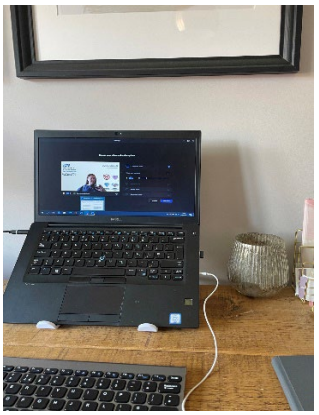
NHS
Derby and Derbyshire
Clinical Commissioning Group

NHS Derby and Derbyshire Clinical Commissioning Group Annual Report & Accounts April to June 2022



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FOREWORD

My introduction covers the three months from the 1st April 2022 when NHS Derby and Derbyshire Clinical Commissioning Group (CCG) would have closed for business and handed over its legacy to the newly formed NHS Derby and Derbyshire Integrated Care Board (ICB), up to the 30th June 2022, when the transition took place.

In our previous annual report, I expressed my gratitude to our health and social care colleagues who had demonstrated extraordinary dedication and compassion as we continued to deliver services through the pandemic. This was in conjunction with high levels of Covid-19-related sickness, working to recover planned care and the inevitable cross system pressures that winter brings. I repeat that enormous thank you now. Although the challenges of the pandemic are different, they still remain alongside significant system pressures and yet despite this, we are making significant progress in terms of recovery.

CCGs launched in 2013 and my reflection as a General Practitioner (GP) is that our profession embraced the role as drivers of the policies to improve local health. I personally feel that placing clinicians at the heart of decision-making has been fundamental to our achievements as initially four local CCGs and finally one CCG for Derby and Derbyshire. Our GP members have worked tirelessly to embed new ways of working to maintain this principle and I am proud to see many of these initiatives continue on into the ICB.

Primary Care Networks are a good example of how new ways of working became embedded. Their central role throughout the pandemic, alongside the relentless efforts of colleagues in Primary and Secondary Care, was fundamental to caring for our patients and keeping them safe. Collaboration and working at scale have been key factors in enabling us to continue to deliver increasing volumes of care to patients as we emerge from the pandemic. In the last three months we have seen a significant increase in the volume of GP appointments and also the number of those that are face to face. This is a great example of our legacy to the ICB. From a Primary Care perspective, we will continue to do all we can to support the system through the stronger voice we have developed over the last nine years of the CCG arrangements.

In my last report I also made reference to the Clinical and Professional Leadership Group which was tasked with delivering an important role as a strategic decision-making group to improve population health outcomes. This has evolved over the last three months and we held a networking event in May 2022 to take some key initiatives forward. This event included everyone from a clinical or care professional background for a discussion on the vision for professional leadership development in Derby and Derbyshire. Key topics included the difference that can be made to care through innovation in leadership connectivity and collaboration. We are now seeing the benefits of that joined up work as it feeds into our system planning and developments for the future and for the ICB to take forward.

There are many other examples of the breadth and depth of work that has taken place over the last three months as we worked to build the best legacy possible for the CCG to hand over to the ICB on the 1st July 2022. The element that I am most proud of is a health and care system built upon partnership and collaboration and a highly skilled, caring and determined workforce which always puts our patients first.

Dr Avi Bhatia
Clinical Chair
NHS Derby and Derbyshire Clinical Commissioning Group
27th June 2023

PERFORMANCE REPORT

Dr Chris Clayton

Accountable Officer

NHS Derby and Derbyshire CCG

27th June 2023

Chief Executive Officer's Statement

There will be a constitutional change to the way that health and social care systems across the country operate from the 1st July 2022. In Derby and Derbyshire and alongside 42 health and care systems nationally we will formally launch our Integrated Care System (ICS) on that date. In Derby and Derbyshire we will retain the Joined Up Care Derbyshire (JUCD) brand for our ICS as it has a strong recognition which has built up over the last six years. These changes will formalise and set out in law the well-established and collaborative partnership we already have in place locally.

The change will also see the launch of our Integrated Care Board (ICB) as the successor organisation to the CCG. The ICB will be a different body to the CCG, acting as the NHS executive for our system and blurring the boundaries of the commissioner/provider split we have seen in recent configurations. This will be of benefit to our patients as we seek collaboration in understanding the needs of our communities. We will adopt NHS Derby and Derbyshire as our identifier to link with the powerful NHS brand recognition.

Preparation for a smooth and effective handover has been a key priority for us over the last three months, as we have worked to draw the CCG to a close. As part of this process, we have looked back on the work of the CCG and its four predecessors during the last nine years. This helped to inform the planning and learning to take forward into the ICB and was also a reminder of the inevitable challenges but also the implementation of a wide range of projects and programmes over that time and their successes. It also reminded us of how grateful we are for the contribution of our public, patients, partners and stakeholders who helped us to shape these initiatives.

One of our most significant challenges since becoming the CCG has been finance. As we moved into the Covid-19 pandemic we were dealing with a significant financial challenge which paused at the point the pandemic began. As it started to retreat over the last three months, we have been preparing for the continuation of that financial challenge. As part of our preparations as a system working towards the launch of our ICS on the 1st July 2022, we have done our very best to ensure that we hand over to the new ICB in the best possible financial shape and with a clear way forward.

Recovering from the pandemic has been another key priority for us over the last three months. Analysis of data illustrates that as of the 30th June 2022, 4 of the 21 constitutional or mandated standards for our patients have been delivered. Although a number of the standards have not been achieved, they do compare well against nationally reported performance. The CCG compared better regionally on a significant number of standards; however there are a number of standards which we will focus on during the remainder of the year within the ICB.

We have seen a significant improvement in the key target of 104-day waits for treatment since the start of 2022. Our projection is that 104-day waits will be down to zero in Derby and Derbyshire by the end of July 2022, except for highly complex cases or people who have opted to delay their treatment. Whilst we recognise that we can never rest on our laurels whilst there are patients waiting for treatment, this progress will enable the ICB to increase focus on other areas of recovery in conjunction with ensuring that we deliver on these projections.

As we close the CCG for business on the 30th June 2022, there will be a shared sense of nostalgia amongst colleagues but also real excitement and anticipation in readying ourselves for the new arrangements from the 1st July 2022. Our preparations include a comprehensive forward plan for our ICB and as part of the wider system plan for the ICS – running some of our decision-making processes in shadow form in recent months has left us particularly well placed to start the new arrangements on the front foot.

As I close, I reflect on the achievements of the CCG with a sense of pride in the knowledge that we have created a strong legacy but also a clear purpose for our incoming ICB. Most importantly of all, I want to acknowledge the tremendous contribution and commitment of CCG colleagues and the outstanding work of colleagues across our health and care system. The last two years in particular have been testament to this. I am proud to be part of a system which strives every day to deliver the very best we can do for our patients and I am incredibly optimistic as we move into the new arrangements.

Dr Chris Clayton
MA MB BChir DRCOG PGCGPE MRCGP
Chief Executive Officer
NHS Derby and Derbyshire Clinical Commissioning Group
27th June 2023

Performance Overview

This overview provides a summary of the purpose and activities of NHS Derby and Derbyshire Clinical Commissioning Group (CCG) and how it performed during the year. It also provides the Chief Executive Officer's perspective on the performance of the CCG.

Purpose and Activities of the CCG

NHS Derby and Derbyshire CCG brings together local General Practices and other NHS organisations to plan and help shape local health services for the people of Derby and Derbyshire. The CCG has representation from 109 General Practices from the area and has a Governing Body, which is made up of local GPs, supported by Specialist Doctors and Nurses, Lay Members and experienced officers. More information on our Governing Body Members can be found on page 89 of this report.

Our CCG area covers residents across Derbyshire, including the populations of Derby city, Chesterfield, Ilkeston and Long Eaton, Amber Valley, Derbyshire Dales, Bolsover District and High Peak. The CCG serves a population of around 1,077,074.

Our mission and values

The CCG's vision is *"to continuously improve the health and wellbeing of the people of Derbyshire, using all resources as fairly as possible"*. The CCG strives to achieve this by:

- providing local clinical leadership to the NHS, and working with everybody who can contribute to our aims;
- being open and accountable to our patients and communities, ensuring they are at the heart of everything we do;
- understanding our population and addressing inequalities so that services are in place to meet needs;
- planning services that best meet those needs, now and in the future;
- aiming to secure the best quality, best value health and social care services we can afford; and
- using our resources fairly and effectively.

There are clear health inequalities within the CCG area. Working together with partner organisations is part of the whole system approach to tackling them, as articulated in our Derbyshire Sustainability and Transformation Plan. The latest update on developments can be found on the JUCD's website here[1].

[1] https://joinedupcarederbyshire.co.uk/get-involved/patient-participation-group-ppg-network

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

The CCG's Governing Body uses an Assurance Framework to test our performance and capability. Part of this annual framework measures performance against what we say we need to deliver and whether these demonstrate improved outcomes for our patients, including how services and quality are delivered and improved. This includes measuring progress in how we delivered the requirements set by the Government in the NHS Mandate and the NHS Constitution.

The key issues and risks to the organisation achieving its objectives are described in the Governance Statement section of this report. The CCG's strategic risks identified during Q1 of 2022/23 can be found on page 107 of this report and here.

Adoption of the Going Concern Approach

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

Our relationships

Patients in our area have access to services from a wide range of providers, including Derbyshire Healthcare NHS Foundation Trust (DHcFT), Derbyshire Community Health Services NHS Foundation Trust (DCHSFT) and East Midlands Ambulance Service NHS Trust (EMAS). Our largest contracts are with Chesterfield Royal Hospital NHS Foundation Trust (CRHFT) and University Hospitals of Derby and Burton NHS Foundation Trust (UHDBFT), and account for approximately 38.1% of our spending.

System Working and Collaboration

JUCD continued to make progress across our main system priorities during the first three months of the year. These included:

- continued attention to the recovery of services affected by the pandemic;
- finding solutions to the sustained pressure facing the health and social care system; and
- implementing the transition of our existing partnership arrangements to a statutory footing, in line with the Health and Care Act 2022.

The pandemic impacted the delivery of services in many ways, and whilst there was some accelerated innovation, for example in the way we use digital technology and communication methods to talk to and treat patients, access to some services was reduced and needs to be recovered. This included our ability to perform surgery and some diagnostics, and waiting lists for these services saw a significant increase during this period. Significant attention was given across our system to ensuring the continuation of performing surgery for the most urgent and critical cases, with constant reviews of waiting lists for our patients. We are aiming to meet the target of having no patients waiting over two years by the end of July 2022, and will continue to ensure that waiting lists reduce further.

JUCD continues to see considerable pressure in our urgent and emergency care, and community care services. This is a national problem, and the impact of workforce pressures and increased activity has been the subject of ongoing local, regional and national media coverage. Our System Resilience Group continue to manage the day-to-day operational challenges in partnership, from a single principle that understands that all parts of our system are reliant upon one another to ensure our patients can receive the care they need at the different stages of their treatment and rehabilitation.

Implementing the Health and Care Act 2022 was another area of significant focus. As a 'partnership of the willing', JUCD made significant progress due to a track record of extensive partnership working between the NHS, local authorities and other partners. In February 2021, the Government issued a draft Health and Care Bill which would put ICSs on a statutory footing, see the replacement of CCGs with ICBs, and the creation of a statutory committee to be known as the Integrated Care Partnership.

NHS Derby and Derbyshire ICB will be established from the 1st July 2022, with the former CCG closed in a professional manner ensuring the handover of statutory duties to its successor. The ICB will have statutory responsibility for NHS services in the Glossop area of Derbyshire, following a decision by the Secretary of State for Health and Social Care.

Changes to the organisational form aside, the remits and duties of these statutory bodies, and the benefits we expect they will have on the health of local citizens, fall largely in line with the planned direction of travel for JUCD. We will continue the conversations we started in 2021 about the ICS's purpose, restating our focus and re-affirming our intention as an NHS, public health and social care partnership. We made significant progress in understanding the role of the new Integrated Care Partnership, and how it connects with the wok of our Health and Wellbeing Boards.

All of this remains in the context of the Covid-19 pandemic, and while we seek to restore and transform services, we will have to continue to deal with the aftermath of the pandemic, such as the impact on tired staff and the backlogs created by depleted or socially-distanced services. However, our continued ability to collaborate and keep what is important to local citizens at the heart of what we do, will be crucial in the success of the new ICS architecture for Derby and Derbyshire, and we are determined to provide a long-lasting legacy for our people.

Place Development and Delivery

Place can be defined as ‘empowering people to live a healthy life for as long as possible through joining up health, care, and community support for people and local communities’. Place-based working is key to the delivery of integrated health and social care in Derby and Derbyshire and is implemented through our eight Local Place Alliances (LPAs) seen here on the map.

Each LPA has a diverse membership and brings together many groups including commissioners, community service providers, Local Authority, Public Health, voluntary sector, community stakeholders, public representation, Primary Care Networks (PCNs), hospitals, and emergency services.

Coordinated by the Integrated Place Executive, LPAs either lead or contribute to a wide variety of work which supports system integration and the health and social care needs of our vibrant and varied communities across the county. Some key priorities and achievements are shared below.

Integrated Place Executive

The Integrated Community Place Board has evolved to become the Integrated Place Executive. The meeting continues to be chaired by Dr Penny Blackwell and brings together key system stakeholders to coordinate and integrate services. The group will lead the development and delivery of an Integrated Care Strategy.

Welcoming Glossop to our Integrated Care System footprint

As part of Derby and Derbyshire health and social care transition to becoming an ICS on the 1st July 2022, we will welcome Glossop to the Derbyshire system as the government boundary change announced in 2021 was enacted on the same day.

In preparation for this, alongside significant public engagement, Place partners have been working with colleagues from Tameside and Glossop to ensure a smooth transition and understand any operational opportunities associated with the boundary change. Colleagues from Glossop have been warmly welcomed to the High Peak LPA, and we are delighted that a lay representative has been appointed Deputy Chair of the LPA.

Team Up Derbyshire (including Ageing Well)

Team Up Derbyshire is an ambitious programme in Derby and Derbyshire that aims to create one team across health and social care who see all the people in a neighbourhood who are currently unable to leave home without support. These individuals tend to receive most of their health and care services where they live, rather than traveling to service providers.

The team covers urgent, planned and preventative care. It is not a new or ‘add on’ service, but a ‘teaming up’ of existing resources and a creation of additional capacity. Team Up Derbyshire integrates General Practices with community providers, mental healthcare providers, adult social care and the voluntary sector. Team Up Derbyshire brings together

home visiting, urgent community response, enhanced health in care homes, and anticipatory care.

PCNs are developing their home visiting service implementation plans which form one element of the Team Up programme. As of June 2022, Derby City PCS and Erewash PCN were providing a full service, with partial or pilot services in place in Chesterfield, Amber Valley and Belper. Implementation plans from other PCNs are proceeding through a robust approval process.

Home visiting services offer a multi-disciplinary team approach for supporting housebound individuals. When a person requests a home visit from their GP, it is passed through to the home visiting team who will triage to the most appropriate member of staff to undertake the visit, for example, a community matron. Due to competing demands on the time of our GPs, they have naturally had limited time available to them to spend on each home visit and have often needed to prioritise the principal problem that has required the home visit, often only being able to focus on the immediate presenting medical problem. The home visiting team is able to spend much longer with an individual and link other services (including the voluntary sector) into the person to offer support, enabling a much more holistic approach. This way of working also supports the other parts of the Team Up programme, especially those linked to anticipatory care, which aims to reduce a person's need for crisis support by taking a much more proactive approach.

Team Up Derbyshire in action case study: getting on the front foot in providing proactive care in the ARCH Primary Care Network

ARCH PCN (covering Alfreton, Ripley, Crich and Heanor) has appointed an elderly care liaison officer, Cheryl Stanley, to visit people in their own homes to take a more holistic assessment of an individual's health and care needs. Cheryl, a former healthcare assistant, began her visits in May 2022 and is taking referrals from across the nine General Practices in the three neighbourhood areas, in an attempt to work with patients before they have a crisis.

Cheryl says: *"GPs and nurses simply do not always have the time to spend with people to listen and understand all of their health and wellbeing needs. I am in a privileged position to be able to sit down with someone in their own home and build up a rapport with them. The time needed varies – from about half-an-hour to more than two hours on occasion – so I can fully understand what a person needs to help them feel safe and as independent as possible."*

Community GP role

The Community GP is a key role within Team Up services, providing senior clinical leadership to these multi-disciplinary teams; mentorship, guidance and support to clinical decision, and senior clinical triage.

A new video demonstrating the opportunities and benefits of becoming a community GP in Derby and Derbyshire is now on YouTube. The video, hosted on DCHSFT's YouTube channel, shows how the innovative Team Up role provides the chance for GPs to develop flexible, portfolio careers working alongside their health and social care colleagues in multi-disciplinary teams in the community.

Dr Amy Lampard, a community GP with Chesterfield and Dronfield PCN, said: *"This model of working allows the community GP and team members to take a more holistic view of the person they are caring for and allows for greater continuity of care. The care provided tends to be more joined up between disciplines, where you can really get to know the patient, and often by doing so, we can anticipate the individual's care needs before any concerns escalate."*

More information on Team Up Derbyshire can be found on the JUCD website here[2] and on the Team Up Derbyshire blog here[3].

Living Well

Our Place Team is delighted to be a key partner in enabling the Living Well programme to be extended across Derbyshire.

Building on the successes of Living Well mental health work in High Peak and Derby City, the 'next wave' projects are launching in Chesterfield, Derbyshire Dales and North East Derbyshire and Bolsover. These LPAs are working with the Innovation Unit (a social enterprise who are experts in service redesign and co-production) to transform the delivery of adult mental health services.

Within Chesterfield there is a real appetite to enable people with lived experience to co-lead this change. For Derbyshire Dales, planning is underway to create a 'Festival of Wellness' to support the mental health and wellbeing of the Dales population, and a similar event is being planned in the High Peak.

The 'wave three' sites of South Derbyshire, Erewash and Amber Valley LPAs will benefit from this approach by 2023.

Population health management and addressing health inequalities

Much of our work at Place is an enabler and a driver of the prevention agenda – to keep people living longer in better health. Place partners lead or are involved in multiple workstreams.

For example, in Derby City, population health management tools provide a targeted approach to personalisation, with a focus on people that are high users of services (particularly emergency or out-of-hours services). And in Chesterfield work is underway to use a 'quality conversations' approach to support individuals with hypertension and anxiety or depression.

[2] https://joinedupcarederbyshire.co.uk/about/our-governance-1/team-up
[3] https://teamupderbyshire.wixsite.com/website

Primary Care Networks and Collaboration

Primary Care Network Development

Despite the ongoing pandemic, General Practices continued to work together and develop their PCN infrastructure. During the period covered by this annual report, Derby and Derbyshire had 17 PCNs, covering all 109 General Practices and their registered population. PCNs are based on General Practice-registered lists, typically serving communities of around 30,000 to 50,000 people. This scale is small enough to provide personal care valued by both patients and GPs, but large enough to have significant impact and economies of scale through better collaboration between General Practices and other service providers. Glossop PCN will be joining NHS Derby and Derbyshire ICB on 1st July 2022.

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

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

PCNs have helped to form stronger relationships across General Practices, and have memorandums of understanding in place for information sharing and supporting the CCG in use of data. Clinical Directors continue to meet regularly to discuss how PCNs are coping throughout the Covid-19 pandemic and resolve any development issues. PCN operational leads also meet regularly to share learning, protocols and best practice, and help recruit to new roles.

The development of each PCN is rated against a maturity matrix. When this was completed in March 2020, all 17 PCNs were rated as foundation for all areas. In October 2021, PCNs had improved the most across leadership; organisational development; clinical director leadership; and asset-based community development. PCNs will be expected to submit a further self-assessment in October 2022.

Leadership and Management funds were available in 2021/22 and PCNs submitted plans outlining how the funds would be spent. Initiatives include supporting organisation development; providing additional PCN management capacity; clinical leadership; strategic planning; and analytical support. All are designed to release time for the existing workforce to provide clinical care. Further funds have been released for 2022/23 due to the success of 2021/22.

PCNs have met the service requirements of the Network Direct Enhanced Service by submitting plans to address neighbourhood health inequalities and deliver enhanced access, to provide more appointments, outside of core General Practice hours. These plans have been developed with ICS colleagues and stakeholders.

Additional Roles Reimbursement Scheme

Expanding the workforce is the top priority for Primary Care. The Additional Roles Reimbursement Scheme (ARRS) enables each PCN to employ additional staff across 21 direct and non-direct patient care roles within Primary Care. The latest addition to this ARRS scheme includes Adult and Children's Mental Health Practitioners, Advanced Clinical Practitioners and Nursing and Trainee Nursing Associates. Currently, PCNs have recruited 79% of the ARRS whole time equivalent target for 2022/23.

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

It has been encouraging to see relationships develop between PCNs and provider organisations, including the Voluntary, Community and Social Enterprise Sector (VCSE), EMAS, DHcFT and DHCSFT to help deploy roles that are new to Primary Care. DCHSFT is actively supporting PCNs with securing further workforce under the scheme by factoring in the 2022/23 and 2023/24 PCN workforce intentions with their own workforce planning. This will also support the development of rotational staff models that have been difficult to launch during the pandemic.

PCNs escalated the recruitment of ARRS roles from November 2021 and deployed staff flexibly, across PCNs and the system, to meet demand. The 'unclaimed funding' process was implemented, and funds were distributed to PCNs that were able to over-recruit, who have now secured additional staff and worked with third party providers to source temporary staff to support PCNs throughout the winter.

In May 2022, PCNs successfully recruited the first Mental Health Practitioners in conjunction with DHcFT. The workforce challenges within mental health are well known so this is a great achievement for Primary Care and will support the improvement of the patient pathway between Primary and Secondary Care mental health support.

Health and Wellbeing Boards and Health Improvement Scrutiny Committee

In accordance with section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007, the CCG contributed greatly to the delivery of the Joint Health and Wellbeing Strategy and is fully engaged with the city and county Health and Wellbeing Boards. The Chief Executive Officer sits 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 CCG's five strategic objectives are closely linked to those of the Health and Wellbeing Boards, ensuring that the CCG is contributing to the delivery of the Health and Wellbeing Strategy. Our first objective is *'to reduce measurably our health inequalities and improve the physical health, mental health and wellbeing of our population'*. These objectives were developed with the Governing Body, which has representation from both Local Authority Directors of Public Health. The CCG reports on progress of the strategic objectives through its Governing Body Assurance Framework.

Derbyshire's Health and Wellbeing Strategy for 2018-23 sets out five priorities for improving health and wellbeing across Derbyshire, focusing on actions to address factors that can influence people's health. The Health and Wellbeing Strategy can be viewed here[4].

The five priorities are:

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

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

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

Information on Derbyshire County Council's Health and Wellbeing Board can be found here[5] and information on Derby City Council's Health and Wellbeing Board can be found here[6].

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

[4] 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
[5] https://www.derbyshire.gov.uk/social-health/health-and-wellbeing/about-public-health/health-and-wellbeing-board/health-and-wellbeing-board.aspx
[6] https://www.derby.gov.uk/health-and-social-care/public-health/hwb/

Joint working with the Local Authority

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

Derbyshire Anchor Institutions

During Q1 of 2022/23, the established System Anchor Group brought together a number of Anchor Institutions, which are defined by the Health Foundation (2018) as:

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

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

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

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

Within Derby and Derbyshire, the signatories to the Anchor Charter include:

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

Performance Analysis

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

How Performance is measured

Performance against the NHS Constitution targets is monitored regularly in the CCG. We look at a range of data, at provider level, CCG level and by specialty where applicable. A large proportion of performance information is supplied via the North of England Commissioning Support Unit (NECS). The CCG produces regular internal reports which are discussed with Executive Directors and Lead Senior Managers. This makes best use of 'formal' and 'informal' intelligence and ensures performance management is continuous.

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

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

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

Performance Summary

As of the 30th June 2022, our overall performance has shown that 4 of the 21 constitutional or mandated standards for our patients have been delivered during the quarter. Those standards that were not achieved are detailed by exception in the performance analysis section of this report.

Performance Analysis up to the end of Quarter 1, 2022/23

Indicator		Standard	DDCCG	NHSE&I
Referral to Treatment	18 weeks Referral to Treatment – Elective Surgery	92%	61.7%	62.5%
	18 weeks Referral to Treatment – 52+ week wait	0	17656	1010490
Diagnostic waits	Diagnostic test waiting more than six weeks from referral	1%	37.7%	27.3%
A&E waits	A&E less than four hours	95%	71.78%	74.93%
Cancer waits less than 14-days	Urgent GP referral to first outpatient appointment	93%	83.2%	80.1%
	Urgent GP referral to first outpatient appointment (breast symptoms)	93%	80.3%	67.1%
28-Day FDS	Diagnosis or decision to treat within 28-days of Urgent GP, Breast Symptomatic or screening referral.	75%	72.1%	70.7%
Cancer waits less than 31-days	Diagnosis to first definitive treatment for all cancers	96%	87.8%	92.1%
	Subsequent surgery within 31-days of decision to treat	94%	73.2%	81.4%
	Subsequent drugs treatment within 31-days of decision to treat	98%	97.6%	98.0%
	Subsequent radiotherapy treatment within 31-days of decision to treat	94%	85.8%	91.6%
Cancer waits less than 62-days	Urgent GP referral to first definitive treatment for cancer	85%	56.0%	62.1%
	NHS screening service to first definitive treatment for all cancers	90%	47.6%	69.5%
	104+ days wait for first treatment	0	101	4555
Mental Health	CPA seven-days follow-up (Retired Dataset)	95%	N/A	N/A
	IAPT access (May 2022)	25.2%	7.48%	–
	IAPT recovery (May 2022)	50%	52.3%	50.0%
	IAPT waiting times (six weeks) (May 2022)	75%	69.7%	88.9%
	IAPT waiting times (18 weeks) (May 2022)	95%	99.8%	98.5%
	Early Intervention in Psychosis – completed	60%	66.7%	68.5%
	Early Intervention in Psychosis – wait <2weeks	60%	40.0%	27.7%
	Dementia diagnosis	67%	62.7%	61.9%

Table 1 – CCG performance against constitutional or mandated standards as at the 30th June 2022

2022/23 Performance Exceptions

Referral to Treatment Time (18 weeks)

At the end of Quarter 1 (Q1) 2022/23, 61.7% of CCG patients on the incomplete pathways list had been waiting less than 18 weeks for their treatment. This was a slight reduction on the figure at the end of 2021/22 which was 65.3%. The number of CCG patients on the incomplete pathways list at the end of March 2022 was 100,552 and by the end of June 2022 this had increased to 109,267.

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

Patients waiting more than 52 weeks for treatment

At the end of March 2022, there were 5,269 CCG patients who had been waiting more than 52 weeks for their treatment; with the largest number on the Trauma and Orthopaedic waiting list. By the end of June 2022 this had increased to 6,214. The majority of these patients are on the waiting list of UHDBFT and CRHFT, but 1,409 are waiting for treatment at various Trusts around the country.

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

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

Diagnostics

This standard has not been met throughout the quarter. The lifting of some of the control regulations has enabled more activity to take place. As with other standards, there has been less focus on actual performance but more on increasing activity to the levels undertaken during 2019/20, which has been difficult for some of the diagnostic tests.

At the end of March 2022, the CCG had 28,867 patients awaiting a diagnostic test. At the end of June 2022 this had increased slightly to 29,361.

In March 2022, 35% of patients had been waiting more than six weeks for their diagnostic procedure, at the end June 2022 this had worsened to 37.7%. The standard is less than 1% of patients should wait more than six weeks. Restoration of diagnostic activity is part of the 2022/23 Operational Plan whereby all Trusts are required to recover their activity to 120% of the 2019/20 level of activity.

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

The majority of Derby and Derbyshire patients attend UHDBFT and CRHFT for their emergency needs. During 2021/22 the volume of attendances had increased and performance for Q1 was 72.1%. This is despite the establishment of co-located Urgent Treatment Centres (UTCs) at the acute Trusts to treat more minor cases, with the number of streamed patients increasing by 188% at CRHFT and by 222% at UHDBFT (Q1 2022/23 compared to Q1 2019/20).

Along with the rise in attendances, the Accident and Emergency departments are still divided according to whether patients are Covid-19 symptomatic or not, ensuring safety but meaning less flexibility in how the spaces could be used. Children's attendances have significantly increased due to rises in cases of suspected respiratory syncytial virus and bronchiectasis. The biggest factor affecting other patient flow occurred at the opposite end of the patient pathway, with severe shortages in social care packages of care leading to long delays in patient discharge.

12 Hour Trolley Breaches

The NHS has a zero target for 12-hour trolley waits (12 hours from decision to admit to being moved to a bed). There were 999 breaches reported during Q1, with 22 taking place at CRHFT and 977 taking place at Royal Derby Hospital (RDH). Not all of these patients were Derbyshire patients.

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

- 964 RDH breaches were due to patients awaiting a bed on the Medical Assessment Unit. This area is also divided according to whether patients are Covid-19 symptomatic or not (limiting space flexibility);
- 13 RDH patients were awaiting a mental health bed elsewhere. At the RDH, these patients are cared for in a bedded area away from the ED, even though they are still kept on ED systems; and
- 22 of the CRHFT delays were due to medical bed availability.

Cancer

Despite the CCG not achieving the overall performance standards for cancers, the performance has varied over the last three months. Breast referrals, both Two-week-wait (2WW) and symptomatic, have now reduced back to more manageable levels and performance has improved. Breast pain clinics were introduced in June 2021 in an effort to divert some patients to those clinics to increase capacity in the other clinics. Although numbers were small at the outset, these have continued to increase and is recognised nationally. However, 2WW referrals for cancer treatment continue to increase nationally and the CCG performance suffered as a result.

28 Day Faster Diagnosis

The CCG did not meet this standard in Q1, although being above the national performance. The number of referrals is impacting on the Trusts' ability to diagnose/rule out cancer within 28-days.

There continues to be a significant challenge to deliver the 85% performance for 62-day treatment, both locally and nationally. As numbers referred have increased, this has resulted in more patients being tracked and going through the cancer pathway. As a CCG this standard has not been met in Q1, at 56%. The national performance was 62.1%, which shows that this is an issue for the whole country.

Early Diagnosis of Cancer

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

Cancer screening programmes

Due to the Covid-19 pandemic, there has been some delays in delivering screening programmes. The cervical and bowel screening programmes have been fully restored in Derbyshire and waiting times are in line with national standards. The bowel screening programme is now being extended to a wider age range enabling more bowel cancers to be picked up at an earlier stage. Breast cancer screening is still recovering and is not yet fully restored, and we are working closely with NHSE&I to reduce the backlog.

Mixed Sex Accommodation

Providers of NHS funded care are expected to have a zero-tolerance approach to mixed-sex accommodation, except where it is in the overall best interest of all patients affected. A mixed sex breach refers to all patients in sleeping accommodation who have been admitted to hospital.

The mixed sex accommodation data was not captured throughout the pandemic, however the collection of data commenced again in October 2021 and the CCG has had 21 breaches of this standard. The Trusts provide our Quality Team with a report for the breaches detailing the circumstances and actions taken.

Planned Care

Outpatients

As a result of the ongoing pandemic and changes in clinical practice, the outpatients programme has been reviewed and redesigned to meet the changing needs of our population.

We are continuing to work with providers to develop digital opportunities for patients to have more control over their care. This will be through self-help resources and/or digital resources including wider roll-out of patient-initiated follow-ups allowing patients to access clinical teams as and when their condition might need support from a specialist.

Advice and Guidance

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

Advice and guidance continues to be provided across the Electronic Referral System and Consultant Connect Platforms through a variety of non-face-to-face methods including calls, messages and photos to support decision-makers to make the most clinically appropriate referrals.

Since there have been a significant number of changes over the last two years, a review of all advice and guidance in the Derbyshire system has commenced with a view to ensuring that this will be offered in all specialties (where clinically appropriate), optimising use of different approaches to support clinical decision-making.

Teledermatology

The continuation of teledermatology advice and guidance services has continued, sharing images of lesions and rashes (excluding suspected cancer). The rapid access to specialist advice and guidance continues to support Primary Care clinicians to care for their patients in the community, avoiding unnecessary hospital referrals and contributing to recovery plans. During Q1 of 2022/23, there were 1,160 requests for dermatology advice and guidance via the Consultant Connect app. Of these, 573 (51%) avoided the need for referral to hospital (either did not need to be referred, were offered treatment advice and/or seen within a community service) and 412 (36%) were recommended for referral. For the requests that were recommended for referral, 184 requests (45%) were recommended for cancer 2WW referrals, with the remainder evenly split between routine and urgent referral recommendations.

The dermatoscope funding secured in February 2021 has enabled 84 practices to be provided with high quality dermatoscopes and basic dermatoscope training for a lead GP in each practice, supported by online interactive consultant-led mentoring sessions using images from participating General Practices to further develop knowledge of dermatology, with 1:1 mentoring available from local specialist GPs.

Patient initiated follow-ups

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

Clinical Specialties

A number of Expert Advisory Forums (EAFs) have met regularly to progress clinically-led redesign to support ongoing restoration and recovery of services. There are currently EAFs for the following specialties:

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

The following pages highlight examples of some of the work undertaken up to the 30th June 2022.

Gynaecology

The CRHFT Women's Health Physiotherapy Team have implemented a Ring Pessary clinic which is currently receiving referrals from within the Trust with plans to expand the service to GP referral once data has been reviewed. Menopause clinics are now in place at both Trusts. The EAF is finalising the development and review of a number of clinical pathways, including polycystic ovarian syndrome, heavy menstrual bleeding, post-menopausal bleeding, pelvic pain, and continence.

Dermatology

In addition to the work around teledermatology, both core local NHS provider Trusts have trialled new models using the Electronic Referral Service advice and guidance route for referring patients into the service. This route allows Primary Care to request advice on patient skin conditions and for the request to be converted to a referral when appropriate. In addition, the model supports two-way communication while the patient is on the waiting list. This has been embedded as business as usual at UHDBFT, with the CRHFT trial due to end in August 2022. The Dermatology EAF is well aligned to the National Dermatology Roadmap and continues to explore additional innovation to support patients and the service.

Urology

Work has continued to address the current challenges around the number of patients waiting to be seen and explore a range of options, including:

Community Urology Model	This is in the early planning stages of development and would include clinics to address flow rate, bladder/haematuria, urinary tract infections, erectile dysfunction and testicular and penile pain.
Prostate-Specific Antigen Testing	Implementation of new NICE guidelines.
Consultant Connect	This has enabled a change in approach at CRHFT where they have implemented Consultant of the Day, running 8am-5pm, Monday to Friday, which has enabled emergency cases to be prioritised where referrals are reviewed daily as well as improving expedited discharges. Patients are also seen face-to-face on the Surgical Assessment Unit. UHDBFT has been using Consultant Connect for some time to support patient referrals when further advice and guidance is required prior to a decision being made.
Updates to clinical pathways	Haematospermia, urinary tract infections in women and testicular pain.
Referral Assessment System and Clinical Assessment Service	As part of a review of the effectiveness of the new Referral Assessment System, a review of urology referrals through the Referral Assessment Service and direct 2WW referrals has been completed. Due to restrictions in place following Covid-19 guidance, there was a reduction of approximately 27% for all referral types during 2020/21, compared to 2019/20. Support was given to clinicians when referring urology patients to CRHFT and UHDBFT through a new referral assessment service and the already implemented clinical assessment service (rolled out in Derby). The aim of these services is to provide advice and guidance to ensure the patient is referred to the right service and reduce repeated conversations on the best treatment plan.

Ophthalmology

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

Work has continued on the following three transformation projects in ophthalmology:

1	Moving post-operative cataracts patient check-ups out of Secondary Care and into community optometrists for low risk, non-complex patients – this project went live on the 25th April 2022 and as cataract surgery numbers increase at the two acute Trusts the numbers of patients benefitting from this are also increasing.
2	Moving the monitoring of stable glaucoma patients out of Secondary Care and into community optometrists – this is due to go-live in phases starting in September 2022.
3	Implementing a virtual ophthalmology triage service trial in the south of the area – the trial went live on the 8th March 2022 and numbers of referrals are gradually increasing as more optometrists and General Practices refer into the service.

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

Additional capacity was also secured from three independent sector providers of cataract services (Derby city, High Peak and Chesterfield areas) to continue to support the recovery of cataract services across the area due to the impact of the Covid-19 pandemic on Secondary Care services. For 2022/23 additional transformation projects are also in progress as follows:

Patient-initiated follow-up for ophthalmology	A project managed by CRHFT.
Improving the process for registering patient with sight loss	Options are being investigated to speed up this process and provide support for patients whilst they are in the process of being registered.
Diagnostic hubs for ophthalmology	Aims to scope out the requirements going forward for Derby and 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 musculoskeletal system. Ageing, injuries, lifestyle and disease can cause pain and limit movement.

