NHS
Derby and Derbyshire
Integrated Care Board

NHS Derby and Derbyshire Integrated Care Board Annual Report

1st April 2023 to 31st March 2024







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FOREWORD

Welcome to the second annual report and accounts of NHS Derby and Derbyshire Integrated Care Board (ICB). The organisation, formed on the 1st July 2022, is responsible for developing plans to meet local health need, managing the NHS budget locally and securing the provision of healthcare services for our population.

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

We continue to embrace the opportunities of 'System' working, building on the relationships and 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. We continue to recognise that the most important 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. Our work on community engagement, which we have progressed in close partnership with our colleagues in Public Health and the voluntary sector, is outlined in detail in the report.

Our integration of care has also progressed through collaboration within our Place partnerships and alliances, and among our NHS providers. This work ensures that local care is further joined up, reflects priorities at a local level while ensuring we retain a universal offer of care which eliminates unwanted variations in experience and improves 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.

Thinking specifically about the NHS, there continues to be a period of recovery following the Covid-19 pandemic, and this has been compounded by periods of industrial action by professional groups including nurses, midwives, radiographers, junior doctors and consultants. Overall, our waiting lists for operations remain higher than we would wish, and our performance against other national targets on accident and emergency department and cancer waiting times are not where we need them to be. However, there are improvements, which have been achieved by the excellent work of our staff working in partnership, and the report highlights some of these.

Shifting the balance from an NHS that treats ill-health to a system that prioritises prevention and strengths-based support remains central to our ability to manage the increased demand for healthcare. 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 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. A range of examples of our work 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 our ambitions for integrated care, seeking to tackle our community's health challenges in partnership.

Richard Wright
Interim Chair
1st July 2023 to 30th April 2024
NHS Derby and Derbyshire Integrated Care Board
19th June 2024

PERFORMANCE REPORT

Dr Chris Clayton

Accountable Officer

NHS Derby and Derbyshire Integrated Care Board

19th June 2024

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

Much has been achieved against the backdrop of additional and exceptional operational challenges, including industrial action, and an operational position that has not yet recovered from the Covid-19 pandemic, and there is more to do. In June 2023 we published the first Derby and Derbyshire 5-Year Plan, also known as our Joint Forward Plan. Within the plan, we agreed to five guiding policies which would direct our efforts towards an improved position in five years' time. These were:

1	Allocate greater resource to activities that will prevent, postpone, or lessen disease complications and reduce inequity of provision.
2	Give the teams working in our localities the authority to determine the best ways to deliver improvements in health and care delivery for local people.
3	Give people more control over their care.
4	Identify and remove activities from the provision of care which result in time and cost being expended but do not materially improve patient outcomes.
5	Prioritise the improvement of the System's intelligence function and the capacity and capability of its research programme.

Work has continued across the NHS during 2023/24 to look at what types of schemes and approaches could support a transition to a more sustainable health and care model and how we wish our services to operate together in the future. Furthermore, work has continued across the broader partnership through our ICP and Health and Wellbeing Boards to agree priorities for the partnership in the domains of Start Well, Live Well and Age/Die Well.

In headline terms, our work has identified the areas of focus for the NHS to deliver the improvements required. The stabilisation of our urgent and emergency care system and the reduction of our waiting lists for operations continue to remain core priorities. From a disease management perspective, it is clear that cardiovascular disease, which includes stroke disease, remains the single biggest cause of death and disability in our population, with tobacco consumption also being our largest risk factor for ill-health. Respiratory, cancer, musculoskeletal and mental health disease and illness are also important other causes of disease and disability, with diet, lifestyle and alcohol consumption remaining other important risk factors for ill health.

Frailty, including multi-morbidity and specific-related incidents such as falls, have increasingly come to the fore from a commissioning perspective. We also know that the transformation of our community care model and general practice models are important to underpinning the future delivery of preventative care and moving the NHS increasingly from a 'treatment' service to a 'wellness' service. This is all based on detailed work which has taken place during 2023/24. These priorities have fed into our plan for 2024/25, with the aim to deliver against the ambitions set for year two of our Joint Forward Plan. We continue to test what the implications will be of following this draft outline plan will be for the health and care system and how we will balance the 'here and now' priorities for the NHS against our ambition of making long-term sustainable changes for both health and healthcare.

From a governance perspective, the ICB is now fully established and working within the broader System architecture. The Board itself is fully formed and is undertaking its statutory duties. While recognising that the ICB is itself a relatively new organisation, as part of its own development, the ICB has considered reviews into its governance from a System and internal-based perspective. The common themes and recommendations from the review relate to the ICB's role on assurance in the broader NHS system, how this relates to developments in our Place and Provider Collaboratives, and the need to set clear objectives and performance indicators to track progress in the delivery of our plans. Dr Kathy McLean will become Chair of the ICB in May 2024, alongside her Chair role of NHS Nottingham and Nottinghamshire Integrated Care Board. The Board and partners will need to understand and support Kathy's ambition for the System as she takes on this important role; and the strategic link with Nottingham and Nottinghamshire borne out by the establishment of the East Midlands Combined Council Authority is important.

In terms of management, following the establishment of an Executive with both statutory and non-statutory roles and in line with the Secretary of State's requirement to reduce the running cost allowance envelope by 20% from April 2024 and a further 10% from April 2025, the ICB concluded a period of formal consultation with its staff in January 2024 on the future staffing structure model. The ICB's Remuneration Committee has reviewed the recommendations of the Executive and has approved the implementation of the structures as set out. The organisational development requirements that support these structural changes should not be understated. A formal organisational development plan for both the ICB as an organisation and for the broader NHS and care system is currently under development. This will form a key enabler for the delivery of the 2024/25 Operational Plan and beyond. The ICB remains in a transition period and 2024/25 will see a further evolution supported by the ICB staff restructure and the developing NHS and system operating model.

Operationally, our health and care system has continued to face challenges through the year, which we have managed in a consistent, careful and coordinated manner. While not always headline news, the legacy from the Covid-19 pandemic continues to affect the NHS; we remain in the recovery phase, seeking to reduce waiting times for operations, maintain performance in our urgent and emergency care system and ensure our staff are supported to be able to provide the best possible care. In addition, continued industrial action by healthcare staff through the year has required careful planning to ensure we have been able to maintain safe services. This has placed additional pressure on staff and, while our planning has enabled our services to cope during periods of action, it has had an inevitable impact on some areas of care, including elective care waiting lists.

It is now evident though that we are seeing improvements – discharge demand continues to be greater than supply and we continue to work on this in detail, but due to action taken this year we have seen an increase in packages of care available to patients. We have also spent time understanding the drivers of demand for discharge care, alongside an awareness of the impact of our historic actions in this area.

Ensuring our financial position is able to support our ambition is crucial; our NHS system is operating with a significant underlying financial 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 2024/25.

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 four years on since the start of the pandemic, these staff have delivered care to our most vulnerable people, in the most challenging circumstances, and they continue to do so. I speak on behalf of the ICB Board in expressing our extreme gratitude for the role everyone has played.

Overall, with finite resource, the shift in our care models described is constrained by all elements of the System being able to fulfil their new duties. The balance between managing today and tomorrow remains a key focus, alongside looking after our staff, as we wish to strategically see a further shift in the balance of our approach.

Dr Chris Clayton
MA MB BChir DRCOG PGCGPE MRCGP
Chief Executive Officer
NHS Derby and Derbyshire Integrated Care Board
19th June 2024

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 has key a role in the delivery of the NHS constitutional standards and statutory duties of the Derby and Derbyshire ICS, which is made up of the ICB and the four NHS providers in Derby and Derbyshire.

The ICB brings together local NHS organisations and Local Authorities to plan and help shape local health services for the people of Derby and Derbyshire. The ICB has a Board, which is made up of Executive Directors, Non-Executive Members, Partner Members from Foundation Trusts, Local Authorities and Primary Medical Services, and clinical representation. More information on our Board Members can be found on page 146 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 1.06 million.

Our Mission and Values

The Health and Care Bill 2022 created ICBs as replacements for Clinical Commissioning Groups (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 population's 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.

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, the annual operational plan priorities and the NHS Constitution.

The key issues and risks to the organisation achieving its objectives are described in the Governance Statement section of this report. The ICB's strategic risks identified during 2023/24 can be found on the JUCD website[i].

Adoption of the Going Concern Approach

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

Our Relationships

Patients in our area have access to services from a wide range of providers, including Derbyshire Healthcare NHS Foundation Trust (DHcFT), Derbyshire Community Health Services NHS Foundation Trust (DCHSFT) and East Midlands Ambulance Service NHS Trust (EMAS). Our largest contracts are with Chesterfield Royal Hospital NHS Foundation Trust (CRHFT) and University Hospitals of Derby and Burton NHS Foundation Trust (UHDBFT), which account for approximately 38% of our spending.

Derbyshire Integrated Care System Working and Collaboration

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

- Integrated Care Boards; and
- Integrated Care Partnerships.

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

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

Statutory Duties of Joined Up Care Derbyshire

The statutory duties and purpose of JUCD is to bring the above partner organisations together to:

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

Derbyshire Integrated Care Strategy

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

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

Strategic Aims

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

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

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

Joint Forward Plan

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

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

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

The plan was co-produced through engagement with ICP partners, including discussion and review at both Health and Wellbeing Boards, ICB Corporate Committees and public consultation. The plan was agreed by the ICB Board on the 20th July 2023.

Further detail on the Derby and Derbyshire NHS 5 Year Plan 2023/24 to 2027/28 can be found on the JUCD website[iii].

How our strategies link together

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

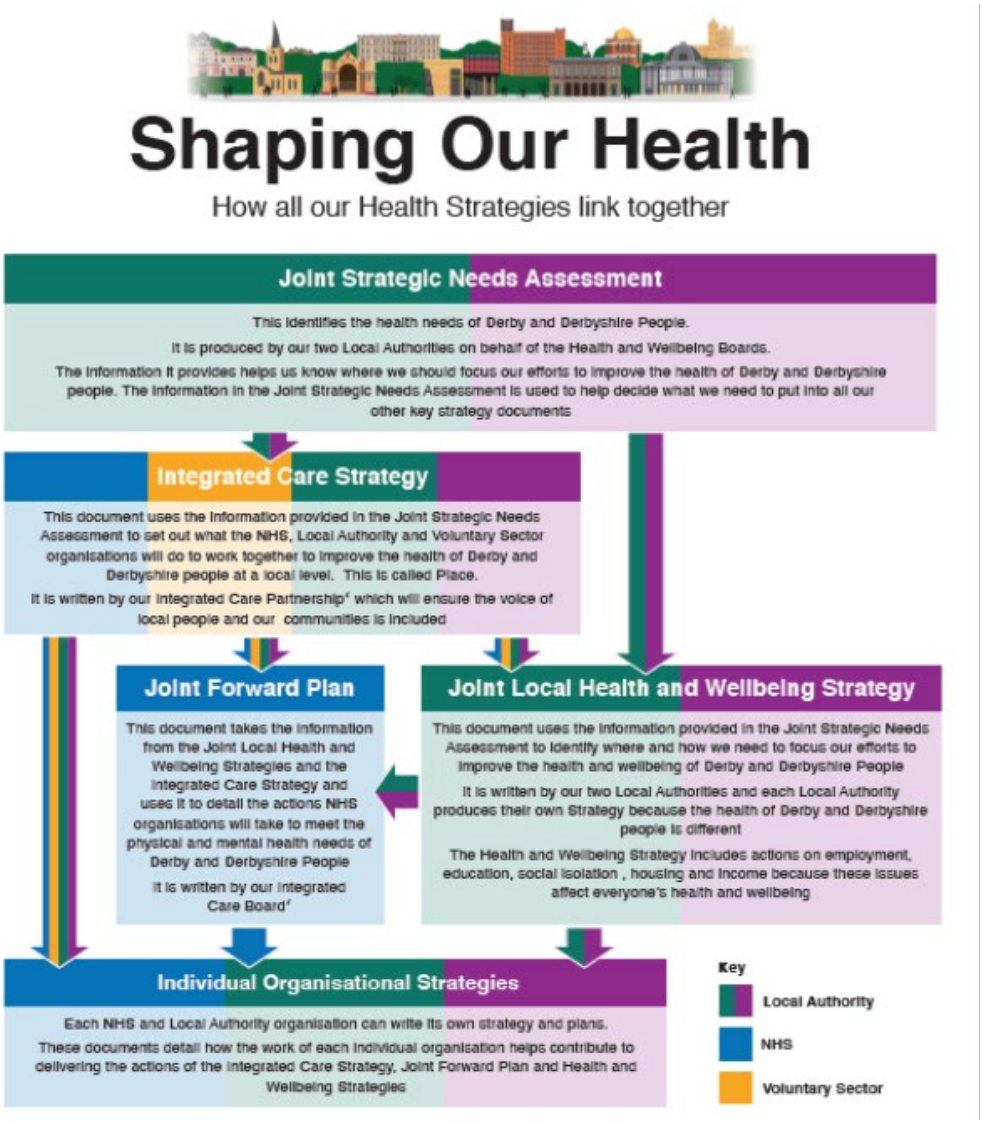


Figure 1 – How our strategies link together

Role of the Integrated Care Board

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

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

The ICB is managed by a Board, which is made up of Executive Directors, Non-Executive Members, Partner Members from Foundation Trusts, Local Authorities and Primary Medical Services, and clinical representation (more information on our Board Members can be found on page 146 of this report). Its role is to join up health and care services, improve people's health and wellbeing and reduce health inequalities.

Our ICB Board has defined our broad functions to be:

- to deliver the statutory duties of the ICB as an NHS organisation;
- to act as the convener of and for the NHS family (statutory and non-statutory NHS providers); and
- an integral partner in the ICP and the Health and Wellbeing Boards.

The key statutory functions of the ICB are:

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

During 2023/24, the ICB has been evolving to achieve its ambition as a valued partner in JUCD, and the broader constituency of the Board provides us with the means to do this and maximise performance against our statutory duties.

The following illustrates the System roles that the ICB, ICP, Place and Provider Collaborative lead on:

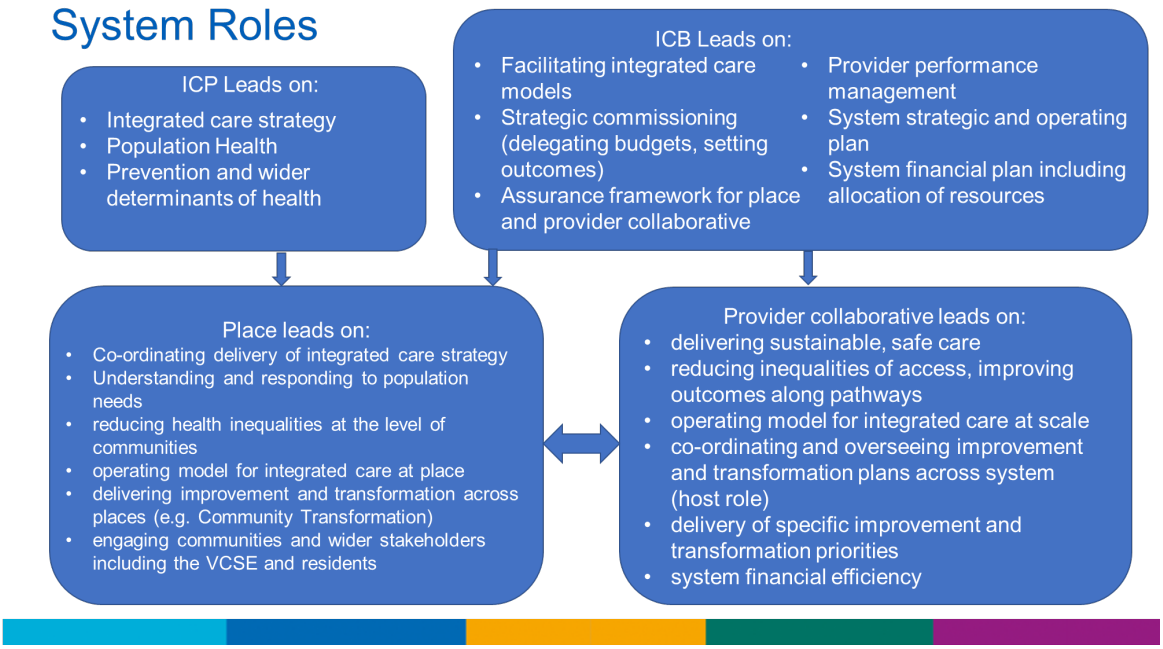


Figure 2 – System roles for the ICB, ICP, Place and Provider Collaborative.

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

In this context, the 'Strategic Framework' for the ICB was approved by the ICB Board in June 2023. It provides clarity of purpose for the organisation, in line with the Joint Forward Plan and the key leadership role it has in driving the integration of health and care services. This is summarised in Figure 3 below.

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.

Figure 3 – NHS Derby and Derbyshire Integrated Care Board Strategic Framework

Role of the Integrated Care Partnership

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.

The NHS organisations and upper-tier local authorities in JUCD run this as a joint committee called Derby and Derbyshire Integrated Care Partnership. This is a broad alliance of partners who all have a role in improving local health, care and wellbeing. They also include social care providers, the VCSE sector and others with a role in improving health and wellbeing for local people such as education, housing, employment or police and fire services.

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

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

In response to this, JUCD has set out a range of markers – referred to as 'Turning the Curve' indicators – that the ICP are aiming to affect, tackling key risk factors for early death, ill-health (physical and mental) and health inequalities:

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

Key Areas of Focus

Three key areas of focus have been agreed by the ICP to test in detail our strategic aims on page 12 and our ambitions for integrated care, in response to population health and care needs. They focus on improvement in prevention, early intervention and service delivery outcomes. The key areas of focus are shown in Figure 4 below:

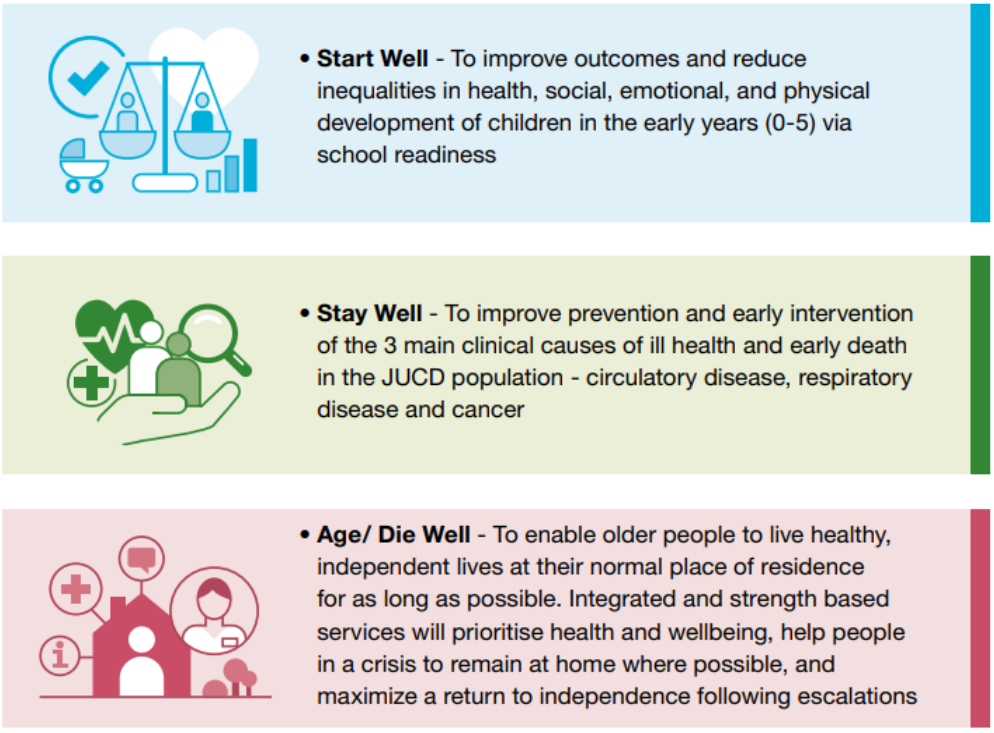


Figure 4 – key areas of focus for the Derby and Derbyshire Integrated Care Partnership

Joint Working with the Local Authority

As a key partner of JUCD, the ICB works closely with colleagues of the two upper-tier Local Authorities Derbyshire County Council and Derby City Council, 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 and the Derby and Derbyshire NHS 5 Year Plan 2023/24 to 2027/28.

Health and Wellbeing Boards

Health and Wellbeing Boards are a formal statutory committee of each Local Authority. They provide a forum where political, clinical, professional and community leaders from across the health and care system come together to improve the health and wellbeing of their local population and reduce health inequalities. 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.

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. Our approach to the development of the Joint Local Health and Wellbeing Strategy can be seen in Figure 4 (above).

Derbyshire's Health and Wellbeing Strategy 2022 Refresh set out five priorities for improving health and wellbeing across Derbyshire, focusing on actions to address factors that can influence people's health. The Health and Wellbeing Strategy can be viewed on the Derbyshire County Council[iv]. 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 also help us work to achieve our overarching aims within the Integrated Care Strategy 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[v] and information on Derby City Council's Health and Wellbeing Board can be found here[vi].

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

System Anchor Partnership

During 2022/23, the System Anchor Partnership brought together a number of Anchor Institutions in Derbyshire, 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 '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 and those who form a part of the System Anchor Partnership include:

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

Together they aim to use their collective influence to help address socio-economic and environmental determinants and enable and facilitate community wealth building, working together through the Derby and Derbyshire Health and Wellbeing Boards and the ICB.

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

During 2023/24, workshops commenced, and the System Anchor Partnership has agreed to initially focus its combined influence and actions on the following two impact areas: workforce and access to work; and social value in procurement.

Provider Collaboratives

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

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

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

Integrated Place Executive

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

Place Partnerships

The ICB has supported the development of Places covering Derby 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.

Figure 5 – Place Partnerships

Integrated Community Care

During 2023/24, the ICB has continued to focus on working collaboratively with health and social care service providers, and voluntary and independent partners including our hospice sector, 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 JUCD Operational Plan, Integrated Care Strategy, the Joint Forward Plan, and the JUCD Palliative and End-of-Life Care Strategy.

During 2023/24 we have used intelligence data and operational evidence across the System to identify opportunities to improve experience and outcomes for older people with the most complex needs. This work will form the basis of significant transformation in 2024/25, building on the foundations of the progress to date.

Place-Based Planning and Delivery

Commissioners, community services providers, Local Authorities, Primary Care, the VCSE sector, community sector and the public come together at geographical levels to join up health, care and support – with the overall aim of empowering people to live a healthy life for as long as possible. The trusting relationships that have been built as part of Place facilitate the transformation of care and support services at a local level.

During 2023/24 we have formally formed two Partnership Boards – one for Derby city and one for Derbyshire county. In order to ensure care and support best meets the needs of local people, we also have Local Place Alliances which largely mirror district and borough-level council footprints and enable people working at that level to collaborate and understand population needs, agree local priorities and deliver services in integrated ways to work with and to serve local communities.

We have an overall IPE to lead the partnership delivery issues that need only to be done once across the System. This approach prevents duplication and divergence. The group has led the development of the Integrated Care Strategy and has oversight of a range of improvement programmes. The IPE also takes a lead on ensuring that activities to ensure enabling functions (e.g. data, digital, estates and workforce) have a focus on Place.

Alongside these Place-based structures, we use a model of distributed leadership to plan and deliver improvements, taking a strengths-based approach in providing local partners with both the flexibility to find solutions together, and the leadership and support from a central team to coordinate and connect related initiatives.

Achievements for 2023/24

Team Up Derbyshire

As part of our System Team Up Programme, using strengths-based and distributed leadership approaches, we have created 12 locally-led teams to deliver integrated home visiting, urgent community response and falls recovery, simplifying pathways and adding extra capacity.

A growing multi-agency workforce, including paramedics, advanced care practitioners, care coordinators and pharmacists, is delivering more than 5,000 extra home visits every month. This provision covers 100% of JUCD, with roughly a quarter of appointments providing proactive care and 90% of appointments being managed entirely within the community.

Workforce surveys demonstrated that 92% of respondents would recommend their service as a place to work and 87% say that their service helps free up General Practice capacity. As part of this community team, DCHSFT's rapid response nursing and therapy service delivers 550+ '2-hour' visits per month, consistently exceeding the 70% urgent community response target.

We have also established community General Practitioners (GPs) across the whole of JUCD, whose primary role is to support the integrated team. They have created consistent access to senior clinical decision-making, and they support considered clinical risk management e.g. supporting paramedics not to convey.

Provision of an enabling culture and local infrastructure has led to many local innovations within existing resources. These include:

- Amber Valley, Ripley, Crich and Heanor Primary Care Networks (PCNs) working with UHDBFT to support a new community geriatrician role; and
- Derby city identifying a gap in support to individuals with chronic pain and high intensity use of services, and developing support to help these cohorts.

Care Home Support

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

- support for PCNs and community partners to deliver the Enhanced Health in Care Homes Direct Enhanced Service, and integration with broader Team Up teams;
- a System-wide group of various operational leads sharing learning and good practice to reduce variation;
- training to support signs of deterioration, capturing information and communicating to other health professionals in a structured way; and
- greater emphasis on care home engagement and support to promote System and integrated working.

Falls

In Derbyshire, almost 70,000 people over the age of 65 will fall in the next year, therefore reducing harms due to falls is a key ambition for our System. This includes improving access to and equity of community-based falls response, and a focus on falls prevention.

During 2023/24, the IPE approved the roll-out of enhanced falls recovery provision to all geographies, testing for the first time a 'Place-based' approach to doing so.

Places were asked to make recommendations on how to implement enhanced falls recovery for their Place populations, by integrating with existing providers capable of delivering at Place-level. There is now Place-based enhanced falls response using local assets across 100% of JUCD.

Work is also underway to understand what Place-based falls prevention services exist and how they can be deployed effectively and appropriately. Places are mapping existing services in each area, gathering examples of good practice by identifying people at high risk and deploying interventions.

Measuring Improvement

While there is tracking of activity, either routinely for specific services or as part of improvement initiatives, the aim is to 'turn some of the big dials' that indicate whether System-level change is having an impact. This work is still in its infancy in terms of identifying relevant, meaningful and consistent measures.

Since the introduction of the work outlined above there have been low levels of growth in a few key measures, including the need to transport a person to hospital following an ambulance Category 3 call, short lengths of stay and re-admissions. Despite a 12.8% growth in the over-75-year-old population, there has been only a 6% growth in non-elective admissions and a 4.5% growth in Emergency Department (ED) attendances, most of which was for non-frailty).

Local Place Achievements

We have drawn out a small number of examples of how working together enables different approaches and solutions in keeping people well and experiencing good care.

<u>Chesterfield</u>

An innovative project is underway in the Chesterfield Local Place Alliance that will tackle some of the highest levels of health inequalities in Derbyshire.

NHS colleagues are working together with other Place partners to ensure that good health and wellbeing is integral to the redevelopment of Barrow Hill Memorial Hall, near Staveley, Chesterfield. Analysis shows that Staveley, and the 1,500 population of Barrow Hill estate in particular, has some of the worst health outcomes in England.

This work is a key illustration of the ICB's commitment to tackling health inequalities, preventing ill health and making investment decisions at Place-level, by working in partnership with councils, the voluntary and community sector, and local communities.

Dr Peter Scriven, the Clinical Lead from General Practice for Chesterfield Local Place Alliance says: *"It is a move away from the medical model of care to an approach that is about empowering people to make decisions that lead to good health and wellbeing – for example work, skills, social activity and exercise – while reducing the barriers to accessing medical care when it is needed"*.

High Peak

High Peak Local Place Alliance has worked with Derbyshire Carers to document the current experiences of carers in High Peak, as well as providing 'best practice' recommendations for the future based on insight gained from speaking to carers.

The project was wide ranging and sought to understand how to improve early identification of all carers, how to preserve and enhance their physical and mental wellbeing, identify the opportunities to support young carers, to reduce delays in access to services and reduce the isolation of carers and their families, as well as recognising and involving carers as experts.

Carers were involved as experts in developing the methodology of the research and the report associated with it. Derbyshire Carers Association have reported that this work has fundamentally changed their approach to working with carers and their families.

Derbyshire Carers Association has already acted on carers' feedback and will strive to incorporate this consultation's findings into future service provision. They identified a range of recommendations relating to the project scope.

Following a review and refresh of the Derbyshire Carers' Strategy in 2022, the System continues to support the adoption of the priorities and its pledges. Throughout 2024/25 further work is planned to continue to review the strategy to ensure that the vision for 2025/26 is on track. Key priorities for 2025/26 are to:

- increase the ways in which carers can be identified and supported at any point within JUCD (including but not limited to health, social care, employment and education);
- make information more easily available;
- support carers to plan ahead and feel more confident in the event of an emergency; and
- ensure carers enjoy better physical health, and have access to emotional help.

Derbyshire County Council, Derby City Council and the ICB are working together to align and promote further System-level work to improve the experience of unpaid carers across the whole of Derbyshire.

Other Community Improvements

The ICB has 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.

Improving Discharge Flow

We continue to build a strong, integrated discharge to assess model which enables and supports Derbyshire people to be discharged from our two acute hospitals, community providers and from out-of-area hospitals.

In collaboration with Derby City Council, Derbyshire County Council, DHcFT and DCHSFT, we have been supporting more people to be discharged from hospital than ever before. Compared with other ICS areas, our providers are performing to a high standard, with the number of people who have to wait for a place on our discharge to assess pathways being well below the national average. We have continued to work jointly to improve all our pathways and during 2023/24 we have been implementing the National Intermediate Care Framework for Rehabilitation and Recovery.

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;
- modelling the required levels of care at home, inpatient beds and community nursing capacity required for all ages of the Derbyshire population;
- reviewing EoL provision across all sectors to better integrate and develop an effective and collaborative EoL offer for Derby and Derbyshire patients, including how General Practices support patient and families who are at the end of their lives; 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 their lives by using a different approach for continuing healthcare (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 the 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 at Place-level.

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 2023, this included providing additional support to people being discharged from hospital.

Social Prescribing

Social prescribing is accessed through General Practices and it connects people to community services and activities that can help them take steps towards their health and wellbeing goals. While connecting with their General Practice, some of the link workers 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 60 to more than 70 workers. Several collaborations continue to be supported with the VCSE sector, including developing a young person's link worker, and musculoskeletal link workers.

We also have a well-established Social Prescribing Advisory Group, which brings key stakeholders together on a regular basis to facilitate a coordinated and 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.

Community Equipment

Our Community Commissioning Team has worked with colleagues at Derby City Council and Derbyshire County Council to ensure that local people continue to be 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 has also supported the continuation of the supply of medical equipment and the consumables needed to enable both adults and children with complex needs to be cared for at home.

Women's Health Hub and Sexual Health Alliance

In September 2023, the ICS Sexual Health Alliance launched the Women's Health Hub Programme. In partnership with Derby City Council and Derbyshire County Council Public Health, NHS Sexual Health Clinics, General Practices and the voluntary sector, we have been working to develop a way of connecting existing provision, provide more training and links to expand and improve services for women, girls and people with a cervix.

To produce a plan for 2024/25, we have been engaging with the public to understand what is working, what needs improving and where there are gaps. We have also been in receipt of a funding grant from NHS England (NHSE) and we hope to use this to better understand and deliver more joined up services to make a difference to service users.

Wheelchairs

The team has worked with colleagues at the Derbyshire Wheelchair Service, a service for residents currently registered with a General Practice in the Derby and Derbyshire, area and who meet the NHS eligibility criteria for the provision of wheelchairs. It provides NHS wheelchair services, including clinical assessments, specialist seating, delivery, repairs and maintenance, and collection when the wheelchair is no longer required. The service received 4,161 referrals in 2023.

Orthotics

The team has worked with the Derbyshire Orthotics Service which delivers both adult and paediatric orthotic outpatient services throughout the whole of Derbyshire at a variety of locations. The service provides a wide range of both custom and ready-made orthoses including insoles and specialist footwear, ankle foot orthoses, knee ankle foot orthoses, knee braces, spinal braces for both acute and chronic conditions, and protective helmets. More than 55,000 of these orthoses were issued in 2023.

Self-Referral Priorities

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

Performance Analysis

Ensuring and driving quality, performance and improvement

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

The focus for 2023/24 has been on improving performance against the delivery metrics set out in the NHS Oversight Framework with a JUCD Quality and Performance Committee established to oversee progress, risks, assurance and improvement plans.

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

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

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

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

Throughout 2023/23, the ICB and regional teams have worked together on providing oversight of NHS providers, assessing delivery against these domains, working through our delivery boards where appropriate. The ICB and regional teams supported those providers requiring more help, this has been seen in JUCD's maternity services and some of our acute Trusts.

UHDBFT have been subject to Tier 1 oversight by the regional NHSE team in relation to performance on elective care and cancer care. Tiers range from 1 to 3, with Tier 1 being the highest level of scrutiny which involves weekly assurance meetings with regional performance managers. The Trust and ICB were able to provide greater assurance on improvements through the year that has led to a positive move to Tier 2 for the coming quarter.

System Performance Management and Oversight – How Performance is Monitored and Managed

The complexities of Covid-19 resulted in changes to the contractual relationships with our providers and altered the approach to contract and performance management. During 2023/24, the ICB started a process to develop a bespoke System Performance Oversight Framework which will be overseen by the System Performance, Productivity and Assurance Group. This enables us to monitor, manage and report on performance across all service areas and delivery domains. The framework includes the production of an integrated quality and performance oversight report. This is reported to several meetings including the Quality and Performance Committee and ICB Board.

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

Through the annual planning round, JUCD is working with providers and localities to develop plans for 2024/25 to improve performance in all areas of operational panning delivery and against wider priorities.

Performance Summary 2023/24

As of the 31st March 2024, our overall performance since the 1st April 2023 has shown that the ICB has successfully achieved seven of the key operational performance priorities during 2023/24. Those standards that were not achieved are detailed by exception in the performance analysis section of this report.

Performance Analysis

Indicator			Target	March 2024
Urgent and Emergency Care	A&E	A&E waits less than 4 hours	76.0%	71.6%
	Ambulance	Category 2 average response time	00:30:00	00:43:06
	General and Acute Beds	General and acute bed occupancy	92.0%	94.6%
Community Health Services	Urgent Community Response	2-hour urgent community response standard	70.0%	81.0%
Primary Care	General Practice	Continue the trajectory to more appointments in General Practice	6,707,340	6,904,865
Elective Care	65-Week Wait	Eliminate waits of over 65 weeks for elective care by March 2024	0	1,077
Cancer	62-Day Standard	Continue to reduce the number of patients waiting over 62 days	311	310
	28-Day Faster Diagnosis Standard	Diagnosis or decision to treat within 28 days of all referrals	75.0%	72.9%
Diagnostics	Diagnostic test	Wait times - more than six weeks from referral	85.0%	79.6%
Mental Health	Children and Young People	Improve access to mental health support	14,431	14,115
	Adults and Older Adults	Increase the number accessing IAPT treatment	28,294	28,360
	Adults and Older Adults	Increase the number of adults and older adults supported by community mental health services (5%)	11,899	11,920
	Out of Area	Work towards eliminating inappropriate adult acute out of area placements	3,803	10,735
	Dementia	Recover the dementia diagnosis rate to 66.7%	66.7%	68.0%
	Perinatal	Improve access to perinatal mental health services	1,113	1,145
Learning Disability and Autism	Learning Disability and Autism	Annual Health Check	75.0%	67.0%
		Reduce reliance on inpatient care	34	39

Table 1 – ICB performance against Operational Planning Priorities 1st April 2023 to 31st March 2024

2023/24 Performance Achievements and Challenges

Urgent and Emergency Care

Accident and Emergency waits under four hours

The majority of Derby and Derbyshire patients attend UHDBFT and CRHFT for their emergency needs. Performance as at 31st March 2024 was 71.7%, falling below the Operational Plan target of 75%. The establishment of co-located Urgent Treatment Centres (UTCs) at the acute Trusts has been successful, treating more minor cases that would otherwise have been seen in ED. While this has eased pressures in EDs, it does lead to patients with higher acuity leading to proportionally more Type 1 four-hour breaches. The scrutiny on performance also includes focus in improving Type 3 and minors performance.

Ambulance – Category 2 Average Response Times

The Ambulance Category 2 Performance Target has proved challenging in 2023/24 with the average Category 2 response time being consistently above the 30-minute target. However, improvements have been made with an approximate 23-minute reduction on average wait times between 2022/23 and 2023/24 despite an 8.5% increase in incidents. It should be recognised that whilst falling short on nationally required performance, Derby and Derbyshire regularly reported best performance in the region.

General and Acute Bed Occupancy

The general and acute bed target was to reduce occupancy to 92% or below, which is considered to provide the optimum occupation to allow good patient flow through the acute hospitals. As of March 2024, the average for UHDBFT and CRHFT was 94.6% and this is a fair reflection of performance throughout the year (yearly average 93.9%) with many weeks over the winter months at much higher occupancy despite additional bed capacity being created. Work is ongoing to improve flow in this area, with particular focus on use of the clinical navigation hub to ensure patients are directed to the most appropriate source of care, urgent community response, improved discharge planning and optimising usage of the virtual wards.

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

The total waiting list reduced by 2% during 2023/24, with a particular emphasis placed on long waits. As at the 31st March, 1,007 patients were waiting above 65 weeks, which represents an in-year reduction of 41%. Plans are in place to reduce these to nil in line with the 2024/25 planning priorities.

Diagnostics – Patients waiting 6+ weeks

Percentage compliance is based on seven diagnostic tests (MRI, CT, non-obstetric ultrasound, echocardiography, colonoscopy, flexi-sigmoidoscopy, and gastroscopy). Progress has been made during 2023/24, and at the beginning of the year our providers were collectively seeing 71.3% of patients within six weeks or less. This improved to 79.6% by March 2024, an improvement of 8.3% over the year, and has resulted in a 5.7% reduction in the overall size of the waiting list.

Cancer

Waiting Times

As at December 2023 there were 86.4% of patients being seen within 31 days but only 64.1% within 62 days. Both measures have changed since October, when the multiple 31-day and 62-day standards were consolidated into just one for each. The 62-day measure is a focus for the Operational Plan, with CRHFT meeting the required reduction but UHDBFT not meeting this, despite a reduction in numbers every month. Improvement teams across UHDBFT and CRHFT have been focused on developing the diagnostic and treatment pathways to expedite implementation of the national best practice timed pathways across key tumour sites. This supported achieving diagnosis of cancer within 28-days of referral or excluded cancer as soon as possible.

The system remains challenged in managing the demand, especially due to the change in referral patterns from Staffordshire into UHDBFT, which has seen a significant increase in lower gastrointestinal and dermatology referrals. The ICB is not meeting the 28-day faster diagnosis standard of 75%, but was approaching compliance at 73.7% for December 2023. Two-week-wait referrals for cancer diagnosis and/or treatment continued to be high nationally and the ICB's performance reflected this, in achieving 80.1% for April to September 2023. This measure is no longer nationally reported because of changes to the constitutional standards in October, however the numbers are still monitored.

28-Day Faster Diagnosis

The ICB achieved an average performance of 73% throughout 2023/24 against this standard. CRHFT consistently overachieved against this target, with an average performance of 78% across the year. UHDBFT averaged 70%.

Mental Health

Improving Access to Mental Health Support – Children and Young People

The ICB 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, emotional health and wellbeing services 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.

Eliminating Inappropriate Out-of-Area Placements

The ICB saw an increase in demand and acuity, issues with flow through acute services resulting in higher length of stays, high occupancy, and an increased use of out-of-area placements. Throughout 2023/24 we invested in additional crisis alternative services such as residential, specialist support and crisis cafés, as well as further promotion of the mental health helpline to help people access urgent support. A recovery action plan is in place focusing on appropriateness and purpose of admissions, improving the therapeutic offer during the inpatient stay (including specialist autism support) and earlier initiation of discharge planning processes.

Learning Disability and Autism

Annual Health Checks

Joint work across specialist learning disabilities teams and Primary Care is ongoing to ensure all those eligible for an annual health check are contacted and offered one. We are taking an 'every contact counts' approach to promoting the importance on the check, including working with specialist schools to ensure that young people and families are aware of the offer from the age of 14.

Reduced Reliance on Inpatient Care

Reducing the reliance on inpatient care for people with a learning disability continues to be challenging for the System. We have made great progress in 2023/24 in providing intensive support for autistic people, enabling them to receive the care they require within their own home thus reducing the number of people requiring admissions into acute mental health inpatient care. We have also managed to support people with higher levels of need, reducing the numbers of people requiring secure care and maintaining low levels of admissions for children and young people requiring specialist mental health support.

Referral to Treatment Time – Long Waiters

The focus in 2023/24 was to have zero 78-week breaches by the end of March 2024. Due to the volume of referrals held in JUCD this has been a particular challenge for the system. Success in these pathways has been a result of internal productivity activities and reorganisation in how care is provided and pathways can be expedited. Mutual aid, including opportunities to work across JUCD providers, alongside increased use of the independent sector and insourcing/outsourcing activities, have driven us to a much better position.

Quarter 4 saw the expectation that we need to develop a route to zero for 65-week breaches by the end of September 2024. The high volume of patients creates a significant challenge for the System, but providers have been working to expedite first outpatient appointments for this cohort by the end of June 2024.

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.

In 2023/24 the Outpatients Delivery Board worked to align work programmes across our main providers and support a system view of innovation opportunities including advice and guidance, and patient-initiated follow-ups.

Advice and Guidance

Advice and guidance is defined as non-face-to-face activity delivered by consultant-led services which can be:

- synchronous (e.g. a telephone call);
- asynchronous (enabled electronically through the NHS e-Referral Service, or through other agreed IT platforms or email addresses); and
- by providing a digital communication channel, advice and guidance allows a clinician (often in Primary Care) to seek advice from another (usually a specialist) prior to or instead of referral.

There were 62,644 advice and guidance requests during 2023/24, which was an increase of 27% from the same period in 2022/23.

Patient Initiated Follow-Up Appointments

Patient initiated follow-up appointments give patients and their carers the flexibility to arrange their follow-up appointments 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, 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. The following sections highlight examples of some of the work undertaken up to the 31st March 2024.

Gynaecology

The Gynaecology EAF is chaired with support from a Primary Care ICB Clinical Lead for women's health, and has reviewed pathways across Derby and Derbyshire to ensure consistency of care. This has included pathways for heavy menstrual bleeding for CRHFT's menopause clinics, and the consolidation of menopause guidance across JUCD into one clear guide. The forum is also near the end stages of finalising a pelvic pain in Primary Care pathway.

Paediatrics

The Paediatrics EAF has been working together to streamline procedures and increase efficiency at Derby and Chesterfield's child development centres. The forum has been concentrating on combining various forms into four simple to use referral forms for the neurodevelopmental pathway, which is responsible for the evaluation of neurodevelopmental illnesses such as autism spectrum disorder and attention deficit hyperactivity disorder.

The forum has also been enabling access for all schools to the child development centres, so that they can direct pupils into the pathway – ensuring that referrals are forwarded to the appropriate place and cutting down on needless delays by enabling the collection of accurate patient data.

Dermatology

Both core Secondary Care dermatology providers (CRHFT and UHDBFT) receive all referrals via the NHS e-Referral Service (a national digital platform used to refer patients from GP surgeries into hospital services), reducing the work required in Primary Care. The Dermatology EAF membership includes clinicians from Secondary Care dermatology teams and GPs with extended roles. The forum meets quarterly to collaborate on service improvement and innovations to support Primary, Community and Secondary Care, with the patient at the centre of all decisions.

Routine Teledermatology

The dermatoscope funding secured in February 2021 enabled 84 practices to be provided with high quality dermatoscopes and basic dermatoscope training for a lead GP in each participating practice. This was expanded in 2023 with additional intermediate dermatoscope training for nine GPs from the remaining funding. A dermatoscope is a handheld 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. The project is supported by online interactive consultant-led mentoring sessions using images from participating General Practices to further develop knowledge of dermatology.

In 2023/24, there were a total of 16,371 individual requests for dermatology advice and guidance. Of these, 2,379 were returned with advice or otherwise diverted from Secondary Care and community care referral. There were 3,886 e-referral service advice and guidance requests converted to referral.

Key work areas in 2023/24 have included Ophthalmology and MSK at a whole pathway level, with clinically led innovation groups in development. Both these groups are currently being refreshed to enhance the work programme to deliver targeted work in the coming 12 months. Further work has continued through the EAF to enhance gynaecology pathways, support continued developed of routine tele dermatology and work to support primary care pathways/ referral processes to support efficient referral processes.

Ophthalmology

The primary focus of this work programme continues to be around ensuring patients are seen in the right place, first time through the development community services to support challenges with acute capacity. This has included development of existing minor eye conditions service (MECS), developing Optom eRS and working to develop triage services and maximise use of the Independent Sector to support NHS services in the delivery of services.

Patients continue to be supported in the community by the minor eye conditions service that was set up in trial form, following a pause due to Covid-19 where it was replaced temporarily by the Covid-19 Urgent Eye Service. The service enables patients to be seen and treated in the community rather than hospital-based eye services. During 2023/24 a total of 11,295 patients have used the service. Activity reports from the service demonstrate continued positive impacts for patients:

- 80% seen and treated outside of a hospital setting;
- 16% referred to hospital eye services; and
- 4% referred to their General Practice.

The eyecare referral system specifically for Optometrists to use is currently being implemented across the System for a smoother referral process for community Optometrists' referrals.

National funding has been secured for the training and placements of several community Optometrists to undertake an independent prescribing and higher glaucoma certificate. Additional capacity from independent sector providers has also been procured and continues to support the System with cataract surgery services across the area.

Work continues on the following three transformation projects in ophthalmology, which aim to reduce the impacts on Secondary Care hospital eye services by providing a range of timely services in the community, often closer to home for patients:

1	Moving post-operative cataract patient check-ups from Secondary Care to community optometrists for low-risk, non-complex patients.
2	Moving the monitoring of stable glaucoma patients from Secondary Care to community optometrists.
3	Implementation of a face-to-face triage and treat service trial in the south of Derbyshire.

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 MSK system. Ageing, injuries, lifestyle and disease can cause pain and limit movement. MSK conditions account for up to 33% of General Practice consultations in England. Around a third of the UK population, more than 20 million people (20,295,706), live with an MSK condition. Lower back and neck pain are the greatest cause of years lost to disability, with chronic joint pain or osteoarthritis affecting over 10 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. By February 2024, all General Practices, Secondary Care NHS Trusts, DCHSFT and all contracted independent physiotherapy providers had been offered the getUbetter platform. The peri-operative aspect of the platform is now in development. 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 Health Innovation Network and NECSU has been completed, with the final version of the report due by the end of April 2024. The aim of the evaluation is to demonstrate potential 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 ICB has also used stakeholder engagement funding to support the training of several GPs who are helping JUCD in the review of key clinical pathways – promoting awareness and education of MSK-related conditions and increasing clinical engagement across the System.

Physiotherapy

The ICB have continued to work to review and understand the community physio offer across JUCD with a view to maximising opportunities and ensuring equitable access and outcomes that meets our population health needs.

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 a link to the site to support them.

Commissioners have engaged with providers across JUCD to further develop consistent data flows to inform future work. There is work planned to align pathways across the Derbyshire System.

