Derby and Derbyshire
Clinical Commissioning Group

NHS DERBY AND DERBYSHIRE CCG

GOVERNING BODY – MEETING IN PUBLIC

Date & Time: Thursday 13th January 2022 – 9.30am to 11.00am
Via Microsoft Teams

Questions from members of the public should be emailed to DDCCG.Enquiries@nhs.net and a response will be provided within seven working days

Item	Subject	Paper	Presenter	Time
GBP/2122/214	**Welcome, Apologies & Quoracy** Apologies: Professor Ian Shaw	**Verbal**	**Dr Avi Bhatia**	**9.30**
GBP/2122/215	**Questions from members of the public**	**Verbal**	**Dr Avi Bhatia**	
GBP/2122/216	**Declarations of Interest** • Register of Interests • Summary register for recording any conflicts of interests during meetings • Glossary	**Papers**	**Dr Avi Bhatia**	
CHAIR AND CHIEF OFFICER REPORTS				
GBP/2122/217	**Chair's Report**	**Paper**	**Dr Avi Bhatia**	**9.35**
GBP/2122/218	**Chief Executive Officer's Report**	**Paper**	**Dr Chris Clayton**	
FOR DISCUSSION				
GBP/2122/219	**2022-23 NHS Priorities and Operational Planning Guidance**	**Paper**	**Zara Jones**	**9.55**
GBP/2122/220	**Update to Transition Timeline and implications for consideration**	**Paper**	**Helen Dillistone**	
CORPORATE ASSURANCE				
GBP/2122/221	**Finance Report – Month 9**	**Paper**	**Richard Chapman**	**10.20**

GBP/2122/222	**Finance Committee Assurance Report – December 2021**	**Verbal**	**Andrew Middleton**	
GBP/2122/223	**Audit Committee Assurance Report – December 2021**	**Paper**	**Ian Gibbard**	
GBP/2122/224	**Clinical and Lay Commissioning Committee Assurance Report – December 2021**	**Paper**	**Dr Ruth Cooper**	
GBP/2122/225	**Primary Care Commissioning Committee Assurance Report – December 2021**	**Verbal**	**Simon McCandlish**	
GBP/2122/226	**Quality and Performance Committee Assurance Report – December 2021**	**Paper**	**Dr Buk Dhadda**	
GBP/2122/227	**Governing Body Assurance Framework - Quarter 3**	**Paper**	**Helen Dillistone**	
GBP/2122/228	**CCG Risk Register – December 2021**	**Paper**	**Helen Dillistone**	
FOR INFORMATION				
GBP/2122/229	**Ratified Minutes of Corporate Committees:** • Primary Care Commissioning Committee – 24.11.2021 • Quality and Performance Committee – 25.11.2021	**Papers**	**Committee Chairs**	**10.45**
MINUTES AND MATTERS ARISING FROM PREVIOUS MEETING				
GBP/2122/230	**Minutes of the Governing Body Meeting in Public held on 2nd December 2021**	**Paper**	**Dr Avi Bhatia**	
GBP/2122/231	**Matters arising from the minutes not elsewhere on agenda:** • Action Log – December 2021	**Paper**	**Dr Avi Bhatia**	
GBP/2122/232	**Forward Planner**	**Paper**	**Dr Avi Bhatia**	
GBP/2122/233	**Any Other Business**	**Verbal**	**All**	

Date and time of future meetings:

Thursday 3rd February 2022 from 9.30am to 11am – via Microsoft Teams
Thursday 3rd March 2022 from 9.20am to 11am – via Microsoft Teams

NHS DERBY AND DERBYSHIRE CCG GOVERNING BODY MEMBERS' REGISTER OF INTERESTS 2021/22

NHS
Derby and Derbyshire
Clinical Commissioning Group

*denotes those who have left the CCG, who will be removed from the register six months after their leaving date

