NHS
Derby and Derbyshire
Integrated Care Board

NHS Derby and Derbyshire Integrated Care Board Annual Report

1st July 2022 – 31st March 2023







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FOREWORD

Welcome to the first annual report and accounts of NHS Derby and Derbyshire Integrated Care Board (ICB). The organisation was formed on the 1st July 2022 and 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 (VCSE) 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 all now enshrined in law, with clearly defined strategic outcomes. This is in fact now much simpler in practice than it may sound, and this report seeks to explain these inter-relationships.

The legislation and subsequent implementation of these structural changes to our health and care system was welcomed in Derby and Derbyshire and helped to cement the arrangements we had already been developing to integrate care. Our history of partnership working stretches back many years and is strengthened by these arrangements, including the formal inclusion of new partners to benefit from increased expertise in our understanding of communities. One of the most important additions to the role and remit of ICBs is for us to secure the engagement and involvement of citizens in all elements of our work, ensuring that citizens are driving our decision-making processes through the sharing of their priorities and preferences. We already have expertise in formal engagement processes around service transformation, and our strengthened partnerships with community-facing organisations means we can further benefit from their knowledge and expertise in collaborating with people in local places at grassroots level.

As well as collaboration with citizens, the new structures also benefit from strengthened collaboration among services and partners. Collaborating at district level – identified in the legislation as 'Places' – and across NHS provider organisations working at scale will bring many benefits. These benefits are local as care is further joined up, and universal as we seek to eliminate unwanted variations in care delivery and improve the outcomes for local people. We already have many examples of how these partnerships are making a difference in communities, and this report highlights just some of them.

All these steps are founded on having strong relationships, and implementation will take time before the true results can be quantified, particularly regarding increased life expectancy and reducing health inequalities. In Derby and Derbyshire, we are faced with a wide variation in the health outcomes of the population. As an example, on average, living in Bolsover means you will die three or four years earlier than someone who lives in the Derbyshire Dales, and life expectancy in Bolsover is below the national average. Smoking is the most significant cause of preventable ill health and early death in the UK; Derbyshire overall has lower

numbers of adults smoking than the national average, but parts of Derbyshire have rates much higher and suffer disproportionately from cancers and other related illnesses as a result. We have higher rates of vaccination among our White British population than in Black African, Black Caribbean and Asian populations, which means that there are lower rates of protection against some diseases in these communities. There are multiple other measures which identify that while we have good health in many parts of Derby and Derbyshire, there are communities for which we must do more.

This first ICB annual report begins to articulate the steps we are making, and we believe we are on the right track to deliver our aims of improving health and reducing health inequalities across the population of Derby and Derbyshire. The solutions lie in:

- Integrated Care – where services work together in communities to improve the health and wellbeing of our population and empower individuals and communities to make their own improvements using the skills and strengths they already hold;
- Integrated Commissioning – where we seek to align funding and priorities to commission across the spectrum of local needs, taking into account the impact of wider issues on a person's health and wellbeing; and
- Integrated Governance – where we remove duplication from planning and decision-making, mutually manage outcomes and ensure there is collective focus on the overall objectives we are seeking to achieve.

Alongside the new arrangements for working within the ICS, our health and care system has spent the last year managing significant pressure in our services, and more recently planning to continue to provide services during a range of industrial action measures across the NHS and wider public sector. Details of our approaches to managing pressure are provided within this report and I wanted to take the opportunity in this foreword to say thank you to everyone who has been involved in the continued planning and delivery of services. We continue to try to understand the sources of service pressure, and to solve issues relating to discharge and backlogs of care, but the thing that has remained constant is the commitment of health and care staff in working beyond the call of duty to keep our citizens safe and to provide the best possible care. I know that I speak on behalf of the whole ICB Board in expressing our considerable gratitude, and to provide an assurance that we are doing all we can to find solutions and make improvements. We also believe that many of the solutions to these challenges lie in on our ambitions for integrated care, seeking to tackle our community's health challenges in partnership.

John MacDonald
Chair
NHS Derby and Derbyshire Integrated Care Board
27th June 2023

PERFORMANCE REPORT

Dr Chris Clayton

Accountable Officer

NHS Derby and Derbyshire Integrated Care Board

27th June 2023

Chief Executive Officer's Statement

I am proud to be compiling this statement as the Chief Executive Officer of NHS Derby and Derbyshire Integrated Care Board at the end of its first period as a new NHS body. We have established a new organisation after receiving a sound, secure and compliant organisation from the former NHS Derby and Derbyshire Clinical Commissioning Group (CCG) on the 1st July 2022. I am grateful to the CCG's Governing Body for overseeing this process; the transition was important to ensure the ICB had a smooth start without avoidable legacy issues.

The ICB has spent time these first few months of establishment engaging with staff on our strategic framework; the Derby and Derbyshire Together programme has run in two waves during November and January and has engaged a significant proportion of staff and external partners in setting a defined purpose and vision.

Operationally, our health and care system has faced a series of challenges which we have continued to manage in a consistent, careful and coordinated manner. The Covid-19 pandemic continues, and we see ongoing waves of the disease, resulting in patient admissions to our hospitals, the success of the vaccination programme has meant that we are now in a post-Covid-19 phase and seeking to deal with the fallout from that challenging period, whilst also looking to the future.

In the immediate term, partnership working has had significant focus on the pressure our services have faced, particularly in the provision of urgent and emergency care. At the time of writing (April 2023), we have seen 18 out of the previous 20 months with service providers operating at the highest level of escalation and in this reporting period we have declared three critical incidents, outlining that pressure had reached levels where patient safety may have become compromised. Pressure has often been driven by an inability to discharge patients when they are medically fit, leading to congestion of patients in our hospital wards, our emergency departments and arriving in ambulances. The system is working through a range of actions to resolve the discharge challenge, which in part is driven by workforce constraints.

Additional planning has been required to respond to the periods of industrial action taken in the second half of the year by ambulance, nursing and junior doctors' unions, as well as teaching unions, where we see a knock-on effect to our ability to deliver care with increased childcare requirements for our staff. National publicity for the ongoing action has been heeded by patients, and their wise use of services during these times has been welcome.

Our attention has also continued to be focused on the recovery of our activity positions following the depths of the pandemic. This has included our performance on seeing patients who have urgent cancer referrals and the reduction in times that patients are waiting for an operation. The NHS in Derby and Derbyshire achieved the target for ensuring no patients were waiting for longer than 104 weeks by the 31st July 2022, and was set to achieve the further milestone of no patients waiting longer than 78 weeks for treatment by the 31st March 2023, although the deadline was extended by the need to cancel some surgery during the periods of junior doctors' industrial action in March 2023, which meant we would see the target delivered during April 2023.

What has helped sustain services through this challenging period has been our collaboration in seeking solutions, and understanding the individual and collective position of partners to make sure we can seek to shore up any gaps in services by working across organisational boundaries. The agenda of today – managing the pressure, seeking arrangements for a range of temporary care solutions, and trying to find rapid solutions to our challenges around discharge – could easily dominate if allowed to. We have though worked in parallel to continue to think through the long-term goals of our system, to improve the health of our population and reduce health inequalities.

The NHS alone will not be able to deliver the transformation of care towards a more preventative and strengths-based system, where citizens are supported to remain healthy and independent for as long as possible throughout their lives. Working with colleagues in local authorities, the voluntary sector and with our citizens is the correct path to deliver change in the long term. Our chapter on system working covers detail about our first Integrated Care Strategy, the statutory product of the new ICP, and in addition to this we have made good progress on developing our Place partnerships, provider collaborative, our Clinical and Professional Leadership Group, as well as supporting the further development of our GP providers in Primary Care Networks (PCNs). Of importance has been the work to understand and define the roles of the ICP and our Health and Wellbeing Boards in delivering the health improvement and prevention agenda, with Health and Wellbeing Boards focusing on prevention through the wider determinants of health such as housing and environment, and the ICP focusing on prevention through the provision of health and care services.

We are making good advancements in our work to progress integrated care, integrated assurance and integrated commissioning and these collaborations are fundamental to success. The ICB Board received a seminal update at its meeting in March, reflecting on the inter-connections between our teams and the shared priorities at play. From an NHS perspective, we end the 2022/23 financial year with the ICB and NHS family developing our first 'Derby and Derbyshire NHS' Five Year Plan 2023/24 to 2027/28'. This will be a five-year joint forward plan to address nationally mandated targets as well as seeking to find solutions to local challenges. The plan will also seek to respond directly to the areas of focus outlined in the Integrated Care Strategy. Progress has been supported by the first Operational Plan which has followed a robust and collaborative process; given the challenges the health and care system faces, the initial submission of the plan contained delivery risks on finance, cancer waiting times and the elective care recovery plan, which we will continue to work through.

What is important to reflect is that these strands of work are all driving towards the same overall goal, to ensure our system is making the right decisions, involving the right people, to see an overall advancement of our desire to improve health through integration of health and care. There is more to do now on ensuring we are all driven by the same priorities, and having a forward plan will ensure that we see the medium and long term gains we need in health improvement and life expectancy. This is a programme for the longer-term and we believe we are setting off in the right direction to deliver.

Ensuring our financial position is able to support this ambition is crucial; our NHS system is operating with a significant underlying deficit, and council finances are also under pressure. However, working to a long-term financial plan will see us able to invest in steps towards increased preventative health measures and this is a conversation we will start to have with our citizens during 2023/24.

It is very important to recognise that at the forefront of this work to improve health and to manage pressure are our staff in the ICB, NHS trusts and our Local Authorities, VCSE and other sectors, working tirelessly to ensure local people have the best care and treatment. Now three years since the start of the pandemic, these staff have delivered care to our most vulnerable people, in the most challenging circumstances and continue to do so. I speak on behalf of the ICB Board in expressing our extreme gratitude for the role everyone has played.

Dr Chris Clayton
MA MB BChir DRCOG PGCGPE MRCGP
Chief Executive Officer
NHS Derby and Derbyshire Integrated Care Board
27th June 2023

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.

Purpose and Activities of the ICB

The ICB brings together local General Practices and other NHS organisations 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 Directors, 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 120 of this report.

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 serves a population of around 1,118,447.

Our mission and values

The Health and Care Bill 2022 created ICBs as replacements for CCGs, and established in law the role of ICPs as the committee where health, social care, the voluntary sector and other partners come together as an ICS. ICSs have four main functions:

- improving outcomes in population health and healthcare;
- tackling inequalities in outcomes, experience and access;
- enhancing productivity and value for money;
- supporting broader social and economic development.

Our ICS is known as Joined Up Care Derbyshire (JUCD); 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 the ICB area. Working together with partner organisations is part of the whole system approach to tackling them.

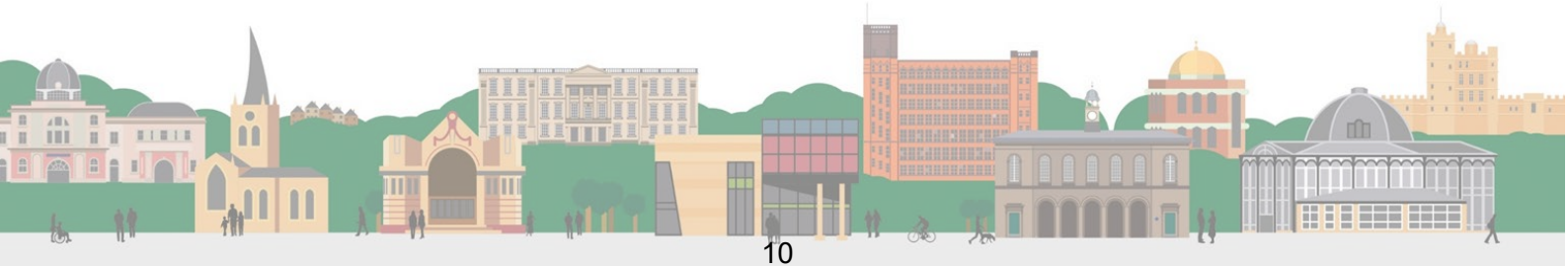
In February 2023, staff and trusted partners were invited to join the second Derby and Derbyshire Together conversation and to review the draft purpose, vision and goal statements and the values and behaviours framework that were created with input from the first online engagement in November 2022, and share what they thought was strong, wrong or missing from these statements.

The conversation ran for two weeks, until the 1st March 2023, and was accessible from any device, 24 hours a day – so everyone could participate no matter what their work pattern was. 38% of invited people joined the Derby and Derbyshire Together validation conversation and together they shared more than 1,000 contributions in the form of written ideas and comments, as well as votes. We saw representatives from all ICB directorates, as well as invited partners from among GPs, VSCEs and the Local Authorities.

The new Strategic Framework and recommendations for next steps were considered by the ICB Board in April 2023 and the final version below will be approved by the ICB Board on the 27th June 2023.

Purpose	To support people in Derby and Derbyshire to live their healthiest lives, creating a sustainable, joined-up health and social care system for now and the future.			
Vision	We will improve the health and wellbeing of people across all communities in Derbyshire by leading and supporting change, being a great partner and making progress easier across all sectors			
Goals	**Enable and prevent** Support people across all communities in Derbyshire to maximise their health and wellbeing, with a shift from treatment to prevention.	**Health and care equity** Reduce health inequalities throughout Derbyshire communities by working with partners to address the factors influencing people's health.	**Impact and learnings** Prioritise evidence-based actions that will have the greatest sustainable impact, utilise data and digital solutions, and share our learnings across organisations, populations and sectors.	**Clarity and connection** Consistently provide clarity to our people, partners, and Derbyshire communities on the ICB's contributions and its overarching ambitions, priorities and responsibilities.

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.



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 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 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 2022/23 can be found on the JUCD website here.

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), and account for approximately 57.4% of our spending.

Derbyshire Integrated Care System Working and Collaboration

It has been a year of great significance for ICSs. The introduction of legislation on the 1st July 2022 to formally establish ICSs – and ICPs as the decision-making body – was welcomed by JUCD. This date also saw the legal establishment of the ICB, taking the place of the former CCG as an NHS partner in the system.

The ICS legislation that was enacted on the 1st July 2022 also saw an important local development as Glossop was incorporated into the ICS through the boundary changes announced by the Secretary of State in July 2021. The alignment of health and social care enables more opportunities for joined-up working with the Local Authorities and the creation of joined-up plans for prevention and population health to improve provision for local people. It also facilitates greater alignment between community, mental health and ambulance service provision. The rapid integration of Glossop into the ICS and High Peak Place is testament to the strength of the local networks that were already well developed ahead of the transition and this process has also helped to inform our other cross-border relationships.

The ICP is the formal gathering of all ICS partners and sets strategy for health and care improvement in our area. Membership now includes NHS organisations, Local Authorities, as well as formal representation from the VCSE sector, Healthwatch Derby and Healthwatch Derbyshire. The ICP has met in shadow form since early 2022, with an early objective to understand the interface with the local Health and Wellbeing Boards, which also have legal duties around health improvement. Both the Health and Wellbeing Boards and ICP have a shared ambition and accountability to:

- increase life expectancy;
- increase healthy life expectancy; and
- reduce inequalities in life expectancy and healthy life expectancy.

Alongside these shared responsibilities, it was agreed that Health and Wellbeing Boards take the lead on driving preventative action and on the wider determinants of health contributing most to the health and wellbeing of the populations of Derby and Derbyshire; the ICP will take the lead on driving preventative action within health and social care service organisations with member organisations all supporting delivery across all areas. To cement this connection, the ICP is co-chaired by the elected member Chairs of the Health and Wellbeing Boards, with an NHS Vice-Chair.

Integrated Assurance

Since the establishment of the ICB, the key strategic themes of assurance and focus required across the ICS have been discussed by Trust Chairs, Audit Chairs and Trust secretaries across Derbyshire.

As a result of this conversation, the ICS has agreed that there is a need to facilitate a system governance model which focuses on system goals and transformation in both the short and longer team, with a principle of light touch reporting to avoid duplication and ensure that system assurance adds genuine value to the delivery of the key areas of transformation across the system.

It was noted that to achieve this, the ICB would need to have good reporting based on quality information that enables good conversations and constructive challenge.

It was also recognised that the ICB has a new and emerging role in system oversight as part of the National Oversight Framework, and that the characteristics of good oversight in this context would be useful to explore.

Integrated Care Strategy

Since summer 2022, attention has been focused on the development of the first Integrated Care Strategy. Our system recognises that integrated care is not a solution in itself; however, it will allow us to develop new ways of working, utilise new technology, maximise the skills of our precious workforce to create new opportunities to collaborate and work together. There is a shared local commitment to do all we can within the resources available to do our best for Derby and Derbyshire. Our Integrated Care Strategy summarises the first steps on the journey and describes how we will further grow and develop our shared approaches. There is huge ambition and commitment across the City and County to get this right for our communities. Delivering against the proposals in this strategy has the potential to help us provide a more preventative approach to health, tackle inequality and improve outcomes for local residents.

We have taken the chance to identify key areas of focus that will be used to test out our integration approach. They were not framed as priorities, as they are not necessarily regarded as being more important than other topics. Instead, they were chosen by senior responsible owners from across the system as ideal areas to test our strategic aims and ambitions for integrated care, in response to population health and care needs. The areas of focus will be across the three key life stages:

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

These areas of focus will be supported by a range of enabler functions, including workforce, estates and engagement, and the overall development and delivery of the strategy will be overseen by our Integrated Place Executive. The concept of Place was first developed and introduced five years ago. The objective was to support the development of working relationships at a local level to facilitate the delivery of enhanced, joined up health and social care for our patients and citizens. Since then, we have seen some tremendous progress across our eight Places with some great examples of delivering improvements in the way services are delivered; these are described in the Place section of this report.

As noted elsewhere in the report, our health and care system continues to work collaboratively to meet the challenges faced following the Covid-19 pandemic, the sustained service pressure we have seen since mid-2021 and the planning and preparation for the range of industrial action taken by public sector workers since December 2022. This month also saw the Derby and Derbyshire health and care system declare the first of two critical incidents in the lead-up to Christmas with the second at New Year. These were declared in response to a significant rise in demand for services across the system and their purpose was to help us to prioritise and maintain safe services for our patients.

We review and take forward the learning from significant events alongside our day-to-day experiences which help to inform our priorities and planning. One of our current priorities is the work we are undertaking on improvements to discharge performance which is seeking to unlock the patient flow we require through our NHS and social care services. Activity levels within services are relatively flat in comparison to the pre-pandemic period, but workforce capacity challenges have seen an increase of medically-fit patients waiting for their discharge due to a shortage of community care packages. This has been a national challenge and locally we have identified designated leads to work across organisational boundaries to find solutions.

Changes to the organisational form aside, the remits and duties of these statutory bodies, and the benefits we expect they will have on the health of local citizens, fall largely in line with the planned direction of travel for JUCD.

Joint Forward Plan

The ICB is required under the Health and Care Act 2022 to review the extent to which the 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 regards to the Capital Resource Plan for IT equipment.

The ICB and its partner NHS Trusts and NHS Foundation Trusts have prepared a Derby and Derbyshire NHS' Five Year Plan 2023/24 to 2027/28, which was published on the 30th June 2023 and can be found here[i]. It 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:

- being fully aligned with the wider system partnership's ambitions;
- supporting subsidiarity by building on existing local strategies and plans as well as reflecting the universal NHS commitments; and
- being delivery-focused, including specific objectives, trajectories and milestones as appropriate.

The plan has been co-produced through engagement with ICP partners, including discussion and review at both Health and Wellbeing Boards; Corporate Committees; and public consultation. A guide will be published alongside the plan to ensure consideration is given to all stakeholders and organisations.

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:

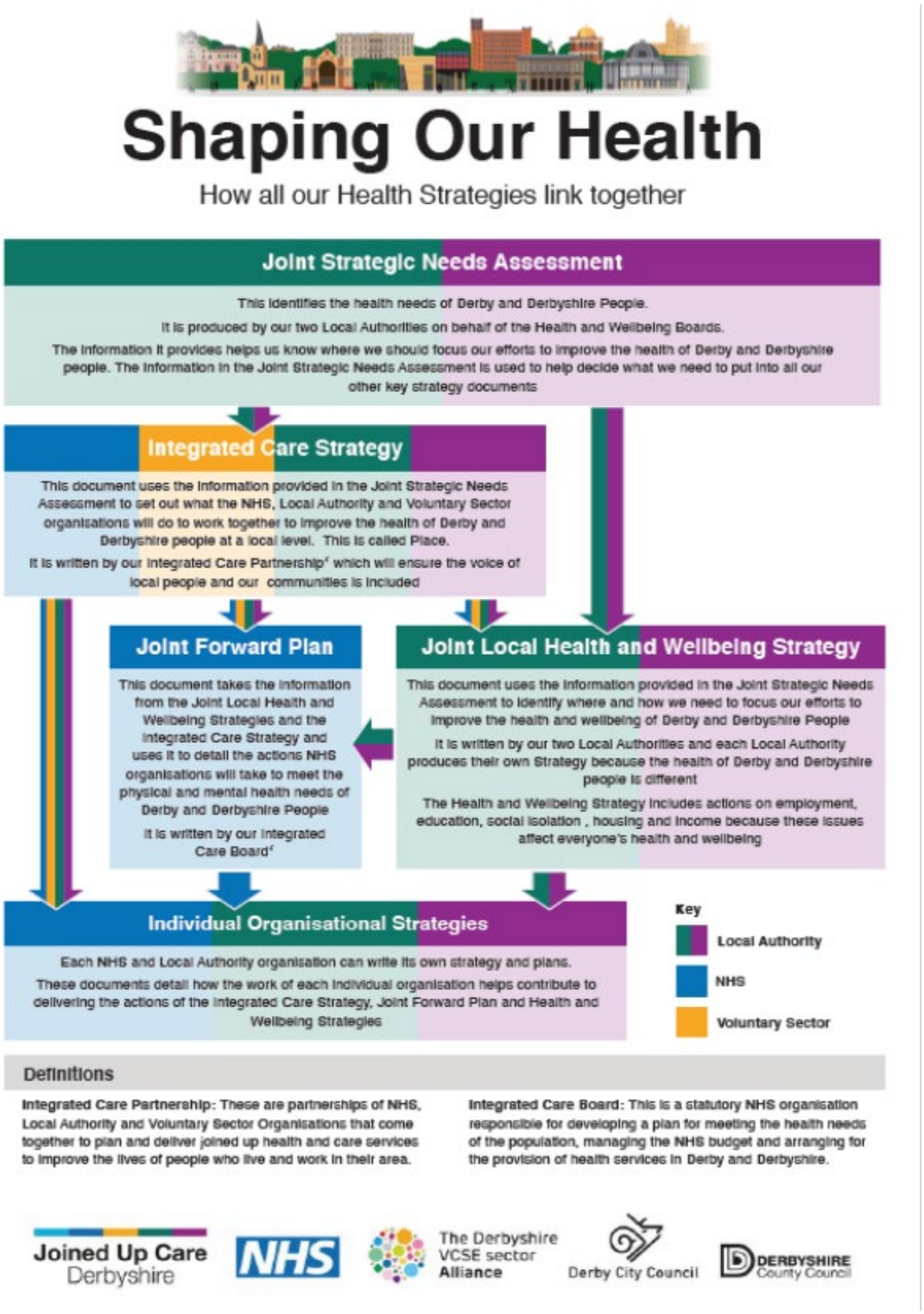


Figure 1 – How our strategies link together

Place Development and Delivery

Derbyshire is a diverse county famous for the beauty of the Peaks and Dales, as well as open access to the National Forest, many historic towns and the bustling city of Derby. In order to ensure care and support best meets the needs of local people, we have broken the county into eight areas known as Local Place Alliances (LPAs).

Commissioners, Community Services Providers, Local Authorities, Primary Care, Voluntary and Community Sector, and the public come together at this 'Local Place' 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.

Since Place was first set up five years ago, it has developed from establishing good working relationships between different partner organisations at a local level, which led to better coordination of local care and support. This was especially apparent during the pandemic response as the LPAs mobilised their support to their communities, and services worked together effectively. Now those trusted working relationships and confidence are enabling transformation of care and support services, as can be seen below.

Evolving Governance Structures

Derby and Derbyshire have had great success in partnership working at this local level, but recognise there is value in coming together at scale. In order to embrace the new opportunities brought in through progression to an ICS, the formal governance structures associated with Place have developed and evolved over the past year.

Our Integrated Place Executive (IPE) continues to be chaired by Dr Penny Blackwell, and brings together key system stakeholders to coordinate and integrate services. The group is leading the development and delivery of an Integrated Care Strategy. Work to ensure enabling functions like digital, estates and workforce have a Place focus is also influenced by the IPE.

Place Partnership Boards in Derby City and Derbyshire County have recently been formed. This will provide a 'home' for the integration of health and care in Derbyshire County, and will help ensure well established local partnerships are able to take on more strategic functions in Derby City.

Welcoming Glossop to the High Peak Local Place Alliance

The Glossop area of High Peak transitioned into the ICB in July 2022 having previously been part of Tameside and Glossop CCG. As part of this transition, Glossop was integrated into the High Peak Place Alliance. The High Peak Place Alliance has continued to thrive with its extended range of partner organisations benefiting from the mutual learning and the enthusiasm for coming together from the two areas. Joint work has already commenced on engaging with informal carers to understand how they can be supported effectively and exploring opportunities to improve end-of-life care.

Team Up Derbyshire

Team Up Derbyshire is creating one team across health and social care in Derby and Derbyshire who see all the people in a neighbourhood who are currently unable to leave home without support. This team is a teaming up of existing services within a Place and the creation of additional capacity – with General Practice, Community Care, Mental Health Care, Adult Social Care and the Voluntary and Community Sector all working together and with their local communities. It provides care for people at home, avoiding the need for them to have to go to hospital wherever possible. The team provides both preventative care (anticipating health issues before they occur) and reactive/urgent care as and when required.

The programme is being advanced at a local level by PCNs (groups of General Practices working together) across Derby and Derbyshire, health and care organisations (such as DCHSFT and Local Authorities) and the LPAs (representatives of organisations in an area). Team Up is encouraging new ways of working among colleagues:

- helping better integrate social care services with health;
- taking on existing services and expanding others;
- opening up access to some services; and
- exploring opportunities to deliver some services differently.

Dr Ian Lawrence, clinical lead for Team Up Derbyshire, said:

> *"The thing I am most proud of with Team Up Derbyshire is that we have created the conditions for local teams to figure things out for themselves and to learn from each other. It hasn't always been comfortable, but these innovations are testament to the power of this approach. We haven't always got what we expected, but that is usually because a local team has come up with something better than we could have planned."*

A core offer of Team Up is the urgent community response (UCR) service. This provides crisis response care within two hours of referral and reablement care (support to help people live at home) within two days of referral.

There are four components of this UCR service. These are:

1	**PCN-led home visiting services**	People are visited at home by a range of different health and care professionals – overseen by the PCNs.
2	**Rapid response nursing and therapy services**	Provided by DCHSFT.
3	**Adult social care rapid response services**	Provided by Local Authorities and increasingly being integrated with NHS services.
4	**Falls recovery and prevention**	Currently being expanded in local Places across the city and county under Team Up Derbyshire.

During 2022/23 the national UCR target of at least 70% of patients being referred within two hours was met and exceeded. As at the 31st March 2023, 6,982 people have received the UCR service.

During 2022/23, 24,259 Team Up home visits were recorded. For UCR and home visiting, the outcome of the contact is that most people are managed within the services rather than needing hospital care. The programme is beginning to see encouraging outcomes data that demonstrates a reduction in Accident and Emergency (A&E) attendance for our target patient cohort, as well as a reduction in short lengths of stay in hospital, and a reduction in Category 3 and 4 ambulance responses.

A recent survey of General Practices across Derby and Derbyshire has found overwhelming support for the roll-out of Team Up Derbyshire home visiting services. A total of 83% of respondents said home visiting services had freed up GP capacity. Feedback included:

"The service is invaluable to assist with the unmanageable demands… There's no way we could revert back to managing our own home visits."

"Team Up have provided follow-up for patients where needed to help with consistency of care and reduce hospital admissions."

"It has really helped to free-up GP time. Patients have also been complimentary about the service."

"The home visiting service has made a huge difference in allowing clinical staff to have more time to see and speak to more patients in the practice."

Team Up is also overseeing the national Enhanced Health in Care Homes (EHCH) programme, which has a broad remit to implement the EHCH Framework[i] across Derby and Derbyshire, focusing on specific priorities within this.

In addition, Team Up is supporting Care Home staff to identify and manage signs of deterioration in residents. Managing deterioration refers to spotting that a person's condition is worsening and responding appropriately to support best health outcomes, keeping them safe and providing a positive experience of care. The programme aims to reduce harm related to deterioration by improving the planning, identification, escalation and response to residents through improved co-ordination and effective multi-disciplinary team support. The aim is to ensure that all our Care Homes receive training on managing deterioration.

Falls is another key focus for EHCH and a transformational workstream is due to roll out a project that was successfully piloted across 41 of our homes. The work involves providing and training Care Homes with falls lifting equipment and structured assessments for residents who have fallen. We will also work closely with care homes to support them in managing falls effectively and seeking clinical advice and care in a timely manner if needed.

In preparation for winter, and to help reduce pressure on emergency services, we have worked with key partners across health and social care to undertake data analysis to better understand which of our care homes utilise ambulance services most frequently. There are many reasons why care homes may require ambulance support and one of the reasons is that they might not be able to access the care and support they need in a timely manner through their local health teams.

Patient stories

Avoiding hospital admission through dedicated patient care

An 85-year-old woman, unable to leave her home without support, had been discharged from hospital and referred into the Team Up home visiting service. The person had a terrible night with a very upset stomach, nausea and vomiting. A re-admission to hospital looked very likely, however the triaging GP asked an Advanced Nurse Practitioner (ANP) to visit the patient who was an insulin-dependent diabetic and had very low blood sugar levels but did not want to return to hospital. The ANP stayed with her for 90 minutes, offered support, checked her blood sugar levels every 15 minutes and gave the patient something to eat until she felt better. The ANP gave her some medication to relieve the nausea and vomiting. The ANP advised other services that the patient's insulin dose should be halved due to low blood sugar levels and a reduced appetite. She also asked the district nurses to check the patient's blood sugar levels in the afternoon and evening of that day. The ANP spent 1.5 hours with the patient providing support, both clinically and socially, preventing a hospital admission and then contacting the patient the following morning to check that she felt better.

Supporting patients with complex needs

An 82-year-old man, who was known to constantly call their GP, 111 and Derbyshire Health United Community Interest Company (DHU), was receiving frequent visits from Carers, District Nurses, a Physiotherapist and an Occupational Therapy Team. He was referred into the complex needs service and was visited by a Community GP, who recognised an unmet need of loneliness and isolation. The patient was discussed at the multi-disciplinary team meeting, with the agreement to explore social prescribing. The Social Prescriber arranged for a befriending service to see this patient. Now linked in with the befriending service, the patient is happier and has had a reduction in calls to the ambulance service.

Living Well Collaborative

Living Well is a Derbyshire-wide programme that sets out to transform Community Mental Health services. The ambition is to look at mental health and wellbeing in a holistic way, putting individuals at the heart of what we do. The programme will transform services across voluntary and statutory organisations; through creating new teams, enhancing community support and networks. Local Places are designing what the new offer will look like, with the aim of ensuring people get support when and where they need it, to move away from criteria and repeat assessments to open access, strong relationships, warm handovers and joint working.

This focuses on services being able to give people the help they need – but also ensuring communities are filled with support and activities so people spend their daily lives living happily and with purpose. Local Place discussions are at different stages across the county, but in Chesterfield for example, the LPA, along with other partnership groups, has developed a shared set of principles to support this work, one of which is to be "data and insight-led in developing solutions, listening to people and communities".

Integrated Place Executive, Dr Penny Blackwell, comments:

"The Place agenda has grown and developed beyond all recognition from the seed that was sown in 2018. Place is about organisations working together to improve health and wellbeing for people who live and work in a geography. I'm really proud of the immense amount of 'difficult to measure' work that has and continues to happen around attitudes and behaviours to create truly integrated care and services within a distributed leadership framework. Team Up has been our first integrated service and is testing and adjusting all the difficult challenges, in order to make things easier for the next service and the next one and I look forward to this approach extending into falls recovery and prevention; and extended care in care homes over this next year. I'm really pleased to be able to house end-of-life and discharge flow workstreams at the IPE and look forward to being able to give these two key areas some focus and attention."

Primary Care Networks and Collaboration

Primary Care Network Development

Throughout the pandemic, General Practices continued to work together and develop their PCN infrastructure. During the period covered by this annual report, Derby and Derbyshire had 17 PCNs, covering all 114 General Practices and their registered population. We also welcomed Glossop PCN to the area on the 1st July 2022. PCNs are based on General Practice-registered lists, typically serving communities of around 30,000 to 50,000 people. This scale is small enough to provide personal care valued by both patients and GPs, but large enough to have significant impact and economies of scale through better collaboration between General Practices and other service providers.

PCNs across Derby and Derbyshire are providing care in different ways to match individual needs, including flexible access to advice and support for 'healthier' sections of the population, and joined up care for those with complex conditions. They have focused on prevention and personalised care; supporting patients to make informed decisions about their care and look after their own health better. Through the use of data and technology, they have been able to understand their patients' needs better and deliver ways of providing care at a scale bigger than just a single General Practice. The PCNs will continue to monitor how services perform and check on any differences in the quality of services across areas.

By making best use of collective resources across General Practices and other local health and care providers, PCNs are able to ensure that the workload is managed among a larger range of professional groups.

PCNs have helped to form stronger relationships across General Practices and have Memorandums of Understanding in place for information sharing and supporting the ICB in the use of data. Clinical Directors continue to meet regularly to discuss how PCNs are coping following the pandemic and to resolve any development issues. PCN operational leads also meet regularly to share learning, protocols and best practice, and help recruit to new roles.

The development of each PCN is rated against a maturity matrix. When this was completed in March 2020, all 17 PCNs were rated as foundation for all areas. In October 2021, PCNs had improved the most across leadership; organisational development; clinical director leadership; and asset-based community development. A further self-assessment was submitted in October 2022 and four PCNs are now rated as step 3 for all domains, which is the most advanced level on the matrix. PCNs fed back to NHS England (NHSE) that they required the most support on population health management and community asset development. All of our PCNs have a development plan in place and the delivery of this is supported by our General Practice Provider Board.

Over the last two years, leadership and management funds have been available to PCNs and their initiatives have included supporting organisational development; providing additional PCN management capacity; clinical leadership; strategic planning; and analytical support. All are designed to release time for the existing workforce to provide clinical care.

PCNs have met the service requirements of the Network Direct Enhanced Service by submitting plans to address neighbourhood health inequalities, deliver enhanced access, provide more appointments outside of core General Practice hours, and develop a proactive social prescribing service using the personalisation roles recruited under the Additional Roles Reimbursement Scheme (ARRS). These plans have been developed with ICS colleagues and stakeholders.

Additional Roles Reimbursement Scheme

Expanding the workforce is the top priority for Primary Care. The ARRS enables each PCN to employ additional staff across 18 direct and non-direct patient care roles within Primary Care. The latest addition to this ARRS scheme includes General Practice Assistants and Digital and Transformation Leads. PCNs have recruited 123% of the ARRS whole time equivalent target for 2022/23.

Recruitment to these roles required a large degree of planning and joint working across the wider system. Health Education Derbyshire (HED) has been pivotal in supporting the PCNs with their workforce plans. It conducted a survey across all ARRS staff employed within PCNs to measure job satisfaction and training and development needs. This has helped to design training and supervision packages to support new ARRS staff. It has also undertaken an investigation to explore which staff mix would suit the PCN best. Intelligence gained has led to all available training being collated into one online portal. Courses provided by Secondary Care have been made available to Primary Care staff, to support the development of a 'training passport' to enable staff to provide clinical care, no matter where they are normally based, as their competencies will be consistent.

From February 2023, GP Task Force Derbyshire has been providing a multi-module, centralised induction programme to all newly qualified staff joining Derbyshire. The programme will meet the key needs of induction, Primary Care orientation, career support and networking and hopes to streamline a quality induction and alleviate pressure on practices. The programme will bring together colleagues from across practices and PCNs increasing the feeling of ‘one workforce’ and in so doing, support retention. It will also support retention by helping in-house educators and reducing educator burnout.

PCNs escalated the recruitment of ARRS roles from October 2022 and deployed staff flexibly, across PCNs and the system, to meet demand. The 'unclaimed funding' process was implemented, and funds were distributed to PCNs that were able to over-recruit, who have now secured additional staff and worked with third party providers to source temporary staff to support PCNs throughout the winter.

During 2022/23, PCNs were led by DHcFT in successfully recruiting several Adult Mental Health Practitioners and we now have 11.2 WTEs working in Primary Care. The workforce challenges within mental health are well known – this is a great achievement for Primary Care and will support the improvement of the patient pathway between Primary and Secondary Care mental health support. We are looking to replicate this approach with the Children's and Young Persons' Mental Health Practitioner role for 2023/24. We are also starting discussions with GP Task Force Derbyshire around introducing recruitment leads for specific roles, to provide additional capacity to PCNs to maximise recruitment in the last year of ARRS.

Health and Wellbeing Boards

In accordance with section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007, the ICB has consulted and engaged with system partners to the delivery of the Joint Health and Wellbeing Strategy and is fully engaged with the city and county Health and Wellbeing Boards.

The Chief Executive Officer and an ICB Non-Executive Member sit on both Health and Wellbeing Boards. A sub-group ensures that coordinated progress on integrated care is made, as well as jointly progressing the development of the Better Care Fund (which brings together funding for certain health and social care activities).

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.

Derbyshire's Health and Wellbeing Strategy is currently under review and development, alongside the collaborative co-production of the Integrated Care Strategy and Derby and Derbyshire NHS' Five Year Plan, by the ICP and the ICB. Our approach to the development of the Joint Local Health and Wellbeing Strategy can be seen in Figure 1.

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.

Derbyshire's Health and Wellbeing Strategy for 2018-23 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 here[ii]. The five priorities are:

1. enable people in Derbyshire to live healthy lives;
2. work to lower levels of air pollution;
3. build mental health and wellbeing across the life course;
4. support our vulnerable populations to live in well-planned and healthy homes; and
5. strengthen opportunities for quality employment and lifelong learning.

Addressing these priorities will help us work to achieve our overarching outcomes for Derbyshire:

- increased healthy life expectancy; and
- reduced differences in life expectancy and healthy life expectancy between communities.

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

In addition, representatives from the ICB regularly attend the Derbyshire Improvement and Scrutiny Committee – Health and the Derby City Protecting Vulnerable Adults Committee to update and present reports to Derby City Council and Derbyshire County Council Councillors.

Joint working with the Local Authority

The ICB is a key partner of the JUCD ICS, which involves working closely with colleagues in Derbyshire's provider organisations and the two unitary authorities to develop health and care priorities for local people. This has strengthened links between the local Health and Wellbeing Board Strategies and the priorities emerging from the NHS Long Term Plan.

Role of Place

The ICB has supported the development of the two Places covering Derby City and Derbyshire County 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, built on a mutual understanding of the population and a shared vision;
- taking accountability for the delivery of coordinated, high quality care and improved outcomes for their populations; and
- the planning, management of resources, delivery and performance of a range of community-based health and care services, in line with the strategic requirements of the ICB and ICP.

Derbyshire Anchor Institutions

During 2022/23, the established System Anchor Group brought together a number of Anchor Institutions, which are defined by The Health Foundation (2018) as:

> *"An institution that, alongside its main function, plays a significant and recognised role in a locality by making a strategic contribution to the local economy. Anchor institutions are so called because they are effectively anchored in their local communities and are unlikely to relocate. They have sizeable assets that can be used to build wealth in and develop their local community through procurement and spending power; workforce and training; and buildings and land."*

The Derbyshire Anchor Institutions' aims are to have a positive impact on the following five key areas through their commitment to long-term collaboration, improving collective wellbeing and creating a strong, resilient and inclusive Derbyshire economy:

Employment	Widening access to work.
Partnering in place	Across organisations and the voluntary and community sector.
Procurement	Purchasing more locally and for social benefit.
Buildings	Using buildings and spaces to help communities.
Environment	Reducing environmental impact.

The 'Anchor Charter' is now in place as a way of securing commitment from the Derbyshire Anchor Institutions and providing a framework to benefit communities across Derby and Derbyshire. The Anchor Charter was formally approved by both the JUCD Board, and Health and Wellbeing Boards across the county during 2021/22. It was also rolled out to system organisations to ensure that it is embedded within their organisational strategies and plans. Within Derby and Derbyshire, the signatories to the Anchor Charter include:

- NHS organisations;
- Joined Up Care Derbyshire;
- Derbyshire County Council;
- Derby City Council;
- Rolls-Royce;
- Derby County Community Trust; and
- University of Derby.

Performance Analysis

One of the key areas of focus outlined in the ICB's Commissioning Intentions is to make sure the resilience of the local health and care system is maintained, while meeting national standards. These standards are outlined in the NHS Constitution and include measures such as the time it takes to get treatment, Emergency Department (ED) waiting times and cancer waiting time standards.

How Performance is measured

Performance against the NHS Constitution targets is monitored regularly 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 information is supplied via the North of England Commissioning Support Unit (NECS). The ICB produces regular internal reports which are discussed with Executive Directors and Lead Senior Managers. 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 Quality and 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.

The complexities of Covid-19 resulted in changes to the contractual relationships with our providers, and altered the approach to contract management. During the year, the ICB was not able to performance manage the standards as in previous years.

Performance Summary 2022/23

As of the 31st March 2023, our overall performance since the 1st July 2022 has shown that 4 of the 20 constitutional or mandated standards for our patients have been delivered year-to-date, all for mental health. Those standards that were not achieved are detailed by exception in the performance analysis section of this report.

Performance Analysis

Indicator		Standard	DDICB	NHSE
Referral to Treatment	18 weeks Referral to Treatment – Elective Surgery	92%	56.1%	58.3%
	18 weeks Referral to Treatment – 52+ week wait	0	7,713	379,245
Diagnostic waits	Diagnostic test waiting more than six weeks from referral	1%	35.7%	30.8%
A&E waits	A&E less than four hours	95%	72.3%	74.8%
Cancer waits less than 14-days	Urgent GP referral to first outpatient appointment	93%	85.8%	81.8%
	Urgent GP referral to first outpatient appointment (breast symptoms)	93%	71.5%	76.9%
28-day faster diagnosis standard	Diagnosis or decision to treat within 28-days of Urgent GP, Breast Symptomatic or screening referral.	75%	70.4%	67.0%
Cancer waits less than 31-days	Diagnosis to first definitive treatment for all cancers	96%	82.5%	88.5%
	Subsequent surgery within 31-days of decision to treat	94%	70.8%	76.2%
	Subsequent drugs treatment within 31-days of decision to treat	98%	93.8%	95.7%
	Subsequent radiotherapy treatment within 31-days of decision to treat	94%	72.7%	86.7%
Cancer waits less than 62-days	Urgent GP referral to first definitive treatment for cancer	85%	54.6%	60.8%
	NHS screening service to first definitive treatment for all cancers	90%	53.2%	68.4%
	104+ days wait for first treatment	0	590	21,788
Mental Health	CPA seven days follow-up (retired dataset)	95%	N/A	N/A
	IAPT access	25.2%	31.5%	–
	IAPT recovery	50%	50.6%	49.8%
	IAPT waiting times (six weeks)	75%	74.0%	89.3%
	IAPT waiting times (18 weeks)	95%	99.8%	98.3%
	Early Intervention in Psychosis – completed	60%	69.3%	68.6%
	Early Intervention in Psychosis – wait <2weeks	60%	60.5%	26.1%
	Dementia diagnosis	67%	64.1%	62.6%

Table 1 – ICB performance against constitutional or mandated standards from 1st July 2022 to 31st March 2023

2022/23 Performance Exceptions

Referral to Treatment Time (18 weeks)

At the end of March 2023, 56.1% of ICB patients on the incomplete pathways list had been waiting less than 18 weeks for their treatment. This was a further reduction on the proportion at the end of 2021/22, which was 62.3%. The number of ICB patients on the incomplete pathways list at the end of March 2022 was 100,552 but by the end of March 2023 this had reduced to 125,523.

The operational plan for 2022/23 has continued to focus on increasing activity to restore 2019/20 levels, to reduce the number of incomplete pathways, and focusing on day-case and overnight elective activity. Independent sector provision has been used across the county to provide more capacity in offering health services.

Patients waiting more than 52 weeks for treatment

At the end of March 2022, there were 5,275 ICB patients who had been waiting more than 52 weeks for their treatment; with the largest number on the trauma and orthopaedic waiting list. By the end of March 2023 this had increased to 6,785. The majority of these patients were on the waiting list of UHDBFT and CRHFT, but 1,890 were waiting for treatment at various Trusts around the country.

There were 434 ICB patients who had been waiting more than two years for their treatment at the end of March 2022. NHSE have stipulated that there should be no patients who have waited for more than two years for their treatment by the end of June 2022. At the end of June 2022 there were 39 patients who had been waiting over 104 weeks and at the end of March 2023 there were 3. The majority of this number are delayed due to the complexity of their condition or patient choice.

In the 2022/23 Operational Plan the ask is that at the end of March 2023 there should be no patients at that time who have waited longer than 78 weeks (18 months) for their treatment. There will be continued focus on our providers to reduce this number.

Diagnostics

This standard has not been met throughout the year. The lifting of some of the control regulations has enabled more activity to take place, however the demand has increased due to urgent care pressures and elective recovery requirements.

At the end of March 2022, the ICB had 28,867 patients awaiting a diagnostic test. At the end of March 2023 this had decreased to 26,539.

In March 2022, 35% of patients had been waiting more than six weeks for their diagnostic procedure, at the end March 2023 this had decreased to 28.9%. The standard is that less than 1% of patients should wait more than six weeks. Restoration of diagnostic activity is part of the 2022/23 Operational Plan whereby all Trusts are required to recover their activity to 120% of the 2019/20 level of activity.

Accident and Emergency Waiting Time – proportion with total time in Accident and Emergency under four hours

The majority of Derby and Derbyshire patients attend UHDBFT and CRHFT for their emergency needs. Although the volume of attendances is lower than pre-pandemic levels, performance had dropped to 67.7% at the end of March 2023. The establishment of co-located Urgent Treatment Centres (UTCs) at the acute Trusts has been successful, treating more minor cases that would have been seen in ED and accounting for 60% of emergency attendances. Although this has eased pressures in EDs somewhat, this means they see the more acute patients, with higher acuity leading to proportionally more Type 1 4-hour breaches.

Children's attendances have significantly increased due to rises in cases of suspected respiratory syncytial virus and bronchiectasis. However, the biggest factor affecting other patient flow occurred at the opposite end of the patient pathway, with severe shortages in social care packages of care leading to long delays in patient discharge.

12-hour trolley breaches

The NHS has a zero target for 12-hour trolley waits (12 hours from decision to admit to being moved to a bed). There were 6,925 breaches reported during July 2022 to March 2023, with 638 taking place at CRHFT and 6,287 taking place at UHDBFT. Not all of these patients were Derbyshire patients.

All reported breaches are subject to an investigation which is shared with our Quality Team. The team reviews the information to identify if any harm has occurred because of extended stays in the ED. All reported breaches were investigated, and the ICB is assured that no harm was caused by these delays.

Cancer

Two-week-wait referrals for cancer diagnosis and/or treatment continue to increase nationally and the ICB's performance reflects this from achieving 85.8% for January 2023. Despite activity levels being higher than usual, this is still affecting performance further down the patient pathway, with 82.5% being seen within 31 days but only 48.6% being seen within 62 days (however, some of these may turn out not to be cancer).

The ICB did not meet the 28-day faster diagnosis standard this year but remains above the national performance. The number of referrals is impacting on the Trusts' ability to diagnose/rule out cancer within 28 days.

Early diagnosis of cancer

There is a national ambition to diagnose 75% of cancers at an early stage by 2028 and to improve the number of patients who survive for longer following a cancer diagnosis. We are following national guidelines to implement 'faster diagnosis standards' by giving early access to diagnostics so we can detect cancer or rule out cancer as soon as possible. In particular, we have focused on breast, colorectal and prostate cancer pathways and will be focusing on head and neck, and gynaecological cancer pathways next.