Referral Optimisation

Referral optimisation is the improvement of System-wide pre-hospital pathways, to ensure that if a referral is necessary, specialist clinicians have the information they need to determine the best course of treatment for the patient. It also ensures that Primary Care and other professionals in the community have the support and information they need to diagnose, treat and support more patients closer to home, without the need for onward referral.

It enables people, especially those living with long-term conditions, to have the knowledge, skills, confidence, and support for preventive care, in order to increasingly manage their own care and live more independently.

The ICB is in the process of streamlining Referral Optimisation across programmes within the system, to support working collaboratively across organisational and geographical boundaries in supporting the streamlining of the referral process, reducing waiting times, enhancing patient outcomes, and making the best use of available healthcare resources.

Patient-Initiated Digital Mutual Aid System

Under the NHS Constitution, patients in England have a right to request a new provider when they have been waiting for treatment for more than18 weeks. In October 2023, an initiative was launched by NHSE to encourage patients to act on this right. Secondary Care providers with consultant-led services were required proactively to offer patients waiting 40 weeks or more for a first outpatients' appointment or operation the option to move to a new provider for treatment. The ICB was tasked with overseeing and supporting the System-level plans and processes to ensure that the initiative was coordinated across JUCD and was also asked to support all providers involved in the process of validating patients and offering capacity across the JUCD footprint.

The ICB developed systems to support the Patient Initiated Digital Mutual Aid System data flows and engaged with various specialist teams across JUCD to develop processes to support the initiative. The ICB was also responsible for coordinating the reporting between providers, the ICB and NHSE. Over the course of six months, the ICB supported providers with contacting patients, exploring capacity options with alternative providers, and providing patients with the opportunity to move their treatment to a new provider to enable them to be seen earlier. The initiative also aimed to relieve pressure on providers, enabling them to bring forward the care of more complex patients that were not suitable to transfer to a new provider.

CRHFT and UHDBFT sent out 13,789 invitations to patients, of which 753 valid requests to opt into the initiative were received. Following clinical validation of the viability to transfer, 568 patients were forwarded to the ICB to explore the possibility of moving providers, which resulted in 240 patients being transferred for treatment earlier with a new provider.

The Patient Initiated Digital Mutual Aid System is supporting the already robust work which is ongoing with providers to ensure that patients are seen as soon as possible, and that patients are not waiting over 78 weeks from Referral to Treatment, unless there is patient choice to do so.

Urgent Care

The JUCD System continues to be under significant pressure due to ongoing operational challenges, and capacity overall continues to be affected by ongoing staff shortages. A daily System call takes place to support System partners to manage this, with a particular focus on patient flow in and out of hospital. Key focus areas include supporting patients to easily access care and maintaining strong links between service providers. Our main aims are to improve access to urgent care services.

Transformation

We know we need to think differently, be innovative, and work together to change health and care services so that people in Derby and Derbyshire can 'Start Well, Live Well, Age Well and Die Well'. During 2023/24, urgent care has been collaboratively working across our Acute Trusts, Primary Care, Place and community to transform services, with a focus on patients receiving the right care, in the right place, first time.

In working together, we are increasing efficiency, improving effectiveness and, most importantly, improving the health and wellbeing of people who live in Derby and Derbyshire. This work is governed and discussed in our Urgent, Emergency and Critical Care Board and Transformation Delivery Group meetings. Meetings with service providers continue to be held regularly to discuss urgent, emergency, and critical care and deliver the Urgent Care Transformation Programme.

Operational Support

The operational team comprised a series of significant events during 2023/24, which included:

Operational Coordination Centre

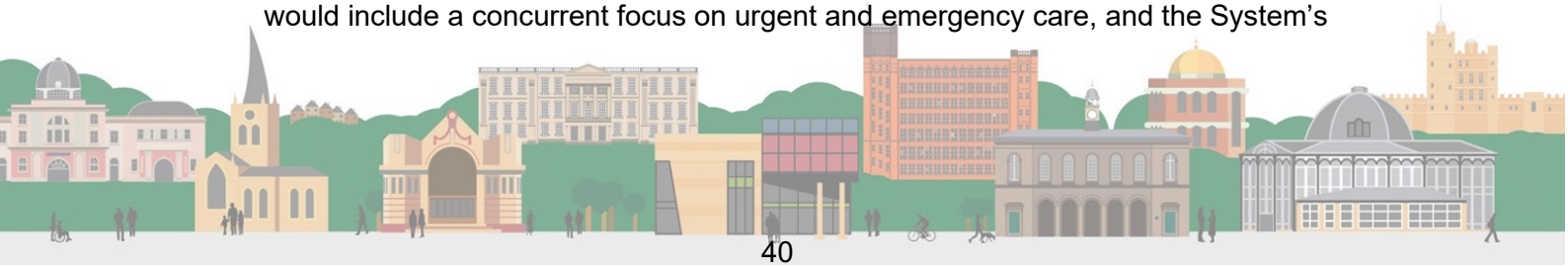
The establishment of a NHSE-directed System Co-ordination Centre, known as the Operational Coordination Centre (OCC), to ensure the ICB has visibility of operational pressures and risks across providers and System partners. The requirement is for the co-ordination centre to be operational 8am to 6pm, seven days a week. The OCC is made up of three commanders and three coordinators.

The OCC exists to be a central co-ordination service to providers of care across the ICB footprint, with the aim to support patient access to the safest and best quality of care possible.

As part of their role, OCC is responsible for the co-ordination of an integrated System response using the Operating Pressure Escalation Level (OPEL) Framework alongside constituent ICS providers and ICB policies. The OPEL Framework contains specified and incremental core actions for the OCC at each stage of OPEL.

The OCC is also responsible for supporting:

- interventions across JUCD on key systemic issues that influence patient flow. This would include a concurrent focus on urgent and emergency care, and the System's



wider capacity including, but not limited to: NHS 111, Primary Care, intermediate care, social care, urgent community response and mental health services. The Ambulance Handover Improvement Group meet weekly and focus on improving alternative pathway referrals for EMAS and improving existing processes. An example of this work is the development and sign off of the EMAS direct to UTCs pathway at UHDBFT (Derby site) which went live at the end of February 2024;

- System-wide planning to assure operational output before, during and after industrial action and bank holidays; and
- summits and workshops, including the Midlands regionally-led ICS escalation workshops to define a way forward in de-escalating System-wide pressure.

System operational and tactical-level meetings were frequently convened to deal with the pressure across the System, with partners and providers alike seeking support. Operational and tactical-level activities were supported by strategic meetings as part of the escalation process when required.

Demand Management

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

Virtual Wards

Virtual wards allow patients to receive hospital-level care and monitoring at home safely, helping speed up their recovery whilst also freeing up hospital beds for patients that need them more urgently. Virtual wards in Derby and Derbyshire have continued to grow from 120 to 160 beds during 2023/24. Patients on a virtual ward have been supported by Doccla remote monitoring, which went live in September. This launch was one of the most successful for Doccla, and the Derby and Derbyshire project achieved regular weekly awards among the Doccla teams to acknowledge its success.

There has also been a drive to promote public awareness of virtual wards which has included press releases, interviews with local press, and surveys to gauge where gaps in awareness may lie. The results of the survey showed a good awareness with respondents indicating that they are happy using a virtual ward.

System-wide clinical summits have taken place to enable providers to share best practice and work collaboratively to further develop on the successful implementation of virtual wards. These developments will include a generalist model that incorporates existing virtual wards using specialist support and further development of step-up pathways, including working with care homes.

Same Day Emergency Care

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

There has also been a focus on maximising pathways to give our patients the right care, in the right place, first time, and increasing SDEC service opening times to support this. Visits to other Systems have been undertaken, linking together to understand different models of care and share best practice to support internal forward plans. There have been several pilots and changes implemented, trialling new processes, new staffing models and new estates which have had a positive impact on SDEC activity.

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

Last year we reported that demand on NHS 111 and 999 services was continuing to rise. In response, work was done to expand the-then Clinical Navigation Hub model to deliver a Derby and Derbyshire single point of access assessment service. This service would offer clinical advice and support, reducing pressures on ambulance services, EDs and Primary Care, to achieve more positive outcomes for patients as well as the System.

This hub has continued to evolve and has now become the Derby and Derbyshire Single Point of Access – supporting the ethos of patients receiving the right care, in the right place, first time. The service deals with calls from healthcare professionals in the community, and in this way supports the "no decision in isolation" ethos.

The desired outcome of these interventions is to offer better quality care close to home by moving towards a 'consult and complete' model for advice, prescriptions, face-to-face appointments for further assessment, treatment, or referrals by ambulance crew to a community service when a hospital visit is not clinically appropriate.

Within Derby and Derbyshire, the Primary Care General Practice out-of-hours service continues to be a key member of the emergency care networks, working alongside other partner organisations continually to improve and streamline the patient pathway. The ICB has recently awarded a contract to Derbyshire Health United Community Interest Company (DHU) to deliver the Primary Care General Practice out-of-hours service across Derby and Derbyshire. It supports more than 250,000 patients a year and is a service for patients needing appropriate Primary Care across Derby and Derbyshire when their General Practice is closed. The service is accessed through NHS 111 and operates every day of the year, 6.30pm to 8am Monday to Friday and 24 hours at weekends and bank holidays.

The service provides both face-to-face assessment and treatment of patients either in a residential setting or at an out-of-hours Primary Care centre, and clinician advice to patients over the phone or via video consultation (following an initial NHS 111 health advisor assessment). The new contract will ensure a continued service supporting Derby and Derbyshire's Primary Care General Practice out of hours service.

Urgent Treatment Centres

UTCs continue to provide valuable and locally accessible urgent on-the-day 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 services across Derbyshire have worked to ensure they are now compliant with the national standards published in September 2023.

The ICB's Urgent and Emergency Care Team, led by the UTC Strategy Group, Derby UTC Task and Finish Group and public and patient engagement, have reviewed the current, and potential future use of the service provided by the Derby UTC. The service is to provide assessment, care and treatment for both minor injuries and minor illnesses.

A procurement process concluded in February 2024. It was based on a revised service specification focused on working together with other Derbyshire health and care services to integrate the UTC services offer with those in Primary Care and the wider health community. The new service will go live on the 1st July 2024, subject to the necessary ICB approvals.

The team are also undertaking a strategic review of all community UTC provision. The review will cover Derbyshire's five existing community UTCs, as well as other services that fit within the wider community urgent on-the-day offer, such as walk-in centres. The community UTCs will be considered within the context of the wider UEC system in Derby and Derbyshire to ensure that we deliver an integrated urgent treatment system that fits with the needs of the local population and supports urgent on-the-day access needs. It will also align to developments around Primary Care and Place across Derbyshire. A task and finish group of System stakeholders has been established to work through the progress and next steps around the strategic review, and to develop baseline and mapping data to support the development of options.

In 2023, a delivery plan for recovering urgent and emergency care services set out the expectation that UTCs should be co-located within EDs; helping to ease the pressure on ED and enabling emergency medicine specialists to focus on those patients who are seriously unwell. In addition to Derby and Derbyshire's five community UTCs, GP-led co-located type 3 UTC services have been reviewed and contracted at our hospital front doors at Royal Derby Hospital and CRHFT to provide urgent care across the Derbyshire population.

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 are supported by, and help us deliver, the national priorities as set out in the NHS Long Term Plan, Primary Care System Development Programmes, 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 2024 was 3,865 working a full time equivalent (FTE) of 2,840.66. This is an increase of 9.47 FTEs since March 2023. Within the workforce there are four main staff groups; these are:

General Practitioners	942 headcount (732.47 FTE)
General Practice nursing	481 headcount (337.15 FTE)
Direct patient care (those other than GPs and nurses who provide care to patients, for example, health care assistants, physiotherapists, pharmacists or paramedics)	369 headcount (269.19 FTE)
Administration and non-clinical	2,073 headcount (1,501.85 FTE)

Table 2 – Primary Care Workforce staff group data as at the 31st March 2024

The General Practice workforce in Derbyshire is stable and we have seen an increase in our overall number and GP numbers. From October 2021, our GP numbers started to decline but we have seen a gradual increase over the last 12 months in headcount and FTE (from the available data via the National Workforce Reporting System), which is a real positive for Derbyshire.

Direct patient care staffing groups have also increased over the last 12 months, and our numbers of administration and non-clinical staff have remained static. Unfortunately, we are starting to see another decrease in our nursing numbers, a reduction of 14.9 FTE (as of 31st March 2024), which is disappointing as this staff group had been static throughout 2022/23.

In terms of age profile, our workforce is comparable with other areas of the country although we are continuing to see a positive shift in the General Practice profile. For our GP workforce, 42.4% are under the age of 40, with 6.5% of these being under 30. This is a 6% increase on 2022/23 which means we are successfully attracting a younger workforce into the area. Our numbers of GPs over the age of 55 remain at 13%. The nursing workforce remains unchanged, with 22.9% under the age of 40 and 34% over the age of 55. All the nationally recommended recruitment and retention schemes are in place and delivering.

It is important to note that the data above does not include staff recruited by PCNs under the Additional Roles Reimbursement Scheme (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 455 Whole Time Equivalents by March 2024. As of the 31st March 2024, PCNs had recruited 825.09 FTEs under the scheme, exceeding the target by 81%. 2024/25 will be the last year that PCNs are able to recruit under the scheme and we expect to see fewer temporary roles and an increase in permanent recruitment.

Primary Care Access Recovery Plan

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

1. to tackle the 8am rush and reduce the number of people struggling to contact their General Practice – patients will no longer be asked to call back another day to book an appointment; and

2. for patients to know on the day they contact their General Practice how their request will be managed. If their need is:

    - clinically urgent it will be assessed on the same day by a telephone or face-to-face appointment. If the patient contacts their General Practice in the afternoon they may be assessed on the next day, where clinically appropriate; and

    - not urgent, but it needs a telephone or face-to-face appointment, this will be scheduled within two weeks.

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

On the 30th June 2023, PCNs and member practices submitted their baseline access position, which is a co-developed and co-owned local improvement plan setting out the changes General Practice intends to make to improve access. The funding provided through the National Capacity and Access Support Improvement Payment can be used by PCNs to drive the development and delivery of their local improvement plans.

Following submission of the PCN plans, the ICB produced the System-Level Access Improvement Plan which was signed off by the ICB Board in November 2023. This plan outlined our long-term vision for access in Derbyshire and how we will deliver the national ask. There are three key areas to the plan: patient experience and contact; ease of access and demand management; and accuracy of recording appointment books.

Patient Experience and Contact

The Primary Care Access Recovery Plan mid-year reviews were conducted throughout November and all 18 PCNs engaged with the process. PCNs are performing well against improving the patient experience and contact domain, but further improvement is still required across the other two domains for the majority of PCNs.

Ease of Access and Demand Management

Those PCNs that have employed an experienced digital and transformation lead (using ARRS funds) are making the most progress in demand management and accuracy of recording.

There are a number of programmes available to support General Practice. As of February 2024, 25 General Practices have signed up for the Intermediate General Practice Improvement Programme (GPIP). North East Derbyshire PCN and 16 practices have signed up to the intensive version of the programme.

Any practice that has signed up to the national GPIP automatically receives a Support Level Framework visit as part of that programme. The framework is a tool to support organisations in understanding their development needs and where they are on the journey to embedding modern General Practice. There are real benefits to signing up to the GPIP programme and, although it is not a contractual requirement, the ICB is actively encouraging practices to take advantage of the offer while it is available.

General Practice Appointment Data

Data up to the 31st March 2024 shows General Practice in Derbyshire provided approximately 551,000 appointments (573,000 including Glossop, which did not join the ICB until July 2022 so cannot be used when comparing to previous years' figures), which is a 12.4% increase (when corrected for working days). In addition, there were 5,279 home visits provided by the Ageing Well Support Programme, which relieves pressure in General Practice.

Most appointments were face-to-face (approximately 71%) and 40% of appointments were offered to be seen same day, an increase of 16.4% compared to March 2019. The number of video/online appointments delivered were approximately 23,000, which is an increase of 322% compared with March 2019 (corrected for working days), making up 4% of overall appointments.

As of the 1st October 2022, Enhanced Access formed part of the PCN Direct Enhanced Service Contract to help General Practice deliver more of its potential to improve the care available to patients. Longer opening times (via geographically-based hubs which operate additional appointments Monday to Friday, 6.30pm to 8pm and 9am to 5pm on Saturdays) for patients in Primary Care have been rolled out across every PCN in Derby and Derbyshire.

There were approximately 19,203 Enhanced Access appointments offered by PCNs across Derbyshire during 2023/24, and 245,855 enhanced access appointments have been delivered by General Practice this year. Practice-level data is available, and General Practice is monitored against eight standard indicators to measure their patient access.

Derbyshire has recovered by 112% compared to pre-pandemic levels of activity (corrected for working days). The Primary Care Team work with those General Practices who regularly show lower levels of recovery; firstly it is established if there is a data issue and then if not, informal support is offered by talking through any issues to identify actions the ICB can support with. Targeted support is offered through the 'Accelerate' programme and the newly released GPIP.

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, and strategic outline cases where appropriate, have been undertaken in South East Derby, South West Derby, Mickleover, Mackworth, North East Derbyshire, Southern Derbyshire and Swadlincote areas. Updates included:

- an expressions of interest exercise to determine a Primary Care contractor for a branch site in Mickleover, in response to housing development and with some funding through developer contributions;
- in Mackworth a pre-application has been submitted for the identified site for a replacement building, with work ongoing to determine which Primary Care contractors will deliver services from the site;
- the development of a plan to replace the Sinfin Moor Health Centre in Derby, following a national hold on the proposed Cavell Centre development. Developer contributions are available and the ICB remains committed to improving capacity in this location;
- two schemes are being developed for an extension and for a replacement building, as a significant increase in capacity in the South Hardwick PCN area was identified; and
- completion of the extended east Staffordshire/south Derbyshire feasibility study, and an expressions of interest exercise to identify a preferred provider for a new branch surgery on the Drakelow power station site. This opportunity has been offered to local General Practices in both Derbyshire and Staffordshire given the proximity to the county borders. Developer contributions will provide much of the capital needed for the new build.

The ICB continues to work with local planning authorities to identify solutions in areas of significant growth and to develop plans in line with the timeframes of new housing developments. The availability of developer contributions, including developments at Boulton Moor and Infinity Garden Village, represents a change in the way we work with the local planning authorities, given the significant progress made with working through the backlog of developer contributions inherited from predecessor organisations, and giving space for a more proactive and forward-thinking approach.

Individual estates strategies have been developed for PCNs in Derbyshire, working within a national programme, and are being collated regionally and nationally to provide some evidence of the estates needs generated by the introduction of PCNs and ARRS staff. PCN estates strategies have also fed into the Derbyshire System Infrastructure Strategy.

The Primary Care Estates Team is working alongside colleagues from Derbyshire NHS Trusts to identify opportunities for estates efficiencies such as site disposals and improved utilisation of existing System estates.

Primary Care Quality

Quality Improvement Patient Safety Project – Improving Communication Flow Between General Practices and System Partners

A small working group comprising Derbyshire Local Medical Committee, GPs, PCNs, the ICB, NECSU and DCHSFT representatives was established in 2021 to work together to address concerns raised and reduce the barrier to safe effective communication across different disciplines and levels of staff using the two clinical systems, EMIS and TPP SystmOne.

It has taken some time to go through the various scenarios, pilot stages, agree the standard operating procedure and ongoing work to share the findings of the working group wider with System partners.

A comprehensive standard operating procedure is in place across JUCD, to enhance communications between System partners and, ultimately support the best possible outcomes for our patients. The latest version is available on the JUCD website[viii]. In essence, all clinicians are being asked to consider if their message is urgent and, if so, to ring the General Practice concerned.

Failure to follow the task principles set out in the standard operating procedure will mean that tasks are missed and will present clinical risk, such as patient safety concerns, delayed or missed patient care, staff safety and wellbeing. This procedure does not make recommendations for how tasks are processed within individual General Practices, only when tasking between System partners.

General Practice Visiting Programme

General Practice Quality Visit (GPQV) formerly known as quality assurance visits, are scheduled on a yearly to 18-monthly rolling programme 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 improvements in quality.

The visiting programme delivered by the ICB's Primary Care Quality Team brings all areas of JUCD together to strengthen quality assurance and improvement outcomes in all areas in the practice setting. GPQVs are intended to be an informal way for practices to have an open discussion about areas of their practice, and to 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. GPQVs continue to be a mechanism for encouraging practice development and sharing good practice.

The National General Practice Level Support Programme (formerly known as General Practice Improvement Programme)

The National General Practice Level Support Programme will provide support for General Practices and PCNs over two years (2023–2025) to make changes and improvements to how they work. This is to help General Practices transition to the 'Modern General Practice Access Model' as set out in the Recovery Plan. There are two levels of support offered, the 'Universal General Practice Improvement Support' – Quick Wins and Tips, which is open to everyone, and the 'Practice Level Support Programme', which provides three months of hands-on support with a facilitator. The objectives of the programme are to support General Practices and PCNs to:

- better align capacity with demand;
- improve the working environment;
- improve patient experience; and
- build their capability to sustain improvement.

Practices or PCNs participating in the support will need to be able to access data from their telephony system, in order to plan and track improvement. There are no requirements for General Practices to participate however, NHSE have stated that the improvement programme will support General Practices to make the changes and move towards a Modern General Practice Access Model more easily. General Practices not wishing to participate in the national offer do have the option of a local offer supported by the Hub Plus.

It was agreed that the national programme will not be incorporated into the GPQV programme. The national assessment focuses on the internal process whereas the ICB model has an external focus on assurance. GPQVs will continue under the remit of the Primary Care Quality Team, however information captured from visits will be recorded under the headings as detailed in the national programme and will support reporting themes and trends to the wider teams in the ICB.

The National Practice Improvement Programme is promoted during a GPQV and the ICB has seen a lot of interest from practices wanting to accept this offer.

A practice completing the National Practice Improvement Programme may wish to postpone their ICB Quality Assurance visit until a suitable time or date. However, all General Practices undertaking this national programme will have a data review completed by the Primary Care Quality Team. If this highlights the General Practice as an outlier, this may initiate a visit or discussion from a member of the team to seek assurance on the quality of Primary Care being delivered.

A comprehensive General Practice Visiting Programme Standard Operating Procedure has been written which clearly sets the model of delivery in JUCD. In January 2024, a meeting was held with NHSE colleagues to discuss the programme and to seek comments from the NHSE National Team. The approach taken by Derbyshire has been met with a positive response.

Care Quality Commission

The Primary Care Quality Team continues to work in collaboration with the Care Quality Commission (CQC), in their role as the independent regulator of health and adult social care in England, and our practices across Derby city and Derbyshire, to ensure health services commissioned by the ICB provide people with safe, effective, compassionate, high-quality care. Working in partnership we encourage General Practice to improve, develop and grow their services to enhance patient care.

The CQC is currently implementing a new approach to how they carry out their inspections and the Primary Care Quality Team will be working closely with the inspectorate to understand fully how these changes will impact our General Practices, in order that the support we offer can be altered to meet the CQC's changing approach.

Table 3 identifies the ratings awarded to General Practices by the CQC during 2023/24:

Rating	Total General Practices
Outstanding	18
Good	89
Requires improvement	7
Inadequate	1

Table 3 – CQC ratings awarded to General Practices during 2023/24

The Primary Care Quality Team implements a tailored approach to seeking assurance from General Practices following a CQC inspection with those having an Inadequate or Requires Improvement rating receiving more frequent meetings with the team.

Primary Care Assurance

The Primary Care Quality Team conduct regular reviews of the Primary Care key quality and performance indicators through the quality matrix dashboard along with additional supporting intelligence from the ICB. The purpose of the review is to support the identification of practices where there are areas of quality or performance different to the national or local average. The purpose of the review is to gather intelligence and triangulate information from various data sources relating to General Practice and highlight any variations through a monthly review.

The Primary Care Quality Team will agree actions, interventions and support in relation to both individual practice and PCNs through the Primary Care Quality Operation Group. The reviewed information will be shared with General Practices through the Primary Care Quality Visits Programme.

The data review and subsequent conversation with General Practice also includes the identification of areas of good practice which can be shared across practices through Clinical Governance Leads meetings.

Digital Development

The ICB has 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 JUCD to bring together health and care organisations across Derbyshire. The programme priorities include 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 a data management solution (Axym) to facilitate population health management and accessibility of data. The strategy can be found on the JUCD website[ix].

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 strategy is ambitious; however it is essential if JUCD 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, JUCD 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 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 Director of GP Development is responsible for the delivery of Primary Care digital services 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. These lead roles are underpinned by a number of working groups involving representatives from the Local Medical Committee, GP Provider Board and other ICS partner organisations to facilitate System-wide collaborative working.

The ICB's Digital Development Team supports a number of local, regional and national projects across both Primary Care, corporate IT and the wider ICS. For Primary Care, the majority of the routine operational work is undertaken through contracts with Tameside and Glossop Integrated Care NHS Foundation Trust and NECSU.

The team also deliver programmes of work ranging from organisational safety and the management of mobile devices, through to the development of information systems to address waiting lists and System recovery from Covid-19.

Focus on activity

In 2023/24 our main activity included:

- supporting the delivery of the national Primary Care Access Recovery Programme and the implementation of advanced cloud telephony solutions into Primary Care;
- the redevelopment of the Derbyshire Pathfinder referral optimisation system into a cloud-based solution capable of interfacing with all Primary Care clinical information systems across Derbyshire and other ICS partners;
- the establishment of a Primary Care Digital Group, bringing together colleagues from the ICB, General Practices, PCNs, Local Medical Committee and GP Provider Board to advise on Primary Care digital investments and programmes;
- chairing a learning collaboration group with colleagues from JUCD, NHSE and other Midlands regional partners to address issues with access to physical health checks for patients with a serious mental illness;
- gaining agreement from the Confidentiality Advisory Group of the Health Research Authority to continue to support the ICB's risk stratification work with Primary Care;
- supporting the development of population health management across JUCD and delivery of a number of use cases;
- implementation of multi-factor authentication for all Primary Care and corporate NHS e-mail accounts; and
- implementation of a Microsoft 365 Digital Champions programme to support increased use of Microsoft 365 applications across the ICB and Primary Care with appropriate training and support.

Strategic Clinical Conditions and Pathways

The planning and performance objectives focus on the following long-term conditions (LTCs):

- respiratory;
- cardiovascular disease;
- diabetes; and
- stroke.

These LTCs are aligned to the NHS Long Term Plan, the Integrated Care Strategy for Derby and Derbyshire and the ICB Strategic Framework.

In each of these LTCs, outcomes have focused on improving the quality-of-care provision, addressing health inequalities and population health management, promoting local access to services, improving prevention support 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 and Long-Covid-19.

Programme objectives are agreed through the ICB's planning process and the medical directorate. The programmes are overseen by 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 2023/24 include:

Respiratory	
Review of specialist respiratory community service ImpACT+	ImpACT+ proactively manages people at risk of developing, or who have a diagnosis of respiratory disease, via the provision of a Place-based preventative approach to care. The ICB worked with ImpACT+ to conduct a service review. The outcome of this review identified the need for updated KPIs, as well as the identification of service improvements, as part of a continuous quality improvement approach. The three key areas for service improvements include early identification of at-risk patients, increasing 'stop smoking' interventions and improving efficiencies, productivity and better care pathways for the population. The reporting of new KPIs and service development activity will be initiated from April 2024.

Chronic obstructive pulmonary disease winter toolkit	A bespoke chronic obstructive pulmonary disease winter toolkit was developed to provide information and resources to support people with the disease over winter. The toolkit formed part of a resource pack issued to General Practices and included a communications pack to help them send targeted messages to respiratory patients.
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 continuing to address health inequalities. Work to support the promotion of the pulmonary rehabilitation service has also been completed, and resource and capacity planning has taken place.
Cardiovascular Disease	
Cardiovascular disease prevention	There has been a continued focus on cardiovascular disease prevention with the development of a five-year phased and prioritised prevention plan. The plan focuses on ensuring optimal treatment and case findings of patients with undiagnosed atrial fibrillation, high blood pressure (hypertension) and elevated cholesterol. The plan will ensure health inequalities across Derby and Derbyshire are addressed.
Hypertension case finding	The ICB continue to work alongside public health lifestyle improvement workers to undertake blood pressure monitoring within communities where low hypertension prevalence rates and health inequalities exist. In addition, the ICB was awarded NHSE funding for test models to reduce the number of undiagnosed people with hypertension in Derby city. The models included a communications campaign, public engagement, upskilling volunteers in various communities in Derby city to take blood pressure readings and increasing the number of healthcare professional-led blood pressure clinics. The programme saw over 4,000 additional blood pressure tests carried out. The learning from this pilot will help support the ICB's cardiovascular disease prevention plan.

Cardiac rehabilitation	NHSE funding has been utilised to increase access and referrals for heart failure patients. Cardiac rehabilitation services are continuing in the development of a Derbyshire-wide standardised service with the extension of Phase 4 cardiac rehabilitation provision within leisure centres. A digital platform has also been implemented with Recap Health, to support patient education on cardiac rehabilitation. NHSE funding has been received to support the exploration of the integration of both cardiac and pulmonary rehabilitation services. This will include an extension on Phase 3 cardiac rehabilitation provision, providing more opportunity for access outside of acute settings.
Heart failure	NHSE-targeted heart failure funding has been received to support a 12-month pilot to provide three heart failure in-reach nurses working across the acute hospitals. The programme's aim is to improve hospital discharge for heart failure patients and reduce waiting lists for the community heart failure services.
Stroke	
Stroke rehabilitation	Derbyshire services have been benchmarked against the NHSE Integrated Community Stroke Services specification to identify gaps in provision. There is a focus on developing an equitable pathway to drive patient outcomes. Engagement for the review has begun and a case for change is in development.
Stroke critical service review	Due to continued difficulties regarding workforce and service pressures nationally, a cross-border critical services review has commenced to support the sustainability and running of hyper acute and acute stroke units.
Diabetes	
Derbyshire footcare pathway	Following the implementation of a Derbyshire footcare pathway, the additional footcare clinic has been extended further at CRHFT. Implementation of Silhouette software has begun to further ensure equity of service and standardisation across all providers.
Diabetes-specific psychology support	A clinical health psychologist has been appointed to support this service which treats complex patients across the System with an aim of reducing non-elective admissions.
Intermittent and continual glucose monitoring devices	Updated National Institute for Health and Care Excellence (NICE) guidance advised 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.

Structured education	A review is ongoing to understand health inequalities and barriers to access structured education for patients living with type 2 diabetes.
National Diabetes Prevention Programme	The gestational diabetes referral pathway to enhance access onto the National Diabetes Prevention Programme has been implemented in both acute Trusts.
Type 2 path to remission (low calorie diet) programme	An additional facilitator has been funded to increase the reach and impact of the General Practice register sharing project, increasing referrals into the programme.

Nigel Ayers, of Wirksworth, saw his weight drop from 112kg to 89kg after he took part in the NHS Type 2 Diabetes Path to Remission programme.

He said: "Now I feel like I have a new lease of life – it's unreal. The pains in my knees have gone and being able to cycle again is just incredible."

Mehreen Hashmi, a diabetes coach with Xyla Health, which provides the programme in Derbyshire, said: "I tell people that if they can stick to these products for three months, then they can stick to a healthy, balanced, diet for the rest of their lives.

"We do things in a personalised way. By helping them to understand themselves better you can help them to manage their diet and weight."

NHSE and JUCD Programmes

Long-Covid-19 (post-Covid-19 syndrome)	
Long-Covid- 19 service	An options appraisal has been developed with key stakeholders to identify a preferred service model for 2024/25. A review was required due to a reduction in service demand. A health inequalities toolkit has also been developed to enhance equity of access to under-represented groups.
Tobacco Dependency Treatment Services	
Tobacco Dependency Programme	Tobacco dependency champions and advisors continue to work with inpatients across acute providers and maternity services. Since the programme was introduced within mental health services in January 2023, the referral numbers are continuing to increase.

Medicines, Prescribing and Pharmacy

Since the formation of the ICB, the Medicines Management and Clinical Policies Team has embedded and evolved our functions to meet the needs of the 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 the delivery of efficiency targets, governance reviews to ensure continued clinical decision-making and quality initiatives such as antimicrobial stewardship.

A key part of our strategy is to drive pharmacy professional leadership, and to integrate pharmacy and medicines initiatives within the System. Highlights include:

- the Medicines Optimisation and Delivery Team's programme of work to improve the quality and value of medicines utilising digital innovation and greener NHS medicines carbon footprint;
- recognising the opportunities for community pharmacy System-integration such as developing the independent prescriber pathfinder initiative and launch of Pharmacy First supporting Primary Care access; and
- the successful multi-stakeholder hypertension case finding 'Go Further Faster' award winning programme in Derby city.

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 has 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 This is aimed at ensuring optimal use of medicines to reduce the avoidable and unjust differences in health outcomes for the population of Derby and Derbyshire.

Medicines Savings Programme

During the year, the team delivered an ambitious programme saving over £16m. This included work in the following areas:

- medicines optimisation;
- nutrition;
- Optimise Rx prescribing support software tool;
- 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 2023/24, 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.

The team continued to support the Controlled Drugs Destruction Authorised Witnessed Programme, and the team witnessed the safe destruction of controlled drugs with five pharmacies across Derbyshire in 2023/24.

The collaborative work with Health Innovation East Midlands to improve management of chronic pain by reducing harm from opioids also continued in 2023/24 and resulted in a reduction in high dose opioid prescribing from the 2021 baseline.

Medicines Safety

The Derbyshire Medicines Safety Network, a System-wide group comprising of medicines safety officers from all Derbyshire providers, met during 2023/24 with learning from local incidents shared and discussed. Implementation of the System safety workplan continued during 2023/24 with a focus on System assurance of compliance with National Patient Safety Alerts. The group also set up an oversight process to ensure all providers delivered actions in relevant alerts.

Investigation and analysis of medication-related incidents also continued during 2023/24, including supporting General Practices and other providers to transition to a new 'learning from patient safety events' reporting system.

Antimicrobial Stewardship

Antimicrobial stewardship is key to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness. The Derbyshire Antimicrobial Resistance Strategy was refreshed for a further two years in 2023 and incorporates all national antimicrobial prescribing and healthcare associated infection targets, with specific actions to ensure progress towards achievement and improvement where necessary.

Prescribing data was also circulated to practices during 2023/24 to help us better understand volumes and variations in prescribing.

Community Pharmacy Services and Community Pharmacy Integration

As part of the national investment to community pharmacy over the next two years to support the Primary Care Access Recovery Plan, the Pharmacy First Service was launched. With support from JUCD, four sites across Derbyshire will be involved in the NHSE independent prescriber pathfinder sites. The service supports the management of low acuity patients in community pharmacy and replaces the Community Pharmacy Consultations Service.

In addition, seven common conditions can be managed in this setting. As part of the Pharmacy First Service, there was the re-launch of hypertension case findings and a service to allow supply of oral contraception, which will support General Practice workload pressures.

This work has been led by a dedicated community pharmacy integration role who is a member of the Midlands General Practice Community Pharmacy Consultations Service Implementation Oversight Group. They work across Derby and Derbyshire with the Local Pharmaceutical Committee, NHSE programme managers, PCNs and community pharmacies to promote and develop local plans for implementation, troubleshooting and monitoring uptake. Other community pharmacy services continue to be supported, for example discharge medicines service, new medicines service, and plans to support smoking cessation schemes in community pharmacy.

Contracting and Procurement

The expiring commissioner-led contracts were reviewed by the Medicines Management and Clinical Policies Team and procured in line with current governance processes during 2023/24. The team populated the ICB's contract register and continued to update it with any changes to contracts, governance process and outcomes of due diligence checks. The team have also provided pharmaceutical input on the procurement of wider ICB-commissioned contracts.

Decision-Making

Managing Individual Funding Requests

The Individual Funding Request (IFR) process upholds ICB statutory duties and continues to be managed by the Clinical Policies Team. It 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 monthly when required, with decisions being made within agreed timescales. Mandatory IFR training has been undertaken for new 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

The Clinical Policies Advisory Group continues to manage a work programme for existing policies, while also 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

The Joint Area Prescribing Committee manages the entry of new medicines into the NHS, and it develops and maintains prescribing guidelines and formulary. Following the publication of national shared care protocols the 14 relevant Derbyshire shared care guidelines were reviewed and updated. Processes and principles for agreeing formulary, shared care, and patient group directions were established in order to strengthen clarity and collaboration within the System.

The 'Guideline Group' has 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

The Derbyshire Prescribing Group covers medicines oversight, quality, safety and cost effectiveness, along with transformation of services.

High-Cost Drugs – ICB-Commissioned

In 2023/24 the budget continued on a block contract arrangement, and despite significant staffing change both in the ICB and the acute Trusts, the high-cost drugs finance meetings continued to operate regularly and monitored the uptake of biosimilars, which are medicines similar to an approved medicine.

The Clinical Policies and Decisions Team continues to monitor and adopt new NICE technology appraisals, approving ICB-commissioned algorithms and seeking assurance and compliance through the use of Bluetec. All ICB-commissioned NICE technology appraisals published in 2023/24 were approved for local use within expected timeframes and included within the appropriate commissioning algorithms. In addition, the team has scoped the use of new and emerging biosimilars which provide cost efficiencies for JUCD.

Support to Place, Primary Care Networks and General Practice

We have dedicated Place, PCN and General Practice-based support from an ICB Medicines Optimisation and Delivery Pharmacist and/or Pharmacy Technician in all General Practices. This 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 at all levels of the System, to influence change and improvement across the Derbyshire footprint.

There has been continued development and delivery of education sessions which are available to pharmacy teams (ICB, PCN and practice-employed) across the ICB.

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

The Derbyshire Prescribing Service with the Medicines Order Line continues to provide efficient medicine ordering for 83% of General Practices – reducing waste and easing workload for General Practices and pharmacies. Digital ordering options via the NHS App or the new Medicines Order Line online order form are encouraged for those patients and carers able to access them, ensuring timely access for those who need to call.

Community Pharmacy Commissioning

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

Covid-19 Vaccination, Treatment and Other Vaccination Programmes

The ICB has a dedicated Head of Medicines Optimisation for Vaccinations providing dedicated clinical and pharmaceutical support for the Vaccination Operations Cell. This has responsibility for Covid-19 Vaccination programmes, the Covid-19 Medicine Delivery Unit Programme and it provides leadership on other vaccination programmes in advance of delegation in April 2025 (such as flu and measles, mumps and rubella).

Our vaccination incident process has been aligned with the regional NHSE Screening and Immunisation Team process across all programmes. The Covid-19 Medicine Delivery Unit Programme underwent significant changes in relation to patient access of the service via in-reach, and new pathways were established to transfer from the previous out-reach model. From November 2023, eligible patients were able to collect lateral flow device Covid-19 tests from community pharmacies as part of a new service.

In September 2023, all community pharmacies were able to sign up to provide Covid-19 vaccination services for the autumn/winter programme. This was different to previous years where it was done by exceptionality if there was insufficient coverage for an area. As a result, the programme increased its number of community pharmacies offering the service from 38 in 2022/23, to 77 in 2023/24. Community pharmacies were able to support initiatives to improve low uptake in particular communities facing health inequalities, which was facilitated by the Head of Medicines Optimisation for Vaccinations.

Ambulance and NHS 111 Commissioning

The East Midlands Coordinating Commissioning Team manages the ambulance and NHS 111 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.

National Standards

At a Trust-level, EMAS did not achieve any of the six national standards over the course of 2023/24. NHS Leicester, Leicestershire and Rutland ICB, and NHS Northamptonshire ICB achieved C1 90th centile for Q1, Quarter 2 (Q2) and Q3. Nottingham and Nottinghamshire ICB achieved C1 90th centile for all four questers.

Nationally, Ambulance Trusts were awarded additional funding for the delivery of Category 2 mean performance of 30 minutes, and EMAS received £23.5m of this national allocation. This money has been used to fund additional resources, implement NHS pathways into the Emergency Operations Centre, and recruit further workforce.

A trajectory was developed to deliver a regional C2 mean average of 30 minutes across the year, due to non-achievement this was revised to 39 minutes 49 seconds in October 2024. The new trajectory was met in October and November but was not achieved for the other months of the year. At the end of 2023/24 the trajectory was exceeded by 3 minutes 34 seconds with an average C2 mean of 43 minutes 23 seconds.

Whilst the six national standards were not met, we have seen an improvement in performance in all categories at a Trust-level during Q1–Q3 when compared to the same quarters in 2022/23, Q4 saw an improvement in all categories except C1, however both C1 mean and 90th centile are comparable to the same time period last year as shown in Table 4 below:

	National Standards 2023/24							
	Category 1				Category 2			
	Mean		90th Centile		Mean		90th Centile	
	2023/24	2022/23	2023/24	2022/23	2023/24	2022/23	2023/24	2022/23
National Standard	00:07:00		00:15:00		00:18:00		00:40:00	
Q1	00:08:36	00:09:37	00:15:33	00:17:29	00:36:02	01:04:57	01:17:50	02:23:45
Q2	00:08:34	00:09:30	00:15:35	00:17:13	00:38:38	01:02:40	01:23:34	02:24:47
Q3	00:09:00	00:09:59	00:16:13	00:18:13	00:47:00	01:28:33	01:40:53	03:23:59
Q4	00:09:13	00:08:55	00:16:22	00:16:07	00:47:41	00:46:57	01:41:37	01:43:32
	Category 3				Category 4			
	90th Centile				90th Centile			
	2023/24		2022/23		2023/24		2022/23	
National Standard	02:00:00				03:00:00			
Q1	05:15:55		08:15:24		04:28:02		08:25:38	
Q2	05:55:12		08:25:17		04:41:24		08:10:03	
Q3	07:25:28		09:59:20		06:07:29		09:11:07	
Q4	06:57:04		05:51:55		06:37:03		05:57:18	

Table 4 – EMAS Performance for-2023/24

During Q1, Q2 and Q3 of 2023/24, the number of ambulance crews waiting to hand patients over at EDs improved when compared to the same period in 2022/23. Q4 saw a deterioration on 2022/23 performance. Over the course of 2023/24 EMAS lost a total of 147,401 hours due to pre-handover delays that were greater than 15 minutes, this is a 17.8% reduction on 2022/23 when 179,367 hours were lost. The average pre-handover times can be seen in Table 5 below:

	Average Pre-Hospital Handover Times					
	Q1			Q2		
	April	May	June	July	August	September
2023/24	00:24:49	00:28:34	00:26:03	00:24:57	00:25:54	00:30:20
2022/23	00:42:39	00:35:45	00:42:05	00:41:39	00:37:41	00:55:16
	Q3			Q4		
	October	November	December	January	February	March
2023/24	00:39:59	00:35:06	00:41:18	00:49:45	00:44:29	00:35:13
2022/23	00:44:45	00:37:57	01:04:21	00:33:41	00:31:11	00:32:44

Table 5 – Average pre-hospital handover times for 2023/24

As part of the contractual agreement reached with EMAS and the six ICB associate commissioners of the emergency ambulance contract, all ICBs with the exception of Humber and North Yorkshire submitted improvement trajectories linked to operational plans that commit to a reduction in the average pre handover time and handover delays in excess of 60 and 120 minutes. Achieving this as a minimum would have had a positive impact on performance, as well as quality and patient safety. Whilst the start of the year saw a positive achievement, this deteriorated from September onwards with trajectories being missed by all ICBs except NHS Lincolnshire ICB. The average pre handover trajectories and achievement can be seen in Table 6 below:

		2023/24 Average Pre-Handover Time					
		Q1			Q2		
		Apr	May	Jun	Jul	Aug	Sept
Derby & Derbyshire ICB	Trajectory	00:23:22	00:22:20	00:25:07	00:25:00	00:24:38	00:24:46
	Average	00:22:24	00:26:27	00:22:14	00:21:42	00:21:29	00:26:16
Leicestershire ICB	Trajectory	00:28:10	00:28:10	00:28:10	00:28:10	00:28:10	00:28:10
	Average	00:23:56	00:26:04	00:28:02	00:20:06	00:23:21	00:24:27
Lincolnshire ICB	Trajectory	00:45:10	00:42:33	00:48:18	00:48:51	00:50:15	00:52:32
	Average	00:36:31	00:40:42	00:34:45	00:34:30	00:41:13	00:49:03
Humber & North Yorkshire ICB	Trajectory	00:56:59	00:56:59	00:56:59	00:56:59	00:56:59	00:56:59
	Average	00:24:46	00:24:55	00:24:21	00:24:41	00:23:38	00:38:07
Northamptonshire ICB	Trajectory	00:25:08	00:25:00	00:26:05	00:26:30	00:25:26	00:25:37
	Average	00:26:29	00:26:58	00:26:28	00:24:21	00:23:14	00:25:49
Nottingham & Nottinghamshire ICB	Trajectory	00:23:03	00:22:18	00:23:28	00:24:21	00:23:34	00:23:07
	Average	00:19:57	00:27:11	00:23:14	00:25:29	00:24:19	00:26:37
		Q3			Q4		
		Oct	Nov	Dec	Jan	Feb	Mar
Derby & Derbyshire ICB	Trajectory	00:27:38	00:24:04	00:29:22	00:24:31	00:23:17	00:23:50
	Average	00:29:29	00:29:46	00:36:28	00:31:54	00:33:01	00:24:32
Leicestershire ICB	Trajectory	00:28:10	00:28:10	00:28:10	00:28:10	00:28:10	00:28:10
	Average	00:42:13	00:44:39	00:47:03	01:03:45	00:51:42	00:44:22
Lincolnshire ICB	Trajectory	00:52:24	00:48:28	00:51:55	00:44:34	00:43:43	00:42:55
	Average	01:08:04	00:46:08	00:41:47	00:44:24	00:39:50	00:33:42
Humber & North Yorkshire ICB	Trajectory	00:56:59	00:56:59	00:56:59	00:56:59	00:56:59	00:56:59
	Average	00:51:45	00:28:52	00:44:22	00:51:38	01:08:26	00:40:36
Northamptonshire ICB	Trajectory	00:27:50	00:25:10	00:33:52	00:27:21	00:24:17	00:24:37
	Average	00:30:48	00:31:31	00:40:55	00:45:59	00:33:12	00:33:16
Nottingham & Nottinghamshire ICB	Trajectory	00:24:25	00:23:21	00:25:31	00:24:40	00:24:16	00:24:11
	Average	00:32:52	00:31:18	00:40:20	00:58:10	00:49:17	00:37:24

Table 6 – Average pre-handover trajectories and action performance times for East Midlands during 2023/24

Call Demand

Call demand for 2023/24 has been lower than plan, for 6 months out of 12. As a yearly total, calls were +0.3% above plan. The monthly variance can be seen in Table 7 below:

		Call Demand					
		Q1			Q2		
		April	May	June	July	August	September
Calls	Actual	92,377	99,793	101,691	100,407	100,431	105,544
	Plan	99,275	101,641	105,238	111,295	98,818	95,218
	Variance	-6.90%	-1.80%	-3.40%	-9.80%	1.60%	10.80%
		Q3			Q4		
		October	November	December	January	February	March
Calls	Actual	113,941	103,533	112,482	105,582	98,539	102,667
	Plan	107,032	102,500	114,103	97,539	91,962	108,817
	Variance	6.50%	1.00%	-1.40%	8.20%	7.20%	-5.70%

Table 7 – Call demand for Quarter 1 to Quarter 3 of 2023/24

For 2023/24 there was a decrease in the percentage of duplicate calls as a proportion of total calls. The percentage reduced to 20.6% compared to 23.3% in 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.