Name	Job Title	Committee Member	Also a member of	Declared Interest (including direct/ indirect Interest)	Type of Interest				Date of Interest		Action taken to mitigate risk
					Financial Interest	Non Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To	
Bhatia, Dr Avi	Clinical Chair	Governing Body	Erewash Place Alliance Group Derbyshire Primary Care Leadership Group Joined Up Care Derbyshire Long Term Conditions Workstream	GP Partner at Moir Medical Centre	✓				2000	Ongoing	Withdraw from all discussion and voting if organisation Is potential provider unless otherwise agreed by the meeting chair
				GP Parter at Erewash Health Partnership	✓				April 2018	Ongoing	
				Spouse works for Nottingham University Hospitals in Gynaecology				✓	Ongoing	Ongoing	
				Part landlord/owner of premises at College Street Medical Practice, Long Eaton, Nottingham	✓				Ongoing	Ongoing	
Blackwell, Dr Penny	Governing Body GP	Governing Body	Derbyshire Primary Care Leadership Group Gastro Delivery Group Derbyshire Place Board Dales Health & Wellbeing Partnership Dales Place Alliance Group Joined Up Care Derbyshire Long Term Conditions Workstream	Director of Flourish Derbyshire Dales CIC, which aims to provide creative arts and activity projects and to support others in this activity for the Derbyshire Dales		✓			Feb 2019	Ongoing	Withdraw from all discussion and voting if organisation Is potential provider unless otherwise agreed by the meeting chair
				GP partner at Hannage Brook Medical Centre, Wirksworth. Interests in Drug misuse	✓				Oct 2010	Ongoing	
				GP lead for Shared Care Pathology, Derbyshire Pathology		✓			2011	Ongoing	
				Clinical advisor to the board of Sinfonia Viva, a professional orchestra		✓			1 Apr 2021	Ongoing	
Braithwaite, Bruce	Secondary Care Specialist	Governing Body	Audit Committee Clinical & Lay Commissioning Committee	Shareholder in BD Braithwaite Ltd, which provides clinical services to Independent Healthcare Groupand provides private medical services in the East Midlands (including patients who are not eligible for NHS funded treatment according to CCG guidelines)	✓				Aug 2014	Ongoing	Withdraw from all discussion and voting if organisation Is potential provider unless otherwise agreed by the meeting chair
				Employed by Nottingham University Hospital NHS Trust which is commissioned by the CCG to provide services to NHS patients.	✓				Aug 2000	Ongoing	Declare interest in relevant meetings
				Founder Member, Shareholder and Director of Clinical Services for Alliance Surgical plc which is a company that bids for NHS contracts.	✓				July 2007	Ongoing	Withdraw from all discussion and voting if organisation Is potential provider unless otherwise agreed by the meeting chair
				Fellow of the Royal College Of Surgeons of England and Member of the Vascular Society of Great Britain and Ireland. Advisor to NICE on an occasional basis.		✓			Aug 1992	Ongoing	No action required
				Honorary Associate Professor, University of Nottingham, involved in clinical research activity in the East Midlands.		✓			Aug 2009	Ongoing	No action required
				Medical Director of Independent Healthcare Group which provides local anaesthetic services to NHS patients in Leicestershire, Gloucestershire, Wiltshire and Somerset.	✓				Oct 2020	Ongoing	Withdraw from all discussion and voting if organisation Is potential provider unless otherwise agreed by the meeting chair
				Chief Medical Officer for Circle Harmony Health Limited which is part owned by Circle Health Group who run BMI and Circle Hospitals	✓				Aug 2020	Ongoing	Withdraw from all discussion and voting if organisation Is potential provider unless otherwise agreed by the meeting chair
Chapman, Richard	Chief Finance Officer	Governing Body	Clinical & Lay Commissioning Committee Finance Committee Primary Care Commissioning Committee	Nil							No action required
Clayton, Dr Chris	Chief Executive Officer	Governing Body	Clinical & Lay Commissioning Committee Primary Care Commissioning Committee	Spouse is a partner in PWC				✓	2019	Ongoing	Declare interest at relevant meetings
Cooper, Dr Ruth	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Finance Committee	Locum GP at Staffa Health, Tibshelf	✓				Dec 2020	Ongoing	Declare interests at relevant meetings and Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
			North East Derbyshire & Bolsover Place Alliance Group	Shareholder in North Eastern Derbyshire Healthcare Ltd	✓				2015	Ongoing	
			Derbyshire Primary Care Leadership Group CRHFT Clinical Quality Review Group GP Workforce Steering Group Conditions Specific Delivery Board	Director of IS and RC Limited, providing medical services to Staffa Health and South Hardwick PCN, which includes the role of clinical lead for the Enhanced Health in Care Homes project	✓				3 Feb 2021	Ongoing	
				Fundraising Activities through Staffa Health to support Ashgate Hospice and Blythe House			✓		Ongoing	Ongoing	
Dentith, Jill	Lay Member for Governance	Governing Body	Audit Committee Governance Committee Primary Care Commissioning Committee Remuneration Committee System Transition Committee System People and Culture Group	Self-employed through own management consultancy business trading as Jill Dentith Consulting	✓				2012	Ongoing	Declare interests at relevant meetings
				Providing part-time, short term corporate governance support to Rotherham NHS Foundation Trust	✓				6 Oct 2020	8 April 2021	
				Director of Jon Carr Structural Design Ltd	✓				6 Apr 2021	Ongoing	
				Providing part-time, short term corporate governance support to Sheffield Teaching Hospitals NHS Foundation Trust	✓				07.06.2021	31.12.2021	