MSK conditions account for 30% of General Practice consultations in England. Low back and neck pain are the greatest cause of years lost to disability, with chronic joint pain or osteoarthritis affecting more than 8.75 million people in the UK.

Funding has been secured to support the development of digital solutions for patients and providers of MSK services in Derbyshire. Following a robust evaluation process, Getubetter, a digital MSK Platform, has been procured and will be made available to patients, General Practice and providers of MSK services over the next few months. The platform will support people with new and ongoing MSK conditions by providing lots of useful information to help people either whilst they are waiting to be seen, recovering following surgery or to manage an ongoing condition.

The digital MSK funding is also being used to engage with patients and clinicians to ensure the platform is accessible to as many patients as possible. This means that the platform will be changed to meet the needs of people in Derbyshire specifically.

We are also working with people from hospital Trusts to identify the best ways to use the money we have received from NHSE&I to support people on MSK waiting lists for hospital appointments, tests or treatment. We expect to be setting up ways to support people on waiting lists by October 2022. This support will include useful information and exercises directing people to additional help and trying to prevent unnecessary medical treatment where appropriate.

Physiotherapy

A suite of self-management advice and information is made available to patients to enable them to manage their MSK conditions while waiting for treatment. Patients who have had their appointment cancelled have been provided with the link to the site to support them during their extended waiting times.

Integrated Community Care

During Q1, the Joint and Community Commissioning Team continued to focus on working collaboratively with health and social care service providers, voluntary and independent partners to develop strong integrated community services across Derbyshire. Transformation work has been targeted at projects which will enable the health and social care system to operate as effectively as possible in extremely challenging circumstances.

Covid-19 Support and Recovery Projects

The projects below illustrate our continued response to the Covid-19 pandemic:

Care homes support	Continued coordination and support to care homes across Derby and Derbyshire throughout the pandemic to ensure ongoing access to training and support. Building opportunities for care home staff to access support for mental wellbeing and to be part of a collaborative response across Derby and Derbyshire.
Local Resilience Forum Community Response and Recovery Cells	Strengthening a joint approach among partner organisations in mitigating the impact of the pandemic in communities through the support of community hubs and partner forums.
Enhanced support for patients with delirium and dementia	Continued support to patients with delirium and dementia to ensure that, as far as possible, they can be cared for away from hospital settings, either in their own home or in a care home.
Discharge to Assess	Building a strong, collaborative discharge to assess model which enables and supports Derbyshire people to be discharged from our two acute hospital Trusts, community providers and from out-of-area hospitals. Together, with partner organisations, we have developed more than 70 temporary beds across residential and nursing settings and ensured that the commissioned services have been able to deliver even in the most difficult of circumstances. We have maximised our packages of care to discharge people home as quickly as possible.

Transformation Projects

We have focused on leading and supporting the projects and initiatives described below, which were identified as being most useful to the overall, longer-term response to the Covid-19 pandemic.

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 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;
- piloting a 'palliative care urgent response service' to ensure that patients wishing to die at home have access to support, including pain management, within two hours;
- modelling the required levels of care at home, inpatient beds and community nursing capacity required for Derbyshire's population.

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 CCG is committed to engaging with the sector in the development of community-focused services and supporting nationally promoted initiatives such as development of VCSE leadership roles.

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

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

VCSE organisations have played an essential role throughout the Covid-19 pandemic, working together with the CCG and other partners to ensure that people receive local help. This included supporting the reduction of food poverty; providing emotional support to help reduce the likelihood of emerging mental health problems; delivering prescriptions to people who are shielding and isolating; and supporting the NHS vaccine programme.

Social Prescribing

Social prescribing is accessed through General Practices and connects people to community services and activities that can help them take steps towards their health and wellbeing goals. Some of the link workers, while connecting with the General Practice, are hosted by a local voluntary sector organisation and are a great example of working in partnership. Since last year, the number of social prescribing link workers in each PCN has increased from 30 to more than 50 workers. Several collaborations have been set up with the VCSE sector, including developing a young person's link worker, and MSK link workers. Whilst these new roles are not commissioned by the CCG, we have taken an active involvement in supporting

PCNs to make the most of the opportunities they present. We established the Social Prescribing Advisory Group, which brings key stakeholders together on a regular basis, to facilitate a coordinated, joined-up approach. The group provides a forum for link workers and promotes collaboration with the wider community including the Local Area Coordination network and community wellbeing coaches.

In March 2022, the Social Prescribing Advisory Group oversaw a successful tender for a social prescribing platform which will allow all link workers, GPs and partners to manage caseloads, record outcomes and performance data, and share wider marketplace intelligence in one place. It is a proof-of-concept project that will evaluate and test the platform during 2022/23.

In addition, the Social Prescribing Advisory Group is overseeing the second year of a county/city-wide cross-sector 'test and learn' project called 'Greenspring' which has secured funding of £500k over two years. To date, the project has tested several green interventions for people recovering from/living with mental ill health and will be further testing across each place during 2022/23. The project delivery started in April 2021 and will run until March 2023.

Community Equipment

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

Urgent Care

The JUCD system continues to be under significant pressure due to post Covid-19 demand and ongoing operational challenges. Capacity overall continues to be affected by ongoing staff shortages and sickness. The System Operational Resilience Group meets on a weekly basis to support system partners to manage this, with a particular focus on patient flow in and out of hospital.

Key focus areas to support the system includes supporting patients to access care in the right place first time and maintaining strong links between service providers. Our main aims are to improve access to urgent care services and a summary is shown below.

Transformation

Meetings with service providers continued regularly to deliver the Urgent Care Transformation Programme, and the Accident and Emergency Delivery Board continued to meet virtually to discuss urgent, emergency and critical care. Transformation projects restarted in March 2022 and a monthly Transformation Delivery Group meeting was established. This forum discusses all the system transformation projects which are highlighted below.

Operational Support

The operational team comprised a series of significant events during Q1, which included:

- system-wide planning to assure operational output before, during and after the Queen's Platinum Jubilee extended Bank Holiday period;
- collaborative work with the Emergency Preparedness, Resilience, and Response Team ahead of the CCG's transition to an ICB construct and associated Category 1 responder status; and
- the organisation and hosting of an Urgent, Emergency, and Critical Care Team summit.

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

Efforts to decompress the EDs through improved ambulance handover times and expeditious discharges continued during the period; the approval to establish a hospital/ambulance liaison role and the pursuit of a 100-day discharge programme are but two of the initiatives established to meet challenges.

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.

Same Day Emergency Care

Same Day Emergency Care continued to be maximised across the system and organisations worked collaboratively to continually improve their Same Day Emergency Care service for patients. Several workshops have taken place to look at the current offer and further opportunities. A final workshop is organised for September 2022, which will prioritise direct referrals and generate actions to take forward. Same Day Emergency Care remains a priority and will be an ongoing focus for the system.

Urgent Treatment Centres

UTCs continue to provide valuable and locally accessible urgent care services to the Derbyshire population. Our UTC services are working towards achieving the new national standards which, for example, includes the use of digital technology to provide direct booking facilities for appointments. As an established ICS for Derbyshire, we are focused on working together with other Derbyshire health and care services to integrate our UTC services offer with those in Primary Care and the wider health community.

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

The integrated urgent care service specification was published on the 25th August 2017 outlining a national specification for the provision of an integrated 24/7 urgent care access, clinical advice and treatment service that incorporates NHS111 and out-of-hours services, called an Integrated Urgent Care Clinical Assessment Service.

An Integrated Urgent Care Clinical Assessment Service fundamentally changes the way patients access health services, allowing patients to receive a complete episode of care concluding with either advice, a prescription or a face-to-face appointment for further assessment/treatment.

The Derby and Derbyshire Clinical Assessment Service continues to provide another valuable locally accessible urgent care service via NHS111 as described above. The demand on 111 and 999 service continues to rise therefore work is going on to further expand the current clinical assessment service to become a Derby and Derbyshire Clinical Navigation Hub to support reducing pressures on ambulances services, ED and Primary Care which will achieve more positive outcomes for patients as well as the system.

Primary Care

Derbyshire's vision for Primary Care

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

1. all patients will have access to a General Practice-led multi-disciplinary team of community care professionals by 2024;
2. in Derbyshire, the share of NHS resources spent on Primary Care should increase (from 9% to 15%) within 10 years; and
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 30th June 2022 was 3,825, working a Full Time Equivalent (FTE) of 2,821.62. Within the workforce there are four main staff groups; these are:

General Practitioners	898 headcount (713.31 FTE)
General Practice Nursing	514 headcount (365.23 FTE)
Direct Patient Care (those other than GPs and Nurses who provide care to patients, e.g. Health Care Assistants, Physiotherapists, Pharmacists or Paramedics)	366 headcount (268.08 FTE)
Administration and Non-Clinical	2047 headcount (1475.00 FTE)

Table 2 – Primary Care Workforce staff group data as at the 30th June 2022

The General Practice workforce in Derbyshire is stable, with a slight increase in all four staffing groups over the past 12 months.

In terms of age profile, our workforce is comparable with other areas of the country. For our GP workforce, 39% are under the age of 40 and 15% over the age of 55. For our nursing workforce, 21% are under the age of 40 and 32% are over the age of 55. Alongside our retention and recruitment initiatives, we are collaboratively working with partners and stakeholders to develop a five-year workforce plan to share with General Practice.

It is important to note that the data above does not include staff recruited by PCNs under the ARRS. The scheme is available to PCNs via 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&I for salary and on-costs. As of the 30th June 2022, PCNs had recruited 290.92 FTEs under the scheme.

Extended Access

Following on from the General Practice Forward View, Extended Access has been included in 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 on weekday evenings, and weekend mornings, including bank holidays) for patients in Primary Care have been rolled out across Derby and Derbyshire and significantly increased access to Primary Care.

Throughout the pandemic, most hubs diverted capacity from within this service to support other areas where General Practices in their PCNs were seeing patients in local hubs with suspected Covid-19. This progressed to delivering the vaccination programme. For those hubs which have continued to provide longer opening hours, appointments have been undertaken via telephone triage and treatment, virtual appointments and face-to-face for those who need it most.

As of the 30th June 2022, General Practice in Derbyshire provided approximately 495,201 appointments, which is a 32,500 increase on June 2019 (a 2.7% decrease when corrected for working days). Most appointments were face-to-face (approximately 69%) and 41% were a same-day appointment. Any Extended Access appointments are additional to these statistics.

Primary Care Estates

The Primary Care Estates Strategy was approved by the Primary Care Commissioning Committee in November 2020, providing a framework for the development of the Primary Care estate across Derbyshire to 2025. The strategy identified 20 activities and work has commenced on the five highest priority actions, which will determine what is required for the estate. Feasibility studies have been undertaken in South East Derby, South West Derby, Mickleover and Mackworth, North East Derbyshire Southern and Swadlincote areas.

The South East Derby strategic work is primarily being taken forward through the development of an outline business case for a new system-owned building at Sinfin, one of six national pilot sites being supported by NHSE&I. The Mickleover and Mackworth feasibility study has progressed to two strategic outline cases, completed in December 2021, with discussions to follow around how the project proceeds to the outline business case stage. The South East Derby feasibility study is being taken forward by a piece of work to identify the potential to relocate some administrative functions and to convert existing practice space for clinical use. The draft report on the feasibility study for North East Derbyshire Southern was completed in March 2022 and is undergoing an internal review before being finalised. The Swadlincote feasibility study was finalised in March 2022 and will be extended in collaboration with NHS Staffordshire and Stoke-on-Trent ICB to provide a broader view of estates needs in the area.

Quality

Quality Assurance Visiting Programme

The Quality Assurance (QA) Visiting programme for General Practices are scheduled on a yearly 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 improvement in quality.

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

National Screening and Immunisation Programmes

During Q1 of 2022/23 the National Screening programmes continue their recovery and restoration plans in response to the Covid-19 pandemic:

Diabetic eye screening	High-risk patients and previous 'did not attends' continue to be invited for their screening. All patients with a previous R0M0 screen are being invited, within two years from their last screen. All patients will be invited by their service when they are due their screen.
Antenatal and new-born screening programme	Screening continued as normal.
Breast cancer screening programme	The Breast Cancer Screening programme remained open for screening. Services continued to be restored at CRHFT, UHDBFT, Sherwood Forest Hospitals NHS Foundation Trust and Nottingham University Hospitals NHS Trust. High-risk breast screening also continued.

Cervical screening programme	Screening and colposcopy clinics continued as normal.
Bowel cancer screening	Programme has restored the service, routine invitations and test kits are being sent, and additional precautions are being taken to ensure the pathway for colonoscopy is Covid-19 secure.
Abdominal aortic aneurysm	Programme has restored the service, primary screening and surveillance patients continue to be invited. Additional measures are in place where indicated to ensure attendance is Covid-19 secure.
National childhood immunisations schedule	Screening continued as normal.

General Practice Nursing

The CCG works closely with HED to support General Practice Nurses across membership practices. This has involved the development of the JUCD 'Our Primary Care Nursing Strategy' in 2021 which outlines the forward view for General Practice Nurses. To achieve these ambitions, a Practice Nurse Working Group and General Practice Workforce Steering Group were established. The aims of these groups were to:

- raise the profile of General Practice Nursing and promote General Practice in Derbyshire;
- extend leadership and educator roles;
- increase the number of pre-registration placements in General Practice;
- establish induction and preceptorship/new to practice programmes;
- improve access to return to practice programmes and support nurses who need to return to the NMC register;
- support access to educational programmes;
- increase access to clinical academic careers and advanced clinical practice programmes, including nurses working in advanced practice roles in General Practice;
- develop healthcare support worker, apprenticeship and nursing associate career pathways; and
- improve retention.

From these aims, the following achievements were made in 2021/22:

- increased student supervision and assessment transitioned General Practice Nurses by 49%;
- increased Trainee Nurse Associates by 83%;
- increased Pre-Registration Nurse placements by 16%;
- increased practices taking Pre-Registration Nurse placements by 17%; and
- increased newly qualified Nurses in General Practice by 27%.

Care Quality Commission inspections of Primary Care

Delivering high quality services in Primary Care is an important part of managing the health of Derbyshire's population. Every Derbyshire General Practice has been visited by the Care Quality Commission (CQC) and has received an inspection rating of either outstanding, good, requires improvement or inadequate. Table 3 identifies the ratings awarded to General Practices by the CQC for the reporting period up to the 30th June 2022:

Rating	Total General Practices
Outstanding	20
Good	89
Requires improvement	2
Inadequate	1

Table 3 – CQC ratings awarded to General Practices up to the 30th June 2022

CQC launched its strategy for 2021–2026 in May 2021. The new strategy combined learning and experience, and was developed with contributions from the public, service providers and partners. The regulation will now be more relevant to the way care is delivered, more flexible to manage risk and uncertainty, and will enable CQC to respond in a quicker and more proportionate way as the health and care environment continues to evolve. Further information can be found here[7].

Digital Development

The Digital Development Team supports the digitalisation of Primary Care and the corporate information technology (IT) requirements of the CCG. Most of this work is undertaken through the underlying General Practice IT and corporate IT contracts with NECS, which the team manages on behalf of the CCG and Primary Care. The team also supports a number of ICS-wide projects and programmes and acts as a conduit between the system digital teams and colleagues within Primary Care.

Focus on activity

For 2021/22 our main goals included:

- supporting the movement of some patient facing services from hospital providers into Primary Care sites and closer to the patient;
- introducing increased resilience across the clinical network infrastructure by upgrading General Practice connections;
- the procurement of additional virtual desktop services to allow Primary Care colleagues to quickly relocate to a non-NHS site in case of an emergency and still be able to access clinical systems and operate a number of services; and
- supporting the adoption of NHSmail and the Data Security and Protection Toolkit in care homes across Derbyshire to improve security of data and access to digital services.

[7] https://www.cqc.org.uk/about-us/our-strategy-plans/new-strategy-changing-world-health-social-care-cqcs-strategy-2021

System-wide working

The team continues to be involved in a number of Derbyshire-wide, regional and national groups across both Digital and Information Governance in support of national programmes and local priorities. The team is also heavily involved in working with social care and health partners across Derbyshire to develop the ICS; working to support true cross organisational working and supporting teams from multiple organisations in the delivery of patient services through Team Up Derbyshire and other integrated teams.

Working through system groups such as the ICS Design Authority, and working with colleagues across the county to understand how we could be more agile with working from other organisation's premises while still having access to core systems and applications.

Support for Third Party Organisations

The team continues to support the laptop and tablet devices that have been deployed into care homes to support video consultation with patients through to ordering of medication. This includes a rebuild of all the devices deployed through the Covid-19 pandemic to improve performance, make them easier to support remotely and provide basic user support for the devices.

The team has also commissioned a third-party consultancy to undertake a series of engagement sessions with our care homes to provide a baseline of their current digital capability and to pick up any barriers or constraints to adoption of digital services.

Digital First Primary Care

The team continues to ensure that General Practice have access to online consultation and video consultation systems as part of their patient triage and engagement tools and in line with contractual guidance. We are increasingly working with communities who historically would find it difficult to interact digitally with Primary Care to better understand their experiences to feed into wider system conversations around digital inclusion.

Strategic Clinical Conditions and Pathways

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

In each of these LTCs, outcomes have focused on improving the quality-of-care provision; addressing health inequalities; promoting local access to services; improving prevention support; recovering and restoring services following the pandemic; and targeting variances in the quality of clinical treatment and care. In addition, the team leads on key NHSE&I funded programmes that include tobacco dependency treatment, post-Covid-19 syndrome, virtual wards, and LTC Hubs.

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

Delivery highlights during Q1 of 2022/23 include:

Respiratory	
Quality assured diagnostic spirometry	Spirometry is one of the main investigations used for diagnosing respiratory diseases such as chronic obstructive pulmonary disease and asthma. To improve the quality of diagnostic spirometry a total of 179 General Practice staff are being trained to Association for Respiratory Technology and Physiology accredited status.
Spirometry (recovery and restoration)	At the height of the pandemic spirometry was paused in General Practice. To drive the recovery and restoration of the diagnostic, ongoing support is provided to both practices and PCNs. 50% of practices have now restarted and this figure continues to increase monthly.
Mobile spirometry	NHSE&I funding was received to provide a mobile spirometry unit to support catch up of the spirometry backlog. The mobile unit was sited and used at RDH for six weeks during May to June 2022. A total of 118 spirometry investigations and 28 FENO tests were performed, reducing their waiting list down by one third.
Pulmonary rehabilitation – (recovery and restoration)	NHSE&I funding that was received to support the recovery and restoration of the service led to a decrease in the waiting list. Additional NHSE&I funding has been sought to expand service provision and to develop a five-year plan for submission in August 2022.

Cardiovascular Disease	
Hypertension Case Finding and Prioritisation	A PCN prevalence data dashboard has been developed to measure programme progression and to support the identification of high-risk patients who are not already on the practice hypertension register. Nominated PCNs are working with the East Midlands Academic Health Science Network to utilise risk stratification tools that support the prioritisation of hypertensive patients.
Cardiovascular disease prevention	NHSE&I funding is to be utilised to develop a plan to work alongside Public Health England to extend on the role of existing health improvement workers, to prioritise blood pressure monitoring within communities where a low hypertension prevalence rate exists. There will be engagement with PCN leads, local pharmacies and General Practices to support this programme.
Familial Hypercholesteremia Service	An East Midlands Familial Hypercholesteremia (FH) service has now been given the go ahead from the NHSE&I Regional FH Steering Group. One FH nurse will be recruited within JUCD to lead on FH testing of high-risk patients and, as FH is a heredity condition, also cascade testing of family members.
Cardiac rehabilitation	Cardiac rehabilitation for heart failure patients is not currently commissioned in Derbyshire and only a small number of heart failure referrals are made for cardiac rehabilitation. NHSE&I funding has been secured to enhance the existing cardiac rehabilitation provision for heart failure patients. Transformation of the cardiac rehabilitation services across Derbyshire continues. The menu of options is being extended further to include phase IV cardiac rehabilitation referrals onto Derby County Football Community Trust, where a specific pathway has been developed to support patients.
Out of hospital cardiac arrest	JUCD have worked with EMAS to identify localities with the greatest need of community-based defibrillators and community first responders. Localities were based on deprivation, hypertension prevalence, and high conveyances for cardiovascular disease-related conditions.
Clinical stewardship for heart failure	JUCD have been selected as one of two pilot sites. The programme will provide support and sponsorship from NHSE&I to help deliver on the triple aim for people with heart failure: • improve the health and wellbeing of the population served; • improve the quality of healthcare; and • use NHS resources sustainably and efficiently.
Remote monitoring for pacemakers	CRHFT secured funding as part of the cardiology and cardiac surgery elective care NHSE&I funding to support the introduction of a six-month pilot programme to provide remote monitoring capability for existing and new patients fitted with a pacemaker. This provides service equity across Derbyshire as UHDB already provide this service.

Gastroenterology	
Inflammatory bowel disease remote monitoring	Funded by NHSX, both acute Trusts have implemented a home testing solution for inflammatory bowel disease to allow patients to measure disease activity, effectiveness of treatments, as well as predicting relapses.
Diabetes	
Derbyshire footcare pathway	The Derbyshire footcare pathway is being developed and implemented, with an aim of service equity and standardisation across all providers. The Primary Care pathway has been agreed for implementation and the community and Secondary Care pathway is in development. Silhouette software to support wound management has been upgraded.
Diabetes specific psychology support	A proposal to implement a diabetes specialist psychology service to support complex patients across the system has been developed.
Intermittent and continual glucose monitoring devices	Updated NICE guidance, advises an increase in the use of intermittent and continual glucose monitoring for patients living with type 1 or type 2 diabetes. A system-wide task and finish group has been formed to develop a business case and implementation plan.
Diabetes education portal-single point of access for clinicians	Additional investment has been made with HED to develop the diabetes education portal; optimising education offers for clinicians to upskill the workforce in General Practice.
Children and young adults service	A successful bid was submitted to NHSE&I resulting in additional funds to support service improvements for this cohort, providing increased access to clinicians to better manage their diabetes and reduce the risk of further complications.
National Diabetes Prevention Programme	NHSE&I have approved a gestational diabetes referral pathway to enhance access onto the National Diabetes Prevention Programme. JUCD have been recognised as the first system in England to implement this pathway.
Low Calorie Diet Programme	Commenced implementation of a revised delivery plan that aims to increase referrals to the programme in line with national targets.
Stroke	
Stroke pathway review	Work has continued with providers and East Midlands Integrated Stroke Network to deliver service redesign improvements in line with the National Stroke Model, with a particular emphasis on rehabilitation and hyper acute pathways.

NHSE&I/System Programmes

Long-Covid-19 (post-Covid-19 syndrome)	
Long-Covid-19 (post-Covid-19 syndrome) service	Two rehabilitation hubs were launched in April 2022 to provide patients with vocational, chronic fatigue and breathlessness rehabilitation. Health psychology support is also embedded within the hubs. The assessment and rehabilitation services have now merged to create one Long-Covid-19 service and pathway for patients. Extensive work has been done on the development of a virtual offering for patients, alongside specific 1-2-1 rehabilitation support where appropriate.
Tobacco Dependency Treatment Services	
Tobacco Dependency Programme	Tobacco Dependency Champions and Advisors have been successfully recruited to support the phased rollout of the programme. Further recruitment will be established as the phased roll-out continues across UHDBFT, CRHFT and DHcFT. This service will be offered to all inpatients, including mental health and maternity patients and their partners. All Trusts are to have full roll-out by March 2024.
Long Term Conditions Hub	
Long Term Conditions Hub Project	PCNs have been identified to deliver proof of concept to increase LTC annual review activity; targeting patients with comorbidities and prioritising those in most need. Patients are to be provided with a personalised care plan, based on a holistic review of all conditions at one point in time.
Virtual Wards	
Virtual Wards two-year plan	Virtual Wards support patients who would otherwise be in hospital to receive the acute care, monitoring, and treatment they need in their own home. A detailed planning submission was submitted to NHSE&I in June 2022 detailing how the ICB will develop and implement a number of Virtual Wards across different specialties with Derbyshire providers over the next two years.

Medicines, Prescribing and Pharmacy

The Derbyshire Medicines Management and Clinical Policies Team works with member practices and local providers to enable the best health outcomes through the best use of medicines. Working with stakeholders across the system, four key work themes were identified:

Health outcome	Key work theme
Improving experience of care	High quality and safe use of medicines
Improving the health of the population	Delivering effective interventions
Reducing the per capita cost of healthcare	Value use of medicines
Improving staff experience and resilience	Skilled and agile pharmacy workforce

The Covid-19 pandemic continued to have a significant impact on the planned work of the team during 2022/23. The team prioritised activity in line with the CCG business continuity levels in order to focus on statutory functions and Covid-19 pandemic support across the system, as well as the restoration and recovery of other functions and services.

Covid-19 response

Continued support to the system-wide Covid-19 effort was provided for the vaccination programme and restoration and recovery work; this included:

- staff re-deployment (clinical and non-clinical) within vaccination sites including Midland House Vaccination Centre, School Age Immunisation Service, the Covid-19 Vaccination Allergy Service and acute providers to support essential medicines-related work;
- Covid-19 vaccination incident management and investigation;
- supporting the development of the Covid-19 Antiviral Service;
- providing assurance visits and pharmacy sign-off visits for all of the PCN Local Vaccination Sites as well as extension of the programme to additional cohorts, enhanced pop-up sites and roving sites as necessary within Derbyshire;
- worked with the Local Pharmaceutical Committee to support NHSE&I in community pharmacy site selection and assurance visits;
- providing pharmaceutical support to all vaccination pillars, including community pharmacy;
- management of pharmaceutical aspects of Covid-19 vaccine mutual aid requests (seven-days-a-week);
- support to General Practice;
- providing pharmaceutical support to system inequalities work; and

- maintaining, enhancing and expanding the Medicines Order Line to ensure all patients especially those considered more vulnerable can order medicines safely and efficiently.

Derbyshire Medicines Management and Clinical Policies Team functions

In addition to the Covid-19 response, the team continued to deliver the functions below, including statutory functions.

Clinical Policies Team

Managing individual funding requests

Managing individual funding requests as a statutory function continued and although we saw a reduction in the number of referrals being processed, Individual Funding Requests Panels continued to be triaged by a screening panel, with only those requests which meet the Individual Funding Requests policy definition of 'rarity' or 'clinical exceptionality' being forwarded to the Individual Funding Requests Panel for consideration. Individual Funding Requests Panels are held monthly when required and decisions are made within the agreed timescales.

Clinical Policies Advisory Group

Following a recent review, and in light of the successful Covid-19 vaccination programme, it was agreed that Clinical Policies Advisory Group meetings, would be held on a bi-monthly basis via MS Teams, for items that require an in-depth discussion. For those monthly meetings which fall in between we continued to circulate routine papers for virtual agreement. This arrangement will continue to be monitored in accordance with the CCG's Business Continuity levels and the Covid-19 pandemic. The Clinical Policies Advisory Group has continued to review and agree several new and updated clinical policies.

Joint Area Prescribing Committee/Guideline Group

The Joint Area Prescribing Committee has continued to be flexible in how it undertakes its duties in response to the changing environment and demands of Covid-19. It has operated as a bi-monthly virtual meeting and with email correspondence in between. The Guideline Group has continued to operate as monthly virtual attended meetings.

The Clinical Policies Team continued to commit to attending and supporting the Secondary Care drugs and therapeutic meetings with provider Trusts.

High-Cost Drugs – CCG-Commissioned

At the beginning of the pandemic, all CCG-commissioned High-Cost Drugs (HCD) were taken into a block contract. Monthly finance meetings with providers were stood down. However, the Clinical Policies Team continued to monitor HCD expenditure, answering HCD commissioning queries, horizon scanning for new drugs in 2022/23 and has restarted the HCD finance meetings on a quarterly basis. Furthermore, the Clinical Policies Team continues to monitor and adopt new NICE technology appraisals, approving CCG-commissioning policies and seeking assurance and compliance through Blueteq.

Medicines Optimisation and Delivery Team

Derbyshire Prescribing Group

The Derbyshire Prescribing Group continued to meet routinely during Q1 to ensure that the work to support the Derbyshire system to improve the safety and quality of prescribing was delivered.

Prescribing Leads Forums are held periodically to update General Practices on key work relating to medicines safety, quality and cost-effective prescribing.

Primary Care Prescribing Support

The Medicines Management Team has continued to focus on the roll-out and training for the use of Eclipse Live software to support the delivery of prescribing quality, safety and cost improvements and to help PCNs with the PCN Direct Enhanced Services and Investment and Impact Fund contractual requirements. Support has been given during the transfer of Glossop practices to Derbyshire with consideration for medicines management and prescribing implications which will continue into the next year. Support has also included:

- a review and update of Optimise Rx profiles (Systmone and EMIS formularies) and sharing the latter through a memorandum of understanding with UHDBFT and DCHSFT;
- developing and creating clinical system searches for safety recalls and quality improvement projects;
- developing relationships and working arrangements with PCN and practice-based teams to share resources, including the delivery of training packages for newly employed practice staff and PCN pharmacy teams which were very well received; and
- rolling out and providing education and training for Proxy ordering of prescriptions for care home patients to enable prescription requests to be handled more efficiently without the need to access each individual patients clinical record.

Greener NHS

The work of the Medicines Management Team has focused on improving the environmental impact of inhaler prescribing. There have been several strands to this work, including hosting awareness, training and education sessions. More information on this can be found on page 76.

Training and education

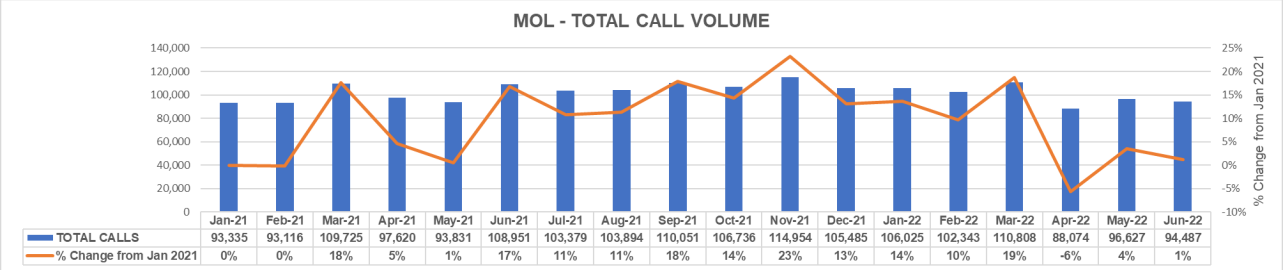
Regular education sessions have taken which are available to all pharmacy teams (CCG, PCN and practice-employed) across the CCG. The aim is to roll out some sessions to General Practice (GPs, nurses and associated health care practitioners) where appropriate.

Sessions offered during Q1 have included:

- Proxy ordering of prescriptions for care home patients; and
- new PCN pharmacy team introductory training and orientation for medicines optimisation in Derbyshire.

Medicines Order Line

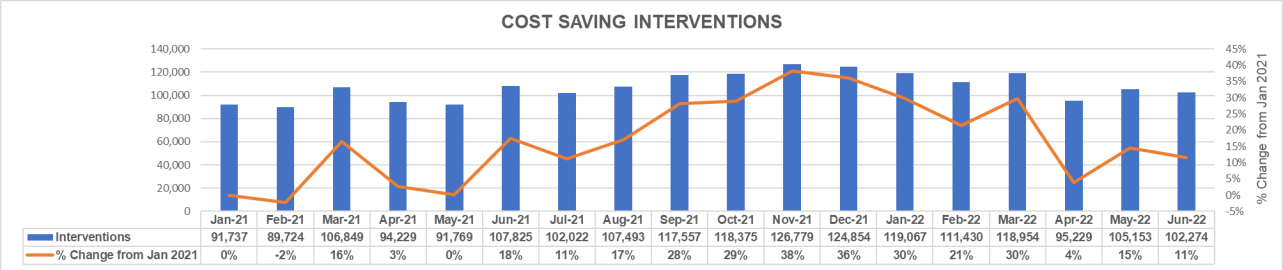
The start of 2021/22 saw the Medicines Order Line sustain high levels of patient demand, with continued growth delivered each quarter of the year. Patients from existing General Practices continued to utilise the service, while a concentrated effort was initiated to further increase stakeholder inclusion, through the continued roll-out of the service across Derbyshire. We saw a decline in total call volume from the 1st April 2022 due to staffing capacity however this is now starting to increase after successful recruitment campaigns.



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
TOTAL CALLS	93,335	93,116	109,725	97,620	93,831	108,951	103,379	103,894	110,051	106,736	114,954	105,485	106,025	102,343	110,808	88,074	96,627	94,487
% Change from Jan 2021	0%	0%	18%	5%	1%	17%	11%	11%	18%	14%	23%	13%	14%	10%	19%	-6%	4%	1%

Figure 1 – total call volume January 2021 to June 2022

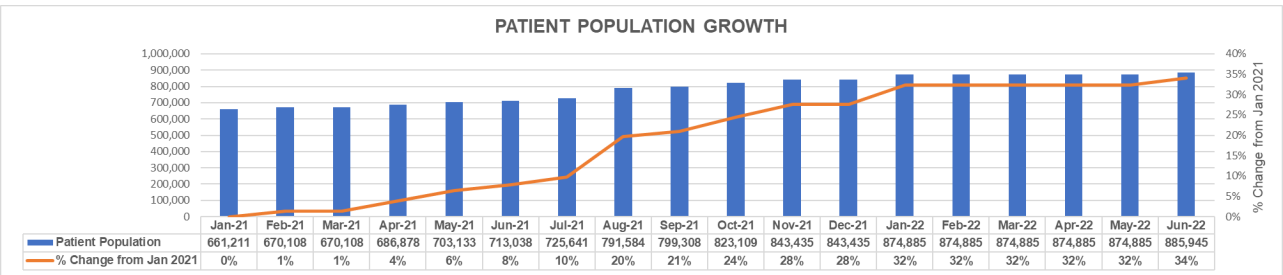
Cost saving intervention activity increased by 30% during the year, averaging 1.1 interventions made per call received to the service. This intervention rate has been sustained into Q1 of 2022/23.



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Interventions	91,737	89,724	106,849	94,229	91,769	107,825	102,022	107,493	117,557	118,375	126,779	124,854	119,067	111,430	118,954	95,229	105,153	102,274
% Change from Jan 2021	0%	-2%	16%	3%	0%	18%	11%	17%	28%	29%	38%	36%	30%	21%	30%	4%	15%	11%

Figure 2 – total cost interventions January 2021 to June 2022

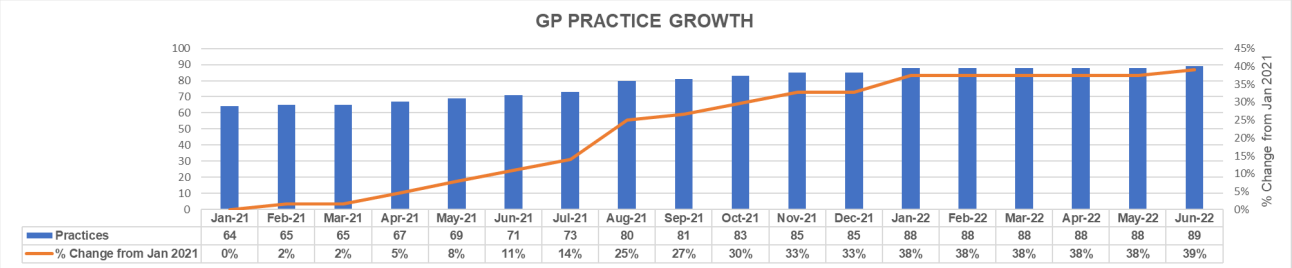
Patient inclusion significantly increased by 28% throughout the year, enabling the service to be accessible to a far wider proportion of Derbyshire patients, with continued expansion planned for the remainder of the year.



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Patient Population	661,211	670,108	670,108	686,878	703,133	713,038	725,641	791,584	799,308	823,109	843,435	843,435	874,885	874,885	874,885	874,885	874,885	885,945
% Change from Jan 2021	0%	1%	1%	4%	6%	8%	10%	20%	21%	24%	28%	28%	32%	32%	32%	32%	32%	34%

Figure 3 – patient population with access to the Medicines Order Line from January 2021 to June 2022

Support given to Primary Care continued to grow at a high rate with the addition of 25 General Practices utilising the service. This equates to system-wide coverage (including Glossop) of 76%. The remaining practices are either ineligible (non-electronic prescription service) or have chosen currently not to participate in the service, with remaining practices planning to join within this financial year.



	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Practices	64	65	65	67	69	71	73	80	81	83	85	85	88	88	88	88	88	89
% Change from Jan 2021	0%	2%	2%	5%	8%	11%	14%	25%	27%	30%	33%	33%	38%	38%	38%	38%	38%	39%

Figure 4 – General Practices utilising the Medicines Order Line from January 2021 to June 2022

Strategy, Assurance and RightCare Team

Integrated Pharmacy and Medicines Optimisation

Work continued to implement the Derbyshire-wide strategic plan with the ambition of integrating Pharmacy and Medicines Optimisation across the system, within Pharmacy services and wider, ensuring optimal use of medicines to reduce the avoidable and unjust differences in health outcomes for the population of Derby and Derbyshire. The integrated pharmacy and medicines optimisation workstream was recognised as one of the JUCD workstreams.