Incidents (where a patient receives a face-to-face response or clinical assessment over the telephone) were above plan for 7 months out of 12. On-scene activity has been above plan since July 2023, with February 2024 being the largest deviation from plan. As an annual total, incidents and on-scene activity were both above plan at +1.8% and +4.0% respectively. Activity level for incidents and on-scene activity can be seen in Tables 8 and 9 below:

		Q1			Q1		
		April	May	June	July	August	September
Incidents	Actual	63,418	66,085	65,447	66,967	65,843	65,709
	Plan	66,237	69,210	66,851	67,227	65,260	64,021
	Variance	-4.30%	-4.50%	-2.10%	-0.40%	0.90%	2.60%
		Q3			Q4		
		October	November	December	January	February	March
Incidents	Actual	68,835	66,166	70,289	70,304	64,639	69,445
	Plan	67,573	67,406	66,916	65,034	57,848	65,214
	Variance	1.90%	-1.80%	5.00%	8.10%	11.70%	6.50%

Table 8 – Incidents for 2023/24

		Q1			Q1		
		April	May	June	July	August	September
On-Scene	Actual	55,166	57,098	65,447	57,580	57,351	56,786
	Plan	56,451	59,039	66,851	55,755	54,605	53,935
	Variance	-2.30%	-3.30%	-2.10%	3.30%	5.00%	5.30%
		Q3			Q4		
		October	November	December	January	February	March
On-Scene	Actual	57,574	57,341	59,044	58,050	54,324	58,270
	Plan	56,657	56,496	54,581	53,692	47,686	53,284
	Variance	1.60%	1.50%	8.20%	8.10%	13.90%	9.40%

Table 9 – On-scene activity for 2023/24

EMAS post-handover times were above the 15-minute national standard in April 2023, and between October 2023 to March 2024. The increase in post-handover times from October onwards is due to a coding change for electronic patient record form completion, previously this was coded to vehicle off road time. Post-handover times for the year can be seen in Table 10 below:

	Average Post-Hospital Handover Times					
	Q1			Q2		
	April	May	June	July	August	September
2023/24	00:15:04	00:14:27	00:14:22	00:14:21	00:13:45	00:13:22
2022/23	00:20:10	00:21:16	00:21:05	00:22:35	00:22:03	00:17:54
	Q3			Q4		
	October	November	December	January	February	March
2023/24	00:18:57	00:19:50	00:19:17	00:18:48	00:18:58	00:19:34
2022/23	00:15:16	00:14:47	00:14:07	00:14:38	00:14:01	00:14:31

Table 10 – Average post-hospital handover times for 2023/24

Serious Incidents

During 2023/24, EMAS identified 42 incidents requiring investigation. 10 were investigated under the previous Serious Incident Framework and 32 were investigated under the PSIRF. This compares to 99 in the previous year. The majority of these were identified as being delayed responses or prolonged waits to patients who had called 999.

Actions are already underway both internally and as part of the wider System to address these issues. Any incident that occurred on or after the 1st April 2023 sits within the Patient Safety Incident Response Framework (PSIRF), which has adopted new terminology for patient safety incidents. Key documentation has been updated in line with the changes and policies are in the process of being updated to reflect the changes. Full implementation of the PSIRF will be in place from the 1st April 2024. The learning from patient safety events service (previously called the patient safety incident management system) is now live and offers a single national NHS system for recording patient safety events. EMAS are now able

to record patient safety events through this service to strengthen wider learning and improvement.

The ICB 999 Clinical Quality Review Group remains the main mechanism to ensure oversight of continuous improvements is taken from the learning of patient safety incidents. The group's focus is to ensure that effective, appropriate and timely action is taken to respond and learn from incidents to develop and enable a shared vison for quality care and improved patient safety.

NHS 111 (East Midlands) Performance

The NHS 111 contract with DHU contains five KPIs and a further KPI associated with the validation of Category 3 ambulance dispositions. Due to the original go-live date of the NHS 111 contract with DHU being mid-financial year (October 2016), the quarterly performance reporting does not mirror the quarters in a fiscal year. Within this report, Q1 of 2023/24 data demonstrates Q3 of the DHU NHS 111 contract, Q2 demonstrates Quarter 4 (Q4), and Q3 demonstrates Q1.

Performance against the call handling KPIs for 2023/24 is summarised within Tables 10 to 14 below:

Calls abandoned after 30 seconds

	Q1 (DHU Q3)			Q2 (DHU Q4)		
	April	May	June	July	August	September
Actual	3.90%	3.10%	2.30%	1.50%	1.10%	3.50%
Target	5%	5%	5%	5%	5%	5%
	Q3 (DHU Q1)			Q4 (DHU Q2)		
	October	November	December	January	February	March
Actual	3.70%	1.70%	2.90%	2.70%	2.90%	3.50%
Target	5%	5%	5%	5%	5%	5%

Table 11 – Performance of DHU NHS 111 calls abandoned after 30 seconds during 2023/24

Average call answer time

	Q1 (DHU Q3)			Q2 (DHU Q4)		
	April	May	June	July	August	September
Actual	00:01:19	00:00:54	00:00:37	00:00:27	00:00:19	00:00:48
Target	00:00:27	00:00:27	00:00:27	00:00:27	00:00:27	00:00:27
	Q3 (DHU Q1)			Q4 (DHU Q2)		
	October	November	December	January	February	March
Actual	00:00:46	00:00:24	00:00:49	00:00:41	00:00:48	00:00:56
Target	00:00:27	00:00:27	00:00:27	01:00:27	02:00:27	03:00:27

Table 12 – Performance of DHU NHS 111 average call answer time during 2023/24

Proportion of triaged calls transferred to a clinician

	Q1 (DHU Q3)			Q2 (DHU Q4)		
	April	May	June	July	August	September
Actual	67.00%	66.50%	65.70%	67.00%	65.80%	67.40%
Target	50%	50%	50%	50%	50%	50%
	Q3 (DHU Q1)			Q4 (DHU Q2)		
	October	November	December	January	February	March
Actual	67.70%	67.50%	70.40%	64.80%	64.40%	65.40%
Target	50%	50%	50%	50%	50%	50%

Table 13 – Performance of DHU NHS 111 proportion of triaged calls transferred to a clinician during 2023/24

Proportion of triaged calls closed with self-care within 111

	Q1 (DHU Q3)			Q2 (DHU Q4)		
	April	May	June	July	August	September
Actual	17.60%	18.30%	18.90%	19.80%	20.30%	20.40%
Target	17%	17%	17%	17%	17%	17%
	Q3 (DHU Q1)			Q4 (DHU Q2)		
	October	November	December	January	February	March
Actual	20.10%	19.60%	20.00%	19.90%	18.70%	17.60%
Target	17%	17%	17%	17%	17%	17%

Table 14 – Performance of DHU NHS 111 proportion of triaged calls closed with self-care within 111 during 2023/24

Proportion of callers satisfied with their experience

	Q1 (DHU Q3)			Q2 (DHU Q4)		
	April	May	June	July	August	September
Actual	74%			74%		
Target	85%			85%		
	Q3 (DHU Q1)			Q4 (DHU Q2)		
	October	November	December	January	February	March
Actual	74%			74%		
Target	85%			85%		

Table 15 – Performance of DHU NHS 111 proportion of callers satisfied with their experience during Quarter 1 to Quarter 3 of 2023/24

Clinical Assessment Services

In relation to the validation of C3 ambulances, due to a cyber-attack in 2022, which caused a major outage to the Adastra data system used by many integrated urgent care providers, data was unavailable between September 2022 and November 2022, and therefore 2023/24 cannot be compared accurately to the previous financial year. For 2023/24, the number of clinical validations remained above the 50% target and the percentage which are downgraded continue to be positive, as shown in Table 16 below:

	Category 3 validations					
	Q1 (DHU Q3)			Q2 (DHU Q4)		
	April	May	June	July	August	September
Patients available for validation	13,214	13,500	13,639	12,905	12,162	12,075
Total clinically validated	8,993	9,072	9,007	9,372	8,876	8,963
% Clinically validated (target 50%)	68.10%	67.20%	66.00%	72.60%	73.00%	74.20%
	Q3 (DHU Q1)			Q4 (DHU Q2)		
	October	November	December	January	February	March
Patients available for validation	14,495	14,252	15,895	15,445	13,985	15,105
Total clinically validated	11,235	10,867	12,355	13,005	11,801	12,491
% Clinically validated (target 50%)	77.50%	76.20%	77.70%	84.20%	84.40%	82.70%

Table 16 – Performance of category 3 validations during 2023/24

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. ICBs and NHSE are required to update it on an ongoing basis, as it is critical to the delivery of urgent and emergency care. Working alongside service providers, services are profiled onto the directory, enabling users to make informed decisions regarding the appropriateness of the services local to patients in need. Within EMAS, they use a combination of NHS Service Finder and their own clinical decision support system. This combination provides real-time, trusted information for health care professionals involved in patient care, allowing patients to receive the right care, in the right place, first time.

The DoS is integrated within NHS pathways and once someone has gone through a triage, the DoS provides information about where they should go next. The DoS uses the information already collected about the patient, such as their location and how quickly they need treatment, to provide a list of the best services for them. For example, this might be the nearest pharmacy, UTC or ED.

The list is ranked by factors, such as how close the facility is, when it is open and what services are available when they get there. This helps to improve the management of service capacity across the System. Work will continue with 111 and 999 providers during 2024/25 to ensure that, moving forwards, the NHS Pathways are implemented in a co-ordinated timeframe across both the East and West Midlands.

Following a period of testing during October 2023, EMAS introduced a new telephone triage system during November 2023 where 999 ambulance calls are handled in their Emergency Operations Centres. NHS Pathways replaced the Advanced Medical Priority Dispatch System that was in use for processing, assessing and categorising all 999 calls. It is a well-established and trusted clinical tool already used by several ambulance services across the country and by the 111 providers across the country.

EMAS continue to categorise 999 calls into the same categories as before and were supported during the testing and early implementation by West Midlands Ambulance Service), who have been using NHS Pathways for a long time. To support them in the development of NHS Pathways, EMAS have recruited two Directory of DoS leads, who are part of the wider Midlands-wide DoS team that support the use and development of NHS pathways to meet local and national needs.

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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, and to achieve NHSE Long-Term Plan ambitions. Achievements and progress include:

Community mental health	Transformation of community-level support for adults with a serious mental illness continues to develop. This programme, called 'Living Well Derbyshire' and 'Derby Wellbeing' in Derby city is currently being rolled out across the rest of Derbyshire in 2025. It has been developed in High Peak and Derby and the learning is being used to take these plans forward elsewhere.
	Living Well Collaboratives are now operational across JUCD and are developing processes of communication and practical collaboration methods, bringing key agencies and the voice of lived experience together to improve pathways, outcomes and health equalities for people with a serious mental illness.
	Co-producing and co-designing the 'Living Well' model and living well teams, which has involved integrated working with VCSE, Local Authorities and the NHS.
Inpatient care	The JUCD 'Making Room for Dignity' Programme aims to meet the government pledge to eradicate dormitory accommodation from mental health facilities across the country to improve dignity and outcomes for people needing inpatient care. These plans are developing as follows: • Carsington Unit – a new 54-bed male adult acute unit at Kingsway Hospital; • Derwent Unit – a mixed adult acute unit at CRHFT; • Kingfisher House – a new male psychiatric intensive care unit at Kingsway Hospital; • Bluebell Ward – a ward for older adults at Walton Hospital; • Radbourne Unit – two 17-bed female acute wards at Royal Derby Hospital; and • Audrey House – an 8-bed female acute-plus facility at Kingsway House. More information about these plans and latest information can be found here[x].
NHS Talking Therapies	Access to Talking Therapies continues to be positively received across Derby and Derbyshire. JUCD are expected to meet the access targets set by NHSE within 2023/24, as around 28,000 people have accessed this service in Derby and Derbyshire. Recovery and reliable improvement rates also show that most people are receiving positive outcomes as a result of entering this treatment for anxiety and depression.

Reducing health inequalities	Work continues around NHSE's Core20PLUS5 Framework which supports JUCD in taking a strategic population health management approach to cohorts of people with multiple disadvantages. Serious mental illness and physical health improvement is a key clinical area of focus, with System partners continuing to work together strategically and operationally to improve in areas such as cross-sector working, and information and data sharing to create a personalised care approach. The mental health needs of Derby and Derbyshire's deaf community continues to be an area of focus and the year ahead will also see increased activity aimed at tackling outcome differences dependant on ethnicity.
	The implementation of reasonable adjustments to ensure equity in access, experience and outcomes is a golden thread that runs through all areas of work in adult mental health commissioning.
Crisis alternatives development	Considerable progress has been made to expand the range of support and services available for people who are facing immediate mental health needs. These services are designed to support people who would otherwise need to access ED to help keep themselves safe: • three new open access community drop-in services run by Derbyshire MIND are available at weekends in Buxton, Ripley and Swadlincote; • two Safe Havens run by Richmond Fellowship and P3 are open to anyone to access in both Derby and Chesterfield every night of the year from 4.30pm to 12.30pm; • two Crisis Houses in Derby and Chesterfield, also run by Richmond Fellowship and P3, are designed to support people who would otherwise need to access inpatient mental health care; • the Mental Health Helpline continues to grow and expand, and from December 2023 people who are deaf and communicate in British Sign Language can also access this service. Further information can be found here[xi]; and • plans are developing to increase access to the mental health helpline through the national NHSE plan for the NHS 111 'select mental health option' which will be in place during April 2024. • More information about all of these services can be found here[xii].

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, which 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.
	Establishing 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. JUCD is committed to improving its approach to co-production with local people and has approached key stakeholders, including local Partnership Boards, to understand how to do this.

Children, Young People and Young Adult Mental Health

JUCD has continued to implement the commitments of the local Children and Young People's Transformation Plan, which can be found here[xiii]. The ICB has also continued to work alongside a wide range of voluntary and community sector partners, Local Authorities and NHS partners locally to design and deliver support for children and young people with mental health needs and to achieve NHSE Long-Term Plan ambitions. Achievements and progress include:

Increasing access to mental health support	We increased funding to Kooth, our universally available digital offer to all children and young people in Derby and Derbyshire, so they are able to access text-based counselling, advice and support via moderated forums.
	Within the education sector we have expanded mental health support teams, so more schools have this dedicated service. We have also reviewed our other early intervention and targeted support service to ensure it meets the needs of children, young people and families who are not served by a mental health support team. This means every child and family in Derby and Derbyshire has access to an early intervention and targeted support offer, no matter where they live, which school they attend or whether they are home schooled.
	We continue to fund services that meet the needs of our most vulnerable children, with psychology support to children in youth justice services and the provision of a specialist service for children in care.
	During 2023/24, 14,115 children and young people had accessed emotional and mental health services. More information about what is available can be found here[xiv].
Eating disorders, restricted eating	We increased funding to First Steps, our eating disorder prevention and early support service, who now provide support to children and young people across the whole of Derby and Derbyshire.
	We are working with partners to improve the offer for children and young people with a broad range of eating difficulties and restricted eating, particularly for those with autism.
	Recruitment to our specialist child and adolescent mental health services eating disorder services has helped to make the services more responsive in assessing both urgent and routine cases.
Improving urgent care and crisis response	We have achieved NHSE's ambition of a 24/7 crisis response available to all children and young people. This can be accessed through the 24/7 Derbyshire mental health helpline and support service, which offers advice, support and onward triage when a clinical service is indicated. Our urgent care services have expanded their hours to provide assessments, brief interventions, intensive home treatment and day support when it is most needed.

Young adults	We have successfully piloted a new innovative service for those aged 18 to 25 who traditionally face 'a cliff edge' of care on their 18th birthday. This has supported young adults who would normally not receive a mental health service and has helped services work in a more integrated fashion. We have also developed an information session about how services can meet the emotional and mental health needs of young adults in Derby and Derbyshire.
Reducing health inequalities	We have focussed efforts on improving access for boys and young men, and ethnic minority communities. Our services have begun to change how they reach out into communities and how they engage. We expect more changes going forward, for example reviewing logos to make sure they are not too 'feminine'.
Co-production and collaborative working	MH2K enables young people to explore mental health issues and influence decision-making in their local areas. Citizen researchers aged 14–25 years conducted peer research to inform the development of our services, details of which can be found here[xv].
	We have funded experts by experience in our children adolescent mental health services and ensured that children's and their families' voices are part and parcel of our normal work practice. For example, it is our partners with lived experience who have told us some service logos are too 'feminine' and we have ensured that an expert by experience has been involved in all stages of our planning and decision-making when undertaking our pilot young adults service.

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

The areas of focus during 2023/24 were:

Children and Young People's Delivery Board	The Children and Young People's Delivery Board continues in delivering key programmes of work aligned to its vision that: *We will provide a seamless health, education and social care pathway for children and young people in Derby and Derbyshire - one that enables all children and young people to be healthy and resilient and, if support is needed, enables them to plan their care with people who work together, allowing them to achieve the outcomes that are important to them.* Our key priority from the Integrated Care Strategy is to have a particular focus on school readiness. The aim of this is to ensure that we are targeting prevention, reducing health inequalities and avoiding the need for more specialist intervention by enabling children and their families to access support at the earliest opportunity.
Neuro-development	We have continued to work with System partners in the voluntary and community sector, education and social care to deliver the co-produced plans to address neurodevelopmental assessment waiting times, and to improve the experience of children and young people, and their families when they need to access support.
	We have mobilised four neuro-diversity community hubs across Derby and a Derbyshire. These are providing access without a referral to support, advice and information for children, young people and their families before or after they have received a diagnosis for a neurodevelopmental condition. Further information and support can be found here[xvi].
Physical health transformation programme	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, and each area has a specific System-wide plan. We are part of the national working group that is developing the Right Care Toolkit for diabetes, and the System work that we have been leading on for asthma and transitioning to adulthood has been recognised by NHSE. As a result, Derby and Derbyshire have been put forward as an area of best practice. The latest plan for epilepsy will focus on addressing the variation in care between epilepsy services across Derby and Derbyshire and improving the mental health and wellbeing of children and young people with epilepsy.

Special Educational Needs and Disabilities	The CQC and Ofsted published a revised joint area Special Educational Needs and Disabilities (SEND) Inspection Framework in 2023. We have been working with Derby City Council and Derbyshire County Council to prepare for Local Area SEND Inspections under the new framework.
Reducing health inequalities	The NHS approach to reducing health inequality is called Core20 Plus 5. The clinical priorities of this approach align to our physical health transformation programme and embeds our commitment to this important agenda. The approach within the neuro-diversity community hubs is in response to community groups who are underrepresented in service provision.
Co-production and collaborative working	A range of partners, including experts by experience, came together to develop the neuro-diversity community hubs to ensure that they were designed to meet the needs of the people who will use them. We are continuing to use this approach by capturing feedback from people who are using the hubs and by having experts by experience working within them. The neuro-diversity community hubs alongside our approach to their development have been nationally recognised, and we have shared our approach with other ICSs and at national events.

Environmental Matters

Sustainable Development

Vision and Purpose

In its Net Zero Strategy, first published in October 2020, the NHS set out a vision to become the world's first net zero carbon health service and respond to climate change, improving health now and for future generations. The NHS 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.

Every part of the NHS will act both in the short and long-term to meet this ambition. Addressing carbon emissions will result in a wide range of ancillary benefits, from reduced plastic waste and improved air quality to reductions in health inequalities related to environmental factors as well as the broader impacts of climate change. Though the positive impact of carbon emission reduction on health inequalities is recognised, it is important that the NHS teams and organisations across the Midlands region collaborate to realise and address co-benefits related to health inequalities across the Net Zero programme.

Greenhouse Gas Protocol

Figure 6 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.

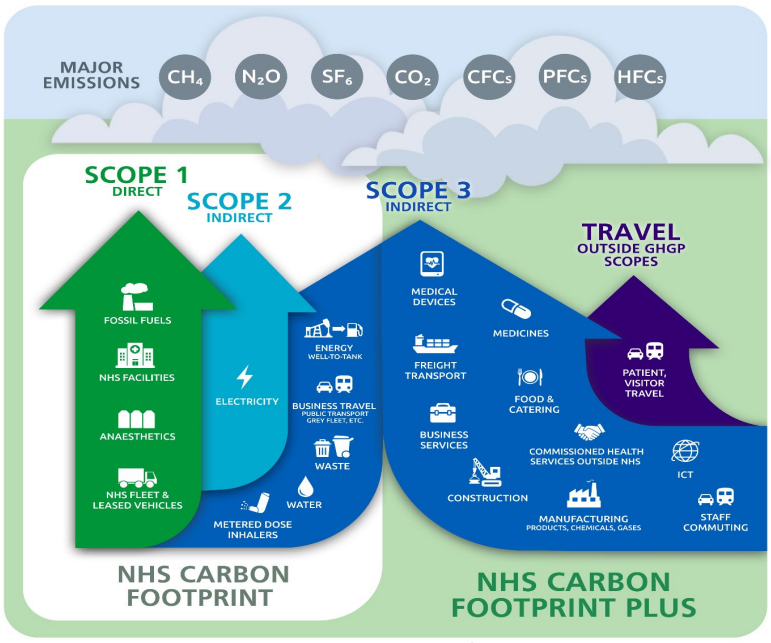


Figure 6 – GHGP scopes in the context of the NHS (Source: NHSE)

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 7 below shows that the greatest areas of opportunity, or challenge, for change are in the supply chain, estates and facilities, pharmaceuticals, medical devices, and travel.

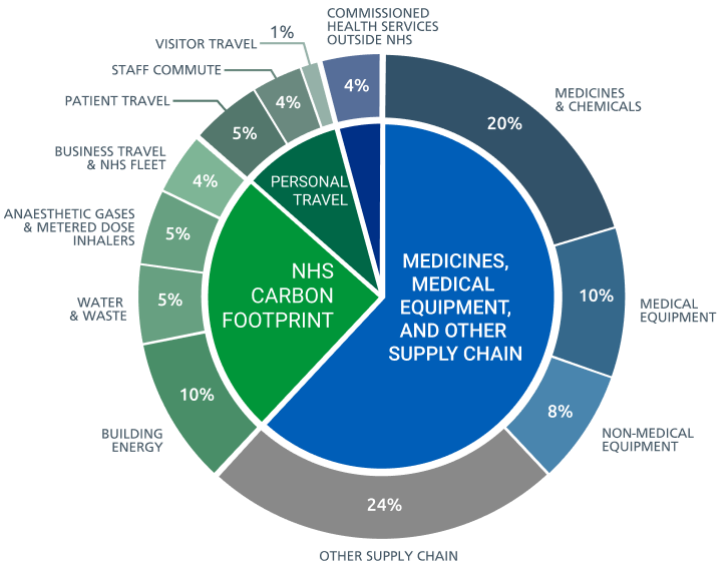


Figure 7 – Sources of carbon emissions by proportion of NHS Carbon Footprint Plus (Source: NHSE)

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 Assurance and Governance

The Midlands Regional Greener NHS Team is led by a Senior Responsible Officer, this is required for both funding and governance purposes. The Chief Sustainability Officer and Regional Directors are held to account by the NHSE Executive Team and by the NHSE Public Board.

The Midlands Greener NHS work is led, assured and governed by the Midlands Regional Greener NHS Team and the Midlands Regional Greener NHS Board which meets every six weeks and is attended by each Senior Responsible Officer and other regional leads (e.g. Estates, Medicines and Procurement).

Appropriate processes and governance structures are in place to manage finances, delivery and risks.

Trusts and ICSs have developed Board-approved Green Plans, aligned with the ambitions set out in 'Delivering a Net Zero NHS'. During the 2023/24 financial year, ICSs were asked to deliver on these plans with regional support, and ensure plans were aligned with the ambitions set out in 'Delivering a Net Zero NHS'.

The NHS Midlands region defined seven regional priorities for carbon reduction for 2023/24 for JUCD as follows:

Governance and Assurance	Every Trust and ICB to have a Board-approved Green Plan aligned with the 'Delivering a Net Zero NHS' report.
	Regional Greener NHS Board in place meeting every six to eight weeks.
Travel and Transport	**Collaboration with Local Authorities:** All ICSs to engage and work with Local Authorities and/or local transport authorities to explore funding opportunities and deliver at least one SMART sustainable travel objective, which is agreed with regional teams. These engagements are to include, or be led by, the relevant ICBs and Trusts where appropriate.
	Low Emission Fleets: Ensuring that the region's owned and leased fleet is made up of at least 90% Low Emission Vehicles by March 2024. Including 11% of the fleet being made up of ultra-low emissions and zero emission vehicles by March 2024.
	Staff travel survey: 100% of organisations to complete a staff travel survey at least every 24 months, but ideally annually.
	Modal Shift: 100% of Trusts have three or more of the following schemes/interventions in place to support modal shift, such as: ○ only ultra-low emissions or zero emission vehicles available for salary sacrifice schemes; ○ salary sacrifice cycle-to-work scheme; ○ discounted public transport scheme; ○ shuttle buses between two or more sites; ○ park and rides; ○ sustainable travel options included within staff induction; and ○ staff webpage focused on promoting sustainable travel options.
Medicines	**Desflurane:** In all Trusts, limit the use of desflurane to only exceptional circumstances , in line with the NHS' ambition to eliminate its use by early 2024.
	Nitrous Oxide Waste: Reduce emissions from nitrous oxide (N_2O) and mixed N_2O products by 19–23% in 2023/24 against a 2019/20 baseline.
	Inhalers: Reduce emissions from inhalers by 25% in 2023/24 against a 2019/20 baseline, by rolling out the principles of high-quality low carbon respiratory care.

Estates and Facilities	Assist in the preparation for future readiness for low carbon heating systems, including collating information on readiness by March 2024.
	Promote and raise awareness of the NHS Net Zero Building Standard, and NHS Estates Net Zero Carbon Delivery Plan.
	Promote and coordinate Trusts' and ICBs' access to funding opportunities supporting estates decarbonisation, including Public Sector Decarbonisation Scheme, Low Carbon Skills Fund, the Green Heat Network Fund, the Boiler Upgrade Scheme and other locally-identified funds.
Procurement and Supply Chain	Support Trusts and ICBs to: ○ adopt procurement policy note 06/20 to ensure that 100% of new NHS procurements, where relevant and proportional, include a minimum 10% net zero and social value weighting; and ○ be ready for implementation of the 2024 Net Zero Supplier Roadmap requirements, including supporting national and local action to improve supplier readiness for this requirement.
	Support procurement colleagues in Trusts and ICBs to ensure all new procurements over £5 million per annum include the Carbon Reduction Plan requirement aligning with procurement policy note 06/21.
Net Zero Clinical Transformation	Develop a detailed plan to support all staff in Primary Care, and especially leadership, to incorporate greener actions into their professional lives and embed into System and regional ways of working.
	Embed the Green ED Framework, carbon monitoring and lessons learned through the UEC and Accident and Emergency Delivery Boards.
Workforce and Leadership	Strategically influence leaders at regional, System and provider-level to be visible leaders on this agenda.
	Engage the regional workforce through education, events, and training as appropriate.

The success of the programme is measured via carbon emissions and trajectories collected, measured and shared by the National Greener NHS Team.

Joined Up Care Derbyshire Integrated Care System Greener Delivery Group

JUCD established a Greener Delivery Group in June 2021, and meets quarterly. The ICB's Chief of Staff is the Chair of the group. The Derbyshire Provider Trust Sustainability Leads and workstream subject matter experts are members of the group, together with specialist Lead Pharmacists within JUCD. The workstream areas focus on governance, medicines, Primary Care, travel and transport, estates and facilities, supply chain and procurement, and data and digital.

The purpose of the Joined Up Care Derbyshire Integrated Care System Greener Delivery Group is to provide the JUCD oversight and accountability for the achievement of the carbon reduction targets against both the NHS Carbon Footprint and the NHS Carbon Footprint Plus, as specified in 'Delivering a Net Zero NHS', as well as monitoring progress against expected trajectories.

The JUCD ICS Green Plan is supported by a Green Action Plan. The action plan is reviewed by workstream leads monthly and reported to the Joined Up Care Derbyshire Integrated Care System Greener Delivery Group on a quarterly basis.

The following section details the key priorities for 2023/24 and highlights the areas of progress and achievement:

2023/24 Priority	Action Plan Progress Update
Reduce emissions from nitrous oxide and mixed nitrous oxide products by 19–23% in 2023/24 against a 2019/20 baseline	Focus on Derbyshire Acute Trusts (CRHFT and UHDBFT).
	CRHFT have established a Medical Gases Safety Group and have reviewed baseline nitrous oxide data to compare supply and clinical usage.
	UHDBFT have established a sub-group to prioritise reduction of nitrous oxide use and waste. Pilot complete in Paediatric Theatres.
Reducing the CO_2e impact of inhalers, in line with the commitment of a 25% in 2023/24 on a 2019/20 baseline	A 25% reduction (based on a 2019/20 baseline) to 16,451 is the target for 2023/24. The ICB's 2022/23 emissions totalled 16,796, and are predicting to surpass the 2023/24 with a 34% reduction.
	The ICB are the best performing ICB in the Midlands for the reduction of inhalers emissions.
Reduce desflurane usage to <2%, in line with the 2023/2024 Standard Contract	Data shows Desflurane as a percentage of all anaesthetic gases being < 2%.
Support Trusts and ICBs to adopt procurement policy note 06/20 so that 100% of new NHS procurements where relevant and proportional include a minimum 10% net zero and social value weighting	All Trusts have 10% social value weighting included in every tender issued.
	The ICB's Procurement Team has a suite of documents to support social value and the key themes to support any new procurements.

Support procurement colleagues in Trusts and ICBs to ensure all new procurements over £5m per annum include the Carbon Reduction Plan requirement aligning with procurement policy note 06/21	Procurement teams have identified suppliers requiring a carbon reduction plan to qualify for NHS contracts from April 2023. Where applicable (contract over £5m annually), the ICB identify suppliers requiring a carbon reduction plan as part of any new NHS procurements.
Promote and raise awareness of the NHS Net Zero Building Standard, and NHS Estates Net Zero Carbon Delivery Plan	Projects undertaken prior to publication of the Net Zero Standards will not comply. Current projects include an evaluation of decarbonisation/net zero.
	An ICS Estates Strategy is in development.
Achieve a 50% reduction in use of office paper by 2025 compared to baseline, and ensuring ICSs and constituent NHS Trusts only purchase 100% recycled content paper for all office and non-office-based functions by 2025	Derbyshire NHS organisations meet social value requirements in tenders, embedded as business as usual through Procurement Regulations. Derbyshire are also purchasing 100% recycled paper.
Assist preparation for future readiness for low carbon heating systems	ICB and Derbyshire Trusts purchased all electricity from renewable sources. This will change from April 2024 due to new contracts across Derbyshire.
	UHDBFT only use fuel oil as a back-up fuel source in case of gas supply failure.
	CRHFT were successful in sourcing £200k funding for LED lighting and solar projects.
Collectively develop a Derbyshire ICS Strategy for enhancing the resilience of care to extreme weather events	ICS wide adaptation plan is in development.
Promote and increase awareness of sustainability through communications, education, and training	ICB implemented ESR Net Zero Training as mandatory from the 1st October 2023.

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 our 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[xvii] for 2022–25 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 approved and adopted the JUCD ICS Green Plan, and an ICS Climate Change Adaptation Strategy is in development.

The ICB has also developed an ICT and Digital Policy which includes the adherence to ethical and environmental standards. Climate change adaptation and the consideration of net zero targets is embedded within the ICB's governance, decision-making and assurance processes. It is a key component of JUCD's performance and project management, including the monitoring of impact assessments and the effective use of sound evidence in policy making.

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 JUCD ICS 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 17 below shows our energy consumption for the last four years, for our shared ICB headquarters at Cardinal Square, Derby – the cost of which totalled £28,007 for 2023/24:

	2023/24	2022/23	2021/22	2020/21	2019/20
Electricity (kWh)	94,233	136,513	107,389	94,142	169,927
Water (m^3)	988	1,703	590	589	1,177

Table 17 – ICB headquarters' energy consumption for 2023/24, 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 a reduction in carbon emissions and travel costs. Digital working (Microsoft Teams meetings and remote collaboration) has also led to a reduction in consumables. Table 18 below illustrates the actual travel costs against budget, which shows a significant increase due to a significantly lower budget than in previous years.

	2023/24	2022/23	2021/22	2020/21
% Actual travel cost versus budget	315%	54.5%	39.5%	43.4%

Table 18 – Actual travel cost versus budget for 2023/24, 2022/23, 2021/22 and 2020/21

During the Covid-19 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. The ICB did not utilise any air travel during 2023/24.

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 over the past two years we have advocated switches to lower carbon choices to reduce our inhaler carbon footprint. Figures from Open Prescribing[xviii] show that our mean carbon emission per salbutamol inhaler has reduced significantly:

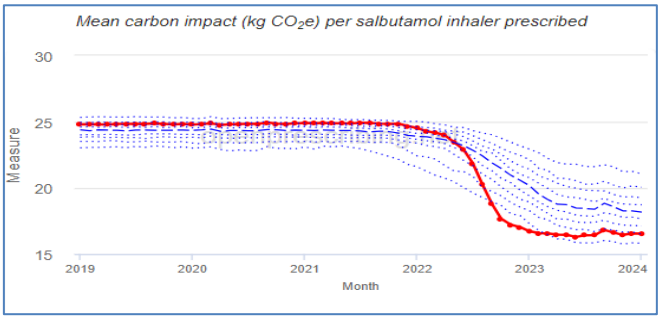


Figure 8 – mean carbon impact (KgCO2e) per salbutamol inhaler prescribed (31st March 2024)

As at the 31st March 2024, OpenPrescribing data for the ICB states that the mean carbon impact is 16.5 KgCO2e per inhaler, which is below the national median figure of 18.1 KgCO2e. In August 2023, NHSE Midlands confirmed that the ICB were the best performing ICB in the Midlands on the average carbon footprint per salbutamol inhaler.

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, as per Figure 9 below:

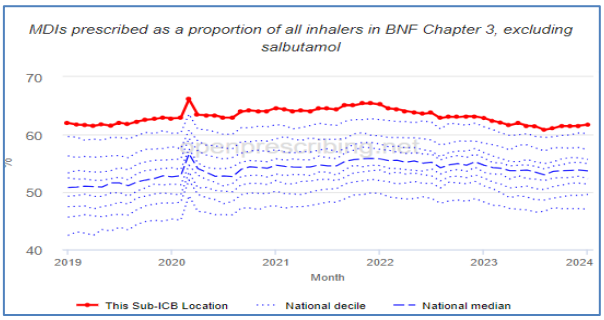


Figure 9 – MDIs prescribed as a proportion of all inhalers in BNF Chapter 3, excluding salbutamol (31st March 2024)

Greener NHS Dashboard data shows that the carbon emissions of all inhalers, for Derbyshire during 2023/24, amounted to 14,666 KtCO2e. This is a 33% reduction on the 2019/20 baseline, exceeding our target to achieve a 25% reduction.

Greening Government Committee's Performance

In response to the Greening Government Committee's 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 2023/24

The ICB and the Derbyshire healthcare system has faced another challenging period financially during 2023/24. Whilst the ICB delivered a surplus of £1.0m (2022/23: £14.8m deficit), JUCD returned a deficit of £58.0m (2022/23: £31.6m).

The ICB experienced significant inflationary pressures during the financial year, in particular across prescribing, mental health and CHC. Further pressures were the result of national Primary Care contracting arrangements, and an increased need for both mental health care (section 117, learning disabilities, and psychiatric intensive care) and CHC. These pressures were mitigated by significant underspends in dental expenditure (as a result of historic national policies and continued national directions following delegation from the 1st April 2023), over-delivery of the ICB's efficiency programme, and a reduction in its administration costs, to deliver the surplus of £1.0m.

JUCD has worked as a collective to identify efficiencies and deliver its financial position. However, the resultant £58.0m deficit reflects pressures outside of its control including inflation, pay award funding, changes in national capital policies, equal pay for health care support, and the shortfall in Primary Care funding (discussed above).

Financial Position

Total resources of £2,512.7m (2022/23: £1,706.8m) were available for the year including income of £36.8m (2022/23: £9.4m) and £2,475.7m (2022/23: £1,697.4m) of allocations from the Department of Health and Social Care. The ICB committed expenditure totalling £2,474.7m (2022/23: £1,721.6m), leaving the ICB with an underspend of £1.0m (2022/23: £14.8m deficit). Further details can be found in the Annual Accounts section of this report on page 221.

Pharmacy, ophthalmic and dental services were delegated to the ICB from the 1st April 2023, increasing allocations by £108.0m and expenditure by £93.9m. The underspend has in part mitigated the cost pressures detailed above.

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.

Gross Operating Costs for the period to 31st March 2024

Category of Expenditure	2023/24 Spend	2022/23 Spend[1]
	£m	
Services from Foundation Trusts	1439.7	1021.4
Services from Other NHS Trusts	147.8	100.9
Purchase of healthcare from non-NHS bodies	355.2	260.4
Prescribing	188.2	139.9
Primary Care	222.2	156.4
Dental	57.5	0.0
Pharmacy	36.2	0.1
Ophthalmic	10.9	0.3
Staff	28.6	21.8
Supplies and services – general	5.0	4.4
Services from other ICBs and NHSE	11.4	7.8
Other	8.7	8.2
TOTAL	**2,511.4**	**1,721.6**

Table 19 – Gross Operating Costs for 2023/24 and 2022/23

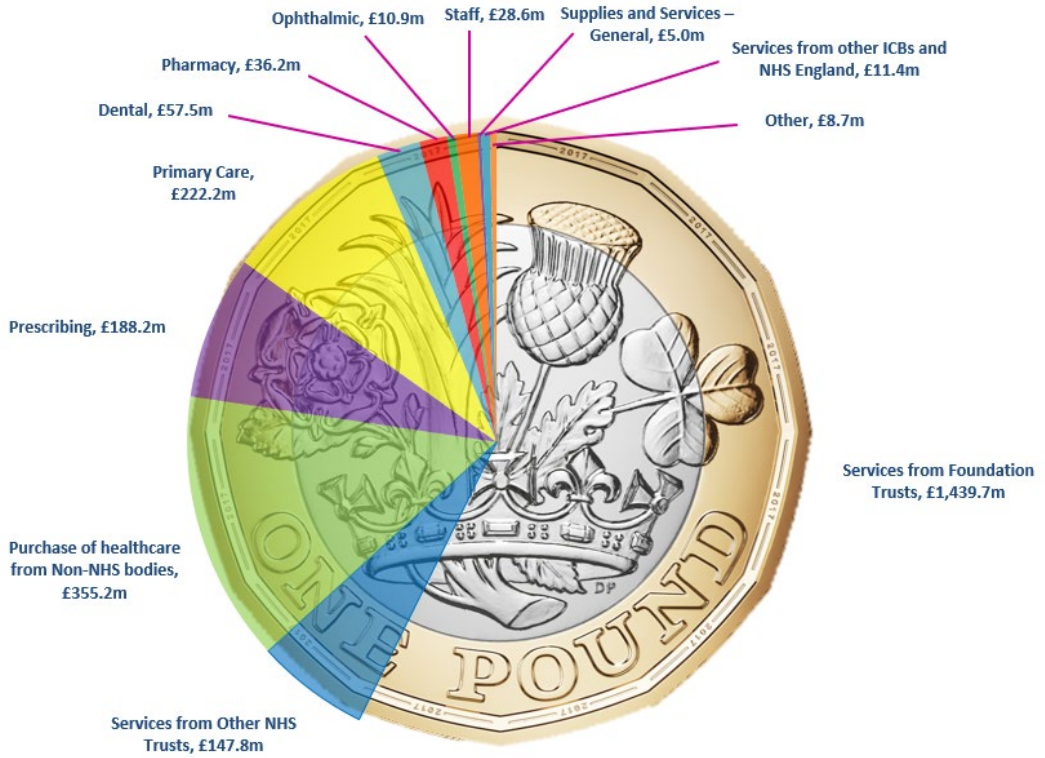


Figure 10 – Gross Operating Costs 2023/24 – 'The Derbyshire Pound'

[1] Reflects the period 1st July 2022 to 31st March 2023.

Mental Health Spend

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

For the purposes of MHIS, mental health spend is recurrent spend on mental health services excluding learning disability, autism and dementia. It also excludes spend relating to Mental Health Service Development Funds.

The proportion of mental health spend by the ICB of the overall programme allocation was 8.66% (2022/23: 9.41%), which is demonstrated in Table 20 below. The ICB was established on the 1st July 2022, succeeding the CCG. For the purposes of the comparator, the CCG period has been completed for 2022/23.

	Financial Years			
	ICB	Total	ICB	CCG
	2023/24	2022/23	2022/23 (Q2–Q4)	2022/23 (Q1)
	£m			
Mental health spend	212.4	207.1	155.7	51.4
Programme allocation	2,452.5	2,201.9	1,679.2	522.7
Mental health spend as a proportion of programme allocation	8.66%	9.41%	9.27%	9.83%

Table 20 – amount and proportion of expenditure incurred in relation to mental health for 2023/24 and 2022/23

The ICB MHIS target for 2023/24 is £212.067m (£206.898m 2022/23). This is an increase of 2.50% from 2022/23. The ICB reported MHIS expenditure for the year of £212.4m (2022/23: £207.1m), which is an over achievement of the MHIS target detailed above.

The ICB confirms that the figure reported has been calculated in accordance with the MHIS guidance and the financial information that forms the basis of the calculation. This includes the design, implementation, and maintenance of internal controls to ensure that mental health expenditure is 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 to the 31st March 2024 was only the second reporting 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 in the prior period, and are included in the prior year comparator in Table 21 below. The primary movement in receivables reflects the delegation of primary dental care to the ICB from the 1st April 2023. Liabilities has reduced by a smaller amount in comparison, linked to the utilisation of the provisions.

Property, plant and equipment includes IT equipment additions; utilising the ICB's capital resource allocated during the period. The ICB has reviewed its headquarter buildings during the year, resulting in a reduction of its right of use assets and corresponding lease liabilities.

	31 March 2024	31 March 2023
	£'000	£'000
Non-current assets		
Property, plant and equipment	321	155
Right of-use assets	262	822
Total non-current assets	**583**	**977**
Current assets		
Trade and other receivables	18,471	7,542
Cash and cash equivalents	279	220
Total current assets	**18,750**	**7,762**
Total assets	**19,333**	**8,739**
Current liabilities		
Trade and other payables	(119,778)	(119,855)
Lease liabilities	(270)	(405)
Provisions	(1,372)	(2,598)
Total current liabilities	**(121,420)**	**(122,858)**
Total assets less current liabilities	**(102,087)**	**(114,119)**
Non-current liabilities		
Lease liabilities	–	(410)
Provisions	(351)	(532)
Total non-current liabilities	**(351)**	**(942)**
Total assets less liabilities	**(102,438)**	**(115,061)**
Financed by Taxpayers' Equity and other reserves		
General Fund	(102,438)	(115,061)
Total Equity	**(102,438)**	**(115,061)**

Table 21 – Statement of Financial Position, as at 31st March 2024

Provider Selection Regime and Compliance with Procurement Regulations

The Health and Care Act 2022 set an expectation that all those involved in planning, purchasing, and delivering health and care services work together to agree and address shared objectives, making it easier for them to do so.

A key component of the changes introduced by the Health and Care Act 2022, and strongly supported by stakeholders across the NHS and local government, is the Provider Selection Regime (PSR) which is set out in the Health Care Services (Provider Selection Regime) Regulations 2023[xix].

The new PSR Regulations come into force in England on the 1st January 2024 and replace the following previous regulations:

- Public Contracts Regulations 2015; and
- National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013.

The following legal obligations will still apply:

- National Health Services Act 2006;
- Equality Act 2010;
- Modern Slavery Act 2015;
- Local Government and Public Involvement in Health Act 2007;
- Local Authorities (Executive Arrangements) (Meeting and Access to information (England) Regulations 2012; and
- Subsidy Control Act 2022.

ICBs, NHS and Foundation Trusts, NHSE, Local Authorities and combined authorities must comply with the regulations. The PSR only applies to clinical healthcare procurements; existing regulations apply to all other procurements. Three “direct award” processes are available, plus a “most suitable provider” process, and competitive procurement remains as an option.

Regulation Aims and Principles

The aims of the PSR are designed to support greater integration and collaboration across health and social care systems, offer a flexible and proportionate process for selecting providers of health care services (made in the best interest of the service users), and reduce bureaucracy and costs.

The principles require relevant authorities to secure the needs of the people who use the services, improve quality of the services, improve the efficiency of the services, and consider value for money. Decision-making is required to be transparent, fair and proportionate.

What the Provider Selection Regime Regulation means for ICBs

ICBs must follow the transparency process relevant to the approach being followed to ensure that there is proper scrutiny and accountability of decisions made about health care services. Notices are required to be published when contracts are awarded or in some situations before a contract is made.

ICBs must keep detailed evidence of their decisions and decision-making process, which is required to be shared should the ICB receive a representation. Representations can be made by dissatisfied providers which if not resolved, can be escalated to an NHSE panel.

Commissioners must apply five criteria alongside the standard criteria of capacity, capability, financial standing, and must demonstrate how they have done this:

1. quality and innovation;
2. value;
3. integration, collaboration and service sustainability;
4. improving access, reducing health inequalities and facilitating choice; and
5. social value.

Annual Summary

ICBs must publish an annual summary, which details how many contracts have been awarded using the PSR Process.

Due to the PSR Regulations coming into force from the 1st January 2024, there have been no PSR competitive processes completed from the 1st January to 31st March 2024.

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 JUCD with the ambition of empowering local health and care leaders to build strong and effective systems for their communities.

The NHS Oversight Framework sets out how NHSE will gain assurance on the performance of ICBs and providers. NHSE has statutory accountability for oversight of both ICBs and NHS providers, with NHSE leading on the oversight of ICBs, and ICBs leading on oversight of providers in their System, with support where appropriate from NHSE.

NHSE and ICBs work together to ensure that agreed roles in local plans are delivered, and work together effectively for the benefit of the populations they serve. ICBs are responsible for initial problem solving and intervention should providers fail, or be unable, to deliver their agreed role. NHSE regional teams offer support as required, drawing on the expertise of the NHSE National Team as needed.

The NHS Oversight Framework outlines the segmentation approach and key metrics which will be considered in assessing performance of the System and providers against six key domains:

1	Quality of care, access and outcomes.
2	Preventing ill-health and reducing inequalities.
3	Finance and use of resources.
4	People.
5	Leadership and capability.
6	Local strategic priorities.

Progress is reviewed at a quarterly System review meeting led by the NHSE Regional Team, to assess and assure System performance, identify whether any support is required and to gather evidence for any change to provider or System segmentation. Individual provider oversight meetings are also scheduled to review performance at provider-level.

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:

- restoring services inclusively;
- mitigating against digital exclusion;
- ensuring data sets are complete and timely; and
- strengthening leadership and accountability.

