Strategy. It is focused on creating a systematic and proactive approach to planning, procuring, and delivering NHS services for all communities of the Derby and Derbyshire population.

The ICB also brings together local General Practices to plan and help shape local health services for the people of Derby and Derbyshire. Our ICB area covers residents across Derbyshire, including the populations of Derby city, Chesterfield, Ilkeston and Long Eaton, Amber Valley, Derbyshire Dales, Bolsover District, High Peak and Glossop.

The ICB is managed by a Board, which is made up of Executive Directors, Non-Executive Members, Partner Members from Foundation Trusts, Local Authorities and Primary Medical Services, and clinical representation (more information on our Board Members can be found on page 117 of this report). Its role is to join up health and care services, improve people's health and wellbeing and reduce health inequalities.

The three functions of the ICB are:

1	Deliver the statutory duties of the ICB as an NHS organisation.
2	Act as the convener of and for the NHS family (statutory and non-statutory NHS providers).
3	An integral partner in the ICP and the Health and Wellbeing Boards.

The key statutory overarching functions of the ICB are:

- to lead the Strategic Commissioning and Resource Allocation of NHS Services;
- the development and delivery of the System Strategic and Operational Plan;
- to provide oversight of the Assurance Framework and Performance Management of our NHS providers; and
- to lead the Integrated Care Model in partnership with the Provider Collaborative, Place, ICP, Health and Wellbeing Boards and the Anchor Institution.

During 2024/25, the ICB has continued to evolve to achieve its ambition as a valued partner in JUCD, and the broader constituency of the Board provides us with the means to do this and maximise performance against our statutory duties.

The ICB is required under the Health and Care Act 2022 to review the extent to which the ICB Board has exercised its functions in accordance with the plans published under section 14Z52 (Joint Forward Plan) and 14Z56 (capital resource use plan). The ICB receives allocations in regard to the Capital Resource Plan for IT equipment.

The NHS 10-Year Plan

An independent investigation of the NHS in England was commissioned by the government to understand the performance of the NHS and provide an analytical diagnosis of issues that exist. The investigation was led by the former health minster Professor Lord Darzi, and was published on the 12th September 2024. It concluded that the NHS is in a 'critical condition', highlighting failures to deliver key obligations since 2015, and Lord Darzi recommended a systemic 10-year reformation plan. The 10-year plan will be built around the following three shifts as set out by the Secretary of State for Health and Social Care following the report:

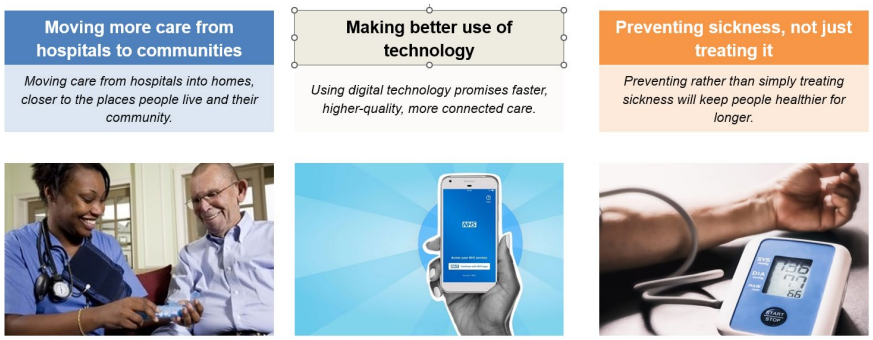


Figure 2 – The NHS 10-Year Plan Three Shifts

The ICB have been working on these key transformation areas for many years, and therefore the ICB and JUCD are aligned to this government directive. The following showcases the programmes the ICB are delivering in relation to the three shifts and where you can find more information on these within this Annual Report:

Moving care from hospitals to community		
By providing better care close to or in people's own homes, helping them to maintain their independence for as long as possible, only using hospitals when it is clinically necessary for their care	Team Up Derbyshire	Page 22
	VCFSE	Page 24
	Community Equipment/Orthotics	Page 26
	Urgent Treatment Centres	Page 41
	Empowering General Practice Programme	Page 43
	Virtual Wards	Page 53
	Community Pharmacy Services	Page 56
	Enhanced Health in Care Homes	Page 92
	Allied Health Professionals	Page 95
Making better use of technology		
Having greater use of digital infrastructure and solutions to improve care	Eyecare electronic referral system	Page 35
	Teledermatology	Page 38
	Central Navigation Hub	Page 41
	Primary Care Digital	Page 49
	Virtual Wards	Page 53
	JUCD Involvement Platform	Page 179
Preventing sickness, not just treating it		
By promoting health literacy, supporting early intervention and reducing health deterioration or avoidable exacerbations of ill health	Barrow Hill Memorial Hall	Page 24
	Women's Health Hubs	Page 25
	Self-Referrals	Page 25
	Earlier screening for cancers	Page 39
	Cancer prevention at a neighbourhood-level	Page 39
	Mental health	Page 59
	Patient experience	Page 89
	Public involvement and consultation	Page 103

2025/26 Operational Plan

NHSE's priorities and operational planning guidance was published on the 30th January 2025, with the number of national priorities reduced when compared with 2024/25 guidance. For 2025/26 the focus will be on a small set of headline ambitions and key enablers:

1	Reducing elective care wait times.
2	Improving A&E and ambulance response times.
3	Enhancing access to General Practice and urgent dental care.
4	Improve participation in physical activity.
5.	Improving mental health and learning disability services.
6.	Living within the budget allocated, reducing waste and improving productivity.
7.	Maintaining collective focus on the overall quality and safety of services.
8.	Addressing inequalities and shift towards prevention.

In response, the ICB and its partners submitted a credible and compliant Operational Plan for 2025/26. The ICB's 2025/26 position is supported by some significant achievements in 2024/25, which has given the ICB a solid foundation for next year.

Role of the Integrated Care Partnership

The Integrated Care Partnership (ICP) is a statutory committee jointly formed between the ICB and the Derby City and Derbyshire County Councils. The ICP brings together a broad alliance of partners concerned with improving the care, health and wellbeing of the population. The ICP is the ‘guiding mind’ of our local health and care system, and it is responsible for producing an integrated care strategy on how to meet the health and wellbeing needs of the population we serve

The ICP ensures that the Integrated Care Strategy facilitates subsidiarity in decision-making, ensuring that it only addresses priorities that are best managed at a System-level and does not replace or supersede the priorities that are best done locally through the Derby and Derbyshire Joint Local Health and Wellbeing Strategies.

A major focus of JUCD is to increase life expectancy and healthy life expectancy, and reduce inequalities. Poorer outcomes are linked to areas of socio-economic deprivation and certain groups including, but not limited to, those from ethnic minority backgrounds, those with serious mental illness, people living with disabilities, LGBTQ+ people and people who are currently homeless.

Key Areas of Focus

Three key areas of focus have been agreed by the ICP to test in detail our strategic aims and our ambitions for integrated care, in response to population health and care needs. They focus on improvement in prevention, early intervention and service delivery outcomes.

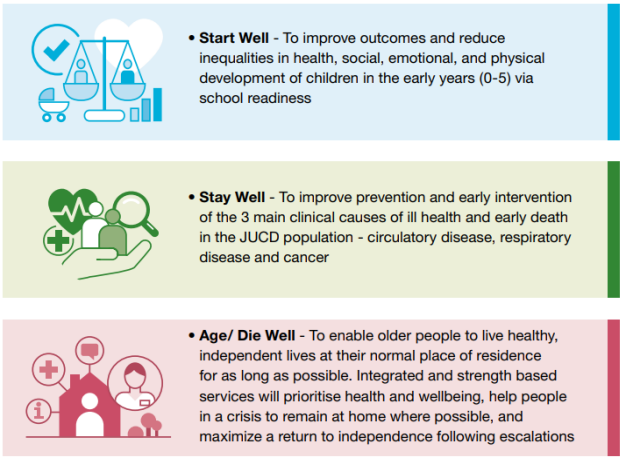


Figure 3 – key areas of focus for the Derby and Derbyshire Integrated Care Partnership

Joint Working with the Local Authority

As a key partner of JUCD, the ICB has shared statutory duties between the Local Authorities Derbyshire County Council and Derby City Council and our system partners, to develop health and care priorities for local people and improving population health and reducing health inequalities. This has strengthened links between the local Health and Wellbeing Board Strategies and the priorities emerging from the NHS Long Term Plan and the Derby and Derbyshire NHS 5 Year Plan 2023/24 to 2027/28.

To make the best decisions for our population, we must understand the health and care needs of people living across Derby and Derbyshire. Joint Strategic Needs Assessments provide the ICB with key information about the health and wellbeing of our local population. These demographics vary significantly between the City and County districts, including by age, by ethnicity, by disability, and by levels of deprivation. The production of Joint Strategic Needs Assessments is a shared duties across Local Government and the ICB.

The new East Midlands Combined County Authority was established in April 2024 and we continue to have dialogue with the Mayor, Claire Ward and colleagues at the East Midlands Combined Council Authority. It has been a period of accelerated set-up for this new body since the elections in May 2024, and the Authority's Board has begun making investment decisions using their delegated funding. During 2024/25, these included proposals to move oversight of public transport functions from Local Authorities to the Combined Council Authority, with a phased approach starting in 2025; and £9.5m funding to go to local projects that will help support economic growth for the region. There is a joint commitment in understanding how the NHS can support the devolution agenda in addressing the wider determinants of health, especially in the area of employment and skills. The Authority continues to establish itself and it is important that the NHS remains a key partner in its

delivery of local priorities. In December 2024, The Secretary of State for Housing, Communities and Local Government published the White Paper on English Devolution. The White Paper set out the Government's intended approach to accelerate and standardise the processes by which it passes powers, funding and programmes from Westminster to local areas. Its central aim is to support a boost to the economy and to promote growth, reflecting that decisions are better made closer to communities. The White Paper also announced that there will be a programme of local government reorganisation for two-tier areas, with a move to unitary authorities.

Health and Wellbeing Boards

Section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007 requires us to have regard to joint health and wellbeing strategies when exercising our functions. The Derby and Derbyshire Health and Wellbeing Boards are statutory partnerships established to lead and advise on work to improve the health and wellbeing of the populations of Derby and Derbyshire and specifically to reduce health inequalities experienced by citizens. These Boards bring partners together to address city and county-wide issues where collaborative approaches between partners are essential. In addition to the ICB and City and County Councils, the Boards' memberships include a range of local partners including Derbyshire Police, Derbyshire Fire and Rescue Service, Healthwatch, NHSE, local NHS Trusts and representatives from the voluntary sector.

We are active members of the Derby and Derbyshire Health and Wellbeing Boards; our Chief Executive Officer and an ICB Non-Executive Member sit on both Health and Wellbeing Boards. Our Joint Forward Plan describes how the ICB, together with the NHS organisations within our ICS, will contribute to the delivery of the Derby and Derbyshire Local Health and Wellbeing Strategies and the Integrated Care Strategy, produced by our Integrated Care Partnership. Both Health and Wellbeing Boards were engaged throughout the development of our Joint Forward Plan; the Chairs of the County and City Health and Wellbeing Boards provided positive statements on how the ICB has contributed to and reviewed its delivery of the Health and Wellbeing Strategies, confirming that it clearly articulates the ICB's commitment and contribution to the delivery of their Joint Local Health and Wellbeing Strategies. During the year, we have presented regular updates to meetings of the Health and Wellbeing Boards and the Integrated Care Partnership to demonstrate progress in delivery of our Joint Forward Plan towards achievement of their strategies.

The ICB's three strategic aims are closely linked to those of the Health and Wellbeing Boards, ensuring that the ICB is contributing to the delivery of the Health and Wellbeing Strategy:

1	To improve overall health outcomes for the population of Derby and Derbyshire including improving life expectancy and healthy life expectancy rates.
2	To improve health and care gaps currently experienced in the population and engineer best value from our assets to deliver this.
3	Reduce health inequalities by fully appreciating the determinants of health.

These objectives were developed with the ICB Board, which has representation from both Local Authority Directors of Public Health. The ICB reports on progress of the strategic objectives through its Board Assurance Framework. Our approach to the development of the Joint Local Health and Wellbeing Strategy can be seen in Figure 1.

Derbyshire's Health and Wellbeing Strategy 2022 Refresh set out five priorities for improving health and wellbeing across Derbyshire, focusing on actions to address factors that can influence people's health. The Health and Wellbeing Strategy can be viewed on the Derbyshire County Council website.

Information on Derbyshire County Council's Health and Wellbeing Board can be found here and information on Derby City Council's Health and Wellbeing Board can be found here.

Furthermore, in preparing the Annual Report, the ICB has engaged with the Chairs of the County and City Health and Wellbeing Boards and received positive feedback on how the ICB has contributed to and reviewed its delivery of the Health and Wellbeing Strategies.

System Anchor Partnership

In line with the ICS's fourth aim to help the NHS support broader social and economic development, our ICS acts as an 'anchor system', working together with our partners to address the physical, social and environmental factors that can cause ill-health; sometimes called the wider determinants of health. The ICB is an active strategic partner in the University of Derby which is committed to enhance the economic, social, and cultural life, and the health and wellbeing of the population of Derby and Derbyshire. During 2024/25, the ICB have:

- developed a social value (procurement) strategy for ICS partners, with the aim of gaining efficiencies from our combined purchasing power and supporting sustainability and social value in our communities; and
- progressed delivery of national and local priorities and opportunities to reduce carbon emissions, as outlined in our ICS Green Plan. You can read more about this work in the statutory duties section of this Annual Report, under 'Environmental matters' on page 66.

Together, the collective influence aims to 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 ICB. The work of the System Anchor Partnership is to be incorporated into delivery plans for the Integrated Care Strategy, and will consider how best to align this work with key enabling functions and across the Start Well, Stay Well, and Age/Die Well areas of focus.

Provider Collaboratives

NHS organisations that provide care to patients are known as 'providers'. Patients are often seen by more than one NHS provider for their care. This means that it is vital that providers work closely to ensure they coordinate patient care in an effective and seamless way. Therefore, in Derby and Derbyshire the providers are working together as a Provider Collaborative to ensure they all have a shared purpose and effective arrangements in place to allow them to make decisions.

The Provider Collaborative's aim is to improve the way care is delivered, by working together while supporting the JUCD's strategic aims. Their role is to:

- develop and deliver collaborative approaches to specific challenges;
- develop partnership relationships, strengthening communication between providers, sharing approaches to challenges and opportunities;
- improve efficiency, productivity and sustainability through collaborative working, integration or the consolidation of service delivery or corporate functions;
- contribute to reducing inequalities of access and unwarranted variation, where provider collaboration can best achieve this; and
- improve decision-making and accelerate change by taking on collective decision-making and commissioning responsibilities.

Integrated Place Executive

The ICP is accountable for the Integrated Care Strategy, with oversight and delivery management arrangements delegated to the Integrated Place Executive. The Integrated Place Executive has been delegated oversight in monitoring the progress of mobilisation of the Integrated Care Strategy. This ensures there is a single point in JUCD where key enabling opportunities and constraints for integrated care are collated, managed, and where necessary escalated to other JUCD Boards.

Place Partnerships

The ICB has supported the development of Places covering Derby and Derbyshire, and the important role they play in helping with local delivery of the Health and Wellbeing Strategy and the work of the ICP. The Place Partnerships have an ethos of equality between partners and are established to deliver a range of functions on behalf of the ICB and ICP. These include:

- co-ordinating and integrating local services;
- taking accountability for the delivery of coordinated, high quality care and improved outcomes; and
- the planning, management of resources, delivery and performance of a range of community-based health and care services.

Neighbourhood Integration

Place-Based Planning and Delivery

To ensure care and support best meets the needs of local people, the county is organised into eight areas known as Place Alliances. Commissioners, community services providers, Local Authority, Primary Care, the voluntary and community sector, and the public come together at a 'Local Place', neighbourhood-level, to join up health, care and support, with the overall aim of empowering people to live a healthy life for as long as possible. The trusting relationships that have been built as part of a Local Place facilitate the transformation of care and support services at a local level. Derby and Derbyshire have had great success in partnership working at this local-level, but recognise there is value in coming together at scale.

Using these Place-based structures to plan and deliver improvements, a model of distributed leadership is used, taking a strengths-based approach to give local partners the flexibility to find solutions together, with leadership and support from a central team who coordinate and connect related initiatives. Achievements for 2024/25 include:

- investment in capacity and new types of provision;
- gaining benefits through the building of coherence and connectivity between existing and emerging improvement programmes; and
- optimisation of Place structures to secure a formal mechanism for connectivity.

Team Up Derbyshire

Team Up is an ambitious transformation programme, integrating neighbourhood teams throughout Derby and Derbyshire. It stands out from other integrated neighbourhood projects nationally through its scale to incorporate all neighbourhoods across the ICS, and by its breadth in incorporating, as a minimum, community health, adult social care and crucially General Practice.

Team Up Vision
Health, care and other professionals work as one with each other and with their communities to improve the lives of those who need it most.
Team Up Mission
Create the conditions for people to come together and find their own solutions to improving the experience of receiving and providing care.
Agreement from practices to the relevant data provision notice for data to be provided to NHSE as part of the 'Submissions via Online Consultation Systems in General Practice' publication.

Team Up started in April 2021 and has drawn heavily on behavioural and organisational science to understand what motivates people (autonomy, learning and higher purpose) and

what makes change more likely to be successful in complex systems. In working together, it increases efficiency and effectiveness, and improves health and wellbeing.

Home Visiting Services

Strengths-based, distributed leadership approaches have created 12 locally-led teams who deliver integrated home visiting, urgent community response and falls recovery, which simplifies pathways and adds extra capacity. A growing multi-agency workforce, including paramedics, advanced care practitioners, care coordinators, pharmacists and many others, have delivered an average of 6,500 home visits a month up to 31st March 2025.

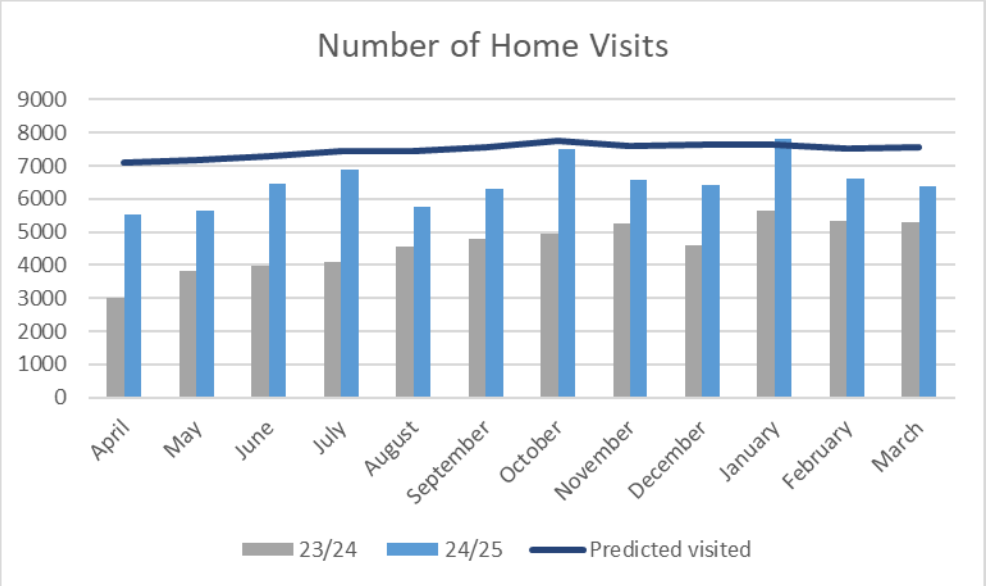


Figure 4 – Team Up Home Visiting Service activity for 2024/25 and 2023/24

Community General Practitioners (GPs) are in place across the whole ICS to support the integrated team by creating consistent access to senior clinical decision-making and supporting considered clinical risk management.

Care Home Support

Providing more responsive, integrated and preventative care through teaming up and building integrated neighbourhood teams benefits residents in care homes as much as those in their own home. However, there are additional opportunities to support improved working specifically with care homes and their residents, which have included:

- data analysis to identify and support care homes that are the highest users of unplanned urgent care;
- recruitment of a small team, hosted by Derby City Council, to train and support care homes in the use of lifting equipment, with the aim of reducing ambulance calls and conveyance to hospital for those who have fallen; and
- greater emphasis on care home engagement and support to promote system and integrated working.

Falls Response

Enhanced falls response helps those who have fallen and who cannot be recovered without support and/or require further clinical assessment. The response is designed to encompass both reactive, two-hour community-based falls response and proactive, holistic falls risk assessment and interventions. It is an alternative to an ambulance response, with the aim of helping manage EMAS demand and reduce conveyances to hospital. This year, we have also focused on coproducing an 'ask, assess, act' pathway that aims to help professionals refer 'at risk' fallers onto falls prevention support, like strength and balance classes. You can read more about patient stories in Appendix 1.

Measuring Impact

Team Up has significantly slowed the growth in hospital attendances and admissions for people living with frailty over the past two years, saving approximately 1,000 attendances and 700 non-elective admissions per year, with national benchmarking data showing a positive change in Derbyshire. Team Up releases an estimated 3,500 hours per month back to core General Practice. 93% of Team Up staff recommend their service as a place to work and 93% of General Practice staff would recommend Team Up services for their patients.

Tackling Health Inequalities in Chesterfield

Barrow Hill, a suburb of Chesterfield, has a population of nearly 1,500 and is one of the most deprived areas in Derbyshire, where life expectancy is almost 10 years shorter than in neighbouring affluent areas. A programme of work is underway with Place partners to help improve the health and wellbeing of residents, and to build trust and relationships with partners and the public.

Barrow Hill Memorial Hall is one of only a few amenities in the village and has been closed for the last few years. It is now being renovated thanks to the Barrow Hill Community Trust and the capital build on the project is being supported by the Staveley Town Deal.

Place partners are working with community stakeholders to understand how they could complement the vision for delivering a range of services from the Memorial Hall, including social activities, health and care services, a breakfast club, women's services, housing and much more.

The clinical lead for Chesterfield Place, Dr Alice Fenton, says *"It's early days for this work but it will significantly help us to get ahead of the disease curve in the future. We have many great partners that are all contributing to this work from local families and community leaders, to the Barrow Hill Memorial Trust and other voluntary and community sector partners, through to NHS, public health and council services and organisations"*.

Voluntary, Community and Social Enterprise and Faith Sector

The ICB's commitment to the VCFSE recognises the crucial role that VCFSE organisations play in supporting our healthcare system, and ensuring their sustainability and effectiveness. The VCFSE sector in Derby and Derbyshire encompasses a diverse range of services, from infrastructure support and social prescribing to condition-specific care. These services have

consistently demonstrated their value, contributing significantly to preventative healthcare and reducing pressure on clinical services.

Women's Health Hubs

The ICB have successfully established Women's Health Hubs in Derby and Derbyshire, in partnership with Derby City Council and Derbyshire County Council Public Health, General Practices, Secondary Care. community providers, patient and public partners, and VCFSE organisations. Through a collaborative, community-led approach the ICB developed initiatives to improve access, experience, and outcomes for women, girls, and people with a cervix while addressing health inequalities among underserved communities.

The ICB invested in strengthening local workforce capacity in contraception services and culturally tailored menopause clinics, providing support through group workshops and digital resources. The women's health ambassadors and champions training programmes empower local women, girls and people with a cervix to promote health literacy, improve service uptake, and advocate for their communities. Engagement with local communities is at the heart of this work, with insights from over 40 community-led workshops and nearly 800 survey responses driving co-production of next steps to evolve local health needs.

Weight Management

There are around 405,000 people living in Derby and Derbyshire with a BMI of 25+, who have a higher prevalence in the population in relation to deprivation, age, disability, ethnicity and employment status. The ICB and partners have been working operationally and strategically to continue to develop, improve and optimise current weight management services and pathways to meet the growing demand for services. Through the Stay Well Sprint and the Obesity Alliance all tiers of weight management services are being reviewed in terms of access, delivery, investment, capacity and variation. New models of care that expand current offers in terms of digital support, prescribing of weight loss medication and wrap-around care are being developed.

Self-Referral Priorities

One of the ICB's priorities from NHSE is to support the recovery of our core services and productivity. Expanding direct access and self-referrals empowers people to take control of their healthcare, and as part of this the ICB have worked to both introduce and improve self-referral routes to falls response services, audiology (including hearing aid provision), weight management services, community podiatry, orthotics, wheelchair and low-level community equipment services.

Sexual Health

In May 2024, the ICB started working with partners and providers through a quarterly 'termination of pregnancy service providers and associated services' meeting, working to develop ways of connecting existing provision and improving links and pathways across services. The ICB are mapping services to identify areas where there has been a greater increase in abortions, particularly with emphasis on repeat abortions, contraception and

educational need. In addition to this, DCHSFT and the ICB are working to improve access to vasectomy services and looking at options to enhance the service.

Discharge

During 2024/25 there was significant focus on improving hospital discharge processes and outcomes, with a dedicated discharge improvement team. This included the introduction of a Care Transfer Hub, a multi-disciplinary team who take responsibility for all Derbyshire pathway 1–3 referrals, including step-up, step-down and out-of-area. The hub triages strength-based referrals asking, 'Why not home? Why not today?' and prescribes and sources the most appropriate pathway for citizens.

Another key initiative during 2024/25 was the procurement of the transport and settle scheme for Derbyshire, to complement existing schemes in Derby city and the High Peak. It helps to improve discharge outcomes by providing wheelchair-accessible transport and low-level support for patients returning home from hospital. The service is designed to ensure that patients' basic needs, such as heating and food, are met during the critical first few hours post-discharge, reducing the risk of readmission. In March 2024, a provider transported 100 people back into their homes with the support of voluntary sector providers. This initiative has not only expedited patient discharge but also linked patients to further support services, ensuring a smooth transition back home, and maximising independence and sustainable outcomes for citizens.

During 2024/25, the ICB worked with colleagues from Derby City Council, Derbyshire County Council and JUCD to ensure local people of all ages are supported to be as independent as possible, and to receive care closer to home through the provision of enabling equipment. The service underpins both hospital discharge and admissions avoidance, with equipment ranging from basic items through to bespoke specialist seating and sleeping systems.

Orthotics

The Derbyshire Orthotics Service, which delivers both adult and paediatric orthotic outpatient services throughout the whole of Derbyshire has undergone a full competitive procurement, which was carried out during 2024, due to the current contract expiration date. The service continues to perform well, issuing circa 30,000 ready-made orthoses every year including insoles and specialist footwear, ankle foot orthoses, knee ankle foot orthoses, knee braces, spinal braces for both acute and chronic conditions, and protective helmets. The service regularly receives excellent feedback from service users.

As part of the procurement process, the ICB worked with clinicians across JUCD to review key contract documentation, as well as engaging with patients and other ICB colleagues who acted as subject experts. The process was a great example of System partnership working and resulted in a successful contract award to a new provider, which will start from the 1st June 2025. The ICB will continue to work alongside the new provider and engage with wider JUCD colleagues to continuously review the service going forward.

Audiology

One in six people in the UK have some form of hearing loss, the majority being older people who are gradually losing their hearing as part of the ageing process, with more than 70% of

over 70-year olds and 40% of over 50 year-olds having some form of hearing loss. Hearing aids are crucial, not only for improving hearing but also for preventing other health conditions. Untreated hearing loss has been linked to various health issues, including dementia, social isolation, depression, and even an increased risk of falls. We currently commission five providers to deliver a service that assesses patients with reported hearing loss and provide simple hearing aids where indicated. This service offers a self-referral pathway for patients aged 55 and over, with under 55s needing a referral into the service from their GP.

Macmillan Palliative and End-of-Life Care Transformational Lead

The ICB is one of 24 areas selected to receive funding for a palliative and end-of-life care transformational lead as part of Macmillan Cancer Support's National Transformational Leaders Programme, who will play a pivotal role in strengthening the strategic direction of end-of-life care within our local health and social care system. By fostering collaboration, facilitating co-production and co-design and building strong partnerships, this role will help create equitable, outcomes focussed and sustainable services.

This pioneering initiative is designed to drive strategic change and service development across ICBs, tackling disparities in end-of-life care and shaping high quality, patient centred services. It is being delivered in collaboration with the National Leadership Academy, and represents a significant investment in leadership, innovation, and System-wide transformation to ensure that individuals receive compassionate, high-quality end-of-life care.

Marie Curie Innovation Fund

Marie Curie has committed to funding clinical and non-clinical roles for two years as part of an action learning initiative aimed at enhancing the delivery of end-of-life care services in Derby and Derbyshire. The roles support a number of Primary Care Networks (PCNs) and work collaboratively with System partners, focusing on troubleshooting challenges and developing improvement plans within teams. The resource is expected to rotate across the System to maximise impact by:

- supporting the reduction of inappropriate admissions for end-of-life care in the last 90 days of life, through localised improvement plans;
- informing education and training plans within teams to support early identification, digital ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) and advance care planning;
- embedding roles to see a more coordinated transition from acute to community settings, leading to improved patient care;
- non-clinical roles raising awareness on end-of-life care, access to services and the voluntary sector support available to patients and their families;
- the Marie Curie research and policy team conducting an ongoing evaluation of the project, including baseline data reviews; and
- gathering ongoing qualitative insights through collation of feedback from staff working in acute, community and voluntary sectors, as well as interviews and focus groups with patients and families at key stages of the project.

Performance Analysis

This section of the report describes our performance measures in more detail and illustrates the level of delivery achieved during the reporting period. It also explains how we have discharged our key statutory duties.

2024/25 has been another challenging year, and our focus has remained on recovering core services and productivity and ensuring the resilience of our local health and care system is maintained, while meeting national standards and organisational objectives; in particular:

- making it easier for people to access primary care;
- improving urgent and emergency care waiting times, particularly ambulance response times and waiting times in Accident and Emergency Departments; and
- reducing long waits and backlogs for elective care and cancer treatments and improving waiting times for diagnostic tests.

Whilst doing this, we have also worked with partners to make progress in delivering the key ambitions in the NHS Long Term Plan and to transform health and care services for the future. This has seen a focus on improving maternity and neonatal services, mental health services, and services for people with a learning disability and autistic people.

Performance expectations have been achieved against nine of the key operational performance priorities during 2024/25, where performance targets have not been achieved, explanations and further detail can be found in the 'performance summary' on page 31 and the 'performance achievements and challenges' section on page 32 of this report.

How we measure our performance

Performance against the NHS Constitution targets is continually monitored in the ICB. We look at a range of data, at provider level, ICB-level and by specialty where applicable. A large proportion of performance, business intelligence information is commissioned by the North of England Commissioning Support Unit (NECSU). The ICB produces regular internal reports which are discussed with executive directors and directors. This makes best use of ‘formal’ and ‘informal’ intelligence and ensures performance management is continuous.

We have contracts in place with our providers, including a series of performance and quality indicators, to ensure that delivery against priorities can be measured and accounted for. Key performance indicators (KPIs) for our commissioning priorities are reported monthly to the Quality and Performance Committee through the Integrated Performance Report. This report highlights current performance, any known and emerging issues, performance trends, patient impacts and corrective action to manage current challenges. The ICB Board also receives reports at each of its meetings in public in order to provide assurance around performance and quality of services. A key data set is a set of performance metrics which can give an idea of progress against any targets.

The KPIs cover the NHS Constitution and how programmes are performing against the national and local priority standards. They also include KPIs for the acute hospitals, mental health and community Trusts. Exception reports are produced for any indicators off track. Any issues or risks are captured in the Risk Register and Board Assurance Framework.

Ensuring and driving quality, performance and improvement

In July 2022, NHS Derby and Derbyshire Clinical Commissioning Group and the four Derbyshire Trusts, came together to form one single statutory organisation, NHS Derby and Derbyshire Integrated Care Board. At this time, the ICB assumed responsibility for performance, improvement and assurance; working closely with regional teams and delivery partners including hospital trusts.

The focus for 2024/25 was to improve performance against the delivery metrics set out in the NHS Oversight Framework. The ICB's Quality and Performance Committee, with membership from System partners, oversees progress, risks, assurance and improvement plans.

The NHS Oversight Framework provides a single, consistent NHS monitoring framework with the flexibility to support different system delivery and governance arrangements, as well as local partnership working. The framework takes account of:

- the establishment of statutory ICBs with commensurate responsibilities;
- NHSE's duty to undertake an annual performance assessment of these ICBs;
- early learning since implementing the System Oversight Framework in 2021/22; and
- NHS priorities as set out in the 2023/24 operational planning guidance.

Ongoing oversight continued to focus on the delivery of priorities set out in NHS planning guidance, and overall aims of the NHS Long Term Plan and NHS People Plan, as well as the shared local ambitions and priorities of individual ICSs. To achieve this, the NHS Oversight Framework is built around:

1	Five national themes that reflect the ambitions of the NHS Long Term Plan and apply across Trusts and ICBs: quality of care, access and outcomes; preventing ill-health and reducing inequalities; people; finance and use of resources; and leadership and capability.
2	A set of high-level oversight metrics, at ICB and trust level, aligned to these themes.
3	A sixth theme, local strategic priorities. This reflects the ICB's contribution to the wider ambitions and priorities.
4	A description of how ICBs will work alongside NHSE to provide effective, proportionate oversight for quality and performance across the NHS.
5	A three-step oversight cycle that frames how NHSE teams and ICBs will work together to identify and deploy the right delivery support and intervention to drive improvement and address the most complex and challenging problems, respectively.

Throughout 2024/25, the ICB and regional teams worked together to provide oversight of NHS providers and assess the delivery against these domains, working with delivery boards where appropriate. The ICB and regional teams also supported those providers requiring support where services were under-performing.

During 2024/25, UHDBFT were subject to Tier 1 oversight by the regional NHSE team in relation to performance on elective and cancer care. Tiers range from 1 to 3, with Tier 1

being the highest level of scrutiny and involves weekly assurance meetings with Regional Performance Managers. UHDBFT, with support from the ICB, were able to provide greater assurance on improvements throughout 2024/25, which led to a positive move to Tier 2 in Quarter 4 (Q4).

System Performance Management and Oversight

The ICB has established a process to develop a bespoke System Performance Oversight Framework which enables performance to be monitored, managed and reported across all service areas and delivery domains. The framework includes the production of an integrated quality and performance oversight report, which is reported to the ICB Board, and the Quality and Performance Committee.

JUCD has faced a number of performance challenges over recent years, many of which are legacies from the Covid-19 pandemic, extensive industrial action, staff recruitment and retention, as well as the cost of living (financial pressures/inflation). In line with other ICBs nationally, this has impacted all delivery areas with, for example, a reduction in elective activity, while seeing an increase in waiting lists for diagnostic tests and procedures. There have also been challenges with meeting the national cancer standards as demand for cancer services recovered and exceeded pre-pandemic levels. The urgent care system was not only tested over the winter period but was under constant pressure throughout the year due to a significant increase in demand for health and care services locally.

Through the annual planning round, JUCD is working with providers and localities to develop plans for 2025/26, to improve performance in all areas of operational panning delivery and against wider priorities. The key risks for the ICB which could affect the ICB's delivery of its objectives and future performance and plans as identified in the ICB Corporate Risk Register are in relation to:

- acute providers being unable to meet the new target in respect of 78% of patients being seen, treated, admitted or discharged from the ED within four hours by March 2025. This would impact on the System's failure to meet ICB constitutional standards and quality statutory duties, whilst also taking into account the clinical impact on patients and the clinical mitigations in place where long waits result;
- the risk to patients on provider waiting lists as a result of the continuing delays in treatment, resulting in increased clinical harm;
- failure to deliver a timely response to patients due to excessive ambulance handover delays, leading to significant response times for patients waiting in the community for an ambulance response, and resulting in potential levels of harm;
- the risk to RTT and cancer performance as a result of increased demand and insufficient capacity; and
- significant waiting times for moderate to severe stroke patients for community rehabilitation.

The ICB and System are managing these risks daily and are a key priority for achievement in the Joint Forward Plan and 2025/26 Operation Plan. Further information on the ICB's principal risks can be found in the 'key issues and risks that could affect the ICB delivering its objectives' section on page 11 and within the Accountability Report – 'Risk Management Arrangements and Effectiveness' section on page 128.

Performance Summary 2024/25

As of the 31st March 2025, overall performance since the 1st April 2024 showed that the ICB successfully achieved 9 of the key operational performance priorities during 2024/25. Any standards not achieved are detailed by exception within Table 1 in the performance analysis section of this report.

Performance Analysis

Indicator			Target	31st March 2025
Urgent and Emergency Care	A&E	A&E waits less than 4 hours	78.0%	63.1%
	Ambulance	Category 2 average response time	00:24:00	00:34:28
	General and Acute Beds	General and acute bed occupancy	93.0%	95.1%
		Beds occupied by patients no longer meeting the criteria to reside	8.7%	10.0%
	Virtual Wards	Virtual ward capacity	181	145
		Virtual ward utilisation	80%	77%
Primary and Community Care	Primary Care	Increase General Practice appointment activity	6,912,094	7,111,182
		GP Appointments delivered within 2 weeks	75.0%	75.0%
		Increase dental activity	1,527,839	1,303,172
	Community	Patients waiting over 52 weeks on Community waiting lists	2,463	2,940
Elective Care	65-Week Wait	Eliminate waits of over 65 weeks for elective care by September 2024	0	142
	Referral to Treatment	Total RTT incomplete waiting list	125,880	125,416
Cancer	62-Day Standard	Treatment within 62 days	72.4%	72.7%
	28-Day Faster Diagnosis Standard	Diagnosis or decision to treat within 28 days of all referrals	77.1%	76.1%
Diagnostics	Diagnostic test	Wait times - more than six weeks from referral	95.0%	70.7%
		Total diagnostic waiting list	20,979	27,700
Mental Health	Dementia	Recover the dementia diagnosis rate to 66.7%	68.0%	68.8%
	Talking Therapies	Talking Therapies adults reporting Reliable Improvement	67.3%	70.1%
		Talking Therapies adults reporting Reliable Recovery	50.9%	51.5%
	Children and Young People	Improve access to mental health support	14,555	14,430
	Adults and Older Adults	Increase the number of adults and older adults supported by community mental health services	8,427	13,850

Indicator			Target	31st March 2025
	Out of Area	Work towards eliminating inappropriate adult acute out of area placements	0	10
	Severe Mental Illness	Annual Health Checks for those with SMI	73.0%	59.0%
	Perinatal	Improve access to perinatal mental health services	1,111	1,340
Learning Disability and Autism	Learning Disability and Autism	LD Annual Health Check	75.0%	69.9%
		Reduce reliance on inpatient care	32	37

Table 1 – ICB performance against Operational Planning Priorities as at 31st March 2025

Performance Achievements and Challenges

Urgent and Emergency Care

Accident and Emergency waits under four hours

The majority of Derby and Derbyshire patients attend UHDBFT and CRHFT for their emergency needs. Performance as at the 31st March 2025 was 63.1%, falling below the operational plan target of 78.0%. Co-located UTCs at the acute Trusts continued to treat more minor cases that would otherwise have been seen in ED. Whilst this has eased pressures in EDs, it does lead to patients with higher acuity attending EDs leading to proportionally more Type 1 four-hour breaches. The scrutiny on performance also included focus in improving Type 3 and minors performance.

Ambulance – Category 2 Average Response Times

The ambulance Category 2 (C2) performance target remained challenging in 2024/25, with the average C2 response time being consistently above the 30-minute target. In March 2025, the average response time for EMAS was 34 minutes and 28 seconds, which is higher than the 24 minute target.

General and Acute Bed Occupancy

The general and acute bed target to reduce occupancy to 93% or below, is considered to provide the optimum occupation to allow good patient flow through the acute hospitals. In March 2025, the average for UHDBFT and CRHFT was 95.1%.

Elective Care - Referral to Treatment Time (65-week wait)

The total waiting list increased by 0.3% between April 2024 and March 2025, although this is within plan and there was a decrease in longer waits. As at the 31st March 2025, 92 patients were waiting above 65 weeks, which represents an 87% drop since March 2024. Plans are in place to reduce these to nil, in line with the 2025/26 planning priorities.

Diagnostics - Patients waiting 6+ weeks

Percentage compliance is based on seven diagnostic tests (magnetic resonance imaging (MRI), computed tomography (CT) scan, non-obstetric ultrasound, echocardiography, colonoscopy, flexi-sigmoidoscopy, and gastroscopy). At the 31st March 2024 there were 72.4% waiting less than six weeks for their test, but this worsened to 70.7% by the 31st March 2025. The overall size of the waiting list has risen by 12.3%.

Cancer

Waiting Times

As at the 31st March 2025, there were 72.7% of patients being treated within 62 days, which is better than the 72.4% target. The 62-day measure is a focus for the operational plan, with both Trusts achieving better than plan. Improvement teams across UHDBFT and CRHFT focused on developing the diagnostic and treatment pathways to expedite implementation of the national best practice timed pathways across key tumour sites.

28-Day Faster Diagnosis

The ICB is not meeting the 28-day faster diagnosis standard of 77%, but both Trusts have done so at some point during 2024/25. Compliance was near this standard (76.1%) on the 31st March 2025.

Mental Health

Eliminating Inappropriate Out-of-Area Placements

The ICB continued to experience high demand and acuity, issues with flow through acute services resulting in higher length of stays, high occupancy, and an increased use of out-of-area placements. By 31st March 2025 there were 10 patients in inappropriate out-of-area placements. Capacity within the System should be increased by the dormitory eradication programme.

Annual Health Checks for those with Severe Mental Illness

The ICB has a cumulative target for 78% of those with severe mental illness to receive an annual physical health check by the end of March 2025. By the 31st March 2025, 59.0% of patients had received their health check, which does not meet the ambition.

Learning Disability and Autism

Annual Health Checks for those with Learning Disabilities

The ICB has a target for 75% of those registered with a learning disability and/or autism to receive an annual health check by the end of March 2025. By 31st March 2025, 69.9% of patients had received their health check, which did not meet the ambition.

Reducing the reliance on inpatient care for people with a learning disability continues to be challenging for the System. By 31st March 2025, there were 37 patients in this situation, which is above the 32 expected.

Planned Care

The focus for planned care during 2024/25 was to reduce long-waits and improve referral to treatment (RTT) times to enhance patient outcomes and satisfaction. Long-waits can lead to worsening health conditions, increased anxiety and lower satisfaction with healthcare services. Addressing these issues is essential to ensure timely access to care, improve patient outcomes and maintain trust in the healthcare system. Significant progress has been made in reducing the number of patients waiting over 78 weeks, starting the year with 28 breaches and ending with two. Similarly, the number of patients waiting over 65 weeks has been reduced from 1,057 to 142.

To address the large RTT elective wait list, several measures are being implemented:

Advice and guidance	Allows Primary Care providers to seek specialist advice before making a referral, strengthening shared decision-making and avoiding unnecessary outpatient activity.
NHS elective hubs	Dedicated facilities for planned, non-urgent surgeries to improve efficiency, reduce waiting times, and enhance patient outcomes by concentrating surgical expertise and resources in one place.
Community diagnostic centres	Development of centres across Derbyshire, which focus on diagnostics.
Provider productivity	Implementing national approaches of 'getting it right first time' and 'further faster' to improve efficiency and speed up care. Virtual consultations allow patients to receive care without visiting the hospital, improving convenience and reducing travel time.
	Empowering patients to book their follow-up appointments when required, through the 'patient-initiated follow-up' system, rather than on a fixed schedule, to manage clinic capacity more effectively.
Ring-fencing elective care capacity	Protecting elective care from seasonal pressures and future pandemics.

Understanding Waiting Lists

Understanding waiting lists is crucial for addressing population health needs; by focusing on the most deprived 20% of the population and other vulnerable groups, healthcare inequalities can be addressed.

Waiting Well

This approach helps patients maintain their health while waiting for appointments. In some cases, new services such as specialised clinics for high-demand procedures may be needed to streamline patient flow and reduce wait times. Providers also offer varying levels of support, focusing on communication and pre-surgery assistance to ensure consistent and effective patient care.

Specialty Focused Pathway Work

Gynaecology

During 2024/25 the ICB worked towards transforming and reviewing various specialties using best practice guidelines, activity data, and population health needs assessments. In gynaecology, efforts included implementing the pelvic pain pathway and working on menopause, polycystic ovary syndrome and fertility issues. The Referral Optimisation Group and the Expert Advisory Forum began reviewing pathways to improve access and standardisation. The ICB are also developing the Women's Health Hub and the JUCD Gynae Elective Recovery Group to manage the gynaecology wait list and shift activities to Primary Care settings.

Ear, nose and throat

The Expert Advisory Forum is collaborating with regional teams to understand best practices and explore further opportunities to work together. The ICB are also identifying and addressing training gaps through GP Education Hub+ training, developing a dizziness pathway, and understanding ear wax management and hearing loss pathways with Primary Care and Place teams.

Dermatology

Dermatology services currently face significant challenges, including high demand and workforce shortages. Skin disorders affect over half the population annually, leading to 13 million Primary Care consultations and 880,000 specialist referrals. In Derby and Derbyshire, efforts focus on maintaining dermatology services and collaborating with other ICBs to manage contracts. To improve access to care, prioritising community dermatology opportunities is essential; shifting routine care to community settings can reduce the burden on hospital outpatient clinics and provide more accessible care, aligning with efforts to reduce health inequalities.

Ophthalmology

The ICB is committed to ensuring patients receive the right care at the right time, and community services like the minor eye conditions service play a crucial role in this. In 2024/25, 10,936 patients used the minor eye conditions service, with 79% treated outside of a hospital setting. This has helped to reduce the burden on hospital services and ensure patients get timely care.

The ICB are also implementing the eyecare electronic referral system for optometrists, which streamlines the referral process and provides advice and guidance from Trusts. A Derbyshire model is in development for ophthalmology triage, to manage the expected growth in ophthalmology services, ensuring patients are seen in the right place, first time.

Musculoskeletal

Musculoskeletal (MSK) conditions are the leading cause of work absence and physical disability in the UK. To address this, the ICB launched a pilot digital platform for MSK services in November 2022, which concludes in April 2025. The insights gained from this pilot will help shape future digital solutions.

Nationally, the 'getting it right first time' programme is helping to improve MSK services by identifying best practices and reducing variations in care, and a sustainable model which includes MSK is in development. This initiative supports our local efforts to enhance service delivery and patient care.

Review of historic contract arrangements

During 2024/25, the ICB reviewed historic contract arrangements to ensure current needs were being met and they provided good value for money. It also aimed to ensure all patients receive consistent and high-quality care, ultimately improving the healthcare system.

The review focused on services that were once tailored for specific populations but were no longer justified by population health needs. The goal was to ensure everyone had equal access to high-quality services. Equality Impact Assessments and patient and public involvement in the decision-making process helped decide whether to renew certain services or provide alternative options. The ICB ensured a smooth transfer of patients to new services and maintained clear communication with providers throughout the process.

Patient-initiated digital mutual aid system

During 2024/25, the patient-initiated digital mutual aid system allowed patients with long waits to request transfers to providers with shorter waiting times. While the system provided options for many patients, not all could be moved due to clinical suitability or capacity issues. Challenges included limited capacity at alternative providers, clinical appropriateness of transfers, and increased administrative workload. Although the process was eventually closed down, it highlighted the importance of patient choice and flexible solutions for managing waiting lists.

Diagnostics

The NHS uses several key measures to ensure diagnostic services are efficient and effective. One important measure is the wait time for diagnostic tests, which refers to the time patients wait from being referred to actually receiving their tests. Shorter wait times lead to quicker diagnoses and treatments, significantly improving health outcomes. The NHS aims to keep diagnostic wait times within six weeks for timely care.

CRHFT began 2024/25 with 70.7% of diagnostics waiting less than six weeks, however faced a reduction in performance to 59.3% by the end of the year. Despite seeing improvements during the year, UHDBFT began 2024/25 at 78.9% of diagnostics waiting less than six weeks and ended at 78.5%. Challenges have included increased referral volumes and workforce shortages, which have impacted on timely diagnostic services. These factors strained capacity and hindered the ability to meet demand, affecting healthcare delivery efficiency.

Community Diagnostic Centres

Focusing on diagnostics offers vast opportunities to enhance the healthcare system, including Primary Care and community services. Direct access can streamline patient pathways, reduce waiting times, and improve early detection and treatment. Expanding diagnostic capabilities ensures timely and effective care. However, challenges include financial constraints and workforce shortages, which must be addressed to fully realise the potential of enhanced diagnostic services.

Cancer

During 2024/25, the ICB have developed plans to enhance early diagnosis initiatives. The national ambition is to have 75% of cancers diagnosed at stage 1 or 2 by 2028. Currently, JUCD as a System is at 53%, indicating that more work is needed.

The NHS cancer constitutional standards ensure timely access to diagnosis and treatment, including the 28-day faster diagnosis standard; the 62-day standard – from urgent referral to treatment; and the 31-day standard – from decision to treat to the start of treatment. These standards are crucial for early detection and prompt treatment, improving patient outcomes and survival rates.

University Hospitals of Derby and Burton NHS Foundation Trust

UHDBFT faced significant challenges with referral volumes during 2024/25, the 28-day faster diagnosis standard started the year at 71.2% and ended at 75.1%. The 31-day standard was challenged due to insufficient linear accelerator capacity, impacting the NHS cancer pathway. Workforce challenges led to a short-term shortage, causing delays in treatment and longer waiting times. While these workforce issues have been resolved, ongoing capital risks associated with maintaining the equipment remain.

Chesterfield Royal Hospital NHS Foundation Trust

CRHFT started the year with a 28-day faster diagnosis standard at 77.2%, which fluctuated during the year and ended at 76.9%. CRHFT has faced challenges with pathway flows into Sheffield, affecting the efficiency of patient pathways. Additionally, rising demand in gastroenterology and upper gastrointestinal tract services has added further strain on performance.

Colorectal and endometrial cancers

Lynch syndrome testing screens for genetic mutations that increase the risk of colorectal and endometrial cancers. It starts with tumour testing using immunohistochemistry or microsatellite instability testing, followed by germline testing if Lynch syndrome is suspected. Early identification allows for targeted surveillance and preventive measures, reducing cancer risk, and also enables cascade testing for family members, allowing early intervention and improved outcomes. Ensuring sustainability involves addressing challenges like consistent testing practices, adequate funding, and integrating testing into routine clinical practice. This test is fully implemented across both CRHFT and UHDBFT.

The implementation of the faecal immunochemical test (FIT) pathway across Derbyshire and Staffordshire has led to the ICB achieving an 83.6% compliance rate, surpassing the national ambition of 80%. This non-invasive test allows for early detection of colorectal cancer by identifying hidden blood in stool samples, making it more comfortable for patients compared to a colonoscopy.

Nationally, UHDBFT was the first to implement FIT@80, adopting a threshold of 80 micrograms of haemoglobin per gram of faeces for further investigation. This has streamlined patient pathways, reduced waiting times, and improved early detection and treatment outcomes. However, challenges with provider compliance have been noted, particularly with the influx from Staffordshire, where a different delivery model is used. Addressing these challenges is crucial for maintaining high compliance rates and ensuring the success of the FIT pathway.

Transvaginal ultrasound

Implementing a direct access gynaecological transvaginal ultrasound pathway at UHDBFT has significantly improved patient care and outcomes. This service allows for quick cancer ruling out, early detection and treatment, reducing anxiety and unnecessary referrals. Transvaginal ultrasounds provide detailed imaging of pelvic organs, aiding prompt diagnosis and treatment. Patients receive immediate results, speeding up the diagnostic process and reducing the psychological burden of waiting. Early detection through this service leads to better treatment outcomes and improved survival rates. Additionally, it has reduced outpatient referrals, streamlined patient pathways and eased the workload on outpatient clinics, ensuring more efficient use of resources.

East Midlands Cancer Alliance

The Midlands faces significant oncology workforce shortages and the East Midlands Cancer Alliance aims to improve workforce stability and ensure equitable access to non-surgical oncology treatments. Despite efforts, challenges remain in integrating genomic data into clinical practice and maintaining a sustainable workforce. Addressing these issues is crucial for improving cancer outcomes and ensuring patients benefit from genomic advancements. The ICB are therefore working on a System-wide approach to cancer prevention, addressing health inequalities, and promoting early diagnosis. This involves a community and neighbourhood approach to support local areas in defining their specific needs. By leveraging the support of the East Midlands Cancer Alliance, we aim to improve cancer experiences and outcomes for all patients.

Teledermatology

During 2024/25 there was an increased focus on teledermatology, due to its potential to revolutionise patient care. Teledermatology relies on the quality of patient-provided images, which can sometimes be inadequate and delay treatment. By focusing on the right patient pathway and the delivery of routine dermatology services in the community, timely and effective treatment closer to patients' homes can be provided, reducing the burden on hospitals and improving patient outcomes. This will continue to be a significant focus for 2025/26, in order to enhance the efficiency and effectiveness of cancer prevention and early diagnosis initiatives, ultimately improving patient outcomes across the region.

Oesophageal cancer

The ICB has partnered with Heartburn Cancer UK to tackle oesophageal cancer, launching a pilot project in March 2024 to spread the learning across JUCD, East Midlands and beyond. oesophageal cancer is one of the deadliest cancers, often diagnosed late when treatment is less effective. Early detection and increased awareness are crucial for improving outcomes.

The partnership with Heartburn Cancer UK aims to raise awareness and support early diagnosis through community engagement and targeted campaigns. This approach has shown positive impacts, with an increased awareness among patients and early diagnosis, which is crucial for better treatment outcomes.

Lung cancer

During 2024/25, the ICB have invested resources to understand the opportunities and impact of implementing lung cancer screening. Using low-dose CT scans, screening detects cancer at an early, more treatable stage, significantly improving outcomes and saving lives. Nationally, early detection leads to more effective treatments, improved survival rates and reduced lung cancer burden on the healthcare system. It also helps identify high-risk individuals for preventive measures. Addressing financial and logistical challenges is crucial for the success and sustainability of lung cancer screening, allowing us to fully realise its benefits and provide better care for patients.