Cancer screening programmes

The cervical and bowel screening programmes have been fully restored in Derbyshire and waiting times are in line with national standards. The bowel screening programme is now being extended to a wider age range enabling more bowel cancers to be picked up at an earlier stage. Breast cancer screening is still recovering and is not yet fully restored, and we are working closely with NHSE to reduce the backlog.

Mixed Sex Accommodation

Providers of NHS funded care are expected to have a zero-tolerance approach to mixed-sex accommodation, except where it is in the overall best interest of all patients affected. A mixed sex breach refers to all patients in sleeping accommodation who have been admitted to hospital and there have been 119 breaches between the 1st July 2022 and the 31st March 2023. The Trusts provide our Quality Team with a report for the breaches detailing the circumstances and actions taken.

Planned Care

Outpatients

As a result of the ongoing programme of work around restoration, transformation and changes in clinical practice, the outpatients programme is constantly being reviewed and updated to meet the changing needs of our population. This has been further affected by the industrial action, which has seen outpatient appointments and procedures cancelled.

We are continuing to work with providers to develop digital opportunities for patients to have more control over their care through self-help resources and/or digital resources. This includes the wider roll-out of patient-initiated follow-ups, allowing patients to access clinical teams as and when their condition might need support from a specialist and pre-assessment services to ensure patients are seeing the most appropriate clinicians in the optimum environment for their care.

Advice and Guidance

Advice and guidance covers non-face-to-face communication between services to enhance the patient pathway. Digital communication channels allow peer-to-peer conversations across the system to discuss individual cases.

Advice and guidance continues to be provided through a variety of non-face-to-face methods including calls, messages and photos to support decision-makers to make the most clinically appropriate referrals or to enable clinicians to support patients in the community.

A review of all advice and guidance in the Derbyshire system has been completed and demonstrated the need for all the channels to continue to be available to clinicians, which has been agreed. There were 49,341 advice and guidance requests in 2022, which was an increase of 41% from 2021. Work is underway to ensure that all services address any operational findings from the review in order to optimise the use of these channels to support clinical decision-making.

Teledermatology

The dermatoscope funding secured in February 2021 has enabled 84 practices to be provided with high quality dermatoscopes and basic dermatoscope training for a lead GP in each participating practice. A dermatoscope is a hand-held visual aid device used to examine and diagnose skin lesions and diseases, and can be used with a smartphone to acquire images to support triage and/or referral; this can then be added to the patient record.

This is supported by online interactive consultant-led mentoring sessions using images from participating General Practices to further develop knowledge of dermatology, with one-to-one mentoring available from local specialist GPs. During 2022/23 there were additional online consultant-led mentoring sessions which were well attended by GPs in the project. Sessions are planned for each quarter going forwards.

In 2022/23 there were a total of 13,693 requests for dermatology advice and guidance across two advice and guidance platforms. Of these, 5,335 were returned with advice and guidance or otherwise diverted from Secondary Care referral. There were 6,155 requests which were converted to a referral and included 1,540 recommended referrals in one platform and therefore converted to a referral in the NHS eRS platform. Numbers cannot be 100% accurate due to an overlap between the two advice and guidance platforms, one of which is also the referral pathway for dermatology. The start dates for the change of referral pathway is different for each provider, with one not starting until June 2022.

Patient initiated follow-ups

Patient initiated follow-ups give patients and their carers the flexibility to arrange their follow-up appointment as and when they need them. Local NHS providers have implemented this across a range of specialties and continue to monitor their usage.

Clinical Specialties

Expert Advisory Forums (EAFs) are expert multi-professional advisory 'think-tanks' to support 'what good looks like' for services and promote consistent and sustained implementation of quality standards across Derbyshire, focusing on patient and clinical outcomes. A number of EAFs have met regularly to progress clinically-led redesign to support ongoing restoration and recovery of services. There are currently EAFs for the following specialties:

1. gynaecology;
2. ear, nose and throat;
3. paediatrics;
4. dermatology;
5. urology; and
6. ophthalmology.

The following sections highlight examples of some of the work undertaken up to the 31st March 2023.

Gynaecology

There is now a clinical lead for gynaecology in place, based in Primary Care. The CRHFT Women's Health Physiotherapy Team's 'ring pessary clinic' is currently receiving referrals from within CRHFT, with plans to expand the service to GP referral once data has been reviewed. Pathways have been reviewed and implemented including pathways for pelvic pain and post-menopausal bleeding.

Ear Nose and Throat

The Ear Nose and Throat (ENT) EAF group continues to improve pathway integration with a wide variety of partners from across the Derbyshire healthcare system. The ENT group have created a template on Pathfinder (a locally created suite of referral guidance and clinical templates for GPs) for standardising ENT referral pathways to help ensure all necessary information is provided, and appropriate investigations have been undertaken, prior to patients being referred. The EAF group have also helped implement patient-initiated follow-

up appointments at UHDBFT. CRHFT clinicians have provided GP education sessions to help provide guidance around common ENT problems.

Paediatrics

The EAF group has been working in collaboration to develop a number of clinical pathways to help GPs and other clinical professionals manage conditions that affect children, such as headaches, sleep disorders, tics, wheezing, allergies and abdominal pain. These pathways are all available on the Derbyshire Pathfinder system so GPs have the latest guidance to refer to.

The Paediatrics EAF is currently working collaboratively to streamline various paediatric neurodevelopment pathways processes into Derby and Chesterfield Child Development Centre. The Neurodevelopmental Pathway is a specialist service responsible for the assessment of neurodevelopmental conditions such as autism spectrum disorder and attention deficit hyperactivity disorder. They will review the information in manageable pieces, beginning with the referral pathway for attention deficit hyperactivity disorder. The team is currently working on who can refer, referral criteria and reviewing the standard school report.

Dermatology

Both core Secondary Care dermatology providers (CRHFT and UHDBFT) moved to a new referral pathway in 2022. All referrals to the providers are directed via the NHS e-Referral Service (a national digital platform used to refer patients from GP surgeries into hospital services) advice and guidance for referral route.

To further support the services, a clinical audit of the quality of the images and medical history sent with the requests is being conducted at both Trusts. The outcome of the audit will analyse how Primary Care is supported to provide good quality images and medical histories to support confident tele-triaging of patients and appropriate responses and will be progressed via the EAF.

The Dermatology EAF continues to collaborate on reviewing and initiating clinical pathways and ensuring they are included in the Derbyshire Pathfinder to support Primary Care.

Urology

Work has continued to address the current challenges around the number of patients waiting to be seen and explore a range of options, for example, funding has been successfully secured to provide additional staff for community urology.

Ophthalmology

The Minor Eye Conditions Service trial has continued since June 2021, following a pause due to Covid-19 where it was replaced temporarily by the Covid-19 Urgent Eye Service. The service continues to support patients that can be seen and treated in the community rather than in hospital eye services.

Latest reporting demonstrates that around 80% of patients are seen and treated in the community, with only 20% requiring onward referral to hospital eye services. Work continues on the following three transformation projects in ophthalmology:

1	Moving post-operative cataract patient check-ups from Secondary Care to community optometrists for low-risk, non-complex patients. As cataract surgery numbers increase, patients will benefit from receiving their follow-up appointment in the community.
2	Moving the monitoring of stable glaucoma patients from Secondary Care to community optometrists – progress has been slower than anticipated, but when fully functioning it will enable patients to be monitored/followed up in a community setting.
3	Outcomes for the virtual ophthalmology triage service trial in the south of the area are under review, along with an audit of referrals into hospital eye services linked to the trial, which have provided key evidence in addition to the triage data. This evidence will be evaluated and utilised to inform the next steps in the project.

All the above three projects have the same aims – to reduce impacts on Secondary Care Hospital Eye Services, provide services closer to home for patients and to provide access to a range of services in a timely manner.

Additional capacity from independent sector providers of cataract surgery services continues to support the recovery of cataract services across the area due to the impact of the Covid-19 pandemic on these Secondary Care services. During 2022/23 the following transformation projects have also been initiated and progress is as follows:

Patient-initiated follow-up for ophthalmology	A project managed by CRHFT – who are testing the patient-initiated follow-up approach in ophthalmology and will share their learning across the system.
Improving the process for registering patient with sight loss	The Local Optical Committee is supportive of its optometrists providing the required evidence to speed up the sight loss registration process by providing this direct to ophthalmic consultants. In addition to this, optometrists and GPs are now aware of signposting patients to support available to them while their registration is processed.
Diagnostic hubs for ophthalmology	Aims to scope out the requirements going forward for Derby and Derbyshire. To date, scoping has been carried out to provide glaucoma follow-up appointments in a local diagnostic hub – this work continues.

Musculoskeletal Services

A musculoskeletal (MSK) condition is any injury, disease or problem with muscles, bones and joints. Muscle and joint problems are the biggest cause of work absence and physical disability in the UK. A wide range of disorders and conditions can lead to problems in the musculoskeletal system. Ageing, injuries, lifestyle and disease can cause pain and limit movement. MSK conditions account for 30% of General Practice consultations in England. Low back and neck pain are the greatest cause of years lost to disability, with chronic joint pain or osteoarthritis affecting more than 8.75 million people in the UK.

Funding was secured in November 2022 to support the development of digital solutions for patients and providers of MSK services in Derbyshire. Following a robust evaluation process, Getubetter, a digital MSK Platform, was procured and is currently being made available to patients. The roll-out of the app was initially targeted towards General Practices and is now being rolled out to providers and hospital services. The platform supports people with new and ongoing MSK conditions by providing useful information to help people waiting to be seen, recovering following surgery or managing an ongoing condition. An evaluation delivered in partnership with the Academic Health Science Network will occur to demonstrate future benefits and how the new community MSK service model can benefit from this platform as part of its future core offer across Derbyshire.

The digital MSK funding is also being used to engage with patients and clinicians to ensure the platform is accessible to as many patients as possible. The remainder of the digital MSK funding is being spent on a Patient Activation Measures digital platform. Patient activation is a measure of a person's knowledge, skills and confidence to manage their own health and wellbeing. Patient Activation Measures help to improve health-related behaviours, and can result in better outcomes, better experiences of care and fewer episodes of unplanned and emergency care, leading to financial benefits for the healthcare system.

We have worked with the local NHS provider Trusts to identify the optimum ways to use funding from NHSE to support people on MSK waiting lists. Following approval from the MSK and Orthopaedic Delivery Board and the Planned Care Delivery Board, the money is being used to fund a support worker at each Secondary Care Trust and also to provide additional capacity at UHDBFT. Support from link workers include useful information and exercises directing people to additional help and trying to prevent unnecessary medical treatment where appropriate.

Physiotherapy

A suite of self-management advice and information is made available to patients to enable them to manage their MSK conditions while waiting for treatment to be provided, with the link to the site to support them. There is work planned to align pathways across the Derbyshire system.

Integrated Community Care

After successfully transitioning to the new ICB arrangements, the Joint and Community Commissioning Team continued to focus on working collaboratively with health and social care service providers, voluntary and independent partners to develop strong integrated community services across Derbyshire. Transformation work has been targeted at projects which will enable the health and social care system to operate as effectively as possible in challenging circumstances and in line with the ICS Operational Plan, Integrated Care Strategy 2023 and Derby and Derbyshire NHS' Five Year Plan. The projects below illustrate our continued commitment to integrated working across community services through Place based and strategic commissioning:

Carers Strategy	The Derbyshire Carers Strategy has recently been refreshed and the system-wide adoption of the priorities and pledges set out to ensure its greatest impact in effectively supporting unpaid family carers. Priorities within the Carers Strategy include improving carer health and wellbeing, information, advice and support, carer employment and financial wellbeing, support to young carers and involving carers as experts.
Enhanced support for patients with delirium and dementia	Continued support to patients with delirium and dementia to ensure that, as far as possible, they can be cared for away from hospital settings, either in their own home or in a care home.
Falls Recovery Service	The Team have been working across Place with Councils – County, City, District and Borough to develop a new falls recovery service. Currently the service is being piloted in Chesterfield and Derby City and is being expanded across the whole of Derbyshire in 2023.
Discharge to Assess	Building a strong, collaborative discharge to assess model which enables and supports Derbyshire people to be discharged from our two acute hospital Trusts, community providers and from out-of-area hospitals. Together, with partner organisations, we have developed more than 218 temporary bedded placements across residential and nursing settings and ensured that the commissioned services have been able to deliver even in the most difficult of circumstances. We have maximised our packages of care to discharge people home as quickly as possible with the system having arranged 838 more packages of care over the winter period.

Transformation Projects

We have focused on leading and supporting the projects and initiatives described below, which were identified as being most useful to the overall, longer-term response to patient care.

Palliative and End of Life Provision

Providing high quality, coordinated care to people at the end of their life is a key priority locally and nationally. The Community Commissioning Team has supported the JUCD End of Life (EoL) Programme and specific projects have included:

- ensuring that the Shared Care Record includes the right information and functionality to facilitate coordinated care for people at the end of their lives;
- continuing to support and work collaboratively with all EoL providers through the EoL Delivery Board. We are in the final stages of reviewing and further developing the Board, terms of reference and refreshing the strategy;
- modelling the required levels of care at home, inpatient beds and community nursing capacity required for Derbyshire's population;
- reviewing all EoL provision across all sectors to better integrate and develop an effective and collaborative EoL offer for Derby and Derbyshire patients; and
- piloting a new home care provision for patients and families to enable them to be better supported at home when at the end of life by using a different approach for CHC fast track provision.

Voluntary, Community and Social Enterprise Sector

There are many VCSE organisations working across Derby and Derbyshire to support the health and wellbeing of local people. The ICB is committed to engaging with the sector in the development of community-focused services and supporting nationally promoted initiatives such as development of VCSE leadership roles.

Our efforts for the wider sector are based on commissioning 12 VCSE infrastructure organisations to provide support to the sector. This support enables an effective, locally based voluntary and community sector, working to help maintain or improve the health and wellbeing of the people of Derby and Derbyshire by:

1. supporting group development and sustainability;
2. increasing the amount of external funding being accessed by VCSE groups in Derbyshire;
3. supporting the delivery of a comprehensive volunteer brokerage service; and
4. bringing the voice of the VCSE into the system and providing information to the people of Derby and Derbyshire about what the VCSE sector offers

VCSE organisations play an essential role in the integrated community offer, working together with the ICB and other partners to ensure that people receive local help. Over winter 2022, this included additional support to people being discharged from hospital providing support to an extra 100 people.

Social Prescribing

Social prescribing is accessed through General Practices and connects people to community services and activities that can help them take steps towards their health and wellbeing goals. Some of the link workers, while connecting with the General Practice, are hosted by a local voluntary sector organisation and are a great example of working in partnership. Since last year, the number of social prescribing link workers in each PCN has increased from 50 to more than 60 workers. Several collaborations have been set up with the VCSE sector, including developing a young person's link worker, and MSK link workers. Whilst these new roles are not commissioned by the ICB, we have taken an active involvement in supporting PCNs to make the most of the opportunities they present. We established the Social Prescribing Advisory Group, which brings key stakeholders together on a regular basis, to facilitate a coordinated, joined-up approach. The group provides a forum for link workers and promotes collaboration with the wider community including the Local Area Coordination Network and community wellbeing coaches.

In March 2023, the Social Prescribing Advisory Group agreed the continuation and funding for a further year of the social prescribing platform 'Joy' which allows all link workers, GPs and partners to manage caseloads, record outcomes and performance data, and share wider marketplace intelligence in one place. It is a proof-of-concept project that will evaluate and further test the platform during 2023/24.

In addition, the Social Prescribing Advisory Group celebrated the final year of a county/city-wide cross-sector 'test and learn' project called 'Greenspring' which secured funding of £500k over two years. The project tested several green interventions for people recovering from/living with mental ill health, and has set up a green provider collaborative with over 50 different green providers. Funding has been secured for a further year to provide community development which will enhance system change, further explore how green providers can be embedded in the Derby and Derbyshire offer to help prevent people from accessing intensive health interventions and remain independent and living well.

Community Equipment

The team has worked with colleagues at Derby City Council and Derbyshire County Council to ensure that local people are supported to be as independent as possible, and to receive care closer to home, through the provision of enabling equipment. This ranges from basic items such as walking sticks and Zimmer frames, through to bespoke specialist seating and sleeping systems. The team also has also supported the continuation of the supply of medical equipment and the consumables needed to enable patients with complex needs to be cared for at home.

Better Care Fund

The team are embarking on a review of the Better Care Fund in collaboration with Derby City and Derbyshire County Councils and DHcFT to better understand and utilise the funds in order to deliver a joined up and integrated offer which links with the new Team Up model.

Urgent Care

The JUCD system continues to be under significant pressure due to ongoing operational challenges. Capacity overall continues to be affected by ongoing staff shortages and sickness. The System Operational Resilience Group meets on a weekly basis to support system partners to manage this, with a particular focus on patient flow in and out of hospital. Key focus areas to support the system includes supporting patients to access care in the right place, first time, and maintaining strong links between service providers. Our main aims are to improve access to urgent care services and a summary is shown below.

Transformation

A review and refresh of the terms of reference for the Urgent, Emergency and Critical Care (UECC) Board and Transformation Delivery Group meetings has been completed to align with the ICB and UECC system. Meetings with service providers continue to be held regularly to discuss urgent, emergency and critical care and deliver the Urgent Care Transformation Programme. System transformation projects are highlighted below.

Operational Support

The operational team comprised a series of significant events during 2022/23, which included:

- collaborative work with the Emergency Preparedness, Resilience, and Response Team ahead of the CCG's transition to an ICB and associated Category 1 responder status;
- the refresh and relaunch of the fortnightly Ambulance Handover Improvement Group;
- creation of a NHSE-directed system control centre, known as the operational coordination centre, to ensure the ICB has visibility of operational pressures and risks across providers and system partners. It ensures concerted action across the ICS on key systemic and emergent issues impacting patient flow, ambulance handover delays and other performance, clinical and operational challenges;
- system-wide planning to assure operational output before, during and after industrial action and bank holidays;
- UECC Team summits and workshops, including the Midlands Region-led ICS, system escalation workshops to define a way forward to de-escalate system-wide pressure;

- a NHSE-directed acute hospital discharge '100-Day Challenge' – a taskforce which worked with 14 NHS pilot sites and 12 social care sites to define the 10 best practice initiatives that demonstrably improve flow;
- the establishment of two hospital ambulance liaison officer roles, one each at the UHDBFT and CRHFT hospitals;
- high intensity user engagement – a multi-disciplinary team worked together to identify and support the most complex patients to improve the quality of their care.

System Operational Resilience Group (tactical-level) meetings were frequently convened to deal with the pressure across the system, with partners and providers alike seeking support. Tactical-level activities were supported by strategic meetings as part of the escalation process.

Additional System Operational Resilience Group (silver-level command) meetings were convened, driven primarily by operational pressure within EDs compounded by challenges associated with mental health patient placements in the community; moreover, the declaration of a critical incident required system escalation calls (gold-level command) until the situation was resolved. Upward reporting of situation, background, activity and recommendation reports to both the System Operations Centre and Midlands Regional Operations Centre was consistent throughout.

Demand Management

The system continued to work together to identify areas of opportunity for alternative ways of providing care, reducing pressure in EDs, and managing increasing demand.

Virtual Wards

Virtual wards allow patients to get the care they need at home safely and conveniently, rather than being in hospital. The system continues to deliver virtual wards, for example, acute respiratory infection virtual wards to support people at the place they call home, including care homes to meet NHSE requirements.

Same Day Emergency Care

Same day emergency care consistent patient pathways continued to be maximised across the system to support the care of emergency patients who would otherwise be admitted to hospital. Organisations worked collaboratively to continually improve their same day emergency care service for patients. Several workshops have taken place to look at how under this care model, patients can be assessed, diagnosed and treated without being admitted to a ward. An established system working group ensures that same day emergency care remains a priority and will be an ongoing priority focus for the system.

Integrated Urgent Care Clinical Navigation Hub and Primary Care Out-of-Hours

The integrated urgent care service specification outlined a national specification for the provision of an integrated 24/7 urgent care access, clinical advice and treatment service that incorporates NHS111 and out-of-hours services. In Derbyshire this is called a Clinical Navigation Hub.

This service fundamentally changes the way patients access health services, allowing patients to receive a complete episode of care concluding with either advice, a prescription, or a face-to-face appointment for further assessment/treatment.

Within Derby and Derbyshire, the Primary Care out-of-hours GP service continued to be a key member of the emergency care networks, working alongside other partner organisations to continually improve and streamline the patient pathway. A collaborative review of the service and revised service specification has been completed to ensure patients as far as possible receive the right care, first time, in the right place.

The demand on NHS111 and 999 services continues to rise. In response, work continues to further expand the current Clinical Navigation Hub model to deliver a Derby and Derbyshire single point of access assessment service. This service will offer clinical advice and support reducing pressures on ambulance services, ED and Primary Care which will achieve more positive outcomes for patients as well as the system.

Urgent Treatment Centres

UTCs continue to provide valuable and locally accessible urgent care services to the Derbyshire population. In Derby and Derbyshire, we want to deliver a joined-up, urgent treatment system that meets the needs of our local population. Our UTC services across Derbyshire have been working to ensure they are now ready to achieve the new draft national standards.

The ICB's Urgent and Emergency Care Team is reviewing the current, and potential future use of the service provided by the Derby Urgent Treatment Centre (DUTC). The service is to provide assessment, care and treatment for both minor injuries and minor illnesses.

A focus on the future model for UTCs has been led by the UTC Strategy Group, Derby UTC Task and Finish Group and public and patient engagement. The focus is 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.

Primary Care

Derbyshire's vision for Primary Care

Our vision has been developed by our local GPs, with the aim of providing high quality, patient-centred, General Practice-led care which has the freedom to innovate to meet patients' needs; with organisations and professionals behaving in a mutually supportive manner. The vision outlines three goals, which will be supported by, and help us deliver, the national priorities as set out in the NHS Long Term Plan; Primary Care System Development Programmes (previously known as the General Practice Forward View) and General Practice Contract over the course of five years.

1. All patients will have access to a General Practice-led multi-disciplinary team of community care professionals by 2024.
2. In Derbyshire, the share of NHS resources spent on Primary Care should increase (from 9% to 15%) within 10 years.
3. By 2024, no member of the General Practice team will leave the profession as a consequence of an unsustainable workload and/or unreasonable working demands.

Derbyshire General Practice Workforce

The total permanent General Practice workforce headcount for Derbyshire as of the 31st March 2023 was 3,851 working a Full Time Equivalent (FTE) of 2,831.29. This is a decrease of 21.52 FTEs since December 2022. Within the workforce there are four main staff groups; these are:

General Practitioners	909 headcount (726.79 FTE)
General Practice Nursing	497 headcount (352.05 FTE)
Direct Patient Care (those other than GPs and Nurses who provide care to patients, for example, Health Care Assistants, Physiotherapists, Pharmacists or Paramedics)	364 headcount (264.33 FTE)
Administration and Non-Clinical	2,081 headcount (1,488.12 FTE)

Table 2 – Primary Care Workforce staff group data as at the 31st March 2023

The General Practice workforce in Derbyshire is stable and we have seen a decrease in our GP and direct patient care staffing groups over the last three months. Our numbers of nurses have remained static for the last quarter of the year, which is a change in trend, as this staff group has been steadily declining. Our numbers of admin and non-clinical staff have increased.

In terms of age profile, our workforce is comparable with other areas of the country although we are starting to see a positive shift in the GP profile. For our GP workforce, 36.2% are under the age of 40, with 6.2% of these being under 30, and 13% over the age of 55. The nursing workforce remains the same, with 22.3% under the age of 40 and 33% over the age of 55. All the nationally recommended recruitment and retention schemes are in place and delivering. We are also collaboratively working with partners and stakeholders to develop a five-year workforce plan to share with General Practice.

It is important to note that the data above does not include staff recruited by PCNs under the ARRS. The scheme is available to PCNs participating in the PCN Direct Enhanced Service Contract. The ARRS scheme began in July 2019 and allows 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 369 WTE by March 2023. As of the 31st March 2023, PCNs had recruited 461.95 FTEs under the scheme, exceeding the target by 25%.

Enhanced Access

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–Friday, 6.30pm–8pm and 9am–5pm on Saturdays) for patients in Primary Care have been rolled out across every PCN in Derby and Derbyshire and significantly increased access to Primary Care.

A wide range of appointments are offered including General Practice appointments for acute and chronic conditions, long-term condition reviews, screening, vaccinations, clinical pharmacist appointments and phlebotomy. Appointments have been undertaken via telephone triage and treatment, virtual appointments and face-to-face for those who need it most.

General Practice Appointment Data

Data for March 2023 shows General Practice in Derbyshire provided approximately 598,000 appointments (621,000 including Glossop, which did not join the ICB until July 2022 so cannot be used when comparing to previous years' figures), which is a 6% increase (when corrected for working days) and 83,000 more than what was delivered in 2019. These figures include 2,692 same day winter access hub appointments and 3,486 home visits from the Ageing Well Support Programme to relieve pressure in General Practice.

Most appointments were face-to-face (approximately 75%) and 41% of appointments were offered to be seen same day. There were approximately 19,500 Enhanced Access appointments offered by PCNs across Derbyshire. Practice-level data is now available, and practices are monitored against eight standard indicators to measure their patient access.

The ICB reviews any practices which appear to be having difficulties with access through the newly formed access working group. The review includes General Practice appointment data, along with soft intelligence such as patient survey scores and practice feedback. Where appropriate, practices will be supported by the ICB with areas of difficulty and then monitored monthly.

Primary Care Estates

The Primary Care Estates Strategy provides a framework for the development of the Primary Care estate across Derbyshire to 2025. It identifies 20 activities and work has commenced on the five highest priority actions, to determine what is required for the estate. Feasibility studies have been undertaken in South East Derby, South West Derby, Mickleover and Mackworth, North East Derbyshire Southern and Swadlincote areas. Updates include:

- pre-planning application work is being undertaken across Mickleover and Mackworth to understand if preferred sites are viable options, the results of which will lead to two Outline Business Cases being commissioned for both areas;
- a strategic outline case has been completed for Sinfin in Southwest Derby;
- work is under way with North East Derbyshire Council on a proposal to use 'Towns Fund' money to support a new building in the centre of Clay Cross; and
- the extended east Staffordshire/south Derbyshire feasibility study was submitted at the end of March 2023. The study has arisen due to a new housing estate in Drakelow, on the county border.

Quality

Quality Assurance Visiting Programme

The Quality Assurance (QA) visiting programme for General Practices is scheduled on a yearly rolling basis across Derbyshire. The visit is a systematic and transparent process of checking to see whether a practice is meeting specified requirements and involves the assessment of quality-of-care against agreed thresholds and standards, to determine the level of quality within the practice. This also includes assurance that actions identified are implemented via reviews against progress and improvement in quality.

QA visits are intended to be an informal way for practices to have an open discussion about areas of their practice, and review and reflect on the wealth of current health care information in relation to individual practice quality and performance. This is intended to be a supportive process and part of the on-going dialogue with practices and the ICB. QA visits continue to be a mechanism for encouraging practice development and sharing good practice.

National Screening and Immunisation Programmes

During 2022/23 the National Screening programmes continued their recovery and restoration plans in response to the Covid-19 pandemic:

Diabetic eye screening	High-risk patients and previous 'did not attends' continued to be invited for their screening. All patients with a previous R0M0 screen were invited, within two years from their last screen.
Antenatal and new-born screening programme	Screening continued as normal.
Breast cancer screening programme	The Breast Cancer Screening programme remained open for screening. Services continued to be restored at CRHFT, UHDBFT, Sherwood Forest Hospitals NHS Foundation Trust and Nottingham University Hospitals NHS Trust. High-risk breast screening also continued.
Cervical screening programme	Screening and colposcopy clinics continued as normal.
Bowel cancer screening	Programme has restored the service, routine invitations and test kits are being sent, and additional precautions have been taken to ensure the pathway for colonoscopy is Covid-19 secure.
Abdominal aortic aneurysm	Programme has restored the service, primary screening and surveillance patients continued to be invited. Additional measures in place where indicated to ensure attendance is Covid-19 secure.
National childhood immunisations schedule	Screening continued as normal.

General Practice Nursing

During 2022/23 there has been a continued challenge for General Practice Nursing (GPN) across the UK and this has been seen across Derbyshire. The ICB has continued to work closely with HED to recruit and retain and reform GPN. Over the past 12 months, the Training Hub has:

- supported our 506 GPNs across Derbyshire;
- ran a successful GPN conference for Derbyshire, covering a diverse range of topics and highlighting the value of GPNs' work;
- worked to expand new nursing roles and the profile of GPN and promote General Practice in Derbyshire;
- continued to run a comprehensive nursing education programme to meet continuing professional development needs and ensure access to funding; and
- appointed new GPN leadership roles, including a 'GPN Champion' and a 'New to Practice Nursing Ambassador'.

Our continued work has seen an increase in:

- student supervision and assessment transitioned GPNs by 39.6%;
- Trainee Nurse Associates by 92%;
- pre-registration nurse placements by 53.2%;
- General Practice taking pre-registration nurse placements by 35%; and
- 'new to practice' nurses in General Practice by 100%.

Over the next 12 months we will seek to appoint a new GPN Strategic Lead and refresh the GPN Strategy, this will include:

- the roll out of the 'Connected, Authentic, Resilient, Empowered' programme and work with leaders to embed GPN leadership within the Derbyshire Primary Care infrastructure;
- engagement events with GPNs across the county to inform a comprehensive refreshment of the Derbyshire GPN Strategy; and
- embedding a professional nurse advocate role.

Care Quality Commission inspections of Primary Care

Delivering high quality services in Primary Care is an important part of managing the health of Derbyshire's population. Every Derbyshire General Practice has been visited by the Care Quality Commission (CQC) and has received an inspection rating of either outstanding, good, requires improvement or inadequate. Table 3 identifies the ratings awarded to General Practices by the CQC for the reporting period up to the 14th March 2023:

Rating	Total General Practices
Outstanding	20
Good	90
Requires improvement	4
Inadequate	1

Table 3 – CQC ratings awarded to General Practices up to the 14th March 2023

In 2022 the CQC laid out its approach to how and when it would take the next steps in delivering its proposed new strategy. However, the CQC has recognised the need to make sure that this is done as smoothly as possible, particularly as providers continue to experience persistent pressures. Further information on the CQC's proposed implementation of their new regulatory approach can be found here[v].

Digital Development

The ICB have developed a Joined Up Care Derbyshire Digital and Data Strategy, which was published in November 2021 and recently refreshed to ensure continued alignment with local priorities and national initiatives. It is a plan to use technology to improve the health and care of people in the city and county. The strategy was developed by Joined Up Care Derbyshire, an Integrated Care System (ICS) that brings together health and care organisations across Derbyshire. The programme priorities includes deployment of an electronic patient record across acutes trusts, continuation of the Derbyshire shared care record roadmap, implementation of virtual wards (remote monitoring), implementation of digital solutions (Optica) to support patient flow and data management solution (Axym) to facilitate population health management and accessibility of data. The strategy can be found here.

The Joined Up Care Derbyshire Digital and Data strategy has three main goals to:

- improve the patient experience by making it easier for people to access information and services, and by providing them with more control over their care;
- improve the quality of care by using technology to support clinicians in making better decisions, and by providing them with access to the latest evidence-based information; and
- reduce the cost of care by using technology to make care more efficient and effective.

The Digital Health Strategy is a key part of Joined Up Care Derbyshire's plan to transform the health and care system in Derbyshire. The strategy is ambitious, however it is essential if the ICS is to achieve its goal of providing high-quality, person-centred care that is both affordable and sustainable.

In addition to the specific actions outlined in the strategy, Joined Up Care Derbyshire is also committed to embedding a culture of digital innovation across the health and care system. This means creating an environment where staff are encouraged to use technology to improve their work, and where patients are supported to use digital services to manage their own health. This culture and commitment is underpinned by ensuring as safe an operating environment as possible through the use of up-to-date digital infrastructure and a tight, distributed team approach to cyber protection and awareness.

The ICB's Chief Digital Information Officer is responsible for Digital Development and the ICB Chief Medical Officer has the accountability for the use of data; there are clear links and dependencies between data, digital and technology.

The ICB's Digital Development Team supports a number of local, regional and national projects across both Primary Care and corporate IT. For Primary Care, the majority of the operational work is undertaken through contracts with Tameside and Glossop Integrated Foundation Trust and the NECS. The team also supports a number of other organisations which enable the delivery of Primary Care services including VCSE organisations.

Focus on activity

For 2022/23 our main activity included:

- managing the integration of General Practices in Glossop into the Derbyshire system and the transfer from CCG to ICB;
- enabling General Practices to be compliant with their contractual obligations by providing access to video consultation services and the ability for patients to securely submit information to the General Practice through a website;
- replacement of network equipment and upgrading secure internet connections for Primary Care sites to improve the bandwidth available and support delivery of additional services from the site;
- replacement of laptop and desktop computers, other devices and software to ensure colleagues have access to appropriate technology and to manage the risks associated with technology and software which is no longer actively supported;
- commissioning a training needs analysis to support corporate and Primary Care colleagues in fully utilising the capabilities of the applications provided;
- working with community groups for whom English is not a first language to understand any additional barriers which digitalisation of services introduces and subsequent partnership working the community groups, General Practices and PCNs within that area to develop digital solutions capable of limited translation between English and other languages;
- supporting General Practices to enable prospective access to medical records for patients;
- working with Care Homes to benchmark their current digital maturity to inform other system-wide programmes of work; and
- providing subject matter advice to a number of procurement programmes, internal and Primary Care projects.

Strategic Clinical Conditions and Pathways

The planning and performance objectives focus on the long-term conditions (LTCs) of respiratory, cardiovascular disease, stroke and diabetes, which are aligned to the NHS Long Term Plan and JUCD priorities.

In each of these LTCs, outcomes have focused on improving the quality-of-care provision; addressing health inequalities; promoting local access to services; improving prevention support; recovering services following the pandemic; and targeting variances in the quality of clinical treatment and care. In addition, the team leads on key NHSE-funded programmes that include tobacco dependency treatment, long service (post syndrome syndrome) and virtual wards.

Programme objectives are overseen by monthly condition-specific or programme delivery groups. The delivery groups are attended by key stakeholders such as system clinical leads, service providers, patient representatives and third sector organisations.

Delivery highlights during Q2 to Quarter 4 (Q4) of 2022/23 include:

Respiratory	
Quality assured diagnostic spirometry	Spirometry is one of the main investigations used for diagnosing respiratory diseases. An additional 57 General Practice staff have received training to Association for Respiratory Technology and Physiology accredited standards.
Spirometry (recovery and restoration)	Approximately 76% of practices have performed some spirometry, with a 43% increase in activity from Q3 to Q4 2022/23. In addition, more than 50 practice staff attended an 'Ask the Expert' seminar, enabling staff to speak directly with a spirometry expert.
Pulmonary rehabilitation	NHSE funding has been received to support the delivery of the pulmonary rehabilitation five-year vision document. Providers and the ICB are working closely together to increase referrals and programme capacity as well as addressing health inequalities.
Winter Communications campaign – 'Keep your condition under wraps'	A bespoke respiratory winter campaign called 'Keep your condition under wraps' was launched. The respiratory-focused campaign toolkit was created to support patients over winter. Practices shared messages via their websites and social media, as well as sending targeted text messages to respiratory patients.

Cardiovascular Disease	
Hypertension Case Finding and Prioritisation	Ongoing support has been offered to General Practice to enable practices to achieve the delivery of performance indicators related to high-risk patients. This includes review of the data dashboard at quarterly meetings chaired by the ICB's Cardiovascular Disease Clinical Lead. A formal offer of support was also provided by the East Midlands Academic Health Science Network for the Hypertension Proactive Care Framework as part of the national Academic Health Science Network blood pressure optimisation programme. The NHS community pharmacy blood checking service is provided in Derbyshire pharmacies and additional NHSE funding has been secured to expand on this, with a focus on Derby City where there is the lowest hypertension prevalence.
Cardiovascular disease prevention	NHSE funding has been secured and a plan has now been developed to work alongside (the body replacing) Public Health England to extend the role of existing health improvement workers, to undertake blood pressure monitoring within communities where low hypertension prevalence rate exists and health inequalities.
Familial Hypercholesteremia Service	An East Midlands Familial Hypercholesteremia (FH) service has been given the go-ahead from the NHSE Regional FH Steering Group. One FH Nurse will be recruited to each ICB within the East Midlands. The FH Nurse for Derbyshire will lead on FH testing of high-risk patients and, as FH is a heredity condition, also cascade testing of family members.
Cardiac rehabilitation	Cardiac rehabilitation for heart failure patients is not currently commissioned in Derbyshire and only a small number of heart failure referrals are made for cardiac rehabilitation. NHSE funding has been secured to enhance provision for heart failure patients. Transformation of the cardiac rehabilitation services across Derbyshire continues. The menu of options is being extended further to include intravenous cardiac rehabilitation referrals to Derby County Football Community Trust, where a specific pathway has been developed to support patients. Extending the provision across leisure centres is also being developed.
Out of hospital cardiac arrest	JUCD has worked with EMAS to identify localities with the greatest need of community-based defibrillators and community first responders. This work has helped EMAS to secure funding to support improved provision for Derbyshire.
Clinical stewardship for heart failure	As part of a funded pilot programme, JUCD has been working alongside NHSE and NHS Arden and Greater East Midlands Commissioning Support Unit to develop an understanding of the stewardship approach for Derbyshire to help deliver on the triple aim for people with heart failure. The outcome of this work will involve a review of heart failure interventions, to support the identification of transformational improvement programmes.

Cardiovascular Disease	
Remote monitoring for pacemakers	CRHFT has now completed the six-month pilot programme funded by NHSE to develop the remote monitoring capacity for patients fitted with pacemakers. It provided system efficiencies, with CRHFT looking to maintain remote monitoring capability for the patient cohort.
Winter communications campaign – blood pressure monitoring	The ICB developed a communications campaign across Derbyshire to encourage the public to monitor their own blood pressure or to visit their local community pharmacy to receive a blood pressure check to reduce the likelihood of heart attack, stroke and other cardiovascular-related conditions.
Diabetes	
Derbyshire footcare pathway	A Derbyshire footcare pathway has been implemented, ensuring an equity of service and standardisation across all providers. Silhouette software to support wound management has been upgraded at provider sites.
Diabetes specific psychology support	A proposal to implement a diabetes specialist psychology service to support complex patients across the system has been approved and developed. The service will be implemented in April 2023.
Intermittent and continual glucose monitoring devices	Updated NICE guidance advises an increase in the use of intermittent and continual glucose monitoring for patients living with type 1 or type 2 diabetes. A business case and phased implementation plan has been developed for consideration.
Diabetes education portal-single point of access for clinicians	A plan has been implemented to provide additional support to clinicians attending 'Effective Diabetes Education Now' training to initiate injectable medication in Primary Care (GLP2s and insulin).
Structured Education	Increased course provision is implemented with the aim to have no waiting list for the 'dose adjustment for normal eating' course for patients living with Type 1. A review is ongoing to understand health inequalities and barriers to access structured education for patients living with type 2. Further development of bespoke education sessions to reach under-represented groups is in place.
Children and young adults service	A successful bid was submitted to NHSE to support service improvements for this cohort of patients. Recruiting to additional workforce to increase appointments to the Children and Young Adults Diabetes Service. A young adult 'dose adjustment for normal eating' course is being developed.

Diabetes	
National diabetes prevention programme	The gestational diabetes referral pathway to enhance access onto the National Diabetes Prevention Programme has been implemented. Additional facilitators funded to increase the reach and impact of the GP register sharing project, increasing referrals to the programme.
Low calorie diet programme	An additional facilitator has been funded to increase the reach and impact of the GP register sharing project, increasing referrals to the programme.
Stroke	
Critical services review	Initiated a review across a broader geographical footprint to identify recommendations leading to the long-term sustainability for Hyper Acute Stroke Units in the region.
Stroke Rehabilitation Pathway	A review of the stroke rehabilitation pathway has commenced. Derbyshire services have been benchmarked against the NHSE Integrated Community Stroke Services Specification to identify gaps in provision. Focus on developing an equitable pathway to drive patient outcomes.

NHSE/System Programmes

Long-Covid-19 (Post-Covid-19 Syndrome)	
Long-Covid-19 Service	The service continues to receive referrals on a weekly basis. There is continued service improvement based on evidence to understand how the pathway can be further enhanced. To enhance access for under-represented groups (health inequalities), a research and engagement project has been implemented to understand barriers to access and to drive referral rates.
Tobacco Dependency Treatment Services	
Tobacco Dependency Programme	Tobacco Dependency Champions and Advisors have extended their communications campaign to branch out to all wards across both acute providers. Inpatient and maternity programmes commenced in September and referrals continue to increase on a weekly basis. DHcFT commenced implementation in January 2023 and is rolling out the programme across the Trust.
Virtual Wards	
Virtual Wards two-year plan	Support for patients who would otherwise be in hospital to receive the acute care, monitoring and treatment they need in their own home. The community respiratory virtual ward has been successfully implemented providing a valuable aid to winter pressures. Virtual wards soon to be implemented are end-of-life care with Ashgate Hospice as a key partner and heart failure in both acute and community providers. To implement a frailty virtual ward, a frailty lead has been appointed to work across the ICB with all system partners.

Medicines, Prescribing and Pharmacy

Since the formation of the ICB, the Medicines Management and Clinical Policies (MM&CP) Team has embedded and evolved our functions to meet the needs of the emergent ICB and wider system. From a core business perspective, we have delivered key functions supporting the safe, effective and efficient use of medicines. This includes delivery of efficiency targets, governance review to ensure continued clinical decision-making and quality initiatives such as driving greener inhaler use. Alongside this, there has been continued professional support to vaccination programmes; the transfer of Glossop in to the ICB; and further roll-out of the Medicines Order Line (MOL).

A key part of our strategy is to drive pharmacy professional leadership and integrating pharmacy and medicines initiatives with the system. A standout success has been the work on long term and high dose opiates in non-cancer pain, with the MM&CP Team working with system partners to innovate. Furthermore, we are seeking to lead and facilitate initiatives to improve pharmaceutical public health and reduce inequalities.

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 to go further and faster addressing pharmaceutical public health including unmet need and inequality.

Work continued to implement the Derbyshire-wide strategic plan with the ambition of integrating pharmacy and medicines optimisation across the system, within pharmacy services and wider, ensuring optimal use of medicines to reduce the avoidable and unjust differences in health outcomes for the population of Derby and Derbyshire.

Medicines Savings Programme

During the year the team delivered an ambitious medicines savings programme of £10m. This included work in the following areas:

- medicines optimisation;
- self-care;
- nutrition;
- Optimise Rx prescribing software;
- reducing medicines waste;
- Primary Care prescribing rebates; and
- patent expiries.

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 2022/23, with declarations being returned by the relevant practices to the ICB for assurance. In addition, benchmarking prescribing data for controlled drugs and drugs with dependence potential was circulated to practices highlighting variation in prescribing and thus promoting safe prescribing of controlled drugs.

Medicines Safety

The Derbyshire Medicines Safety Network, a system-wide group comprising medicines safety officers from all Derbyshire providers, met virtually during Quarter 1 (Q1) of 2022/23 with learning from local incidents shared and discussed. A system safety workplan was also agreed for implementation by the group. The Derbyshire Medicines Safety Network continued to lead and facilitate implementation of the workplan, with some actions expected to continue into 2023/24.

Monitoring incident reports and sharing learning from incidents related to Covid-19 vaccines continued, with system-wide dissemination of relevant learning and preventative actions resulting from vaccination incidents.

Investigation and analysis of critical non-vaccine, medication-related incidents also continued during 2022/23, including supporting General Practices and other providers to transition to the new learning from the patient safety events reporting system. Completion of this has been extended to September 2023 by the National Patient Safety Team.

Antimicrobial Stewardship

Antimicrobial stewardship is key to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness. Implementation of the Derbyshire Antimicrobial Resistance Strategy continued during 2022/23.

Prescribing data was circulated to practices during 2022/23 to help us better understand volumes and variations in prescribing. It is anticipated that the recent outbreak of Group A Streptococcus infections nationally, which occurred during Q3 and Q4 of 2022/23, will have an impact on the overall volume of antibiotic prescribing, however the prescribing data to quantify this is still awaited.

General Practice Community Pharmacist Consultation Service and Extended Care Services

NHSE continued to ask systems to support with NHSE nationally and regionally commissioned community pharmacy services, including the General Practice Community Pharmacist Consultation Service (GP-CPCS) and extended care services. GP-CPCS supports the management of low acuity patients in alternative settings, supporting General Practice workload pressures.

The team continued as member of the Midlands GP-CPCS Implementation Oversight Group and worked with the General Practice Commissioning Team, Local Pharmaceutical Committee, NHSE programme managers, PCNs and community pharmacies to promote and develop local plans for implementation, troubleshoot and monitor uptake. The team also reviewed new patient group directions as part of the increased roll-out of the extended care service and supported the implementation of the discharge medicines and smoking cessation services.

Contracting and Procurement

The MM&CP Team commissioner-led contracts that were due to expire were reviewed and procured in line with current governance processes. The Contracting and Performance Team is regularly updated on the governance process and procurement status of contracts that are due to expire within the year. The team populated the organisation contract register and continued to update it with any changes to contracts, governance process and outcomes of due diligence checks.

Decision-making

Managing Individual Funding Requests

The Individual Funding Request (IFR) process upholds ICB statutory duties. It continues to be managed by the Clinical Policies Team, and is accountable to the Clinical Policies Advisory Group, who receive a monthly oversight report confirming decisions that have been made.

As part of the management of the process, requests are triaged by a screening panel whose role is to establish whether there is a case of exceptionality or rarity, with only those requests appearing to meet the IFR policy definition of 'rarity' or 'clinical exceptionality' being forwarded to the IFR Panel for consideration.

The IFR Panel meets on a monthly basis when required, with decisions being made within agreed timescales. Following the transition of Glossop to the ICB in July 2022, the scope of IFR has widened to encompass requests for patients that reside within the Glossop area.

Mandatory IFR training has been undertaken for new and existing members of the IFR panel to ensure that they have the necessary skills and expertise to enable them to make effective decisions.

Clinical Policies Advisory Group

Following the establishment of the ICB, the Clinical Policies Advisory Group received delegated authority from the Population Health and Strategic Commissioning Committee. As a result, the group reviewed the terms of reference to ensure the strengthening of membership and stakeholder engagement accordingly. The group continues to manage a work programme for existing policies while scoping new areas. Effective clinical policies serve to meet ICB statutory duties, for example, NICE adherence, and provide assurance within clinical pathways and services for evidence-based interventions.

Joint Area Prescribing Committee/Guideline Group

Following the establishment of the ICB, the Joint Area Prescribing Committee received delegated authority from the Population Health and Strategic Commissioning Committee. The Terms of Reference have been reviewed to strengthen membership and stakeholder engagement. The 'Guideline Group' continues to receive delegated responsibility from the Joint Area Prescribing Committee for minor formulary reviews and amendments.

The Clinical Policies and Decisions Team continued to provide system leadership and assurance through attendance at Secondary Care Drugs and Therapeutic Committee meetings with provider Trusts.

Derbyshire Prescribing Group

Following the establishment of the ICB, the Derbyshire Prescribing Group received delegated authority from the Population Health and Strategic Commissioning Committee to make decisions and operational implementation within their financial envelope. The terms of reference have been reviewed to strengthen membership and stakeholder engagement. The group covers medicines oversight, quality, safety and cost effectiveness, along with transformation of services.

High-Cost Drugs – ICB-commissioned

In 2022/23 the ICB resumed the monthly High-Cost Drugs (HCDs) finance meetings. Furthermore, the Clinical Policies Team continues to monitor and adopt new NICE technology appraisals, approving ICB-commissioned algorithms and seeking assurance and compliance through Bluetop. In addition, the team has scoped the use of new and emerging biosimilars which provide cost efficiencies for the ICS.

Support to Place/PCNs/Practice

Continued dedicated Place/PCN and General Practice based support from an ICB Medicines Optimisation and Delivery Pharmacist and Pharmacy Technician in all General Practices means that we are able to engage with clinicians and deliver actions to improve the quality, safety and cost effectiveness of medicines, both on an individual patient level, and also at all levels of the system to influence change and improvement across the Derbyshire footprint.