Controlled Drugs

The CCG supports NHSE&I with its statutory responsibility for controlled drugs oversight under a memorandum of understanding. During the pandemic some controlled drugs monitoring was paused due to business continuity levels. During Q1 of 2022/23 this monitoring was restarted. In addition, prescribing data for controlled drugs and drugs with dependence potential was circulated to practices highlighting variation in prescribing and thus promote safe prescribing of controlled drugs.

Medicines Safety

The Derbyshire Medicines Safety Network, a system-wide group comprising Medicines Safety Officers from all Derbyshire providers, met virtually during Q1 of 2022/23 with learning from local incidents shared and discussed. A system safety workplan was also agreed for implementation by the group.

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

Investigation and analysis of critical non-vaccine, medication-related incidents also continued during Q1 of 2022/23, including supporting General Practices and other providers to transition to the new learning from patient safety events reporting system which is due for completion by March 2023.

Antimicrobial Stewardship

Antimicrobial stewardship is key to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness. Prescribing data was circulated to practices during Q1 of 2022/23 to help us better understand volumes and variations in prescribing.

Implementation of the Derbyshire Antimicrobial Resistance Strategy continued during Q1 of 2022/23.

General Practice Community Pharmacist Consultation Service and Extended Care Services

NHSE&I continued to ask systems to support with NHSE&I nationally and regionally commissioned community pharmacy services, including the General Practice Community Pharmacist Consultation Service (GP-CPCS) and Extended Care Services. GP-CPCS supports the management of low acuity patients in alternative settings, supporting General Practice workload pressures. The team continued as member of the Midlands GP-CPCS Implementation Oversight Group and worked with the General Practice Commissioning Team, Local Pharmaceutical Committee, NHSE&I programme managers, PCNs and community pharmacies to promote and develop local plans for implementation, troubleshoot and monitor uptake. The team also reviewed new patient group directions as part of the increased roll out of the Extended Care Service and supported the implementation of the Discharge Medicines and Smoking Cessation Services.

Contracting and Procurement

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

Transfer of community pharmacy commissioning

The team continued to engage with NHSE&I on preparing for the transfer of community pharmacy commissioning from NHSE&I to the ICB, ready for April 2023. The team supported the Primary Care Team with engagement and feedback to NHSE&I.

Ambulance and 111 Commissioning

The East Midlands Coordinating Commissioning Team manages the Ambulance and NHS111 contracts with EMAS, and Derbyshire Health United Community Interest Company (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.

In Q1 of 2022/23, the team successfully implemented the 2022/23 Emergency Ambulance Service Contract with EMAS and is leading negotiations in relation to the Year 7 NHS111 contract with DHU commencing on 1st October 2022.

East Midlands Ambulance Service NHS Trust Performance

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

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

In Q1 of 2022/23 Trust performance against all six standards deteriorated which was a further deterioration in performance when compared to the same quarter in 2021/22.

When measuring the standard, the mean is used to calculate the average time in which a patients received a response and the 90th centile measures the time in which 9 out of 10 patients received a response to a 999 call. This position was replicated in all EMAS Divisions with the exception of Nottinghamshire which achieved the 90th Centile in Category 1 response (14 minutes and 57 seconds).

The performance position for Q1 of 2022/23 and 2021/22 are shown in Tables 4 and 5 below.

National Standards 2022/23				
EMAS	Category 1		Category 2	
	Mean	90th Centile	Mean	90th Centile
	2022/23	2022/23	2022/23	2022/23
National Standard	**00:07:00**	**00:15:00**	**00:18:00**	**00:40:00**
Quarter One	00:09:37	00:17:29	01:04:57	02:23:45
EMAS	Category 3		Category 4	
	90th Centile		90th Centile	
	2022/23		2022/23	
National Standard	**02:00:00**		**03:00:00**	
Quarter One	08:15:24		08:25:38	

Table 4 –Quarter 1 2022/23 national standards and actual response time

National Standards 2021/22				
EMAS	Category 1		Category 2	
	Mean	90th Centile	Mean	90th Centile
	2021/22	2021/22	2021/22	2021/22
National Standard	00:07:00	00:15:00	00:18:00	00:40:00
Quarter One	00:07:53	00:14:03	00:33:38	01:10:07
EMAS	Category 3		Category 4	
	90th Centile		90th Centile	
	2021/22		2021/22	
National Standard	02:00:00		03:00:00	
Quarter One	04:30:07		04:43:53	

Table 5 –Quarter 1 2021/22 national standards and actual response time

Nationally, Ambulance Trusts were struggling to meet performance standards, primarily linked with resource availability. Throughout 2021/22 and Q1 of 2022/23, an increase in the number of ambulance crews waiting to hand patients over to EDs had increased significantly, which resulted in delays in response times for patients waiting in the community. During Q1 there were 36,647 resource hours lost due to delays compared with 1,984 in Q1 of 2019/20.

As part of the contractual agreement reached with EMAS and the five ICB associate commissioners of the Emergency Ambulance Contract, all ICS's have provided improvement trajectories linked to operational plans that commit to a reduction in handover delays in excess of 60 minutes. Achieving this as a minimum would have a positive impact on performance, as well as quality and patient safety, but it remains dependent on multiple factors such as service delivery and resource availability across the whole health and social care system.

ICS's are committed to improving access to urgent care services including pharmacy provision, General Practice and NHS111 to reduce demand on emergency services. EMAS is working with systems to support the development and access to pathways that are alternative to direct conveyance to an ED, these include two-hour urgent community response services, Same Day Emergency Care, direct admission to specialities and virtual wards. ICSs have also made a commitment to reduce the number of delayed discharges and are working closely with local authority colleagues to increase system flow. Following approval of the business case for mental health funding, recruitment commenced for mental health practitioners to be based in the Emergency Operations Centre to provide support and advice to patients experiencing mental health illness.

As at the 30th June 2022 EMAS had seen an increase in the number of calls received when compared to 2021/22, however the number of actual calls remained below plan, which is demonstrated in Table 6 below.

EMAS		April 2022	May 2022	June 2022
Calls	Actual	106,366	104,878	110,424
	Plan	108,496	112,247	111,212
	Variance	-2.0%	-6.6%	-0.7%

Table 6 –call activity during Quarter 1 2022/23

A contributing factor linked with an increase in the number of calls is duplicate calls, and increasingly this relates to multiple calls being made by members of the public to enquire when an ambulance will arrive due to delays in response times described above. For comparison in Q1 of 2021/22, 20.4% of the total calls represented a duplicate call, rising to an average of 24.8% in Q1 of 2022/23.

Despite a deterioration in response time performance, there was an increase in non-ambulance system indicators such as see and treat, and hear and treat activity. This takes place with lower acuity patients who can be provided with advice over the telephone by clinical teams in the EMAS Emergency Operations Centre, or when an ambulance is dispatched, treatment can be provided by a crew on scene without a patient needing to be conveyed to an ED. This is a positive outcome for patients and reduces demand for and dispatch of an emergency ambulance.

Table 7 below demonstrates that the number of incidents (when a patient receives a face-to-face response or clinical assessment over the telephone) were lower than plan during Q1 of 2022/23.

EMAS		April 2022	May 2022	June 2022
Incidents	**Actual**	64,116	66,864	64,310
	Plan	67,295	70,238	70,158
	Variance	-4.7%	-4.8%	-8.3%

Table 7 –incidents activity in Quarter 1 2022/23

EMAS post-handover times remained above the 15-minute national standard during Q1 of 2022/23 when compared to Q1 of 2021/22.

Average Post-Hospital Handover Times	April 2022	May 2022	June 2022
Q1 2022/2023	0:20:10	0:21:16	0:21:05
Q1 2021/2022	0:19:57	0:20:08	0:20:37

Table 8 — average post-hospital handover times for Quarter 1 of 2022/23, compared to Quarter 1 of 2021/22

There were 23 serious incidents reported by EMAS in Q1 of 2022/23 compared with nine during the same period in 2021/22. A presentation will be made to the Clinical Quality Review Group in July 2022 to highlight the impact on patient safety of prolonged waits and to acknowledge that system measures are required to address all the contributory factors.

EMAS Emergency Operations Centre and headquarters were inspected by the CQC as part of the Leicester, Leicestershire and Rutland system urgent care pathway review. Immediate feedback from the inspection was positive.

NHS 111 (East Midlands) Performance

The NHS111 contract with DHU contains five KPIs and a further KPI associated with the validation of ambulances assessed to require a Category 3 response. Due to the original go-live date of the NHS111 contract with DHU being mid-financial year (October 2016), the quarterly performance reporting does not mirror the quarters in a financial year. Q1 of 2022/23 performance demonstrates Quarter 3 of the Year 6 contract.

Performance against the call handling KPIs can be summarised as:

- calls abandoned after 30 seconds was achieved, however when compared to the same period in 2021/22 this demonstrated a drop in performance;
- average call answer time was not achieved and had deteriorated compared to the same period in 2021/22; and
- both KPIs for calls triaged were achieved and the proportion of calls closed with advice given for patients to administer self-care saw an increase when compared to 2021/22.

The deterioration in performance related to a significant increase in demand for NHS111; generated by national adverting campaigns, an increase in staff absence and challenges in the recruitment of call handlers.

For context, the increase in demand and deterioration in performance was seen nationally, and DHU remained to be one of the best performing 111 providers in the country.

Calls abandoned after 30 seconds	**April 2022**	**May 2022**	**June 2022**
Actual	4.50%	1.90%	3.00%
Target	5%	5%	5%
Average call answer time	**April 2022**	**May 2022**	**June 2022**
Actual	00:01:44	00:00:39	00:00:59
Target	00:00:27	00:00:27	00:00:27
Of call triaged, proportion transferred to a clinician	**April 2022**	**May 2022**	**June 2022**
Actual	65.80%	65.50%	64.70%
Target	50%	50%	50%
Of call triaged, proportion closed with self-care within 111	**April 2022**	**May 2022**	**June 2022**
Actual	19.20%	18.40%	18.00%
Target	17%	17%	17%
Proportion of callers satisfied with their experience	**This data bi-annual measure last updated March 2022**		
Actual	87%		
Target	85%		

Table 9 –DHU NHS111 performance for Quarter 1 of 2022/23

Clinical Assessment Services and Emergency

In relation to validation of Category 3 Ambulances, DHU have validated more than plan, which is demonstrated in Table 10 below. However, when comparing year six performance to year five there was a reduction in the validations completed due to a combination of staff shortage and increased demand, which resulted in clinician support being redirected to respond to 'core' demand rather than ambulance validations. However, the number of clinical validations remained above the 50% target and the percentage which were downgraded remained positive.

Category 3 Validations	April 2022	May 2022	June 2022
Patients available for validation	14,329	14,485	14,301
Total clinically validated	9,967	10,605	10,692
% Clinically validated (target 50%)	69.6%	73.2%	74.8%

Table 10 – Category 3 validations for Quarter 1 of 2022/23

DHU were inspected by the CQC as part of the Leicester, Leicestershire and Rutland Urgent and Emergency Care System review. Initial feedback was very positive and it was acknowledged that DHU staffing is challenging due to continued turnover of call centre staff. DHU therefore undertook a wide range recruitment and put retention measures in place.

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.

Improvements made to the DOS have included the introduction of appointment bookings for patients at the ED following contact with NHS111; helping patients avoid lengthy waits in ED waiting rooms and supporting the management of demand for urgent care services, so flow can be managed with a planned response based on need, not patient expectation.

CRHFT ED and RDH ED continued to use a streaming and redirection tool linked to the DOS to help patients attending ED to carry out a self-triage so they are directed to the best service to receive the treatment they need. Both CRHFT and RDH also implemented 'Same Day Emergency Pathways' to direct patients straight to an appropriate service at the Trust to reduce the build-up of patients waiting in the ED department following contact with NHS111.

A tool used by health care professionals, described as Service Finder, takes a feed from the DOS to identify services for patients. This has been particularly helpful for ambulance crews on scene with patients. Work has been targeted at reviewing and improving the pathways used by EMAS to meet the requirements of the National Joint Ambulance Improvement Group and continues to be a focus of the work undertaken by the Regional DOS Lead who is based within the Coordinating Commissioning Team.

The national NHS Pathways (the clinical assessment tool used to direct patients to services) Team has significantly increased the number of pathways releases each year from 2 to 10.

This is to enable the DOS to be more resilient and responsive to essential changes during the Covid-19 pandemic. Two releases have been implemented during Q1 of 2022/23.

Mental Health

The CCG has been working in partnership developing a whole system approach to the delivery of the Mental Health Long Term Plan. We have continued to meet our commitment to increase mental health spending in proportion with our income.

Adult Mental Health

We have continued to work alongside a wide range of VCSE and statutory partners to design and deliver support for adults with mental health needs, to achieve NHSE&I Long Term Plan ambitions. Achievements and progress made in Q1 of 2022/23 included:

Community Mental Health	Transformation of community level support for adults with Serious Mental Illness (SMI) expanded across the High Peak and Derby City and is developing in Chesterfield, North East Derbyshire and Bolsover, and the Derbyshire Dales. The offer is called *Living Well Derbyshire* and in Derby City it is named *Derby Wellbeing*. Living Well will be phased across the rest of Derbyshire by 2024.
	Creating five multi-agency, community-level collaboratives, bringing key agencies and the voice of lived experience to improve pathways and improve outcomes and health equalities for people with SMI.
	Co-producing and co-designing the 'Living Well' model and Living Well Teams – integrated working with VCSE, Local Authorities and Health.
Inpatient Care	Further developing plans to eradicate dormitory style bedrooms and improve mental health inpatient facilities provided across Derbyshire to improve the environment and quality of services provided.
	Seeking to develop local provision of psychiatric intensive care services to reduce the need for people to travel out of area for specialist care.
	Developing plans to align our inpatient older people mental health services in one location in both Derby and Chesterfield.
Covid-19 response: staff wellbeing	Increasing access to talking therapies for frontline NHS staff working at RDH, CRHFT and community hospitals across Derbyshire. Two of the four talking therapy service providers are working in RDH and CRHFT to ensure staff can get rapid access to support when needed.

Reducing health inequalities	Increasing access to key services has included working closely with the Polish and Romanian communities in Derbyshire to raise awareness of talking therapies and building links with the four service providers. Some of the talking therapy service providers engaged with carers and carer organisations to increase access from older adults. Work is taking place to draw on evidence to look at equity of access and outcomes for some of our population. This included developing a better understanding of the needs of the deaf community around mental health, including barriers and gaps.
	A multi-agency pilot is underway to provide health coaching and the provision of personal fitness trackers to people with a SMI, to support their physical health outcomes.
Co-production and collaborative working	New ways of working alongside the local VCSE sector are being explored. For example, an 'open statement' has been circulated widely to communicate key priorities and to identify how organisations and providers can help to shape local delivery. This is leading to much greater engagement from local groups and organisations who are interested in delivery and collaborative working, for example in relation to crisis alternatives. An Alliance Partnership has been formed to bring together statutory, independent sector and voluntary sector partners around shared goals, to identify barriers and collaborate on future approaches.
	The Maternity and Neonatal Voices Partnership has resulted in valuable insights emerging from engagement with women who have experienced trauma or loss as a result of their maternity experience. Additional learning is being drawn from Experts by Experience from LGBTQ+ communities, the deaf community and by engaging with ethnic minority groups. This work is informing our new Maternal Mental Health Service, which commenced in Q1 of 2022/23.
Crisis alternatives development	Undertaking widespread engagement with local people, professionals, and groups and providers of services to explore what our model of crisis alternatives for people with urgent mental health care needs should look like. This work has led to a new service model for our Safe Haven offer in Derby where open access is incorporated, and has shaped our specification for out-of-hours mental health support within the community which is to be progressed via a tendering exercise within 2022/23.

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	Gaining agreement to implement a prototype 'crisis in reach' service which aims to prevent placement or family support breakdown and mitigate the risk of inpatient admission. The service will be available during 2022, 24/7 for an initial period of 19 weeks.
	Commencing 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. This role, a commitment of the Long-Term Plan, will initially focus on autistic children and young people and those with a learning disability who are inpatients or at risk of inpatient admission.
	Developing and gaining approval for an 'initial' strategic outline case which aims to identify and implement improvements to bedded inpatient care for autistic people and for people with a learning disability. The next phase in 2022/23 is to co-design a new clinical model of care which meets national guidance and the needs of local people.
	Focusing on the development of a more sophisticated understanding of the 'pathways to admission'. By working alongside partners, especially those in adult mental health, it is anticipated that better processes and procedures can be put in place that can prevent inpatient 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 'mini' Parent Carer Forums.
	Working alongside colleagues from DCHSFT and Derbyshire County Council to restart the review of NHS Learning Disability Short Breaks services. The objective is to ensure fair and equitable access to care and support, alongside making best use of public resources.
	Developing a business case which aims to significantly reduce the waiting times for neurodiverse diagnostic assessments for children and young people. This includes an initial funding allocation to support improving the diagnostic pathway for adults.
	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, from those large and with regional footprints to those smaller and embedded in local communities.
	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 of this work is listening and acting on what local autistic people and people with a learning disability and their families are telling JUCD. The ICS will be committed to improving its approach to co-production with local people and has approached key stakeholders, including the local Partnership Boards, to understand how to do this.

Children, Young People and Young Adult Mental health

We saw a steady rise in the number of children and young people (0–17 years) having at least one meaningful contact with NHS-funded mental health services in a rolling 12-month period, reaching 12,927 in March 2022. These contacts were with mental health services across the Derby and Derbyshire graduated pathway including specialist Children Adolescent Mental Health Services (CAMHS), Derby and Derbyshire Emotional Health and Wellbeing service for Children in Care, Changing Lives (mental health support teams in education), Build Sound Minds (targeted early intervention services) and our universal digital offer with Kooth.

In April 2021, we introduced two new Mental Health Support Teams (MHSTs) in education settings at Bemrose School and Noel Baker Academy, with staff commencing specialist training. These teams arrived alongside our more established MHSTs at Bolsover School, Ormiston Academy Ilkeston, Lady Manners Bakewell and Kingsmead special school and the Pupil Referral Unit. We have NHSE&I funding to increase our MHST offer to 11 teams by 2024.

We have invested nearly £1.9m in CAMHS urgent care and crisis response and are recruiting staff to expand the current offer to be able to provide the NHSE&I required 24/7 assessment and brief response to all children and young people in crisis by 2024.

Our universal digital service continued with Kooth, an anonymous service which young people report is *"accessible for all ages"*, *"easy to navigate and easy to understand"*, and *"enables people to talk about their experiences so that they don't feel alone".*

We have expanded capacity for online Cognitive Behavioural Therapy and Autism Post Diagnosis Interventions to help reduce waiting times. We are mindful that online does not suit everyone and these offers complemented our CAMHS face-to-face service. There were increases in eating disorder presentations and capacity was expanded in specialist eating disorder teams. We plan to further improve the offer for children and young people with eating difficulties, particularly for those with autism.

Work was undertaken by a small multi-agency working group to look at how we could assist integration between schools and the mental health pathway. This resulted in new school pathway guidance which was distributed across the school settings.

Our young adults work is looking at how we improve our mental health support to 18 to 25-year-olds who can find that services become disjointed after 18 years and they fall between children and young people, and adult services. This work involved experts by experience and an initial pilot will be starting in the summer of 2022 with VCSE partners providing peer workers, wellbeing workers and engagement workers, which will particularly support young adults transitioning from CAMHS.

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

During Q1 of 2022/23, alongside Derby City Council and system partners, including experts by experience, we worked to develop the best outcomes to improve the lives of Children and Young people with Special Educational Needs and Disability. In addition to this we worked in the county to consider the emerging inspection framework and ensure the system was inspection ready. We started to implement the co-produced plans to address neurodevelopment assessment waiting times across our footprint which included a neurodevelopment research project and the development of Neurodevelopment Community Hubs. The work will continue to be led in conjunction with the JUCD Children and Young People Board. We will ensure that these intentions and learning gained are considered for all ages to improve the experience for adults too.

We continued to drive forward the Children and Young People's Physical Health Transformation Programme, aligned to the NHS Long Term Plan, with local system delivery groups for diabetes, epilepsy, asthma and healthy weight in children and families. We are talking to our young people and families about their experiences of using our asthma services. We will be hosting a system-wide week-long asthma campaign in September 2022 with further engagement and co-production events being planned for 2022/23.

Finance Review

Addressing Our Financial Challenge during Quarter 1 of 2022/23

The Health and Care Act 2022, resulted in the CCG being subsumed into the ICB from the 1st July 2022. The below information relates to the CCG's final reported position for the first quarter of the 2022/23 financial year.

To a lesser extent than previous years, the Covid-19 pandemic continued to affect all aspects of the NHS in Q1 of 2022/23, including its financial regime. National NHS contracting arrangements were brought forward into the current financial year based on expenditure in the prior year, adjusted to reflect national uplifts and efficiencies. These contracting arrangements were alongside the gradual reintroduction of financial efficiency deliverables; thus ensuring all available resources could be directed at delivering front-line services.

The CCG and the Derbyshire system has continued to be flexible, whilst maintaining the highest standard of financial governance to remain within the system's financial envelope.

Financial Position

Total resources of £527.9m for the quarter were available, made up of an income of £0.5m and £527.4m of allocations from the Department of Health and Social Care. The CCG committed expenditure totalling £528.0m, leaving the CCG with a small deficit. Further details can be found in the Annual Accounts section of this report.

Considerable work has been undertaken to understand the extent of the financial challenges being faced across the system as we continue into 2022/23, and the backlog of routine healthcare that has built up. Contracting and funding arrangements for the remainder of 2022/23 have been agreed at a system level. Delivery of high-level transformation will be required to achieve financial efficiencies.

Gross Operating Costs, Quarter 1 2022/23

Category of Expenditure	2022/23 Spend	2021/22 Spend
	£m	£m
Services from Foundation Trusts	305.5	1,173.3
Services from Other NHS Trusts	30.9	124.4
Purchase of healthcare from Non-NHS bodies	80.4	311.6
Prescribing	39.7	162.1
Primary Care	47.8	193.0
Staff	6.4	25.3
Supplies and Services – General	2.1	5.6
Services from other CCGs and NHSE&I	2.8	10.1

Category of Expenditure	2022/23 Spend	2021/22 Spend
	£m	£m
Other	2.9	11.4
Covid-19	9.5	103.7
TOTAL	**528.0**	**2,120.5**

Table 11 – Gross Operating Costs, Quarter 1 of 2022/23 and 2021/22

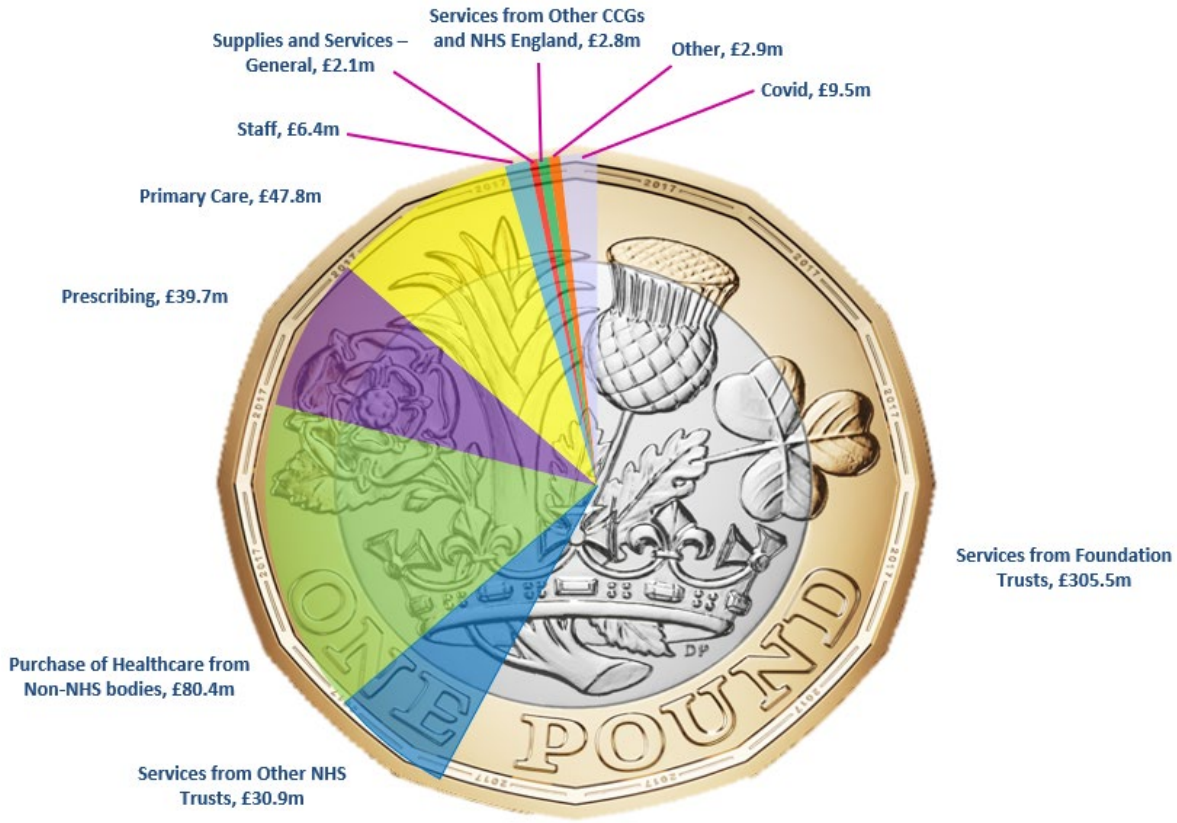


Figure 5 – Gross Operating Costs, Quarter 1 of 2022/23 – 'The Derbyshire Pound'

Covid-19 Expenditure

The CCG committed considerable expenditure in tackling the pandemic, much of this being funded from within system financial envelopes. The funding received, continued to support the whole of the Derbyshire health care system.

	30th June 2022	31st March 2022
	£m	£m
Block Payments	8.80	43.20
Hospital Discharge Programme	0.00	39.61
Primary Care Costs	0.01	8.52
DHU Testing Service and Calls	0.00	5.15
Mental Health Services	0.00	1.86

	30th June 2022	31st March 2022
	£m	£m
Community After Care and Support	0.68	0.78
Mental Health After Care and Support	0.00	1.97
Acute Remote Management of Patients	0.00	0.96
Other Remote Management of Patients	0.01	0.69
Running Costs	0.01	0.40
Continuing Health Care After Care	0.00	0.31
Other	0.01	0.64
	9.52	**104.09**

Table 12 – Covid-19 expenditure, Quarter 1 of 2022/23 and 2021/22

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.

For comparative purposes, the 2021/22 statement is provided which shows there was an increase throughout assets and liabilities during Q1 of 2022/23. The primary movement in non-current assets and the corresponding current and non-current liabilities is due to the implementation of International Financial Reporting Standards 16 on the 1st April 2022 and the requirement to report Right of Use Assets on the Statement of Financial Position.

	30th June 2022	31st March 2022
	£'000	£'000
Non-current assets		
Property, plant and equipment	218	267
Right of-use Assets	1,270	0
Total non-current assets	**1,488**	**267**
Current assets		
Trade and other receivables	9,348	4,965
Cash and cash equivalents	42	27
Total current assets	**9,390**	**4,992**
Total assets	**10,878**	**5,259**
Current liabilities		
Trade and other payables	(115,938)	(98,756)
Lease liabilities	(452)	0
Provisions	(6,741)	(5,847)
Total current liabilities	**(123,131)**	**(104,603)**
Total Assets less current liabilities	**(112,253)**	**(99,344)**

	30th June 2022	31st March 2022
	£'000	£'000
Non-current liabilities		
Lease liabilities	(819)	0
Provisions	(532)	(532)
Total non-current liabilities	**(1,351)**	**(532)**
Total assets less liabilities	**(113,604)**	**(99,876)**
Financed by Taxpayers' Equity		
General Fund	(113,604)	(99,875)
Total Taxpayers' Equity	**(113,604)**	**(99,876)**

Table 13 – Statement of Financial Position, Quarter 1 of 2022/23 and 2021/22

Financial Trend Data

Since the CCG's inception in April 2019, the organisation has followed a different financial regime in each of the financial years of its existence. The 2019/20 year was the commencement of usual business to deliver healthcare to Derbyshire patients as a newly-merged CCG representing the whole county. However, national contracting replaced this in 2020/21 as the Covid-19 pandemic hit the UK, which was further changed in 2021/22 to reinstate independent sector contracting. These measures remained in place during Q1 of 2022/23. Due to these differing financial regimes and priorities for healthcare delivery, financial trend analysis is not considered to be meaningful to the users of this report.

Our Duties

Improvement in quality of services

The CCG has a statutory requirement to discharge its duties under Section 14R of the NHS Act 2006 (as amended) to improve the quality of services, as detailed in the CCG Constitution.

Patient Safety

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

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

Providers report Patient Safety Incident Investigations as identified within their plans and once the investigations are complete a thematic review is undertaken and the outcomes shared at Clinical Quality Review Groups. Updated PSIRF documentation will be issued in August 2022 and those providers which are not part of the early adopter programme will commence from September 2022 as a phased approached, with the aim for all providers to be working to PSIRF by September 2023.

Patient Safety Partner involvement in organisational safety relates to the role that patients and other lay people can play in supporting and contributing to a healthcare organisation’s governance and management process for patient safety. An advert for Patient Safety Partners has been published and these will be recruited as part of a system approach. DCHSFT will host Patient Safety Partners with assistance from the ICB's Patient Safety Team. The Derbyshire system hope to recruit 12 Patient Safety Partners for the system, with the first ones coming into post in September 2022.

Healthcare-associated infections

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

The NHS Standard Contract 2022/23 includes quality requirements for NHS Trusts and NHS Foundation Trusts with a zero-tolerance approach across all organisations to

Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia and the aim to minimise rates of both Clostridioides difficile infection and of Gram-negative bloodstream infections to threshold levels set by NHSE&I.

Methicillin-resistant Staphylococcus aureus

During Q1 of 2022/23, three cases of MRSA bacteraemia were reported relevant to the population of Derby and Derbyshire. One case was identified as a hospital onset infection within UHDBFT, one at CRHFT, and the other was a repeat/relapse of a previous known infection in an external NHS acute Trust.

In line with national guidance, all MRSA bacteraemia are subject to a post infection review; with any identified learning being shared not only with those involved but with the wider health economy to support prevention of future cases. These reviews are pending and will be reported through the Trust's internal infection control committees which are attended by the ICB for assurance.

Methicillin-sensitive Staphylococcus aureus

Methicillin-sensitive Staphylococcus aureus bloodstream infections have been subject to mandatory reporting since January 2011, though no organisational objectives are set.

There were 70 cases identified during Q1 of 2022/23, compared to 77 in Quarter 4 of 2021/22. The epidemiology reported by Public Health England noted increasing numbers of Methicillin-sensitive Staphylococcus aureus being seen nationally, driven by an increase in community associated cases (72% of CCG cases).

Clostridioides difficile infection

There were 95 cases of Clostridioides difficile for the CCG during Q1 of 2022/23. Annual objectives for each organisation are set by NHSE&I, with the ICB's objective being set at no more than 252 Clostridioides difficile cases during the rest of 2022/23. Given the high numbers of cases reported during Q1 of 2022/23, it is unlikely that trajectories for the ICB and both acute providers for the full year will be met.

Oversight of this issue is through internal infection control committees, which are attended by the ICB for assurance, and Clinical Quality Review Group meetings. A deep dive is being undertaken at both Trusts to determine the issues and a Midlands regional collaborative group has also been convened to discuss the issue as this rise is not isolated to Derbyshire.

Gram-negative bloodstream infections

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

Case numbers for Derby and Derbyshire residents in all GNBSIs have demonstrated downward trends over the last five years with all three within the NHSE&I trajectory for this year so far.

Infection Prevention and Control Teams continue to work collaboratively across the system to support the reduction of GNBSIs, including an initiative to support hydration across care homes. Work will continue with the Derbyshire health and social care system to implement the system antimicrobial resistance strategic action plan as this will play a key role in supporting the ambitions to reduce the numbers of GNBSIs. There is also a Midlands regional collaborative group for GNBSI which will be supporting completion of a regional deep dive to inform this work further and the development of regional principles.

Never Events

Never Events are patient safety incidents that are entirely preventable, with guidance or safety recommendations providing strong systemic protective barriers at a national level and which should be implemented by all healthcare providers.

There was one Never Event reported during Q1 of 2022/23. The investigations are completed as part of the PSIRF as thorough Patient Safety Incident Investigations. Previously there were a cluster of Never Events that were similar in nature. When these occurred, the acute Trust adopted the principles from the new PSIRF framework and reviewed the themes relating to this cluster to develop a robust improvement plan for the Trust. This was completed in conjunction with the Patient Safety Team at the CCG. Learning from Never Events are shared at the Clinical Quality Review Groups to ensure oversight and scrutiny.

Safeguarding children, looked after children and adults at risk

The CCG remains highly committed to ensuring that the population of Derby and Derbyshire are safe and receive high quality care and support.

The CCG continued to work in close partnership with partner agencies and our commissioned services to continuously improve systems and processes to safeguard children, young people and adults in our community. The CCG's Safeguarding Children and Adults' Team continued to ensure that the organisation met its statutory safeguarding responsibilities and functions and had clear processes to monitor the safeguarding arrangements of our commissioned health services to provide assurance that children and adults at risk of abuse are safeguarded.

End of Life Services

The Health and Care Act 2022 includes a new legal right to NHS funded End of Life (EoL) care. System work is to be undertaken to understand priority actions to ensure compliance of legal requirements.

The Palliative End of Life Strategy refresh is to be completed in Autumn 2022, the focus is on alignment to national ambitions and establishing whether the workstreams the CCG currently have are still the correct ones required to deliver the strategy. Commissioning intentions for 2022/23 have been agreed in partnership with stakeholders and a new commissioning and sustainability workstream has been established, which is responsible for reviewing and mapping demand modelling and hospice sector sustainability.

Patient Experience and Involvement in Our Services

The CCG gathers patient experience from many different sources and works in partnership with patients, carers and local partners to ensure that the services we commission are responsive to the needs of our population. In the last year, the focus of the team has changed to enable work to focus on key priorities in response to the Covid-19 pandemic. This has seen the deployment of the Patient Experience Team to support essential and mandated initiatives such as the delivery of the Covid-19 Vaccination Programme. This resulted in a reduction of patient experience work plans. The CCG recognises the importance of this aspect of its work and plans are in place for a return of the function with an initial focus on supporting the Derby and Derbyshire wide EoL care and the Derbyshire special educational needs and disability agendas.

Quality and Equality Impact Assessments

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

Discharge to Assess

The team continued to engage with patients who have been discharged from hospital care into a temporary care home bed whilst their needs are further assessed and rehabilitation takes place. Interviews and surveys were carried out over the telephone and patients have shared their experiences of discharge and their progress in the care home facility. This feeds into the appropriate planning groups and has resulted in revised information for patients and improved discharge information between the hospitals and the care homes.

The team worked closely with Healthwatch Derbyshire and Healthwatch Derby and ensured that their feedback was used to influence commissioning. There has been a focus on access to General Practice, pain management, NHS dentistry, pharmacy assessments and general feedback including complaints and compliments.

JUCD are in the process of implementing an EoL Strategy which aims to deliver consistent EoL care across the county. The outcome of the Delivery Plan states, *"The voice of local people will drive the development of services"*. A member of the Patient Experience Team led the EoL People Driving Change workstream, which ensured that patients and their families and carers were involved in identifying the fundamental outcomes that are important to them when receiving EoL and Palliative care and informing all aspects of the EoL Delivery Plan, including the development of an EoL Single Point of Access.

Care Homes

Care homes have continued to work incredibly hard to keep both staff and residents as safe as possible and reported daily to the National Capacity tracker tool to record the number of Covid-19 outbreaks, both for residents and staff, the level of personal protective equipment available, bed capacity, staffing levels and vaccination uptake. This gave both Derby City and Derbyshire County Local Authorities and system partners valuable information to be able to respond to issues identified by the sector.

The local multi-agency information sharing meetings have continued weekly in order to monitor and respond to emerging risk promptly, including the Local Authority, CCG, CQC and the Continuing Care Team. All agencies adapted their monitoring methodology during 2021/22, only visiting services where extreme risk was identified or to undertake focused visits such as Infection, Prevention and Control inspections. Agencies employed joint quality assurance methods of monitoring, using a mixture of virtual and desktop monitoring. As the infection rates reduced, there was more face-to-face quality assurance visits to care homes providing much needed support to the homes and providing the ICB 'eyes on' services from a quality assurance perspective whilst continuing to utilise some of the virtual methodology to improve efficiency and reduce time on site.