Cancer Prevention

By developing a neighbourhood approach to support cancer prevention and early diagnosis, increasing public awareness and educating GPs through partnering with the GP Hub, the ICB aims to deliver sustainable care at community-level, focusing on preventative, early diagnostic and personalised care. Additionally, we emphasise rehabilitation in a community setting to help patients recover in a more familiar and supportive environment. This strategy aims to improve health outcomes, reduce the burden on hospitals, and ensure care is tailored to the unique needs of each community.

The ICB also aims to develop a System-wide approach to cancer prevention, addressing health inequalities, and promoting early diagnosis. This has included a community and neighbourhood approach to support local areas in defining their specific needs. By leveraging the support of the East Midlands Cancer Alliance, we aim to improve cancer experiences and outcomes for all patients.

Urgent Care

The JUCD System continues to be under sustained and significant pressure and the ICB supports System partners every day of the year to manage this, with a particular focus on patient flow in and out of hospital, and improving access to urgent care services. Other key focus areas include supporting systems to maintain strong links between service providers, so that patients can easily access care.

System Coordination Centre

Throughout 2024/25, the System Coordination Centre has been operational from 8am to 6pm, seven days a week, ensuring the ICB has visibility of operational pressures and risks across providers and System partners. It coordinates an integrated System response using the National Operating Pressure Escalation Level Framework, which outlines core actions.

The System coordination centre is also responsible for supporting:

- interventions on key systemic issues affecting patient flow, including a concurrent focus on urgent and emergency care, and the System's wider capacity including, but not limited to: discharge; NHS 111; Primary Care; patient transport; intermediate care; social care; urgent community response; and mental health services;
- System-wide planning to assure operational output before, during and after industrial action and bank holidays;
- escalations for mental health, patient transport, community and out-of-area issues;
- ambulance pre- and post-handover monitoring, to support patient flow; and
- the delivery of a live operational management platform providing instant visibility of whole-System data and status, for improved patient flow and safer care.

During 2024/25, System operational and tactical-level meetings were frequently convened to support and manage pressure. Operational and tactical-level activities were supported by strategic meetings as part of the escalation process when required.

Demand Management

The System continued to work together to identify areas of opportunity for alternative ways of providing care, which reduced pressure in EDs, decreased ambulance handover times, managed increasing demand and optimised the opportunity to provide good quality care.

Seasonal Planning and Monitoring

During 2024/25 a seasonal plan was implemented across the System to plan, execute, and monitor operations throughout winter. Collaborative efforts ensured seasonal planning and monitoring were effective.

Urgent Care Transformation

By thinking differently, being innovative, and working together to change health and care services, people in Derby and Derbyshire can 'Start Well, Live Well, Age Well and Die Well'. During 2024/25, the ICB collaboratively worked with acute Trusts, Primary Care, Place and community to transform services, with a continuous focus on patients receiving the right care, in the right place, first time.

Collaborative working is increasing efficiency, improving effectiveness, and future proofing the local NHS so it is sustainable and adaptable to future challenges, by investing in things like community-based services. Most importantly, it is improving the health and wellbeing of people who live in Derby and Derbyshire. This work is governed by and discussed in the Urgent, Emergency and Critical Care Board and Transformation Delivery Group meetings.

Meetings with service providers continue to be held regularly to discuss urgent, emergency, and critical care and to deliver the Urgent Care Transformation Programme.

Same-day emergency care

Same-day emergency care (SDEC) is the provision of same-day care for emergency patients who would otherwise be admitted to hospital. SDEC continues to be a priority for the acute Trusts, and the ICB reviews where the System can further progress and maximise SDEC within Derby and Derbyshire.

During 2024/25, a focus on maximising direct pathways resulted in the expansion of SDEC service opening times to support increased demand. Several pilots and changes were implemented to trial new processes, staffing models and estates, all of which had a positive impact on SDEC activity. The SDEC service are proactively accepting direct referrals from ambulance services, General Practice and the central navigation hub (CNH), reducing the need for patients to visit our EDs.

Central Navigation Hub

The CNH is Derby and Derbyshire's single point of access for health care professionals to navigate care for their patients. Its primary function is to ensure patients have a positive experience and outcome in their care. Parallel to this, it also aims to provide staff with a positive experience when accessing the CNH, by helping them navigate the right part of the system smoothly and efficiently, with clinical safety always being of the utmost importance.

As the CNH continues to further embed itself as the single point of access, it is having a positive impact on the already pressurised urgent and emergency care system. During 2024/25 the CNH deflected, on average, over 1,000 patients per month from our EDs to a more suitable care pathway. In addition to this, the CNH supported approximately 1,200 patients per month by redirecting them to a more suitable alternative to Primary Care.

By following three key principles 'keeping things simple, do it once and do it right' – this model of working is becoming a cornerstone of integration. The ICB are working with System partners to continue to define and enhanced the CNH further. JUCD are the first System in England to incorporate pathways from NHS 111 online relating to Primary Care and General Practice into the CNH.

Urgent Treatment Centres

Urgent Treatment Centres (UTCs) continue to provide valuable and locally accessible urgent on-the-day services to the Derbyshire population. In Derby and Derbyshire, the aim is to deliver a joined-up urgent treatment system which meets the needs of the local population and is compliant with national standards.

Derby City Urgent Treatment Centre

The ICB, led by the UTC Strategy Group, Derby UTC Task and Finish Group and public and patient engagement, have reviewed the current and potential future use of the service provided by the Derby city centre UTC, which provides assessment, care and treatment for both minor injuries and illnesses.

A procurement process based on a revised service specification concluded in February 2024, and focused on working together with other Derbyshire health and care services to integrate the UTC services offer with those in Primary Care and the wider health community. The new service went live on the 1st July 2024, with Derbyshire Health United Community Interest Company (DHU) as the new provider.

Community and Urgent Same Day Care

The ICB continues to undertake a strategic review of community and urgent same day care, and following extensive ICS engagement, the focus has now widened to the strategic vision for community urgent and same day care in Derby and Derbyshire.

This work will be led by the ICB, but is a shared workstream across numerous parts of the ICS, with particular focus on Place and Primary Care within the urgent care system.

Working closely with Place and Primary Care, the co-production of a System-wide, jointly owned programme of work will support the vision, drive integrated improvements and maximise the potential that is already available within community services expertise and infrastructure. This will result in an integrated model shaped by clinical expertise, evidence-based practice and lived experience which considers population needs and health inequalities.

The Derby and Derbyshire vision for an integrated community urgent and same day care system, will be one that embeds care within the local community for each Derbyshire patient. This begins with self-care, supported by an offer from Pharmacy First, General Practice and linking into the wider PCN offer within that geographical area, which will be specific to local population need. Bridging, signposting, and supporting care will be delivered via CNH and 111 to support this.

Following a delivery plan for recovering urgent and emergency care services, there is an expectation that UTCs should be co-located within EDs to help ease pressure on EDs and enable emergency medicine specialists to focus on those patients who are seriously unwell. In addition to Derby and Derbyshire's five community UTCs, GP-led co-located UTC services have been contracted at the hospital front doors of Royal Derby Hospital and CRHFT to provide urgent care across the Derbyshire population. Further work is now underway to review the current impact and performance, as well as plans for the co-located UTC provision at both acute Trusts.

Primary Care

Empowering General Practice Programme

The Empowering General Practice Programme (EGPP) plans to create a sustainable, thriving General Practice. The programme was developed partly in response to Dr Claire Fuller's 'Next steps for integrating Primary Care: Fuller stocktake Report' (2022) and was affirmed by Lord Darzi's report on 'The State of the National Health Service in England' (2024).

The pressure in General Practice means that there is a need to move care closer to home with a focus on the importance of improving productivity and flow. The EGPP will deliver a framework to do this, as well as a strategic response to some of the pressures and concerns that are driving the current GP collective action.

Aims

The aims of the model are to provide a consistent offer of access to Primary Care for all people to:

- provide responsive care for people with low complexity through a neighbourhood hub model;
- improve the relational continuity for all people with high and rising complexity;
- provide enhanced care coordination for those with extreme complexity;
- support local practices that are under strain and improve staff wellbeing; and
- support the achievement of key system objectives, through plans that are integrated with Place, the Provider Collaborative and JUCD Delivery Boards.

The core focus throughout 2024/25 was stakeholder engagement and ensuring PCNs understood the EGPP vision. This was also an opportunity to alleviate concerns and any misconceptions in preparation for phase one, the accelerator projects.

Phase One Accelerator Projects

For phase one we empowered PCNs to work on projects to benefit their population and align simultaneously to the model. As a result, 13 out of 18 PCNs are participating in this phase. We are also providing PCNs with regular supported one-to-ones to initiate neighbourhood working. A summary of the projects are as follows:

Belper
Identification of a system tool to better support complex patients in accessing the right care.
Chesterfield & Dronfield
To provide improved, coordinated care for the top 5% most complex patients by trialling an innovative referral process which incorporates multi-disciplinary team (MDT) care.
Derby City North
Develop and set up a palliative care GP home-visiting service to improve patient continuity of care.

Derbyshire Dales
Increase pharmacy role to deliver medication and health reviews to create capacity in individual practices.
Erewash
To use population stratification to better allocate resource to need, to patients with long term conditions.
Greater Derby
Focused support for housebound patients ensuring they have better outcomes and reduced need for emergency care.
North Derbyshire
To reduce the number of high impact users and support these patients to remain well at home and cared for in the community.
North Hardwick
Multi-targeted approach to key demographics in the PCN to reduce obesity and late diagnosis of CVD, hypertension, and cancer.
Oakdale
Improve quality of life, reduce hospitalisations and enhance care co-ordination for the frail population, with a focus on housebound patients.
Primary Care Contractor Organisation
Establish a system to measure and report the number of patients trying to access healthcare in the low complexity cohort and map service delivery to their needs.
South Dales
To pilot a falls prevention service to reduce avoidable attendance at A&E, admissions, length of stay and improve patient discharge.
South Hardwick
Improve activity between General Practice and community pharmacy to benefit patients.
Swadlincote
To utilise the PCN hub to support low complexity patients at scale and increase capacity in individual practices for more complex patients.

The programme goals for 2025/26 are to:

1	Identify and pilot a population stratification tool in a minimum of one PCN.
2	Run year-one of the accelerator programme.
3	Draft a business case to set out the future plan for the EGPP.
4	Develop and agree the organisational infrastructure that could take forward the plan at scale.
5	General Practice support for other key transformational aims.

Derbyshire Primary Care Workforce

General Practice Workforce

The total permanent General Practice workforce headcount for Derbyshire as of the 31st March 2025 was 3,956, working a full-time equivalent (FTE) of 3,004.0. This is an increase of 57.0 FTEs since the 31st March 2024, which equates to an overall increase of 2%. Within the workforce there are four main staff groups; all available data is taken from the National Workforce Reporting System, as per Table 2.

General Practitioners	999 headcount (799 FTE)
General Practice nursing	496 headcount (360 FTE)
Direct patient care (those other than GPs and nurses who provide care to patients, for example, health care assistants, physiotherapists, pharmacists or paramedics)	356 headcount (268 FTE)
Administration and non-clinical	2,105 headcount (1,577 FTE)

Table 2 – Primary Care Workforce staff group data as at the 31st March 2025

The General Practice workforce in Derbyshire is positive and the staff group is showing an increase, but this is likely due to trainees qualifying and joining the workforce. GPs are showing the healthiest growth; nursing numbers remain the same and all other staff groups are showing slight decreases. There is a possibility that the decrease in direct patient care and administration roles could be due to the success of the Additional Roles Reimbursement Scheme (ARRS) recruitment. Finances are another key factor, as the agreed uplift and increase in National Insurance contributions is putting additional financial pressure on practices, which may mean they choose not to replace core staff.

In terms of age profile, historically the General Practice workforce was comparable with other areas of the country, however we are currently seeing an increase in younger age groups. 59% are now under the age of 44, which is a 25% increase since September 2024, and 23% are under 34, which has doubled since September 2024. Our numbers of GPs over the age of 55 have decreased to 12%. The nursing workforce has shifted favourably by 10%, with 36% under the age of 44, and 32% are now over the age of 55 (an increase of 5%). All the nationally recommended recruitment and retention schemes are in place and delivering. The ICB have worked with System partners to ensure schemes were funded at 2023/24 levels to ensure continuity of service.

Additional Roles Reimbursement Scheme

It is important to note that the data above does not include staff recruited by PCNs under the ARRS, which is available to PCNs participating in the PCN Direct Enhanced Service (DES)Contract. ARRS began in July 2019 to allow PCNs to recruit additional staff, outside of GPs and nurses, to work in General Practice and be reimbursed by NHSE for salary and on-costs. Derbyshire's share of the national target was 455 whole-time equivalents (WTE) by March 2024; this target has not been increased with the extension of the DES to March 2026.

As of the 31st March 2025, PCNs had recruited 727.70 FTEs under the scheme, exceeding the target by 59%. This is a decrease from 2023/24, however there is a shift towards more permanent recruitment. PCNs had £26.9m to invest in additional staff this year and have spent 98% of the available core funding. In addition to the original ARRS investment, funds are also available to recruit GPs under the scheme, providing they meet the criteria of being newly qualified and not having worked in General Practice substantively before. Derbyshire received £1.5m for GP ARRS recruitment, and collectively PCNs have spent 54% of this budget, which equates to £837k. As of the 31st March 2025:

- 15 of 18 PCNs planned to recruit GPs;
- only three PCNs were undecided, and this is largely due to the funding available; and
- across the PCNs, 34.13 WTEs were in post.

2025/26 will be the last year that PCNs are able to recruit under the ARRS and we expect PCNs to utilise their full financial allocation.

Pharmacy, optometry and dental workforce

Workforce data for optometry is not yet available to ICBs; pharmacy and optometry data is not as in-depth as the NWRS data available for General Practice, as it only covers staff and activity, which is broken down by contract type and gender.

Dental workforce has reduced due to Covid-19, however in the Midlands our numbers have increased slightly by 0.4% (when compared with 2019/20 data).

The pharmacy workforce data is submitted annually and the most recent return illustrated that there was a response from 87% of pharmacies, which NHSE were able to aggregate up to 100%. Nationally, the number of pharmacists appear static, although the data is only available in headcount and not WTE, and the number of technicians has decreased. The pharmacy workforce for the Midlands region increased by 6.3%, which is positive when compared to the national increase of 4%.

Primary Care Access Recovery Plan

A joint NHS and Department of Health and Social Care Delivery plan for recovering access to Primary Care was published on the 9th May 2023. The plan focuses on recovering access to General Practice and supports two key ambitions:

1. tackling the 8am rush and reducing the issue of people struggling to contact General Practice – patients will no longer need to call back another day to book appointments;
2. for patients to know on the day they contact their General Practice how their request will be managed. If their need is:
    - clinically urgent it will be assessed on the same day by a telephone or face to face appointment. If the patient contacts their General Practice in the afternoon they may be assessed on the next day, where clinically appropriate; and
    - not urgent, but it needs a telephone or face-to-face appointment, this will be scheduled within two weeks.

Where appropriate, patients will be signposted to self-care or other local services (e.g. community pharmacy or self-referral services).

Capacity and access improvement plans

Over the last two years, the ICB has worked with 18 PCNs to develop their capacity and access improvement plans. These plans incorporate all requirements of the Primary Care access recovery plan, with the ambition to achieve or work towards the target, where appropriate. The ICB continues to work with General Practice to make progress against plans, in particular around working with practices whose number of appointments per mode highlight them as an outlier compared with the rest of Derbyshire.

Derbyshire has made significant progress against the 'registering with a General Practice' metric, with all 111 practices now enrolled. Work is ongoing with the GP Provider Board to implement the new clinical model for General Practice, ensuring the two plans continue to complement each other. Progress has been made across the following three main domains for the 2024/25 Primary Care access recovery plan:

Better Digital Telephony
Digital telephony solution implemented, including call back functionality, with each practice complying with Data Provision Notice.
Digital telephony data routinely used to support capacity and demand service planning and quality improvement discussions.
Simpler Online Requests
Online consultations available for patients to make administrative and clinical requests at least during core hours.
Agreement from practices to the relevant data provision notice for data to be provided to NHSE as part of the 'Submissions via Online Consultation Systems in General Practice' publication.
Faster Care Navigation, Assessment and Response
Consistent approach to care navigation and triage for parity between online, face-to-face and telephone access, including collection of structured information for walk-in and telephone requests.
Asking patients their preference to wait for a preferred clinician, if appropriate.

General Practice Appointment Data

The total number of appointments provided during 2024/25 was 599,277, which is approximately the same as 2023/24 (when corrected for working days). In addition, there were 6,386 home visits provided by the Ageing Well Support Programme, relieving pressure in General Practice.

Approximately 69% of appointments were face-to-face (415,156 in total) and 39% of patients were seen on the same day, which is a slight decrease on the previous year. However, telephone appointments have increased by 1% compared to 2023/24, and make up 21% of appointments. The number of video/online appointments delivered make up 6% (approximately 34,046) of overall appointments, which is an increase of 39% compared with the previous year.

During 2024/25, there were 61,000 online consultations (an increase of 30% compared to 2023/24), as a result of practices moving to the 'Modern General Practice Model'.

As of the 1st October 2022, enhanced access formed part of the PCN Direct Enhanced Service contract to help General Practice deliver more of its potential to improve the care available to patients. Longer opening times (via geographically based hubs which operate additional appointments Monday to Friday, 6.30pm to 8pm and 9am to 5pm on Saturdays) for patients in Primary Care have now been rolled out across every PCN in Derby and Derbyshire. There were approximately 19,000 enhanced access appointments offered by PCNs across Derbyshire during 2024/25.

NHS Dental Services

In April 2024, ICBs took responsibility for the commissioning of pharmacy, optometry and dental services. As a result of this, an oral health needs assessment (OHNA) for was produced, which informs the ICB of areas of need and will be used to plan and prioritise NHS dental services in future years. Using the findings of the OHNA, three-year plans were drafted and agreed, which will drive commissioning of dental services in Derbyshire for the next three years. Activity in areas where dental providers have closed or significantly reduced their NHS commitment have received increased provision and support from community dental services, and are embarking on a pilot service to provide NHS dental care in residential care homes.

The ICB have also strengthened links with System partners and attended a range of stakeholder events and meetings with the Local Dental Network, Local Dental Committee, and Oral Health Steering Group. The ICB are working with colleagues in Public Health and the NHS East Midlands Primary Care Team, who play a key role in the commissioning and development of NHS dental services. In December 2024, the ICB facilitated an event which brought together a range of stakeholders to discuss and develop outline plans not only for NHS dental services, but the wider oral health agenda. A range of additional schemes are commissioned to increase current activity and NHS service provision, including 110% activity being commissioned through high-performing providers. Flexible commissioning targets, sessions for the most vulnerable residents and a significant amount of sessional activity is being utilised to bolster urgent access for patients in association with 111. Additionally, the ICB have fulfilled the requirements of the national dental recovery plan, which encouraged ICBs to provide:

- an increase to the minimum unit value we pay our providers to ensure equity and encourage retention of NHS services;
- a new patient premium incentive to encourage NHS dental providers to see patients who had not accessed a dental service in two or more years;
- a 'golden hello' scheme to attract dental professionals in geographical areas known to be difficult to recruit, including four new recruits for services in Derby, Bolsover and Amber Valley;
- the commissioning of services on a flexible basis by offering the ability for providers to use underutilised dental activity in alternative ways to increase access for patients; and
- increased access to urgent dental services by commissioning additional sessions from current providers, thereby providing further incentive for providers to deliver more NHS activity.

Primary Care Estates

During 2024/25 the ICB took a lead role in the NHS Local Improvement Finance Trust Programme, which involved key discussions with System colleagues around the utilisation of the estate. Several options are under development, which aim to improve utilisation, remove unsuitable or surplus buildings and support providers in the rationalisation of their estates.

The benefits of improved System-level working are significant and highlight opportunities through a shared understanding of strategic aims within a confidential environment. These working relationships will be vital to the development of plans for neighbourhood hubs during 2025/26, as issues regarding Primary Care estates are now better placed alongside those of Trusts and other public sector organisations. Relationships with Local Planning Authorities have further developed during 2024/25, with proactive conversations around infrastructure taking place ahead of the development of local plans, which is crucial as housing allocations continue to grow.

The ICB supported eight practices to secure £159.7k in Section 106 contributions in 2024/25, including capital investment to enable Swadlincote PCN to develop Ragsdale House, which is operational and delivering services to patients. One practice was supported to secure a total of £626.5k in business as usual capital investment.

Looking forward to 2025/26 the ICB aims to work with General Practice to develop a capital programme for the investment of £1.922m in utilisation and modernisation funding and £919.0k in business as usual capital, whilst also continuing to ensure that Section 106 funding is utilised where available. Work will also commence to update the Primary Care Estates Strategy, to primarily refresh housing and population growth, and review strategic priorities.

Primary Care Digital and Information Governance

The ICB has developed an increasingly close relationship with colleagues from the Local Medical Committee, GP Provider Board and colleagues across Primary Care culminating in the establishment of a Primary Care Digital Steering Group to allow a formal forum for discussing and agreeing strategic aims, priorities and funding decisions to support front line services. Reporting to the Primary Care and Community Delivery Board, the steering group supports the strategic aims of the modern General Practice agenda while understanding the impact of programmes such as Team Up and how these should be supported and incorporated into the work of the ICB.

During 2024/25, the ICB's Section 251 application was renewed to support risk stratification and the ability for the ICB, with Primary Care partners to identify particular cohorts of patients who may benefit from increased interventions or new techniques to allow them to continue to live healthy lives.

An information sharing framework has also been developed to support the flow of data across the various ICS partners and to introduce a data sharing agreement, which will allow the ICB to deliver on their objectives around population health management and research.

The ICB continue to work with partners across JUCD, the wider Midlands region and nationally to look at ways of collaborating to improve the delivery of digital and information

governance services to NHS organisations and front-line services. The ICB also work closely with colleagues within Emergency Preparedness, Resilience and Response (EPRR) and from the cyber security community to help keep patient and other confidential information secure, ensuring the availability of key systems such as Primary Care clinical systems.

Focus on activity

During 2024/25, activity included:

- commissioning a replacement secure network across Primary Care and the ICB to provide additional capacity and resilience, linked to the growth in digital tools within Primary Care;
- supporting the national programme to replace outdated telephony systems across Primary Care with cloud-based alternatives, providing additional functionality to General Practices and patients;
- overseeing a technical refresh programme across Primary Care to replace devices no longer performing necessary functions, so patient-facing staff would benefit from dual monitors and larger screens;
- supporting the selection and procurement of advanced digital tools to support improvements in patient triage within General Practice and across the PCN;
- continued development of the Derbyshire Pathfinder Programme, providing clinical colleagues with a curated set of approved patient pathways and electronic referral forms to help ensure patients are placed on the correct pathway at the earliest opportunity and the necessary data is captured to evaluate the referral; and
- increasing access to a wider range of automation tools to assist with delivering more efficient back-office functions.

Programme Management, Design, Quality and Assurance

The Programme Management, Design, Quality and Assurance Team are part of the ICB's Medical Directorate's remit to lead on ICB and JUCD programmes and projects. Programme objectives are agreed through the ICB's planning process and by the Medical Directorate, and are aligned to the NHS Long Term Plan, the Integrated Care Strategy for Derby and Derbyshire and local NHS plans.

The scope of projects includes but is not limited to:

- NHSE national programmes and initiatives;
- fragile services;
- long-term conditions;
- prevention; and
- work, health and skills.

The team also provide assurance to NHSE initiatives, coordinate System interface, and support ICB clinical leads in the coordination of long-term condition delivery groups. Delivery highlights during 2024/25 include:

Cardiovascular Disease	
Cardiovascular disease prevention plan	A five-year prevention plan was developed and approved, which focuses on ensuring optimal treatment and case findings of patients with undiagnosed atrial fibrillation, high blood pressure (hypertension) and elevated cholesterol. The plan targets the most deprived areas (index of multiple deprivation areas 1–3) as national evidence identifies that people living in the most deprived areas are almost four times more likely to die prematurely of cardiovascular disease than those in the least deprived area. It is proposed that the plan will be delivered as a Place-based approach across smaller geographical footprints to suit local population needs and demographics.
Stroke	
Stroke rehabilitation service pathway redesign	Stroke rehabilitation services have been benchmarked against the NHSE integrated community stroke service model to identify gaps in local service provision. There is a focus on developing an equitable patient pathway to drive patient outcomes. A public engagement programme has been implemented to obtain feedback to support patient pathway redesign, A stakeholder task and finish group has also been established to develop future service model options aligned to national guidance.

Hyper acute and acute stroke services review	It is recognised that stroke workforce capacity is a national issue. The ability of a single acute provider or System to mitigate risks to the stroke service workforce is limited within this national context. The team led an engagement event with regional stakeholders to identify opportunities of joint working to support the sustainability of services. Feedback from the event and System governance led to the recommendation that the East Midlands Acute Providers (EMAP), a collaboration of eight NHS Trusts is best positioned to stabilise stroke services at a regional level. EMAP objectives include: • cross-border sub regional contingency planning; • service redesign at scale; and • interface between acute Trust providers.
Diabetes	
Type 2 Diabetes in the Young Programme – an initiative for people with early onset type 2 diabetes	Year two delivery of the programme was implemented to enable additional reviews for patients with type 2 diabetes aged 18–39 across General Practice., with a focus on eight care processes and three treatment targets.
Diabetes-specific psychology support	A consultant psychologist was recruited for a fixed-term period. 63 referrals were received with 69% opting-in for support and 77% appointments being attended. Patients reported improvements to their health and reductions to the perceived burden living with diabetes had on their life, this included a 25% reduction in diabetes-specific distress, and 73% of patients reported improvements to how they rated their health daily.
Long-Covid-19 (post-Covid-19 syndrome)	
Post-Covid-19 service	Following an options appraisal process, a new service model was implemented in line with national guidance and the service transitioned to a one service provider model.
Tobacco Dependency Treatment Services	
Tobacco Dependency Programme	Tobacco dependency champions and advisors continue to provide smoking cessation support to patients who are admitted to an inpatient setting including a focus on mental health inpatients and maternity services. Over 6,000 inpatients and 1,000 maternity clients have been referred into the programme this year. For the patients that opt into the service, over 50% achieve a 4-week quit. Additional fixed term funding has been received in-year to provide smoking cessation support within the ED at Royal Derby Hospital. A research project will be initiated to inform best practice in the delivery of health promotion and quick interventions in this setting.

Primary and Secondary Care	
Primary and Secondary Care interface	Good organisational care across the interface between Primary Care (including General Practice) and Secondary Care providers is crucial in ensuring that patients receive high quality care, to make the best use of clinical time and NHS resources in all settings. A JUCD Primary and Secondary Care Interface Group was established in April 2024 to provide leadership in how care can be improved through better interface processes and behaviours. An agreed priority to implement a single point of contact provided within each Trust for General Practice to contact regarding patient queries was implemented in March 2025, and there is a shared ambition to extend the model to be patient and public facing in the future.
Virtual Wards	
Virtual wards services	Virtual wards allow patients to receive hospital-level care and monitoring at home safely, helping speed up their recovery whilst also freeing up hospital beds for patients that need them more urgently. Virtual ward services are delivered across acute, community and hospice providers, and patient feedback remains positive. Following a service review, the delivery of virtual wards will continue to develop to improve access, with a focus to shift services from hospital to community to support a reduction of avoidable hospital admissions.
Work and Health	
Work, health and skills integration	The delivery of the Work, Health and Skills Integration Programme commenced to reduce health-related economic inactivity. To date a baseline report has been submitted to NHSE, and the team have engaged with several key stakeholders. A strategic overview has been developed to detail next steps.

Medicines, Prescribing and Pharmacy

During 2024/25, a restructure of the Pharmacy Directorate Team was designed to embed and evolve functions to meet the needs of the ICB and wider System. From a core business perspective, the key functions were delivered in supporting the safe, effective and efficient use of medicines. This includes the delivery of efficiency targets, governance reviews to ensure continued clinical decision-making and quality initiatives such as antimicrobial stewardship.

The vision is to make a difference to the System's population health through medicines and pharmacy, and to achieve this a key part of our strategy is driving pharmacy professional leadership, community pharmacy integration and collaborative working to integrate pharmacy and medicines initiatives within the System. Highlights from 2024/25 include:

- programmes of work to improve the quality and value of medicines utilising digital innovation and greener NHS medicines carbon footprint;
- recognising the opportunities for community pharmacy System-integration such as developing an independent prescriber pathfinder initiative and implementation of Pharmacy First supporting Primary Care access; and
- working in partnership with our Secondary Care pharmacy colleagues to identify, coordinate and monitor cost improvement programmes of work.

Strategic Oversight and Assurance

Integrated Pharmacy and Medicines Optimisation

Medicines are the most common intervention in the NHS and are essential to the delivery of care to improve the health of the population we collectively serve. System integration across pharmacy is essential to deliver effective, safe and efficient interventions, which go further and faster addressing pharmaceutical public health, including unmet need and inequality.

Work has continued to implement the Derbyshire-wide strategic plan with the ambition of integrating pharmacy and medicines optimisation across the System. This is aimed at ensuring optimal use of medicines to reduce the avoidable and unjust differences in health outcomes for the population of Derby and Derbyshire.

Working in partnership with System pharmacy chiefs and leads, through the Integrated Pharmacy and Medicines Optimisation Delivery Board continues, to co-ordinate System-wide medicines optimisation priorities across JUCD. This is enabled by four pillars:

- effective interventions;
- medicines value;
- workforce; and
- quality and safety.

During 2024/25, the team delivered an ambitious programme saving over £17m. This included work in the following areas:

Medicines Optimisation	Nutrition	Patent Expiries
Reducing Medicines Waste	Primary Care Prescribing Rebates	Optimise Rx Prescribing Support Software Tool

Controlled Drugs

The ICB supports NHSE with its statutory responsibility for controlled drugs oversight under a Memorandum of Understanding. Deep-dive monitoring of General Practice controlled drugs prescribing continued on a rolling schedule during 2024/25, with declarations being returned by the relevant practices to the ICB for assurance. The team also supported the Controlled Drugs Destruction Authorised Witnessed Programme and witnessed the safe destruction of controlled drugs with six pharmacies across Derbyshire.

The collaborative work with Health Innovation East Midlands to improve management of chronic pain by reducing harm from opioids also continued in 2024/25, seeing a further reduction in high-dose opioid prescribing from the 2021 baseline.

Medicines Safety

The Derbyshire Medicines Safety Network, a System-wide group comprising of medicines safety officers from all Derbyshire providers, share and discuss local incidents. Implementation of the Safety Workplan continued during 2024/25 which focused on System assurance of compliance with National Patient Safety Alerts. The network also set up an oversight process to ensure all providers delivered actions for relevant alerts.

Investigation and analysis of medication-related incidents also progressed during 2024/25, by supporting General Practices and other providers to utilise the 'Learning From Patient Safety Events' reporting system.

Antimicrobial Stewardship

Antimicrobial stewardship is key to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness. The Derbyshire Antimicrobial Resistance Strategy incorporates all national antimicrobial prescribing and healthcare associated infection targets, with specific actions to ensure progress towards achievement and improvement where necessary. The Strategy is currently being reviewed, with a view to capture System ambition as well as incorporating the updated National Action Plan for Antimicrobial Resistance 2024-29. Prescribing data was also circulated to General Practices during 2024/25 to better understand volumes and variations in prescribing.

Community Pharmacy Services and Integration

The Pharmacy First Service is in place to support the Primary Care Access Recovery Plan and the management of low acuity patients in community pharmacy. It enables patients to be referred to a community pharmacy for minor illness, urgent repeat medication supply and seven common conditions: uncomplicated urinary tract infection in women; shingles; impetigo; acute otitis media; infected insect bites; sinusitis; and sore throat. A community pharmacy blood pressure check service and oral contraception service are also available, which will support General Practice workload pressures.

This work has been led by a dedicated community pharmacy integration role, enabling collaboration across Derby and Derbyshire with the Local Pharmaceutical Committee, NHSE Programme Managers, PCNs and community pharmacies to promote and develop local plans for implementation, troubleshooting and monitoring uptake.

Four Independent Prescriber Pathfinder community pharmacy sites went live in Derbyshire in 2024/25. These sites work collaboratively with local General Practices and agree appointment slots for minor illness; acne; hypertension; and menopause.

Other community pharmacy services continue to be supported, for example discharge medicines service, new medicines service and plans to support smoking cessation schemes in community pharmacy.

High-Cost Drugs – ICB-Commissioned

Recently a System-wide High-Cost Drugs Working Group was established, with representation from pharmacy, finance and procurement professionals from both CRHFT and UHDBFT. The aims of the group are to provide assurance regarding biosimilar uptake and a consensus on high-cost drug commissioning pathways and to share knowledge and learning.

The team also work closely with the Trusts to ensure high-cost drugs are used effectively and appropriately and new biosimilars are implemented quickly to ensure maximal cost efficiencies across the System.

In 2024/25, nine high-cost drug pathways were updated and published in response to new National Institute for Health and Care Excellence (NICE) technology appraisals. These included pathways for the treatment of alopecia, osteoporosis, migraine and ulcerative colitis.

Contracting and Procurement

Expiring commissioner-led contracts were reviewed and procured in line with current governance processes during 2024/25. A contract register was populated and updated with any changes to contracts, governance processes and outcomes of due diligence checks. Pharmaceutical input was also provided on the procurement of wider ICB-commissioned contracts.

Support to Place, Primary Care Networks and General Practice

Dedicated Place, PCN and General Practice-based support from an ICB Pharmacist and/or Pharmacy Technician is in place at all General Practices. This enables engagement with clinicians and the delivery of actions to improve the quality, safety and cost effectiveness of medicines to influence change and improvement across Derby and Derbyshire.

The development and delivery of educational sessions to pharmacy teams and the successful delivery of the following projects have enabled the delivery of safe and effective efficiencies during 2024/25:

- consistent delivery of key messages, medicines changes and transactional actions;
- engagement via prescribing lead forums and PCNs;
- continued promotion of self-care and the 'Greener NHS' low carbon footprint choices for inhalers, including a publicity campaign to promote the return of inhalers to community pharmacies and reduce overuse of 'reliever' inhalers;
- continued monthly reviews of digital medicines support software profile messages to maximise the transaction and safety of medicines to deliver annual savings of £2.5m;
- clinical system formulary updates and sharing of formulary status for prescribing;
- providing education and training for proxy-ordering of prescriptions for care home patients to enable efficient requests; and
- being a point of contact for queries and advice about medicines.

The Derbyshire prescription service, along with the Medicines Order Line continues to provide efficient medicine ordering for 90% of General Practices and pharmacies, by reducing waste, easing workload and increasing the uptake of Electronic Repeat Dispensing. Digital ordering options via the NHS App or the new Medicines Order Line online order form are encouraged for those patients and carers able to access them, ensuring timely access for those who need to call.

Community Pharmacy Commissioning

From the 1st April 2023, the ICB assumed delegated responsibility for Primary Care services, which incorporated pharmacy, optometry and dentistry services. NHS Nottingham and Nottinghamshire Integrated Care Board became the host organisation for the East Midlands, and the Pharmacy Directorate provide professional pharmacy support to the ICB's Primary Care Commissioning Team, who work in conjunction with the host organisation to ensure robust processes and governance are in place for the delegated commissioning of community pharmacy.

Ambulance and NHS 111 Commissioning

The East Midlands Coordinating Commissioning Team manages the emergency ambulance and NHS111 contracts with EMAS and DHU Healthcare on behalf of the six East Midlands ICBs, and with DHU on behalf of the 11 Midlands ICBs. The team is hosted by the ICB and manages all aspects of the contracts, including demand and capacity modelling, performance and quality.

East Midlands Ambulance Service NHS Trust Performance

Emergency ambulance performance is measured against six national performance standards within four response categories:

Category 1 (C1)	Life-threatening illnesses or injuries, specifically cardiac arrest.
Category 2 (C2)	Emergency calls, such as stroke, burns or epilepsy.
Category 3 (C3)	Urgent calls, such as abdominal pains and non-severe burns.
Category 4 (C4)	Less urgent calls, such as diarrhoea, vomiting or back pain.

When measuring the performance standards, the 'mean' is used to calculate the average time in which a patient receives a response and the 90th centile measures the time in which 9 out of 10 patients receive a response to a 999 call.

National Standards

At Trust-level, EMAS did not achieve any of the six national standards over the course of 2024/25. C2 mean performance was 43 minutes and 18 seconds, which was above the C2 30 minute national ambition by 13 minutes and 18 seconds, and above the national standard by 25 minutes and 18 seconds.

Whilst the six national standards have not been achieved, at Trust-level, Q1 and Quarter 2 (Q2) saw an improvement in C2 mean performance, C2 90th centile and C4 90th centile when compared to the same period of 2023/24. You can read more about our performance against national standards of the EMAS performance in Appendix 2.

Patient Safety Incidents

EMAS has fully transitioned to the NHS Patient Safety Incident Response Framework (PSIRF), which aims to maximise learning and safety improvements beyond national requirements. EMAS encourages reporting of patient safety incidents as part of its mature safety culture. Key patient safety incident categories for Patient Safety Incident Investigations (PSII) have been identified to enhance system learning and safety.

In 2024/25, EMAS identified 42 patient safety incidents requiring investigation – 10 under the previous Serious Incident framework and 32 under PSIRF. This compares to 99 in the previous year. Most incidents involved prolonged waits, leading to harm. To address this, EMAS extended their investigations to adopt a broader Systems thinking approach with partners.

EMAS has used the outcomes of patient safety incidents to improve practices, including focused sessions on ECG interpretation, increased maternity and newborn resources, training, and development of mental health clinicians' roles.

Launched in July 2024, the EMAS Quality Strategy prioritises:

Patient safety	Providing harm-free care.
High-quality patient experience	Ensuring patients rate the service as good or excellent.
Enabling staff	Allowing time for what matters to frontline staff.
Continuous improvement	Empowering EMAS colleagues to enhance safety and quality.

Quality improvement will be monitored through local quality schedule reporting to the coordinating commissioner.

NHS 111 Midlands Performance

On the 9th April 2024, a Midlands-wide NHS111 service went live and was awarded to DHU, following a national procurement process. The service is delivered to approximately 10.5 million patients across the Midlands' geographical footprint and is commissioned by 11 ICBs. The contract contains four KPIs and a further KPI associated with the validation of C3 ambulance dispositions. You can read more about NHS 111 performance in Appendix 3.

Mental Health

Adult Mental Health

The ICB has continued to work alongside a wide range of VCFSE and statutory partners to design and deliver support for adults with mental health needs, and to achieve NHS Long Term Plan ambitions. Achievements and progress include:

Community Mental Health

Living Well Transformation Programme

The four-year planning and development stage of the programme came to its planned end in March 2025. All localities across Derby and Derbyshire are fully mobilised and continue to work to the NHS Long Term Plan and the aims of the Community Mental Health Framework (CMHF).

There is regular oversight of KPIs including the:

- number of people seen by the service;
- length of time in service; and
- average waiting time and number of people on waiting lists.

By using quality indicators, the teams also report on:

- a 'no wrong door' approach, to avoid referrals being rejected;
- local integration with commissioned partners and Primary Care;
- co-production, using feedback from people using the service;
- health inequalities, through routine data collection; and
- evidence-based psychological interventions.

Living Well Collaboratives

Living Well Collaboratives provided key forums for providers and service users to provide feedback on what people with lived experience would like to see as part of service development.

The collaboratives were an invaluable community setting for local networking and supported increased knowledge of the Living Well service across Derbyshire. Whilst these forums are to no longer be facilitated after March 2025, a sustainability plan has been created in each area by members to find alternative ways of keeping valuable connections and conversations going.

Co-Production and Design

Co-producing and co-design has been a key feature in the development of the Living Well service. Various 'design sprints' ensured projects within the service were fully co-produced with the voice of the service user being included at each stage.

The creation of a 'living well mid-point review' document, with the support of all stakeholders, will show next steps and an open and honest evaluation on the development of the service throughout the four years.

Inpatient Care

The JUCD ‘Making Room for Dignity’ Programme aims to meet the government pledge to eradicate dormitory accommodation from mental health facilities across the country, and to improve dignity and outcomes for people needing inpatient care. Plans are as follows:

- Carsington Unit – a new 54-bed male adult acute unit at Kingsway Hospital;
- Derwent Unit – a mixed adult acute unit at CRHFT;
- Kingfisher House – a new male psychiatric intensive care unit at Kingsway Hospital;
- Bluebell Ward – a ward for older adults at Walton Hospital;
- Radbourne Unit – two 17-bed female acute wards at Royal Derby Hospital; and
- Audrey House – an eight-bed female acute-plus facility at Kingsway House.

More information about these plans and latest information can be found here.

NHS Talking Therapies

Following a competitive tender, a new NHS Talking Therapies contract will commence on the 1st July 2025. Vita Healthcare Group have been awarded the contract to operate as lead provider, giving consistency and centrality across Derby and Derbyshire. The priority is to deliver continuity of care; good access and positive outcomes for local people with anxiety

and depression will continue. Planning is in place to support transitional and mobilisation arrangements of the contract.

During 2024/25, JUCD delivered 17,820 treatments, which exceeded the completed treatment targets set by NHSE by 31%. Individuals experienced positive outcomes as a result of undertaking this treatment for anxiety and depression. The reliable recovery rate was 49%, exceeding the NHSE target of 48%; and the reliable improvement rate was 69%, exceeding a target of 67%.

Reducing Health Inequalities

Work continues around NHSE's Core20PLUS5 Framework, which supports JUCD in taking a strategic population health management approach to cohorts of people with multiple disadvantages. Serious mental illness and physical health improvement are key clinical areas of focus, with System partners continuing to work together strategically and operationally to improve cross-sector working, along with information and data sharing to create a personalised care approach.

The mental health needs of Derby and Derbyshire's deaf community continues to be an area of focus and 2025/26 will see increased activity aimed at tackling outcome differences dependant on ethnicity.

The implementation of reasonable adjustments to ensure equity in access, experience and outcomes is a golden thread that runs through all areas of work in adult mental health commissioning.

Crisis alternatives development

Continued support to adult mental health crisis alternative services across the footprint, for those with immediate mental health needs and who would otherwise need to access ED to help keep themselves safe, has included:

- three community drop-in services ran by Derbyshire Mind in Buxton, Ripley and Swadlincote, operating Fridays and Saturdays 6pm to 11pm, and Sundays 2.30pm to 5.30pm;
- Safe Havens which operate every day from 4.30pm to 12.30am, and Crisis Houses are run by WayThrough and P3 in Derby and Chesterfield respectively;
- launching the NHS 111 ‘select mental health option’;
- access for deaf and hearing impaired people to NHS 111 BSL via the SignVideo app or SignVideo website;
- supporting children's and adults' mental health through the 24/7 Derbyshire Mental Health Helpline;
- launching a Derbyshire mental health response vehicle into the EMAS ambulance fleet in November 2024, which operates every day between 4pm and 12am; and
- actively exploring options to develop a local SMS mental health text service to expand the local mental health crisis offer.

More information about all of these services can be found here.

Learning Disabilities and Autism

During 2024/25, JUCD continued to implement the commitments of the local 'Learning Disability and Autism Road Map 2021–25' through:

Implementing new approaches to crisis and inpatient support	Evaluating the success of the in-reach approach and using the learning to inform future service delivery.
	Evaluating a review of local intensive support teams, looking at how best to utilise specialist learning disability and autism expertise to improve outcomes for local people.
	Co-designing a new 'children and young people keyworker' service with local stakeholders. A commitment of the Long-Term Plan, to initially focus on autistic children and young people (CYP) and those with a learning disability who are inpatients or at risk of admission.
	Co-designing a new clinical model of inpatient care development which meets national guidance and the needs of local people.
	Focusing on the development of a more sophisticated understanding of 'pathways to admission'.
Ensuring the quality and availability of care and support services	Continued work with a small number of local schools to understand how the experience of education can be improved for autistic children and their families. This includes the implementation of Parent Carer Forums.
	Evaluating the findings from engagement on the short breaks review alongside Derbyshire County Council, to ensure the best use of public resources in a fair way.
	Establishing an accepted business case for neurodiverse diagnostic assessments for CYP.
	Addressing health inequalities through the learning from deaths programme, and exceeding national targets for the number of people with a learning disability over the age of 14 who receive annual health checks.
Building strong and sustainable community assets	Rolling out the 'Community of Practice', a new approach to working in better partnership with the VCFSE sector, which includes more than 25 local organisations.
	Agreeing that opportunities can be released to the Community of Practice for local input, collaboration and influence.
	Co-designing 'community hubs' with partners to support neurodivergent people before, during and after diagnosis. The initial focus is on CYP and their families, with a view to expanding to adults in the future.

The foundation of all the above work is listening to and acting on the views of local autistic people, those with a learning disability and their families. JUCD is committed to improving its approach to co-production with local people and has approached key stakeholders, including local partnership boards, to understand how to do this.

Children, Young People and Young Adult Mental Health

JUCD has continued to implement the commitments of the local Children and Young People's Transformation Plan, which can be found here. The ICB has continued to work alongside a wide range of VCFSE partners, local authorities and NHS partners to design and deliver support for CYP with mental health needs and to achieve NHSE Long-Term Plan ambitions. We are proud that across Derby and Derbyshire we have a robust offer of support to any child via early intervention and digital interventions, which during 2024/25 included:

Increasing access to mental health support	Kooth, a universally available digital offer, enables all CYP in Derby and Derbyshire to access text-based counselling, advice and support via moderated forums. During 2024/25, Kooth have enabled a further 1,288 CYP across Derbyshire to access help via the platform, with most contacts being outside of office hours, meaning CYP have a trusted source of information and advice with no waiting lists.
	A fully integrated early intervention and targeted support service known as Changing Lives is available across the whole of Derby and Derbyshire for CYP and their families (ages 5 to 18). Changing Lives is made up of mental health support teams, early intervention and targeted support services and is delivered by one provider, Compass. Access to the service is streamlined, which has improved navigation in the mental health system and reduced confusion about where to refer. Additionally, mental health support teams have been expanded into more schools; this offer is being introduced to a college for 16 and 17 year olds, where the ICB will monitor the outcomes.
	Specialist child and adolescent mental health services (CAMHS) have updated internal processes which are reducing waiting times and demonstrating a significant improvement in the joint working between CAMHS and Changing Lives. This ensures no child with a mental health concern falls between an early intervention or specialist support service.
	Continued funding for services that meet the needs of our most vulnerable children, with psychological support to children in youth justice services and the provision of a specialist service for children in care.
	During 2024/25, 14,430 CYP had accessed emotional and mental health services, which exceeds the ICB's access target of 14,200.
Eating disorders, restricted eating	Continued funding for First Steps, an early intervention and prevention service, who provide support to CYP across the whole of Derby and Derbyshire.
	Working with partners to improve the offer for CYP with a broad range of eating difficulties and restricted eating, particularly for those with autism.
	Recruitment to specialist CAMHS and eating disorder services has helped to make them more responsive in assessing both urgent and routine cases.
Improving urgent care and crisis response	The achievement of NHSE's ambition of a 24/7 crisis response available to all CYP. This is accessed through 111 or the Derbyshire Mental Health Helpline and Support Service, which offers advice, support and onward triage when a clinical service is indicated. Urgent care services have expanded hours to provide assessments, brief interventions, intensive home treatment and day support when it is most needed.

Young adults	Expansion of the young adults service for 18 to 24 year olds who had previously faced 'a cliff edge' of care on their 18th birthday. This service supports young adults who would normally not receive a mental health service and has helped services work in a more integrated fashion.
Reducing health inequalities	Continued focus on improving access for boys and young men, and ethnic minority communities. Services have started to change the community engagement process, which has included reviewing logos to make sure they are gender inclusive.
	The Changing Lives Mental Health Support Team placement has been implemented to improve access and reduce inequalities in areas of higher need and deprivation. This has been able to evidence that the outcomes and experiences of special educational needs and disabilities (SEND)/autism spectrum disorder for black and ethnic minority CYP are comparable to the global majority population.
Coproduction and collaborative working	Working with partners to create a 'strategic participation approach' which captures the participation outputs from across the System, enabling understanding of key themes and improvement areas identified by children, young people, families and carers.

Children and Young People Physical Healthcare, Neuro Development and Special Educational Needs and Disability

The areas of focus during 2024/25 were:

Children and Young People's Delivery Board

Continued oversight by the Children and Young People's Delivery Board on the delivery of transformation plans, to target prevention, reduce health inequalities and offer a robust graduated response to reduce the need for more specialist intervention by enabling children and their families to access the right support at the right time. The plans include:

- early help and start well;
- CAMHS community, eating disorders and mental health crisis;
- respite care;
- cancer and palliative, or end-of-life care;
- long term physical health conditions; and
- neurodevelopment.

Neuro-development

Continued work with System partners in VCFSE organisations, education, health and social care to deliver the co-produced plans to address neurodevelopmental assessment waiting times. The current focus is ensuring children and families can access the right advice, information and support at the earliest opportunity and to improve their experience.

Working in partnership with Derby City and Derbyshire County Councils and Parent Carer Forums on the delivery of the partnership for inclusion of neuro development in schools project, which is a national pilot programme developed jointly by the Department for Education and the Department of Health and Social Care. The aim is for local area

partnerships to work together with schools to create environments that enable CYP with characteristics of neuro-developmental challenges to thrive in education. The project is under evaluation and the intended outcome is for this to be a universal offer across all education settings.

Physical Health Transformation Programme

Continued development of the CYP Physical Health Transformation Programme, which is aligned to the NHS Long Term Plan and focuses on diabetes, epilepsy, asthma and healthy weight. The most recent work package focused on addressing the variation in epilepsy care across services throughout Derby and Derbyshire, and also improving the mental health and wellbeing of CYP with epilepsy.

Leading a local transitions network, together with key stakeholders, to develop a strategy and toolkit for support services to ensure that young people transition seamlessly from child to adult physical health services. The approach taken by the network was recognised by NHSE and has been used to inform national guidance.

Special Educational Needs and Disabilities

The Care Quality Commission (CQC) and Ofsted undertook a joint inspection of SEND provision across Derbyshire (not including Derby city) and found that there were widespread or systemic failings across the local area. The ICB are working closely with Derbyshire County Council in the development and implementation of the local area SEND partnership priority impact plan, which aims to improve the experience with SEND of Derbyshire CYP and their families.

Reducing health inequalities

The NHS approach to reducing health inequality is called Core20PLUS5. The clinical priorities of this approach align to our Physical Health Transformation Programme and embed our commitment to this important agenda. The approach within the neuro-diversity community hubs is in response to community groups who are underrepresented in service provision.

Co-production and collaborative working

Development of a model for engaging with CYP that will provide a standardised approach across the ICB and health providers in Derby and Derbyshire, and providing strong working relationships with Parent Carer Forums in Derbyshire to help facilitate a System-wide workshop to evaluate current practice and what needs to be addressed in response to the increased demand for autism and ADHD assessments, ensuring the right support is available at the right time.

Environmental Matters

Sustainable Development

Vision and Purpose

The NHS has set out a vision to become the world's first net zero carbon health service and to respond to climate change, improving health now and for future generations. The NHS has set two clear targets to work towards a 'net zero' health service:

NHS carbon footprint (emissions under NHS direct control)	Net zero by 2040, with an ambition for an interim 80% reduction by 2028 to 2032.
NHS carbon footprint plus (includes wider supply chain)	Net zero by 2045, with an ambition for an interim 80% reduction by 2036 to 2039.

These targets are set out in the NHS's Net Zero Strategy, Delivering A Net Zero NHS (2022), which is underpinned by a suite of statutory guidance around delivering the actions required in specific areas. All parts of the NHS have a statutory duty with regards to tackling climate change and are required to act both in the short-term and long-term to meet both these ambitious targets and mitigate the impacts of climate change that are being experienced, such as the recent increase in heat waves and flooding.

The Joint Forward Plan for the ICS acknowledges the responsibility of the NHS in Derby and Derbyshire to this agenda, and how the net zero commitment is part of the System's plan for delivery moving forwards. It is important that NHS organisations across Derby and Derbyshire collaborate to continue to address carbon emissions, which will not only bring environmental improvements but can also reduce waste in the way that services are delivered and have a positive impact on the health outcomes for our population.

Trusts and ICSs have a statutory requirement to develop Board-approved Green Plans, aligned with the ambitions set out in 'Delivering a Net Zero NHS'. The ICB is responsible for the development and monitoring of the Joined Up Care Derbyshire ICS Green Plan, which establishes a three-year sustainability strategy from 2022–25.

Greenhouse Gas Protocol

Figure 5 sets out what is within scope for achievement of an overall reduction in emissions. There are four areas ('scopes' – as defined by the Greenhouse Gas Protocol), which are categorised for the NHS as either NHS Carbon Footprint, or NHS Carbon Footprint Plus.

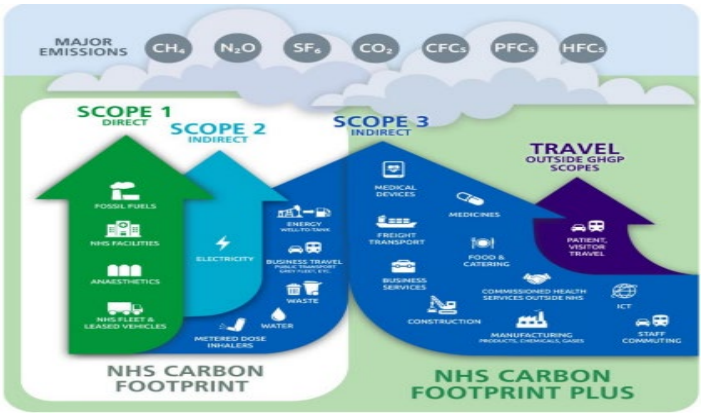


Figure 5 – GHGP scopes in the context of the NHS (Source: NHSE)

The NHS will work towards net zero for a NHS Carbon Footprint Plus that includes, as well as the three scopes below, emissions from patient and visitor travel to and from NHS services, and medicines used within the home.