There has been continued development and delivery of regular education sessions which are available to all pharmacy teams (ICB, PCN and practice-employed) across the ICB, with plans to review and open to all General Practice clinicians.

The successful delivery of projects to deliver safe and effective efficiencies continues, including:

- anticoagulant formulary choice to access prices secured through the National Procurement Framework to significantly above the national average;
- consistent delivery of key messages, medicines changes and current transactional actions;

- continuing to promote self-care and the 'Greener NHS' low carbon footprint choices for inhalers;
- monthly review of digital medicines support software profile messages to maximise transactional and safety of medicines continues to deliver annual savings of £2m;
- clinical system formulary update and sharing for formulary status for prescribing;
- providing education and training for proxy ordering of prescriptions for care home patients to enable requests to be handled more efficiently without the need to access each individual patient's clinical record;
- point of contact for queries and advice about medicines.

The MOL continues to expand and deliver an exceptional service to those requiring assistance with ordering medicines, while reducing waste and expenditure on medicines. The move to permanent contracts for MOL telephone operatives has provided stability to the team and improved service parameters. Patient feedback is positive and there are minimal complaints. The service is currently provided to 76% of practices, with further roll-out planned to include Glossop.

Community Pharmacy

The team continued to engage with NHSE on preparing for the transfer of community pharmacy commissioning from NHSE to the ICB, ready for April 2023. The team supported the Primary Care Team with engagement and feedback to NHSE. Community pharmacy integration is a separate medicines optimisation priority and there is ongoing engagement work with stakeholders to develop plans to better integrate community pharmacy into pathways, projects and to support delivery of pharmaceutical needs at place and PCN level.

Covid-19

Senior medicines optimisation and delivery support for the Vaccination Operations Cell continued on a weekly basis for vaccinations and other areas requiring similar approaches, for example, monkey pox and typhoid outbreaks in asylum seeker populations.

Direct support to the Covid-19 vaccination centre continued with re-deployment of the Medicines Optimisation and Delivery Team members until the end of August 2022. The Covid-19 vaccination allergy service was provided through the work of two Pharmacists from the Medicines Optimisation and Delivery Team from its inception until February 2023.

A dedicated fixed term Head of Medicines Optimisation for Vaccinations was appointed in January 2023 to provide dedicated support for the Vaccination Operations Cell and subsequent vaccination programmes.

Ambulance and NHS111 Commissioning

The East Midlands Coordinating Commissioning Team manages the ambulance and NHS111 contracts with EMAS and DHU on behalf of all East 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

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 standard, 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.

At a Trust-level, EMAS did not achieve any of the six national standards for Q2 and Q4 of 2022/23. Both Derbyshire and Lincolnshire matched the regional position, whilst Nottinghamshire achieved C1 90th centile for both Q2 and Q4, and Leicestershire and Northamptonshire both achieved C1 90th centile in Q4. Q2 and Q3 saw deterioration in performance at a Trust-level when compared to the same quarters in 2021/22, however there was significant improvement in performance during Q4 as shown in Table 4 below:

EMAS	National Standards Q2 to Q4 2022/23							
	Category 1				Category 2			
	Mean		90th Centile		Mean		90th Centile	
	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22	2022/23	2021/22
National Standard	00:07:00		00:15:00		00:18:00		00:40:00	
Quarter 2	00:09:30	00:09:05	00:17:13	00:16:26	01:02:40	00:49:28	02:24:47	01:46:25
Quarter 3	00:09:59	00:09:16	00:18:13	00:16:33	01:28:33	00:56:38	03:23:59	02:03:37
Quarter 4	00:08:55	00:09:05	00:16:07	00:16:28	00:46:57	00:50:46	01:43:32	01:50:38

EMAS	Category 3		Category 4	
	90th Centile		90th Centile	
	2022/23	2021/22	2022/23	2021/22
National Standard	02:00:00		03:00:00	
Quarter 2	08:25:17	07:17:52	08:10:03	06:45:03
Quarter 3	09:59:20	08:24:09	09:11:07	06:55:08
Quarter 4	05:51:55	07:00:04	05:57:18	07:00:31

Table 4 – EMAS Performance for Quarter 2 to Quarter 4 of 2022/23

Nationally, Ambulance Trusts have been unable to deliver performance standards. During Q2 and Q3, the number of ambulance crews waiting to hand patients over at EDs increased significantly, resulting in delays in response times for patients waiting in the community. During Q2, EMAS lost 43,378 hours due to pre-handover delays greater than 15 minutes, this increased to 59,152 during Q3. This demonstrates a tangible increase when compared to Q2 and Q3 of 2021/22, with 30,646 and 36,583 lost hours respectively. During Q4, the number of lost hours fell significantly when compared to Q3, with 31,120 hours lost due to pre-handover delays, a reduction of 28,032 hours. The average pre-handover times can be seen in Table 5 below:

Average Pre-Hospital Handover Times	Quarter 2			Quarter 3			Quarter 4		
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022/23	00:41:39	00:37:41	00:55:16	00:44:45	00:37:57	01:04:21	00:33:41	00:31:11	00:32:44
2021/22	00:28:00	00:29:26	00:31:37	00:32:49	00:34:16	00:32:06	00:32:39	00:34:59	00:41:32

Table 5 – Average pre-hospital handover times for Quarter 2 to Quarter 4 of 2021/22 and 2022/23

As part of the contractual agreement reached with EMAS and the six ICB associate commissioners of the Emergency Ambulance Contract, all ICSs were asked to provide improvement trajectories linked to operational plans that commit to a reduction in handover delays in excess of 60 minutes and two hours. Achieving this as a minimum would have had a positive impact on performance, as well as quality and patient safety, but has remained dependent on multiple factors such as service delivery and resource availability across the whole health and social care system. At the end of Q4 none of these trajectories were achieved by the ICBs.

ICSs are committed to improving access to urgent care services including pharmacy provision, General Practice and NHS111 to reduce demand on emergency services. EMAS is working with systems to support the development and access to pathways that are alternative to direct conveyance to an ED. These include two-hour urgent community response services, same-day emergency care, direct admission to specialities and virtual wards. ICSs have also made a commitment to reduce the number of delayed discharges and are working closely with local authority colleagues to increase system flow.

Call demand for Q2 to Q4 (except for December 2022) has been lower than plan, this can be seen in Table 6 below.

EMAS		Quarter 2			Quarter 3			Quarter 4		
		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Calls	**Actual**	115,375	98,332	94,060	109,349	101,920	128,225	89,559	85,500	102,115
	Plan	118,039	111,631	112,184	116,276	108,482	110,780	103,194	95,074	110,451
	Variance	-2.3%	-11.9%	-16.2%	-6.0%	-6.0%	15.7%	-13.2%	-10.1%	-7.5%

Table 6 – Call demand for Quarter 2 to Quarter 4 of 2022/23

While call demand is lower than planned, the number of duplicate calls received has increased. During Q3 of 2021/22, 21.2% of calls were categorised as a duplicate call, this has increased to 24.9% in Q3 of 2022/23. 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, and there is a link between an increase in duplicate calls and deterioration in response times. During Q4 when there was an improvement in response times, duplicate calls fell to 19.8%.

In line with calls being below the indicative action plan in all months except December 2022, incidents (where a patient receives a face-to-face response or clinical assessment over the telephone) and on-scene activity were also below plan, however while calls and incidents were above plan in December, on-scene activity remained significantly below plan. It is worth noting that December 2022, which had the highest average pre-handover times seen year-to-date, also saw the first day of industrial action for the ambulance service, which was a clear contributing factor. Further industrial action took place during January and February 2023, but due to the updated/revised contingency plans in place we did not see a further impact in performance.

Activity level for incidents and on-scene activity can be seen in Tables 7 and 8 below:

EMAS		Quarter 2			Quarter 3			Quarter 4		
		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Incidents	Actual	64,506	62,273	60,719	64,708	64,246	70,453	62,995	57,342	64,585
	Plan	72,876	68,397	66,546	69,061	67,077	69,131	66,580	59,494	66,897
	Variance	-11.5%	-9.0%	-8.8%	-6.3%	-4.2%	1.9%	-5.4%	-3.6%	-3.5%

Table 7 – Incidents for Quarter 2 to Quarter 4 of 2022/23

EMAS		Quarter 2			Quarter 3			Quarter 4		
		Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
On Scene	Actual	53,922	52,795	52,151	54,794	54,629	51,977	52,547	48,315	55,549
	Plan	63,375	60,326	58,500	61,071	59,166	60,344	59,060	52,471	58,549
	Variance	-14.9%	-12.5%	-10.9%	-10.3%	-7.7%	-13.9%	-11.0%	-7.9%	-5.1%

Table 8 – On scene activity for Quarter 2 to Quarter 4 of 2022/23

EMAS post-handover times remained above the 15-minute national standard during Q2. As part of contract negotiations, EMAS were asked to submit a trajectory to reduce average post-handover times. The trajectories commenced in July, and we have seen a reduction month-on-month since, with the 15-minute national standard being achieved from November onwards (see Table 9 below).

Average Post-Hospital Handover Times	Quarter 2			Quarter 3			Quarter 4		
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2022/23	00:22:35	00:22:03	00:17:54	00:15:16	00:14:47	00:14:07	00:14:38	00:14:01	00:14:31
2021/22	00:20:23	00:20:21	00:20:19	00:20:22	00:20:32	00:20:40	00:20:33	00:20:38	00:20:15

Table 9 – Average post-hospital handover times for Quarter 2 to Quarter 4 of 2022/23

EMAS has faced resourcing challenges, and while it has not been able to resource the indicative action plan each month, it has been able to resource actual activity due to this being lower than planned. There were 25 serious incidents reported by EMAS in Q2, 17 of which were due to delayed responses. In Q3, 16 serious incidents were reported and 11 of these were due to delayed responses. In Q4 there were 35 serious incidents reported by EMAS, of which 30 were due to delayed responses.

NHS 111 (East Midlands) Performance

The NHS111 contract with DHU contains five KPIs and a further KPI associated with the validation of ambulances assessed to require a C3 response. Due to the original go-live date of the NHS111 contract with DHU being mid-financial year (October 2016), the quarterly performance reporting does not mirror the quarters in a financial year. Within this report, Q2 of the 2022/23 data demonstrates Q4 of the year six DHU 111 contract and Q3 of the 2022/23 data shows Q1 of the year seven DHU 111 contract.

Between the 4th August to 25th August 2022 there was a national outage of the Adastra Clinical Patient Management System used by DHU which had a significant impact on all NHS111 systems. While the frontline IT issue was quickly resolved, restoration of other system functions was not completed until December 2022. In August and November 2022, the clinical calls and transfer to clinician information were unavailable and there was no C3 validation data between September and November 2022.

Performance against the call handling KPIs for Q2, Q3 and Q4 2022/23 can be seen below in Table 10, and is summarised as:

- 'calls abandoned after 30 seconds' was achieved five months out of nine (July, September, October, January and February) when compared to the same period in 2021/22 – this demonstrated a slight improvement in months achieved;
- 'average call answer time' was not achieved when compared to the same period in 2021/22 – a deterioration was seen in the months of July, August, November, December, February and March;
- 'calls triaged proportion transferred to a clinician' was achieved for the months of July, September, October, December, January, February and March when compared to the same period in 2021/22 – a further increase was seen in September, December, January and February; and
- 'calls closed with advice given for patients to administer self-care' saw an increase in July and August 2022 when compared to 2021/22.

Calls abandoned after 30 seconds	Quarter 2			Quarter 3			Quarter 4		
	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Actual	2%	8.1%	2.4%	3.9%	6.50%	18%	3.8%	4.7%	6.1%
Target	5%	5%	5%	5%	5%	5%	5%	5%	5%
Average call answer time	**Jul 2022**	**Aug 2022**	**Sep 2022**	**Oct 2022**	**Nov 2022**	**Dec 2022**	**Jan 2023**	**Feb 2023**	**Mar 2023**
Actual	00:00:47	00:03:14	00:00:53	00:01:31	00:02:35	00:05:50	00:01:28	00:01:41	00:02:21
Target	00:00:27	00:00:27	00:00:27	00:00:27	00:00:27	00:00:27	00:00:27	00:00:27	00:00:27

Of call triaged, proportion transferred to a clinician	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
Actual	63.9%	Data Unavailable	67.2%	66.2%	Data Unavailable	71.9%	78.2%	67.8%	64.3%
Target	50%	50%	50%	50%	50%	50%	50%	50%	50%
Of call triaged, proportion closed with self-care within 111	**Jul 2022**	**Aug 2022**	**Sep 2022**	**Oct 2022**	**Nov 2022**	**Dec 2022**	**Jan 2023**	**Feb 2023**	**Mar 2023**
Actual	19.1%	18.5%	16.2%	18.2%	Data Unavailable	17.6%	16.4%	17.7%	18.2%
Target	17%	17%	17%	17%	17%	17%	17%	17%	17%

Table 10 – DHU NHS111 performance for Quarter 2 to Quarter 4 of 2022/23

Clinical Assessment Services

In relation to the validation of C3 ambulances, due to the Adastra issues, the current data available is limited, therefore this cannot be compared accurately to the previous year 2021/22. For the months of July, August and December 2022, plus January, February and March 2023, the number of clinical validations remained above the 50% target and the percentage which are downgraded continue to be positive, as shown in Table 11 below.

Category 3 Validations	Quarter 2 (DHU Q4)			Quarter 3 (DHU Q1)			Quarter 4 (DHU Q2)		
	July 2022	August 2022	September 2022	October 2022	November 2022	December 2022	January 2023	February 2023	March 2023
Patients available for validation	14,293	1,286	Data Unavailable	Data Unavailable	Data Unavailable	17,183	14,547	12,559	13,445
Total clinically validated	10,203	910	Data Unavailable	Data Unavailable	Data Unavailable	13,598	12,232	10,193	8,885
% Clinically validated (target 50%)	71.4%	70.8%	Data Unavailable	Data Unavailable	Data Unavailable	79.1%	84.1%	81.2%	66.1%

Table 11 – Category 3 validations for Quarter 2 to Quarter 4 of 2022/23

Directory of Services

The Directory of Services (DoS) is the tool used to identify the most appropriate service to manage patients' clinical needs. The DoS is accessed and utilised by health care professionals and is not a patient-facing service. The introduction of appointment bookings to the DoS for patients at the ED following contact with NHS111 helps patients avoid lengthy waits in ED waiting rooms and supports the management of demand for urgent care services, so flow can be managed with a planned response based on need, not patient expectation. This builds on the appointment booking that is already in place for patients whose clinical needs may better be served by an appointment within urgent care or Primary Care.

The streaming and re-direction tool linked to the DoS continues to be used by CRHFT ED and UHDBFT ED to help patients attending ED carry out a self-triage so they are directed to the best service to receive the treatment they need. Both CRHFT and UHDBFT (in line with many hospitals across the East Midlands) continue to build on the 'Same Day Emergency Care' pathways to direct patients straight to an appropriate service at the Trust to reduce the build-up of patients waiting in the ED department following contact with NHS111 by adding further pathways for hyperemesis and early pregnancy bleeding to the already established pathways for ENT, trauma, orthopaedic and urology.

The Service Finder Tool, which is used by healthcare professionals, takes a feed from the DoS to identify services for patients, and has been particularly helpful for ambulance crews on-scene with patients. Work continues in reviewing and improving the pathways used by EMAS to meet the requirements of the National Joint Ambulance Improvement Group and the National Pathways Team continues to be a focus of the work undertaken by the Regional DoS Lead who is based within the Coordinating Commissioning Team. The recent NHS Pathways releases have also included national mapping for ambulance pathways which is helpful for patients and staff.

The NHS Pathways Team continues to produce releases at the regular pace of one every eight weeks. This enables the DoS to be more resilient and responsive to essential changes and to meet clinical needs in a more timely manner such as the recent Group A Streptococcus and respiratory challenges.

Mental Health

Adult Mental Health

We have continued to work alongside a wide range of VCSE and statutory partners to design and deliver support for adults with mental health needs, to achieve NHSE Long Term Plan ambitions. Achievements and progress include:

Community Mental Health	Transformation of community-level support for adults with Serious Mental Illness (SMI) expanded across the High Peak and Derby City and is developing in other areas. The offer is called 'Living Well Derbyshire' and in Derby City is named 'Derby Wellbeing'. Living Well will be phased across the rest of Derbyshire by 2024.
	Creating five multi-agency, community-level collaboratives, bringing key agencies and the voice of lived experience to improve pathways and improve outcomes and health equalities for people with SMI.
	Co-producing and co-designing the 'Living Well' model and Living Well Teams – integrated working with VCSE, Local Authorities and health.
Inpatient Care	Confirmed additional funding required due to inflation, to eradicate dormitory style bedrooms and improve mental health inpatient facilities provided across Derbyshire to improve the environment and quality of services provided.
	Progress on the additional funding required for provision of psychiatric intensive care services to reduce the need for people to travel out-of-area for specialist care.
	Developing plans to align our inpatient older people mental health services in one location in both Derby and Chesterfield.
Staff wellbeing	Maintaining well used access to talking therapies for frontline NHS to ensure staff can get rapid access to support when needed.
Reducing health inequalities	Work is taking place to draw on Health Needs Assessment evidence to look at equity of access and outcomes for some of our population. This includes developing a better understanding of the needs of the deaf community around mental health, including barriers and gaps.
	A multi-agency pilot is underway to provide health coaching and the provision of personal fitness trackers to people with a SMI, to support their physical health outcomes.
Co-production and collaborative working	New ways of working alongside the local VCSE sector are being explored.
	The Maternity and Neonatal Voices Partnership has resulted in valuable insights emerging from engagement with women who have experienced trauma or loss as a result of their maternity experience. Additional learning is being drawn from experts by experience from LGBTQ+ communities, the deaf community and engaging with ethnic minority groups.
Crisis alternatives development	Widespread engagement with local people, professionals, groups and providers of services to explore what our model of crisis alternatives for people with urgent mental health care needs should look like. This work has led to a new service model for our Safe Haven offer in Derby where open access is incorporated, and has shaped our specification for out-of-hours community mental health support.

Learning Disabilities and Autism

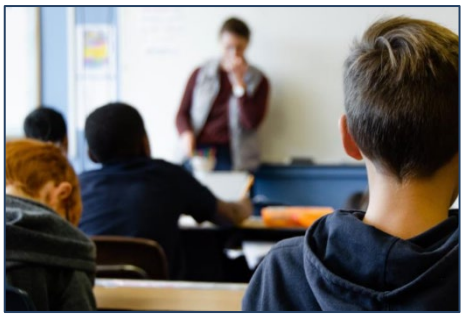
JUCD continued to implement the commitments of the local 'Learning Disability and Autism Road Map 2021–25'.

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, this will initially focus on autistic children and young people 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 the '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. The objective is to ensure we are making best use of public resources in a fair way.
	Gained an accepted business case for neurodiverse diagnostic assessments for children and young people.
	Addressing health inequalities through the Learning from Deaths programme and continuing to exceed national targets for the number of people with a learning disability over the age of 14 who receive their annual health check.
Building strong and sustainable community assets	Rolling out a new approach to working in better partnership with the VCSE sector. The Community of Practice now 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 children and young people and their families but with a view to expanding to adults in the future.

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

Children, Young People and Young Adult Mental Health

We saw a steady rise in the number of children and young people (0–17 years) having at least one meaningful contact with mental health services across the Derby and Derbyshire graduated pathway, including specialist Children Adolescent Mental Health Services (CAMHS), Emotional Health and Wellbeing Service for children in care, Changing Lives (mental health support teams in education), Build Sound Minds (targeted early intervention services) and our universal digital offer with Kooth, a service which can be used anonymously. Young people reported this as being *"accessible for all ages"*, *"easy to navigate and easy to understand"*, and *"enables people to talk about their experiences so that they don't feel alone".*



Our Mental Health Support Teams (MHSTs) in education settings at Bemrose School and Noel Baker Academy are settling in. These teams arrived alongside our more established MHSTs at Bolsover School, Ormiston Academy Ilkeston, Lady Manners Bakewell and Kingsmead special school and the Pupil Referral Unit. Work was undertaken by a small multi-agency working group to look at how we could assist integration between schools and the mental health pathway. This resulted in new school pathway guidance which was distributed across the school settings.

We have invested nearly £1.9m in CAMHS urgent care and crisis response and are recruiting staff to provide the NHSE required 24/7 assessment and brief response to all children and young people in crisis by 2024. We have expanded capacity for online cognitive behavioural therapy and autism post-diagnosis interventions to help reduce waiting times. We are mindful that online does not suit everyone and these offers complemented our CAMHS face-to-face service. There were increases in eating disorder presentations and capacity was expanded in specialist eating disorder teams. We plan to further improve the offer for children and young people with eating difficulties, particularly for those with autism.

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

Since July 2022, we have been working together to refresh the strategy for the JUCD Children and Young People's Delivery Board. The strategy is aligned to the ambition of JUCD to improve life expectancy and healthy life expectancy for the people and communities of Derby and Derbyshire and to reduce the health inequalities that are causing differences within our local area. We have implemented co-produced plans to address neurodevelopmental assessment waiting times, including how we can work differently as a system to improve the experience of children and young people, and their families who need to access support. Alongside this, we are in the process of setting up some Neurodevelopmental Community Hubs to provide support at the earliest opportunity.

The Children and Young People Physical Health Transformation Programme, aligned to the NHS Long Term Plan, continues to move forward. The areas of focus are diabetes, epilepsy, asthma and healthy weight; each area has a specific system-wide plan. We are currently

working with colleagues from both Derby City Council and Derbyshire County Council to look at how we can improve air quality and housing conditions for children and young people with asthma. We are also working with colleagues from Public Health and mental health to develop a range of different interventions as part of a healthier weight programme.

Children and Young People Safeguarding

The ICB's Safeguarding Children and Looked After Children Team remains highly committed to ensuring that the population of Derby and Derbyshire are safe and that they receive high quality care support. The team works in close partnership with our partner agencies and our commissioned services to continuously improve systems and processes to safeguard children, young people and adults in our community. The ICB has a Safeguarding Children Strategy which is to be read alongside the ICB's Safeguarding Children Policy, both of which can be found here[vi].

The ICB's Safeguarding Team continues to ensure that the organisation meets its statutory safeguarding responsibilities and functions, and has clear processes to monitor the safeguarding arrangements of our commissioned health services to provide assurance that children and adults at risk of abuse are safeguarded. The Safeguarding Team take on board national and local guidance, directives and learning from reviews in order to continuously improve and develop our services. It works closely with regulators such as NHSE in providing assurance that the ICB is fulfilling safeguarding statutory functions, duties, roles and responsibilities based on requirements highlighted within the NHSE Safeguarding Accountability and Assurance Framework (2022). NHSE regional leads provide feedback to the ICB and, if required, further information and clarification on any specified areas of monitoring in order to provide the required assurance or data requested.

The ICB also completes safeguarding annual reports that are shared with our Board. The Derby and Derbyshire Safeguarding Children Partnership and the Derby and Derbyshire Adult Safeguarding Board also produce annual reports which provide an excellent overview of performance and activity undertaken. The Derby and Derbyshire Safeguarding Children Annual Report, which comprehensively reflects the partnership's work, can be found here[vii].

The ICB is one of the three key partners of the Derby and Derbyshire Safeguarding Children Partnership whose main responsibility is to support and enable organisations and agencies across Derby and Derbyshire to work together so that:

- children are safeguarded and their welfare promoted;
- partner organisations and agencies collaborate, share and co-own the vision for how to achieve improved outcomes for vulnerable children;
- organisations and agencies challenge appropriately and hold one another to account effectively;
- there is early identification, analysis and responsive actions in respect of new safeguarding issues and emerging threats;
- learning is promoted and embedded to ensure that local services become more reflective and implement changes to practice identified as positive for children and families;
- information is shared effectively to facilitate more accurate and timely decision-making for children and families.

The Derby and Derbyshire Safeguarding Children Partnership also has a 'Children and Young People's Partnership Participation Strategy' which sets out the principles for engaging children, young people and family members. The strategy can be found here[viii].

The ICB's Safeguarding Adult Team works closely with partners across the NHS to ensure that all statutory safeguarding responsibilities are met in full and that patients and families are protected from abusive behaviour and practice. Inter-agency collaboration is an imperative element of effective safeguarding arrangements and the ICB remains active participants in all Safeguarding Adult Board activities to drive forward any local, national reviews and independent inquiries in order to safeguard children, young people and adults within our community.

ICB safeguarding professionals are key members of the Derby and Derbyshire child practice review and domestic homicide review meetings and action planning groups. These are examples of local multi-agency forums that look to undertake, share and implement learning identified from reviews in order to improve and develop practice. Local review reports are published on the Derby and Derbyshire Safeguarding Children Partnership or Adult Safeguarding Board websites. Action plans made in regard to recommendations from reviews are progressed via the local action plan sub-groups.

Safeguarding operational themes and priorities are closely monitored and evaluated. Our staff training programme is well-received, and we continue to ensure that other aspects of safeguarding such as Prevent and the Mental Capacity Act are given prominence against other competing demands and financial constraints.

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Environmental Matters

Sustainable Development

In 2020, the NHS launched the campaign 'For a Greener NHS' and an expert panel, chaired by the then NHS Chief Executive Sir Simon Stevens, set out a practical and evidence-based path towards a 'net zero' health service, with two clear targets:

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.

Eight early steps have been identified that will support an overall reduction as follows:

1	**Our care**	By developing a framework to evaluate carbon reduction associated with new models of care being considered and implemented as part of the NHS Long Term Plan.
2	**Our medicines and supply chain**	By working with our suppliers to ensure that all meet or exceed our commitment on net zero emissions before the end of the decade.
3	**Our transport and travel**	By working towards road-testing for what would be the world's first zero-emission ambulance by 2022, with a shift to zero emission vehicles by 2032 feasible for the rest of the fleet.
4	**Our innovation**	By ensuring the digital transformation agenda aligns with our ambition to be a net zero health service and implementing a net zero horizon scanning function to identify future pipeline innovations.
5	**Our hospitals**	By supporting the construction of 40 new 'net zero hospitals' as part of the Government's Health Infrastructure Plan with a new Net Zero Carbon Hospital Standard.
6	**Our heating and lighting**	By completing a £50 million LED lighting replacement programme, which, expanded across the entire NHS, would improve patient comfort, and save over £3 billion during the coming three decades.
7	**Our adaptation efforts**	By building resilience and adaptation into the heart of our net zero agenda, and vice versa, with the third Health and Social Care Sector Climate Change Adaptation Report in the coming months.
8	**Our values and our governance**	By supporting an update to the NHS Constitution to include the response to climate change, launching a new national programme for a greener NHS, and ensuring that every NHS organisation has a board-level net zero lead, making it clear that this is a key responsibility for all our staff.

Figure 2 below 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) and are categorised for the NHS as either NHS Carbon Footprint, or NHS Carbon Footprint Plus.

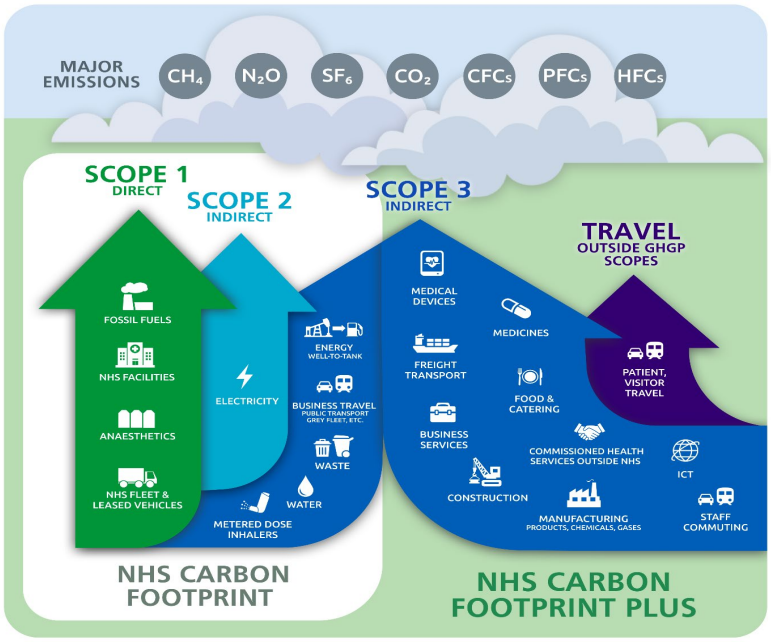


Figure 2 – GHGP scopes in the context of the NHS (Source: NHSE)

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

It is recognised that the NHS has already made a considerable contribution to an overall reduction, however, every area of the NHS will need to act if net zero is to be achieved. Observing the wider scope of the NHS Carbon Footprint Plus, Figure 3 below shows that the greatest areas of opportunity, or challenge, for change are in the supply chain, estates and facilities, pharmaceuticals and medical devices, and travel.

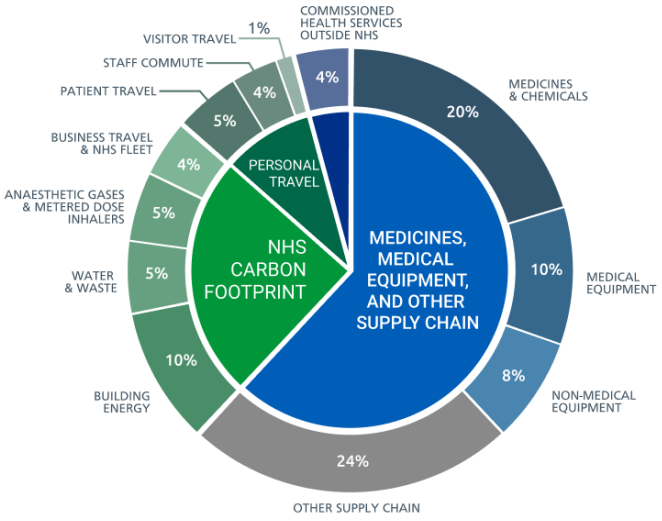


Figure 3 – Sources of carbon emissions by proportion of NHS Carbon Footprint Plus (Source: NHSE)

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.

Greener Governance

NHS Midlands Regional Delivery Board

The ICS is a member of the NHS Midlands Regional Greener NHS Delivery Board, established in June 2021. The ICB's Executive Director for Corporate Affairs is the Senior Responsible Officer for net zero. The Board meets bi-monthly and defined the following priorities for carbon reduction:

Medicines

- Reducing the proportion of desflurane used in surgery to less than 5% of overall volatile anaesthetic gases volume in all Trusts, in line with the proposed 2022/23 NHS Standard Contract.
- Implementing approaches to optimise use of medical gases, including reducing nitrous oxide waste and preventing the atmospheric release of medical gases.
- Reducing the carbon impact of inhalers, in line with the commitment of a 50% reduction by 2028 on a 2019/20 baseline, by:
    - supporting patient choice of less carbon intensive inhalers, for example dry powder inhalers, where clinically appropriate;
    - working with the national team to ensure schemes for green disposal of inhalers are rolled out across the region.

Travel and transport

- Ensuring that the region's owned and leased fleet is made up of at least 90% Low Emission Vehicles (LEV) by March 2024. This includes a target of 5% of the fleet being made up of Ultra-Low Emissions (ULEV) and Zero Emission Vehicles (ZEV) by March 2023, ensuring that all vehicles (under 3.5 tonne) purchased or leased from the 1st April 2022 onwards are ULEVs or ZEVs.
- Ensuring that only ULEVs or ZEVs are available to staff through car salary sacrifice schemes from the 1st April 2022.
- Ensuring all ICBs have a salary sacrifice cycle-to-work scheme in place for staff; as well as facilities available to encourage staff and visitors to cycle-to-work where appropriate.

Supply Chain and Procurement

- Supporting implementation of the NHS Net Zero Supplier roadmap, including through:
    - the adoption of the PPN 06/20 by Trusts and the ICB to ensure all new NHS procurements include a minimum 10% net zero and social value weighting from April 2022; and
    - ensuring procurement teams have identified suppliers requiring a carbon reduction plan to qualify for NHS contracts from April 2023 (contract over £5m annually) or April 2024 onwards (contracts over minimum procurement thresholds).
- Achieving a 50% reduction in use of office paper by 2025 compared to the baseline, and ensuring the ICS and constituent NHS trusts only purchase 100% recycled content paper for all office and non-office-based functions by 2025.
- 60% of Trusts in the region to operate walking aid refurbishment schemes, with at least a 20% return rate, by end of March 2023.

Estates and Facilities

- Trusts must ensure that all electricity is purchased from renewable sources (excluding nuclear).
- Ensure plans are in place to phase out fuel oil as a primary heat source by ensuring all sites with oil fuel heating as a primary source have a business case for its removal.
- Ensure all new builds and retrofits over £15m are compliant with the Net Zero Hospital Buildings Standards.
- Support regional estates teams to ensure:
    - the implementation of projects receiving funding through the Public Sector Decarbonisation Scheme;
    - Trusts actively participate in the Regional Estates Delivery Hubs; and
    - a minimum of 150 estates and facilities staff in each region undertake the accredited carbon literacy training in 2022/23.

Workforce and Leadership

- Trusts and the ICB to have a named Greener Non-Executive Director in 2022/23 alongside a named Executive-Lead Director.
- PCNs to have a named Greener Lead Director and undertake carbon literacy and sustainability training.
- Support the advertisement and uptake of sustainability training opportunities that are finalised and publicised by the national Greener NHS Team during 2022/23.

Joined Up Care Derbyshire Integrated Care System Greener Delivery Group

JUCD established a Greener Delivery Group in June 2021, who initially met bi-monthly and now meets quarterly. The ICB's Executive Director of Corporate Affairs is the Chair of the Group. The Derbyshire Provider Trust Sustainability Leads are members, together with specialist Lead Pharmacists within the ICS. The workstream areas focus on the following:

- governance;
- medicines;
- Primary Care;
- travel and transport;
- estates and facilities;
- supply chain and procurement; and
- data and digital.

Integrated Care System Commitments

In accordance with the Health and Care Act 2022, the ICB has a duty to section 14Z44 as to tackling climate change. As set out in the Derby and Derbyshire NHS' Five Year Joint Forward Plan, the NHS has acknowledged its responsibility in this agenda and has committed to achieving a net-zero health service by 2045. As part of this commitment, NHSE made it mandatory for all Trusts and ICSs to produce a Board-approved Green Plan which establishes a three-year sustainability strategy.

The JUCD ICS Green Plan for 2022–25[ix] sets out our response to the above, by establishing the system-level strategy for sustainability. It presents our regional-level carbon footprint data and outlines our commitment to sustainability. It summarises our organisation-level Green Plans, including our carbon hotspots and the sustainability strategies employed to address them. The ICB Board and individual Derbyshire Trust Boards have approved and adopted the JUCD ICS Green Plan, and the ICS will develop and implement a Climate Change Adaptation Strategy during 2023/24.

The ICB has 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 the ICS performance and project management, including the monitoring of impact assessments and the effective use of sound evidence in policy making.

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

- working with system partners, Local Authorities, the VCSE sector, patients and the public to tackle carbon emissions from travel and transport associated with each organisation, for example, by improving local public transport links to NHS sites, investing and only purchasing ultra-low emission and zero-emission vehicles for owned and leased fleets, and maximizing efficiencies in the transport of goods and services commissioned by the organisations;

- encouraging the adoption of activities and interventions which slow the associated health impacts of climate change, which can improve population health, for example, by reducing the number of heatwave-related excess deaths and the number of pollution-related respiratory illnesses;
- embedding net zero principles across all clinical services, considering where carbon reduction opportunities may exist;
- supporting action to address poor air quality, which disproportionally affects vulnerable and deprived communities in the UK through prevalence of respiratory illnesses, therefore tackling existing inequalities in outcomes, experience and access;
- enhancing productivity and value for money, by 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;
- driving broader social and economic development by ensuring all NHS procurements include a minimum 10% net zero and social value weighting and adhere to future requirements set out in the NHS Net Zero Supplier Roadmap;
- harnessing the opportunities presented by digital transformation to streamline service delivery and supporting functions, while improving the associated use of resources and reducing carbon emissions; and
- involving local stakeholders, people and communities in the delivery of the Green Plan.

In line with local priorities and arrangements, a Derbyshire Estates Working Group has also been established to focus on the delivery of net zero targets. Progress is reported to the Derbyshire Local Estates Forum.

Carbon Hotspots

One in every 100 tonnes of domestic waste generated in the UK comes from the NHS, with the vast majority going to landfill. The New Economic Foundation calculates that recycling all paper, cardboard, magazines and newspapers produced by the NHS in England and Wales could save up to 42,000 tonnes of carbon dioxide. Travel by patients, staff and visitors, is a crucial part of the way the NHS delivers services. 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. Table 12 below shows our energy consumption for the last four years, for our shared ICB headquarters at Cardinal Square, Derby:

	2022/23	2021/22	2020/21	2019/20
Electricity (kWh)	136,513	107,389	94,142	169,927
Water (m^3)	1,703	590	589	1,177

Table 12 – ICB headquarters' energy consumption for 2022/23, 2021/22, 2020/21 and 2019/20

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

Energy	Reducing total consumption in the ICB sites.
Consumables	Working paperless and distributing committee agenda and paper packs electronically, and encouraging recycling.
Travel	Reducing the carbon footprint through Sustainable Travel Plans and operating a hybrid working model. This has reduced business mileage over the last three years.
Procurement	Recognising the Procurement for Carbon Reduction Sustainable Procurement Tool and ensuring procurement teams have identified suppliers requiring a carbon reduction plan to qualify for NHS contracts from April 2023.

The environmental benefits achieved as a result of new hybrid working models during the pandemic are continuing to deliver reduction in carbon emissions and travel costs. Digital working (Microsoft Teams meetings and remote collaboration) has also led to a reduction in consumables. Table 13 below illustrates the continued reduction in actual travel costs against budget.

	2022/23	2021/22	2020/21
% Actual travel cost v budget	54.5%	39.5%	43.4%

Table 13 – actual travel cost versus budget for 2022/23, 2021/22 and 2020/21

During the pandemic in 2020/21 there was a significant reduction in actual travel costs against budget, however the anticipated level of recovery in travel has not materialised due to the continuation of operating in a hybrid working model. The ICB operates a cycle to work scheme which is available to all employees, as is the Electric Vehicle Car Lease Scheme.

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. This Act places a clear expectation on public services to demonstrate how their work makes a difference and delivers greater social value. It highlights the importance of considering social value in advance of commencing any commissioning procurement process. Such considerations should help inform and shape the purpose of the products needed, and perhaps more importantly, the design of the services required.

Reducing the carbon impact of inhalers

A priority for the Derbyshire system is to reduce the use of high-volume salbutamol metered dose inhalers (MDIs) and switch to a lower carbon alternative. Salbutamol MDIs are our most commonly prescribed inhaler and switching could reduce our inhaler carbon footprint by up to a third. Work is underway and figures from Open Prescribing[x] show that our mean carbon emission per salbutamol inhaler has reduced significantly over the past year:

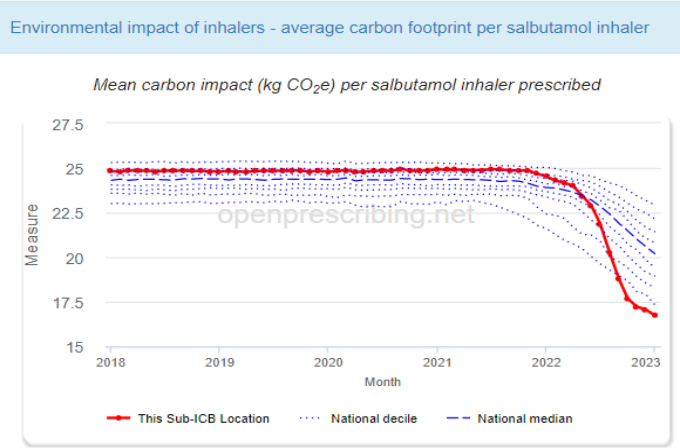


Figure 4 – mean carbon impact (KgCO2e) per salbutamol inhaler prescribed

Our current figure is 16.72 KgCO2e per inhaler which is below the national median figure of 20.17 KgCO2e and continuing to fall. Our second priority is to utilise 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 in order to change inhalers, and traditionally Derbyshire has been a very high user of MDIs. However, there has also been some recent progress made in reducing the prescribing of MDIs:

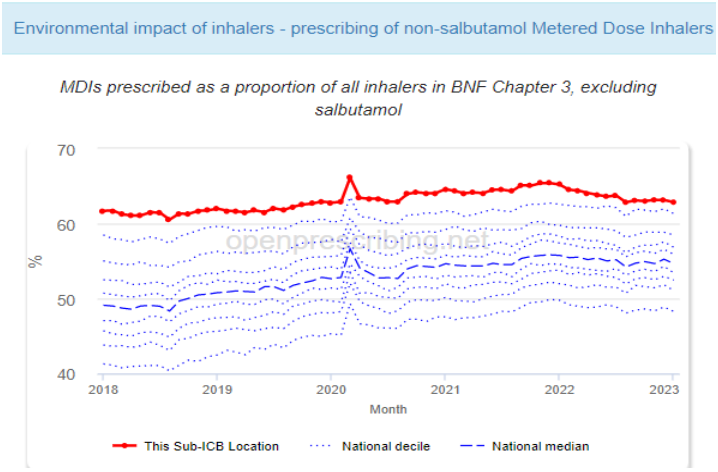


Figure 5 – MDIs prescribed as a proportion of all inhalers in BNF Chapter 3, excluding salbutamol

The carbon emissions of all inhalers, for Derbyshire in 2021, amounted to 20,072 KtCO2e. The latest figures from The Greener NHS Dashboard for 2022 show that this has reduced to 18,302 KtCO2e, a reduction of 8.8%.

Greening Government Committees Performance

In response to the Greening Government Committees (GGCs) reporting requirements, the ICB recognises the requirement to evaluate our performance against the following targets:

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

Currently the level of data required to demonstrate compliance with the above targets is not captured at an ICB-level. We acknowledge the need to record and report the data at a sufficient level to measure performance. The ICB is working towards capturing the financial and non-financial information for the above targets and this will be developed by the Derbyshire ICS Greener Delivery Group and the Derbyshire Providers.

Finance Review

Addressing Our Financial Challenge during July 2022 to March 2023

The Health and Care Act 2022 resulted in the CCG being superseded by the ICB from the 1st July 2022. The below information relates to the ICB's final reported position for the nine months of the 2022/23 financial year.

To a lesser extent than previous years, the Covid-19 pandemic continued to affect all aspects of the NHS, including its financial regime. National NHS contracting arrangements were brought forward into the current financial year based on expenditure in the prior year, adjusted to reflect national uplifts and efficiencies. These contracting arrangements were alongside the gradual reintroduction of financial efficiency deliverables; thus, ensuring all available resources could be directed at delivering front-line services.

The ICB and the ICS have seen a challenging period financially, due to expenditure outside of its control – cost of living increases, impact of the national pay award and Covid-19 related costs, resulting in a £31.6m system deficit. The ICB saw pressures in prescribing, continuing healthcare fast track packages to support hospital discharge and Section 117 in mental health cases. However, the ICS has worked as a collective to identify efficiencies and deliver its financial position.

Financial Position

Total resources of £1,706.8m were available for the nine-month period, including income of £9.4m £1,697.4m of allocations from the Department of Health and Social Care. The ICB committed expenditure totalling £1,721.6m, leaving the ICB with a deficit of £14.8m. Further details can be found in the Annual Accounts section of this report.

Considerable work has been undertaken to understand the extent of the financial challenges being faced across the system throughout 2022/23, and the backlog of routine healthcare that has built up. Delivery of high-level transformation has been required to achieve financial efficiencies.

Gross Operating Costs, Quarter 2 to Quarter 4 2022/23

Category of Expenditure	2022/23 Spend
	£m
Services from Foundation Trusts	997.8
Services from Other NHS Trusts	96.9
Purchase of healthcare from non-NHS bodies	258.4
Prescribing	139.9
Primary Care	156.4
Staff	22.4
Supplies and Services – General	4.8
Services from other ICBs and NHSE	7.8
Other	8.5
Covid-19	28.7
TOTAL	**1,721.6**

Table 14 – Gross Operating Costs, Quarter 2 to Quarter 4 of 2022/3

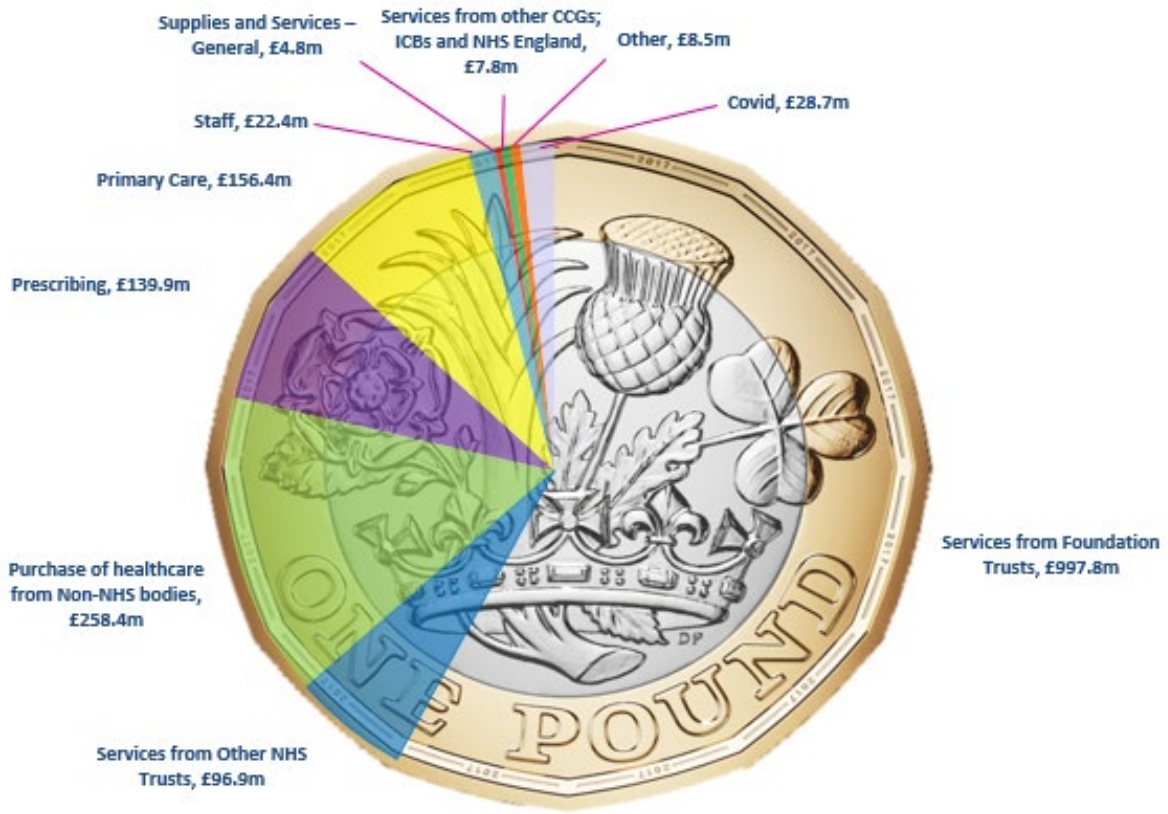


Figure 6 – Gross Operating Costs July 2022 to March 2023 – 'The Derbyshire Pound'

Covid-19 Expenditure

The ICB expenditure resulting from the pandemic has reduced due to a return to business as usual. Recurrent expenditure from Covid-19 (such as increased cleaning regimes) has been funded from within system financial envelopes. The ICB Covid-19 expenditure for the period was £28.7m, which predominantly funded Derbyshire healthcare providers. No fraudulent or irregular payments are considered to be included in this expenditure.

Mental Health Spend

All ICBs are expected to increase the proportion of their spend of their overall allocation each year on mental health services. 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 on Mental Health SDF funds.

As shown in Table 15 below, in 2021/22 the proportion of Mental Health spend by the CCG of the overall programme allocation was 9.04%. For 2022/23, this proportion increased to 9.41%.