The Enhanced Health in Care Homes programme continues 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. The Enhanced Health in Care Homes programme forms one element of the national Ageing Well programme alongside anticipatory care and urgent community response. These workstreams contribute to Team Up Derbyshire, a programme of transformation which requires effective system governance and leadership. A system-wide approach to care homes for older people is needed to lead and coordinate all complementary workstreams to promote a safe, sustainable and high-quality care home sector for our vulnerable populations of Derby and Derbyshire. The Integrated Care Homes Strategic Group continues to act within a leadership and strategic capacity to promote collaboration and an integrated approach.

Continuing Health Care and Discharge to Assess

In March 2020, multi-agency guidance was issued in respect of enabling the safe and effective discharge of patients from hospital. The CCG established a group with members from UHDBFT, CRHFT, DCHSFT, Midlands and Lancashire Commissioning Support Unit – Continuing Healthcare (CHC) Team, Derby City Council and Derbyshire County Council. A clear discharge pathway was defined which reflected the requirements of the guidance supported by multi-agency Standard Operating Procedures.

Covid-19 has spurred unprecedented co-operation and collaboration, between different NHS organisations and with partners in local authorities and the private sector, especially the care

home sector. The CHC Team became a much more visible and stronger system partner, leading on a Trusted Assessor model for assessing individuals' care needs following discharge from hospital. The team has developed new ways of supporting people who receive NHS CHC, or Personal Health Budgets; responding to people's individual needs, adapting care plans where necessary, and making sure their budget meets the costs of the new arrangements.

The use of technology to support the CHC process was rapidly introduced with technologies such as video conferencing ensuring that people can attend multi-disciplinary team meetings regardless of where they live. Access to Microsoft Teams and Zoom has made this a reality for all, including CCGs, local authorities, individuals and their families. Using these technologies allowed CHC teams to restart their processes with confidence to complete high quality CHC assessments and reviews while being compliant with the National Framework.

Feedback from families involved in our CHC reviews confirmed that by completing them on Zoom, we were able to *"include all the family in mum's review"* which would not have been an option before Covid-19. Using video conferencing has also allowed for a greater level of flexibility.

The CCG Commissioning of NHS Continuing Healthcare for Adults Policy was refreshed and ratified, to describe the way in which the CCG plan and commission services for people who have been assessed as eligible for an episode of fully funded NHS CHC, and patients who are eligible for CHC who wish to have a Personal Health Budget. It also sets out CCG principles for joint funded packages of health and social care.

The CCG has a prime responsibility to ensure that services it procures are clinically appropriate and meet agreed quality standards. The safety, welfare and potential risks to the individual are considered in care purchased, and the personalisation of support and care for an individual are central to decision-making once the principles of the policy have been assured. The need to balance personal choice, alongside safety and effective use of finite resources in the provision of CHC services, is also embedded within the policy. This provides the panel with a framework which ensures consistent and equitable decisions can be made around the provision of care regardless of the person's age, condition or disability. All procurement decisions need to provide transparency and fairness in the allocation of resources.

Commissioning for individuals

The CCG established a Commissioning for Individuals Panel to provide governance and a decision-making process for individualised packages of care with a view to ensuring that there is a fair and consistent approach. The panel is chaired by a lay representative and the panel consists of representatives from finance, contracting, commissioning and quality colleagues. The panel considers the appropriateness, safety, quality and cost effectiveness of requests for complex/specialist care placements/packages and interventions and ensures that people in need of NHS healthcare funding are in receipt of a package of care which meets their needs, respects their wants, and is safe and sustainable.

As a result of the work carried out by the Commissioning for Individuals Team, supported by other CCG Teams and Directorates, there is now one process in place where previously there had been many. This has resulted in the ability to offer significant assurance to the CCG that where the CCG is commissioning services for individual service users, they now

fully understand the costs, complexities, risks, and contracts required. Due to the continued hard work of the Commissioning for Individuals Team, the CCG is now in a much stronger position moving forward as a result.

The process is ever evolving and will continue to evolve during transition to the ICB, for example closer co-ordination with local authorities on ensuing timely assessments and care packages and closer monitoring of enhanced carer support to ensure the least restrictive option is always used. As further assurance, the Commissioning for Individuals governance processes were reviewed as part of the recent Personal Health Budget 360 Assurance audit. The overall audit result was significant assurance.

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

Learning Disability Mortality Review (LeDeR) is a service improvement programme which aims to improve care, reduce health inequalities and prevent premature mortality of people with a learning disability and autistic people by reviewing information about the health and social care support people received.

There was a total of 14 new notifications of deaths to the LeDeR programme for Derbyshire during Q1 of 2022/23. There were three notifications received for people from ethnic minority communities (two were male and one female). There was one notification for the death of someone under the age of 18. One of the notifications was for an individual who had autism with no learning disability although this was found to be out of scope of the LeDeR programme as there had been no formal medical diagnosis of autism.

During Quarter 4, 14 reviews were completed; 11 were completed as 'initial reviews' and three completed as the more detailed 'focused' review. There was no top reason for death of the completed reviews as the numbers were spread quite evenly across a number of conditions, which included pneumonias, dementia and heart disease. There were no deaths directly from Covid-19 although two of the deaths had Covid-19 listed on the death certificate as a condition leading to the death. LeDeR reviews are only undertaken for individuals 18 years and over, although the programme does work closely with the Child Death Overview Panel where child death reviews are reviewed by a panel. There were six completed Child Death Overview Panel cases in during Q1.

LeDeR captures themes and trends in order to identify learning and actions and work is in progress to address inequalities across ethnic minority communities, capturing gaps in understanding epilepsy and the promotion of learning disability annual health checks. Other priority areas that have been identified are constipation and bowel conditions, and osteoporosis. Reviews are quality assured and learning is identified through the Clinical Quality Review Group 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 continued to follow the LeDeR Strategy which has been produced locally for Derbyshire including a vision, aims and objectives.

Developing robust Derbyshire Host Commissioner arrangements

The CCG has a well-established oversight for our eight local Independent Hospitals. During 2021 developed robust local Host Commissioner arrangements following the publication of national guidance by NHSE&I in January 2021. This described a clear framework and expectation that local CCGs maintain ongoing assurance, surveillance and oversight for Independent Hospitals located within their geographical area. We have widened our role beyond national expectations to encompass the care of people with a diagnosis of learning disability, autism and/or mental health needs. An important element of our local Host Commissioner model is to support the Independent Hospitals in our areas to build on their quality improvement work. This includes supporting them to achieve a 'Good' CQC rating following inspection. We are pleased to note that all eight hospitals have a 'Good' rating with six of these having inspection reports published after April 2022. We continue to work across all stakeholders to support each hospital to sustain this rating and build on it further.

Transforming Care Partnership

The CCG continued to work with partners through the Transforming Care Partnership (TCP). The TCP consists of the CCG, CRHFT, UHDBFT, DCHSFT, DHcFT, Derby City Council, Derbyshire County Council, service users and carers. The TCP continued to develop collaborative ways of working to improve health and care services so that more individuals with learning disabilities and/or autism can live in the community, with the right support closer to home. Through earlier intervention and support in the community, the aim is that fewer individuals will be admitted to hospital for their care associated with their learning disability, autism and/or mental health needs unless it is clinically appropriate for their needs to be met in a specialist hospital. For those individuals for whom a clinically-led evidence-based need is indicative of hospital admission, the aim of the admission, assessment and treatment pathway and discharge plan from hospital, will be clear from the point of admission.

The TCP Team, hosted within DHcFT since the 1st of October 2021, has contributed to improvements in quality and services by ensuring that as a health and social care system we better understand the needs of individuals with a learning disability and/or autism who are likely to need additional support in the community to reduce the likelihood of clinically inappropriate admission to hospital. As a direct outcome of collaborative working, three individuals with learning disability and/or autism have been discharged from specialist inpatient hospitals during Q1 of 2022/23.

Maternity and Neonatal Transformation

The CCG takes a leadership role in the Derbyshire Local Maternity and Neonatal System (LMNS) and has continued to steer the programme of work to respond to the recommendations of the Better Births report, the NHS Long Term Plan maternity commitments and the actions following the Kirkup and Ockenden Reports. The LMNS formed a quad buddy relationship with Staffordshire and Stoke-on-Trent LMNS, Shropshire, Telford and Wrekin LMNS and Black Country and West Birmingham LMNS, offering the opportunity for sharing, learning and the opportunity to develop more formal peer support. The CCG has worked closely with providers to develop midwifery Continuity of Carer to become the default model of care, including developing an enhanced model of care for people from ethnic minorities and the most deprived communities which has been piloted in one of our Derby city communities.

Reducing Health Inequality

The CCG has discharged its duties under Section 14T of the NHS Act 2006 (as amended), as detailed in the CCG Constitution, by agreeing strategic priorities which aim to contribute to increasing life expectancy. These are:

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

Equality Delivery System

The CCG has demonstrated a proactive approach to meeting the requirements of the Public Sector Equality Duty through use of the NHS Equality Delivery System 2.

Through recognition of the impact of the pandemic and ongoing NHS pressures a new tool has been drafted providing a more proportionate way to illustrate required evidence. In Derby and Derbyshire it has been decided to use this draft tool for this year's submission. There are three sections:

- Domain 1: Commissioned or provided services;
- Domain 2: Workforce health and wellbeing; and
- Domain 3: Inclusive leadership.

The CCG's Equality Delivery System 2 return can be found here[8].

Derby and Derbyshire's approach to Equality, Quarter 1 2022/23

Phase 3 of the Covid-19 vaccination programme has continued to build on phases 1 and 2 in the identification of vaccine inequality or hesitancy. Work has continued to understand the reasons for non-vaccination and provide reasonable alternative offers, which has been overseen by the Vaccine Inequalities Group.

With the restoration and recovery of services following necessary changes during the outset of the Covid-19 pandemic the assessment of Equality Impacts of service change has been enhanced.

Quality Impact Assessments (QIA) and Equality Impact Assessments (EIA) are undertaken on all service changes within the CCG. Through feedback from those completing the EIA as well as lessons learned through the pandemic around digital exclusion and inequalities the EIA has been simplified and now mirrors the two-stage process of the QIA.

This new form has been discussed with the CCG's Diversity and Inclusion Network to gain opinion on whether it could accurately assess and capture assessment of equality impacts, as well as clarifying and including the protected characteristics to be considered, additional

[8] https://www.derbyandderbyshireccg.nhs.uk/about-us/equality-inclusion-and-human-rights/

assessments around digital exclusion, health inequalities and community impact. The new form is being used and will be assessed after six months with both those using the form and those at the QEIA panel.

Further development has included the creation of a Senior Patient and Public Equality Manager role, to assess need and develop ways to understand and make reasonable adjustments across the ICS.

Equality considerations for corporate committees

The process around Quality and Equality Impact Assessments (QEIA) are now embedded in the CCG. Each proposed change to services has to have a completed QEIA form which outlines any risks and mitigations to the proposed change. This information is then included in the cover sheet on all of the decision-making committees to ensure that risks and mitigations are understood, and robust decisions can be made.

Where the panel seeks further information then the QEIA is updated and reviewed again. An updated version of the QEIA is reviewed as per the needs of the project.

In addition to the QEIA process, the CCG Engagement Committee receives a monthly update on the completed Section 14Z2 forms which supports the assessment of legal duties around patient engagement or consultation.

All of our corporate committees have a cover sheet for papers that require a statement of assurance from the senior project lead about the assessment of equality considerations before a decision will be made. There is either assurance that an EIA has been completed and/or that discussion has taken place at the Quality Impact Assessment Panel or, on occasion and where appropriate, a different process has been followed to challenge and confirm equality considerations.

Procurement

We continue to ensure that there are robust processes in place in the procurement of healthcare services. Each aspect of procurement activity includes embedded equality considerations (where relevant) and comprehensive equality-related tender questions in both the Pre-Qualifying Questionnaires and Invitation to Tender stages. These processes ensure that there is assurance that providers of healthcare services in Derby and Derbyshire understand our population and the important equality considerations that they should make. These include, but are not limited to, making reasonable adjustments to ensure that their services are accessible to all.

Equality Statement

An equality commitment statement is embedded in all CCG policy developments and implementations, while also providing a framework to support CCG decisions through equality analysis assessed at QEIA Panel.

In carrying out its function, the CCG must have ‘due regard’ to the Public Sector Equality Duty. This applies to all activities for which the CCG is responsible, including policy development, review and implementation.

Equality Analysis and 'Due Regard'

The CCG 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 Governing Body and corporate committee cover-sheets.

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

Workforce

NHS Workforce Race Equality Standard

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

The CCG 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 for staff and brings together people from across the CCG that identify with a particular protected characteristic. The network meets bi-monthly to discuss and consider issues that they feel need addressing/considering by the CCG and works with us to improve staff experience on specific issues, including race and religion.

Key initiatives have included:

- celebrating and promoting key dates in the inclusion calendar;
- introducing a programme of reverse mentoring with senior directors;
- raising awareness of the lived experiences of under-represented staff;
- informing the Derby and Derbyshire healthcare systems approach to engagement with diverse communities relating to the Covid-19 vaccination programme and vaccine hesitancy;
- learning and development: hidden disabilities and unconscious bias training; and
- informing the WRES, Workforce Disability Equality Standard (WDES) and Staff Survey action plans.

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

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

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

CCG Ethnic Minority Groups

The proportion of the CCG's population that belong to ethnic minority groups is estimated at 6.7%, based on the 'covered by population' data from the 2011 census and Office for National Statistics mid-year population estimates in 2017. The 2011 census data stated the proportion of the population belonging to ethnic minority within Derby City as 24.7%.

At the 31st March 2022, the proportion of employees within the CCG from ethnic minority groups is 11.35%. This is an increase of 1.71% since 2019.

	2019	2020	2021	2022
CCG employees from an ethnic minority group	9.64%	9.41%	10.34%	11.35%

Table 14 – percentage of CCG employees from an ethnic minority group between 2019 and 2022

A breakdown of proportion of CCG staff from an ethnic minority group across the banding structure within the CCG is detailed below. Table 15 shows that these employees are underrepresented at a senior level:

CCG employees from an ethnic minority group	2019	2020	2021	2022
Band 8d/VSM	4.55%	4.35%	4.76%	4.35%
Bands 8a–8c	12.4%	13.38%	15.28%	15.97%
Bands 1–7	8.49%	7.99%	8.54%	9.85%

Table 15 – proportion of CCG staff from an ethnic minority group across the banding structure between 2019 and 2022

The senior management team within the CCG has been stable over the past four years with minimal turnover, which represents a barrier to achieving a diverse workforce at all levels across the organisation. To address this, the CCG has undertaken a review of the recruitment and selection procedure, working with the Diversity and Inclusion Network. The CCG is also working with partners in the Derbyshire Healthcare system to promote development opportunities for staff from underrepresented groups and participating in an expert-led system-wide cultural intelligence programme.

The following actions from the NHS People Plan to improve workforce equality and diversity are being progressed by the CCG:

- 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 WDES is a set of 10 specific measures which enable NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff.

The WDES enables NHS organisations to better understand the experiences of their disabled staff and supports positive change for all existing employees by creating a more inclusive environment for disabled people working and seeking employment in the NHS.

Completion of the WDES is mandatory for NHS Trusts and the metrics data is used to develop and publish an action plan, which the CCG reviews and monitors. Although not compulsory for the CCG, we collate the WDES metrics data to help us better understand the experiences of our disabled staff and developed an action plan.

Public Involvement and Consultation

Engaging People and Communities – Duty to Involve

Following the developments around collaborative working and engagement with a wide range of stakeholders during the pandemic, we continue to build on our learning and developments. The continued support from our constituent partners and stakeholders including provider organisations, Healthwatch, the VCSE sector as well as individuals and groups who have contributed to our communication and engagement activities is very much appreciated.

We have seen a growth in digital engagement, our Engagement Platform and virtual Derbyshire Dialogue sessions. At the same time we have worked with advocacy and support organisations to design the best engagement options to meet particular needs.

There have been continued developments with the Derbyshire Engagement Committee to support the transition to the ICB's Public Partnerships Committee. We are delighted that members of the Derbyshire Engagement Committee will continue to work with us and would like to thank the committee members for their support.

Looking forward we are continuing to work on systems to support our ICS staff to ensure robust engagement processes are in place to maximise the amount of involvement with local communities.

The CCG would like to thank all constituent partners and stakeholders including provider organisations, Healthwatch, the VCSE sector and all individuals and groups who have contributed to our communication and engagement activities during 2021/22.

We have listened to the experiences and opinions of local people as the pandemic continues to expose inequalities across the city. This has renewed our commitment to listening and

hearing from those most affected. We continue to refine and develop our use of digital technology and this approach has enabled us to continue conversations and see an increase in the numbers of people engaging in decision-making processes and providing feedback to help shape services.

The Derbyshire Engagement Committee, which has continued to meet virtually, reports to the Governing Body and JUCD Board and is comprised of a broad spectrum of representatives across the health and social care system. These range from statutory engagement bodies such as Healthwatch to the VCSE sector, Foundation Trust governors and members of the public. The objectives of the committee are to assure service changes and plans are developed via effective engagement with those most affected by potential changes to the service and that patients, carers and the public are at the centre of shaping the future of health and care in Derbyshire.

The footprints for the CCG and JUCD are aligned as we move towards an ICB. Our teams have worked closely together on our ‘Get Involved’ page of the JUCD website, which directs members of the public to opportunities to become involved in work being carried out by the organisation. The website also includes key information to the Covid-19 response including details of pop-up vaccination clinics.

Sustainable Development

In 2020, the NHS launched the campaign 'For a Greener NHS' and an Expert Panel, chaired by Sir Simon Stevens, set out a practical, evidence-based and quantified path to a 'Net Zero' NHS.

Two clear and feasible targets emerged for the NHS Net Zero commitment, based on the scale of the challenge posed by climate change, current knowledge, and the interventions and assumptions that underpin this analysis:

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

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

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

Figure 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.

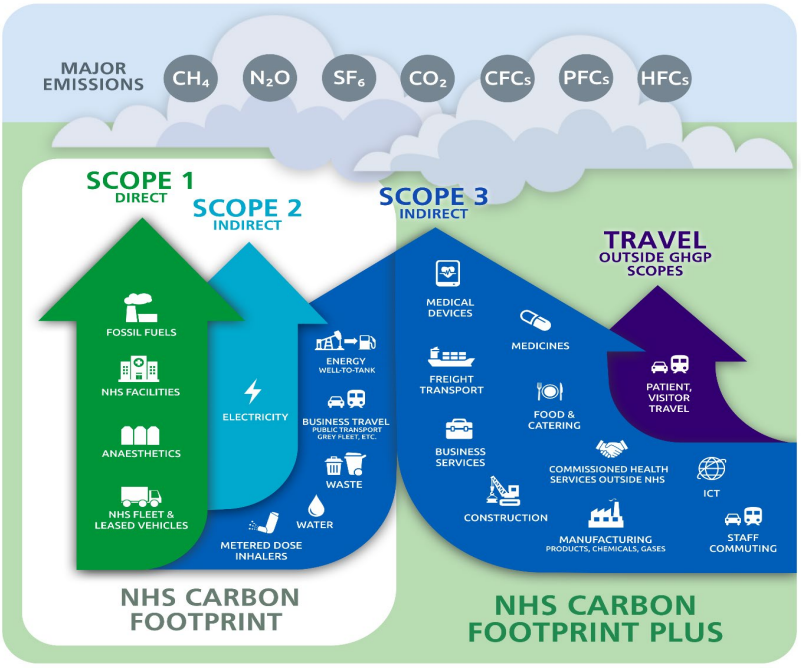


Figure 6 – GHGP scopes in the context of the NHS (Source: NHSE&I)

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 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 and medical devices, and travel.

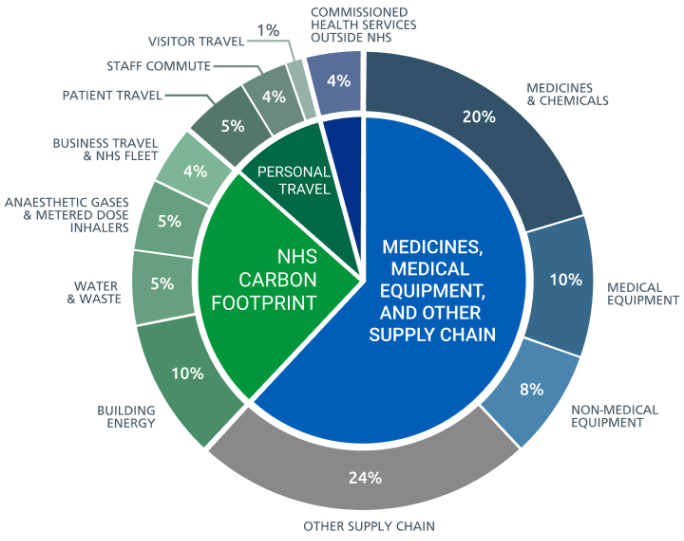


Figure 7 – Sources of carbon emissions by proportion of NHS Carbon Footprint Plus (Source: NHSE&I)

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

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

Greener Governance

NHS Midlands Regional Delivery Board

The JUCD ICS is a member of the NHS Midlands Regional NHS Delivery Board which was established in June 2021. The CCG's Executive Director for Corporate Strategy and Delivery is the Senior Responsible Officer for Net Zero and represents the JUCD ICS. The Board meets bi-monthly. The Midlands Regional NHS Delivery Board defined three priorities for carbon reduction as follows:

Medicines

- Reducing the proportion of desflurane used in surgery to less than 10% of overall volatile anaesthetic gases volume in all Trusts, in line with the proposed 2021/22 NHS Standard Contract.
- Implementing approaches to optimise use of medical gases, including reducing nitrous oxide waste and preventing the atmospheric release of medical gases.
- Reducing the carbon impact of inhalers, in line with the commitment of a 50% reduction by 2028 and a 6% reduction in 2021/22 on a 2019/20 baseline, by:
    - supporting patient choice of less carbon intensive inhalers, for example dry powder inhalers, where clinically appropriate, resulting in a 2% reduction of emissions by March 2022; and
    - working with the national team to ensure schemes for green disposal of inhalers are rolled out across the region.

Travel and transport

- Ensuring that systems solely purchase and lease cars that are ultra-low emissions vehicles (ULEVs) or zero emission vehicles (ZEVs), and work towards purchasing vans (under 3.5 tonne) that are ULEVs or ZEVs, in line with the LTP and Net Zero Strategy commitments.
- Ensuring that only ULEVs or ZEVs are available to staff through car salary sacrifice schemes.
- Identifying a cycle-to-work lead in every Trust, as outlined in the People Plan.
- Ensuring all systems have:
    - a salary sacrifice cycle-to-work scheme in place for staff; and

- where appropriate all sites have facilities available to encourage staff and visitors to cycle-to-work.

- Working with the national Greener NHS Team to undertake a review of the existing fleet within the region.

Midlands Region Priority Deliverables

These regional priorities are linked to the recovery, sustainability and resilience improvement across our systems and organisations and will support the adoption of national policies or strategies at scale to accelerate greener change:

Plastics	Following a significant organisational uptake in the Plastics Pledge in February 2020, we will lead regional projects aimed at reducing the use of clinical single-use plastics.
Paper	Ensuring all systems only purchase 100% recycled content paper for all office-based functions as soon as possible and across non-office-based functions as soon as practically possible.
PPE usage and waste management	Supporting sustainable PPE procurement and use, and PPE improved waste management solutions. For example, adopting the national PPE gown pilot regionally if successful.

Joined Up Care Derbyshire Integrated Care System Greener Delivery Group

JUCD established a Greener Delivery Group in June 2021, meeting bi-monthly. The CCG's Executive Director of Corporate Strategy and Delivery is the Group Chair. The Derbyshire Provider Trust Sustainability Leads are members of the group together with specialist Lead Pharmacists within the Derbyshire ICS.

The group agreed the following local priority areas:

- governance;
- medicines;
- travel and transport;
- estates and facilities;
- Midlands region priority deliverables: single use plastics, paper, PPE usage; and
- waste management.

The Derbyshire provider Trusts have approved their individual Green Plans and worked together to develop the JUCD ICS Green Plan, approved by the Derbyshire Trust Boards during March and April and the CCG Governing Body on the 7th April 2022. The ICB Board will formally adopt the Green Plan in July 2022, when the ICB is a statutory organisation.

Our Commitments

The CCG works in accordance with the Sustainable Development Unit's guidance for CCGs and has embedded the Sustainable Development Strategy for the NHS, public health and social care system into its programme development. The CCG is compliant with those elements of the Climate Change Act and adaptation reporting requirements, which are relevant to it as a commissioning organisation with no responsibility for estate/property assets. The CCG is aware of its responsibilities as a socially responsible commissioner and includes this within procurement programmes. The Governing Body Lay Member for Finance is the CCG's Sustainability Champion.

The Social Value Act 2012 requires us to consider how to use our contracts to improve the economic, social and environmental wellbeing of our communities. The CCG is committed to the NHS Carbon Reduction Scheme and there is an ongoing focus to reduce our direct building-related greenhouse gas emissions, business travel and waste going to landfill.

Our key commitments to sustainability are as follows:

Leadership and Workforce Development

Sustainable and resilient services will only emerge from a culture that understands and values environmental and social resources alongside financial. This requires strong leadership from within the CCG coupled with raising awareness of staff and the profile of sustainability.

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 the 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 16 below shows our energy consumption for the last three years, for our CCG headquarters at Cardinal Square, Derby:

	Q1 2022/23	2021/22	2020/21	2019/20
Electricity (kWh)	33,639	107,389	94,142	169,927
Water (m^3)	426	590	589	1,177

Table 16 – CCG headquarters' energy consumption for Q1 2022/23, 2021/22, 2020/21 and 2019/20

Commissioning and Procurement

In England more than £212.1bn of public money is spent on health and care services. The commissioning of services and the procurement of products are powerful levers to influence the delivery of sustainable services. The CCG recognises that we can develop and use criteria to stimulate more ambitious and innovative approaches to delivering care that costs less, creates less environmental harm and reduces inequalities.

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 using a lower carbon alternative. Salbutamol MDIs are our most commonly prescribed inhaler and switching could reduce our inhaler carbon footprint by up to a third. Work has been underway since the beginning of the year and figures from Open Prescribing (www.openprescribing.net) show that our mean carbon emission per salbutamol inhaler has reduced significantly over the last few months:

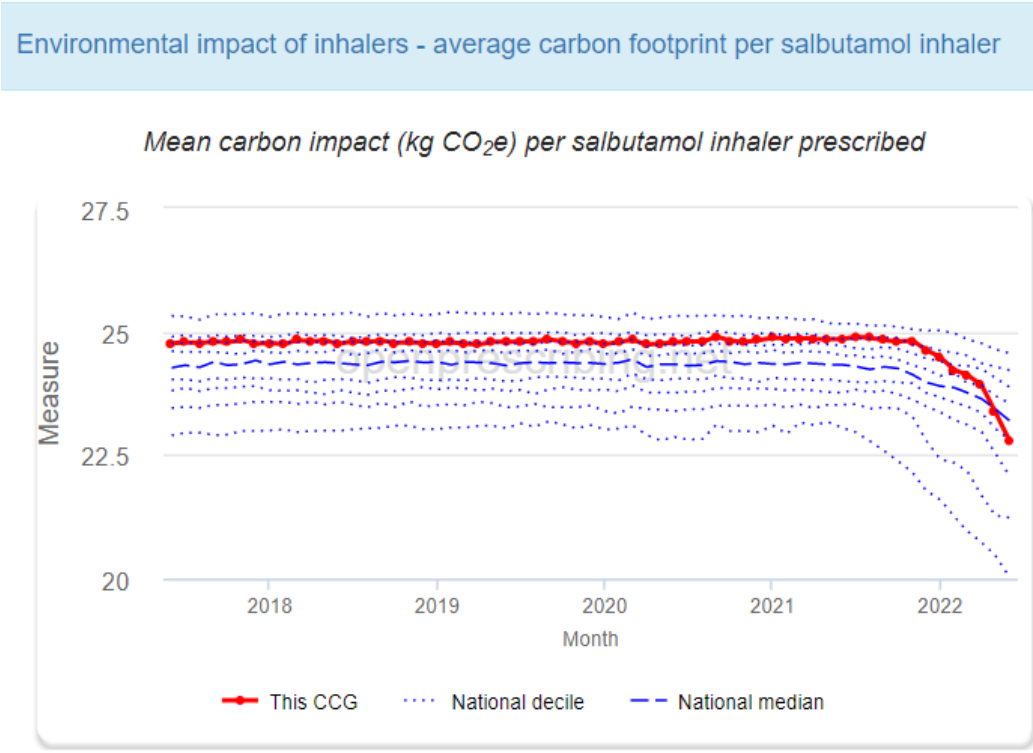


Figure 8 – mean carbon impact (KgCO2e) per salbutamol inhaler prescribed

Our current figure is 22.8KgCO2e per inhaler which is now below the national median figure of 23.2 KgCO2e and continuing to fall sharply.

Our second priority is to utilise more dry powder inhalers, which have a much lower carbon footprint than MDIs. This is a more complicated piece of work, with patients needing an individual review in order to change inhalers, and traditionally Derbyshire has been a very high user of MDIs. However, there has also been some recent progress made in reducing the prescribing of MDIs:

Environmental impact of inhalers - prescribing of non-salbutamol Metered Dose Inhalers

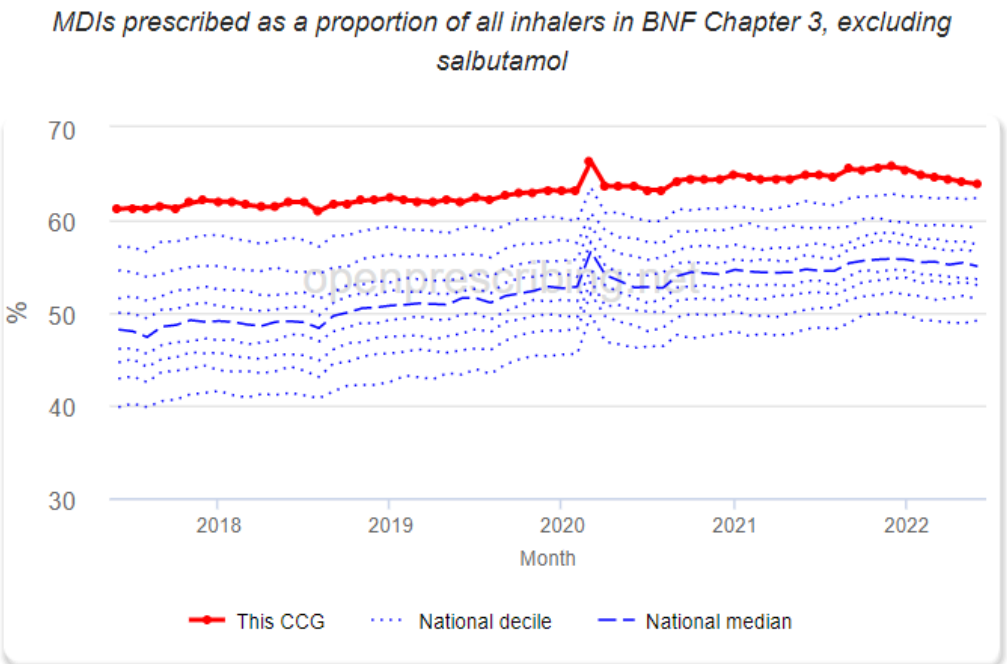


Figure 9 – MDIs prescribed as a proportion of all inhalers in BNF Chapter 3, excluding salbutamol

Taking all inhalers together, the inhaler carbon emissions for Derbyshire from April to June 2021 were 6,429,419 KgCO2e. The latest figures from PrescQIPP (March to May 2022) show that this has reduced to 4,844,865 KgCO2e, a reduction of nearly 25%.

Sustainability and the impact of Covid-19

The CCG has continued to evidence securing emission reductions and improving sustainability in the following areas:

Energy	Reducing total consumption in CCG 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 working remotely during the pandemic.
Procurement	Taking account of the Procurement for Carbon Reduction Sustainable Procurement Tool.

ACCOUNTABILITY REPORT

Dr Chris Clayton

Accountable Officer

NHS Derby and Derbyshire CCG

27th June 2023

Accountability Report Overview

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

Corporate Governance Report

The Corporate Governance Report sets out how we have governed the organisation during Q1 of 2022/23, including membership and 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

Members Report

Member Practices

The CCG is comprised of 109 member General Practices and a further 56 branch surgeries, which are detailed in Table 17 below:

Main Practice	Branch Surgery
Adam House Medical Centre	Hillside Surgery
Aitune Medical Practice	–
Alvaston Medical Centre	Aston Surgery
Appletree Medical Practice	Little Eaton Surgery
Arden House Medical Practice	–
Arthur Medical Centre	–
Ashbourne Medical Practice	–
Ashbourne Surgery	–
Ashover Medical Centre	–
Barlborough Medical Practice	Renishaw Surgery
Baslow Health Centre	–
Blackwell Medical Centre	–
Blue Dykes Surgery (DCHSFT Partnership)	Grassmoor Surgery
Brailsford Medical Centre	Hulland Ward Medical Centre
Brimington Surgery	–
Brook Medical Centre	–
Brooklyn Medical Practice	–
Buxton Medical Practice	–
Calow and Brimington Practice	Calow Surgery
Castle Street Medical Centre	–
Chapel Street Medical Centre	Mayfield Medical Centre
Chatsworth Road Medical Centre	–
Chellaston and Melbourne Medical Practice	Melbourne Medical Centre
Chesterfield Medical Partnership	Holme Hall Surgery Whittington Medical Centre
Clay Cross Medical Centre	Tupton Surgery
College Street Medical Practice	–
Crags Health Care	Whitwell Health Centre
Creswell Medical Centre	Langwith Medical Centre

Main Practice	Branch Surgery
Crich Medical Practice	Halloway Surgery South Winfield Surgery
Darley Dale Medical Centre (Credas Medical)	Winster Surgery Youlgreave Surgery
Derby Family Medical Centre	–
Derwent Medical Centre	–
Derwent Valley Medical Practice	Derwent Valley Medical Practice, Sitwell Street
Dr Webb and Partners	–
Dronfield Medical Practice	–
Eden Surgery	–
Elmwood Medical Centre	–
Emmett Carr Surgery	Eckington Health Centre
Evelyn Medical Centre	Hathersage Surgery
Eyam Surgery	Bradwell Surgery
Friar Gate Surgery	–
Friendly Family Surgery	–
Gladstone House Surgery	–
Goyt Valley Medical Practice	Chapel-en-le-Frith Surgery
Gresleydale Healthcare Centre	–
Hannage Brook Medical Centre	–
Hartington Surgery	–
Heartwood Medical Practice	–
Hollybrook Medical Centre	Sinfin Surgery
Horizon Healthcare	Mackworth Surgery, Humbleton Drive Mackworth Surgery, Tufnell Gardens
Imperial Road Surgery	–
Inspire Health (formerly Avenue House and Hasland)	Hasland Medical Centre Hasland Surgery
Ivy Grove Surgery	–
Jessop Medical Practice	Church Farm Primary Care Centre
Kelvingrove Medical Centre	–
Killamarsh Medical Practice	–
Lime Grove Medical Centre	–
Limes Medical Centre	–
Lister House Chellaston Surgery	Coleman Health Centre
Lister House Surgery	Oakwood Medical Centre
Littlewick Medical Centre	The Dales Medical Centre
Macklin Street Surgery	Park Farm Surgery

Main Practice	Branch Surgery
Mickleover Medical Centre	–
Mickleover Surgery	–
Moir Medical Centre	Sawley Surgery Draycott Surgery
Newbold Surgery	–
Newhall Surgery	–
North Wingfield Medical Centre	–
Oakhill Medical Practice	–
Old Station Surgery	Cotmanhey Surgery Kirk Hallam Surgery
Osmaston Surgery	–
Overdale Medical Practice	Breaston Surgery
Park Farm Medical Centre	Vernon Street Surgery
Park Lane Surgery	–
Park Medical Practice	Borrowash Surgery University Surgery Oakwood Surgery
Park Surgery	–
Parkfields Surgery	–
Parkside Surgery	–
Peak and Dales Medical Partnership	Tideswell Surgery
Peartree Medical Centre	–
Ripley Medical Centre (DCHSFT partnership)	–
Riversdale	–
Royal Primary Care	Rectory Road Medical Centre Inkersall Family Health Centre
Sett Valley Medical Centre	The Old Bank Surgery, Market Street
Shires Healthcare	Shires Healthcare, Bishops Walk
Somercotes Medical Centre	–
Springs Health Centre	–
St. Lawrence Road Surgery	–
St. Thomas Road Surgery	–
Staffa Health	Stonebroom Surgery Pilsley Surgery Holmewood Surgery
Stewart Medical Centre	–
Stubley Medical Centre	–
Swadlincote Surgery	–
The Surgery at Wheatbridge	–

Main Practice	Branch Surgery
The Valleys Medical Partnership	Moss Valley Medical Practice
Thornbrook Surgery	Chinley Surgery
Vernon Street Medical Centre	The Lane Medical Centre
Village Surgery, Alfreton	–
Village Surgery, Derby	–
Welbeck Road Surgery	Glapwell Surgery
Wellbrook Medical Centre	–
West Hallam Medical Centre	–
West Park Surgery	–
Whitemoor Medical Centre	–
Whittington Moor Surgery	–
Willington Surgery	–
Wilson Street Surgery	Taddington Road Surgery
Wingerworth Medical Centre	–
Woodville Surgery	–

Table 17 – list of CCG General Practices

Composition of Governing Body

The Governing Body members for the CCG are shown in Table 18 below.