The main areas of action for the NHS and its partners can be categorised into:

- direct interventions within estates and facilities, travel and transport, supply chain and medicines; and
- enabling actions, including sustainable models of care, workforce, networks and leadership, and funding and finance mechanisms.

Statutory guidance has been issued by NHSE with relation to the direct interventions required. Figure 6 sets out a clear road map of what interventions are required by when.

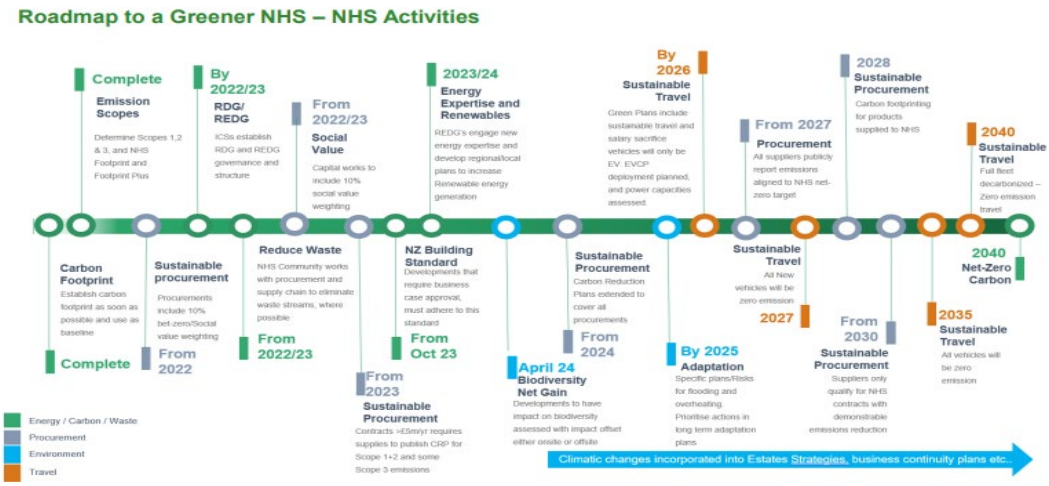


Figure 6 – Roadmap to a Greener NHS – NHS Activities
(Source: Derby and Derbyshire ICS Infrastructure Strategy 2024–34)

Integrated Care System Commitments

During the 2024/25 financial year, ICSs were asked to continue to deliver on ICS-level green plans with regional support and to ensure plans were aligned with the ambitions set out in 'Delivering a Net Zero NHS'. The NHS Midlands region defined six core regional priorities for carbon reduction for 2024/25 for JUCD as follows:

Medicines	Reduce emissions from nitrous oxide and mixed nitrous oxide waste by 9–14% in 2024/25 against the 2023/24 baseline – implementing actions from the revised nitrous oxide waste reduction toolkit.
	Reduce emissions from inhalers by 6–7% in 2024/25 against the 2023/24 baseline by rolling out the principles of high-quality low carbon respiratory care.
Estates and facilities	Understand the maturity of heat decarbonisation plans across all Trusts, using a maturity matrix, and targeted engagement with Trusts with no plans.
Travel and Transport	Ensure the region's owned and leased fleet is made up of >90% low emission vehicles by March 2025. Including 11% of the fleet being made up of ultra-low emissions and zero emission vehicles.
	100% of Trusts to complete a staff travel survey at least every 24 months, ideally annually.
Procurement and Supply Chain	Implement the 2024 Net Zero Supplier Roadmap Requirements (compliance with CRP or NZC requirement for all contracts over procurement thresholds.
Green Plan Development	Work with stakeholders to develop the next iteration of the Green Plan.

The ICB co-ordinates the work across JUCD to deliver on the regional core objectives and the NHS Green Plan. The detailed governance oversight within JUCD and the ICB is described in the 'Taskforce for Climate Related Financial Disclosures (TCFD)' section of this report as part of the 'Governance' section on page 75. The progress against the ICS NHS Green Action Plan is described in the 'Metrics and Targets' section in the TCFD disclosures on page 77.

Climate change posts a major threat to our health, as well as our planet, and is known to be accelerating, which is having direct and immediate consequences for our patients, public and the NHS.

As an ICB, we have a duty to ensure we support the overall ICS with the Green Plan Refresh which summaries the organisational green plans, including our carbon hotspots and the sustainability strategies employed to address them.

In addition, it highlights how the System is continuing to build on the great work being accomplished by Trusts across the county, and sharing ideas on how to reduce the impact on public health and the environment, save money and reach net carbon zero.

The ICB proactively works to ensure sustainability becomes mainstream into systems and processes to improve environmental, health, social value and staff experiences. We provide guidance, leadership and assurance, along with upskilling our workforce to understand how they can help tackle the climate and health crisis and move to business-as-usual reflecting net zero into their roles.

The ICB is committed to discharging its statutory duty to deliver against targets and actions in 'Delivering a Net Zero NHS' by:

- acknowledging the importance of achieving net zero, dedicating resource through investment in an ICB Sustainability Programme Manager to support the System to achieve carbon reductions and meet the net zero targets;
- expanding and strengthening a network of stakeholders across the System to work collaboratively to tackle carbon emissions, ensuring our plans and strategies are aligned and to share learning and good practice. This includes System partners, local authorities, the new East Midlands Combined Authority (EMCA), VCFSE sector, patients and the public;
- encouraging the adoption of activities and interventions which slow the associated health impacts of climate change, which can improve population health by reducing the number of heatwave related excess deaths and the number of pollution-related respiratory illnesses;
- embedding net zero principles across all systems and processes in the ICB and across Trusts to ensure green becomes business-as-usual for staff roles and to continue to consider reducing the carbon footprint where opportunities may exist;
- strategic alignment to the Derbyshire and Derby Air Quality Strategy, working with stakeholders across the ICS area to address poor air quality, which disproportionally affects vulnerable and deprived communities in the UK through prevalence of respiratory illness, thereby tackling existing inequalities in outcomes, experience and access;
- enhancing productivity and value for money, planning to improve energy efficiency and switching to renewable energy sources in the NHS estate across the Derbyshire ICS footprint, reducing long-term energy bills for the NHS; and
- all ICB procurements now include a 10% net zero and social value weighting and we will continue to adhere to the requirements set out in the NHS Net Zero Roadmap.

Carbon Hotspots

Move to Derby City Council Offices

A review of the ICB's running costs was undertaken and a reduced footprint due to the organisation's hybrid working policy was agreed. To facilitate this, the ICB worked with Derby City Council to establish office space at the Derby City Council House in April 2024, therefore consolidating the ICB's estate in terms of cost saving and emissions. When the ICB vacated previous premises all office furniture was made available to other NHS providers for reuse.

Derby City Council are fully compliant with the 'Simpler Recycling' laws, which includes separating recyclable waste. Derby City Council are also proud of its 'Green Excellence' which includes:

- energy performance certification A+;
- BREEAM excellent;
- hydro-electric power;
- solar panels;
- adiabatic cooling;
- rainwater harvesting; and
- recycling facilities.

Travel

Travel by patients, staff and visitors is a crucial part of the way NHS delivers service. The NHS accounts for 5% of all road traffic in England and travel is responsible for 18% of the NHS carbon footprint in England. This is an important area for reducing carbon impact, improving sustainability, convenience and safety as well as saving time and money. There was no air travel incurred by the ICB.

The ICB undertook an employee travel survey during 2024, of which 163 responses were received. The key findings are illustrated below:

Full-time staff: 113 Part-time staff: 48	Remote working: 115 staff work 3-4 days at home	Site attendance: Council House (104) Scarsdale (59)
Most popular days to attend the office: Wednesday, followed by Tuesday and Thursday	Main reasons for travelling: reliability and total travel time	Average time travelled: 15–30 minutes
Average mileage to site: 10–15 miles	20 staff travel 25–50 miles	141 travelled in their own car to work
4 staff can walk to work	12 staff have an electric or hybrid vehicle	Fuel is still predominantly petrol or diesel

Energy

By moving its headquarters to shared accommodation with Derby City Council, the ICB gained economies of scale through shared accommodation, closer joint-working with the Local Authority and reduced energy consumption.

Table 3 shows our energy consumption for the last five years for ICB headquarters at Cardinal Square in Derby and the figures for 2024/25 at Derby City Council House. The newly established office space at the Derby City Council House in April 2024 and the Council's 'Green Excellence' detailed on the previous page has further reduced the ICB's electricity and water consumption, which is illustrated in Table 3 below:

	2024/25	2023/24	2022/23
Electricity (kWh)	51,775	94,233	136,513
Water (m^3)	98	988	1,703

Table 3 – ICB headquarters' energy consumption for 2024/25, 2023/24 and 2022/23

The ICB has continued to secure emission reductions and improve sustainability in the following areas:

Energy	Reducing total consumption in the ICB sites, particularly through the move to Derby City Council offices.
Consumables	Working paperless, distributing committee agenda and paper packs electronically and continuing to encourage recycling.
Travel	Continuing to operate a hybrid working model which has reduced staff commuting from daily to twice per week.
Waste	The ICB does not currently collect data for waste management.

Reducing environmental impacts from ICT and Digital

The ICB is engaged in a conversation with auditors about how best to recirculate and re-use equipment, which is no longer fit for purpose for the ICB, but which may have uses to community and other organisations. At this point, due to data security considerations all of data holding devices that are sent for disposal are shredded. The ICB is exploring options through which devices may be securely wiped by a third party and made available for re-use for staff, charities, community organisations, etc with an appropriate warranty from the third party.

Any non-data holding devices which are still safe and operational, such as monitor, mice, keyboards, etc are gifted to charities and community organisations. Any of these devices which are not currently working are sent for disposal.

The ICB is currently engaged with Primary Care to support more agile working practices which would see a reduction in the number of devices currently in circulation. They are also embarking on a programme of work which will remove servers from data centres and make further use of existing cloud hosting functions.

Through the digital transformation work linked to the Primary Care Access Recovery Programme and predecessors, the ICB has enabled the deployment of online consultation, video consultation, online forms and two way text messaging to reduce the number of physical patient presentations within General Practice; and thereby reduce unnecessary journey for patients and the ability of clinical and non-clinical staff to work from other locations, assisting with managing the growth of the built estate. The local implementation of document storage solutions for those GP Practices with the greatest estate pressures has enabled rooms to be re-purposed for clinical use, again removing the need for extensions and additional construction work.

Creating Social Value

Actively designing and delivering social value is a core part of the transformation needed across public sector organisations and, as such, this concept is now protected in legislation through the Public Services (Social Value) Act 2012. The ICB has embedded Social Value as well as net zero considerations into the design of new procurements, ensuring that all commissioned services clearly demonstrate how their work makes a difference and delivers greater social value back to the community in Derby and Derbyshire.

Reduction in the carbon impact of inhalers

A priority for the System is to reduce the use of high-volume salbutamol metered dose inhalers (MDIs) and switching to lower carbon alternatives. Data from Open Prescribing show that the mean carbon emission per salbutamol inhaler has reduced significantly (see Figure 7).

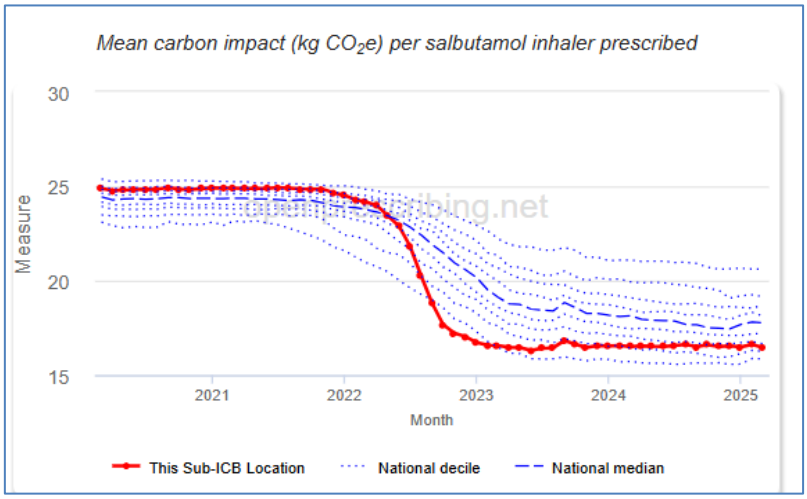


Figure 7 – mean carbon impact (KgCO2e) per salbutamol inhaler prescribed

As at the 31st March 2025, Open Prescribing data for the ICB stated that the mean carbon impact is 16.5 KgCO2e per inhaler, which is below the national median figure of 17.8 KgCO2e.

The second priority is to advocate the use of more dry powder inhalers, which have a much lower carbon footprint than MDIs. This is a more complicated piece of work, with patients

needing an individual review to change inhalers, and traditionally Derbyshire has been a very high user of MDIs, as per Figure 8 below:

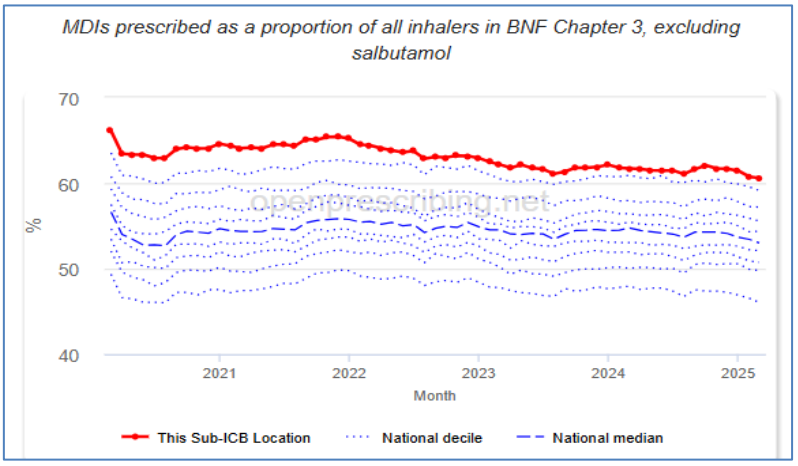


Figure 8 – MDIs prescribed as a proportion of all inhalers in BNF Chapter 3, excluding salbutamol

Greener NHS Dashboard data shows that the carbon emissions of all inhalers for Derbyshire during 2023/24 amounted to 14,666 KtCO2e. This is a 33% reduction on the 2019/20 baseline, exceeding our target to achieve a 25% reduction. Results during 2024/25 amounted to 13,786 KtCO2e which is only a 2% reduction. It has been more difficult in 2024/25 to achieve the 6-7% reduction target, against the 23/24 baseline, due to supply issues. The ICB is committed to reduce the environmental impact of inhalers, reducing its carbon footprint by 50% in 2028. To achieve this an 8% reduction target (against the 2024/25 total) has been set for 2025/26, with emissions reducing to 12,187 KtCO2e.

New asthma guidance was released in November 2024, and Trusts are reviewing guidelines and formularies to reflect this. The new guidance advocates the use of dry powder inhalers in certain therapy areas, which will potentially have a positive impact on the greener agenda. During 2024/25, a greener inhalers toolkit was developed. Resources and information from this was shared widely with the public, community pharmacies and General Practice. This toolkit highlighted three ways to help the NHS in Derby and Derbyshire reduce its carbon emissions:

Switch to a greener inhaler	Encourage patients to ask about switching to a greener inhaler at their next review.
Correct inhaler disposal	Advise patients to return their used inhalers to their community pharmacy, so that they are disposed of correctly and DO NOT release harmful gases into the atmosphere. They should not be thrown in to the bin.
Manage asthma effectively	Encourage patients to see their health care professional or asthma nurse if they are using their reliever inhaler more than three times a week or waking up with nighttime symptom, as this may indicate that their asthma is not under control.

Primary Care

Moving forwards the ICB plans to work alongside Primary Care to support General Practices with decarbonisation and becoming more sustainable, which will in turn support them to gain financial efficiencies, reduce waste and meet CQC sustainability requirements. General Practices will be supported to engage with the Green Impact for Health Toolkit which is a multi-award-winning sustainability learning and awards programme, designed to embed sustainable General Practices across the teams. Alongside embedding sustainability, the toolkit will assist with building a community of people learning about sustainability and working together to create positive changes.

A programme of targeted engagement launched in August 2024 to evaluate the actions General Practices are currently taking and to understand their barriers to achieving net zero so that the right support can be given to mitigate these barriers. One practice in Derbyshire has formed a small team to discuss projects and track the progress of the toolkit. This practice gained the bronze award in 2023/24 and achieved silver in 2024/25.

Green Plan Refresh 2025-28

Trusts and ICSs have been requested by NHSE to develop a Green Plan Refresh for the period 2025–28. The ICB is working with system stakeholders to refresh the Green Plan in line with the priorities outlined in the statutory guidance.

Greening Government Committee's Performance

The Greening Government Committee's reporting requires the ICB to recognise the requirement to evaluate our performance against the targets below:

- mitigating climate change: working towards net zero by 2050;
- minimising waste and promoting resource efficiency;
- reducing our water waste;
- procuring sustainable products and services;
- nature recovery and biodiversity action planning;
- adapting to climate change; and
- reducing environmental impacts from ICT and Digital.

Currently some of the data required to demonstrate compliance with these targets is not all captured at ICB-level. Water consumption is shown in Table 3 on page 71, and the ICB has developed an adaptation plan for adverse weather conditions. In addition, the ICB is working towards procuring sustainable products and services through contracts and working with AGEM CSU.

The ICB acknowledges the need to record and report the data at a sufficient level to measure performance and continues to work towards capturing the financial and non-financial information for these targets.

The ICB recognise that some information and data is not available to meet minimum reporting requirements and plans are in place to improve data collection in the future.

Taskforce on Climate-related Financial Disclosures

The Department of Health and Social Care Group Accounting Manual has adopted a phased approach to incorporating the recommended HM Treasury's Taskforce on Climate-related Financial Disclosures (TCFD), as part of sustainability annual reporting requirements for NHS bodies, stemming from the TCFD aligned disclosure guidance for public sector annual reports.

Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHSE. TCFD recommended disclosures, as interpreted and adapted for the public sector aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year.

For 2024/25, the phased approach incorporates the disclosure requirements of the following 'pillars': governance, risk management, metrics and targets. These disclosures are as follows:

Governance

The Board's oversight of climate-related risks and opportunities

The ICB is the strategic commissioner for the Derby and Derbyshire System and as such is responsible for the development, coordination and ongoing management of the JUCD ICS Green Plan. The ICS Green Plan details the System's strategic approach towards climate risks and opportunities and the collaboration required to achieve the net zero targets by 2040 for scope 1 and 2 and 2045 for scope 3. The JUCD ICS Green Plan for 2022–25 was approved by NHS Derby and Derbyshire Clinical Commissioning Group in 2022 the Green Plan is currently being refreshed and will require ICB Board oversight and approval during 2025.

Two ICB Board members, the Non-Executive Member for Finance and Performance and the Chief of Staff hold the portfolio for sustainability; the ICB's Chief of Staff is the Senior Responsible Officer for net zero carbon and climate for both the ICB and ICS. The Chief of Staff chairs a quarterly JUCD Greener Delivery Group, which is attended by all NHS Trusts and the NHSE regional net zero team. The purpose of the JUCD Greener Delivery Group is to provide oversight and accountability for the achievement of the carbon reduction targets. The JUCD Greener Delivery Group reports to the NHS Midlands Greener Delivery Board on the systems progress towards the core regional objectives.

Management's role in assessing and managing climate-related risks and opportunities

The ICB Board, whilst maintaining overall responsibility, have delegated responsibility to its Audit and Governance Committee for the detailed oversight of the NHS Green Plan, and monitoring of the System's activities towards achieving the net zero targets.

The JUCD Greener Delivery Group reports progress into the Audit and Governance Committee, escalating any issues and key risks which would have an impact upon the net zero trajectory.

The ICB employs a Sustainability Programme Manager to provide dedicated oversight of the delivery of the NHS Green Plan, which includes managing risks and opportunities relating to achieving the objectives of the JUCD ICS Green Plan. The JUCD Greener Delivery Group maintains a risk register which is managed and maintained by the Sustainability Programme Manager. The ICB has also developed an ICT and Digital Policy, which includes the adherence to ethical and environmental standards. Climate change adaptation and the consideration of net zero targets is embedded within the ICB's governance, decision-making and assurance processes. It is a key component of JUCD's performance and project management, including the monitoring of impact assessments and the effective use of sound evidence in policy making.

Risk Management

Identifying and assessing climate related risk

The ICB's approach to identifying and assessing risks is set out in the Risk Management Policy. This policy describes the management of strategic and operational risks across the ICB, and how risk arrangements within the ICB will interface with the system. Included on the ICB's risk register, is a risk that failure to meet the NHS net zero targets will put further pressure on the NHS's ability to meet the health and care needs of patients in two ways:

- contributing to a warming climate and subsequent increase in extreme weather events impacting on business continuity; and
- the production of harmful emissions impacting upon air quality which is in turn damaging to the health of our population.

The ICB Board have strategic oversight of this risk and the corporate risk register recognises the importance of meeting the net zero targets in relation to the NHS's ability to meet the health care needs of the population. More information on these risks can be found on the ICB's website.

The ICB also has an adaptation plan in place which assesses current and future threats from climate change and the measures which the organisation has in place to mitigate the impact upon staff and business continuity. The plan was jointly developed by colleagues from across the ICB to ensure that identified climate change threats and opportunities are embedded within ICB policies, communication plans and protocols, business continuity and EPRR incident response plans, providing assurance that the organisation has robust processes in place to respond to extreme weather events.

The ICB chairs the Local Health Resilience Partnership for the Derby and Derbyshire System, and it is through this forum that any climate-related risks to the System's ability to deliver healthcare services and maintain business continuity, patient and staff safety are identified, assessed and managed in line with the ICB's EPRR Policy. The key risk areas are as follows:

Wildfires	Storms	High temperatures and heatwaves	Low temperatures and snow
Fluvial flooding	Surface water flooding	Drought	Poor air quality

Managing climate-related risks

The ICB manages climate related risks in line with the organisation's Risk Management Policy.

Identifying, assessing, and managing climate-related risks are integrated into the organisations overall risk management

The ICB manages climate related risks in line with the organisation's Risk Management Policy.

Metrics and targets

Assessing and managing climate-related risks and opportunities

The ICB and NHS Trusts report on several metrics to NHSE through The Greener NHS Dashboard. These are collected through quarterly returns completed by each ICB and Trust, and the Secondary Care estates data through the Estates Return Information Collection (ERIC) which is collated annually. These metrics are used to monitor progress towards net zero and are not currently all in the public domain.

The NHS in Derby and Derbyshire is committed to reaching net zero carbon for direct emissions by 2040 and indirect emissions by 2045, as per the national targets. The ICB manages the JUCD ICS Green Plan on behalf of the System and progress is monitored against the national targets and milestones which are laid out in Delivering a Net Zero National Health Service (2022) and accompanying statutory guidance.

The JUCD ICS Green Plan is supported by a Green Action Plan. The action plan is reviewed by workstream leads monthly and reported to the Joined Up Care Derbyshire Integrated Care System Greener Delivery Group on a quarterly basis. Table 4 details the key priorities for 2024/25 and highlights the areas of progress and/or achievement:

2024/25 Priority	Achievements and/or progress
Reduce emissions from nitrous oxide and mixed nitrous oxide waste by 9-14% against the 2023/24 baseline	Plans to cap pipework are being progressed.
Reduce emissions from inhalers by 6-7% in 2024/25 against the 2023/24 baseline by rolling out the principles of high-quality low carbon respiratory care	It has been more difficult in 2024/25 to achieve the 6-7% reduction target, due to inhaler supply issues. New guidance advocates use of dry powder inhalers in certain therapy areas.
Derbyshire's owned and leased fleet to be made up of >90% Low Emission Vehicles by 2025	Derbyshire total: 91% low emission vehicles of which 11% ultra-low emission vehicles and 15% zero emission vehicles.

2024/25 Priority	Achievements and/or progress
100% of trusts to be delivering 3 or more schemes/interventions to support modal shift	The ICB offers its staff a salary sacrifice cycle-to-work scheme to support modal shift. The ICB does not currently offer only electric vehicles; whilst these would still be affordable for staff on lower bands, this does not consider any other outgoings.
Implement the 2024 Net Zero Supplier Roadmap requirements (compliance with CRP or NZC requirement for all contracts over procurement thresholds)	Compliance is in place; additional work is around KPIs and Contract Management.
Implement the net zero element of the net zero and social value requirement across all new procurements	In place for all new procurements. The NHS Supply Chain is utilised where possible.
Engage with stakeholders to inform the refresh of the ICS NHS Green Plan	Stakeholder engagement has been taking place since September 2024, combining targeted engagement and thematic review sessions. Green Plan refresh is due July 2025.
Support Trusts to access national funding and implement capital improvement schemes contributing to decarbonisation	All funding opportunities are disseminated across the System when known, however funding bids are submitted on a Trust-by-Trust basis. Local stakeholders are committed to working collaboratively to secure funding for the System estate should the opportunity arise.
Examine where office space can be used between partners to reduce overall energy requirements	Green Plan delivery aligned to ICS Infrastructure Strategy and opportunities for co-location and consolidation have System oversight through the Infrastructure Strategy delivery mechanisms. From April 2024, the ICB co-located with Derby City Council in the Council House, gaining efficiencies in energy, waste, water and costs.
Collectively develop a strategy for enhancing the resilience of care to extreme weather events	An adaptation plan has been developed by colleagues across the ICB. There are plans for an EPRR exercise in the future to test the effectiveness of all the NHS Trust Adaptation Plans and to use the learning to develop a system-wide adaptation plan.

Table 4 - JUCD ICS Green Plan key priorities and updates for 2024/25

Greenhouse gas emissions

Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally, by NHSE.

Finance Review

Addressing Our Financial Challenge during 2024/25

The ICB is responsible for managing the NHS funding allocated to it, for ensuring that daily commitments are fulfilled, and investments are made to improve the quality of services provided to our patients and population, and for addressing health inequalities. Several factors impact our ability to spend and manage within the financial allocations provided to us, including national economic conditions, unexpected increases/surges in demand for local health services and project delays.

The ICB and the Derbyshire healthcare System has faced another challenging period financially during 2024/25. The ICB delivered a surplus of £1.4m (2023/24: £1.0m surplus), as part of JUCD's delivery of the planned financial balance for the year (2023/24: £nil). JUCD has worked as a collective throughout the financial year to identify efficiencies and deliver its financial position.

The ICB faced substantial pressures during the financial year, mainly due to rising mental health and urgent and emergency demand, alongside changes in national policies. Additional pressures arose from national Primary Care contracting arrangements. These pressures were mitigated by underspends in newly delegated specialised services expenditure (effective from 1st April 2024), the efficiency programme, and reduced administration costs, resulting in a £1.4m surplus.

Financial Performance

The ICB is statutorily required to deliver key financial targets, including an income and expenditure target. Total resources of £2.953.7m (2023/24: £2,512.4m) were available for the year, including income of £36.1m (2023/24: £36.8m) and £2,917.6m (2023/24: £2,475.7m) of allocations from the Department of Health and Social Care. The ICB committed expenditure totalling £2,952.3m (2023/24: £2,511.4) leaving the ICB with a surplus of £1.4m (2024/25: £1.0m surplus). This is demonstrated in the Table 5 below. Further details can be found in the Financial Statements section of this report on page 164.

	Financial Years	
	2024/25	2023/24
	£m	£m
Total Resources	2,953.7	2,512.4
Total Committed Expenditure	2,952.3	2,511.4
Surplus	1.4	1.0

Table 5 – ICB's total resources and committed expenditure for 2024/25 and 2023/24

Specialised commissioning services were delegated to the ICB from the 1st April 2024, increasing allocations by £206.1m and expenditure by £202.5m. The underspend has in part mitigated the cost pressures detailed above.

Gross Operating Costs for the period to 31st March 2025

Category of Expenditure	2024/25 Spend	2023/24 Spend
	£m	
Services from Foundation Trusts	1,727.3	1,439.7
Services from other NHS Trusts	205.1	147.8
Purchase of healthcare from non-NHS bodies	409.9	355.2
Prescribing	191.3	188.2
Primary Care	236.5	222.2
Dental	70.8	57.5
Pharmacy	38.3	36.2
Ophthalmic	11.6	10.9
Staff	31.7	28.6
Supplies and services – general	8.5	5.0
Services from other ICBs and NHSE	10.2	11.4
Other	11.1	8.7
TOTAL	**2,952.3**	**2,511.4**

Table 6 – Gross Operating Costs for 2024/25 and 2023/24

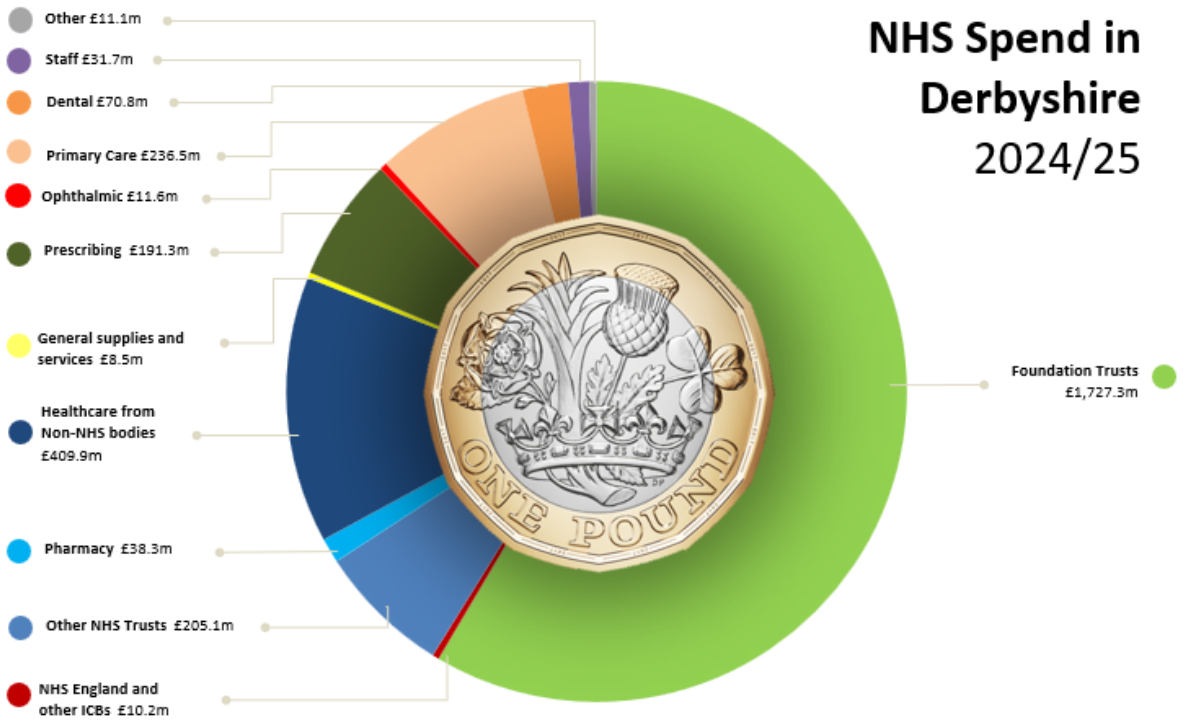


Figure 9 – Gross Operating Costs 2024/25 – 'The Derbyshire Pound'

Mental Health Spend

All ICBs are expected to increase their mental health service spend annually. ICBs demonstrate this through the Mental Health Investment Standard (MHIS) each year, which ensures the recurrent mental health spend exceeds a target based on the previous year's spend plus additional growth. This is reviewed by independent auditors.

For the purposes of MHIS, mental health spend is recurrent spend on mental health services excluding learning disability, autism and dementia. It also excludes spend relating to Mental Health Service Development Funds. The proportion of mental health spend by the ICB of the overall programme allocation was 7.86% (2023/24: 8.66%), which is demonstrated in Table 7 below.

	Financial Years	
	2024/25	2023/24
	£m	£m
Mental health spend	227.7	212.4
Programme allocation	2,897.0	2,452.5
Mental health spend as a proportion of programme allocation	7.86%	8.66%

Table 7 – amount and proportion of expenditure incurred in relation to mental health for 2024/25 and 2023/24

The ICB MHIS target for 2023/24 is £227.140m (£212.067m 2023/24). This is an increase of 7.11% from 2023/24. The ICB reported MHIS expenditure for the year of £227.7m (2023/24: £212.4m), which is an over achievement of the MHIS target detailed above.

The ICB confirms that the figure reported has been calculated in accordance with the MHIS guidance and the financial information that forms the basis of the calculation. This includes the design implementation and maintenance of internal controls to ensure that mental health expenditure is both correctly classified and included in the calculations, and that the report is free from material misstatement, whether due to fraud or error.

Financial Trend Analysis

The ICB was established on 1st July 2022. Resources and spend have increased in each period. These reflect the delegations of pharmacy, dental and ophthalmic services from NHSE as of 1st April 2023, and specialised commissioning services as of 1st April 2024. Inflationary uplifts have also had an impact on both resources and operating costs.

Category of Expenditure	2024/25 Spend	2023/24 Spend	2022/23* Spend
	£m	£m	£m
Total Resources	2,953.7	2,512.4	1,706.8
Gross Operating Costs	2,952.3	2,511.4	1,721.6

Table 8 – resources and expenditure for each of the ICB's reported financial periods.
**Note that 2022/23 is the 9 month period from 1st July 2022 to 31st March 2023.*

Statement of Financial Position

Traditionally known as the Balance Sheet, this financial statement is generally accepted to be a helpful indication of financial health. The statement reviews the assets, liabilities and equity of an organisation.

The primary movement in payables reflects increased provider costs which will be settled early in 2025/26. Property, plant and equipment includes IT equipment additions, utilising the ICB's capital resource allocated during the period. The ICB has included the Council House Building in Derby as a new right of use asset in year with corresponding lease liabilities.

	31st March 2025	31st March 2024
	£'000	£'000
Non-current assets		
Property, plant and equipment	347	321
Right of-use assets	175	262
Total non-current assets	**522**	**583**
Current assets		
Trade and other receivables	18,248	18,471
Cash and cash equivalents	214	279
Total current assets	**18,462**	**18,750**
Total assets	18,984	**19,333**
Current liabilities		
Trade and other payables	(137,803)	(119,778)
Lease liabilities	(87)	(270)
Provisions	(514)	(1,372)
Total current liabilities	**(138,404)**	**(121,420)**
Total assets less current liabilities	**(119,420)**	**(102,087)**
Non-current liabilities		
Lease liabilities	(91)	–
Provisions	(286)	(351)
Total non-current liabilities	**(377)**	**(351)**
Total assets less liabilities	**(119,797)**	**(102,438)**
Financed by Taxpayers' Equity and other reserves		
General Fund	(119,797)	(102,438)
Total Equity	**(119,797)**	**(102,438)**

Table 9 – Statement of Financial Position, as at 31st March 2025

Our Duties

The responsibility for discharging our key statutory duties lies with the Board; consequently we have established a robust reporting framework, which ensures that the appropriate assurances on the delivery of key duties are received in a timely manner. The Board has delegated oversight and scrutiny responsibilities for its key duties to its: Audit and Governance Committee; Finance, Estates and Digital Committee; Quality and Performance Committee; and Population Health and Strategic Commissioning Committee. The following sections focus specifically on how we are meeting these duties, and you can read more about the work of the Board's committees in the Governance Statement section of this Annual Report, starting on page 124.

Improvement in Quality of Services

The ICB has a statutory requirement to discharge its duties in accordance with Section 14Z34 to 14Z45 and 14Z49 (general duties of ICBs) of the NHS Act 2006 (as amended), as inserted by Section 25 of the Health and Care Act 2022, to provide evidence that it keeps under review the skills, knowledge and experience necessary for members of the ICB Board to effectively deliver its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality (safe, effective, person-centred, well-led, sustainable and equitable), as set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021.

ICBs are required to exercise their functions with a view to securing continuous improvement in the quality of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness. We ensure that quality is at the heart of our functions, and organisations that we commission healthcare services from must meet essential standards of quality and safety as defined by the CQC.

Nursing and Quality Governance

The National Quality Board (2021) sets out the quality expectations of ICSs and the principles to follow. JUCD has established a governance structure that holds all parts of the ICS accountable for delivery of high-quality services. Improving quality is about making health care safe, effective, patient-centred, timely, efficient and equitable. An organisational approach to improvement consists of an overarching improvement vision that is understood and supported at every level of the System. The Nursing and Quality Directorate work closely with the Medical Directorate to ensure that this vision is realised through a coordinated and prioritised programme of interventions aimed at improving the quality, safety, efficiency, timeliness and person-centredness of the organisation's care processes, pathways and systems.

During 2024/25, a number of key nursing and quality strategies were developed or updated. These included:

2024–26 Integrated Care System Quality Risk Escalation	Sets out the approach to Quality Risk Management and escalation to be used across the ICS.
ICB/JUCD Quality and Safety Risk Assessment Toolkit	Outlines dynamic risk assessment principles designed to provide a range of tools to facilitate the ICS's approach to risk management and governance.
ICB Quality Framework 2024/25	Aligns priorities across the NHS and with wider System partners, identifying where ICBs and/or NHS providers may benefit from or require support, and providing an objective basis for decisions about when and how NHSE will intervene. The four identified quality improvement initiatives for 2024/25 were: • infection prevention and control; • patient safety incident response framework; • learning from lives and death or people with a learning disability and autistic people; and • Oliver McGowan mandatory training.
ICB Quality Strategy	Designed to complement the overarching ambitions of the ICS priorities and the ICS Joint Forward Plan with quality and safety being the golden thread running through them all.

In 2024/25, 360 Assurance, our internal auditors conducted an audit of the Quality Governance Framework to provide independent assurance that the ICB had put in place a robust quality governance framework. The audit identified a number of medium and low actions which will be completed by the end of Quarter 1 in 2025/26.

Quality Improvement

During 2024/25, the ICB have worked closely alongside DHcFT to provide support and guidance in relation to their acute wards for adults of working age and psychiatric intensive care units following a CQC inspection in April 2024, where regulators undertook urgent enforcement action. As a result of this the ICB moved from 'routine' to 'enhanced' monitoring and surveillance, as described in the Derbyshire Quality Oversight Framework. Assurance on quality improvement progress was reported through the ICB Clinical Quality Review Group, which is chaired by the ICB Director of Quality and Deputy Chief Nurse, with updates to the Derbyshire System Quality Group. Key areas included:

- an ongoing rolling programme of ICB monthly quality visits between the Radbourne and Hartington Units to meet both patients and staff in addition to reviewing how improvements were implemented and sustained;
- focused support and assurance of DHcFT environmental safety enhancements and ligature risk reduction initiatives; and
- ongoing input at the DHcFT Executive CQC oversight meeting to monitor implementation of recommendations and actions.

Following a two-day re-visit inspection by the CQC in December 2024, significant improvements were made and restrictions lifted. The final CQC report noted the role of the ICB as a 'critical friend' through the support provided in delivering the required improvements.

The ICB also supports organisations throughout Derbyshire to foster and develop service improvements, such as the Royal Academy of Improvement at CRHFT which is dedicated to nurturing an improvement culture where anyone can bring ideas and improvements to life, placing staff, patients and carers at the heart of the improvement approach.

Maternity and Neonatal Transformation

The ICB takes a leadership role in the Derbyshire Local Maternity and Neonatal System (LMNS) and continues to steer the programme of work to respond to the recommendations of the Three-Year Delivery Plan for Maternity and Neonatal Services (2023) and delegated responsibility from NHSE.

Care Quality Commission Maternity Service Inspections

In 2023, both CRHFT and UHDBFT received CQC maternity service inspections.

University Hospitals of Derby and Burton NHS Foundation Trust

UHDBFT received an 'inadequate' rating and enforcement notices; section 31 at Royal Derby Hospital, and section 29a at Royal Derby Hospital and Queen's Hospital Burton). The CQC rating reflected earlier reports by the Healthcare Safety Investigation Branch (2022) and the NHSE review (2023) that led to voluntary admission to the NHSE Maternity Safety Support Programme in March 2023. The oversight for governance and compliance of the subsequent maternity improvement plan in 2024 was via the Tier 3 Oversight meeting, which is chaired jointly by the Regional Chief Nurse and ICB Chief Nurse Officer.

The identified areas for improvement, including fetal monitoring in labour and training, post-partum haemorrhage, clinical escalation, triage, leadership and governance have continued to be addressed, with support of the NHS Midlands perinatal team and the NHSE maternity improvement advisors. Progress has been made with leadership and governance, and the introduction of an improved triage system. A reinspection in December 2024 was undertaken by CQC and six of eight recommendations under section 31 were requested for removal, with the remaining conditions being worked through. The programme will remain in place until January 2026 pending review.

Monthly assurance of maternity and neonatal services is undertaken in line with the perinatal quality surveillance model, through provider reports and data reviews. Improvements have been made in perinatal mortality rates, which had been a previous area of concern.

Chesterfield Royal Hospital NHS Foundation Trust

CRHFT were rated 'good' for safe and well-led services. An LMNS-led oversight visit to CRHFT was completed in December 2024 to review progress against the Three-Year Delivery Plan. No safety concerns were identified and progress against the interventions was evidenced. A further LMNS visit will take place in July 2025 for full oversight and assurance of maternity and neonatal services.

Compliance

There was improved oversight of compliance with the Clinical Negligence Scheme for Trusts – Maternity Incentive Scheme year six in 2024, with both Trusts reporting an improved compliance from year five. Saving Babies Lives Care Bundle version 3 compliance has been assessed quarterly by the LMNS. Although neither of the Trusts met 100% compliance with implementation of the interventions at the end of 2024/25, assurance was provided of progress being made.

The LMNS has worked collaboratively with System partners to implement the Equity and Equality Plan which aims to improve equity for mothers and babies, improve race equality for maternity and neonatal staff, and develop a perinatal pelvic health service to support those affected by birth trauma by providing physical and psychological support.

Healthcare-Associated Infections

Healthcare-associated infections can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. Healthcare-associated infections pose a serious risk to patients, clients, staff and visitors to health and social care premises. They can incur significant costs and cause significant morbidity and mortality for those infected. As a result, infection prevention and control are a key priority for the NHS in order to prevent healthcare-associated infections and any associated risks to health.

Quality standards within the NHS Standard Contract (2024/25) for NHS Trusts and NHS Foundation Trusts included a zero-tolerance approach to Methicillin-resistant Staphylococcus aureus bacteraemia ((MRSA BSI – blood stream infection) and objectives to minimise rates of both Clostridioides difficile (CDI) and Gram-negative bloodstream infections (GNBSI) to levels set by NHSE.

Methicillin-resistant Staphylococcus aureus

During 2024/25, 15 cases of MRSA bacteraemia were reported relevant to the population of Derby and Derbyshire. This is an improved position from 2023/24 where there were 17 cases. Seven of these cases were identified as a healthcare-associated infection within UHDBFT and none were at CRHFT, although there was one case of a Vancomycin-resistant Staphylococcus aureus VRSA which is reported in the same way. The others were cases found in the community.

In line with national guidance, all MRSA bacteraemia are subject to a post-infection review; with any identified learning shared not only with those involved but with the wider health economy to support prevention of future cases. The completed reviews have not identified any lapses in care specific to these cases but have supported the continued implementation of both Trusts' improvement plans; any remaining reports which are pending will be reported through the Trust's internal infection control committees which are attended by the ICB for assurance.

Methicillin-sensitive Staphylococcus aureus

Methicillin-sensitive Staphylococcus aureus bloodstream infections have been subject to mandatory reporting since January 2011, though no organisational thresholds are set. There were 274 cases identified during 2024/25, compared to 296 cases during 2023/24. The epidemiology reported by UK Health Security Agency noted increasing numbers of Methicillin sensitive Staphylococcus aureus being seen nationally, driven by an increase in community associated cases (74% of ICB cases); we are pleased to note that the ICB has observed a decrease rather than following this national trend.

Clostridioides difficile infection

There were 425 cases of CDI assigned to the ICB during 2024/25, compared with 351 for 2023/24 and 360 for 2022/23. Annual thresholds for each organisation are set by NHSE, with the ICB's threshold being set at no more than 261 CDI cases during 2024/25. Both acute Trusts have also breached their thresholds for the year, despite significant increases in the case thresholds allocated. UHDBFT had 191 cases against a threshold of 179, and CRHFT had 64 cases against a threshold of 50.

During 2022/23, both acute Trusts in Derbyshire implemented Trust-wide infection, prevention and control (IPC) improvement plans underpinned by learning identified from post-infection reviews, audit outcomes, feedback from performance and quality colleagues and advice following NHSE and ICB visits. Despite this, the challenge to reduce health-care acquired infections (HCAIs) continues in 2024/25, and recovery plans have been extended to include enhanced internal scrutiny, strengthened governance processes, specialist infection prevention and control leadership and visibility to support further embedding of risk reducing measures. Thus far, no definitive cause has been pinpointed for the rise in HCAIs.

The national and regional landscape mirrors the situation in Derbyshire; the ICB benchmarks in Quarter 3 just above the middle of all ICBs with poor performance driven by an increase in community associated cases during Quarter 1 and Quarter 2. NHSE infection prevention and control teams are leading collaborative efforts and task-oriented groups focused on common themes and representatives from the ICB; NHS providers are integral members of these initiatives and a regional piece of work to understand what we can learn from the best performing systems is planned.

Gram-negative bloodstream infections

The national action plan ‘Confronting Antimicrobial Resistance 2024–2029’, contains outcomes and commitments to make progress towards the government's 20-year vision for antimicrobial resistance to be contained, controlled and mitigated. By 2029, the ICB aim to prevent any increase in GNBSI in humans from the 2019 to 2020 financial year baseline, which is in line with Target 1b of the plan. This includes bloodstream infections caused by Escherichia Coli (E.coli), Pseudomonas and Klebsiella species.

Case numbers for Derby and Derbyshire residents for all GNBSI infections showed increases during 2024/25, with the except of pseudomonas, which is in common with increases shown in the other alert HCAIs. The thresholds set have been breached for both our acute Trusts and consequently at System-level. Findings of GNBSI post-infection reviews did not suggest any additional actions were required to those already included in the existing Trust-wide HCAI improvement plans. Work to refine practice associated with cannulas, and particularly catheters, were included as part of the wider improvement plans. During 2024/25, UHDBFT

reported a 10% reduction of patients with GNBSI, with urinary tract infection as a probable source since April 2024, which they feel was a result of work undertaken around the care of catheters. Work to look at UTI prevention as a whole Trust is planned for 2025/26.

Patient Safety

Derbyshire was an early adopter of the PSIRF in October 2019; a pivotal component of the NHS Patient Safety Strategy published in July 2019. Aligned with the strategy's objective to enhance safety, PSIRF facilitates insight extraction from patient safety incidents, formulation of improvement plans and collaboration with quality improvement colleagues to embed and sustain improvements.

Providers are progressing well with PSIRF which has now been implemented across all NHS organisations, demonstrating successful integration into diverse institutions. The framework equips providers to customise learning responses for individual incidents, cultivating a culture that prioritises systemic improvement. The emphasis is on ensuring that improvements are not only implemented but also ingrained into practice, fostering sustainability. Providers have devised comprehensive plans for both national and local incidents. Thematic analyses and improvement plans, once finalised, undergo discussions at routine Clinical Quality Review Groups. This forum ensures examination of assurances regarding the integration of improvements and their sustainability. Additionally, the insights and learnings are disseminated across the System during an annual learning event, promoting a collaborative and shared approach to enhancing patient safety.

Patient safety partner involvement in organisational safety is a crucial aspect, and involves the engagement of patients and laypeople in supporting healthcare organisation governance and management processes for patient safety. DCHSFT with support from the ICB, recruited five Patient Safety Partners; the review of their workload and training now forms a part of scheduled meetings to provide support, gain feedback on their progress and identify any training required to develop the role in the future. There is an ongoing recruitment campaign to recruit a further seven partners.

It should be noted that all providers should include a minimum of two Patient Safety Partners on their safety-related clinical governance committees. It is intended that this will become a contractual requirement in the NHS Standard Contract.

Learning from Patient Safety Events

Learning from patient safety events (LFPSE), a recently implemented national NHS system, revolutionises the recording of patient safety events. This system enhances capabilities for analysing safety events across healthcare, providing deeper insights and more relevant learning in the current NHS environment. LFPSE has been universally adopted by NHS and independent healthcare providers, with General Practices leading the transition to this innovative system. Learning outcomes are reviewed by the ICB's patient safety team and Primary Care Quality Team, and any significant learning is shared at quarterly clinical governance leads meetings. LFPSE is a standing agenda item to exchange learning, share reporting and any LFPSE updates. All providers have now transitioned on to this new system.

The ICB held its first System-wide learning event on the 11th October 2024 at the Queens Hospital Burton, where acute, community, mental health, ambulance and 111 presented their positive learning progress and challenges. The day was a huge success with lots of questions and interaction on how partner organisations are sharing learning across their organisations and as a wider System. The day also gave ideas and support on how teams liaise and support families and staff when incidents are investigated.

Never Events

Never Events encompass preventable patient safety incidents, fortified by national-level guidance and safety recommendations that serve as robust systemic protective barriers, essential for adoption by all healthcare providers. Extracting lessons from healthcare events is pivotal for averting future harm.

During the period from April 2024 to March 2025, 14 Never Events were reported by Derbyshire providers. All of these incidents underwent a thorough investigation, as part of the PSIRF, and a distinct pattern with shared similarities was identified through comprehensive patient safety incident investigations. Themes and trends were discerned, leading to the formulation and completion of improvement plans. The insights derived from Never Events are disseminated at Clinical Quality Review Groups to ensure thorough oversight and scrutiny. All improvement plans are openly shared and, upon completion, evidence is gathered to verify the integration of all learned lessons into practice.

Harm Reviews

Understanding harm reviews in organisations is crucial for fostering a culture of accountability, safety and continuous improvement. These reviews provide valuable insights into past incidents, allowing organisations to identify causes, assess risk factors and implement effective preventive measures. Embracing a transparent approach to harm reviews builds trust among employees, fosters a sense of ownership in addressing challenges and ultimately contributes to the overall resilience and success of the organisations.

Provider organisations across Derbyshire have risk stratification and harm review processes in place. As with other processes, the providers review and revise them accordingly. As an ICB, there is oversight at Clinical Quality Review Group meetings, with quarterly reporting to the ICB Quality and Performance Committee.

Patient Experience

The ICB continues to work collaboratively with partner organisations and agencies across the System, benefits of which have included:

- opportunities to build and maintain positive, trusted working relationships;
- easier access to provider-led feedback and insight, facilitating an ethnographic approach to utilisation and synergised projects;
- reduced duplication;
- expedited responses; and
- increased occasions for shared learning and quality improvement.

The ICB work with and listen to patients, carers and other groups on several key work programmes, which include discharge to care homes, stroke services, virtual wards,

maternity services and end-of-life care. Collaborative working with Healthwatch has developed ways of using insight effectively across the System and a joint strategy, supporting the production of service specifications, evaluation and moderation on service procurement panels.

The ICB have also worked on a range of procurement programmes including urgent treatment centres, non-emergency patient transport, General Practice services and out-of-hours services. This ensures that patient insight informs the services that we commission and that performance measures reflect patient and public needs. Changes made as a result of gathering patient insight include:

Patient discharge	Improved information about discharge from hospital on different pathways of support.
	Early supported discharge for stroke patients.
	Increased staffing numbers in care homes providing discharge to assess care home beds and clarity for patients and carers on the process, including finance and payments, through newly designed information leaflets.
Virtual wards	Revised information about the benefits of staying on a virtual ward to avoid an admission or facilitate an early discharge from hospital.
Rehabilitation pathways	Review of rehabilitation pathways following a stroke resulting in the development of a case for change.
End-of-life	Improvements to the Derbyshire Alliance End-of-life Toolkit.
Talking therapies	Re-procurement of service, ensuring patient needs are understood in the development of service specifications.
Cultural sensitivities	Raised awareness within Primary Care of cultural sensitivities around death and dying within BME groups and communities.
Maternity equity	Improved relationships with System partners and supporting the development and implementation of clear and effective patient experience pathways to support maternity equity.
Women's Health Hub	Areas of women's health services where there is limited evidence of patient involvement and experience have been highlighted and the ICB's involvement will continue to ensure consistency in the gathering of patient experience and to carry out the analysis of the data.

Quality and Equality Impact Assessments

In order to improve the health of the local population and enable services to work in an efficient and effective way, changes in local service pathways are often required. Robust planning and implementation is essential to ensure that the potential for unintended harmful impact on patient safety, clinical effectiveness or patient experience is minimised.

The ICB are committed to ensuring that a consistent approach is taken to inform commissioning decisions, business plans and financial recovery plans, including a robust evaluation for their impact on both healthcare quality and equality. The completion of the assessments is a continuous and dynamic process to help decision makers understand the

consequences and potential impact of financial and operational initiatives and changes to existing services. They provide evidence of fair and proportionate reasoning when making challenging decisions about local healthcare services, whilst providing assurance that actual or potential risks to patients and service users have been considered and mitigations provided where practicable.

Care Homes

Quality Assurance

The ICB has a team of Clinical Quality Managers who are responsible for quality monitoring activity within the care home sector for nursing homes in which the ICB funds patient care. They provide assurance on the quality of our local nursing homes and highlight any quality concerns, themes, trends and subsequent actions taken.

The System quality assurance process for the care home sector is supported by a local multi-agency information sharing group who monitor and respond to emerging risk promptly. The group includes representatives from local authorities, the ICB, CQC and the continuing care. During this year, CQC reviewed their inspection regime and moved to a change in monitoring services under a revised single assessment framework of risk management. This meant that services rated as 'requires improvement' were not automatically reinspected within the same timeframe as was done previously but were reinspected based on the level of risk the provider presents. The continued multi-agency partnership working has therefore been vital to ensure information is shared between agencies to inform this process and manage risk accordingly.