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 and 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.

The Population Health Steering Group is chaired by a colleague from DCHSFT and the group have undertaken a ‘sprint’ approach to consider tackling tobacco. This work has been considered by the ICP, and a Tobacco Control Board is now taking this work forward. The ICB's commitment to the tobacco dependency agenda is an important part of the System strategy.

The children’s healthy weight strategy is led by Derby City Public Health colleagues, in collaboration with ICB colleagues and monitored through the System Children’s Delivery Board. The work has also been discussed at the City Health and Wellbeing Board.

Core20PLUS5

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, including the progress which has been made during 2023/24 are:

Indicator	Description	2023/24 Progress
Maternity	Ensuring continuity of care for 75% of people from ethnic minority communities and from the most deprived groups.	Local Maternity and Neonatal System Equity and Equality Action Plan updated.
		Action plan in place to implement targeted and enhanced continuity of carer.
Severe mental illness and learning disabilities	Ensuring annual health checks for 60% of those living with severe mental illness or learning disabilities.	ICB are funding additional Health Care Assistants to support the increase in annual health checks for people living with Severe Mental Illness.
		Health Care Assistants and General Practices are now trained in mental health, through the DHcFT Health Protection Unit Pilot.
		A mental health GP lead has been appointed to sit on the GP Provider Board.
		Completion of a system maturity tool.
Improving vaccination uptake	Reducing inequalities in the uptake of life course, Covid-19, flu and pneumonia vaccines.	All community pharmacies were able to sign-up to provide Covid-19 vaccination services for the autumn/winter programme. As a result, the programme increased its number of community pharmacies offering the service and this supported initiatives to improve low uptake in particular communities facing health inequalities.
		The vaccination programme for influenza and Covid-19 boosters was successfully rolled out to all care homes across Derby and Derbyshire.
		The measles elimination plan has been developed and partners are working together to improve measles vaccination rates. This has included a pop-up clinic at the University of Derby and at Derby's initial assessment centre for those seeking asylum.

Indicator	Description	2023/24 Progress
Early cancer diagnosis	75% of cases diagnosed at stage 1 or 2 by 2028.	Health equity audit of bowel cancer screening programme is underway.
		Plan in development to improve bowel cancer screening uptake in those with learning disability.
		Prostate cancer case finding pilot with Black community has been undertaken, with learning to be shared for future work.
		Monitoring of impact of fecal immunochemical test prior to referral policy.
		The ICB engaged a behavioural science provider, who have worked with city General Practices to increase the uptake of cervical screening.
		The Derby City Council Director of Public Health chairs the cancer prevention group and is developing plans for the coming year. These include linking with the cancer alliance advancing cancer equity programme, along with exploring health literacy in cancer pathway communications.
Hypertension case-finding	To allow for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.	Over 3,000 blood pressure checks have been carried out in Derby City as part of NHSE's Going Further Faster funded programme.
		Blood pressure testing has been carried out by public health in areas of high deprivation (e.g. warm spaces, food banks and large employers).
		A data dashboard has been published and shared with nominated CVD leads.

Healthcare Inequalities Board Assurance Tool

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, as listed below. To date, this has been achieved by:

1.	**Restoring NHS services inclusively**	**Patient data**
		Pseudo identification numbers in all datasets link across together.
		Provider board performance packs broken down by ethnicity and deprivation.
2.	**Mitigating against 'digital exclusion'**	**Quality equality impact assessments**
		getUbetter – MSK digital enabler to support patients to manage and prevent deterioration of conditions and ensure patients access the right local services at the right time.
		Recap Health – digital enabler secured to support cardiac rehab patients.
		Digital weight management programme – offer of patient self-referral mechanism.
		Virtual wards – digital enablement provider in place.
		ICS digital and data programme
		Use of secondary uses service outpatient data to identify both face-to-face and virtual activity.
3.	**Ensuring datasets are complete and timely**	**Utilising data**
		There is an ability to link datasets through RAIDR - a locally developed data intelligence system.
		A population health management dashboard has been developed within RAIDR.
		A pilot programme to review planned care waiting lists at CRHFT has been undertaken, including the identification of deprivation and ethnicity.
4.	**Strengthening leadership and accountability**	Core20PLUS5 Ambassadors have now been appointed for the ICB, including a finance fellow.
		A Health Inequalities and Prevention Board has been agreed by the ICP, which will build upon informal leadership arrangements between public health leaders within the ICB, Derby City Council, Derbyshire County Council and DCHSFT. The first meeting has been held and terms of reference agreed.

A project during autumn 2023 saw 4,113 people at high risk have their blood pressure checked by GPs, pharmacists and trained local community volunteers.

Deafinitely Women is among the groups where volunteers were trained and are now continuing to carry out blood pressure checks.

Becky Daykin, connections manager, said: "We have good links with the NHS and Deaf communities and we are able to bridge access to health services at events like ours."

Becky is pictured left, with Louise Peck, who is a volunteer and British Sign Language user.

Equality Delivery System

As an ICB we have continued to demonstrate a proactive approach to meeting the requirements of the Public Sector Equality Duty through use of the NHS Equality Delivery System.

Through recognition of the impact of the Covid-19 pandemic and ongoing NHS pressures, a new tool was produced to better illustrate the required evidence. In Derby and Derbyshire, the tool was piloted during 2022/23 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.

Derby and Derbyshire's Approach

During 2023/24, the following three project areas were reported as per the guidance.

Domains 1 and 2

It was agreed that each provider would choose their own Core20PLUS5 areas and link with the ICB to ensure that there was a connection with the relevant commissioning team to provide a System response. Areas for 2023/24 by provider are:

DCHSFT	Weight management inequalities
	Community podiatry inequalities evaluation
CRHFT	The provision of safe and personalised care: achieving equity and reducing health inequalities and early diagnosis for bowel cancer
	Reducing inequalities for those who are living with a learning disability
DHcFT	Perinatal community mental health services
UHDBFT	Alcohol care
	Tobacco dependency

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

Domain 3

It was agreed that the recent work on hypertension would be presented by the ICB to illustrate the success of joint working with communities, as well as across providers within the System.

Scoring

The ICB facilitated a System-wide scoring event during February 2024. 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:

- LGBTQ+ and Allies Employee Network
- Disabled Employees Network
- Black, Asian and Minority Ethnic Employee Support Network
- Access, Equality and Inclusion Hub
- Race Equality Hub
- 60+Forum/AGE UK
- Learning Difficulties Partnership Board
- Deaf and Hard of Hearing People's Commitment Group
- Derbyshire Maternity and Neonatal Voices Partnership
- Healthwatch
- Links: the Chesterfield and North East Derbyshire Council for Voluntary Service and Action Limited
- Chesterfield Equality and Diversity Group
- Derbyshire Black, Asian and Minority Ethnic Group
- Derbyshire Carers Collaborative
- Trust patient partners
- Trust 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. The outcome of the scoring event was that each of the providers and JUCD were deemed to be 'developing'.

Equality

The Quality and Equality Impact Assessment process continues in its robust assessments of impact of changes of developments. Links between the equality and engagement assessments of service changes and developments have been further developed, with sharing and discussions of assessments to offer the maximum level of assurance.

Further developments have included the permanent recruitment 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 JUCD.

Procurement

We continue to ensure that there are robust processes in place to support 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 assurance that providers of healthcare services in Derby and Derbyshire understand the local 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 Commissioning and Procurement Review Group is being established with representation to ensure equality and engagement legal duties are considered and 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 Quality and Equality Impact Assessments 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 foster 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;
- raising awareness of the lived experiences of under-represented staff;
- re-launching reciprocal mentoring;
- informing the healthcare System's approach to engagement with diverse communities relating to health inequalities;
- fair and inclusive recruitment and selection training;
- identifying actions for the ICB to help improve the lived experiences of staff; and
- informing the Workforce Race Equality Standard, Workforce Disability Equality Standard, and staff survey action plans.

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 2024, the proportion of employees within the ICB from ethnic minority groups was 9.74%. A breakdown of proportion of ICB staff from an ethnic minority group across the banding structure within the ICB is detailed below. Table 22 below shows that these employees are under-represented within the lower Bands 1 to 7:

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

Table 22 – proportion of ICB staff from an ethnic minority group across the banding structure for 2023/24, 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 0%. The Senior Management Team within the ICB has had minimal turnover during 2023/24, which represents a barrier to achieving a diverse workforce at all levels across the organisation.

The ICB Board is undertaking a Building Leadership for Inclusion programme, facilitated by external diversity consultants with the aim of developing leadership that:

- works positively, collaboratively, and proactively to embed equality, equity, and social justice into every aspect of the ways it works;
- has deep individual and collective understanding of inequality and its impact for marginalised groups including ethnic minorities, LGBTQ+, disability and gender, and a commitment to working towards ending inequity;
- is ambitious in its aspirations in relation to leading for greater equity; and
- is clear about the types of action needed to bring about change that makes a change.

Areas covered by the programme include:

- equality, diversity and inclusion – key concepts;
- diversity, power, and practice;
- intersectionality and intersectional lifelines;
- allyship and how to become a better ally;
- culture change and action planning; and
- coaching for inclusion.

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.

Career and Leadership Development Aspirations Survey

The JUCD leadership and talent workstream has an area of focus to provide leadership development opportunities to ethnic minority colleagues to support their career progression. To ensure the development opportunities provided are helpful, meaningful and accessible, a survey was designed, tested and circulated to ethnic minority colleagues to seek their views. The survey was circulated via ethnic minority colleagues within each JUCD organisation. Each organisation chose their own method of distribution, the aim being to reach as many ethnic minority colleagues as possible. The survey was open from the 13th January 2023 to the 10th February 2023, and was completed by 75 people. The following has been summarised from the results of the survey:

What are your long-term career aspirations?	The most common themes received were leadership development and specialising in a clinical field. 12% of respondents expressed their dissatisfaction about opportunities, flexibility, experiences made available, and manager support for development in their career.
What development and support would be most helpful for you to progress your NHS career in the next 12–24 months?	Over 50% of respondents felt that career conversation and advice, coaching and mentoring, the expansion of skills in their current role, leadership development, and shadowing opportunities would be the most helpful.

On a scale of 1–5 please rate your aspiration to develop into leadership role in the NHS	52% of respondents rated 5 (yes, definitely) 21% of respondents rated 4 9.5% of respondents rated 3 8% of respondents rated 2 9.5% of respondents rated 1 (not likely)
Are you aware of national and local leadership development opportunities that are available?	Over 60% of participants were not aware of local and national leadership development opportunities.
What leadership skills or knowledge might help you to do your job more effectively / or develop your career?	The highest scoring areas were: • communicating and influencing; • leading teams effectively; • quality and service improvement; and • understanding myself as a leader.
What are you preferred ways of learning?	Face-to-face workshops were felt to be the preferred way of learning, and over 50% of respondents favoured learning in the workplace, online learning and webinars.
What gets in the way of you accessing learning?	Respondents indicated that not having enough protected time away from the workplace was the biggest barrier to accessing learning, alongside reduced awareness of the opportunities available and a lack of encouragement/support.

Participants were given the option, as a final question in the survey, to leave their contact details if they wished to be kept informed of future learning and leadership development opportunities. 43 people left their details and were emailed to thank them for completing the survey, and provided with some existing development opportunities that are available. Respondents were also offered a career conversation with a colleague from our the ICB's Organisational Development group.

NHS People Plan

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

Public Involvement and Consultation

The ICB has a legal duty to 'make arrangements' to ensure individuals to whom services are being or may be provided, and their carers/representatives, are involved when commissioning services for NHS patients.

The main duties to make arrangements to involve the public are set out in the National Health Services Act 2006, as amended by the Health and Care Act 2022.

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

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

More information about the specific legal duties in relation to working in partnership with people and communities can be found on the NHS England website.

In addition to these legal duties, the ICB also recognises that working in partnership with people and communities creates a better chance of developing services that meet people's needs, improve their experience of services, and ultimately improve their health outcomes. People have the knowledge, skills, experiences, and connections that services need to understand what might support a person's physical and mental health. The benefits of this are:

Improved health outcomes	Ensuring services meet people's needs, improving their experience and outcomes. People have the knowledge, skills, experiences and connections services need to understand in order to support their physical and mental health.
Value for money	Services that are designed with people and therefore effectively meet their needs are a better use of NHS resources. They improve health outcomes and reduce the need for further, additional care or treatment because a service did not meet their needs first time.
Better decision making	Business cases and decision making are improved when insight from local people is used alongside financial and clinical information. Challenge from outside voices can promote innovative thinking that can lead to new solutions that would not have been considered had the decision only been made internally.
Improved quality	Services can be designed and delivered more appropriately, because they are personalised to meet the needs and preferences of local people.
Accountability and transparency	Engaging more meaningfully with local communities helps to build public confidence and support as well as being able to demonstrate public support for proposals.

Participating for health	Being involved can reduce isolation, increase confidence, and improve motivation towards wellbeing. Individuals' involvement in delivering services that are relevant to them and their community can lead to more formal volunteering roles and employment in health and care sectors.
Addressing health inequalities	Jointly identifying solutions to barriers to access, developed in partnership with people using community-centred approaches, can help address health inequalities.

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

Therefore, gathering insight from Derby and Derbyshire's diverse population is a key component of our strategic approach to engagement. Their insight and diverse thinking enable the ICB to tackle health inequalities, ensure equality of access, improve quality of life, and help to meet other challenges faced by our health and care system.

To achieve this we work to 10 key principles that underpin our ways of working, in regards to how we will listen consistently to, and collectively act on, the experience and aspirations of local people and communities within Joined Up Care Derbyshire's geography. The 10 principles for working with people and communities are:

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

Our ambition

The ICB's 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; and
- 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.

Integrated Care System Engagement Strategy

Our comprehensive approach to realising our ambition is outlined in the JUCD Engagement Strategy – 'People and Communities Strategic Approach to Engagement 2022–23. We are currently working with our JUCD colleagues and the Patient Experience Team to update this strategy to set our vision for the next two years. 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, and that there is a System-wide approach to public involvement. Moreover, this approach is led by the desire to develop a culture within JUCD that promotes decisions always underpinned by patient and public insight.

To ensure we develop and implement a systematic approach, our involvement of people and communities is supported by several frameworks. These frameworks have been developed with System partners, including people and communities, and are outlined below. This report identifies the progress made over the last 12 months within each of these frameworks.

Governance	Examines, develops, and evaluates the structures and processes that provide the interface between people and communities and JUCD at all levels, allowing insight to feed into the system, influence decision-making, and nurture the trust and relationships we aspire to in order to deliver on the 10 principles. It seeks to provide assurance that we are meeting our legal and moral duties around public involvement across all areas of health and care system transformation, and change.
Engagement	Outlines a range of methods and tools available to all our System partners to support involvement of people and communities in work to improve, change and transform the delivery of our health and care provision.

Evaluation	We are developing a model that enables the ICB to continually examine our public involvement practice and the impact this has on our work, people, and communities. The aim is to outline how we will measure and appraise our five frameworks to support ongoing continuous improvement. This in turn will support us to demonstrate how well we are acting on people's needs and lived experience to reduce inequalities in health and care provision.
Co-production	Realising our ambition to embed, support, and champion co-production in the culture, behaviour, and relationships of JUCD, through a co-designed multi-agency approach.
Insight	Our approach to identifying and making best use of insight that is readily available in local communities to inform the work of JUCD and promote the development of reciprocal relationships with people and communities to promote social action and establish mechanisms for continuous involvement.

Application in practice across Joined Up Care Derbyshire

Governance Framework

Our desire to embed the voice of people and communities at the heart of planning, priority setting and decision-making to drive transformation is reflected in our governance architecture at the ICB.

The Governance Framework examines the structures that provide the interface between people and communities at all levels of decision-making within JUCD, 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 JUCD Engagement Strategy across the System. One of the main building blocks of this framework is our Public Partnership Committee.

Public Partnership Committee

Our Public Partnership Committee is one of five formal sub-committees of the ICB Board and reflects the significance we place on seeking to hear the views and voices of local people to help influence our work. 2023/24 reflects the first full year in the development of the ICB and JUCD. In this time we have been very clear about the need to move away from statutory NHS compliance with public and patient involvement, engagement, and consultation to developing a culture of true public involvement, having continuous conversations.

The Public Partnership Committee oversees the delivery of all five of the engagement frameworks set out in our strategy, and the way in which these have been carefully developed through building relationships and partnerships with those who share our outlook and with whom we can learn and collaborate on the approach.

During 2023/24 there has been a continued development of the role, remit and membership of the Committee. Understanding the scope of the Committee in the context of the new ways of working for an ICB has taken time, including close interpretation of our legal duties and how they apply, or do not apply, to NHS providers. This has been particularly important in understanding the balance between the ICB's emerging assurance role in our System, where we may have felt it necessary to put in place measures to review arrangements of our NHS providers in delivering their legal duties, and acting as the NHS family's convenor – sharing best practice and acting in a supportive way. Our convenor role has precedence here, and we continue to work with NHS Trusts in sharing our knowledge and processes for them to consider in their work. Similarly, the engagement legal duties of General Practice have been explored, given their very different commissioning and contractual relationship with the NHS, and we have confirmed the scope of the Committee's role, and the processes to be followed, to support good engagement with practice patients.

The Committee has also grasped its role on assurance in the engagement space, and while members are well-able to comment on the tactics and deployment of engagement programmes, there has been ongoing and significant development discussions to reach clarity on how the Committee works within its terms of reference to provide the ICB Board with assurance that we are compliant with both our legal and moral duties of involvement. Supporting this has been the agreement of a sub-group of the Committee, known as the Lay Reference Group. This group will be established during Quarter 1 of 2024 and will seek to be the 'engine room' of the Committee where the specifics of engagement approaches can be developed and tested, prior to Committee review.

The Committee membership has also evolved to reflect this emerging understanding of their role. There has been a strengthening of membership from Local Authority and VCSE partners to reflect the collaborative work that is required and also underway, through communication with our population, as well as recognising that these partners already have a significant community interface which we must utilise and not seek to recreate.

The number of lay representative members on the Committee has increased, and we will further add to this during 2024/25 with new lay representation from Derby city. It is also important to ensure we have a pathway through which lay people can become involved in a range of ways, develop their confidence, skills and understanding of the agenda and ultimately feel equipped to become lay representatives. Ensuring that our assurance processes are overseen by lay people who reflect the communities we serve is also a clear aspiration for the Committee and ICB Board. We will be seeking to ensure that membership of the Lay Reference Group is taken up by as broad a range of people as possible and will actively seek to encourage involvement from those either representing or from seldom heard communities.

A future development is to work with the Integrated Care Partnership to understand the broader remit and mandate of the Committee and the connections it has with engagement in other parts of our JUCD architecture, including Local Authorities and our Health and Wellbeing Boards. This is based on our 'one population' approach, where we seek to connect and integrate our conversations with local people, to help understand their needs and desires and to inform the way in which we provide future care and support.

Of equal priority will be the progress towards seeing the outputs of our framework's development, through which we would expect to see a very different way of feeding the views of local people, collected continuously through our contacts and interactions with people in their places, into the decision-making process to ensure that local people are truly at the heart of all we do.

Guidance

We have a comprehensive set of guidance available to all our commissioner and provider colleagues working within JUCD to help people to navigate the common legal and policy issues from the very start of a service change programme through to the final decision-making.

A Guide to Patient and Public Involvement in JUCD and its associated Engagement Model is available publicly on our website, and describes the current legal framework and the likely steps required to discharge legal duties when making changes to services. It reflects many of the changes brought about by the Health and Care Act 2022 and is due to be updated within the next few months to reflect a new power for the Secretary of State to which came into effect on the 31st January 2024.

This guidance is accompanied by our patient and public involvement assessment process, which ensures that a comprehensive assessment is undertaken of all service changes proposed by the ICB, to determine if they trigger the Public Involvement Duty, and at what level. This process is outlined in our Patient and Public Involvement Assessment Guidance and recorded on our Patient and Public Involvement, Assessment and Planning Form. We have been working to embed this process across the System, in planning and policy making, proposals to change services, and transformation work aimed at joining up pathways of care across multiple providers.

Additionally, we are collaborating with Joined Up Improvement Derbyshire and their use of a digital project management tool to enhance our ability to achieve lasting improvements for the people of Derbyshire. This has been in operation now for approximately two years, and is an important step forward in delivering successful and sustainable improvement outcomes for Derbyshire. During the last few months, we have made significant progress in integrating the patient and public involvement (PPI) process into its structure. This integration makes sure that incorporating feedback from our community is a key feature of the tool, making our System more attuned to the needs and suggestions of the public.

All PPI assessments are logged, and this log is tabled bi-monthly at our Public Partnership Committee and is also sent to our Health Overview and Scrutiny members, in Derby and Derbyshire, both of which are invited to ask questions, or request further information with regards to any areas of change that elicit concern.

Case Study – Post-Long-Covid-19 Service

The Derbyshire Post-Long-Covid-19 service has been under review during the past 12 months due to a change in funding and demand for the service. To aid transparency around the review taking place, a tile was created on the JUCD Involvement Platform – a digital platform allowing patients and members of the public to sign up to events, engagement activities, read documentation, watch online sessions, and see the timeline for a project.

A Case for Change was produced prior to engagement to ensure that everyone was clear about why change was needed. This then led into the pre-engagement stage, which included a survey, and five workshops.

The key areas that were engaged on included:

- people's knowledge of Long-Covid-19 and the Derbyshire Post-Long-Covid-19 Service;
- people's experiences of the current service;
- what works well and what could be improved; and
- what is important to people for the future service.

A pre-engagement report was completed which has informed and influenced the options appraisal phase. An online feedback session was arranged for Long-Covid-19 patient and public partners, who were then supported to do an analysis of the four main options available to commissioners.

Following this an Evaluation Panel took place made up of all key stakeholders, including patient representation to consider all the relevant information for each option, including quality and equality impact assessments, SWOT analysis, the pre-engagement report, and the case for change. The outcome of which was fed into the final proposal for next steps for the service.

Insight Framework

Insight is defined as *"the capacity to gain an accurate and deep understanding of someone or something"*. During exploratory conversations, colleagues involved in engagement work across JUCD described it as *"truly understanding people and issues and making them known".*

The Insight Framework aims to identify and make better use of insight that is available in local communities to inform the work of JUCD and promote the development of reciprocal relationships with people and communities to enable long-term engagement. The Insight Framework aims to:

- have the voice and lived experiences of people and communities at the heart of the Places that make up JUCD;
- enable local people to take action to promote good health and wellbeing in their communities;
- promote a culture of listening, learning, and taking action together;
- create a long-term and continuous process, not a one-off conversation; and
- create an approach that is seen as a 'must have' not a 'nice to have'.

Insight Toolkit

An Insight Toolkit was developed with stakeholders during 2023/24 to enable partners working in JUCD to better engage with people and communities and to build lasting, meaningful relationships. The toolkit is modelled on five key themes, offering good practice descriptors at three levels per theme to:

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

A testing phase is underway using the toolkit with live examples across many and varied settings. Expressions of intent were invited from across the System, particularly from communities of interest such as the Black and Minority Ethnic Forum and communities of Place where there was energy, enthusiasm, and curiosity for bringing to life and making meaning of what can sometimes feel like abstract principles and practice.

To date, 25 initiatives have been returned and are underway. Several of these need little or no support, as they are interested in self-assessing their approach to engaging with communities. Others are more complex and are being supported by members of the ICB Engagement Team.

Insight Learning Network

An Insight Learning Network has been convened involving people from each of the initiatives and anyone else who is interested in this work. The network meets monthly, hosted in a community setting and allows for sharing of experiences, peer support and a spotlight on a piece of work or place. This is an unfolding learning journey intended to strengthen social connection, resident voice, and agency to address inequities and promote wellbeing.

Learning and development emerging from this work across Derby and Derbyshire has been shared through presentations at the NHSE Insights event and the Midlands Health Inequalities Conference at the later end of 2023.

It has also led by JUCD representing all other ICSs in the Expert Advisory Group for the development of a framework for use by ICSs to help them measure how well they listen to the experiences and needs of people and communities to reduce health inequalities. The CQC is working in collaboration with the Point of Care Foundation and National Voices to create this framework and the associated learning tools. The Expert Advisory Group for this project is being established to enable the framework to be coproduced with VCSE organisations representing key communities affected by health inequalities, as well as with people with lived experience.

Insight Library

The Patient and Public Insight library is a central hub for collating and storing patient and public insight gathered across Derbyshire health, care, statutory and voluntary organisations. The library is open to a wide variety of professionals to help inform decision-making. 42 reports were uploaded in 2023 and included local insights such as 'JUCD's Neurodevelopmental Delivery Programme's Working Together Report: March 2023', and 'How easy is it to find an NHS dentist in Derbyshire', as well as national insights such as 'Better End of Life 2022', and 'Patient experience before the Omicron wave; the storm before the storm'. We feature regular updates about the content on the library in our JUCD Newsletter following its relaunch in May 2023.

Engagement Framework

The Engagement Framework encompasses our growing range of methods and tools available to all our System partners to support involvement of people and communities in work to improve, change and transform the delivery of our health and care provision.

Digital Infrastructure

We have strategically deployed a suite of digital platforms to cater to the diverse needs of our people and communities, ensuring accessibility, transparency, and effective communication, through our Online Engagement Platform, our workspace on the FutureNHS Platform, and our website. Our journey towards digital transformation is driven by a commitment to accessibility, transparency, and effective communication, ensuring that every stakeholder and community member is an integral part of conversations about current and future health and care provision.

Online Engagement Platform: Derbyshire Involve

Derbyshire Involve represents our commitment to engagement with people and communities. This platform is designed to facilitate interactive dialogue between healthcare providers and citizens, encouraging their participation in a wide range of conversations about health and care services in Derby and Derbyshire. Our aim is to have an open and transparent approach to keep our citizens informed of developments in the commissioning of health services across JUCD. This platform is offered free of charge to voluntary and

community sector organisations as well as health and social care organisations in Derby and Derbyshire.

One of the users of the platform is the Perinatal Mental Health Project, an initiative led by Connected Perinatal Support Community Interest Company, in partnership with Family Hubs Derby, aiming to address the perinatal mental health needs of new and expectant parents in Derby. This project, which is in the crucial stage of gathering insights and data, utilises the platform as a key tool in facilitating broad community involvement and feedback.

Futures: A Collaboration Platform

Using the FutureNHS Collaboration Platform is our solution to creating seamless communication and collaboration amongst JUCD partners. We use it to help connect key stakeholders across the System together for shared learning. We have developed an overarching space on the platform to house all manner of collaborative projects, including the North East Derbyshire and Bolsover Place Alliance.

Our collaborative workspace on FutureNHS, has been instrumental in bridging the gap between health and care professionals across North East Derbyshire and Bolsover, by providing a virtual space for real-time interaction, resulting in the platform becoming a cornerstone for the alliance's efforts to improve community health and wellbeing. The platform's capabilities have streamlined the way partners share information, resources, and engage in meaningful dialogue.

Joined Up Care Derbyshire website: Online Guide to Services, News, and Support

The JUCD website provides information about health and care services in Derby and Derbyshire, and how residents can access these services. It is a place where people can find helpful resources, the latest news and contact details to get the support they need.

Readers' Panel

We currently have 36 volunteers on our Readers' Panel 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 partners. In 2023 some examples the panel provided feedback for included:

- cardiac rehabilitation interview information and consent forms for participants;
- virtual wards patient leaflet;
- use of flipbooks as a method of providing information;
- patient information about medicine prescriptions;
- patient information about managing pain after surgery; and
- wound clinic service patient information.

Read our guide to the panel on the Derbyshire Involve website.

In Autumn 2023 we have been linking with and understanding functions of other Readers' Panels across JUCD to work collaboratively and avoid duplication.

In February 2024, we ran a Readers' Panel development workshop with our members aimed at identifying how we further enhance our offer for partners across Derby and Derbyshire. This led to the development of a tile on our Online Engagement Platform to help promote the Readers' Panel more broadly, and identified three key development areas:

Feedback developments	This relates to how the panel provides feedback following a request, and also how the panel receives feedback on the outcome and impact of that request.
Readers' Panel recruitment	Marketing and communication of opportunities to join the panel to encourage a diverse range of panel members.
Supporting information for panel and requesters	The development of guides, information, and training, alongside support for all involved.

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.

PPGs are vital in ensuring the patient voice is heard as they provide an opportunity for local people to get involved and influence the provision of local health services. In Derby and Derbyshire, there is a PPG Network that meets bi-monthly and is facilitated by the ICB's Engagement Team. Over the last 12 months the PPG Network has undergone developments to ensure it is a place where members can share learning and best practice. At each meeting, the PPG Network discuss:

- updates around System changes or transformation projects, which have included updates on JUCD, the Urgent Treatment Centre review, social prescribing and the medicines order line;
- updates from the Primary Care Quality Team, and members are encouraged to suggest any specific topics they would like an update around;
- sharing learning and best practice to ensure PPGs have the support they need to run their PPG and effectively engage with their population.

As part of the PPG Network development, members wanted to hear from all PPGs across Derby and Derbyshire to:

- understand what support is needed to help PPGs meaningfully communicate and engage with their Practice population;
- provide an assessment/baseline of the status of patient engagement in a General Practice/PPG;
- identify where good practice engagement might be found; and
- provide the Public Partnership Committee with an assessment of engagement in PPGs.

As a result, a survey was co-produced by the PPG Network members with the support and input of Healthwatch Derbyshire and the ICB's Engagement Team. The findings from the survey have helped the PPG Network to understand and evidence the current position of PPGs locally, and to share learning and resources. The intention is to repeat the survey at every 12–18 months to continually get an up-to-date snapshot. You can read a summary of the survey results on the Derbyshire Involve website and access the current resources for our PPG Network members.

Patient and Public Partners Programme

We facilitate a Patient and Public Partner Programme, where patients, service users, carers and their families, and members of the public are appointed as lay members who want to be involved in improving health and care services. Patient and Public Partner Programmes have been appointed to a range of boards and groups to bring lived experiences and support decision-making including cancer care, cardiovascular disease, diabetes, respiratory care and Long-Covid-19.

Derbyshire Dialogue

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

Relationship Manager Role

Over the past 12 months we have been developing our Relationship Manager role where we are working with teams across our ICB and System to develop relationships and the understanding of pathways and services.

A key element of this work is putting an engagement infrastructure in place to establish methods of involvement between commissioning teams, patients and the public. The aim is to ensure patients and members of the public are at the heart of decision-making, through the development of long-lasting relationships within communities, and more opportunities for them to get involved in co-design and co-production to improve services and the experiences of patients. This approach involves a 3-stage process of:

- **Mapping** – to scope out what current involvement there is, which will highlight good practice and gaps.
- **Planning** – to plan how involvement infrastructure will look going forward and make an improvement plan.
- **Implement** – to implement improvement plan and review methods in place.

Areas where we have commenced this work include:

- children and young people: special educational needs and disabilities, and physical health;
- children and young people mental health;
- maternity;
- perinatal mental health; and
- adult mental health.

Co-production Framework

The aim of the Co-production Framework is to embed, support, and champion co-production in the culture, behaviour, and relationships of JUCD.

We are co-producing our framework with key partners across the System, including those in the Local Authorities, Public Health, the NHS, VCSE and members of the public. We have recruited two patient and public partners to join a working group, where members all have equal input into the development of the framework.

The group undertook training together to look at the principles of co-production in more detail and gain a better, shared understanding, to aid collaborative working. The core actions agreed by the group comprise of:

Scoping	The group have developed a method of sharing good practice through 'co-production on a page', where a project lead can share a local project and the learning gained. This method of scoping is continuous and at each meeting there is a presentation from a group member about a System-wide project.
Principles	The group have recently agreed on the aims of the framework, a System-wide definition of co-production and the key principles to adopt.
Enablers	During 2024/25 the group will turn its attention to the enablers that will support co-production.
Toolkits/guidance	To be completed during 2024/25.
Evaluations	To be completed during 2024/25.

Evaluation Framework

The Evaluation Framework highlights the importance for the ICB to continually examine public involvement practice and the impact this has on our work with people and communities.

The development of the evaluation framework presented us with a golden opportunity to co-produce and co-design an approach to how we evaluate, and quality assure our work with people and communities.

We held an evaluation event in the summer of 2023 which was an opportunity for colleagues across the System, including people using services in Derby and Derbyshire, VCSE partners, System-wide lay representatives and other stakeholders to come together to help co-design our approach. We held discussions around the:

1	Importance of ensuring the voices of patients, carers and communities are sought out listened to and utilised.
2	Ultimate goal of engaging people and communities.
3	Importance of how people are involved in the work of JUCD.
4	Key elements of success.

The feedback from the event been used to inform the development of a Theory of Change, which is a representation or description of why a certain way of doing things can be effective in helping achieve a desired goal or impact. It is recommended to involve a variety of stakeholders in the development of the Theory of Change.

Following its development, we continued to work with a smaller group of lay representatives, to share the Theory of Change, check that it fully reflected the feedback given, and to further refine and finalise it. The next steps for this work are to develop the:

- indicators to measure the progress of the Theory of Change; and
- Lay Reference Group which will oversee the implementation of the Theory of Change model and will monitor its success. This group will be a formal sub-group of the Public Partnership Committee as outlined in the previous section.

Integrated Care Experience Survey

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

In summary the Integrated Care Experience Survey:

- is a survey targeted at specific at-risk population cohorts to measure and track the impact of new joined up, proactive, personalised and preventative care models. It asks a limited number of questions about the use and experience of integrated health and care services. These questions have been co-designed with patient, carer and public groups, VCSE organisations and national bodies. Currently no other survey does this;
- will focus initially on people with complex health and care needs, who rely on multiple services and staff that care for them, recognising the importance of integrated services and proactive care to this group. People will be identified through GP records based on their electronic Frailty Index score;
- will provide genuinely useful intelligence for local place and neighbourhood teams to act on, as well as a robust comparable dataset nationally across all ICSs;
- will make data and actionable insights available to participating Systems and Places in near real-time with the intent that these will help drive improvements to the way services across multiple agencies are planned, coordinated and delivered;
- includes two questionnaires – one for people/patients and one for their informal carers. The main themes covered include:
    - use of local health and care services;
    - personalisation and continuity of care;
    - experience of proactive care; and
    - the way health and care partners work together and share information.

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.

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 Three-Year Delivery Plan for Maternity and Neonatal Services (2023).

As part of the National Maternity Inspection Programme, the CQC visited Derbyshire Maternity Services during 2023/24 to review the quality and safety of services. Following the visits, CRHFT were rated 'good' in May 2023, and UHDBFT were rated 'inadequate' in November 2023. Immediately following the inspection, the CQC issued UHDBFT enforcement notices (section 31 at Royal Derby Hospital, and section 29a for Royal Derby Hospital and Queen's Hospital Burton). The CQC rating reflected earlier reports by the Healthcare Safety Investigation Branch (2022) and the NHS England Review (2023) which led to voluntary admission to the NHS England Maternity Safety Support Programme in March 2023.

The oversight for governance and compliance of the subsequent action plan is via the tier 3 oversight meeting, which is chaired jointly by the regional NHSE Chief Nurse Officer and the ICB's Chief Nurse Officer. It ensures oversight of progress against the identified areas for improvement, including foetal monitoring in labour and training, post-partum haemorrhage, clinical escalation, triage, leadership and governance.

Monthly assurance of maternity and neonatal services is undertaken in line with the perinatal quality surveillance model, through provider reports and assurance visits to review progress against safe staffing, personalisation, risk assessment and clinical escalation with both CRHFT and UHDBFT during 2023.

During 2023, the LMNS received delegated responsibility from NHSE to monitor progress against 'Saving Babies Lives Care Bundle' (version 3). Reviews are undertaken quarterly with the aim that both CRHFT and UHDFT meet 100% compliance with implementation of the interventions by March 2024.

The LMNS has worked collaboratively with System partners to finalise an equity and equality plan, which aims to improve equity for mothers and babies, and race equality for maternity and neonatal staff.

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 2023/24 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 Clostridium difficile infection and of Gram-negative bloodstream infections (GNBSIs) to below threshold levels set by NHSE.

Methicillin-resistant Staphylococcus Aureus

During 2023/24, 17 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, five 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 shown have not identified any lapses in care specific to these cases but have supported the continued implementation of both UHDBFT and CRHFT improvement plans. Any remaining reports which are pending will be reported through internal infection control committees within UHDBFT and CRHFT, 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 thresholds are set. There were 296 cases identified during 2023/24, compared to 259 in 2022/23. 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 (63% of ICB cases).

Clostridium Difficile Infection

There were 351 cases of Clostridium difficile assigned to the ICB during 2023/24. Annual thresholds for each organisation are set by NHSE, with the ICB's threshold being set at no more than 262 Clostridium difficile cases during 2023/24. Both UHDBFT and CRHFT have also breached their thresholds for the year. UHDBFT had 187 cases against a threshold of 97, and CRHFT had 52 cases against a trajectory of 30.

During 2022/23, both UHDBFT and CRHFT implemented Trust-wide Infection Prevention and Control (IPC) improvement plans underpinned by learning identified from post-infection reviews, audit outcomes, feedback from performance and quality colleagues and advice following NHSE/ICB visits. Despite this, the challenge to reduce healthcare-acquired infections continues in 2023/24. Recovery plans have been extended to include enhanced internal scrutiny, strengthened governance processes and specialist IPC leadership, and visibility to support further embedding of risk reducing measures. A planned review aims to assess the current level of clinical detail to enhance the quality and effectiveness of post-infection reviews. Thus far, no definitive cause for the increase in healthcare-acquired infections.

The national and regional picture is reflective of the Derbyshire position and NHSE IPC teams continue to support 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

A Government ambition aims to halve healthcare associated GNBSIs by 2024/25. This includes bloodstream infections caused by Escherichia Coli, Pseudomonas and Klebsiella species.

Case numbers for Derby and Derbyshire residents for all GNBSI infections showed an increase, in common with increases shown in the other alert healthcare associated infections and have breached the thresholds set for both our acute Trusts and consequently at System-level. It is anticipated that the IPC action plans implemented within the Trusts address the underlying issues, particularly around the care of catheters and peripheral intravenous lines, that have been identified in deep dives and infection reviews as likely contributing to this rise.

IPC teams continue to work collaboratively across JUCD to support the reduction of GNBSIs. Work will continue with the Derbyshire health and social care System to implement the System's antimicrobial resistance strategic action plan as this will play a key role in supporting the ambitions to reduce the numbers of GNBSIs.

Patient Safety

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

After a positive assessment, PSIRF has been implemented across all NHS organisations, demonstrating successful integration into diverse institutions. The framework equips providers to customise learning responses for individual incidents, cultivating a culture that prioritises systemic improvement. The emphasis is on ensuring that improvements are not only implemented but also ingrained into practice, fostering sustainability. Providers have devised comprehensive plans for both national and local incidents.

Thematic analyses and improvement plans, once finalised, undergo thorough discussions at our routine Clinical Quality Review Groups. This forum ensures a robust examination of assurances regarding the integration of improvements and their sustainability. Additionally, the insights and learnings are disseminated across JUCD during an annual learning event, promoting a collaborative and shared approach to enhancing patient safety.

Patient Safety Partner involvement in organisational safety, a crucial aspect, comprises the engagement of patients and laypeople in supporting healthcare organisation governance and management processes for patient safety. DCHSFT, with support from the ICB'S Patient Safety Team, will host Patient Safety Partners and aim to recruit 12 individuals. To date there are five Patient Safety Partners recruited, with an ongoing recruitment campaign.

Learning from Patient Safety Events, a recently implemented national NHS system, revolutionises the recording of patient safety events. This system enhances capabilities for analysing safety events across healthcare, providing deeper insights and more relevant learning in the current NHS environment. Learning from Patient Safety Events has been universally adopted by NHS and independent healthcare providers, with General Practices leading the transition to this innovative system. All providers have now transitioned on to this new system.

Never Events

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

During 2023/24, nine Never Events were reported by Derbyshire providers. All of these incidents underwent a thorough investigation, as part of the PSIRF. A distinct pattern of Never Events, sharing similarities, was identified through comprehensive Patient Safety Incident Investigations. Themes and trends have been discerned, leading to the formulation and completion of improvement plans. The insights derived from Never Events are disseminated at Clinical Quality Review Groups to ensure thorough oversight and scrutiny. All improvement plans are openly shared, and upon completion, evidence is gathered to verify the integration of all learned lessons into practice.

Harm Reviews

Understanding harm reviews in organisations is crucial for fostering a culture of accountability, safety, and continuous improvement. These reviews provide valuable insights into past incidents, allowing organisations to identify causes, assess risk factors, and implement effective preventive measures.

Embracing a transparent approach to harm reviews builds trust among employees, fosters a sense of ownership in addressing challenges, and ultimately contributes to the overall resilience and success of the organisations.

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

Delivery and Transformation Board Quality Groups

ICSs provide a positive opportunity for Derby and Derbyshire residents to receive joined up care and support to meet their health and care needs. A key element of the ICB's Integrated Care Strategy is for Delivery and Transformation Boards to focus on enabling actions that are critical to the development of high quality and sustainable integrated care for the population's health and care needs.

Over the past 12 months the nursing and quality directorate has been linking with the separate Delivery and Transformation Board to ensure quality assurance and quality improvement are embedded and have a 'voice' on the agenda.

This has led to a roll out of quality sub-groups which report directly to their respective Delivery and Transformation Board. The aim of these groups is to enable System alignment on quality across JUCD, focused on:

- collective actions needed to address risks and issues;
- quality oversight in relation to appropriate actions as required to reduce health inequalities;
- discussions on quality across pathways; and
- sharing good and notable practice, knowledge and learning understanding variation and risks to quality across the System.

The aim is to bring together System partners to focus on enabling actions that are critical to the development of high quality and sustainable integrated care.

Patient Experience and Involvement in Our Services

The ICB's Patient Experience Team continue to work collaboratively with partner organisations, service providers and agencies across the local System in continuing to engage with patients, carers, service users and staff. The team use a range of techniques to gather insight, experience, and service improvement suggestions across a range of services.

During 2023, the ICB took part in a King's Fund national project to improve collaborative working with providers across the System. This project focused specifically on stroke services and benefits of this collaborative approach have included:

- increased opportunities to build and maintain positive, trusting working relationships;
- easier access to service user feedback and insight at the point of service delivery and at significant points of the care experience; and
- reduced duplication and increased occasions for shared learning and quality improvement.

Throughout the year, the team have been strengthening relationships across the System, particularly with providers and their respective patient experience teams. They have been working with and listening to patients, carers, and other groups on several key work programmes, which include stroke rehabilitation, discharge to care homes, virtual wards, maternity services, EoL care and children and young people's mental health.

The team have also worked collaboratively with Healthwatch and the Engagement Team in developing a joint strategy, supporting the production of service specifications and evaluation and moderation on service procurement panels.

The team have also worked on a range of procurement programmes including UTCs, non-emergency patient transport, cataract surgery and out-of-hours services. This is to ensure that patient insight informs the services that we commission and that performance measures reflect patient and public needs. Changes made as a result of gathering patient insight include:

Discharge	Improved information about discharge from hospital on different pathways of support.
	Increased staffing numbers in care homes providing Discharge to Assess care home beds and clarity for patients and carers on the process, including finance and payments, through newly designed information leaflets.
Stroke rehabilitation	Revised processes and pathways of support for stroke patients.
	Early supported discharge for stroke patients.
	Review of rehabilitation pathways following a stroke.
Virtual wards	Revised information about the benefits of staying on a virtual ward to avoid an admission or facilitate an early discharge from hospital.
End-of-life	Improvements to the Derbyshire Alliance End-of-Life Toolkit.
	Raised awareness within Primary Care of cultural sensitivities around death and dying within ethnic minority groups and communities.
Maternity	Improved relationships with System partners and supporting the development and implementation of clear and effective patient experience pathways to support the Maternity Equity and Action Plan.

Project work has also commenced on the below workstreams:

- falls reduction and management;
- reviewing community pharmacy dispensing of palliative care medicines;
- designing a women's health hub model in Derby and Derbyshire;
- production of a maternity and neo-natal information video for deaf women and birthing people;
- leading a follow up EoL Patient Experience Project to build on the work already done during the Covid-19 pandemic and a project with Derbyshire Black and Minority Ethnic Forum to improve EoL experience for lack and minority ethnic communities;

- patient engagement in the production of the cardiovascular disease prevention strategy; and
- further engagement with wider public regarding virtual wards, as well as establishing virtual ward focus groups.

Quality and Equality Impact Assessments

Significant changes are required to recognise and address any variance to improve the health of our local population and enable services to work in an efficient and effective way. Achieving these efficiencies requires changes in local service pathways. This requires robust planning and implementation to ensure that the potential for unintended harmful impact on patient safety, clinical effectiveness or patient experience is minimised.

The ICB is committed to ensuring that a consistent approach is taken to inform commissioning decisions, its business plan and financial recovery plans, including robust evaluation of their impact on healthcare quality.

Completion of the quality and equality impact assessment is a continuous and dynamic process to help decision makers understand the consequences and potential impact of financial and operational initiatives and changes. They support evidence of fair and proportionate reasoning and a process for making challenging decisions about local healthcare services, whilst providing assurance that actual or potential risks to patients and service users are being managed.

Care Homes

During 2023/24, the care home clinical quality managers have undertaken quality assurance activity within the care home sector for nursing homes in which ICB funds patient care. This work enables the team to provide assurance of the quality of our local nursing homes and to highlight any quality concerns, themes, trends, and subsequent actions taken. The team have access to a care home dashboard that pulls together intelligence enabling further analysis to be undertaken to inform the priorities of the team and provide additional assurance to the ICB.

Covid-19 is no longer treated in a separate way from other outbreaks. The management of infection outbreaks, irrespective of cause, is overseen by the UK Health Security Agency who convene an Outbreak Control Team meeting to ensure control measures are put into place and support is given where needed. During this year, there have been several outbreaks within nursing homes for example outbreaks of scabies and invasive Group A Streptococcus, that have been managed in this way. In all cases, actions were appropriately taken, and support was provided where necessary. To support effective infection control and promote public health, the vaccination programme for influenza and Covid-19 boosters was successfully rolled out to all care homes across Derby and Derbyshire.

The System quality assurance for the care home sector is supported by local multi-agency information sharing meetings which continue bi-weekly to monitor and respond to emerging risks promptly. This includes both Local Authorities, the ICB, CQC and the Continuing Care Team. All agencies continue with quality monitoring visits using a variety of quality assurance methods of monitoring, in this way ensuring the most effective use of time. Joint

visits between the ICB and the Local Authority are conducted where appropriate. CQC are now monitoring services under a revised framework of risk management called the Single Assessment Framework. The continued multi-agency partnership working is vital to ensure information is shared between agencies to manage risk accordingly.

Derbyshire currently has five nursing homes which have achieved an outstanding rating by CQC in their last inspections and it has only one home that is rated inadequate. Quality assurance activity from the ICB is prioritised based on the level of risk and shows that 100% of providers have had either a short or a full quality monitoring visit within the last year.

Both Local Authorities 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 and trends are identified the clinical quality managers follow up with the care home to ensure appropriate action is being taken and to support where needed, including signposting to other services. Many safeguarding concerns are self-reported by the Care Home provider, demonstrating a positive reporting culture in the sector.