Governing Body Member	Position
Voting	
Dr Avi Bhatia	Clinical Chair
Martin Whittle	Lay Member for Patient and Public Involvement and Vice Governing Body Chair
Dr Chris Clayton	Chief Executive Officer
Richard Chapman	Chief Finance Officer
Brigid Stacey	Chief Nurse Officer
Dr Steven Lloyd	Executive Medical Director
Helen Dillistone	Executive Director of Corporate Strategy and Delivery
Zara Jones	Executive Director of Commissioning Operations
Dr Penny Blackwell	GP Member
Dr Bukhtawar Dhadda	GP Member
Dr Emma Pizzey	GP Member
Dr Greg Strachan	GP Member
Dr Merryl Watkins	GP Member
Jill Dentith	Lay Member for Governance and Freedom to Speak Up Guardian
Ian Gibbard	Lay Member for Audit and Conflicts of Interest Guardian
Andrew Middleton	Lay Member for Finance and Sustainability Champion
Simon McCandlish	Lay Member for Patient and Public Involvement
Professor Ian Shaw	Lay Member for Primary Care Commissioning
Dr Bruce Braithwaite	Secondary Care Consultant
Non-Voting	
Dr Robyn Dewis	Derby City Council Representative
Dean Wallace	Derbyshire County Council Representative

Table 18 – members of the CCG's Governing Body during Quarter 1 of 2022/23

Audit Committee

The Audit Committee is accountable to the CCG Governing Body and provides them with an independent and objective view of the financial systems, financial information and compliance with laws, regulations and directions governing the CCG. The Governing Body approved and keeps under review the Terms of Reference for the Audit Committee, which includes the membership of the Audit Committee.

Full details of other sub-committees can be found in the Governance Statement on page 96.

Audit Committee Membership

The membership of the Audit Committee of the CCG is shown in Table 19 below.

Audit Committee Member	Position
Ian Gibbard	Chair – Lay Member for Audit and Conflicts of Interest Guardian
Jill Dentith	Deputy Chair – Lay Member for Governance and Freedom to Speak Up Guardian
Andrew Middleton	Lay Member for Finance and Sustainability Champion
Dr Bruce Braithwaite	Secondary Care Consultant ('by invitation' in accordance with the Committee's workplan or where clinical input is required)

Table 19 – members of the CCG's Audit Committee during Quarter 1 2022/23

Register of Interests

The CCG holds a register of interests for all individuals who are engaged by the CCG. The registers are viewable here[9] and available on request at the CCG Headquarters.

Personal Data Related Incidents

There have been no Information Governance incidents during Q1 of 2022/23 that met the criteria for reporting through the Data Protection and Security Toolkit to the Information Commissioner's Office.

Statement of Disclosure to Auditors

Each individual who is a member of the CCG at the time the Members' Report is approved confirms:

- so far as the member is aware, there is no relevant audit information of which the CCG's auditor is unaware that would be relevant for the purposes of their audit report; and
- the member has taken all the steps that they ought to have taken in order to make him or herself aware of any relevant audit information and to establish that the CCG's auditor is aware of it.

Modern Slavery Act

NHS Derby and Derbyshire CCG 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 30th June 2022 is published on our website at https://www.derbyandderbyshireccg.nhs.uk/.

[9] https://www.derbyandderbyshireccg.nhs.uk/about-us/conflict-of-interest/

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each CCG shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed the Chief Executive Officer to be the Accountable Officer of NHS Derby and Derbyshire CCG.

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities 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 CCG and enable them to ensure that the accounts comply with the requirements of the Accounts Direction);
- for safeguarding the CCG's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities);
- the relevant responsibilities of accounting officers under Managing Public Money;
- ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended));
- ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHS England has directed each CCG 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 the CCG and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

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

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 CCG'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.

I also confirm that as far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as 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 the CCG's auditors are aware of that information.

Dr Chris Clayton

Accountable Officer

NHS Derby and Derbyshire CCG

27th June 2023

Governance Statement

Introduction and Context

NHS Derby and Derbyshire Clinical Commissioning Group (CCG) is a body corporate established by NHSE&I on the 1st April 2019 under the National Health Service Act 2006 (as amended).

The CCG's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG 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 2022 and 30th June 2022 the clinical commissioning group was not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006 (as amended).

The CCG brings together local General Practices (General Practitioners) and other healthcare professionals to commission hospital and community NHS services for Derbyshire, comprising of 109 member General Practices with a registered population of around 1,077,074.

The geographical footprint and eight areas known as 'Places' covered by the CCG 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 eight Place Alliances across the Derbyshire Joined up Care Unit of Planning have been identified as a means to engage people in the development of services.

The CCG had a revenue income of circa £545k for the period 1st April 2022 to the 30th June 2022, and had a workforce of 497 employees on the 30th June 2022.

Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the CCG'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 National Health Service Act 2006 (as amended) and in my NHS Derby and Derbyshire Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the CCG 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 CCG as set out in this governance statement.

Governance Arrangements and Effectiveness

The main function of the Governing Body 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 Governing Body is corporate responsibility for the CCG's strategies, actions and finances. As a Governing Body of an NHS organisation, it is the custodian of a national asset, provides stewardship and remains publicly accountable.

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

The CCG is a clinically led organisation and has 109 member General Practices as detailed in the Constitution. In addition to our accountability to the public and patients we serve, the CCG is accountable to NHSE&I and to its Membership.

Corporate Governance Framework

The Corporate Governance Framework for the CCG is set out in its Constitution, which ensures that the CCG complies with section A of the UK Corporate Governance Code in all respects. The Constitution was last amended in December 2021.

Governing Body

The Governing Body is responsible for ensuring that the CCG exercises its functions effectively, efficiently and economically, and in accordance with sections 14L(2) and (3) of the National Health Service Act 2006 (as amended), as inserted by section 25 of the Health and Social Care Act 2012 and the Constitution of the CCG.

The Governing Body was appointed in accordance with section 14L of the National Health Service Act 2006 (as amended). The appointment process for Governing Body members varies according to the role they undertake and the appointment process specific to each role is therefore specified in detail within Appendix 3 (Standing Orders) to the Constitution. The CCG 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 Governing Body is supported by a Head of Governance and its composition is described in Table 20 below, each with a single non-transferable vote unless detailed otherwise.

Governing Body Member	Position
Voting	
Dr Avi Bhatia	Clinical Chair
Martin Whittle	Lay Member for Patient and Public Involvement and Vice Governing Body Chair
Dr Chris Clayton	Chief Executive Officer
Richard Chapman	Chief Finance Officer
Brigid Stacey	Chief Nurse Officer
Dr Steven Lloyd	Executive Medical Director
Helen Dillistone	Executive Director of Corporate Strategy and Delivery
Zara Jones	Executive Director of Commissioning Operations

Governing Body Member	Position
Dr Penny Blackwell	GP Member
Dr Bukhtawar Dhadda	GP Member
Dr Emma Pizzey	GP Member
Dr Greg Strachan	GP Member
Dr Merryl Watkins	GP Member
Jill Dentith	Lay Member for Governance and Freedom to Speak Up Guardian
Ian Gibbard	Lay Member for Audit and Conflicts of Interest Guardian
Andrew Middleton	Lay Member for Finance and Sustainability Champion
Simon McCandlish	Lay Member for Patient and Public Involvement
Professor Ian Shaw	Lay Member for Primary Care Commissioning
Dr Bruce Braithwaite	Secondary Care Consultant
Non-Voting	
Dr Robyn Dewis	Derby City Council Representative
Dean Wallace	Derbyshire County Council Representative

Table 20 – members of the CCG's Governing Body during Quarter 1 of 2022/23

Since January 2021, the Governing Body has been operating at business continuity level four as a result of the Covid-19 pandemic. The Governing Body agreed the quorum necessary for the transaction of business during business continuity level four escalation as:

- Clinical Chair, Vice Chair (Lay Member for Patient and Public Involvement), or Audit Committee Chair;
- 1 x CCG Officer (Chief Executive Officer, Chief Finance Officer or Chief Nurse Officer) or Executive Director;
- 2 x Lay Members; and
- 3 x voting clinicians (to include GP Members, Secondary Care doctor and/or Clinical Chair).

The Governing Body met in public and confidentially three times during Q1 of 2022/23. All meetings were fully quorate.

The membership and attendance record for the Governing Body and sub-committees can be found in Appendix One.

Governing Body Performance

As a result in the national delay to the establishment of the ICB to the 1st July 2022, Governing Body members contracts were extended to the 30th June 2022.

The Governing Body has continued to meet on a virtual basis via Microsoft Teams each month during Q1 of 2022/23, both in public and confidentially. From the 1st April 2021, the Governing Body meeting in public has been livestreamed to the public every month.

During Q1 of 2022/23, the Governing Body continued to oversee the ICB transition, through a System JUCD Transition Assurance Sub-Committee (STAC) and a CCG ICS Transition Working Group (TWG).

The STAC chaired by the CCG's Clinical Chair, met monthly throughout 2021/22 and the final quarter of the CCG. The primary purpose of the STAC is to provide expertise and assistance to support the JUCD Board in providing the oversight of the transition of the current system into a statutory ICS. The STAC oversees the iterative process and is influenced by emerging national guidance. The STAC is a time-limited sub-committee to oversee the safe and legal transition process up to the end of June 2022, after which it would be stood down upon the demise of the CCG.

The CCG ICS TWG met monthly following the CCG Governing Body meetings. TWG is also chaired by the CCG's Clinical Chair and attended by members of the Governing Body and CCG Officers. The group is accountable to the Governing Body and provides updates to and receives assurance from the CCG Transition Project Group, which ensure the delivery of the transition actions required. The TWG was established to oversee the transition plan to:

- facilitate the movement from the CCG's existing arrangements to the transfer of functions to the Derbyshire ICS;
- implement the engagement plan to ensure that the Governing Body, membership, staff and the public are appropriately informed of the process to implement the new arrangements;
- provide assurance that the transfer and closure of CCG functions meets with legislative requirements to support the new ICB Constitution; and
- provide assurance of the safe and legal transfer of staff to appropriate roles within the ICS.

The group reviewed its Terms of Reference and the governance of this programme of work, including the agreement that a standing item be included on Governing Body agendas for reporting progress. A detailed action plan was produced which incorporated both system and CCG-level actions. The group also reviewed progress on the current thinking around mapping the future locations of the CCG's commissioning functions. The CCG successfully delivered the Due Diligence process for the closure of the CCG and the Readiness to Operate Statement process, which was approved by NHSE&I.

Corporate Committees of the Governing Body

To support the Governing Body in carrying out its duties effectively, Committees reporting to the Governing Body have been formally established. The remit and Terms of Reference of these Corporate Committees are reviewed every six months. Each committee receives regular reports, as outlined within their Terms of Reference and provides exception and highlight reports to the Governing Body.

The governance structure of the CCG comprises:

- Governing Body;
- Committees of the Governing Body:
    - Audit Committee;
    - Clinical and Lay Commissioning Committee;
    - Engagement Committee;
    - Finance Committee;
    - Governance Committee;
    - Primary Care Commissioning Committee;
    - Quality and Performance Committee; and
    - Remuneration Committee.

Ratified Corporate Committee minutes are formally recorded and submitted to the Governing Body in its meeting in public sessions, wherever possible, 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 Governing Body. The Governing Body 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 the submission of the ratified minutes.

Audit Committee

The Audit Committee is constituted in line with the provisions of the NHS Audit Committee Handbook and the 'Towards Excellence' guidance. It has overseen internal and external audit plans and the risk management and internal control processes (financial and quality), including control processes around counter fraud.

The duties of the Audit Committee are driven by the priorities identified by the CCG, and the associated risks. It operates to a programme of business, agreed by the CCG, which is flexible to new and emerging priorities and risks. The Audit Committee also monitors the integrity of the financial statements of the CCG and any other formal reporting relating to the CCG's financial performance.

Audit Committee Membership

The composition of the Audit Committee is shown in Table 21 below.

Audit Committee Member	Position
Ian Gibbard	Chair – Lay Member for Audit and Conflicts of Interest Guardian
Jill Dentith	Deputy Chair – Lay Member for Governance and Freedom to Speak Up Guardian
Andrew Middleton	Lay Member for Finance and Sustainability Champion
Dr Bruce Braithwaite	Secondary Care Consultant ('by invitation' in accordance with the Committee's workplan or where clinical input is required)

Table 21 – members of the CCG's Audit Committee during Quarter 1 of 2022/23

The Audit 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 Q1 of 2022/23 are shown in Table 22 below.

Significant items approved/discussed by Audit Committee during Quarter 1 of 2022/23	
Governance, Risk Management and Internal Control	
Financial Transition Project	AccuRx Lessons Learned
Closure of NHS Derby and Derbyshire CCG and boundary change for the Derbyshire ICB	Audit Committee Annual Report and transfer of live CCG matters of business to the ICB
2021/22 Annual Report, Accounts and Annual Governance	Audit Committee Terms of Reference

Significant items approved/discussed by Audit Committee during Quarter 1 of 2022/23	
CHC Service – Annual Report 2021/22	Late Receipt allocation issue/ Better Care Fund Section 75
Single Tender Waivers	
Internal Audit	
360 Assurance: Draft Internal Audit Plan Covering Final Three months of CCG's Existence	2021/22 Head of Internal Audit Opinion and Annual Report
External Audit	
KPMG draft year-end report 2021/22– ISA260	KPMG Auditor's Annual Report 2021/22
Service Auditor Reports 2021/22	

Table 22 – significant items approved/discussed by Audit Committee during Quarter 1 of 2022/23

A benchmark of one meeting per quarter at appropriate times in the reporting and audit cycle is suggested. The Committee met twice during Q1 of 2022/23 and also met once extraordinarily and twice confidentially.

All meetings were fully quorate. The quorum necessary for the transaction of business is two members.

Primary Care Commissioning Committee

The role of the Primary Care Commissioning Committee is to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act 2006 (as amended). This enables the members, as detailed in Table 23 below, to make collective decisions on the review, planning and procurement of Primary Care services in the CCG, under delegated authority from NHSE&I. The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

Primary Care Commissioning Committee Membership

Primary Care Commissioning Committee Member	Position
Professor Ian Shaw	Chair – Lay Member for Primary Care Commissioning
Simon McCandlish	Deputy Chair – Lay Member for Patient and Public Involvement
Jill Dentith	Lay Member for Governance and Freedom to Speak Up Guardian
Richard Chapman	Chief Finance Officer
Brigid Stacey	Chief Nurse Officer
Dr Steven Lloyd	Executive Medical Director

Table 23 – members of the CCG's Primary Care Commissioning Committee during Quarter 1 of 2022/23

Significant items that were discussed and approved during Q1 of 2022/23 are shown in Table 24 below.

Significant items approved/discussed by Primary Care Commissioning Committee during Quarter 1 of 2022/23	
Finance update	Risk register exception report
Hollybrook Medical Centre and Haven Medical Centre Practice Merger	Primary Care Commissioning Committee – Terms of Reference
NHSE/I Primary Medical Care Policy and Guidance Manual	The Golden Brook Practice and Park Medical Centre Full Practice Merger
Primary Care Quality and Performance Assurance Report Quarter 4	Committee Annual Report and transfer of live CCG matters of business to the ICB
The Village Surgery update	

Table 24 – significant items approved/discussed by Primary Care Commissioning Committee during Quarter 1 of 2022/23

The Committee met a total of three times during Q1 of 2022/23 and all meetings were quorate. They also met three times confidentially. The quorum necessary for the transaction of business is four members, at least two of whom are Lay Members and include the Chair or Deputy Chair.

Remuneration Committee

The Remuneration Committee is accountable to the Governing Body and makes recommendations to the Governing Body on determinations about the remuneration, fees and other allowances for employees and for people providing services to the CCG.

The Governing Body has approved and keeps under review the Terms of Reference for the Committee, which includes information on the membership. The Governing Body ensures that all members appointed remain independent. No decisions are made by Executive Officers.

The Governing Body has delegated specific functions and responsibilities, in relation to remuneration, as specified in the Terms of Reference and the CCG's Scheme of Reservation and Delegation. The work of the Remuneration Committee enables the CCG to declare compliance with Section D of the Corporate Governance Code of Conduct.

In order to avoid any conflict of interest, in respect of Lay Members who are the only members of the Remuneration Committee, their own remuneration is set directly by the Governing Body. The Lay Members who are conflicted are not part of the decision-making.

Remuneration Committee Membership

The composition of the Remuneration Committee is shown in Table 25 below.

Remuneration Committee Member	Position
Martin Whittle	Chair – Lay Member for Patient and Public Involvement and Vice Governing Body Chair
Ian Gibbard	Lay Member for Audit and Conflicts of Interest Guardian
Jill Dentith	Lay Member for Governance and Freedom to Speak Up Guardian

Remuneration Committee Member	Position
Andrew Middleton	Lay Member for Finance and Sustainability Champion

Table 25 – members of the CCG's Remuneration Committee during Quarter 1 of 2022/23

Significant items that were discussed and approved during Q1 of 2022/23 are shown in Table 26 below.

Significant items approved/discussed by Remuneration Committee during Quarter 1 of 2022/23	
Executive Pay Review	Terms of Reference
Running Costs Report – Month 12	Update of the Development Plan for the Executive Director of Strategy and Planning
Salary Recommendation	

Table 26 – significant items approved/discussed by Remuneration Committee during Quarter 1 of 2022/23

The Committee meets as required but as a minimum annually. The Committee met once during Q1 of 2022/23. The quorum necessary for the transaction of business is two of the four members of the Remuneration Committee. The meetings were fully quorate and in accordance with its Terms of Reference.

Clinical and Lay Commissioning Committee

The purpose of the Clinical and Lay Commissioning Committee is to provide a clinical forum within which discussions can take place; recommendations are made on the clinical direction of the CCG; and it helps secure the continuous improvement of the quality of services. The membership detailed below in Table 27 has delegated authority to make financial recommendations as set out in the Standing Financial Instructions on disinvestment/ de-commissioning decisions.

Clinical and Lay Commissioning Committee Membership

Clinical and Lay Commissioning Committee Member	Position
Professor Ian Shaw	Chair – Lay Member for Primary Care Commissioning
Ian Gibbard	Deputy Chair – Lay Member for Audit and Conflicts of Interest Guardian
Dr Bukhtawar Dhadda	Governing Body GP
Dr Emma Pizzey	Governing Body GP
Dr Greg Strachan	Governing Body GP
Dr Merryl Watkins	Governing Body GP
Dr Bruce Braithwaite	Secondary Care Consultant
Simon McCandlish	Lay Member for Patient and Public Involvement
Brigid Stacey	Chief Nurse Officer
Dr Steven Lloyd	Executive Medical Director
Richard Chapman	Chief Finance Officer

Clinical and Lay Commissioning Committee Member	Position
Dr Robyn Dewis	Public Health Representative
Zara Jones	Executive Director of Commissioning Operations

Table 27 – members of the CCG's Clinical and Lay Commissioning Committee during Quarter 1 of 2022/23

Significant items that were discussed and approved during Q1 of 2022/23 are detailed below in Table 28.

Significant items approved/discussed by Clinical and Lay Commissioning Committee during Quarter 1 of 2022/23	
Audiology Services 2022/23 Contract	Hospital Discharge Interim Funding
Audiology update	Governing Body Assurance Framework
Care Leaver Prescriptions	Independent Sector Provider Contract
CHC Domiciliary homecare	Health Services in the North of the County
Children's Vision Screening	Hospice Contracts
Risk Management	Neuro Development Research Project
Committee Annual Report and transfer of live CCG matters of business to the ICB	Nursing Home Preferred Provider List Window 5
Clinical and Lay Commissioning Committee Terms of Reference	Mental Health Support Teams in education settings
Procurements	High Dependency Hospital Rehabilitation and Complex Hospital Care Rehabilitation
Commissioning of Non-Scalpel Vasectomies	Psychosexual Therapy
Clinical policies	Service Provision for Unaccompanied Asylum-Seeking Children
Derbyshire Post-Covid-19 Service	Team Up Update
DHcFT Acute Mental Health Dormitory Eradication and Psychiatric Intensive Care Unit Programme	Tobacco Dependency Treatment
Discharge to Assess Interim NHS funding	UHDBFT – change of referral pathway for dermatology
Glossop Transition	Urgent Treatment Centre update

Table 28 – significant items approved/discussed by Clinical and Lay Commissioning Committee during Quarter 1 of 2022/23

The Committee met a total of three times during Q1 of 2022/23. The quorum necessary for the transaction of business is six members, to include four clinicians, one Lay Member and one Executive Lead. All meetings were fully quorate.

Engagement Committee

The Engagement Committee meets with the purpose of assuring the Governing Body that the CCG is involving patients in its decisions about health services and that robust processes are in place to ensure that the CCG is fully compliant with their statutory obligations. Members are detailed in Table 29 and include representatives from the Governing Body, public representatives from communities, Foundation Trust Governors, Healthwatch and the voluntary sector. Staff from

the CCG are invited to attend the Engagement Committee to update on the programme or scheme that they are working on, including an update on the communications and engagement strategy in place for that specific piece of work. This approach provides oversight and facilitates confirm and challenge opportunities for the Engagement Committee.

Engagement Committee Membership

Engagement Committee Member	Position
Voting Members	
Martin Whittle	Chair – Lay Member for Patient and Public Involvement and Vice Governing Body Chair
Simon McCandlish	Deputy Chair – Lay Member for Patient and Public Involvement
Professor Ian Shaw	Lay Member for Primary Care Commissioning
Maura Teager	Foundation Trust Governor – Secondary Care
Margaret Rotchell	Foundation Trust Governor – Secondary Care
Lynn Walshaw	Foundation Trust Governor – Community
Christopher Mitchell	Foundation Trust Governor – Mental Health
Ram Paul	Derby City Council Representative
Jocelyn Street	Place Engagement Representative
Ruth Grice	Place Engagement Representative
Trevor Corney	Place Engagement Representative
Roger Cann	Place Engagement Representative
Steve Bramley	Place Engagement Representative
Tim Peacock	Place Engagement Representative
Helen Dillistone	Executive Director of Corporate Strategy and Delivery
Non-Voting Members	
Beth Soraka	Healthwatch Derby Representative
Helen Henderson-Spoors	Healthwatch Derbyshire Representative
Kim Harper	Voluntary Sector City Representative
Sean Thornton	Assistant Director Communications and Engagement, CCG
Vikki Taylor	ICS Director, Joined Up Care Derbyshire
Karen Lloyd	Head of Engagement, Joined Up Care Derbyshire

Table 29 – members of the CCG's Engagement Committee during Quarter 1 of 2022/23

Significant items that were discussed and approved during Q1 of 2022/23 are detailed below in Table 30.

Significant items approved/discussed by Engagement Committee during Quarter 1 of 2022/23	
Committee Annual Report and transfer of live CCG matters of business to the ICB	Integrated Care System branding
Communications and Engagement performance report	Integrated Care System Engagement Strategy
Risk Management	Integrated Care System Communications and Engagement Plan
Derbyshire Engagement Committee Terms of Reference	Section 14Z2/Equality Impact Assessments and Log
Engagement Model and Governance Guidance	Post July Committee arrangements & terms of reference development
Enhanced access in PCNs	Urgent Treatment Centres
Governing Body Assurance Framework	Working in partnership with people and communities – national guidance consultation

Table 30 – significant items approved/discussed by Engagement Committee during Quarter 1 of 2022/23

The Committee met a total of three times during Q1 of 2022/23. The quorum necessary for the transaction of business is five members, to include two Lay Members for Patient and Public Involvement, two Place Engagement Representatives and one Executive Lead. All meetings were quorate.

Finance Committee

The purpose of the Finance Committee is to review both the financial and service performance of the CCG against financial control targets and the annual commissioning plan. The Committee also identifies where remedial action is needed, ensuring that action plans are put in place and delivery is monitored.

Finance Committee Membership

The composition of the Finance Committee is detailed in Table 31 below.

Finance Committee Member	Position
Andrew Middleton	Chair – Lay Member for Finance and Sustainability Champion
Martin Whittle	Deputy Chair – Lay Member for Patient and Public Involvement and Vice Governing Body Chair
Ian Gibbard	Lay Member for Audit and Conflicts of Interest Guardian
Dr Bukhtawar Dhadda	Governing Body GP
Richard Chapman	Chief Finance Officer
Brigid Stacey	Chief Nurse Officer

Table 31 – members of the CCG's Finance Committee during Quarter 1 of 2022/23

Significant items that were discussed and approved during Q1 of 2022/23 are detailed in Table 32.

Significant items approved/discussed by Finance Committee during Quarter 1 of 2022/23	
Acute Front Door Redesign Project FBC	Financial Plan, Assumptions and Risks
Business As Usual Capital Finance Plan	Making Room for Dignity Programme
Capital Report	Hospice Financial Sustainability
CCG Finance Committee Terms of Reference	Local Estates Strategy
CCG Finance Reports	JUCD Finance Reports
Committee Annual Report and transfer of live CCG matters of business to the ICB	Governing Body Assurance Framework
Risk Management	Vaccination Operations Cell Structure
Discharge to Assess Interim NHS Funding	Virement Report
Financial Planning Update 2022/23	

Table 32 – significant items approved/discussed by Finance Committee during Quarter 1 of 2022/23

The Committee met a total of four times during Q1 of 2022/23. The quorum necessary for the transaction of business is five members, to include one Executive Lead (Chief Finance Officer); at least one Clinical Representative and at least two Governing Body Lay Members. All meetings were quorate.

Governance Committee

The purpose of the Governance Committee is to ensure that the CCG complies with the principles of good governance whilst effectively delivering the statutory functions of the CCG. It also has delegated authority to make decisions as set out in the CCG's Prime Financial Policies and the Scheme of Reservation and Delegation.

Governance Committee Membership

The composition of the Governance Committee is detailed in Table 33 below.

Governance Committee Member	Position
Jill Dentith	Chair – Lay Member for Governance and Freedom to speak up Guardian
Ian Gibbard	Deputy Chair – Lay Member for Audit and Conflicts of Interest Guardian
Martin Whittle	Lay Member for Patient and Public Involvement and Vice Governing Body Chair
Dr Emma Pizzey	Governing Body GP
Dr Greg Strachan	Governing Body GP
Helen Dillistone	Executive Director of Corporate Strategy and Delivery

Table 33 – members of the CCG's Governance Committee during Quarter 1 of 2022/23

Significant items that were discussed and approved during Q1 of 2022/23 are detailed in Table 34.

Significant items approved/discussed by Governance Committee during Quarter 1 of 2022/23	
Business Continuity, Emergency Planning Resilience and Response update	Governance Contracts Update
CCG Estates Update	Governance of Provider Contract Transfers
Committee Annual Report and transfer of live CCG matters of business to the ICB	Health and Safety Report
Governing Body Assurance Framework Quarter 1 2022/23	Information Governance and GDPR Update Report
Contracts Oversight Group Update	Mandatory training
Contract Oversight Update	Non-Clinical Adverse Incidents
Procurement Highlight Report	Procurement Decisions in ICS Transition
Diversity Inclusion Network Terms of Reference	Risk Management
Digital Development Update	2021 Staff Survey Action Plan
Extension for clinical and place leads	2021/22 Annual Complaints Report
Governance Committee Terms of Reference	2021/22 Q4 Freedom of Information Report

Table 34 – significant items approved/discussed by Governance Committee during Quarter 1 of 2022/23

The Committee met twice during Q1 of 2022/23. The quorum necessary for the transaction of business is four members, to include two Governing Body Lay Members, one clinician and the Executive Lead (or nominated deputy). All meetings were quorate.

Quality and Performance Committee

The purpose of the Quality and Performance Committee is to provide assurance to the CCG's Governing Body in relation to the quality, performance, safety, experience and outcomes of services commissioned by the CCG. It also ensures that the CCG discharges its statutory duties in relation to the achievement of continuous quality improvement and safeguarding of vulnerable children and adults.

Quality and Performance Committee Membership

The composition of the Quality and Performance Committee is detailed in Table 35 below.

Quality and Performance Committee Member	Position
Dr Bukhtawar Dhadda	Chair – Governing Body GP
Andrew Middleton	Deputy Chair – Lay Member for Finance and Sustainability Champion
Dr Emma Pizzey	Governing Body GP
Dr Greg Strachan	Governing Body GP
Dr Merryl Watkins	Governing Body GP

Quality and Performance Committee Member	Position
Simon McCandlish	Lay Member for Patient and Public Involvement
Martin Whittle	Lay Member for Patient and Public Involvement and Vice Governing Body Chair
Brigid Stacey	Chief Nurse Officer
Dr Steven Lloyd	Executive Medical Director
Dr Bruce Braithwaite	Secondary Care Consultant
Zara Jones	Executive Director of Commissioning Operations
Helen Henderson-Spoors	Health Watch Derbyshire County Representative

Table 35 – members of the CCG's Quality and Performance Committee during Quarter 1 of 2022/23

Significant items that were discussed and approved during Q1 of 2022/23 are detailed in Table 36.

Significant items approved/discussed by Quality and Performance Committee during Quarter 1 of 2022/23	
Care homes	Ockenden submission to outline progress against recommendations
Committee Annual Report and transfer of live CCG matters of business to the ICB	Patient Safety Incident Reporting Framework
Commissioning for Individuals Report	Personal Health Budgets Policy
Commissioning for Individuals	Quality Accounts
Continuing Healthcare	Quality and Safety Visit Reports
Elective Waiting List – Investigating Health Inequalities	Quality and Performance Committee Terms of Reference
EMAS Update	Risk Register
Governing Body Assurance Framework	Safeguarding Adults Report
Infection Prevention Control	Safeguarding Children Update
Integrated Performance Report	Special Educational Needs and Disability Update
Medicines Management Update	System Review of Category 2 Responses
Quality and Equality Impact Assessments	360 Assurance Personal Health Budgets Audit

Table 36 – significant items approved/discussed by Quality and Performance Committee during Quarter 1 of 2022/23

The Committee met a total of three times during Q1 of 2022/23. The quorum necessary for the transaction of business is five members, to include two clinicians, two Lay Members and one Executive Lead. All meetings were quorate.

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 CCG.

The Governance Statement is intended to demonstrate how the CCG has regard to the principles set out in the Code considered appropriate for CCGs for the financial year ended the 30th June 2022.

For the financial year ended the 30th June 2022, and up to the date of signing this statement, the CCG had regard to the provisions set out in the Code. All aspects that NHS Derby and Derbyshire CCG must reference within this statement are fully compliant.

Discharge of Statutory Functions

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

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

Risk Management Arrangements and Effectiveness

The CCG's integrated risk management system continued to be developed during Q1 of 2022/23 in line with internal audit recommendations.

The CCG 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 CCG 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 framework (strategy and procedural documents), Governing Body Assurance Framework, and the Corporate Risk Register. 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 CCG objectives.

The strategy applies to all employees of the CCG, the Governing Body, Executive Team and all senior managers to ensure that risk management is a fundamental part of the CCG's approach to the governance of the organisation and all its activities.

The organisation's strategic aims and objectives have been reviewed by the Governing Body during the year together with the strategic risks to integrate the impact of Covid-19.

The Risk Management Strategy was reviewed and approved by the Governance Committee in November 2020. It details the CCG's statement of intent in relation to risk management:

> *"Risk Management is not just the responsibility of one role or person within an organisation; it's everyone's responsibility"*

Risk management is embedded in the activities of the organisation. Through its Corporate Committees and line management structures, the CCG is able to ensure accountability for risk at all levels of the organisation.

The CCG identifies, assesses, manages and governs risk in line with widely available standards and guidance, and specifically in line with ISO 31000:2009. 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 CCG, 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 CCG'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 Governing Body membership has always been made inclusive to ensure diverse public stakeholders and other stakeholders' voices help inform CCG decision-making and can assist in highlighting risks at Governing Body level. The Governing Body has a strong lay membership for Audit, Finance and Governance, and Public and Patient Engagement; other Governing Body members include our GP members, Executive Directors, Secondary Care and Public Health representation.

The CCG 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 CCG continues to extend the opportunities for involvement further through the 'Derbyshire Dialogue', which is a virtual opportunity for anyone with an interest in health and care to join sessions covering a range of health and care services. Membership includes individuals from the public, Patient Participation Groups, Citizens Panel, and hospital employees. Governing Body colleagues share the passion with colleagues across the CCG to involve our public and patients at every opportunity and we were well represented at these sessions.

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

Prevention and deterrence of risk

The CCG has strong processes in place to assist in the identification and mitigation of risks arising. All reports to the Governing Body and Corporate Committees have mandatory sections on the assessment of quality and equality impact, privacy impact and risk assessment. The Governing Body 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 CCG 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&I and other appropriate bodies. Serious incidents are also reported through the Strategic Executive Information System. Any breaches of Information Governance which meet the level two criteria of the Information Commissioner's Office will be reported using the Data Protection and Security Toolkit to the Information Commissioner's Office as appropriate. 360 Assurance (Internal Audit) provide specialist advice with regard to Counter Fraud.

The CCG continues to work closely with the Local Authorities, Local Health Resilience Partnership and other partnership groups, and it has an established relationship with NHSE&I in respect of Emergency Preparedness, Resilience and Response.

Each year the CCG is required to complete an annual self-assessment against the Emergency Preparedness, Resilience and Response National Core Standards and submit to NHSE&I. In 2021/22 the CCG submitted a ‘substantial’ self-assessment. The CCG submitted a letter of assurance on the above process to NHSE&I on behalf of the CCG and Derbyshire providers, which was also confirmed by NHSE&I as 'substantial' assurance.

Capacity to Handle Risk

The Governing Body has a duty to assure itself that the organisation has properly identified the risks it faces, 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 CCG’s Risk Management Framework, as follows:

Governing Body	Oversight and holding CCG management to account.
Finance Committee	Development and implementation of risk management processes.
Audit Committee	Reviewing the effectiveness of the Governing Body Assurance Framework and risk management systems.
Governance Committee	Ensuring that the CCG complies with the principles of good governance whilst effectively delivering the statutory functions of the CCG.
Accountable Officer	Ensuring the CCG has an effective risk management system in place for meeting all statutory requirements.
Executive Team	Supporting the Accountable Officer and collectively and individually managing risk.

Executive Director of Corporate Strategy and Delivery	Ensuring the delivery of risk management.
Risk Group	Reviewing, monitoring and managing the risks on the CCG'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 Governing Body.
Head of Governance	Development, implementation and maintenance of the risk management arrangements for the CCG.
All Staff	Identifying, reporting and managing risks within their areas.

The Governing Body Assurance Framework was presented to the Governing Body, Audit Committee and relevant lead committees during Q1 of 2022/23 for scrutiny and assurance. The Governing Body approved the 2022/23 opening Governing Body Assurance Framework on the 16th June 2022.

Risks to the CCG are reported, discussed and challenged at the monthly Governing Body and Corporate Committee meetings. Communication is two-way, with the Committees escalating concerns to the Governing Body and the Governing Body delegating actions to the responsible Committee where appropriate. Monthly Risk Reports are also scrutinised by the Governing Body and each Corporate Committee.

As Accountable Officer, I have ultimate responsibility for risk management within the CCG. Day-to-day responsibility for risk management is delegated to the Executives of the Governing Body with executive leadership being vested in the Chief Finance Officer and Executive Director of Corporate Strategy and Delivery.

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 CCG's Risk Management Strategy and supporting Risk Management Framework which provides executives, managers and staff with the appropriate tools to identify, score and treat risk properly.

The Governing Body and Audit Committee fully support the Risk Management Framework within the CCG. There has been continuous improvement and refinement during Q1 of 2022/23, taking into account comments from members, resulting in processes and documents which are easy to read and readily accessible.

The CCG's Executive Director of Corporate Strategy and Delivery 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 Framework of the CCG.

Risk Assessment

Risk identification, assessment and monitoring is a continuous structured process in ensuring that the CCG 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 e.g. information governance, equality impact assessment and business continuity. Control measures are in place to ensure that the CCG's obligations under equality, diversity and human rights legislation are complied with. The CCG operates a standard 5x5 matrix for assessing risk.