Care Quality Commission Inspections

During 2024/25, the above partnership working has also supported a care home in north Derbyshire to improve their rating with CQC from 'inadequate' to 'good'. The staff at the home are to be commended for their dedication to improve standards across the service.

There has also been an instance of one service, which was initially rated as 'outstanding' by CQC, receiving an 'inadequate' rating following concerns raised; in this case contract suspensions were put in place jointly with the Local Authority, with supporting action plans to oversee a programme of quality improvement. With the support from the ICB and Local Authority, the quality of care improved and a rating of 'good' was received from CQC, which again, is a credit to the care home staff and their hard work.

Four nursing homes have achieved an 'outstanding' rating by CQC in recent assessments and only one home is rated 'inadequate'. The quality assurance activity undertaken by the ICB is prioritised based on the level of risk and shows that 100% of providers have had either a short or full quality monitoring visit within 2024/25.

Safeguarding concerns

Both Local Authorities in Derby and Derbyshire are responsible for investigating safeguarding concerns. The ICB receives safeguarding reports regarding nursing homes and attends safeguarding meetings where appropriate. Where clinical quality themes and trends are identified the Clinical Quality Managers follow-up with the care home to provide support and ensure appropriate action is being taken. Many safeguarding concerns this year were self-reported by the care home provider, demonstrating a positive reporting culture.

Enhanced Health in Care Homes Programme

As part of the national Ageing Well Programme, the Enhanced Health in Care Homes Programme continued during 2024/25, under the leadership of the Integrated Care Homes Strategic Group, to support the wider agenda of support within the sector. Key priorities included falls, improving engagement and communication with care homes and leading on developments related to the enhanced health in care homes direct enhanced service that is provided by Primary Care and community partners.

Earlier in the year, the East Midlands Care Awards were presented at a regional conference. This was a great story of success in the region as Derby and Derbyshire services were awarded the following:

- winner of Support Team of the Year;
- winner for Care Home Manager of the Year; and
- highly commended/runner up for Care Home of the Year (two winners).

It is a credit to the sector and the dedication of the staff who have worked hard to achieve these awards, demonstrating high quality care delivery for their residents.

Learning from lives and deaths of people with a learning disability and/or autistic people

The Learning Disabilities Mortality Review (LeDeR) is a national service improvement initiative commissioned by NHSE aimed at reviewing the lives and deaths of people with learning disabilities and/or autistic people. It aims to improve care, reduce health inequalities and prevent premature mortality through reviews of individuals who have died, looking at information about the health and social care support they received.

All reviews are quality assured, and learning is identified through the LeDeR Governance Panel where individual reviews are discussed, and actions and learning agreed. Learning from LeDeR is shared across the System through the LeDeR Steering Group, where members discuss the learning to ensure priority areas are agreed and fed back to care providers. The LeDeR Programme continues to follow the LeDeR Strategy which has been produced locally for Derbyshire, including a vision, aims and objectives. During 2024/25 this has included:

- increased efforts to improve both the number of reviews completed to reach NHSE national targets, which has included ensuring the quality of reviews is maintained, and reviewing processes of how learning is shared;
- working with System partners to share learning in relation to the ReSPECT/DNACPR (Do Not Attempt Cardiopulmonary Resuscitation Process), including the importance of holding and documenting end-of-life conversations with individuals and their carers;
- increased scrutiny of deaths from aspiration pneumonia and any apparent themes;
- capturing data through LeDeR and sharing this with the Health Facilitation Team to support the increase in uptake and quality of learning disability annual health checks and health action plans, with work ongoing to reduce the number of health checks not attended; and
- working with other Systems and NHSE to peer-review the quality of LeDeR reviews, sharing process and learning across the Midlands Systems.

Special Educational Needs and Disabilities

Between September 2021 and November 2024, NHSE monitored the ICB's progress in relation to SEND for those aged between 0–25 years, to ensure the necessary governance and infrastructure was in place to:

- fulfil its statutory duties in relation to children and young people with SEND;
- ensure compliance with the existing SEND code of practice and statutory requirements of the Children and Families Act 2014; and
- enable an assessment of the ICS's maturity in relation to children and young people with SEND.

Based on evidence submitted to the NHSE regional team and a regional peer review exercise, key lines of enquiry for leadership and SEND improvement were rated as 'green', while data/intelligence, workforce and training, engagement and coproduction were rated as 'amber'. The assessment indicated that Derby and Derbyshire were rated overall as high 'amber' with 'emerging: maturity in relation to SEND', which is in line with 10 out of the 11 ICS areas across the East and West Midlands regions.

Quality Assurance Framework

In November 2024, the ICB were chosen to pilot a new NHSE quality assurance framework designed to support ICB's in the delivery of SEND services at System and Place-level, which is to be evaluated by the Council for Disabled Children before national roll-out in April 2025.

Performance Reporting

The ICB has continued to work through the established partnership with Local Authorities and Trusts, including those providing services within Glossop to drive SEND improvements across Derbyshire. Each Trust has an executive lead for SEND and produces its own annual SEND report to evidence progress against the SEND self-assessment tool, KPI data, quality assurance activity for health advice, engagement with CYP and their families, transition, training and quality governance. Each report is reviewed by the designated clinical officer for SEND and children's commissioners. Information is also used to inform the SEND local area self-evaluation framework, with ongoing monitoring through the ICB's health SEND footprint assurance meetings.

During 2024/25, performance reporting by all Trusts for services across Derbyshire showed high levels of compliance for health advice requests, averaging between 70-100% within the national standard of six weeks. This is a remarkable achievement given the significant increase in the number of requests from both local authorities. Audit reporting on the quality of health advice also remains high with an average of 81-100% of reports meeting the agreed standard.

Local Area SEND Inspection Framework

In April 2024, a new Joint Ofsted and CQC Local Area SEND Inspection Framework and handbook came into force. The Derbyshire County Local Area Partnership was inspected in September 2024 and the outcome can be viewed here. The ICB and Trusts are therefore working with Derbyshire County Council to develop and deliver changes within a priority action plan, which aims to address long waiting times for specialist assessments, mental health support, and specialist chairs or seating. The ICB also continue to work in partnership with other stakeholders in preparation for the Derby City Council inspection.

Primary Care Assurance

The ICB conducts regular reviews of Primary Care quality and performance indicators through the early warning system dashboard. The reviews support the identification of quality or performance which is different to the local or national average, and gather intelligence and triangulate information from various data sources relating to General Practice to highlight monthly variations. The reviewed information will also be shared with practices through the Primary Care Quality Visits Programme, and actions, interventions and support in relation to both individual practice and PCNs are agreed through the Primary Care Quality Operation Group.

The data review and subsequent conversation with General Practice can also identify areas of good practice which can be shared across practices through clinical governance leads meetings.

All Age Continuing Care

All Age Continuing Care (AACC) is a collective term for services provided by the NHS. AACC is the process for determining whether an adult is eligible for NHS Continuing Healthcare (CHC) or NHS-funded nursing care, or whether a child or young person is eligible for continuing care. Adults are deemed to be eligible for CHC if they have a primary health need, a concept developed by the Secretary of State to assist in determining when the NHS is responsible for providing for all of the individual's assessed health and associated social care needs. These services assess and provide funding for the care of individuals of all ages to meet their ongoing identified health and care needs. These services also include jointly-funded packages of care with local authorities and education.

The ICB recognise that those being assessed for CHC are frequently facing significant changes in their lives and a positive, personalised experience of the assessment process is fundamental. The ICB places the individual at the heart of the care-planning process, promoting choice and control, which results in a much more positive outcome.

National Frameworks

Both ICB operational policies which support this work outline how the AACC services are delivered, and are in accordance with the National Framework for CHC and Funded Nursing Care (2022, revised) and the National Framework for Children and Young Peoples Continuing Care (2016).

The national frameworks provide tools and guidance to be used in the assessment process, including fast track referrals. They also outline the roles and responsibilities of all statutory bodies, in order for individuals who may have complex health needs to have a 'whole system' approach to assess and manage health and social care needs. During 2024/25, there was continued transformation for AACC, with a strong focus on continued improvement, collaboration and partnership working with both local authorities and acute hospital discharge leads.

NHSE has also set national quality premiums for all CHC teams, which includes at least 80% of assessments for all new referrals being completed within 28-days and at least 85% of assessments completed outside of a hospital. The ICB has successfully met compliance targets against the national quality premiums in both areas in Quarter 1 and Quarter 2 of 2024/25, despite the increase in checklist referrals. Quarter 3 and Quarter 4 compliance reduced to 69% and 59% respectively. A recovery plan has been implemented following the contractual dispute resolution and an improvement in quality premium compliance is anticipated in Quarter 1 of 2025/26.

Discharge to Assess

During 2024/25, the discharge to assess pathway 3 (nursing) standard operating procedure was revised in collaboration with System partners to reflect the national frameworks, which created positive working relationships, improved efficiency and effectiveness, and increased focus upon personalisation and outcome-based commissioning.

Complex Care Assurance and Governance

The Complex Care Governance and Assurance (previously Commissioning for Individuals) Panel continues to consider the appropriateness, safety, quality, and cost effectiveness of requests for complex/specialist care placements/packages and interventions, and ensures that people in need of NHS healthcare funding are in receipt of a package of care that is reflective of their assessed needs. The panel is chaired by a lay representative and the panel consists of representatives from quality, contracting, commissioning and finance.

The panel also help to identify themes and trends, promotes professional challenge and engages in discussion relating to funding requests. This ensures that the least restrictive package is in place and reviews are completed, in line with national and local guidance. Processes are in place to support robust quality assurance of applications prior to panel, confirming that locally commissioned services have been explored and highlighting to the panel the unmet need for consideration.

Allied Health Professionals

Allied Health Professionals (AHPs) are degree-level professionals and professionally autonomous practitioners who provide System-wide care to assess, treat, diagnose and discharge patients through adopting a holistic approach to healthcare. AHPs focus on prevention and improvement of health and wellbeing to maximise the potential for individuals to live full and active lives within their family circles, social networks, education, training and workplace. During 2024/25, the ICB continued to support an interim lead for AHPs to strengthen AHP leadership across the ICS and ensure future system AHP leadership is adequate to harness the transformational ability of the current and future workforce.

Derbyshire Allied Health Professionals Council

The Derbyshire AHP Council brings together Chief AHPs from local providers across the System and is chaired by the ICB AHP lead. It works collectively, as part of the wider System architecture, to support the quality, operational delivery and financial priorities of the ICS. The key strategic areas of focus for the Derbyshire AHP Council are aligned to the national strategy and include:

- quality;
- productivity;
- workforce – supply, education, training, transformation; and
- strategic thinking, leadership and transformation.

During 2024/25, an AHP governance, risk and quality highlight report process, established through the Derbyshire AHP Council, continued to be embedded within the System to ensure oversight and provide assurance around the AHP workforce and services. This report is now incorporated into a quarterly report to the Midlands Regional AHP Board.

The Derbyshire AHP Council and faculty has continued to support the development of the AHP workforce to ensure a sustainable AHP workforce for the future. In 2024/25, £108k of workforce, training and education funding was secured from national bids to support these priorities. Projects include the implementation of the AHP preceptorship, workforce and educator career frameworks, which supported colleagues to undertake various AHP apprenticeships and upskilled AHP educators. In addition, funding was also secured through the multiprofessional education and training plan and cancer and diagnostics workforce training. Development and upskilling of the AHP workforce is critical as there are several AHP professions identified as at risk, so this funding has been utilised to support individuals into training for these professions.

The Derbyshire AHP Council has also overseen and supported clinical pathway transformation projects, aligned to the ICB's Integrated Care Strategy, to develop high-quality and sustainable integrated care for the population's health care needs. Over the past 12 months reviews were undertaken to reduce variation of access to services and ensure quality, equitable services to the local population. These included:

Children's speech and language pathway	A review of the children's speech and language therapy services to bring the two services together to improve the quality, effectiveness and efficiency of the joint service. The transfer of services is planned for 1 April 2025.
Dietetic services	Significant pressures to dietetic services were identified, predominantly due to workforce recruitment and retention challenges which are subsequently impacting on the delivery of dietetic provision across pathways. Ongoing collaborative work is in progress with the dietetics services to support recruitment initiatives and more collaborative service delivery, with a key area of focus on paediatrics and mental health.
Post-Covid-19 rehabilitation	A review of post-Covid-19 rehabilitation services resulted in individual services being transferred to DCHSFT to provide one community offer for the service, ensuring equitable provision across the System.

Stroke rehabilitation	The community stroke services are at capacity, with patient demand and limited resource with inequitable provision across parts of Derbyshire. Transformation of stroke rehabilitation services across the ICS is necessary; a project team is developing an options appraisal for the future delivery of the stroke rehabilitation services to improve the quality and reduce inequities in the current provision.
Community services transformation	In line with Lord Darzi's investigation into the NHS and the shift from hospital to community care, a programme of work has taken place for community integration which involves AHP services and focuses on facilitating discharge and avoiding admissions, to decrease pressure on the acute setting and improve patient outcomes and experience.

Safeguarding Adults

The ICB is fully committed to fulfilling its safeguarding responsibilities in ensuring that adults at risk are protected from abusive behaviour and practice in all of its forms. This includes working in partnership with a wide range of care providers and stakeholders to ensure that there is clear leadership, governance and lines of accountability, having appropriate policies and procedures, providing safeguarding training and working in partnership with relevant agencies to protect adults at risk of harm.

The ICB is also responsible for ensuring that the statutory responsibilities to safeguard and promote the welfare of adults at risk are embedded in the services that it commissions and that providers work within the national and local legislation and guidance. To ensure that ICB-commissioned services have robust safeguarding arrangements in place, a range of self-assessment tools have been developed. These tools provide assurance that commissioned services are fulfilling requirements in line with the Care Act (2014) and the Safeguarding Adult Accountability and Assurance Framework. The ICB also provide annual and quarterly safeguarding assurance regarding its arrangements to the national and regional NHSE safeguarding teams.

The ICB is represented at a range of associated public safety work programmes – including the Mental Capacity Act (2006), Prevent, Multi-agency Public Protection Arrangements, human trafficking, serious violence, serious organised crime, domestic abuse, and community safety – to influence and shape local, regional, and national initiatives and strategies.

The ICB also provide a consultancy professional advice service across the partnership, providing expert safeguarding advice, support and supervision whilst also capturing and disseminating learning from safeguarding adult and domestic homicide reviews. This is essential to facilitate learning, practice development and service improvement. More information on safeguarding adults can be found on the ICB's website.

Safeguarding Children and Looked after Children

The ICB's Safeguarding Children and Looked After Children Team consists of nurses and doctors who provide expert advice and support to a broad range of health professionals. The team are proactive in implementing national and local guidance, directives and learning from

reviews to continually improve services. Safeguarding policies have also been updated, which are in line with multiagency procedures.

During 2024/25, the ICB continued to demonstrate that it has the appropriate safeguarding governance arrangements in place for discharging their statutory safeguarding duties and functions in accordance with Working Together to Safeguard Children (2023). The ICB also maintained assurance and oversight of its duties as outlined in the NHSE Safeguarding and Accountability And Assurance Framework (2022). This was achieved through compliance in the following areas:

Leadership and Organisational Accountability	A clear line of accountability for safeguarding, reflected in the ICB governance arrangements, i.e. a named executive lead to take overall leadership responsibility for the ICB's safeguarding arrangements. In addition, a team made up of designated professionals for safeguarding children, looked after children, and safeguarding adults.
Training	Training all ICB staff to recognise and report safeguarding issues supported by a training strategy and compliance percentage in line with intercollegiate documents and national guidance for Prevent.
Safe recruitment	Clear policies describing the commitment and approach to safeguarding, including safe recruitment practices and arrangements for dealing with allegations against people who work with children and adults, as appropriate.
Inter-agency working	Effective inter-agency working with the ICB, Local Authority, police and key partners, including within the operation of Derby and Derbyshire Safeguarding Children Partnership and Derby and Derbyshire Safeguarding Adult Boards.
Implementation	Appropriately engaged with all safeguarding investigations, multi-agency case reviews or safeguarding practice reviews and that the evidence of learning has been embedded into practice.
Patient engagement	Ensures appropriate and accessible information is provided for its population in relation to how it discharges its duties for safeguarding.
Supervision	Safeguarding supervision is available to staff in line with intercollegiate guidance.
Assurance	As a commissioner of local health services, the ICB must be assured that there are effective safeguarding arrangements in place in the services and must gain assurance throughout the year to ensure continuous improvement.

The ICB remain fully committed to delivering a safe and effective safeguarding service and continually strive to strengthen arrangements to safeguard children and young people across the ICS. This is achieved by working in close partnership with partner agencies and commissioned services to continuously improve systems and processes to safeguard children and young people within our community.

Close working with ICB-commissioned health providers ensures that robust safeguarding arrangements are in place, in accordance with section 11 of the Children Act (2004) and

national and local legislation and guidance. The ICB have clear processes in place to monitor the safeguarding arrangements of ICB-commissioned services by using agreed assurance tools.

The ICB has also continued its leadership and membership of the child death overview processes at monthly panel meetings, which review Derby and Derbyshire deaths for those aged 0-18 years. The reviews identify any modifiable factors and disseminate key learning to help prevent future deaths. Regular reporting takes place by the meeting's Chair and statutory partners from both city and county Public Health.

Reducing Health Inequality

Health inequalities are defined as unfair and avoidable differences in health across the population, and between different groups within society. A person's chance of enjoying good health and a longer life is determined by the social and economic conditions in which they are born, grow, work, live and age. These conditions also affect the way in which people look after their own health and access services. Nationally, addressing health inequalities is a recognised factor in addressing the prevention of avoidable illness and in improving overall experience and health outcomes.

ICBs are statutorily required to have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved. This means that health inequalities must be properly considered when making commissioning decisions for the population. We do this by ensuring that the consideration of inequalities is firmly embedded within our strategic plans and key business activities, examples of which include:

- ensuring plans and strategies are in line with the needs of the local population;
- ensuring the framework for generating citizen intelligence is fully inclusive; working with local forums that enable us to hear from those who are experiencing the greatest health inequalities;
- following a clear decision-making framework to ensure that investment, disinvestment and service change decisions are made following a reasonable evaluation of available evidence. This includes assessment of local community health requirements;
- ensuring that proposals to change or remove a service, policy or function clearly demonstrate;
- the impact on reducing health inequalities; and
- ensuring appropriate oversight and scrutiny of our arrangements to tackle health inequalities and improve health outcomes through the ICB's Board and committee structure.

The ICB have recognised health equity (the ability for all individuals to attain their full potential for health and wellbeing) as one of three core principles within our Integrated Care Strategy. This builds on and supports the delivery of our health inequalities duty and aligns with the ICB's commitment to delivering equity in access and experience across our system, which is further demonstrated in our NHS Joint Forward Plan.

To drive forward the NHS focus on health inequalities, in November 2023, NHSE published a Statement on Information on Health Inequalities. The Statement set out a description of the powers available to relevant NHS bodies to collect, analyse and publish information. NHSE has provided a list of key metrics for monitoring that are the focus of the Statement. The metrics align with the national five strategic health inequality priorities alongside the

clinical areas of the Core20PLUS5 approach.

In response to this, during 2024/25, we have produced our first annual Health Inequalities Statement for Derby and Derbyshire, which will be published alongside this Annual Report on our website at www.derbyandderbyshireicb.nhs.uk in the 'Annual Reports and Accounts' section. In producing the Statement, we have developed a robust health inequalities dashboard that supports ongoing monitoring across the NHSE five priority areas for health inequalities and the Core20PLUS5 approach. The dashboard will continue to evolve as we further develop our understanding of access, experience and outcomes in the context of health inequalities.

Equality, Diversity and Inclusion

The Public Sector Equality Duty (PSED) of the Equality Act 2010 requires us to have due regard to the need to eliminate discrimination, harassment and victimisation, advance equality of opportunity and foster good relations. These are often referred to as the three general aims of the PSED. Having due regard requires the ICB to consider removing or minimising disadvantages, take steps to meet people's needs, tackling prejudice, and promoting understanding. As an ICB we have continued to demonstrate a proactive approach to meeting the requirements of the Public Sector Equality Duty through use of the NHS Equality Delivery System during 2024/25. You can read more about this at Appendix 4.

The ICB recognises and values the diverse needs of the population we serve, and we are committed to reducing health inequalities and improving the equality of health outcomes for local people. The ICB is committed to embedding equality and diversity considerations into all aspects of our work, including policy development, commissioning processes and employment practices, and recognises that equality is about ensuring that access to opportunities is available to all and that no one should have poorer life chances because of the way they were born, where they come from, what they believe, or whether they have a disability. The ICB believes that diversity is about recognising and valuing differences by being inclusive, regardless of age, disability, gender re- assignment, marriage or civil partnership status, pregnancy and maternity, race, religion or belief, sex, or sexual orientation. The ICB is committed to:

- improving equality of access to health services and health outcomes for the diverse population we serve;
- building and maintaining a diverse, culturally competent ICB workforce, supported by an inclusive leadership team; and
- creating and maintaining an environment where dignity, understanding and mutual respect, free from prejudice and discrimination, is experienced by all and where patients and staff feel able to challenge discrimination and unacceptable behaviour.

In practice, delivery against these commitments is achieved by ensuring the following actions are undertaken across our business activities:

- assessing the health needs of the population; working with Local Authority Public Health colleagues to ensure that Joint Strategic Needs Assessment chapters consider all protected characteristic and other disadvantaged groups to accurately inform equality considerations in our commissioning intentions; and
- public engagement and communications; engaging with people from all protected characteristic and other disadvantaged groups, particularly those whose voices may

not be routinely heard, through a range of different mechanisms to ensure that the right information is available to commission the right health services and can be accessed by the people who need them. The ICB also delivers targeted and tailored messaging that reaches the right people more effectively.

Quality and Equality Impact Assessments

The Quality and Equality Impact Assessment process continues in its robust assessments of impact of changes or developments. Links between the equality and engagement assessments of service changes and developments have been further developed with sharing and discussing of assessments to offer the maximum level of assurance. The organisational objective around equality focuses on developing community profiles to support basic level knowledge of each of the ICB communities. These profiles aid the development of communication and engagement plans reaching into communities to deliver work in a way which meets their needs.

Procurement

The ICB continues to ensure that there are robust processes in place in the procurement of healthcare services. Each aspect of procurement activity includes embedded equality considerations (where relevant) and comprehensive equality-related tender questions in both the pre-qualifying questionnaires and invitation to tender stages. These processes ensure that there is assurance that providers of healthcare services in Derby and Derbyshire understand our population and the important equality considerations that they should make. These include, but are not limited to, making reasonable adjustments to ensure that their services are accessible to all, including those individuals with protected characteristics.

Equality Statement

An equality commitment statement is embedded in all ICB policy developments and implementations, while also providing a framework to support ICB decisions through equality analysis assessed at Quality and Equality Impact Assessment Panel. In carrying out its function, the ICB must have ‘due regard’ to the Public Sector Equality Duty. This applies to all activities for which the ICB is responsible, including policy development, review and implementation.

Equality Analysis and ‘Due Regard’

The ICB adopts a robust model of equality analysis and ‘due regard’, which it has embedded within its decision-making process. This is evidenced in the design of policies, service specifications and contracts. Such evidence is reviewed as part of the decision-making process and summarised in all ICB Board and Corporate Committee cover-sheets.

The ICB has ‘due regard’ for the need to eliminate unlawful discrimination, promote equality of opportunity and provide for good relations between people of diverse groups, in particular on the grounds of the characteristics protected by the Equality Act (2010). These are: age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief and sexual orientation, in addition to offending background, Trade Union membership or any other personal characteristic.

Workforce

With the publication of the NHS Workforce Race Equality Standard (WRES), the ICB reviewed submissions by the main NHS providers in Derbyshire, identifying their compliance with the standard, current position in terms of ethnic minority staff experience and the actions they intend to take. The ICB is required to demonstrate progress against a number of workforce equality indicators detailed in the WRES. The ICB reviewed the WRES, and has taken 'due regard' in its own activities, and reviews and monitors its WRES action plan.

The ICB has an established staff Diversity and Inclusion Network, which is inclusive of all staff and protected characteristics, including ethnic minority colleagues. The network is run by staff and brings together colleagues across the ICB who identify with a particular protected characteristic.

The purpose of the Network is to work with the ICB in its strategic objectives to support people in Derby and Derbyshire to live their healthiest lives and help the organisation to be an inclusive and equitable employer by utilising the skills of its Diversity and Inclusivity Network and wider ICB staff to be an inclusive and diverse employer. The group is consultative and makes recommendations in support of ICB staff. During 2024/25, the terms of reference for the network were reviewed and updated to provide protected time for the Chair and Vice Chair.

The network meets monthly to discuss and consider issues that they feel need addressing/considering by the ICB, and works to improve staff experience on specific issues, including race and religion. Key initiatives for 2024/25 included:

- celebrating and promoting key dates in the inclusion calendar;
- raising awareness of the lived experiences of underrepresented staff;
- re-launching reciprocal mentoring;
- informing the healthcare System's approach to engagement with diverse communities relating to health inequalities;
- fair and inclusive recruitment and selection training;
- identifying actions for the ICB to help improve the lived experiences of staff; and
- informing the WRES, WDES, staff survey actions and the ICB organisational development plan.

While no internal targets have been set with regard to workforce representation, the ICB aims to have a workforce that is representative of the community at all levels of the organisation.

ICB Ethnic Minority Groups

The proportion of the ICB's population that belong to ethnic minority groups is estimated at 6.3% (6.5% in the 2011 census), based on the 'covered by population' data from the 2021 census. The 2021 census data stated the proportion of the population belonging to an ethnic minority within Derby city as 26.2%, an increase of 0.5% since the 2011 census.

At the 31st March 2025, the proportion of employees within the ICB from ethnic minority groups was 10.78%. A breakdown of proportion of ICB staff from an ethnic minority group across the banding structure within the ICB is detailed below. Table 10 below shows that these employees are underrepresented within the lower Bands 1 to 7:

ICB employees from an ethnic minority group	2024/25	2023/24	2022/23	2021/22	2020/21	2019/20
Band 8d/VSM	8.82%	7.69%	16%	4.35%	4.76%	4.35%
Bands 8a–8c	13.38%	13.33%	14.65%	15.97%	15.28%	13.38%
Bands 1–7	9.88%	9.34%	7.41%	9.85%	8.54%	7.99%

Table 10 – proportion of ICB staff from an ethnic minority group across the banding structure between the financial years 2019/20 to 2024/25

At a Very Senior Manager (VSM) level the proportion of ICB staff from an ethnic minority group is 0%. The Senior Management Team within the ICB has had minimal turnover during 2024/25, which represents a barrier to achieving a diverse workforce at all levels across the organisation.

The ICB is also working with System healthcare partners to create and promote development opportunities for staff from underrepresented groups. JUCD is committed to supporting people from ethnic minority groups to successfully progress their career and be represented in leadership positions. We promote national and local leadership development opportunities but recognise that some people may face barriers to joining and attending.

NHS Workforce Disability Equality Standard

The Workforce Disability Equality Standard (WDES) is a set of 10 specific measures which enable NHS organisations to compare and understand the workplace and career experiences of disabled and non-disabled staff. It supports positive change for all existing employees by creating a more inclusive environment for disabled people working and seeking employment in the NHS. Completion of the WDES is mandatory for NHS Trusts and the metrics data are used to develop and publish an action plan, which the ICB reviews and monitors. Although not compulsory for the ICB, we collate the WDES metrics data to help us better understand the experiences of our disabled staff and develop an action plan.

Actions have included a review and update of the ICB Disability and Long-term Conditions Policy, including the reasonable adjustment passport and promotion of 'Access to work'.

Public Involvement and Consultation

The ICB has a legal duty to ‘make arrangements’ to ensure individuals to whom services are being or may be provided, and their carers/representatives, are involved when commissioning services for NHS patients. The main duties to make arrangements to involve the public are set out in the National Health Services Act 2006, as amended by the Health and Care Act 2022.

To fulfil the public involvement duty, the arrangements must provide for the public to be involved in the:

- planning of services;
- development and consideration of proposals for changes which, if implemented, would have an impact on the manner or range of services; and
- decisions which, when implemented, would have such an impact.

More information about the specific legal duties in relation to working in partnership with people and communities can be found on the NHS England website. The terminology used in this section of the Annual Report is detailed below:

Working in partnership with people and communities	Covers a variety of approaches such as engagement, participation, involvement, co-production, and consultation. These terms often overlap, mean different things to different people, and sometimes have a technical or legal definition too.
People	Everyone of all ages, their representatives, relatives, and unpaid carers. This is inclusive of whether they use or access health and care services and support.
Communities	Groups of people that are interconnected, by where they live, how they identify or shared interests. They can exist at all levels, from neighbourhood to national, and be loosely or tightly defined by their members.
Community-centred approaches	Recognise that many of the factors that create health and wellbeing are at community level, including social connections, having a voice in local decisions, and addressing health inequalities.

The ICB also recognises that working in partnership with people and communities creates a better chance of developing services that meet people's needs, improve their experience and ultimately improve their health outcomes. The full benefits are:

Improved health outcomes	People have the knowledge, skills, experiences and connections that services need to understand in order to support their physical and mental health.
Value for money	Services are designed with people and therefore effectively meet their needs. They improve health outcomes and reduce the need for further, additional care or treatment because a service did not meet their needs first time.
Better decision-making	Business cases and decision-making are improved when insight from local people is used alongside financial and clinical information. Challenge from this insight can promote innovative thinking and lead to new solutions which may not have been considered through internal decision-making processes.
Improved quality	Services can be delivered more appropriately, because they are personalised to meet the needs and preferences of local people.

Accountability and transparency	Engaging meaningfully with local communities helps to build public confidence, trust and support, as well as being able to demonstrate public support for proposals.
Participating for health	Involvement in delivering services that are relevant to patients and their community can lead to social action, formal volunteering roles and employment in health and care sectors. It can also reduce isolation, increase confidence, and improve wellbeing.
Addressing health inequalities	Jointly identifying solutions to barriers to access, developed in partnership with people using community-centred approaches, can help address health inequalities.

Source: Why work with people and communities? NHS England (2022)

ICB approach and ambition

Approach

Demand for health and care services is growing and the resources available are struggling to keep up with that demand, not just in terms of finance, but also staff, estate and equipment. To enable the System to think differently about how services can be provided using the resource that is available, genuine, purposeful, and long-term engagement and the support of local communities is essential. Gathering feedback from a diverse population in local communities about their experiences of care, their views and suggestions for improvement, 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 ICS. These insights, and the diverse thinking of people and communities are also essential in tackling health inequalities and the other challenges faced by our health and care system.

During 2024/25, the ICB have developed a new approach to working with people and communities, which is focused on building relationships, connections and trust and which supports people to sustain and improve their health and wellbeing, through social agency, as well as their involvement in developing plans and priorities to continually improve services. This insight and the diverse thinking of individuals enables the ICB to tackle health inequalities, ensure equality of access, improve quality of life, and help to meet other challenges faced by our health and care system.

The ICB are also trying to develop a System-wide approach to share expertise and resource, which will in turn reduce duplication, improve effectiveness, and unlock capacity from across the System, and within communities to address health and care needs. The aim is to help the System demonstrate the motivation, capability, cultures and tools to make engagement with people and communities the default starting point for all neighbourhood health and care initiatives, System transformation programmes and quality improvement work. This also includes the processes, governance and a culture which aligns to ensure this approach is considered business as usual.

Ambition

During 2024/25, the ICB's ambition has been advanced in order to:

- embed people and communities within planning, priority setting and decision-making, 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 within neighbourhood initiatives, System transformation, commissioning and quality improvement;
- promote relationship building and authentic conversation, including its importance in increasing trust and improving involvement; raising awareness of the need to consider how this is done in a planned, and systematic way, on a continuous basis with the required investment of time and resource; and
- understand the experiences of people and communities, and support the sharing of power, to create authentic connections that bring people and communities into the discussion rather than talking to them about the decision.

To achieve this 10 key principles underpin the ICB's ambition:

1	Centre decision-making and governance around the voices of people and communities.
2	Involve people and communities at every stage and feed back to them about how their involvement has influenced activities and decisions.
3	Understand the community's needs, experiences, ideas and aspirations for health and care, using engagement to find out if change is working.
4	Build relationships based on trust, especially with marginalised groups and those affected by health inequalities.
5	Work with Healthwatch and the voluntary, community and social enterprise sector.
6	Provide clear and accessible public information.
7	Use community-centred approaches that empower people and communities, making connections what works already.
8	Have a range of ways for people and communities to take part in health and care services.
9	Tackle system priorities and service reconfiguration in partnership with people and communities.
10	Learn from what works and build on the assets of all health and care partners; networks, relationships and activity in local places.

Insight – truly understanding people and issues and make them known

To be serious about working in partnership with people and communities it is necessary to move away from transactional engagement where professionals 'do the engaging', and people are the subjects 'being engaged'. This can turn people away from having their own agency, by effectively saying 'we will solve this for you'.

The ICB's engagement culture has started to move towards a more equal, honest, authentic relationship with people, which encourages them to be an integral and respected part of the decision-making process. With this people are valued, listened to, more confident and developing new skills. It also moves the conversation away from the experience of using services to a wider discussion about what matters to people, their community, or what it is like to live with a condition and what is necessary improve their lives. You can read more about our four case studies in Appendix 5.

Health inequalities are often the result of a severe and earlier experience of multiple long-term conditions, and the experience of fragmented care. In order to tackle these inequalities, the design and delivery of care must be done in partnership with people and communities, not for them. Continuous authentic conversations generate mutual respect and allow for problems to be worked on together to create solutions.

To enable engagement the ICB have used the Insight Framework, which led to the ICS being one of three ICSs invited to be part of an expert advisory group for the development of a framework for use by ICSs to help them measure how well they listen to the experiences and needs of people and communities to reduce health inequalities.

The framework, designed to stimulate honest reflection, shared learning and practical action planning, is modelled on five key themes, offering good practice descriptors at three levels per theme to:

Understanding power	Achieve meaningful relationships with the community.
	Build trust.
	Develop and share the importance of an accurate understanding of community needs and ambitions.
Enable social action	Ensure change is led by the community.
	Explore what people want to talk about, change and influence.
	Understand how they want to do this.
Community experiences, needs, ideas and ambitions	Understand and share accurate and deep community-led insights.
Connecting community and Joined Up Care Derbyshire	Ensure community-led insights shape solutions and services.
Making a difference together	Address health inequalities.
	Improve services and health outcomes.
	Translate community-led insight into action.

This approach has been tested during 2024/25 with System partners, and supported by a learning network to bring people together and share good practice. The network meets regularly in a community setting and allows for sharing of experiences and peer support. This is an unfolding learning journey intended to strengthen social connection, resident voice and agency to address inequalities and promote wellbeing.

Governance

The ICB's desire to drive transformation and embed the voice of people and communities at the heart of planning, priority setting and decision-making is reflected in the ICB's governance architecture. The structures that provide an interface between people and communities at all levels of decision-making have been systematically examined within JUCD, allowing insight, decision-making, trust and relationships. Through influencing these structures, the ICB can ensure that systems are in place to consider patients, people and their communities in decision-making.

Public Partnership Committee

Our Public Partnership Committee is one of five formal sub-committees of the ICB Board and reflects the significance placed on seeking the views and voices of local people to influence work. During 2024/25, the committee continued to oversee the delivery of our engagement strategy and the underpinning frameworks on insight, coproduction and the way in which we seek to meet our legal and moral duties on engagement. Following a review of the ICB's committees, the assurance functions of the committee will now transfer to the new Strategic Commissioning and Integration Committee and, the Public Partnership Committee will be stood down. Bringing patient and public involvement into the centre of the ICB's strategic planning and commissioning will help to mainstream engagement work with communities and ensure that decisions around priorities and services are informed by the insight and opinions of our population.

The ICB will continue to develop and implement the wide range of approaches we take to working with people and communities, all of which will feed into the assurances received at committee and Board-level. As with all transitions, there are risks of gaps emerging during handover and the ICB will actively manage this to ensure delivery of the ICB engagement strategy. A development session will be held with the members of the new committee to ensure they are fully sighted on the engagement approach and the strategic aim to ensure the public are at the centre of decision-making.

Patient and public involvement assessment process

Patient and public involvement is fully embedded into governance within the ICB, and during 2024, 63 potential service changes were assessed. A significant number of these assessments required some level of involvement with patients, people and their communities, to ensure they can influence decisions that are being made.

All assessments are logged and shared with members of the Public Partnership Committee and Health Overview and Scrutiny Committee, both of which are invited to ask questions, or request further information with regards to any areas of change that elicit interest or concern.

Involvement infrastructure

A range of methods and tools have been made available to all our System partners 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:

- a JUCD webpage detailing how patients and public partners can get involved;
- the 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;
- an online engagement platform, JUCD Involvement, which represents the commitment to engage with people and communities and is designed to facilitate interactive dialogue between healthcare providers and citizens, to encourage their participation and inform of developments. This platform is offered free of charge to VCFSE organisations, as well as health and social care organisations in Derbyshire; and
- volunteers on our Readers' Panel, who are available to review new and revised information for all JUCD partners that is to be shared with patients and the public.

Patient Participation Groups

Patient Participation Groups (PPGs) represent the patient population of General Practices and are generally made up of a group of volunteer patients, the Practice Manager, and one or more GPs. They meet to discuss the services on offer, and how improvements can be made for the benefit of patients and the General Practice. You can find out more about PPGs by visiting the JUCD website or contacting your General Practice.

PPGs are vital in ensuring the patient voice is heard as they provide an opportunity for local people to get involved and influence the provision of local health services. In Derby and Derbyshire, there is a PPG Network that meets bi-monthly and is facilitated by the ICB's Engagement Team. At each meeting, the PPG Network discuss:

- System changes and transformation projects;
- updates from the Primary Care Quality Team, and members are encouraged to suggest any specific topics they would like an update on; and
- shared learning and best practice to ensure PPGs have the support they need to run their PPG and effectively engage with their population.

Derbyshire Dialogue

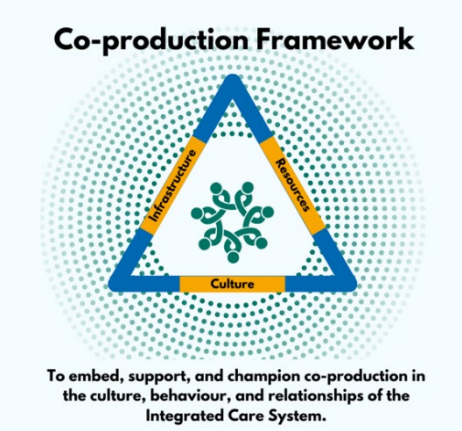
Launched in September 2020, the Derbyshire Dialogue was set up to start a conversation between the residents of Derby and Derbyshire, and those commissioning and providing services, to update on the response to the Covid-19 pandemic. It now has a broader remit and sessions are delivered by senior clinicians, or officers in their field. All sessions allow participants to ask questions both in the chat box, and by raising their hand. We aim to include a British Sign Language interpreter in each session and recordings of sessions are uploaded to the Derbyshire Dialogue space on our Online Engagement Platform.

Derbyshire Dialogue is valuable because it improves communication between healthcare providers and the community, and enhances engagement by providing a platform for residents to voice their opinions. It has built trust through open conversations, informing decision-making with gathered insights, and improving services based on feedback.

A notable session on crisis prevention support for young people's mental health was delivered by representatives from the ICB, Derbyshire County Council, and Public Health. It addressed challenges and covered the strategic focus on improving mental health services over the past decade, the need for accessible mental health services, support for families and carers and the role of community-based approaches in preventing mental health crises. It also highlighted the efforts of crisis prevention support teams in improving mental health services for young people and detailed how these teams work to enhance communication and coordination of care, ensuring that young people receive timely and effective support.

Coproduction Framework

During 2024/25, a coproduction event with over 80 participants from various sectors was held to develop three fundamental pillars for the Coproduction Framework: resources; culture; and infrastructure. As a result, a comprehensive System-wide action plan was created. Clear outcomes from these actions include developing senior management commitment to coproduction and launching a 'Coproduction – Champion Programme' to empower people into co-production and sharing their learning.



Integrated Care Experience Survey

The ICB were invited to be an early implementer of the Integrated Care Experience Survey, which linked to the development of a 'National Integration Index' in the NHS Long Term Plan with the aim of: *"measuring, from patients', carers' and the public's point of view, the extent to which the local health service and its partners are genuinely providing joined up, personalised and anticipatory care".*

The aim of the survey was to measure and track the impact of new joined up, proactive, personalised and preventative care models, and provide useful intelligence for local place and neighbourhood teams to act on, as well as a robust comparable dataset nationally across all ICSs. The survey, which was sent out to patients and carers in 2024, asked a number of questions about the use and experience of integrated health and care services. These questions were co-designed with patient, carer and public groups, VCFSE organisations and national bodies. The main themes included:

- use of local health and care services;
- personalisation and continuity of care;
- experience of proactive care; and
- the way health and care partners work together and share information.

The sample for the survey was identified through General Practice records based on their electronic frailty index score and the ICB were able to gather together a sample of 8,357 to receive the survey and in total received 1,940 responses from patients and 382 from carers. The findings from the survey have been fed into the newly developed National Integrated Index, which as enabled, for the first time, a connected view of how ICSs are delivering optimal care for a specific population group, linking experience of care with quality markers and service utilisation at a person-level to drive an understanding of progress across

systems, identify unwarranted variation and best practice and generate actionable insight for local health and care teams.

Learning from the work has been fed into the roll out, and we are currently exploring how we can use the data provided by the Integration Index Dashboard to support our work in the coming year around health inequalities, and transformation work such as the strategic review of urgent care.

Mental Health Together

Mental Health Together, hosted by Healthwatch Derbyshire, was established as a System-wide mental health engagement service in 2017. The service includes 35–40 volunteer Experts by Experience who bring diverse valuable insights from their lived experience of mental health services. The ICB brought the service in-house in April 2024, however the service remains arms-length in order to protect its independence. The transition was successful in bringing additional knowledge and insights to the team, particularly around the co-production and co-design of services, and Mental Health Together has continued seamlessly with valuable insights into the mental health system.

Mental health managers are increasingly required by NHS commissioners to involve people with lived experience in the design and delivery of their services. Examples of how the ICB are meeting this requirement in line with the Community Mental Health Framework include:

- co-designing mandatory risk assessment training with DHcFT staff and Experts by Experience;
- providing vital patient insights as part of the new model of care training being delivered to 900 inpatient staff at DHcFT, with over 90% satisfaction ratings;
- sharing patient insights with consultant psychiatrists regarding outpatient appointments, and prescribing practice and therapeutic relationships in order to improve the culture of care;
- publishing a 'Good Practice Guide on Co-designing' with voices of lived experience, to help professionals co-design by providing clear guidance on the benefits and overcoming challenges;
- creating a video on the importance of co-production for a Co-production Framework Development event in July 2024 and for wider use in the System;
- producing a 'Therapeutic Relationships' learning tool for all health and social care professionals on the vital ingredients for therapeutic relationships with their clients;
- producing a 'Trauma Informed Care' learning tool for Primary Care staff to ensure a better experience for patients and staff;
- providing expert advice in relation to gatekeeping protocols for the mental health Crisis and Home Treatment Teams, and also advising a local GP leading lifestyle changes work in Primary Care for people with a severe mental illness.

Living Well

The Living Well Engagement Service (which includes Experts by Experience) was managed by the ICB in April 2024. The aim was to provide a final year of the service that would leave a legacy to ensure that the work continues. Throughout the year, over 70 participants were interviewed to understand their experience of the service, and a further eight stories were gathered from participants to illustrate their journey of recovery and to inspire others who may be struggling with their mental health to seek help.

In addition to feedback and stories, the ICB supported the Derby Lived Experience Forum who met every six weeks and provided valuable feedback to improve welcome packs, leaflets, websites and clinical letters. The ICB also supported Living Well Collaboratives to enable the voice of lived experience to be heard through the implantation of a comprehensive action plan identifying key areas for improvement. Actions are monitored by the Living Well Delivery Group.

The Older Adult Team has also committed to embedding the voice of lived experience, and participant stories are shared with Integrated Patch Leadership groups and the Community of Practice. They are now looking for other ways to raise awareness of older adults' experience of being supported to improve their mental health and have joined the Insight Learning Network.

Emergency Planning, Resilience and Response

The ICB is a designated Category 1 Responder under the Civil Contingencies Act 2004. As such, it has the following key civil protection duties that it must fulfil:

- assessing the risk of emergencies occurring and using this to inform contingency planning;
- implementing emergency plans and business continuity management arrangements;
- providing information to the public about civil protection matters and issuing warnings, information and advice in the event of an emergency;
- sharing information with other local responders to enhance coordination; and
- cooperating with other local responders to enhance coordination and efficiency.

The ICB fulfils these duties through the EPRR programme, which is supported by various NHS-specific guidance related to preparedness and response to emergencies, major incidents, critical incidents and business continuity incidents.

The ICB coordinates and assures the EPRR preparedness and response for Derby and Derbyshire, ensuring the system can effectively respond in the event of an incident. The ICB also acts as the health representative within the wider response arena, working with partners on preparedness and, where required, response. During 2024/25, the ICB has responded to and supported the response to several incidents, the majority of which have been business continuity in nature or adverse weather conditions.

As part of the preparedness work, all health organisations are expected to complete EPRR Core Standards assurance, led by NHSE. The ICB attained a 'substantially compliant' status this year, an improvement from the previous year's 'partially compliant' status, providing a good level of assurance regarding our EPRR preparedness. The ICB continues to focus its EPRR programme of work, specifically within the fields of cyber resilience and climate change impacts, to further improve standards and utilise new ways of working to embed EPRR within all aspects of ICB operations and delivery.

The ICB engages with the Derbyshire Resilience Partnership to ensure there are links to upcoming exercises. It also collaborates closely with other ICB EPRR teams and the NHSE regional team to ensure holistic preparedness for incidents affecting the public, patients and staff of the Derby and Derbyshire health economy. This work will continue into 2025/26, with a work plan focusing on individual ICB preparedness as well as System resilience for incidents.

Promoting Research and Innovation

The ICB has a duty to facilitate and promote research and the use of evidence obtained from research under section 14Z40 of the Health and Care Act 2022. The executive lead for research and innovation for both the ICB and JUCD is the Chief Medical Officer.

JUCD has an established Derbyshire Research Forum, which meets bi-monthly to take a cross-ICS approach to research and advancing the contributions of research in JUCD. The forum is chaired by the ICB's Chief Medical Officer and brings together research leadership from NHS provider organisations. Primary Care. Local Authorities, Clinical Research Network East Midlands, local and regional Universities, and public contributors.

The Derbyshire Research Forum's mission statement is:

> *"To actively promote and encourage research and equitable access to research in order to improve the health, wellbeing and care of the population of Derbyshire."*

Joined Up Care Derbyshire Health and Care Research Strategy 2024-2029

Our JUCD Health and Care Research Strategy takes into account NHSE's Maximising the benefits of research: Guidance for integrated care systems guidance, which sets out ICB, ICS and ICP responsibilities. The value of research in transforming health and care is significant and the strategy sets out how research will be transformed over the next five years for the benefit of the people of Derby and Derbyshire. It also aligns with the Integrated Care Strategy to reduce health inequalities and improve population health.

The diverse voices of the Community Research Engagement Network helped shape the language of the strategy's vision and aims and develop a 'valued voices' charter, which is embedded within the strategy. The charter describes the principles for how health and care organisations engage with communities when planning, undertaking and disseminating research studies and findings. The aims of the strategy include:

Grow diversely	Significantly grow and expand the breadth and diversity of research participation, capacity and funding, through agreed System-wide actions.
Impact equitably	Ensure inclusive research, which helps to accelerate delivery of the Integrated Care Strategy, with a positive impact on population health, health inequalities and the lived experiences of underserved communities.
Involve meaningfully	Address challenges experienced in delivering organisational research strategies, and implement actions to develop a culture where the use of research is prioritised and a core element of daily work and every role.
Collaborate inclusively	Transform collaborative working and partnership to undertake research and understand how findings are disseminated and adopted for the benefit of patients, communities and the public.

The research strategy was ratified by the ICB on the 18th July 2024 and shared with the Integrated Care Partnership Board on the 5th February 2025. Impact and evaluation of the vision, strategic aims and goals is to be considered as part of the implementation plan to be co-developed by the Derbyshire Research Forum. A Research Strategy Implementation Programme Manager was also appointed through the University of Derby during 2024/25, which is funded by the Research Delivery Network East Midlands.

Other activities during 2024/25 have included:

Actively managed research network	An improvement goal of the research strategy is to establish a Derby and Derbyshire network for researchers and staff from all sectors who are interested in research. The network will support collaboration opportunities, share knowledge, skills and experiences and demonstrate impact. Following an options appraisal comparing platforms for the network, a multi-organisation editorial panel will be established during 2025/26 to oversee the research network.
National Institute of Health and Care Research Applied Research Collaboration East Midlands	Supporting the Applied Research Collaboration East Midlands funding application for continuity of applied health and care research infrastructure in the region from the 1st April 2026. There is strong strategic alignment between System priorities and the Applied Research Collaboration East Midlands research themes, with a real opportunity to collaborate and maximise local and national impact. Clinical and professional leaders from across the System are joining other East Midlands leaders to plan future work programmes with Applied Research Collaboration East Midlands theme leads. This collaboration is also exploring opportunities for knowledge mobilisation, and the use and adoption of research evidence.
General Practice and wider Primary Care Research	The role of strategic GP lead for Primary Care research commenced in 2024/25, and with senior leadership now in place a Primary Care-specific implementation plan aligned to the research strategy is in development. The role enables a better understanding of the local Primary Care research landscape to inform the future development of research infrastructure for this setting. Primary Care is ideally situated within communities and best placed to run research at General Practice or PCN, neighbourhood and Place levels. As a research setting accessible to most of the population, improvements in Primary Care research have the potential for significant impact on the population of Derby and Derbyshire.

Joined Up Care Derbyshire Research Engagement Network	The JUCD Research Engagement Network is now in its third year of operation and is funded by NHSE as part of the Accelerated Access Collaborative. The network is called REBALANCE (Research Building Alliances for Action with Community Enterprise) and aims to improve access to research for underserved communities, increase participation and help reduce health inequalities in Derby and Derbyshire. Working in partnership with the University of Derby and established core VCFSE partners, Links CVS and Community Action Derby, a community-led participatory action research project has been co-designed in an area of priority identified by communities. Focus group data was collected and analysed, and the final report is expected to be launched during 2025 to propose and plan actions for change. A second initiative has commenced in 2024/25 to improve research participation through General Practices in a PCN which serves a diverse population in the most deprived geographical areas of Derby city. PCNs are well placed to support their local communities and tackle health inequalities, and a GP research inclusion lead has been appointed.
Public Health Collaboration for drug and alcohol-related research	The aim of this new area of work for 2024/25 prepared a research grant application to: • build a long-term sustainable collaboration amongst partners with an interest in drug and alcohol-related issues; • gain new insights to initiate effective public health action and contribute to meeting local unmet needs; and • fund future research. This work is being led by the University of Derby and is funded by the National Institute for Health and Care Research Delivery Network East Midlands under-served funding stream, which is aimed at widening access to research across different under-served communities.

Participation in National Institute of Health and Care Research Studies

The number of participants recruited to the National Institute of Health and Care Research portfolio of research studies during 2024/25 for JUCD was 8,929. There were 172 different studies available to potential participants through the four NHS provider organisations, General Practices and other settings.

Participants in Research Experience Survey 2024/25

Participants in clinical research studies are routinely asked to give feedback on their experience of participating in National Institute of Health and Care Research studies, and to understand how taking part in research can be made better in the future. During 2024/25, 258 participants completed a participant research experience survey across four NHS partner organisations. For 64% of participants, it was the first research study they had taken part in, and overall 89% of participants either agreed or strongly agreed they would consider taking part in research again. Partner organisations are grateful to everyone who has participated in research and provided feedback, which enables a culture of continuous improvement in research delivery.

ACCOUNTABILITY REPORT

Dr Chris Clayton

Accountable Officer

NHS Derby and Derbyshire Integrated Care Board

19th June 2025

Corporate Governance Report

Directors Report

Composition of the ICB Board

The ICB Board members are shown in Table 11 below:

ICB Board Member	Position
Voting	
Dr Kathy McLean	Chair (from 1st May 2024)
Richard Wright	Chair (up to 30th April 2024) Non-Executive Member (from 1st May 2024 to 8th November 2024)
Dr Adedeji Okubadejo	Clinical Lead Member
Dr Chris Clayton	Chief Executive Officer
Stephen Posey	Partner Member – University Hospitals of Derby and Burton NHS Foundation Trust
Mark Powell	Partner Member – Derbyshire Healthcare NHS Foundation Trust
Dr Andrew Mott	Partner Member – Primary Medical Services
Perveez Sadiq	Partner Member – Derby City Council (up to 31st October 2024)
Paul Simpson	Partner Member – Derby City Council (from 1st November 2024)
Ellie Houlston	Partner Member – Derbyshire County Council
Margaret Gildea	Non-Executive Member and Senior Independent Director
Sue Sunderland	Non-Executive Member
Jill Dentith	Non-Executive Member
Nigel Smith	Non-Executive Member (from 1st January 2025)
Michelle Arrowsmith	Chief Strategy and Delivery Officer, and Deputy Chief Executive
Keith Griffiths	Chief Finance Officer (up to 30th November 2024)
Claire Finn	Interim Chief Finance Officer (from 1st December 2024)
Dr Chris Weiner	Chief Medical Officer
Prof Dean Howells	Chief Nurse Officer
Linda Garnett	Interim Chief People Officer (up to 31st July 2024)
Lee Radford	Chief People Officer (from 1st July 2024)
Non-Voting	
Tracy Allen	Participant Member to the Board for Place – Derbyshire Community Health Services NHS Foundation Trust (up to 15th September 2024)
James Austin	Participant to the Board for Place – Derbyshire Community Health Services NHS Foundation Trust (from 16th September 2024) Chief Digital Information Officer (up to 1st August 2024)
Helen Dillistone	Chief of Staff
Dr Avi Bhatia	Clinical and Professional Leadership Group Participant Member to the Board

Table 11 – members of the ICB Board 2024/25

Audit and Governance Committee

The membership of the Audit and Governance Committee of the ICB is shown in Table 12 below.