Supporting the wider agenda, as part of the National Ageing Well Programme, the Enhanced Health in Care Homes Programme has continued under the leadership of the Integrated Care Homes Strategic Group, providing a programme of work to support the wider agenda of support within the sector.

Personalisation

Personalised care was one of the five major, practical changes to the NHS that was set out in the NHS Long Term Plan. This followed a decade of evidence-based research working with patients and community groups and included the following key changes:

- rolling out the NHS comprehensive model of personalised care, so that 2.5 million people can have choice and control over support for their mental and physical health with an aim to double this number within a decade;
- ensuring up to 200,000 people benefit from a PHB by 2023/24, so they can control their own care, improve their life experiences, and achieve better value for money;
- putting in place more than 1,000 social prescribing link workers by the end of 2020/21, rising further by 2023/24, with the aim that more than 900,000 people are connected to wider community services that can help improve health and well-being; and
- rolling out training to help staff identify and support people in the last year of their life, and to jointly develop a personalised and proactive care plan which reduces avoidable hospital admissions and enables more people to die in a place of their choosing.

Personalised care means people have choice and control over the way their care is planned and delivered. It is based on ‘what matters’ to them and their individual strengths and needs. This happens within a system that makes the most of the expertise, capacity and potential of people, families, and communities in delivering better outcomes and experiences.

Personalised care represents a new relationship between people, professionals and the health and care system. It provides a positive shift in power and decision-making that enables people to have a voice, to be heard and be connected to each other and their communities.

In Derby and Derbyshire System partners have worked collaboratively to achieve the personalisation objectives within the NHS Long Term Plan and to contribute to achieving the national targets in terms of number of PHBs, social prescribing link workers and the number of staff trained to embed and delivery personalised care and to support the development of personalised care and support plans.

The Operational Planning Guidance required ICBs to submit trajectories via their ICS for the number of PHBs to be in place by the end of 2023/24. The ICB submitted PHB trajectories on behalf of JUCD, with performance monitored against them.

The ICB submitted PHB trajectories on behalf of JUCD, with performance monitored against them. As of the end of Q4 2023/24, 3,308 people in Derby and Derbyshire have a PHB against a trajectory of 3,240.

There are more than 50 prescribing link workers working across the Derby and Derbyshire System with a well-established Social Prescribing Advisory Group in place.

Additionally, there is also a well-established programme of training 'Quality Conversations' in place across the System. This provides a person-centred approach and covers general communication skills and specific health coaching skills, including understanding the factors underpinning a person's health and wellbeing. It leads to conversations about 'what matters to you?' not 'what's the matter with you?', helps staff understand and individuals know what is important to them and how to engage citizens in their own care and supports the development of personal care and support planning.

There are now also a number of trained peer leaders, care co-ordinators and health and wellbeing coaches in place who are all contributing to delivering a personalised approach to care across Derby and Derbyshire.

Learning from Lives and Deaths of People with a Learning Disability

Learning from lives and deaths review (LeDeR) of people with a learning disability is a service improvement programme which aims to improve care, reduce health inequalities and prevent premature mortality of adults with a learning disability through reviews of individuals who have died, looking at information about the health and social care support they received. By the end of Q4 in 2023/24, there was a total of 79 notifications of deaths in the year to the LeDeR Programme. Four of the notifications were for people from ethnic minority communities, and there were six notifications for an individual who had autism with no learning disability. During the year, 65 reviews have been completed in total; 49 reviews have been completed as 'initial reviews' and 16 completed as the more detailed 'focused' review. Two of the focused reviews were completed as autism-only (no learning disability) reviews. In those reviewed during 2023/24, the top reason for death was pneumonia/chest infection (23 deaths), with six of these being aspiration pneumonia.

LeDeR captures themes and trends to identify learning and actions, and priority areas of work have been identified this year in the following areas:

- aspiration pneumonia;
- do not attempt cardiopulmonary resuscitation;
- cancer screening; and
- weight management/healthy lifestyle.

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.

Special Educational Needs and Disabilities 0-25 years

Between September 2021 and March 2023 NHSE-monitored the progress of all CCGs towards ICSs in relation to SEND, having the necessary governance and infrastructure to ensure:

- it can fulfil its statutory duties in relation to children and young people with SEND;
- health leaders develop leadership, governance and infrastructure arrangements, that are informed by and ensure compliance with the existing SEND Code of Practice and the statutory requirements of the Children and Families Act 2014; and
- an assessment of the ICSs maturity is carried out in relation to children and young people with SEND.

Current assessment indicates that the Derby and Derbyshire position remains rated high (amber – emerging: maturity in relation to SEND). Based on evidence submitted to NHSE Regional Team and a regional peer review exercise, the ICB's key lines of enquiry ratings are as below:

- leadership and SEND improvement is 'green';
- data/intelligence is 'amber';
- workforce and training is 'amber'; and
- engagement and coproduction is 'amber'.

The ICB's overall 'amber' assessment is in line with 10 out of the 11 ICS areas across the East and West Midlands region.

The ICB has received the feedback below from NHSE SEND regional advisor:

"It's absolutely brilliant to see the breadth of evidence showing how SEND is well and truly on the ICS agenda and how the ICS intend to progress this further".

During 2023/24, the ICB has continued to work through established partnerships with both Local Authorities and NHS provider Trusts to drive SEND improvements across the footprint. The ICB has specifically strengthened and enhanced the accountability and governance for

SEND within NHS Trusts this year by securing executive board leads for SEND in each Trust, additionally each Trust produces its own annual SEND report.

These annual reports evidence progress against the SEND self-assessment tool, six-week KPI data, quality assurance activity for health advice, engagement with children and young people and their families, transitions, training and quality governance. Each report is reviewed by the Designated Clinical Officer for SEND and children's commissioners. Information will also be used to inform the SEND Local Area Self Evaluation Framework and the SEND Footprint Assurance Meeting workplan.

The ICB proposes to extend the assurance during 2023/4 into a specific annual quality monitoring meeting with Trust senior leads, Designated Clinical Officer and commissioners to triangulate data and intelligence for each Trust provider.

Nursing and Midwifery Excellence

The Chief Nursing Officer for England's Shared Governance: Collective Leadership programme, launched in April 2019, aimed to deliver the Chief Nurse Officer's vision of collective leadership and one professional voice.

Central to this vision is ensuring the nursing and midwifery collective voice is heard across all sectors so that the professions' contribution is valued and listened to in all decision-making conversations. A core component of the Chief Nursing Officer for England's Shared Governance: Collective Leadership programme was the development of local accreditation approaches, and the commitment to support the sharing of best practice and learning across healthcare.

Following initial scoping exercises the Nursing Directorate in NHSE identified funding to support the Midlands region to further develop the work relating to the excellence agenda. This was to include the development of a System-wide approach to nursing and midwifery excellence and the development of a Nursing and Midwifery Excellence Network for the Midlands. This aimed to help harness positive working environments, strong nursing leadership and improve retention; all of which are essential to ensuring the right transition to the new System architecture and delivery of the NHS Long-Term Plan. Focusing on continuous improvement, as an essential component of quality, enabling us to achieve more consistent, high-quality care, is a key component of the excellence agenda.

The ICB have led on the development of the Regional Nursing and Midwifery Network. The Network was launched in March 2023 and is now well established with identified System champions and Senior Responsible Officers from all 11 Systems within the Midlands region. Regional mapping has been completed and regional priorities are now being identified.

The agenda is moving at pace and Derby and Derbyshire has been supporting and driving much of this work to date.

Alongside the regional network the JUCD Nursing and Midwifery Excellence Forum was also established in March 2023 with a System champion having been identified to lead this forum and a Senior Responsible Office identified through the local distributed leadership model. It was agreed early on that the forum would also include Allied Health Professionals (AHP), recognising the contribution of these professions to achieving care excellence. Membership from local NHS organisations, hospices, DHU, Midlands and Lancashire Commissioning Support Unit, and Primary Care were identified, and members have enthusiastically shared learning and outcomes relating to activities that support the excellence agenda such as ward and unit accreditation approaches, shared decision-making, staff wellbeing, reward and recognition and leadership/professional development and quality improvement approaches.

Local mapping has been undertaken to understand the System position in relation to the System-agreed six pillars of excellence:

- ward/unit/team accreditation;
- shared decision-making;
- meaningful recognition;
- leadership at all levels;
- quality improvement; and
- research and innovation.

This has identified what activity is embedded, in development or pending in each organisation in regard to achieving care excellence and improving quality. There has been sharing of good practice across the System and some agreed priorities which now need to be built upon. A System-level staff reward and recognition programme is in development in collaboration with the JUCD Workforce Team.

We also now have a draft dashboard in place which is being further developed, it is anticipated that this will reflect key indicators of excellence once these have been identified by the System. Going forwards we intend to create a local culture of excellence and continuous quality improvement and agree our priorities as a system with ownership of the agenda now being firmly placed with the JUCD Chief Nursing Officer and AHP Leadership Cabinet.

Discharge to Assess Pathway 3 (Nursing)

The Discharge to Assess model works on the principle of making sure patients do not stay in hospital for any longer than they need to. Patients are discharged as soon as their acute medical treatment is complete and all assessments are followed up within the community after discharge. These assessments will be based around the patient's level of function, environment and care needs, to ensure they remain as independent as possible at home. The Discharge to Assess model focuses on a home first principle and is comprised of three different discharge pathways.

Pathway 1	For patients going home from hospital requiring some support from carers either short-term or longer term.
Pathway 2	Discharge for patients to an alternative location that is not home, for a short-term period for rehabilitation and reablement before returning home.
Pathway 3	Relates to discharges to a new residential or nursing home setting, for people who are considered likely to need long-term residential or nursing home care.

The Hospital Discharge and Community Support Guidance (updated 26th January 2024) states that Pathway 3 should be used only in exceptional circumstances. A small proportion of individuals with complex healthcare needs who are discharged on this pathway require an assessment for eligibility for CHC.

The Continuing Healthcare Framework is clear that *"in the majority of cases, it is preferable for eligibility for CHC 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 discharge 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, the ICB has supported the funding of this Pathway for individuals with new nursing needs who require discharge from acute care into bed-based care.

In the first instance, via a single stage procurement process, the ICB commissioned a number of block booked beds in nursing homes on our Any Qualified Provider Framework. The aim of this is to support availability of bedded care in nursing homes where patients could 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.

Admissions commenced on the 16th March 2023 and the remaining discharge to assess pathway 3 (nursing) discharges were achieved via the established spot purchase process.

The project supported a joined up working approach across JUCD organisations leading to a better understanding of each other's challenges, identification of unintended impacts and lessons learnt, and an evidence base for the planning phase of a revised Discharge to Assess Pathway 3 (nursing) model.

All Age Continuing Care

All Age Continuing Care (AACC) is a collective term for services provided by the NHS. These services assess and provide funding for the care of individuals of all ages to meet their ongoing health and care needs. These services include:

- continuing healthcare;
- funded nursing care;
- children and young people's continuing care; and
- jointly funded packages of care with Local Authorities and education providers.

AACC brings together those services as described above to ensure smooth transitions when people's needs change and/or they move between eligibility for different services.

At the heart of the AACC is the process for determining whether an individual is eligible for CHC or NHS-funded nursing care or whether a child of young person is eligible for continuing care. Adults may be eligible for CHC if they have a primary health need, a concept developed to determine when the NHS is responsible for providing assessed health and associated social care needs.

We know that people who are being assessed for CHC are frequently facing significant changes in their lives and a positive, person-centric experience of the assessment process is crucial. The AACC Team places the individual at the heart of the care-planning process, promoting genuine choice and control which results in a much better outcome.

The Adults Continuing Healthcare and Children and Young People's Continuing Care operational policies outline how the AACC services are delivered, and this is in accordance with the National Framework for Continuing Healthcare and Funded Nursing Care and the National Framework for Children and Young Peoples Continuing Care (2016).

The frameworks provide national tools to be used in assessment applications and for fast track cases. They outline the roles and responsibilities of all statutory bodies, in order that individuals who may have complex health needs have a ‘whole System’ approach to assess and manage social and health care needs.

The year has been one of continued transformation and progress for AACC, with a strong focus on continued improvement, collaboration, and partnership working with both aligned Local Authorities and with acute hospital Trust discharge leads.

Some key areas of improvement and transformation this year have been:

- both Local Authorities are now associates to the ICB's Any Qualified Provider Domiciliary Care Framework meaning they can use our framework providers and provide these providers as a choice for local authority clients;
- a Joint Funding Policy is now in place, which was coproduced and agreed with both Local Authorities and it outlines processes and arrangements where joint funding is considered to be indicated. Separate but aligned joint funding processes have been established specifically in regard to individuals with learning disability and/or autism. Using a 'safe, effective, affordable and legal' approach, proposed care arrangements are jointly considered to ensure they can safely and effectively meet individual's needs;
- a Dispute Policy is now in place, which was coproduced and agreed with both Local Authorities and outlines processes to be followed and adhered to by all parties when there is a dispute regarding eligibility for CHC or joint funding;
- an Enhanced Observations Policy is now in place, which provides a framework for enhanced levels of safe and supportive observations to be implemented when individuals are considered to be at risk of harm to themselves or to others which encompasses the Mental Capacity Act, and Deprivation of Liberty Safeguards legislation; and
- joint training has been established, bringing together health and social care colleagues to update and refresh understanding of CHC, children and young people's continuing care, fast track to CHC and learning disabilities and autism 'safe, effective, affordable and legal approach' processes.

This has created positive working relationships and improved efficiency and effectiveness as well as increasing the focus upon personalisation and outcome-based commissioning.

Complex Care Assurance and Governance (previously commissioning for individuals)

The Complex Care Assurance and Governance Panel continues to consider the appropriateness, safety, quality, and cost effectiveness of requests for complex or 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 Complex Care Assurance and Governance Team Panel's time and resources. It also 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.

End-of-Life Care

The Health and Care Act 2022 included a new legal right to NHS funded EoL Care. The Palliative End-of-Life Care Strategy was refreshed in 2023 with greater alignment of the National Ambitions for Palliative EoL Care to local delivery workstreams, with the aim of making the workstreams more strategically focused on delivering the NHSE Ambitions. Regular reporting by the workstream leads to the JUCD EoL Board was implemented to support robust governance and routes for escalation. The JUCD EoL Care Board membership also had facilitated sessions to support greater clarity around the role of the EoL Board as an enabler, which supports the delivery of the EoL Care Strategy. There are a number of areas of work currently underway, including developing an education and training strategy, roll-out of Electronic Palliative Care Coordination Systems to allow record sharing and greater coordination of care, 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.

Allied Health Professional

During 2023/24 JUCD committed to supporting an interim 'chief' lead role, two days per week, to strengthen AHP leadership across JUCD and to ensure future System AHP leadership is adequate to harness the transformational ability of the current and future workforce. This is in line with the NHS document which was released in June 2022 ‘Allied health professionals within integrated care systems: guidance for System executives and senior leaders.’

The ICB lead AHP chairs the Derby and Derbyshire AHP council which brings together chief AHPs from local providers across the System. They work collectively, as part of the wider System architecture, to support the quality, operational delivery and financial priorities of JUCD. The outputs from the council are shared across the wider ICS architecture and now reports into the Midlands AHP Regional Board.

The key strategic areas of focus for the Derbyshire AHP Council are aligned to the national strategy and include:

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

The AHP council has established a process to ensure oversight and provide assurance on how AHPs are embedded into JUCD's Risk Management Strategy. The establishment of the Derby and Derbyshire ICS AHP governance, risk and quality report has facilitated the identification and reporting of AHP related risks and discussion on how these can be addressed.

The AHP Council and faculty have continued to support the development of the AHP workforce aligned to national and local workforce priorities to know, grow, recruit and retain a sustainable AHP workforce for the future. In 2023/24 £155k of workforce, training and education funding has been secured from national bids to support these priorities. Projects include System-wide collaboration to procure local apprenticeship programmes for physiotherapy and occupational therapy. They also include career development tools for AHP support workers and registered workforce. A draft JUCD AHP workforce dashboard has been developed with the ICB workforce analysts to provide oversight.

The AHP council has overseen and supported several clinical pathway transformation projects aligning to the Integrated Care Strategy to develop high quality and sustainable integrated care for the populations health care needs.

Over the past 12 months, the AHP Council has supported and coordinated a number of pathway reviews to reduce variation IN access to services and to ensure quality, equitable services to the local population. As well as stroke and neuro rehabilitation, these have also included:

Children's speech and language pathway	Review of the current service structures and delivery with a business case being developed to realign the current service model to improve the quality, effectiveness and efficiency of the service.
Dietetic services	Significant pressures facing the dietetic services across Derby and Derbyshire have been identified. These are predominantly due to workforce recruitment and retention challenges which are subsequently impacting on the delivery of dietetic provision across pathways. Collaborative work is in progress with all dietetics services to support recruitment initiatives and more collaborative service delivery.
Perinatal pelvic health service	Work commenced to identify perinatal pelvic health service clinical programme leads to support and work alongside senior colleagues across the LMNS, to scope and facilitate the delivery of the perinatal pelvic health service in line with national service specifications and within agreed timeframes. The service will deliver the national ambition to identify, prevent and treat common pelvic floor dysfunction in pregnant women, birthing people, and new mothers, and to ultimately reduce the number of women and birthing people living with pelvic floor dysfunction in England postnatally and in later life.
Post-covid-19 rehabilitation	Assisted in the review of the post-Covid-19 rehabilitation service and the development of the future service options appraisal and evaluation panel.

Safeguarding Adults

The ICB's Safeguarding Adults Team has worked in partnership with a wide and diverse range of NHS providers and key stakeholders to reduce the risk of adults at-risk being subjected to abusive behaviour and practice. The team coordinates an effective assurance programme and contributes to local, regional and national safeguarding initiatives. The team provides an extensive staff training programme and team members are active participants in implementing the Safeguarding Adults Board's strategic programme and objectives.

Safeguarding Children and Looked after Children

The ICB's Safeguarding Team is fully committed to delivering a safe and effective safeguarding service, and continually strive to strengthen arrangements to safeguard children and young people across JUCD. This is achieved by working in close partnership with our partner agencies and our commissioned services to continuously improve systems and processes.

Through annual reporting, the ICB's safeguarding children and looked after children service regularly reports via the ICB governance structure and via NHSE. Assurance processes are in place to demonstrate that the ICB is fulfilling its statutory functions, roles and areas of responsibilities. A good example of this assurance is from an internal audit on safeguarding arrangements completed by 360 Assurance during 2023/24, which gave an opinion of 'significant assurance'.

The ICB is also responsible for ensuring that the statutory responsibilities to safeguard and promote the welfare of children are embedded in the services that we commission and that providers work within the national and local legislation and guidance. To ensure that the ICB-commissioned services have robust safeguarding arrangements in place, the team uses a range of self-assessment tools that have been developed. These tools enable the team to gain assurance from our commissioned services that they are fulfilling their requirements in line with Section 11 of the Children Act (2004) and the NHS England Safeguarding Children, Young People and Adults at Risk in the NHS; Safeguarding Accountability and Assurance Framework (2022).

The team, which consists of nurses and doctors provides expert advice and support to a broad range of health professionals. The team is proactive in implementing national and local guidance, directives and learning from reviews to continually improve our services.

The ICB have to update safeguarding policies which are in line with Derby and Derbyshire Safeguarding multiagency procedures. Information regarding the team and resources can be found here[xxii].

Emergency Planning, Resilience and Response

The ICB is defined as a Category 1 Responder under the Civil Contingencies Act 2004 and as such has several 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 for Derby and Derbyshire, ensuring the System can effectively respond in the event of an incident. The ICB also acts as the health representative within the wider response arena, working with partners on preparedness, and where required, response. During 2023/24 the ICB has responded to a number of incidents, including flooding, ongoing industrial action within the health sector and major incidents affecting the population of Derby and Derbyshire.

As part of the preparedness work, all health organisations are expected to complete EPRR Core Standards assurance, led by NHSE. The ICB attained a 'partially compliant' status this year, which is an improvement on the status for the previous reporting year of 'non-compliant'. The ICB now continues to focus its EPRR programme of work to further improve standards and utilise new ways of working to engrain EPRR within all aspects of ICB working and delivery.

The ICB engages with the Derbyshire Resilience Partnership (formerly Local Resilience Forum) to ensure there are links into upcoming exercises. It also 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 2024/25, with a work plan focusing on individual ICB preparedness as well as System resilience for incidents.

Promoting Research and Innovation

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

JUCD has an established Derbyshire Research Forum, which meets bi-monthly and is chaired by the ICB's Chief Medical Officer. The forum meets regularly to advance the contributions of research in JUCD, and to establish governance and reporting arrangements for patient and population benefit. The forum brings together research leads from:

- NHS provider organisations;
- Primary Care;
- Local Authorities,
- Clinical Research Network East Midlands; and
- the 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."

Developing a Joined Up Care Derbyshire Research Strategy

In 2023/24 a key focus of the Derbyshire Research Forum has been the development of the Derbyshire ICS Research Strategy. This has been led by a representative working group of the forum and is being shaped by a wide range of stakeholders from across JUCD and beyond.

The Research Engagement Network has enabled the Derby and Derbyshire community perspective to be built into the research strategy. The strategy aims to align with the Integrated Care Strategy and deliver on the recommendations of the Maximising the Benefits of Research Guidance for Integrated Care Systems.

The co-creation of a shared vision, strategic aims and underpinning delivery goals has supported a unifying approach and facilitated improvements to be made along the way, such as the strengthening of structures for General Practice research leadership.

The final version of the research strategy is expected to go through the ICB and ICP meetings for sign-off in May and June 2024 respectively.

The JUCD research strategy development has been enabled through funding from the Clinical Research Network East Midlands. Other forum activities have included:

Health Innovation East Midlands	Exploring interconnections and opportunities to work more closely with Health Innovation East Midlands through the ICB's innovations lead joining the Forum. This is an area of further discussions and development in 2024/25.
Applied Research Collaboration East Midlands Governance Board	Attendance at the Applied Research Collaboration East Midlands Governance Board meeting to share JUCD's priorities and explore alignment with Applied Research Collaboration research priorities. This has followed on to an invitation to be represented at the Board, which provides an opportunity to share knowledge across all partners, and to share opportunities.
General Practice Research Task and Finish Group	A General Practice Research Task and Finish Group was established with the broad aims of assessing engagement across Derby and Derbyshire General Practice and involvement in research, and setting regional comparisons. The group sought to identify and learn from General Practice and PCNs in regard to what works well, and to understand what the barriers are in engaging in research, so that recommendations can be made to facilitate research activity.
Vaccine innovation pathway for clinical trials	Forum and ICB partners came together to contribute to a scoping exercise for the vaccine innovation pathway for clinical trials. The exercise was to inform potential future enablement funding to support the new vaccines innovation pathway nationally for future regional delivery of clinical trials in infectious diseases. A Derby and Derbyshire collaborative proposal for a mobile unit was submitted so that clinical trials can be taken closer to communities and patients.
Equity in Doctoral Education through Partnership and Innovation	An opportunity was shared through the forum for organisations to work in partnership with Nottingham Trent University and offer the ‘equity in doctoral education through partnership and innovation’ initiative. This enables access to a funded part-time PhD programme for NHS clinical and professional service staff from racially-minoritised groups. The initiative targets recruitment, admissions and transition as critical points of systemic inequality, which have historically disadvantaged racialised groups.

Men at Work project	The Men at Work project was undertaken following a successful joint bid made to Clinical Research Network East Midlands by Derbyshire County Council and the University of Nottingham around targeting underserved communities in research. The project looked to understand health and wellbeing and protective factors amongst isolated male workers in Derbyshire and to improve inclusion of underserved groups in research, helping to understand further regional health inequalities, whilst increasing that research capacity in under-served communities.
Joined Up Care Derbyshire Research Engagement Network	The JUCD Research Engagement Network was established in 2022/23 and was funded through the Accelerated Access Collaborative. A project called REBALANCE (Research Building Alliances for Action with Community Enterprise) aims to improve access to research for underserved communities, increase participation and help reduce health inequalities in Derby and Derbyshire. Learning from the initial phase has been applied during 2023/24 to build our community partnerships further following a successful second phase funding application. We are also working in partnership with VCSE partners and the University of Derby to co-design a community-led participatory research project in an area of priority for research identified by the communities.

Participation in National Institute of Health and Care Research Studies

The number of participants recruited to the National Institute of Health and Care Research portfolio of research studies during 2023/24 for JUCD was 14,895. 217 different studies were available to potential participants through the four NHS provider organisations, General Practices including dental practices and other settings such as community pharmacies.

Participants in Research Experience Survey 2023/24

Participants in clinical research studies are routinely asked to give feedback on their experience of participating in National Institute of Health and Care Research portfolio research, and to suggest how we can make taking part in research better in the future. Just under 400 participants completed a participant research experience survey across four NHS partner organisations. For 77% of participants, it was the first research study they had taken part in, and 86% of participants would consider taking part again.

Feedback showed that participants were unsure how they would receive the results of the research, so research teams have highlighted where this can be found, are having regular conversations with participants to provide updates and timelines for results, and are sharing feedback with those designing the studies to build this in routinely, which has shown noticeable improvements. Some teams are also actively chasing results of studies and for one team this forms a part of their 'end of study and archiving standard operating procedure'.

ACCOUNTABILITY REPORT

Dr Chris Clayton

Accountable Officer

NHS Derby and Derbyshire Integrated Care Board

19th June 2024

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 of the 1st April 2023 to 31st March 2024, 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 23 below:

ICB Board Member	Position
Voting	
John MacDonald	Chair (up to 30th June 2023)
Richard Wright	Non-Executive Member (Finance, Estates and Digital) (up to 30th June 2023) Vice Chair (from 25th May 2023 to 30th June 2023) Interim Chair (from 1st July 2023 to 30th April 2024)
Dr Adedeji Okubadejo	Clinical Lead Member and Vice ICB Board Chair (from 1st April 2023)
Dr Chris Clayton	Chief Executive Officer
Tracy Allen	Participant Member to the Board for Place – Derbyshire Community Health Services NHS Foundation Trust
Stephen Posey	Partner Member – University Hospitals of Derby and Burton NHS Foundation Trust (from 1st August 2023)
Mark Powell	Partner Member – Derbyshire Healthcare NHS Foundation Trust (from 1st April 2023)
Dr Andrew Mott	Partner Member – Primary Medical Services
Andy Smith	Partner Member – Derby City Council
Ellie Houlston	Partner Member – Derbyshire County Council
Julian Corner	Non-Executive Member (Population Health and Strategic Commissioning) (up to 30th November 2023)
Margaret Gildea	Non-Executive Member (People and Culture) and Senior Independent Director
Sue Sunderland	Non-Executive Member (Audit and Governance)
Jill Dentith	Non-Executive Member (Finance, Estates and Digital) (from 1st July 2023)
Michelle Arrowsmith	Chief Strategy and Delivery Officer, and Deputy Chief Executive (from 2nd October 2023)
Keith Griffiths	Chief Finance Officer
Dr Chris Weiner	Chief Medical Officer
Brigid Stacey	Chief Nurse Officer and Deputy Chief Executive Officer (up to 4th July 2023)
Paul Lumsdon	Interim Chief Nurse Officer (from 1st July 2023 to 31st August 2023) Executive Director of Operations (from 1st September 2023 to 31st December 2023)

ICB Board Member	Position
Prof Dean Howells	Chief Nurse Officer (from 1st September 2023)
Amanda Rawlings	Chief People Officer (up to 30th April 2023)
Linda Garnett	Interim Chief People Officer (from 1st May 2023)
Non-Voting	
Helen Dillistone	Chief of Staff
Zara Jones	Executive Director of Strategy and Planning (up to 24th September 2023)
Dr Avi Bhatia	Clinical and Professional Leadership Group Participant Member to the Board
James Austin	Chief Digital Information Officer

Table 23 – members of the ICB Board 2023/24

Audit and Governance Committee

The membership of the Audit and Governance Committee of the ICB is shown in Table 24 below.

Audit and Governance Committee Member	Position
Sue Sunderland	Chair – Non-Executive Member (Audit and Governance)
Richard Wright	Non-Executive Member (Finance, Estates and Digital) (up to 30th June 2023)
Jill Dentith	Non-Executive Member (Finance, Estates and Digital) (from 1st July 2023)
Margaret Gildea	Non-Executive Member (People and Culture) and Senior Independent Director ('by invitation' in accordance with the Committee's workplan)

Table 24 – members of the ICB's Audit and Governance Committee during 2023/24

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

Register of Interests

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

Personal Data Related Incidents

There has been one Information Governance incident during 2023/24 that met the criteria for reporting through the Data Protection and Security Toolkit to the Information Commissioner's Office. The incident required no follow-up action.

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 2024 is published on our website here[xxiv].

Statement of Accountable Officer's Responsibilities

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

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

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

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

Dr Chris Clayton
Accountable Officer
NHS Derby and Derbyshire Integrated Care Board
19th June 2024

Governance Statement

Introduction and Context

NHS Derby and Derbyshire Integrated Care Board (ICB) is a corporate body established by NHSE on the 1st July 2022 under the NHS Act 2006 (as amended).

The ICB's statutory functions are set out under the NHS Act 2006 (as amended). The ICB's general function is arranging the provision of services for persons for the purposes of the health service in England. The ICB is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its population.

Between the 1st April 2023 and the 31st March 2024, 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 1.06 million people in Derbyshire.

The geographical footprint and eight areas known as 'Places' covered by the ICB are Amber Valley, Bolsover and North East Derbyshire, Chesterfield, Derby city, Derbyshire Dales, Erewash, High Peak and South Derbyshire. Our five-year plan recognises that the health and social care needs of people varies significantly across Derby 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 £36.6m for the period 1st April 2023 to the 31st March 2024, and had a workforce of 475 employees on the 31st March 2024.

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[xxv].

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 2023.

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

ICB Board Member	Position
Voting	
John MacDonald	Chair (up to 30th June 2023)
Richard Wright	Non-Executive Member (Finance, Estates and Digital) (up to 30th June 2023) Vice Chair (from 25th May 2023 to 30th June 2023) Interim Chair (from 1st July 2023 to 30th April 2024)
Dr Adedeji Okubadejo	Clinical Lead Member and Vice ICB Board Chair (from 1st April 2023)
Dr Chris Clayton	Chief Executive Officer
Tracy Allen	Participant Member to the Board for Place – Derbyshire Community Health Services NHS Foundation Trust
Stephen Posey	Partner Member – University Hospitals of Derby and Burton NHS Foundation Trust (from 1st August 2023)
Mark Powell	Partner Member – Derbyshire Healthcare NHS Foundation Trust (from 1st April 2023)
Dr Andrew Mott	Partner Member – Primary Medical Services
Andy Smith	Partner Member – Derby City Council
Ellie Houlston	Partner Member – Derbyshire County Council
Julian Corner	Non-Executive Member (Population Health and Strategic Commissioning) (up to 30th November 2023)
Margaret Gildea	Non-Executive Member (People and Culture) and Senior Independent Director
Sue Sunderland	Non-Executive Member (Audit and Governance)
Jill Dentith	Non-Executive Member (Finance, Estates and Digital) (from 1st July 2023)
Michelle Arrowsmith	Chief Strategy and Delivery Officer, and Deputy Chief Executive (from 2nd October 2023)
Keith Griffiths	Chief Finance Officer
Dr Chris Weiner	Chief Medical Officer
Brigid Stacey	Chief Nurse Officer and Deputy Chief Executive Officer (up to 4th July 2023)
Paul Lumsdon	Interim Chief Nurse Officer (from 1st July 2023 to 31st August 2023) Executive Director of Operations (from 1st September 2023 to 31st December 2023)
Prof Dean Howells	Chief Nurse Officer (from 1st September 2023)
Amanda Rawlings	Chief People Officer (up to 30th April 2023)
Linda Garnett	Interim Chief People Officer (from 1st May 2023)

ICB Board Member	Position
Non-Voting	
Helen Dillistone	Chief of Staff
Zara Jones	Executive Director of Strategy and Planning (up to 24th September 2023)
Dr Avi Bhatia	Clinical and Professional Leadership Group Participant Member to the Board
James Austin	Chief Digital Information Officer

Table 25 – members of the ICB Board during 2023/24

The ICB Board met in public seven times from the 1st April 2023 to 31st March 2024. 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

In the ICB Board's second year of formation, the Board has continued to mature and grow. The ICB Board deliberated 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. During 2023/24, the ICB Board made the decision that they would continue to meet monthly, and the meetings would alternate between meetings specifically for public and confidential matters, and a development session.

The ICB Board held seven public and confidential meetings on the 20th April, 15th June, 20th July, 21st September, 16th November 2023 and the 18th January and 21st March 2024.

Eight ICB Board development sessions took place during April, May, June, August, October, November 2023 and February 2024. The development sessions which took place from October to February 2024 were JUCD partner development events, which had a primary purpose to bring the System leaders together to develop a shared understanding and a co-designed action plan to enable the NHS Operating Model to work more effectively to deliver the Joint Forward Plan and ICB Operational Plan for our population.

In August 2023, the new Fit and Proper Person Test Framework guidance was published by NHSE. In response to the guidance, the ICB has developed a Fit and Proper Person Test Framework to assess the appropriateness of an individual to discharge their duties effectively in their capacity as an ICB Board member. The purpose of the framework is to strengthen/reinforce individual accountability and transparency for ICB Board members, thereby enhancing the quality of leadership within the NHS. The ICB Fit and Proper Person Test Framework was approved by the Audit and Governance Committee on the 14th March 2024.

The framework aims to help ICB Board members build a portfolio to support and provide assurance that they are fit and proper, while demonstrably unfit members will be prevented from moving between NHS organisations. The framework applies to ICB Board members who are ICB Executive Directors and Non-Executive Members.

The framework will be a core element of a broader programme of board development, effective appraisals and values-based (as well as competency-based) appointments – all of which are part of the good practice required to build a 'healthy' board.

ICB Board Development during 2023/24

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

- fulfilling the statutory obligations of the ICB and the continued oversight of key assurance areas across the NHS;
- management of the ICB's Board Assurance Framework, ICB Corporate Risk Register and associated risk management approach;
- the transfer of delegated commissioning functions of pharmaceutical, dental and ophthalmic services from and specialised commissioning functions from NHSE to the ICB;
- development of the Derby and Derbyshire Strategic Framework;
- responding to national and regional planning and assurance requirements (for example, winter plan) and oversight of key operational priority areas (urgent and emergency care);
- continued organisational and cultural development of the ICB as a Board, an organisation and as a key member of the Derby and Derbyshire NHS family;
- continued development of key strategic areas such as integrated commissioning (population health management, health inequalities, health protection, clinical policy and joint commissioning), integrated care (provider collaboration, Place and scale including transformation, productivity and operational delivery) and integrated assurance (people, finance, estates, quality, performance, audit and governance) approaches;
- the future of General Practice and delivery of Primary Care health care in Derby and Derbyshire;
- continued clinical delivery and support of the Clinical and Professional Leadership Group;
- development of building leadership for inclusion; and
- development of the Digital ICS Programme and harnessing leadership to develop the System ambitions.

The joint ICB Board and JUCD partner development sessions focused on:

- the development and implementation of the Joint Forward Plan and Integrated Care Strategy;
- the development of a shared understanding and co-designed action plan to enhance the NHS Operating Model to work more effectively to deliver the NHS 5 Year Operational Plan for our population; and
- setting of the key strategic aims and the key forming parts of the Joint Forward Plan for 2024/25 and 2027/28, including key NHS and partnership schemes.

Corporate Committees of the ICB Board

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

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

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

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

Audit and Governance Committee

The purpose of the Audit and Governance Committee is to ensure that the ICB complies with the principles of good governance while effectively delivering the statutory functions of the ICB. The committee contributes to the overall delivery of the ICB objectives by providing oversight and assurance to the ICB Board on the adequacy of governance, risk management and internal control processes within the ICB. The composition of the Audit and Governance Committee is shown in Table 26 below.

Audit and Governance Committee Member	Position
Sue Sunderland	Chair – Non-Executive Member (Audit and Governance)
Richard Wright	Non-Executive Member (Finance, Estates and Digital) (up to 30th June 2023)
Jill Dentith	Non-Executive Member (Finance, Estates and Digital) (from 1st July 2023)
Margaret Gildea	Non-Executive Member (People and Culture) and Senior Independent Director ('by invitation' in accordance with the Committee's workplan)

Table 26 – members of the ICB's Audit and Governance Committee during 2023/24

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 2023/24 are shown in Table 27 below:

Significant items approved/discussed by Audit and Governance Committee during 2023/24	
Governance, Risk Management and Internal Control	
Accounting Policies	Governance Handbook
Annual Report and Accounts	Health and Safety
Accruals – Month 9	ICB Annual Assessment
Aged Debt, Write-Offs, Losses and Special Payments	Information Governance
	Integrated Assurance Mapping
	Joined Up Care Derbyshire National Oversight Framework
Board Assurance Framework 2023/24	Legal Cases
Complaints	Mandatory Training Compliance
Committee Effectiveness	Mental Health Investment Standard Statement of Compliance
Conflicts of Interest	NHS Oversight Framework
Corporate and HR Policies	Non-Clinical Adverse Incidents
Derbyshire ICS Green Sustainability	Primary Care, Pharmacy, Optometry and Dental Delegated Services
Digital and Cyber Security	Procurement Highlights

Significant items approved/discussed by Audit and Governance Committee during 2023/24	
Draft ICB Annual Governance Statement	Provider Selection Regime
EPRR and Business Continuity	Risk Management and Deep Dives
Equality Delivery System 2023/24	Single Tender Waivers
Estates	Specialised Commissioning Services
Financial Position 2023/24	Staff Survey Action Plan
Fit and Proper Person Test Framework	Verdict of Lucy Letby – Freedom to Speak up Plan
Freedom of Information	Violence Reduction Standards
Freedom to Speak Up and Whistleblowing	
Internal Audit – 360 Assurance	
Counter Fraud Plan 2023/24 and Progress Report	Internal Audit Strategic Plan 2023–26
Head of Internal Audit Opinions – CCG and ICB	Internal Audit Recommendations Tracker
Internal Audit Plan 2024/25	Transformation and Efficiency Final Report
External Audit – KPMG	
External Audit Plans and Progress Reports	ISA 260 Reports – CCG and ICB

Table 27 – Significant items discussed and approved by the Audit and Governance Committee during 2023/24

The Committee formally met seven times during 2023/24 and also met once extraordinarily. All meetings were fully quorate. The quorum necessary for the transaction of business is two members.

Remuneration Committee

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

The ICB Board has approved and keeps under review the Terms of Reference for the Committee. The ICB Board also ensures that all members appointed remain independent and no decisions are made by Executive Officers. The ICB Board has delegated specific functions and responsibilities, in relation to remuneration, as specified in the Terms of Reference and the ICB's Scheme of Reservation and Delegation. The work of the Committee enables the ICB to declare compliance with Section D of the Corporate Governance Code of Conduct. In order to avoid any conflict of interest, in respect of Non-Executive Members who are the only members of the Remuneration Committee, their own remuneration is set directly by the ICB Board. The Non-Executive Members who are conflicted are not part of the decision-making. The composition of the Remuneration Committee is shown in Table 28 below.

Remuneration Committee Member	Position
Margaret Gildea	Chair – Non-Executive Member (People and Culture) and Senior Independent Director
Julian Corner	Non-Executive Member (Population Health and Strategic Commissioning) (up to 30th November 2023)
Dr Adedeji Okubadejo	Clinical Lead Member and Vice ICB Board Chair (member from 1st July 2023)
Richard Wright	Non-Executive Member (Finance, Estates and Digital) (member until 30th June 2023)

Table 28 – members of the ICB's Remuneration Committee during 2023/24

Significant items that were discussed and approved during 2023/24 are shown in Table 29 below.

Significant items approved/discussed by Remuneration Committee during 2023/24	
Executive Director Appointments, Structure and Remuneration	Non-Executive Members' Review of Pay
Functional Director Pay Progression	Relocation Policy and Hybrid Working
General Practice Place Lead Remuneration	Running Cost Reduction and ICB Restructure
ICB Board – Clinical (Other) Member Role	Staff Consultation Process and Restructure
ICB Chair Appointment Arrangements	Very Senior Manager Pay Award and Structure

Table 29 – Significant items discussed and approved by the Remuneration Committee during 2023/24

The Committee formally met 10 times during 2023/24 and all meetings were fully quorate. The quorum necessary for the transaction of business is a minimum of two Non-Executive Members.

Finance, Estates and Digital Committee

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

The composition of the Finance, Estates and Digital Committee is detailed in Table 30 below:

Finance, Estates and Digital Committee Member	Position
Core NHS Members	
Richard Wright	Chair – Non-Executive Member (Finance, Estates and Digital) (up to 30th June 2023)
Jill Dentith	Chair – Non-Executive Member (Finance, Estates and Digital) (from 1st July 2023)
Sue Sunderland	Non-Executive Member (Audit and Governance)
Keith Griffiths	Chief Finance Officer, ICB
Darran Green	Acting Operational Director of Finance, ICB
Zara Jones	Executive Director of Strategy and Planning, ICB (up to 24th September 2023)
Michelle Arrowsmith	Chief Strategy and Delivery Officer, and Deputy Chief Executive, ICB (from 2nd October 2023)
Linda Garnett	Interim Chief People Officer, ICB
Stephen Jarratt	Non-Executive Director, UHDBFT (up to 31st August 2023)
Ian Lichfield	Non-Executive Director, DCHSFT (up to 31st August 2023) Non-Executive Director, UHDBFT (from 1st September 2023)
Stuart Proud	Non-Executive Director, DCHSFT (from 1st July 2023)
Steve Heppinstall	Executive Director of Finance, CRHFT
Simon Crowther	System Estates Lead/Executive Director Finance and Performance/Interim Deputy CEO, UHDBFT
Peter Handford	Chief Finance Officer, DCHSFT
Michelle Veitch	Chief Operating Officer, CRHFT
Ade Odunlade	Chief Operating Officer, DHcFT
James Sabin	Director of Finance, DHcFT (from 1st November 2023)
Mike Naylor	Director of Finance, EMAS
System Members	
James Austin	Chief Digital Information Officer, ICB/DCHSFT
Maria Riley	Director of Transformation and PMO, JUCD (up to 30th September 2023)
Susan Whale	Director of System PMO & Improvement, JUCD (from 1st October 2023)
Tamsin Hooton	JUCD Programme Director

Table 30 – members of the Finance, Estates and Digital Committee during 2023/24

Significant items that were discussed and approved by the Finance, Estates and Digital Committee during 2023/24 are shown in Table 31 below.

Significant items approved/discussed by Finance, Estates and Digital Committee during 2023/24	
5 Year Plan	National Oversight Framework
Annual Accounts	Pharmacy, Optometry and Dental Delegation
Board Assurance Framework	Planning Priorities and Timetable
Estates Strategy and Updates	Population Health and Out of Hospital Funding
Financial Sustainability Board Governance Arrangements	Productivity and Efficiency
Financial Allocations, Planning and Sustainability	Risk Management
ICS Transformation Programme	Shared Care Records Deep Dive
Industrial Action	System Transformation and Efficiency
JUCD Digital and Data Strategy	UHDBFT Productivity Deep Dive
Monthly System Financial Position Reviews	Workforce Deep Dive

Table 31 – Significant items discussed and approved by the Finance, Estates and Digital Committee during 2023/24

The Committee formally met 12 times during 2023/24 and all meetings were fully quorate, expect the meeting on the 26th September 2023. The quorum necessary for the transaction of business is one ICB Non-Executive Member, one provider Non-Executive Director, and three Executive Directors, of which one should be the ICB Chief Finance Director or nominated deputy and one a System Director of Finance or their nominated deputy.

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 32 below:

People and Culture Member	Position
Margaret Gildea	Chair – Non-Executive Member (People and Culture) and Senior Independent Director
Jill Dentith	Non-Executive Member (Finance, Estates and Digital) (from 1st July 2023)
Linda Garnett	Interim Chief People Officer (from 1st May 2023)
Janet Dawson	Non-Executive Member, DCHSFT
Ralph Knibbs	Non-Executive Member, DHcFT
Joy Street	Non-Executive Member, UHDBFT (up to 31st August 2023)
Billie Lam	Non-Executive Member, UHDBFT (from 1st September 2023)
Jeremy Wight	Non-Executive Member, CRHFT (up to 31st August 2023)
Atul Patel	Non-Executive Member, CRHFT (from 1st September 2023)
Vijay Sharma	Non-Executive Director, EMAS (up to 31st August 2023)
Will Pope	Non-Executive Director, EMAS (from 1st September 2023)
Amanda Rawlings	Chief People Officer, ICB (up to 30th April 2023) and UHDBFT
Darren Tidmarsh	Chief People Officer, DCHSFT
Mark Powell	Chief Executive Officer, DHcFT (from 1st April 2023)
Jaki Lowe	Director of People and Inclusion, DHcFT
Kerry Gulliver	Director of HR and Organisational Development, EMAS
Caroline Wade	Director of HR and Organisational Development, CRHFT
Penelope Blackwell	Chair of Integrated Place Executive
Emma Crapper	HR Director, Derbyshire County Council
Liz Moore	Head of HR, Derby City Council
Susie Bayley	Medical Director, General Practice Taskforce Derbyshire
Zahra Leggatt	Derbyshire Health United 111 (East Midlands) Community Interest Company representation

Table 32 – members of the People and Culture Committee during 2023/24

Significant items that were discussed and approved by the People and Culture Committee during 2023/24 are shown in Table 33 below.

Significant items approved/discussed by People and Culture Committee during 2023/24	
Agency Reduction Plan	People Services Delivery Board
Board Assurance Framework	Section 75 – Derby City Integration Work
Freedom to Speak Up	Workforce Plan
People Services Collaborative Priorities	Workforce Oversight

Table 33 – Significant items discussed and approved by the People and Culture Committee during 2023/24

The Committee formally met four times during 2023/24 and all meetings were fully quorate. The quorum necessary for the transaction of business is one ICB Non-Executive Member, one System Non-Executive Member, one ICB Executive Member and three other 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 JUCD by ensuring contracts and agreements are in place to deliver the ICB's commissioning strategy and operating plans. It seeks to support providers to lead major service transformation programmes and councils to ensure that the NHS plays a full part in social and economic development and environmental sustainability, while focusing on reducing health inequalities, improving outcomes and quality, and ensuring that the delivery of the ICB's strategic and operational plans are achieved within financial allocations. The composition of the Population Health and Strategic Commissioning Committee is shown in Table 34 below.