This financial year has been challenging in a number of areas for the CCG, particularly in relation to the Covid-19 pandemic, in turn this has had a major impact on the risk profile of the CCG.

The Operational Risk Register is reviewed, updated and reported to the Corporate Committees and Governing Body on a monthly basis.

Significant risks identified during Quarter 1 of 2022/23

In context, the most significant risks we faced during Q1 of 2022/23 were:

- failure to meet the CCG's Constitutional standards and quality statutory duties in regard to Accident and Emergency;
- transforming care plans are unable to maintain and sustain the performance, pace and change required to meet national Transforming Care Plan requirements;
- failure of General Practices across Derbyshire results in failure to deliver quality Primary Care services, resulting in negative impact on patient care;
- patients deferring seeking medical advice for non-Covid-19 issues due to the belief that Covid-19 takes precedence. This may impact on health issues outside of Covid-19, LTCs, cancer patients etc.;
- the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the CCG to move to a sustainable financial position;
- risk to patients on waiting lists as a result of their delays to treatment as a direct consequence of the Covid-19 pandemic. Provider waiting lists have increased in size and it is likely that it will take significant time to fully recover the position against these; and
- the CCG NHS Mail container includes NHS Mail accounts for individuals who are not directly employed by the CCG, but by other clinical services. Employees external to the CCG are potentially accessing NHS Mail services (including MS Teams and One Drive) to which they may not be entitled. This generates a cost to the CCG for each additional user.

Sources of Assurance

Internal Control Framework

A system of internal control is the set of processes and procedures the CCG 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 CCG. 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 CCG's Internal and External Auditors. The Audit Committee is charged with receiving reports on the operation of key controls and ensuring that risks identified are appropriately mitigated and that actions are completed.

The CCG 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 CCG 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 Committee and the Clinical and Lay Commissioning Committee.

The CCG is committed to maximising public involvement through the use of the Patient Reference Groups, Stakeholder Groups and Public Events. The CCG is committed to ensuring that patients and the public are fully involved at all levels of the CCG's activity and have a meaningful impact on commissioning decisions, as required by the public involvement duty in Section 14Z2 of the NHS Act 2006 (as amended).

The CCG 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 CCG has also engaged a Local Security Management Specialist via 360 Assurance, to provide appropriate advice and support.

Annual Audit of Conflicts of Interest Management

The CCG 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 CCG 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 CCG, its Governing Body, its employees and associated General Practices from allegations and perceptions of wrongdoing. A conflicts of interest report is presented at each Audit Committee meeting.

To further strengthen the scrutiny and transparency of the decision-making processes, the Lay Member for Audit is the CCG's Conflicts of Interest Guardian. The Conflicts of Interest Guardian provides support and advice to CCG employees, General Practice staff, members of the public and healthcare professionals who have any concerns regarding conflicts of interest.

The CCG has managed its conflicts of interest by requesting declarations from all Governing Body and Committee members, decision makers and General Practice staff with CCG involvement; all of which can be found here[10].

The CCG also requests declarations from all staff and sub-committee members. These declarations are provided at CCG 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. CCG employees are all requested to declare these when they arise and details of those declared within 2021/22 can also be found at the web link above.

The revised statutory guidance on managing conflicts of interest for CCG's (published June 2017) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHSE&I published a template audit framework. 360 Assurance carried out an audit of the CCG's management of conflicts of interest in September 2021. The objective of the audit was to evaluate the design of the arrangements that the CCG has in place to manage conflicts of interest and gifts and hospitality, and to ensure this complies with NHSE&I's guidance on managing conflicts of interest. The assurance opinion for this audit was 'substantial assurance'.

Freedom to Speak Up Guardian

The CCG has a Raising Concerns at Work (Whistleblowing) Policy which supports employees in reporting genuine concerns about wrongdoing at work without any risk to themselves. The Freedom to Speak Up Guardian supports employees to speak up when they feel that they are unable to do so by any other means. The CCG's Lay Member for Governance 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.

[10] https://www.derbyandderbyshireccg.nhs.uk/about-us/conflict-of-interest/

In October 2021, the CCG recruited three members of staff to become Freedom to Speak Up Ambassadors. The Freedom to Speak Up Ambassador's role is to support and advise CCG 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 CCG to improve speaking up and to ensure that lessons are learnt and things are improved when workers do speak up.

The Raising Concerns at Work (Whistleblowing) Policy is the responsibility of the Governance Committee, and a Freedom to Speak Up Guardian report is presented at each Audit Committee meeting to update it of any concerns that have been raised. During Q1 of 2022/23 the CCG has had one concern raised through the freedom to speak up process. The CCG'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 CCG and senior management.

Data Quality

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

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

Information Governance

In order to provide assurance publicly that the CCG understands and complies with national requirements around confidentiality, integrity, and availability for data sources we hold, each year we complete a DSPT.

For 2021/22, the CCG submitted their DSPT on the 28th June 2022. This was a 'standards met' position, and represents that the CCG was compliant across all areas of assessment as required. This position was reported to the Governance Committee on the 23rd June 2022.

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

CCG Information Governance policies have been reviewed in-year, and the understanding of our staff has been tested through an Information Governance Awareness questionnaire which provided a positive picture.

The governance and oversight of Information Governance activities continued by the Information Governance Assurance Forum during Q1 of 2022/23, with an agenda taken via email approval in May, and a report (retrospective) confirming completion of the DSPT and movement into the ICB on the 19th July 2022. This forum is chaired by the Senior Information Risk Owner, and attended

by the Caldicott Guardian and Data Protection Officer, reporting to the Governance Committee as part of the overall CCG Governance structure. Included in the forum's annual forward plan are reviews of DSPT compliance activities and policies, access to information, cyber security updates, Information Governance incidents, training and staff communications. The CCG has not had any incidents which have necessitated report to the Information Commissioner's Office.

The forum met once during Q1 of 2022/23. 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 meeting regarding compliance with requirements regarding information flow mapping, Caldicott activity, and Data Protection Officer involvement in all completed Data Protection Impact Assessments (Stage 2).

The annual DSPT audit was undertaken by 360 Assurance during February and March 2022, and the CCG received a 'significant' assurance opinion.

Business Critical Models

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

Third party assurances

Table 37 shows the range of services which are provided by third party providers.

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

Table 37 – services provided to the CCG by third party providers

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

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

The CCG 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 CCG 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 CCG 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 CCG's objectives. Monthly financial performance is scrutinised by the Finance Committee and reported to the Governing Body. Internal and External Audit arrangements give assurance to the Governing Body on the delivery of the CCG's statutory financial responsibilities and the achievement of value for money. The CCG complies with the NHS Pension Scheme regulations. Through our Internal Auditors, the CCG'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 CCG 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 Governing Body, Quality and Performance Committee and Finance Committee.

The CCG 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 CCG uses commissioning support services to deliver economies of scale in the provision of some back-office and similar services.

Table 38 shows the CCG's running costs for the last three financial years and during Q1 of 2022/23.

	Allocation	Expenditure
	£'000	£'000
2019/20	23,431	17,864
2020/21	18,986	18,210
2021/22	19,824	19,824
Q1 2022/23	4,695	4,695

Table 38 – CCG's running costs for 2019/20, 2020/21, 2021/22 and during Quarter 1 of 2022/23

Table 39 identifies how the CCG's running costs were used during Q1 of 2022/23.

Breakdown of expenditure during Quarter 1 2022/23	
Expenditure	**£'000**
Pay costs	3,511
Travel expenses	11
Premises costs	284
Charges from Commissioning Support Unit	327
Other non-pay costs	676
Commissioning income	(114)

Table 39 – breakdown of expenditure during Quarter 1 of 2022/23

NHSE&I has a legal responsibility to review CCG performance on an annual basis, which historically has been carried out under the auspices of the CCG Improvement and Assessment Framework and, more recently, the NHS Oversight Framework. In 2020/21 the annual assessment was in the form of a self-assessment. As a result of the continued impact of Covid-19 a simplified approach for 2021/22 has been agreed which involves NHSE&I undertaking a review against 12 Nationally determined Key Lines of Enquiry (KLOE). The assessment used the CCG's Annual report as one of the main source documents along with the consideration of the views of Health and Wellbeing Boards.

Delegation of Functions

The CCG keeps its governance structures under constant review with the aim of delegating decision-making responsibility where this enables the Governing Body to devote more time to strategy and optimises the use of clinical leadership. All such arrangements are set out in the CCG's Scheme of Delegation. During the period reported, the CCG amended these delegations as a result of the ongoing response to the pandemic; ensuring senior clinical staff could continue to prioritise the delivery of healthcare to its patients in relation to Covid-19.

The CCG has two external delegation chains:

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

Counter Fraud Arrangements

Effective from the 1st April 2021, the NHS Counter Fraud Authority implemented the Government Functional Standard 013: Counter Fraud within the NHS. During the year, the NHS Counter Fraud Authority have developed their requirements in relation to the Functional Standard and all NHS funded services are required to comply with this. Progress against the requirements of the Functional Standard is overseen by the CCG's Chief Finance Officer and Audit Committee.

The CCG's Chief Executive Officer and Chief Finance Officer are jointly responsible for ensuring adherence to the Functional Standard. The CCG is required to self-assess against the requirements of the Functional Standard annually by completing and submitting the CCG's Counter Fraud Functional Standard Return. This requires prior sign off by the CCG's Chief Finance Officer and the Audit Committee Chair. Further detail of the CCG's submission can be found in the Counter Fraud Annual Report. The CCG aligns counter fraud, bribery and corruption work to the NHS Counter Fraud Authority's counter fraud, bribery and corruption strategy.

In May 2021, the CCG's Fraud, Bribery and Corruption Policy was reviewed by the CCG's Accredited Counter Fraud Specialist, approved by the Governance Committee, and made available to all staff. Counter fraud awareness has also taken place and regular updates including distribution of the publication 'Fraudulent Times' are made available. The Accredited Counter Fraud Specialist attends meetings of the Audit 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 Q1 for the CCG, the Head of Internal Audit issued an independent and objective interim opinion on the adequacy and effectiveness of the CCG's system of risk management, governance and internal control. The Head of Internal Audit concluded at Month 3 that:

> *"In consideration of the above, 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 that controls are generally being applied consistently.*
>
> *Throughout the period we continued to provide transition support to the CCG, through attendance at the CCG Transition Working Group, the Transition Assurance Committee and the Finance Transition Project Board."*

During Q1 of 2022/23, Internal Audit, 360 Assurance gave consideration as to whether the CCG 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:

- strategic governance and risk management;
- conflicts of interest
- NHSE/I delegated primary medical care services;
- data security and protection toolkit; and
- general ledger and financial reporting.

Review of the effectiveness of governance, risk management and internal control

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 CCG 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 CCG achieving its principles objectives has been reviewed.

I have been advised on the implications of the result of this review by the Governing Body, Audit Committee, Primary Care Commissioning Committee, Remuneration Committee, Finance Committee, Clinical and Lay Commissioning Committee, Governance Committee, Quality and Performance Committee and Engagement 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 Committee which scrutinises and challenges the reports provided by the CCG. In addition, the reports in relation to the programme of work in the Internal Audit Plan are presented to the Audit Committee. A log of recommendations and electronic 'Pentana Tracker system' from the Internal Audit Reports is maintained and reported to each Audit Committee meeting.

My review is also informed via assurances provided by:

- Governing Body;
- Audit Committee;
- NHSE&I – NHS Oversight Framework and My NHS;
- 360 Assurance – Internal Audit reviews and Head of Internal Audit Opinion;
- KPMG – External Audit;
- NECS – via monthly contract monitoring meetings;
- Committees of the Governing Body; and
- the Executive Team.

Conclusion

No significant internal control weaknesses have been identified during the year. The CCG has received positive feedback from Internal Audit on the assurance framework and this, in conjunction with other sources of assurance, leads the CCG to conclude that it has a robust system of control.

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

The CCG 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 CCG. The Committee is chaired by a Lay Member. The composition of the Remuneration Committee is shown in Table 25 on page 99.

Percentage change in remuneration of highest paid director

	Salary and allowances	Performance pay and bonuses
The percentage change from the previous financial year in respect of the highest paid director	0%	0%
The average percentage change from the previous financial year in respect of employees of the entity, taken as a whole	0%	0%

Table 40 – Percentage change in remuneration of highest paid director during Quarter 1 of 2022/23

Pay ratio information

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director/member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration 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 NHS Derby and Derbyshire CCG in the period to the 30th June 2022 was £197,500 (2021/22, £197,500). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

The calculation of the 25th percentile, median and 75th percentile remuneration of the workforce includes the remuneration of members of the Governing Body but excludes the highest paid Member.

The period to the 30th June 2022 median, 25th percentile and 75th percentile ratios have remained static. Staff remuneration used in the calculation below does not reflect the Agenda for Change 2022/23 pay uplift, which in part was agreed later in the 2022/23 financial year.

Table 41 shows 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.

1st April 2022 to 30th June 2022	25th percentile	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	27,258	47,091	59,867
Salary component of total remuneration	24,882	42,121	53,219
Pay ratio information	8	5	4
2021/22			
Total remuneration (£)	27,095	46,713	60,131
Salary component of total remuneration	24,882	42,121	53,219
Pay ratio information	8	5	4

Table 41 – relationship to the remuneration of the CCG's workforce

During the reporting period 1st April 2022 to 30th June 2022, nil (2021/22, nil) employees received remuneration in excess of the highest-paid director/member. Remuneration ranged from £22,500 to £192,500 (2021/22 £22,500 to £192,500) excluding the highest paid director/member. Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Policy on the remuneration of senior managers

For the purpose of this section the phrase 'senior managers' include all those individuals who have an influence in the decisions of the CCG, 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 Lay Members who constitute the majority of the membership of the Remuneration Committee, their own remuneration is set directly by the Governing Body. The Lay Members who are conflicted are not part of the decision-making.

Remuneration of Very Senior Managers (subject to audit)

Employment terms for a Very Senior Manager (VSM) or member of the CCG'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 CCG. There is no national body to determine remuneration for VSM employees; therefore, a robust process is in place within the CCG. The Remuneration Committee sets and approves the remuneration for all VSM employees. The Remuneration Committee comprises Lay Members from the Governing Body 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 CCG Remuneration Guidance (updated) issued by the NHS Commissioning Board (2012) as adjusted to take account of the previous remuneration of the staff members concerned. All VSM salaries are reviewed by the Remuneration Committee and a recommendation is presented to Governing Body for their approval. 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 42 and 43 show the Senior Manager total salary during Q1 of 2022/23, and 2021/22.

Salaries and allowances during Quarter 1 of 2022/23

Name	Title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
		£000	£	£000	£000	£000	£000
Dr Avi Bhatia	Clinical Chair	20-25	0	0	0	0-2.5	20-25
Dr Chris Clayton	Chief Executive Officer	45-50	0	0	0	20-22.5	65-70
Richard Chapman	Chief Finance Officer	35-40	0	0	0	5-7.5	40-45
Brigid Stacey	Chief Nurse Officer	30-35	0	0	0	30-32.5	60-65
Dr Steven Lloyd	Executive Medical Director	25-30	0	0	0	5-7.5	35-40
Helen Dillistone	Executive Director of Corporate Strategy and Delivery	30-35	0	0	0	7.5-10	35-40
Zara Jones	Executive Director of Commissioning Operations	30-35	0	0	0	7.5-10	40-45
Dr Penny Blackwell	GP Member	5-10	0	0	0	0-2.5	5-10
Dr Bukhtawar Dhadda	GP Member	5-10	0	0	0	0-2.5	5-10
Dr Emma Pizzey	GP Member	5-10	0	0	0	0-2.5	5-10
Dr Greg Strachan	GP Member	5-10	0	0	0	0-2.5	5-10
Dr Merryl Watkins	GP Member	5-10	0	0	0	0-2.5	5-10
Simon McCandlish	Lay Member for Patient and Public Involvement	0-5	0	0	0	0-2.5	0-5
Jill Dentith	Lay Member for Governance	0-5	0	0	0	0-2.5	0-5
Ian Gibbard	Lay Member for Audit	5-10	0	0	0	0-2.5	5-10
Andrew Middleton	Lay Member for Finance	0-5	0	0	0	0-2.5	0-5

Name	Title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
		£000	£	£000	£000	£000	£000
Professor Ian Shaw	Lay Member for Primary Care Commissioning	0-5	0	0	0	0-2.5	0-5
Martin Whittle	Lay Member for Patient and Public Involvement and Vice GB Chair	5-10	0	0	0	0-2.5	5-10
Dr Bruce Braithwaite	Secondary Care Consultant	0-5	0	0	0	0-2.5	0-5
Robyn Dewis	Derby City Council Representative	0-5	0	0	0	0-2.5	0-5
Dean Wallace	Derbyshire County Council Representative	0-5	0	0	0	0-2.5	0-5

Table 42 – Senior Manager remuneration during Quarter 1 of 2022/23

Notes to salaries and allowances for Quarter 1 of 2022/23

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 Local Authority Representatives nor were recharges made by their employers.
3. Where a salary amount sits exactly on a pay boundary then the salary is reported at the lower band. For example, if an employee had a salary of £50,000, they would be shown in the salary band 45-50.
4. The total remuneration disclosed in the table above for Dr Penny Blackwell includes clinical advisory services provided to the CCG unrelated to the roles as senior manager.
5. Dr Chris Clayton's salary disclosed in the table above includes 10% additional remuneration for his role as the Integrated Care Board Chief Executive Officer.
6. Two Executive Members will not take up posts within the Integrated Care Board on 1st July 2022 and, as such, their employment as Executive Members ceased on 30 June 2022. The value of any redundancy payments was not yet formally agreed during the period, therefore the remuneration in the above table excludes estimates of such payments.

Salaries and allowances 2021/22

Name	Title	2021/22					
		(a) Salary (bands of £5,000)	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits to the nearest £1,000	(f) TOTAL (a to e) (bands of £5,000)
		£000	£	£000	£000	£000	£000
Dr Avi Bhatia	Clinical Chair	95-100	0	0	0	0	95-100
Dr Chris Clayton	Chief Executive Officer	170-175	0	0	0	57.5-60	230-235
Richard Chapman	Chief Finance Officer	140-145	0	0	0	52.5-55	195-200
Brigid Stacey	Chief Nurse Officer	125-130	0	0	0	55-57.5	180-185
Dr Steven Lloyd	Executive Medical Director	115-120	0	0	0	52.5-55	165-170
Dr Penny Blackwell	GP Member	35-40	0	0	0	0	35-40
Dr Ruth Cooper	GP Member	35-40	0	0	0	0	35-40
Dr Bukhtawar Dhadda	GP Member	35-40	0	0	0	0	35-40
Dr Emma Pizzey	GP Member	35-40	0	0	0	0	35-40
Dr Greg Strachan	GP Member	35-40	0	0	0	0	35-40
Dr Merryl Watkins	GP Member	35-40	0	0	0	0	35-40
Jill Dentith	Lay Member for Governance	10-15	0	0	0	0	10-15
Ian Gibbard	Lay Member for Audit	15-20	0	0	0	0	15-20
Andrew Middleton	Lay Member for Finance	10-15	0	0	0	0	10-15
Professor Ian Shaw	Lay Member for Primary Care Commissioning	10-15	0	0	0	0	10-15
Martin Whittle	Lay Member for Patient and Public Involvement and Vice GB Chair	20-25	0	0	0	0	15-20

Name	Title	2021/22					
		(a) Salary (bands of £5,000)	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits to the nearest £1,000	(f) TOTAL (a to e) (bands of £5,000)
		£000	£	£000	£000	£000	£000
Dr Bruce Braithwaite	Secondary Care Consultant	5-10	0	0	0	0	05-10
Helen Dillistone	Executive Director of Corporate Strategy and Delivery	120-125	0	0	0	57.5-60	180-185
Zara Jones	Executive Director of Commissioning Operations	125-130	0	0	0	62.5-65	185-190
Simon McCandlish	Lay Member for Patient and Public Involvement	10-15	0	0	0	0	10-15
Robyn Dewis	Derby City Council Representative	0	0	0	0	0	0
Dean Wallace	Derbyshire County Council Representative	0	0	0	0	0	0

Table 43 – Senior Manager remuneration for 2021/22

Notes to Salaries and Allowance for 2021/22

1. 'All Pension related benefits' shows the increase in 'lifetime' pension which has arisen in 2021-22. The sum reported reflects the amount by which the annual pension received on retirement age has increased in 2021-22, multiplied by 20 (the average number of years a pension is paid to members of the NHS scheme following retirement), plus the lump sum increase in 2021-22. 'All pension related benefits' exclude employee contributions as directed in the Finance Act 2004.
2. No payments were made to Local Authority Representatives nor were recharges made by their employers.
3. Where a salary amount sits exactly on a pay boundary then the salary is reported at the lower band. For example, if an employee had a salary of £50,000 they would be shown in the salary band 45-50.
4. The total remuneration disclosed in the table above for Dr Bukhtawar Dhadda and Dr Penny Blackwell includes clinical advisory services provided to the CCG unrelated to their roles as senior managers.
5. Dr Chris Clayton's salary disclosed in the table above includes 10% additional remuneration for his role as the Integrated Care Board Chief Executive Officer.

Pension Benefits as at 30th June 2022

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 30 June 2022 (bands of £5,000)	Lump sum at pension age related to accrued pension at 30 June 2022 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2022	Real Increase/ (Decrease) in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 30 June 2022	Employers Contribution to Stakeholder Pension
		£000	£000	£000	£000	£000	£000	£000	£000
Dr Chris Clayton	Chief Executive Officer	0-2.5	0-2.5	35-40	35-40	450	13	478	0
Richard Chapman	Chief Finance Officer	0-2.5	0-2.5	45-50	90-95	789	13	827	0
Brigid Stacey	Chief Nurse Officer	0-2.5	2.5-5	50-55	135-140	1,020	31	1,083	0
Dr Steven Lloyd	Executive Medical Director	0-2.5	0-2.5	30-35	90-95	0	0	4	0
Helen Dillistone	Executive Director of Corporate Strategy and Delivery	0-2.5	0-2.5	35-40	60-65	580	7	605	0
Zara Jones	Executive Director of Commissioning Operations	0-2.5	0-2.5	35-40	55-60	427	5	445	0

Table 44 – pension benefits as at 30th June 2022

Cash equivalent transfer values (subject to audit)

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

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

Compensation on early retirement or for loss of office

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

Payments to past members (subject to audit)

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

Staff Report

Number of Senior Managers and Staff Composition

Table 45 shows the gender and pay band of VSMs and gender of the other CCG Employees during Q1 of 2022/23.

	Male	Female	Total
Executive Members (including Functional Directors)	9	11	20
Band 8d	2	3	5
Band 8c	5	18	23
Band 8b	8	31	39
Band 8a	20	62	82
Other banded CCG employees	35	296	331
Total CCG employees	**79**	**421**	**500**
Other non-permanent engagements including non-executive directors and lay members	31	29	60
Total	**110**	**450**	**560**

Table 45 – number of senior managers and staff composition during Quarter 1 of 2022/23

Staff numbers and costs (subject to audit)

The staff costs during Q1 of 2022/23, and 2021/22 are shown in Tables 45 and 46.

Employee Benefits during Quarter 1 of 2022/23

Employee Benefits	Quarter 1 2022/23		
	Permanent Employees	Other	Total
	£000	£000	£000
Salaries and wages	4,711	171	4,882
Social security costs	534	2	536
Employer Contributions to NHS Pension scheme	903	3	906
Other pension costs	2	-	2
Apprenticeship Levy	21	-	21
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	27	-	27
Gross employee benefits expenditure	**6,198**	**176**	**6,374**
Less recoveries in respect of employee benefits	(6)	-	(6)
Total - Net admin employee benefits including capitalised costs	**6,192**	**176**	**6,368**
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	**6,192**	**176**	**6,368**

Table 46 – staff numbers and costs in Quarter 1 2022/23

Employee Benefits 2021/22

Employee Benefits	2021/22		
	Permanent Employees	Other	Total
	£000	£000	£000
Salaries and wages	19,032	638	19,670
Social security costs	1,991	-	1,991
Employer Contributions to NHS Pension scheme	3,627	-	3,627
Other pension costs	6	-	6
Apprenticeship Levy	83	-	83
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	-	-	-
Gross employee benefits expenditure	**24,739**	**638**	**25,377**
Less recoveries in respect of employee benefits	(295)	-	(295)
Total - Net admin employee benefits including capitalised costs	**24,444**	**638**	**25,082**
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	**24,444**	**638**	**25,082**

Table 47 – staff numbers and costs in 2021/22

Average number of people employed

Table 48 shows the average number of staff employed by the CCG, excluding non-executive members and lay members.

	Quarter 1 2022/23			2021/22		
	Permanently employed	Other	Total	Permanently employed	Other	Total
Total	440	9	**449**	437	16	**453**

Table 48 – average number of people employed by the CCG in Quarter 1 of 2022/23 compared to 2021/22

During Q1 of 2022/23 the staff turnover for the CCG was 15%.

Sickness absence data

Table 49 shows the sickness absence data of staff permanently employed by the CCG, excluding non-executive members and lay members.

	Q1 2022/23			2021/22		
	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	**193**	440	**0.44**	**2,934**	437	**6.71**

Table 49 – average absence days of staff permanently employed by the CCG in Q1 2022/23 compared to 2021/22

Supporting and Developing Our People

Support during the Pandemic

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

Figure 10 – Working Differently. Our Way

In order to support the practical application of the commitments to staff, all managers have held 1 to 1 wellbeing conversations throughout the year with every team member, and risk assessments were implemented for all staff.

The CCG has supported colleagues who needed to work from a CCG base for health and wellbeing reasons. A new operating model has also been introduced ensure that Government guidance, Covid-19 related safety procedures and general health and safety processes are shared and adhered to by all staff attending a CCG site for any reason, or for any period of time. The new operating model takes into account Covid-19 transmission rates and enables a mix of working from home and a CCG base.

Disability Confident

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

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

The CCG'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 once normal service resume, 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 CCG's Recruitment and Selection Policy.

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

Once appointed, and throughout an employee's employment, where necessary the CCG'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.

We have also signed up to the Mindful Employer Charter to demonstrate our commitment to increasing the awareness of mental health, providing strong support networks and information, and making it healthier 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 CCG has nine trained Mental Health First Aiders working within the CCG. Mental Health First Aiders are trained by Mental Health First Aid England and act as a point of contact if an employee, or someone they are concerned about, is experiencing a mental health issue or emotional distress. They are not therapists or psychiatrists, but they can provide initial support and signpost to appropriate help if required.

Human Resources Policies

We are committed to ensuring equal opportunities in employment and have appropriate HR policies in place to ensure they are compliant with the relevant employment law as appropriate. Due to prioritising support for the Covid-19 response and vaccination programme the development of new HR policies was temporarily paused during 2021/22. Over the course of the year the Raising Concerns at Work (Whistleblowing) Policy, and Flexible Working Policy have been reviewed and updated.

The CCG has introduced Freedom to Speak up Ambassadors provide enhanced opportunities for colleagues to speak up on a variety of issues including, but not limited to the following:

- when things might go wrong or have gone wrong to ensure lessons are learnt;
- offering a suggestion for improvement;
- bullying, harassment or dignity at work concerns;
- making a complaint or taking out a grievance; and
- whistleblowing.

The Governance Committee is responsible for approving the HR Policies and they are made available to staff on the CCG's Intranet. The Governing Body continues to demonstrate their focus and support to the importance of flexible working, in accordance with the NHS People Plan,

the processes for flexible working arrangements, recruitment, inductions and appraisals, and line management development.

All our HR policies are developed to ensure due regard to the Equality Act 2010 duties and include an Equality Commitment Statement which is designed to ensure that through the implementation of these policies no person is treated less favourably.

Where necessary, throughout an employee's employment our Occupational Health service is available to advise on any reasonable adjustments which need to be made to ensure the wellbeing of our staff. 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 CCG 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.

Joint Partnership Working Forum

We, alongside CCGs in Nottinghamshire, are part of a regional Joint Partnership Working Forum which represents the interests of all CCG employees from across the two counties. The forum meets every quarter and is used as a vehicle to discuss and consult on matters with the recognised trade union organisations and staff within each separate CCG. The established partnership agreement describes the way in which the CCGs and recognised trade unions work together. The Trade Union (Facility Time Publication Requirements) Regulations 2017 requires public sector organisations to report on trade union time in their organisation.

Staff Network

As a CCG 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 and is run by people from protected characteristics that are under-represented within the CCG 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;
- introducing a programme of reverse mentoring with senior directors;
- raising awareness of the lived experiences of under-represented staff;
- learning and development: hidden disabilities, and unconscious bias; and

- informing the:

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 CCG 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 CCG to ensure that it is an inclusive organisation and an inclusive health service commissioner

The CCG Senior Leadership Team recognise the importance of the Diversity and Inclusion Network and have agreed to updated terms of reference for the Network that provide a clear purpose, line of accountability and clarification how the Network is to be integrated into the decision-making of the CCG. 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.

Staff Engagement

Staff Survey

The 2021 NHS Staff Survey was open to all staff, and is the third year the CCG participated in the survey. The purpose of the survey is to collect staff views about working in the CCG. Data is used to improve local working conditions for staff, and ultimately to improve patient care. It also allows the CCG to compare the experiences of staff in similar organisations, and to compare the experiences of staff in the CCG with the national picture.

This year, our response rate was 87%, which is higher than the comparative average of 78% for similar organisations. Figure 11 provides a summary of the results.

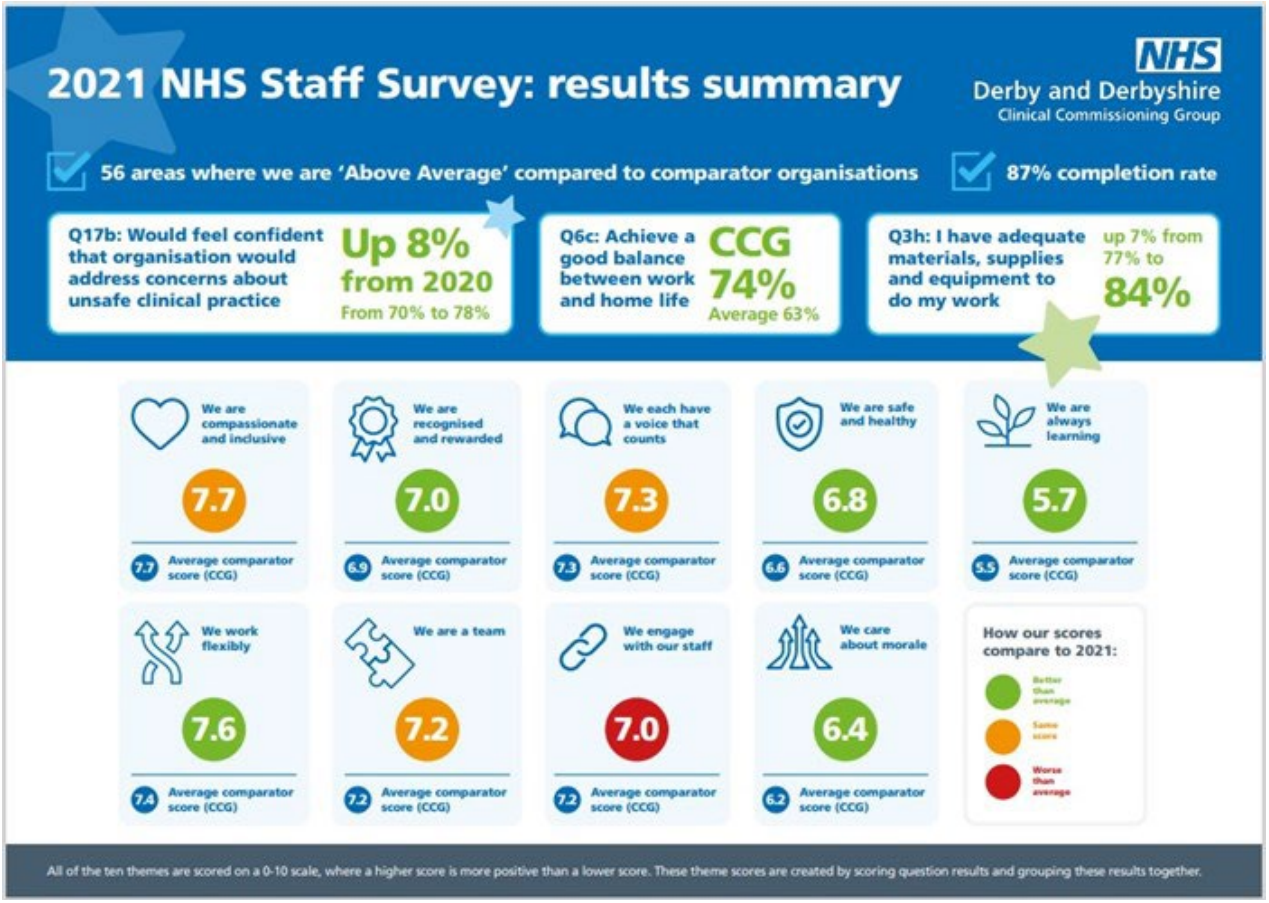


Figure 11 – 2021 NHS Derby and Derbyshire CCG Staff Survey Results

Organisation Effectiveness and Improvement Group

In line with Government guidance and to help reduce the transmission of Covid-19 the large majority of CCG staff have been working remotely from home over the last 12 months. This 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 CCG. It plays a vital role in helping to shape our organisational approaches, strategies and policies in different ways. OEIG have informed our approach to health and wellbeing, working differently and in helping make the

CCG a better place for us all. Examples of the types of initiative that have already been instigated by OEIG are:

Social Connectivity	Maintaining social connections whilst working remotely, including social 'buddies', virtual interest groups, virtual coffee breaks.
Think Green	Introducing various initiatives to make it easier to 'go green' and also raise awareness of the wider sustainability agenda in the NHS.
Mental Health First Aiders	The CCG has nine qualified employees.
Freedom to Speak up Ambassadors	The CCG has three employees who have undergone the National Ambassadors Office speak up training to become Freedom to Speak Up Ambassadors.

The OEIG also helped to shape the CCG's organisational values, which are newly embedded into the CCG Annual Review Conversation (appraisal) process.

Figure 12 – Our Values and Behaviours

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. Through 'Our Big Conversations' we are engaging with staff on issues that affect them at work and using the feedback to inform our approach and decision-making. There were a number of ways in which staff could offer feedback, including via email, a staff Facebook page, intranet discussion, Microsoft Teams discussion groups and manager briefings.

We have conducted a number of 'health and wellbeing' surveys to help us to understand how staff were feeling and also identify what further interventions, actions and support they would find most helpful. On the back of the survey, we have introduced a number of measures aimed at improving the physical and mental wellbeing of our staff whilst working remotely, including wellbeing checks, Covid-19 individual risk assessments and access to advice/support.

Staff Flu Immunisation

On the 17th July 2021, the Department for Health and Social Care and Public Health England communicated detail on the national flu immunisation programme 2021/22. The letter placed a requirement for the CCG 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 CCG adopted the best practice guidance provided in the letter and implemented a flu vaccination plan for CCG staff, which was made available to all employees, including those eligible for a free flu jab under the NHS programme. Employees were able to access the flu jab via clinics run by Occupational Health at CCG premises and also by arranging their own flu jab at a private provider and claiming back the expense.

As at the 30th June 2022, 51% of all CCG 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 CCG 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.

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 CCG 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 CCG does not have a Trade Union Official. The CCG is required to publish the following information on their website by the 31 July 2022.

Relevant Union Officials

What was the total number of your employees who were relevant union officials during the relevant period?	
Number of employees who were relevant union officials during the relevant period (full-time equivalent employee number)	0

Table 50 – relevant Union officials

Percentage of time spent on facility time

Relevant employed union officials who spent their working hours on facility time	
Percentage of time	**Number of employees**
0%	0%
1%-50%	0%
51%-99%	0%
100%	0%

Table 51 – percentage of time spent on facility time

Percentage of pay bill spent on facility time

Total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period	
Provide the total cost of facility time	0%
Provide the total pay bill	0%
Provide the percentage of the total pay bill spent on facility time	0%

Table 52 – percentage of pay bill spent on facility time

Paid Trade Union Activities

Percentage of total paid facility time hours – the amount of hours spent by employees who were relevant union officials on paid trade union activities	
Time spent on paid trade union activities as a percentage of total paid facility time hours	0

Table 53 – paid Trade Union activities

Expenditure on consultancy

The expenditure on consultancy for Q1 of 2022/23 for the CCG was £12,535.29.

Business consultancy is used sparingly by the CCG 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. Use of consultants is reviewed by the Audit Committee.

Off-payroll engagements

In line with HM Treasury guidance the CCG is required to disclose information about 'Off payroll Engagements'. These are reviewed by the Finance Committee and Audit Committee.

The information relating to the CCG is provided in the following tables:

Length of all highly paid off-payroll engagements

Table 54 shows all off-payroll engagements as at the 30th June 2022 for more than £245 per day[11].