	Financial Years	
	2021/22	2022/23
	£'000	£'000
Mental Health Spend	188,854	207,123
Programme Allocation	2,090,051	2,201,894
Mental Health Spend as a proportion of Programme Allocation	9.04%	9.41%

Table 15 – amount and proportion of expenditure incurred in relation to mental health 2021/22 and 2022/23

The ICB MHIS target for 2022/23 is £206.898m (£188.311m 2021/22). This is an increase of 9.87% from 2021/22. The increase includes £4.2m due to the transfer of Glossop locality from NHS Tameside and Glossop Clinical Commissioning Group to the ICB on the 1st July 2022.

The ICB reported MHIS expenditure for the year of £207.123m which is an over-achievement of the MHIS target of £225k. 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 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 period from July 2022 to March 2023 was the inception period of the organisation. As such, financial trend analysis will be available in future periods.

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. Balances were transferred from the predecessor CCG on the 1st July 2022. For comparative purposes, these opening balances are disclosed in the table below, which shows there has been a decrease in receivables and liabilities. The primary movement in liabilities are the utilisation of provisions during the period, and the national drive to settle NHS invoices each March. 'Property plant and equipment' includes IT equipment additions; utilising the ICB's capital resource allocated during the period.

	31st March 2023	1st July 2022
	£'000	£'000
Non-current assets		
Property, plant and equipment	155	218
Right of-use Assets	822	1,270
Total non-current assets	**977**	**1,488**
Current assets		
Trade and other receivables	7,542	9,348
Cash and cash equivalents	220	42
Total current assets	**7,762**	**9,390**
Total assets	**8,739**	**10,878**
Current liabilities		
Trade and other payables	(119,855)	(115,938)
Lease liabilities	(405)	(452)
Provisions	(2,598)	(6,741)
Total current liabilities	**(122,858)**	**(123,131)**
Non-current assets plus/less Net current assets/liabilities	**(114,119)**	**(112,253)**
Non-current liabilities		
Lease liabilities	(410)	(819)
Provisions	(532)	(532)
Total non-current liabilities	**(942)**	**(1,351)**
Total assets less liabilities	**(115,061)**	**(113,604)**
Financed by Taxpayers' Equity		
General Fund	(115,061)	(113,604)
Total Taxpayers' Equity	**(115,061)**	**(113,604)**

Table 16 – Statement of Financial Position, as at 31st March 2023

Our Duties

NHS Oversight Framework

From the 1st July 2022, the ICB was established with the general statutory function of arranging health services for their population and being responsible for performance and oversight of NHS services within the ICS, with the ambition of empowering local health and care leaders to build strong and effective systems for their communities.

The NHS Oversight Framework outlines NHS England's approach to the ICB's oversight for 2022/23 and is aligned with the ambitions set out in the NHS Long Term Plan and the 2022/23 NHS Operational Planning and Contracting Guidance. It also reflects the significant changes enabled by the Health and Care Act 2022 including the formal establishment of ICBs and the merging of NHS Improvement into NHS England.

NHSE regional teams lead the oversight of ICBs on the delivery against the domains in the NHS Oversight Framework and, through them, gain assurance of place-based systems and individual organisations. The ICB will lead the oversight of Derbyshire NHS providers, assessing delivery against the following five national themes, working through provider collaboratives where appropriate:

- quality of care, access and outcomes;
- preventing ill-health and reducing inequalities;
- finance and use of resources;
- people;
- leadership and capability.

Reducing Health Inequality

The ICB has discharged its duties in accordance with Section 14Z35 of the NHS Act 2006 (as amended), as inserted by Section 25 of the Health and Care Act 2022 and as detailed in the ICB Constitution, by agreeing strategic priorities which aim to contribute to increasing life expectancy. These are:

- Reducing mortality rates from preventable diseases
- Working with General Practices to tackle practice and clinical variation
- Focusing on evidence-based and effective delivery
- Improving the integration of health and social care
- Improving integration of Primary and Secondary Care to improve care for the frail elderly and those with one or more LTCs
- Working with partners to improve lifestyle choices of the Derbyshire population in relation to smoking, alcohol, diet and exercise

Population Health and Care Needs

Work has been undertaken by system colleagues to develop a set of JUCD priority population outcomes and key indicators (known as Turning the Curve) based upon the Derby and Derbyshire Joint Strategic Needs Assessments. These focus on increasing life expectancy, increasing healthy life expectancy, and reducing inequalities.

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

- reducing smoking prevalence, harmful alcohol consumption, and the number of children living in low-income households;
- increasing the proportion of children and adults who are a healthy weight, and access to suitable, affordable, and safe housing; and
- improving air quality, self-reported wellbeing and participation in physical activity.

JUCD has also identified additional indicators to reduce specific inequalities in the system drawing on local data and NHS recommendations. One area must be from the Core20PLUS5 with the other area being from any other service. Core20PLUS5 is a national NHSE approach to support the reduction of health inequalities at both national and system level. The approach defines a target population cohort and identifies 'five' focus clinical areas requiring accelerated improvement. These areas are:

Maternity	Ensuring continuity of care for 75% of people from Black, Asian and minority ethnic communities and from the most deprived groups.
Severe mental illness and learning disabilities	Ensuring annual health checks for 60% of those living with SMI or learning disabilities.
Improving vaccination uptake	Reducing inequalities in uptake of life course, Covid-19, flu and pneumonia vaccines.
Early cancer diagnosis	75% of cases diagnosed at stage 1 or 2 by 2028.
Hypertension case-finding	To allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

In order to achieve improvements in the above areas, the ICB needs to demonstrate, through the use of the Healthcare Inequalities Board Assurance Tool, that it is delivering against the five national priorities for tackling healthcare inequalities listed below. To date, this has been achieved by:

1.	**Restoring NHS services inclusively**	<u>Health Inequalities report for Elective Care</u> • Analysis undertaken as part of 2022/23 Operational Planning Programme. • Focus on Elective Care to understand the impact and the development of a plan.
		<u>Quality Conversations</u> • Individual recently recruited to review waiting lists. • Working with Derbyshire Voluntary Action on a referral pathway.
		<u>Primary Care</u> • Derbyshire GP Practices offering more appointments than pre-pandemic. The total number of appointments in March 2023 increased by 6% compared to March 2019. • Majority of appointments are face to face (c.70%), this is a shift in modality since the pandemic.

		• GP Practices have restarted services which were paused during the pandemic.
		Children and Young People • A theatre improvement programme is in place at CRHFT for ENT services. Speech and Language Therapists are running joint clinics and additional paediatric clinics are in place. • Restoration and recovery continuation. • Implementation of Patient Initiated Follow Up (PIFU) to allow for patients/families to access services should their condition change. • Referrals triaged upon receipt at UHDBFT. Referral Assessment Service implemented for certain specialities which cuts triage time down.
2.	**Mitigating against 'digital exclusion'**	Quality Equality Impact Assessments • GetUBetter – support for patients to access, manage and prevent deterioration of MSK conditions. • Recap Health – digital enabler secured to support cardiac rehab patients. • Digital Weight Management Programme – offer of patient self-referral mechanism. • Virtual Wards – contract for digital enablement provider awarded. ICS Digital and Data Programme • Engaged with Rural Action Derbyshire and Citizens On-line to understand and mitigate challenges experienced by our population in accessing information and services via a digital route. • Rural Action Derbyshire has established the Derbyshire Digital Support Network to identify provision and gaps; connect people and groups with support; and also pilot activities such as digital devices and support in community food projects – linking the Food, Finance and Digital relationship and impacts.
3.	**Ensuring datasets are complete and timely**	Utilising data • Identifying areas to improve through analysis toolkits. • Other local data tools will support identification of target areas for further development.
4.	**Accelerating preventative programmes**	Management of LTCs • NHSE 'Going Faster Further with Hypertension' funding secured to support programme. • Increasing the number of community pharmacy blood pressure checks in Derby City to increase detection of those with undiagnosed hypertension and optimise blood pressure management. • Focus on engagement to understand barriers in patient uptake supported by DHIP. • Update to CVD HNA currently being undertaken.

		<u>Vaccination Uptake</u> • Reporting lines established into Health Protection Board and System Quality Group. • Vaccination programme data incorporated into forthcoming Joint Strategic Needs Assessment (JSNA). • Black communities feedback event took place in February 2023. A report on the event findings was produced and shared with stakeholders. The event was found to be a positive start to building trust and collaborative working. Funding for further events has been agreed as part of the 2023/24 vaccination programme. • Pharmacy leaflet issued with prescriptions countywide promoting uptake of Covid-19, flu, shingles and pneumococcal vaccine. • Vaccine Inequalities Strategy is being refreshed with Public Health colleagues. This will support the wider Health Inequalities Strategy and Core20PLUS5 programme.
		<u>Maternity</u> There are currently three 'Continuity of Carer' teams, which includes an 'Enhanced Continuity of Carer' team at UHDBFT who target the top 10% deprived areas in the area.
5.	**Strengthening leadership and accountability**	Establishment of a group to address prevention, population health management and health inequalities to bring all Senior Responsible Officers together to oversee the ICS strategy, which includes objectives linked to health inequalities. The Senior Responsible Officer for the ICB is the Executive Medical Director.

The improvements in health outcomes are long term and are aligned and part of the Integrated Care Strategy which can be found here.

Improvements can be seen in some health outcomes which are illustrated in the graphs below:

Smoking prevalence and Lung Cancer mortality

Public Health JSNA data illustrates that Smoking Prevalence and Lung Cancer Mortality have reduced:

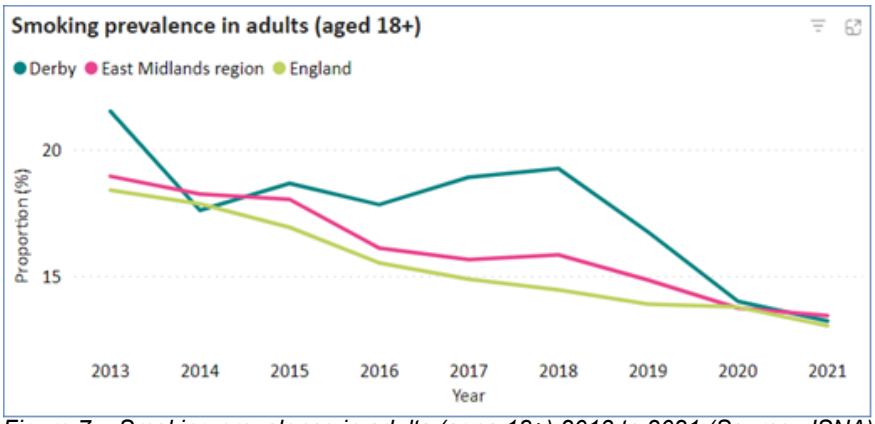


Figure 7 – Smoking prevalence in adults (ages 18+) 2013 to 2021 (Source: JSNA)

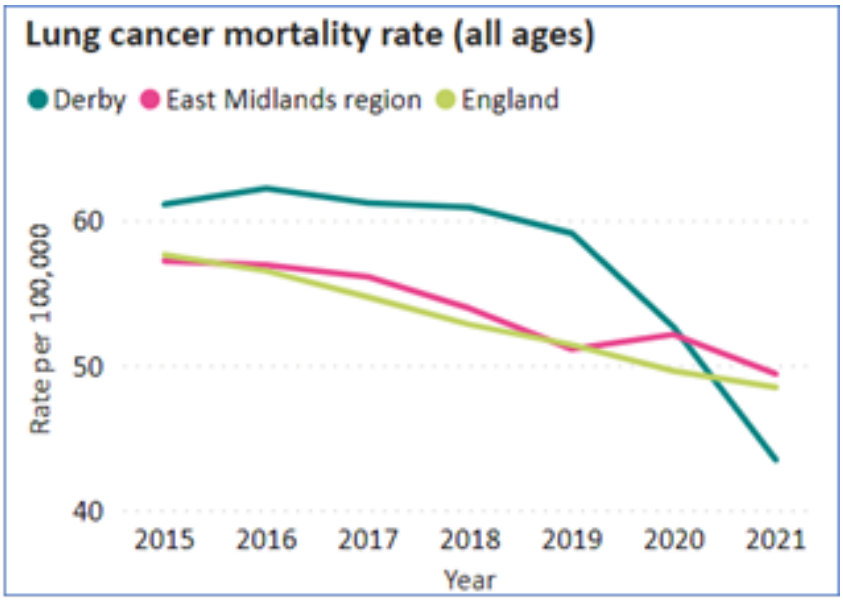


Figure 8 – Lung cancer mortality rate (all ages) 2015 to 2021 (Source: Derby JSNA)

Maternity data illustrates lower numbers for women who smoke during booking:

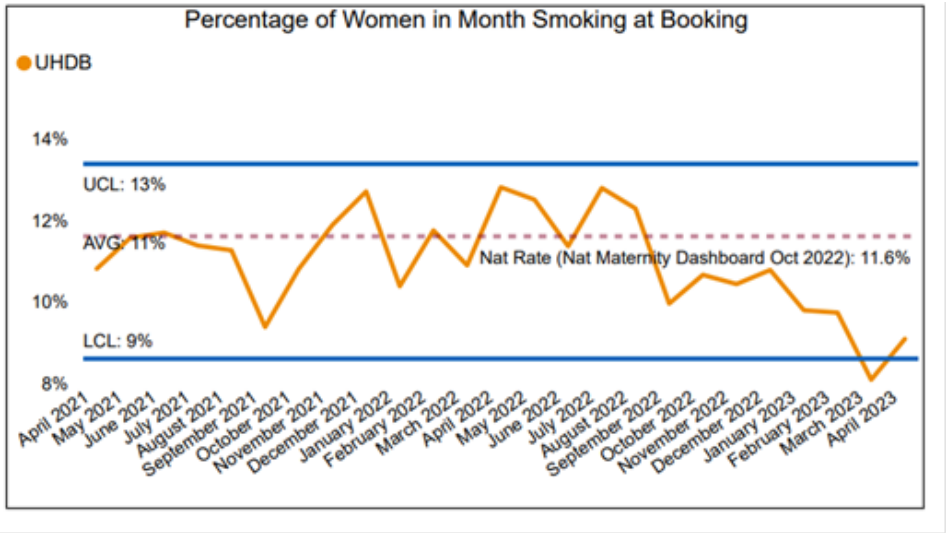


Figure 9 – Percentage of Women in Month Smoking at Booking 2021 to 2023 (Source: Maternity Data Pack)

Equality Delivery System

Equality Delivery System

In transitioning from the CCG to the 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 2.

Through recognition of the impact of the pandemic and ongoing NHS pressures a new tool has been produced to better illustrate required evidence. In Derby and Derbyshire, the tool is being used for 2022/23 during the pilot stage, with full usage for 2023/24. There are three sections:

Domain 1	Commissioner or provided services
Domain 2:	Workforce health and wellbeing
Domain 3:	Inclusive leadership

The developments of the new EDS tool are reflected in the 2022/23 report. This year has been identified as a transition year with Domain 1 requiring two areas to be highlighted rather than the three in full reporting expected from 2023/24 onwards.

Derby and Derbyshire's approach

Area 1

It has been agreed that each provider will choose their own Core20PLUS5 area and link with the ICB to ensure that there is a connection with the relevant commissioning team to provide a system response. Areas for this year by provider are:

DCHSFT	Integrated sexual health services and Long-Covid-19 (two areas identified as required by taking part in the pilot scheme)
CRHFT	Maternity services
DHcFT	Perinatal community mental health services
UHDBFT	Tobacco dependency treatment

You can find more information about this work here[xi].

Area 2

There is already work progressing around population health management being led by the Director of Strategy, Partnerships and Population Health and Consultant in Public Health at DCHSFT. This is a data tool to support the system and providers in identifying and understanding communities, deprivation and areas for development.

Scoring

The ICB facilitated a system-wide scoring event during February 2023. Invitations were sent to a wide range of community representatives through the VCSE sector to obtain feedback on the equality work that the system had been doing and to give the opportunity for individuals to score how effective the work had been. This included but was not limited to:

- Links CVS infrastructure organisations and their members;
- Public Diversity Forums, both City and County;
- a selected list of organisations covering the nine protected characteristics;
- Provider Governors; and
- Public Partnership Committee members.

The event was an opportunity for those attending to hear a short presentation about the equality and diversity work that has been done over the past year and vote on how effective people viewed this to be. Providers have also shared this information with their patients and internal patient groups.

Equality

During Q2 to Q4 of 2022/23, developments with the quality impact assessments and equality impact assessments have continued with review and strengthening of the process, form and panel meeting. In addition, the QEIA process is now a required checkpoint step in the ICS's electronic programme management system. This process is ensuring robust compliance with legal duties.

Service changes are now either assessed at provider level if it is a very local or no impact service specific change or via the ICS QEIA panel for wider-reaching changes.

The updated equality impact assessment elements of the form are being well received and a recent survey about the QEIA process as a whole will inform further changes.

Further developments have included the embedding of the Senior Patient and Public Equality Manager role, to support all aspects of public-facing equality including assessing needs and developing ways to understand and make reasonable adjustments across the ICS.

Procurement

We continue 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. A review of the processes for procurements is in the planning stages to ensure that the legal, organisational and system needs are being met.

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 QEIA 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

NHS Workforce Race Equality Standard

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/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 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 have included:

- celebrating and promoting key dates in the inclusion calendar;
- launching the ICB Disability and Long-term Conditions Policy, including reasonable adjustment passport;
- introducing reciprocal mentoring, and diversity and inclusion ambassadors;
- raising awareness of the lived experiences of under-represented staff;
- informing the healthcare system's approach to engagement with diverse communities relating to the Covid-19 vaccination programme and vaccine hesitancy;
- fair and inclusive recruitment and selection for disability/long-terms conditions; and
- informing the WRES, WDES and Staff Survey action plans.

The Senior Leadership Team (SLT) agreed to updated terms of reference for the Network that provides a clear purpose, line of accountability and clarification of how the Network is to be integrated into the decision-making of the ICB. This includes the Network:

- reporting directly to SLT;
- having representatives at the SLT with regards to decision-making, especially on issues which may impact diversity and inclusion; and
- receiving protected time to undertake their roles.

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 2023, the proportion of employees within the ICB from ethnic minority groups is 9.87%. A breakdown of proportion of ICB staff from an ethnic minority group across the banding structure within the ICB is detailed below. Table 17 below shows that these employees are under-represented within the lower Bands 1 to 7:

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

Table 17 – proportion of ICB staff from an ethnic minority group across the banding structure for 2022/23, 2021/22, 2020/21 and 2019/20

At a Very Senior Manager (VSM) level the proportion of ICB staff from an ethnic minority group is 5%. The senior management team within the ICB has had minimal turnover during Quarter 2 to Quarter 4 of 2022/23, which represents a barrier to achieving a diverse workforce at all levels across the organisation. To address this, the ICB has undertaken a review of the recruitment and selection procedure, working with the Diversity and Inclusion Network.

The ICB is also working with system healthcare partners to create and promote development opportunities for staff from under-represented 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.

A system-wide survey has been undertaken to better understand these barriers and create development opportunities for 2023, and beyond that will support under-represented colleagues and enable effective career and leadership progression. The following actions from the NHS People Plan to improve workforce equality and diversity are being progressed by the ICB:

- overhauling recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets; and
- discussing equality, diversity and inclusion as part of the health and wellbeing conversations.

NHS Workforce Disability Equality Standard

The Workforce Disability Equality Standard (WDES) is a set of 10 specific measures which enable NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. It enables NHS organisations to better understand the experiences of their disabled staff and 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 is 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 developed an action plan.

Public Involvement and Consultation

In accordance with the Health and Care Act 2022, the ICB has a duty to section 14Z45 Public Involvement and Consultation; has a duty to section 14Z36 in the exercise of its functions to promote the involvement of patients and their carers and representatives in decision which relate to the prevention or diagnosis of illness in patients and their care or treatment; and to section 14Z37, Duty as to Patient Choice, to exercise its functions to act with a view to enabling patients to make choices with respect to aspects of health service provided to them.

Integrated Care System's Approach to Public Involvement

Gathering insight from our diverse population about their experiences of care, views and suggestions for improvement of services, and their wider needs in order to ensure equality of access and quality of life is a key component of an effective and high performing ICS in Derbyshire. These insights, and the diverse thinking of people and communities will be essential to enabling JUCD to tackle health inequalities and the other challenges faced by our health and care system. As a result, JUCD, via the ICB, has developed a strategic approach to engagement, which includes key principles and frameworks that will underpin our ways of working. It sets out how we will listen consistently to, and collectively act on, the experience and aspirations of local people and communities within JUCD. This includes supporting people to sustain and improve their health and wellbeing, as well as involving people and communities in developing plans and priorities, and continually improving services. Our ambition is to:

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

Our comprehensive approach to realising our ambition is outlined in our ICS Engagement Strategy – 'People and Communities Strategic Approach to Engagement 2022-23'[xii]. This strategy is due to be updated as part of our work outlined in the section below titled 'Evaluation Framework'.

It is essential for both reasons of alignment and good practice, but also to ensure that the population's views and experiences are sought and responded to in a systematic way that reflects their priorities, that there is a system-wide approach to public involvement. Moreover, this approach is led by the desire to develop a culture within our system that promotes decisions underpinned by patient and public insight at all times.

To ensure we develop and implement a systematic approach, our involvement of people and communities is supported by several frameworks. These frameworks are in different stages of development and co-production with system partners, including people and communities, and are outlined below:

Governance Framework	Critical to the success of all our frameworks, providing the necessary interface between people, communities and the ICS, allowing insight to feed into the system and influence decision-making.
Insight Framework	Looks at how we identify and make better use of insight that is already available in local communities to inform the work of the ICS. All components of this framework have been, or are currently being, co-produced with a wide range of system partners.
Engagement Framework	The most developed of the frameworks and outlines a range of methods and tools available to all our system partners to support involvement of people and communities in transformational work.
Co-production Framework	Will embed, support and champion co-production in the culture, behaviour and relationships of the ICS, including senior leadership level. This is still in the early stages of development and will be underpinned by the other frameworks.
Evaluation Framework	It is important that we are continually examining our public involvement practice and the impact this has on our work, people and communities. It will outline how we measure and appraise our range of methods and support ongoing continuous improvement. This is in the early stages of development.

Governance Framework

The Governance Framework examines the structures that provide the interface between people and communities at all levels of decision-making within the ICS, allowing insight to feed into the system, influence decision-making, and nurture the trust and relationships we aspire to in our ambition. It also ensures appropriate assurance frameworks are in place to implement the 10 'principles' outlined in our Engagement Strategy across the system:

Figure 10 – 10 principles for engagement

Guide to Patient and Public Involvement

A Guide to Patient and Public Involvement in our ICS[xiii] and its associated Engagement Model[xiv] were launched in September 2022 to support those considering, and involved in, service change across the system. It aims to help navigate the common legal and policy issues from the very start of a service change programme through to the final decision-making. It describes the current legal framework and the likely steps required to discharge legal duties when making changes to services, and reflects many of the changes brought about by the Health and Care Act 2022, embedding the new statutory guidance issued by NHSE Working in Partnership with People and Communities: Statutory Guidance[xv].

This guidance is accompanied by our recently published Patient and Public Involvement Assessment Guidance[xvi] that outlines a comprehensive process for assessing whether our legal duties apply to a service change which are recorded on our Patient and Public Involvement, Assessment and Planning Form[xvii]. We are proposing that this is adopted by all our NHS system partners. In addition, guidance[xviii] on liaising with the Joint Health Overview and Scrutiny Committee is also available.

We successfully applied to a NHSE bespoke training programme for colleagues leading and working on service change within our ICS. The sessions clarified the service reconfiguration process, legal duties, assurance requirements and accountabilities around service change, and also went into detail about effective stakeholder engagement for a successful change process.

The ICB Engagement Team also offered a series of lunch and learn sessions as an introduction to the guide and to answer questions. The offer of training for all system partners around the guide is still available, and most recently was delivered to the Planned Care Team at CRHFT, which has led to joint working around setting up a robust process for assessing legal duties around service change.

Electronic Project Management Tool

Related to the publication of the guide is our work with Joined Up Improvement Derbyshire[xix], the development of an Electronic Project Management Tool that aims to help deliver sustainable improvement outcomes for Derbyshire's population, by ensuring project leads stop and think about the need for public involvement in any proposed change to services. This involves the completion of the Patient and Public Involvement, Assessment and Planning Form. This has also supported the dissemination of our guidance across system partners.

Case Study – All-Age Early Intervention and Prevention Offer for Eating Disorders

The contracts for the current all-age early intervention and prevention offer for eating disorders across Derby and Derbyshire were due to end in March 2023, allowing us to apply our Engagement Model outlined in the ICS Guide to Patient and Public Involvement in this procurement. We worked closely with lead commissioners and the current service providers to ensure we could meaningfully engage and understand the needs, views and opinions of our local population around early help for eating disorders, and for this to be used to help shape the specification at a formative stage.

Following the completion of a Patient and Public Involvement, Assessment and Planning Form, our assessment indicated that we had a legal duty to engage to realign and refresh the provision and ensure it meets the needs of current and future users of the service. When we started to develop the case for change, we set up meetings with the current service providers, MH:2K (delivered by the social enterprise, Leaders Unlocked. MH:2K is a powerful, youth-led model for engaging young people in conversations about mental health and emotional wellbeing and is embedded in our work at the ICB). We researched what local insight already exists around early intervention and prevention for eating disorders and to also gain early input into our thoughts for the engagement plan. This was helpful as it provided us with an opportunity to share draft versions of our case for change, and survey and work together to plan the format of the focus groups, to help us get the right approach.

The engagement period ran between July and September 2022, and we engaged with approximately 114 people to better understand their perspectives, and lived experiences, of either accessing services or supporting a loved one. The feedback and learning from the engagement influenced:

Service Specification	The broad themes that emerged from the engagement were included in the new service specification and the full report was included as an appendix.
Insight Framework	The full engagement report was shared alongside the tender documentation (as well as being embedded within the service specification) and providers were encouraged to use examples from the engagement report to support their answers.

We have published the All-ages Early Intervention and Prevention Report and we have also produced a You Said, We Did to provide a snapshot of the action taken.

Patient and Public Partner Programme

Our Patient and Public Partner Programme[xx] is a new initiative to build a network of lay members who want to be involved in improving health and care. They are experts by experience, either as a patient, family member or caregiver, or involved in the health and care system in a professional manner. Our Patient and Public Partners (PPPs) help develop and improve services, and the aim is to embed them at all levels of decision-making. They provide important insights and ideas for quality improvement efforts, improve communication between patients and health care providers, and help health care providers embrace potential changes, as they are able to see them from the patients' perspectives.

We have recently developed a Peer Support Network for our PPPs. Our first meeting was held in January 2023, and has helped to develop the programme to meet their needs. With the help and support of our PPPs, we have produced a 'Guide to Recruiting Patient and Public Partners'[xxi] to promote the role across the system, and we are currently working to develop an induction checklist and training programme to help ensure our PPPs feel well-equipped and supported. Since July 2022, we have successfully recruited to the:

- Joint and Community Commissioning Team – eight PPPs to share their experiences and expertise with regards to community-based services, support with infrastructure and signposting, and to help provide a strategic role in supporting the social prescribing service in Derbyshire;
- JUCD Systemwide Co-production Workstream – two PPPs who will be involved in the creation of a system-wide co-production approach; and
- MSK Digital (Planned Care Delivery Board) – two PPPs who will be involved in providing feedback on an MSK app that offers digital self-management in terms of accessibility, ease of use and improvements.

Case Study – Cancer Board Patient and Public Partners

The Engagement Team was approached by the Cancer Commissioning Team in regard to PPPs sitting on the three workstreams that sit beneath the Cancer Board. They really valued the role but wanted to look at evaluating the position and further developing the role to ensure it had impact and that people felt valued and listened to.

The Engagement Team has led this work, firstly developing a survey for both staff and PPPs to look at their expectations and aspirations of the role, what they thought was the current impact of the role and finally what works well and what could be improved. The results from the survey were shared with a working group which consists of PPPs and workstream leads. A further workshop discussion around the report then led to the development of an action plan from the findings, which is in the process of being implemented.

Engagement Framework

These are the methods and tools available to all our system partners to support 'continuous conversations' with people and communities in transformational work to improve health and care services. This includes:

- The Citizens' Panel[xxii]: This is a virtual group of people, of all ages, living across Derby and Derbyshire who want to help shape health and care services by offering their views and feedback on services, helping to ensure that services are designed to take into account 'what matters most to people'. The panel is in the process of being relaunched, which will begin with a system-wide recruitment campaign in spring 2023;
- Online Engagement Platform[xxiii]: We launched the platform in June 2021. It provides interactive feedback and analytical tools to make it easier for communities to be involved in decisions being made around system transformation. These are some of the key features of the platform:
    - offers people the opportunity to explore a wide range of projects and work where we are seeking their input and involvement;
    - uses a variety of interactive tools including surveys, quick polls, questions and answers, maps, document sharing and ideas boards;
    - provides a space to share experiences, hear from others, build networks and share ideas; and
    - helps our communities better understand and relate to the transformations we intend to facilitate as part of the ICS through frequently asked questions and a news feed.

Patient Participation Group Network

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.

The implementation of PPGs across the city and county is currently very inconsistent, with some General Practices having exceptionally well-run groups, while others have no PPG at all. The pandemic increased the inconsistency due to some groups feeling more confident than others to move to an online format. We responded to this by creating a countywide PPG Network to bring PPG Chairs and their members together, offering support, and a forum for discussing areas of interest and concern.

The PPG Network meets bi-monthly and the agenda is determined by both the members of the Network and ICB staff. We have a standing item for any systems changes, developments, and/or transformation projects and also a standing item from the Primary Care Quality Team who provide relevant updates and answer questions about Primary Care.

Readers' Panel

We currently have 35 volunteers on our Readers' Panel[xxiv] who are available to review new and revised information that is to be shared with patients and members of the public. The Readers' Panel can be used by all JUCD system partners. Since July 2022 the panel has provided feedback for:

- tobacco dependency leaflet;
- urgent and emergency care questionnaire;
- individualised commissioning leaflet;
- any qualified provider community audiology and hearing support service webpage content; and
- DCHSFT wound care clinic letters.

Read our guide to the panel here[xxv].

Derbyshire Dialogue

Launched in September 2020, the 'Derbyshire Dialogue[xxvi]' was set up to start a conversation between the residents of 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 our Derbyshire Dialogue sessions include a British Sign Language interpreter (if one is available) and they are recorded.

Case Study – Involvement in the Integrated Care Strategy

The purpose of the Integrated Care Strategy is to set out how Local Authority, NHS, Healthwatch and Voluntary Sector organisations will work together to improve the health of Derby and Derbyshire citizens, and further the transformative change needed to tackle system health and care challenges. During the early stages of its development, the Engagement Team agreed to look at what we already knew about 'what matters to people' by looking at the current insight available across the system. The majority of this was already housed on our Patient and Public Insight Library. All the key themes from national, regional and local reports were pulled together to create an insight document. This was shared with our system colleagues for comments.

This insight document was then used alongside other data and sources of evidence to agree the key areas of focus, which were an integral part of the Integrated Care Strategy. Following on from this, we set up a Derbyshire Dialogue session, where system leads presented the draft strategy to the public of Derbyshire, which was followed by a live question and answer session. A recording of this session is available here, alongside a space for people to leave comments and ideas. More than 70 people attended the session, which led to a positive and open discussion around the content of the strategy.

Partnerships

Our Engagement Framework is not just about creating new and exciting ways to have continuous conversations with our people and communities, it is also about making the best use of existing networks, tools, and mechanisms set up by our system partners, working together to prevent duplication. Many of these partnerships are outlined in our Engagement Strategy[xxvii] and include the following groups:

- Healthwatch;
- VCSE Alliance;
- Derby Inequalities Partnership;
- Health and Wellbeing Partnerships;
- Community Champions;
- Children and Young People's Network; and
- Adult Care Partnerships.

However, this is also being developed through our newly created 'Relationship Manager' role in the ICB Engagement Team. We are now developing Relationship Managers within the team for all manner of topic areas, including the ethnic minority community, children and young people, carers, the VCSE sector and women accessing maternity services. This is not just about knowing where to look to find insight or to have conversations, it is working on how people's views are having an impact on the decisions being made in the system.

BME forums and community leaders	Working in partnership with Derbyshire County Council and Links CVS to build relationships with the BME Partnership that currently exists in the county. The BME partnership is a sustained and coordinated engagement mechanism, which provides an infrastructure to enable the ethnic minority communities to actively engage with decisions being made about Derbyshire County Council services. This aims to broaden the conversations of the partnership to support the work of the ICS and gain insight on key areas of transformational work. It is also looking at how the work taking place in Derby to develop the Derby Health Inequalities Partnerships[xxviii] could be replicated in the county.
Children and young people's networks	Working in partnership with organisations that have mechanisms in place to listen to the voices of children and young people, to record mechanisms, share information, and ensure that there is a shared understanding across the system of what exists to hear the voice of children and young people.
Maternity Networks	Conducting an engagement and insight mapping exercise around maternity services to collect how people's experiences of maternity services are captured and reported to understand the impact and how action resulting from insight is communicated back. This is to create a picture of how we listen as a system, show areas of good practice, pathways, improvements, gaps and opportunities for different layers of continuous engagement.
Derbyshire VCSE Alliance	Working closely with the VCSE Alliance to help facilitate a shared space to support digital infrastructure projects. This has included a hub to house infrastructure organisations, networks and forums on the NHS Futures platform and the ability to use the JUCD online engagement platform to host engagement events.

The networks we have nurtured are being called on to support the system with a piece of work around high blood pressure.

Case Study – Hypertension Insight

The Medicines Management Team has secured funding to increase hypertension (high blood pressure) case findings in Derby city for high-risk populations and wanted insight to lead and guide this work. The Engagement Team developed relationships with Community Action Derby and Derby Health Inequality Partnership to look at developing this work in partnership with those who already have trusting relationships with these communities.

Together, we are developing a bespoke engagement and communication plan which will gain insight into the knowledge and understanding of hypertension, barriers to blood pressure checks, preferred methods of communication, who should be delivering key messages, and where they would like pop-up clinics to be located, which will be led by community pharmacies.

Co-production Framework

The Co-production Framework will help embed, support and champion co-production in the culture, behaviour and relationships of the ICS, including senior leadership level. We are in the process of setting up a task group which will include Patient and Public Partners, in addition to a wide range of professionals from across the ICS. The aim is to 'co-produce' the co-production framework. From initial conversations it is clear that there needs to be discussion/development around the following areas:

What is co-production?	A shared understanding of the terms and key principles, as there is currently a lack of understanding/consistency in the system about what co-production is and is not.
Payment of Patient and Public Partners involved in co-production	Should we pay? How would this work? How can we develop a system-wide policy? How would it be funded?
What would a systemwide approach to co-production look like?	How would we support its implementation?

It is hoped that discussion within the task group will generate actions to move this work forward during 2023/24. The ICB has identified a member of staff to co-ordinate this work, and DCHSFT has allocated resource of £20,000 in support.

Evaluation Framework

To ensure our work with people and communities is at the heart of planning, priority setting, and decision-making across the ICS and to drive system transformation work, we are about to embark on a process of co-producing an evaluation framework with our system partners. This will enable us to reflect on and examine our public involvement practice and the impact this has both on our work and on our people and communities. The evaluation framework will outline how we will measure and appraise our range of methods, and how this will support ongoing continuous improvement.

Insight Framework

The Insight Framework is the most exciting development so far and looks at how we identify and make better use of insight that is already available in local communities to inform the work of the ICS. Many communities already have established mechanisms of finding out what's important to people, with regards to their wants, needs and aspirations. We will be seeking to harness and examine that insight and present it in a way that will enable the ICS to listen to and take action, to truly put the voice of people and communities at the heart of decision-making in the ICS.

This approach is about authentic collaboration with communities without a pre-set agenda and will require that we are brave and believe that people know what they need to be well and happy. It will also require us to align our Governance structures to support community led action. Figure 11 below was collected from a rapid review of community learning conducted by ROC Consultancy[xxix].

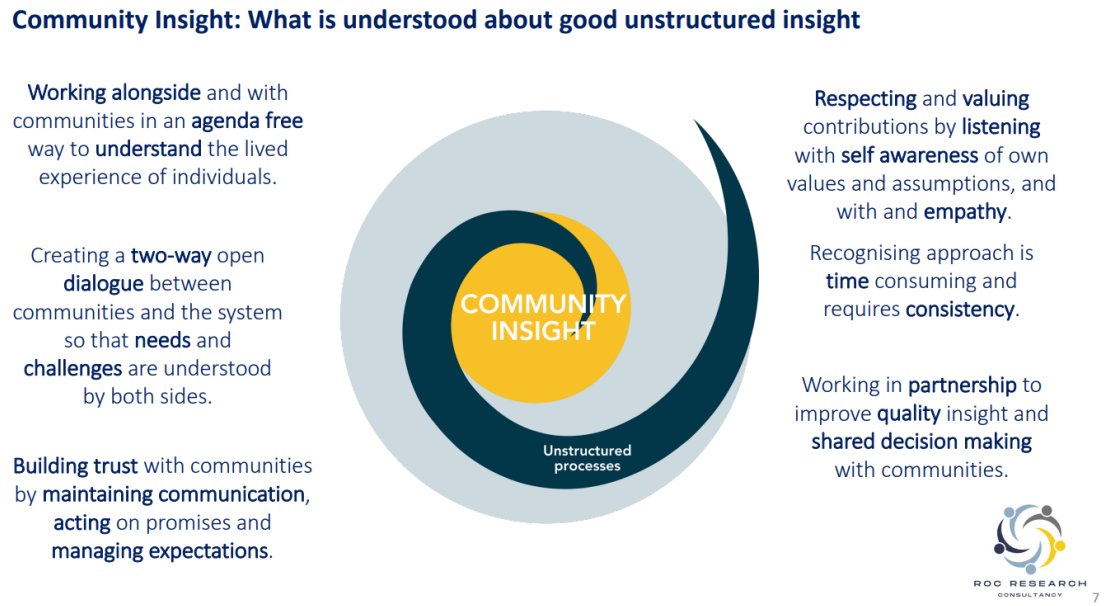


Figure 11 – Community Insight: What is understood about good unstructured insight

A key part of the Insight Framework is our process map (see Figure 12), which outlines five phases. We plan to co-produce what good looks like in all five phases of our model, and then build on strengths-based approaches within communities to support them to overcome the barriers that we know they currently encounter. This work will be centred around Place

Partnerships, and the eight Place Alliances, to support their ambition to be a social model that is outcome driven and strength-based, focusing on the assets of individuals and communities and developed with them through local leadership.

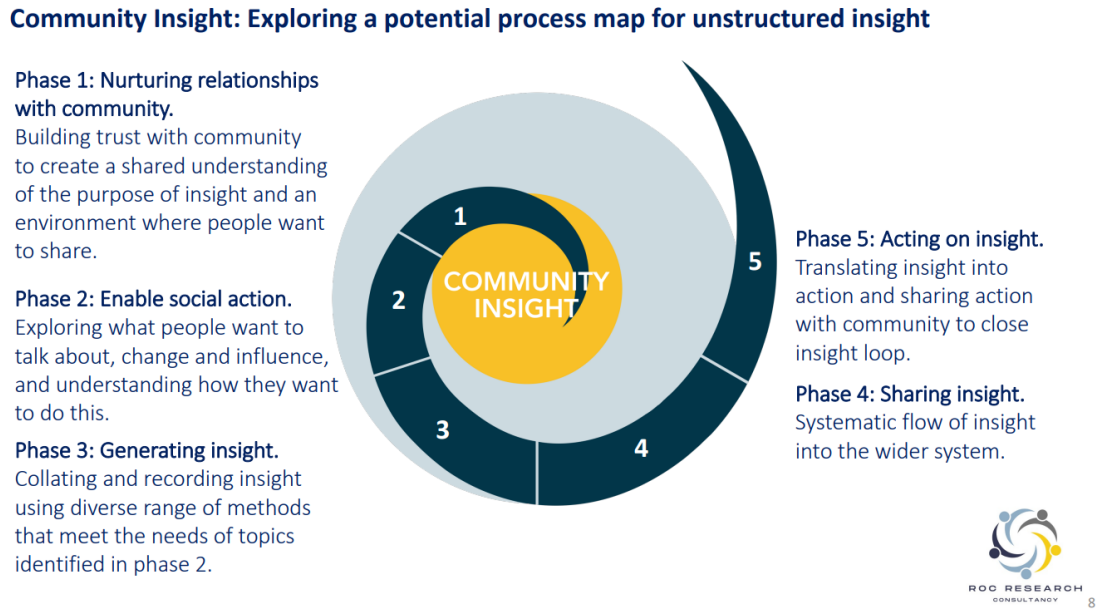


Figure 12 – Community Insight: Exploring a potential process map for unstructured insight

Case Study – Developing a culture of being insight-led across the system when making decisions

At the start of the Covid-19 pandemic, organisations working within the ICS system all wanted to gather insight on how people were experiencing the pandemic, and how it was impacting on their lives. Residents in Derby and Derbyshire began to get inundated with requests to share their experiences and stories. Duplication was rife, and no one was seeing the benefit of collaborating.

To try to coordinate our efforts to gather patient and public insight, we set up the System Insight Group to bring together patient and public experience and engagement leads from across the ICS system. The inaugural meeting was in June 2020 and its vision was to ‘develop a culture of being insight-led across the system when making decisions'.

One of the outcomes of the System Insight Group to support this vision was the Patient and Public Insight Library. This was developed as a solution for collecting and collating insight gathered across the system, which is then easily accessible and searchable by a wide variety of professionals to inform decision-making. This is set up on the FutureNHS Platform. The Patient and Public Insight Library was discussed at an ICB Engagement Leads Share and Learn session last year, and due to the level of interest from other systems, NHSE has developed a template on FutureNHS based on our approach. This can be found on their collaborative workspace, alongside other tools and discussions around the subject.

Our work on the System Insight Group also featured in The King's Fund guide to [Understanding integration: How to listen to and learn from people and communities] (see Figure 14).

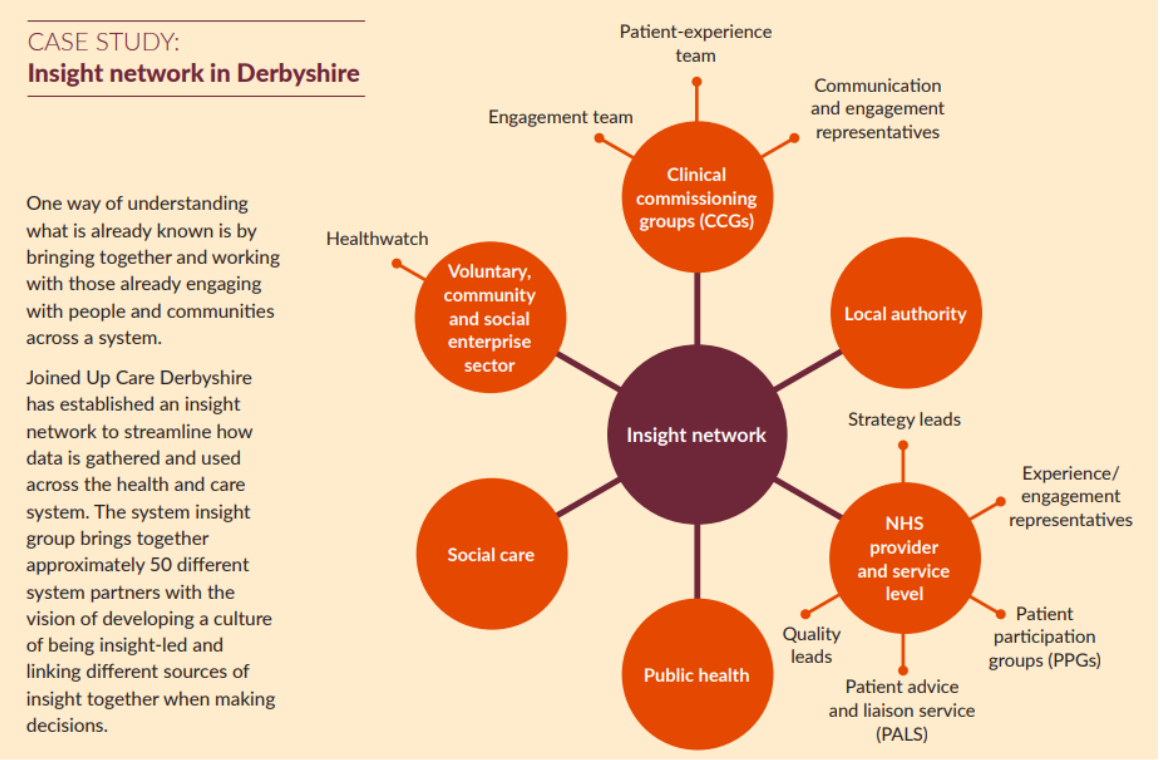


Figure 14 – Case Study: Insight Network in Derbyshire

Joined Up Care Derbyshire Newsletter

Our work is showcased in the bi-monthly [Joined Up Care Derbyshire Newsletter]. This has included:

- measuring the experience of integration (March 2023, page 3);
- understanding how we can improve pulmonary rehabilitation services (March 2023, page 10);
- national recognition for work to reduce harm from opioids in chronic pain (March 2023, page 17);
- MH:2K – youth-led citizen research (January 2023, page 15);
- Dronfield Patient Participation Group self-service kiosk (January 2023, page 20);
- embedding strong engagement with people and communities (November 2022, page 16);
- exciting new opportunity to join our Peer Leadership Programme (September 2022, page 5);
- our guide to working with people and communities (September 2022, page 6); and
- embedding strong engagement with people and communities (July 2022, page 16).

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 ICB's) 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), set out in the Shared Commitment to Quality and enshrined in the Health and Care Bill 2021.

Patient Safety

Derbyshire has been an early adopter of the new Patient Safety Incident Response Framework (PSIRF) since October 2019. PSIRF is a key part of the NHS Patient Safety Strategy (published July 2019). It supports the strategy's aim to help the NHS improve its understanding of safety by drawing insight from patient safety incidents, developing improvement plans and working alongside our quality improvement colleagues to ensure improvements are embedded and sustained.

PSIRF has been slowly embedded into the five organisations which were chosen in Derbyshire as part of the early adopter's programme. The PSIRF has evaluated well and was seen to be a framework that supports systematic, compassionate, and proficient response to patient safety incidents; anchored in the principles of openness, fair accountability, learning and continuous improvement.

PSIRF has allowed our providers to look at each individual incident to determine the most proportionate learning response required. The organisations are seeing a culture shift start to emerge to a 'no blame' culture, looking at systems and processes instead of blaming individuals.

Patient Safety Partner involvement in organisational safety relates to the role that patients and other lay people can play in supporting and contributing to a healthcare organisation’s governance and management process for patient safety. DCHSFT will host Patient Safety Partners with assistance from the ICB's Patient Safety Team. The Derbyshire system hopes to recruit 12 Patient Safety Partners.

Learning from Patient Safety Events (LFPSE) is a new single National NHS system for recording patient safety events. This system has improved capabilities for the analysis of patient safety events occurring across healthcare and offers a greater depth of insight and learning that is more relevant to the current NHS environment. LFPSE is being rolled out to all NHS and independent providers of healthcare. General Practices have been the first providers to be asked to move across to this new system. By April 2023, all providers should have access to a test site and should be working towards full implementation of LFPSE by September 2023.

Never Events

Never Events are patient safety incidents that are entirely preventable, with guidance or safety recommendations providing strong systemic protective barriers at a national level and which should be implemented by all healthcare providers. Learning from what goes wrong in healthcare is crucial to preventing future harm.

In total there were four Never Events reported from June 2021 to June 2022. The investigations are completed as part of the PSIRF as thorough Patient Safety Incident Investigations. A cluster of Never Events were identified that were similar in nature. When these occurred, the acute Trust adopted the principles from the new PSIRF framework and reviewed the themes relating to this cluster to develop a robust improvement plan for the Trust. Learning from Never Events is shared at the Clinical Quality Review Groups to ensure oversight and scrutiny.

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 is a key priority for the NHS in order to prevent healthcare-associated infections and any associated risks to health.