Population Health and Strategic Commissioning Committee	Position
Julian Corner	Chair – Non-Executive Member (Population Health and Strategic Commissioning) (up to 30th November 2023)
Richard Wright	Non-Executive Member (Finance, Estates and Digital) (from 1st April to 30th June 2023, membership reinstated from 1st December 2023)
Dr Adedeji Okubadejo	Clinical Lead Member and Vice ICB Board Chair (from 1st April 2023)
James Reilly	Non-Executive Director, DCHSFT (from 1st November 2023)
Sardip Sandhu	Non-Executive Director, UHDBFT (from 1st January 2024)
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 (up to 30th April 2023)
Robyn Dewis	Director of Public Health, Derby City Council
Mark Powell	Chief Executive Officer, DHcFT (from 1st April 2023)
Zara Jones	Executive Director of Strategy and Planning (up to 24th September 2023)
Michelle Arrowsmith	Chief Strategy and Delivery Officer, and Deputy Chief Executive (from 2nd October 2023)
Brigid Stacey	Chief Nurse Officer and Deputy Chief Executive Officer (up to 4th July 2023)
Paul Lumsdon	Interim Chief Nurse Officer (from 1st July 2023 to 31st August 2023) Executive Director of Operations (from 1st September 2023 to 31st December 2023)
Prof Dean Howells	Chief Nurse Officer (from 1st September 2023)
Dr Chris Weiner	Chief Medical Officer, ICB

Population Health and Strategic Commissioning Committee	Position
Keith Griffiths	Chief Finance Officer, ICB
Clive Newman	Director of GP Development, ICB
Steve Hulme	Director of Medicines Management and Clinical Policies, ICB
Amanda Rawlings	Chief People Officer, ICB (up to 30th April 2023)
Linda Garnett	Interim Chief People Officer (from 1st May 2023)

Table 34 – members of the ICB's Population Health and Strategic Commissioning Committee during 2023/24

Significant items that were discussed and approved by the Population Health and Strategic Commissioning Committee during 2023/24 are shown in Table 35 below.

Significant items approved/discussed by Population Health and Strategic Commissioning Committee 2023/24	
5 Year Plan	General Practice Out of Hours
Board Assurance Framework	Health Protection Board
Business Cases	Joint Area Prescribing Group
Clinical Policy Advisory Group	Joint Forward Plan
Clinical and Professional Leadership Group	Long-Covid-19
Community Audiology	Mental Health Delivery Board
Contract Extensions	NHS Operational Plan
Contracting Overview	Non-Emergency Patient Transport
Cardiovascular Disease Prevention Plan	Population Health Management
Delegation of Pharmacy, Optometry and Dental Services	Primary Care Sub-Committee
Derbyshire Prescribing Group	Procurements
Ethical Framework for Decision-Making Policy	Risk Management
Glossop Transition	VCSE Contracts

Table 35 – Significant items discussed and approved by the Population Health and Strategic Commissioning Committee during 2023/24

The Committee formally met seven times during 2023/24 and all meetings were fully quorate, expect the meeting on the 11th October 2023. The quorum necessary for the transaction of business is one ICB Non-Executive Member, one System Non-Executive Director, one ICB 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 36 below:

Public Partnership Committee Member	Position
Voting Members	
Julian Corner	Chair – Non-Executive Member (Population Health and Strategic Commissioning) (up to 30th November 2023)
Richard Wright	Chair – ICB Chair (from 1st December 2023)
Sue Sunderland	Non-Executive Member (Audit and Governance)
Steven Bramley	Lay Representative
Tim Peacock	Lay Representative
Jocelyn Street	Lay Representative
Patricia Coleman	Lay Representative (from 1st January 2024)
Carol Warren	Lead Governor, CRHFT
Maura Teager	Lead Governor, UHDBFT (up to 30th September 2023)
Val Haylett	Public Governor, UHDBFT (from 1st October 2023)
Lynn Walshaw	Deputy Lead Governor, DCHSFT
Christopher Mitchell	Public Governor, DHcFT (up to 31st May 2023)
Hazel Parkyn	Public Governor, DHcFT (from 1st June 2023)
Sam Dennis	Director of Communities, Derby City Council (from 2nd October 2023 to 26th February 2024)
Neil Woodhead	Service Manager – Locality Working, Derby City Council (from 27th February 2024)
Kim Harper	Chief Officer, Community Action Derby

Public Partnership Committee Member	Position
Non-Voting Members	
Helen Henderson	Chief Executive Officer, Healthwatch Derbyshire (up to 29th May 2023)
Amy Salt	Engagement and Involvement Manager, Healthwatch Derbyshire (from 30th May 2023)
Helen Dillistone	Chief of Staff, ICB
Sean Thornton	Deputy Director Communications and Engagement, ICB/JUCD
Karen Lloyd	Head of Engagement, ICB/JUCD

Table 36 – members of the Public Partnership Committee during 2023/24

Significant items that were discussed and approved by the Public Partnership Committee during 2023/24 are shown in Table 37 below.

Significant items approved/discussed by Public Partnership Committee during 2023/24	
Board Assurance Framework	Living Well
Citizen's Panel	Long-Covid-19 Services
Engagement Strategy and Frameworks	New Powers for Secretary of State in Service Reconfiguration
Equality Delivery System	Patient and Public Involvement Assessment Log
Evaluation Framework	Patient Participation Groups
Fertility	Performance Reporting
Glossop Services Engagement Approach	Primary Care Process Assurance
General Practice Access	Public Engagement Annual Report
Insight Framework	Risk Management
Joint Forward Plan	System Insight Group
Learning Disability Short Breaks	

Table 37 – Significant items discussed and approved by the Public Partnership Committee during 2023/24

The Committee formally met five times during 2023/24 and all meetings were fully quorate. The quorum necessary for the transaction of business is one ICB Non-Executive Member, to include the Chair or Vice Chair, plus at least two representatives drawn from the lay members and Foundation Trust Governors, and one Executive Director or deputy.

Quality and Performance Committee

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

The composition of the Quality and Performance Committee is detailed in Table 38 below:

Quality and Performance Committee Member	Position
Dr Adedeji Okubadejo	Chair – Clinical Lead Member and Vice ICB Board Chair (from 1st April 2023)
Margaret Gildea	Non-Executive Member (People and Culture) and Senior Independent Director (up to 30th June 2023)
Richard Wright	Non-Executive Member (Finance, Estates and Digital) (up to 30th June 2023)
Jill Dentith	Non-Executive Member (Finance, Estates and Digital) (from 1st July 2023)
Brigid Stacey	Chief Nurse Officer and Deputy Chief Executive Officer (up to 4th July 2023)
Paul Lumsdon	Interim Chief Nurse Officer (from 1st July 2023 to 31st August 2023) Executive Director of Operations (from 1st September 2023 to 31st December 2023)
Prof Dean Howells	Chief Nurse Officer (from 1st September 2023)
Dr Chris Weiner	Chief Medical Officer
Zara Jones	Executive Director of Strategy and Planning (up to 24th September 2023)
Michelle Arrowsmith	Chief Strategy and Delivery Officer, and Deputy Chief Executive (from 2nd October 2023)
Christine Fearns	Non-Executive Director, UHDBFT (up to 28th April 2023)
Chris Harrison	Non-Executive Director, UHDBFT (from 1st October 2023)
Jayne Stringfellow	Non-Executive Director, CRHFT (up to 31st August 2023)
Nora Senior	Non-Executive Director, CRHFT (from 1st September 2023)
Lynn Andrews	Non-Executive Director, DHcFT
Kay Fawcett	Non-Executive Director, DCHSFT
Robyn Dewis	Director of Public Health, Derby City Council
Gemma Poulter	Assistant Director Adult Social Care, Derbyshire County Council

Table 38 – members of the Quality and Performance Committee during 2023/24

Significant items that were discussed and approved by the Quality and Performance Committee during 2023/24 are shown in Table 39 below.

Significant items approved/discussed by Quality and Performance Committee during 2023/24	
Board Assurance Framework	Pharmacy, Optometry and Dental Delegation
Cancer	Public Health Inequalities
Children's and Young Peoples Eating Disorders	Quality Framework
Discharge and Flow	Risk Management
Dormitory Eradication	Risk Stratification and Harm
Infection Prevention and Control	Local Maternity and Neonatal Services
Integrated Performance Report	Safeguarding Adults and Children
Learning Disabilities and Autism	Serious Violence Strategy
Maternity Services	Stroke Services
National Oversight Framework	System Quality Group Assurance
Neurodevelopment	Serious Violence Strategy
Personal Health Budgets	

Table 39 – Significant items discussed and approved by the Quality and Performance Committee during 2023/24

The Committee formally met 11 times during 2023/24 and meetings were fully quorate. except the meetings on the 29th June, 27th July, 31st August, 28th September, 2nd November and 21st December 2023. The quorum necessary for the transaction of business is one ICB Non-Executive Member, to include the Chair or Vice Chair, plus at least the Chief Nurse Officer, or Chief Medical Officer from the ICB (or deputy), and two provider representatives (to include one provider Non-Executive Director, with responsibility for Quality).

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 2024.

For the financial year ended the 31st March 2024, and up to the date of signing this statement, the ICB had regard to the provisions set out in the Code. All aspects that the ICB must reference within this statement are fully compliant.

Discharge of Statutory Functions

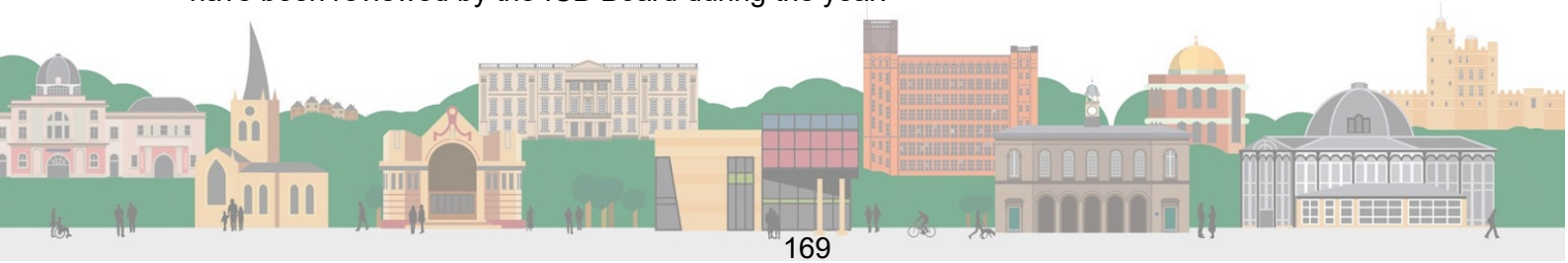
The ICB has reviewed all of the statutory duties and powers conferred on it by the NHS Act 2006 (as amended) and other associated legislation and regulations. As a result, and as the Accountable Officer, I can confirm that the ICB is clear about the legislative requirements associated with each of the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

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

Risk Management Arrangements and Effectiveness

The ICB's integrated risk management system has matured during 2023/24 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 ICB Corporate Risk Register.

The Risk Management Policy was reviewed and approved by the Audit and Governance Committee in 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 JUCD and partners. The policy applies to all employees of the ICB, the ICB Board, Executive Team, and all senior managers to ensure that risk management is a fundamental part of the ICB's approach to the governance of the organisation and all its activities. It enables the organisation to have a clear view of the risks and issues affecting each area of its activity; how those risks are being mitigated, the likelihood of occurrence and their potential impact on the successful achievement of the ICB objectives. 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, Estates and Digital; People and Culture; Population Health and Strategic Commissioning; and Quality and Performance. Other ICB Board members include our Partner members from Trusts, Local 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, PPGs, Citizens' Panel, and hospital employees. ICB Board colleagues share the passion with colleagues across the ICB to involve our public and patients at every opportunity and we were well represented at these sessions.

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

Prevention and deterrence of risk

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

The ICB has a mature serious incident reporting system that is reviewed regularly. Staff are trained in carrying out systematic root cause analysis investigations in line with the National Patient Safety Agency guidance. Any serious incidents which have occurred are reported to NHSE and other appropriate bodies. Serious incidents are also reported through the Strategic Executive Information System. Any breaches of Information Governance which meet the level two criteria of the Information Commissioner's Office will be reported using the Data Protection and Security Toolkit to the Information Commissioner's Office as appropriate. 360 Assurance (Internal Audit) provide specialist advice with regard to Counter Fraud. During 2023/24, the ICB did not identify any fraud losses.

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

Capacity to Handle Risk

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

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

ICB Board	Oversight and holding ICB management to account.
Audit and Governance Committee	Reviewing the effectiveness of the ICB Board Assurance Framework and risk management systems, and ensuring that the ICB complies with the principles of good governance while effectively delivering the statutory functions of the ICB.
Accountable Officer	Ensuring the ICB has an effective risk management system in place for meeting all statutory requirements.
Executive Team	Supporting the Accountable Officer and collectively and individually managing risk.
Chief of Staff	Ensuring the delivery of risk management.
Risk Group	Reviewing, monitoring and managing the risks on the ICB's Risk Register, and ensuring the risk management process is firmly embedded within the organisation. The group supports the Committees' understanding and parity in relation to risk, enabling them to provide assurance to the ICB Board.
Head of Governance	Development, implementation and maintenance of the risk management arrangements for the ICB.
All Staff	Identifying, reporting and managing risks within their areas.

The ICB Board Assurance Framework was presented for scrutiny and assurance to the ICB Board, Audit and Governance Committee and responsible Corporate Committees during 2023/24. Risks to the ICB are reported, discussed and challenged at the ICB Board and Corporate Committee meetings. Communication is two-way, with the Committees escalating concerns to the ICB Board and the ICB Board delegating actions to the responsible Committee where appropriate.

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

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

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

Risk Assessment

This financial year has been challenging in a number of areas for the ICB, particularly in relation to the establishment of the ICB and the ongoing System pressures. Risk identification, assessment and monitoring is a continuous structured process in ensuring that the ICB works within the legal and regulatory framework, identifying and assessing 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 2023/24

In context, the most significant risks we faced during 2023/24 were:

- Acute providers may not meet the new target in respect of 76% of patients being seen, treated, admitted or discharged from the ED within four hours by March 2024, resulting in the failure to meet the ICB constitutional standards and quality statutory duties, taking into account the clinical impact on patients and the clinical mitigations in place where long waits result;
- the sustainability of individual General Practices across Derby and Derbyshire resulting in failure of individual General Practices to deliver quality Primary Medical Care services resulting in negative impact on patient care;
- Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the ICB to move to a sustainable financial position;
- patients on provider waiting lists due to the continuing delays in treatment resulting in increased clinical harm;
- 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;

- national funding for the 2023/24 pay award and 2022/23 one-off payments excluded all staff who were not on NHS payrolls. Consequently staff employed by DHU, NHS subsidiary bodies, in PFI arrangements and Primary Care were not eligible. Consequently there is an increasing risk of legal challenge as well as real, emerging loss of morale for over 4,500 staff across JUCD, which could affect recruitment and retention of critical frontline colleagues;
- JUCD performance against the cancer standards, including 28-day faster diagnosis standard, 62-day waits and 104+ days, due to an increase in referrals from Staffordshire into UHDBFT and resulting in significant capacity challenges to meet increased level of demand for diagnostic investigations, diagnosis and treatment; and
- significant waiting times for moderate to severe stroke patients for community rehabilitation. This means patients may have discharges from acute delayed, be seen by non-stroke specialist therapists and require more robust social care intervention.

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 and Governance Committee is charged with receiving reports on the operation of key controls and ensuring that risks identified are appropriately mitigated and that actions are completed.

The ICB fulfils its duties in relation to the Equality Act 2010 and the Public Sector Equality Duty contained within that Act, through a robust equality analysis of all policies, procedures and decisions. This ensures that due regard is given to Equality, Inclusion and Human Rights with the aim of eliminating discrimination; harassment; 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, Estates and Digital Committee and the Population Health and Strategic Commissioning Committee.

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

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

Conflicts of Interest Management

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

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

To further strengthen the scrutiny and transparency of the decision-making processes, the Non-Executive Member 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[xxvi].

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 2023/24 can also be found at the web link above.

With the dissolution of CCGs, the online training module for CCG staff on Conflicts of Interest was retired by NHSE on the 23rd December 2022. Following national discussions, a new training module has now been released by NHSE and will be made available to all staff through the ICB's usual training system in 2024/25.

Freedom to Speak Up Guardian

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

The ICB also has three members of staff who are Freedom to Speak Up Ambassadors. 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 2023/24 the ICB has had 12 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.

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

Information Governance

The Information Governance Assurance Forum is responsible for the governance and oversight of 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 Data Security and Protection Toolkit compliance activities and policies, access to information (subject access requests), cyber security updates, Information Governance incidents, Freedom of Information requests, training, and staff communications.

The Information Governance Assurance Forum is scheduled to take place on a monthly basis, taking the form of formal meetings or circulation of documents for review, approval and assurance depending upon the agreed work plans. From the Information Governance Assurance Forum's minutes and papers, there is evidence of challenge, appropriate reporting and action being taken where required. Assurance 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.

Information Governance policies and privacy notices have recently been updated to improve readability and to ensure that all facets of the ICB's work are appropriately covered. Public facing policies and privacy notices are available here[xxvii].

Each year, the ICB completes the Data Security and Protection Toolkit which is a requirement for all organisations that have access to NHS patient data and systems. This provides assurance that the ICB are practicing good data security and that personal data are being handled appropriately. The annual Data Security and Protection Toolkit audit will be carried out by 360 Assurance during May 2024. The outcome of this audit will be reported to the Audit and Governance Committee to provide independent validation of the ICB's self-assessment.

The ICB submitted their baseline toolkit assessment on the 27th February 2024. 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 2024. The ICB is on track for achieving a 'standards met' position based upon current progress against the agreed work plan.

The ICB has had one incident this year which necessitated reporting to the Information Commissioner's Office with no follow up action required. The ICB also received contact from the Information Commissioner's Office following a complaint linked to a subject access request which again required no follow up action. 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 40 shows the range of services which are provided by third party providers.

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

Table 40 – 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 – Ambulance Services

For Q4 2023/24, EMAS were non-compliant for all six national response time standards at a regional level across every month. When compared to the same time of 2022/23 there has been a deterioration in all six of the national standards. The Derbyshire position matches that of the region, with none of the six national standards being achieved.

During March 2024, only 26.9% of EMAS ambulance pre-handovers happened within 15 minutes, with CRHFT running at 47.1% and UHDBFT at 22.4%. The average pre-handover time for EMAS was 35 minutes and 13 seconds, an increase of 2 minutes and 29 seconds on the previous year. For Derbyshire, the average pre-handover time was 24 minutes 32 seconds, compared to 29 minutes and 15 seconds in the previous year, which is a significant improvement.

In order to facilitate the improvement in performance ICB's were asked to develop a number of pre-handover improvement trajectories, for January 2024 to March 2024 only Lincolnshire ICB achieved their trajectory. Derbyshire missed their average 2023/24 pre-handover trajectory by 2 minutes and 30 seconds.

Category 2, 30-minute plan

The Operational Plan which was submitted to NHSE assumed a category 2 mean response time (for all EMAS's portfolio) of 30 minutes average across the 2023/24 financial year. This plan was revised and a new mean average target across 2023/24 was agreed at 39 minutes and 49 seconds.

At a regional level the revised trajectory was not met in January, February, or March. The average C2 mean response time for 2023/24 was 43 minutes and 23 seconds this was 3 minutes and 34 seconds above trajectory.

At an ICB-level Derbyshire did not achieve the trajectory for any months during Q4 and missed the 2023/24 annual target by 4 minutes and 37 seconds.

Trust-level on-scene activity for Q4 2023/24 was +10.3% above plan, with Derbyshire being +7.8% above plan.

NHS pathways

EMAS have implemented a new telephone triage system to assess 999 calls received in the emergency operations centres. NHS Pathways replaced advanced medical priority dispatch system and the processes of assessing and categorising all 999 calls will change. The full implementation of NHS Pathways went live in November 2023 at Bracebridge Heath, Lincoln; and Horizon Place, Nottingham.

Following the implementation of the NHS Pathways full utilisation of NHS pathways is being realised, as of March 2024, EMAS had access to 96% of targeted services via the DoS. Work continues for further targeted services e.g., District nursing, Urgent Community Response and urgent care/urgent treatment centres with appointment booking.

Quality and Performance – Maternity

Quality and safety of maternity services

UHDBFT remains subject to monthly tier 3 oversight meetings for the CQC section 31 and 29a regulations received in August 2023. An exit plan has been drafted with trajectories to meet the criteria by Autumn 2024. NHS Midlands and the NHSE maternity improvement advisors are supporting UHDBFT to meet the requirements of the maternity improvement programme. A Preventing Future Deaths Notice was issued following an inquest held in March 2024 into a neonatal death in 2022. A response was provided to the coroner in May 2024 with an action plan to be shared with the LMNS for assurance.

National compliance exceptions

UHDBFT have shown continued improvements in compliance with national recommendations and reports. Saving Babies Lives Care Bundle version 3 (SBLCBv3) compliance improved to 54% in February with a further assessment planned in June. The LMNS completed an insight visit and assessment of compliance with the seven Immediate and Essential Actions (IEAs) identified in the interim Ockenden report (2020). Compliance improved to 69%, with improvements in senior leadership and governance processes

evident. Areas for improvement include communication, development opportunities for junior midwives and specialist teams to provide support for the workforce. Actions have been identified to improve on the CNST MIS year 5 safety actions. Year 6 declarations are required by the 3rd March 2025 and the LMNS will have monthly oversight of progress.

CRHFT are 78% compliant with the Ockenden seven IEA's following an insight visit in November 2023. This will be followed up in 2024 with an insight visit to review the 3-year delivery plan for maternity and neonatal services action implementation, which incorporates the Ockenden actions. SBLCBv3 compliance shows consistent improvements. Financial investment by the Trust is required to achieve some of the remaining interventions.

Maternal morbidity

UHDBFT continue to report third and fourth-degree tear and postpartum hemorrhage rates around the national average. Postpartum hemorrhage was highlighted in the CQC regulations issued and NHS Midlands have provided support to the Trust to embed management pathways for risk assessment, early identification and escalation.

CRHFT's rate of third and fourth-degree tears have remained consistently above the national average and on occasion been an outlier. NHS Midlands have offered support to understand the reasons for the increased rates and to identify practices to embed and improve the quality of care. The LMNS are implementing a perinatal pelvic health service which will support those women experiencing pelvic injury and long-term morbidity. Currently this is in the project planning and scoping stage with implementation to begin in Q3 of 2024. Postpartum haemorrhage rates remain around the national average for similar sized units.

The LMNS have oversight and assurance through monthly perinatal quality and safety groups and improvements are being seen across the system with improvements in processes and multidisciplinary working across maternity and neonatal care.

Quality and Performance – Infection Prevention Control

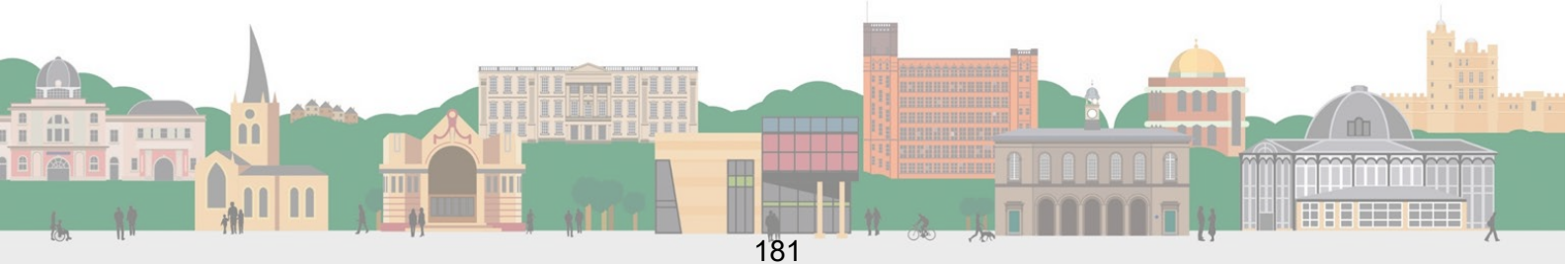
At the end of 2024/24, JUCD performance shows that CDI cases were 34% over threshold at both acute Trusts and as a result at System-level (350 cases versus a year-end threshold of 262 at the end of January 2024).

17 cases of MRSA blood stream infections were reported against a zero tolerance (11 healthcare associated at ICB trusts).

The number of Gram-negative infections reported have all breached thresholds at both Trust and System-level, the increased numbers seen at the beginning of the year are stabilising.

Post-infection reviews are not identifying any new learning and Trusts are implementing PSIRF methodology for IPC. Recovery plans remain in place. CRHFT and UHDBFT remain on enhanced monitoring and support as per the NHSE Midlands IPC escalation matrix.

UHDBFT have received a report from NHSE in December 2023, stating that further work is needed around the use of PPE, surgical site infection surveillance, storage and embedding responsibility for IPC standards at ward/department-level.



Additional support has been offered by regional teams and ICB to CRHFT pending the start of an IPC lead nurse in April 2024. Progress has been made around embedding skin decolonisation for MRSA, but further work is needed around maintenance of estates.

Assurances obtained relating to the implementation of Trust-focused recovery action plans are obtained at each Trust's internal IPC committees, and the IPC System Assurance Group.

Quality and Performance - Continuing Health Care

Personal Health Budgets

The operational planning guidance required ICBs to submit trajectories for the number of personal health budgets to be in place by the end of 2023/24. As of the end of 2023/24 there was:

- 917 children and young people with a personal health budget;
- 2,391 adults with a personal health budget;
- 139 personal health budgets were via a direct payment;
- 10 personal health budgets were via third party; and
- 3,159 personal health budgets via notional budget.

Personal health budgets default for all CHC home care packages, children and young people with continuing care needs, and wheelchair budgets. Prior to the Covid-19 pandemic NNHS Derby and Derbyshire Clinical Commissioning Group (now the ICB) also offered non-CHC personal health budgets for individuals with LTCs, learning disabilities, mental health issues and complex needs. This offer was put on hold during the pandemic with a full review of all personal health budgets agreed through this route. Although a refreshed local offer has not yet been agreed ad hoc exceptional circumstances to support hospital discharge have been approved through the ICB.

Quality and Performance - Mental Health and Dementia

Increase in Access to Talking Therapies

This has continued to exceed the six-week-wait and 18-week-wait national standard, and recovery rates were all exceeding the national target. Plans were agreed with providers to improve this position.

Perinatal Improving Access

As of December 2023, this service is achieving 8.5% against a target of 10%, which is an improved position for the System. The service is now fully recruited to, and capacity is in place to achieve the national standard, however referral rates and 'did not attends' are having an impact on performance. Stronger links are being made through to antenatal services for early identification of people who are appropriate for support.

Dementia diagnosis rate

Dementia diagnosis rates have exceeded the national standard by 68% against a target of 66.5%. As of December 2023, 1,670 people were waiting up to 34 weeks for their initial appointment. There are also 100 referrals per month and demand is continuing to rise. A pilot to improve diagnosis of advanced dementia is in place and is having a positive impact on diagnosis rates and enabling improved care for the cohort.

Children and young people increase in access

The current target is 14,431, based on a 12-month rolling total. In October 2023, actual performance was underperforming at 13,370 and plans were in place to recover performance by the end of Q4. However due to data capture issues at CRHFT and nationally, reported performance is below actual. Data issues were resolved with CRHFT, and national issues should be resolved by end of Q4.

Community mental health service increase in access

The stretching target, representing 14% increase on 2022/23 activity, has continued to achieve, however there has been an impact of industrial action on the ability to sustain waiting times. The Community Mental Health Framework was refreshed, and a delivery plan is in place.

Mental health out-of-area placements

Continued pressure within acute services has resulted in a greater demand for the psychiatric intensive care unit. In October 2023 there were 1,105 bed days spent in out-of-area placements. All admissions were subject to a gatekeeping review by the Crisis Home Treatment Team, with additional crisis alternative capacity in place. Improvements in were in place across the North Derbyshire pathway, which supported a reduction in acute mental health admissions.

There has been a focus on the discharge pathway, which has included a strategic integrated flow lead and clinical directors driving the decision-making and flow leads working between inpatient wards and the community. Additional short-term beds have been funded for people with no fixed abode, alongside severe mental illness step-down beds to support discharge flow. Case management oversight is in place to oversee the care of all elderly patients in repatriating as soon as clinically and operationally appropriate.

Learning disability and autism transforming care program

As at the end of November 2023, the in-year trajectory was being achieved. A recovery action plan and assurance oversight remained in place to support the achievement of national requirement. There is a focus on recovery actions within inflow, flow and outflow. The joint NHS Local Authority strategic approach and action plan is in place regarding care and accommodation.

Sever mental illness annual health checks: increase in access

As at the end of September 2023, 50.6% of people on the severe mental illness register had received all six aspects of annual health checks, the national standard is 60%. Across these six aspects, performance ranged from 70-80% of eligible patients.

There has been improved engagement with Primary Care, General Practice clinical champions are in place, and QOF payment has been linked to the achievement of all six aspects so there is an expectation that all General Practices ensure outstanding checks are completed during Q4.

An awareness-raising communications plan is in place to promote annual health checks across public and Primary Care teams by utilising social media platforms. A pilot of this showed a sustained improvement in performance, with positive feedback received on patient and staff experience.

Learning disabilities annual health checks: increase in access

Q2 performance exceeded trajectory, with 919 checks completed against a target of 895. During Q3, performance was below trajectory due to a dip in Q1 and September 2023 performance.

A flag has been added to SystmOne to identify the annual health check status of patients to Secondary Care clinicians, so they can promote and undertake checks (if appropriate) within Secondary Care consultations.

A Strategic Health Facilitation Team is in place to deliver continual training to GPs and includes a bespoke action plans for General Practices below 75% compliance. Targeted work is also in place with specialist schools to promote annual health checks to those over 14 years, including collaboration with education, health and care plans.

Quality and Performance – Accident and Emergency

Accident and emergency in Derbyshire failed to deliver against the national 95% 4-hour standard during December (72.8%). Underperformance for the ICB is attributed predominantly to underperformance 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 4-hour national standard, with current performance for December 2023 at 73.0%. The Type-1 element achieved 54.1%, which is well below target but an improvement in December 2022 when 32.3% was achieved.

12-hour Trolley Breaches

From April to end of December 2023 there have been 3,520 x 12-hour trolley breaches, against a target of zero, but accounting for 14% less than the same period last year (there were 4,131 for April to November 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 4-hour national standard, with performance for December 2023 at 72.1%. A shortage of Packages of Care availability in the county has delayed discharges and therefore patient flow through CRHFT.

12-hour Trolley Breaches

From April to end of December 2023 there were 1,070 x 12-hour breaches at CRHFT, mainly due to limited availability of medical beds. These have almost tripled in comparison to last year, when there were 362 between April and December 2022.

Quality and Performance – Diagnostics

As a System, JUCD are forecasting to be compliant with the 85% standard for patients waiting under six weeks for a diagnostic test by March 2024.

Performance at CRHFT in October 2023 was 77.3% under six weeks. This presents an improvement from 75.2% in September 2023.

UHDBFT's performance is in October 2023 was 79.9%. This presents an improvement from 72.6% in September 2023.

The CDC programme timescales remain largely on track, with some disruption anticipated over the coming months, during the building work at Ilkeston and FNCH in particular.

JUCD have made more progress than most Midlands ICBs in diagnostic performance and are now 13th of 18 Systems in the region. In October 2023 Imaging performance in strongest at 87.9% less than six weeks – endoscopy is at 67.4% and physiological medicine is at 58.6%.

Both endoscopy and PM are anticipating stronger performance in the coming reporting months. Endoscopy performance has improved significantly and has been achieving the 85% standard since November 2023.

Actions put in place to recover performance include additional weekend sessions which have been successful as a result of the enhanced pay rate and has halved the waiting list.

Quality and Performance - Access to Service/Capacity

Urgent and Emergency Care

The number of occupied beds by adult patients for 7+, 14+ and 21+ days across the ICB have fluctuated but remained relatively level through the year – by the end of December 2023 the proportion of 21+ day patients at CRHFT stood at 14.7% and 14.4% at UHDBFT. G&A adult bed occupancy was better than plan at UHDBFT at 92.5% (plan of 93.6%) but CRHFT were worse than plan at 94.7% (plan of 83.3%).

Quality and Performance - Cancer

The nine constitutional standards were reduced to three this year, losing the two-week-wait standard and consolidating the 31-day and 62-day standards. The 28-day faster diagnosis standard remains unchanged.

28-day faster diagnosis standard

As of November 2023, Derbyshire were close to achieving the 75% target at 72%, primarily due to Chesterfield achieving the target at 80%.

31-day standard

The ICB achieved 86.4% for November 2023, a sustained improvement but short of the 96% target.

62-day standard

The ICB achieved 64.9% for November 2023, a sustained improvement but short of the 85% target.

Key areas of focus for improvement

UHDBFT have recruited a cancer turnaround lead who is working with the ICB to develop a recovery action plan that will provide system assurance. High-impact actions are being agreed/completed within key tumour sites, with support from regional and national best practice. Referral volumes continue to be a challenge and further work in development to improve referral quality and support effective clinical triage across JUCD (and into Staffordshire).

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

18-week referral to treatment

Incomplete pathways continue to be non-compliant for Derbyshire in November at 55.1% (YTD 55.9%), and both main providers in Derbyshire (UHDBFT and CRHFT) failed to meet the 92% standard (55.8% and 52.7% respectively).

Those patients who have been prioritised at P2 or P3 are receiving their surgery in a timelier manner but there are still a large number of patients waiting over 52 weeks. During the year, General Practice urgent and routine referrals continued to rise, and urgent care issues led to procedures being cancelled.

Long-waiting referral to treatment

The total numbers of 52+ week waits have risen to 7,512 for November 2023 in Derbyshire. However, there has been a focus on having zero very long waiters. For most months there are zero patients waiting 104+ weeks and the numbers of 78+ week waits had reduced to 247 by November 2023. However, these should have been at zero and the ambition is to have zero patients waiting 65+ weeks by then end of March 2024.

Recovery plans

UHDBFT have recruited elective turnaround leads who are working with the ICB to develop a recovery action plan that will provide system assurance. High impact actions are being agreed/completed within key tumour sites with support from regional and national best practice. JUCD forecasts to deliver the NHS ambition of having zero patients waiting more than 78 weeks by the end of March 2023. To facilitate this and continued improvement towards the 65-week target for March 2024, JUCD continues to progress improvement projects in theatre productivity, outpatients, referral optimisation, 'getting it right first time', 'further-faster' and looking at how independent sector capacity can be maximised.

CRHFT outpatients recovery work continues with video or telephone appointments being offered for outpatient activity without a procedure if appropriate. 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.

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

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

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

The ICB prepares an annual Finance Plan that sets out the financial resources available to the organisation and the means by which these will be used to deliver the ICB's objectives. Monthly financial performance is scrutinised by the Finance, Estates and Digital Committee and reported to the ICB Board. Internal and External Audit arrangements give assurance to the ICB Board on the delivery of the ICB's statutory financial responsibilities and the achievement of value for money. The ICB complies with the NHS Pension Scheme regulations. Through our Internal Auditors, the ICB's performance is benchmarked against similar organisations. It uses expert commissioning support to ensure the delivery of best value through procurement. It develops efficiency schemes that enable it to use its resources effectively and efficiently through improving patient pathways which make best use of available healthcare resources and reduce the use of expensive acute care where more convenient and better value local alternatives are available. In exceptional cases there may be instances where information is not reported as it is not accurate or reliable.

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

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

Table 41 shows the ICB's running costs, as reporting in the Annual Accounts.

	Allocation	Expenditure
	£'000	£'000
2023/24	23,163	19,296
2022/23[2]	18,277	15,631

Table 41 – ICB's total running costs allocation and expenditure during 2023/24 and 2022/23

[2] 2022/23 reflects the allocations and expenditure for the period 1st July 2022 to 31st March 2023.

Table 42 identifies how the ICB's running costs were used during 2023/24, alongside the prior period.

	2023/24	2022/23[3]
	£'000	£'000
Pay costs	14,829	11,495
Travel expenses	10	11
Premises	633	669
Charges from Commissioning Support Units	1,190	883
Other non-pay	3,172	2,929
Commissioning income	(538)	(356)

Table 42 – breakdown of running costs expenditure during 2023/24 and 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 considers how successfully the ICB has:

- led the NHS within JUCD;
- contributed to each of the four fundamental purposes of JUCD;
- 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 evaluates 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.

[3] 2022/23 reflects the allocations and expenditure for the period 1st July 2022 to 31st March 2023.

For 2022/23, NHSE provided the following feedback on the ICB annual assessment:

"The ICB has made significant progress in working and engaging with System partners to ensure that strategic priorities are aligned and that there is a developing approach to truly integrated health and care. Good progress has been made with leadership and governance arrangements, however there are some areas of operational and financial challenge which will require further development of oversight arrangements and focussed improvement activity in the coming year."

The 2023/24 ICB annual assessment process will be undertaken in the first quarter of 2024/25.

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.

During 2023/24, the ICB has been responsible for the delegation of Primary Pharmacy Services, Optometry Services and Primary and Secondary Dental Services from NHSE to ICBs. This was in accordance with NHSE's long-term policy ambition of giving systems responsibility for managing local population health needs, tackling inequalities and addressing fragmented pathways of care. The services that have been delegated to the ICB are:

- Primary Pharmacy, Optometry and Primary and Secondary Dental Services from the 1st April 2023;
- complaints functions associated with Primary Pharmacy, Optometry and Primary and Secondary Dental Services from the 1st July 2023; and
- Specialised Commissioning from the 1st 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 Chief Finance Officer are jointly responsible for ensuring adherence to the Functional Standard.

Annually, the ICB is required to self-assess against the Functional Standard by submitting the ICB's Counter Fraud Functional Standard Return. Further detail of the ICB's submission can be found in the Counter Fraud Annual Report. In 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 2023/24 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.*

***Strategic risk management and Board Assurance Framework** – I am providing an opinion of significant assurance. The ICB has appropriate arrangements to ensure an up to date Board Assurance Framework is in place throughout the year.*

***Internal Audit outturn** – I am providing an opinion of moderate assurance. We have issued four reports with a limited assurance opinion three of which are core topic areas.*

***Implementation of Internal Audit Actions** – I am providing an opinion of significant assurance. The ICB's first follow up implementation rate is currently 92% and the ICB has maintained robust internal processes for monitoring outstanding actions.*

This opinion should be taken in its entirety for the Annual Governance Statement and any other purpose for which it is repeated.

During 2023/24, 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 43:

Audit Assignment	Assurance Level/Comments
Accounts payable, Treasury and Cash Management	Substantial
Data Quality and Performance Management Framework	Limited
Data Security and Protection Toolkit	Substantial – NHSE opinion level
Delegated primary care functions – review of annual self-declaration	Advisory review
Financial Ledger and Reporting	Substantial
Health Inequalities	Developing
Mental Health Act Assessment Claims	Limited
Operational Planning	Limited
Personalised Care and Support: Section 117 payments	Limited
Risk Management Developmental Review	Developing

Audit Assignment	Assurance Level/Comments
Safeguarding	Significant
System-Wide Discharge Management	Emergent
Transformation and Efficiency Follow-Up	Limited

Table 43 – Internal Audit reports issued in 2023/24 by 360 Assurance

Review of the effectiveness of governance, risk management and internal control

As Accountable Officer, my review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the ICB who have responsibility for the development and maintenance of the Internal Control Framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the ICB achieving its principles objectives has been reviewed.

I have been advised on the implications of the result of this review by the ICB Board, Audit and Governance Committee, Remuneration Committee, Finance, Estates and Digital Committee, People and Culture Committee, Population Health and Strategic Commissioning Committee, Public Partnership Committee, and Quality and Performance Committee; and have addressed any weaknesses during the year and ensure continuous improvement of the system is in place.

The effectiveness of the governance, risk management and internal control 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 reviewed at each meeting of the 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;
- NECSU – via monthly contract monitoring meetings;
- Corporate Committees of the ICB Board; and
- Executive Team.

Conclusion

No significant internal control weaknesses have been identified during the year. The ICB has received positive feedback from Internal Audit on the assurance framework and this, in conjunction with other sources of assurance, leads the ICB to conclude that it has a robust system of control.

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

The ICB has an established Remuneration Committee. The committee makes recommendations on determinations about the remuneration, fees and other allowances for employees and for people/organisations providing services to the ICB. The Committee is chaired by a Non-Executive Member. The composition of the Remuneration Committee is shown in Table 28 on page 158.

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 VSM or member of the ICB's Executive Team are determined separately and, where appropriate, the principles of Agenda for Change are applied to these employees to ensure equity across the ICB. There is no national body to determine remuneration for VSM employees; therefore, a robust process is in place within the ICB. The Remuneration Committee sets and approves the remuneration for all VSM employees. The Remuneration Committee comprises Non-Executive Members from the ICB Board and their decisions are informed by independent, local and national benchmarking to ensure the best use of public funds and to help with recruitment and retention. Their decisions also take into consideration annual Agenda for Change pay circulars to ensure parity where appropriate.

The Chief Executive Officer and Chief Finance Officer are remunerated in line with the ICB Remuneration Guidance (updated) issued by the NHS Commissioning Board in late 2012 as adjusted to take account of the previous remuneration of the staff members concerned. All VSM salaries are reviewed and agreed by the Remuneration Committee and reported to the ICB Board. The VSM pay review process includes a requirement for 100% compliance with mandatory training.

Senior Manager Remuneration (including salary and pension entitlements) (subject to audit)

Tables 44 and 45 show the Senior Manager total salary during 2023/24 and for the period to the 31st March 2023.

Salaries and allowances for the year to 31st March 2024

Name	Title	1st April 2023 to 31st March 2024					
		(a) Salary (bands of £5,000)	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long-term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
		£000	£	£000	£000	£000	£000
John MacDonald	ICB Chair	15-20	0	0	0	0-2.5	15-20
Richard Wright	ICB Chair	45-50	0	0	0	0-2.5	45-50
Dr Chris Clayton	Chief Executive Officer	205-210	1200	0	0	0-2.5	205-210
Keith Griffiths	Chief Finance Officer	170-175	0	0	0	0-2.5	170-175
Brigid Stacey	Chief Nurse Officer and Deputy Chief Executive Officer	40-45	0	0	0	0-2.5	40-45
Paul Lumsdon	Interim Chief Nurse Officer	75-80	0	0	0	0-2.5	75-80
Prof Dean Howells	Chief Nurse Officer	90-95	2200	0	0	32.5-35	125-130
Dr Chris Weiner	Chief Medical Officer	145-150	1200	0	0	0-2.5	145-150
Amanda Rawlings	Chief People Officer	5-10	0	0	0	0-2.5	5-10
Linda Garnett	Interim Chief People Officer	105-110	0	0	0	0-2.5	105-110
Helen Dillistone	Chief of Staff	135-140	200	0	0	0-2.5	135-140
Zara Jones	Executive Director of Strategy and Planning	65-70	0	0	0	0-2.5	65-70

Name	Title	1st April 2023 to 31st March 2024					
		(a) Salary (bands of £5,000)	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long-term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
		£000	£	£000	£000	£000	£000
Michelle Arrowsmith	Chief Strategy and Delivery Officer and Deputy Chief Executive	70-75	0	0	0	2.5-5	75-80
James Austin	Chief Digital Information Officer	65-70	2100	0	0	15-17.5	85-90
Julian Corner	Non-Executive Member (Population Health and Strategic Commissioning)	5-10	0	0	0	0-2.5	5-10
Dr Adedeji Okubadejo	Clinical Lead Member and Vice ICB Board Chair	40-45	0	0	0	0-2.5	40-45
Margaret Gildea	Non-Executive Member (People and Culture) and Senior Independent Director	15-20	0	0	0	0-2.5	15-20
Sue Sunderland	Non-Executive Member (Audit and Governance)	10-15	100	0	0	0-2.5	10-15
Jill Dentith	Non-Executive Member (Finance, Estates and Digital)	10-15	200	0	0	0-2.5	10-15
Tracy Allen	Participant to the Board for Place – Derbyshire Community Health Services NHS Foundation Trust	0-5	0	0	0	0-2.5	0-5
Mark Powell	Partner Member - Derbyshire Healthcare NHS Foundation Trust	0-5	0	0	0	0-2.5	0-5
Stephen Posey	Partner Member - University Hospitals of Derby and Burton NHS Foundation Trust	0-5	0	0	0	0-2.5	0-5
Ellie Houlston	Partner Member – Derbyshire County Council	0-5	0	0	0	0-2.5	0-5
Dr Andrew Mott	Partner Member – Primary Medical Services	5-10	0	0	0	0-2.5	5-10
Andy Smith	Partner Member - Derby City Council	0-5	0	0	0	0-2.5	0-5

Name	Title	1st April 2023 to 31st March 2024					
		(a) Salary (bands of £5,000)	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long-term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
		£000	£	£000	£000	£000	£000
Dr Avi Bhatia	Clinical and Professional Leadership Group Participant to the Board	70-75	0	0	0	0-2.5	70-75

Table 44 – Senior Manager remuneration for the year to 31st March 2024

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 (£'000) 45-50.
4. The total remuneration disclosed in the table above for Dr Avi Bhatia, Dr Andrew Mott and Dr Adedeji Okubadejo includes clinical advisory services provided to the ICB unrelated to their roles as senior managers.
5. James Austin is employed by Derbyshire Community Healthcare Services NHS Foundation Trust, and is recharged to the ICB on a 50% basis. It is this shared which is disclosed in the remuneration table.
6. Amanda Rawlings is employed by the University Hospitals of Derby and Burton NHS Foundation Trust, with the ICB being recharged 50% of the salary and it is the ICB share which is disclosed in the remuneration table. Amanda Rawlings position with the ICB ceased in April 2023, and Linda Garnett commenced in May 2023 in an interim position.
7. John MacDonald ceased his role as Chair of the ICB in June 2023, and Richard Wright commenced from July 2023. At this point, Richard Wright ceased his role as Non-Executive Member (Finance, Estates and Digital), and Jill Dentith commenced this position from July 2023.
8. Brigid Stacey retired in July 2023 as Chief Nursing Officer, and Paul Lumsdon carried out this role between July 2023 and August 2023. Dean Howells commenced as Chief Nursing Officer from September 2023.
9. Zara Jones ceased the role as Executive Director of Strategy and Planning in September 2023, and Michelle Arrowsmith commenced as Chief Strategy and Deliver Officer, and Deputy Chief Executive in October 2023.
10. Partner member changes include the cessation of Carolyn Green for Derbyshire Healthcare NHS Foundation Trust in March 2023, replaced by Mark Powell from April 2023, and Stephen Posey commenced as representative for University Hospitals of Derby and Burton NHS Foundation Trust from August 2023.
11. Taxable benefits disclosed in the above table include business miles and salary sacrifice lease cars.