Audit and Governance Committee Member	Position
Sue Sunderland	Chair – Non-Executive Member
Jill Dentith	Non-Executive Member
Margaret Gildea	Non-Executive Member and Senior Independent Director ('by invitation' in accordance with the Committee's workplan)

Table 12 – members of the ICB's Audit and Governance Committee during 2024/25

Each director knows of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware. They have taken all the steps that they ought to have taken to make themselves aware of any such information and to establish that the auditors are aware of it.

Register of Interests

The ICB holds a register of interests for all individuals who are engaged by the ICB. The registers are viewable here and available on request at the ICB Headquarters.

Personal Data Related Incidents

There have been no Information Governance incidents during 2024/25 that have met the criteria for reporting through the Data Protection and Security Toolkit to the Information Commissioner's Office.

Modern Slavery Act

Our ICB fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the period ending on the 31st March 2025 is published on our website here.

Statement of Accountable Officer's Responsibilities

Under the Health and Care Act 2022, NHS England has directed each Integrated Care Board to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of NHS Derby and Derbyshire Integrated Care Board and of its income and expenditure, Statement of Financial Position and cash flows for the financial year. In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- observe the Accounts Direction issued by NHSE, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts;
- prepare the accounts on a going concern basis; and
- confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

The NHS Act 2006 (as amended) states that each Integrated Care Board shall have an Accountable Officer and that Officer shall be appointed by NHS England. NHS England has appointed the Chief Executive Officer to be the Accountable Officer of NHS Derby and Derbyshire Integrated Care Board. The responsibilities of an Accountable Officer, including responsibility for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Integrated Care Board and enable them to ensure that the accounts comply with the requirements of the Accounts Direction), and for safeguarding the NHS Derby and Derbyshire Integrated Care Board's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Accountable Officer Appointment Letter, the NHS Act 2006 (as amended), and Managing Public Money published by the Treasury.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS Derby and Derbyshire Integrated Care Board's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Dr Chris Clayton
Accountable Officer
NHS Derby and Derbyshire Integrated Care Board
19th June 2025

Governance Statement

Introduction and Context

NHS Derby and Derbyshire Integrated Care Board (ICB) is a corporate body established by NHSE on the 1st July 2022 under the NHS Act 2006 (as amended). The ICB's statutory functions are set out under the NHS Act 2006 (as amended). The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.

Between the 1st April 2024 and the 31st March 2025, the ICB was not subject to any directions from NHSE issued in accordance with Section 14Z61 of the NHS Act 2006 (as amended), as inserted by Section 25 of the Health and Care Act 2022.

The ICB brings the NHS together locally to improve population health and care services for over 1.4 million people in Derbyshire. The geographical footprint and eight areas known as 'Places' covered by the ICB are Amber Valley, Bolsover and North East Derbyshire, Chesterfield, Derby city, Derbyshire Dales, Erewash, High Peak and South Derbyshire. Our five-year plan recognises that the health and social care needs of people varies significantly across Derby and Derbyshire. Consequently, these seven Place Alliances across the JUCD Unit of Planning have been identified as a means to engage people in the development of services.

The ICB had a revenue income of circa £36.1m for the period 1st April 2024 to the 31st March 2025, and had a workforce of 465 employees on the 31st March 2025.

Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the ICB's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the NHS Act 2006 (as amended) and in my NHS Derby and Derbyshire Integrated Care Board Accountable Officer Appointment Letter.

I am responsible for ensuring that the ICB is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the ICB as set out in this governance statement.

Governance Arrangements and Effectiveness

The main function of the ICB Board is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it. The role of the ICB Board is corporate responsibility for the ICB's strategies, actions and finances. As an ICB Board of an NHS organisation, it is the custodian of a national asset, provides stewardship and remains publicly accountable.

Key Features of the ICB's Constitution in relation to Governance

The ICB has a distinct purpose, with governance and leadership arrangements designed to promote greater collaboration across the NHS and with other local partners. The main powers and duties of the ICB are to commission certain health services are set out in Sections 3 and 3A of the NHS Act 2006 (as amended), as inserted by Section 21 of the Health and Care Act 2022. These provisions are supplemented by other statutory powers and duties that apply to ICBs, as well as by regulations and directions (including, but not limited to, those made under the NHS Act 2006.

In accordance with Section 14Z25(5), and paragraph 1 of Schedule 1B to the NHS Act 2006, as inserted by Section 19 and Schedule 2 of the Health and Care Act 2022, the ICB must have a Constitution, which must comply with the requirements set out in that Schedule. The ICB is required to publish its Constitution (section 14Z29 of the NHS Act 2006, as inserted by Section 19 of the Health and Care Act 2022). The Constitution is published here.

Corporate Governance Framework

The Corporate Governance Framework for the ICB is set out in the ICB's Governance Handbook, which is a formal related document to the Constitution, and ensures that the ICB complies with section A of the UK Corporate Governance Code in all respects. The Constitution was last amended in November 2024.

ICB Board

The ICB Board is responsible for ensuring that the ICB exercises its functions effectively, efficiently and economically, and in accordance with Section 14Z33 of the NHS Act 2006 (as amended), as inserted by Section 25 of the Health and Care Act 2022 and the Constitution of the ICB. The ICB Board was appointed in accordance with section 14Z25 of the NHS Act 2006, as inserted by Section 19 of the Health and Care Act 2022.

The appointment process for ICB Board members varies according to the role they undertake and the appointment process specific to each role is therefore specified in detail within Appendix 1 (Standing Orders) to the Constitution. The ICB has therefore necessarily had to depart from sections B2 and B3 of the Code in that it is not in a position to have a Nomination Committee as set out in the Code.

The ICB Board is supported by a Head of Governance and its composition is described in Table 13 below, each with a single non-transferable vote unless detailed otherwise.

ICB Board Member	Position
Voting	
Dr Kathy McLean	Chair (from 1st May 2024)
Richard Wright	Chair (up to 30th April 2024) Non-Executive Member (from 1st May 2024 to 8th November 2024)
Dr Adedeji Okubadejo	Clinical Lead Member
Dr Chris Clayton	Chief Executive Officer
Stephen Posey	Partner Member – University Hospitals of Derby and Burton NHS Foundation Trust

ICB Board Member	Position
Mark Powell	Partner Member – Derbyshire Healthcare NHS Foundation Trust
Dr Andrew Mott	Partner Member – Primary Medical Services
Perveez Sadiq	Partner Member – Derby City Council (up to 31st October 2024)
Paul Simpson	Partner Member – Derby City Council (from 1st November 2024)
Ellie Houlston	Partner Member – Derbyshire County Council
Margaret Gildea	Non-Executive Member and Senior Independent Director
Sue Sunderland	Non-Executive Member
Jill Dentith	Non-Executive Member
Nigel Smith	Non-Executive Member (from 1st January 2025)
Michelle Arrowsmith	Chief Strategy and Delivery Officer, and Deputy Chief Executive
Keith Griffiths	Chief Finance Officer (up to 30th November 2024)
Claire Finn	Interim Chief Finance Officer (from 1st December 2024)
Dr Chris Weiner	Chief Medical Officer
Prof Dean Howells	Chief Nurse Officer
Linda Garnett	Interim Chief People Officer (up to 31st July 2024)
Lee Radford	Chief People Officer (from 1st July 2024)
Non-Voting	
Tracy Allen	Participant Member to the Board for Place – Derbyshire Community Health Services NHS Foundation Trust (up to 15th September 2024)
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Helen Dillistone	Chief of Staff
Dr Avi Bhatia	Clinical and Professional Leadership Group Participant Member to the Board

Table 13 – members of the ICB Board 2024/25

The ICB Board met in public six times from the 1st April 2024 to 31st March 2025. All meetings were fully quorate. The attendance record for the ICB Board and corporate committees can be found in Appendix 8.

ICB Board Performance

In the ICB's third year of establishment, the ICB Board has continued to mature, develop and grow. Dr Kathy McLean joined the ICB as Chair on the 1st May 2024, and therefore further development of the Board naturally evolved. Kathy has brought a stronger level of challenge and greater ambition to the Board.

The Board continued to meet monthly, alternating between public and confidential meetings, and development/seminar meetings. The ICB Board held six public and confidential meetings and five Board seminar/development sessions took place in April, June, October, December and February.

During 2024/25, a governance review was undertaken. The review concluded a change in the ICB Committee structure and the names and responsibilities of committees. The review also

included consideration of committee membership and attendance in a slightly different context. The new committee structure will be implemented from the 1st April 2025.

During 2024/25, the ICB Board undertook a Building Leadership for Inclusion Programme. The programme involved a discovery phase, which included one-to-one conversations with Board members as well as focus groups with stakeholders and coaching sessions. The learning outcomes of the programme were:

1. a greater awareness and deeper understanding of inequality and its impact on minoritised workforce and patient/service users;
2. commitment and ambitious aspirations in relation to leading for greater equity, diversity and inclusion;
3. identification of required actions needed to bring about change and a personal and collective action agreement to bring about change and a personal and collective agreement to take action; and
4. to effectively embed equity, equality, social and racial justice into every aspect of the System and System working.

ICB Board Development Programme

As the new ICB Chair, Dr Kathy McLean commissioned a Board Development Programme which commenced in December 2024. Board diagnostic interviews with all Board members took place during December and January. The programme consists of five Board development sessions, the first one took place in March 2025, with further sessions planned from May to December 2025.

The objectives of the programme are:

- appreciation of the individuals and the milestones of individual motorways;
- roles of the Board and making use of the Board's strengths;
- coalescence between Executive and Non-Executive Members;
- individual Board member roles; the ICB role and how the Board operates within the ICS;
- understanding the routes the Board are taking and destinations the Board are working towards;
- exploring leadership and building opportunity within ICB teams;
- building progress on earlier inclusive leadership developments;
- agreeing the ICB's vision;
- building on the Board's progress;
- developing greater trust; and
- exploring and clarifying the role of partners.

A full outcome report of the Board Development Programme will be produced in 2025/26.

Fit and Proper Person Test

In 2023/24 the ICB implemented the Fit and Proper Person Test Framework which aims to help ICB Board members build a portfolio to support and provide assurance that they are fit and proper, while demonstrably unfit members being prevented from moving between NHS organisations. The framework applies to ICB Board members who are ICB Executive Directors and Non-Executive Members. The framework is a core element of a broader programme of board development, effective appraisals and values-based (as well as competency-based)

appointments, all of which are part of the good practice required to build a 'healthy' board. Updated Board member appraisal guidance was published on the 1st April 2025, this guidance has been followed for our 2024/25 appraisal processes.

ICB Board Development during 2024/25

To ensure that the ICB Board complies with the functions of an ICB, the main focus of the ICB Board's time using its formal (public and confidential) and informal (seminar and development) meetings has been in the following areas:

- scrutinising and approving the 2024/25, and 2025/26 planning submissions;
- focus on delegated functions and understanding opportunities for the future;
- reflecting on the Joint Forward Plan refresh and update; and
- focus on mental health and health inequalities in relation to mental health and the national and local position for adults and children.

Corporate Committees of the ICB Board

To support the ICB Board in carrying out its duties effectively, committees reporting to the ICB Board have been formally established. The remit and terms of reference of these corporate committees are regularly reviewed. Each committee receives regular reports, as outlined within their terms of reference and provide exception and highlight reports to the ICB Board. The governance structure of the ICB comprises:

- ICB Board.
- Statutory Committees of the ICB Board:
  - Audit and Governance Committee; and
  - Remuneration Committee.
- Non-Statutory Committees of the ICB Board:
  - Finance, Estates and Digital Committee;
  - People and Culture Committee;
  - Population Health and Strategic Commissioning Committee;
  - Public Partnership Committee; and
  - Quality and Performance Committee.

Ratified minutes are formally recorded and submitted to the ICB Board, as soon as practicable after meetings have taken place. As a final agenda item, the committees are asked to review how effective the meeting was and to decide whether anything should be escalated to the ICB Board.

The ICB Board then receives an assurance report following each committee meeting, provided by the respective Chairs. This report outlines key assurances and/or risks, and allows for timely information to be provided prior to submission of ratified minutes.

Audit and Governance Committee

The purpose of the Audit and Governance Committee is to ensure that the ICB complies with the principles of good governance while effectively delivering the statutory functions of the ICB. The committee contributes to the overall delivery of the ICB objectives by providing oversight and

assurance to the ICB Board on the adequacy of governance, risk management and internal control processes within the ICB.

The Committee formally met six times during 2024/25 and also met twice extraordinarily. All meetings were fully quorate. The quorum necessary for the transaction of business is two members.

Remuneration Committee

The Remuneration Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006 (as amended), as inserted by Schedule 2 of the Health and Care Act 2022. In summary, it confirms the ICB's Pay Policy, including the adoption of any pay frameworks for all employees, which includes senior managers/directors (including ICB Board members) and Non-Executive Members. The Remuneration Committee is accountable to the ICB Board and reports to them on how it discharges its responsibilities in regard to remuneration, fees and other allowances for employees and for people providing services to the ICB.

The ICB Board has approved and keeps under review the Terms of Reference for the Committee. The ICB Board also ensures that all members appointed remain independent and no decisions are made by Executive Officers. The ICB Board has delegated specific functions and responsibilities, in relation to remuneration, as specified in the Terms of Reference and the ICB's Scheme of Reservation and Delegation. The work of the Committee enables the ICB to declare compliance with Section D of the Corporate Governance Code of Conduct. In order to avoid any conflict of interest, in respect of Non-Executive Members who are the only members of the Remuneration Committee, their own remuneration is set directly by the ICB Board. The Non-Executive Members who are conflicted are not part of the decision-making. You can read more about the Committee membership and significant items discussed in Appendix 6.

The Committee formally met seven times during 2024/25 and all meetings were fully quorate. The quorum necessary for the transaction of business is a minimum of two Non-Executive Members.

Finance, Estates and Digital Committee

The purpose of the Finance, Estates and Digital Committee is to provide oversight and assurance to the ICB Board in the development and delivery of a robust, viable and sustainable System financial and estates plan; and processes which meet the health and care needs of the citizens of Derby and Derbyshire and aid the implementation of the JUCD vision and strategy.

The Committee formally met 11 times during 2024/25 and all meetings were fully quorate, except for the meetings on the 23rd July 2024 and 25th March 2025. The quorum necessary for the transaction of business from the 1st April 2024 to 27th January 2025 was one ICB Non-Executive Member, one provider Non-Executive Director, and three Executive Directors, of which one should be the ICB Chief Finance Director or nominated deputy and one a System Director of Finance or their nominated deputy. A decision was made by the ICB Board on the 16th January 2025 to no longer require Trust Non-Executive Directors to form part of the quoracy of this Committee. Quoracy was therefore changed from the 28th January 2025 to one ICB Non-Executive Member and two ICB Executive Directors.

People and Culture Committee

The purpose of the People and Culture Committee is to oversee the development, delivery and implementation of an ICS People and Culture Strategy which supports the sovereign organisations in JUCD, Provider Leadership Collaborative and Integrated Place Partnership, City and County to achieve their objective of improving the health and wellbeing of the people in Derby and Derbyshire and the identification and mitigation of people, culture and workforce risks.

The Committee meets on a bi-monthly basis, and formally met four times during 2024/25, with all meetings fully quorate. The quorum necessary for the transaction of business from the 1st April 2024 to 26th February 2025 was one ICB Non-Executive Member, one System Non-Executive Member, one ICB Executive Member and three other members. A decision was made by the ICB Board on the 16th January 2025 to no longer require Trust Non-Executive Directors to form part of the quoracy of this Committee. Quoracy was therefore changed from the 27th February 2025 to one ICB Non-Executive Member and one ICB Executive Director.

Population Health and Strategic Commissioning Committee

The purpose of the Population Health and Strategic Commissioning Committee is to ensure that the ICB complies with the principles of good governance while effectively delivering their statutory functions. The Committee has delegated responsibility for overseeing the provision of health services in line with the allocated resources across JUCD by ensuring contracts and agreements are in place to deliver the ICB's commissioning strategy and operating plans. It seeks to support providers to lead major service transformation programmes and councils to ensure that the NHS plays a full part in social and economic development and environmental sustainability, while focusing on reducing health inequalities, improving outcomes and quality, and ensuring that the delivery of the ICB's strategic and operational plans are achieved within financial allocations.

The Committee formally met nine times during 2024/25 and all meetings were fully quorate, except for the meeting on the 24th October 2024. The quorum necessary for the transaction of business from the 1st April 2024 to 12th February 2025 was 2 Non-Executive Members (to include 1 ICB Non-Executive Members and 1 System Non-Executive Director), 1 ICB Executive Director and 4 other members including two clinical. A decision was made by the ICB Board on the 16th January 2025 to no longer require Trust Non-Executive Directors to form part of the quoracy of this Committee. Quoracy was therefore changed from the 13th February 2025 to one ICB Non-Executive Member and two ICB Executive Directors and one other member (clinical).

Public Partnership Committee

The purpose of the Public Partnership Committee is to monitor the development and delivery of the JUCD Engagement Strategy, and to ensure alignment with the 10 principles for working with people and communities. The Committee also ensures that patients, carers and the public are engaged with any service changes.

The Committee assesses levels of assurance and risk in relation to the delivery of statutory duties in public and patient involvement and consultation, as defined within the Health and Care Act 2022, while retaining a focus on the need for engagement in strategic priorities and programmes, ensuring the local health and care system develops robust processes in the discharging of duties relating to involvement and consultation. The Committee also ensures that

there is due regard when considering and implementing service changes, as defined by the Equality Act 2010.

The Committee formally met eight times during 2024/25 and all meetings were fully quorate. The quorum necessary for the transaction of business is one ICB Non-Executive Member, to include the Chair or Vice Chair, plus at least two representatives drawn from the lay members and Foundation Trust Governors, and one Executive Director or deputy.

Quality and Performance Committee

The purpose of the Quality and Performance Committee is to provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of service and performance, against each of the dimensions of quality set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021. This includes reducing inequalities in the quality of care. The Committee exists to also scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and performance.

The Committee formally met 10 times during 2024/25 and meetings were fully quorate, except for the meetings on the 30th May, 27th June, 25th July and 29th August 2024. The quorum necessary for the transaction of business from the 1st April 2024 to 29th January 2025 was one ICB Non-Executive Member, to include the Chair or Vice Chair, plus at least the Chief Nurse Officer, or Chief Medical Officer from the ICB (or deputy), and two provider representatives (to include one provider Non-Executive Director, with responsibility for Quality). A decision was made by the ICB Board on the 16th January 2025 to no longer require Trust Non-Executive Directors to form part of the quoracy of this Committee. Quoracy was therefore changed from the 30th January 2025 to one ICB Non-Executive Director and two ICB Executive Directors.

UK Corporate Governance Code

NHS bodies are not required to comply with the UK Corporate Governance Code. However, we have reported on our Corporate Governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the ICB.

The Governance Statement is intended to demonstrate how the ICB has regard to the principles set out in the Code considered appropriate for ICBs for the financial year ended the 31st March 2025.

For the financial year ended the 31st March 2025, and up to the date of signing this statement, the ICB had regard to the provisions set out in the Code. All aspects that the ICB must reference within this statement are fully compliant.

Discharge of Statutory Functions

The ICB has reviewed all of the statutory duties and powers conferred on it by the NHS Act 2006 (as amended) and other associated legislation and regulations. As a result, and as the Accountable Officer, I can confirm that the ICB is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Chief Officer. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the ICB's statutory duties.

Risk Management Arrangements and Effectiveness

The ICB's integrated risk management system continued to mature during 2024/25, in line with internal audit recommendations from the previous year. The ICB has a responsibility to ensure that the organisation is properly governed in accordance with best practice corporate, clinical, and financial governance. Every activity that the ICB undertakes, or commissions others to undertake on its behalf, brings with it some element of risk that has the potential to threaten or prevent the organisation achieving its objectives. This integrated risk management system includes a Risk Management Policy and Standard Operating Procedure, Board Assurance Framework and the ICB Corporate Risk Register.

The Risk Management Policy, which was reviewed and approved by the Audit and Governance Committee in 2024/25, details the ICB's approach to the management of strategic and operational risks. It also references how risk arrangements within the ICB will interface with other key parts of JUCD and partners. The policy applies to all employees of the ICB, the ICB Board, Executive Team, and all senior managers to ensure that risk management is a fundamental part of the ICB's approach to the governance of the organisation and all its activities. It enables the organisation to have a clear view of the risks and issues affecting each area of its activity, how those risks are being mitigated, the likelihood of occurrence and their potential impact on the successful achievement of the ICB objectives. A key part of the policy is the ICB's defined risk appetite. A comprehensive review was undertaken by the ICB Board to review and strengthen the ICB's risk appetite statement, enabling the Board to assess risk appetite levels and quantitative risk tolerance scores to all risks.

Risk management is embedded in the activities of the organisation. Through its Corporate Committees and line management structures, the ICB is able to ensure accountability for risk at all levels of the organisation. The ICB identifies, assesses, manages and governs risk in line with widely available standards and guidance, and specifically in line with ISO 31000:2018.

Stakeholder involvement in managing risks

The ICB Board membership has always been made inclusive to ensure diverse public stakeholders and other stakeholders' voices help inform ICB decision-making and can assist in highlighting risks at ICB Board level. The ICB Board has a strong non-executive membership for Audit and Governance; Finance, Estates and Digital; People and Culture; Population Health and Strategic Commissioning; and Quality and Performance. Other ICB Board members include our Partner members from Trusts, Local Authorities and Primary Medical Services; Executive Directors; and representation from the Clinical and Professional Leadership Group.

The ICB is passionate about involving people wherever opportunities to do things differently present themselves and we continue to collate a wealth of patient experience and feedback. The ICB continues to extend the opportunities for involvement further through 'Derbyshire Dialogue', which is a virtual opportunity for anyone with an interest in health and care to join sessions covering a range of health and care services. Membership includes individuals from the public, PPGs, Citizens' Panel, and hospital employees. ICB Board colleagues share the passion with

colleagues across the ICB to involve our public and patients at every opportunity and we were well represented at these sessions.

Stakeholder Engagement Forums continued to take place virtually throughout the year with the population and community groups. These provide the opportunity to engage with the public and highlight areas of risks.

Prevention and deterrence of risk

The ICB has strong processes in place to assist in the identification and mitigation of risks arising. All reports to the ICB Board and Corporate Committees have mandatory sections on the assessment of quality and equality impact, privacy impact and risk assessment. The ICB Board continually keeps up to date through the Board Assurance Framework on matters of strategic risk and controls related to challenges within the local health economy and changes to national policy.

The ICB has a mature serious incident reporting system that is reviewed regularly. Staff are trained in carrying out systematic root cause analysis investigations in line with the National Patient Safety Agency guidance. Any serious incidents which have occurred are reported to NHSE and other appropriate bodies. Serious incidents are also reported through the Strategic Executive Information System. Any breaches of Information Governance which meet the level two criteria of the Information Commissioner's Office will be reported using the Data Protection and Security Toolkit to the Information Commissioner's Office as appropriate. 360 Assurance (Internal Audit) provide specialist advice with regard to Counter Fraud. During 2024/25, the ICB did not identify any fraud losses.

The ICB continues to work closely with the Local Authorities, Local Health Resilience Partnership and other partnership groups, and it has an established relationship with NHSE in respect of EPRR.

Capacity to Handle Risk

The ICB Board has a duty to assure itself that the organisation has properly identified the risks it faces, the processes and controls in place to mitigate those risks and the impact they have on the organisation and its stakeholders.

The accountabilities, roles and responsibilities for Risk Management are detailed within the ICB's Risk Management Framework, as follows:

ICB Board	Oversight and holding ICB management to account.
Audit and Governance Committee	Reviewing the effectiveness of the ICB Board Assurance Framework and risk management systems, and ensuring that the ICB complies with the principles of good governance while effectively delivering the statutory functions of the ICB.
Accountable Officer	Ensuring the ICB has an effective risk management system in place for meeting all statutory requirements.
Executive Team	Supporting the Accountable Officer and collectively and individually managing risk.
Chief of Staff	Ensuring the delivery of risk management.

Risk Group	Reviewing, monitoring and managing the risks on the ICB's Risk Register and ensuring the risk management process is firmly embedded within the organisation. The group supports the Committees' understanding and parity in relation to risk, enabling them to provide assurance to the ICB Board.
Head of Governance	Development, implementation and maintenance of the risk management arrangements for the ICB.
All Staff	Identifying, reporting and managing risks within their areas.

The ICB Board Assurance Framework was presented for scrutiny and assurance to the ICB Board, Audit and Governance Committee and responsible Corporate Committees during 2024/25. Risks to the ICB are reported, discussed and challenged at the ICB Board and Corporate Committee meetings. Communication is two-way, with the Committees escalating concerns to the ICB Board and the ICB Board delegating actions to the responsible Committee where appropriate.

As Accountable Officer, I have ultimate responsibility for risk management within the ICB. Day-to-day responsibility for risk management is delegated to the Chief Officers of the ICB Board with executive leadership being vested in the Chief Finance Officer and Chief of Staff. In conjunction with these structures, all appropriate staff are provided with training in the principles of risk management and assessment in order for them to manage and treat appropriate levels of risk within their designated authority and day-to-day duties. Detailed procedures and guidelines are set out in the ICB's Risk Management Policy and supporting Standard Operating Procedure, which provides executives, managers and staff with the appropriate tools to identify, score and treat risk properly.

The ICB Board and Audit and Governance Committee fully support the Risk Management Policy within the ICB. There has been continuous improvement in the maturity of the Board Assurance Framework working in collaboration with internal audit, increased responsibility of corporate committees and taking into account comments from board members.

The ICB's Chief of Staff coordinates the risk management processes and systems of internal control, ensuring that all staff and committee members are fully aware of their responsibilities within the Risk Management Policy of the ICB.

Risk Assessment

This financial year has been challenging in a number of areas for the ICB, particularly in relation to the establishment of the ICB and the ongoing System pressures. Risk identification, assessment and monitoring is a continuous structured process in ensuring that the ICB works within the legal and regulatory framework, identifying and assessing strategic and operational risks facing the organisation and planning to prevent and respond to these. Risk management is embedded in the activity of the organisation through the above measures and also through assessments of specific risks, for example information governance, equality impact assessment and business continuity. Control measures are in place to ensure that the ICB's obligations under equality, diversity and human rights legislation are complied with. The ICB operates a standard five-by-five matrix for assessing risk.

Significant operational risks identified during 2024/25

In context, the most significant operational risks we faced during 2024/25 were:

- acute providers may not meet the new target in respect of 78% of patients being seen, treated, admitted or discharged from the ED within four hours, resulting in failure to meet the ICB constitutional standards and quality statutory duties, taking into account the clinical impact on patients and the clinical mitigations in place where long waits result;
- the sustainability of individual General Practices across Derby and Derbyshire resulting in failure of individual General Practices to deliver quality Primary Medical Care services and a negative impact on patient care;
- the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the ICB to move to a sustainable financial position, and deliver the 2024/25 Financial Plan and 2-year Break Even;
- increased clinical harm to patients on provider waiting lists as a result of continuing delays in treatment;
- failure to deliver a timely response to patients due to excessive handover delays, leading to significant response times for patients whilst waiting in the community for an ambulance response and resulting in potential levels of harm;
- a lack of digital interoperability across information platforms leading to inadequate visibility of discharge information and communication between providers. A lack of effective performance indicators to monitor and manage discharge processes. Inadequate data collection and analysis to identify bottlenecks in discharge pathways. Lack of system data intelligence to inform decision making to manage risks when in system escalation;
- under the Immigration and Asylum Act 1999, the Home Office has a statutory obligation to provide those applying for asylum in England with temporary accommodation within Derby and Derbyshire. Due to the number of contingency hotels in the city and county there is concern that there will be an increase in demand and pressure placed specifically upon Primary Care services and looked after children services in supporting asylum seekers and unaccompanied asylum seekers with undertaking health assessments;
- performance against RTT and the cancer standards due to an increase in referrals into UHDBFT, resulting in significant capacity challenges to meet increased level of demand for diagnostic investigations, diagnosis and treatment;
- significant waiting times for moderate to severe stroke patients for community rehabilitation. This means patients may have discharges from acute Trusts delayed, may be seen by non-stroke specialist therapists and may require more robust social care intervention; and
- the current contractual dispute with Midlands and Lancashire Commissioning Support Unit may result in a failure to deliver against national statutory performance and financial targets leading to a reputational risk for the ICB.

Sources of Assurance

Internal Control Framework

A system of internal control is the set of processes and procedures the ICB has in place to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise risks, including evaluation of the likelihood of those risks being realised and the impact should they be realised, and enables risks to be managed efficiently, effectively and economically. The system of internal control also allows risks to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable, and not absolute, assurance of effectiveness.

As Accountable Officer, I am responsible for the system of internal control within the ICB. Responsibility for specific elements of the Internal Control Framework is delegated to individual members of the Senior Management Team, who will establish the controls relevant to the key business functions, in line with the risks implicit in those functions. I receive assurance on the adequacy of those controls both in their design and their performance from the ICB's Internal and External Auditors. The Audit and Governance Committee is charged with receiving reports on the operation of key controls and ensuring that risks identified are appropriately mitigated and that actions are completed.

The ICB fulfils its duties in relation to the Equality Act 2010 and the Public Sector Equality Duty contained within that Act, through a robust equality analysis of all policies, procedures and decisions. This ensures that due regard is given to Equality, Inclusion and Human Rights with the aim of eliminating discrimination; harassment and victimisation to advancing equality of opportunity and to fostering good relations. The ICB adopts the Derbyshire-wide Quality Schedule, which includes explicit reference to compliance with the Public Sector Equality Duty, enabling a robust and auditable process going forward. The process for equality impact assessments and quality impact assessments has been strengthened and a robust system has been developed to support the programme management office in the production of project initiation documents, which are thoroughly scrutinised by the Executive Team, Finance, Estates and Digital Committee and the Population Health and Strategic Commissioning Committee.

The ICB is committed to maximising public involvement through the use of the Patient Reference Groups, stakeholder groups and public events. The ICB is committed to ensuring that patients and the public are fully involved at all levels of the ICB's activity and have a meaningful impact on commissioning decisions, as required by the public involvement duty in accordance with Section 14Z45 of the NHS Act 2006 (as amended), as inserted by Section 25 of the Health and Care Act 2022.

The ICB engages the services of Counter Fraud Specialists via 360 Assurance and uses their input to ensure that appropriate policies and procedures are in place to mitigate the risks posed by Fraud, Bribery and Corruption. The ICB has also engaged a Local Security Management Specialist via 360 Assurance, to provide appropriate advice and support.

Conflicts of Interest Management

The ICB is responsible for the stewardship of significant public resources when making decisions about the commissioning of health and social care services. In order to ensure and be able to evidence that these decisions secure the best possible services for the population it serves, the ICB must demonstrate accountability to relevant stakeholders (particularly the public), probity and transparency in the decision-making process.

A key element of this assurance involves the management of conflicts of interest with respect to any decisions made. Although such conflicts of interest are inevitable, having processes to appropriately identify and manage them is essential to maintain the integrity of the NHS commissioning system and protect the ICB, its Board, its employees and associated General Practices from allegations and perceptions of wrongdoing. A conflicts of interest report is presented quarterly at Audit and Governance Committee meetings.

To further strengthen the scrutiny and transparency of the decision-making processes, the Non-Executive Member and Chair of Audit and Governance Committee is the ICB's Conflicts of Interest Guardian. The Conflicts of Interest Guardian provides support and advice to ICB employees and healthcare professionals who have any concerns regarding conflicts of interest.

On the establishment of the ICB on the 1st July 2022, it was agreed that an annual audit of conflicts of interest management was not mandated, therefore such an audit was not included in the internal audit plan. This was taken on the basis of risk and that, as the processes the ICB inherited from the Clinical Commissioning Group were strong and had a previous record of being audited regularly with no major issues being identified, the area was not considered to be of sufficient risk to be included. The ICB's Local Counter Fraud Specialist has however conducted a proactive exercise comparing a list of all ICB officers who are authorised to incur expenditure on behalf of the Board and those of company directors listed at Companies House.

The ICB has managed its conflicts of interest by requesting declarations from all ICB Board and Committee members and decision-makers, all of which can be found here. All Board members and decision-makers returned their completed forms during 2024/25, and 97% of Committee members completed their forms.

The ICB also requests declarations from all staff and sub-committee members. These declarations are provided at ICB meetings in the form of a register to enable the decision-making processes to be transparent and managed effectively. Conflicts can also arise in the form of Gifts and Hospitality and within the commissioning cycle from contracts and procurements. ICB employees are all requested to declare these conflicts when they arise and details of those declared within 2024/25 can also be found at the web link above.

An online mandatory training module for ICB staff on Conflicts of Interest is available to all staff through the ICB's usual training system. Compliance with this is monitored by the ICB's Corporate Governance Manager and reported to the Audit and Governance Committee on a quarterly basis.

Freedom to Speak Up Guardian

The ICB has a Raising Concerns at Work (Whistleblowing) Policy which supports employees in reporting genuine concerns about wrongdoing at work without any risk to themselves. The Freedom to Speak Up Guardian supports employees to speak up when they feel that they are unable to do so by any other means. An ICB employee is our Freedom to Speak Up Guardian, and they act as an independent and impartial source of advice to staff at any stage of raising a concern.

The ICB also has three members of staff who are Freedom to Speak Up Ambassadors. A Freedom to Speak Up Ambassador's role is to support and advise ICB staff, usually when they are unable to resolve problems locally when raising concerns. This role does not replace the role of line managers or Human Resources (HR), but it does provide an avenue for speaking up where staff do not feel able to go to their line manager or HR. The Freedom to Speak Up Ambassadors work within the ICB to improve speaking up and to ensure that lessons are learnt and things are improved when employees do speak up.

The Raising Concerns at Work (Whistleblowing) Policy is the responsibility of the Audit and Governance Committee, and a Freedom to Speak Up Guardian report is presented quarterly to update it of any concerns that have been raised. During 2024/25 the ICB has had 103 concerns raised through the freedom to speak up process. The ICB's whistleblowing arrangements act as a deterrent to unacceptable behaviour by encouraging openness and promoting transparency underpin the risk management systems and help to protect the reputation of the ICB and senior management.

Data Quality

Data quality is crucial; the availability of complete, relevant, accurate, accessible and timely data is important in supporting patient care, clinical governance, management and service agreements for healthcare planning and accountability. We have a Data Quality Policy in place which sits alongside the regular monitoring of data standards which are a requirement of the NHS Data Security and Protection Toolkit.

To provide the management of information necessary to manage commissioned activities, we commission our Business Intelligence Information Services from NECSU. ICB leads have worked with the team at NECSU to develop the reports provided to the ICB to ensure that the information given is fit for purpose. This has involved the delivery of a monthly Performance Report to the ICB Board, Finance, Estates and Digital Committee, and Quality and Performance Committee.

Information Governance

The Information Governance Assurance Forum is responsible for the governance and oversight of cyber security and information governance activities. This forum is chaired by the Senior Information Risk Owner and attended by the Caldicott Guardian, Data Protection Officer and Head of Digital and Information Governance, and reports to the Audit and Governance Committee as part of the overall ICB Governance structure. Included in the forum's annual forward plan are reviews of the data security and protection toolkit compliance activities and policies, access to information (subject access requests), cyber security updates, information governance incidents, training, and staff communications.

The Information Governance Assurance Forum takes place on a bi-monthly basis, as a formal meeting or through the circulation of documents for review, approval and assurance depending upon agreed work plans. From the Information Governance Assurance Forum's minutes and papers there is evidence of challenge, appropriate reporting and action being taken where required. Assurance is provided within the meetings on compliance with requirements regarding information flow mapping, Caldicott activity and Data Protection Officer involvement in all completed data protection impact assessments. Information governance policies and privacy notices have been reviewed in line with current activities to ensure that all facets of the ICB's work are appropriately covered. Public facing policies and privacy notices are available here.

In line with Department of Health and Social Care policy, all organisations which have access to NHS patient information must provide assurance for practising good information governance and must use the data security and protection toolkit to evidence this through the publication of annual assessments. The toolkit allows the ICB to measure itself against the National Cyber Security Centre Cyber Assurance Framework health overlay which consists of 47 outcomes. The ICB is planning for the annual data security and protection toolkit audit to be carried out by 360 Assurance during May 2025. The outcome of this audit will be reported to the Audit and Governance Committee to provide independent validation of the ICB's self-assessment.

The ICB submitted their baseline toolkit assessment on the 18th December 2024. This is an interim assessment to indicate that the ICB's self-assessment is underway and highlights the areas which need particular focus ahead of the full assessment deadline on the 30th June 2025. The ICB is working towards meeting the required achievement level across all the outcomes in the toolkit taken from the Health and Care Cyber Assurance Framework overlay.

No incidents have been reported to the Information Commissioner's Office by the ICB during 2024/25. Furthermore, in line with HM Treasury Guidance the ICB does not charge for public sector information.

Business Critical Models

An appropriate framework and environment is in place to provide quality assurance of business critical models, in line with the recommendations in the MacPherson report.

Third party assurances

Table 14 shows the range of services which are provided by third party providers.

Service	Provider	Assurances
Prescribing Payment Processing	NHS Business Services Authority	Service Auditor Report
Dental Payment Processing	NHS Business Services Authority	Service Auditor Report
Finance and Accounting Services	NHS Shared Business Services	Service Auditor Report
HR and Payroll Management	Electronic Staff Record (ESR)	Service Auditor Report
Primary Care Support	Capita	Service Auditor Report
Calculating Quality Reporting Service (CQRS)	NHSE/South, Central and West Commissioning Support Unit (SCW CSU)	Service Auditor Report
General Practitioner Data Services	NHSE	Service Auditor Report
Internal Audit	360 Assurance	Head of Internal Audit Opinion
External Audit	KPMG	Annual Audit Letter

Table 14 – services provided to the ICB by third party providers

The ICB keeps all contracts under review in order to ensure efficiency and value for money.

Control Issues

In the Month 9 Governance Statement return the ICB reported a number of control issues to NHSE. You can read more about the detail of the control issues at Appendix 7.

Review of economy, efficiency and effectiveness of the use of resources

The ICB is charged with ensuring that it achieves economy, efficiency and effectiveness in its use of resources.

The review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive directors and clinical leads within the ICB who have responsibility for the development and maintenance of the Internal Control Framework. The recommendations from external auditors in their annual audit letter and other reports are also taken into consideration.

The ICB prepares an annual Finance Plan that sets out the financial resources available to the organisation and the means by which these will be used to deliver the ICB's objectives. Monthly financial performance is scrutinised by the Finance, Estates and Digital Committee and reported to the ICB Board. Internal and external audit arrangements give assurance to the ICB Board on the delivery of the ICB's statutory financial responsibilities and the achievement of value for money. The ICB complies with the NHS Pension Scheme regulations. Through our internal auditors, the ICB's performance is benchmarked against

similar organisations. It uses expert commissioning support to ensure the delivery of best value through procurement. It develops efficiency schemes that enable it to use its resources effectively and efficiently through improving patient pathways which make best use of available healthcare resources and reduce the use of expensive acute care where more convenient and better value local alternatives are available. In exceptional cases there may be instances where information is not reported as it is not accurate or reliable.

The ICB regularly reviews performance across its General Practices, facilitates the comparison of relative performance in the use of resources as well as in health outcomes, and provides opportunities for General Practices to share best practice and develop initiatives for wider roll-out. Performance reports are reviewed at the ICB Board, Quality and Performance Committee, and Finance, Estates and Digital Committee.

The ICB also has a running cost allowance (typically 1% of total resource) within which it must operate, ensuring that as much resource as possible is concentrated on the commissioning and delivery of services to patients. In achieving this, the ICB uses commissioning support services to deliver economies of scale in the provision of some back-office and similar services.

Table 15 shows the ICB's running costs, as reported in the Annual Accounts.

	Allocation	Expenditure
	£'000	£'000
2024/25	20,402	18,699
2023/24	23,163	19,296

Table 15 – ICB's total running costs allocation and expenditure during 2024/25 and 2023/24

Table 16 identifies how the ICB's running costs were used during 2024/25, alongside the prior period.

	2024/25	2023/24
	£'000	£'000
Pay costs	15,059	14,829
Travel expenses	44	10
Premises	1,001	633
Charges from Commissioning Support Units	1,357	1,190
Other non-pay	1,884	3,172
Commissioning income	(646)	(538)

Table 16 – breakdown of running costs expenditure during 2024/25 and 2023/24

ICB Annual Assessment

We work in collaboration with NHSE to oversee local performance in line with the NHS Oversight Framework, which reflects the ambitions of the NHS Long Term Plan, covering quality of care, access and outcomes; preventing ill-health and reducing inequalities; people; finance and use of resources; and leadership and capability. As at Quarter 4 of 2024/25, NHS Derby and Derbyshire ICB are in segment 3 of the National Oversight Framework.

NHSE has a statutory duty to undertake annual assessments of ICBs following the end of each reporting year. In undertaking this assessment, NHSE will consider how successfully the ICB has met its four core aims and delivered its system leadership role, while meeting its key statutory duties. The outcome of these assessments will be published in NHSE's Annual Report 2024/25, which will be available on its website at www.england.nhs.uk.

For 2023/24, NHSE provided the following feedback on the ICB annual assessment:

"This has been a challenging year in many respects and in making our assessment of your performance we have sought to fairly balance our evaluation of how successfully you have delivered against the complex operating landscape in which we are working. This is the first full year in which you have been operating as well as the first year of your Joint Forward Plan and we are keen to continue to see progress towards a maturing system of integrated care structured around placing health and care decisions as close as possible to those people impacted by them. We will continue to work alongside you in the year ahead and look forward to working with you to support improvement throughout your system."

The 2024/25 ICB annual assessment process will be undertaken in the first quarter of 2025/26.

Delegation of Functions

The ICB keeps its governance structures under constant review with the aim of delegating decision-making responsibility where this enables the ICB Board to devote more time to strategy and optimise the use of clinical leadership. All such arrangements are set out in the ICB's Scheme of Delegation. The ICB has two external delegation chains:

- delegated responsibility for Primary Medical Care from NHSE; this responsibility is led by the Population Health and Strategic Commissioning Committee under specific Terms of Reference common to all ICBs who have taken full delegated powers; and
- the Derbyshire Better Care Fund under the authority of the Health and Wellbeing Board.

During 2024/25, the ICB has been responsible for the delegation of Primary Pharmacy Services, Optometry Services and Primary and Secondary Dental Services from NHSE to ICBs. This was in accordance with NHSE's long-term policy ambition of giving systems responsibility for managing local population health needs, tackling inequalities and addressing fragmented pathways of care. The services delegated to the ICB are:

- Primary Pharmacy, Optometry and Primary and Secondary Dental Services; and
- complaints functions associated with Primary Pharmacy, Optometry and Primary and Secondary Dental Services.

The ICB signed a delegation agreement with NHSE on the 27th March 2025 for the commissioning of specialised services from the 1st April 2025.

East Midlands Joint Committee

During 2023, the Board approved a Joint Working Agreement with the four other East Midlands ICBs (NHS Derby and Derbyshire ICB, NHS Leicester, Leicestershire and Rutland ICB, NHS Lincolnshire ICB and NHS Northamptonshire ICB) in order to effectively deliver additional commissioning functions delegated to them by NHSE via a formal Delegation Agreement. A separate Joint Working Agreement between the five ICBs and NHSE was also agreed as a step towards the formal delegation of specialised commissioning functions from the 1st April 2024. The East Midlands Joint Committee was established to satisfy the two Joint Working Agreements. Membership of the Joint Committee comprises the Chief Executives and Chairs of the East Midlands ICBs and, for matters currently concerning specialised commissioning, representatives from NHSE. The Joint Committee met five times within the reporting period.

The Committee routinely received assurance reports on the delivery of Primary Care functions and Primary Care finance, which considered some of the specific challenges being faced and how these were being addressed. Deep dive reports were received in relation to dentistry, adult critical care and vascular surgery. In relation to specialised services, the Committee regularly discussed preparation and plans for the commencement of formal delegated arrangements, which included national updates on the readiness of ICBs to take on the new delegated responsibilities and more local reports on the current status of specialised services in the Midlands Region.

Counter Fraud Arrangements

The ICB is required to comply with the NHS Counter Fraud Authority's requirements and Government Functional Standard 013: Counter Fraud. Progress is overseen by the ICB's Chief Finance Officer and Audit and Governance Committee. The ICB's Chief Executive Officer and Chief Finance Officer are jointly responsible for ensuring adherence to the Functional Standard.

Annually, the ICB is required to self-assess against the Functional Standard by submitting the ICB's Counter Fraud Functional Standard Return. Further detail of the ICB's submission can be found in the Counter Fraud Annual Report. In October 2024, the ICB's Fraud, Bribery and Corruption Policy was reviewed by the ICB's Accredited Counter Fraud Specialist, approved by the Audit and Governance Committee and made available to all staff. The Accredited Counter Fraud Specialist attends meetings of the Audit and Governance Committee and provides comprehensive updates on progress towards completion of the Annual Work Plan and compliance with the Functional Standard.

Head of Internal Audit Opinion

Following completion of the planned audit work for 2024/25 for the ICB, the Head of Internal Audit issued an independent and objective interim opinion on the adequacy and effectiveness of the ICB's system of risk management, governance and internal control. The Interim Head of Internal Audit Opinion concluded that:

> *"I am providing an **opinion of significant assurance** that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and controls are generally being applied consistently.*
>
> *My opinion takes into account third party assurances received by the organisation.*
>
> *This opinion should be taken in its entirety for the Annual Governance Statement and any other purpose for which it is repeated."*

During 2024/25, Internal Audit, 360 Assurance gave consideration as to whether the ICB had maintained appropriate oversight of strategic governance and risk management and that key controls continued to operate during this period for the following areas, as detailed below in Table 17:

Audit Assignment	Assurance Level/Comments
Accounts Receivable (core)	Substantial
Appraisals (core)	Moderate
Budget Setting, reporting and monitoring (core)	Significant
Board Assurance Framework (core)	Significant
Data Security and Protection Toolkit (core)	Moderate Assurance (NHSE opinion level)
Pay Expenditure (core)	Significant
Quality Governance Framework (core)	Limited
Risk Management Workshop (Stage 1)	Advisory
Risk Management Workshop (Stage 2)	Advisory
Mental Health Act assessments benchmarking	Advisory

Table 17 – Internal Audit reports issued in 2024/25 by 360 Assurance

Review of the effectiveness of governance, risk management and internal control

As Accountable Officer, my review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the ICB who have responsibility for the development and maintenance of the Internal Control Framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the ICB achieving its principles objectives has been reviewed.

I have been advised on the implications of the result of this review by the ICB Board, Audit and Governance Committee, Remuneration Committee, Finance, Estates and Digital Committee, People and Culture Committee, Population Health and Strategic Commissioning Committee, Public Partnership Committee, and Quality and Performance Committee; and have addressed any weaknesses during the year and ensure continuous improvement of the system is in place.

The effectiveness of the governance, risk management and internal control are reviewed by the Audit and Governance Committee which scrutinises and challenges the reports provided by the ICB. In addition, the reports in relation to the programme of work in the Internal Audit Plan are presented to the Audit and Governance Committee. A log of recommendations and electronic 'Pentana Tracker system' from the Internal Audit Reports is maintained and reviewed at each meeting of the Audit and Governance Committee.

My review is also informed via assurances provided by the:

- ICB Board;
- Audit and Governance Committee;
- NHSE – NHS Oversight Framework;
- 360 Assurance – Internal Audit reviews and Head of Internal Audit Opinion;
- KPMG – External Audit;
- NECSU – via monthly contract monitoring meetings;
- Corporate Committees of the ICB Board; and
- Executive Team.

Conclusion

No significant internal control weaknesses have been identified during the year. The ICB has received positive feedback from Internal Audit on the assurance framework and this, in conjunction with other sources of assurance, leads the ICB to conclude that it has a robust system of control.

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

The ICB has an established Remuneration Committee. The committee makes recommendations on determinations about the remuneration, fees and other allowances for employees and for people/organisations providing services to the ICB. The Committee is chaired by a Non-Executive Member. The composition of the Remuneration Committee is shown at Appendix 6, Table 51 on page 180.

Policy on the remuneration of senior managers

For the purpose of this section the term 'senior managers' includes all those individuals who have an influence in the decisions of the ICB, as listed in the remuneration tables later in this report. The Remuneration Committee is responsible for determining the remuneration of all individuals who are non-employees and engaged under the Contracts for Services. Remuneration for these positions is informed by local and national pay benchmarking. Their remuneration is reviewed periodically to ensure that it keeps pace with increasing demands on the time of the individuals in those positions. In order to avoid any conflict of interest, in respect of Non-Executive Members who constitute the majority of the membership of the Remuneration Committee, their own remuneration is set directly by the ICB Board. The Non-Executive Members who are conflicted are not part of the decision-making process.

Remuneration of Very Senior Managers (subject to audit)

Employment terms for a VSM or member of the ICB's Executive Team are determined separately and, where appropriate, the principles of Agenda for Change are applied to these employees to ensure equity across the ICB. There is no national body to determine remuneration for VSM employees; therefore, a robust process is in place within the ICB. The Remuneration Committee sets and approves the remuneration for all VSM employees. The Remuneration Committee comprises Non-Executive Members from the ICB Board and their decisions are informed by independent, local and national benchmarking to ensure the best use of public funds and to help with recruitment and retention. Their decisions also take into consideration annual Agenda for Change pay circulars to ensure parity where appropriate.

The Chief Executive Officer and Chief Finance Officer are remunerated in line with the ICB Remuneration Guidance (updated) issued by the NHS Commissioning Board in late 2012 as adjusted to take account of the previous remuneration of the staff members concerned. All VSM salaries are reviewed and agreed by the Remuneration Committee and reported to the ICB Board. The VSM pay review process includes a requirement for 100% compliance with mandatory training.

Senior Manager Remuneration (including salary and pension entitlements) (subject to audit)

Tables 18 and 19 show the senior manager total salary during 2024/25 and for the period to the 31st March 2025.

Salaries and allowances for the year to 31st March 2025

Name	Title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
		£000	£	£000	£000	£000	£000
Executive Members – Voting							
Michelle Arrowsmith	Chief Strategy and Delivery Officer, and Deputy Chief Executive	155-160	0	0-5	0	37.5-40	200-205
Dr Chris Clayton	Chief Executive Officer	215-220	1,200	0	0	42.5-45	260-265
Claire Finn	Interim Chief Finance Officer	40-45	0	0	0	0	40-45
Linda Garnett	Interim Chief People Officer	85-90	0	0	0	0	85-90
Keith Griffiths	Chief Finance Officer	120-125	600	0	0	0-2.5	25-30
Prof Dean Howells	Chief Nurse Officer	160-165	5,800	0	0	70-72.5	240-245
Lee Radford	Chief People Officer	100-105	100	0	0	77.5-80	180-185
Dr Chris Weiner	Chief Medical Officer	150-155	1,200	0	0	12.5-15	165-170
Executive Member – Non-Voting							
Helen Dillistone	Chief of Staff	145-150	300	0	0	32.5-35	180-185
Non-Executive Members – Voting							
Jill Dentith	Non-Executive Member	10-15	300	0	0	0	10-15
Margaret Gildea	Non-Executive Member and Senior Independent Director	15-20	0	0	0	0	15-20
Dr Kathy McLean	ICB Chair	50-55	200	0	0	0	55-60
Nigel Smith	Non-Executive Member	0-5	0	0	0	0	0-5
Sue Sunderland	Non-Executive Member	10-15	100	0	0	0	10-15
Richard Wright	Chair and Non-Executive Member	10-15	0	0	0	0	10-15
Partner Members – Voting							
Ellie Houlston	Partner Member – Derbyshire County Council	0-5	0	0	0	0	0-5

Name	Title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
		£000	£	£000	£000	£000	£000
Dr Andrew Mott	Partner Member – Primary Medical Services	5-10	0	0	0	0	5-10
Dr Adedeji Okubadejo	Clinical Lead Member	40-45	0	0	0	0	40-45
Stephen Posey	Partner Member – University Hospitals of Derby and Burton NHS Foundation Trust	0-5	0	0	0	0	0-5
Mark Powell	Partner Member – Derbyshire Healthcare NHS Foundation Trust	0-5	0	0	0	0	0-5
Perveez Sadiq	Partner Member – Derby City Council	0-5	0	0	0	0	0-5
Paul Simpson	Partner Member – Derby City Council	0-5	0	0	0	0	0-5
Participant Members – Non-Voting							
Tracy Allen	Participant Member to the Board for Place – Derbyshire Community Health Services NHS Foundation Trust	0-5	0	0	0	0	0-5
James Austin	Chief Digital Information Officer	25-30	700	0	0	25-27.5	50-55
Dr Avi Bhatia	Clinical and Professional Leadership Group Participant Member to the Board	70-75	0	0	0	0	70-75

Table 18 – Senior manager remuneration for the year to 31st March 2025

1. The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual
2. No payments were made to partner members from Local Authority or NHS bodies, nor were recharges made by their employers.
3. Where a salary amount sits exactly on a pay boundary then the salary is reported at the lower band. For example if an employee had a salary of £50,000 they would be shown in the salary band (£'000) 45-50.
4. The total remuneration disclosed in the table above for Dr Avi Bhatia, Dr Andrew Mott and Dr Adedeji Okubadejo includes clinical advisory services provided to the ICB unrelated to their roles as senior managers.
5. James Austin is employed by Derbyshire Community Healthcare Services NHS Foundation Trust. The Integrated Care Board is charged for 50% of his time as a Director and time proportioned to 1st August 2024 when his position ceased with the ICB. The new Chief Digital Officer is not considered a senior manager and hence the remuneration of this post is no longer disclosed.
6. Dr Adedeji Okubadejo salary includes a clinical excellence award.
7. Linda Garnett's contract as Interim Chief People Officer was terminated in July 2024. Termination benefits of £47k are included within the salary figure, and form part of the Exit Package disclosure within the Annual Report. Lee Radford commenced as Chief People Officer in July 2024.
8. Keith Griffiths retired in November 2024 as Chief Finance Officer, and Claire Finn carried out this role between December 2024 and March 2025.
9. Richard Wright ceased the role as Chair in April 2024, and resumed his Non-Executive Member role until November 2024. Dr Kathy McLean commenced as Chair in May 2024, and Nigel Smith commenced as Non-Executive Member in January 2025.
10. Perveez Sadiq ceased his role as Derby City Council Member in October 2024; Paul Simpson commenced in this role from November 2024.
11. Tracy Allen ceased the role as participant member for Place in September 2024.
12. Taxable benefits disclosed in the above table include business miles and salary sacrifice lease cars.
13. All senior manager salaries are reviewed and approved by the ICB's Remuneration Committee. The Committee assures the ICB that all remuneration packages for senior managers are reasonable, including those above £150k per annum.
14. The performance pay for Michelle Arrowsmith was due to a non-consolidated performance-related payment for recruitment and retention.