Dewis, Dr Robyn	Director of Public Health, Derby City Council	Governing Body	Clinical & Lay Commissioning Committee Clinical Policy Advisory Group Joint Area Prescribing Committee Conditions Specific Delivery Board CVD Delivery Group Derbyshire Place Board Derby City Place Alliance Group Respiratory Delivery Group	Nil							No action required
Dhadda, Dr Bukhtawar S	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Finance Committee Quality & Performance Committee UHDB Clinical Quality Review Group Clinical Policy Advisory Group	GP Partner at Swadlincote Surgery	✓				2015	Ongoing	Withdraw from all discussion and voting if organisation Is potential provider unless otherwise agreed by the meeting chair
Dillistone, Helen	Executive Director of Corporate Strategy & Delivery	Governing Body	Engagement Committee Governance Committee	Nil							No action required
Gibbard, Ian	Lay Member for Audit	Governing Body	Audit Committee Clinical & Lay Commissioning Committee Finance Committee Governance Committee Remuneration Committee Individual Funding Requests Panel	Nil							No action required
Jones, Zara	Executive Director of Commissioning & Operations	Governing Body	Clinical & Lay Commissioning Committee Quality & Performance Committee CRHFT Contract Management Board	Nil							No action required
Lloyd, Dr Steven	Medical Director	Governing Body	CVD Delivery Group Clinical & Lay Commissioning Committee CRHFT Contract Management Board 999 Quality Assurance Group Derbyshire Prescribing Group Derbyshire System Flu Planning Cell Finance Committee Primary Care Commissioning Committee Quality & Performance Committee GP Information Governance Assurance Forum Primary & Community Collaborative Delivery Board	Salaried sessions at Eyam Surgery Shareholder in premises of Emmett Carr Surgery, Renishaw	✓ ✓	✓			Oct 2021 Ongoing	Ongoing Ongoing	Declare interests at relevant meetings
McCandlish, Simon	Lay Member for Patient and Public Involvement	Governing Body	Clinical & Lay Commissioning Committee Engagement Committee Primary Care Commissioning Committee Quality & Performance Committee Commissioning for Individuals Panel (Shared Chair)	Nil							No action required
Middleton, Andrew	Lay Member for Finance	Governing Body	Audit Committee Finance Committee Quality & Performance Committee Remuneration Committee Commissioning for Individuals Panel (Shared Chair) Derbyshire System Finance Oversight Group	Lay Vice Chair of East Riding of Yorkshire Clinical Commissioning Group Lay Chair of Performers List Decision Panels for NHS England Central Midlands Lay Chair of Appointment Advisory Committees at United Hospitals Leicester - chairing panels for appointing hospital consultants Independent Non-Executive Director for Finance and Governance for Barnsley Healthcare Federation	✓ ✓ ✓ ✓				Jan 2017 May 2013 Mar 2020 Aug 2021	Mar 2023 Ongoing Mar 2023 Jul 2022	Declare interests at relevant meetings Will not sit on any case which has knowledge of the GP or their practice, or a consultant at Leicester
Pizzey, Dr Emma	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Governance Committee Quality & Performance Committee Erewash Place Alliance Group	Partner at Littlewick Medical Centre Executive director Erewash Health Partnership	✓ ✓				2002 Apr 2018	Ongoing Ongoing	Declare interests at relevant meetings. The INR service interest is to be noted at Governance Committee due to the procurement highlight report, which refers to, for information only, the INR service re-procurement. No further action is necessary as no decisions will
Shaw, Professor Ian	Lay Member for Primary Care Commissioning	Governing Body	Clinical & Lay Commissioning Committee Engagement Committee Primary Care Commissioning Committee Primary Care Enhanced Services Review Group	Professor at the University of Nottingham Subject Matter Expert and advisory panel member in relation to research and service development at the Department of Health and Social Care	✓	✓			1992 Jan 2020	Ongoing Jan 2021	Declare interests at relevant meetings
Stacey, Brigid	Chief Nurse Officer	Governing Body	Clinical & Lay Commissioning Committee Finance Committee Primary Care Commissioning Committee Quality & Performance Committee CRHFT Contract Management Board CRHFT Clinical Quality Review Group UHDB Contract Management Board UHDB Clinical Quality Review Group EMAS Quality Assurance Group Maternity Transformation Board (Chair)	Daughter is employed as a midwifery support worker at Burton Hospital				✓	Aug 2019	Ongoing	Declare interest at relevant meetings
Strachan, Dr Alexander Gregory	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Governance Committee Quality & Performance Committee CRHFT Clinical Quality Review Group	GP Partner at Killamarsh Medical Practice Member of North East Derbyshire Federation Adult and Children Safeguarding Lead at Killamarsh Medical Practice Member of North East Derbyshire Primary Care Network Director of Killamarsh Pharmacy LLP - I do not run the pharmacy business, but rent out the building to a pharmacist Involvement with INR service	✓ ✓	 ✓ ✓		 ✓	2009 2016 2009 18 Mar 2020 2015 1 Apr 2021	Ongoing	Withdraw from all discussion and voting if organisation Is potential provider unless otherwise agreed by the meeting chair INR service interest is to be noted at Governance Committee due to the procurement highlight report, which refers to, for information only, the INR service reprocurement. No further action is necessary as no decisions will be made at this meeting and the information provided does not cause a conflict.
Wallace, Dean	Director of Public Health, Derbyshire County Council	Governing Body	Derbyshire Place Board	Nil							No action required
Watkins, Dr Merryl	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Quality & Performance Committee	GP Partner at Vernon Street Medical Centre Husband is Anaesthetic and Chronic Pain Consultant at Royal Derby Hospital	✓			✓	2008 1992	Ongoing Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Whittle, Martin	Lay Member for Patient and Public Involvement	Governing Body	Engagement Committee Finance Committee Governance Committee Quality & Performance Committee Remuneration Committee	Remunerated role of Chair of the Independent Gynae Review Panel relating to activities at UHDBFT	✓				13 December 2021	Ongoing	Declare interest if relevant

SUMMARY REGISTER FOR RECORDING ANY INTERESTS DURING MEETINGS

A conflict of interest is defined as “a set of circumstances by which a reasonable person would consider that an Individual’s ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold” (NHS England, 2017).

Meeting	Date of Meeting	Chair (name)	Director of Corporate Delivery/CCG Meeting Lead	Name of person declaring interest	Agenda item	Details of interest declared	Action taken

Abbreviations & Glossary of Terms

A&E	Accident and Emergency	FGM	Female Genital Mutilation	PAD	Personally Administered Drug
AfC	Agenda for Change	FIRST	Falls Immediate Response Support Team	PALS	Patient Advice and Liaison Service
AGM	Annual General Meeting	FRG	Financial Recovery Group	PAS	Patient Administration System
AHP	Allied Health Professional	FRP	Financial Recovery Plan	PCCC	Primary Care Co-Commissioning Committee
AQP	Any Qualified Provider	GAP	Growth Abnormalities Protocol	PCD	Patient Confidential Data
Arden & GEM CSU	Arden & Greater East Midlands Commissioning Support Unit	GBAF	Governing Body Assurance Framework	PCDG	Primary Care Development Group
ARP	Ambulance Response Programme	GDPR	General Data Protection Regulation	PCN	Primary Care Network
ASD	Autistic Spectrum Disorder	GNBSI	Gram Negative Bloodstream Infection	PEARS	Primary Eye care Assessment Referral Service
ASTRO PU	Age, Sex and Temporary Resident Originated Prescribing Unit	GP	General Practitioner	PEC	Patient Experience Committee
BAME	Black Asian and Minority Ethnic	GPFV	General Practice Forward View	PHB's	Personal Health Budgets
BCCTH	Better Care Closer to Home	GPSI	GP with Specialist Interest	PHSO	Parliamentary and Health Service Ombudsman
BCF	Better Care Fund	GPSOC	GP System of Choice		
BMI	Body Mass Index	HCAI	Healthcare Associated Infection	PHE	Public Health England
bn	Billion	HDU	High Dependency Unit	PHM	Population Health Management
BPPC	Better Payment Practice Code	HEE	Health Education England	PICU	Psychiatric Intensive Care Unit
BSL	British Sign Language	HI	Health Inequalities	PID	Project Initiation Document
CAMHS	Child and Adolescent Mental Health Services	HLE	Healthy Life Expectancy	PIR	Post Infection Review
CATS	Clinical Assessment and Treatment Service	HNA	Health Needs Assessment	PLCV	Procedures of Limited Clinical Value
CBT	Cognitive Behaviour Therapy	HSJ	Health Service Journal	POA	Power of Attorney
CCE	Community Concern Erewash	HWB	Health & Wellbeing Board	POD	Point of Delivery
CCG	Clinical Commissioning Group	H1	First half of the financial year	POD	Project Outline Document
CDI	Clostridium Difficile	H2	Second half of the financial year	POD	Point of Delivery
CEO (s)	Chief Executive Officer (s)	IAF	Improvement and Assessment Framework	PPG	Patient Participation Groups