Salaries and allowances for the period 1st July 2022 to 31st March 2023

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 (bands of £2,500)	(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 Population Health and Strategic 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 and Culture	5-10	0	0	0	0-2.5	5-10
Sue Sunderland	Non-Executive Member for Audit and Governance	5-10	0	0	0	0-2.5	5-10

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 (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
		£000	£	£000	£000	£000	£000
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
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 45 – Senior Manager remuneration for the period 1st July 2022 to 31st March 2023

Notes
1. 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.
2. James Austin commenced the role with the ICB in November 2022. James 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' 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 2024

Name	Title	Real Increase in Pension at pension age (bands of £2,500)	Real Increase in Pension Lump Sum at pension age (bands of £2,500)	Total Accrued Pension at pension age at 31 March 2024 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2024 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2023	Real Increase/ (Decrease) in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2024	Employers Contribution to Stakeholder Pension
		£000	£000	£000	£000	£000	£000	£000	£000
Dr Chris Clayton	Chief Executive Officer	0-2.5	50-52.5	35-40	95-100	546	170	799	0
Keith Griffiths	Chief Finance Officer	0-2.5	20-22.5	80-85	230-235	1,777	139	2,119	0
Prof Dean Howells	Chief Nurse Officer	0-2.5	17.5-20	45-50	130-135	753	132	1,075	0
Amanda Rawlings	Chief People Officer	0-2.5	0-2.5	35-40	95-100	730	5	885	0
Helen Dillistone	Chief of Staff	0-2.5	35-37.5	40-45	105-110	642	164	889	0
Zara Jones	Executive Director of Strategy and Planning	0-2.5	30-32.5	35-40	90-95	477	65	679	0
Michelle Arrowsmith	Chief Strategy and Delivery Officer/Deputy Chief Executive	0-2.5	0-2.5	45-50	140-145	971	8	1,104	0
James Austin	Chief Digital Information Officer	2.5-5	0	25-30	0	283	86	395	18

Table 46 – pension benefits as at 31st March 2024

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 the 31st March 2024.
2. The CETVs shown in the table above, and prior year comparator values have been provided by the NHS Business Services Authority (BSA) and have been used to calculate the real movement in CETV value.
3. The Chief Medical Officer, Dr Chris Weiner and the Interim Chief People Officer, Linda Garnett, chose not to be covered by the pension arrangements during the reporting period.
4. The Chief Information Officer, James Austin and Chief People Officer, Amanda Rawlings' pension balances have been disclosed in full in this report, however their roles are shared with Derbyshire Community Healthcare Services NHS Foundation Trust and University Hospitals of Derby and Burton NHS Foundation Trust respectively.
5. Brigid Stacey was Chief Nurse Officer until the 4th July 2024 and took retirement on the 12th July 2024.

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 47 – pension benefits as at 31st March 2023

Notes:
1. The Executive Medical Director, Dr Chris Weiner, chose not to be covered by the pension arrangements during the reporting period.
2. The Chief Information Officer, James Austin and Chief People Officer, Amanda Rawlings' pension balances have been disclosed in full in this report, however their roles are shared with Derbyshire Community Healthcare Services NHS Foundation Trust and University Hospitals of Derby 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).

Pension disclosures for members affected by the public service pensions remedy

On the 1st April 2015, the government made changes to public service pension schemes which treated members differently based on their age. The public service pensions remedy puts this right and removes the age discrimination for the remedy period, between the 1st April 2015 and 31st March 2022. Part 1 of the remedy closed the 1995/2008 Scheme on the 31st March 2022, with active members becoming members of the 2015 Scheme on the 1st April 2022. For Part 2 of the remedy, eligible members had their membership during the remedy period in the 2015 Scheme moved back into the 1995/2008 Scheme on the 1st October 2023.

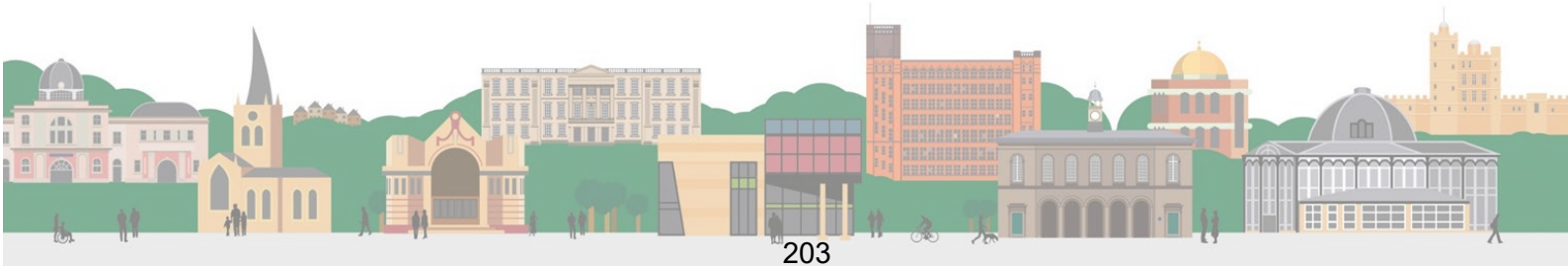
Where members are affected by the Public Service Pensions Remedy, and their membership between the 1st April 2015 and 31st March 2022 was moved back into the 1995/2008 Scheme on the 1st October 2023, this is disclosed as a note to the Pension Benefits (Table 46).

Compensation on early retirement or for loss of office

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

Payments to past members (subject to audit)

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



Percentage change in remuneration of highest paid director (subject to audit)

	Salary and Allowances	Performance Pay and Bonuses
The percentage change from the previous financial year in respect of the highest paid director	5.06%	0.00%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	3.18%	0.00%

Table 48 – percentage change in remuneration of highest paid director

During the financial year ending the 31st March 2024, employees were awarded a 5% pay uplift under the Governments' Agenda for Change Pay Award. The ICB's Directors received uplifts in line with this award, as seen in Table 48 above.

Due to staffing changes at NHS Derby and Derbyshire ICB during the year reducing the average salary, the employee percentage change is lower than the 5% uplift awarded.

Pay ratio information (subject to audit)

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

The banded remuneration of the highest paid director/member in the ICB in the period to the 31st March 2024 was £207,500 (2022/23: £197,500). The relationship to the remuneration of the organisation's workforce is disclosed in Tables 48 and 49.

The calculation of the 25th percentile, median and 75th percentile remuneration of the workforce includes the remuneration of members of the Board but excludes the highest paid director/ member.

In the period to the 31st March 2024, nil (2022/23: nil) employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £22,500–£207,500 (2022/23: £22,500 to £197,500). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Tables 49 and 50 show the relationship between the remuneration of the highest-paid director in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce as at the 31st March 2024 and 31st March 2023.

	25th percentile	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	30,298	48,222	60,933
Salary component of total remuneration	28,407	45,996	58,972
Pay ratio information	7:1	4:1	3:1

Table 49 –Pay ratio information as at 31st March 2024

	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	3:1

Table 50 – Pay ratio information as at 31st March 2023

Staff Report

Number of Senior Managers and Staff Composition

Table 51 shows the gender and pay band of VSMs and gender of the other ICB Employees during 2023/24.

	Male	Female	Total
Executive Members (including Functional Directors)	8	10	18
Band 8d	4	4	8
Band 8c	6	18	24
Band 8b	9	29	38
Band 8a	14	59	73
Other banded ICB employees	37	295	332
Total ICB employees	**78**	**415**	**493**
Other non-permanent engagements including non-executive directors and lay members	22	26	48
Total	**100**	**441**	**541**

Table 51 – number of senior managers and staff composition during 2023/24

Staff numbers and costs (subject to audit)

The staff costs for the period 1st April 2023 to 31st March 2024 are shown in Table 52. There has been an increase in non-permanent employees (categorised as 'Other' in the tables below). In the main, this reflects the delegation of pharmacy, ophthalmology and dentistry services to the ICB from the 1st April 2023, and the associated staff costs of managing this delegation; hosted by another ICB within the East Midlands region.

Employee Benefits in the period to 31st March 2024

Employee Benefits	2023/24		
	Permanent Employees	Other	Total
	£000	£000	£000
Salaries and wages	20,429	1,260	21,689
Social security costs	2,266	47	2,313
Employer contributions to NHS Pension scheme	4,105	56	4,161
Other pension costs	4	–	4
Apprenticeship levy	93	–	93
Termination benefits	335	–	335
Gross employee benefits expenditure	**27,232**	**1,363**	**28,595**
Less recoveries in respect of employee benefits	(35)	–	(35)
Total – net admin employee benefits including capitalised costs	**27,197**	**1,363**	**28,560**
Less: employee costs capitalised	–	–	–
Net employee benefits excluding capitalised costs	**27,197**	**1,363**	**28,560**

Table 52 – staff numbers and costs in the period to 31st March 2024

Employee Benefits in the period to 31st March 2023

The staff costs for the period 1st July 2022 to 31st March 2023 are shown in Table 53.

Employee Benefits	1st July 2022 to 31st March 2023		
	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
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 53 – staff numbers and costs in the period 1st July 2022 to 31st March 2023

Average number of people employed

Table 54 shows the average number of staff employed by the ICB, excluding non-executive members and lay members.

2023/24			1st July 2022 to 31st March 2023		
Permanently employed	Other	Total	Permanently employed	Other	Total
451	24	**475**	456	12	**468**

Table 54 – average number of people employed by the ICB in 2023/24 and for the period 1st July 2022 to 31st March 2023

During the year to 31st March 2024, the staff turnover for the ICB was 13.8% (2022/23: 9.3%).

Sickness absence data

Table 55 shows the sickness absence data of staff permanently employed by the ICB, up to the 31st March 2024 and for the period 1st July 2022 to 31st March 2023, excluding non-executive members and lay members. This data is provided by NHS Digital, and is reflective of the January to December 2023 calendar year (2022/23: 2022 calendar year).

	2023/24			1st July 2022 to 31st March 2023 (restated)		
	Absence Days (FTE)	Average FTE of Staff	Average Absence Days per FTE	Absence Days (FTE)	Average FTE of Staff	Average Absence Days per FTE
Total	4,836	466	6.4	3,712	464	7.4

Table 55 – average absence days of staff permanently employed by the ICB during 2023/24 and for the period 1st July 2022 to 31st March 2023

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.

Disability Confident

The ICB is committed to employing, supporting and promoting disabled people in our workplace. In 2023/24 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.

The ICB's 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.

The ICB has embedded a Disability and Long-Term Conditions Policy, which includes a reasonable adjustment passport that aims to eliminate barriers and discrimination and support staff to reach their full potential. The policy embodies the social model of disability and gives paid time off to staff, where appropriate, helping to create and maintain a positive working environment for those with a disability or LTC in the ICB.

The ICB is also signed up to the Mindful Employer Charter to demonstrate our commitment to increasing the awareness of mental health, providing strong support networks and information, and making it easier for 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

The ICB is 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 during 2023/24 and introduced the following new policies:

- Relocation Policy; and
- Photography Consent and Image Storage Policy.

The Audit and Governance Committee is responsible for approving the HR Policies and they are made available to staff on the ICB's Intranet. The ICB Board continues to demonstrate its focus and support to the importance of flexible working, in accordance with the NHS People Plan, the processes for flexible working arrangements, recruitment, inductions and appraisals, and line management development.

All HR policies are developed to ensure due regard to the Equality Act 2010 duties and include an Equality Commitment Statement which is designed to ensure that through the implementation of these policies no person is treated less favourably.

The ICB has signed the Dying to Work Charter which is part of the Trades Union Congress's wider Dying to Work campaign. This helps members of staff who have a terminal diagnosis to receive support, protection and guidance to continue their employment as a therapeutic activity and help maintain dignity.

The ICB has also signed up to the 'Sexual Safety in Healthcare – Organisational Charter' and committed to a zero-tolerance approach to any unwanted, inappropriate and/or harmful sexual behaviours towards our workforce. In support of the Charter, the ICB has published a toolkit designed to support colleagues in the ICB to discuss and appropriately react to sexual safety of staff in the workplace. To sit alongside the ICB sexual safety charter the ICB has a domestic abuse pledge, which provides signposts colleagues to sources of support and provides that employees:

- will be listened to;
- will be believed;
- will have control;
- will be supported;
- confidentiality will be respected; and
- will be helped to keep safe.

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.

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 2023 NHS Staff Survey was open to all staff, and is the fifth 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 84%, which is higher than the comparative average of 78% for similar organisations. Figure 11 provides a summary of the results.

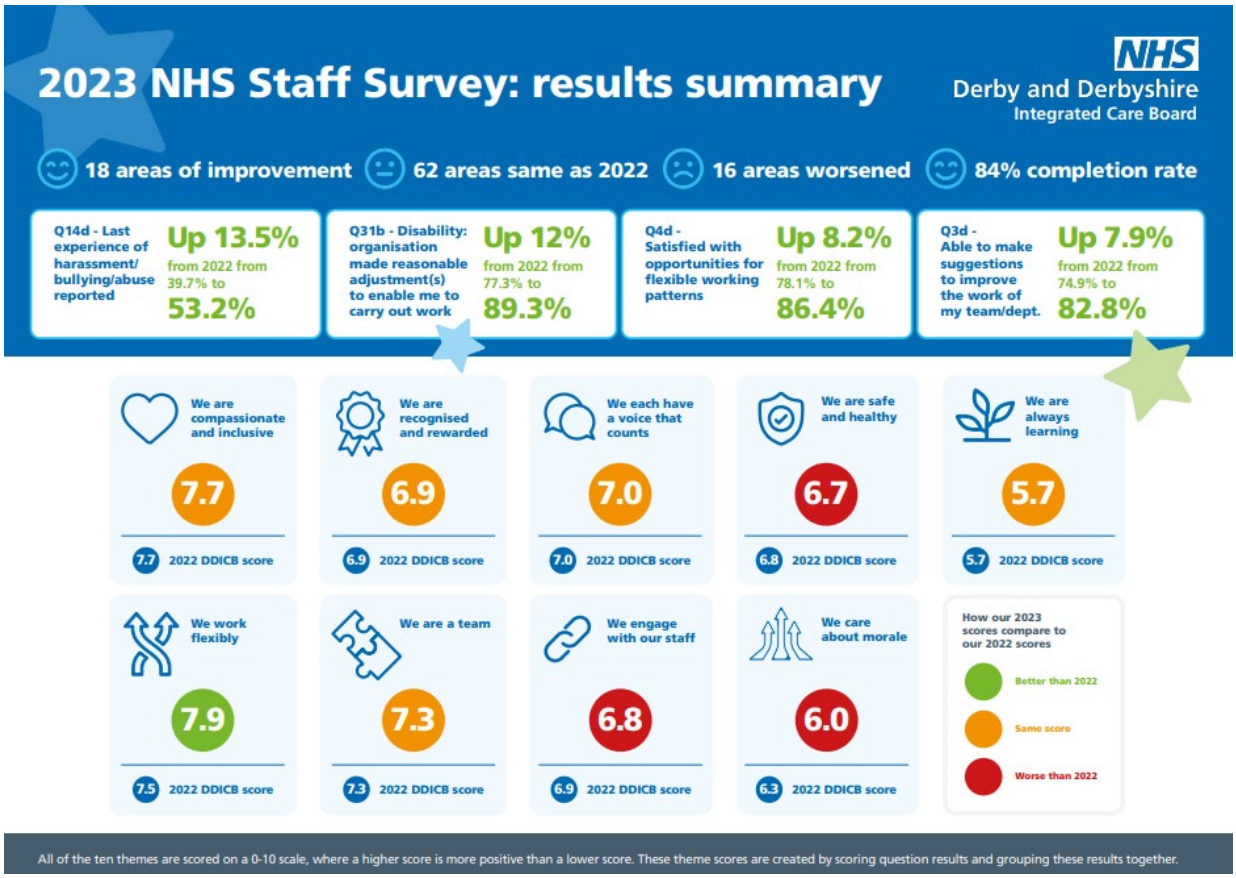


Figure 11 – 2023 NHS Derby and Derbyshire ICB Staff Survey Results

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 three 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 JUCD 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 the wellbeing timetable on topics such as staff wellbeing needs, women on road to wellbeing, men and women's health, looking after your teams wellbeing, speaking up support, BAME and LGBGTQIA+ cafes, menopause, stress awareness, 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, Transgender Awareness Week, and 16 days of action against domestic violence;
- access to our Employee Assistance Provider – Health Assured;
- access to a range of health and wellbeing apps for example Unmind, Headspace, Balance+, Catch it, and Cove; and
- training on areas of health and wellbeing, for example REACTmh, Reflective Practice, StRaW and TRIM.

Staff Flu Immunisation

On the 3rd July 2023, the Department for Health and Social Care and Public Health England communicated detail on the national flu immunisation programme for 2023/24. 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 and also by arranging their own flu jab at a private provider and claiming back the expense.

As at the 31st March 2024, 21.79% 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 2024.

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)	0.76

Table 56 – 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%	1
51%-99%	0
100%	0

Table 57 – 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	£614.14
Provide the total pay bill	£28,560
Provide the percentage of the total pay bill spent on facility time	0.002%

Table 58 – percentage of pay bill spent on facility time

Paid Trade Union Activities

Percentage of total paid facility time hours – the amount of hours spent by employees who were relevant union officials on paid trade union activities	
Time spent on paid trade union activities as a percentage of total paid facility time hours	100%

Table 59 – paid Trade Union activities

Expenditure on consultancy

The expenditure on consultancy for 2023/24 was £nil (2022/23: £26,271). Business consultancy is used sparingly by the ICB and only for limited periods where there is demonstrable cost-effectiveness. Consultancy assignments are used where specialist skills and knowledge do not exist within the permanent staff team and are required to address urgent matters.

Off-payroll engagements

In line with HM Treasury guidance the ICB is required to disclose information about 'Off-payroll Engagements'. These are reviewed by the Finance, Estates and Digital 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 60 shows all off-payroll engagements as at the 31st March 2024 and 31st March 2023 for more than £245 per day.

	Number 31st March 2024	Number 31st March 2023
Number of existing engagements as of the 31st March 2023	4	1
Of which, the number that have existed:		
for less than one year at the time of reporting	4	1
for between one and two years at the time of reporting	–	–
for between 2 and 3 years at the time of reporting	–	–
for between 3 and 4 years at the time of reporting	–	–
for 4 or more years at the time of reporting	–	–

Table 60 – length of off-payroll engagements as at the 31st March 2024 and 31st March 2023

New off-payroll engagements

Table 61 shows all new off-payroll engagements or those that have exceeded a six-month period, for the year to 31st March 2024 and the period to 31st March 2023, of more than £245 per day:

	Number to 31st March 2024	Number to 31st March 2023
Number of new engagements during 2023/24	4	3
Of which:		
Number not subject to off-payroll legislation	1	3
Number subject to off-payroll legislation and determined as in-scope of IR35[4]	–	–
Number subject to off-payroll legislation and determined as out of scope of IR35	3	–
Number of engagements reassessed for compliance or assurance purposes during the year	–	–
Number of engagements that saw a change to IR35 status following review	–	–

Table 61 – new off-payroll engagements for 2023/24 as at the 31st March 2024 and 31st March 2023

Off-payroll engagements/senior official engagements

Table 62 shows any off-payroll engagements of Board members and/or senior officials with significant financial responsibility, during the year to the 31st March 2024 and the period to the 31st March 2023:

	Number to 31st March 2024	Number to 31st March 2023
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the reporting period[5]	–	–
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	21	22

Table 62 – off-payroll engagements/senior official engagements as at the 31st March 2024 and 31st March 2023

[4] 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.

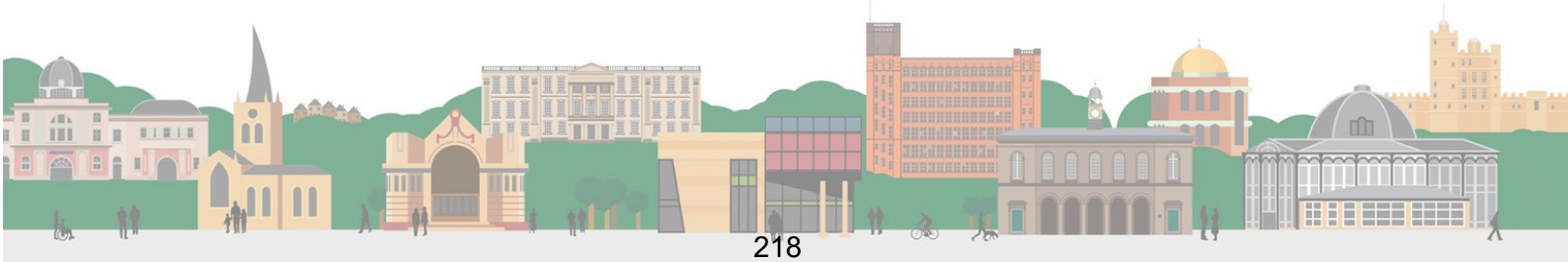
[5] There should only be a very small number of off-payroll engagements of Board members and/or senior officials with significant financial responsibility, permitted only in exceptional circumstances and for no more than six months.

Exit packages, including special (non-contractual) payments (subject to audit)

Termination packages totalling £nil (2022/23: £26,667) were agreed for nil (2022/23: 1) members of staff during the year.

During 2023/24, the ICB consulted on a staffing restructure. Details of the provision of termination benefits are detailed within the notes to the Annual Accounts, but these are not agreed as at 31st March 2024.

Dr Chris Clayton
Accountable Officer
NHS Derby and Derbyshire ICB
19th June 2024



Parliamentary Accountability and Audit Report

NHS Derby and Derbyshire ICB is not required to produce a Parliamentary Accountability and Audit Report. As such the regularity of expenditure, further Parliamentary accountability disclosures and the Certificate and Report of the Controller and Auditor General to the House of Commons are not applicable to the ICB.

Disclosures on remote contingent liabilities, losses and special payments, gifts, 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.

ICB Complaints

Two complaints were accepted for investigation by the Parliamentary Ombudsman during 2023/24. Of which, one case from 2023/24 was closed following an initial review, with no further action required. The second case was in relation to a complaint from 2022/23, which is still under investigation.

Cost allocation and setting of charges (subject to audit)

NHS Derby and Derbyshire Integrated Care Board certifies that it has complied with the HM Treasury guidance on cost allocation and the setting of charges. Table 63 provides details of income generation activities whose full cost exceeded £1 million or was otherwise material (responsibility for the commissioning of Pharmaceutical and Dental services was delegated to the Integrated Care Board from NHS England, 1 April 2023).

Activity	Accounts Note	2023/24		
		Income	Full Cost	Surplus/ (Deficit)
		£'000	£'000	£'000
Dental fees and charges	2 & 5	16,231	(57,507)	(41,276)
Prescription fees and charges	2 & 5	12,606	(224,372)	(211,766)
Total Fees and Charges		**28,837**	**(281,879)**	**(253,042)**

Table 63 – fees and charges for Pharmaceutical and Dental services

The fees and charges information in this note is provided in accordance with section 6.7.1 of the Government Financial Reporting Manual. It is provided for fees and charges purposes and not for International Financial Reporting Standards (IFRS) 8 purposes.

The financial objective is to collect charges from those patients that do not meet the eligibility criteria for free prescriptions and dental treatments.

Prescription charges are a contribution to the cost of pharmaceutical services including the supply of drugs. In 2023/24, the NHS prescription charge for each medicine or appliance dispensed was £9.65. However, around 95% of prescription items are dispensed free each year where patients are exempt from charges. In addition, patients who were eligible to pay charges could purchase pre-payment certificates at £31.25 for three months or £111.60 (£19.30 for Hormone Replacement Therapy) for a year. A number of other charges were payable for wigs and fabric supports.

NHS dental charges fall into 3 bands dependent on the level and complexity of care provided. Those who meet the eligibility criteria for exemption are not required to pay such charges. In 2023/24, the charge for Band 1 treatments was £25.80, for Band 2 was £70.70 and for Band 3 was £306.80.

FINANCIAL STATEMENTS

Dr Chris Clayton

Accountable Officer

NHS Derby and Derbyshire ICB

19th June 2024

Foreword to the accounts

Integrated Care Boards were legally established on the 1st July 2022, replacing Clinical Commissioning Groups and taking on the NHS planning and commissioning responsibilities previously held by Clinical Commissioning Groups, as well as absorbing some planning and commissioning functions from NHS England.

This years' 2023/24 accounts (1st April 2023 to 31st March 2024), report the first full 12-month reporting cycle since the Integrated Care Board was established and the prior year comparators are for a nine month period (1st July 2022 to 31st March 2023).

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 31 March 2024

	Note	2023-24 £'000	1 July 22 - 31 March 23 £'000
Income from sale of goods and services	2	(36,614)	(9,317)
Other operating income	2	(137)	(33)
Total operating income		**(36,751)**	(9,350)
Staff costs	4	28,595	21,787
Purchase of goods and services	5	2,482,895	1,700,253
Depreciation and impairment charges	5	456	507
Provision expense	5	(1,415)	(1,899)
Other operating expenditure	5	857	919
Total operating expenditure		**2,511,388**	1,721,567
Net Operating Expenditure		**2,474,637**	1,712,217
Finance expense	8	18	(29)
Other Gains & Losses	7	(1)	-
Total Net Expenditure for the Financial Year ending 31 March		**2,474,654**	1,712,188
Net (Gain)/Loss on Transfer by Absorption		-	(612)
Total Net Expenditure for the Financial Year		2,474,654	1,711,576
Comprehensive Expenditure for the year ending 31 March		**2,474,654**	1,711,576

The notes on pages 228 to 252 form part of this statement.

Statement of Financial Position

	Note	31 March 2024 £'000	31 March 2023 £'000
Non-current assets:			
Property, plant and equipment	10	321	155
Right-of-use assets	10a	262	822
Total non-current assets		**583**	977
Current assets:			
Trade and other receivables	11	18,471	7,542
Cash and cash equivalents	12	279	220
Total current assets		**18,750**	7,762
Total assets		**19,333**	8,739
Current liabilities			
Trade and other payables	13	(119,778)	(119,855)
Lease liabilities	10a	(270)	(405)
Provisions	14	(1,372)	(2,598)
Total current liabilities		**(121,420)**	(122,858)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(102,087)**	(114,119)
Non-current liabilities			
Lease liabilities	10a	-	(410)
Provisions	14	(351)	(532)
Total non-current liabilities		**(351)**	(942)
Assets less Liabilities		**(102,438)**	(115,061)
Financed by Taxpayers' Equity			
General fund		(102,438)	(115,061)
Total taxpayers' equity:		**(102,438)**	(115,061)

The notes on pages 228 to 252 form part of this statement.

The financial statements on pages 224 to 252 were approved by the Audit & Governance Committee (as delegated by the Board of the ICB), on 19 June 2024 and signed on its behalf by:

Chief Executive Officer
Dr Chris Clayton

Statement of Changes In Taxpayers' Equity for the year ended 31 March 2024

	General fund £'000
Changes in taxpayers' equity for 2023-24	
Balance at 31 March 2023	(115,061)
Adjusted NHS Integrated Care Board Balance at 1 April 2023	**(115,061)**
Changes in NHS Integrated Care Board taxpayers' equity for 2023-24	
Net operating expenditure for the financial year	(2,474,654)
Net Recognised NHS Integrated Care Board Expenditure for the Financial year	**(2,474,654)**
Net funding	2,487,277
Balance at 31 March 2024	**(102,438)**

	General fund £'000
Changes in taxpayers' equity for 1 July 22 to 31 March 23	
Balance at 1 July 2022	-
Transfer of assets and liabilities from closed NHS bodies	(113,604)
Adjusted NHS Integrated Care Board Balance at 1 July 2022	(113,604)
Changes in NHS Integrated Care Board taxpayers' equity for 2022-23	
Net operating costs for the financial year	(1,712,188)
Transfers by absorption to (from) other bodies	(612)
Net Recognised NHS Integrated Care Board Expenditure for the Financial Year	(1,712,800)
Net funding	1,711,343
Balance at 31 March 2023	(115,061)

The notes on pages 228 to 252 form part of this statement.

Statement of Cash Flows for the period ended 31 March 2024

	Note	2023-24 £'000	1 July 22 - 31 March 23 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(2,474,654)	(1,712,188)
Depreciation and amortisation	5	456	507
Lease adjustments	10a	9	(22)
Movement due to transfer by Modified Absorption		-	(107,202)
Interest paid / received	8	10	8
Other Gains and Losses	7	(1)	-
Finance Costs	14	(24)	-
Unwinding of Discounts	8	8	(37)
(Increase)/decrease in trade & other receivables	11	(10,929)	(7,542)
Increase/(decrease) in trade & other payables	13	(77)	119,855
Provisions utilised	14	(335)	(2,207)
Increase/(decrease) in provisions	14	(1,056)	(1,899)
Net Cash Inflow (Outflow) from Operating Activities		**(2,486,593)**	(1,710,727)
Cash Flows from Investing Activities			
(Payments) for property, plant and equipment	10	(248)	(90)
Net Cash Inflow (Outflow) from Investing Activities		**(248)**	(90)
Net Cash Inflow (Outflow) before Financing		**(2,486,841)**	(1,710,817)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		2,487,277	1,711,343
Repayment of lease liabilities	10a	(377)	(348)
Net Cash Inflow (Outflow) from Financing Activities		**2,486,900**	1,710,995
Net Increase (Decrease) in Cash & Cash Equivalents	12	**59**	178
Cash & Cash Equivalents at the Beginning of the Financial Year	**12**	**220**	42
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**279**	220

The notes on pages 228 to 252 form part of this statement.

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of Integrated Care Boards (ICBs) shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2023-24 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Integrated Care Boards, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board (FRAB). Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Integrated Care Board the purpose of giving a true and fair view has been selected. The particular policies adopted by the Integrated Care Board are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on a going concern basis.

Public sector bodies are assumed to be a going concern 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.

The financial statements for Integrated Care Boards 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. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 **Joint arrangements**

Joint operations are arrangements in which the Integrated Care Board has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The Integrated Care Board includes within its financial statements its share of the assets, liabilities, income and expenses.

The Integrated Care Board's participation in Section 75 agreements (see note 1.5) are joint arrangements.

Joint ventures are arrangements in which the Integrated Care Board has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.

1.5 **Pooled Budgets**

The Integrated Care Board has entered into a pooled budget arrangement for better care with Derbyshire County Council; and separately with Derby City Council (both arrangements are in accordance with section 75 of the NHS Act 2006). Under the arrangements, the two funds are separately pooled for the Derbyshire County "Better Care Fund", and Derby City "Better Care Fund", respectively. The Better Care funds aim to improve the provision of health and social care, with the overarching objective to support the integration of health and social care and align commissioning, as agreed between the partners.

Additionally the Integrated Care Board is a partner of the "Children and Young People with Complex Needs" pooled budget with Derbyshire County Council. Under the arrangement, funds are pooled for children with a range of health and special educational needs that cannot collectively be addressed by local or ordinary services.

The Integrated Care Board is also in a pooled arrangement with Derby City Council for the "Integrated Disabled Children's Centre and Services in Derby". This arrangement provides funds for the purchase and supply of equipment and technological aids for disabled children in Derby.

The Derbyshire County "Better Care Fund" and "Children and Young People with Complex Needs" pools are both hosted by Derbyshire County Council. The Derby City "Better Care Fund" and "Integrated Disabled Children's Centre and Services in Derby" pools are both hosted by Derby City Council.

The Integrated Care Board accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budgets, identified in accordance with the pooled budget agreements.

1.6 **Operating Segments**

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the Integrated Care Board.

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.

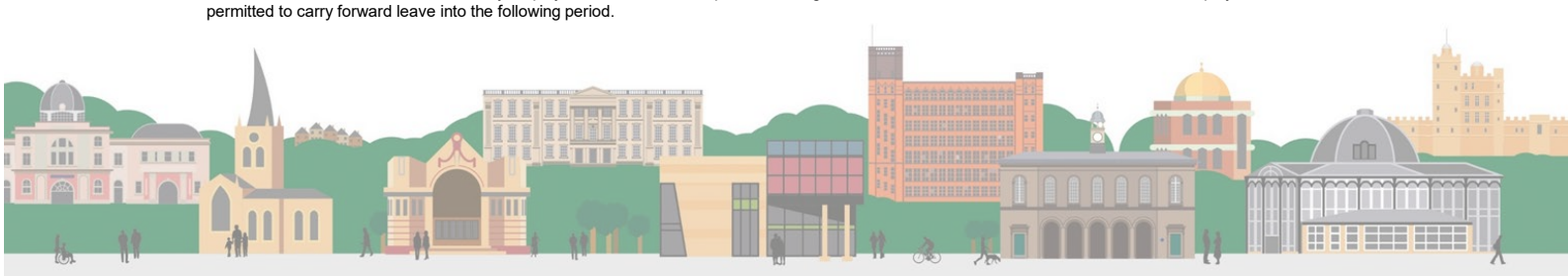
The value of the benefit received when the Integrated Care Board accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and 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.



Notes to the financial statements

1.8.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Integrated Care Board commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.9 **Other Expenses**

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.10 **Grants Payable**

Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the Integrated Care Board recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.11 **Property, Plant & Equipment**

1.11.1 **Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the Integrated Care Board;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.11.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.11.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.11.4 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Integrated Care Board expects to obtain economic benefits or service potential from the asset. This is specific to the Integrated Care Board and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the Integrated Care Board checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.12 **Leases**

A lease is a contract, or part of a contract, that conveys the right to control the use of an asset for a period of time in exchange for consideration.
The Integrated Care Board assesses whether a contract is or contains a lease, at inception of the contract.

Notes to the financial statements

1.12.1 **The Integrated Care Board as Lessee**

A right-of-use asset and a corresponding lease liability are recognised at commencement of the lease.

The lease liability is initially measured at the present value of the future lease payments, discounted by using the rate implicit in the lease. If this rate cannot be readily determined, the prescribed HM Treasury discount rates are used as the incremental borrowing rate to discount future lease payments.

The HM Treasury incremental borrowing rate of 3.51% is applied for leases commencing, transitioning or being remeasured in the 2023 calendar year; and 4.72% to new leases commencing in 2024 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.

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
- A nominal short-term rate of 4.26% (2022-23: 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 4.03% (2022-23: 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 4.72% (2022-23: 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 4.40% (2022: 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.

Notes to the financial statements

1.17 **Contingent liabilities and contingent assets**
A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Integrated Care Board, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Integrated Care Board. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.18 **Financial Assets**
Financial assets are recognised when the Integrated Care Board becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:
- Financial assets at amortised cost;
- Financial assets at fair value through other comprehensive income and ;
- Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.18.1 **Financial Assets at Amortised cost**
Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.18.2 **Financial assets at fair value through other comprehensive income**
A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Integrated Care Board elected to measure an equity instrument in this category on initial recognition.

1.18.3 **Financial assets at fair value through profit and loss**
Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.

1.18.4 **Impairment of financial assets**
For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets or assets measured at fair value through other comprehensive income, the Integrated Care Board recognises a loss allowance representing the expected credit losses on the financial asset.

The Integrated Care Board adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The Integrated Care Board therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the Integrated Care Board does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

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.

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.

Notes to the financial statements

1.21 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Integrated Care Board not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.22 **Critical accounting judgements and key sources of estimation uncertainty**

In the application of the Integrated Care Board's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.22.1 **Critical accounting judgements in applying accounting policies**

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the Integrated Care Board's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

- The Integrated Care Board has assessed the pooled element of the Better Care Fund as being a lead commissioning arrangement under IFRS 11: Joint Arrangements. The Integrated Care Board will report balances with the lead commissioner (local authority) only and not the providers with which the local authority contracts.

1.22.2 **Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

- Prescription costs are material in value. Financial data for prescribing is available two months in arears, therefore the Integrated Care Board estimates two months of costs at each period end. There are a number of factors considered when estimating the costs including: historic; seasonal; price-related or volume related. Estimating the two months of costs in this way, recognises there is a risk and level of uncertainty involved.

1.23 **Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.24 **New and revised IFRS Standards in issue but not yet effective**

● IFRS 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.

● IFRS 18 Presentation and Disclosure in Financial Statements - Issued in April 2024 and applies to periods beginning on or after 1 January 2027. The standard has not yet been adopted by FRAB for inclusion within the FREM and therefore it is not yet possible to confirm how this will impact on our accounts in the future.

2 Other Operating Revenue

	2023-24 Total	1 July 22 - 31 March Total
	£'000	£'000
Income from sale of goods and services (contracts)		
Education, training and research	-	925
Non-patient care services to other bodies	5,753	4,995
Prescription fees and charges	12,606	-
Dental fees and charges	16,231	-
Other Contract income	1,989	3,308
Recoveries in respect of employee benefits	35	89
Total Income from sale of goods and services	**36,614**	9,317
Other operating income		
Non cash apprenticeship training grants revenue	39	33
Other non contract revenue	98	-
Total Other operating income	**137**	33
Total Operating Income	**36,751**	9,350

3.1 Disaggregation of Income - Income from sale of good and services (contracts)

	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Source of Revenue					
NHS	987	-	-	225	35
Non NHS	4,766	12,606	16,231	1,764	-
Total	**5,753**	**12,606**	**16,231**	**1,989**	**35**

	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Dental fees and charges £'000	Other Contract income £'000	Recoveries in respect of employee benefits £'000
Timing of Revenue					
Point in time	-	-	-	-	-
Over time	5,753	12,606	16,231	1,989	35
Total	**5,753**	**12,606**	**16,231**	**1,989**	**35**

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 (2022/23 £nil).

4. Employee benefits and staff numbers

4.1.1 Employee benefits 2023-24

	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	20,429	1,260	21,689
Social security costs	2,266	47	2,313
Employer Contributions to NHS Pension scheme	4,105	56	4,161
Other pension costs	4	-	4
Apprenticeship Levy	93	-	93
Termination benefits	335	-	335
Gross employee benefits expenditure	**27,232**	**1,363**	**28,595**
Less recoveries in respect of employee benefits (note 4.1.2)	(35)	-	(35)
Net employee benefits excluding capitalised costs	**27,197**	**1,363**	**28,560**

Effective from 1 April 2023, "Other" staff included the Integrated Care Board share of Hosted services staff commissioning the pharmaceutical, general ophthalmic and dental (POD) services.

4.1.1 Employee benefits 1 July 2022 to 31 March 2023

	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
Gross employee benefits expenditure	20,977	810	21,787
Less recoveries in respect of employee benefits (note 4.1.2)	(89)	-	(89)
Net employee benefits excluding capitalised costs	20,888	810	21,698

4.1.2 Recoveries in respect of employee benefits

	2023-24			1 July 22 - 31 March 23
	Permanent Employees £'000	Other £'000	Total £'000	Total £'000
Employee Benefits - Revenue				
Salaries and wages	(28)	-	(28)	(69)
Social security costs	(3)	-	(3)	(9)
Employer contributions to the NHS Pension Scheme	(4)	-	(4)	(11)
Total recoveries in respect of employee benefits	**(35)**	**-**	**(35)**	(89)

4.2 Average number of people employed

	2023-24			1 July 22 - 31 March 23		
	Permanently employed Number	**Other Number**	**Total Number**	Permanently employed Number	Other Number	Total Number
Total	**451**	**24**	**475**	456	12	468

Effective from 1 April 2023, "Other" staff included the Integrated Care Board share of Hosted services staff commissioning the pharmaceutical, general ophthalmic and dental (POD) services. Of the above, nil staff were engaged on capital projects (1 July 2022 to 31 March 2023, nil staff).

4.3 Exit packages agreed in the financial year

There were no exit packages or agreed departures during the year (1 July 2022 to 31 March 2023 £nil).

4.4 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.
An outline of these follows:

4.5.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2024, is based on valuation data as 31 March 2023, updated to 31 March 2024 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.5.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (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 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

5. Operating expenses

	2023-24 Total £'000	1 July 22 - 31 March 23 Total £'000
Purchase of goods and services		
Services from other ICBs and NHS England	11,450	7,822
Services from foundation trusts	1,439,674	1,021,398
Services from other NHS trusts	147,833	100,943
Purchase of healthcare from non-NHS bodies	299,932	218,056
Purchase of social care	55,220	42,379
General Dental services and personal dental services	57,507	-
Prescribing costs	188,216	139,888
Pharmaceutical services	36,156	100
General Ophthalmic services	10,908	308
GPMS/APMS and PCTMS	222,192	156,384
Supplies and services – clinical	44	-
Supplies and services – general	4,993	4,414
Consultancy services	-	26
Establishment	3,553	3,969
Transport	10	1
Premises	3,639	3,132
Audit fees	180	174
Other non statutory audit expenditure		
· Other services	18	22
Other professional fees	800	819
Legal fees	350	196
Education, training and conferences	181	189
Non cash apprenticeship training grants	39	33
Total Purchase of goods and services	**2,482,895**	1,700,253
Depreciation and impairment charges		
Depreciation	456	507
Total Depreciation and impairment charges	**456**	507
Provision expense		
Change in discount rate	(24)	-
Provisions	(1,391)	(1,899)
Total Provision expense	**(1,415)**	(1,899)
Other Operating Expenditure		
Chair and Non Executive Members	141	116
Grants to Other bodies	587	694
Expected credit loss on receivables	9	5
Other expenditure	120	104
Total Other Operating Expenditure	**857**	919
Total operating expenditure	**2,482,793**	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 (£150,000 excluding VAT). The audit fees were £145,200 excluding VAT for period 1 July 2022 to 31 March 2023.

6. Payment Compliance Reporting

6.1 Better Payment Practice Code

Measure of compliance	2023-24		1 July 22 - 31 March 23	
	Number	**£'000**	Number	£'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	51,761	383,830	41,240	277,734
Total Non-NHS Trade Invoices paid within target	50,058	372,705	41,153	276,147
Percentage of Non-NHS Trade invoices paid within target	**96.71%**	**97.10%**	99.79%	99.43%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	3,947	1,605,712	2,373	1,148,543
Total NHS Trade Invoices Paid within target	3,937	1,605,510	2,361	1,148,120
Percentage of NHS Trade Invoices paid within target	**99.75%**	**99.99%**	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

The Integrated Care Board incurred £nil charges relating to claims made under this legislation (1 July 2022 to 31 March 2023 £nil).

7. Other gains and losses

	2023-24 £'000	1 July 22 - 31 March 23 £'000
Gain/(loss) on disposal of property, plant and equipment assets other than by sale	(1)	-
Total	**(1)**	-

8. Finance costs

	2023-24 £'000	1 July 22 - 31 March 23 £'000
Interest		
Interest on lease liabilities	10	8
Total interest	**10**	8
Provisions: unwinding of discount	8	(37)
Total finance costs	**18**	(29)

9. 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 Comprehensive Net Expenditure, and is disclosed separately from operating costs.

	2023-24 £'000	1 July 22 - 31 March 23 £'000
Transfer of property plant and equipment	-	218
Transfer of Right of Use assets	-	1,270
Transfer of cash and cash equivalents	-	42
Transfer of receivables	-	9,348
Transfer of payables	-	(115,938)
Transfer of provisions	-	(7,273)
Transfer of Right Of Use liabilities	-	(1,271)
Transfer of PUPOC liability	-	(612)
Net loss on transfers by absorption	**-**	(114,216)

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 in 2022-23.

10. Property, plant and equipment

2023-24	Information technology £'000
Cost or valuation at 01 April 2023	679
Additions purchased	248
Cost/Valuation at 31 March 2024	**927**
Depreciation 01 April 2023	524
Charged during the year	82
Depreciation at 31 March 2024	**606**
Net Book Value at 31 March 2024	**321**
Purchased	321
Total at 31 March 2024	**321**

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

2023-24	Buildings excluding dwellings £'000	Of which: leased from DHSC group bodies £'000
Cost or valuation at 01 April 2023	1,284	877
Lease remeasurement	(18)	(18)
Disposals on expiry of lease term	(60)	(60)
Derecognition for early terminations	(408)	(408)
Cost/Valuation at 31 March 2024	**798**	391
Depreciation 01 April 2023	462	324
Charged during the year	374	230
Disposals on expiry of lease term	(60)	(60)
Derecognition for early terminations	(240)	(240)
Depreciation at 31 March 2024	**536**	254
Net Book Value at 31 March 2024	**262**	137

NBV by counterparty	
Leased from Non-Departmental Public Bodies	137
Leased from other group bodies	125
Net Book Value at 31 March 2024	**262**

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. This resulted in the lease being recalculated and the impact disclosed in last year's accounts. Early terminations of contract were made in May 2023 and 9 May 2024, for the Meeting Room corridor and the North floor respectively. This resulted in the asset values and lease liabilities being reduced for early termination and are reflected in the accounts for this year.

10a.2 Lease liabilities

2023-24	2023-24 £'000	1 July 22 - 31 March 23 £'000
Lease liabilities at 01 April 2023	(815)	(1,271)
Interest expense relating to lease liabilities	(10)	(8)
Repayment of lease liabilities (including interest)	377	348
Lease remeasurement	9	20
Modifications	-	96
Derecognition for early terminations	169	-
Lease liabilities at 31 March 2024	**(270)**	(815)

10a Leases cont'd

10a.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	2023-24 £'000	**Of which: leased from DHSC group bodies £000**	1 July 22 - 31 March 23 £'000	Of which: leased from DHSC group bodies £000
Within one year	(273)	(131)	(411)	(279)
Between one and five years	-	-	(411)	(270)
Balance at 31 March 2024	**(273)**	**(131)**	(822)	(549)
Balance by counterparty				
Leased from Non-Departmental Public Bodies		(131)		(549)
Leased from other bodies		(142)		(273)
Balance as at 31 March 2023		**(273)**		(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. This resulted in the lease being recalculated and the impact disclosed in last year's accounts. Early terminations of contract were made in May 2023 and 9 May 2024, for the Meeting Room corridor and the North floor respectively. This resulted in the asset values and lease liabilities being reduced for early termination and are reflected in the accounts for this year.

10a.4 Amounts recognised in Statement of Comprehensive Net Expenditure

	2023-24 £'000	1 July 22 - 31 March 23 £'000
Depreciation expense on right-of-use assets	374	354
Interest expense on lease liabilities	10	8

10a.5 Amounts recognised in Statement of Cash Flows

	2023-24 £'000	1 July 22 - 31 March 23 £'000
Total cash outflow on leases under IFRS 16	377	348

11.1 Trade and other receivables

	Current 31 March 2024 £'000	Current 31 March 2023 £'000
NHS receivables: Revenue	1,862	1,831
NHS prepayments	56	69
NHS accrued income	62	134
NHS Contract Receivable not yet invoiced/non-invoice	730	620
Non-NHS and Other WGA receivables: Revenue	2,588	1,765
Non-NHS and Other WGA prepayments	1,833	1,909
Non-NHS and Other WGA accrued income	899	94
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	9,944	10
Expected credit loss allowance-receivables	(15)	(6)
VAT	498	1,108
Other receivables and accruals	14	8
Total Trade & other receivables	**18,471**	7,542
Total current and non current	**18,471**	7,542

There are no prepaid pension contributions included in note 10.1 (31 March 2023, £nil).

11.2 Receivables past their due date but not impaired

	Current 31 March 2024		Current 31 March 2023	
	DHSC Group Bodies £'000	**Non DHSC Group Bodies £'000**	DHSC Group Bodies £'000	Non DHSC Group Bodies £'000
By up to three months	468	732	57	609
By three to six months	37	378	1	40
By more than six months	3	33	-	-
Total	**508**	**1,143**	58	649

11.3 Loss allowance on asset classes	**Trade and other receivables - Non DHSC Group Bodies £'000**
Balance at 01 April 2023	(6)
Lifetime expected credit losses on trade and other receivables-Stage 2	(9)
Total expected credit loss at 31 March 2024	**(15)**

(A stage 2 adjustment is for the provision of a credit loss where the debt has the potential to become a bad debt).

12. Cash and cash equivalents

	2023-24	1 July 22 - 31 March 23
	£'000	£'000
Balance at 01 April 2023	220	42
Net change in year	59	178
Balance at 31 March 2024	**279**	220
Made up of:		
Cash with the Government Banking Service	279	220
Cash and cash equivalents as in statement of financial position at 31 March 2024	**279**	220

The Integrated Care Board does not hold patients monies.