Salaries and allowances for the year to 31st March 2024

Name	Title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
		£000	£	£000	£000	£000	£000
Executive Members – Voting							
Michelle Arrowsmith	Chief Strategy and Delivery Officer and Deputy Chief Executive	70-75	0	0	0	2.5-5	75-80
Dr Chris Clayton	Chief Executive Officer	205-210	1200	0	0	0-2.5	205-210
Linda Garnett	Interim Chief People Officer	105-110	0	0	0	0-2.5	105-110
Keith Griffiths	Chief Finance Officer	170-175	0	0	0	0-2.5	170-175
Prof Dean Howells	Chief Nurse Officer	90-95	2200	0	0	32.5-35	125-130
Zara Jones	Executive Director of Strategy and Planning	65-70	0	0	0	0-2.5	65-70
Paul Lumsdon	Interim Chief Nurse Officer	75-80	0	0	0	0-2.5	75-80
Amanda Rawlings	Chief People Officer	5-10	0	0	0	0-2.5	5-10
Brigid Stacey	Chief Nurse Officer and Deputy Chief Executive Officer	40-45	0	0	0	0-2.5	40-45
Dr Chris Weiner	Executive Medical Director	145-150	1200	0	0	0-2.5	145-150
Executive Member – Non-Voting							
Helen Dillistone	Chief of Staff	135-140	200	0	0	0-2.5	135-140
Non-Executive Members – Voting							
Julian Corner	Non-Executive Member (Population Health and Strategic Commissioning)	5-10	0	0	0	0-2.5	5-10
Jill Dentith	Non-Executive Member (Finance and Estates)	10-15	200	0	0	0-2.5	10-15
Margaret Gildea	Non-Executive Member (People and Culture) and Senior Independent Director	15-20	0	0	0	0-2.5	15-20
John MacDonald	ICB Chair	15-20	0	0	0	0-2.5	15-20
Sue Sunderland	Non-Executive Member (Audit and Governance)	10-15	100	0	0	0-2.5	10-15
Richard Wright	ICB Chair	45-50	0	0	0	0-2.5	45-50
Partner Members – Voting							
Ellie Houlston	Partner Member – Derbyshire County Council	0-5	0	0	0	0-2.5	0-5

Name	Title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
		£000	£	£000	£000	£000	£000
Dr Andrew Mott	Partner Member – Primary Medical Services	5-10	0	0	0	0-2.5	5-10
Dr Adedeji Okubadejo	Clinical Lead Member	40-45	0	0	0	0-2.5	40-45
Stephen Posey	Partner Member – University Hospitals of Derby and Burton NHS Foundation Trust	0-5	0	0	0	0-2.5	0-5
Mark Powell	Partner Member – Derbyshire Healthcare NHS Foundation Trust	0-5	0	0	0	0-2.5	0-5
Andy Smith	Partner Member – Derby City Council	0-5	0	0	0	0-2.5	0-5
Participant Members – Non-Voting							
Tracy Allen	Participant to the Board for Place – Derbyshire Community Health Services NHS Foundation Trust	0-5	0	0	0	0-2.5	0-5
James Austin	Chief Digital Information Officer	65-70	2100	0	0	15-17.5	85-90
Dr Avi Bhatia	Clinical and Professional Leadership Group Participant to the Board	70-75	0	0	0	0-2.5	70-75

Table 19 – Senior manager remuneration for the year to 31st March 2024

1. The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.
2. No payments were made to partner members from Local Authority or NHS bodies, nor were recharges made by their employers.
3. Where a salary amount sits exactly on a pay boundary then the salary is reported at the lower band. For example if an employee had a salary of £50,000 they would be shown in the salary band (£'000) 45-50.
4. The total remuneration disclosed in the table above for Dr Avi Bhatia, Dr Andrew Mott and Dr Adedeji Okubadejo includes clinical advisory services provided to the ICB unrelated to their roles as senior managers.
5. James Austin is employed by Derbyshire Community Healthcare Services NHS Foundation Trust, and is recharged to the ICB on a 50% basis. It is this shared which is disclosed in the remuneration table.
6. Amanda Rawlings is employed by the University Hospitals of Derby and Burton NHS Foundation Trust, with the ICB being recharged 50% of the salary and it is the ICB share which is disclosed in the remuneration table. Amanda Rawlings position with the ICB ceased in April 2023, and Linda Garnett commenced in May 2023 in an interim position.
7. John MacDonald ceased his role as Chair of the ICB in June 2023, and Richard Wright commenced from July 2023. At this point, Richard Wright ceased his role as Non-Executive Member (Finance & Estates), and Jill Dentith commenced this position from July 2023.
8. Brigid Stacey retired in July 2023 as Chief Nurse Officer, and Paul Lumsdon carried out this role between July 2023 and August 2023. Prof Dean Howells commenced as Chief Nurse Officer from September 2023.
9. Zara Jones ceased the role as Executive Director of Strategy and Planning in September 2023, and Michelle Arrowsmith commenced as Chief Strategy and Deliver Officer, and Deputy Chief Executive in October 2023.
10. Partner member changes include the cessation of Carolyn Green for Derbyshire Healthcare NHS Foundation Trust in March 2023, replaced by Mark Powell from April 2023, and Stephen Posey commenced as representative for University Hospitals of Derby and Burton NHS Foundation Trust from August 2023.
11. Taxable benefits disclosed in the above table include business miles and salary sacrifice lease cars.

Pension Benefits as at 31st March 2025

Name	Title	Real Increase in Pension at pension age (bands of £2,500)	Real Increase in Pension Lump Sum at pension age (bands of £2,500)	Total Accrued Pension at pension age at 31 March 2025 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2024	Real Increase/ (Decrease) in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2025	Employers Contribution to Stakeholder Pension
		£000	£000	£000	£000	£000	£000	£000	£000
Executive Members – Voting									
Michelle Arrowsmith	Chief Strategy and Delivery Officer, and Deputy Chief Executive	2.5-5	0-2.5	55-60	150-155	1,104	43	1,241	0
Dr Chris Clayton	Chief Executive Officer	2.5-5	0-2.5	45-50	100-105	799	32	911	0
Prof Dean Howells	Chief Nurse Officer	2.5-5	2.5-5	55-60	140-145	1,075	75	1,241	0
Lee Radford	Chief People Officer	2.5-5	0-2.5	90-95	0-5	1,405	82	1,626	0
Dr Chris Weiner	Chief Medical Officer	0-2.5	0-2.5	40-45	95-100	805	13	897	0
Executive Member – Non-Voting									
Helen Dillistone	Chief of Staff	2.5-5	0-2.5	45-50	110-115	889	33	1,000	0
Partner Member – Non-Voting									
James Austin	Chief Digital Information Officer	0-2.5	0-2.5	25-30	0-5	395	23	472	19

Table 20 –Pension Benefits as at 31st March 2025

1. Pensions figures included in the above table are for senior managers that have pensions paid directly by the ICB and include all of their NHS Service not just pension payments that relate to the period to 31 March 2025.
2. The CETVs shown in the table above, and prior year comparator values have been provided by the NHS Business Services Authority (BSA) and have been used to calculate the real movement in CETV value.
3. The Interim Chief Finance Officer, Claire Finn, and Interim Chief People Officer, Linda Garnett, chose not to be covered by the pension arrangements during the reporting period.
4. The Chief Information Officer, James Austin pension balances have been disclosed in full in this report but have been time proportioned to 1st August 2024.Their role was shared with Derbyshire Community Healthcare Services NHS Foundation Trust who will also disclose pension balances.
5. Keith Griffiths was Chief Finance Officer until 30 November 2024 and took retirement on this date.
6. The McCloud public sector pensions remedy affects members who were in the NHS 1995 and 2005 pension scheme (old schemes) between 1 April 2018 and 31 March 2022. Members in the old schemes can decide before retirement whether the pension contributions for the period April 2018 to March 2022 go into the old pension schemes or the new 2015 scheme. For the purposes of the pension calculations these contributions have been included in the old pension scheme. This applies to: Michelle Arrowsmith, Dr Chris Clayton, Helen Dillistone, Keith Griffiths, Prof Dean Howells, Lee Radford and Dr Chris Weiner.

Pension Benefits as at 31st March 2024

Name	Title	Real Increase in Pension at pension age (bands of £2,500)	Real Increase in Pension Lump Sum at pension age (bands of £2,500)	Total Accrued Pension at pension age at 31 March 2024 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2023	Real Increase/ (Decrease) in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2024	Employers Contribution to Stakeholder Pension
		£000	£000	£000	£000	£000	£000	£000	£000
Executive Members – Voting									
Michelle Arrowsmith	Chief Strategy and Delivery Officer/Deputy Chief Executive	0-2.5	0-2.5	45-50	140-145	971	8	1,104	0
Dr Chris Clayton	Chief Executive Officer	0-2.5	50-52.5	35-40	95-100	546	170	799	0
Keith Griffiths	Chief Finance Officer	0-2.5	20-22.5	80-85	230-235	1,777	139	2,119	0
Prof Dean Howells	Chief Nurse Officer	0-2.5	17.5-20	45-50	130-135	753	132	1,075	0
Zara Jones	Executive Director of Strategy and Planning	0-2.5	30-32.5	35-40	90-95	477	65	679	0
Amanda Rawlings	Chief People Officer	0-2.5	0-2.5	35-40	95-100	730	5	885	0
Executive Member – Non-Voting									
Helen Dillistone	Chief of Staff	0-2.5	35-37.5	40-45	105-110	642	164	889	0
Participant Member – Non-Voting									
James Austin	Chief Digital Information Officer	2.5-5	0	25-30	0	283	86	395	18

Table 21 –Pension Benefits as at 31st March 2024

1. Pensions figures included in the above table are for senior managers that have pensions paid directly by the ICB and include all of their NHS Service not just pension payments that relate to the period to 31 March 2024.
2. The CETVs shown in the table above, and prior year comparator values have been provided by the NHS Business Services Authority (BSA) and have been used to calculate the real movement in CETV value
3. The Executive Medical Director, Dr Chris Weiner and the Interim Chief People Officer, Linda Garnett, chose not to be covered by the pension arrangements during the reporting period.
4. The Chief Information Officer, James Austin and Chief People Officer, Amanda Rawlings' pension balances have been disclosed in full in this report, however their roles are shared with Derbyshire Community Healthcare Services NHS Foundation Trust and University Hospitals of Derby & Burton NHS Foundation Trust respectively.
5. Brigid Stacey was Chief Nurse Officer until 4 July 2024 and took retirement 12 July 2024.

Cash equivalent transfer values (subject to audit)

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in cash equivalent transfer value

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Pension disclosures for members affected by the public service pensions remedy

On the 1st April 2015, the government made changes to public service pension schemes which treated members differently based on their age. The public service pensions remedy puts this right and removed the age discrimination for the remedy period, between the 1st April 2015 and 31st March 2022. Part 1 of the remedy closed the 1995/2008 Scheme on the 31st March 2022, with active members becoming members of the 2015 Scheme on the 1st April 2022. For Part 2 of the remedy, eligible members had their membership during the remedy period in the 2015 Scheme moved back into the 1995/2008 Scheme on the 1st October 2023.

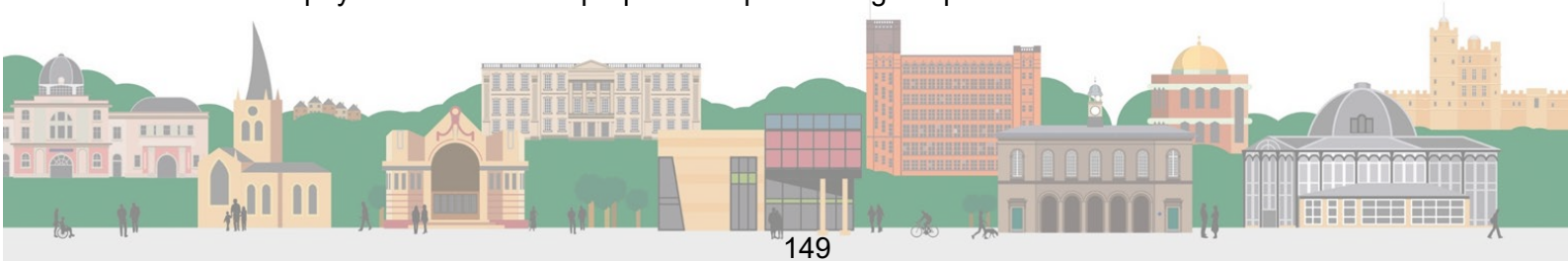
Where members are affected by the Public Service Pensions Remedy, and their membership between the 1st April 2015 and 31st March 2022 was moved back into the 1995/2008 Scheme on the 1st October 2023, this is disclosed as a note to the Pension Benefits (Table 19).

Compensation on early retirement or for loss of office

The contract for Linda Garnett as Interim Chief People Officer was terminated in July 2024. Termination benefits of £47k are included within the remuneration report, and form part of the Exit Package disclosure within the Annual Report.

Payments to past members (subject to audit)

No such payments have been proposed or paid during the period.



Percentage change in remuneration of highest paid director (subject to audit)

2024/25	Salary and Allowances	Performance Pay and Bonuses
The percentage change from the previous financial year in respect of the highest paid director	5%	-
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	1%	-

Table 22 – percentage change in remuneration of highest paid director as at 31st March 2025

2023/24	Salary and Allowances	Performance Pay and Bonuses
The percentage change from the previous financial year in respect of the highest paid director	5%	-
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	3%	-

Table 23 – percentage change in remuneration of highest paid director as at 31st March 2024

During the financial year ending the 31st March 2025, employees were awarded a 5.5% (2034/24 5%) pay uplift under the Governments' Agenda for Change Pay Award. The ICB's Directors received uplifts in line with this award, as seen in Table 22 above.

Due to staffing changes at the ICB during the year reducing the average salary, the employee percentage change is lower than the 5.5% uplift awarded.

Pay ratio information (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

The banded remuneration of the highest paid director/member in the ICB in the period to the 31st March 2025 was £217,500 (2023/24, £207,500). The relationship to the remuneration of the organisation's workforce is disclosed in Tables 20 and 22.

The calculation of the 25th percentile, median and 75th percentile remuneration of the workforce includes the remuneration of members of the Board but excludes the highest paid director/ member.

In the period to the 31st March 2025, nil employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £22,500–£217,500. (2023/ 24, £22,500-£207,500). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Tables 24 and 25 show the relationship between the remuneration of the highest-paid director in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce as at the 31st March 2025 and 31st March 2024 The ratios have remained comparable between the two financial years.

	25th percentile	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	29,970	48,526	63,702
Salary component of total remuneration	29,970	48,526	60,504
Pay ratio information	7:1	4:1	3:1

Table 24 –Pay ratio information as at 31st March 2025

	25th percentile	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	30,298	48,222	60,933
Salary component of total remuneration	28,407	45,996	58,972
Pay ratio information	7:1	4:1	3:1

Table 25 – Pay ratio information as at 31st March 2024

Staff Report

Number of Senior Managers and Staff Composition

Table 26 shows the gender and pay band of VSMs and gender of the other ICB Employees during 2024/25.

	Male	Female	Total
Executive Members (including Directors)	10	10	20
Band 8d	7	7	14
Band 8c	5	19	24
Band 8b	12	32	44
Band 8a	18	56	74
Other banded ICB employees	39	295	334
Total ICB employees	**91**	**419**	**510**
Other non-permanent engagements including non-executive directors and lay members	19	28	47
Total	**110**	**447**	**557**

Table 26 – number of senior managers and staff composition during 2024/25

Staff numbers and costs (subject to audit)

The staff costs for the years to 31st March 2025 and 31st March 2024 are shown in Tables 27 and 28. There has been an increase in permanent employee costs during the year (categorised as 'Other' in the tables below). In the main, this reflects the national pay uplift to staff of 5.5%, an increase of employer pension contributions from 20.6% to 23.7% and a small increase in average staff numbers.

Employee Benefits in the period to 31st March 2025

The staff costs for the period 1st April 2024 to 31st March 2025 are shown in Table 27.

Employee Benefits	2024/25		
	Permanent Employees	Other	Total
	£000	£000	**£000**
Salaries and wages	23,155	672	**23,827**
Social security costs	2,551	-	**2,551**
Employer Contributions to NHS Pension scheme	5,244	-	**5,244**
Other pension costs	2	-	**2**
Apprenticeship Levy	100	-	**100**
Gross employee benefits expenditure	31,052	672	**31,724**
Less recoveries in respect of employee benefits	(240)	-	**(240)**
Total - Net admin employee benefits including capitalised costs	30,812	672	**31,484**

Table 27 – staff costs in the period to 31st March 2025

Employee Benefits in the period to 31st March 2024

The staff costs for the period 1st April 2023 to 31st March 2024 are shown in Table 28.

Employee Benefits	2023/24		
	Permanent Employees	Other	Total
	£000	**£000**	**£000**
Salaries and wages	20,429	1,260	21,689
Social security costs	2,266	47	2,313
Employer contributions to NHS Pension scheme	4,105	56	4,161
Other pension costs	4	–	4
Apprenticeship levy	93	–	93
Termination benefits	335	–	335

Employee Benefits	2023/24		
	Permanent Employees	Other	Total
	£000	£000	£000
Gross employee benefits expenditure	**27,232**	**1,363**	**28,595**
Less recoveries in respect of employee benefits	(35)	–	(35)
Total – net admin employee benefits including capitalised costs	**27,197**	**1,363**	**28,560**
Less: employee costs capitalised	–	–	–

Table 28 – staff costs in the period to 31st March 2024

Average number of people employed

Table 29 shows the average number of staff employed by the ICB, excluding non-executive members and lay members.

2024/25			2023/24		
Permanently employed	Other	Total	Permanently employed	Other	Total
457	8	**465**	451	24	**475**

Table 29 – average number of people employed by the ICB in 2024/25 and 2023/24

During the year to 31st March 2025, the staff turnover for the ICB was 10.79% (2023/24: 13.8%).

Sickness absence data

Table 30 shows the sickness absence data of staff permanently employed by the ICB, up to the 31st December 2024 and for 2023/24, excluding non-executive members and lay members. This data is provided by NHS Digital, and is reflective of the January to December 2025 calendar year. year (2023-24: 2023 calendar year).

	2024/25			2023/24		
	Absence Days (FTE)	Average FTE of Staff	Average Absence Days per FTE	Absence Days (FTE)	Average FTE of Staff	Average Absence Days per FTE
Total	3,371	447	7.5	4,836	466	6.4

Table 30 – average absence days of staff permanently employed by the ICB up to 31st December 2024/25 and 2023/24

Supporting and Developing Our People

Our way of working

The ICB values and behaviours are key to how we work and set our culture and our identity. Through our organisational development plan, we are working to bring our values and behaviours to life and create a consistent inclusive and compassionate culture.

Values	ONE TEAM	COMPASSIONATE	INNOVATIVE
Behavioural expectations	We are **collaborative**, a peer and a partner; we role-model integrated, collaborative working.	We are **kind** and respectful.	We **listen** to our communities and colleagues, fostering two-way communication and embracing co-production.
	We are **open** and transparent in engaging with others and worthy of their trust.	We are **inclusive**, embracing diversity for all people across the organisation, the system, and the communities we serve.	We **learn** with, develop and grow our people, staying curious and bold in challenging convention.
	We are **accountable**, visible and responsible leaders in our communities.	We are **supportive**, celebrating each other's skills, accomplishments and contributions.	We are **flexible** and adaptable, taking decisions that best serve the needs of staff and our communities.

We have implemented 'kindness into action' workshops and made the following commitments to our people:

- creating a consistent inclusive and compassionate culture within the ICB through its values, knowing that not all colleagues consistently experience this culture and there is continued work to do in this area;
- developing and supporting leaders to create compassionate cultures where diversity is valued, people feel that they belong and are empowered to deliver great work that makes a difference;
- making the ICB an even better place to work; and
- better recognising the amazing hard work that is delivered every single day to support people and communities.

The ICB operates a hybrid operating model, enabling colleagues to have a balance of on-site working and remote working from home.

Disability Confident

The ICB are accredited under the Disability Confident employer scheme, which encourages the ICB to think differently about disability and take action to improve how it recruits, retains and develops disabled people. As part of this, the ICB operate a guaranteed interview scheme, which ensures an interview for any candidate with a disclosed disability whose application meets all of the essential criteria for the post.

The ICB has embedded a Disability and Long-Term Conditions Policy, which includes a reasonable adjustment passport that aims to eliminate barriers and discrimination and support staff to reach their full potential. The policy embodies the social model of disability

and gives paid time off to staff, where appropriate, helping to create and maintain a positive working environment for those with a disability or long-term condition in the ICB.

The ICB is also signed up to the Mindful Employer Charter to demonstrate our commitment to increasing the awareness of mental health, providing strong support networks and information and making it easier for its employees to talk about mental ill health without fear of rejection or prejudice.

Human Resources Policies

The ICB is committed to ensuring equal opportunities in employment and having appropriate HR policies in place to ensure compliance with the relevant employment law, as appropriate. The ICB has reviewed a number of HR policies during 2024/25 and introduced a new Agency Temporary Workers Policy.

The Audit and Governance Committee is responsible for approving the HR Policies and they are made available to staff on the ICB's Intranet. The ICB Board continues to demonstrate its focus and support to the importance of flexible working in accordance with the NHS People Plan, the processes for flexible working arrangements, recruitment, inductions and appraisals, and line management development.

All HR policies are developed to ensure due regard to the Equality Act 2010 duties and include an equality commitment statement which is designed to ensure that, through the implementation of these policies, no person is treated less favourably.

The ICB has signed the Dying to Work Charter which is part of the Trades Union Congress's wider Dying to Work campaign. This helps members of staff who have a terminal diagnosis to receive support, protection and guidance to continue their employment as a therapeutic activity and help maintain dignity.

The ICB has also signed up to the 'Sexual Safety in Healthcare – Organisational Charter' and committed to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce. In support of the Charter, the ICB has published a toolkit designed to support colleagues in the ICB to discuss and appropriately react to sexual safety of staff in the workplace. To sit alongside the ICB sexual safety charter the ICB has a domestic abuse pledge, which signposts colleagues to sources of support. and ensures that employees will be listened to; believed; have control; be supported; confidentiality will be respected; and helped to keep safe.

Staff Network

The ICB aims to address health inequalities and provide an inclusive working environment where everyone is treated fairly with dignity and respect. The ICB is committed to creating a more diverse and inclusive organisation, where difference is embraced and people feel able to bring their whole self to work.

The ICB has a staff Diversity and Inclusion Network (DIN), which is an open, peer-led forum to provide a safe and supportive environment in which to discuss issues relating to equality,

diversity, inclusion and the lived experiences of colleagues from under-represented groups within the ICB. It is open to colleagues from under-represented protected characteristic groups and allies; the purpose of the DIN is to work with ICB leaders in its strategic objectives to support people in Derby and Derbyshire to live their healthiest lives and help the organisation to be an inclusive and equitable employer by utilising the skills of DIN and wider ICB staff. The group is consultative and makes recommendations as appropriate. Key network initiatives have included:

- celebrating and promoting key dates in the inclusion calendar;
- raising awareness of the lived experiences of under-represented staff
- training on neurodiversity awareness; and
- informing the following standards:

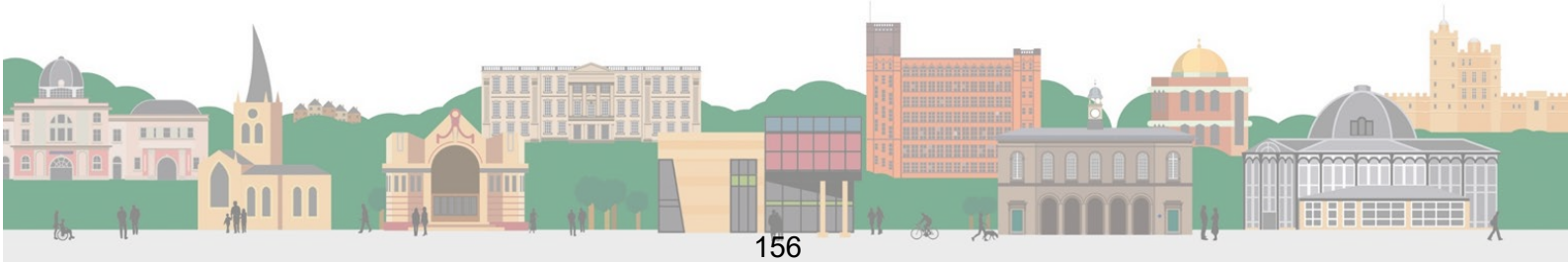
Workforce Race Equality Standard	Supporting and understanding the nature of the challenge of workforce race equality.
	Focusing on enabling people to work comfortably with race equality.
Workforce Disability Equality Standard	Enabling the ICB to better understand the experiences of their disabled staff.
	Supporting positive change for all existing employees by creating a more inclusive environment for disabled people working and seeking employment in the NHS.
Diversity and Inclusion action plans	Empowering the ICB to ensure that it is an inclusive organisation and an inclusive health service commissioner.

The ICB senior leadership team recognises the importance of the DIN and agreed to updated terms of reference that provide a clear purpose, line of accountability and clarification as to how the DIN is to be integrated into the decision-making of the ICB. This included:

- having a dedicated Chair with protected time to undertake duties (up to two days per month) to oversee and co-ordinate the running of DIN, and also attendance at the ICB Delivery Group (senior leadership team) meetings;
- having a Vice-Chair with protected time of up to half a day each month; and
- members participating in reciprocal mentoring of senior leaders within the ICB.

Staff Engagement

The ICB's weekly ‘Team Talks’ have enabled the Chief Executive Officer and Executive Directors to share key messages and updates via Microsoft Teams and also give staff the opportunity to ask questions. Staff engagement on issues that affect them at work continues to inform the ICB's approach and decision-making. There are a number of ways in which staff can offer feedback including via email, a staff Facebook page, intranet discussion, Microsoft Teams discussion groups and manager briefings.



Staff Survey

The ICB participated in the 2024 NHS Staff Survey and had a response rate of 86% (2023/24: 84%), which is in line with the average response rate for the ICB benchmark group of 78%. The purpose of the survey is to collect staff views about working in the ICB; data is used to improve local working conditions for staff, and ultimately to improve patient care. It also allows the ICB to compare the experiences of staff in similar organisations, and nationally. The survey showed good progress and improvement in 12 areas; figure 10 provides a summary of the results.

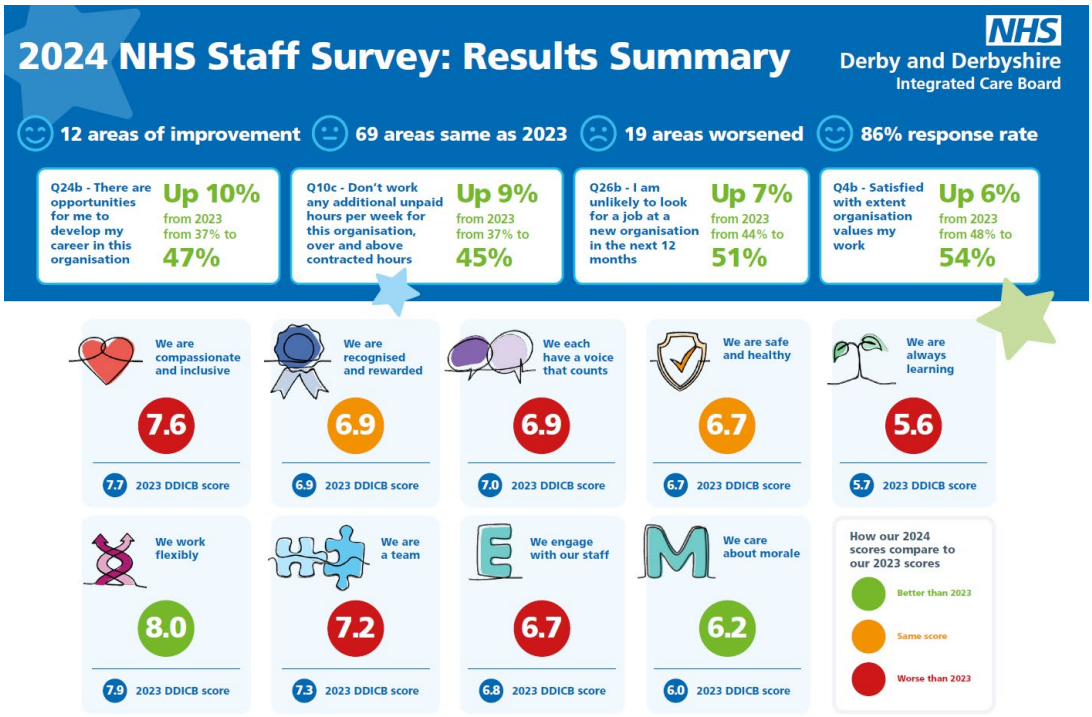


Figure 10 – 2024 NHS Derby and Derbyshire ICB Staff Survey Results

Organisation Effectiveness and Improvement Group

The purpose of the Organisation Effectiveness and Improvement Group (OEIG) is to give all staff the opportunity to contribute to and influence positive change in the ICB. It plays a vital role in helping to shape our organisational approaches, strategies and policies in different ways. OEIG has informed our approach to health and wellbeing, working differently and in helping make the ICB a better place for us all. Examples of the types of initiative that have already been instigated by OEIG are:

Organisational Development (OD) Plan	Providing feedback on the OD Plan, including NHS Staff Survey Results analysis and the development of ideas to make working for the ICB better for all.
Cardiopulmonary Resuscitation and Defibrillator Training	Introducing training on Cardiopulmonary Resuscitation and use of a defibrillator.

Hybrid Working Model	Providing feedback and making recommendations to continually improve the working environment.
Menopause Champions	Influenced the introduction of menopause champions/ambassadors.
Mental Health First Aiders	The ICB has six qualified employees.
Freedom to Speak up Ambassadors	The ICB has three employees who have undergone the National Ambassadors Office speak up training to become Freedom to Speak Up Ambassadors.

The ICB provides colleagues with support to manage health and wellbeing at work and regularly disseminates key health and wellbeing information, offers and initiatives. A dedicated intranet page sign posts staff to sources of support, including:

Virtual fitness classes and activities	A timetable of events with themes such as body weight, menopause, bereavement support and access to peer psychological support.
Employee assistance	A confidential helpline for stress or anxiety, medical information, alcohol or drug issues, provided by Health Assured.
Occupational health	Access to a number of services including management referrals, employee self-referrals, counselling and support, flu vaccinations, health and wellbeing advice, and a 24/7 confidential telephone employee assistance service.
Wellness at work resources	Resources to avoid burnout, getting more exercise, coping with anxiety, uncertainty and loneliness, and menopause awareness.
Mental Health First Aiders	An initial point of contact if colleagues, or someone they are concerned about, are experiencing a mental health issue or emotional distress.

Staff Flu Immunisation

On the 12th March 2024, the Department for Health and Social Care and Public Health England communicated detail on the National Flu Immunisation Programme for 2024/25. The ICB were to commission a service to enable frontline staff to easily access the vaccine, encourage staff to be vaccinated and monitor delivery. The ICB adopted best practice guidance and vaccinations were made available to all employees through flu clinics, including those eligible for a free flu jab under the NHS programme. Employees could also arrange their own flu jab at a private provider and claim back the expense.

As at the 31st March 2025, 37% of all ICB staff confirmed that they had received the vaccination. The benefits of the flu vaccination will continue to be promoted to staff during 2025/26 via the ICB weekly staff bulletin and Team Talk meetings, ensuring our executive and senior leaders lead the messaging. Employees will also be offered a variety of options to access a flu vaccination.

Health and Safety

Our health and safety at work responsibilities are given equal priority along with our other statutory duties and objectives. Expertise and advice is provided to the ICB by a private professional company, which is a specialist HR, employment law and health and safety team. They provide us with a health and safety policy, which is supported by a management system suite of procedures to ensure compliance with relevant legislation.

Trade Union Facility Time Reporting Requirements

The Trade Union (Facility Time Publication Requirements) Regulations 2017 requires public sector organisations to report on trade union time in their organisation. The ICB is required to publish the following information on their website by the 31st July 2025.

Relevant Union Officials

What was the total number of your employees who were relevant union officials during the relevant period?	
Number of employees who were relevant union officials during the relevant period (full-time equivalent employee number)	1.67

Table 31 – relevant Union officials

Percentage of time spent on facility time

Relevant employed union officials who spent their working hours on facility time	
Percentage of time	**Number of employees**
0%	1
1%-50%	1
51%-99%	0
100%	0

Table 32 – percentage of time spent on facility time

Percentage of pay bill spent on facility time

Total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period	
Total cost of facility time	£864.90
Total pay bill	£30,812,000
Percentage of total pay bill spent on facility time	0.0028%

Table 33 – percentage of pay bill spent on facility time

Paid Trade Union Activities

Percentage of total paid facility time hours – the amount of hours spent by employees who were relevant union officials on paid trade union activities	
Time spent on paid trade union activities as a percentage of total paid facility time hours	100%

Table 34 – paid Trade Union activities

Expenditure on consultancy

The expenditure on consultancy for year to 31st March 2025 was £nil. (2023/24: £nil). Business consultancy is used sparingly by the ICB and only for limited periods where there is demonstrable cost-effectiveness. Consultancy assignments are used where specialist skills and knowledge do not exist within the permanent staff team and are required to address urgent matters.

Off-payroll engagements

In line with HM Treasury guidance the ICB is required to disclose information about 'off-payroll engagements'. The information relating to the ICB is provided in the following tables:

Length of all highly paid off-payroll engagements

Table 35 shows all off-payroll engagements as at the 31st March 2025 and 31st March 2024 for more than £245 per day.

	31st March 2025	31st March 2024
Number of existing engagements as of the 31st March 2025	–	4
Of which, the number that have existed:		
for less than one year at the time of reporting	–	4
for between one and two years at the time of reporting	–	–
for between 2 and 3 years at the time of reporting	–	–
for between 3 and 4 years at the time of reporting	–	–
for 4 or more years at the time of reporting	–	–

Table 35 – length of off-payroll engagements as at the 31st March 2025 and 31st March 2024

New off-payroll engagements

Table 36 shows all new off-payroll engagements or those that have exceeded a six-month period, for the years to 31st March 2025 and 31st March 2024, of more than £245 per day. There were nil tax liabilities as a result of off-payroll engagements' IR35 status during the financial year:

	Number to 31st March 2025	Number to 31st March 2024
Number of new engagements during 2024/25	2	4
Of which:		
Number not subject to off-payroll legislation	2	1

	Number to 31st March 2025	Number to 31st March 2024
Number subject to off-payroll legislation and determined as in-scope of IR35[1]	–	–
Number subject to off-payroll legislation and determined as out of scope of IR35	–	3
Number of engagements reassessed for compliance or assurance purposes during the year	–	–
Number of engagements that saw a change to IR35 status following review	–	–

Table 36 – new off-payroll engagements for 2024/25 as at the 31st March 2025 and 31st March 2024

Off-payroll engagements/senior official engagements

Table 37 shows any off-payroll engagements of Board members and/or senior officials with significant financial responsibility, during the years to the 31st March 2025 and 31st March 2024. There were nil off-payroll engagements of Board members during the financial year:

	Number to 31st March 2025	Number to 31st March 2024
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the reporting period[2]	–	–
Total number of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements	19	21

Table 37 – off-payroll engagements/senior official engagements as at the 31st March 2025 and 31st March 2024

Exit packages, including special (non-contractual) payments (subject to audit)

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

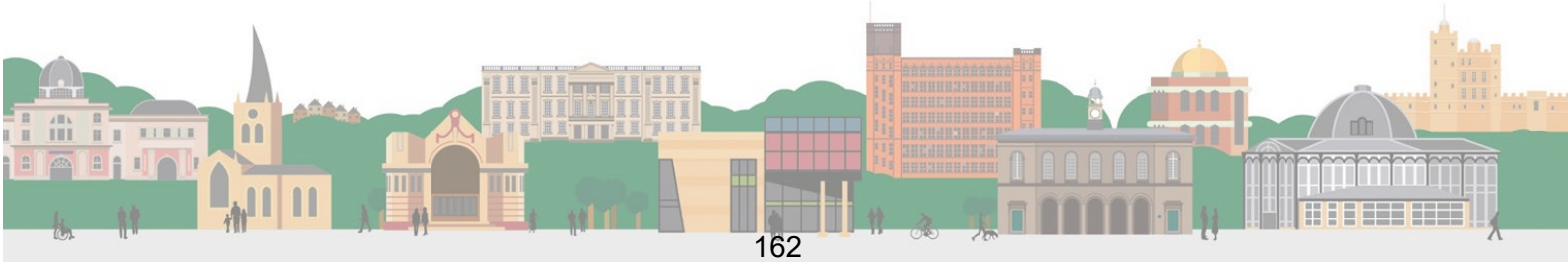
Where entities have agreed early retirements, the additional costs are met by NHS Entities, and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

[1] A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the department must undertake an assessment to determine whether that worker is in scope of intermediaries' legislation (IR35) or put off scope for tax purposes.
[2] There should only be a very small number of off-payroll engagements of Board members and/or senior officials with significant financial responsibility, permitted only in exceptional circumstances and for no more than six months.

Termination packages totalling £174k (2023/24: £nil) were agreed for four (2023/24: nil) members of staff during the year.

During the year to 31st March 2024, the ICB consulted on a staffing restructure. A provision of the termination benefits was included as at 31st March 2024, and has been utilised against the termination benefits paid during the financial year to 31st March 2025. This is detailed within the notes to the Annual Accounts.

Dr Chris Clayton
Accountable Officer
NHS Derby and Derbyshire ICB
19th June 2025



Parliamentary Accountability and Audit Report

NHS Derby and Derbyshire ICB is not required to produce a Parliamentary Accountability and Audit Report. As such the regularity of expenditure, further Parliamentary accountability disclosures and the Certificate and Report of the Controller and Auditor General to the House of Commons are not applicable to the ICB.

Disclosures on remote contingent liabilities, losses and special payments, gifts, fees and charges are included as notes in the Financial Statements of this report. An Audit Certificate and report is also included after the Financial Statements.

ICB Complaints

The ICB received 53 formal complaints in regard to its statutory functions during 2024/25. In addition, three referrals were made to the Parliamentary and Health Service Ombudsman/ Local Government and Social Care Ombudsman. All referred cases related to complaints received in 2023/24 and were closed following an initial review by the Parliamentary and Health Service Ombudsman, with no further action required.

Cost allocation and setting of charges (subject to audit)

NHS Derby and Derbyshire Integrated Care Board certifies that it has complied with the HM Treasury guidance on cost allocation and the setting of charges. Table 38 provides details of income generation activities whose full cost exceeded £1 million or was otherwise material (responsibility for the commissioning of Pharmaceutical and Dental services was delegated to the Integrated Care Board from NHSE on the 1st April 2023).

Activity	Accounts Note	2024/25		
		Income	Full Cost	Surplus/ (Deficit)
		£'000	£'000	£'000
Dental fees and charges	2 & 5	17,558	70,759	(53,201)
Prescription fees and charges	2 & 5	13,147	229,602	(216,455)
Total Fees and Charges		**30,705**	**300,361**	**(269,656)**

Table 38 – fees and charges for Pharmaceutical and Dental services

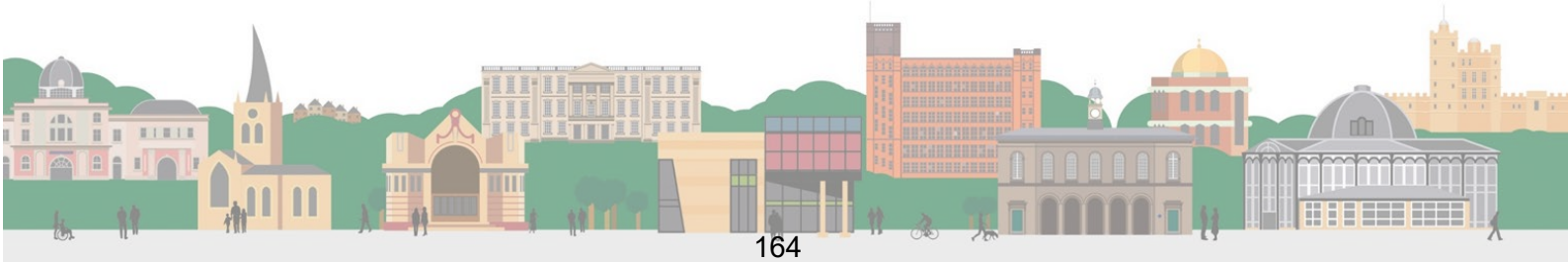
FINANCIAL STATEMENTS

Dr Chris Clayton

Accountable Officer

NHS Derby and Derbyshire ICB

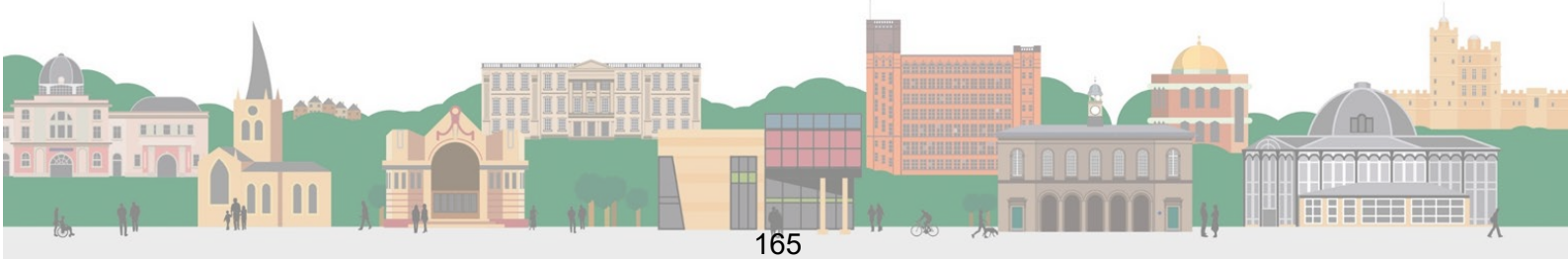
19th June 2025



Foreword to the accounts

Integrated Care Boards were legally established on the 1st July 2022, replacing Clinical Commissioning Groups and taking on the NHS planning and commissioning responsibilities previously held by Clinical Commissioning Groups, as well as absorbing some planning and commissioning functions from NHSE.

This year's 2024/25 accounts (1st April 2024 to 31st March 2025) report a full 12-month reporting cycle and the prior year's comparators for 2023/24 (1st April 2023 to 31st March 2024).



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The Primary Statements:

Statement of Comprehensive Net Expenditure for the year ended 31 March 2025

	Note	2024-25 £'000	2023-24 £'000
Income from sale of goods and services	2	(36,065)	(36,614)
Other operating income	2	(29)	(137)
Total operating income		**(36,094)**	**(36,751)**
Staff costs	4	31,724	28,595
Purchase of goods and services	5	2,919,697	2,482,895
Depreciation and impairment charges	5	483	456
Provision expense	5	(75)	(1,415)
Other operating expenditure	5	494	857
Total operating expenditure		**2,952,323**	**2,511,388**
Net Operating Expenditure		**2,916,229**	**2,474,637**
Finance expense	8	20	18
Other Gains & Losses	7	-	(1)
Net expenditure for the Year		**2,916,249**	**2,474,654**
Total Net Expenditure for the Financial Year		**2,916,249**	**2,474,654**
Other Comprehensive Expenditure			
Comprehensive Expenditure for the year		**2,916,249**	**2,474,654**

The notes on pages 171 to 198 form part of this statement.

Statement of Financial Position as at 31 March 2025

	Note	2024-25 £'000	2023-24 £'000
Non-current assets:			
Property, plant and equipment	9	347	321
Right-of-use assets	10	175	262
Total non-current assets		**522**	583
Current assets:			
Trade and other receivables	11	18,248	18,471
Cash and cash equivalents	12	214	279
Total current assets		**18,462**	**18,750**
Total assets		**18,984**	**19,333**
Current liabilities			
Trade and other payables	13	(137,803)	(119,778)
Lease liabilities	10.2	(87)	(270)
Provisions	14	(514)	(1,372)
Total current liabilities		**(138,404)**	(121,420)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(119,420)**	(102,087)
Non-current liabilities			
Lease liabilities	10.2	(91)	-
Provisions	14	(286)	(351)
Total non-current liabilities		**(377)**	**(351)**
Assets less Liabilities		**(119,797)**	(102,438)
Financed by Taxpayers' Equity			
General fund		(119,797)	(102,438)
Total taxpayers' equity:		**(119,797)**	(102,438)

The notes on pages 171 to 198 form part of this statement

The financial statements on pages 171 to 198 were approved by the Audit & Governance Committee (as delegated by the Board of the ICB), on 19 June 2025 and signed on its behalf by:

Chief Executive Officer
Dr Chris Clayton

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2025

	General fund £'000
Changes in taxpayers' equity for 2024-25	
Balance at 01 April 2024	(102,438)
Adjusted NHS Integrated Care Board balance at 31 March 2024	**(102,438)**
Changes in NHS Integrated Care Board taxpayers' equity for 2024-25	
Net operating expenditure for the financial year	(2,916,249)
Net Recognised NHS Integrated Care Board Expenditure for the Financial year	**(2,916,249)**
Net funding	2,898,890
Balance at 31 March 2025	**(119,797)**

	General fund £'000
Changes in taxpayers' equity for 2023-24	
Balance at 01 April 2023	(115,061)
Adjusted NHS Integrated Care Board balance at 31 March 2024	**(115,061)**
Changes in NHS Integrated Care Board taxpayers' equity for 2023-24	
Net operating costs for the financial year	(2,474,654)
Net Recognised NHS Integrated Care Board Expenditure for the Financial Year	**(2,474,654)**
Net funding	2,487,277
Balance at 31 March 2024	**(102,438)**

The notes on pages 171 to 198 form part of this statement

Statement of Cash Flows for the year ended 31 March 2025

	Note	**2024-25 £'000**	2023-24 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(2,916,249)	(2,474,654)
Depreciation and amortisation	5	483	456
Lease adjustments	10	-	9
Interest paid / received	12	12	10
Other Gains & Losses		-	(1)
Finance Costs	5	(7)	(24)
Unwinding of Discounts	8	8	8
(Increase)/decrease in trade & other receivables	11	223	(10,929)
Increase/(decrease) in trade & other payables	13	18,025	(77)
Provisions utilised	14	(856)	(335)
Increase/(decrease) in provisions	14	(68)	(1,056)
Net Cash Inflow (Outflow) from Operating Activities		**(2,898,429)**	(2,486,593)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment	9	(160)	(248)
Net Cash Inflow (Outflow) from Investing Activities		**(160)**	(248)
Net Cash Inflow (Outflow) before Financing		**(2,898,589)**	(2,486,841)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		2,898,890	2,487,277
Repayment of lease liabilities	10	(366)	(377)
Net Cash Inflow (Outflow) from Financing Activities		**2,898,525**	2,486,900
Net Increase (Decrease) in Cash & Cash Equivalents	12	**(65)**	59
Cash & Cash Equivalents at the Beginning of the Financial Year		**279**	220
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**214**	**279**

The notes on pages 171 to 198 form part of this statement

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of Integrated Care Boards (ICBs) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2023-24 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board (FRAB). Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Integrated Care Board the purpose of giving a true and fair view has been selected. The particular policies adopted by the Integrated Care Board are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

On 13 March 2025 the government announced NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated. If services will continue to be provided in the public sector the financial statements should be prepared on the going concern basis. The statement of financial position has therefore been drawn up at 31 March 2025, on a going concern basis.

1.2 **Accounting Convention**

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 **Movement of Assets within the Department of Health and Social Care Group**

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 **Joint arrangements**

Joint operations are arrangements in which the Integrated Care Board has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The Integrated Care Board includes within its financial statements its share of the assets, liabilities, income and expenses.

The Integrated Care Board's participation in Section 75 agreements (see note 1.5) are joint arrangements.

Joint ventures are arrangements in which the Integrated Care Board has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.

1.5 **Pooled Budgets**

The Integrated Care Board has entered into a pooled budget arrangement for better care with Derbyshire County Council; and separately with Derby City Council (both arrangements are in accordance with section 75 of the NHS Act 2006). Under the arrangements, the two funds are separately pooled for the Derbyshire County "Better Care Fund", and Derby City "Better Care Fund", respectively. The Better Care funds aim to improve the provision of health and social care, with the overarching objective to support the integration of health and social care and align commissioning, as agreed between the partners.

Additionally the Integrated Care Board is a partner of the "Children and Young People with Complex Needs" pooled budget with Derbyshire County Council. Under the arrangement, funds are pooled for children with a range of health and special educational needs that cannot collectively be addressed by local or ordinary services.

The Integrated Care Board is also in a pooled arrangement with Derby City Council for the "Integrated Disabled Children's Centre and Services in Derby". This arrangement provides funds for the purchase and supply of equipment and technological aids for disabled children in Derby.

The Derbyshire County "Better Care Fund" and "Children and Young People with Complex Needs" pools are both hosted by Derbyshire County Council.

The Derby City "Better Care Fund" and "Integrated Disabled Children's Centre and Services in Derby" pools are both hosted by Derby City Council.

The Integrated Care Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budgets, identified in accordance with the pooled budget agreements.

1.6 **Operating Segments**

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the Integrated Care Board.

Notes to the financial statements

1.7 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

• As per paragraph 121 of the Standard, the Integrated Care Board will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The Integrated Care Board is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date,

• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the Integrated Care Board to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the Integrated Care Board is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred. Payment terms are standard reflecting cross government principles. There are no significant terms.

The value of the benefit received when the Integrated Care Board accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.8 **Employee Benefits**

1.8.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.8.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Integrated Care Board commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.9 **Other Expenses**

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.10 **Grants Payable**

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the Integrated Care Board recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.11 **Property, Plant & Equipment**

1.11.1 **Recognition**

Property, plant and equipment is capitalised if:

· It is held for use in delivering services or for administrative purposes;
· It is probable that future economic benefits will flow to, or service potential will be supplied to the Integrated Care Board;
· It is expected to be used for more than one financial year;
· The cost of the item can be measured reliably; and,
· The item has a cost of at least £5,000; or,
· Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
· Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Notes to the financial statements

1.11.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

· Land and non-specialised buildings – market value for existing use; and,

· Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.11.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.11.4 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Integrated Care Board expects to obtain economic benefits or service potential from the asset. This is specific to the Integrated Care Board and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the Integrated Care Board checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.12 **Leases**

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.

The Integrated Care Board assesses whether a contract is or contains a lease, at inception of the contract.

1.12.1 **The Integrated Care Board as Lessee**

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The HM Treasury incremental borrowing rate of 3.51% is applied for leases commencing, transitioning or being remeasured in the 2023 calendar year; and 4.81% to new leases commencing in 2025 under IFRS 16.

Lease payments included in the measurement of the lease liability comprise:

- Fixed payments;
- Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
- The amount expected to be payable under residual value guarantees;
- The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
- Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.

Notes to the financial statements

Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.

The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.

The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.

The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.
Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.

Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.

Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.

For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.

Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.13 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Integrated Care Board's cash management.

1.14 **Provisions**

Provisions are recognised when the Integrated Care Board has a present legal or constructive obligation as a result of a past event, it is probable that the Integrated Care Board will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

• A nominal short-term rate of 4.03% (2023-24: 4.26%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 4.07% (2023-24: 4.03%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

• A nominal long-term rate of 4.81% (2023-24: 4.72%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.

• A nominal very long-term rate of 4.55% (2023-24: 4.40%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Integrated Care Board has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.15 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the Integrated Care Board pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with Integrated Care Board.

Notes to the financial statements

1.16 **Non-clinical Risk Pooling**

The Integrated Care Board participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Integrated Care Board pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.17 **Contingent liabilities and contingent assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Integrated Care Board, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Integrated Care Board. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.18 **Financial Assets**

Financial assets are recognised when the Integrated Care Board becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

· Financial assets at amortised cost;
· Financial assets at fair value through other comprehensive income and ;
· Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.18.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.18.2 **Financial assets at fair value through other comprehensive income**

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Integrated Care Board elected to measure an equity instrument in this category on initial recognition.