CETV	Cash Equivalent Transfer Value	IAPT	Improving Access to Psychological Therapies	PPP	Prescription Prescribing Division
CfV	Commissioning for Value	ICM	Institute of Credit Management	PRIDE	Personal Responsibility in Delivering Excellence
CHC	Continuing Health Care	ICO	Information Commissioner's Office	PSED	Public Sector Equality Duty
CHP	Community Health Partnership	ICP	Integrated Care Provider	PSO	Paper Switch Off
CMHT	Community Mental Health Team	ICS	Integrated Care System	PwC	Price, Waterhouse, Cooper
CMP	Capacity Management Plan	ICU	Intensive Care Unit	Q1	Quarter One reporting period: April – June
CNO	Chief Nursing Officer	IG	Information Governance	Q2	Quarter Two reporting period: July – September
COO	Chief Operating Officer (s)	IGAF	Information Governance Assurance Forum	Q3	Quarter Three reporting period: October – December
COP	Court of Protection	IGT	Information Governance Toolkit	Q4	Quarter Four reporting period: January – March
COPD	Chronic Obstructive Pulmonary Disorder	IP&C	Infection Prevention & Control	QA	Quality Assurance
CPD	Continuing Professional Development	IT	Information Technology	QAG	Quality Assurance Group
CPN	Contract Performance Notice	IWL	Improving Working Lives	QIA	Quality Impact Assessment
CPRG	Clinical & Professional Reference Group	JAPC	Joint Area Prescribing Committee	QIPP	Quality, Innovation, Productivity and Prevention
CQC	Care Quality Commission	JSAF	Joint Safeguarding Assurance Framework	QUEST	Quality Uninterrupted Education and Study Time
CQN	Contract Query Notice	JSNA	Joint Strategic Needs Assessment	QOF	Quality Outcome Framework
CQUIN	Commissioning for Quality and Innovation	JUCD	Joined Up Care Derbyshire	QP	Quality Premium
CRG	Clinical Reference Group	k	Thousand	Q&PC	Quality and Performance Committee
CRHFT	Chesterfield Royal Hospital NHS Foundation Trust	KPI	Key Performance Indicator	RAP	Recovery Action Plan
CSE	Child Sexual Exploitation	LA	Local Authority	RCA	Root Cause Analysis
CSF	Commissioner Sustainability Funding	LAC	Looked after Children	REMCOM	Remuneration Committee
CSU	Commissioning Support Unit	LCFS	Local Counter Fraud Specialist	RTT	Referral to Treatment

CTR	Care and Treatment Reviews	LD	Learning Disabilities	RTT	The percentage of patients waiting 18 weeks or less for treatment of the Admitted patients on admitted pathways
CVD	Chronic Vascular Disorder	LGBT+	Lesbian, Gay, Bisexual and Transgender	RTT Non admitted	The percentage if patients waiting 18 weeks or less for the treatment of patients on non-admitted pathways
CYP	Children and Young People	LHRP	Local Health Resilience Partnership	RTT Incomplete	The percentage of patients waiting 18 weeks or less of the patients on incomplete pathways at the end of the period
D2AM	Discharge to Assess and Manage	LMC	Local Medical Council	ROI	Register of Interests
DAAT	Drug and Alcohol Action Teams	LMS	Local Maternity Service	SAAF	Safeguarding Adults Assurance Framework
DCC	Derbyshire County Council	LOC	Local Optical Committee	SAR	Service Auditor Reports
DCCPC	Derbyshire Affiliated Clinical Commissioning Policies	LPC	Local Pharmaceutical Council	SAT	Safeguarding Assurance Tool
DCHSFT	Derbyshire Community Health Services NHS Foundation Trust	LPF	Lead Provider Framework	SBS	Shared Business Services
DCO	Designated Clinical Officer	LTP	NHS Long Term Plan	SDMP	Sustainable Development Management Plan
DHcFT	Derbyshire Healthcare NHS Foundation Trust	LWAB	Local Workforce Action Board	SEND	Special Educational Needs and Disabilities
DHSC	Department of Health and Social Care	m	Million	SHFT	Stockport NHS Foundation Trust
DHU	Derbyshire Health United	MAPPA	Multi Agency Public Protection arrangements	SIRO	Senior Information Risk Owner
DNA	Did not attend	MASH	Multi Agency Safeguarding Hub	SNF	Strictly no Falling
DoF (s)	Director (s) of Finance	MCA	Mental Capacity Act	SOC	Strategic Outline Case
DoH	Department of Health	MDT	Multi-disciplinary Team	SPA	Single Point of Access
DOI	Declaration of Interests	MH	Mental Health	SQI	Supporting Quality Improvement
DoLS	Deprivation of Liberty Safeguards	MHIS	Mental Health Investment Standard	SRG	Systems Resilience Group
DPH	Director of Public Health	MHMIS	Mental Health Minimum Investment Standard	SRO	Senior Responsible Officer
DRRT	Dementia Rapid Response Team	MIG	Medical Interoperability Gateway	SRT	Self-Assessment Review Toolkit
DSN	Diabetic Specialist Nurse	MIUs	Minor Injury Units	SSG	System Savings Group