13. Trade and other payables

	Current 31 March 2024 £'000	Current 31 March 2023 £'000
NHS payables: Revenue	1,707	13,387
NHS accruals	20,669	5,471
NHS deferred income	-	20
Non-NHS and Other WGA payables: Revenue	3,968	2,565
Non-NHS and Other WGA accruals	73,516	75,183
Non-NHS and Other WGA deferred income	-	20
Social security costs	293	315
Tax	259	255
Other payables and accruals	19,366	22,639
Total Trade & Other Payables	**119,778**	119,855
Total current and non-current	**119,778**	119,855

The Integrated Care Board does not have any liabilities included above for arrangements to buy out the liability for early retirement. (31st March 2023 £nil).

Other payables include £1.78m outstanding pension contributions at 31 March 2024 (at 31 March 2023, £2.2m).

14. Provisions

	31 March 2024		31 March 2023	
	Current	**Non-current**	Current	Non-current
	£'000	**£'000**	£'000	£'000
Redundancy	335	-	-	-
Continuing care	560	-	848	-
Other	477	351	1,750	532
Total	**1,372**	**351**	2,598	532
Total current and non-current	**1,723**		3,130	

	Redundancy	**Continuing Care**	**Other**	**Total**
	£'000	**£'000**	**£'000**	**£'000**
Balance at 01 April 2023	**-**	**848**	**2,282**	**3,130**
Arising during the year	448	-	-	**448**
Utilised during the year	-	(288)	(47)	**(335)**
Reversed unused	(113)	-	(1,391)	**(1,504)**
Unwinding of discount	-	-	8	**8**
Change in discount rate	-	-	(24)	**(24)**
Balance at 31 March 2024	**335**	**560**	**828**	**1,723**
Expected timing of cash flows:				
Within one year	335	560	477	**1,372**
Between one and five years	-	-	351	**351**
Balance at 31 March 2024	**335**	**560**	**828**	**1,723**

Following it's formation, the Integrated Care Board has continued to review it's staff structures to improve it's economy and efficiency. The organisation is nearing the completion of its staff structures and during the year this identfied staff being placed at risk. A more recent review has found that some staff previously previously placed at risk have been helped to find other suitable roles and so the provision has been reduced to £335k. This cost is reported in note 4.1 of the accounts, as "termination benefits".

The continuing healthcare retrospective claims were partially utilised during the year with £288k being used. This left a remaining balance of £560k for remaining claims.

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' (current discounted value is £0.47m, 2022-23 £0.49m) to cover the cost of putting the offices back to an expected condition, when the lease is terminated. (As the timing of these costs span greater than one year, the costs were discounted for inflation, resulting in a credit of £24k (included in note 5 operating cost statement) and the discount factor for the most recent year being unwound, resulting in a finance cost of £8k reported in note 8 Finance costs).

Other provisions include the following balances carried forward from 2022-23:

· Primary Care Estates and Technology Transformation Fund, £0.49m brought forward, £0.46m reversed as unused, leaving £0.03m balance.

· Digital Transformation, £0.34m brought forward. ££0.05m utilised and £0.05m reversed as unused, resulting in £0.25m carried forward.

· Corporate Education and Training, £0.08m brought forward with no amounts utilised in 2023-24.

· Minor Surgery Backlog, brought forward £0.08m which has now been reversed as ununused during the year.

· Acute EMAS PTS Leases, £0.8m brought forward and reversed as unused during the year.

Legal claims are calculated from the number of claims currently lodged with NHS Resolution and the probabilities provided by them. There were no claims identified by NHS resolution as at 31 March 2024 (nil claims, 31 March 2023).

15. Financial instruments

15.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS Derby and Derbyshire Integrated Care Board is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Derby and Derbyshire Integrated Care Board has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Derby and Derbyshire Integrated Care Board in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS Derby and Derbyshire Integrated Care Board standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS Derby and Derbyshire Integrated Care Board and internal auditors.

15.1.1 Currency risk

The NHS Derby and Derbyshire Integrated Care Board is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS Derby and Derbyshire Integrated Care Board has no overseas operations and therefore has low exposure to currency rate fluctuations.

15.1.2 Interest rate risk

The NHS Derby and Derbyshire Integrated Care Board borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The NHS Derby and Derbyshire Integrated Care Board therefore has low exposure to interest rate fluctuations.

15.1.3 Credit risk

Because the majority of the NHS Derby and Derbyshire Integrated Care Board revenue comes parliamentary funding, NHS Derby and Derbyshire 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.

15.1.4 Liquidity risk

NHS Derby and Derbyshire Integrated Care Board is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS Derby and Derbyshire Integrated Care Board draws down cash to cover expenditure, as the need arises. The NHS Derby and Derbyshire Integrated Care Board is not, therefore, exposed to significant liquidity risks.

15.1.5 Financial Instruments

As the cash requirements of NHS Derby and Derbyshire Integrated Care Board are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS Derby and Derbyshire Integrated Care Board's expected purchase and usage requirements and NHS Derby and Derbyshire Integrated Care Board is therefore exposed to little credit, liquidity or market risk.

15. Financial instruments cont'd

15.2 Financial assets

	Financial Assets measured at amortised cost 2023-24 £'000	Financial Assets measured at amortised cost 1 July 22 - 31 March 23 £'000
Trade and other receivables with NHSE bodies	1,447	1,807
Trade and other receivables with other DHSC group bodies	2,055	871
Trade and other receivables with external bodies	12,597	1,783
Cash and cash equivalents	279	220
Total at 31 March 2024	**16,378**	4,681

15.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2023-24 £'000	Financial Liabilities measured at amortised cost 1 July 22 - 31 March 23 £'000
Trade and other payables with NHSE bodies	987	358
Trade and other payables with other DHSC group bodies	21,461	19,306
Trade and other payables with external bodies	97,048	100,397
Total at 31 March 2024	**119,496**	120,061

All financial liabilties are due within one year.

16. Operating segments

The Integrated Care Board has one operating segment, the commissioning of healthcare services.

17. 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:

	2023-24	1 July 22 - 31 March 23
	£'000	£'000
Income	(101,002)	(73,270)
Expenditure	101,469	73,771
	467	501

Better Care Fund (BCF)
The Integrated Care Board has two BCFs: The Derbyshire County BCF; and the Derby City BCF, which both became operational in 2015.

NHS Derby and Derbyshire Integrated Care Board is a partner to the Derbyshire County BCF, along with Derbyshire County Council. NHS Tameside and Glossop Clinical Commissioning Group were part of this arrangement until 30 June 2022 when the Glossop healthcare responsibilities were transferred to NHS Derby and Derbyshire Integrated Care Board. NHS Derby and Derbyshire Integrated Care Board is also a partner to the Derby City BCF, along with Derby City Council. The operation of the pools is ultimately managed by the Derbyshire Health and Wellbeing Board represented by members from each of the partners. The Funds operate as Section 75 pooled budgets.

Total annual agreed contributions to the Derbyshire County BCF Pool are £125,286,018 including iBCF funding (£93,290,573 excluding iBCF). Total annual agreed contributions to the Derby City BCF Pool are £38,596,614, including iBCF funding (£27,734,963 excluding iBCF).

The BCF aims to improve the provision of health and social care. All partners contribute to a pooled fund and the overarching objective of the fund is to support the integration of health and social care and align commissioning as agreed between the partners.

In April 2017 the Improved Better Care Fund (iBCF) commenced. This is a direct grant to local government, with a condition that it is pooled into the local BCF plan. In the 2023-24 Derbyshire County Council received an additional £5,009,663; and Derby City Council an additional £1,688,692, of discharge funding direct from the Government with the aim of:
- Meeting adult social care needs
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready
- Ensuring that the local social care provider market is supported

Under the agreements, the two BCF pools are each split into 2 areas:
- Contributions to a pooled fund by all partners and commissioned by the local authority who are host and lead
- Commissioning of existing funded schemes directly by each partner

17. Joint arrangements - interests in joint operations, continued.

The memorandum account for the "Derbyshire County Better Care Fund" pooled budget is:

	2023-24 £'000	2023-24 Pool Share %	1 July 22 - 31 March 23 £'000	1 July 22 - 31 March 23 Share %
Income				
NHS Derby & Derbyshire ICB	(74,689)	59.85	(53,946)	59.27
Derbyshire County Council	(50,104)	40.15	(37,067)	40.73
Total Income	**(124,793)**	**100.00**	(91,013)	100.00
Expenditure				
ICB schemes aimed at reducing non elective activity	28,021		17,857	
ICB schemes - wheelchairs	1,196		854	
Derbyshire County Council schemes	7,898		5,924	
ICES (Integrated Community Equipment Service)	6,890		6,013	
Reablement	19,576		14,144	
Administration, Performance and Information Sharing	606		435	
Care Bill	2,573		1,859	
Delayed Transfer of Care	9,121		5,768	
Carers	2,464		1,780	
Integrated Care	3,320		1,312	
Workforce Development	472		346	
Dementia Support	463		332	
Autism and Mental Health	1,944		1,398	
iBCF	31,995		24,233	
Winter Pressures Grant	3,737		2,830	
Discharge Fund	5,010		6,802	
Total Expenditure	**125,286**		91,887	
Net position for Pool	**493**		874	
Balance Brought Forward as at 1 April 2023	(306)			
Balance carried Forward at the end of period	**187**			
NHS Derby and Derbyshire ICB share of deficit as at end of period	**111**			

The Derby County BCF pooled budget reported an overspend of £493k for the period, with a total accumulated overspend of £187k at 31 March 2024. NHS Derby and Derbyshire Integrated Care Board's share of the overspend was £111k. This amount has been carried forward in the pool.

The memorandum account for the "Derby City Better Care Fund" pooled budget is:

	2023-24 £'000	2023-24 Pool Share %	1 July 22 - 31 March 23 £'000	1 July 22 - 31 March 23 Share %
Income				
NHS Derby & Derbyshire ICB	(22,384)	57.97	(16,652)	58.46
Derby City Council	(16,227)	42.03	(11,832)	41.54
Total Income	**(38,611)**	**100.00**	(28,484)	100.00
Expenditure				
ICB schemes aimed at reducing non elective activity	4,396		3,121	
Derby City Council schemes	2,323		1,709	
Community Health Services	7,403		4,825	
Social Care	9,925		7,045	
Mental Health	615		437	
Accident & Emergency	201		142	
iBCF	10,862		8,076	
Winter Pressures Grant	1,183		881	
Discharge Fund	1,689		2,154	
Total Expenditure	**38,597**		28,390	
Net position for Pool	**(14)**		(95)	
Balance Brought Forward as at 1 April 2023	(95)			
Balance Carried forward	**(109)**			
NHS Derby and Derbyshire ICB share of surplus as at end of period	**(63)**			

The Derby City BCF pooled budget reported a surplus of £14k for the period, with a total accumulated surplus of £109k at 31 March 2024. NHS Derby and Derbyshire Integrated Care Board's share of the underspend was £63k. This amount has been carried forward in the pool.

17. 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:

	2023-24	**2023-24 Pool Share**	1 July 22 - 31 March 23	1 July 22 - 31 March 23 Share
	£'000	**%**	£'000	%
Income				
NHS Derby and Derbyshire ICB	(2,918)	33.00	(1,918)	33.00
Derbyshire County Council	(5,924)	67.00	(3,894)	67.00
Total Income	**(8,842)**	**100.00**	(5,812)	100.00
Expenditure				
Purchase of equipment and healthcare services	8,842		5,812	
Total Expenditure	**8,842**		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:

	2023-24	**2023-24 Pool Share**	1 July 22 - 31 March 23	1 July 22 - 31 March 23 Share
	£'000	**%**	£'000	%
Income				
NHS Derby and Derbyshire ICB	(1,011)	47.69	(754)	42.48
Derby City Council	(1,109)	52.31	(1,021)	57.52
Total Income	**(2,120)**	**100.00**	(1,775)	100.00
Expenditure				
Residential Services	1,269		970	
Community Service Team (Outreach Service)	282		182	
Disability and Fieldwork Social Work Services	1		2	
Management and Administration	945		712	
Total Expenditure	**2,497**		1,866	
Net position for Pool	**377**		91	
Balance Brought forward at 1st April 2023	(558)			
Balance carried forward as at end of period	**(181)**			
NHS Derby and Derbyshire ICB share of surplus as at	**(86)**			

The Integrated Disabled Children's Centre and Services in Derby pooled budget reported an overspend of £377k for the period, with a total accumulated underspend of £181k at 31 March 2024.
NHS Derby and Derbyshire Integrated Care Board's share of the accumulated underspend was £86k. This amount has been carried forward in the pool.

18. Related party transactions

During the year none of the Board Members or parties related to them have undertaken any material transactions with NHS Derby and Derbyshire Integrated Care Board, other than those set out below (transactions identified were not with the members but between the Integrated Care Board and the related party):

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Accurx Ltd	363	-	-	-
Amber Valley Health Ltd	1,118	-	-	-
Cera Care Ltd	2	-	-	-
College Street Medical Practice	-	-	163	-
Derby And Derbyshire GP Provider Board	678	-	-	-
Derby City Council	26,885	337	3,877	153
Derbyshire Community Health Services NHS Foundation Trust	172,128	230	698	13
Derbyshire County Council	84,763	1,843	5,595	2,102
Derbyshire Healthcare NHS Foundation Trust	170,224	-	80	122
Erewash Health Partnership	1,424	-	-	-
First Steps	260	-	-	-
High Peak & Buxton PCN	2,212	-	-	-
Jessop Medical Practice	2,520	-	488	-
Milton Keynes University Hospital NHS Foundation Trust	29	-	-	-
Moir Medical Centre	82	-	335	-
NHS England	-	-	-	1,023
Nottinghamshire Healthcare NHS Foundation Trust	2,841	-	51	-
Police & Crime Commissioner For Derbyshire	89	-	-	-
University Hospitals of Derby & Burton NHS Foundation Trust	644,613	-	6,027	2
University Hospitals Of Leicester NHS Trust	1,412	50	-	133

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 Foundation Trusts including: Chesterfield Royal Hospitals NHS Foundation Trust; Derbyshire Community Healthcare Services 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.

During the period 1 July 2022 to 31 March 2023, none of the Board Members or parties related to them have undertaken any material transactions with NHS Derby and Derbyshire Integrated Care Board, other than those set out below (transactions identified were not with the members but between the Integrated Care Board and the related party):

Details of related party transactions with individuals are as follows:

	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
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	-

19. Events after the end of the reporting period

Following the end of the reporting period, NHS England delegated responsibility for a suite of Specialised commissioning services to NHS Derby and Derbyshire ICB on 1 April 2024, on behalf of other NHS bodies (different suites of specialised commissioning were also granted to a number of other Integrated Care Bodies but not all). This follows a significant amount of work over the previous 18 months to ensure robust governance, reporting and management arrangements were in place. NHS England have advised that the scope of delegated services for the NHS Derby and Derbyshire ICB is £185m in 2024/25 and which will be reported in the ICB's income and expenditure.

20. Losses and special payments

20.1 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 2023-24 Number	**Total Value of Cases 2023-24 £'000**	Total Number of Cases 1 July 22 - 31 March 23 Number	Total Value of Cases 1 July 22 - 31 March 23 £'000
Fruitless payments	-	-	2	95
Total	**-**	**-**	2	95

During 2022/23, a healthcare litigation was settled in full for £95k. A further clinical overpayment of £366 was written off during the period.

20.2 Special payments

	Total Number of Cases 2023-24 Number	**Total Value of Cases 2023-24 £'000**	Total Number of Cases 1 July 22 - 31 March 23 Number	Total Value of Cases 1 July 22 - 31 March 23 £'000
Ex Gratia Payments	1	120	-	-
Total	**1**	**120**	-	-

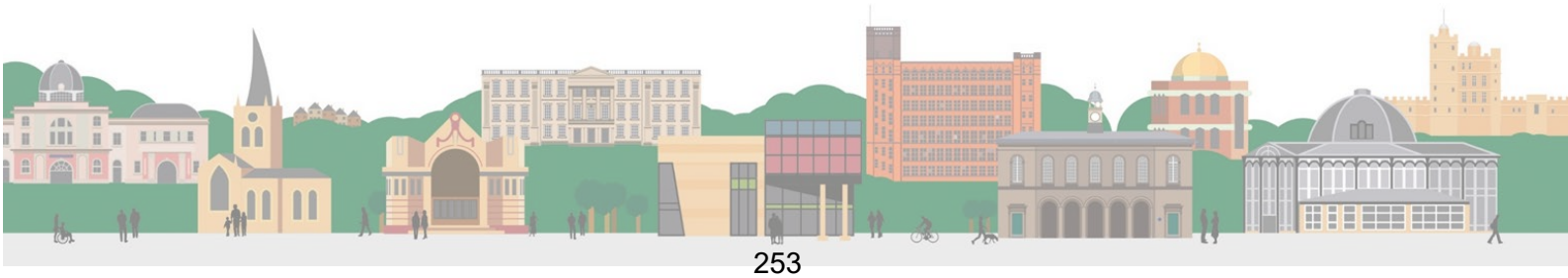
During 2023/24, a supplier litigation was issued. The estimated settlement of the case is £120k.

21. 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:

	2023-24 Target	**2023-24 Performance**	**Duty Achieved? Yes/No**	1 July 22 - 31 March 23 Target	1 July 22 - 31 March 23 Performance
Expenditure not to exceed income	2,512,687	2,511,655	**Yes**	1,706,806	1,721,627
Capital resource use does not exceed the amount specified in Directions	250	248	**Yes**	90	90
Revenue resource use does not exceed the amount specified in Directions	2,475,686	2,474,654	**Yes**	1,697,366	1,712,188
Revenue administration resource use does not exceed the amount specified in Directions	23,163	19,296	**Yes**	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

AUDITOR'S REPORT



INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD OF NHS DERBY AND DERBYSHIRE INTEGRATED CARE BOARD

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Derby and Derbyshire Integrated Care Board ("the ICB") for the year ended 31 March 2024 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the ICB as at 31 March 2024 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State on 22 April 2024 as being relevant to ICBs in England and included in the Department of Health and Social Care Group Accounting Manual 2023/24; 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 Committee and internal audit, and inspection of policy documentation as to the ICB's high-level policies and procedures to prevent and detect fraud , including the internal audit function, and the ICB's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Assessing the incentives for management to manipulate reported expenditure as a result of the need to achieve statutory targets delegated to the ICB by NHS England.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls, in particular the risk that ICB management may be in a position to make inappropriate accounting entries.

On this audit we did not identify a fraud risk related to revenue recognition because of the nature of funding provided to the ICB, which is transferred from NHS England and recognised through the Statement of Changes in Taxpayers' Equity. We therefore assessed that there was limited opportunity for the ICB to manipulate the income that was reported.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we recognised a fraud risk related to expenditure recognition, specifically, the risk associated with the recognition of Non-NHS Expenditure, excluding prescribing expenditure and Pharmaceutical, Ophthalmic and Dental expenditure, at the period end.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included unusual posting to cash, journals posted by unexpected users and unusual postings to expenditure.
- Inspecting transactions in the period prior to and following 31 March 2024 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.

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 fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accountable Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

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 2023/24. 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 2023/24.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 149, 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

The Accountable Officer is responsible for ensuring the regularity of expenditure and income.

We are required to report on the following matters under Section 21(4) and (5) of the Local Audit and Accountability Act 2014.

In our opinion, in all material respects, the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Basis for opinion on regularity

We conducted our work on regularity in accordance with Statement of Recommended Practice - Practice Note 10: *Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2022)* issued by the FRC. We planned and performed procedures to obtain sufficient appropriate evidence to give an opinion over whether the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them. The procedures selected depend on our judgement, including the assessment of the risks of material irregular transactions. We are required to obtain sufficient appropriate evidence on which to base our opinion.

Report on the ICB's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the ICB to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 149, 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.

We have nothing to report in this respect.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

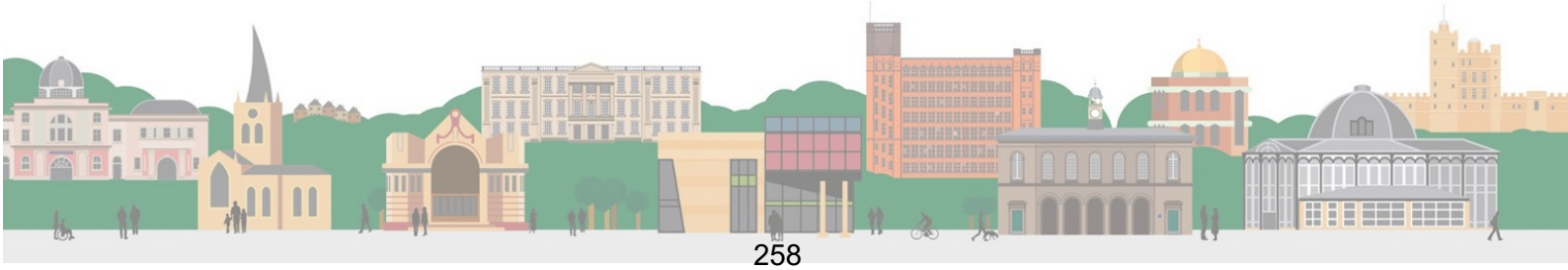
This report is made solely to the Members of the Board of NHS Derby and Derbyshire Integrated Care Board, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Board of the ICB, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Board of the ICB, as a body, for our audit work, for this report or for the opinions we have formed.

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 year ended 31 March 2024 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 Accountants1 Snow Hill Queensway,
1 Snow Hill Queensway,
Birmingham,
B4 6GH

25 June 2024



APPENDICES

Appendix 1: ICB Attendance at Meetings during 2023/24

ICB Board

ICB Board Member		20 Apr 2023	15 Jun 2023	20 Jul 2023	21 Sep 2023	16 Nov 2023	18 Jan 2024	21 Mar 2024
John MacDonald	Chair (up to 30th June 2023)	✓	✓					
Richard Wright	Non-Executive Member (Finance, Estates & Digital) (up to 30th June 2023) Vice Chair (from 25th May 2023 to 30th June 2023) Chair (from 1st July 2023)	✓	✓	✓	✓	✓	✓	✓
Dr Adedeji Okubadejo	Clinical Lead Member and Vice ICB Board Chair (from 1st April 2023)	✓	✓	✓	✓	✓	✓	✓
Dr Chris Clayton	Chief Executive Officer	✓	✓	✓	✓	✓	✓	✓
Tracy Allen	Participant Member to the Board for Place – Derbyshire Community Health Services NHS Foundation Trust	✓	✓	✓	✓	X	✓	✓
Stephen Posey	Partner Member – University Hospitals of Derby and Burton NHS Foundation Trust (from 1st August 2023)				✓	✓	✓	✓
Mark Powell	Partner Member – Derbyshire Healthcare NHS Foundation Trust (from 1st April 2023)	✓	X	✓	✓	✓	X	✓
Dr Andrew Mott	Partner Member – Primary Medical Services	✓	✓	✓	✓	✓	✓	X
Andy Smith	Partner Member – Derby City Council	✓	X	X	✓	X	✓	X
Ellie Houlston	Partner Member – Derbyshire County Council	X	✓	X	X	✓	X	✓
Julian Corner	Non-Executive Member (Population Health & Strategic Commissioning) (up to 30th November 2023)	X	✓	✓	X	X		
Margaret Gildea	Non-Executive Member (People & Culture) and Senior Independent Director	✓	✓	✓	✓	✓	✓	✓
Sue Sunderland	Non-Executive Member (Audit & Governance)	✓	✓	✓	✓	✓	✓	✓
Jill Dentith	Non-Executive Member (Finance, Estates & Digital) (from 1st July 2023)			✓	✓	✓	✓	✓
Michelle Arrowsmith	Chief Strategy and Delivery Officer, and Deputy Chief Executive (from 2nd October 2023)					✓	✓	X
Keith Griffiths	Chief Finance Officer	✓	✓	✓	✓	✓	✓	✓
Dr Chris Weiner	Chief Medical Officer	✓	✓	✓	✓	✓	✓	✓
Brigid Stacey	Chief Nurse Officer and Deputy Chief Executive Officer (up to 4th July 2023)	✓	✓					

ICB Board Member		20 Apr 2023	15 Jun 2023	20 Jul 2023	21 Sep 2023	16 Nov 2023	18 Jan 2024	21 Mar 2024
Paul Lumsdon	Interim Chief Nurse Officer (from 1st July to 31st August 2023) Executive Director of Operations (from 1st September to 31st December 2023)			✓	X	✓		
Prof Dean Howells	Chief Nurse Officer (from 1st September 2023)				✓	✓	✓	✓
Amanda Rawlings	Chief People Officer (up to 30th April 2023)	✓						
Linda Garnett	Interim Chief People Officer (from 1st May 2023)		✓	✓	✓	✓	✓	✓
Helen Dillistone	Chief of Staff	✓	✓	X	✓	✓	✓	✓
Zara Jones	Executive Director of Strategy & Planning (up to 24th September 2023)	✓	✓	✓	✓			
Dr Avi Bhatia	Clinical & Professional Leadership Group Participant Member to the Board	✓	X	X	✓	✓	✓	✓
James Austin	Chief Digital Information Officer	✓	✓	✓	✓	✓	✓	✓

Audit and Governance Committee

Audit and Governance Committee Member		4 May 2023	8 Jun 2023	10 Aug 2023	12 Oct 2023	14 Dec 2023	8 Feb 2024	14 Mar 2024
Sue Sunderland	Chair – Non-Executive Member (Audit & Governance)	✓	✓	✓	✓	✓	✓	✓
Richard Wright	Non-Executive Member (Finance, Estates & Digital) (up to 30th June 2023)	✓	✓					
Jill Dentith	Non-Executive Member (Finance, Estates & Digital) (from 1st July 2023)			✓	✓	✓	✓	✓
Margaret Gildea[6]	Non-Executive Member (People & Culture) and Senior Independent Director	X	X	✓	✓	✓	✓	X

[6] 'By invitation' in accordance with the Committee's workplan

Remuneration Committee

Remuneration Committee Member		28 Apr 2023	11 May 2023	24 May 2023	21 Jul 2023	1 Aug 2023	14 Sep 2023	16 Oct 2023	12 Dec 2023	26 Jan 2024	25 Mar 2024
Margaret Gildea	Chair – Non-Executive Member (People & Culture) and Senior Independent Director	✓	✓	✓	✓	X	✓	✓	✓	✓	✓
Julian Corner	Non-Executive Member (Population Health & Strategic Commissioning) (up to 30th November 2023)	X	X	✓	✓	X	✓	X			
Dr Adedeji Okubadejo	Clinical Lead Member and Vice ICB Board Chair (member from 1st July 2023)	X	X	✓	✓	✓	✓	X	X	✓*	✓*
Richard Wright	Non-Executive Member (Finance, Estates & Digital) (member until 30th June 2023)	✓	✓	✓							

Finance, Estates and Digital Committee

Finance, Estates and Digital Committee Member		25 Apr 2023	23 May 2023	27 Jun 2023	25 Jul 2023	22 Aug 2023	26 Sep 2023	24 Oct 2023	28 Nov 2023	19 Dec 2023	23 Jan 2024	27 Feb 2024	26 Mar 2024
Core NHS Members													
Richard Wright	Chair – Non-Executive Member (Finance, Estates & Digital) (up to 30th June 2023)	✓	✓	✓									
Jill Dentith	Chair – Non-Executive Member (Finance, Estates & Digital) (from 1st July 2023)				✓	✓	✓	✓	✓	✓	✓	✓	✓
Sue Sunderland	Non-Executive Member (Audit & Governance)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Keith Griffiths	Chief Finance Officer, ICB	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Darran Green	Acting Operational Director of Finance, ICB	✓	✓	✓	✓	✓*	✓	✓	✓	✓	✓*	✓	✓
Zara Jones	Executive Director of Strategy and Planning (up to 24th September 2023)	X	✓	X	✓*	X	X						

* Indicates where a member was deputised.

Finance, Estates and Digital Committee Member		25 Apr 2023	23 May 2023	27 Jun 2023	25 Jul 2023	22 Aug 2023	26 Sep 2023	24 Oct 2023	28 Nov 2023	19 Dec 2023	23 Jan 2024	27 Feb 2024	26 Mar 2024
Michelle Arrowsmith	Chief Strategy and Delivery Officer, and Deputy Chief Executive (from 2nd October 2023)							X	✓	X	✓	✓	X
Linda Garnett	Interim Chief People Officer, ICB	X	✓*	X	✓*	✓	✓	✓	✓	✓	✓	✓	✓
Stephen Jarratt	Non-Executive Director, UHDBFT (up to 31st August 2023)	X	X	X	X								
Ian Lichfield	Non-Executive Director, DCHSFT (up to 31st August 2023) Non-Executive Director, UHDBFT (from 1st September 2023)	✓	X	X	X	✓	X	✓	X	X	X	X	X
Stuart Proud	Non-Executive Director, DCHSFT (from 1st July 2023)				✓	✓	X	✓	✓	✓	✓	✓	✓
Steve Heppinstall	Executive Director of Finance, UHDBFT						✓*	✓	✓*	✓	✓	✓	✓
Simon Crowther	System Estates Lead/Executive Director Finance & Performance/Interim Deputy CEO, UHDBFT	✓	X	✓	✓	✓	✓*	✓	✓*	✓	✓*	✓*	✓
Peter Handford	Chief Finance Officer, DCHSFT	✓	✓	✓	✓	✓	✓	✓	✓	✓*	✓	X	X
Michelle Veitch	Chief Operating Officer, CRHFT	✓*	✓*	✓*	✓*	✓	✓	✓*	X	X	X	X	X
Ade Odunlade	Chief Operating Officer, DHcFT	✓	X	✓	X	✓*	X	✓	X	X	X	X	X
James Sabin	Director of Finance, DHcFT (from 1st November 2023)								✓*	X	X	✓	✓
Mike Naylor	Director of Finance, EMAS	✓	✓	✓	✓	✓	✓	✓	✓*	X	✓	✓	✓
System Members													
James Austin	Chief Digital Information Officer, ICB	✓	X	X	X	✓	✓	✓	✓	✓	✓	✓	✓
Maria Riley	JUCD Director of Transformation & PMO (up to 30th September 2023)	X	✓	✓	X	X	✓						
Susan Whale	JUCD Director of System PMO &							X	✓	✓	X	✓	X

* Indicates where a member was deputised.

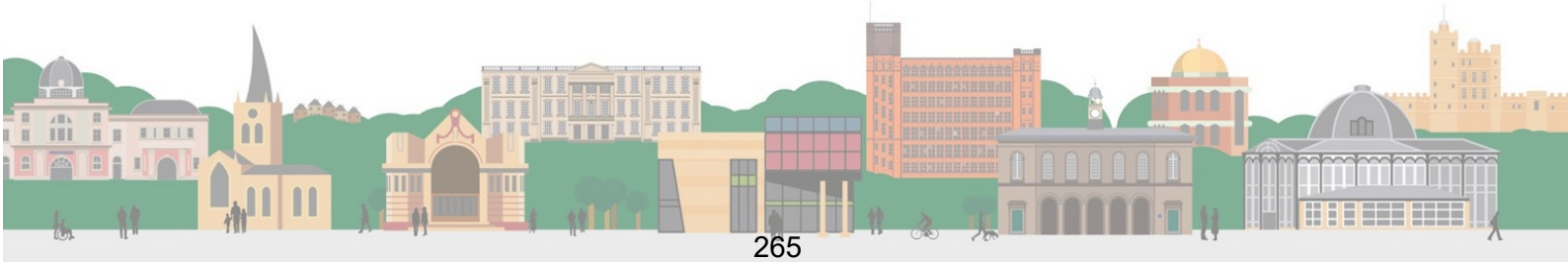
Finance, Estates and Digital Committee Member		25 Apr 2023	23 May 2023	27 Jun 2023	25 Jul 2023	22 Aug 2023	26 Sep 2023	24 Oct 2023	28 Nov 2023	19 Dec 2023	23 Jan 2024	27 Feb 2024	26 Mar 2024
	Improvement (from 1st October 2023)												
Tamsin Hooton	JUCD Programme Director	✓	✓	X	✓	✓	X	X	✓	✓	✓	✓	✓

People and Culture Committee

People and Culture Committee Member		7 Jun 2023	6 Sep 2023	6 Dec 2023	22 Feb 2024
Margaret Gildea	Chair – Non-Executive Member (People & Culture) and Senior Independent Director	✓	✓	✓	✓
Jill Dentith	Non-Executive Member (Finance, Estates & Digital) (from 1st July 2023)		X	✓	✓
Linda Garnett	Interim Chief People Officer (from 1st May 2023)	✓	✓	✓	✓
Janet Dawson	Non-Executive Member, DCHSFT	✓	X	✓	✓
Ralph Knibbs	Non-Executive Member, DHcFT	X	✓	X	✓
Joy Street	Non-Executive Member, UHDBFT (up to 31st August 2023)	X			
Billie Lam	Non-Executive Member, UHDBFT (from 1st September 2023)		X	✓	✓
Jeremy Wight	Non-Executive Member, CRHFT (up to 31st August 2023)	✓			
Atul Patel	Non-Executive Member, CRHFT (from 1st September 2023)		✓	✓	X
Vijay Sharma	Non-Executive Director, EMAS (up to 31st August 2023)	X			
Will Pope	Non-Executive Director, EMAS (from 1st September 2023)		X	X	X
Amanda Rawlings	Chief People Officer, ICB (up to 30th April 2023) and UHDBFT	✓	✓*	✓	✓
Darren Tidmarsh	Chief People Officer, DCHSFT	✓	✓	✓	✓
Mark Powell	Chief Executive Officer, DHcFT (from 1st April 2023)	X	X	X	X
Jaki Lowe	Director of People & Inclusion, DHcFT	X	X	X	X
Kerry Gulliver	Director of HR & Organisational Development, EMAS	X	X	X	X
Caroline Wade	Director of HR & Organisational Development, CRHFT	✓	✓	✓	✓
Penelope Blackwell	Chair of Integrated Place Executive	X	X	X	X
Emma Crapper	HR Director, Derbyshire County Council	X	✓*	X	X

* Indicates where a member was deputised.

People and Culture Committee Member		7 Jun 2023	6 Sep 2023	6 Dec 2023	22 Feb 2024
Liz Moore	Head of HR, Derby City Council	✓	✓	✓	✓
Susie Bayley	Medical Director, General Practice Taskforce Derbyshire	✓	✓	✓	X
Zahra Leggatt	Derbyshire Health United 111 (East Midlands) Community Interest Company representation	X	X	X	✓



Population Health and Strategic Commissioning Committee

Population Health and Strategic Commissioning Committee Member		11 May 2023	13 Jul 2023	14 Sep 2023	12 Oct 2023	9 Nov 2023	11 Jan 2024	14 Mar 2024
Julian Corner	Chair – Non-Executive Member (Population Health & Strategic Commissioning), ICB (up to 30th November 2023)	X	✓	✓	✓	X		
Richard Wright	Non-Executive Member (Finance, Estates & Digital), ICB (from 1st April to 30th June 2023, membership reinstated from 1st December 2023)	✓					✓	✓
Dr Adedeji Okubadejo	Clinical Lead Member and Vice ICB Board Chair, ICB (from 1st April 2023)	X	✓	✓	X	✓	X	✓
James Reilly	Non-Executive Director, DCHSFT (from 1st November 2023)					✓	✓	✓
Sardip Sandhu	Non-Executive Director, UHDBFT (from 1st January 2024)						✓	✓
Dr Penny Blackwell	Representative for Provider Collaborative at Place	X	X	✓	X	X	X	X
Dr Avi Bhatia	Representative for Clinical & Professional Leadership Group	✓	X	✓	✓	✓	✓	✓
Dr Emma Pizzey	GP Clinical Lead	✓	✓	✓	✓	✓	✓	✓
Dr Suneeta Teckchandani	Secondary Care Doctor	✓	X	✓	✓	✓	✓	✓
Dominic Fackler	Allied Health Professional Representative (up to 30th April 2023)							
Robyn Dewis	Director of Public Health, Derby City Council	✓	✓	✓	✓	✓	✓	✓
Mark Powell	Chief Executive Officer, DHcFT (from 1st April 2023)	X	X	✓	X	X	X	X
Zara Jones	Executive Director of Strategy and Planning, ICB (up to 24th September 2023)	✓	✓	✓				
Michelle Arrowsmith	Chief Strategy and Delivery Officer, and Deputy Chief Executive, ICB (from 2nd October 2023)				✓	✓	✓	✓
Brigid Stacey	Executive Director of Nursing & Quality, and Deputy Chief Executive Officer, ICB (up to 4th July 2023)	✓						
Paul Lumsdon	Interim Chief Nurse Officer, ICB (from 1st July 2023 to 31st August 2023) Executive Director of Operations, ICB (from 1st September 2023 to 31st December 2023)		✓	X	✓	✓		
Prof Dean Howells	Chief Nurse Officer, ICB (from 1st September 2023)			X	✓	✓	✓	✓

Population Health and Strategic Commissioning Committee Member		11 May 2023	13 Jul 2023	14 Sep 2023	12 Oct 2023	9 Nov 2023	11 Jan 2024	14 Mar 2024
Dr Chris Weiner	Chief Medical Officer, ICB	✓	✓	✓	X	✓	✓	✓
Keith Griffiths	Chief Finance Officer, ICB	✓	X	✓	X	X	✓	✓
Clive Newman	Director of GP development, ICB	✓	✓	✓	✓*	✓	✓	✓
Steve Hulme	Director of Medicines Management & Clinical Policies, ICB	✓	✓	✓	✓	✓*	✓	✓
Amanda Rawlings	Chief People Officer, ICB (up to 30th April 2023)							
Linda Garnett	Interim Chief People Officer, ICB (from 1st May 2023)	X	X	X	X	X	✓	✓

* Indicates where a member was deputised.

Public Partnership Committee

Public Partnership Committee Member		30 May 2023	29 Aug 2023	31 Oct 2023	30 Jan 2024	27 Feb 2024
Voting Members						
Julian Corner	Chair – Non-Executive Member (Population Health and Strategic Commissioning) (up to 30th November 2023)	✓	✓	✓		
Richard Wright	Chair – ICB Chair (from 1st December 2023)				✓	✓
Sue Sunderland	Non-Executive Member (Audit & Governance)	✓	✓	✓	✓	✓
Steven Bramley	Lay Representative	✓	✓	✓	✓	✓
Tim Peacock	Lay Representative	✓	✓	✓	✓	✓
Jocelyn Street	Lay Representative	✓	✓	✓	✓	✓
Patricia Coleman	Lay Representative (from 1st January 2024)				✓	X
Carol Warren	Lead Governor, CRHFT	✓	✓	✓	✓	X
Maura Teager	Lead Governor, UHDBFT (up to 30th September 2023)	✓*	✓*			
Val Haylett	Public Governor, UHDBFT (from 1st October 2023)			✓	X	X
Lynn Walshaw	Deputy Lead Governor, DCHSFT	X	✓	✓*	✓	✓
Christopher Mitchell	Public Governor, DHcFT (up to 31st May 2023)	✓				
Hazel Parkyn	Public Governor, DHcFT (from 1st June 2023)		X	✓	X	✓
Sam Dennis	Director of Communities, Derby City Council (from 2nd October 2023 to 26th February 2024)			X	X	X
Neil Woodhead	Service Manager – Locality Working, Derby City Council (from 27th February 2024)					X
Kim Harper	Chief Officer, Community Action Derby	X	X	X	X	X
Non-Voting Members						
Helen Henderson	Chief Executive Officer, Healthwatch Derbyshire Up to 29th May 2023)					
Amy Salt	Engagement and Involvement Manager, Healthwatch Derbyshire (from 30th May 2023)	✓	✓	✓	✓	✓
Helen Dillistone	Chief of Staff, ICB	X	X	✓*	✓	✓
Sean Thornton	Deputy Director Communications & Engagement, ICB/JUCD	✓	✓	✓	✓	✓
Karen Lloyd	Head of Engagement, ICB/JUCD	✓	✓	✓	✓*	✓

* Indicates where a member was deputised.

Quality and Performance Committee

Quality and Performance Committee Member		27 Apr 2023	25 May 2023	29 Jun 2023	27 Jul 2023	31 Aug 2023	28 Sep 2023	2 Nov 2023	30 Nov 2023	21 Dec 2023	25 Jan 2024	28 Mar 2024
Dr Adedeji Okubadejo	Chair – Clinical Lead Member and Vice ICB Board Chair (from 1st April 2023)	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓
Margaret Gildea	Non-Executive Member (People and Culture) and Senior Independent Director (up to 30th June 2023)	✓	✓	X								
Richard Wright	Non-Executive Member (Finance, Estates & Digital) (up to 30th June 2023)	✓	✓	X								
Jill Dentith	Non-Executive Member (Finance, Estates & Digital) (from 1st July 2023)				✓	✓	✓	✓	✓	✓	✓	✓
Brigid Stacey	Chief Nurse Officer and Deputy Chief Executive Officer (up to 4th July 2023)	✓	✓	✓								
Paul Lumsdon	Interim Chief Nurse Officer (from 1st July 2023 to 31st August 2023) Executive Director of Operations (from 1st September 2023 to 31st December 2023)				✓	✓						
Prof Dean Howells	Chief Nurse Officer (from 1st September 2023)						✓*	✓*	✓	✓	✓	✓
Dr Chris Weiner	Chief Medical Officer	X	✓	✓	X	✓	X	✓	✓	✓	✓	✓
Zara Jones	Executive Director of Strategy & Planning (up to 24th September 2023)	✓*	✓	✓	✓*	✓*						
Michelle Arrowsmith	Chief Strategy and Delivery Officer, and Deputy Chief Executive (from 2nd October 2023)							✓	✓*	✓*	✓	✓*

* Indicates where a member was deputised.

Quality and Performance Committee Member		27 Apr 2023	25 May 2023	29 Jun 2023	27 Jul 2023	31 Aug 2023	28 Sep 2023	2 Nov 2023	30 Nov 2023	21 Dec 2023	25 Jan 2024	28 Mar 2024
Christine Fearns	Non-Executive Director, UHDBFT (up to 28th April 2023)	X										
Chris Harrison	Non-Executive Director, UHDBFT (from 1st October 2023)						X	X	✓	✓	X	X
Jayne Stringfellow	Non-Executive Director, CRHFT (up to 31st August 2023)	X	X	X	✓	X						
Nora Senior	Non-Executive Director, CRHFT (from 1st September 2023)						X	X	✓	X	X	X
Lynn Andrews	Non-Executive Director, DHcFT	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓
Kay Fawcett	Non-Executive Director, DCHSFT	✓	✓	✓	X	✓	X	X	✓	X	✓	✓
Robyn Dewis	Director of Public Health, Derby City Council	✓	✓	X	X	X	✓	X	✓	✓	✓	✓
Gemma Poulter	Assistant Director Adult Social Care, Derbyshire County Council	X	X	X	X	X	X	X	X	X	X	X

Appendix 2: Glossary

A&E	Accident and Emergency
AHP	Allied Health Professionals
ARRS	Additional Roles Reimbursement Scheme
bn	Billion
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
EAF	Expert Advisory Forum
ED	Emergency Department
EMAS	East Midlands Ambulance Service NHS Trust
EoL	End-of-Life
EPRR	Emergency Preparedness Resilience and Response
FTE	Full Time Equivalent
GNBSI	Gram-negative bloodstream infection
GP	General Practitioner
GPIP	General Practice Improvement Programme
GPQV	General Practice Quality Visit
HCAI	Healthcare-Acquired Infection
HR	Human Resources

ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
IFR	Individual Funding Request
IPC	Infection Prevention and Control
IPE	Integrated Place Executive
IT	Information Technology
JUCD	Joined Up Care Derbyshire
k	Thousand
KPI	Key Performance Indicator
LeDeR	Learning from Lives and Deaths Review
LMNS	Local Maternity and Neonatal System
LTC	Long-Term Condition
m	Million
MDI	Metered Dose Inhaler
MHIS	Mental Health Investment Standard
MRSA	Methicillin-resistant Staphylococcus aureus
MSK	Musculoskeletal
N_2O	Nitrous Oxide
NECSU	North of England Commissioning Support Unit
NHS	National Health Service
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
OCC	Operational Coordination Centre
OEIG	Organisation Effectiveness and Improvement Group
OPEL	Operating Pressure Escalation Level

PCN	Primary Care Network
PPG	Patient Participation Group
PSIRF	Patient Safety Incident Response Framework
PSR	Provider Selection Regime
Q1/Q2/Q3/Q4	Quarter 1/2/3/4
SDEC	Same Day Emergency Care
SEND	Special Educational Needs and Disabilities
ToC	Theory of Change
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/risk-management/
[ii] https://joinedupcarederbyshire.co.uk/about-us/derbyshire-integrated-care-partnership/our-strategy/
[iii] NHS five year plan will prioritise prevention of ill health » Joined Up Care Derbyshire
[iv] 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
[v] https://www.derbyshire.gov.uk/social-health/health-and-wellbeing/about-public-health/health-and-wellbeing-board/health-and-wellbeing-board.aspx
[vi] https://www.derby.gov.uk/health-and-social-care/public-health/hwb/
[vii] https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/
[viii] https://joinedupcarederbyshire.co.uk/?s=task+allocation&id=2847
[ix] https://joinedupcarederbyshire.co.uk/about-us/jucd-workstreams/digital-transformation/
[x] https://www.derbyshirehealthcareft.nhs.uk/services/service-developments/making-room-for-dignity
[xi] https://www.derbyshirehealthcareft.nhs.uk/services/helpline-and-support-service
[xii] https://derbyandderbyshireemotionalhealthandwellbeing.uk/resources/urgent-mental-health-crisis-care-services
[xiii] https://joinedupcarederbyshire.co.uk/your-services/children-and-young-people/children-young-people-mental-health-wellbeing/
[xiv] https://derbyandderbyshireemotionalhealthandwellbeing.uk/resources/urgent-mental-health-crisis-care-services
[xv] https://leaders-unlocked.org/publications/
[xvi] https://derbyandderbyshireemotionalhealthandwellbeing.uk/neurodiversity/neurodiverse-community-hubs-support-for-0-25-years
[xvii] https://joinedupcarederbyshire.co.uk/about-us/jucd-workstreams/green-plan/
[xviii] www.openprescribing.net
[xix] https://www.legislation.gov.uk/ukdsi/2023/9780348252613/contents
[xx] https://joinedupcarederbyshire.co.uk/about-us/derbyshire-integrated-care-partnership/our-strategy/
[xxi] [xxi] https://joinedupcarederbyshire.co.uk/about-us/equality-inclusion-and-human-rights/#The_Equality_Delivery_System_EDS
[xxii] https://joinedupcarederbyshire.co.uk/your-services/safeguarding/safeguarding-children/#Resources
[xxiii] https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/conflicts-of-interest/
[xxiv] https://joinedupcarederbyshire.co.uk/download/modern-slavery-statement/
[xxv] https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/
[xxvi] https://joinedupcarederbyshire.co.uk/derbyshire-integrated-care-board/conflicts-of-interest/
[xxvii] https://joinedupcarederbyshire.co.uk/privacy-notice/

NHS
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 1.06 million people in Derbyshire. Our vision is to continuously improve the health and wellbeing of the people of Derby and Derbyshire, using all resources as fairly as possible.

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