	Number
Number of existing engagements as of the 30th June 2022	5
Of which, the number that have existed:	
for less than one year at the time of reporting	5
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

Table 54 – length of off-payroll engagements for Quarter 1 2022/23

New off-payroll engagements

Table 55 shows all new off-payroll engagements during Q1 of 2022/23, for more than £245 per day:

	Number
Number of new engagements during Quarter 1 of 2022/23	2
Of which:	
Number not subject to off-payroll legislation	0
Number subject to off-payroll legislation and determined as in-scope of IR35[12]	2

[11] The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.
[12] 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 of scope for tax purposes

Number subject to off-payroll legislation and determined as out of scope of IR35	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following review	0

Table 55 – new off-payroll engagements for Quarter 1 of 2022/23

Off-payroll engagements/senior official engagements

Table 56 shows any off-payroll engagements of Board members and/or senior officials with significant financial responsibility, during Q1 of 2022/23:

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the reporting period[13]	0
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the reporting period. This figure should include both on payroll and off-payroll engagements[14]	22

Table 56 – off-payroll engagements/senior official engagements during Quarter 1 of 2022/23

Exit packages, including special (non-contractual) payments (subject to audit)

One notice of compulsory redundancy was issued immediately after the reporting period. Whilst not agreed or paid during the period, the value of £26,667 has been provided for in this Annual Report to ensure a true and fair view.

Dr Chris Clayton

Accountable Officer

NHS Derby and Derbyshire CCG

27th June 2023

[13] 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

[14] As both on payroll and off-payroll engagements are included in the total figure, no entries here should be blank or zero. In any cases where individuals are included within the first row of this table the department should set out:
(i) details of the exceptional circumstances that led to each of these engagements; and
(ii) details of the length of time each of these exceptional engagements lasted.

Parliamentary Accountability and Audit Report

NHS Derby and Derbyshire CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report. An Audit Certificate and report is also included after the Financial Statements.

FINANCIAL STATEMENTS

Dr Chris Clayton

Accountable Officer

NHS Derby and Derbyshire CCG

27th June 2023

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The Primary Statements:

Notes to the Accounts

Statement of Comprehensive Net Expenditure for the year ended 30 June 2022

	Note	Apr 2022 to June 2022 £'000	2021-22 £'000
Income from sale of goods and services	2	(530)	(6,961)
Other operating income	2	(15)	(144)
Total operating income		**(545)**	**(7,105)**
Staff costs	4	6,373	25,377
Purchase of goods and services	5	519,955	2,091,894
Depreciation and impairment charges	5	157	175
Provision expense	5	1,358	2,577
Other Operating Expenditure	5	113	464
Total operating expenditure		**527,956**	**2,120,487**
Net Operating Expenditure		**527,411**	**2,113,382**
			-
Finance income		-	-
Finance expense	7	3	-
Net expenditure for the Year		**527,414**	**2,113,382**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**527,414**	**2,113,382**
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		-	-
Net (gain)/loss on revaluation of right-of-use assets		-	-
Net (gain)/loss on revaluation of Intangibles		-	-
Net (gain)/loss on revaluation of Financial Assets		-	-
Net (gain)/loss on assets held for sale		-	-
Actuarial (gain)/loss in pension schemes		-	-
Impairments and reversals taken to Revaluation Reserve		-	-
Items that may be reclassified to Net Operating Costs			-
Net (gain)/loss on revaluation of other Financial Assets		-	-
Net gain/loss on revaluation of available for sale financial assets		-	-
Reclassification adjustment on disposal of available for sale financial assets		-	-
Total other comprehensive net expenditure		**-**	**-**
			-
Comprehensive Expenditure for the year		**527,414**	**2,113,382**

The notes on pages 148 to 173 form part of this statement.

Statement of Financial Position as at 30 June 2022

	Note	Apr 2022 to June 2022 £'000	2021-22 £'000
Non-current assets:			
Property, plant and equipment	8	218	267
Right-of-use assets	9	1,270	-
Intangible assets		-	-
Investment property		-	-
Trade and other receivables		-	-
Other financial assets		-	-
Total non-current assets		1,488	267
			-
Current assets:			-
Inventories		-	-
Trade and other receivables	10	9,348	4,965
Other financial assets		-	-
Other current assets		-	-
Cash and cash equivalents	11	42	27
Total current assets		**9,390**	**4,992**
Non-current assets held for sale		-	-
Total current assets		**9,390**	**4,992**
			-
Total assets		**10,878**	**5,259**
			-
Current liabilities			-
Trade and other payables	12	(115,938)	(98,756)
Other financial liabilities		-	-
Other liabilities		-	-
Lease liabilities	9	(452)	-
Borrowings		-	-
Provisions	13	(6,741)	(5,847)
Total current liabilities		**(123,131)**	**(104,603)**
Non-Current Assets plus/less Net Current Assets/Liabilities		**(112,253)**	**(99,344)**
Non-current liabilities			-
Trade and other payables		-	-
Other financial liabilities		-	-
Other liabilities		-	-
Lease liabilities	9	(819)	-
Borrowings		-	-
Provisions	13	(532)	(532)
Total non-current liabilities		**(1,351)**	**(532)**
			-
Assets less Liabilities		**(113,604)**	**(99,876)**
Financed by Taxpayers' Equity			
General fund		(113,604)	(99,876)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(113,604)**	**(99,876)**

The notes on pages 148 to 173 form part of this statement.

The financial statements on pages 144 to 147 were approved by the Audit Committee on 27 June and signed on its behalf by:

Chief Accountable Officer
Dr Chris Clayton

Statement of Changes In Taxpayers Equity for the year ended 30 June 2022

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for Apr 2022 to June 2022				
Balance at 01 April 2022	(99,876)	-	-	**(99,876)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	-	-	-	-
Adjusted NHS Clinical Commissioning Group balance at 31 March 2022	**(99,876)**	**-**	**-**	**(99,876)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for Apr 2022 to June 2022				
Total transition adjustment for initial application of IFRS 16	-			-
Net operating expenditure for the financial year	(527,414)			**(527,414)**
Net gain/(loss) on revaluation of property, plant and equipment		-		-
Net gain/(loss) on revaluation of right-of-use assets		-		-
Net gain/(loss) on revaluation of intangible assets		-		-
Net gain/(loss) on revaluation of financial assets		-		-
Total revaluations against revaluation reserve		**-**		**-**
Net gain (loss) on available for sale financial assets	-	-	-	-
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)			-	-
Net gain (loss) on revaluation of assets held for sale	-	-	-	-
Impairments and reversals	-	-	-	-
Net actuarial gain (loss) on pensions	-	-	-	-
Movements in other reserves	-	-	-	-
Transfers between reserves	-	-	-	-
Release of reserves to the Statement of Comprehensive Net Expenditure	-	-	-	-
Reclassification adjustment on disposal of available for sale financial assets	-	-	-	-
Transfers by absorption to (from) other bodies	-	-	-	-
Reserves eliminated on dissolution	-	-	-	-
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(527,414)**	**-**	**-**	**(527,414)**
Net funding	513,686	-	-	**513,686**
Balance at 30 June 2022	**(113,604)**	**-**	**-**	**(113,604)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2021-22				
Balance at 01 April 2021	(94,966)	-	-	**(94,966)**
Transfer of assets and liabilities from closed NHS bodies	-	-	-	-
Adjusted NHS Clinical Commissioning Group balance at 31 March 2022	**(94,966)**	**-**	**-**	**(94,966)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2021-22				
Net operating costs for the financial year	(2,113,382)			(2,113,382)
Net gain/(loss) on revaluation of property, plant and equipment		-		-
Net gain/(loss) on revaluation of right-of-use assets		-		
Net gain/(loss) on revaluation of intangible assets		-		-
Net gain/(loss) on revaluation of financial assets		-		-
Total revaluations against revaluation reserve		**-**		**-**
Net gain (loss) on available for sale financial assets	-	-	-	-
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)	-	-	-	-
Net gain (loss) on revaluation of assets held for sale	-	-	-	-
Impairments and reversals	-	-	-	-
Net actuarial gain (loss) on pensions	-	-	-	-
Movements in other reserves	-	-	-	-
Transfers between reserves	-	-	-	-
Release of reserves to the Statement of Comprehensive Net Expenditure	-	-	-	-
Reclassification adjustment on disposal of available for sale financial assets	-	-	-	-
Transfers by absorption to (from) other bodies	-	-	-	-
Reserves eliminated on dissolution	-	-	-	-
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	**(2,113,382)**	**-**	**-**	**(2,113,382)**
Net funding	2,108,474	-	-	2,108,474
Balance at 31 March 2022	**(99,876)**	**-**	**-**	**(99,876)**

The notes on pages 148 to 173 form part of this statement.

Statement of Cash Flows for the year ended 30 June 2022

	Note	Apr 2022 to June 2022 £'000	2021-22 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(527,414)	(2,113,382)
Depreciation and amortisation	5	157	175
Impairments and reversals		-	-
Non-cash movements arising on application of new accounting standards		-	-
Movement due to transfer by Modified Absorption		-	-
Other gains (losses) on foreign exchange		-	-
Donated assets received credited to revenue but non-cash		-	-
Government granted assets received credited to revenue but non-cash		-	-
Interest paid		-	-
Release of PFI deferred credit		-	-
Other Gains & Losses		-	-
Finance Costs		-	-
Unwinding of Discounts		-	-
(Increase)/decrease in inventories		-	-
(Increase)/decrease in trade & other receivables	10	(4,383)	365
(Increase)/decrease in other current assets		-	-
Increase/(decrease) in trade & other payables	12	17,182	2,413
Increase/(decrease) in other current liabilities		-	-
Provisions utilised	13	(491)	(616)
Increase/(decrease) in provisions	13	1,385	2,577
Net Cash Inflow (Outflow) from Operating Activities		**(513,564)**	(2,108,468)
Cash Flows from Investing Activities			
Interest received		-	-
(Payments) for property, plant and equipment		-	(87)
(Payments) for intangible assets		-	-
(Payments) for investments with the Department of Health		-	-
(Payments) for other financial assets		-	-
(Payments) for financial assets (LIFT)		-	-
Proceeds from disposal of assets held for sale: property, plant and equipment		-	-
Proceeds from disposal of assets held for sale: intangible assets		-	-
Proceeds from disposal of investments with the Department of Health		-	-
Proceeds from disposal of other financial assets		-	-
Proceeds from disposal of financial assets (LIFT)		-	-
Non-cash movements arising on application of new accounting standards		-	-
Loans made in respect of LIFT		-	-
Loans repaid in respect of LIFT		-	-
Rental revenue		-	-
Net Cash Inflow (Outflow) from Investing Activities		**-**	(87)
Net Cash Inflow (Outflow) before Financing		**(513,564)**	(2,108,555)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		513,686	2,108,471
Other loans received		-	-
Other loans repaid		-	-
Repayment of lease liabilities		(110)	-
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		3	-
Capital grants and other capital receipts		-	-
Capital receipts surrendered		-	-
Non-cash movements arising on application of new accounting standards		-	-
Net Cash Inflow (Outflow) from Financing Activities		**513,579**	2,108,471
Net Increase (Decrease) in Cash & Cash Equivalents	11	**15**	(83)
Cash & Cash Equivalents at the Beginning of the Financial Year		**27**	110
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		-	-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**42**	27

The notes on pages 148 to 173 form part of this statement.

Notes to the financial statements

1 **Accounting Policies**

NHS England has directed that the financial statements of Clinical Commissioning Groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2022-23 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Clinical Commissioning Groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Clinical Commissioning Group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Clinical Commissioning Group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 **Going Concern**

These accounts have been prepared on a going concern basis despite the issue of a report to the Secretary of State for Health and Social Care under Section 30 of the Local Audit and Accountability Act 2014.

The Health and Social Care Act was introduced into the House of Commons on 6 July 2021. The Bill will allow for the establishment of Integrated Care Boards (ICB) across England and will abolish clinical commissioning groups (CCG). ICBs will take on the commissioning functions of CCGs. The CCG functions, assets and liabilities were transferred to an ICB on 1 July 2022.

Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Where a clinical commissioning group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided, the Clinical Commissioning Group is a going concern and the financial statements are prepared on the going concern basis.

1.2 **Accounting Convention**

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 **Movement of Assets within the Department of Health and Social Care Group**

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 **Joint arrangements**

Arrangements over which the Clinical Commissioning Group has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the Clinical Commissioning Group is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

The Clinical Commissioning Group's participation in Section 75 agreements (see note 1.5) are joint arrangements.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

1.5 **Pooled Budgets**

The Clinical Commissioning Group has entered into a pooled budget arrangement for better care with NHS Tameside & Glossop Clinical Commissioning Group and 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 Clinical Commissioning Group 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 Clinical Commissioning Group 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 Clinical Commissioning Group 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 clinical commissioning group.

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 clinical commissioning group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

• The clinical commissioning group 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 clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.

Notes to the financial statements

The main source of funding for the Clinical Commissioning Group 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 Clinical Commissioning Group 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 corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.8 **Employee Benefits**

1.8.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.
The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.8.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes 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, the schemes are accounted for as if they were a defined contribution scheme; the cost recognised in these accounts represents the contributions payable for the year. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.
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 clinical commissioning group commits itself to the retirement, regardless of the method of payment.
The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.9 **Other Expenses**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.10 **Property, Plant & Equipment**

1.10.1 **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 clinical commissioning group;
- 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.

1.10.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.
Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date
Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.
IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.
An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.10.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

Notes to the financial statements

1.10.4 **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 clinical commissioning group expects to obtain economic benefits or service potential from the asset. This is specific to the clinical commissioning group 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 clinical commissioning group 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.

1.11 **Leases**

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. IFRS 16 Leases is effective across public sector from 1 April 2022.

1.11.1 **The Clinical Commissioning Group 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 2022 calendar year under IFRS 16.

Lease payments included in the measurement of the lease liability comprise
-Fixed payments;
-Variable lease payments dependent on an index or rate, initially measured using the index or rate at commencement;
-The amount expected to be payable under residual value guarantees;
-The exercise price of purchase options, if it is reasonably certain the option will be exercised; and
-Payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease.
Variable rents that do not depend on an index or rate are not included in the measurement the lease liability and are recognised as an expense in the period in which the event or condition that triggers those payments occurs.
The lease liability is subsequently measured by increasing the carrying amount for interest incurred using the effective interest method and decreasing the carrying amount to reflect the lease payments made. The lease liability is remeasured, with a corresponding adjustment to the right-of-use asset, to reflect any reassessment of or modification made to the lease.
The right-of-use asset is initially measured at an amount equal to the initial lease liability adjusted for any lease prepayments or incentives, initial direct costs or an estimate of any dismantling, removal or restoring costs relating to either restoring the location of the asset or restoring the underlying asset itself, unless costs are incurred to produce inventories.
The subsequent measurement of the right-of-use asset is consistent with the principles for subsequent measurement of property, plant and equipment. Accordingly, right-of-use assets that are held for their service potential and are in use are subsequently measured at their current value in existing use.

Right-of-use assets for leases that are low value or short term and for which current value in use is not expected to fluctuate significantly due to changes in market prices and conditions are valued at depreciated historical cost as a proxy for current value in existing use.
Other than leases for assets under construction and investment property, the right-of-use asset is subsequently depreciated on a straight-line basis over the shorter of the lease term or the useful life of the underlying asset. The right-of-use asset is tested for impairment if there are any indicators of impairment and impairment losses are accounted for as described in the 'Depreciation, amortisation and impairments' policy.
Peppercorn leases are defined as leases for which the consideration paid is nil or nominal (that is, significantly below market value). Peppercorn leases are in the scope of IFRS 16 if they meet the definition of a lease in all aspects apart from containing consideration.
For peppercorn leases a right-of-use asset is recognised and initially measured at current value in existing use. The lease liability is measured in accordance with the above policy. Any difference between the carrying amount of the right-of-use asset and the lease liability is recognised as income as required by IAS 20 as interpreted by the FReM.
Leases of low value assets (value when new less than £5,000) and short-term leases of 12 months or less are recognised as an expense on a straight-line basis over the term of the lease.

1.12 **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 clinical commissioning group's cash management.

1.13 **Provisions**

Provisions are recognised when the clinical commissioning group has a present legal or constructive obligation as a result of a past event, it is probable that the clinical commissioning group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:
All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A nominal short-term rate of 3.27% (2021-22: 0.47%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 3.20% (2021-22: 0.70%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 3.51% (2021-22: 0.95%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 3.00% (2021-22: 0.6%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

Notes to the financial statements

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 clinical commissioning group 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.

1.14 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the clinical commissioning group 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 clinical commissioning group.

1.15 **Non-clinical Risk Pooling**

The clinical commissioning group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.16 **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 clinical commissioning group, 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 clinical commissioning group. 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.

1.17 **Financial Assets**

Financial assets are recognised when the clinical commissioning group 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.

1.17.1 **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.

1.17.2 **Financial assets at fair value through other comprehensive income**

Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.17.3 **Financial assets at fair value through profit and loss**

Financial assets measure at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.17.4 **Impairment**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.

The clinical commissioning group 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 clinical commissioning group 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 clinical commissioning group 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.

1.18 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group 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.

1.18.1 **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.

1.18.2 **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 clinical commissioning group's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

Notes to the financial statements

1.18.3 **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.

1.19 **Value Added Tax**
Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.20 **Foreign Currencies**
The clinical commissioning group's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the clinical commissioning group's surplus/deficit in the period in which they arise.

1.21 **Third Party Assets**
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the clinical commissioning group has no beneficial interest in them.

1.22 **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 clinical commissioning group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.23 **Critical accounting judgements and key sources of estimation uncertainty**
In the application of the clinical commissioning group's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.23.1 **Critical accounting judgements in applying accounting policies**
In the application of the Clinical Commissioning Group's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.23.2 **Sources of estimation uncertainty**
The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

• Prescription costs.

1.24 **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.

1.25 **Adoption of new standards**
On 1 April 2022, the Clinical Commissioning Group adopted IFRS 16 'Leases'. The new standard introduces a single, on statement of financial position lease accounting model for lessees and removes the distinction between operating and finance leases.
Under IFRS 16 the group will recognise a right-of-use asset representing the group's right to use the underlying asset and a lease liability representing its obligation to make lease payments for any operating leases assessed to fall under IFRS 16. There are recognition exemptions for short term leases and leases of low value items.

In addition, the group will no longer charge provisions for operating leases that it assesses to be onerous to the statement of comprehensive net expenditure. Instead, the group will include the payments due under the lease with any appropriate assessment for impairments in the right-of-use asset

Notes to the financial statements

Impact assessment

The Clinical Commissioning Group has applied the modified retrospective approach and will recognise the cumulative effect of adopting the standard at the date of initial application as an adjustment to the taxpayers' equity with no restatement of comparative balances.

IFRS 16 does not require entities to reassess whether a contract is, or contains, a lease at the date of initial application. HM Treasury has interpreted this to mandate this practical expedient and therefore the group has applied IFRS 16 to contracts identified as a lease under IAS 17 or IFRIC 4 at 1 April 2022.

The group has utilised three further practical expedients under the transition approach adopted:

a) The election to not make an adjustment for leases for which the underlying asset is of low value.

b) The election to not make an adjustment to leases where the lease terms ends within 12 months of the date of application.

c) The election to use hindsight in determining the lease term if the contract contains options to extend or terminate the lease

The most significant impact of the adoption of IFRS 16 has been the need to recognise right-of-use assets and lease liabilities for any buildings previously treated as operating leases that meet the recognition criteria in IFRS 16. Expenditure on operating leases has been replaced by interest on lease liabilities and depreciation on right-of-use assets in the statement of comprehensive net expenditure.

As of 1 April 2022, the group recognised £1,378m or right-of-use assets and lease liabilities of £1,378m. The weighted average incremental borrowing rate applied at 1 April 2022 is 0.95% and on adoption of IFRS 16 there was a nil impact to tax payers' equity.

The following table reconciles the group's operating lease obligations at 31 March 2022, disclosed in the group's 21/22 financial statements, to the lease liabilities recognised on initial application of IFRS 16 at 1 April 2022.

	Total £000
Operating lease commitments at 31 March 2022	1,319
Impact of discounting at 1 April 2022 using the weighted average incremental borrowing rate of 0.95%	(25)
Operating lease commitments discounted used weighted average IBR	1,294
Add: Leases without full documentation previously excluded from the operating lease disclosure	89
Less: Low value leases	5
Lease liability at 1 April 2022	**1,378**

1.26 Accounting Standards That Have Been Issued but Have Not Yet Been Adopted

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2022. These Standards are still subject to HM Treasury FReM adoption, with the government implementation date for IFRS 17 still subject to HM Treasury consideration.

• IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021. IFRS 17 is yet to be adopted by the FReM, therefore early adoption is not permitted.

The CCG does not have insurance contracts therefore no impact is expected from the implementation of this standard.

• 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.

2 Other Operating Revenue

	Apr 2022 to June 2022 Admin	Apr 2022 to June 2022 Programme	Apr 2022 to June 2022 Total	2021-22 Total
	£'000	£'000	£'000	£'000
Income from sale of goods and services (contracts)				
Education, training and research	-	-	**-**	9
Non-patient care services to other bodies	114	322	**436**	6,611
Patient transport services	-	-	**-**	-
Prescription fees and charges	-	-	**-**	-
Dental fees and charges	-	-	**-**	-
Income generation	-	-	**-**	-
Other Contract income	-	88	**88**	46
Recoveries in respect of employee benefits	-	6	**6**	295
Total Income from sale of goods and services	**114**	**416**	**530**	**6,961**
Other operating income				
Rental revenue from finance leases	-	-	**-**	-
Rental revenue from operating leases	-	-	**-**	-
Charitable and other contributions to revenue expenditure: NHS	-	-	**-**	-
Charitable and other contributions to revenue expenditure: non-NHS	-	-	**-**	-
Receipt of donations (capital/cash)	-	-	**-**	-
Receipt of Government grants for capital acquisitions	-	-	**-**	-
Continuing Health Care risk pool contributions	-	-	**-**	-
Non cash apprenticeship training grants revenue	15	-	**15**	59
Other non contract revenue	-	-	**-**	85
Total Other operating income	**15**	**-**	**15**	**144**
Total Operating Income	**129**	**416**	**545**	**7,105**

3 Income from sale of goods and services (contracts)

3.1 Disaggregation of Income - Income from sale of good and services (contracts)

	Non-patient care services to other bodies	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000
Source of Revenue			
NHS	147	7	6
Non NHS	289	81	-
Total	**436**	**88**	**6**

	Non-patient care services to other bodies	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000
Timing of Revenue			
Point in time	-	-	-
Over time	436	88	6
Total	**436**	**88**	**6**

3.2 Transaction price to remaining contract performance obligations

NHS Derby and Derbyshire Clinical Commissioning Group had no contract revenue expected to be recognised in future period,

4. Employee benefits and staff numbers

4.1.1 Employee benefits	**Total**		**Apr 2022 to June 2022**
	Permanent Employees £'000	**Other £'000**	**Total £'000**
Employee Benefits			
Salaries and wages	**4,711**	**171**	**4,882**
Social security costs	**534**	**2**	**536**
Employer Contributions to NHS Pension scheme	**903**	**2**	**905**
Other pension costs	**2**	**-**	**2**
Apprenticeship Levy	**21**	**-**	**21**
Other post-employment benefits	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**
Termination benefits	**27**	**-**	**27**
Gross employee benefits expenditure	6,198	175	6,373
Less recoveries in respect of employee benefits (note 4.1.2)	**(6)**	**-**	**(6)**
Total - Net admin employee benefits including capitalised costs	6,192	175	6,367
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	6,192	175	6,367

4.1.1 Employee benefits	Total		2021-22
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	19,032	638	19,670
Social security costs	1,991	-	1,991
Employer Contributions to NHS Pension scheme	3,627	-	3,627
Other pension costs	6	-	6
Apprenticeship Levy	83	-	83
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	-	-	-
Gross employee benefits expenditure	24,739	638	25,377
Less recoveries in respect of employee benefits (note 4.1.2)	(295)	-	(295)
Total - Net admin employee benefits including capitalised costs	24,444	638	25,082
Less: Employee costs capitalised	**-**	**-**	**-**
Net employee benefits excluding capitalised costs	24,444	638	25,082

4.1.2 Recoveries in respect of employee benefits			**Apr 2022 to June 2022**	2021-22
	Permanent Employees £'000	**Other £'000**	**Total £'000**	Total £'000
Employee Benefits - Revenue				
Salaries and wages	**(4)**	**-**	**(4)**	(235)
Social security costs	**(1)**	**-**	**(1)**	(27)
Employer contributions to the NHS Pension Scheme	**(1)**	**-**	**(1)**	(33)
Other pension costs	**-**	**-**	**-**	-
Other post-employment benefits	**-**	**-**	**-**	**-**
Other employment benefits	**-**	**-**	**-**	**-**
Termination benefits	**-**	**-**	**-**	**-**
Total recoveries in respect of employee benefits	(6)	-	(6)	(295)

4.2 Average number of people employed

	Apr 2022 to June 2022			2021-22		
	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number	Total Number
Total	**440**	**9**	**449**	**437**	**16**	**453**
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**	**-**	**-**

4.3 Exit packages agreed in the financial year

	Apr 2022 to June 2022 Compulsory redundancies		Apr 2022 to June 2022 Other agreed departures		Apr 2022 to June 2022 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	1	26,667	-	-	1	26,667
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**1**	**26,667**	**-**	**-**	**1**	**26,667**

	2021-22 Compulsory redundancies		2021-22 Other agreed departures		2021-22 Total	
	Number	£	Number	£	Number	£
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**-**	**-**	**-**	**-**	**-**	**-**

	Apr 2022 to June 2022 Departures where special payments have been made		2021-22 Departures where special payments have been made	
	Number	£	Number	£
Less than £10,000	-	-	-	-
£10,001 to £25,000	-	-	-	-
£25,001 to £50,000	-	-	-	-
£50,001 to £100,000	-	-	-	-
£100,001 to £150,000	-	-	-	-
£150,001 to £200,000	-	-	-	-
Over £200,001	-	-	-	-
Total	**-**	**-**	**-**	**-**

Analysis of Other Agreed Departures

	Apr 2022 to June 2022 Other agreed departures		2021-22 Other agreed departures	
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval*	-	-	-	-
Total	**-**	**-**	**-**	**-**

Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

Where entities have agreed early retirements, the additional costs are met by NHS Entities and not by the NHS Pension Scheme, and are included in the tables. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

The Remuneration Report includes the disclosure of exit payments and early retirements relating to individuals named in that Report.

One exit package was agreed in relation to the redundancy of one Exective Member in 2022-23, with a value of £26,667 (2021-22, £Nil).

4.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

5. Operating expenses

	Apr 2022 to June 2022 Total £'000	2021-22 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	2,834	10,145
Services from foundation trusts	313,134	1,247,778
Services from other NHS trusts	32,211	137,633
Provider Sustainability Fund	-	-
Services from Other WGA bodies	-	4
Purchase of healthcare from non-NHS bodies	67,299	264,702
Purchase of social care	13,079	61,940
General Dental services and personal dental services	-	-
Prescribing costs	39,665	162,084
Pharmaceutical services	40	143
General Ophthalmic services	73	346
GPMS/APMS and PCTMS	47,763	193,748
Supplies and services – clinical	1	2
Supplies and services – general	2,689	5,638
Consultancy services	13	45
Establishment	512	3,822
Transport	1	-
Premises	183	2,314
Audit fees	174	192
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services	-	14
Other professional fees	194	775
Legal fees	40	230
Education, training and conferences	35	280
Funding to group bodies	-	-
CHC Risk Pool contributions	-	-
Non cash apprenticeship training grants	15	59
Total Purchase of goods and services	**519,955**	**2,091,894**
Depreciation and impairment charges		
Depreciation	157	175
Amortisation	-	-
Impairments and reversals of property, plant and equipment	-	-
Impairments and reversals of right-of-use assets	-	-
Impairments and reversals of intangible assets	-	-
Impairments and reversals of financial assets	-	-
· Assets carried at amortised cost	-	-
· Assets carried at cost	-	-
· Available for sale financial assets	-	-
Impairments and reversals of non-current assets held for sale	-	-
Impairments and reversals of investment properties	-	-
Total Depreciation and impairment charges	**157**	**175**
Provision expense		
Change in discount rate	-	-
Provisions	1,358	2,577
Total Provision expense	**1,358**	**2,577**
Other Operating Expenditure		
Chair and Non Executive Members	115	459
Grants to Other bodies	-	-
Clinical negligence	-	-
Research and development (excluding staff costs)	-	-
Expected credit loss on receivables	(2)	2
Expected credit loss on other financial assets (stage 1 and 2 only)	-	-
Inventories written down	-	-
Inventories consumed	-	-
Other expenditure	-	3
Total Other Operating Expenditure	**113**	**464**
Total operating expenditure	**521,583**	**2,095,110**

Internal Audit Services are provided by 360 Assurance (hosted by Leicestershire Partnership NHS Trust) and the associated expenditure is included within "Other Professional Fees".

The audit fees relating to the statutory external audit provided by KPMG LLP (UK) include VAT (£145,200 excluding VAT).

6.1 Better Payment Practice Code

Measure of compliance	Apr 2022 to June 2022 Number	Apr 2022 to June 2022 £'000	2021-22 Number	2021-22 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	14,246	88,724	51,296	337,917
Total Non-NHS Trade Invoices paid within target	14,179	88,503	51,059	336,913
Percentage of Non-NHS Trade invoices paid within target	**99.53%**	**99.75%**	**99.54%**	**99.70%**
NHS Payables				
Total NHS Trade Invoices Paid in the Year	525	329,437	2,120	1,406,167
Total NHS Trade Invoices Paid within target	521	329,430	2,111	1,406,010
Percentage of NHS Trade Invoices paid within target	**99.24%**	**100.00%**	**99.58%**	**99.99%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

NHS Derby and Derbyshire Clinical Commissioning Group incurred £nil during 2021-22 (2020-21: £Nil) relating to claims made under this

7 Finance costs

	Apr 2022 to June 2022 £'000	2021-22 £'000
Interest		
Interest on loans and overdrafts	-	-
Interest on lease liabilities	3	-
Interest on late payment of commercial debt	-	-
Other interest expense	-	-
Total interest	**3**	**-**
Other finance costs	-	-
Provisions: unwinding of discount	-	-
Total finance costs	**3**	**-**

8 Property, plant and equipment

Apr 2022 to June 2022	Information technology £'000	Total £'000
Cost or valuation at 01 April 2022	589	589
Addition of assets under construction and payments on account		-
Additions purchased	-	-
Additions donated	-	-
Additions government granted	-	-
Additions leased	-	-
Reclassifications	-	-
Reclassified as held for sale and reversals	-	-
Disposals other than by sale	-	-
Upward revaluation gains	-	-
Impairments charged	-	-
Reversal of impairments	-	-
Transfer (to)/from other public sector body	-	-
Cumulative depreciation adjustment following revaluation	-	-
Cost/Valuation at 30 June 2022	**589**	**589**
Depreciation 01 April 2022	322	322
Reclassifications	-	-
Reclassified as held for sale and reversals	-	-
Disposals other than by sale	-	-
Upward revaluation gains	-	-
Impairments charged	-	-
Reversal of impairments	-	-
Charged during the year	49	49
Transfer (to)/from other public sector body	-	-
Cumulative depreciation adjustment following revaluation	-	-
Depreciation at 30 June 2022	**371**	**371**
Net Book Value at 30 June 2022	**218**	**218**
Purchased	218	218
Donated	-	-
Government Granted	-	-
Total at 30 June 2022	**218**	**218**
Asset financing:		
Owned	218	218
Held on finance lease	-	-
On-SOFP Lift contracts	-	-
PFI residual: interests	-	-
Total at 30 June 2022	**218**	**218**

Revaluation Reserve Balance for Property, Plant & Equipment

	Information technology £'000	Total £'000
Balance at 01 April 2022	-	-
Revaluation gains	-	-
Impairments	-	-
Release to general fund	-	-
Other movements	-	-
Balance at 30 June 2022	**-**	**-**

9.1 Leases

9.1 Right-of-use assets

Apr 2022 to June 2022	Buildings excluding dwellings £'000	Total £'000
Cost or valuation at 01 April 2022	-	-
IFRS 16 Transition Adjustment	1,378	1,378
Addition of assets under construction and payments on account		-
Additions	-	-
Reclassifications	-	-
Upward revaluation gains	-	-
Lease remeasurement	-	-
Modifications	-	-
Disposals on expiry of lease term	-	-
Derecognition for early terminations	-	-
Transfer (to) from other public sector body	-	-
Cost/Valuation at 30 June 2022	**1,378**	**1,378**
Depreciation 01 April 2022	-	-
Charged during the year	108	108
Reclassifications	-	-
Upward revaluation gains	-	-
Impairments charged	-	-
Reversal of impairments	-	-
Disposals on expiry of lease term	-	-
Derecognition for early terminations	-	-
Transfer (to) from other public sector body		
Depreciation at 30 June 2022	**108**	**108**
Net Book Value at 30 June 2022	**1,270**	**1,270**

NBV by counterparty	
Leased from Non-Departmental Public Bodies	886
Leased from other bodies	384
Net Book Value at 30 June 2022	**1,270**

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.

The IFRS 16 transition adjustment is the capitalisation of leases due to the adoption of the Standard from 1st April 2022.

9.2 Leases cont'd

9.2 Lease liabilities

Apr 2022 to June 2022	**Apr 2022 to June 2022 £'000**	2021-22 £'000
Lease liabilities at 01 April 2022	-	-
IFRS 16 Transition Adjustment	1,378	-
Addition of Assets under Construction & Payments on Account	-	-
Additions purchased	-	-
Reclassifications	-	-
Interest expense relating to lease liabilities	3	-
Repayment of lease liabilities (including interest)	(110)	-
Lease remeasurement	-	-
Modifications	-	-
Disposals on expiry of lease term	-	-
Derecognition for early terminations	-	-
Transfer (to) from other public sector body	-	-
Other	-	-
Lease liabilities at 30 June 2022	**1,271**	-

9.3 Lease liabilities - Maturity analysis of undiscounted future lease payments

	Apr 2022 to June 2022 £'000	2021-22 £'000
Within one year	(452)	-
Between one and five years	(819)	-
After five years	-	-
Balance at 30 June 2022	**(1,271)**	**-**
Balance by counterparty		
Leased from Non-Departmental Public Bodies	(886)	
Leased from other bodies	(385)	
Balance as at 31 March 2023	**(1,271)**	**-**

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.

9 Leases cont'd

9.4 Amounts recognised in Statement of Comprehensive Net Expenditure

Apr 2022 to June 2022	**Apr 2022 to June 2022 £'000**	2021-22 £'000	
Depreciation expense on right-of-use assets	108		-
Interest expense on lease liabilities	3		-
Expense relating to short-term leases	-		-
Expense relating to leases of low value assets	-		-
Expense relating to variable lease payments not included in the measurement of the lease liability	-		-
Income from sub-leasing right-of-use assets	-		-
Gain/(loss) from sale and leaseback transactions	-		-
Gain/(loss) resulting from COVID-19 related rent concessions	-		-

9.5 Amounts recognised in Statement of Cash Flows

	Apr 2022 to June 2022 £'000	2021-22 £'000	
Total cash outflow on leases under IFRS 16	(110)		-
Total cash outflow for lease payments not included within the measurement of lease liabilities	-		-
Total cash inflows from sale and leaseback transactions	-		-

10.1 Trade and other receivables

	Current Apr 2022 to June 2022 £'000	Non-current Apr 2022 to June 2022 £'000	Current 2021-22 £'000	Non-current 2021-22 £'000
NHS receivables: Revenue	473	-	1,197	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	335	-	4	-
NHS accrued income	839	-	5	-
NHS Contract Receivable not yet invoiced/non-invoice	56	-	479	-
NHS Non Contract trade receivable (i.e pass through funding)	-	-	-	-
NHS Contract Assets	-	-	-	-
Non-NHS and Other WGA receivables: Revenue	544	-	803	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	4,521	-	1,591	-
Non-NHS and Other WGA accrued income	1,870	-	-	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	-	-	99	-
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	-	-	-	-
Non-NHS Contract Assets	-	-	-	-
Expected credit loss allowance-receivables	(2)	-	(3)	-
VAT	708	-	789	-
Private finance initiative and other public private partnership arrangement prepayments and accrued income	-	-	-	-
Interest receivables	-	-	-	-
Finance lease receivables	-	-	-	-
Operating lease receivables	-	-	-	-
Other receivables and accruals	4	-	1	-
Total Trade & other receivables	**9,348**	**-**	**4,965**	**-**
Total current and non current	**9,348**		**4,965**	
Included above:				
Prepaid pensions contributions	-		-	

10.2 Receivables past their due date but not impaired

	Apr 2022 to June 2022 DHSC Group Bodies £'000	Apr 2022 to June 2022 Non DHSC Group Bodies £'000	2021-22 DHSC Group Bodies £'000	2021-22 Non DHSC Group Bodies £'000
By up to three months	365	181	455	417
By three to six months	3	2	-	17
By more than six months	-	0	-	-
Total	**368**	**183**	**455**	**434**

10.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies £'000	Other financial assets £'000	Total £'000
Balance at 01 April 2020	(4)	1	**(3)**
Lifetime expected credit loss on credit impaired financial assets	-	(1)	**(1)**
Lifetime expected credit losses on trade and other receivables-Stage 2	2	-	**2**
Lifetime expected credit losses on trade and other receivables-Stage 3	-	-	**-**
Credit losses recognised on purchase originated credit impaired financial assets	-	-	**-**
Amounts written off	-	-	**-**
Financial assets that have been derecognised	-	-	**-**
Changes due to modifications that did not result in derecognition	-	-	**-**
Other changes	-	-	**-**
Total	**(2)**	**-**	**(2)**

11 Cash and cash equivalents

	Apr 2022 to June 20	2021-22
	£'000	£'000
Balance at 01 April 2022	27	110
Net change in year	15	(83)
Balance at 30 June 2022	**42**	**27**
Made up of:		
Cash with the Government Banking Service	42	27
Cash with Commercial banks	-	-
Cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**42**	**27**
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	**-**
Balance at 30 June 2022	**42**	**27**

NHS Derby and Derbyshire Clinical Commissioning Group does not hold patients' money.