DTOC	Delayed Transfers of Care	MMT	Medicines Management Team	STAR PU	Specific Therapeutic Group Age-Sec Prescribing Unit
ED	Emergency Department	MOL	Medicines Order Line	STEIS	Strategic Executive Information System
EDEN	Effective Diabetes Education Now	MoM	Map of Medicine	STHFT	Sheffield Teaching Hospital NHS Foundation Trust
EDS2	Equality Delivery System 2	MoMO	Mind of My Own	STOMPLD	Stop Over Medicating of Patients with Learning Disabilities
EDS3	Equality Delivery System 3	MRSA	Methicillin-resistant Staphylococcus aureus	STP	Sustainability and Transformation Partnership
EIA	Equality Impact Assessment	MSK	Musculoskeletal	T&O	Trauma and Orthopaedics
EIHR	Equality, Inclusion and Human Rights	MTD	Month to Date	TAG	Transformation Assurance Group
EIP	Early Intervention in Psychosis	NECS	North of England Commissioning Services	TCP	Transforming Care Partnership
EMASFT	East Midlands Ambulance Service NHS Foundation Trust	NEPTS	Non-emergency Patient Transport Services	TDA	Trust Development Authority
EMAS Red 1	The number of Red 1 Incidents (conditions that may be immediately life threatening and the most time critical) which resulted in an emergency response arriving at the scene of the incident within 8 minutes of the call being presented to the control room telephone switch.	NHAIS	National Health Application and Infrastructure Services	UEC	Urgent and Emergency Care
EMAS Red 2	The number of Red 2 Incidents (conditions which may be life threatening but less time critical than Red 1) which resulted in an emergency response arriving at the scene of the incident within 8 minutes from the earliest of; the chief complaint information being obtained; a vehicle being assigned; or 60 seconds after the call is presented to the control room telephone switch.	NHSE/ I	NHS England and Improvement	UEC	Urgent and Emergency Care

EMAS A19	The number of Category A incidents (conditions which may be immediately life threatening) which resulted in a fully equipped ambulance vehicle able to transport the patient in a clinically safe manner, arriving at the scene within 19 minutes of the request being made.	NHS e-RS	NHS e-Referral Service	UHDBFT	University Hospitals of Derby and Burton NHS Foundation Trust
EMLA	East Midlands Leadership Academy	NICE	National Institute for Health and Care Excellence	UTC	Urgent Treatment Centre
EoL	End of Life	NOAC	New oral anticoagulants	YTD	Year to Date
ENT	Ear Nose and Throat	NUHFT	Nottingham University Hospitals NHS Trust	111	The out of hours service is delivered by Derbyshire Health United: a call centre where patients, their relatives or carers can speak to trained staff, doctors and nurses who will assess their needs and either provide advice over the telephone, or make an appointment to attend one of our local clinics. For patients who are house-bound or so unwell that they are unable to travel, staff will arrange for a doctor or nurse to visit them at home.
EPRR	Emergency Preparedness Resilience and Response		Official Journal of the European Union	52WW	52 week wait
FCP	First Contact Practitioner	OOH	Out of Hours		
FFT	Friends and Family Test	ORG	Operational Resilience Group		

Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

13th January 2022

Item No: 217

Report Title	Chair's Report – January 2022
Author(s)	Dr Avi Bhatia, CCG Clinical Chair
Sponsor (Director)	Dr Avi Bhatia, CCG Clinical Chair

Paper for:	**Decision**		**Assurance**		**Discussion**		**Information**	x
Assurance Report Signed off by Chair				N/A				
Which committee has the subject matter been through?				N/A				

Recommendations

The Governing Body is requested to **NOTE** the contents of the report.

Report Summary

NHS England's planning guidance, issued on 24th December 2021, outlined that the timescale for the establishment of Integrated Care Boards (ICB) will change from 1st April 2022 to 1st July 2022. This means that the Clinical Commissioning Group (CCG) will retain statutory responsibility for NHS commissioning functions until 30th June 2022.

Our plan is progressing well to ensure the safe transfer of responsibilities from CCG to ICB, and the establishment of new functions to enable the delivery of draft legislation and duties were earmarked for completion for 31st March 2021. NHS England has been assured by our plans and agreed that Derbyshire is making good progress, so whilst the revised establishment date for ICBs gives us additional time, we are satisfied with our current progression.

We had planned for the ICB to begin to operate in shadow form during the first three months of 2022, before being fully established from 1st April. We believe this is still the correct plan and we will continue with the recruitment of ICB board members as planned, including our non-executive and executive members. Clearly the revised timetable will require the CCG to retain statutory responsibility for an additional three months; the CCG's Governing Body will work closely with the shadow ICB to ensure a smooth transition, and build on some of the commonality of work we have already started.

I referenced in my report to the December Governing Body meeting the work of the Clinical and Professional Leadership Group (CPLG). The group has evolved in recent years and now aims to ensure we have a full range of clinicians and care professionals embedded in decision making and policy development. The recent period of sustained pressure across our services has been the most challenging in memory. Our system resilience approach has been very successful in understanding the challenges faced

and working in collaboration to find solutions to them. Along with a recent increase in staff absences due to the Omicron variant, a recurring challenge has been our ability to maintain the flow of patients. Patients often travel on what we describe as a 'pathway' through our emergency services, through a period of care in hospital and then into the care of community teams at the point of discharge. Each element of care is inter-related, and a challenge in one area very often creates a challenge in others. Derbyshire is very good at working together to solve blockages and the level of mutual support and mutual aid is what usually enables the system to continue functioning and to ensure our patients receive the right type of care at the right time.

Since July, we have seen a sustained increase in pressure, and I have written about it before in these reports. However, it is correct to say that the modelling for the expected increase in hospitalisations and staff absences into mid-January is of great concern. Given that our system has already been stretched to the limit in maintaining safe care, it is expected that we will need to take some additional and less favourable actions to ensure we are able to continue to care for the poorliest patients. CPLG will be fully engaged in this decision-making process, but we must be transparent and say that measures may need to be taken to once again review our capacity, and difficult decisions will be required.

This will include discussions about whether we are able to continue to deliver anything other than the most urgent level of surgery during this period, against a backdrop of already challenging waiting lists following the delays in surgery caused by the pandemic so far. We may need to temporarily close some services to ensure that we can shore up critical departments such as ED, intensive care units, maternity services and cancer operating theatres. It will also likely mean that patients will not receive the same package of community care that they would have expected to receive, including community nursing support, therapy support and the availability of adult care workers, which will place an increasingly heavy reliance upon families and friends to support care.