The NHS Standard Contract 2022/23 includes quality requirements for NHS Trusts and NHS Foundation Trusts with a zero-tolerance approach across all organisations to Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia and the aim to minimise rates of both Clostridioides difficile infection and of Gram-negative bloodstream infections to threshold levels set by NHSE.

Methicillin-resistant Staphylococcus aureus

During 2022/23, 16 cases of MRSA bacteraemia were reported relevant to the population of Derby and Derbyshire. Six cases were identified as a hospital onset infection within UHDBFT, and one at CRHFT, and the others were cases 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 shown any lapses in care and the remaining reports are pending and will be reported through the Trust's internal infection control committees which are attended by the ICB for assurance. The rise in case numbers is not isolated to Derbyshire and is reflected both regionally and nationally.

Methicillin-sensitive Staphylococcus aureus

Methicillin-sensitive Staphylococcus aureus bloodstream infections have been subject to mandatory reporting since January 2011, though no organisational objectives are set. There were 259 cases identified during 2022/23, compared to 262 in 2021/22. 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 (68% of ICB cases).

Clostridioides difficile infection

There were 367 cases of Clostridioides difficile assigned to the ICB during 2022/23. Annual objectives for each organisation are set by NHSE, with the ICB's objective being set at no more than 252 Clostridioides difficile cases during the rest of 2022/23. Both acute Trusts have also breached their trajectories for the year. UHDBFT had 166 cases against a trajectory of 98, and CRHFT had 57 cases against a trajectory of 31.

Post-infection reviews, deep dives, NHSE and ICB quality visits have been undertaken to understand issues and have identified some common trends and themes across both acute Trusts around diarrhoea management, basic infection, prevention and control practices and use of antibiotics. Both acute Trusts have implemented Trust-wide infection, prevention and control action plans, which are monitored through Trust internal infection control committees.

The national and regional picture is reflective of the Derbyshire position and NHSE infection, prevention and control teams are hosting various collaboratives and task and finish groups around some of the common themes which Derbyshire representatives from the ICB and NHS providers are part of.

Gram-negative bloodstream infections

The Government had an initial ambition to reduce healthcare associated Gram-negative bloodstream infections (GNBSIs) by 50% by 2021, which previously resulted in targets being set for CCGs focusing on the reduction of Escherichia coli bloodstream infections. The Government has since revised this ambition and now aims to halve healthcare associated GNBSIs by 2024/25. This also now includes bloodstream infections caused by Pseudomonas and Klebsiella species.

Case numbers for Derby and Derbyshire residents for Klebsiella are below trajectory for this year. However, E. Coli and Pseudomonas infections showed an increase, in common with increases shown in the other alert healthcare associated infections. Although both acute

Trusts were just under trajectory, the IPC action plans implemented within the Trusts address the underlying issues, particularly around the care of catheters and peripheral intravenous lines, identified in deep dives and infection reviews as possibly contributing to this rise.

Infection Prevention and Control Teams continue to work collaboratively across the system to support the reduction of GNBSIs. Work will continue with the Derbyshire health and social care system to implement the system antimicrobial resistance strategic action plan as this will play a key role in supporting the ambitions to reduce the numbers of GNBSIs.

End-of-Life Services

The Health and Care Act 2022 includes a new legal right to NHS funded EoL Care. The Palliative End-of-Life Care Strategy refresh is to be completed in spring 2023, and the focus is on the alignment of the National Ambitions for Palliative EoL Care to local delivery workstreams, and the further development of the EoL Care Board as an enabler which supports the delivery of the EoL Care Strategy. There are a number of areas of work currently underway, including reviewing how we can deliver improved access to EoL care, equitable services across our Places, supporting hospice sustainability through longer term contracts, and capacity and demand modelling which allows us to put the right level of resources in the right place, at the right time.

Patient Experience and Involvement in Our Services

The ICB gathers patient experience from many different sources and works in partnership with patients, carers, and local partners to ensure that the services we commission are responsive to the needs of our population. In the last year we have been working closely with patients who have been discharged to care homes for reablement. We have utilised this feedback to improve the discharge process and their rehabilitation experiences and this work will continue. Following this, we have commissioned specific support beds in care homes, and from February 2023 onwards, have been evaluating the experiences of patients in this new service.

The team worked closely with Healthwatch Derbyshire and Healthwatch Derby and ensured that their feedback was used to influence commissioning. There has been a continued focus on access to General Practice, pain management relating to opiate use, NHS dentistry, Medicines Order Line and general feedback including complaints and compliments. The Patient Experience Team has provided advice and support to the Joint and Community Commissioning Team in the recruitment of Patient Partners to work alongside them in the commissioning process.

Work is ongoing to ensure patient experience is an integral part of shaping and delivering EoL services across Derbyshire. This has included the merger of the People Driving Change and Compassionate Communities workstreams to share their resources and expertise. The workstream is developing a new work plan which includes ensuring that information about EoL care is available to everyone in the most appropriate format for their cultural and individual needs. There will also be opportunities for patients and carers to be involved in ongoing and time-limited projects, as well as sharing their experiences of EoL care.

We have worked with women on their experiences of maternity care and have engaged with women and the families of those who traditionally have been under-represented around their experiences of maternity and neonatal services in Derbyshire. We will build on this work and it will inform the development of local action plans to improve services and support for women for the coming year.

Data on protected characteristics is collected and analysed as part of gathering patient experience feedback to support the ICB's commitment to recognising diversity and ensuring that everyone has equitable access to services and is treated with respect and dignity.

Quality and Equality Impact Assessments

Quality and Equality Impact Assessments (QEIAs) are evolving to make sure that we engage with our staff and local communities to ensure that healthcare services meet the needs of our population.

Over the last year, work has continued in relation to the QEIA process and ensuring that projects and system changes are presented to the QEIA Panel. The purpose is to demonstrate an awareness and understanding of how changes may impact patients and the public. In many cases significant work has already been done to gather feedback and inform the plans, in others, project leads are working with the Patient Experience Team to gather the feedback after initial presentation at QEIA.

Discharge to Assess

The ICB continued to engage with patients who have been discharged from hospital care into a temporary care home bed while their needs are further assessed, and rehabilitation takes place. Informal interviews and surveys were resumed face-to-face and patients have shared their experiences of discharge and their progress in the care home facility. An extension of this work included the development of commissioned pathway 3 beds and engagement with patients regarding their experiences of this service. This feeds into the appropriate planning groups and has resulted in improved discharge information between the hospitals and the care homes.

Discharge to Assess Pathway 3

Prior to the onset of the Covid-19 pandemic, patients requiring an assessment to determine eligibility for NHS funding (NHS Continuing Healthcare (CHC) or Funded Nursing Care), were often delayed in the acute setting. Alternatively, they would be discharged into community hospital beds to await assessment which could be for up to 28 days (timeframe for CHC assessments to be completed). Consequently, community hospital bed capacity was reduced which further impacted upon discharges from the Acute setting.

The CHC Framework is clear that *"in the majority of cases, it is preferable for eligibility for NHS Continuing Healthcare to be considered after discharge from hospital when the person's ongoing needs should be clearer"*. Where an individual is ready to be safely discharged from acute hospital it is very important that this happens without delay. Therefore, the assessment process for CHC should not be allowed to delay hospital discharge. To ensure that unnecessary stays on acute wards are avoided, there should be consideration of whether the provision of further NHS-funded services is appropriate. The interim services should continue until it has been decided whether the individual has a need for CHC. There must be no gap in the provision of appropriate support to meet the individual's needs' (National Framework for CHC and NHS Funded Nursing Care October 2018 (revised)).

In view of the above and to build upon the positive collaborative and integrated partnership working, in 2022 the relevant authorising bodies within the former CCG approved a single stage procurement process to establish a multi-provider framework agreement for discharge to assess pathway 3 (nursing) beds. The aim is to support availability of bedded care in nursing homes where patients, who require discharge from acute care, via pathway 3 (nursing), can be optimised outside of an acute hospital and have their CHC assessment undertaken within 28 days, before moving on to the place that will be home. The procurement process aimed to achieve block-booked contracts for 40 Nursing Home beds across the Derby and Derbyshire geographical area, with an expectation that the availability and ICB oversight (as part of the project) would result in:

- improved wellbeing and recovery for patients who have had an acute admission;
- less decompensation of this cohort of patients through more timely discharge and reduced length of stay in an acute hospital setting;
- active discharge planning for discharge to assess pathway 3 (nursing) who required a CHC assessment where their estimated dates of discharge, are agreed with patients, carers and nursing homes;
- review of hospital processes so that discharges occur earlier in the day, and patients are adequately prepared;
- reduction in the number of this cohort of patients in the acute setting who do not meet the criteria to reside;
- improvement in flow through the system, resulting in increased capacity in acute hospitals and reduced waiting times in A&E and ambulances;
- assessment of eligibility for CHC, if still required, being undertaken, in a non-acute hospital setting, when the individual has reached a point in recovery where it is possible to make an accurate assessment of their longer-term needs, an accurate assessment of ongoing needs can be made (as per the National Framework for CHC).

Care Homes

Care homes have continued to work incredibly hard to keep both staff and residents as safe as possible while they work through the legacy of the Covid-19 pandemic. The ICB has resumed its face-to-face quality assurance function undertaken by the Care Home Clinical Quality Managers. This has been well received by the care home managers as the team has been able to provide support more effectively which has been vital given the significant challenges of the last few years.

Care homes are mandated to report daily the number of Covid-19 outbreaks both for residents and staff, bed capacity, and vaccination uptake on the National Capacity tracker. This provides both Derby City and Derbyshire County Local Authorities and the ICB with valuable information to be able to respond to issues identified by the sector.

Covid-19 prevalence is monitored daily to ensure action and support is provided to the sector as appropriate. Local infection, prevention and control, and Public Health teams have supported the care homes with clinical and practical advice. Outbreak Control Team meetings have continued to meet weekly led by Local Authority Public Health to assess and manage the risk for individual services, putting in appropriate support where needed. Given the pressure in the system for beds in care homes however, the Outbreak Control Teams have implemented a process to consider admissions to care homes on a case-by-case basis where there are exceptional circumstances for those individuals and where an approved risk assessment is in place.

Care homes are no longer required to undertake routine whole home asymptomatic testing. Instead, where any resident or staff member becomes symptomatic, a lateral flow test is required and if positive the home will take appropriate measures in line with current infection, prevention and control guidance. An outbreak is declared if there are two or more cases that are epidemiologically linked to that setting. The home is then required to close to new admissions and carry out outbreak testing at days four to seven and then undertake recovery testing at day 10.

From mid-September 2022, onwards the responsibility for declaring an outbreak moved from the UK Health Security Agency, as had been the case since the start of the pandemic, to the care home themselves. The number of outbreaks has decreased steadily across the year with a spike during the winter months following an increase in respiratory infections.

The autumn booster vaccination programme was successfully rolled out for all care homes across Derby City and Derbyshire. Alongside this, the PCNs and community pharmacies have also rolled out the flu vaccination programme for 2022.

Quality Assurance Process

The local multi-agency information sharing meetings continue weekly to monitor and respond to emerging risks promptly. This includes the Local Authority, ICB, CQC and the CHC Team. All agencies have now returned to face-to-face quality monitoring visits to providers. However, following learning from the pandemic, all agencies have adopted a variety of quality assurance methods of monitoring using a mixture of virtual, desktop and face-to-face monitoring.

Both Local Authorities in Derby City and Derbyshire County are responsible for investigating safeguarding concerns. The ICB receives the safeguarding reports regarding the nursing homes and attends safeguarding meetings where appropriate. Where clinical quality themes are identified, the Clinical Quality Managers follow up with the care home to ensure appropriate action is being taken and to offer support where needed.

Sadly, there have been some care homes that have closed during the Covid-19 pandemic. This has been mainly due to a combination of quality and financial viability concerns. In total, since 2020, there have been four nursing homes that have closed, one in Derby City and three in Derbyshire County. In all cases, both the Local Authorities and the ICB provided support to the home to ensure the residents safely moved to alternative placements and that appropriate support was provided to the staff and residents' families during this difficult time. The programme's work is covered in this report's Team Up section.

Continuing Health Care

The new CHC Framework was published at the end of February 2022 with an incremental timetable for implementation from April 2022. The CHC Team is seeking to ensure that all ICB processes are reviewed and refreshed to ensure compliance with the new framework as well as ensuring these processes are staff-friendly.

The year has been one of transformation and progress for CHC with a strong focus on continued improvement, collaboration, and partnership working with both aligned Local Authorities. Building upon the positive relationships forged during the Covid-19 pandemic, the CHC service has worked with social care colleagues in both adult and children's services and joint processes have been agreed in the following areas:

- joint funding where adults do not have a primary health need, but their care and support needs are over and above those that can be met by social care in isolation, or where their health needs cannot be met by mainstream NHS commissioned services;
- children and young people's continuing care – a joint policy with associated processes and panels with joint training;
- Any Qualified Provider Framework for home care – working towards Local Authorities as associates to ICB contracts with providers;
- working together with healthcare partners to focus around supporting safe discharge from hospitals and creating additional capacity in the community;
- focus on quality of our providers – ICB Quality Team and Local Authority teams working closely where providers of concern are identified to support providers to ensure the required improvements are made. Quality of our providers remains a key priority, while at the same time acknowledging the challenges in the care home and home care markets; and
- embedding the Trusted Assessment Model and thereby ensuring more assessments can take place in the right location and time when the individual’s on-going needs are known.

This has created positive working relationships at every level and has laid the foundation for joint working in several contracting and commissioning priorities moving forwards.

The ICB has worked with the CHC service to better manage how CHC is delivered at scale with a particular focus on internal processes, policies and governance to improve efficiency and effectiveness. The establishment of uplifts panels to ensure transparency and equity in terms of provider requests for fee increases is an example of this. Other examples this year include an increasing focus on personalisation and outcome-based commissioning, working with all system partners to improve the appropriate use of the Fast Track to CHC pathway and a total refresh of the ICB website content relating to CHC and children and young people's continuing care.

Commissioning for individuals

The 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 which meets their assessed health needs, respects their wants, and is safe and sustainable. The panel is chaired by a lay representative and the panel consists of representatives from finance, contracting, commissioning and quality colleagues.

This year has seen an increase in the numbers of cases brought to panel, however, this may be due to staff having a greater awareness of the processes. By bringing cases together in this way, and by having a team of panel decision-makers who are consistent each week, we are readily able to identify themes and trends which will support commissioning decisions in the future. Screening out prior to panel is an efficient use of the Commissioning for Individuals Team and Panel's time and resources, and provides assurance that requests follow clinical policies and do not bypass locally commissioned services, having had clinical discussions with colleagues in and around the system to ensure the appropriate clinical services are there for the individual.

Learning from lives and deaths of people with a learning disability and autistic people – the Learning Disability and Autistic People Programme

Learning Disabilities Mortality Review (LeDeR) is a service improvement programme which aims to improve care, reduce health inequalities and prevent premature mortality of people with a learning disability and autistic people through reviews of individuals who have died, looking at information about the health and social care support they received. By the end of Q3 2022/23 there was a total of 49 notifications of deaths to the LeDeR Programme. Eight of the notifications were for people from ethnic minority communities. There was one notification for an individual who had autism with no learning disability. 33 reviews have been completed as 'initial reviews' and 12 completed as the more detailed 'focused' review. In those reviewed throughout the year, the top two reasons for death were aspirational pneumonia (eight deaths) and heart disease/failure (seven deaths).

LeDeR reviews are only undertaken for individuals 18 years and over, although the programme does work closely with the Child Death Overview Panel where child death reviews are reviewed by a panel. There have been seven completed Child Death Overview

Panels up to the end of Q3. LeDeR captures themes and trends to identify learning and actions and work continues to:

- address inequalities across ethnic minority communities;
- capturing gaps in understanding epilepsy;
- monitoring and capturing detail in relation to the correct completion and following of 'do not attempt cardiopulmonary resuscitation'; and
- supporting the attendance at and quality of learning disability annual health checks and health action plans.

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 Derbyshire 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.

Host commissioner arrangements

The ICB has well-established oversight for the eight independent hospitals in Derbyshire in line with national host commissioner guidance. This provides a clear framework and expectation to maintain ongoing surveillance of overall quality of care for each hospital. Our model has widened the scope of our oversight beyond national expectations to encompass the overall quality of care for people with a diagnosis of learning disability, autism and/or mental health needs. As a local ICB, we can flexibly respond to concerns to ensure that people placed in Derbyshire remain safe and well where concerns arise. We ensure that there is effective communication and coordination with stakeholders such as CQC or Local Authority Safeguarding Leads. This also extends to sharing information with other commissioners placing into Derbyshire.

An important element of our work is to maintain ongoing contact with local independent hospitals and to support their own quality improvement priorities. With this in mind, we have undertaken a quality visit to each hospital in 2022/23 and we are working with local leads to monitor the improvements that have been agreed. We are pleased to note that all eight independent hospitals have been inspected by the CQC and received a rating of 'good'. We continue to support work to build on this achievement.

Transforming Care Partnership

The Transforming Care Partnership consists of the ICB, CRHFT, UHDBFT, DCHSFT, DHcFT, Derby City Council, Derbyshire County Council, service users and carers. It seeks to develop collaborative ways of working to improve health and care services to ensure that individuals with learning disabilities and/or autism, receive the right support at the right time, closer to home and continue to live their best lives in the community. For those individuals for whom a clinically led evidence-based need is indicative of hospital admission, the aim of the admission, assessment and treatment pathway and discharge plan from hospital, will be clear from the point of admission. The new NHSE Dynamic Support Register and Care (Education) Treatment Review Policy and Guidance was published on the 25th January 2023. A task and finish group, with representation from all system partners, has been

established to operationalise the requirements of the new policy ready for an implementation date of the 1st May 2023. The JUCD Dynamic Support Register (DSR), is a risk stratification meeting with a key focus on prevention, early identification and intervention for people who have a diagnosis of learning disability and/or autism, to ensure that they are receiving the right support in the community and to avoid an admission to a mental health hospital. Working collaboratively across the system, significant changes have been implemented to the DSR during this past year.

Training workshops have been held with learning disability, autism and mental health, health and social care teams to embed the DSR into 'business as usual' with shared ownership across JUCD. The DSR has evolved further by integrating the Children and Young People DSR with the Adult DSR into the JUCD All-age DSR. The aim is to have a consistent approach across children and young people and adults, to aid understanding of children and young people's cases during transition to support a smooth transition to adults.

As a direct result of this collaborative working, in 2022/23 five of our long-stay patients, with learning disability and/or autism, were discharged from a specialist hospital setting. One of these had been in hospital for nine years and the others up to three years. There was also a patient who was discharged from a medium secure unit to community supported living who had been in hospital for five years.

Maternity and Neonatal Transformation

The ICB takes a leadership role in the Derbyshire Local Maternity and Neonatal System (LMNS) and has continued to steer the programme of work to respond to the recommendations of the Better Births report, the NHS Long Term Plan maternity commitments and the actions following the Kirkup and Ockenden Reports. During 2022, UHDBFT identified a cluster of seven serious incidents in maternity services and contacted the ICB to request external expertise to review the cases, provide assurance that no quality concerns were being missed, and ensure that opportunities to prevent future serious incidents had been fully identified. Having sought the advice of NHSE Midlands, the Healthcare Safety Investigation Branch was secured to undertake the review, which identified five safety recommendations. The LMNS has received delegated responsibility from the ICB's Quality and Performance Committee, for ensuring the timely and effective delivery of UHDBFT's response plan to the review.

There has also been a focus on recovery of services following the pandemic in line with the operational guidance, and the LMNS has continued to work towards delivering a range of transformation objectives to make maternity and neonatal care safer, and more personalised and equitable. Working closely with providers and where safe staffing is in place, local plans have been developed for midwifery continuity of carers so that people of ethnic minorities and those from the most deprived areas receive it.

The LMNS has worked collaboratively with system partners to develop an Equity and Equality Plan which aims to improve equity for mothers and babies and race equality for maternity and neonatal staff. This outlines our intentions of what we want to achieve locally to embed equity into local maternity and neonatal services.

Emergency Planning, Resilience and Response

The ICB is defined as a Category 1 Responder under the Civil Contingencies Act 2004 and as such has seven key civil protection duties that it must fulfil:

- assessing the risk of emergencies occurring and using this to inform contingency planning;
- putting in place emergency plans and business continuity management arrangements;
- making information available to the public about civil protection matters and to warn, inform and advise the public 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 through the Emergency Preparedness Resilience and Response (EPRR) programme, which is supported by a variety of NHS-specific guidance in relation to preparedness and response to emergencies, major incidents, critical incidents and business continuity incidents.

The ICB coordinates and assures the EPRR preparedness and response of the wider Derby and Derbyshire health system, 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 and works with partners on preparedness, and where required response. During 2022/23 the ICB has responded to a number of incidents, including critical incidents for capacity and flow, industrial action and adverse weather.

As part of the preparedness work, all health organisations are expected to complete EPRR Core Standards assurance led by NHSE. The ICB attained a 'non-compliant' status this year, which was linked to changes to the category status from Category 2 to Category 1. This required the ICB to comply against a greater number of core standards compared to the CCG. Since this submission, a new Head of EPRR has joined the ICB and, in conjunction with the wider EPRR team and ICB staff, has improved a number of standards by updating specific incident plans and creating a new training programme.

The ICB engages with the Local Resilience Forum to ensure there are links into upcoming exercises and works closely with other ICB EPRR teams and the NHSE regional team to ensure holistic preparedness for incidents for the public, patients and staff of the Derby and Derbyshire health economy. This work will continue into 2023/24, 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 innovation under section 14Z39 of the Health and Care Act 2022. The Executive Lead for research and innovation for the ICB and Derbyshire ICS is the Executive Medical Director.

The ICS has an established Derbyshire Research Forum which meets bi-monthly and is chaired by the ICB's Deputy Medical Director. The forum meets regularly to consider the role of research in JUCD to establish governance and reporting arrangements. The forum brings together:

- research leads from NHS provider organisations;
- Primary Care;
- Local Authorities,
- Clinical Research Network East Midlands; and
- University of Derby.

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."

The Forum's primary purpose is to:

- promote and support research across health and social care within Derbyshire;
- increase the amount of research that is undertaken both at organisational and population level;
- have sight of research activity in health and social care across Derbyshire, both existing and emerging research;
- support the development and initiation of research ideas which address the local health and social care needs and reflect patient and public voices;
- encourage the engagement and the ownership of Derbyshire-led health and social care research;
- act as a group to ensure local and regional initiatives around research engagement and partnerships are aligned;
- facilitate alignment of research to the NHS Long Term Plan; and
- promote best practice and encourage consistency in matters of research management across Primary, Secondary, Community, Public Health and Social Care in Derbyshire.

Research is well established in several JUCD partner organisations and research leadership is connected at a regional-level within East Midlands, offering shared learning opportunities and support structures. Derbyshire Research progress includes:

- supporting all staff who want to get involved in research activity, starting in primary care where we have identified gaps, through re-investment of Research Capability Funds via an Expression of Interest call to increase primary care clinical research delivery;
- promoting engagement with patients and the public from all communities has started focusing initially on under-served communities/CORE20Plus5 Health Inequalities groups following a successful NHSE funding application for Community Research Engagement Network Development;
- contributing to East Midlands Outline Business Case for sub-national Secure Data Environment for Research, which is planned to include commercialisation models. In the Data Saves Lives Strategy, NHSE committed to implementing Secure Data Environments as the default way to access NHS health and social care data for research and analysis;
- designing a co-production model for research in the county, supporting the public to be involved in all steps of research – with a focus on underserved communities to identify the health and wellbeing aspirations of some under-served populations in Derby and Derbyshire, allowing alignment of services/interventions to maximise impact;
- implementation of a project which identified that exclusion of those unable to communicate in English happened in approximately one in five studies that recently took place in the East Midlands; and
- delivery of a series of events focusing on increasing the diversity (in terms of race, gender, sexuality, socio-economic status and religion) of public involvement in the area of mental health.

The number of participants recruited to research studies on the Clinical Research Network Portfolio during 2022/23 for the ICS was 9,346 (Open Data Platform. In developing the research strategy, consideration will be given to how we can better facilitate and promote the routine use of research evidence in care, clinical and commissioning decisions.

The Derbyshire ICS Research Strategy will be developed during 2023/24 and will provide an opportunity to embed research as an integral part of the Derby and Derbyshire NHS' Five Year Joint Forward Plan.

ACCOUNTABILITY REPORT

Dr Chris Clayton

Accountable Officer

NHS Derby and Derbyshire Integrated Care Board

27th June 2023

Accountability Report Overview

The Accountability Report describes how we meet key accountability requirements and embody best practice to comply with corporate governance norms and regulations. It comprises three sections:

Corporate Governance Report

The Corporate Governance Report sets out how we have governed the organisation during the period 1st July 2022 to the 31st March 2023, including the organisation of our governance structures and how they supported the achievement of our objectives.

Remuneration and Staff Report

The Remuneration and Staff Report describes our remuneration polices for executive and non-executive directors, including salary and pension liability information. It also provides further information on our workforce, remuneration and staff policies.

Parliamentary Accountability and Audit Report

The Parliamentary Accountability and Audit Report brings together key information to support accountability, including a summary of fees and charges, remote contingent liabilities, and an audit report and certificate.

Corporate Governance Report

Directors Report

Composition of the ICB Board

The ICB Board members are shown in Table 18 below:

ICB Board Member	Position
Voting	
John MacDonald	Chair
Dr Bukhtawar Dhadda	Non-Executive Member (Quality and Performance) and Vice ICB Board Chair (up to the 31st January 2023)
Dr Chris Clayton	Chief Executive Officer
Tracy Allen	Partner Member – Derbyshire Community Health Services NHS Foundation Trust
Ifti Majid	Partner Member – Derbyshire Healthcare NHS Foundation Trust (up to the 30th November 2022)
Carolyn Green	Partner Member – Derbyshire Healthcare NHS Foundation Trust (from the 1st December 2022)
Dr Andrew Mott	Partner Member – Primary Medical Services
Andy Smith	Partner Member – Derby City Council
Dean Wallace	Partner Member – Derbyshire County Council (up to the 30th August 2022)
Ellie Houlston	Partner Member – Derbyshire County Council (from the 1st September 2022)
Julian Corner	Non-Executive Member (Population Health and Strategic Commissioning)
Margaret Gildea	Non-Executive Member (People and Culture)
Sue Sunderland	Non-Executive Member (Audit and Governance)
Richard Wright	Non-Executive Member (Finance and Estates)
Keith Griffiths	Executive Director of Finance
Dr Chris Weiner	Executive Medical Director
Brigid Stacey	Executive Director of Nursing and Quality and Deputy Chief Executive Officer
Amanda Rawlings	Chief People Officer
Non-Voting	
Helen Dillistone	Executive Director of Corporate Affairs
Zara Jones	Executive Director of Strategy and Planning
Dr Avi Bhatia	Chair of Clinical and Professional Advisory Group
James Austin	Chief Digital Information Officer (from the 1st November 2022)

Table 18 – members of the ICB Board during Quarter 2 to Quarter 4 of 2022/23

Audit and Governance Committee

The membership of the Audit and Governance Committee of the ICB is shown in Table 19 below.

Audit and Governance Committee Member	Position
Sue Sunderland	Chair – Non-Executive Member (Audit and Governance)
Richard Wright	Non-Executive Member (Finance and Estates)
Dr Bukhtawar Dhadda	Non-Executive Member (Quality and Performance (up to the 31st January 2023)
Margaret Gildea	Non-Executive Member (People and Culture) ('by invitation' in accordance with the Committee's workplan)

Table 19 – members of the ICB's Audit and Governance Committee during Quarter 2 to Quarter 4 of 2022/23

Register of Interests

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

Personal Data Related Incidents

There have been no Information Governance incidents during Q2 to Q4 of 2022/23 that 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 2023 is published on our website here[xxxi].

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 NHS England, 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
27th June 2023

Governance Statement

Introduction and Context

NHS Derby and Derbyshire Integrated Care Board (ICB) is a body corporate 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 July 2022 and the 31st March 2023, 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 around 1,118,447 people in Derbyshire.

The geographical footprint and seven areas known as 'Places' covered by the ICB are Amber Valley, Bolsover and North East Derbyshire, Chesterfield, 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 city 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 £14.4m for the period 1st July 2022 to the 31st March 2023, and had a workforce of 468 employees on the 31st March 2023.

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 is 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) of, 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[xxxii].

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 December 2022.

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 20 below, each with a single non-transferable vote unless detailed otherwise.

ICB Board Member	Position
Voting	
John MacDonald	Chair
Dr Bukhtawar Dhadda	Non-Executive Member (Quality and Performance) and Vice ICB Board Chair (up to the 31st January 2023)
Dr Chris Clayton	Chief Executive Officer
Tracy Allen	Partner Member – Derbyshire Community Health Services NHS Foundation Trust
Ifti Majid	Partner Member – Derbyshire Healthcare NHS Foundation Trust (up to the 30th November 2022)
Carolyn Green	Partner Member – Derbyshire Healthcare NHS Foundation Trust (from the 1st December 2022)
Dr Andrew Mott	Partner Member – Primary Medical Services
Andy Smith	Partner Member – Derby City Council
Dean Wallace	Partner Member – Derbyshire County Council (up to the 30th August 2022)
Ellie Houlston	Partner Member – Derbyshire County Council (from the 1st September 2022)
Julian Corner	Non-Executive Member (Population Health and Strategic Commissioning)
Margaret Gildea	Non-Executive Member (People and Culture)
Sue Sunderland	Non-Executive Member (Audit and Governance)
Richard Wright	Non-Executive Member (Finance and Estates)
Keith Griffiths	Executive Director of Finance
Dr Chris Weiner	Executive Medical Director
Brigid Stacey	Executive Director of Nursing and Quality and Deputy Chief Executive Officer
Amanda Rawlings	Chief People Officer
Non-Voting	
Helen Dillistone	Executive Director of Corporate Affairs
Zara Jones	Executive Director of Strategy and Planning
Dr Avi Bhatia	Chair of Clinical and Professional Advisory Group
James Austin	Chief Digital Information Officer (from the 1st November 2022)

Table 20 – members of the ICB Board during Quarter 2 to Quarter 4 of 2022/23

The ICB Board met in public five times from the 1st July 2022 to 31st March 2023. All meetings were fully quorate. The membership and attendance record for the ICB Board and corporate committees can be found in Appendix One.

ICB Board Performance

On the 1st July 2023 (the formal establishment of the ICB) the inaugural ICB Board Meeting was held. At this meeting the ICB Chair and Chief Executive Officer welcomed and introduced the Board members, and gave an outline of the Non-Executive Member roles. At this first meeting the Board formally adopted the following key statutory documentation for the new ICB:

- Constitution and Governance Handbook;
- Health and Safety Policy;
- appointment of the ICB Founder Members of the Integrated Care Partnership;
- opening Board Assurance Framework and Risk Register; and
- appointment process of the External Auditors.

The ICB Board held meetings in public on the 21st July and 17th November 2022, and the 19th January and 16th March 2023. The meeting on the 15th September 2022 could not be held in public due to Operation London Bridge and the mourning period of Her Majesty the Queen. ICB Board confidential sessions took place in July, September and November 2022, and January and March 2023.

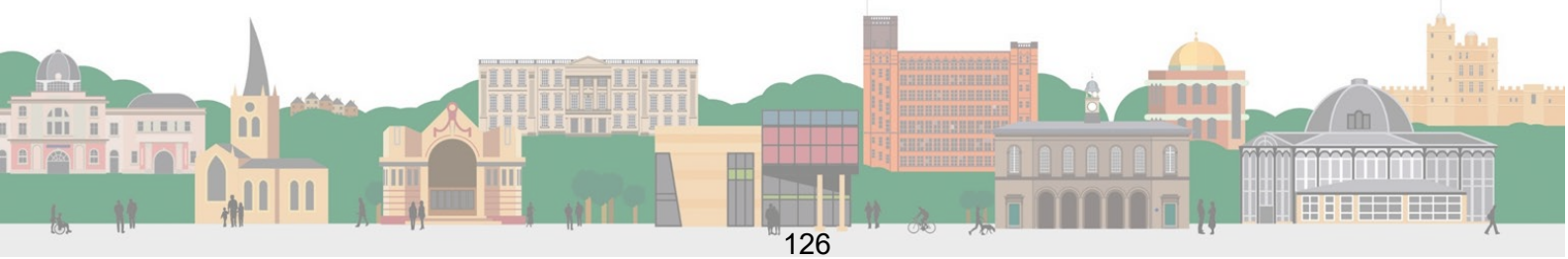
Four ICB Board Development Sessions have taken place during August, October and December 2022 and February 2023. The ICB Board has understood and is developing its approach to the following core functions of the ICB, to:

- effectively fulfil its statutory duties as an organisation in its own right;
- support the development of integration across the NHS; and
- support the development of integration and partnership working across the broader ICS.

ICB Board Development during 2022/23

Following the rapid development and creation of the ICB, the main focus of the ICB Board's time using its formal (public and confidential) and informal (development) meetings has been in the following areas:

- statutory formation of the ICB as an organisation with a Board, committees and team structure;
- safe transition and continuance of commissioning functions from the CCG;
- development of new functional statutory areas (for example, system people function) and the continued oversight of key assurance areas across the NHS;
- continued development of the Clinical and Professional Leadership group;
- response to national and regional planning and assurance requirements (for example, winter plan) and oversight of key operational priority areas (urgent and emergency care);
- development of key strategic areas such as our Integrated Commissioning (population health management, health inequalities, health protection, clinical policy and joint commissioning), Integrated Care (provider collaboration at place and scale including transformation, productivity and operational delivery) and Integrated Assurance (people, finance, estates, quality, performance, audit and governance) approaches;
- creation of the ICB's Board Assurance Framework and associated risk approach;
- approach to organisational and cultural development of the ICB as a Board, an organisation and as a key member of the Derby and Derbyshire NHS family.



Following key developments in the above areas, the ICB Board discussed how to best use its time to ensure it continues to develop and deliver against its ambition of improving health outcomes for the Derby and Derbyshire population.

At the ICB Board confidential meeting in January 2023, a new format for the ICB Board was proposed, and these arrangements will commence from the new financial year, starting April 2023. The proposal set out the following three different types of Board meetings to ensure it provides time to conduct the business as usual and developments:

Meeting Type	Key information
ICB Business	• Meetings held publicly and privately. • Focus on ICB statutory duties, commissioning and ICB-specific statutory duties, for example, review of commissioning plans, specific business cases, organisational risks and ICB assurance.
ICB System Focus	• Meetings held publicly and privately. • Focus on 'system-based' strategic business, taking a broader perspective across the NHS and ICP/ICS. • Development of Place and Provider Collaboratives.
Development	• Meetings held privately. • Focus on areas of development that are best suited to development space.

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;
  - Remuneration Committee; and
  - System Quality Group.
- Non-Statutory Committees of the ICB Board:
  - Finance and Estates 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 composition of the Audit and Governance Committee is shown in Table 21 below.

Audit and Governance Committee Member	Position
Sue Sunderland	Chair – Non-Executive Member (Audit and Governance)
Richard Wright	Non-Executive Member (Finance and Estates)
Dr Bukhtawar Dhadda	Non-Executive Member (Quality and Performance) (up to the 31st January 2023)
Margaret Gildea	Non-Executive Member (People and Culture) ('by invitation' in accordance with the Committee's workplan)

Table 21 – members of the ICB's Audit and Governance Committee during Quarter 2 to Quarter 4 of 2022/23

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 Q2 to Q4 of 2022/23 are shown in Table 22 below:

Significant items approved/discussed by Audit and Governance Committee during Quarter 2 to Quarter 4 of 2022/23	
Governance, Risk Management and Internal Control	
Accounting Policies 2022/23	Draft ICB Annual Governance Statement
Accountable Officer Assurance Letter	EPRR and Business Continuity
Accruals – Month 9	Equality Delivery System 2022/23
Aged Receivables, Payable Credit Notes, Write Offs and Losses and Special Payments	Estates
	Financial Position 2023/24
	Financial Sustainability Assessment
Board Assurance Framework 2022/23	Freedom of Information
CCG Accounting Policies for Final Accounts	Freedom to Speak Up and Whistleblowing
Committee Meeting Logs	Health and Safety
Complaints	Information Governance
Conflicts of Interest	Mandatory Training Compliance
Corporate and HR Policies	Non-Clinical Adverse Incidents
Delegation of Pharmacy, Optometry and Dental Services and the Joint Commissioning Arrangements	Policy Management Framework

Significant items approved/discussed by Audit and Governance Committee during Quarter 2 to Quarter 4 of 2022/23	
Digital and Cyber Security	Pre-Delegation Assessment Framework
	Procurement Highlights
Draft CCG Annual Report, Governance Statement and Accounts – April to June 2022/23	Risk Management
	Scheme of Delegation and Reservation
Internal Audit – 360 Assurance	
Counter Fraud Plan 2022/23, Progress Report and Annual Risk Assessment	Head of Internal Audit Opinion (CCG – April to June 2022)
Draft 2023-26 Internal Audit Strategic Plan	Interim Head of Internal Audit Opinion Stage 2
Governance and Risk Management Report	Internal Audit Plan 2022/23 and 2023/24
HFMA Financial Sustainability Action Plan	Internal Audit Recommendations Report and Tracker
External Audit – KPMG	
External Audit Plans and Progress Report	Update on Month 3 Accounts

Table 22 – Significant items discussed and approved by the Audit and Governance Committee during Quarter 2 to Quarter 4 of 2022/23

The Committee met nine times during Q2 to Q4 of 2022/23 and also met once confidentially. 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 regards 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. The composition of the Remuneration Committee is shown in Table 23 below.

Remuneration Committee Member	Position
Margaret Gildea	Chair – Non-Executive Member (People and Culture)
Julian Corner	Non-Executive Member (Population Health and Strategic Commissioning and Public Partnership)
Dr Bukhtawar Dhadda	Non-Executive Member (Quality and Performance) (up to the 31st January 2023)
Richard Wright	Non-Executive Member (Finance and Estates)

Table 23 – members of the ICB's Remuneration Committee during Quarter 2 to Quarter 4 of 2022/23

Significant items that were discussed and approved during Q2 to Q4 of 2022/23 are shown in Table 24 below.

Significant items approved/discussed by Remuneration Committee during Quarter 2 to Quarter 4 of 2022/23	
Executive Director Appointments and Remuneration	Notice of Redundancy
Functional Director Pay Progression	Review of Clinical Remuneration
ICB Board – Clinical (Other) Member Role	Very Senior Manager Pay Increase and Salary Review

Table 24 – Significant items discussed and approved by the Remuneration Committee during Quarter 2 to Quarter 4 of 2022/23

The Committee met three times during Q2 to Q4 of 2022/23 and all meetings were fully quorate. The quorum necessary for the transaction of business is a minimum of two Non-Executive Members.

System Quality Group

The System Quality Group provides quality oversight in relation to public health outcomes and the wider determinants of health; and takes appropriate action as required to reduce health inequalities. The committee focuses on quality across pathways by receiving information against key performance trajectories and identifies quality issues, ensuring they are acted upon. The composition of the System Quality Group is shown in Table 25 below.

System Quality Group	Position
Brigid Stacey	Chair – Executive Director of Nursing and Quality and Deputy Chief Executive Officer, ICB
Krishna Kallianpur	Chief Nurse, CRHFT
Carolyn Green	Executive Director of Nursing, DHcFT (up to the 30th November 2022)
Tumi Banda	Executive Director of Nursing, DHcFT (from the 1st December 2022)
Garry Marsh	Chief Nurse, UHDBFT
Michelle Bateman	Chief Nurse Officer, DCHSFT
Jenny Tilson	Director Of Nursing Quality, DHU
Nichola Bramhall	Executive Director of Quality Improvement and Patient Safety, EMAS
Dr Chris Weiner	Executive Medical Director, ICB
Dr Ben Pearson	Medical Director, DCHSFT
Dr James Crampton	Interim Executive Medical Director, UHDBFT
Dr Arun Chidambaram	Medical Director, DHCFT
Kevin Sargen	Executive Medical Director, CRHFT
Dr Aqib Bhatti	Medical Director, DHU
Dr Leon Roberts	Executive Medical Director, EMAS (up to the 31st December 2022)
Dr Nicole Atkinson	Executive Medical Director, EMAS (from the 1st January 2023)
James Moore	Chief Executive Officer, Healthwatch Derby
Helen Henderson	Chief Executive Officer, Healthwatch Derbyshire
Robyn Dewis	Director of Public Health, Derby City Council
Ellie Houlston	Director of Public Health, Derbyshire County Council
Caroline Bell	Interim Inspection Manager, CQC
Sarah Dunnett	Interim Head of Inspection, CQC
Rosslyn Young	NHS England Representative
Phil Sugden	Patient Safety Specialist
Dr Andrew Mott	GP Provider Board Representative
Lucy Smith	Allied Health Professions Council Chair
Anne Pridgeon	Maternity Quality Surveillance Group Chair

Table 25 – members of the System Quality Group during Quarter 2 to Quarter 4 of 2022/23

Significant items that were discussed and approved by the System Quality Group during Q2 to Q4 of 2022/23 are shown in Table 26 below.

Significant items approved/discussed by System Quality Group during Quarter 2 to Quarter 4 of 2022/23	
Board Assurance Framework 2022/23	LeDeR Annual Report
Child Death Overview Panel Annual Report 2021/22	Liberty Protection Safeguards
Healthcare Acquired Infections	Maternity Quality and Safety Forum
Covid-19, Flu and nMAB reporting	Nursing and Quality Policies
Clinical Quality Reference Group Terms of Reference	Ockenden Submission – Continuity of Carer
Draft CRHFT Desk Top Quality Review	Patient stories
Drugs Strategy – City and County Local Authority	Quality Accounts
Flu Vaccination Uptake	Quality and Safety Forum
Fragile Services Tracker NHSE July 2022	Restraint and Sexual Safety Amongst Transport Service Failings
General Practice	Risk Register
Health Education England	Vaccination Trends and Outcomes
Independent Review of Children's Social Care	Waiting Lists Review: Patient Waits in Speech and Language Therapy (Children) and Community Podiatry
Independent Thematic Review of Maternity Services in UHDB	
Industrial Action	

Table 26 – Significant items discussed and approved by the System Quality Group during Quarter 2 to Quarter 4 of 2022/23

The Committee met nine times during Q2 to Q4 of 2022/23 and meetings were fully quorate except the meetings on the 5th July, 6th September, 4th October and 1st November 2022, 3rd January and 7th March 2023. The quorum necessary for the transaction of business is one representative from each organisation, and must include two clinical representatives.

Finance and Estates Committee

The purpose of the Finance and Estates 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 composition of the Finance Committee is detailed in Table 27 below:

Finance and Estates Committee Member	Position
Core NHS Members	
Richard Wright	Chair – Non-Executive Member (Finance and Estates)
Sue Sunderland	Non-Executive Member (Audit and Governance)
Keith Griffiths	Executive Director of Finance, ICB
Darran Green	Acting Operational Director of Finance, ICB
Zara Jones	Executive Director of Strategy and Planning, ICB
Stephen Jarratt	Non-Executive Director, UHDBFT
Ian Lichfield	Non-Executive Director, DCHSFT (from the 1st January 2023)
Stuart Proud	Non-Executive Director, DCHSFT
Steve Heppinstall	Executive Director of Finance, CRHFT
Simon Crowther	Executive Director of Finance and Performance, UHDBFT
Catherine Benfield	Interim Chief Finance Officer, DCHSFT (up to the 28th February 2023)
Peter Handford	Chief Finance Officer, DCHSFT (from the 1st March 2023)
Berenice Groves	Chief Operating Officer, CRHFT (up to the 31st December 2022)
Zoe Notley	Interim Chief Operating Officer, CRHFT (from the 1st January to 28th February 2023)
Michelle Veitch	Chief Operating Officer, CRHFT (from the 1st March 2023)
Ade Odunlade	Chief Operating Officer, DHcFT
Mike Naylor	Director of Finance, EMAS
Transition Members	
Simon Crowther	System Estates Lead
James Austin	Chief Digital Information Officer, ICB/DCHSFT
Maria Riley	Director of Transformation and PMO, JUCD

Table 27 – members of the Finance and Estates Committee during Quarter 2 to Quarter 4 of 2022/23

Significant items that were discussed and approved by the Finance and Estates Committee during Q2 to Q4 of 2022/23 are shown in Table 28 below.

Significant items approved/discussed by Finance and Estates Committee during Quarter 2 to Quarter 4 of 2022/23	
5 Year Plan	Losses and Special Payments Policy
Board Assurance Framework	Monthly System Financial Position Reviews
Business Cases	Options to Breakeven
Estates Strategy	Planning Priorities and Timetable
Financial Allocations, Planning and Sustainability	Productivity and Efficiency
Future Revenue Expenditure	Programme Delivery Boards
ICS Transformation Programme	Risk Management
JUCD Digital and Data Strategy	

Table 28 – Significant items discussed and approved by the Finance and Estates Committee during Quarter 2 to Quarter 4 of 2022/23

The Committee met nine times during Q2 to Q4 of 2022/23 and all meetings were fully quorate. The quorum necessary for the transaction of business is two Non-Executive Members and Non-Executive Directors, three Executive Directors, of which one should be a System Executive Director of Finance or their nominated deputy.

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 composition of the People and Culture Committee is detailed in Table 29 below:

People and Culture Member	Position
Margaret Gildea	Chair – Non-Executive Member (People and Culture)
Dr Bukhtawar Dhadda	Non-Executive Member (Quality and Performance) (up to the 31st January 2023)
Amanda Rawlings	Chief People Officer, ICB and UHDBFT
Kaye Burnett	Non-Executive Member, DCHSFT (up to the 31st December 2022)
Janet Dawson	Non-Executive Member, DCHSFT (from the 1st January 2023)
Ralph Knibbs	Non-Executive Member, DHcFT
Joy Street	Non-Executive Member, UHDBFT
Jeremy Wight	Non-Executive Member, CRHFT
Darren Tidmarsh	Chief People Officer, DCHSFT
Ifti Majid	Chief Executive Officer, DHcFT (up to the 30th November 2022)
Carolyn Green	Interim Chief Executive Officer, DHcFT (from the 1st December 2022)
Jaki Lowe	Director of People and Inclusion, DHcFT
Kerry Gulliver	Director of HR and Organisational Development, EMAS
Linda Garnett	Programme Director, People Services Collaborative
Penelope Blackwell	Chair of Integrated Place Executive
Emma Crapper	HR Director, Derbyshire County Council
Liz Moore	Head of HR, Derby City Council
Vijay Sharma	Non-Executive Director, EMAS
Susie Bayley	Medical Director, General Practice Taskforce Derbyshire
Zahra Leggatt	Derbyshire Health United 111 (East Midlands) Community Interest Company representation

Table 29 – members of the People and Culture Committee during Quarter 2 to Quarter 4 of 2022/23

Significant items that were discussed and approved by the People and Culture Committee during Q2 to Q4 of 2022/23 are shown in Table 30 below.

Significant items approved/discussed by People and Culture Committee during Quarter 2 to Quarter 4 of 2022/23	
Agency Spend	Retention Work Programme
Board Assurance Framework	Winter Preparedness
Industrial Action	Workforce Advisory Group
One Workforce Strategy	Workforce Plan
People Services Collaborative 7x5 Work Programme	Workforce Oversight
Project Derbyshire – Digital Work Programme	Workforce Priorities in Local Authorities / Social Care

Table 30 – Significant items discussed and approved by the People and Culture Committee during Quarter 2 to Quarter 4 of 2022/23

The Committee met three times during Q2 to Q4 of 2022/23 and all meetings were fully quorate. The quorum necessary for the transaction of business is 50% of members.

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 the ICS 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 composition of the Population Health and Strategic Commissioning Committee is shown in Table 31 below.