1.18.3 **Financial assets at fair value through profit and loss**

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

1.18.4 **Impairment of financial assets**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets or assets measured at fair value through other comprehensive income, the Integrated Care Board recognises a loss allowance representing the expected credit losses on the financial asset.

The Integrated Care Board adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The Integrated Care Board therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the Integrated Care Board does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

Notes to the financial statements

1.19 **Financial Liabilities**
Financial liabilities are recognised on the statement of financial position when the Integrated Care Board becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.19.1 **Financial Liabilities at Fair Value Through Profit and Loss**
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Integrated Care Board's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

The Integrated Care Board does not have any financial liabilities at fair value through profit and loss.

1.19.2 **Other Financial Liabilities**
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.20 **Value Added Tax**
Most of the activities of the Integrated Care Board are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.21 **Losses & Special Payments**
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Integrated Care Board not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.22 **Critical accounting judgements and key sources of estimation uncertainty**
In the application of the Integrated Care Board's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.22.1 **Critical accounting judgements in applying accounting policies**
The following are the judgements, apart from those involving estimations, that management has made in the process of applying the Integrated Care Board's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

- The Integrated Care Board has assessed the pooled element of the Better Care Fund as being a lead commissioning arrangement under IFRS 11: Joint Arrangements. The Integrated Care Board will report balances with the lead commissioner (local authority) only and not the providers with which the local authority contracts.

1.22.2 **Sources of estimation uncertainty**
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

- Prescription costs are material in value. Financial data for prescribing is available two months in arears, therefore the Integrated Care Board estimates two months of costs at each period end. There are a number of factors considered when estimating the costs including: historic; seasonal; price-related or volume related. Estimating the two months of costs in this way, recognises there is a risk and level of uncertainty involved.

1.23 **Gifts**
Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.24 **New and revised IFRS Standards in issue but not yet effective**
● IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. Standard is not yet adopted by the FReM which is expected to be April 2025: early adoption is not therefore permitted. The Integrated Care Board does not have insurance contracts therefore no impact is expected from the implementation of this standard.

● IFRS 18 Presentation and Disclosure in Financial Statements - Issued in April 2024 and applies to periods beginning on or after 1 January 2027. The standard has not yet been adopted by FRAB for inclusion within the FREM and therefore it is not yet possible to confirm how this will impact on our accounts in the future.

2 Other Operating Revenue

	2024-25 Total	2023-24 Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Non-patient care services to other bodies	**3,393**	5,753
Prescription fees and charges	**13,147**	12,606
Dental fees and charges	**17,558**	16,231
Other Contract income	**1,727**	1,989
Recoveries in respect of employee benefits	**240**	35
Total Income from sale of goods and services	**36,065**	**36,614**
Other operating income		
Non cash apprenticeship training grants revenue	**29**	39
Other non contract revenue	**-**	98
Total Other operating income	**29**	**137**
Total Operating Income	**36,094**	**36,751**

3.1 Disaggregation of Income - Income from sale of good and services (contracts)

	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000
Source of Revenue					
NHS	1,265	-	-	-	234
Non NHS	2,128	13,147	17,558	1,727	6
Total	**3,393**	**13,147**	**17,558**	**1,727**	**240**

	Non-patient care services to other bodies	Prescription fees and charges	Dental fees and charges	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000
Timing of Revenue					
Point in time	-	-	-	-	-
Over time	3,393	13,147	17,558	1,727	240
Total	**3,393**	**13,147**	**17,558**	**1,727**	**240**

3.2 Transaction price to remaining contract performance obligations

NHS Derby and Derbyshire Integrated Care Board had no contract revenue expected to be recognised in a future period, relating to contract performance obligations not yet completed at the reporting date (2023/24 £nil).

4. Employee benefits and staff numbers

4.1.1 Employee benefits 2024-25

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	23,155	672	**23,827**
Social security costs	2,551	-	**2,551**
Employer Contributions to NHS Pension scheme	5,244	-	**5,244**
Other pension costs	2	-	**2**
Apprenticeship Levy	100	-	**100**
Gross employee benefits expenditure	**31,052**	**672**	**31,724**
Less recoveries in respect of employee benefits (note 4.1.2)	(240)	-	**(240)**
Net employee benefits excluding capitalised costs	**30,812**	**672**	**31,484**

4.1.1 Employee benefits 2023-24

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	20,429	1,260	**21,689**
Social security costs	2,266	47	**2,313**
Employer Contributions to NHS Pension scheme	4,105	56	**4,161**
Other pension costs	4	-	**4**
Apprenticeship Levy	93	-	**93**
Termination benefits	335	-	**335**
Gross employee benefits expenditure	27,232	1,363	**28,595**
Less recoveries in respect of employee benefits (note 4.1.2)	(35)	-	**(35)**
Net employee benefits excluding capitalised costs	**27,197**	**1,363**	**28,560**

4.1.2 Recoveries in respect of employee benefits

	2024-25			2023-24
	Permanent Employees £'000	Other £'000	Total £'000	Total £'000
Employee Benefits - Revenue				
Salaries and wages	(191)	-	(191)	(28)
Social security costs	(22)	-	(22)	(3)
Employer contributions to the NHS Pension Scheme	(27)	-	(27)	(4)
Total recoveries in respect of employee benefits	**(240)**	**-**	**(240)**	**(35)**

4.2 Average number of people employed

	2024-25			2023-24		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**457**	**8**	**465**	**451**	**24**	**475**

Nil staff were engaged on capital projects (2023-24 nil staff).

4.3 Exit packages agreed in the financial year

	2024-25 Compulsory redundancies		2024-25 Other agreed departures		2024-25 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	3	123,012	-	-	3	123,012
£50,001 to £100,000	1	51,429	-	-	1	51,429
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**4**	**174,441**	**-**	**-**	**4**	**174,441**

There were no exit packages or agreed departures during the 2023-24 year.

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures was recognised in full in the previous financial year.

Redundancy costs have been paid in accordance with the standard NHS Agenda for Change terms and conditions following organisational restructure.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

4.4 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.

An outline of these follows:

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

4.5.3 Defined contribution workplace pension scheme

As an alternative to the NHS Pension Scheme the Integrated Care Board offers employees the option of the National Employment Savings Scheme (NEST).

5 employees were in the NEST scheme during 2024-25 with employer costs totalling £2k.

5. Operating expenses

	2024-25 Total £'000	2023-24 Total £'000
Purchase of goods and services		
Services from other ICBs and NHS England	10,218	11,450
Services from foundation trusts	1,727,336	1,439,674
Services from other NHS trusts	205,139	147,833
Services from Other WGA bodies	1	-
Purchase of healthcare from non-NHS bodies	345,809	299,932
Purchase of social care	64,073	55,220
General Dental services and personal dental services	70,759	57,507
Prescribing costs	191,267	188,216
Pharmaceutical services	38,336	36,156
General Ophthalmic services	11,551	10,908
GPMS/APMS and PCTMS	236,467	222,192
Supplies and services – clinical	44	44
Supplies and services – general	8,512	4,993
Consultancy services	-	-
Establishment	4,323	3,553
Transport	14	10
Premises	4,168	3,639
Audit fees	180	180
Other non statutory audit expenditure		
· Other services	18	18
Other professional fees	1,001	800
Legal fees	283	350
Education, training and conferences	169	181
Non cash apprenticeship training grants	29	39
Total Purchase of goods and services	**2,919,697**	**2,482,895**
Depreciation and impairment charges		
Depreciation	483	456
Total Depreciation and impairment charges	**483**	**456**
Provision expense		
Change in discount rate	(7)	(24)
Provisions	(68)	(1,391)
Total Provision expense	**(75)**	**(1,415)**
Other Operating Expenditure		
Chair and Non Executive Members	128	141
Grants to Other bodies	-	587
Expected credit loss on receivables	(13)	9
Other expenditure	379	120
Total Other Operating Expenditure	**494**	**857**
Total operating expenditure	**2,920,599**	**2,482,793**

Internal Audit services are provided by 360 Assurance (hosted by University Hospitals of Derby and Burton NHS Foundation Trust) and the associated expenditure is included within "Other Professional Fees".

The audit fees relating to the statutory external audit were estimated at £180,000 including VAT for 2024-25. The final fees for 2024-25, provided by KPMG LLP (UK), are £204,000 including VAT (£180,000 including VAT for 2023-24).

6 Payment Compliance Reporting

6.1 Better Payment Practice Code

Measure of compliance	2024-25 Number	2024-25 £'000	2023-24 Number	2023-24 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	59,478	429,266	51,761	383,830
Total Non-NHS Trade Invoices paid within target	57,699	420,168	50,058	372,705
Percentage of Non-NHS Trade invoices paid within target	**97.01%**	**97.88%**	**96.71%**	**97.10%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	4,082	1,948,884	3,947	1,605,712
Total NHS Trade Invoices Paid within target	4,070	1,948,477	3,937	1,605,510
Percentage of NHS Trade Invoices paid within target	**99.71%**	**99.98%**	**99.75%**	**99.99%**

The Better Payment Practice Code requires the Integrated Care Board to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The target is 95% across all indicators, which has been

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

The Integrated Care Board incurred £nil charges relating to claims made under this legislation (2023-24 £nil).

7. Other gains and losses

	2024-25 £'000	2023-24 £'000
Gain/(loss) on disposal of property, plant and equipment assets other than by sale	-	(1)
Total	**-**	**(1)**

8 Finance costs

	2024-25 £'000	2023-24 £'000
Interest		
Interest on lease liabilities	12	10
Total interest	**12**	**10**
Provisions: unwinding of discount	8	8
Total finance costs	**20**	**18**

9 Property, plant and equipment

2024-25	**Information technology £'000**
Cost or valuation at 01 April 2024	927
Addition of assets under construction and payments on account	
Additions purchased	160
Cost/Valuation at 31 March 2025	**1,087**
Depreciation 01 April 2024	606
Charged during the year	134
Depreciation at 31 March 2025	**740**
Net Book Value at 31 March 2025	**347**
Purchased	347
Total at 31 March 2025	**347**

The information technology equipment, comprising of laptops and associated equipment, is depreciated on a straight line basis over a useful economic life of 3 years.

10 Leases

10.1 Right-of-use assets

2024-25	Buildings excluding dwellings £'000	For local accounts use Of which: leased from DHSC group bodies £000
Cost or valuation at 01 April 2024	798	391
Additions	262	-
Disposals on expiry of lease term	(409)	-
Cost/Valuation at 31 March 2025	**651**	**391**
Depreciation 01 April 2024	536	254
Charged during the year	349	137
Disposals on expiry of lease term	(409)	0
Depreciation at 31 March 2025	**476**	**391**
Net Book Value at 31 March 2025	**175**	**-**

NBV by counterparty	
Leased from other group bodies	175
Net Book Value at 31 March 2025	**175**

NHS Derby and Derbyshire Integrated Care Board held a lease with Cardinal Square LLP, located in Derby and used as office premises which expired on 31 March 2025.

Office space is leased from NHS Property Services Ltd at Scarsdale, Chesterfield. Whilst no formal lease contract is in place, the transaction met the definition of a right-of-use asset during 2024-25.The current lease accounting expired on 31 March 2025. The Integrate Care Board continue to use the Scarsdale building into 2025-26 but without a lease arrangement and have not recognised an ongoing lease or liability for this site in the 2024-25 accounts.

The Integrated Care Board leases part of the Council Building from Derby City Council. This is the only lease reflected in the table above as at 31 March 2025.

10 Leases cont'd

10.2 Lease liabilities

2024-25	**2024-25 £'000**	2023-24 £'000
Lease liabilities at 01 April 2024	(270)	(815)
Additions	(262)	-
Interest expense relating to lease liabilities	(12)	(10)
Repayment of lease liabilities (including interest)	366	377
Lease remeasurement	-	9
Derecognition for early terminations	-	169
Lease liabilities at 31 March 2025	**(178)**	**(270)**

10.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2024-25 £'000	**Of which: leased from DHSC group bodies £000**	2023-24 £'000	Of which: leased from DHSC group bodies £000
Within one year	(93)	-	(273)	(131)
Between one and five years	(93)	-	-	-
Balance at 31 March 2025	**(186)**	**-**	**(273)**	**(131)**
Balance by counterparty				
Leased from Non-Departmental Public Bodies		-		(131)
Leased from other bodies		(186)		(142)
Balance as at end of year		**(186)**		**(273)**

10.4 Amounts recognised in Statement of Comprehensive Net Expenditure

2024-25	**2024-25 £'000**	2023-24 £'000
Depreciation expense on right-of-use assets	349	374
Interest expense on lease liabilities	12	10

10.5 Amounts recognised in Statement of Cash Flows

	2024-25 £'000	2023-24 £'000
Total cash outflow on leases under IFRS 16	366	377

11.1 Trade and other receivables	**Current 2024-25 £'000**	Current 2023-24 £'000
NHS receivables: Revenue	2,377	1,862
NHS prepayments	53	56
NHS accrued income	5,206	62
NHS Contract Receivable not yet invoiced/non-invoice	-	730
Non-NHS and Other WGA receivables: Revenue	4,795	2,588
Non-NHS and Other WGA prepayments	1,743	1,833
Non-NHS and Other WGA accrued income	515	899
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	3,087	9,944
Expected credit loss allowance-receivables	(3)	(15)
VAT	469	498
Other receivables and accruals	6	14
Total Trade & other receivables	**18,248**	**18,471**
Total current and non current	**18,248**	**18,471**

There are no prepaid pension contributions included in note 12.1 (31 March 2024, £nil).

11.2 Receivables past their due date but not impaired

	2024-25 DHSC Group Bodies £'000	**2024-25 Non DHSC Group Bodies £'000**	2023-24 DHSC Group Bodies £'000	2023-24 Non DHSC Group Bodies £'000
By up to three months	26	541	468	732
By three to six months	17	422	37	378
By more than six months	20	596	3	33
Total	**63**	**1,559**	**508**	**1,143**

11.3 Loss allowance on asset classes	**Trade and other receivables - Non DHSC Group Bodies £'000**
Balance at 01 April 2024	**(15)**
Lifetime expected credit losses on trade and other receivables-Stage 2	12
Total	**(3)**

(A stage 2 adjustment is for the provision of a credit loss where the debt has the potential to become a bad debt).

12 Cash and cash equivalents

	2024-25	2023-24
	£'000	£'000
Balance at 01 April 2024	279	220
Net change in year	(65)	59
Balance at 31 March 2025	**214**	**279**
Made up of:		
Cash with the Government Banking Service	214	279
Cash and cash equivalents as in statement of financial position at 31 March	**214**	**279**

The Integrated Care Board does not hold patients monies.

13 Trade and other payables	**Current 31 March 2025**	Current 31-March-2024
	£'000	£'000
NHS payables: Revenue	571	1,707
NHS accruals	32,194	20,669
Non-NHS and Other WGA payables: Revenue	9,111	3,968
Non-NHS and Other WGA accruals	77,469	73,516
Social security costs	318	293
Tax	326	259
Other payables and accruals	17,814	19,366
Total Trade & Other Payables	**137,803**	**119,778**
Total current and non-current	**137,803**	**119,778**

The Integrated Care Board does not have any liabilities included above for arrangements to buy out the liability for

Other payables include £2.29m outstanding pension contributions at 31 March 2025 (at 31 March 2024, £1.78m).

14 Provisions

	Current 2024-25 £'000	**Non-current 2024-25 £'000**	Current 2023-24 £'000	Non-current 2023-24 £'000
Redundancy	-	-	335	-
Continuing care	395	-	560	-
Other	119	286	477	351
Total	**514**	**286**	**1,372**	**351**
Total current and non-current	**800**		**1,723**	

	Redundancy £'000	**Continuing Care £'000**	**Other £'000**	**Total £'000**
Balance at 01 April 2024	**335**	**560**	**828**	**1,723**
Arising during the year	-	266	-	**266**
Utilised during the year	(174)	(431)	(251)	**(856)**
Reversed unused	(161)	-	(173)	**(334)**
Unwinding of discount	-	-	8	**8**
Change in discount rate	-	-	(7)	**(7)**
Transfer (to) from other public sector body	-	-	-	**-**
Transfer (to) from other public sector body under absorption	-	-	-	**-**
Balance at 31 March 2025	**-**	**395**	**405**	**800**
Expected timing of cash flows:				
Within one year	-	395	119	**514**
Between one and five years	-	-	286	**286**
After five years	-	-	-	**-**
Balance at 31 March 2025	**-**	**395**	**405**	**800**

Following it's formation, the Integrated Care Board has continued to review it's staff structures to improve it's economy and efficiency. This restructure resulted in some staff being placed at risk and a provision was recognised in 2023-24 of £335k. The organisation completed its staff structures during the financial year 2024-25. Redundancy payments totalling £174k were made during the year and the balance of the provision (£161k) has been released unused as certain staff previously identified were redeployed. The payment costs have been reported on note 4.3 of the accounts as "exit packages".

The continuing healthcare retrospective claims were partially utilised during the year with £431k being used. Aditional provisions of £266k have been identified and recognised leaving a balance of £395k.

The Integrated Care Board has "other" provisions, including that for the Cardinal Square and Scarsdale offices in Derby and Chesterfield respectively, known as 'dilapidation cost provision' (The opening discounted provision value was £0.47m) to cover the cost of putting the offices back to an expected condition, when the leases are terminated. The revised closing discounted provision value was £0.37m at the end of 2024-25. As the timing of these costs span greater than one year, the costs are discounted for inflation, resulting in a credit of £7k (included in note 5 operating cost statement) and the discount factor for the most recent year being unwound, resulting in a finance cost of £8k reported in note 8 Finance costs).

Legal claims are calculated from the number of claims currently lodged with NHS Resolution and the probabilities provided by them. There were no claims identified by NHS resolution as at 31 March 2025 (nil claims, 31 March 2024).

15 Contingencies

The Integrated Care Board recognised contingent liabilities of £47k at 31 March 2025 relating to employment tribunal claims (nil at 31 March 2024).

16 Commitments

16.1 Capital commitments

The Integrated Care Board does not have any capital commitments as at 31 March 2025 (nil at 31 March 2024).

17 Financial instruments

17.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS Derby and Derbyshire Integrated Care Board is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Derby and Derbyshire Integrated Care Board has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Derby and Derbyshire Integrated Care Board in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS Derby and Derbyshire Integrated Care Board standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS Derby and Derbyshire Integrated Care Board and internal auditors.

17.1.1 Currency risk

The NHS Derby and Derbyshire Integrated Care Board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS Derby and Derbyshire Integrated Care Board has no overseas operations and therefore has low exposure to currency rate fluctuations.

17.1.2 Interest rate risk

The NHS Derby and Derbyshire Integrated Care Board borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The NHS Derby and Derbyshire Integrated Care Board therefore has low exposure to interest rate fluctuations.

17.1.3 Credit risk

Because the majority of the NHS Derby and Derbyshire Integrated Care Board revenue comes parliamentary funding, NHS integrated care board has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

17.1.4 Liquidity risk

NHS Derby and Derbyshire Integrated Care Board is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS Derby and Derbyshire Integrated Care Board draws down cash to cover expenditure, as the need arises. The NHS Derby and Derbyshire Integrated Care Board is not, therefore, exposed to significant liquidity risks.

17.1.5 Financial Instruments

As the cash requirements of NHS Derby and Derbyshire Integrated Care Board are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS Derby and Derbyshire Integrated Care Board expected purchase and usage requirements and NHS Derby and Derbyshire Integrated Care Board is therefore exposed to little credit, liquidity or market risk.

17 Financial instruments cont'd

17.2 Financial assets

	Financial Assets measured at amortised cost 2024-25 £'000	Financial Assets measured at amortised cost 2023-24 £'000
Trade and other receivables with NHSE bodies	2,433	1,447
Trade and other receivables with other DHSC group bodies	5,149	2,055
Trade and other receivables with external bodies	8,403	12,597
Other financial assets	-	-
Cash and cash equivalents	214	279
Total at 31 March 2025	**16,199**	**16,378**

17.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2024-25 £'000	Financial Liabilities measured at amortised cost 2023-24 **£'000**
Loans with group bodies	-	**-**
Loans with external bodies	-	**-**
Trade and other payables with NHSE bodies	553	**987**
Trade and other payables with other DHSC group bodies	32,245	**21,461**
Trade and other payables with external bodies	104,360	**97,048**
Other financial liabilities	-	**-**
Private Finance Initiative and finance lease obligations	179	**-**
Total at 31 March 2025	**137,337**	**119,496**

18 Operating segments

The Integrated Care Board has one operating segment, the commissioning of healthcare services.

19 Joint arrangements - interests in joint operations

The "Better Care Funds", "Children and Young People with Complex Needs" and "Integrated Disabled Children's Centre and Services in Derby", are pooled individually under the Section 75 arrangements of the NHS Act 2006. The total of the Integrated Care Board's share of all pooled budgets are as follows:

	2024-25	2023-24
	£'000	£'000
Income	(111,564)	(101,002)
Expenditure	111,250	101,467
	(314)	465

Better Care Fund (BCF)
The Integrated Care Board has two BCFs: The Derbyshire County BCF; and the Derby City BCF, which both became operational in 2015.

NHS Derby and Derbyshire Integrated Care Board is a partner to the Derbyshire County BCF, along with Derbyshire County Council. NHS Tameside and Glossop Clinical Commissioning Group were part of this arrangement until 30 June 2022 when the Glossop healthcare responsibilities were transferred to NHS Derby and Derbyshire Integrated Care Board. NHS Derby and Derbyshire Integrated Care Board is also a partner to the Derby City BCF, along with Derby City Council. The operation of the pools is ultimately managed by the Derbyshire Health and Wellbeing Board represented by members from each of the partners. The Funds operate as Section 75 pooled budgets.

Total annual agreed contributions to the Derbyshire County BCF Pool are £134,962k including iBCF funding (£102,966k excluding iBCF). Total annual agreed contributions to the Derby City BCF Pool are £42,705k, including iBCF funding (£31,843k excluding iBCF).

The BCF aims to improve the provision of health and social care. All partners contribute to a pooled fund and the overarching objective of the fund is to support the integration of health and social care and align commissioning as agreed between the partners.

In April 2017 the Improved Better Care Fund (iBCF) commenced. This is a direct grant to local government, with a condition that it is pooled into the local BCF plan. In the 2023-24 Derbyshire County Council received an additional £8,349k; and Derby City Council an additional £2,121k, of discharge funding direct from the Government with the aim of:

- Meeting adult social care needs
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready
- Ensuring that the local social care provider market is supported

Under the agreements, the two BCF pools are each split into 2 areas:
- Contributions to a pooled fund by all partners and commissioned by the local authority who are host and lead
- Commissioning of existing funded schemes directly by each partner

19 Joint arrangements - interests in joint operations, continued

The memorandum account for the "Derbyshire County Better Care Fund" pooled budget is:

	2024-25 £'000	**2024-25 Pool Share %**	2023-24 £'000	2023-24 Pool Share %
Income				
NHS Derby & Derbyshire ICB	(81,362)	60.04	(74,689)	59.85
Derbyshire County Council	(54,160)	39.96	(50,104)	40.15
Total Income	**(135,522)**	**100.00**	(124,793)	100.00
Expenditure				
ICB schemes aimed at reducing non elective activity	31,226		28,021	
ICB schemes - wheelchairs	1,265		1,196	
Derbyshire County Council schemes	8,615		7,898	
ICES (Integrated Community Equipment Service)	6,973		6,890	
Reablement	20,685		19,576	
Administration, Performance and Information Sharing	640		606	
Care Bill	2,718		2,573	
Delayed Transfer of Care	9,671		9,121	
Carers	2,604		2,464	
Integrated Care	3,487		3,320	
Workforce Development	488		472	
Dementia Support	489		463	
Autism and Mental Health	2,020		1,944	
iBCF	31,995		31,995	
Winter Pressures Grant	3,737		3,737	
Discharge Fund	8,349		5,010	
Total Expenditure	**134,962**		125,286	
Net position for Pool	**(560)**		493	
Balance Brought Forward as at 1 April 2024	187			
Balance carried Forward at the end of period	**(373)**			
NHS Derby and Derbyshire ICB share of surplus as at end of period	**(224)**			

The Derby County BCF pooled budget reported an underspend of £560k for the period, with a total accumulated underspend of £373k at 31 March 2025. NHS Derby and Derbyshire Integrated Care Board's share of the overspend was £224k. This amount has been carried forward in the pool.

The memorandum account for the "Derby City Better Care Fund" pooled budget is:

	2024-25 £'000	**2024-25 Pool Share %**	2023-24 £'000	2023-24 Pool Share %
Income				
NHS Derby & Derbyshire ICB	(25,142)	58.87	(22,384)	57.97
Derby City Council	(17,563)	41.13	(16,227)	42.03
Total Income	**(42,705)**	**100.00**	(38,611)	100.00
Expenditure				
ICB schemes aimed at reducing non elective activity	4,645		4,396	
Derby City Council schemes	2,534		2,323	
Community Health Services	9,318		7,403	
Social Care	10,487		9,925	
Mental Health	650		615	
Accident & Emergency	212		201	
iBCF	10,862		10,862	
Winter Pressures Grant	1,183		1,183	
Discharge Fund	2,814		1,689	
Total Expenditure	**42,705**		38,597	
Net position for Pool	**-**		(14)	
Balance Brought Forward as at 1 April 2024	(109)			
Balance Carried forward	**(109)**			
NHS Derby and Derbyshire ICB share of surplus as at end of period	**(64)**			

The Derby City BCF pooled budget reported a breakeven position for the period, with a total accumulated surplus of £109k at 31 March 2025. NHS Derby and Derbyshire Integrated Care Board's share of the underspend was £64k. This amount has been carried forward in the pool.

19 Joint arrangements - interests in joint operations, continued

NHS Derby and Derbyshire Integrated Care Board is also a partner of the "Children and Young People with Complex Needs" pooled budget along with Derbyshire County Council. This pool is hosted by Derbyshire County Council.

The memorandum account for the "Children and Young People with Complex Needs" pooled budget is:

	2024-25	**2024-25 Pool Share**	2023-24	2023-24 Pool Share
	£'000	**%**	£'000	%
Income				
NHS Derby and Derbyshire ICB	(3,995)	33.00	(2,918)	33.00
Derbyshire County Council	(8,111)	67.00	(5,924)	67.00
Total Income	**(12,106)**	**100.00**	(8,842)	100.00
Expenditure				
Purchase of equipment and healthcare services	12,106		8,842	
Total Expenditure	**12,106**		8,842	
Net position for Pool	**-**		-	

NHS Derby and Derbyshire Integrated Care Board is also a partner of the "Integrated Disabled Children's Centre and Services in Derby" pooled budget, along with Derby City Council. This pool is hosted by Derby City Council.

The memorandum account for the "Integrated Disabled Children's Centre an Services in Derby" pooled budget is:

	2024-25	**2024-25 Pool Share**	2023-24	2023-24 Pool Share
	£'000	**%**	£'000	%
Income				
NHS Derby and Derbyshire ICB	(1,065)	46.53	(1,011)	47.69
Derby City Council	(1,224)	53.47	(1,109)	52.31
Total Income	**(2,289)**	**100.00**	(2,120)	100.00
Expenditure				
Residential Services	1,348		1,269	
Community Service Team (Outreach Service)	48		282	
Disability and Fieldwork Social Work Services	-		1	
Management and Administration	929		945	
Total Expenditure	**2,325**		2,497	
Net position for Pool	**36**		377	
Balance Brought forward at 1st April 2024	(181)			
Balance carried forward as at end of period	**(145)**			
NHS Derby and Derbyshire ICB share of surplus as at end of period	**(67)**			

The Integrated Disabled Children's Centre and Services in Derby pooled budget reported an overspend of £36k for the period, with a total accumulated underspend of £145k at 31 March 2024.

NHS Derby and Derbyshire Integrated Care Board's share of the accumulated underspend was £67k. This amount has been carried forward in the pool.

20 Related party transactions

During the year none of the Board Members or parties related to them have undertaken any material transactions with NHS Derby and Derbyshire Integrated Care Board, other than those set out below (transactions identified were not with the members but between the Integrated Care Board and the related party):

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Accurx Ltd	473	-	-	-
Amber Valley CVS	117	-	-	-
Amber Valley Health Ltd	1,094	-	-	-
Cera Care Ltd	3	-	-	-
College Street Medical Practice	880	-	29	-
Derby And Derbyshire GP Provider Board	779	-	-	-
Derby City Council	25,736	409	288	273
Derbyshire Community Health Services NHS Foundation Trust	182,966	312	507	146
Derbyshire County Council	94,138	6,268	1	4,045
Derbyshire Healthcare NHS Foundation Trust	190,330	82	448	-
Erewash Health Partnership	1,555	-	-	-
First Steps	195	-	-	-
High Peak & Buxton PCN	2,748	-	-	-
Jessop Medical Practice	2,896	-	17	-
Moir Medical Centre	2,051	-	10	-
NHS Confederation	110	-	-	-
NHS England	9	60	6	1,802
Nottingham University Hospitals NHS Trust	102,500	5	2,193	37
Nottinghamshire Healthcare NHS Foundation Trust	5,736	4	768	-
University Hospitals of Derby & Burton NHS Foundation Trust	784,243	-	17,739	-
Police & Crime Commissioner For Derbyshire	27	39	-	7

All transactions have been at arm's length as part of NHS Derby and Derbyshire Integrated Care Board's healthcare commissioning.

The Department of Health is regarded as a related party. During the year the Integrated Care Board has had a significant number of material transactions

- NHS England including: NHS England Midlands; NHS Arden & GEM Commissioning Support Unit; NHS Midlands and Lancashire Commissioning Support
- NHS Foundation Trusts including: Chesterfield Royal Hospitals NHS Foundation Trust; Derbyshire Community Healthcare Services NHS Foundation
- NHS Trusts including: East Midlands Ambulance Service NHS Trust; and Nottingham University Hospitals NHS Trust
- NHS Resolution; and,
- NHS Business Services Authority

In addition, NHS Derby and Derbyshire Integrated Care Board has had a number of material transactions with other Government departments and other central and local government bodies. Most of these transactions have been with Derby City Council; and Derbyshire County Council, in respect of joint enterprises.

During 2023-24, none of the Board Members or parties related to them have undertaken any material transactions with NHS Derby and Derbyshire Integrated Care Board, other than those set out below (transactions identified were not with the members but between the Integrated Care Board and the related party):

2023-24 details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Accurx Ltd	363	-	-	-
Amber Valley Health Ltd	1,118	-	-	-
Cera Care Ltd	2	-	-	-
College Street Medical Practice	-	-	163	-
Derby And Derbyshire GP Provider Board	678	-	-	-
Derby City Council	26,885	337	3,877	153
Derbyshire Community Health Services NHS Foundation Trust	172,128	230	698	13
Derbyshire County Council	84,763	1,843	5,595	2,102
Derbyshire Healthcare NHS Foundation Trust	170,224	-	80	122
Erewash Health Partnership	1,424	-	-	-
First Steps	260	-	-	-
High Peak & Buxton PCN	2,212	-	-	-
Jessop Medical Practice	2,520	-	488	-
Milton Keynes University Hospital NHS Foundation Trust	29	-	-	-
Moir Medical Centre	82	-	335	-
NHS England	-	-	-	1,023
Nottinghamshire Healthcare NHS Foundation Trust	2,841	-	51	-
Police & Crime Commissioner For Derbyshire	89	-	-	-
University Hospitals of Derby & Burton NHS Foundation Trust	644,613	-	6,027	2
University Hospitals Of Leicester NHS Trust	1,412	50	-	133

21 Events after the end of the reporting period

On 13 March 2025 the government announced NHS England and the Department for Health and Social Care will increasingly merge functions, ultimately leading to NHS England being fully integrated into the Department. The legal status of ICBs is currently unchanged but they have been tasked with significant reductions in their cost base. Discussions are ongoing on the impact of these and the impact of staffing reductions, together with the costs and approvals of any exit arrangements. ICBs are currently being asked to implement any plans during quarter 3 of the 2025/26 financial year.

22 Financial performance targets

NHS Integrated Care Board have a number of financial duties under the NHS Act 2006 (as amended).
NHS Integrated Care Board performance against those duties was as follows:

	2024-25 Target	**2024-25 Performance**	**Duty Achieved? Yes/No**	2023-24 Target	2023-24 Performance
Expenditure not to exceed income	2,954,165	2,952,765	Yes	2,512,687	2,511,655
Capital resource use does not exceed the amount specified in Directions	422	422	Yes	250	248
Revenue resource use does not exceed the amount specified in Directions	2,917,649	2,916,249	Yes	2,475,686	2,474,654
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-		-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	-	-		-	-
Revenue administration resource use does not exceed the amount specified in Directions	20,402	18,699	Yes	23,163	19,296

23 Losses and special payments

Losses

The total number of NHS integrated care board losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2024-25 Number	**Total Value of Cases 2024-25 £'000**	Total Number of Cases 2023-24 Number	Total Value of Cases 2023-24 £'000
Fruitless payments	1	4	-	-
Total	**1**	**4**	**-**	**-**

Special payments

	Total Number of Cases 2024-25 Number	**Total Value of Cases 2024-25 £'000**	Total Number of Cases 2023-24 Number	Total Value of Cases 2023-24 £'000
Ex Gratia Payments	-	-	1	120
Total	**-**	**-**	**1**	**120**

AUDITOR'S REPORT

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD OF NHS DERBY AND DERBYSHIRE INTEGRATED CARE BOARD

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Derby and Derbyshire Integrated Care Board ("the ICB") for the year ended 31 March 2025 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2025 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State on 23 April 2025 as being relevant to ICBs in England and included in the Department of Health and Social Care Group Accounting Manual 2024/25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the ICB in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accountable Officer of the ICB ("the Accountable Officer") has prepared the financial statements on the going concern basis, as they have not been informed by the relevant national body of the intention to either cease the ICB's services or dissolve the ICB without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accountable Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the ICB over the going concern period.

Our conclusions based on this work:

- we consider that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified, and concur with the Accountable Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the ICB's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the ICB will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit and Governance Committee and internal audit and inspection of policy documentation as to the ICB's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the ICB's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Assessing the incentives for management to manipulate reported expenditure as a result of the need to achieve statutory targets delegated to the ICB by NHS England.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls, in particular the risk that ICB management may be in a position to make inappropriate accounting entries.

On this audit we did not identify a fraud risk related to revenue recognition because of the nature of funding provided to the ICB, which is transferred from NHS England and recognised through the Statement of Changes in Taxpayers' Equity. We therefore assessed that there was limited opportunity for the ICB to manipulate the income that was reported.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognized a fraud risk related to expenditure recognition, particularly in relation to year-end accruals.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included unusual posting to cash, unusual postings to expenditure, journals posted by unexpected users and specific words.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- Inspecting transactions in the period after 31 March 2025 to verify expenditure had been recognised in the correct accounting period.
- Assessing a sample of accruals and verifying they had been accurately recorded within the financial statements.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Board and other management (as required by auditing standards), and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

FIrstly, the ICB is subject to laws and regulations that directly affect the financial statements including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Secondly, the ICB is subject to many other laws and regulations where the consequences of non-compliance could have a material effect on amounts or disclosures in the financial statements, for instance through the imposition of fines or litigation. We identified the following areas as those most likely to have such an effect: health and safety, data protection laws, anti-bribery, employment law, recognising the nature of the ICB's activities and its legal form. Auditing standards limit the required audit procedures to identify non-compliance with these laws and regulations to enquiry of the directors and other management and inspection of regulatory and legal correspondence, if any. Therefore if a breach of operational regulations is not disclosed to us or evident from relevant correspondence, an audit will not detect that breach.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accountable Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2024/25.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 119, the Accountable Officer of the ICB is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the ICB's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting

unless they have been informed by the relevant national body of the intention to either cease the services provided by the ICB or dissolve the ICB without the transfer of its services to another public sector entity.

The Audit and Governance Committee is responsible for overseeing the ICB's financial reporting process

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

The Accountable Officer is responsible for ensuring the regularity of expenditure and income.

We are required to report on the following matters under Section 21(4) and (5) of the Local Audit and Accountability Act 2014.

In our opinion, in all material respects, the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Basis for opinion on regularity

We conducted our work on regularity in accordance with Statement of Recommended Practice - Practice Note 10: *Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022)* issued by the FRC. We planned and performed procedures to obtain sufficient appropriate evidence to give an opinion over whether the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them. The procedures selected depend on our judgement, including the assessment of the risks of material irregular transactions. We are required to obtain sufficient appropriate evidence on which to base our opinion.

Report on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the ICB to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 119, the Accountable Officer is responsible for ensuring that the ICB exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the ICB has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources are

operating effectively. We are also not required to satisfy ourselves that the ICB has achieved value for money during the year.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the ICB had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- we issue a report in the public interest under section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we make written recommendations to the ICB under Section 24 and Schedule 7 of the Local Audit and Accountability Act 2014; or
- we refer a matter to the Secretary of State and NHS England under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the ICB, or an officer of the ICB, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Board of NHS Derby and Derbyshire Integrated Care Board, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Board of the ICB, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Board of the ICB, as a body, for our audit work, for this report or for the opinions we have formed.

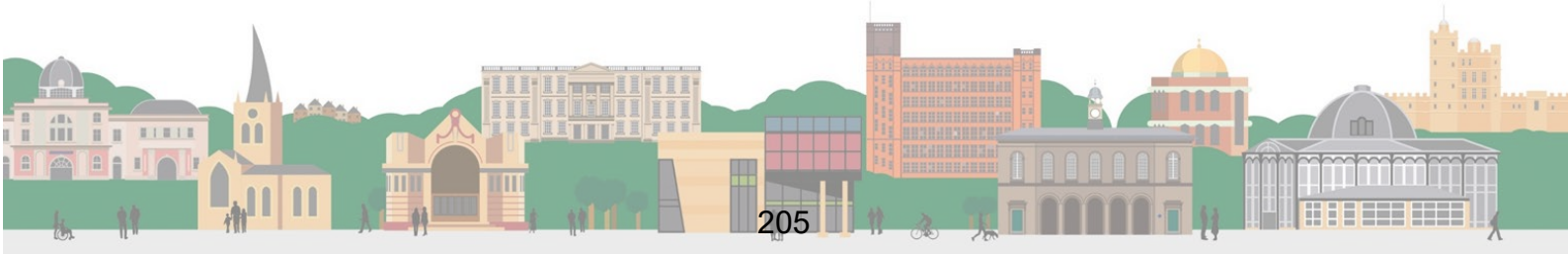
DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the ICB's accounts consolidation template for the year ended 31 March 2025 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of NHS Derby and Derbyshire Integrated Care Board for the year ended 31 March 2025 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the NAO Code of Audit Practice.

Richard Walton
for and on behalf of KPMG LLP
Chartered Accountants
4th Floor
EastWest
Tollhouse Hill
Nottingham, NG1 5FS
20 June 2025

APPENDICES



Appendix 1: Team Up Patient Stories

Prevention of unnecessary hospital admission for palliative deaf and blind 81-year-old saving NHS thousands of pounds and honouring man's wishes

Team Up in ARCH (Ambergate, Ripley, Crich and Heanor, part of Amber Valley Place) recently supported an 81-year-old man, who had been deaf and blind since birth. He had a bipolar diagnosis and a life-long anxiety about attending hospital. He was referred to the Team Up team with unexplained weight-loss and reduced mobility. An underlying malignancy could not be ruled out.

The usual pathway would have been to admit him ,and although this was advised by the registered GP, the family and Team Up team explained this would be too distressing, and that the individual was too frail for surgery or further testing. He consented to non-invasive tests in the community.

As this case was complex and other GPs were uncomfortable with the plan, the case was discussed with a Consultant Geriatrician at Royal Derby Hospital, who agreed this was a "kind and pragmatic approach to his care".

Thanks to bold decision-making, based on the patient and family's wishes, the gentleman was able to avoid an admission. Safeguarding concerns were handled quickly thanks to close multi-disciplinary team working with adult social care. Eight weeks later, he died peacefully at home – the home he had grown up in.

Team Up supports man with waist down paralysis to stay well and out of hospital

A man with waist down paralysis was being admitted to hospital frequently until he was referred into the Team Up in Derby city. The man, who had been a keen sportsman before his accident, had unsuitable housing and was using taxis to get to public toilets because his home needed adapting.

He was referred to the complex care team where, following their multi-disciplinary team meeting, the local area coordinator, social prescriber, pharmacist and health and wellbeing coach stepped in to help him. The GP, social prescriber, health and wellbeing coach and pharmacist helped with housing, mental health, finances and medications.

He has since reduced his use of NHS services, been found some new accommodation with a suitable toilet and has not been taken to hospital since he moved house. He is now trying to get back to some mobility with his health and wellbeing coach.

Appendix 2: EMAS Performance

Quarter 3 of 2024/25 saw a deterioration in performance in comparison to the same period last year in all national standards, and Quarter 4 saw an improvement in all national standards in comparison to 2023/24, as shown in Table 39 below:

	National Standards 2024/25							
	Category 1				Category 2			
	Mean		90th Centile		Mean		90th Centile	
	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24	2024/25	2023/24
National Standard	00:07:00		00:15:00		00:18:00		00:40:00	
Q1	00:09:01	00:08:36	00:15:55	00:15:33	00:35:40	00:36:02	01:15:00	01:17:50
Q2	00:08:50	00:08:34	00:15:28	00:15:35	00:33:39	00:38:38	01:10:20	01:23:34
Q3	00:09:44	00:09:00	00:17:09	00:16:13	01:00:32	00:47:00	02:07:33	01:40:53
Q4	00:09:00	00:09:13	00:15:42	00:16:22	00:40:12	00:47:41	01:22:04	01:41:37

	Category 3		Category 4	
	90th Centile		90th Centile	
	2024/25	2023/24	2024/25	2023/24
National Standard	02:00:00		03:00:00	
Q1	05:20:38	05:15:55	04:06:59	04:28:02
Q2	04:58:34	05:55:12	04:34:34	04:41:24
Q3	10:02:25	07:25:28	14:11:13	06:07:29
Q4	05:51:07	06:57:04	06:51:30	06:37:03

Table 39 – EMAS Performance for-2024/25

During 2024/25, EMAS lost a total of 198,610 hours due to pre-handover delays greater than 15 minutes. This is an increase of 34.7% when compared to 2023/24, when 147,403 hours were lost. The average pre-handover times can be seen in Table 40 below:

	Average Pre-Hospital Handover Times					
	Q1			Q2		
	April	May	June	July	August	September
2024/25	00:34:32	00:33:34	00:34:43	00:34:34	00:31:34	00:38:10
2023/24	00:24:49	00:28:34	00:26:03	00:24:57	00:25:54	00:30:20
	Q3			Q4		
	October	November	December	January	February	March
2024/25	00:49:52	00:50:31	00:54:28	00:49:30	00:40:51	00:34:09
2023/24	00:39:59	00:35:06	00:41:18	00:49:45	00:44:29	00:35:13

Table 40 – Average pre-hospital handover times for 2024/25

As part of the contractual agreement reached between EMAS and the six ICB associate commissioners, improvement trajectories were submitted by all ICBs that committed to a reduction in the average pre-handover time. Achieving this as a minimum would have had a positive impact on performance as well as quality and patient safety.

Whilst some trajectories were achieved at the start of the year, the ICB failed to achieve their monthly trajectories from October 2024 to February 2025. The average pre-handover trajectories and achievements can be seen in Table 41 below:

		2024/25 Average Pre-Handover Time					
		Q1			Q2		
		Apr	May	Jun	Jul	Aug	Sept
NHS Derby and Derbyshire ICB	Trajectory	00:26:45	00:26:29	00:21:41	00:21:03	00:20:25	00:23:35
	Average	00:24:57	00:27:22	00:27:47	00:30:48	00:28:40	00:30:47
		Q3			Q4		
		Oct	Nov	Dec	Jan	Feb	Mar
NHS Derby and Derbyshire ICB	Trajectory	00:25:13	00:27:29	00:32:00	00:28:45	00:25:13	00:23:35
	Average	00:36:43	00:42:41	00:53:30	00:39:32	00:32:51	00:27:18

Table 41 – Average pre-handover trajectories and action performance times for East Midlands during 2024/25

Call Demand

Call demand during 2024/25 was lower than plan. As a yearly total, calls are -7.2% below plan. The monthly variance can be seen in Table 42 below:

		Call Demand					
		Q1			Q2		
		April	May	June	July	August	September
Calls	Actual	91,993	100,579	98,397	100,502	94,847	98,703
	Plan	98,272	105,928	107,795	106,618	106,588	111,984
	Variance	-6.4%	-5.0%	-8.7%	-5.7%	-11.0%	-11.9%
		Q3			Q4		
		October	November	December	January	February	March
Calls	Actual	110,795	109,388	119,199	102,908	TBC	TBC
	Plan	120,972	110,014	119,380	112,032	96,811	115,315
	Variance	-8.4%	-0.6%	-0.2%	-8.2%	-6.1%	-13.5%

Table 42 – Call demand for 2024/25

In 2024/25, there was a decrease in the number of duplicate calls by -11.9% when compared to 2023/24. The percentage of duplicate calls as a proportion of total calls has fallen from 20.6% in 2023/24 to 18.4% in 2024/25. Duplicate calls occur when a member of the public places an additional call with EMAS for the same incident, usually to chase the arrival of an ambulance.

Incidents (where a patient receives a face-to-face response or clinical assessment over the telephone) were above plan for eight months during 2024/25.

On-scene activity has been below plan since June 2024. As an annual total, incidents were above plan at +0.9%, while on-scene activity was below plan at -1.5%. Activity levels for incidents and on-scene activity can be seen in Tables 43 and 44 below:

		Q1			Q2		
		April	May	June	July	August	September
Incidents	Actual	66,127	70,467	67,682	69,941	67,818	67,345
	Plan	65,143	67,972	67,383	68,867	67,555	67,548
	Variance	1.5%	3.7%	0.4%	1.6%	0.4%	-0.3%
		Q3			Q4		
		October	November	December	January	February	March
Incidents	Actual	69,551	69,759	74,575	71,482	TBC	TBC
	Plan	71,120	67,965	72,579	72,812	65,050	68,717
	Variance	-2.2%	2.6%	2.8%	-1.8%	-0.6%	3.4%

Table 43 – Incidents for 2024/25

		Q1			Q2		
		April	May	June	July	August	September
On-Scene	Actual	55,950	58,317	55,822	57,245	56,352	55,117
	Plan	55,166	57,098	55,998	57,581	57,350	56,788
	Variance	1.4%	2.1%	-0.3%	-0.6%	-1.7%	-2.9%
		Q3			Q4		
		October	November	December	January	February	March
On-Scene	Actual	55,966	55,559	57,310	57,089	TBC	TBC
	Plan	57,574	57,340	59,044	58,050	54,324	58,270
	Variance	-2.8%	-3.1%	-2.9%	-1.7%	-4.1%	-1.1%

Table 44 – On-scene activity for 2024/25

EMAS post-handover times were above the 15-minute national standard during 2024/25. Q3 saw lower post-handover times when compared to 2023/24, lower than April to September 2024 and lower than January to March 2025. Post-handover times for the year can be seen in Table 45 below:

	Average Post-Hospital Handover Times					
	Q1			Q2		
	April	May	June	July	August	September
2024/25	00:19:54	00:19:43	00:18:16	00:17:39	00:18:16	00:17:34
2023/24	00:15:04	00:14:27	00:14:22	00:14:21	00:13:45	00:13:22

	Q3			Q4		
	October	November	December	January	February	March
2024/25	00:16:23	00:16:45	00:16:23	00:17:00	00:17:34	00:18:14
2023/24	00:18:57	00:19:50	00:19:17	00:18:48	00:18:58	00:19:34

Table 45 – Average post-hospital handover times for 2024/25

Appendix 3: NHS 111 Performance

Performance against the call handling KPIs for 2024/2025 is summarised within Tables 46 to 49 below, and this data is taken from the Integrated Urgent Care Aggregate Data Collection which is a nationally published data set.

Calls abandoned after 30 seconds

	Q1 (DHU Q3)			Q2 (DHU Q4)		
	April	May	June	July	August	September
Actual	3.9%	6.6%	3.8%	3%	2.6%	2.1%
Target	≤3%	≤3%	≤3%	≤3%	≤3%	≤3%
	Q3 (DHU Q1)			Q4 (DHU Q2)		
	October	November	December	January	February	March
Actual	2.3%	2.1%	1.5%	0.4%	1.0%	0.7%
Target	≤3%	≤3%	≤3%	≤3%	≤3%	≤3%

Table 46 – Performance of DHU NHS 111 calls abandoned after 30 seconds during 2024/25

Average call answer time

	Q1 (DHU Q3)			Q2 (DHU Q4)		
	April	May	June	July	August	September
Actual	45 secs	91secs	66 secs	49 secs	40 secs	36 secs
Target	≤20 secs	≤20 secs	≤20 secs	≤20 secs	≤20 secs	≤20 secs
	Q3 (DHU Q1)			Q4 (DHU Q2)		
	October	November	December	January	February	March
Actual	37 secs	35 secs	29 Secs	7 Secs	18 Secs	12 Secs
Target	≤20 secs	≤20 secs	≤20 secs	≤20 secs	≤20 secs	≤20 secs

Table 47 – Performance of DHU NHS 111 average call answer time during 2024/25 [NB: KPI 1 & 2 were impacted in May & June by the introduction of a new telephony system.]

Proportion of triaged calls transferred to a clinician

	Q1 (DHU Q3)			Q2 (DHU Q4)		
	April	May	June	July	August	September
Actual	36.5%	37.4%	37.4%	37.1%	37.1%	36.9%
Target	≥50%	≥50%	≥50%	≥50%	≥50%	≥50%
	Q3 (DHU Q1)			Q4 (DHU Q2)		
	October	November	December	January	February	March
Actual	36.8%	36.7%	36.6%	37.6%	38.1%	36.4%
Target	≥50%	≥50%	≥50%	≥50%	≥50%	≥50%

Table 48 – Performance of DHU NHS 111 proportion of triaged calls transferred to a clinician during 2024/25 [NB: The KPI target refers to cases that receive clinical input from any service provider in IUC. The above relates only to those that received clinical input from NHS111. It will never, nor should be 50% from 111 alone.]

Proportion of triaged calls closed with self-care within NHS111

	Q1 (DHU Q3)			Q2 (DHU Q4)		
	April	May	June	July	August	September
Actual	8.6%	9.3%	9.1%	9.3%	9.4%	9%
Target	≥15%	≥15%	≥15%	≥15%	≥15%	≥15%
	Q3 (DHU Q1)			Q4 (DHU Q2)		
	October	November	December	January	February	March
Actual	9.3%	9.4%	9.7%	9.3%	8.8%	9.1%
Target	≥15%	≥15%	≥15%	≥15%	≥15%	≥15%

Table 49 – Performance of DHU NHS 111 proportion of triaged calls closed with self-care within 111 during 2024/25

Clinical Assessment Services

For 2024/25, the number of clinical validations remained above the 75% target and the percentage downgraded continued to be positive, as shown in Table 50 below:

	Ambulance Validation					
	Q1 (DHU Q3)			Q2 (DHU Q4)		
	April	May	June	July	August	September
Patients available for validation	31,212	30,781	29,442	28,959	25,863	27,102
Total clinically validated	27,270	25,334	23,447	22,682	20,368	21,334
% Clinically validated (target ≥ 75%)	87.4%	82.3%	79.6%	78.3%	78.8%	78.7%
	Q3 (DHU Q1)			Q4 (DHU Q2)		
	October	November	December	January	February	March
Patients available for validation	30,822	29,948	35,712	31,105	28,420	30,230
Total clinically validated	25,755	24,566	32,198	27,921	25,592	27,100
% Clinically validated (target ≥ 75%)	83.6%	82%	90.2%	89.8%	90.0%	89.6%

Table 50 – Performance of Category 3 validations during 2024/25

Appendix 4: Equality Delivery System

As an ICB we have continued to demonstrate a proactive approach to meeting the requirements of the Public Sector Equality Duty through use of the NHS Equality Delivery System (EDS) during 2024/25.

There are three sections:

Domain 1	Commissioner or provided services
Domain 2:	Workforce health and wellbeing
Domain 3:	Inclusive leadership

Domain 1

It was agreed that each provider would choose two of their own Core20PLUS5 areas and link with the ICB for the third project to provide a System response.

Reflecting on last year's EDS scoring events with those who attended as well as the presenters, it was decided to hold specific events for each provider. By holding five separate events with support from the ICB, it was felt that each project could be allocated enough time for discussion and scoring.

Organisation	Project
East Midlands Ambulance Service	Community Defibrillators
	Long Lies Audit
Derbyshire Community Health Services	Community Podiatry
	Demetia Palliative Care
University Hospitals of Derby and Burton	Maternity
	Palliative care
Chesterfield Royal NHS Foundation Trust	Early diagnosis for Bowel Cancer
	Skin tone bias in wound care
Derbyshire Healthcare NHS Foundation Trust	Living Well

You can find more information about this work here.

Scoring

The ICB facilitated five System-wide scoring events during January and February 2025. The events were an opportunity for a wide range of community representatives through the VCFSE sector to obtain feedback on System equality work and score how effective the work had been. In addition, each provider sent invitations to their own patient and public involvement networks. The System were deemed to be in the 'Developing' stage.

Domain 2

The ICB's Chief People Officer and Assistant Director of Human Resources and Organisational Development led an engagement event with colleagues from all directorates

on the 13th February 2025. As specified in EDS2 guidance, representatives with protected characteristics were invited to attend.

Information was presented on how the ICB has enabled and embedded services to support our ICB workforce in relation to health and wellbeing activities and initiatives against the EDS2 Domain 2 standards.