CPLG's role, along with the system quality and performance committee, risk groups and others, will be to ensure that we are taking balanced decisions that manage the risks to the delivery of safe care to the best of our ability. We do have finite resources, in particular our staff, and it is imperative that while we do not wish to delay anyone's treatment, this may be inevitable for a period while we seek to ensure we can treat those patients who have the most urgent need.

Dr Avi Bhatia
Clinical Chair and CPRG Co-Chair

Are there any Resource Implications (including Financial, Staffing etc)?

None

Has a Privacy Impact Assessment (PIA) been completed? What were the findings?

N/A

Has a Quality Impact Assessment (QIA) been completed? What were the findings?
N/A
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
N/A
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
N/A
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
N/A
Have any Conflicts of Interest been identified/ actions taken?
None
Governing Body Assurance Framework
N/A
Identification of Key Risks
N/A

NHS
Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

13th January 2022

Item No: 218

Report Title	Chief Executive Officer's Report – January 2022
Author(s)	Dr Chris Clayton, Chief Executive Officer
Sponsor (Director)	Dr Chris Clayton, Chief Executive Officer

Paper for:	**Decision**		**Assurance**		**Discussion**		**Information**	x
Assurance Report Signed off by Chair	N/A							
Which committee has the subject matter been through?	N/A							

Recommendations

The Governing Body is requested to **RECEIVE** this report and to **NOTE** the items as detailed.

Report Summary

The Derbyshire health and care system remained resilient during the Christmas and New Year period, despite experiencing one of the most challenging periods of sustained pressure in memory. Our frontline colleagues continued to provide safe care, in many cases going the extra mile in cancelling holidays and working extra shifts to maintain staffing levels. We are always grateful to staff who work through the Christmas period to continue the excellent care for our patients and recognise the additional challenges this year.

There was significant operational leadership discussion taking place behind the scenes throughout the holiday period to ensure partner services were aware of pressure points and challenges and able to offer mutual aid where this was available. Our system provider colleagues have progressed a robust model of escalation through the System Operational Resilience Group, building on long-standing success and aimed at solving the system's challenges together, and this worked well again through the weekends and bank holidays.

What is true though is that the pressure continues. The spread of the Omicron COVID-19 variant across our communities has not yet resulted in the increased use of our Intensive Care Services but general admissions to our hospitals with COVID-19 are increasing, together with an increase in care activity and requirements in our community-based services. With circa 200,000 confirmed cases each day nationally at the time of writing, it is inevitable that our staff – who of course are members of our communities too – will pick up the virus themselves. At present, this is the main challenge to service delivery; in both health and social care we have the estate and the facilities to meet much of the demand, but we are challenged in sustaining the staffing levels required to use it fully. Supporting staff to be tested and return to work is a priority; and we should be following the Government's recent guidance on testing and shortened isolation periods to help the overall position.

The message to local citizens is repeated; please continue to use services where you have an urgent health need and we will make sure you are cared for. This includes calling general practice with worrying symptoms and especially those that are associated with cancer; visiting our urgent treatment centres with suspected

fractures, burns and other injuries; and attending an Emergency Department or calling 999 at times where life is at risk. Our services continue to prioritise these most serious of conditions, but as has been stated nationally, patients without serious symptoms or conditions may be asked to wait much longer than usual, or perhaps even return on a different day if symptoms persist. Anyone in doubt about what to do should visit NHS 111 online to check symptoms or call NHS 111 for further advice. NHS 111 can also now make bookings for appointments at Urgent Treatment Centres, GP practices and Emergency Departments, so it is the best first port of where a condition is not an obvious life or death situation.

In other areas of essential delivery, there has been prioritisation of focus on achieving the Prime Minister's target of every adult receiving the offer of a booster vaccination by 31st December 2021. In Derbyshire we achieved this goal and 80% of adults had not only been offered their booster, but had received it, which is a significant achievement. Our colleagues in general practice have delivered a significant proportion of these vaccinations against what was an accelerated timescale, and consequently general practice received permission from NHSEI to stand down non-essential work during December.

Similarly, CCG staff have been asked to re-prioritise their work in line with business continuity planning and escalation, to support the delivery of the vaccination programme, to support the wider work on system pressures and to maintain only essential statutory duties. Our staff have responded very well, many have now been temporarily redeployed into these other areas of business and we have been grateful for their flexibility. The four current stated priorities for the CCG in our highest level of business continuity escalation are:

1. Support to the vaccination programme
2. Support to system operational resilience
3. Maintaining CCG business continuity, operating at level 4 activities only
4. Transition – statutory activities only

We are keeping this position under constant review through our Senior Leadership Team and in discussion with other system partners.

Finally, NHS England released its annual planning guidance on 24th December 2021. We are reviewing the detail of the guidance, which appears to follow the direction of travel across most areas of care and national priorities, which is very welcome. One significant matter for CCGs to note is the revised date for the establishment of Integrated Care Boards, which will now take place on 1st July 2022 rather than the previously communicated date of 1st April 2022. This subsequently means that the CCG will remain as the statutory NHS commissioning organisation for Derby and Derbyshire until 30th June 2022 and the CCG Governing Body will remain accountable for the delivery of statutory commissioning duties until that date. These changes remain subject to parliamentary approval of new legislation, but we will continue with our development work across the Integrated Care System as planned, including the advertisement of Executive Director roles during January.