Population Health and Strategic Commissioning Committee	Position
Julian Corner	Chair – Non-Executive Member (Population Health and Strategic Commissioning and Public Partnership)
Dr Bukhtawar Dhadda	Non-Executive Member (Quality and Performance) (up to the 31st January 2023)
Sue Sunderland	Non-Executive Member (Audit and Governance)
Margaret Gildea	Non-Executive Member (People and Culture)
Richard Wright	Non-Executive Member (Finance and Estates)
Dr Penny Blackwell	Representative for Provider Collaborative at Place
Dr Avi Bhatia	Representative for Clinical and Professional Leadership Group
Dr Emma Pizzey	GP Clinical Lead
Dr Suneeta Teckchandani	Secondary Care Doctor
Dominic Fackler	Allied Health Professional Representative
Robyn Dewis	Director of Public Health, Derby City Council
Ifti Majid	Representative for Provider Collaborative at Scale, DHcFT (up to the 30th November 2022)
Carolyn Green	Representative for Provider Collaborative at Scale, DHcFT (from the 1st December 2022)
Zara Jones	Executive Director of Strategy and Planning, ICB
Brigid Stacey	Executive Director of Nursing and Quality and Deputy Chief Executive Officer, ICB
Dr Chris Weiner	Executive Medical Director, ICB
Keith Griffiths	Executive Director of Finance, ICB
Clive Newman	Director of GP Development, ICB
Steve Hulme	Director of Medicines Management and Clinical Policies, ICB
Amanda Rawlings	Chief People Officer, JUCD

Table 31 – members of the ICB's Population Health and Strategic Commissioning Committee during Quarter 2 to Quarter 4 of 2022/23

Significant items that were discussed and approved by the Population Health and Strategic Commissioning Committee during Q2 to Q4 of 2022/23 are shown in Table 32 below.

Significant items approved/discussed by Population Health and Strategic Commissioning Committee 2022/23	
Board Assurance Framework	Managing our commissioning resources and prioritisation
Business Cases	Mental Health Crisis Alternatives
Clinical Governance Model	MSK Triage and Therapies
Clinical Navigation Hub	Non-Scalpel Vasectomies
Clinical Policy Advisory Group	Ophthalmology
Contract Extensions	Primary Care Sub-Committee
Delegation of Tender Outcome Ratification and Contract Award Approvals	Procurements
Derby Safe Haven	Regional NHS111 Contract
Derbyshire Hard of Hearing Service	Risk Management
Discharge to Assess	Strategic Priorities
Employment Advisors in Improving Access to Psychological Therapies	The Fuller Stocktake Report
Health Inequalities Strategy	The Health and Social Care Committee Report on The Future of General Practice
Independent Community Advocacy Service	Urgent and Emergency Care Priorities
Integrated Care Commissioning	VCSE Contracts
Lived Experience Engagement Service	Winter Pressures

Table 32 – Significant items discussed and approved by the Population Health and Strategic Commissioning Committee during Quarter 2 to Quarter 4 of 2022/23

The Committee met eight times during Q2 to Q4 of 2022/23 and all meetings were fully quorate. The quorum necessary for the transaction of business is five members, to include two Non-Executive Members, one Executive Director and four other members, including two clinical.

Public Partnership Committee

The purpose of the Public Partnership Committee is to monitor the development and delivery of the JUCD Engagement Strategy, and 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 composition of the Public Partnership Committee is detailed in Table 33 below:

Public Partnership Committee Member	Position
Voting Members	
Julian Corner	Chair – Non-Executive Member (Population Health and Strategic Commissioning and Public Partnership)
Sue Sunderland	Non-Executive Member (Audit and Governance)
Steven Bramley	Lay Representative
Tim Peacock	Lay Representative
Jocelyn Street	Lay Representative
Margaret Rotchell	Lead Governor, CRHFT (up to the 31st December 2022)
Carol Warren	Lead Governor, CRHFT (from the 1st January 2023)
Maura Teager	Lead Governor, UHDBFT
Lynn Walshaw	Deputy Lead Governor, DCHSFT
Christopher Mitchell	Public Governor, DHcFT
Kim Harper	Chief Officer, Community Action Derby
Non-Voting Members	
Beth Fletcher	Strategy and Engagement Manager, Healthwatch Derby (up to the 30th September 2022)
Michelle Butler	Strategy and Engagement Manager, Healthwatch Derby (from the 1st October 2022)
Harriet Nicol	Engagement & Involvement Manager, Healthwatch Derbyshire (up to the 28th February 2023)
Helen Henderson	Chief Executive Officer, Healthwatch Derbyshire (from the 1st March 2023)
Helen Dillistone	Executive Director of Corporate Affairs, ICB
Sean Thornton	Deputy Director Communications and Engagement, ICB/JUCD
Karen Lloyd	Head of Engagement, ICB/JUCD

Table 33 – members of the Public Partnership Committee during Quarter 2 to Quarter 4 of 2022/23

Significant items that were discussed and approved by the Public Partnership Committee during Q2 to Q4 of 2022/23 are shown in Table 34 below.

Significant items approved/discussed by Public Partnership Committee during Quarter 2 to Quarter 4 of 2022/23	
Board Assurance Framework	Insight Framework
Discussion around the development, role and purpose of the committee	Integrated Care Strategy Engagement
Eating Disorders Procurement	Learning Disability Short Breaks
End-of-Life Strategy	Patient and Public Involvement Assessment Log
Equality Delivery System	Primary Care Legal Duties
Glossop Services Engagement Approach	Risk Management
Governance Guide Testing	Terms of Reference for sign off
GP Access Deep Dive	

Table 34 – Significant items discussed and approved by the Public Partnership Committee during Quarter 2 to Quarter 4 of 2022/23

The Committee met seven times during Q2 to Q4 of 2022/23 and all meetings were fully quorate. The quorum necessary for the transaction of business is two Non-Executive Members, 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 composition of the Quality and Performance Committee is detailed in Table 35 below:

Quality and Performance Committee Member	Position
Dr Bukhtawar Dhadda	Chair – Non-Executive Member (Quality and Performance) (up to the 31st January 2023)
Margaret Gildea	Non-Executive Member (People and Culture) (Chair from 1st February 2023)
Richard Wright	Non-Executive Member (Finance and Estates)
Brigid Stacey	Executive Director of Nursing and Quality and Deputy Chief Executive Officer, ICB
Dr Chris Weiner	Executive Medical Director
Zara Jones	Executive Director of Strategy and Planning
Christine Fearns	Non-Executive Director, UHDBFT
Jayne Stringfellow	Non-Executive Director, CRHFT
Sheila Newport	Non-Executive Director, DHcFT (up to the 8th January 2023)
Lynn Andrews	Non-Executive Director, DHcFT (from the 9th January 2023)
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 35 – members of the Quality and Performance Committee during Quarter 2 to Quarter 4 of 2022/23

Significant items that were discussed and approved by the Quality and Performance Committee during Q2 to Q4 of 2022/23 are shown in Table 36 below.

Significant items approved/discussed by Quality and Performance Committee during Quarter 2 to Quarter 4 of 2022/23	
Board Assurance Framework	Maternity
Cancer	Mental Health, Learning Disability and Autism Inpatient Services
Critical Services	Planned Care
Discharge and Outflow	Risk Management
Escalation Policy	Risk Stratification and Harm Review

Significant items approved/discussed by Quality and Performance Committee during Quarter 2 to Quarter 4 of 2022/23	
Healthcare Safety Investigation Branch	System Oversight Framework
Industrial Action	System Quality Group Assurance
Integrated Performance Report	Winter Plan
Kirkup Report	

Table 36 – Significant items discussed and approved by the Quality and Performance Committee during Quarter 2 to Quarter 4 of 2022/23

The Committee met nine times during Q2 to Q4 of 2022/23 and meetings were fully quorate. except the meetings on the 28th July, 27th October, 24th November 2022, 23rd February and 20th March 2023. The quorum necessary for the transaction of business is two Non-Executive Members, plus at least the Executive Director of Nursing and Quality, or Medical Director from the ICB, one provider representative and one Local Authority representative.

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 2023.

For the financial year ended the 31st March 2023, 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 Executive Director. 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 be developed during Q2 to Q4 of 2022/23 in line with internal audit recommendations. 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 Corporate Risk Register.

The Risk Management Policy was reviewed and approved by the Audit and Governance Committee in February 2023, and 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 the system and with system 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. The organisation's strategic aims and objectives have been reviewed by the ICB Board during the year.

The ICB Board has agreed to the following risk appetite statement:

NHS Derby and Derbyshire ICB Board Risk Appetite Statement

The Board of the ICB recognises that long-term sustainability and the ability to improve quality and health outcomes for our population, depends on the achievement of our strategic objectives and that this will involve a willingness to take and accept risks. It may also involve taking risks with our strategic partners in order to ensure successful integration and better health services for the people of Derby and Derbyshire.

The ICB will strive to adopt a mature approach to risk-taking where the long-term benefits could outweigh any short-term losses, particularly when working with strategic partners across the Derby and Derbyshire system. Such risks will be considered in the context of the current environment in line with the ICB's risk tolerance and where assurance is provided that appropriate controls are in place and these are robust and defensible.

The ICB will seek to minimise risks that could impact negatively on the health outcomes and safety of patients or in meeting the legal requirements and statutory obligations of the ICB. We will also seek to minimise any undue risk of adverse publicity, risk of damage to the ICB's reputation and any risks that may impact on our ability to demonstrate high standards of probity and accountability.

In view of the changing landscape, the ICB's risk appetite will not necessarily remain static. The ICB Board will have the freedom to vary the amount of risk it is prepared to take, depending on the circumstances at the time. It is expected that the levels of risk the ICB is willing to accept are subject to regular review.

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. In summary, the risk management system sets out:

- the context within which risk is to be managed is properly identified and understood. In this instance, the context is the entire range of activities carried out within the ICB, including all activities associated with commissioning patient care and treatment;
- how risks are identified;
- how risks are assessed in terms of their likelihood, or probability, and potential consequences or severity of impact, should they materialise;
- a clear and shared understanding of the ICB's 'appetite' for risk enables agreement on which risks can be accepted (tolerated) and which require management through action plans, so that they are either eliminated, transferred or properly controlled;
- assurance that there is proper communication and consultation with relevant stakeholders about all aspects of risk management; and
- that all aspects of the risk management system are regularly monitored and reviewed to ensure the system is working effectively.

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 and Estates; People and Culture; Population Health and Strategic Commissioning; and Quality and Performance. Other ICB Board members include our Partner members from Trusts, Local Authority 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, Patient Participation Groups, 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 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 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.

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 Emergency Preparedness, Resilience and Response.

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.
Executive Director of Corporate Affairs	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 relevant lead committees during Q2 to Q4 of 2022/23. The ICB Board approved the 2022/23 Board Assurance Framework on the 16th March 2023. 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 Executives of the ICB Board with executive leadership being vested in the Executive Director of Finance and Executive Director of Corporate Affairs. 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 and refinement during Q2 to Q4 of 2022/23, taking into account comments from members, resulting in processes and documents which are easy to read and readily accessible.

The ICB's Executive Director of Corporate Affairs 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 possible 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 risks identified during 2022/23

In context, the most significant risks we faced during Q2 to Q4 of 2022/23 were:

- acute providers may breach thresholds in respect of A&E operational standards of 95% to be seen, treated, admitted or discharged within four hours, resulting in the failure to meet the ICB constitutional standards and quality statutory duties;
- the sustainability of the individual General Practices across Derby and Derbyshire and the failure of individual General Practices to deliver quality Primary Medical Care services resulting in negative impact on patient care;
- the Derbyshire health system is unable to manage demand, reduce costs and deliver sufficient savings to enable the ICB to move to a sustainable financial position;
- a risk to patients on waiting lists as a result of their delays to treatment as a direct result of the Covid-19 pandemic;
- the ICB may not have sufficient resource and capacity to service the functions to be delegated by NHSE;
- failure to deliver a timely response to patients due to excessive handover delays and transfer of patients to the appropriate care setting from Acute Hospitals. Risk of leading to significant response times for patients whilst waiting in the community for an ambulance response, resulting in potential significant levels of harm;
- 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 City 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.

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, evaluate the likelihood of those risks being realised and the impact should they be realised, and enables them to be managed efficiently, effectively and economically. The system of internal control also allows risk 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 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; victimisation; to advance equality of opportunity; and foster 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 EIAs 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 and Estates 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 for Audit and Governance 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 CCG 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, decision-makers and General Practice staff with ICB involvement; all of which can be found here[xxxiii].

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 when they arise and details of those declared within 2022/23 can also be found at the web link above.

With the dissolution of CCGs, the online training module for staff on Conflicts of Interest was retired by NHSE on the 23rd December 2022. This decision was made following engagement with designate ICB Chairs, who agreed that the NHSE Conflicts of Interest guidance would not be replicated for ICBs. The ICB will continue to have a Managing Conflicts of Interest Policy in place and expect ICB employees to adhere to this.

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. The ICB's Non-Executive Member (People and Culture) 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 two members of staff who are Freedom to Speak Up Ambassadors. The 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 Q2 to Q4 of 2022/23 the ICB has had four 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. It underpins the risk management systems and helps to protect the reputation of the ICB and senior management.

Data Quality

Data quality is crucial, and the availability of complete, relevant, accurate and 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 (DSPT).

To provide the management of information necessary to manage commissioned activities, we commission our Business Intelligence Information Services from the NECS. ICB leads have worked with the team at NECS 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 and Estates Committee, and Quality and Performance Committee.

Information Governance

In order to provide assurance publicly that the ICB understands and complies with national requirements around confidentiality, integrity, and availability for data sources held by the ICB, each year the ICB completes a Data Security and Protection Toolkit (DSPT). The annual DSPT audit will be carried out by 360 Assurance during April and May 2023. The outcome of this audit will be reported to the Audit and Governance Committee.

The ICB submitted their baseline toolkit assessment on the 28th February 2023. This is an interim assessment to indicate that the ICB's self-assessment is under way and highlights the areas which need particular focus ahead of the full assessment deadline on the 30th June 2023. For 2022/23, the ICB is on track for achieving a 'standards met' position.

Part of the requirements of the DSPT is to have a public facing clear description of the data we hold, and how access to that data is controlled. Further detail about this for the ICB can be found at https://joinedupcarederbyshire.co.uk/privacy-notice/.

The Information Governance Assurance Forum is responsible for the governance and oversight of Information Governance activities. This forum is chaired by the Senior Information Risk Owner, and attended by the Caldicott Guardian and Data Protection Officer, reporting 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 DSPT compliance activities and policies, access to information, cyber security updates, Information Governance incidents, training, and staff communications.

The forum has met five times during 2022/23, with an extraordinary meeting planned for final assurance prior to the final DSPT assessment submission. From the Information Governance Assurance Forum's minutes and papers, there is evidence of challenge, appropriate reporting and action being taken where required. Assurance has been 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 (Stage 2).

Information Governance policies have been reviewed in-year, and the understanding of our staff has been tested through an Information Governance awareness questionnaire which provided an overall positive picture, but also highlighted the areas requiring more staff engagement.

The ICB has not had any incidents which have necessitated reporting to the Information Commissioner's Office. 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 37 shows the range of services which are provided by third party providers.

Service	Provider	Assurances
Prescribing Payment Processing	NHS Shared Business Services	Service Auditor Report
Dental Payment Processing	NHS Shared Business Services	Service Auditor Report
Finance and Accounting Services	NHS Shared Business Services	Service Auditor Report
HR and Payroll Management	Electronic Staff Record	Service Auditor Report
General Practice Payment Services	NHS Digital	Service Auditor Report
Primary Care Support	Capita	Service Auditor Report
Internal Audit	360 Assurance	Head of Internal Audit Opinion
External Audit	KPMG	Annual Audit Letter

Table 37 – 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 following control issues were identified:

Quality and Performance – Mental Health and Dementia

Perinatal Access

The access rate for September was at 4.4% against a target of 10.0%, therefore a Perinatal Community recovery oversight group was formed to monitor progress against Quality Improvement plans in the Recovery Action Plan (RAP) on a monthly basis. A second service-wide group, which includes clinical Community Perinatal staff, discuss progress and planned internal service plans and action from the oversight group every six weeks. Recruitment of psychologists into the Maternal Mental Health Service is complete, and additional psychology recruitment continues for the Perinatal Community Service.

Additional SystmOne service-wide training on the consistent recording of assessments has been undertaken, and identified a more consistent way of recording referrals. Additional staff groups have been added to those who will do assessments including occupational therapists and social workers. An additional Assistant Psychologist will also commence assessments under supervision. An exercise to ascertain referrals by GPs has been undertaken showing the need for wider engagement with referrers across Derbyshire and plans for awareness raising of the service are being formulated.

Severe Mental Health and Physical Health

A total of 52.6% of patients with severe mental illness had received physical health checks by the end of Q4 2022/3 (an increase of 17% since 2021). NHSE undertook a system maturity assessment in April 2023, the results of which will be out in June 2023. A key pilot embedding collaborative working between Secondary and Primary Care is underway and outcomes will be reported in August 2023. The number of vaccines uptakes for this cohort was achieving 81.88% as at end of February 2023.

Out-of-Area Placements

In March 2023 the rolling 3 months position was 1,740 inappropriate out of area placement bed days. The position at the 31st March 2023 was contained with 105% bed occupancy rates.

Improving Access to Psychological Therapies

In January 2023, 83% of patients were seen within six weeks against a target of 75%. Performance has improved significantly over the last three months with Trent Psychological Therapies Service seeing 91% within six weeks in January. We continue to monitor performance monthly across all providers.

Children and Young People's Eating Disorders

For Q4, 77.7% of urgent children and young people patients were seen within one week and 83.5% of routine patients were seen within four weeks. The Children and Young People Eating Disorder Access RAP monitors progress against actions and activity trajectory, and risks to delivery. Progress is monitored at the Mental Health, Learning Disabilities and Autism Delivery Board.

Significant additional funding was provided for a comprehensive service for people with a primary eating disorder in Derby City and the High Peak during 2021/22, and in 2022/23 it is anticipated that the service will increase to a similar extent as the improved access is rolled out to other areas of Derbyshire.

Development of a Derbyshire-wide written agreement between providers in Community Eating Disorders Service, Secondary Care, and Primary Care is ongoing to ensure a consistent approach to medical monitoring for children and young people with eating disorders, which will include the:

- expansion of services to seven days-a-week, across extended hours;
- providing paediatric inpatient support and specialist play therapy for emergency departments; and
- East Midlands CAMHS Provider Collaborative to ensure pathway integration with specialist tier 4 inpatient services.

Transforming Care

As at the 31st March 2023 there were 50 adult inpatients, 32 of whom were in ICB inpatient services and 18 in specialist commissioned beds. The trajectory for Q4 was a total of 30, therefore there were 16 patients over trajectory in ICB inpatients and four over trajectory in specialist commissioning inpatient settings. There were five children and young people in inpatient services, with a trajectory of 3.

Attention Deficit Hyperactivity Disorder and Autism Spectrum Disorder Assessments

We are reflective of the national situation with rapidly increasing prevalence/awareness continuing to drive excessive wait times and increasing demand in the neuro development pathway across all ages. Across Derbyshire, more than 4,500 children and young people are currently waiting for an assessment and in adults, for autism spectrum disorder, there are currently more than 1,600 people waiting. The attention deficit hyperactivity disorder waiting list is not available but is known to be significant. Average waits can be on average over a year. Autism spectrum disorder diagnosis at this scale is not funded in the Long-Term Plan, roadmap or Mental Health Investment Standard and so investment in the assessment transformation programme across the JUCD footprint has to come from non-recurrent sources.

Quality and Performance – Accident and Emergency

Accident and Emergency in Derbyshire failed to deliver against the national 95% four-hour standard, with performance for March 2023 at 67.7%. Under-performance for the ICB is attributed predominantly to under-performance at UHDBFT and CRHFT.

University Hospitals of Derby and Burton NHS Foundation Trust

The ED on the Derby Hospital site has failed to deliver against the four-hour national standard for 90 consecutive months, with type 1 performance for March 2023 at 60.7%. The ED site/network performance for March (including minor injury units and Derby Urgent Care Centre) was 38.5%, compared to 44.3% in March 2022 so this was a further deterioration.

12-hour Trolley Breaches

From April 2022 to the end of March 2023 there have been 6,287 12-hour trolley breaches, which is 6.5 times more than the same period last year (there were 971 for April to March 2022). These are predominantly due to medical bed availability, although a lack of mental health beds still accounts for breaches.

Chesterfield Royal Hospital NHS Foundation Trust

CRHFT has failed to deliver against the four-hour national standard for 19 consecutive months, with type 1 performance for March 2023 at 71.9%. A shortage of Packages of Care availability in the county has delayed discharges and therefore patient flow through the Trust.

12-hour Trolley Breaches

From April 2022 to the end of March 2023, there were 638 12-hour breaches at CRHFT, mainly due to limited availability of medical beds. There were 16 during April 2021 to March April 2022, so this is a significant rise.

Quality and Performance – Diagnostics

Derbyshire failed to deliver against the national 1.0% standard during March 2023 (28.9% with a YTD figure of 35.2%). Both UHDBFT and CRHFT have improved their overall diagnostic performance since November 2022. The system has submitted a trajectory to achieve 15% of patients waiting more than six weeks by the end of March 2024. All modalities are forecast to meet this apart from echocardiography.

Community Diagnostic Centre Programme

The Community Diagnostic Centre Programme successfully delivered its year one plan, which has contributed to the improved diagnostic waiting times position. The financial and activity plans for the Community Diagnostic Centres have been agreed for 2023/24 which will see the Walton Community Diagnostic Centre brought forward into this financial year. Over the course of the second year of the programme, all sites are forecasting to deliver 257,769 diagnostic tests collectively which will further support the elective recovery programme.

Endoscopy

Additional recruitment and expansion of weekend working has enabled UHDBFT to improve the six-week positions in all endoscopy modalities. Further work is required to ensure that the 15% end of year target can be reached but also to facilitate improvements in the cancer pathway. Insourcing options are being explored to help reduce the backlog

Echocardiography

Insourcing continues to provide additional capacity while teams attempt to recruit substantive staff into vacancies. Given the national shortage, organisations are also growing their own talent through training programmes. Echocardiography is one area where the ICS is not forecasting to meet the 15% target for patients waiting over six weeks. This is predominantly at CRHFT, where a focused piece of work is being undertaken to assess productivity opportunities.

Quality and Performance – Cancer

2-week-wait standard

There were 4,487, 2-week-wait e-referrals during March 2023, a 13% increase compared to February 2023. The top tumour sites by number of referrals were skin, breast, lower-gastrointestinal, urology and upper-gastrointestinal.

28-day faster diagnosis standard

The number of Derbyshire patients diagnosed within 28 days reduced slightly in March 2023 to 71.37% (UHDBFT 69.4% and CRHFT 77.43%). The UHDBFT performance is affected by a significant increase in referrals since 2019/20 which has now stabilised at 28.5% higher than pre-pandemic levels.

62-day Standard

Achievement of the 62-day urgent referral to first treatment standard continues to be non-compliant for Derbyshire but has shown slight improvement in March 2023, with achievement of 63.1% for Derbyshire (78.3% CRHFT and 60.3% UHDBFT).

Although both Trusts are challenged with this standard, once a patient is diagnosed the majority of patients are seen within 31 days of their diagnosis, with both Trusts achieving 88.8% during March 2023.

Key areas of focus for improvement include:

- ongoing work with Primary and Secondary Care to improve compliance with NG12 referral guidance. Referral optimisation work has commenced in lower-gastrointestinal, with a recent focus on working with Primary Care to increase the number of FIT tests completed with lower-gastrointestinal referrals. We are now focusing on developing a similar approach for gynaecology, urology and skin; and
- improving the 'faster diagnosis target' through implementation of best practice pathways, particularly in urology, lower-gastrointestinal and gynaecology, which are the tumour sites with the largest backlogs in JUCD.

Quality and Performance – referral to treatment/52-week wait

18-week referral to treatment

Incomplete pathways continue to be non-compliant for Derbyshire in March 2023 at 56.1% (YTD 58.5%), and both main providers in Derbyshire (UHDBFT and CRHFT) failing to meet the 92% standard (58.5% and 60.2% respectively). Those patients who have been prioritised at P2 or P3 are receiving their surgery in a more timely manner but there are still a large number of patients waiting over 52 weeks.

52+ week waits

The number of very long-waiting patients has been increasing but dropped to 6,785 at the end of March 2023 (there were 5,275 at the end of March 2022). Of these, 245 had been waiting 78–103 weeks and three had been waiting over 104 weeks. However, none of these were waiting at a provider within the Derbyshire system. Significant progress was made on the 78-week position over the last year but the delivery of zero by the end of March 2023 was hampered by industrial action and the appointment slot issue at UHDBFT. Both organizations have trajectories which are forecasting that they will deliver zero 65-week-waits by the end the March 2024, but there are a number of key deliverables which need to be achieved to facilitate this.

Recovery plans

JUCD forecasts to deliver the NHS ambition of having zero patients waiting more than 65 weeks by the end of March 2024. To facilitate this, JUCD continues to progress improvement projects in theatre productivity, outpatients, referral optimisation, 'getting it right first time' and looking at how independent sector capacity can be maximised particularly with the return on 'payment by results' in April 2023. Further work continues to promote the usage of advice and guidance on ERS and Consultant Connect. Plans continue for a ‘patient-initiated follow-up’ approach for suitable patients.

Quality and Performance – Ambulance Services

East Midlands Ambulance Service NHS Trust

For March 2023, EMAS was non-compliant for all six response time indicators, at an ICB-level and as a whole organisation 73.3% of EMAS ambulance pre handovers exceeded 15 minutes, with CRHFT running at 49.6% and UHDBFT at 76.7%.

The average pre-handover time for EMAS during March 2023 was 32 minutes and 44 seconds, compared to 41 minutes and 32 seconds in the previous year. During Q1 to Q3, an increase in pre-handover delays resulted in a deterioration in response times which affected performance. In order to facilitate an improvement in performance ICBs were asked to develop a number of pre-handover improvement trajectories. Whilst ICBs did not meet the handover trajectories, significant improvement was seen during Q4.

The recent strike action also contributed to a deterioration in performance during December 2022, with all ambulance services operating at resource escalation action plan level 4. Further industrial action took place during January and February, but due to the updated/revised contingency plans in place we did not see a further impact in performance.

Serious incidents for January 2023 to the end of March 2023 showed 12 recorded serious incidents. Most serious incidents were categorised as delayed responses or prolonged waits (seven prolonged waits, three sub-optimal care of a deteriorating patient, one delayed response and one treatment delay).

The Manchester Arena Inquiry Volume 2 was published in November 2022 and includes 149 recommendations. An EMAS action plan will be developed from these recommendations, and it is likely that these may lead to several impacts on EMAS.

Quality and Performance – Urgent and Emergency Care

The number of occupied beds by adult patients for 7+, 14+ and 21+ days across the ICB saw a step-change rise in January 2022, and they have remained high through the year. As at March 2023, the numbers were similar to the previous March, however there is weekly variation – with the numbers peaking in July 2022 and January 2023. The main cause of delayed discharge of medically optimised patients is access to social and community care capacity.

Quality and Performance – Maternity

Perinatal Mortality Review Tool

The stillbirth rate for CRHFT was 1.76/1,000 total births and the neonatal death rate was 0.35/1,000 which are both below the MBRRACE (2022) rates. Assurance was provided that CRHFT are not outliers for any of the data sets provided.

The stillbirth rate for UHDBFT has continued to increase and was 4.18/1,000 births in December, compared to the ONS (2022) rate of 4.2/1,000. The neonatal rate has stabilised at 1.98/1,000 births compared to the ONS (2022) rate of 2.7/1,000. They are both higher than the MBRRACE (2022) stillbirth rate of 3.33/1,000 and neonatal death rate of 1.53/1,000.

Both Trusts have patient safety review themes with actions which are reviewed monthly. Education is ongoing to improve recognition and escalation of MOH to improve outcomes. The obstetric bleeding strategy Cymru pathway is being adopted at CRHFT to address management of the emergency and implement the risk assessment process, with the aim of improving outcomes. UHDBFT are the focus of specific key programmes of work within the Trust.

National Compliance Exceptions

Ockenden One Year On

Action plans will be shared with the LMNS Board, with quarterly assurance meetings being held from February 2023. Both UHDBFT and CRHFT have seen improvements with compliance.

Clinical Negligence Scheme for Trusts Maternity Incentive Scheme Year 4

Full compliance was not achieved by either Trust. Further clarification of information has been sought from both Trusts. UHDBFT were compliant with seven safety actions and CRHFT were compliant with three of the 10 safety actions.

Saving Babies' Lives Version 2

Neither Trust is fully compliant with Saving Babies Lives Care Bundle version 2. Following the publication of the NHS single delivery plan, the Derbyshire LMNS have taken on the oversight and assurance role, previously conducted by NHSE.

Hospital Standardised Mortality Ratios

Hospital Standardised Mortality Ratios (HSMR) figures for UHDBFT increased in July 2022 to 108.7 (May 2022 was 104.11; June 2022 was 108.9). The top seven codes underneath the HSMR have been identified as requiring further investigation and action. More detailed assurance work is underway and a number of actions are in place to monitor monthly structured judgement review reporting compared to deaths recorded per business unit. From the 1st November 2022, all deaths that have occurred within a 48-hour ED length of stay will have a structured judgement review to identify if the prolonged ED stay has contributed to the cause of death.

The End-of-Life Improvement Group is also working to improve understanding around AMBER (Assessment, Management, Best practice, Engagement, Recovery uncertain) care bundle completion, and the 'continuously operating reference stations' system is having a learning disability death structured judgement review module added to it.

A more robust process to report on avoidable deaths has been developed and launched by triangulating coronial referrals with risk and structured judgement reviews.

Quality and Performance – Regulators (including patient safety)

The ICB has seen an increase in cases of Clostridioides difficile cases, which have breached trajectories for the year against target. Work continues on implementing the actions identified through a collaborative approach between providers, the ICB and NHSE. 'Deep dives' into the healthcare acquired infections have been undertaken, and no additional themes or trends have been identified.

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 and Estates 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 and Estates 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 38 shows the ICB's running costs during Q2 to Q4 of 2022/23.

	Allocation	Expenditure
	£'000	£'000
Q2 to Q4 2022/23	18,277	15,631

Table 38 – ICB's total running costs allocation and expenditure during Quarter 2 to Quarter 4 of 2022/23

Table 39 identifies how the ICB's running costs were used during Q2 to Q4 of 2022/23.

Breakdown of expenditure during Quarter 2 to Quarter 4 2022/23	
Expenditure	**£'000**
Pay costs	11,495
Travel expenses	11
Premises costs	669
Charges from Commissioning Support Unit	883
Other non-pay costs	2,929
Commissioning income	(356)

Table 39 – breakdown of running costs expenditure during Quarter 2 to Quarter 4 of 2022/23

ICB Annual Assessment

NHSE has a legal duty to annually assess the performance of the ICB in respect of each financial year and publish a summary of its findings. In undertaking this assessment, which historically has been carried out under the Improvement and Assessment Framework and more recently the NHS Oversight Framework, NHSE will consider for 2022/23 how successfully the ICB has:

- led the NHS within the ICS;
- contributed to each of the four fundamental purposes of the ICS;
- performed its statutory functions; and
- delivered on any guidance set out for it by NHSE or the Secretary of State for Health and Social Care regarding its functions.

The annual assessment will include an assessment of how well the ICB has performed under the required terms of the Act regarding their specific duties to:

- improve the quality of services;
- reduce inequality of access and outcome;
- take appropriate advice;
- facilitate, promote and use research;
- have regard to the effect of decisions (the "triple aim");
- consult patients and the public about decisions that affect them;
- the financial duties; and
- contribute to wider local strategies.

The outcome of the annual assessment will summarise areas where NHSE believe that the ICB has demonstrated good or outstanding practice, as well as areas of challenge. The 2022/23 ICB annual assessment process will be undertaken in the first quarter of 2023/24.

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 optimises the use of clinical leadership. All such arrangements are set out in the ICB's Scheme of Delegation. During the period reported, the ICB amended these delegations in order to improve the accountability of expenditure and support the achievement of financial sustainability. 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.

From 2023/24, the ICB will be responsible for the delegation of Primary Pharmacy Services, Optometry Services and Primary and Secondary Dental Services from NHSE to ICBs. This is 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 expectation is that by giving ICBs responsibility for a broader range of functions, they will be able to design services and pathways of care that better meet local priorities. ICBs will also have greater flexibility to integrated services across care pathways, ensuring continuity for patients and improved health outcomes for the local population. The services that will be delegated to ICBs are:

- Primary Pharmacy, Optometry and Primary and Secondary Dental Services on the 1st April 2023;
- complaints functions associated with Primary Pharmacy, Optometry and Primary and Secondary Dental Services on the 1st July 2023; and
- Specified Specialised Services (Acute and Pharmacy) April 2024.

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 Executive Director of Finance, and Audit and Governance Committee. The ICB's Chief Executive Officer and Executive Director of Finance 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 August 2022, the ICB's Fraud, Bribery and Corruption Policy was drafted by the ICB's Accredited Counter Fraud Specialist, approved by the Audit and Governance Committee, and made available to all staff. Counter fraud awareness has also taken place including the distribution of the publication 'Fraudulent Times'. 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 Q2 to Q4 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.

In providing my opinion three main areas are considered:

- *Board Assurance Framework;*
- *individual assignments;*
- *follow up of actions.*

I am providing an opinion of significant assurance for the Board Assurance Framework.

I am providing an opinion of significant assurance for the outturn of individual audit assignments.

I am providing an opinion of significant assurance for the follow up of actions, however, it should be noted by the Audit and Governance Committee that we have not received evidence for two medium risk actions in relation to the HFMA Financial Sustainability review which was nationally mandated. We will track these actions to completion in 2023/24."

During Q2 to Q4 of 2022/23, 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 core areas, as detailed below in Table 40:

Audit Assignment	Assurance Level/Comments
Governance and Risk Management	Significant
Transformation and Efficiency	Indicative opinion; limited
Financial Sustainability	Not applicable; no significant concerns raised
General Ledger and Financial Reporting	Indicative opinion; significant
Enhanced Services – Minor Surgery Claims	Not applicable
Committee Effectiveness Review	In progress

Table 40 – Internal Audit reports issued in Q2 to Q4 of 2022/23 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, System Quality Group, Finance and Estates 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 is 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 reported on a quarterly basis to each Audit and Governance Committee meeting.

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;
- NECS – 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 in Table 23 on page 130.

Pay ratio information

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director/member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director/member in the ICB in the reporting period 1st July 2022 to the 31st March 2023 was £197,500. The relationship to the remuneration of the organisation's workforce is disclosed in Table 41 below.

1st July 2022 to 31st March 2023	25th percentile	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	29,334	48,459	61,501
Salary component of total remuneration	27,596	44,682	55,711
Pay ratio information	7:1	4:1	4:1

Table 41 – relationship to the remuneration of the ICB's workforce as at 31st March 2023

During the reporting period 1st July 2022 to the 31st March 2023, nil employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £22,500 to £182,500 excluding the highest paid director/member.

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.

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.

Remuneration of Very Senior Managers (subject to audit)

Employment terms for a Very Senior Manager (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 Executive Director of Finance 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)

Table 42 shows the Senior Manager total salary during Q2 to Q4 of 2022/23.

Salaries and allowances during Quarter 2 to Quarter 4 of 2022/23

Name	Title	1st July 2022 to 31st March 2023					
		(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 to the nearest £1,000	(f) TOTAL (a to e) (bands of £5,000)
		£000	£	£000	£000	£000	£000
John MacDonald	ICB Chair	40-45	0	0	0	0-2.5	40-45
Dr Chris Clayton	Chief Executive Officer	145-150	500	0	0	60-62.5	210-215
Keith Griffiths	Executive Director of Finance	120-125	0	0	0	77.5-80	200-205
Brigid Stacey	Chief Nurse Officer	105-110	0	0	0	87.5-90	195-200
Dr Chris Weiner	Executive Medical Director	100-105	900	0	0	0-2.5	105-110
Amanda Rawlings	Chief People Officer	50-55	0	0	0	0-2.5	50-55
Helen Dillistone	Executive Director of Corporate Affairs	95-100	0	0	0	22.5-25	115-120
Zara Jones	Executive Director of Strategy and Planning	95-100	0	0	0	27.5-30	125-130
James Austin	Chief Digital Information Officer	0-5	0	0	0	0-2.5	0-5
Julian Corner	Non-Executive Member for Strategic Population Health & Commissioning, and Public Partnership	5-10	0	0	0	0-2.5	5-10
Dr Bukhtawar Dhadda	Clinical Non-Executive Member and Vice ICB Chair	15-20	0	0	0	0-2.5	15-20
Margaret Gildea	Non-Executive Member for People & Culture	5-10	0	0	0	0-2.5	5-10
Sue Sunderland	Non-Executive Member for Audit & Governance	5-10	0	0	0	0-2.5	5-10
Richard Wright	Non-Executive Member for Finance	5-10	0	0	0	0-2.5	5-10
Tracy Allen	Partner Member - Derbyshire Community Health Services NHS Foundation Trust	0-5	0	0	0	0-2.5	0-5

Name	Title	1st July 2022 to 31st March 2023					
		(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 to the nearest £1,000	(f) TOTAL (a to e) (bands of £5,000)
		£000	£	£000	£000	£000	£000
Carolyn Green	Partner Member - Derbyshire Healthcare NHS Foundation Trust	0-5	0	0	0	0-2.5	0-5
Ifti Majid	Partner Member - Derbyshire Healthcare NHS Foundation Trust	0-5	0	0	0	0-2.5	0-5
Ellie Houlston	Partner Member - Derbyshire Local Authority	0-5	0	0	0	0-2.5	0-5
Dean Wallace	Partner Member - Derbyshire Local Authority	0-5	0	0	0	0-2.5	0-5
Dr Andrew Mott	Partner Member - GP	15-20	0	0	0	0-2.5	15-20
Andrew Smith	Partner Member - Derby City Local Authority	0-5	0	0	0	0-2.5	0-5
Dr Avi Bhatia	Partner Member - Clinical and Professional Leadership Group	50-55	0	0	0	0-2.5	50-55

Table 42 – Senior Manager remuneration during Quarter 2 to Quarter 4 of 2022/23

Notes

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 45-50.
4. The total remuneration disclosed in the table above for Dr Avi Bhatia, Dr Andrew Mott and Dr Bukhtawar Dhadda includes clinical advisory services provided to the ICB unrelated to their roles as senior managers.
5. The Partner Member for Derbyshire Healthcare NHS Foundation Trust occupied the same post during the year. Ifti Majid ceased his role in November 2022, and Carolyn Green commenced in December 2022.
6. Taxable benefits disclosed in the above table include business miles and a salary sacrifice lease car.
7. James Austin commenced the role with the ICB in November 2022. James Austin is employed by Derbyshire Community Healthcare Services NHS Foundation Trust. As there is no formal agreement between the ICB and the Trust for the role carried out at the ICB, James Austin's remuneration has been wholly disclosed by the Trust in their remuneration report, and hence excluded from the table above.

Pension Benefits as at 31st March 2023

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 2023 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2023 (bands of £5,000)	Cash Equivalent Transfer Value at 1 July 2022	Real Increase/ (Decrease) in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2023	Employers Contribution to Stakeholder Pension
		£000	£000	£000	£000	£000	£000	£000	£000
Dr Chris Clayton	Chief Executive Officer	2.5-5	2.5-5	35-40	40-45	450	41	546	0
Keith Griffiths	Executive Director of Finance	2.5-5	5-7.5	80-85	190-195	1,575	98	1,777	0
Brigid Stacey	Chief Nurse Officer	2.5-5	7.5-8	55-60	145-150	1,020	91	1,194	0
Amanda Rawlings	Chief People Officer	0-2.5	0-2.5	35-40	60-65	713	(2)	730	0
Helen Dillistone	Executive Director of Corporate Affairs	0-2.5	0-2.5	35-40	60-65	580	20	642	0
Zara Jones	Executive Director of Strategy and Planning	0-2.5	0-2.5	35-40	55-60	427	14	477	0
James Austin	Chief Digital Information Officer	0-2.5	0-2.5	20-25	0-5	237	25	283	0

Table 43 – pension benefits as at 31st March 2023

Notes
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 2023.
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, 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's 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 and Burton NHS Foundation Trust respectively.

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 CETV

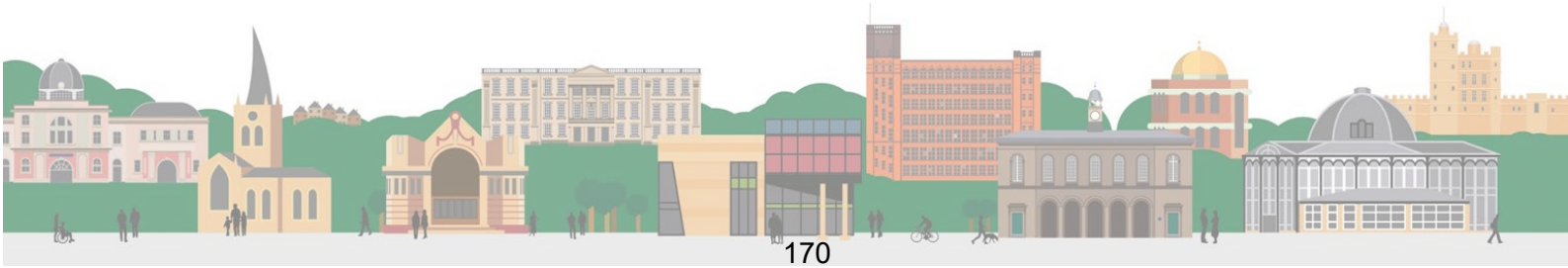
This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement or for loss of office

No such payments have been agreed or paid during the year.

Payments to past members (subject to audit)

No such payments have been proposed or paid during the year.



Staff Report

Number of Senior Managers and Staff Composition

Table 44 shows the gender and pay band of VSMs and gender of the other ICB Employees during Q2 to Q4 of 2022/23.

	Male	Female	Total
Executive Members (including Functional Directors)	8	12	20
Band 8d	4	4	8
Band 8c	6	18	24
Band 8b	10	33	43
Band 8a	18	72	90
Other banded ICB employees	33	318	351
Total ICB employees	**79**	**457**	**536**
Other non-permanent engagements including non-executive directors and lay members	18	24	42
Total	**97**	**481**	**578**

Table 44 – number of senior managers and staff composition during Quarter 2 to Quarter 4 of 2022/23

Staff numbers and costs (subject to audit)

The staff costs during Q2 to Q4 of 2022/23 are shown in Table 45.

Employee Benefits during Quarter 2 to Quarter 4 of 2022/23

Employee Benefits	Quarter 2 to Quarter 4 2022/23		
	Permanent Employees	Other	Total
	£000	£000	£000
Salaries and wages	16,061	810	16,871
Social security costs	1,841	-	1,841
Employer Contributions to NHS Pension scheme	2,996	-	2,996
Other pension costs	5	-	5
Apprenticeship Levy	74	-	74
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	-	-	27
Gross employee benefits expenditure	**20,977**	**810**	**21,787**
Less recoveries in respect of employee benefits	(89)	-	(89)
Total - Net admin employee benefits including capitalised costs	**20,888**	**810**	**21,698**
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	**20,888**	**810**	**21,698**

Table 45 – staff numbers and costs in Quarter 2 to Quarter 4 of 2022/23

Average number of people employed

Table 46 shows the average number of staff employed by the ICB, excluding non-executive members and lay members.

Quarter 2 to Quarter 4 2022/23		
Permanently employed	**Other**	**Total**
456	12	**468**

Table 46 – average number of people employed by the ICB in Quarter 2 to Quarter 4 of 2022/23

During Q2 to Q4 of 2022/23 the staff turnover for the ICB was 9.3%.

Sickness absence data

Table 47 shows the sickness absence data of staff permanently employed by the ICB, excluding non-executive members and lay members.

	Quarter 2 to Quarter 4 2022/23		
	Absence Days (FTE)	**Average FTE of Staff**	**Average Absence Days per FTE**
Total	**2,203**	456	**4.83**

Table 47 – average absence days of staff permanently employed by the ICB during the period

Supporting and Developing Our People

Our way of working

The former CCG recognised that during the Covid-19 pandemic, social distancing, self-isolation and remote working impacted differently on colleagues and adopted a health and wellbeing commitments *'Working differently. Our way'* that focused on each individual's wellbeing needs.

With the lifting of the Covid-19 restrictions, the ICB introduced a new hybrid operating model, enabling colleagues to have a balance of on-site working and remote working from home. In addition to providing flexibility for staff, the new hybrid operating model takes into account Covid-19 transmission rates and continues measures to ensure the health and safety of staff attending an ICB base.

Disability Confident

The ICB is committed to employing, supporting and promoting disabled people in our workplace. In 2019/20 we received certification for another three years as a 'Disability Confident' employer. This means that we:

- have undertaken and successfully completed the Disability Confident self-assessment;
- are taking all the core actions to be a Disability Confident employer; and
- are offering at least one activity to get the right people for our business and at least one activity to keep and develop our people.

The ICB's commitment to action is to help staff understand various types of disabilities, including those which are hidden or invisible and offer work experience opportunities, that allows for a meaningful experience for an individual.

We actively look to attract and recruit disabled people by providing a fully inclusive and accessible recruitment process, as outlined in the ICB's Recruitment and Selection Policy.

Our recruitment process is fair, transparent and free from bias and our vacancies are accessible and available to the widest population possible.

Once appointed, and throughout an employee's employment, where necessary the ICB's Occupational Health service will be consulted to advise on any reasonable adjustments which need to be made. This may include changes to working patterns, adaptations to premises or equipment and provision of support packages to ensure disabled workers are not disadvantaged when applying for and doing their jobs. We are also happy to work in partnership with outside support agencies, such as Access to Work, where necessary.

In November 2022, the ICB implemented 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.

We have 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 our employees to talk about mental ill health without fear of rejection or prejudice.

Mental Health First Aiders

As part of our commitment to support the mental health of our staff, the ICB has six trained Mental Health First Aiders working within the ICB. Mental Health First Aiders are trained by Mental Health First Aid England and act as a point of contact if an employee, or someone they are concerned about, is experiencing a mental health issue or emotional distress. They are not therapists or psychiatrists, but they can provide initial support and signpost to appropriate help if required.

Human Resources Policies

We are committed to ensuring equal opportunities in employment and have appropriate HR policies in place to ensure they are compliant with the relevant employment law as appropriate.

The ICB has reviewed a number of HR policies since its establishment and introduced the following new policies:

- Disability and Long-Term Conditions Policy; and
- Menopause Policy and Procedure.

The Menopause Policy and Procedure has been jointly developed by HR, healthcare professionals, staff representatives and menopausal colleagues for implementation within NHS organisations in Derbyshire.

The changing age of the UK's workforce means that between 75% and 80% of menopausal people are in work. The perimenopause/menopause can bring issues for individuals which can impact upon their work. It is to the benefit of us all that we, as employers work with staff to support them in these circumstances to find mutually beneficial arrangements, maximising staff retention and wellbeing.

This Menopause Policy and Procedure sets out the guidelines for members of staff and managers on providing the right support to individuals to help them manage symptoms at work. The ICB has introduced Freedom to Speak up Ambassadors to provide enhanced opportunities for colleagues to speak up on a variety of issues including, but not limited to the following:

- when things might go wrong or have gone wrong to ensure lessons are learnt;
- offering a suggestion for improvement;
- bullying, harassment or dignity at work concerns;
- making a complaint or taking out a grievance; and
- whistleblowing.

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 our 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.

Staff Network

As an ICB we aim to address health inequalities and provide an inclusive working environment where everyone is treated fairly with dignity and respect. We are committed to creating a more diverse and inclusive organisation, where difference is embraced and people feel able to bring their whole self to work.

We have a staff Diversity and Inclusion Network, which is an open forum run by staff and for staff to provide a safe and supportive environment in which to discuss issues relating to their protected characteristics to support equality and diversity by ensuring that the various protected characteristics have vision and impact. The Network recognises that people have a number of identities and can face challenges associated with their gender, ethnicity, disability, religion and age alongside their sexual orientation. The Network has been set up to welcome people from a diversity of backgrounds.