NHS Derby and Derbyshire Clinical Commissioning Group - Annual Accounts Apr 2022 to June 2022

12 Trade and other payables	**Current Apr 2022 to June 2022 £'000**	**Non-current Apr 2022 to June 2022 £'000**	Current 2021-22 £'000		Non-current 2021-22 £'000
Interest payable	-	-	-	-	-
NHS payables: Revenue	803	-	3,626	-	-
NHS payables: Capital	-	-	-	-	-
NHS accruals	26,784	-	2,248	-	-
NHS deferred income	-	-	-	-	-
NHS Contract Liabilities	-	-	-	-	-
Non-NHS and Other WGA payables: Revenue	2,942	-	6,272	-	-
Non-NHS and Other WGA payables: Capital	-	-	-	-	-
Non-NHS and Other WGA accruals	66,788	-	67,518	-	-
Non-NHS and Other WGA deferred income	-	-	-	-	-
Non-NHS Contract Liabilities	-	-	-	-	-
Social security costs	333	-	309	-	-
VAT	-	-	-	-	-
Tax	246	-	239	-	-
Payments received on account	-	-	-	-	-
Other payables and accruals	18,042	-	18,544	-	-
Total Trade & Other Payables	**115,938**	**-**	**98,756**	**-**	**-**
Total current and non-current	**115,938**		**98,756**		

NHS Derby and Derbyshire Clinical Commissioning Group does not have any liabilities included for arrangements to buy out the liability for early retirement over 5 years (£nil at 31 March 2021).

13 Provisions

	Current Apr 2022 to June 2022 £'000	**Non-current Apr 2022 to June 2022 £'000**	Current 2021-22 £'000	Non-current 2021-22 £'000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	-	-	-	-
Redundancy	27	-	-	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	13	-	13	-
Continuing care	1,053	-	1,430	-
Other	5,648	532	4,404	532
Total	**6,741**	**532**	**5,847**	**532**
Total current and non-current	**7,273**		**6,379**	

	Redundancy £'000	**Legal Claims £'000**	**Continuing Care £'000**	**Other £'000**	**Total £'000**
Balance at 01 April 2022	**-**	**13**	**1,430**	**4,936**	**6,379**
Arising during the year	27	-	-	1,358	**1,385**
Utilised during the year	-	-	(377)	(114)	**(491)**
Reversed unused	-	-	-	-	**-**
Unwinding of discount	-	-	-	-	**-**
Change in discount rate	-	-	-	-	**-**
Transfer (to) from other public sector body	-	-	-	-	**-**
Transfer (to) from other public sector body under absorption	-	-	-	-	**-**
Balance at 30 June 2022	**27**	**13**	**1,053**	**6,180**	**7,273**
Expected timing of cash flows:					
Within one year	27	13	1,053	5,648	**6,741**
Between one and five years	-	-	-	532	**532**
After five years	-	-	-	-	**-**
Balance at 30 June 2022	**27**	**13**	**1,053**	**6,180**	**7,273**

Formal notice of termination of employment was issued to an employee of DDCCG's successor organisation shortly after 30th June 2022, and as such a redundancy provision has been included within these Annual Accounts. Further details are provided within the Exit Packages section of the Annual Report.

Legal claims are calculated from the number of claims currently lodged with NHS Resolution and the probabilities provided by them. One claim totalling £13k was provided for in 2021-22.

The continuing healthcare retrospective claims and disputes have been reviewed with £377k being utilised during the financial period.

The Clinical Commissioning Group has "other" provisions, including that for the Cardinal Square and Scarsdale offices in Derby and Chesterfield respectively, known as 'dilapidation cost provision' (£532k) to cover the cost of putting the offices back to an expected condition, when the lease is terminated.

Other provisions include the following balances carried forward from 2021-22:

- Minor Surgery Backlog, £1.06m brought forward, £0.05m utilised.
- Primary Care Network Roles, £0.52m brought forward, with a further £1.36m arising during the period.
- Primary Care Estates and Technology Transformation Fund, £0.50m brought forward. Minimal amounts utilised.
- Digital Transformation, £0.47m brought forward. Minimal amounts utilised.
- Pension Shortfall, £0.29m brought forward. No amounts utilised.
- On-Line Consultation, £0.05m brought forward, which has been fully utilised.
- Acute service improvement post, £0.02m brought forward. £0.01 utilised in this period.
- Corporate Education and Training, £0.08m. No amounts utilised.
- Acute Waiting List Backlog, £1.43m. No amounts utilised.

14 Contingencies

A contingent liability of £107,000 has been recognised in respect of possible legal fees to be incurred in relation to an ongoing legal matter (2021-22: £107,000).

15 Commitments

NHS Derby and Derbyshire Clinical Commissioning Group had £nil capital commitments or other financial commitments (2021-22: £nil).

16 Financial instruments

16.1 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 clinical commissioning group 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 clinical commissioning group 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 clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS clinical commissioning group and internal auditors.

16.1.1 Currency risk

The NHS clinical commissioning group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS clinical commissioning group has no overseas operations. The NHS clinical commissioning group and therefore has low exposure to currency rate fluctuations.

16.1.2 Interest rate risk

The clinical commissioning group 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 clinical commissioning group therefore has low exposure to interest rate fluctuations.

16.1.3 Credit risk

Because the majority of the NHS clinical commissioning group and revenue comes parliamentary funding, NHS clinical commissioning group 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.

16.1.4 Liquidity risk

NHS clinical commissioning group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS clinical commissioning group draws down cash to cover expenditure, as the need arises. The NHS clinical commissioning group is not, therefore, exposed to significant liquidity risks.

16.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

16 Financial instruments cont'd

16.2 Financial assets

	Financial Assets measured at amortised cost Apr 2022 to June 2022 £'000	Equity Instruments designated at FVOCI Apr 2022 to June 2022 £'000	Total Apr 2022 to June 2022 £'000
Equity investment in group bodies		-	-
Equity investment in external bodies		-	-
Loans receivable with group bodies	-		-
Loans receivable with external bodies	-		-
Trade and other receivables with NHSE bodies	446		446
Trade and other receivables with other DHSC group bodies	2,698		2,698
Trade and other receivables with external bodies	642		642
Other financial assets	-		-
Cash and cash equivalents	42		42
Total at 30 June 2022	**3,828**	**-**	**3,828**

16.3 Financial liabilities

	Financial Liabilities measured at amortised cost Apr 2022 to June 2022 £'000	Other Apr 2022 to June 2022 £'000	Total Apr 2022 to June 2022 £'000
Loans with group bodies	-		**-**
Loans with external bodies	-		**-**
Trade and other payables with NHSE bodies	849		**849**
Trade and other payables with other DHSC group bodies	27,793		**27,793**
Trade and other payables with external bodies	87,989		**87,989**
Other financial liabilities	-		**-**
Private Finance Initiative and finance lease obligations	-		**-**
Total at 30 June 2022	**116,631**	**-**	**116,631**

17 Operating segments

NHS Derby and Derbyshire Clinical Commissioning Group considers that it has one operating segment, the commissioning of healthcare services.

18. 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 Clinical Commissioning Group's share of all pooled budgets are as follows:

	Apr 2022 to June 2022 £'000	2021-22 £'000
Income	(22,156)	(94,042)
Expenditure	21,173	93,858
	(983)	**(184)**

Better CareFund (BCF)
The Clinical Commissioning Group has two BCFs: The Derbyshire County BCF; and the Derby City BCF, which both became operational in 2015.

NHS Derby and Derbyshire Clinical Commissioning Group is a partner to the Derbyshire County BCF, along with NHS Tameside and Glossop Clinical Commissioning Group and Derbyshire County Council. NHS Derby and Derbyshire Clinical Commissioning Group 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 £114,751,200 including iBCF funding (£78,106,163 excluding iBCF). Total annual agreed contributions to the Derby City BCF Pool are £35,712,540, including iBCF funding (£23,359,980 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 period to 30th June 2022 the Derbyshire County Council received additionally £36,645,037 (2021-22: £331,054,728); and Derby City Council additionally £12,352,560 (2021-22: £110,542,289) of funding direct from the Government with the aim of:

- Meeting adult social care needs
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready
- Ensuring that the local social care provider market is supported

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 commissioner
- Commissioning of existing funded schemes directly by each partner

The memorandum account for the "Derbyshire County Better Care Fund" pooled budget is:

	Apr 2022 to June 2022	Apr 2022 to June 2022 Pool Share	2021-22	2021-22 Pool Share
	£'000	**%**	£'000	%
Income				
NHS Derby and Derbyshire CCG	(16,150)	56.29%	(71,139)	59.98
NHS Tameside and Glossop CCG	(694)	2.42%	(2,627)	2.22
Derbyshire County Council	(11,844)	41.29%	(44,838)	37.80
Total Income	**(28,688)**	**100%**	(118,604)	100.00

Expenditure	Apr 2022 to June 2022 **£'000**	2021-22 £'000
CCG schemes aimed at reducing non elective activity	5,800	22,670
CCG schemes - wheelchairs	279	1,088
Derbyshire County Council schemes	1,975	7,898
ICES (Integrated Community Equipment Service)	796	6,533
Reablement	4,384	17,535
Administration, Performance and Information Sharing	138	551
Care Bill	576	2,304
Delayed Transfer of Care	2,864	8,108
Carers	552	2,208
Integrated Care	817	12,396
Workforce Development	110	441
Dementia Support	105	421
Autism and Mental Health	442	1,769
iBCF	7,763	31,055
Winter Pressures Grant	907	3,627
Total Expenditure	**27,508**	118,604
Net position for Pool	**(1,180)**	0
NHS Derby and Derbyshire CCG share of surplus as at end of period	**664**	0

NHS Derby and Derbyshire Clinical Commissioning Group's share of the underspend was £664k (2021-22: £nil). This amount has been carried forward in the pool.

18. Joint arrangements - interests in joint operations, continued.

The memorandum account for the "Derby City Better Care Fund" pooled budget is:

	Apr 2022 to June 2022	**Apr 2022 to June 2022 Pool Share**	2021-22	2021-22 Pool Share
	£'000	**%**	£'000	%
Income				
NHS Derby and Derbyshire CCG	(5,155)	57.74	(19,516)	57.74
Derby City Council	(3,773)	42.26	(14,284)	42.26
Total Income	**(8,928)**	**100.00**	(33,800)	100.00

	Apr 2022 to June 2022	2021-22
Expenditure	**£'000**	£'000
CCG schemes aimed at reducing non elective activity	1,040	3,938
Derby City Council schemes	614	2,323
Community Health Services	1,588	6,227
Social Care	2,348	8,890
Mental Health	146	551
Accident & Emergency	47	180
iBCF	2,785	10,542
Winter Pressures Grant	303	1,149
Total Expenditure	**8,871**	33,800
Net position for Pool	**(57)**	0
NHS Derby and Derbyshire CCG share of surplus as	**33**	0

NHS Derby and Derbyshire Clinical Commissioning Group's share of the underspend was £33k (2021-22: £nil). This amount has been carried forward in the pool.

NHS Derby and Derbyshire Clinical Commissioning Group 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:

	Apr 2022 to June 2022	**Apr 2022 to June 2022 Pool Share**	2021-22	2021-22 Pool Share
	£'000	**%**	£'000	%
Income				
NHS Derby and Derbyshire CCG	(594)	33.00	2,376	33.00
Derbyshire County Council	(1,206)	67.00	4,824	67.00
Total Income	**(1,800)**	**100.00**	**7,200**	**100.00**

	Apr 2022 to June 2022	2021-22
Expenditure	**£'000**	£'000
Purchase of equipment and healthcare services	1,800	7,200
Total Expenditure	**1,800**	7,200
Net position for Pool	**0**	0

18. Joint arrangements - interests in joint operations, continued.

NHS Derby and Derbyshire Clinical Commissioning Group 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:

	Apr 2022 to June 2022	**Apr 2022 to June 2022 Pool Share**	2021-22	2021-22 Pool Share
	£'000	**%**	£'000	%
Income				
NHS Derby and Derbyshire CCG	(257)	44.12	(1,011)	43.71
Derby City Council	(326)	55.88	(1,302)	56.29
Total Income	**(583)**	**100.00**	(2,313)	100.00

	Apr 2022 to June 2022	2021-22
Expenditure	**£'000**	£'000
Residential Services	263	1,052
Community Service Team (Outreach Service)	61	243
Disability and Fieldwork Social Work Services	3	12
Management and Administration	199	795
Total Expenditure	**526**	2,102
Net position for Pool	**(57)**	(211)
Balance brought forward as at 1 April	(592)	(381)
Balance carried forward as at end of period	**(649)**	(592)
NHS Derby and Derbyshire CCG share of surplus as at end of period	**286**	260

The Integrated Disabled Chldren's Centre and Services in Derby pooled budget reported an underspend of £57k for the period (2021-22: £211k), with a total accumulated underspend of £649k at 30 June 2022 (2021-22: £592k).
NHS Derby and Derbyshire Clinical Commissioning Group's share of the accumulated underspend was £286k (2021-22: £260k). This amount has been carried forward in the pool.

19 Related party transactions

Details of related party transactions with individuals are as follows:

Body	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Circle Health Group Ltd	214	-	-	-
College Street Medical	-	-	-	-
Derby City Council	4,320	(90)	1,476	-
Derbyshire County Council	19,340	(187)	-	(2,035)
Emmett Carr Surgery	178	-	-	-
Erewash Health Partnership	969	-	65	-
Hannage Brook Medical Centre	4	-	-	-
Killamarsh Medical Practice	299	-	-	-
Lakhani Jordan Bhatia & Partners	506	-	-	-
Lindop Williams Merrick & Partners	298	-	-	-
Littlewick Medical Centre	602	-	-	-
NHSE Central and Midlands	-	-	3	(28)
Nottingham University Hospitals NHS Trust	11,619	-	610	-
Purnell and Partners	76	0	-	-
Ramchandran & Partners	201	-	-	-
Sheffield Teaching Hospitals NHS Foundation Trust	7,657	-	611	-
St Lawrence Road Surgery	174	-	1	-
Swadlincote Surgery	465	-	-	-
The Rotherham NHS Foundation Trust	129	-	9	-
University Hospitals Of Derby And Burton NHS Foundation Trust	147,287	-	15,294	(5)
University Hospitals of Leicester NHS Trust	351	-	20	-
Vernon Street Medical Centre	367	-	-	-

All transactions have been at arm's length as part of NHS Derby and Derbyshire Clinical Commissioning Group's healthcare commissioning.

The Department of Health is regarded as a related party. During the year the Clinical Commissioning Group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

• NHS England including: NHS England Midlands; NHS Arden & GEM Commissioning Support Unit; NHS Midlands and Lancashire Commissioning Support Unit; NHS North of England Commissioning Support Unit

• NHS Foundation Trusts including: Chesterfield Royal Hospitals NHS Foundation Trust; Derbyshire Community Healthcare Services NHS Foundation Trust; Derbyshire Healthcare NHS Foundation Trust; and University Hospitals of Derby and Burton NHS Foundation Trust

• NHS Trusts including: East Midlands Ambulance Service NHS Trust; and Nottingham University Hospitals NHS Trust

• NHS Resolution; and,

• NHS Business Services Authority

NHS Derby and Derbyshire Clinical Commissioning Group also has material transactions with all the GP Practices within its locality and membership.

In addition, NHS Derby and Derbyshire Clinical Commissioning Group 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 2021-22 the following related party transactions were made with NHS Derby and Derbyshire Clinical Commissioning Group (transactions identified were not with the member but between the Clinical Commissioning Group and the related party):

Body	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
College Street Medical	2	-	-	-
Derby City Council	25,082	(269)	3,343	(135)
Derbyshire County Council	87,916	(522)	9,096	(339)
Emmett Carr Surgery	666	-	-	-
Erewash Health Partnership	3,198	-	-	-
Hannage Brook Medical Centre	23	-	-	-
Killamarsh Medical Practice	1,108	-	-	-
Lakhani Jordan Bhatia & Partners	1,744	-	-	-
Lindop Williams Merrick & Partners	1,269	-	-	-
Littlewick Medical Centre	2,416	-	-	-
Moir Medical Centre	8	-	-	-
NHSE Central and Midlands	-	(577)	-	(498)
North Eastern Derbyshire Healthcare Ltd	1,221	-	-	-
Nottingham University Hospitals NHS Trust	43,765	-	-	-
Purnell and Partners	545	-	-	-
Ramchandran & Partners	772	-	-	-
Sheffield Teaching Hospitals NHS Foundation Trust	27,758	-	-	-
St Lawrence Road Surgery	688	-	1	-
Staffa Health	2,603	-	-	-
Swadlincote Surgery	1,805	-	-	-
University Hospitals Of Derby And Burton NHS Foundation Trust	598,370	(7)	755	(2)
University Hospitals of Leicester NHS Trust	1,304	-	-	-
Vernon Street Medical Centre	1,215	-	-	-

20 Events after the end of the reporting period

On 1 July 2022 the Health and Care Bill was enacted. The Health and Care Bill approves the formation of Integrated Care Boards and for them to take over the functions of Clinical Commissioning Groups. As a result NHS Derby and Derbyshire CCG was dissolved on 30 June 2022 and Derby and Derbyshire Integrated Care Board was formed from the following day. In line with the provisions of the Group Accounting Manual the assets and liabilities of the CCG transferred to the newly formed Integrated Care Board at book value.

Following the enactment of the Health and Care Bill on 1 July 2022, one executive member was given notice of termination employment following the transition to the ICB. The termination payment relating to this has been subsequently recognised in the Exit Packages note, 4.4.

21 Losses and special payments

21.1 Losses

The total number of NHS clinical commissioning group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases Apr 2022 to June 2022 Number	**Total Value of Cases Apr 2022 to June 2022 £'000**	Total Number of Cases 2021-22 Number	Total Value of Cases 2021-22 £'000
Administrative write-offs	-	-	2	1
Fruitless payments	-	-	-	-
Store losses	-	-	-	-
Book Keeping Losses	-	-	-	-
	-	-	-	-
Constructive loss	-	-	-	-
Cash losses	-	-	-	-
Claims abandoned	-	-	-	-
Total	**-**	**-**	**2**	**1**

In 2021-22, £731 of staff costs were written off in relation to two salary overpayments (2020-21, £681).

21.2 Special payments

	Total Number of Cases Apr 2022 to June 2022 Number	**Total Value of Cases Apr 2022 to June 2022 £'000**	Total Number of Cases 2021-22 Number	Total Value of Cases 2021-22 £'000
Compensation payments	-	-	1	3
Compensation payments Treasury Approved	-	-	-	-
Extra Contractual Payments	-	-	-	-
Extra Contractual Payments Treasury Approved	-	-	-	-
Ex Gratia Payments	-	-	-	-
Ex Gratia Payments Treasury Approved	-	-	-	-
Extra Statutory Extra Regulatory Payments	-	-	-	-
Extra Statutory Extra Regulatory Payments Treasury Approved	-	-	-	-
Special Severance Payments Treasury Approved	-	-	-	-
Special Severance Payments	-	-	-	-
Total	**-**	**-**	**1**	**3**

In 2021-22, a settlement of £3,000 was agreed for a legal claim against NHS Derby and Derbyshire CCG

22 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).
NHS Clinical Commissioning Group performance against those duties was as follows:

	Apr 2022 to June 2022 Target £'000	**Apr 2022 to June 2022 Performance £'000**	2021-22 Target £'000	2021-22 Performance £'000
Expenditure not to exceed income	527,946	527,958	2,121,306	2,120,665
Capital resource use does not exceed the amount specified in Directions	-	-	650	87
Revenue resource use does not exceed the amount specified in Directions	527,402	527,414	2,113,550	2,113,473
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	-	-
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	43,563	43,563	168,343	168,380
Revenue administration resource use does not exceed the amount specified in Directions	4,695	4,707	20,905	18,633

NHS Derby and Derbyshire Clinical Commissioning Group achieved an in-year deficit of £12k.

On 6 June 2023 the auditors issued a referral to the Secretary of State and NHS England under Section 30 of the Local Audit and Accountability Act 2014 in respect of the CCG's breach of its Revenue Resource Limit.

The "Revenue resource use on specified matter(s)" relates to primary care co-commissioning, delegated to NHS Derby and Derbyshire Clinical Commissioning Group. Primary care co-commissioning resource and expenditure are also included in the financial performance targets: "Expenditure not to exceed income"; and "Revenue resource use does not exceed the amount specified in directions".

AUDITOR’S REPORT

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE BOARD OF NHS DERBY and DERBYSHIRE INTEGRATED CARE BOARD IN RESPECT OF NHS DERBY and DERBYSHIRE CLINICAL COMMISSIONING GROUP

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Derby and Derbyshire Clinical Commissioning Group ("the CCG") for the three-month period ended 30 June 2022 which comprise of the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the CCG's affairs as at 30 June 2022 and of its income and expenditure for the three month period then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State on 22 June 2022 as being relevant to CCGs in England and included in the Department of Health and Social Care Group Accounting Manual 2022/23; and
- have been prepared in accordance with the requirements of the National Health Services 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 CCG and NHS Derby and Derbyshire Integrated Care Board ("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.

Emphasis of matter – going concern

We draw attention to the disclosure made in note 1.1 to the financial statements which explains that on 1 July 2022, NHS Derby and Derbyshire CCG was dissolved, and its services transferred to NHS Derby and Derbyshire Integrated Care Board. Under the continuation of service principle the financial statements of the CCG have been prepared on a going concern basis because its services will continue to be provided by the successor public sector entity. Our opinion is not modified in respect of this matter.

Going concern

The Accountable Officer of the ICB ("the Accountable Officer") has prepared the financial statements on the going concern basis as the CCG has been dissolved and its services transferred to another public sector entity, the ICB, and the Accountable Officer has not been informed by the relevant national body of the intention to cease the services previously provided by the CCG. 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 CCG and transferred to 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 CCG'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 services provided by the CCG will continue to be provided by the successor body.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit and Governance Committee of the successor ICB and internal audit and inspection of policy documentation as to the CCG's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the CCG'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 CCG by NHS England.
- Reading Governing Body and Audit and Governance Committee minutes of the CCG and the ICB.
- 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 and taking into account possible pressures to meet delegated statutory resource limits, we performed procedures to address the risk of management override of controls, in particular the risk that CCG 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 CCG, which is transferred from NHS England and recognised through the Statement of Changes in Taxpayers' Equity.

We did not identify any additional fraud risks

We performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included unusual postings to cash and unusual postings to expenditure.

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 of the CCG and ICB (as required by auditing standards) and other management the policies and procedures regarding compliance with laws and regulations.

As the CCG is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

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 CCG is subject to laws and regulations that directly affect the financial statements including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

We are required to make a referral to the Secretary of State and NHS England under section 30 of the Local Audit and Accountability Act 2014 if we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

As outlined in the section of this report dealing with other legal and regulatory matters, we made a Section 30 referral to the Secretary of State and NHS England on 6 June 2023 on the basis that the expenditure incurred by the CCG in the three-month period ended 30 June 2022 exceeded its Revenue Resource Limit by £12,000

Whilst the CCG is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accountable Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial 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 2022/23. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the Department of Health and Social Care Group Accounting Manual 2022/23.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 91-92, 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 CCG'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 CCG or dissolve the CCG without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

We are required to report on the following matters under Section 21(4) and (5) of the Local Audit and Accountability Act 2014.

In our opinion, in all material respects, the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Report on the CCG'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 CCG 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 116-118, the Accountable Officer is responsible for ensuring that the CCG 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 CCG 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 CCG's arrangements for securing economy, efficiency, and effectiveness in the 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 CCG 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 CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

As outlined in the section of this report dealing with fraud and breaches of laws and regulations we made a section 30 referral to the Secretary of State and NHS England on 6 June 2023 on the basis that the expenditure incurred by the CCG in the period ended 30 June 2022 exceeded its Revenue Resource Limit by £12,000.

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 in respect of NHS Derby and Derbyshire CCG, 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 CCG for the three month period ended 30 June 2022 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Andrew Cardoza
for and on behalf of KPMG LLP
Chartered Accountants
1 Snow Hill Queensway,
Birmingham,
B4 6GH

27 June 2023

APPENDICES

Appendix One: CCG Attendance at Meetings during Quarter 1 of 2022/23

Governing Body Attendance Record

Governing Body Member	7th Apr 2022	5th May 2022	16th Jun 2022
Dr Avi Bhatia *Clinical Chair*	✓	X	✓
Martin Whittle *Vice Chair, Lay Member for Patient and Public Involvement*	✓	✓	✓
Dr Chris Clayton *Chief Executive Officer*	✓	✓	✓
Richard Chapman *Chief Finance Officer*	✓	✓	✓
Brigid Stacey *Chief Nurse Officer*	✓	✓	✓
Dr Steven Lloyd *Executive Medical Director*	✓	✓	✓
Dr Penny Blackwell *GP Member*	✓	X	✓
Dr Bukhtawar Dhadda *GP Member*	X	✓	✓
Dr Emma Pizzey *GP Member*	X	✓	X
Dr Greg Strachan *GP Member*	✓	✓	✓
Dr Merryl Watkins *GP Member*	✓	X	✓
Jill Dentith *Lay Member for Governance and Freedom to Speak Up Guardian*	X	✓	✓
Ian Gibbard *Lay Member for Audit and Conflicts of Interest Guardian*	✓	X	✓
Andrew Middleton *Lay Member for Finance and Sustainability Champion*	✓	✓	✓
Simon McCandlish *Lay Member for Patient and Public Involvement*	X	✓	✓
Professor Ian Shaw *Lay Member for Primary Care Commissioning*	X	✓	✓
Dr Bruce Braithwaite *Secondary Care Consultant*	✓	X	X
Helen Dillistone *Executive Director of Corporate Strategy and Delivery*	X	✓	✓
Zara Jones *Executive Director of Commissioning Operations*	✓	✓	✓
Dr Robyn Dewis *Derby City Council Representative*	X	X	X
Dean Wallace *Derbyshire County Council Representative*	X	✓	X

Audit Committee Attendance Record

Audit Committee Member	18th May 2022	10th Jun 2022
Ian Gibbard *Chair, Lay Member for Audit and Conflicts of Interest Guardian*	✓	✓
Jill Dentith *Deputy Chair, Lay Member for Governance and Freedom to Speak Up Guardian*	✓	✓
Andrew Middleton *Lay Member for Finance and Sustainability Champion*	✓	✓
Dr Bruce Braithwaite *Secondary Care Consultant*+	X	X

Primary Care Commissioning Committee Attendance Record

Primary Care Commissioning Committee Member	27th Apr 2022	25th May 2022	22nd Jun 2022
Professor Ian Shaw *Chair, Lay Member for Primary Care Commissioning*	✓	✓	✓
Simon McCandlish *Deputy Chair, Lay Member for Patient and Public Involvement*	✓	✓	✓
Jill Dentith *Lay Member for Governance and Freedom to Speak Up Guardian*	✓	✓	✓
Brigid Stacey *Chief Nurse Officer*	X	X*	X*
Richard Chapman *Chief Finance Officer*	X*	X*	X*
Dr Steven Lloyd *Executive Medical Director*	✓	X	✓

Remuneration Committee Attendance Record

Remuneration Committee Member	29th Apr 2022
Martin Whittle *Chair, Lay Member for Patient and Public Involvement*	✓
Ian Gibbard *Lay Member for Audit and Conflicts of Interest Guardian*	✓
Jill Dentith *Lay Member for Governance and Freedom to Speak Up Guardian*	✓
Andrew Middleton *Lay Member for Finance and Sustainability Champion*	✓

+ 'By invitation' in accordance with the Committee's workplan or where clinical input is required.
* Indicates where a member was deputised.

Clinical and Lay Commissioning Committee Attendance Record

Clinical and Lay Commissioning Committee Member	21st Apr 2022	12th May 2022	9th Jun 2022
Professor Ian Shaw *Deputy Chair, Lay Member for Primary Care Commissioning*	✓	X	✓
Dr Bukhtawar Dhadda *GP Member*	✓	X	X
Dr Emma Pizzey *GP Member*	✓	X	✓
Dr Greg Strachan *GP Member*	✓	✓	✓
Dr Merryl Watkins *GP Member*	X	✓	✓
Dr Bruce Braithwaite *Secondary Care Consultant*	X	X	X
Simon McCandlish *Lay Member for Patient and Public Involvement*	✓	✓	✓
Ian Gibbard *Lay Member for Audit and Conflicts of Interest Guardian*	✓	✓	✓
Brigid Stacey *Chief Nurse Officer*	X	✓	✓
Richard Chapman *Chief Finance Officer*	✓	X*	X*
Dr Steven Lloyd *Executive Medical Director*	X	✓	✓
Dr Robyn Dewis *Public Health Representative*	X	X	X*
Zara Jones *Executive Director of Commissioning Operations*	✓	X	✓

Engagement Committee Attendance Record

Engagement Committee Member	26th Apr 2022	17th May 2022	21st Jun 2022
Martin Whittle *Chair, Lay Member for Patient and Public Involvement*	✓	✓	✓
Simon McCandlish *Deputy Chair, Lay Member for Patient and Public Involvement*	✓	✓	✓
Professor Ian Shaw *Lay Member for Primary Care Commissioning*	✓	X	✓
Maura Teager *Foundation Trust Governor – Secondary Care*	X*	✓	✓
Margaret Rotchell *Foundation Trust Governor – Secondary Care*	✓	✓	✓
Lynn Walshaw *Foundation Trust Governor – Community*	✓	X	✓
Chris Mitchell *Foundation Trust Governor – Mental Health*	✓	✓	✓
Ram Paul *Derby City Council Representative*	X	X	X

Engagement Committee Member	26th Apr 2022	17th May 2022	21st Jun 2022
Jocelyn Street *Place Engagement Representative*	✓	X	X
Ruth Grice *Place Engagement Representative*	X	X	X
Roger Cann *Place Engagement Representative*	X	X	X
Trevor Corney *Place Engagement Representative*	X	X	X
Steve Bramley *Place Engagement Representative*	✓	✓	✓
Tim Peacock *Place Engagement Representative*	✓	X	✓
Helen Dillistone *Executive Director of Corporate Strategy and Delivery*	✓	✓	✓
Rebecca Johnson *Healthwatch Derby Representative*	✓	✓	X
Helen Henderson-Spoors *Healthwatch Derbyshire Representative*	X	X*	X
Kim Harper *Community Action Derby*	X	X	✓
Vikki Taylor *Director, Joined Up Care Derbyshire*	X*	X	X
Sean Thornton *Assistant Director Communications and Engagement, CCG*	✓	✓	✓
Karen Lloyd *Head of Engagement, Joined Up Care Derbyshire*	✓	✓	X

Finance Committee Attendance Record

Finance Committee Member	28th Apr 2022	9th May 2022	26th May 2022	30th Jun 2022
Andrew Middleton *Chair, Lay Member for Finance and Sustainability Champion*	✓	✓	✓	✓
Martin Whittle *Lay Member for Patient and Public Involvement*	✓	X	X	✓
Ian Gibbard *Lay Member for Audit and Conflicts of Interest Guardian*	X	X	✓	✓
Dr Bukhtawar Dhadda *GP Member*	X	X	✓	✓
Dr Merryl Watkins *GP Member*	X	✓	✓	✓
Richard Chapman *Chief Finance Officer*	✓	✓	✓	✓
Brigid Stacey *Chief Nurse Officer*	X	X*	X*	✓

Governance Committee Attendance Record

Governance Committee Member	21st Apr 2022	23rd Jun 2022
Jill Dentith *Chair, Lay Member for Governance and Freedom to Speak Up Guardian*	✓	✓
Ian Gibbard *Lay Member for Audit and Conflicts of Interest Guardian*	✓	✓
Martin Whittle *Lay Member for Patient and Public Involvement*	✓	✓
Dr Emma Pizzey *TEAM Member*	✓	✓
Dr Greg Strachan *GP Member*	✓	✓
Helen Dillistone *Executive Director of Corporate Strategy and Delivery*	✓	✓

Quality and Performance Committee Attendance Record

Quality and Performance Committee Member	28th Apr 2022	26th May 2022	30th Jun 2022
Dr Bukhtawar Dhadda *Chair, GP Member*	X	X	✓
Dr Emma Pizzey *GP Member*	✓	✓	✓
Dr Greg Strachan *GP Member*	✓	✓	✓
Dr Merryl Watkins *GP Member*	X	✓	✓
Andrew Middleton *Lay Member for Finance and Sustainability Champion*	✓	✓	✓
Simon McCandlish *Lay Member for Patient and Public Involvement*	✓	✓	✓
Martin Whittle *Lay Member for Patient and Public Involvement*	✓	X	X
Brigid Stacey *Chief Nurse Officer*	✓	X*	✓
Dr Steven Lloyd *Executive Medical Director*	✓	X*	✓
Dr Bruce Braithwaite *Secondary Care Consultant*	X	X	X
Zara Jones *Executive Director of Commissioning Operations*	X*	X*	✓
Helen Henderson-Spoors *Healthwatch Derbyshire Representative*	X	X	X

GLOSSARY

Glossary

2WW	Two-week wait
A&E	Accident and Emergency
ARRS	Additional Roles Reimbursement Scheme
Bn	Billion
CAMHS	Children Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CETV	Cash Equivalent Transfer Value
CHC	Continuing Healthcare
CPA	Care Programme Approach
CQC	Care Quality Commission
CRHFT	Chesterfield Royal Hospital NHS Foundation Trust
DCHSFT	Derbyshire Community Health Services NHS Foundation Trust
DHcFT	Derbyshire Healthcare NHS Foundation Trust
DHU	Derbyshire Health United Community Interest Company
DOS	Directory of Services
DSPT	NHS Data Security and Protection Toolkit
EAF	Expert Advisory Forum
ED	Emergency Department
EMAS	East Midlands Ambulance Service NHS Trust
EoL	End of Life
FH	Familial Hypercholesteremia
FTE	Full Time Equivalent
GNBSI	Gram-negative bloodstream infections
GP	General Practitioner
GP-CPCS	General Practice Community Pharmacist Consultation Service
HCAI	Healthcare-associated infections
HCD	High-Cost Drugs

HED	Health Education Derbyshire
HR	Human Resources
IAPT	Improving Access to Psychological Therapies
ICB	Integrated Care Board
ICS	Integrated Care System
IT	Information Technology
JUCD	Joined Up Care Derbyshire
k	Thousand
KPI	Key Performance Indicator
LeDeR	Learning Disability Mortality Review
LMNS	Local Maternity and Neonatal System
LPA	Local Place Alliance
LTC	Long Term Condition
m	Million
MDI	Metered Dose Inhalers
MHST	Mental Health Support Team
MRSA	Methicillin-resistant Staphylococcus aureus
MSK	Musculoskeletal
NECS	North of England Commissioning Support
NHS	National Health Service
NHSE&I	NHS England and NHS Improvement
NICE	National Institute for Health and Care Excellence
OEIG	Organisation Effectiveness and Improvement Group
PCN	Primary Care Network
PSIRF	Patient Safety Incident Response Framework
Q1	Quarter 1
QA	Quality Assurance
QEIA	Quality and Equality Impact Assessments

RDH	Royal Derby Hospital
SMI	Serious Mental Illness
STAC	System JUCD Transition Assurance Sub-Committee
TCP	Transforming Care Partnership
TWG	Transition Working Group
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

About NHS Derby and Derbyshire Clinical Commissioning Group

NHS Derby and Derbyshire Clinical Commissioning Group brings together the combined expertise of 109 local General Practices to commission health services on behalf of over 1,062,000 patients in Derby and 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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