Chris Clayton
Accountable Officer and Chief Executive

2. Chief Executive Officer calendar – examples from the regular meetings programme

Meeting and purpose	Attended by	Frequency
NHS England and Improvement (NHSE/I)	Senior teams	Weekly
ICS and STP leads	Leads	Frequency tbc
Local Resilience Forum Strategic Coordinating Group meetings	All system partner CEOs	Weekly
System CEO strategy meetings	NHS system CEOs	Fortnightly
JUCD Board meetings	NHS system CEOs	Monthly
System Review Meeting Derbyshire	NHSE/System/CCG	Monthly
Executive Team Meetings	CCG Executives	Weekly
2021/22 Planning – Derbyshire System	CCG/System/NHSE	Monthly
Derbyshire Chief Executives	System/CCG	Bi Monthly
EMAS Strategic Delivery Board	EMAS/CCGs	Bi-Monthly
Joint Health and Wellbeing Board	DCC/System/CCG	Bi-Monthly
NHS Midlands Leadership Team Meeting	NHSE/System/CCG	Monthly
Joint Committee of CCG	CCGs	Monthly
Derbyshire Covid-19 SCG Meetings	CEOs or nominees	Weekly
Outbreak Engagement Board	CEOs or nominees	Fortnightly
Partnership Board	CEOs or nominees	Monthly
Clinical Services and Strategies workstream	System Partners	Ad Hoc
Collaborative Commissioning Forum	CCG/NHSE	Monthly
Urgent and emergency care programme	UDB & CCG	Ad Hoc
System Operational Pressures	CCG/System	Ad Hoc
Clinical & Professional Reference Group	CCG/System	Ad Hoc
Derbyshire MP Covid-19 Vaccination briefings	CCG/MPs	Fortnightly
Regional Covid Vaccination Update	CCG/System/NHSE	Weekly
Gold Command Vaccine Update	CG/DCHS	Ad Hoc
Integrated Commissioning Operating Model	CCG/System/NHSE	Ad Hoc
System Transition Assurance Sub-Committee	CCG/System	Monthly

East Midlands ICS Commissioning Board	Regional AOs/NHSE	Monthly
Team Talk	All staff	Weekly
JUCD Finance & Estates Sub Committee	NHS/System CEOs	Monthly
ICP CEOs Meeting	Local Authority/System	Ad Hoc
JUCD Development Session	CCG/System	Ad Hoc
JUCD System Leadership Team Meeting	System	Monthly
ICS Shared Services Workshop	Regional AOs/NHSE	Ad Hoc
Derbyshire Quarterly System Review Meeting	NHSE/System	Quarterly
Strategic Intent Executive Group	CCG/System	Monthly

3.0 National developments, research and reports

3.1 Changes to Integrated Care Board timetable
The NHS Planning Guidance released on 24 December has confirmed that the target date for the establishment of the new Integrated Care Board (ICB) will now be 1 July 2022. This replaces the previous target date of 1 April 2022.

3.2 UK marks 132 million life-saving COVID-19 vaccinations in 2021
Around 132 million COVID-19 vaccinations were administered across all four nations of the UK in 2021, as part of the largest vaccination programme in British history. It marks the end of a monumental year for the NHS, with over 1.6 million people in the UK receiving a booster or third dose in the final week of 2021 – meaning almost 34 million people now have the protection they need from the Omicron variant at the start of the New Year.

3.3 All adults in England offered COVID-19 booster vaccine
As of 31 December 2021, more than 28.1 million people in England – more than 7 in 10 of eligible adults – had their booster following the rapid expansion of the vaccination programme in December. That figure includes around 90% of those aged 50 and over who are eligible.

3.4 NHS opens bookings for 12-15s to get second COVID jab
From Monday 20 December, 12-15 year-olds were able to book their second COVID-19 vaccination through the national booking service as part of the national mission to get people protected against the Omicron variant.

3.5 Busiest November ever as figures show pressures on NHS staff
Figures released on 9 December 2021 showed NHS staff answered the highest number of 999 calls for any November on record, an average of around one every three seconds. November 2021 was also the second busiest November on record for A&E with more than two million patients seen at emergency departments and

urgent treatment centres. That was up by half a million on the same time the previous year.

3.6 Vulnerable NHS patients to be offered new drug
A new Covid drug designed to reduce the risk of vulnerable patients needing hospital treatment is now available on the NHS. Sotrovimab is a monoclonal antibody given as a transfusion to transplant recipients, cancer patients and other high-risk groups.

4.0 Local developments

4.1 University Hospitals of Derby and Burton announces interim Chief Executive
Dr Magnus Harrison, currently Executive Medical Director and Deputy Chief Executive, will become Interim Chief Executive from 1 February 2022.

4.2 Consultation invites views on relocation of two services for older people with mental health conditions
Consultation invites local people to share their views on proposals to relocate two services for older people with mental health conditions to new facilities in the county. Proposed service moves from Pleasley Ward at the Hartington Unit in Chesterfield to Walton Hospital, Chesterfield and Ward 1, London Road Community Hospital Derby to Tissington House at Kingsway Hospital, Derby.

4.3 Development of short stay approach to care
A ward at Chesterfield Royal Hospital NHS Foundation Trust has been redeveloped to care for patients who can be treated and discharged on the same day. Barnes Ward is now home to the Trust's Same Day Emergency Care Unit (SDEC) and Short Stay Unit (SSU) as part of plans to relieve pressure on the hospital and improve the Trust's acute assessment and admission avoidance.

4.4 Pressure on DCHS Community Podiatry Services
Due to unprecedented pressures in Derbyshire Community Health Services (DCHS) local wound care clinics it has been necessary to consider how they can best meet the needs of their most clinically vulnerable patients. To relieve some of that pressure, a decision has been made that all foot-related wound care (including re-dressing) will come under the care of the community podiatry service, unless compression therapy is required.

4.5 New self-service tool aims to keep emergency care for those who need it most
Chesterfield Royal Hospital NHS Foundation Trust is the first in the region to launch a new self-service tool, in partnership with NHS Digital, to help everyone to use emergency care appropriately.

4.6 Doctors in the East Midlands Ambulance Service control room are helping patients to access the right care, at the right place, at the right time
Doctors assist highly-skilled frontline ambulance crews when they need a second opinion on patients who have complex, but not immediately life-threatening, medical issues.

4.7 Latest vaccination statistics
NHS England and Improvement publishes data on the vaccination programme at system level here.