The Network is run by people from protected characteristics that are under-represented within the ICB and is supported by HR. The Network has a key role in making diversity and inclusion part of our DNA. Key initiatives have included:

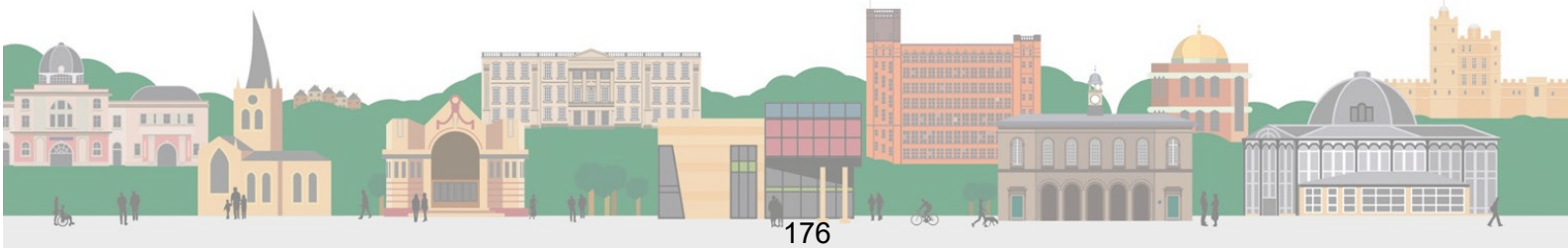
- celebrating and promoting key dates in the inclusion calendar;
- raising awareness of the lived experiences of under-represented staff; and
- informing the following standards:

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 Diversity and Inclusion Network and agreed to updated terms of reference for the Network that provide a clear purpose, line of accountability and clarification as to how the Network is to be integrated into the decision-making of the ICB. This includes the Diversity and Inclusion Network:

- reporting directly to the Senior Leadership Team;
- having representatives at the Senior Leadership Team with regards to decision-making, especially on issues which may impact diversity and inclusion; and
- receiving protected time to undertake their roles.

The SLT has also supported widening participation in reciprocal mentoring and having an SLT Inclusion Ambassador for each of the protected characteristics.



Staff Engagement

Our weekly 'Team Talks' have enabled the Chief Executive Officer and Executive Directors to share key messages and updates via Microsoft Teams and also provide staff with an opportunity to ask questions. We continue to engage with staff on issues that affect them at work and using the feedback to inform our 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 2022 NHS Staff Survey was open to all staff, and is the fourth year the ICB (and former CCG) participated in the survey. 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 to compare the experiences of staff in the ICB with the national picture.

This year, our response rate was 88%, which is higher than the comparative average of 78% for similar organisations. Figure 13 provides a summary of the results.

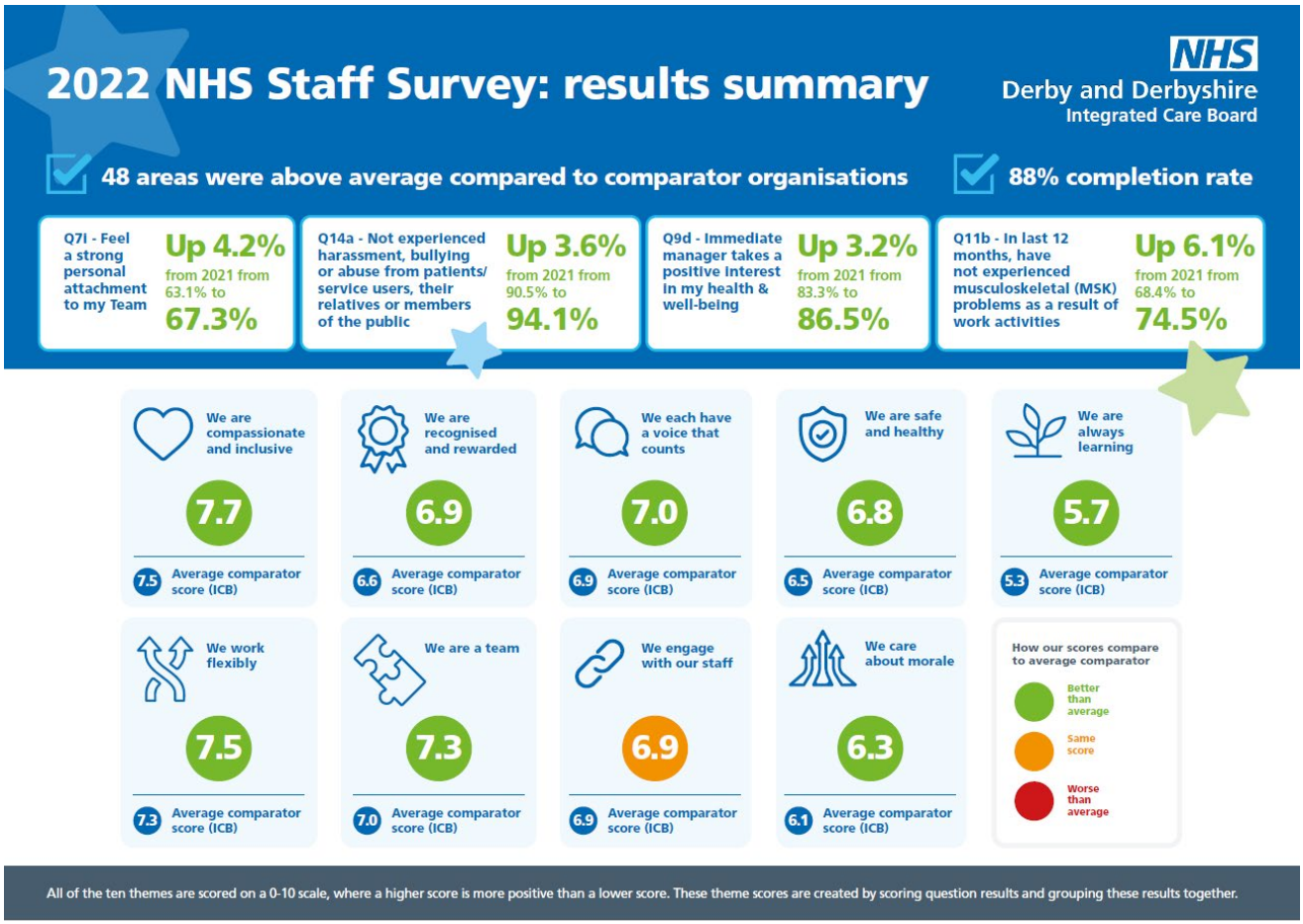


Figure 13 – 2022 NHS Derby and Derbyshire ICB Staff Survey Results

Organisation Effectiveness and Improvement Group

The Covid-19 pandemic restrictions and subsequent introduction of the new hybrid operating model has necessitated a change in how we engage with and involve our staff in shaping the work we deliver and the culture of the organisation. 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:

Staff Survey Action Plan	NHS Staff Survey Results analysis including development of ideas to make working for the ICB better for all.
Think Green	Introducing various initiatives to make it easier to 'go green', including development of a cycling friendly employer initiative for 2023, and raised awareness of the wider sustainability agenda in the NHS.
Hybrid Working Model	Proving feedback and making recommendations to continually improve the working environment.
Health and Wellbeing	Highlighting health issues and supporting wellbeing initiatives, including relaxation sessions, menopause awareness and social connectivity. The group has supported ICB fundraising initiatives.
Mental Health First Aiders	The ICB has six qualified employees.
Freedom to Speak up Ambassadors	The ICB has two employees who have undergone the National Ambassadors Office speak up training to become Freedom to Speak Up Ambassadors.

The ICB has a designated Health Improvement Adviser that works in the JUCD system whom has attended OEIG and Team Talk to disseminate key health and wellbeing information, offers and initiatives. These are also promoted by the HR team within the bi-monthly 'People Matter' bulletin and included:

- self-care packs to support staff, alongside sessions and information on topics such as bereavement, tinnitus, weight management, financial wellbeing, seasonal eating, pre-retirement, posture awareness, menopause, spaces for listening, scalp health and hair loss, positivity and mindfulness;
- access to free wellbeing support activities for both physical and mental health;
- cost of living support;
- promotion of annual events including World Suicide Prevention Day, Stress Awareness Day, Movember, Men's Health Awareness Month, Transgender Awareness Week, 16 days of action against domestic violence;
- access to our Employee Assistance Provider – Confidential Care;
- access to a range of health and wellbeing apps for example Unmind, Headspace, Balance+ app, Catch it app, Cove; and
- training on areas of health and wellbeing, for example REACTmh, Reflective Practice, StRaW and TRIM.

Staff Flu Immunisation

On the 21st July 2021, the Department for Health and Social Care and Public Health England communicated detail on the national flu immunisation programme 2022/23. The letter placed a requirement for the ICB to commission a service which made access easy to the vaccine for all frontline staff, encouraged staff to get vaccinated and monitored the delivery of their programmes. The ICB adopted the best practice guidance provided in the letter and implemented a flu vaccination plan for ICB staff, which was made available to all employees, including those eligible for a free flu jab under the NHS programme. Employees were able to access the flu jab via clinics run by Occupational Health at ICB premises, NHS partner locations and also by arranging their own flu jab at a private provider and claiming back the expense.

As at the 31st March 2023, 37.3% of all ICB staff confirmed that they had received the flu jab. Next year we will continue to promote the benefits of the flu vaccination to staff via the ICB weekly staff bulletin and Team Talk meetings, ensuring our Executive and Senior Leaders lead the messaging. We will also continue to offer staff 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. To assist us in fulfilling our statutory obligations, expertise and advice is provided to the ICB by a private professional company called Peninsula, 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 health and safety management system suite of procedures designed to ensure that we are compliant 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 does not have a Trade Union Official. The ICB is required to publish the following information on their website by the 31st July 2023.

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)	0

Table 48 – 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%	0%
1%-50%	0%
51%-99%	0%
100%	0%

Table 49 – 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	
Provide the total cost of facility time	0%
Provide the total pay bill	0%
Provide the percentage of the total pay bill spent on facility time	0%

Table 50 – 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	0

Table 51 – paid Trade Union activities

Expenditure on consultancy

The expenditure on consultancy for Q2 to Q4 of 2022/23 for the ICB was £40,669.

Off-payroll engagements

In line with HM Treasury guidance the ICB is required to disclose information about 'Off-payroll Engagements'. These are reviewed by the Finance and Estates Committee and Audit and Governance Committee.

The information relating to the ICB is provided in the following tables:

Length of all highly paid off-payroll engagements

Table 52 shows all off-payroll engagements as at the 31st March 2023 for more than £245 per day[1].

	Number
Number of existing engagements as of the 31st March 2023	1
Of which, the number that have existed:	
for less than one year at the time of reporting	1
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

Table 52 – length of off-payroll engagements for Quarter 2 to Quarter 4 2022/23

[1] The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

New off-payroll engagements

Table 53 shows all new off-payroll engagements or those that have exceeded a six-month period for more than £245 per day, during Q2 to Q4 of 2022/23:

	Number
Number of new engagements during Quarter 2 and Quarter 4 of 2022/23	3
Of which:	
Number not subject to off-payroll legislation	3
Number subject to off-payroll legislation and determined as in-scope of IR35[2]	0
Number subject to off-payroll legislation and determined as out of scope of IR35	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following review	0

Table 53 – new off-payroll engagements for Quarter 2 to Quarter 4 of 2022/23

Off-payroll engagements/senior official engagements

Table 54 shows any off-payroll engagements of Board members and/or senior officials with significant financial responsibility, during Q2 to Q4 of 2022/23:

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the reporting period[3]	0
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[4]	22

Table 54 – off-payroll engagements/senior official engagements during Quarter 2 to Quarter 4 of 2022/23

[2] 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

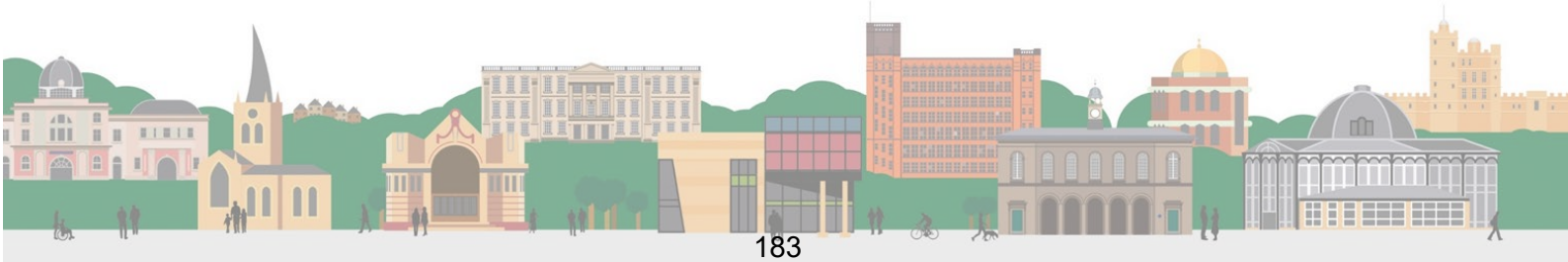
[3] There should only be a very small number of off-payroll engagements of board members and/or senior officials with significant financial responsibility, permitted only in exceptional circumstances and for no more than six months

[4] As both on payroll and off-payroll engagements are included in the total figure, no entries here should be blank or zero. In any cases where individuals are included within the first row of this table the department should set out:
(i) details of the exceptional circumstances that led to each of these engagements; and
(ii) details of the length of time each of these exceptional engagements lasted.

Exit packages, including special (non-contractual) payments (subject to audit)

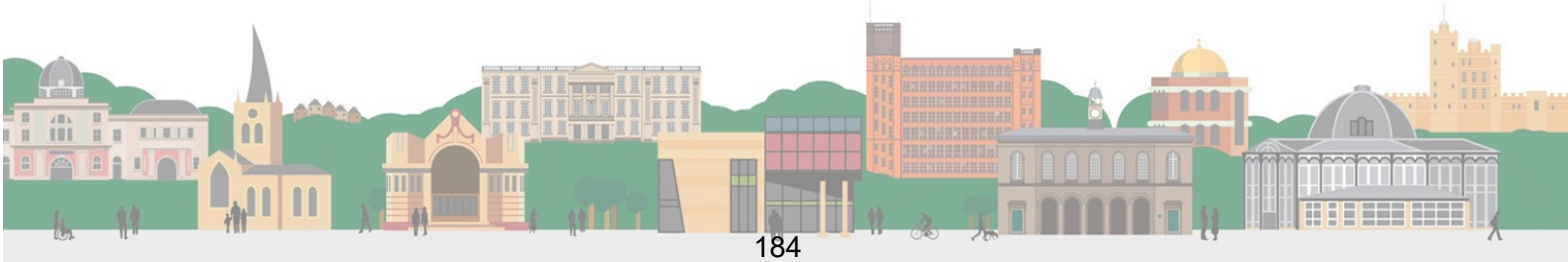
One redundancy was agreed and paid during the period, totalling £26,667. This was provided for in the CCG Accounts, and the liability was transferred to the ICB on the 1st July 2022.

Dr Chris Clayton
Accountable Officer
NHS Derby and Derbyshire ICB
27th June 2023



Parliamentary Accountability and Audit Report

NHS Derby and Derbyshire ICB is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and 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.



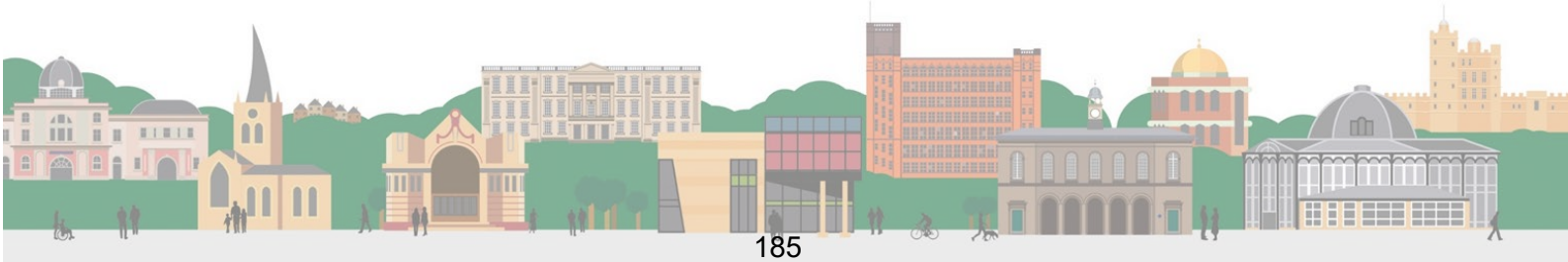
FINANCIAL STATEMENTS

Dr Chris Clayton

Accountable Officer

NHS Derby and Derbyshire ICB

27th June 2023



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The Primary Statements:

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Statement of Comprehensive Net Expenditure for the period ended 31 March 2023

	Note	Jul 22 - Mar 23 £'000
Income from sale of goods and services	2	(9,317)
Other operating income	2	(33)
Total operating income		**(9,350)**
Staff costs	4	21,787
Purchase of goods and services	5	1,700,253
Depreciation and impairment charges	5	507
Provision expense	5	(1,899)
Other Operating Expenditure	5	919
Total operating expenditure		**1,721,567**
Net Operating Expenditure		**1,712,217**
Finance income		-
Finance expense		(29)
Net expenditure for the Period		**1,712,188**
Net (Gain)/Loss on Transfer by Absorption		(612)
Total Net Expenditure for the Financial Year		**1,711,576**
Other Comprehensive Expenditure		
Items which will not be reclassified to net operating costs		
Net (gain)/loss on revaluation of PPE		-
Net (gain)/loss on revaluation of right-of-use assets		-
Net (gain)/loss on revaluation of Intangibles		-
Net (gain)/loss on revaluation of Financial Assets		-
Net (gain)/loss on assets held for sale		-
Actuarial (gain)/loss in pension schemes		-
Impairments and reversals taken to Revaluation Reserve		-
Items that may be reclassified to Net Operating Costs		-
Net (gain)/loss on revaluation of other Financial Assets		-
Net gain/loss on revaluation of available for sale financial assets		-
Reclassification adjustment on disposal of available for sale financial assets		-
Total other comprehensive net expenditure		**-**
Comprehensive Expenditure for the year		**1,711,576**

The notes on pages 191 to 218 form part of this statement.

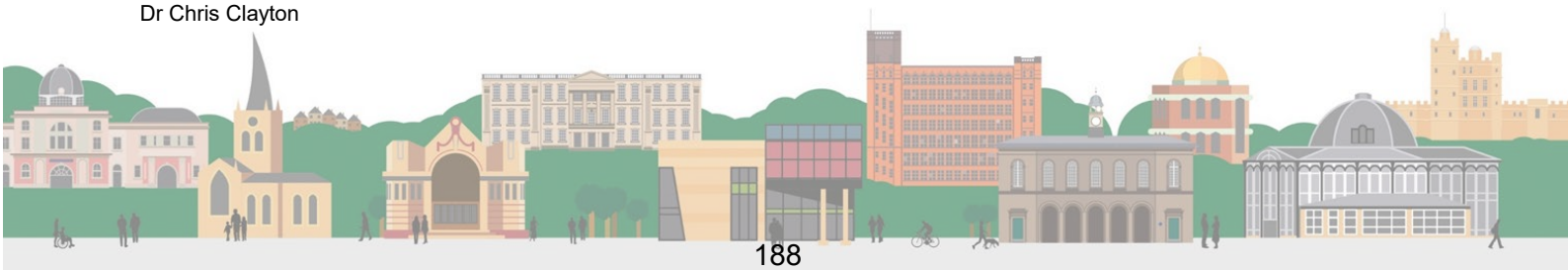
Statement of Financial Position as at 31 March 2023

	Note	31 March 2023 £'000	1 July 2022 £'000
Non-current assets:			
Property, plant and equipment	9	155	218
Right-of-use assets	10a	822	1,270
Intangible assets		-	-
Investment property		-	-
Trade and other receivables		-	-
Other financial assets		-	-
Total non-current assets		**977**	1,488
Current assets:			
Inventories		-	-
Trade and other receivables	11	7,542	9,348
Other financial assets		-	-
Other current assets		-	-
Cash and cash equivalents	12	220	42
Total current assets		**7,762**	**9,390**
Non-current assets held for sale		-	-
Total current assets		**7,762**	9,390
Total assets		**8,739**	10,878
Current liabilities			
Trade and other payables	13	(119,855)	(115,938)
Other financial liabilities		-	-
Other liabilities		-	-
Lease liabilities	10a	(405)	(452)
Borrowings		-	-
Provisions	14	(2,598)	(6,741)
Total current liabilities		**(122,858)**	(123,131)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(114,119)**	(112,253)
Non-current liabilities			
Trade and other payables		-	-
Other financial liabilities		-	-
Other liabilities		-	-
Lease liabilities	10a	(410)	(819)
Borrowings		-	-
Provisions	14	(532)	(532)
Total non-current liabilities		**(942)**	**(1,351)**
Assets less Liabilities		**(115,061)**	(113,604)
Financed by Taxpayers' Equity			
General fund		(115,061)	(113,604)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	
Total taxpayers' equity:		**(115,061)**	(113,604)

The notes on pages 191 to 218 form part of this statement.

The financial statements on pages 187 to 190 were approved by the Audit & Governance Committee (as delegated by the Board) on 27 June 2023 and signed on its behalf by:

Chief Executive Officer
Dr Chris Clayton



Statement of Changes In Taxpayers Equity for the period ended 31 March 2023

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for Jul 22 - Mar 23				
Balance at 01 July 2022	-	-	-	-
Transfer between reserves in respect of assets transferred from closed NHS bodies	-	-	-	-
Transfers by modified absorption to (from) other bodies	(113,604)	-	-	(113,604)
Adjusted NHS Integrated Care Board balance at 01 July 2022	(113,604)	-	-	**(113,604)**
Changes in NHS Integrated Care Board taxpayers' equity for Jul 22 - Mar 23				
Total transition adjustment for initial application of IFRS 16	-			-
Net operating expenditure for the financial year	(1,712,188)			**(1,712,188)**
Net gain/(loss) on revaluation of property, plant and equipment		-		-
Net gain/(loss) on revaluation of right-of-use assets		-		-
Net gain/(loss) on revaluation of intangible assets		-		-
Net gain/(loss) on revaluation of financial assets		-		-
Total revaluations against revaluation reserve		-		-
Net gain (loss) on available for sale financial assets	-	-	-	-
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)			-	-
Net gain (loss) on revaluation of assets held for sale	-	-	-	-
Impairments and reversals	-	-	-	-
Net actuarial gain (loss) on pensions	-	-	-	-
Movements in other reserves	-	-	-	-
Transfers between reserves	-	-	-	-
Release of reserves to the Statement of Comprehensive Net Expenditure	-	-	-	-
Reclassification adjustment on disposal of available for sale financial assets	-	-	-	-
Transfers by absorption to (from) other bodies	(612)	-	-	(612)
Reserves eliminated on dissolution	-	-	-	-
Net Recognised NHS Integrated Care Board Expenditure for the Financial year	**(1,712,800)**	**-**	**-**	**(1,712,800)**
Net funding	1,711,343	-	-	**1,711,343**
Balance at 31 March 2023	**(115,061)**	**-**	**-**	**(115,061)**

The notes on pages 191 to 218 form part of this statement.

Statement of Cash Flows for the period ended
31 March 2023

	Note	Jul 22 - Mar 23 £'000
Cash Flows from Operating Activities		
Net expenditure for the Period		(1,712,188)
Depreciation and amortisation	5	507
Impairments and reversals	5	-
Lease adjustments	10a.1-2	(22)
Non-cash movements arising on application of new accounting standards		-
Movement due to transfer by Absorption	8	(107,202)
Other gains (losses) on foreign exchange		-
Donated assets received credited to revenue but non-cash		-
Government granted assets received credited to revenue but non-cash		-
Interest paid		8
Release of PFI deferred credit		-
Other Gains & Losses		-
Finance Costs		-
Unwinding of Discounts	7.1	(37)
(Increase)/decrease in inventories		-
(Increase)/decrease in trade & other receivables	11	(7,542)
(Increase)/decrease in other current assets		-
Increase/(decrease) in trade & other payables	13	119,855
Increase/(decrease) in other current liabilities		-
Provisions utilised	14	(2,207)
Increase/(decrease) in provisions	14	(1,899)
Net Cash Inflow (Outflow) from Operating Activities		**(1,710,727)**
Cash Flows from Investing Activities		
Interest received		-
(Payments) for property, plant and equipment	9	(90)
(Payments) for intangible assets		-
(Payments) for investments with the Department of Health		-
(Payments) for other financial assets		-
(Payments) for financial assets (LIFT)		-
Proceeds from disposal of assets held for sale: property, plant and equipment		-
Proceeds from disposal of assets held for sale: intangible assets		-
Proceeds from disposal of investments with the Department of Health		-
Proceeds from disposal of other financial assets		-
Proceeds from disposal of financial assets (LIFT)		-
Non-cash movements arising on application of new accounting standards		-
Loans made in respect of LIFT		-
Loans repaid in respect of LIFT		-
Rental revenue		-
Net Cash Inflow (Outflow) from Investing Activities		**(90)**
Net Cash Inflow (Outflow) before Financing		**(1,710,817)**
Cash Flows from Financing Activities		
Grant in Aid Funding Received		1,711,343
Other loans received		-
Other loans repaid		-
Repayment of lease liabilities	10a.2	(348)
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		-
Capital grants and other capital receipts		-
Capital receipts surrendered		-
Non-cash movements arising on application of new accounting standards		-
Net Cash Inflow (Outflow) from Financing Activities		**1,710,995**
Net Increase (Decrease) in Cash & Cash Equivalents		**178**
Cash & Cash Equivalents at the Beginning of the Financial Period		**42**
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**220**

The notes on pages 191 to 218 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 2022-23 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. 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 for 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**

These accounts have been prepared on a going concern basis despite the issue of a report to the Secretary of State for Health and Social Care under Section 30 of the Local Audit and Accountability Act 2014.

The Health and Social Care Act was introduced into the House of Commons on 6 July 2021. The Bill allowed for the establishment of Integrated Care Boards (ICB) across England and abolished Clinical Commissioning Groups (CCG). ICBs took on the commissioning functions of CCGs. The CCG functions, assets and liabilities were transferred to an ICB on 1 July 2022.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

When clinical commissioning group ceased to exist on 1 July 2022, the services continued to be provided by ICBs (using the same assets, by another public sector entity). The financial statements for ICBs are prepared on a Going Concern basis as they will continue to provide the services in the future.

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. For transfers of assets and liabilities from those bodies that closed on 30 June 2022 a modified absorption approach should be applied. For these transactions only gains and losses are recognised in reserves rather than the Statement of Comprehensive Net Expenditure. Where other 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**

Arrangements over which the Integrated Care Board has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the Integrated Care Board is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

The Integrated Care Board's participation in Section 75 agreements (see note 1.5) are joint arrangements.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and 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.

Notes to the financial statements

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.

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.

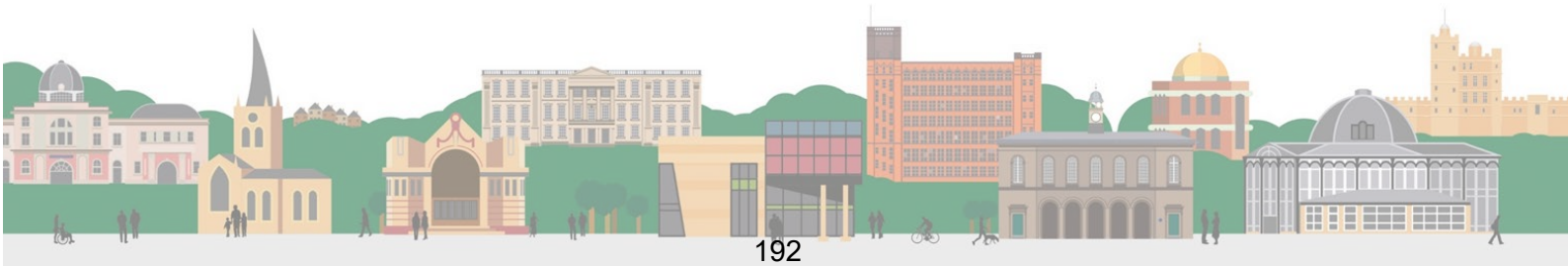
1.8.2 **Retirement Benefit Costs**
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover 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 ICB 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**
Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

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.



Notes to the financial statements

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.

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 but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. 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.

Notes to the financial statements

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 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.

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.

Notes to the financial statements

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 3.27% for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 3.20% 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 3.51% 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 3.00% 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.

1.16 **Non-clinical Risk Pooling**

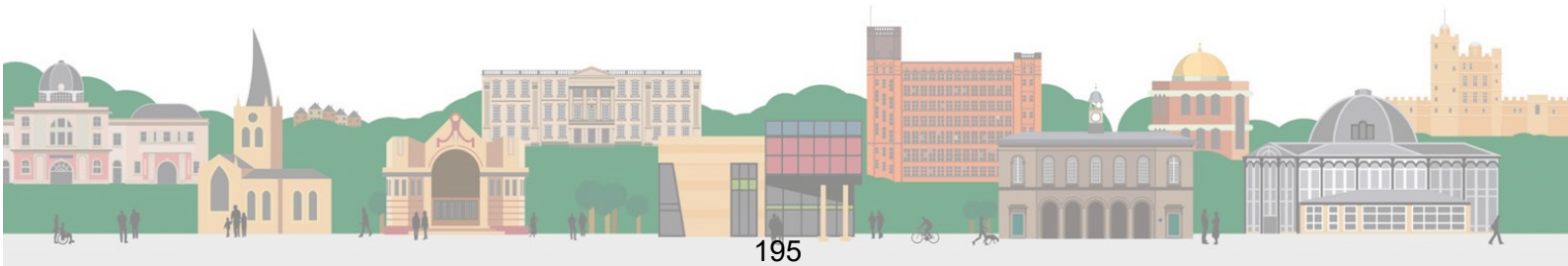
The Integrated Care Board participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Integrated Care Board pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. 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.



Notes to the financial statements

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**

Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.18.3 **Financial assets at fair value through profit and loss**

Financial assets measure at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.18.4 **Impairment**

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, 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.

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 Guarantee Contract Liabilities**

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.19.2 **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.

1.19.3 **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.

Notes to the financial statements

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 **Foreign Currencies**
The Integrated Care Board's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Integrated Care Board's surplus/deficit in the period in which they arise.

1.22 **Third Party Assets**
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Integrated Care Board has no beneficial interest in them.

1.23 **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).

1.24 **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.

1.24.1 **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.

1.24.2 **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

1.25 **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.

1.26 **New and revised IFRS Standards in issue but not yet effective**
The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2022-23. These Standards are still subject to HM Treasury FReM adoption, with the government implementation date for IFRS 17 still subject to HM Treasury consideration.

● IFRS 14 Regulatory Deferral Accounts – Not UK-endorsed. Applies to first time adopters of IFRS after 1 January 2016. Therefore, not applicable to DHSC group bodies.
● 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.

2 Other Operating Revenue

	Jul 22 - Mar 23 Total £'000
Income from sale of goods and services (contracts)	
Education, training and research	**925**
Non-patient care services to other bodies	**4,995**
Patient transport services	**-**
Prescription fees and charges	**-**
Dental fees and charges	**-**
Income generation	**-**
Other Contract income	**3,308**
Recoveries in respect of employee benefits	**89**
Total Income from sale of goods and services	**9,317**
Other operating income	
Rental revenue from finance leases	**-**
Rental revenue from operating leases	**-**
Charitable and other contributions to revenue expenditure: NHS	**-**
Charitable and other contributions to revenue expenditure: non-NHS	**-**
Receipt of donations (capital/cash)	**-**
Receipt of Government grants for capital acquisitions	**-**
Continuing Health Care risk pool contributions	**-**
Non cash apprenticeship training grants revenue	**33**
Other non contract revenue	**-**
Total Other operating income	**33**
Total Operating Income	**9,350**

3 Income from sale of good and services (contracts)

3.1 Disaggregation of Income - Income from sale of good and services (contracts)

	Education, training and research £'000	Non-patient care services to other bodies £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Source of Revenue				
NHS	925	882	-	87
Non NHS	-	4,113	3,308	2
Total	**925**	**4,995**	**3,308**	**89**

	Education, training and research £'000	Non-patient care services to other bodies £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Timing of Revenue				
Point in time	-	-	-	-
Over time	925	4,995	3,308	89
Total	**925**	**4,995**	**3,308**	**89**

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.

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	Total		Jul 22 - Mar 23
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	16,061	810	**16,871**
Social security costs	1,841	-	**1,841**
Employer Contributions to NHS Pension scheme	2,996	-	**2,996**
Other pension costs	5	-	**5**
Apprenticeship Levy	74	-	**74**
Other post-employment benefits	-	-	**-**
Other employment benefits	-	-	**-**
Termination benefits	-	-	**-**
Gross employee benefits expenditure	**20,977**	**810**	**21,787**
Less recoveries in respect of employee benefits (note 4.1.2)	(89)	-	**(89)**
Total - Net admin employee benefits including capitalised costs	**20,888**	**810**	**21,698**
Less: Employee costs capitalised	-	-	**-**
Net employee benefits excluding capitalised costs	**20,888**	**810**	**21,698**

4.1.2 Recoveries in respect of employee benefits

	Jul 22 - Mar 23		
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits - Revenue			
Salaries and wages	(69)	-	(69)
Social security costs	(9)	-	(9)
Employer contributions to the NHS Pension Scheme	(11)	-	(11)
Other pension costs	-	-	-
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	-	-	-
Total recoveries in respect of employee benefits	**(89)**	**-**	**(89)**

4.2 Average number of people employed

	Jul 22 - Mar 23		
	Permanently employed Number	Other Number	Total Number
Total	**456**	**12**	**468**
Of the above:			
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**

4.3 Exit packages agreed in the financial year

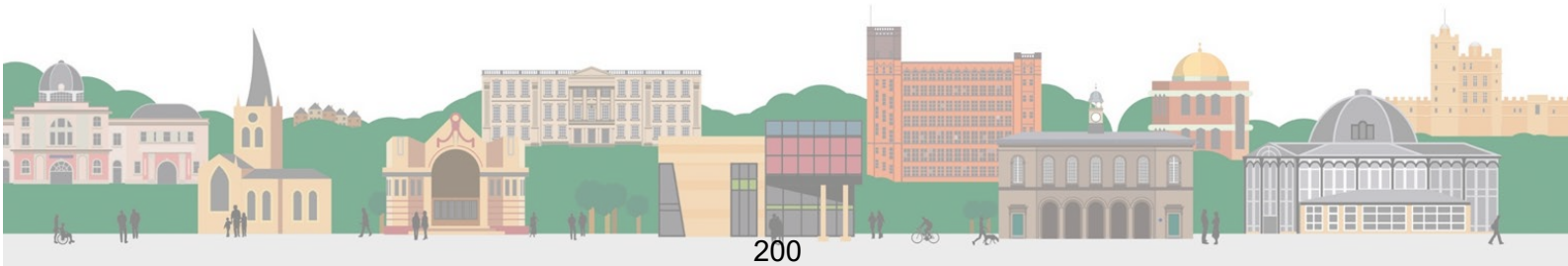
Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

Where **entities** has agreed early retirements, the additional costs are met by NHS **Entities** and not by the NHS Pension Scheme, and are included in thos disclosure. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in this disclosure.

No non-contractual payments were made to individuals where the payment value was more than 12 months' of their annual salary.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

No exit packages have been agreed in the financial period.



4.4 Pension 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.

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:

4.4.1 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 2023, is based on valuation data as 31 March 2022, updated to 31 March 2023 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.4.2 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 (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The actuarial valuation as at 31 March 2020 is currently underway and will set the new employer contribution rate due to be implemented from April 2024.

5. Operating expenses

	Jul 22 - Mar 23 Total £'000
Purchase of goods and services	
Services from other ICBs, CCGs and NHS England	7,822
Services from foundation trusts	1,021,398
Services from other NHS trusts	100,943
Provider Sustainability Fund	-
Services from Other WGA bodies	-
Purchase of healthcare from non-NHS bodies	218,056
Purchase of social care	42,379
General Dental services and personal dental services	-
Prescribing costs	139,888
Pharmaceutical services	100
General Ophthalmic services	308
GPMS/APMS and PCTMS	156,384
Supplies and services – clinical	-
Supplies and services – general	4,414
Consultancy services	26
Establishment	3,969
Transport	1
Premises	3,132
Audit fees	174
Other non statutory audit expenditure	
· Internal audit services	-
· Other services	22
Other professional fees	819
Legal fees	196
Education, training and conferences	189
Funding to group bodies	-
CHC Risk Pool contributions	-
Non cash apprenticeship training grants	33
Total Purchase of goods and services	**1,700,253**
Depreciation and impairment charges	
Depreciation	507
Amortisation	-
Impairments and reversals of property, plant and equipment	-
Impairments and reversals of right-of-use assets	-
Impairments and reversals of intangible assets	-
Impairments and reversals of financial assets	-
· Assets carried at amortised cost	-
· Assets carried at cost	-
· Available for sale financial assets	-
Impairments and reversals of non-current assets held for sale	-
Impairments and reversals of investment properties	-
Total Depreciation and impairment charges	**507**
Provision expense	
Change in discount rate	-
Provisions	(1,899)
Total Provision expense	**(1,899)**
Other Operating Expenditure	
Chair and Non Executive Members	116
Grants to Other bodies	694
Clinical negligence	-
Research and development (excluding staff costs)	-
Expected credit loss on receivables	5
Expected credit loss on other financial assets (stage 1 and 2 only)	-
Inventories written down	-
Inventories consumed	-
Other expenditure	104
Total Other Operating Expenditure	**919**
Total operating expenditure	**1,699,780**

Internal Audit Services are provided by 360 Assurance (hosted by Leicestershire Partnership NHS Trust) and the associated expenditure is included within "Other Professional Fees".

The audit fees relating to the statutory external audit provided by KPMG LLP (UK) include VAT (£145,200 excluding VAT).

6.1 Better Payment Practice Code

Measure of compliance	Jul 22 - Mar 23 Number	Jul 22 - Mar 23 £'000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Year	41,240	277,734
Total Non-NHS Trade Invoices paid within target	41,153	276,147
Percentage of Non-NHS Trade invoices paid within target	**99.79%**	**99.43%**
NHS Payables		
Total NHS Trade Invoices Paid in the Year	2,373	1,148,543
Total NHS Trade Invoices Paid within target	2,361	1,148,120
Percentage of NHS Trade Invoices paid within target	**99.49%**	**99.96%**

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 achieved.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

NHS Derby and Derbyshire Integrated Care Board incurred £nil during 2022-23 (2021-22: £Nil) relating to claims made under this legislation.

7.1 Finance costs

	Jul 22 - Mar 23 £'000
Interest	
Interest on loans and overdrafts	-
Interest on lease liabilities	8
Interest on late payment of commercial debt	-
Other interest expense	-
Total interest	**8**
Other finance costs	-
Provisions: unwinding of discount	(37)
Total finance costs	**(29)**

7.2 Finance income

NHS Derby and Derbyshire Integrated Care Board did not receive finance income during the financial period.

8. Net gain/(loss) on transfer by absorption

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. 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 Changes in Taxpayers' Equity, and is disclosed.

On 1 July 2022, NHS Derby and Derbyshire Clinical Commissioning Group ceased to exist and NHS Derby and Derbyshire Integrated Care Board was established. As part of the establishment, the geographical boundaries were changed such that Glossop's healthcare responsibilities transferred from NHS Tameside and Glossop Clinical Commissioning Group. However, no balances transferred from Tameside and Glossop Clinical Commissioning Group as a result of the boundary change.

Since 2013 NHS England has been holding a provision in relation to potential claims for NHS Continuing Healthcare following the Previously Unassessed Periods of Care PUPoC up to 31 March 2013. The remaining liabilities were transferred to Derby and Derbyshire Integrated Care Board during the financial period.

	Jul 22 - Mar 23		
	Total	NHS England Parent Entities	NHS Derby and Derbyshire CCG
	£'000	**£'000**	**£'000**
Transfer of property plant and equipment	218	-	218
Transfer of Right of Use assets	1,270	-	1,270
Transfer of intangibles	-	-	-
Transfer of inventories	-	-	-
Transfer of cash and cash equivalents	42	-	42
Transfer of receivables	9,348	-	9,348
Transfer of payables	(115,938)	-	(115,938)
Transfer of provisions	(7,273)	-	(7,273)
Transfer of Right Of Use liabilities	(1,271)	-	(1,271)
Transfer of borrowings	-	-	-
Transfer of PUPOC provision	-	-	-
Transfer of PUPoC liability	(612)	(612)	-
Net loss on transfers by absorption	**(114,216)**	**(612)**	**(113,604)**

As NHS Derby and Derbyshire Integrated Care Board is the recipient in the transfer of a function, it has recognised the assets and liabilities received as at the date of transfer. These balances are disclosed within the Statement of Financial Position and accompanying notes as at 1 July 2022. The corresponding net debit reflecting the loss is recognised within the Statement of Changes in Taxpayers' Equity.

9 Property, plant and equipment

Jul 22 - Mar 23	Information technology £'000	Jul 22 - Mar 23 Total £'000
Cost or valuation at 01 July 2022	589	589
Addition of assets under construction and payments on account		-
Additions purchased	90	90
Additions donated	-	-
Additions government granted	-	-
Additions leased	-	-
Reclassifications	-	-
Reclassified as held for sale and reversals	-	-
Disposals other than by sale	-	-
Upward revaluation gains	-	-
Impairments charged	-	-
Reversal of impairments	-	-
Transfer (to)/from other public sector body	-	-
Cumulative depreciation adjustment following revaluation	-	-
Cost/Valuation at 31 March 2023	**679**	**679**
Depreciation 01 July 2022	371	371
Reclassifications	-	-
Reclassified as held for sale and reversals	-	-
Disposals other than by sale	-	-
Upward revaluation gains	-	-
Impairments charged	-	-
Reversal of impairments	-	-
Charged during the year	153	153
Transfer (to)/from other public sector body	-	-
Cumulative depreciation adjustment following revaluation	-	-
Depreciation at 31 March 2023	**524**	**524**
Net Book Value at 31 March 2023	**155**	**155**
Purchased	155	155
Donated	-	-
Government Granted	-	-
Total at 31 March 2023	**155**	**155**
Asset financing:		
Owned	155	155
Held on finance lease	-	-
On-SOFP Lift contracts	-	-
PFI residual: interests	-	-
Total at 31 March 2023	**155**	**155**

Revaluation Reserve Balance for Property, Plant & Equipment

	Information technology £'000	Total £'000
Balance at 01 July 2022	-	-
Revaluation gains	-	-
Impairments	-	-
Release to general fund	-	-
Other movements	-	-
Balance at 31 March 2023	**-**	**-**

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.

10a Leases

10a.1 Right-of-use assets

Jul 22 - Mar 23	Buildings excluding dwellings £'000	Jul 22 - Mar 23 Total £'000	Of which: leased from DHSC group bodies £000
Cost or valuation at 01 July 2022	1,378	1,378	
IFRS 16 Transition Adjustment	-	-	
Addition of assets under construction and payments on account		-	
Additions	-	-	
Reclassifications	-	-	
Upward revaluation gains	-	-	
Lease remeasurement	-	-	
Modifications	(94)	(94)	(94)
Disposals on expiry of lease term	-	-	
Derecognition for early terminations	-	-	
Transfer (to) from other public sector body	-	-	971
Cost/Valuation at 31 March 2023	**1,284**	**1,284**	**877**
Depreciation 01 July 2022	108	108	
Charged during the year	354	354	251
Reclassifications	-	-	
Upward revaluation gains	-	-	
Impairments charged	-	-	
Reversal of impairments	-	-	
Disposals on expiry of lease term	-	-	
Derecognition for early terminations	-	-	
Transfer (to) from other public sector body	-	-	73
Depreciation at 31 March 2023	**462**	**462**	**324**
Net Book Value at 31 March 2023	**822**	**822**	**553**

NBV by counterparty	
Leased from Non-Departmental Public Bodies	553
Leased from other bodies	269
Net Book Value at 31 March 2023	**822**

NHS Derby and Derbyshire Integrated Care Board holds a lease with Cardinal Square LLP, located in Derby and used as office premises.

Additionally, further office space is leased from NHS Property Services Ltd at Cardinal Square, Derby and Scarsdale, Chesterfield. Whilst no formal lease contract is in place, the transaction does meet the definition of a right-of-use asset.

In November 2022, the Integrated Care Board gave six months' notice to NHS Property Services Ltd for part of the building at Cardinal Square, Derby. The lease was recalculated and the impact disclosed as modifications above.

10a Leases cont'd

10a.2 Lease liabilities

Jul 22 - Mar 23	**Jul 22 - Mar 23 £'000**
Lease liabilities at 01 July 2022	(1,271)
IFRS 16 Transition Adjustment	-
Addition of Assets under Construction & Payments on Account	-
Additions purchased	-
Reclassifications	-
Interest expense relating to lease liabilities	(8)
Repayment of lease liabilities (including interest)	348
Lease remeasurement	20
Modifications	96
Disposals on expiry of lease term	-
Derecognition for early terminations	-
Transfer (to) from other public sector body	-
Other	-
Lease liabilities at 31 March 2023	**(815)**

10a.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	Jul 22 - Mar 23 £'000	**Of which: leased from DHSC group bodies £000**
Within one year	(411)	(279)
Between one and five years	(411)	(270)
After five years	-	-
Balance at 31 March 2023	**(822)**	**(549)**

Balance by counterparty	
Leased from Non-Departmental Public Bodies	(549)
Leased from other bodies	(273)
Balance as at 31 March 2023	**(822)**

NHS Derby and Derbyshire Integrated Care Board holds a lease with Cardinal Square LLP, located in Derby and used as office premises.

Additionally, further office space is leased from NHS Property Services Ltd at Cardinal Square, Derby and Scarsdale, Chesterfield. Whilst no formal lease contract is in place, the transaction does meet the definition of a right-of-use asset, hence the asset and liability of the lease are capitalised on the Statement of Financial Position.

In November 2022, the Integrated Care Board gave six months' notice to NHS Property Services Ltd for part of the building at Cardinal Square, Derby. The lease was recalculated and the impact disclosed as modifications above.

10a Leases cont'd

10a.4 Amounts recognised in Statement of Comprehensive Net Expenditure

Jul 22 - Mar 23	**Jul 22 - Mar 23 £'000**
Depreciation expense on right-of-use assets	354
Interest expense on lease liabilities	8
Expense relating to short-term leases	-
Expense relating to leases of low value assets	-
Expense relating to variable lease payments not included in the measurement of the lease liability	-
Income from sub-leasing right-of-use assets	-
Gain/(loss) from sale and leaseback transactions	-
Gain/(loss) resulting from COVID-19 related rent concessions	-

10a.5 Amounts recognised in Statement of Cash Flows

	Jul 22 - Mar 23 £'000
Total cash outflow on leases under IFRS 16	348
Total cash outflow for lease payments not included within the measurement of lease liabilities	-
Total cash inflows from sale and leaseback transactions	-

11.1 Trade and other receivables

	Current Jul 22 - Mar 23 £'000	Non-current Jul 22 - Mar 23 £'000	Current 1 July 2022 £'000	Non-current 1 July 2022 £'000
NHS receivables: Revenue	1,831	-	473	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	69	-	335	-
NHS accrued income	134	-	839	-
NHS Contract Receivable not yet invoiced/non-invoice	620	-	56	-
NHS Non Contract trade receivable (i.e pass through funding)	-	-	-	-
NHS Contract Assets	-	-	-	-
Non-NHS and Other WGA receivables: Revenue	1,765	-	544	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	1,909	-	4,521	-
Non-NHS and Other WGA accrued income	94	-	1,870	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	10	-	-	-
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	-	-	-	-
Non-NHS Contract Assets	-	-	-	-
Expected credit loss allowance-receivables	(6)	-	(2)	-
VAT	1,108	-	708	-
Private finance initiative and other public private partnership arrangement prepayments and accrued income	-	-	-	-
Interest receivables	-	-	-	-
Finance lease receivables	-	-	-	-
Operating lease receivables	-	-	-	-
Other receivables and accruals	8	-	4	-
Total Trade & other receivables	**7,542**	**-**	9,348	-
Total current and non current	**7,542**		9,348	

There are no prepaid pension contributions included in note 11.1.