Scoring

Colleagues were asked to score on how mature they thought that these services were embedded and effective within the ICB, using the nationally prescribed scoring system. The questions were as follows, and the results can be seen in Figure 11 below:

Question 2A:	When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions.
Question 2B:	When at work, staff are free from abuse, harassment, bullying and physical violence from any source.
Question 2C:	Staff have access to support and advice when suffering from stress, abuse, bullying, harassment and physical violence from any source.
Question 2D:	Staff recommended the organisation as a place to work and receive treatment.

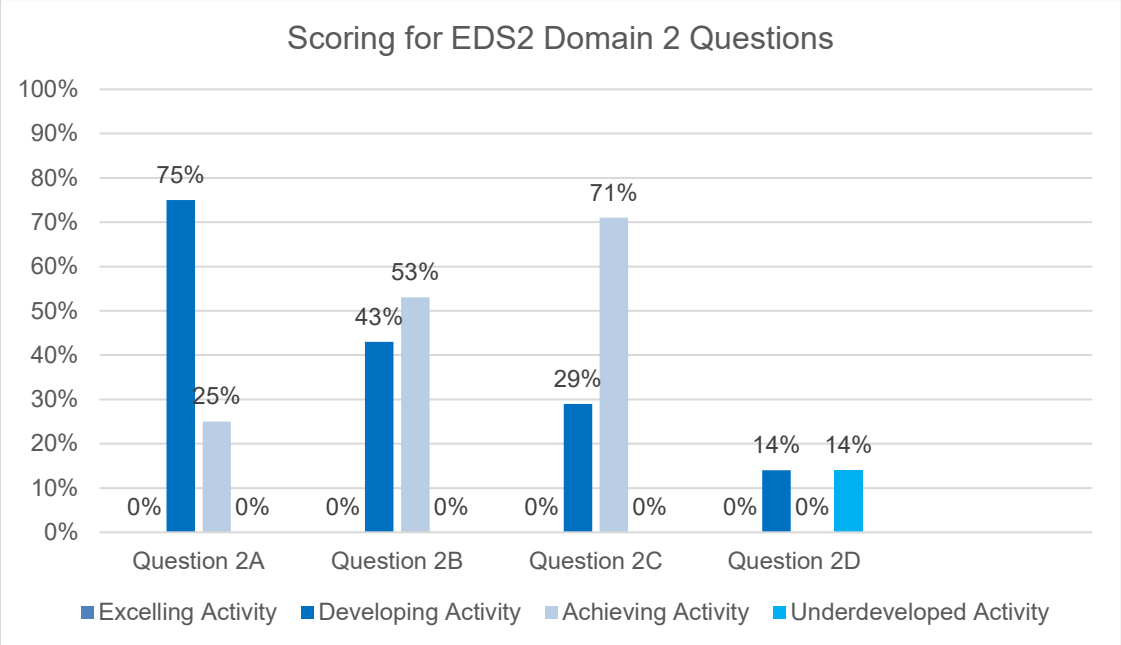


Figure 11: Results of EDS2 Domain 2 Questions

A full report including rationales can be found here.

Appendix 5: Patient and Public Involvement Case Studies

Case Study 1 – Hartington Alive

Hartington Alive is a group of residents who strive to make a rural Derbyshire village a healthy, happy and thriving place to be. They believe that having strong social connections leads to better health outcomes and as such, the village hall is central to their activity.
In 2024, the ICB agreed to fund £2,000 to Hartington Alive (via Hartington Village Hall) to explore how developing a range of activities with and for residents might improve wellbeing and prevent illness and the need to travel to Buxton or beyond to access services.

New Capacity
Whilst there were already strong connections with residents in the village, it was acknowledged that there was work to be done to draw in the Hartington Surgery and support from surrounding health networks. During the 12-month period, community leaders Liz and Kay set about connecting with the lead GP, the Practice Nurse and a range of people working in health and wellbeing. This led to a series of talks to an audience of 60+ people covering topics such as mental health and dementia.

Liz and Kay had also heard from older residents who were concerned about falling and the need to stay fit and strong to avoid injury, so they reached out to Age UK and their 'stronger for longer' programme lead who helped them train a local resident to lead a group from the hall. This has led to a weekly session attended by more than 20 people. A referral scheme is also now in place to enable people from neighbouring communities to attend as part of either rehabilitation after a fall or prevention to build strength and stability.

Hartington Alive has also joined the Derbyshire Community Hub Network and is benefitting from additional funds as well as information, expertise and peer support. Kay and Liz also organise a quarterly 'rural group' in the hall which has featured speakers from Citizens Advice, Living Well, Alzheimer's Association and Derbyshire Carers. The knowledge and support shared has provided much needed information for people who do not often know how to access advice living in a rural community. It also provides a safe space for residents to ask questions and connect with each other over topics which may feel overwhelming.

As a result of the prevention work undertaken by Hartington Alive there have been:
- 200 attendances at health-related talks and events; and
- 33 people signed up to weekly stronger for longer activity sessions.

Case Study 2 – Erewash prevention scheme presented at NHS Confederation best practice webinar

The roll out of the NHS Health Check in deprived communities in Erewash was presented on a national best practice webinar for the NHS Confederation, alongside NHS England Director Dr Bola Olowabi. GP Allie Hill and her colleague Sara Bains, who led the project together, presented 'From Models to Practice: How the Core20PLUS5 Framework can tackle inequalities in cardiovascular disease'. Watch Allie and Sara's presentation from 23 minutes into the webinar.

The team identified communities with the highest prevalence of deprivation and groups that run within them, then used the Derby and Derbyshire Insights Framework to understand how to best engage with the communities. With their partners, including Public Health, Erewash Borough Council and Erewash Voluntary Action, they developed and worked with five hyper-local community wellbeing networks based in Cotmanhay, Kirk Hallam, Petersham, Sawley and Sandiacre. These networks are made up of churches, children's groups, food banks, charities and local residents who all play a part.

Sara Bains (wellness, resilience and inequalities lead for Erewash PCN) spent six months with a breakfast club before bringing in the NHS Health Check. She said: *"Working with communities who need the most support is a real privilege and we seek to do that with respect and by listening carefully. For some people it's very hard to trust services or to engage with a large and complex organisation like the NHS and therefore we need to listen and really hear their concerns before we can start to address any barriers."*

The team, from Erewash PCN, took preventative health checks into workplaces, including a mental health self-help group, a local community breakfast club, and the builder's merchant Travis Perkins. They found that in some places, 70% of people needed a follow-up with their GP for issues such as high blood pressure, hypertension and high cholesterol, and the team was able to

Case Study 3 – Learning Disabilities Short Breaks Service

The ICB has reviewed local NHS learning disability short breaks services since 2018, and although progress was delayed by Covid-19, collaborative work with DCHSFT and Derbyshire County Council enabled focused discussions with stakeholders to shape future service provision. During a review in 2024/25, a 'case for change' was developed, drawing on previous evidence, feedback and data from local NHS partners, and national guidance. Evidence revealed three critical priorities for decision makers:

1. the care and support provided is vital for individuals with LD and their families;
2. services must be equitable and accessible across the population; and
3. NHS resources should be allocated efficiently to meet community health-related needs.

To inform future options, a 12-week engagement process was carried out, involving a wide range of stakeholders, including service users, families, advocates, staff and local representatives. The process incorporated workshops, drop-in sessions, and 1:1s to gather detailed input. 143 participants were involved and included parent and family carers of current LD short break users, people with LD using the services, advocates, staff members, providers, local council representatives, Healthwatch, and community organisations.

Outcome

This engagement process significantly shaped the direction of the review through:

- **Stakeholder Contributions:** participants helped define the assessment criteria for future service options, ensuring they aligned with the needs and priorities of service users and families;
- **Weighted Priorities:** during finalisation workshops, participants actively ranked the importance of criteria, influencing how options will be assessed in the next phase;
- **Inclusive Dialogue:** the broad representation ensured that a wide range of voices, including lived experiences, were heard and reflected in decision-making; and
- **Progress:** the process enabled the ICB to gather a comprehensive list of potential options for the pre-consultation business case.

By centring the voices of stakeholders, the ICB has laid the groundwork for co-produced, evidence-based decision making, ensuring that the future provision of NHS LD Short Breaks reflects the needs and priorities of the community.

Case Study 4 – East Midlands Fertility Service Review

The East Midlands fertility service review utilised the JUCD Involvement platform to host information and gather feedback on behalf of multiple ICBs. This platform played a crucial role in making the engagement process transparent and inclusive for members of the public:

- **Centralised Information Hub:** all information related to the fertility service review;
- **Visual Content:** project stages to make complex information accessible; and
- **Real-Time Updates:** updates, including upcoming events and draft reports.

The JUCD Involvement Platform was particularly useful for members of the public to:

- **Participate Actively:** interactive surveys and visual content made it easier for the public to participate actively in the engagement process, providing valuable feedback to help shape discussions about changes to the policy;
- **View Frequently Asked Questions:** prominently displayed in the space, providing immediate answers to common inquiries;
- **Ask Questions:** a route for the public to ask questions and receive responses, ensuring they were well-informed about the review and proposed changes; and
- **Find Latest Information:** real-time updates and centralised information ensured the public were engaged and informed throughout the process.

Hosting the engagement process for the Fertility review on the Derbyshire Involve system boosted collaboration and transparency, highlighting that a structured, inclusive engagement process via a robust digital platform enhances connections between organisations and the public.

Appendix 6: ICB Committee Membership and Items discussed

The composition of the Remuneration Committee is shown in Table 51 below.

Remuneration Committee Member	Position
Margaret Gildea	Chair – Non-Executive Member and Senior Independent Director
Richard Wright	ICB Chair (up to 30th April 2024) Non-Executive Member (from 1st May 2024 to 8th November 2024)
Dr Kathy McLean	ICB Chair (from 1st May 2024)
Dr Adedeji Okubadejo	Clinical Lead Member

Table 51 – members of the ICB's Remuneration Committee during 2024/25

Significant items that were discussed and approved during 2024/25 are shown in Table 52 below.

Significant items approved/discussed by Remuneration Committee during 2024/25	
Appointments	Restructure and Redundancy Notices
Functional Directors Pay Progression	Very Senior Manager Pay Awards, Pay Banding, Pay Framework and Recruitment
Senior Manager Recruitment	

Table 52 – Significant items discussed and approved by the Remuneration Committee during 2024/25

The composition of the Audit and Governance Committee is shown in Table 53 below.

Audit and Governance Committee Member	Position
Sue Sunderland	Chair – Non-Executive Member
Jill Dentith	Non-Executive Member
Margaret Gildea	Non-Executive Member and Senior Independent Director ('by invitation' in accordance with the Committee's workplan)

Table 53 – members of the ICB's Audit and Governance Committee during 2024/25

The Audit and Governance Committee requests and reviews reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. Significant items that were discussed and approved during 2024/25 are shown in Table 54 below:

Significant items approved/discussed by Audit and Governance Committee during 2024/25	
Governance, Risk Management and Internal Control	
Accounting Policies	Health and Safety
Annual Report and Accounts	ICB Annual Assessment
Accruals – Month 9	Information Governance

Significant items approved/discussed by Audit and Governance Committee during 2024/25	
Aged Debt, Write-Offs, Losses and Special Payments	Joined Up Care Derbyshire National Oversight Framework
Board Assurance Framework 2024/25	Losses and Special Payments
Complaints	Mandatory Training Compliance
Conflicts of Interest	NHS111 Midlands Procurement
Corporate and HR Policies	NHS Oversight Framework
Data Quality and Performance Management Framework	Non-Clinical Adverse Incidents
Digital and Cyber Security	Policy Management Framework
Draft ICB Annual Governance Statement	Post Payment Verification
EPRR and Business Continuity	Procurement Highlights
Equality, Diversity and Inclusion	Risk Management and Deep Dives
Financial Position 2024/25	Service Auditor Reports
Fit and Proper Person Test Submission	Single Tender Waivers
Freedom of Information	Specialised Commissioning Services
Information Governance	
Internal Audit – 360 Assurance	
Counter Fraud Work Plan 2024/25 and Progress Report	Mental Health Act Assessments Benchmarking
Head of Internal Audit Opinion	Progress Reports
Internal Audit Plan 2024/25	
External Audit – KPMG	
Annual Audit Letter	Health Technical Update
Auditor's Annual Report 2023/24	ISA 260 Report
External Audit Plans and Progress Reports	

Table 54 – Significant items discussed and approved by the Audit and Governance Committee during 2024/25

The composition of the Finance, Estates and Digital Committee is detailed in Table 55 below:

Finance, Estates and Digital Committee Member	Position
Core NHS Members	
Jill Dentith	Chair – Non-Executive Member
Sue Sunderland	Non-Executive Member
Keith Griffiths	Chief Finance Officer (up to 30th November 2024)
Claire Finn	Interim Chief Finance Officer (from 1st December 2024)
Jason Burn	Interim Director of Finance - Operations & Delivery (up to 16th August 2024)
Jennifer Leah	Director of Finance - Strategy & Planning, ICB (from 22nd July 2024)
David Hughes	Director of Finance, ICB (from 1st August 2024)

Finance, Estates and Digital Committee Member	Position
Michelle Arrowsmith	Chief Strategy and Delivery Officer, and Deputy Chief Executive, ICB
Ian Lichfield	Non-Executive Director, UHDBFT
Stuart Proud	Non-Executive Director, DCHSFT
Steve Heppinstall	Executive Director of Finance, CRHFT
Simon Crowther	System Estates Lead/Executive Director Finance and Performance/Interim Deputy CEO, UHDBFT (up to 23rd September 2024)
Chris Sands	Director of Finance, UHDBFT (from 26th November 2024)
Peter Handford	Chief Finance Officer, DCHSFT
James Sabin	Chief Finance Officer, DHcFT
Mike Naylor	Director of Finance, EMAS (up to 22nd October 2024)
Stuart Poynor	Director of Finance, EMAS (from 26th November 2024)
System Members	
James Austin	Chief Digital Information Officer, ICB/DCHSFT (up to 1st August 2024)
Dawn Atkinson	Programme Director, ICS Digital Programme, DCHSFT (from 1st August 2024)
Tamsin Hooton	Programme Director, JUCD
Susan Whale	Director of System PMO & Improvement, UHDBFT

Table 55 – members of the Finance, Estates and Digital Committee during 2024/25

Significant items that were discussed and approved by the Finance, Estates and Digital Committee during 2024/25 are shown in Table 56 below.

Significant items approved/discussed by Finance, Estates and Digital Committee during 2024/25	
Annual Plan 2024/25 and 2025/26	NHS IMPACT
Board Assurance Framework	National Pay Award
Capital Plans and Prioritisation	Pharmacy, Optometry and Dental Delegation
Digital Updates	Primary Care Services Growth
Electronic Patient Renewal Programmes	Procurement
Estates Strategy and Updates	Productivity and Efficiency
Financial and Operational Interdependencies	Provider risks and mitigations
ICS Transformation Programme	Resource Distribution
Infrastructure Strategy	Revenue Allocation Funding
JUCD 2025/26 Financial Plan	Risk Management
Monthly System Financial Position Reviews	System Transformation and Efficiency

Table 56 – Significant items discussed and approved by the Finance, Estates and Digital Committee during 2024/25

The composition of the People and Culture Committee is detailed in Table 57 below:

People and Culture Member	Position
Margaret Gildea	Chair – Non-Executive Member and Senior Independent Director
Jill Dentith	Non-Executive Member
Linda Garnett	Interim Chief People Officer (up to 31st July 2024)
Lee Radford	Chief People Officer (from 1st July 2024)
Janet Dawson	Non-Executive Member, DCHSFT
Ralph Knibbs	Non-Executive Member, DHcFT
Billie Lam	Non-Executive Member, UHDBFT
Atul Patel	Non-Executive Member, CRHFT (up to 15th January 2025)
Amanda Rawlings	Chief People Officer, UHDBFT
Darren Tidmarsh	Chief People Officer, DCHSFT
Rebecca Oakley	Acting Director of People & Inclusion, DHcFT
Kerry Gulliver	Director of HR and Organisational Development, EMAS
Caroline Wade	Director of HR and Organisational Development, CRHFT
Penelope Blackwell	Chair, Integrated Place Executive
Jen Skila	Assistant HR Director, Derbyshire County Council (up to 14th November 2024)
Lorraine Booth	Interim Assistant HR Director, Derbyshire County Council (from 15th November 2024)
Liz Moore	Head of HR, Derby City Council
Susie Bayley	Medical Director, General Practice Taskforce Derbyshire
Zahra Leggatt	Derbyshire Health United 111 (East Midlands) Community Interest Company representation

Table 57 – members of the People and Culture Committee during 2024/25

Significant items that were discussed and approved by the People and Culture Committee during 2024/25 are shown in Table 58 below.

Significant items approved/discussed by People and Culture Committee during 2024/25	
Agency Reduction Plan	System Culture and Organisational Development
Board Assurance Framework	Workforce Operational Plan
Derbyshire Academy	Workforce Oversight
People Services Delivery Board	

Table 58 – Significant items discussed and approved by the People and Culture Committee during 2024/25

The composition of the Population Health and Strategic Commissioning Committee is shown in Table 59 below.

Population Health and Strategic Commissioning Committee	Position
System Members	
Richard Wright	Chair – Non-Executive Member (from 1st May 2024 to 8th November 2024) ICB Chair (up to 30th April 2024)
Margaret Gildea	Non-Executive Member and Senior Independent Director
Dr Adedeji Okubadejo	Clinical Lead Member
James Reilly	Non-Executive Director, DCHSFT
Sardip Sandhu	Non-Executive Director, UHDBFT
Mark Powell	Chief Executive Officer, DHcFT (up to 8th August 2024)
Dr Penny Blackwell	Representative for Provider Collaborative at Place
Michelle Arrowsmith	Chief Strategy and Delivery Officer, and Deputy Chief Executive
Dr Chris Weiner	Chief Medical Officer, ICB
Ordinary Members	
Dr Avi Bhatia	Representative for Clinical and Professional Leadership Group
Dr Emma Pizzey	GP Clinical Lead
Dr Suneeta Teckchandani	Secondary Care Doctor
Lucy Smith	Allied Health Representative
Robyn Dewis	Director of Public Health, Derby City Council
Ellie Houlston	Director of Public Health, Derbyshire County Council
Prof Dean Howells	Chief Nurse Officer
Keith Griffiths	Chief Finance Officer (up to 30th November 2024)
Claire Finn	Interim Chief Finance Officer (from 1st December 2024)
Clive Newman	Director of GP Development, ICB
Steve Hulme	Director of Medicines Management and Clinical Policies, ICB
Linda Garnett	Interim Chief People Officer (up to 31st July 2024)
Lee Radford	Chief People Officer (from 1st July 2024)
Wynne Garnett	VCFSE Representative

Table 59 – members of the ICB's Population Health and Strategic Commissioning Committee during 2024/25

Significant items that were discussed and approved by the Population Health and Strategic Commissioning Committee during 2024/25 are shown in Table 60 below.

Significant items approved/discussed by Population Health and Strategic Commissioning Committee 2024/25	
All Age Continuing Care	Living Wage and National Insurance Changes
Board Assurance Framework	Living Well
Business Cases	Operational Plan 2024/25 and 2025/26

Significant items approved/discussed by Population Health and Strategic Commissioning Committee 2024/25	
Children's Physical Health Needs in Education	Performance against strategic direction
Clinical Policy Advisory Group	Pharmacy, Optometry and Dental Services
Clinical Professional Leadership Group	Population Dara Insights
Commissioning and Procurement	Primary Care Access Recovery
Contract Awards and Extensions	Primary Care Sub-Group
CVD Prevention Plan	Provider Selection Regime
General Practice Strategy	Reprocurements
Gender Dysphoria	Research Strategy
Health Protection Board	Respiratory Services
Increased Demand in Services	Seasonal Planning
Integrated Performance Report	Risk Management
IVF Services	VCFSE Services
Joint Area Prescribing Committee	Women's Health Hubs
Joint Forward Plan	

Table 60 – Significant items discussed and approved by the Population Health and Strategic Commissioning Committee during 2024/25

The composition of the Public Partnership Committee is detailed in Table 61 below:

Public Partnership Committee Member	Position
Voting Members	
Richard Wright	Chair – Non-Executive Member (from 1st May 2024 to 8th November 2024) ICB Chair (up to 30th April 2024)
Sue Sunderland	Non-Executive Member
Steven Bramley	Lay Representative
Tim Peacock	Lay Representative
Jocelyn Street	Lay Representative
Patricia Coleman	Lay Representative
Carol Warren	Lead Governor, CRHFT
Val Haylett	Public Governor, UHDBFT
Lynn Walshaw	Deputy Lead Governor, DCHSFT
Hazel Parkyn	Public Governor, DHcFT
Neil Woodhead	Service Manager – Locality Working, Derby City Council
Kim Harper	Chief Officer, Community Action Derby
Non-Voting Members	
Amy Salt	Engagement and Involvement Manager, Healthwatch Derbyshire
James Moore	Chief Executive Officer, Healthwatch Derby (from 25th February 2025)

Public Partnership Committee Member	Position
Helen Dillistone	Chief of Staff, ICB
Sean Thornton	Director Communications and Engagement, ICB/JUCD
Karen Lloyd	Head of Engagement, ICB/JUCD

Table 61 – members of the Public Partnership Committee during 2024/25

Significant items that were discussed and approved by the Public Partnership Committee during 2024/25 are shown in Table 62 below.

Significant items approved/discussed by Public Partnership Committee during 2024/25	
Board Assurance Framework	Learning Disability Short Breaks
Co-Production Framework	Patient and Public Involvement Assessment and Planning Form Log
Community and Same Day Urgent Care	Performance Reporting
Derbyshire Health Inequalities Partnership	Post-Covid-19
Hypertension	Risk Management
Insight Strategy	Stroke Rehabilitation Engagement Plan
Integrated Care Experience Survey	Women's Health Hub
Lay Reference Group	

Table 62 – Significant items discussed and approved by the Public Partnership Committee during 2024/25

The composition of the Quality and Performance Committee is detailed in Table 63 below:

Quality and Performance Committee Member	Position
Dr Adedeji Okubadejo	Chair – Clinical Lead Member
Jill Dentith	Non-Executive Member
Prof Dean Howells	Chief Nurse Officer
Dr Chris Weiner	Chief Medical Officer
Michelle Arrowsmith	Chief Strategy and Delivery Officer, and Deputy Chief Executive
Chris Harrison	Non-Executive Director, UHDBFT
Nora Senior	Non-Executive Director, CRHFT
Lynn Andrews	Non-Executive Director, DHcFT
Kay Fawcett	Non-Executive Director, DCHSFT
Robyn Dewis	Director of Public Health, Derby City Council
Gemma Poulter	Assistant Director Adult Social Care, Derbyshire County Council

Table 63 – members of the Quality and Performance Committee during 2024/25

Significant items that were discussed and approved by the Quality and Performance Committee during 2024/25 are shown in Table 64 below.

Significant items approved/discussed by Quality and Performance Committee during 2024/25	
Ambulance Handover Delays	Patient Safety
Breaches and Long Waits Harm Review	Policies
Blood Spot Testing	Primary Care Early Warning System
Board Assurance Framework	Quality Accounts
Care Quality Commission	Quality of Care
Contract Awards	Quality Framework
Infection Prevention and Control	Right Care Right Person Deep Dive
Integrated Performance Report	Local Maternity and Neonatal Services
Learning Disabilities and Autism	Safeguarding Adults and Children
Mental Health	Stroke Services
National Patient Safety Strategy and Learning	System Quality Group Assurance
Nursing and Midwifery Excellence	Virtual Wards
Operational Plan	

Table 64 – Significant items discussed and approved by the Quality and Performance Committee during 2024/25

Appendix 7: Control Issues

Quality and Performance – Maternity

Quality and Safety of Maternity services

In 2023, both CRHFT and UHDBFT received CQC maternity service inspections. CRHFT were rated 'good' for safe and well-led services. UHDBFT received an 'inadequate' rating and enforcement notices, section 31 at Royal Derby Hospital, and section 29a at both Royal Derby Hospital and Queen's Hospital Burton. Previous concerns highlighted in safety reports led UHDBFT to voluntarily enter the NHSE Maternity Safety Support Programme in March 2023.

The oversight for governance and compliance of the subsequent maternity improvement plan and enforcement notices was via the Tier 3 oversight meeting in 2024/25, which is chaired jointly by the Regional Chief Nurse and ICB Executive Chief Nurse. CQC conducted a reinspection of UHDBFT in December 2024 and the report is awaited by the Trust.

Of the eight recommendations listed under section 31, six were requested for removal following the February 2025 submission of evidence. The remaining conditions are being worked through, for application for removal in 2025/26. The Maternity Safety Support Programme will remain in place until January 2026 pending review by NHSE, CQC and the ICB.

The LMNS led insight visits to review progress against the NHSE 3-Year Delivery Plan were completed in 2024/25 at CRHFT and UHDBFT, with full oversight and assurance of maternity and neonatal services follow up visits in 2025/26. No immediate safety concerns were identified and progress against the interventions to meet the 3-Year Delivery Plan was evidenced.

UHDBFT have received support from the NHS Midlands perinatal team in 2024/25 with quality improvement projects for fetal monitoring in labour and training, post-partum haemorrhage, clinical escalation, triage, leadership and governance. Progress has been made with leadership and governance, and the introduction of an improved triage system and this was evidenced through the recent insight visit, with evidence of improvements in practice and outcomes with regards to fetal monitoring in labour.

National Compliance Exceptions

UHDBFT met 2 out of 10 safety actions of Clinical Negligence Scheme for Trusts Maternity Incentive Scheme year 5, however an improved compliance is anticipated for year 6. Compliance with safety action 6 'saving babies lives' is to be confirmed following the Q3 review. An assurance visit by the LMNS is planned for April 2025, as there is currently an increased level of oversight by NHSE in place for the Maternity Safety Support Programme. CRHFT met 6 out of 10 safety actions of the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme year 5 and are expected to meet compliance with all 10 in year 6. In December, the LMNS conducted an insight visit at CRHFT for oversight of compliance with the 3-Year Delivery Plan for maternity and neonatal services. No safety concerns were identified and evidence of progress with all four themes was seen.

Maternal Morbidity

A maternity improvement plan is currently in place for UHDBFT and includes quality improvements for the management of major obstetric haemorrhage, however this will remain an area of concern until management is evidenced as embedded.

CRHFT's rate of third and fourth-degree tears has fluctuated to above the national average and to an outlier position. The NHS Midlands perinatal team currently support CRHFT with quality improvements to reduce the rates of perineal injury. Plans to implement a perinatal pelvic health service are progressing well and will be supported by a newly appointed Consultant Midwife.

Quality and Performance – Infection Prevention and Control

HCAI performance for the Derbyshire System, up to the 31st March 2025:

- Clostridioides difficile infection (CDI) cases for the Derbyshire System were reported as 425, which was 63% over threshold). At CRHFT, there are 64 cases (28% over threshold) and at UHDBFT there are 191 cases (7% over threshold). Notably, there were more community-related cases, particularly in Q1 and Q2;
- there are 15 cases of MRSA blood stream infection cases reported for 2024/25, against a zero-tolerance policy showing an improvement from the 17 cases reported in 2023/24. No cases were reported in Q4 of 2024/25;
- for GNBSI, Escherichia coli has shown a slow increase over the last few years, which is being monitored. These infections are monitored with provider infection prevention and control (IPC) groups, where additional actions are agreed and added to existing improvement plans. Klebsiella and Pseudomonas infections presented a stabilizing picture during the second half of the year;
- despite continued work and scrutiny around IPC practices, all infections have breached NHSE thresholds at both the System and acute Trust-levels. HCAIs pose a serious risk to patients, clients, staff and visitors to health and social care premises. They can cause significant morbidity and mortality for those infected and can incur significant costs;
- UHDBFT and CRHFT continue to implement the Patient Safety Incident Response Framework methodology for IPC events. DCHSFT is currently reviewing its approach due to a low number of incidents. Both thematic and individual case reviews support learning around practice and outcomes for patients who develop HCAIs. The IPC teams at both providers are involved in any mortality reviews and learning and feedback to clinicians is supported through 'harm review' and 'learning through deaths' processes;
- UHDBFT and CRHFT remain on enhanced monitoring and support as per the NHSE Midlands escalation matrix. Recovery plans are in place for both providers, and assurance has been obtained through IPC groups regarding the implementation of these plans to ensure that actions remain appropriate and start to show improvements. Regional support to investigate the rise in community CDI cases and identify any learning from the best-performing systems has been sought and a task and finish group is due to commence in June 2025; and

- UHDBFT and CRHFT experienced increases in outbreaks associated with winter-related illnesses during Q3 and Q4. Risk-based management of outbreaks supported expediting recovery while minimising disruption to patient flow.

Quality and Performance – Ambulance Services

For March 2025, EMAS were non-compliant for all six national response time standards at a regional-level. At an ICB-level the C1 mean 90th centile was achieved. Derbyshire also saw an improvement across all six standards when compared to the previous month. During 2024/25, Q3 reflected longer response times across Derbyshire, and there was significant improvement seen during Q4 due to the introduction of 45-minute handovers.

During March 2025, 26.8% of EMAS ambulance handovers happened within 15 minutes, with CRHFT running at 46.6% and UHDBFT at 20.6%.

Ambulance Category 2 Response Times

The target C2 response times varied through the year based on seasonal variations, but the overall target was to deliver an average C2 mean of 30 minutes across 2024/25. Unfortunately this target was not met, averaging 43 minutes and 18 seconds. Actual incident numbers have been -0.9% lower than expected during April to March 2025.

Quality and Performance – Mental Health and Dementia

Increase in Access to Talking Therapies

Access continues to be better than the six-week wait and 18-week wait national standard. Recovery rates and reliable improvement rates are both better than target. Timescales for the gap between 1st and 2nd treatment being less than 90 days ended the year at 16% against a target of 10%. Plans have been agreed with providers to improve this position. Recovery performance is exceeding the national standard, and the BME recovery rate is 47% against a 48% standard.

MH Out-of-Area Placements

Continued pressure within acute services is resulting in greater demand for PICU. As at the 31st March 2025, local data indicated that 10 individuals are in inappropriate out-of-area placements against a target of 0. Discussions are taking place between the ICB and DHcFT to ensure that inappropriate OAPs are being captured and reported correctly, paying close attention to official definitions.

SMI Annual Health Checks Increase in Access

As at the 31st March 2025, 59% of people on the serious mental illness register had received all six aspects of an annual health check, which is under the 73% target.

LD Annual Health Checks Increase in Access

As at the 31st March 2025, 69.9% of people on the LD register had received their annual health check, just short of the 75% target.

Quality and Performance – Accident and Emergency

Derbyshire failed to deliver against the national 95% 4-hour standard during the year. A performance of 63.1% by March 2025 for the ICB was attributed predominantly to underperformance at both UHDBFT and CRHFT.

University Hospitals of Derby and Burton NHS Foundation Trust

The ED at the Derby hospital site failed to deliver against the 4-hour national standard, with performance during March 2025 being 64.8%.

12-hour trolley breaches

From the 1st April 2024 to the 31st March 2025 there were 11,286 12-hour trolley breaches, against a target of zero and more than double the number for 2023/24. This was predominantly due to medical bed availability, although a lack of mental health beds still accounted for the breaches.

Chesterfield Royal Hospital NHS Foundation Trust

CRHFT failed to deliver against the 4-hour national standard, with performance during March 2025 being 58.5%.

12-hour trolley breaches

From the 1st April 2024 to the 31st March 2025 there were 1,964 12-hour trolley breaches, mainly due to limited availability of medical beds. These had risen by 38% compared to 2023/24.

Quality and Performance – Diagnostics

JUCD have a 95% standard for patients waiting under six weeks for a diagnostic test. Performance for this standard at CRHFT for March 2025 was 59.3%, which showed a deterioration when compared to the 70.7% achieved in March 2024. UHDBFT's performance for March 2025 was 78.5%, which showed a deterioration from the 78.9% achieved in March 2024.

Quality and Performance – Access to Service/Capacity

The proportion of beds occupied within urgent and emergency care by adult patients without 'criteria to reside' in March 2025 was 10%, which is higher than the 8.7% target. At CRHFT, this was 14.3% (with a target of 14.1%) and 8.4% at UHDBFT (with a target of 7%).

General and acute adult bed occupancy was marginally worse than plan at UHDBFT (95% against a target of 94%), and CRHFT was worse than plan at 96% (against a target of 93%). However, it should be noted that this was not true core bed occupancy as more beds are open.

Quality and Performance – Cancer

28-day faster diagnosis standard

As at March 2025, Derbyshire was not achieving the 75% target, with CRHFT at 77.0% and UHDBFT at 75.1%. However, both Trusts did achieve the target at some point during the year.

31-day standard

The ICB achieved 88.3% in March 2025, which was a sustained level but short of the 96% constitutional standard.

62-day standard

The ICB achieved 72.7% for March 2025, which was an improvement, and the target was achieved.

Quality and Performance – referral to treatment

18-week referral to treatment

Incomplete pathways continue to be non-compliant for Derbyshire. Both UHDBFT and CRHFT had failed to meet the 92% standard (56.8% and 53.9% respectively) for March 2025.

Long-waiting referral to treatment

The total numbers of long-waiting referrals to treatment in Derbyshire had risen to 2,990 for March 2025. However, there was a focus on having zero very long waiters and there were 2,846 patients waiting 52+ weeks in March 2025, a 53% reduction since March 2024. For most months there are zero patients waiting 104+ weeks and the numbers of 78+ week waits had reduced by two by March 2025, waiting at providers outside of the Derbyshire System.

Quality and Performance – Prescribing

Aseptic service fragility

The ICB's System Quality Group ensure system oversight of the current position regarding regulatory compliance within aseptic preparation services at UHDBFT.

UHDBFT approved investment in aseptic preparation services in July 2025. Capital funding in 2025/26 is needed to continue facility upgrades and equipment purchases to meet demand and good manufacturing practice standards.

Collaborative working at a regional level is progressing via the East Midlands Acute Provider Collaborative and includes business continuity planning and the development of a strategic outline case for a regional aseptic preparation hub.

Medicines Shortages

Medicines shortages remain a significant challenge across the NHS and are increasingly recognised as a national issue. We continue to monitor and respond to these pressures through close collaboration with system partners and adherence to national guidance, including the Medicines Supply Tool and tiered impact classifications. We remain committed to ensuring patient safety and equitable access to essential medicines despite these ongoing constraints.

GP Collective Action

We continue to monitor the impact of ongoing GP collective action on medicines optimisation services.

Pharmacy Workforce

The System continues to face challenges in maintaining a stable and sustainable pharmacy workforce. In response, the Derbyshire Pharmacy Faculty has led a series of targeted initiatives to build resilience and sustainability. These include the development of a comprehensive pharmacy workforce programme, aligned with the Integrated Pharmacy and Medicines Optimisation Strategy. System partners have worked together to address issues through workforce planning, education and training initiatives, and support for new roles and placements for foundation trainee pharmacists and pharmacy technicians.

NICE Technology Appraisal

Development of a service model is underway to implement the Tirzepatide NICE technology appraisal.

Appendix 8: ICB Attendance at Meetings during 2024/25

ICB Board

ICB Board Member		16 May 2024	18 Jul 2024	19 Sep 2024	21 Nov 2024	16 Jan 2025	20 Mar 2025
Dr Kathy McLean	Chair (from 1st May 2024)	✓	✓	✓	✓	✓	✓
Richard Wright	Chair (up to 30th April 2024) Non-Executive Member (from 1st May 2024 to 8th November 2024)	✓	X	✓			
Dr Adedeji Okubadejo	Clinical Lead Member	✓	X	✓	✓	✓	✓
Dr Chris Clayton	Chief Executive Officer	✓	✓	✓	✓	✓	✓
Tracy Allen	Participant to the Board for Place – Derbyshire Community Health Services NHS Foundation Trust (up to 15th September 2024)	✓	X				
James Austin	Participant to the Board for Place – Derbyshire Community Health Services NHS Foundation Trust (from 16th September 2024) Chief Digital Information Officer (up to 1st August 2024)	✓	✓	✓	✓	✓	✓
Stephen Posey	Partner Member – University Hospitals of Derby and Burton NHS Foundation Trust	✓	✓	✓	✓	✓	✓
Mark Powell	Partner Member – Derbyshire Healthcare NHS Foundation Trust	✓	✓	X	✓	X	✓
Dr Andrew Mott	Partner Member – Primary Medical Services	✓	✓	✓	✓	✓	✓
Perveez Sadiq	Partner Member – Derby City Council (up to 31st October 2024)	✓	✓	✓*			
Paul Simpson	Partner Member – Derby City Council (from 1st November 2024)				✓	✓	X
Ellie Houlston	Partner Member – Derbyshire County Council	✓	X	✓	✓	✓	X
Margaret Gildea	Non-Executive Member and Senior Independent Director	✓	✓	✓	✓	✓	✓
Sue Sunderland	Non-Executive Member	✓	✓	✓	✓	✓	✓
Jill Dentith	Non-Executive Member	✓	✓	✓	✓	✓	✓
Nigel Smith	Non-Executive Member (from 1st January 2025)					✓	✓
Michelle Arrowsmith	Chief Strategy and Delivery Officer, and Deputy Chief Executive	✓	✓	✓	✓*	✓	✓
Keith Griffiths	Chief Finance Officer (up to 30th November 2024)	✓	✓	✓	✓*		
Claire Finn	Interim Chief Finance Officer (from 1st December 2024)					✓	✓
Dr Chris Weiner	Chief Medical Officer	✓	X	X	✓	✓	X

* Indicates where a member was deputised.

ICB Board Member		16 May 2024	18 Jul 2024	19 Sep 2024	21 Nov 2024	16 Jan 2025	20 Mar 2025
Prof Dean Howells	Chief Nurse Officer	✓	✓	✓	✓	✓	✓
Linda Garnett	Interim Chief People Officer (up to 31st July 2024)	✓	✓				
Lee Radford	Chief People Officer (from 1st July 2024)		✓	✓	✓	✓	✓
Helen Dillistone	Chief of Staff	✓	✓	✓	✓	✓	✓
Dr Avi Bhatia	Clinical & Professional Leadership Group Participant to the Board	✓	✓	X	X	✓	✓

Audit and Governance Committee

Audit and Governance Committee Member		2 May 2024	19 Jun 2024	8 Aug 2024	10 Oct 2024	12 Dec 2024	13 Feb 2025
Sue Sunderland	Chair – Non-Executive Member	✓	✓	✓	✓	✓	✓
Jill Dentith	Non-Executive Member	✓	✓	✓	✓	✓	X
Margaret Gildea[3]	Non-Executive Member and Senior Independent Director	✓	✓	X	✓	✓	✓
Nigel Smith	Non-Executive Member (from 1st January 2025)						✓

[3] 'By invitation' in accordance with the Committee's workplan

Remuneration Committee

Remuneration Committee Member		19 Apr 2024	28 Jun 2024	16 Jul 2024	13 Aug 2024	8 Oct 2024	5 Dec 2024	28 Jan 2025	6 Mar 2025
Margaret Gildea	Chair – Non-Executive Member and Senior Independent Director	✓	✓	✓	✓	✓	✓	✓	✓
Richard Wright	Chair (up to 30th April 2024) Non-Executive Member (from 1st May 2024 to 8th November 2024)	✓	✓	X	✓	✓			
Dr Kathy McLean	Chair (from 1st May 2024)		✓	✓	✓	✓	✓	✓	✓
Dr Adedeji Okubadejo	Clinical Lead Member	✓	X	X	X	X	✓	X	✓
Nigel Smith	Non-Executive Member (from 1st January 2025)							✓	✓

Finance, Estates and Digital Committee

Finance, Estates and Digital Committee Member		23 Apr 2024	28 May 2024	25 Jun 2024	23 Jul 2024	27 Aug 2024	24 Sep 2024	22 Oct 2024	26 Nov 2024	28 Jan 2025	25 Feb 2025	25 Mar 2025
Jill Dentith	Chair – Non-Executive Member	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓
Sue Sunderland	Non-Executive Member	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Keith Griffiths	Chief Finance Officer, ICB (up to 30th November 2024)	✓	✓	✓	✓	✓	✓	✓	✓			
Claire Finn	Director of Finance, UHDBFT (from 24th September 2024 and up to 30th November 2024) Interim Chief Finance Officer (from 1st December 2024)						✓	✓	✓	✓	✓	X
Jason Burn	Interim Director of Finance - Operations & Delivery (up to 16th August 2024)	✓	✓	X	✓							
David Hughes	Director of Finance (from 1st August 2024)					✓	✓	✓	X	✓	✓	✓
Jennifer Leah	Director of Finance - Strategy & Planning, ICB (from 22nd July 2024)				✓	X	X	✓	✓	X	X	✓
Michelle Arrowsmith	Chief Strategy and Delivery Officer, and Deputy Chief Executive	✓	✓	X	X	✓*	✓	✓*	X	✓*	X	✓*
Ian Lichfield	Non-Executive Director, UHDBFT	X	X	X	X	X	✓	X	X	X	X	X
Stuart Proud	Non-Executive Director, DCHSFT	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	X
Steve Heppinstall	Executive Director of Finance, UHDBFT	✓	X	✓	✓	✓	✓	X	✓	✓	✓	X
Simon Crowther	System Estates Lead/Executive Director Finance & Performance/Interim Deputy CEO, UHDBFT (up to 23rd September 2024)	✓*	✓*	X	✓	X						
Chris Sands	Director of Finance, UHDBFT (from 26th November 2024)								✓	✓	X	X
Peter Handford	Chief Finance Officer, DCHSFT	X	✓	✓	✓	✓	✓*	X	✓	X	✓	X
James Sabin	Chief Finance Officer, DHcFT	✓	X	X	X	✓	✓	✓	✓	✓	✓	X

* Indicates where a member was deputised.

Finance, Estates and Digital Committee Member		23 Apr 2024	28 May 2024	25 Jun 2024	23 Jul 2024	27 Aug 2024	24 Sep 2024	22 Oct 2024	26 Nov 2024	28 Jan 2025	25 Feb 2025	25 Mar 2025
Mike Naylor	Director of Finance, EMAS (up to 22nd October 2024)	✓	✓	✓	X	✓	✓	✓				
Stuart Poynor	Director of Finance, EMAS (from 26th November 2024)								✓	✓	X	✓
Transitional Members												
James Austin	Chief Digital Information Officer, ICB (up to 1st August 2024)	✓		✓*								
Dawn Atkinson	Programme Director, ICS Digital Programme, DCHSFT (from 1st August 2024)					✓		✓		X		✓
Tamsin Hooton	Programme Director, Provider Collaborative, JUCD	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Susan Whale	Director of System PMO & Improvement, UHDBFT	✓		✓	✓	X	✓	✓		✓	✓	✓

People and Culture Committee

People and Culture Committee Member		25 April 2024	27 Jun 2024	11 Dec 2024	27 Feb 2025
Margaret Gildea	Chair – Non-Executive Member and Senior Independent Director	✓	✓	✓	✓
Jill Dentith	Non-Executive Member	✓	✓	✓	X
Linda Garnett	Interim Chief People Officer (up to 31st July 2024)	✓	✓		
Lee Radford	Chief People Officer (from 1st July 2024)			✓	✓
Janet Dawson	Non-Executive Member, DCHSFT	✓	✓	✓	X
Ralph Knibbs	Non-Executive Member, DHcFT	X	✓	X	X
Billie Lam	Non-Executive Member, UHDBFT	✓	✓	X	X
Atul Patel	Non-Executive Member, CRHFT (up to 15th January 2025)	X	✓	✓	X
Amanda Rawlings	Chief People Officer, UHDBFT	✓	X	✓*	X
Darren Tidmarsh	Chief People Officer, DCHSFT	✓	✓	✓	✓
Rebecca Oakley	Deputy Director of People & Inclusion, DHcFT	X	X	X	✓
Kerry Gulliver	Director of HR & Organisational Development, EMAS	X	X	X	X

* Indicates where a member was deputised.

People and Culture Committee Member		25 April 2024	27 Jun 2024	11 Dec 2024	27 Feb 2025
Caroline Wade	Director of HR & Organisational Development, CRHFT	✓	✓	✓	✓
Penelope Blackwell	Chair of Integrated Place Executive	X	X	X	✓
Jen Skila	Assistant HR Director, Derbyshire County Council (up to 14th November 2024)	✓	✓		
Lorraine Booth	Interim Assistant HR Director, Derbyshire County Council (from 15th November 2024)			✓	X
Liz Moore	Head of HR, Derby City Council	✓	✓	✓	✓
Susie Bayley	Medical Director, General Practice Taskforce Derbyshire	✓	✓	X	✓
Zahra Leggatt	Derbyshire Health United 111 (East Midlands) Community Interest Company representation	✓	X	✓*	✓

* Indicates where a member was deputised.

Population Health and Strategic Commissioning Committee

Population Health and Strategic Commissioning Committee Member		11 Apr 2024	9 May 2024	13 Jun 2024	8 Aug 2024	24 Oct 2024	14 Nov 2024	9 Jan 2025	13 Feb 2025	13 Mar 2025
Core Members										
Richard Wright	Chair, Non-Executive Member (from 9th May and up to 8th November 2024)		✓	✓	✓	✓				
Maragaret Gildea	Chair (from 9th November 2024) and Non-Executive Member and Senior Independent Director	✓	✓	✓	X	✓	✓	✓	✓	✓
Dr Adedeji Okubadejo	Clinical Lead Member	✓	✓	✓	✓	X	X	✓	✓	✓
James Reilly	Non-Executive Director, DCHSFT	X	✓	✓	✓	X	✓	✓	✓	X
Sardip Sandhu	Non-Executive Director, UHDBFT	✓	X	✓	✓	X	X	X	✓	X
Mark Powell	Chief Executive Officer, DHcFT (up to 8th August 2024)	X	X	X	X					
Dr Penny Blackwell	Representative for Provider Collaborative at Place	X	X	✓	X	X	✓	✓	X	✓
Michelle Arrowsmith	Chief Strategy and Delivery Officer, and Deputy Chief Executive, ICB	✓	✓	✓	✓	✓	X	✓	✓	✓
Dr Chris Weiner	Chief Medical Officer, ICB	✓	✓	✓	✓	✓	X	✓	✓*	✓
Ordinary Members										
Dr Avi Bhatia	Representative for Clinical & Professional Leadership Group	✓	✓	X	✓	X	✓	✓	✓	✓
Dr Emma Pizzey	GP Clinical Lead	X	✓	X	✓	✓	X	✓	✓	✓
Dr Suneeta Teckchandani	Secondary Care Doctor	✓	✓	✓	✓	✓	✓	X	✓	✓
Lucy Smith	Allied Health Professional Representative (from 1st April 2024)	X	X	X	X	X	✓	✓	X	X
Robyn Dewis	Director of Public Health, Derby City Council	X	✓	✓	✓	✓	✓	✓	✓	X
Ellie Houlston	Partner Member – Derbyshire County Council	✓	✓	X	X	✓	X	✓	✓	✓
Prof Dean Howells	Chief Nurse Officer, ICB	✓	X	X	X	✓*	✓	X	X	✓
Keith Griffiths	Chief Finance Officer, ICB (up to 30th November 2024)	✓	✓	✓	X	X	X			
Claire Finn	Interim Chief Finance Officer (from 1st December 2024)							✓	X	✓
Clive Newman	Director GP development, ICB	✓	X	✓	✓	✓	✓	✓	X	X
Steve Hulme	Chief Pharmacy Officer, ICB	✓	X	✓	X	✓	X	X	✓*	✓
Linda Garnett	Interim Chief People Officer, ICB (up to 31st July 2024)	✓	✓	✓						
Lee Radford	Chief People Officer (from 1st July 2024)				✓	✓	X	X	X	X
Wynne Garnett	VCFSE Representative (from 1st April 2024)	✓	✓	✓	✓	✓	✓	X	✓	✓

* Indicates where a member was deputised.

Public Partnership Committee

Public Partnership Committee Member		30 Apr 2024	25 Jun 2024	30 Jul 2024	24 Sep 2024	26 Nov 2024	28 Jan 2025	25 Feb 2025
Voting Members								
Richard Wright	Chair (up to 30th April 2024) Non-Executive Member (from 1st May 2024 to 8th November 2024)	✓	✓	✓	✓			
Sue Sunderland	Non-Executive Member	✓	✓	✓	✓	✓	✓	✓
Steven Bramley	Lay Representative	✓	✓	X	✓	✓	✓	✓
Tim Peacock	Lay Representative	✓	X	✓	✓	✓	✓	✓
Jocelyn Street	Lay Representative	✓	X	✓	✓	✓	✓	✓
Patricia Coleman	Lay Representative	X	✓	✓	X	✓	✓	✓
Carol Warren	Lead Governor, CRHFT	✓	✓	✓	X	✓	✓	✓
Val Haylett	Public Governor, UHDBFT	✓	X	X	X	✓	✓	X
Lynn Walshaw	Deputy Lead Governor, DCHSFT	✓	X	✓	✓	X	✓	✓
Hazel Parkyn	Public Governor, DHcFT	✓	✓	X	✓	X	✓	✓
Neil Woodhead	Service Manager – Locality Working, Derby City Council	✓	X	X	✓	✓	✓	X
Kim Harper	Chief Officer, Community Action Derby	X	X	✓	✓	✓	X	X
Non-Voting Members								
Amy Salt	Engagement and Involvement Manager, Healthwatch Derbyshire	✓	✓	X	✓	X	✓*	✓
Helen Dillistone	Chief of Staff, ICB	✓	✓	✓	✓	X	✓	X
Sean Thornton	Deputy Director Communications & Engagement, ICB/JUCD	✓	✓	✓	✓	✓	✓	✓
Karen Lloyd	Head of Engagement, ICB/JUCD	✓	✓	✓	✓	✓	✓	✓

* Indicates where a member was deputised.

Quality and Performance Committee

Quality and Performance Committee Member		25 Apr 2024	30 May 2024	27 Jun 2024	25 Jul 2024	29 Aug 2024	31 Oct 2024	28 Nov 2024	30 Jan 2025	27 Feb 2025	27 Mar 2025
Dr Adedeji Okubadejo	Chair – Clinical Lead Member	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jill Dentith	Non-Executive Member	✓	✓	✓	✓	X	✓	✓	✓	✓	✓
Prof Dean Howells	Chief Nurse Officer	✓	✓*	✓	✓	✓*	✓*	✓*	✓	✓	✓
Dr Chris Weiner	Chief Medical Officer	✓	X	✓	✓*	✓	✓	✓	✓*	✓	✓
Michelle Arrowsmith	Chief Strategy and Delivery Officer, and Deputy Chief Executive	✓	✓	✓	✓*	X	✓	✓	✓*	✓*	X
Chris Harrison	Non-Executive Director, UHDBFT	X	X	X	X	X	X	X	X	X	X
Nora Senior	Non-Executive Director, CRHFT	X	X	X	X	X	X	X	X	X	X
Lynn Andrews	Non-Executive Director, DHcFT	✓	X	✓	✓	X	✓	✓	X	✓	X
Kay Fawcett	Non-Executive Director, DCHSFT	✓	✓	X	X	✓	✓	✓	X	X	X
Robyn Dewis	Director of Public Health, Derby City Council	✓	X	✓	✓	X	✓	✓	✓	✓	X
Gemma Poulter	Assistant Director Adult Social Care, Derbyshire County Council	X	X	X	X	X	X	X	X	X	X

* Indicates where a member was deputised.

Appendix 9: Glossary

A&E	Accident and Emergency
AACC	All Age Continuing Care
AHP	Allied Health Professionals
ARRS	Additional Roles Reimbursement Scheme
C1/C2/C3/C4	Category 1/2/3/4
CETV	Cash Equivalent Transfer Value
CHC	Continuing Healthcare
CQC	Care Quality Commission
CRHFT	Chesterfield Royal Hospital NHS Foundation Trust
CYP	Children and Young People
DCHSFT	Derbyshire Community Health Services NHS Foundation Trust
DHcFT	Derbyshire Healthcare NHS Foundation Trust
DHU	Derbyshire Health United Community Interest Company
DIN	Diversity and Inclusion Network
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation Process
ED	Emergency Department
EDS	Equality Delivery System
EMAS	East Midlands Ambulance Service NHS Trust
EPRR	Emergency Preparedness Resilience and Response
FTE	Full-Time Equivalent
GNBSI	Gram-negative bloodstream infection
GP	General Practitioner
HCAI	Healthcare-Acquired Infection
HR	Human Resources
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
IT	Information Technology
JUCD	Joined Up Care Derbyshire

k	Thousand
KPI	Key Performance Indicator
LeDeR	Learning Disabilities Mortality Review
LMNS	Local Maternity and Neonatal System
m	Million
MDI	Metered Dose Inhaler
MHIS	Mental Health Investment Standard
MRSA	Methicillin-resistant Staphylococcus aureus
MSK	Musculoskeletal
NECSU	North of England Commissioning Support Unit
NHS	National Health Service
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
OEIG	Organisation Effectiveness and Improvement Group
PCN	Primary Care Network
PPG	Patient Participation Group
PSED	Public Sector Equality Duty
PSII	Patient Safety Incident Investigations
PSIRF	Patient Safety Incident Response Framework
Q1/Q2/Q3/Q4	Quarter 1/2/3/4
ReSPECT	Recommended Summary Plan for Emergency Care and Treatment
SDEC	Same-Day Emergency Care
SEND	Special Educational Needs and Disabilities
UHDBFT	University Hospitals of Derby and Burton NHS Foundation Trust
UTC	Urgent Treatment Centre
VCFSE	Voluntary, Community and Social Enterprise and Faith Sector
VSM	Very Senior Manager
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard

Derby and Derbyshire
Integrated Care Board

About NHS Derby and Derbyshire Integrated Care Board

NHS Derby and Derbyshire Integrated Care Board brings the NHS together locally to improve population health and care services for around 1.4 million people in Derbyshire. Our vision is to continuously improve the health and wellbeing of the people of Derby and Derbyshire, using all resources as fairly as possible.

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