11.2 Receivables past their due date but not impaired

	Jul 22 - Mar 23 DHSC Group Bodies £'000	Jul 22 - Mar 23 Non DHSC Group Bodies £'000
By up to three months	57	609
By three to six months	1	40
By more than six months	-	-
Total	**58**	**649**

11.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000	Other financial assets £'000	Total £'000
Balance at 01 April 2022	**-**	**-**	**-**
Lifetime expected credit loss on credit impaired financial assets	-	-	**-**
Lifetime expected credit losses on trade and other receivables-Stage 2	(4)	-	**(4)**
Lifetime expected credit losses on trade and other receivables-Stage 3	-	-	**-**
Credit losses recognised on purchase originated credit impaired financial assets	-	-	**-**
Amounts written off	-	-	**-**
Financial assets that have been derecognised	-	-	**-**
Changes due to modifications that did not result in derecognition	-	-	**-**
Transfer by Absorption from other entity	(2)	-	**(2)**
Other changes	-	-	**-**
Total	**(6)**	**-**	**(6)**

12 Cash and cash equivalents

	Jul 22 - Mar 23 £'000
Balance at 01 July 2022	42
Net change in year	178
Balance at 31 March 2023	**220**
Made up of:	
Cash with the Government Banking Service	220
Cash with Commercial banks	-
Cash in hand	-
Current investments	-
Cash and cash equivalents as in statement of financial position	**220**
Bank overdraft: Government Banking Service	-
Bank overdraft: Commercial banks	-
Total bank overdrafts	**-**
Balance at 31 March 2023	**220**

NHS Derby and Derbyshire Integrated Care Board does not hold patients' money.

13 Trade and other payables	**Current Jul 22 - Mar 23 £'000**	**Non-current Jul 22 - Mar 23 £'000**	Current 1 July 2022 £'000	Non-current 1 July 2022 £'000
Interest payable	-	-	-	-
NHS payables: Revenue	13,387	-	803	-
NHS payables: Capital	-	-	-	-
NHS accruals	5,471	-	26,784	-
NHS deferred income	20	-	-	-
NHS Contract Liabilities	-	-	-	-
Non-NHS and Other WGA payables: Revenue	2,565	-	2,942	-
Non-NHS and Other WGA payables: Capital	-	-	-	-
Non-NHS and Other WGA accruals	75,183	-	66,788	-
Non-NHS and Other WGA deferred income	20	-	-	-
Non-NHS Contract Liabilities	-	-	-	-
Social security costs	315	-	333	-
VAT	-	-	-	-
Tax	255	-	246	-
Payments received on account	-	-	-	-
Other payables and accruals	22,639	-	18,042	-
Total Trade & Other Payables	**119,855**	**-**	**115,938**	**-**
Total current and non-current	**119,855**			

NHS Derby and Derbyshire Integrated Care Board does not have any liabilities included above for arrangements to buy out the liability for early retirement over 5 years.

Other payables include £2.2m outstanding pension contributions at 31 March 2023

14 Provisions

	Current Jul 22 - Mar 23 £'000	**Non-current Jul 22 - Mar 23 £'000**	Current 1 July 2022 £'000	Non-current 1 July 2022 £'000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	-	-	-	-
Redundancy	-	-	27	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	-	-	13	-
Continuing care	848	-	1,053	-
Other	1,750	532	5,648	532
Total	**2,598**	**532**	**6,741**	**532**
Total current and non-current	**3,130**			

	Redundancy £'000	**Legal Claims £'000**	**Continuing Care £'000**	**Other £'000**	**Total £'000**
Balance at 01 July 2022	**27**	**13**	**1,053**	**6,180**	**7,273**
Arising during the year	-	150	329	800	**1,279**
Utilised during the year	(27)	(95)	(197)	(1,888)	**(2,207)**
Reversed unused	-	(68)	(337)	(2,773)	**(3,178)**
Unwinding of discount	-	-	-	(37)	**(37)**
Change in discount rate	-	-	-	-	**-**
Transfer (to) from other public sector body	-	-	-	-	**-**
Transfer (to) from other public sector body under absorption	-	-	-	-	**-**
Balance at 31 March 2023	**-**	**-**	**848**	**2,282**	**3,130**
Expected timing of cash flows:					
Within one year	-	-	848	1,750	**2,598**
Between one and five years	-	-	-	532	**532**
After five years	-	-	-	-	**-**
Balance at 31 March 2023	**-**	**-**	**848**	**2,282**	**3,130**

Legal claims are calculated from the number of claims currently lodged with NHS Resolution and the probabilities provided by them. One claim had its provision increased by £150k in 2022-23; £95k has been utilised with the remainder reversed following conclusion during 2022-23 and is detailed in note 22. The continuing healthcare retrospective claims and disputes have been reviewed with £329k of new liability identified, £196k being utilised and £337k reversed during the year.
One redundancy totalling £27k was provided for in 2022-23 and was fully utilised during the period.

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' (£495k, 2021-22 £532k) to cover the cost of putting the offices back to an expected condition, when the lease is terminated. Other provisions include the following balances carried forward from 2022-23:

- Minor Surgery Backlog, £1.01m brought forward. £0.34m utilised and £0.60m reversed in 2022-23.
- Primary Care Network Roles, £1.87m brought forward. Provision was fully reversed in 2022-23.
- Primary Care Estates and Technology Transformation Fund, £0.50m brought forward. £0.01m utilised in 2022-23.
- Digital Transformation, £0.47m brought forward. £0.13m utilised in 2022-23.
- Pension Shortfall, £0.29m brought forward. Provision was fully reversed in 2022-23.
- Acute service improvement post, £0.01m brought forward. Provision fully reversed in 2022-23.
- Corporate Education and Training, £0.08. No amounts were utilised in 2022-23.
- Acute Waiting List Backlog, £1.43m. Provision was fully utilised in 2022-23.

Other provisions also include the following balance wholly arising in the 2022-23 year:

- Acute EMA PTS Leases, £0.8m

15 Contingencies

There are currently no legal claims being pursued against NHS Derby and Derbyshire Integrated Care Board, as advised by NHS Resolution, the claim handler.

16 Commitments

The Integrated Care Board has not entered into any non-cancellable contracts during the financial period, other than those disclosed elsewhere in these Accounts.

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 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 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 Integrated Care Board in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS Integrated Care Board standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS Integrated Care Board and internal auditors.

17.1.1 Currency risk

The NHS 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 Integrated Care Board has no overseas operations. The NHS Integrated Care Board and therefore has low exposure to currency rate fluctuations.

17.1.2 Interest rate risk

The 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 Integrated Care Board therefore has low exposure to interest rate fluctuations.

17.1.3 Credit risk

Because the majority of the NHS Integrated Care Board and 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 Integrated Care Board is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS Integrated Care Board draws down cash to cover expenditure, as the need arises. The NHS Integrated Care Board is not, therefore, exposed to significant liquidity risks.

17.1.5 Financial Instruments

As the cash requirements of NHS England 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 England's expected purchase and usage requirements and NHS England 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 Jul 22 - Mar 23 £'000	Equity Instruments designated at FVOCI Jul 22 - Mar 23 £'000	Total Jul 22 - Mar 23 £'000
Equity investment in group bodies		-	-
Equity investment in external bodies		-	-
Loans receivable with group bodies	-		-
Loans receivable with external bodies	-		-
Trade and other receivables with NHSE bodies	1,807		1,807
Trade and other receivables with other DHSC group bodies	871		871
Trade and other receivables with external bodies	1,783		1,783
Other financial assets	-		-
Cash and cash equivalents	220		220
Total at 31 March 2023	**4,681**	**-**	**4,681**

17.3 Financial liabilities

	Financial Liabilities measured at amortised cost Jul 22 - Mar 23 £'000	Other Jul 22 - Mar 23 £'000	Total Jul 22 - Mar 23 £'000
Loans with group bodies	-		**-**
Loans with external bodies	-		**-**
Trade and other payables with NHSE bodies	358		**358**
Trade and other payables with other DHSC group bodies	19,306		**19,306**
Trade and other payables with external bodies	100,397		**100,397**
Other financial liabilities	-		**-**
Private Finance Initiative and finance lease obligations	-		**-**
Total at 31 March 2023	**120,061**	**-**	**120,061**

18 Operating segments

NHS Derby and Derbyshire Integrated Care Board considers that it has one operating segment, ensuring there is appropriate provision of healthcare in Derbyshire.

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:

	Jul 22 - Mar 23 £'000
Income	(73,270)
Expenditure	73,771
	501

Better CareFund (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 £119,702,223 including iBCF funding £77,201,793) excluding iBCF & ASCDF). Total annual agreed contributions to the Derby City BCF Pool are £37,411,797, including iBCF funding (£23,213,805 excluding iBCF & ASCDF).

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 period to 31st March 2023 the Derbyshire County Council received additionally £35,732,684; and Derby City Council additionally £12,045,014 of 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

In 2022-23 additional funding was received by the ICB of £3,744,991 and Derbyshire County Council £3,022,755 (for the County BCF) and further by the ICB of £1,185,834 and Derby City Council £967,144 (for City BCF) for Adult Social Care Discharge Fund (ASCDF). This funding was pooled into the local BCF plan for:

- The interventions that best enable The discharge of patients from hospital to The most appropriate location for their ongoing care.
- Freeing up the maximum number of hospital beds and reducing bed days lost within the funding available, including from mental health inpatient settings.
- Discharge to Assess (D2A) and provision of homecare is recognised as an effective option for discharging more people in a safe and timely manner.

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:

	Jul 22 - Mar 23	Jul 22 - Mar 23
	£'000	%
Income		
NHS Derby and Derbyshire ICB	(53,946)	59.27
Derbyshire County Council	(37,067)	40.73
Total Income	**(91,013)**	**100.00**

	Jul 22 - Mar 23
Expenditure	**£'000**
ICB schemes aimed at reducing non elective activity	17,857
ICB schemes - wheelchairs	854
Derbyshire County Council schemes	5,924
ICES (Integrated Community Equipment Service)	6,013
Reablement	14,144
Administration, Performance and Information Sharing	435
Care Bill	1,859
Delayed Transfer of Care	5,768
Carers	1,780
Integrated Care	1,312
Workforce Development	346
Dementia Support	332
Autism and Mental Health	1,398
iBCF	24,233
Winter Pressures Grant	2,830
Adult Social Care Discharge	6,802
Total Expenditure	**91,887**
Net position for Pool	**874**
Balance transferred by absorption at 1st July 2022	(1,180)
Balance carried forward as at end of period	(306)
NHS Derby and Derbyshire ICB share of surplus as at end of period	**182**

The Derby County BCF pooled budget reported an overspend of £874k for the period, with a total accumulated underspend of £306k at 31 March 2023.

NHS Derby and Derbyshire Integrated Care Board's share of the underspend was £182k. This amount has been carried forward in the pool.

The memorandum account for the "Derby City Better Care Fund" pooled budget is:

	Jul 22 - Mar 23	Jul 22 - Mar 23
	£'000	%
Income		
NHS Derby and Derbyshire ICB	(16,652)	58.46
Derby City Council	(11,832)	41.54
Total Income	**(28,484)**	**100.00**

	Jul 22 - Mar 23
Expenditure	**£'000**
ICB schemes aimed at reducing non elective activity	3,120
Derby City Council schemes	1,709
Community Health Services	4,825
Social Care	7,045
Mental Health	437
Accident & Emergency	142
iBCF	8,076
Winter Pressures Grant	881
Adult Social Care Discharge	2,154
Total Expenditure	**28,389**
Net position for Pool	**(95)**
Balance transferred by absorption at 1st July 2022	(57)
Balance carried forward as at end of period	**(152)**
NHS Derby and Derbyshire ICB share of surplus as at end of period	**89**

The Derby City BCF pooled budget reported an underspend of £94k for the period, with a total accumulated underspend of £151k at 31 March 2023.

NHS Derby and Derbyshire Integrated Care Board's share of the underspend was £87k. 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:

	Jul 22 - Mar 23 £'000	Jul 22 - Mar 23 %
Income		
NHS Derby and Derbyshire ICB	(1,918)	33.00
Derbyshire County Council	(3,894)	67.00
Total Income	**(5,812)**	**100.00**

	Jul 22 - Mar 23 £'000
Expenditure	
Purchase of equipment and healthcare services	5,812
Total Expenditure	**5,812**
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:

	Jul 22 - Mar 23 £'000	Jul 22 - Mar 23 %
Income		
NHS Derby and Derbyshire ICB	(754)	42.48
Derby City Council	(1,021)	57.52
Total Income	**(1,775)**	**100.00**

	2022-23 £'000
Expenditure	
Residential Services	970
Community Service Team (Outreach Service)	182
Disability and Fieldwork Social Work Services	2
Management and Administration	712
Total Expenditure	**1,866**
Net position for Pool	**91**
Balance transferred by absorption at 1st July 2022	(649)
Balance carried forward as at end of period	**(558)**
NHS Derby and Derbyshire ICB share of surplus as at end of period	**237**

The Integrated Disabled Children's Centre and Services in Derby pooled budget reported an overspend of £91k for the period, with a total accumulated underspend of £558k at 31 March 2023.

NHS Derby and Derbyshire Integrated Care Board's share of the accumulated underspend was £237k. 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 member but between the Integrated Care Board and the related party):

Details of related party transactions with individuals are as follows:

Related Party	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Alfreton, Ripley, Crich And Heanor PCN	851	-	-	-
Amber Valley Health LTD	1,755	-	-	-
College Street Medical Practice	8	-	169	-
Derby And Derbyshire GP Provider Board	347	-	-	-
Derby City Council	19,165	347	1,999	165
Derbyshire Community Health Services NHS Foundation Trust	124,074	88	828	118
Derbyshire County Council	58,475	5,771	3,321	1,078
Derbyshire Healthcare NHS Foundation Trust	116,751	30	86	365
Erewash Health Partnership	1,954	-	-	-
First Steps	62	-	-	-
High Peak & Buxton PCN	442	-	-	-
Jessop Medical Practice	1,707	-	512	-
Moir Medical Centre	88	-	347	-
NHS Confederation	1	-	-	-
Nottinghamshire Healthcare NHS Foundation Trust	2,186	-	-	-
Police & Crime Commissioner For Derbyshire	56	-	34	-
Swadlincote Surgery	1,303	-	419	-
University Hospitals of Derby & Burton NHS Foundation Trust	470,499	10	9,143	21
University Hospitals Of Leicester NHS Trust	1,193	-	9	-

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 with entities for which the Department is regarded as the parent Department. For example:

• NHS England including: NHS England Midlands; NHS Arden & GEM Commissioning Support Unit; NHS Midlands and Lancashire Commissioning Support Unit; NHS North of England Commissioning Support Unit
• NHS Foundation Trusts including: Chesterfield Royal Hospitals NHS Foundation Trust; Derbyshire Community Healthcare Services NHS Foundation Trust; Derbyshire Healthcare NHS Foundation Trust; and University Hospitals of Derby and Burton NHS Foundation Trust
• 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.

21 Events after the end of the reporting period

At the time of reporting, no events have occurred after 31st March 2023, which would require an adjustment or disclosure in the Accounts.

22 Losses and special payments

22.1 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 Jul 22 - Mar 23 Number	Total Value of Cases Jul 22 - Mar 23 £'000
Administrative write-offs	-	-
Fruitless payments	2	95
Store losses	-	-
Book Keeping Losses	-	-
Constructive loss	-	-
Cash losses	-	-
Claims abandoned	-	-
Total	**2**	**95**

During the period, a healthcare litigation was settled in full for £95k. This had previously been provided within the A further clinical overpayment of £366 was written off during the period.

22.2 Special payments

	Total Number of Cases Jul 22 - Mar 23 Number	Total Value of Cases Jul 22 - Mar 23 £'000
Compensation payments	-	-
Compensation payments Treasury Approved	-	-
Extra Contractual Payments	-	-
Extra Contractual Payments Treasury Approved	-	-
Ex Gratia Payments	-	-
Ex Gratia Payments Treasury Approved	-	-
Extra Statutory Extra Regulatory Payments	-	-
Extra Statutory Extra Regulatory Payments Treasury Approved	-	-
Special Severance Payments Treasury Approved	-	-
Special Severance Payments	-	-
Total	**-**	**-**

23 Financial performance targets

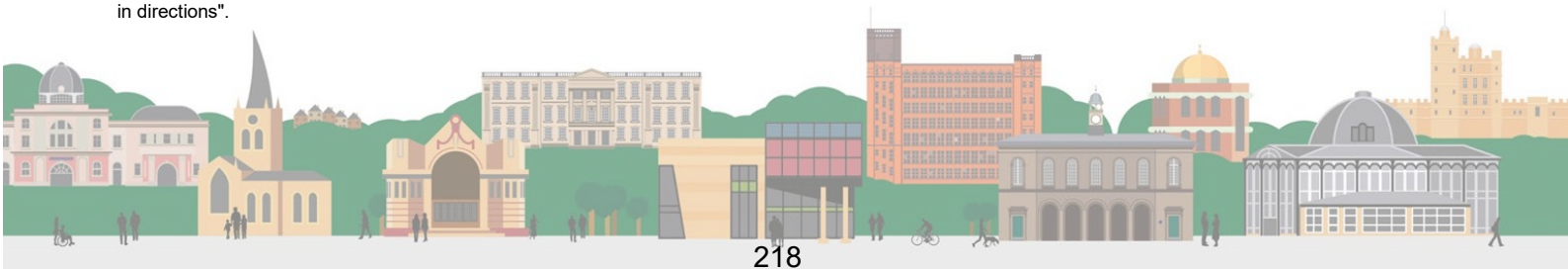
NHS Integrated Care Board have a number of financial duties under the NHS Act 2006 (as amended).
NHS Integrated Care Board performance against those duties was as follows:

	Jul 22 - Mar 23 Target £'000	Jul 22 - Mar 23 Performance £'000
Capital resource use does not exceed the amount specified in Directions	90	90
Revenue resource use does not exceed the amount specified in Directions	1,697,366	1,712,188
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	139,877	139,872
Revenue administration resource use does not exceed the amount specified in Directions	18,277	15,631
Revenue resource use attributable to the agenda for change pay offer shall only be used for its specified purpose in the directions	1,085	1,085

NHS Derby and Derbyshire Integrated Care Board achieved an in-year deficit of £14.822m.

On 6 June 2023 the auditors issued a referral to the Secretary of State and NHS England under Section 30 of the Local Audit and Accountability Act 2014 in respect of the ICB's breach of its Revenue Resource Limit.

The "Revenue resource use on specified matter(s)" relates to primary care co-commissioning, delegated to NHS Derby and Derbyshire Integrated Care Board. Primary care co-commissioning resource and expenditure are also included in the financial performance targets: "Expenditure not to exceed income"; and "Revenue resource use does not exceed the amount specified in directions".



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 nine month period ended 31 March 2023 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 state of the ICB's affairs as at 31 March 2023 and of its income and expenditure for the nine month period 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 26 April 2023 as being relevant to ICBs in England and included in the Department of Health and Social Care Group Accounting Manual 2022/23; 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 and Governance 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. In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we recognised a fraud risk related to expenditure recognition, specifically, the risk associated with the recognition of NHS Expenditure, excluding Non-NHS expenditure, primary care and prescribing expenditure, at the period end.

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 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 postings to cash and unusual postings to expenditure.
- Inspecting transactions in the period prior to and following 31 March 2023 to verify expenditure had been recognised in the correct accounting period.

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.

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.

We are required to make a referral to the Secretary of State and NHS England under section 30 of the Local Audit and Accountability Act 2014 if 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.

As outlined in the section of this report dealing with other legal and regulatory matters, we made a Section 30 referral to the Secretary of State and NHS England on 6 June 2023 on the basis that the expenditure incurred by the ICB in the period ended 31 March 2023 exceeded its Revenue Resource Limit by £14.822 million

Whilst the ICB is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

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 these 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 period is consistent with the financial statements.

Annual Governance Statement

We are required by the Code of Audit Practice published by the National Audit Office in April 2020 on behalf of the Comptroller and Auditor General (the "Code of Audit Practice") to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2022/23. We have nothing to report in this respect.

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 2022/23.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 122, 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.

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

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.

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 160-162, 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 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 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.

As outlined in the section of this report dealing with fraud and breaches of laws and regulations we made a section 30 referral to the Secretary of State and NHS England on 6 June 2023 on the basis that the expenditure incurred by the ICB in the nine month period ended 31 March 2023 exceeded its Revenue Resource Limit by £14.822 million.

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 ICB, 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.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of NHS Derby and Derbyshire ICB for the nine month period ended 31 March 2023 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Andrew Cardoza
for and on behalf of KPMG LLP
*Chartered Accountants*1 Snow Hill Queensway,
1 Snow Hill Queensway,
Birmingham,
B4 6GH

27 June 2023

APPENDICES

Appendix 1: ICB Attendance at Meetings during Quarter 2 to Quarter 4 of 2022/23

ICB Board[5]

ICB Board Member		1 Jul 2022	21 Jul 2022	17 Nov 2022	19 Jan 2023	16 Mar 2023
John MacDonald	Chair	✓	✓	✓	✓	✓
Dr Bukhtawar Dhadda	Non-Executive Member (Quality & Performance) and Vice ICB Board Chair (up to 31st January 2023)	✓	✓	X	✓	
Dr Chris Clayton	Chief Executive Officer	✓	✓	✓	✓	✓
Tracy Allen	Partner Member – Derbyshire Community Health Services NHS Foundation Trust	✓	✓	✓	✓	✓
Ifti Majid	Partner Member – Derbyshire Healthcare NHS Foundation Trust (up to 30th November 2022)	✓	✓	X		
Carolyn Green	Partner Member – Derbyshire Healthcare NHS Foundation Trust (from 1st December 2022)				✓	✓
Dr Andrew Mott	Partner Member – Primary Medical Services	✓	✓	✓	✓	✓
Andy Smith	Partner Member – Derby City Council	X	✓	X	✓	X
Dean Wallace	Partner Member – Derbyshire County Council (up to 30th August 2022)	✓	X			
Ellie Houlston	Partner Member – Derbyshire County Council (from 1st September 2022)			✓	✓	✓
Julian Corner	Non-Executive Member (Population Health & Strategic Commissioning)	✓	✓	✓	✓	✓
Margaret Gildea	Non-Executive Member (People & Culture)	X	✓	✓	✓	✓
Sue Sunderland	Non-Executive Member (Audit & Governance)	✓	✓	✓	✓	✓
Richard Wright	Non-Executive Member (Finance & Estates)	✓	✓	✓	✓	✓
Keith Griffiths	Executive Director of Finance	✓	✓	✓	X*	✓
Dr Chris Weiner	Executive Medical Director	✓	✓	✓	✓	✓
Brigid Stacey	Executive Director of Nursing & Quality, and Deputy Chief Executive Officer	✓	X*	✓	✓	✓
Amanda Rawlings	Chief People Officer	✓	X	✓	✓	✓
Helen Dillistone	Executive Director of Corporate Affairs	✓	✓	✓	✓	✓
Zara Jones	Executive Director of Strategy & Planning	✓	✓	✓	✓	✓
Dr Avi Bhatia	Clinical & Professional Leadership Group Participant to the Board	X	X	✓	✓	✓
James Austin	Chief Digital Information Officer (from 1st November 2022)			✓	✓	✓

[5] * Indicates where a member was deputised

Audit and Governance Committee

Audit and Governance Committee Member		19 Jul 2022	25 Aug 2022	13 Sep 2022	27 Oct 2022	24 Nov 2022	22 Dec 2022	9 Feb 2023	23 Mar 2023
Sue Sunderland	Chair – Non-Executive Member (Audit & Governance)	✓	✓	✓	✓	✓	✓	✓	✓
Richard Wright	Non-Executive Member (Finance & Estates)	✓	✓	✓	X	✓	✓	✓	✓
Dr Bukhtawar Dhadda	Non-Executive Member (Quality & Performance) (up to 31st January 2023)	X	✓	X	✓	✓	X		

Remuneration Committee

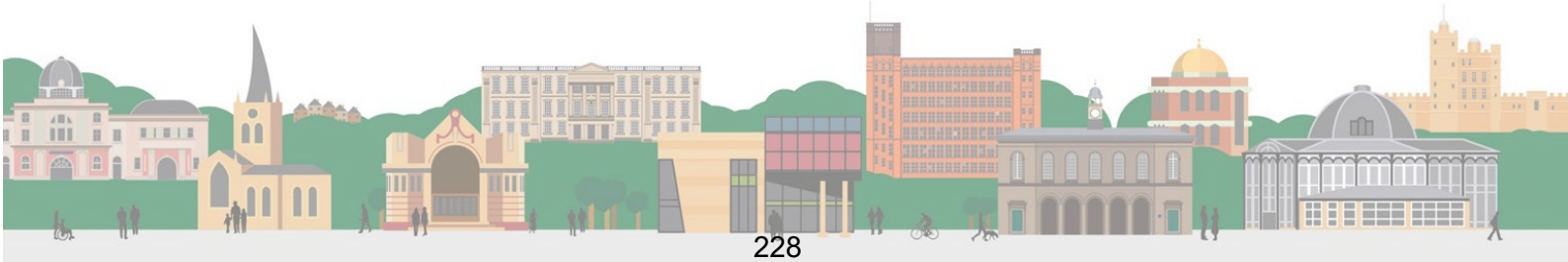
Remuneration Committee Member		1 Jul 2022	21 Oct 2022	20 Jan 2023
Margaret Gildea	Chair – Non-Executive Member (People & Culture)	✓	✓	✓
Julian Corner	Non-Executive Member (Population Health & Strategic Commissioning)	✓	✓	✓
Dr Bukhtawar Dhadda	Non-Executive Member (Quality & Performance) (up to 31st January 2023)	✓	✓	X
Richard Wright	Non-Executive Member (Finance & Estates)	✓	✓	✓

System Quality Group[6]

System Quality Group Member		5 July 2022	2 Aug 2022	6 Sep 2022	4 Oct 2022	1 Nov 2022	6 Dec 2022	3 Jan 2023	7 Feb 2023	7 Mar 2023
Brigid Stacey	Chair – Executive Director of Nursing & Quality, and Deputy Chief Executive Officer, ICB	✓	✓	✓	X*	✓	X*	✓	✓	✓
Krishna Kallianpur	Chief Nurse, CRHFT	✓	✓	X	✓	✓	✓	X	✓	X*
Carolyn Green	Executive Director of Nursing – DHcFT (up to 30th November 2022)	X	✓	X						
Tumi Banda	Executive Director of Nursing – DHcFT (from 1st December 2022)				✓	X	✓	✓	✓	X*
Garry Marsh	Chief Nurse, UHDBFT	✓	✓	X	✓	✓	X	X	X	✓
Michelle Bateman	Chief Nurse Officer, DCHSFT	X	X	✓	✓	✓	✓	✓	X*	✓
Jenny Tilson	Director of Nursing Quality, DHU	✓	✓	X*	✓	X	X	✓	✓	✓

[6] * Indicates where a member was deputised

System Quality Group Member		5 July 2022	2 Aug 2022	6 Sep 2022	4 Oct 2022	1 Nov 2022	6 Dec 2022	3 Jan 2023	7 Feb 2023	7 Mar 2023
Nichola Bramhall	Executive Director of Quality Improvement & Patient Safety, EMAS	✓	X	X	X	X	X	X	X	X
Dr Chris Weiner	Executive Medical Director, ICB	✓	✓	✓	✓	X	✓	✓	✓	✓
Dr Ben Pearson	Medical Director, DCHSFT	✓	✓	X	✓	✓	✓	X		✓
Dr James Crampton	Interim Executive Medical Director, UHDBFT	✓	X	✓	✓	✓	✓	✓	✓	X
Dr Arun Chidambaram	Medical Director, DHCFT	X	X	X	X	X	✓	X	X	X
Kevin Sargen	Executive Medical Director, CRHFT	X	X	X	X	X	X	X	X	X
Dr Aqib Bhatti	Medical Director, DHU	X	X	✓	✓	X	✓	X	✓	X
Dr Leon Roberts	Executive Medical Director, EMAS (up to 31st December 2022)	X	X	X	X	X	X			
Dr Nicole Atkinson	Executive Medical Director, EMAS (from 1st January 2023)							X	X	X
James Moore	Chief Executive Officer, Healthwatch Derby	X	X	X	X	X	X	X	✓	X
Helen Henderson	Chief Executive Officer, Healthwatch Derbyshire	✓	X*	✓	X	✓	X	✓	X	X
Robyn Dewis	Director of Public Health, Derby City Council	X*	X*	X*	X	X*	X*	X	X	X
Ellie Houlston	Director of Public Health, Derbyshire County Council	X	X	X	X	X	X	X	X	X
Caroline Bell	Interim Inspection Manager, CQC	X	X	✓	X	✓	X	X	✓	✓
Sarah Dunnett	Interim Head of Inspection, CQC	✓	✓	X	X	X	X	X	X	X
Rosslyn Young	NHS England Representative	X*	X*	X*	X	X*	X	X*	X*	✓
Phil Sugden	Patient Safety Specialist, ICB	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Andrew Mott	GP Provider Board Representative	✓	✓	✓	✓	✓	✓	✓	✓	✓
Lucy Smith	Allied Health Professions Council Chair	X	✓	✓	✓	X	✓	X	✓	✓
Anne Pridgeon	Maternity Quality Surveillance Group Chair	X	X	X	X	X	✓	X	X	X



Finance and Estates Committee[7]

Finance and Estates Committee Member		26 July 2022	23 Aug 2022	27 Sep 2022	25 Oct 2022	22 Nov 2022	20 Dec 2022	24 Jan 2023	28 Feb 2023	28 Mar 2023
Core NHS Members										
Richard Wright	Chair – Non-Executive Member (Finance & Estates)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sue Sunderland	Non-Executive Member (Audit & Governance)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Keith Griffiths	Executive Director of Finance, ICB	✓	X	✓	✓	✓	✓	X	✓	✓
Darran Green	Acting Operational Director of Finance, ICB	X	✓	X	✓	✓	✓	✓	✓	✓
Zara Jones	Executive Director of Strategy & Planning, ICB	✓	✓	X	X	X	X	✓	✓	✓
Stephen Jarratt	Non-Executive Director, UHDBFT	X	✓	X	✓	✓	✓	✓	✓	✓
Ian Lichfield	Non-Executive Director, DCHSFT	X	✓	✓	✓	✓	✓	X	✓	✓
Stuart Proud	Non-Executive Director, DCHSFT (from 1st January 2023)							X	X	X
Steve Heppinstall	Executive Director of Finance, UHDBFT	X	X	X*	X	X	X*	X*	X	X
Simon Crowther	Executive Director Finance & Performance/Interim Deputy CEO, UHDBFT	✓	✓	X	✓	✓	X	X	✓	✓
Catherine Benfield	Deputy Director of Finance, DCHSFT (up to 28th February 2023)	X	✓	✓	X	X	✓	✓	X	
Peter Handford	Chief Finance Officer, DCHSFT (from 1st March 2023)								✓	✓
Berenice Groves	Chief Operating Officer, CRHFT (up to 31st December 2022)	X	X	X	✓	✓	X			
Zoe Notley	Interim Chief Operating Officer, CRHFT (from 1st January to 28th February 2023)							X	✓	X
Michelle Veitch	Chief Operating Officer, CRHFT (from 1st March 2023)									
Ade Odunlade	Chief Operating Officer, DHcFT	X	X	✓	✓	X	✓	✓	✓	X
Mike Naylor	Director of Finance, EMAS	✓	✓	✓	✓	✓	X	✓	X	✓
Transition Members[8]										
Simon Crowther	System Estates Lead		✓		X		X	X	✓	✓
James Austin	Chief Digital Information Officer, ICB		✓		✓		✓	✓	✓	X
Maria Riley	JUCD Director of Transformation & PMO		X		✓		✓	X	X*	X

[7] * Indicates where a member was deputised
[8] Transition members are invited to every alternate meeting and not expected to attend unless there is an agenda item they wish to be present for

People and Culture Committee[9]

People and Culture Committee Member		7 Sep 2022	7 Dec 2022	8 Mar 2023
Margaret Gildea	Chair – Non-Executive Member (People & Culture)	✓	✓	✓
Dr Bukhtawar Dhadda	Non-Executive Member (Quality & Performance) (up to 31st January 2023)	X	X	
Amanda Rawlings	Chief People Officer	✓	✓	✓
Kaye Burnett	Non-Executive Member, DCHSFT (up to 31st December 2022)	✓		
Janet Dawson	Non-Executive Member, DCHSFT (from 1st January 2023)	✓	✓	✓
Ralph Knibbs	Non-Executive Member, DHcFT	✓	X	✓
Joy Street	Non-Executive Member, UHDBFT	X	X	X
Jeremy Wight	Non-Executive Member, CRHFT	X	✓	✓
Darren Tidmarsh	Chief People Officer, DCHSFT	X	✓	✓
Ifti Majid	Partner Member – Derbyshire Healthcare NHS Foundation Trust (up to 30th November 2022)	X		
Carolyn Green	Partner Member – Derbyshire Healthcare NHS Foundation Trust (from 1st December 2022)		X	X
Jaki Lowe	Director of People & Inclusion, DHcFT	✓	✓	X
Kerry Gulliver	Director of HR & Organisational Development, EMAS	X	X	✓
Caroline Wade	Director of HR & Organisational Development, CRHFT	X	X*	✓
Linda Garnett	Programme Director, People Services Collaborative	✓	✓	✓
Penelope Blackwell	Chair of Integrated Place Executive	✓	X	X
Emma Crapper	HR Director, Derbyshire County Council	X	X	X*
Liz Moore	Head of HR, Derby City Council	✓	X	✓
Vijay Sharma	Non-Executive Director, EMAS	✓	X	X
Susie Bayley	Medical Director, General Practice Taskforce Derbyshire	✓	✓	X
Zahra Leggatt	Derbyshire Health United 111 (East Midlands) Community Interest Company representation	X	X	✓

[9] * Indicates where a member was deputised

Population Health and Strategic Commissioning Committee[10]

Population Health and Strategic Commissioning Committee Member		14 July 2022	8 Sep 2022	6 Oct 2022	10 Nov 2022	8 Dec 2022	12 Jan 2023	9 Feb 2023	9 Mar 2023
Julian Corner	Chair – Non-Executive Member (Population Health & Strategic Commissioning)	✓	✓	✓	✓	✓	✓	✓	✓
Dr Bukhtawar Dhadda	Non-Executive Member (Quality & Performance) (up to 31st January 2023)	X	✓	✓	X	X	✓		
Sue Sunderland	Non-Executive Member (Audit & Governance)	✓	✓	✓	✓	✓	✓	✓	✓
Margaret Gildea	Non-Executive Member (People & Culture)	✓	✓	✓	✓	✓	✓	✓	✓
Richard Wright	Non-Executive Member (Finance & Estates)	X	✓	✓	X	✓	✓	✓	✓
Dr Penny Blackwell	Representative for Provider Collaborative at Place	✓	✓	✓	✓	X	X	✓	✓
Dr Avi Bhatia	Representative for Clinical & Professional Leadership Group	X	✓	X	✓	✓	✓	✓	✓
Dr Emma Pizzey	GP Clinical Lead	X	X	✓	✓	✓	✓	✓	✓
Dr Suneeta Teckchandani	Secondary Care Doctor	X	X	✓	✓	X	✓	X	X
Dominic Fackler	Allied Health Professional Representative	X	X	X	✓	X	✓	✓	✓
Robyn Dewis	Director of Public Health, Derby City Council	X*	✓	X*	✓	✓	✓	✓	✓
Ifti Majid	Representative for Provider Collaborative at Scale, DHcFT (up to 30th November 2022)	X	X	X	X				
Carolyn Green	Representative for Provider Collaborative at Scale, DHcFT (from 1st December 2022)					X	✓	✓	X
Zara Jones	Executive Director of Strategy & Planning, ICB	✓	✓	✓	✓	✓	✓	✓	✓
Brigid Stacey	Executive Director of Nursing & Quality, and Deputy Chief Executive Officer, ICB	X*	X*	✓	✓	X*	✓	✓	✓
Dr Chris Weiner	Executive Medical Director, ICB	✓	✓	✓	✓	✓	✓	✓	✓
Keith Griffiths	Executive Director of Finance, ICB	X	✓	✓	✓	✓	✓	✓	✓
Clive Newman	Director of GP development, ICB	✓	✓	✓	✓	✓	✓	✓	✓
Steve Hulme	Director of Medicines Management & Clinical Policies, ICB	✓	X	✓	✓	✓	✓	✓	✓
Amanda Rawlings	Chief People Officer, ICB	✓	X	X	✓	✓	✓	✓	✓

[10] * Indicates where a member was deputised

Public Partnership Committee

Public Partnership Committee Member		2 Aug 2022	20 Sep 2022	18 Oct 2022	29 Nov 2022	24 Jan 2023	28 Feb 2023	28 Mar 2023
Voting Members								
Julian Corner	Chair – Non-Executive Member (Population Health & Strategic Commissioning)	✓	✓	✓	✓	✓	✓	✓
Sue Sunderland	Non-Executive Member (Audit & Governance)	X	X	✓	✓	✓	✓	✓
Steven Bramley	Lay Representative	✓	✓	X	✓	✓	X	✓
Tim Peacock	Lay Representative	✓	✓	✓	✓	✓	✓	✓
Jocelyn Street	Lay Representative	✓	✓	✓	✓	✓	✓	✓
Margaret Rotchell	Lead Governor, CRHFT (up to 31st December 2022)	✓	✓	✓	✓			
Carol Warren	Lead Governor, CRHFT (from 1st January 2023)					X	✓	✓
Maura Teager	Lead Governor, UHDBFT	✓	X	X	✓	✓	X	X
Lynn Walshaw	Deputy Lead Governor, DCHSFT	✓	X	✓	✓	✓	✓	✓
Christopher Mitchell	Public Governor, DHcFT	X	X	✓	✓	X	X	✓
Kim Harper	Chief Officer, Community Action Derby	✓	X	X	X	X	X	X
Non-Voting Members								
Beth Fletcher	Strategy & Engagement Manager, Healthwatch Derby (up to 30th September 2022)	✓	X					
Michelle Butler	Strategy & Engagement Manager, Healthwatch Derby (from 1st October 2022)			✓	X	X	X	X
Harriet Nicol	Engagement & Involvement Manager, Healthwatch Derbyshire (up to 28th February 2023)	X	✓	✓	✓	✓	X	
Helen Henderson	Chief Executive Officer, Healthwatch Derbyshire (from 1st March 2023)							X
Helen Dillistone	Executive Director of Corporate Affairs, ICB	✓	✓	✓	✓	✓	✓	✓
Sean Thornton	Deputy Director Communications & Engagement, ICB/JUCD	X	✓	✓	X	✓	✓	✓
Karen Lloyd	Head of Engagement, ICB/JUCD	✓	✓	✓	✓	✓	✓	✓

Quality and Performance Committee[11]

Quality and Performance Committee Member		28 July 2022	25 Aug 2022	29 Sep 2022	27 Oct 2022	24 Nov 2022	22 Dec 2022	26 Jan 2023	23 Feb 2023	30 Mar 2023
Dr Bukhtawar Dhadda	Chair – Non-Executive Member (Quality & Performance) (up to 31st January 2023)	✓	✓	✓	✓	✓	✓	✓		
Margaret Gildea	Non-Executive Member (People & Culture) (Chair from 1st February 2023)	✓	✓	X	✓	✓	X	✓	✓	✓
Richard Wright	Non-Executive Member (Finance & Estates)	✓	✓	✓	✓	✓	✓	✓	✓	X
Brigid Stacey	Executive Director of Nursing & Quality, and Deputy Chief Executive Officer	✓	X*	X*	✓	✓	✓	✓	✓	X
Dr Chris Weiner	Executive Medical Director	✓	✓	✓	✓	✓	✓	✓	X	✓
Zara Jones	Executive Director of Strategy & Planning	✓	✓	X*	X*	X*	X*	X*	X*	✓
Christine Fearns	Non-Executive Director, UHDBFT	✓	X	✓	✓	X	X	✓	✓	X
Jayne Stringfellow	Non-Executive Director, CRHFT	✓	X	X	✓	X	X	✓	X	X
Sheila Newport	Non-Executive Director, DHcFT (up to 8th January 2023)	✓	✓	X	X	✓	X			
Lynn Andrews	Non-Executive Director, DHcFT (from 9th January 2023)							✓	X	✓
Kay Fawcett	Non-Executive Director, DCHSFT	X	X	✓	✓	X	✓	X	✓	✓
Robyn Dewis	Director of Public Health, Derby City Council	X	X	X	X	✓	✓	✓	X	X
Gemma Poulter	Assistant Director Adult Social Care, Derbyshire County Council	X	✓	X	X	X	✓	X	X	X

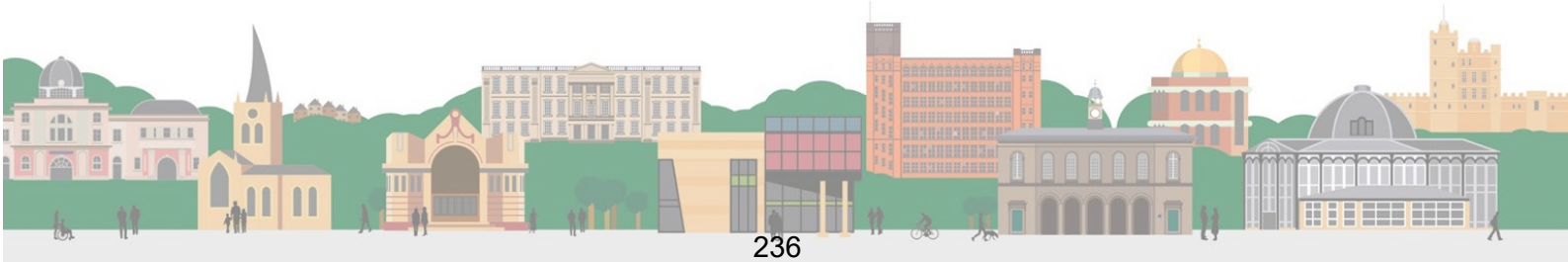
[11] * Indicates where a member was deputised

Appendix 2: Glossary

A&E	Accident and Emergency
ANP	Advanced Nurse Practitioner
ARRS	Additional Roles Reimbursement Scheme
bn	Billion
C1/2/3/4	Category 1/2/3/4
CAMHS	Children Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CETV	Cash Equivalent Transfer Value
CHC	Continuing Healthcare
CQC	Care Quality Commission
CRHFT	Chesterfield Royal Hospital NHS Foundation Trust
DCHSFT	Derbyshire Community Health Services NHS Foundation Trust
DHcFT	Derbyshire Healthcare NHS Foundation Trust
DHU	Derbyshire Health United Community Interest Company
DOS	Directory of Services
DSPT	NHS Data Security and Protection Toolkit
EAF	Expert Advisory Forum
ED	Emergency Department
EHCH	Enhanced Health in Care Homes
EMAS	East Midlands Ambulance Service NHS Trust
ENT	Ear Nose and Throat
EoL	End-of-Life
FH	Familial Hypercholesteremia
FTE	Full Time Equivalent
GP	General Practitioner

GP-CPCS	General Practice Community Pharmacist Consultation Service
GPN	General Practice Nursing
HCD	High-Cost Drugs
HED	Health Education Derbyshire
HR	Human Resources
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board
ICS	Integrated Care System
IFR	Individual Funding Request
IPE	Integrated Place Executive
IT	Information Technology
JUCD	Joined Up Care Derbyshire
k	Thousand
KPI	Key Performance Indicator
LeDeR	Learning Disability Mortality Review
LMNS	Local Maternity and Neonatal System
LPA	Local Place Alliance
LTC	Long Term Condition
m	Million
MHST	Mental Health Support Team
MM&CP	Medicines Management and Clinical Policies
MOL	Medicines Order Line
MSK	Musculoskeletal
NECS	North of England Commissioning Support
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
PPP	Patient and Public Partner
PSIRF	Patient Safety Incident Response Framework
Q1/Q2/Q3/Q4	Quarter 1/2/3/4
QA	Quality Assurance
QEIA	Quality and Equality Impact Assessments
SLT	Senior Leadership Team
SMI	Serious Mental Illness
UCR	Urgent Community Response
UECC	Urgent, Emergency and Critical Care
UHDBFT	University Hospitals of Derby and Burton NHS Foundation Trust
UTC	Urgent Treatment Centre
VCSE	Voluntary, Community and Social Enterprise Sector
VSM	Very Senior Manager
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard
YTD	Year to Date



Appendix 3: Full links to referenced documentation

[i] https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/our-plans/

[ii] https://www.england.nhs.uk/wp-content/uploads/2020/03/the-framework-for-enhanced-health-in-care-homes-v2-0.pdf

[iii] https://www.derbyshire.gov.uk/social-health/health-and-wellbeing/about-public-health/health-and-wellbeing-board/health-and-wellbeing-strategy/health-and-wellbeing-strategy.aspx

[iv] https://www.derbyshire.gov.uk/social-health/health-and-wellbeing/about-public-health/health-and-wellbeing-board/health-and-wellbeing-board.aspx

[v] https://www.derby.gov.uk/health-and-social-care/public-health/hwb/

[vi] https://www.cqc.org.uk/news/our-revised-plan-and-approach-transformation

[vii] https://joinedupcarederbyshire.co.uk/your-services/safeguarding/safeguarding-children/#Resources

[viii] www.ddscp.org.uk

[ix]https://www.derby.gov.uk/media/derbycitycouncil/contentassets/documents/councilanddemocracy/voiceofthechild/cyp-partnership-participation-strategy-2020-2023.pdf

[x] https://joinedupcarederbyshire.co.uk/about-us/jucd-workstreams/green-plan/

[xi] www.openprescribing.net

[xii] [xii] https://joinedupcarederbyshire.co.uk/about-us/equality-inclusion-and-human-rights/#The_Equality_Delivery_System_EDS

[xiii] https://joinedupcarederbyshire.co.uk/download/joined-up-care-derbyshire-engagement-strategy/?wpdmdl=13171&refresh=641828ebb435b1679304939

[xiv] https://joinedupcarederbyshire.co.uk/download/a-guide-to-public-and-patient-involvement/?wpdmdl=13868&refresh=641825c21dd5d1679304130

[xv] https://joinedupcarederbyshire.co.uk/download/engagement-model/?wpdmdl=11177&refresh=641825c2a77a41679304130

[xvi] https://www.england.nhs.uk/publication/working-in-partnership-with-people-and-communities-statutory-guidance/#pdf-version

[xvii] https://joinedupcarederbyshire.co.uk/download/patient-and-public-involvement-ppi-form-guidance/

[xviii] https://joinedupcarederbyshire.co.uk/download/patient-and-public-involvement-assessment-and-planning-form/

[xix] https://joinedupcarederbyshire.co.uk/download/health-overview-and-scrutiny-committee-hosc-guidance/

[xx] https://joinedupcarederbyshire.co.uk/about-us/joined-up-improvement-derbyshire/

[xxi] https://joinedupcarederbyshire.co.uk/involving-people-communities/how-to-get-involved/patient-and-public-partners/

[xxii] https://joinedupcarederbyshire.co.uk/download/guide-to-patient-and-public-partners/

[xxiii] https://joinedupcarederbyshire.co.uk/involving-people-communities/how-to-get-involved/citizens-panel/

[xxiv] https://derbyshireinvolvement.co.uk/

[xxv] https://joinedupcarederbyshire.co.uk/involving-people-communities/how-to-get-involved/readers-panel/

[xxvi] https://joinedupcarederbyshire.co.uk/download/guide-to-jucd-readers-panel/

[xxvii] https://joinedupcarederbyshire.co.uk/involving-people-communities/how-to-get-involved/derbyshire-dialogue/

[xxviii] https://joinedupcarederbyshire.co.uk/download/joined-up-care-derbyshire-engagement-strategy/?wpdmdl=13171&refresh=641828ebb435b1679304939

[xxix] https://mailchi.mp/8998330ac6cf/dhip

[xxx] https://drive.google.com/file/d/1M-mAXXYhsObbYG3E6kWp9ZOfhePhqJ3J/view

[xxxi] https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/conflicts-of-interest/

[xxxii] https://joinedupcarederbyshire.co.uk/download/modern-slavery-statement/

[xxxiii] https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/

[xxxiv] https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/conflicts-of-interest/

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 1,118,447 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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