4.8 Media update
You can see examples of recent news releases here.

Are there any Resource Implications (including Financial, Staffing etc.)?
Not Applicable
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?
Not Applicable
Has a Quality Impact Assessment (QIA) been completed? What were the findings?
Not Applicable
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
Not Applicable
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
Not Applicable
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Not Applicable
Have any Conflicts of Interest been identified/ actions taken?
None Identified
Governing Body Assurance Framework
Not Applicable
Identification of Key Risks
Not Applicable

Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

13th January 2021

	Item No: 219

Report Title	2022-23 NHS Priorities and Operational Planning Guidance
Author(s)	Zara Jones, Executive Director of Commissioning Operations
Sponsor (Director)	Zara Jones, Executive Director of Commissioning Operations

Paper for:	**Decision**		**Assurance**		**Discussion**	x	**Information**	
Assurance Report Signed off by Chair				N/A				
Which committee has the subject matter been through?				N/A				

Recommendations

The Governing Body is requested to **NOTE** the content of the guidance and will be updated further as the planning work proceeds over coming weeks.

Report Summary

The Operational Planning Guidance for 2022/23 was published on 24th December 2021. This can be accessed here: https://www.england.nhs.uk/operational-planning-and-contracting/. The operational planning round for 2022/23 will enable systems to articulate how they will increase capacity and resilience to deliver safe, high quality services that meet people's health and care needs. The delivery of these plans will be underpinned by:

- Accelerating plans to grow the substantive workforce
- Using the lessons from the pandemic to adopt new models of care
- Working in partnership as systems to make the most effective use of resources
- Using additional funding to increase capacity
- The assumption that COVID-19 will return to low levels

The guidance highlights a series of priorities for the NHS during 2022/23, which are:

- Accelerating work to transform and grow the substantive workforce, and make the NHS a better place for our staff
- Continuing to deliver the NHS COVID-19 vaccination programme and meet the needs of patients with COVID
- Delivering significantly more elective care, tackle the elective backlog, reduce long waits, and improve performance against cancer waiting time standards

- Improving the responsiveness of urgent and emergency care and build community care capacity (equivalent to 5,000 additional beds through virtual wards)
- Improving timely access to primary care by maximising the impact of the investment in primary medical care and primary care networks to expand capacity, increase the number of appointments available and drive integrated working at neighbourhood and place-level
- Improving mental health services and services for people with a learning disability and / or autistic people by maintaining continued mental health investment to transform and expand community health services and improve access
- Continuing to develop the approach to population health management, prevent ill health, and address health inequalities by using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities
- Exploiting the potential of digital technologies to transform the delivery of care and patient outcomes to achieve a core level of digitisation in every system
- Making the most effective use of resources
- Establishing Integrated Care Boards (ICB) and continue collaborative working

The guidance also notes that the planning timetable for 2022/23 has been extended to April 2022 to support systems in prioritising actions during the current period.

Are there any Resource Implications (including Financial, Staffing etc)?
Not Applicable
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?
Not Applicable
Has a Quality Impact Assessment (QIA) been completed? What were the findings?
Not Applicable
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
Not Applicable
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
Not Applicable
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Not Applicable
Have any Conflicts of Interest been identified / actions taken?
None Identified

Governing Body Assurance Framework
Strategic risk 3 - Ineffective system working may hinder the creation of a sustainable health and care system by failing to deliver the scale of transformational change needed at the pace required.
Identification of Key Risks
As identified in the report

Classification: Official

Publication approval reference: B1160

2022/23 priorities and operational planning guidance

24 December 2021

Dear colleague

Thank you to you and your teams for your continued extraordinary efforts for all our patients.

At the end of January, we will mark two years since paramedics from Yorkshire Ambulance Service and hospital teams in Hull and Newcastle started to treat this country's first patients with COVID-19, and earlier this month we marked the anniversary of the first COVID-19 vaccine dose – and the milestone of 100 million doses – delivered in the biggest and fastest vaccination programme in NHS history.

The last two years have been the most challenging in the history of the NHS, and staff across the service – and many thousands of volunteers – have stepped up time and time again:

- expanding and flexing services to meet the changing demands of the pandemic
- developing and rolling out new treatments, new services and new pathways to respond to the needs of patients with COVID-19 and those without
- pulling out all the stops to recover services that have been disrupted.

At the time of writing, we are again operating within a Level 4 National Incident in response to the emergence of the Omicron variant. Teams from across the NHS and our partners are:

- significantly increasing vaccination capacity to provide the maximum level of immunity for the maximum number of people
- rolling out new antiviral and monoclonal antibody treatments through COVID medicines delivery units
- preparing for a potentially significant increase in those requiring life-saving care.

This concrete and rapid action in the face of uncertainty has characterised the NHS response to the pandemic. We face that uncertainty again now – in terms of the potential impact of Omicron over the coming weeks and months and the development of the pandemic as we look ahead to 2022/23. Despite this, the clear message I have had from colleagues across the NHS is that it is important to provide certainty and clarity where we can by now setting out the priorities and financial arrangements for the whole of 2022/23, recognising that they will have to be kept under review.

The objectives set out in this document are based on a scenario where COVID-19 returns to a low level and we are able to make significant progress in the first part of next year as we continue to rise to the challenge of restoring services and reducing the COVID backlogs.

Building on the excellent progress seen during 2021/22, this means significantly increasing the number of people we can diagnose, treat and care for in a timely way. This will depend on us doing things differently, accelerating partnership working through integrated care systems (ICSs) to make the most effective use of the resources available to us across health and social care, and ensure reducing inequalities in access is embedded in our approach. As part of this, and when the context allows it, we will need to find ways to eliminate the loss in non-COVID output caused by the pandemic.

Securing a sustainable recovery will depend on a continued focus on the health, wellbeing and safety of our staff. ICSs will also need to look beyond the immediate operational priorities and drive the shift to managing the health of populations by targeting interventions at those groups most at risk and focusing on prevention as well as treatment. Thank you for the significant progress that has been made in preparing for the proposed establishment of statutory Integrated Care Systems. To allow sufficient time for the remaining parliamentary stages, a new target date of 1 July 2022 has been agreed for statutory arrangements to take effect and ICBs to be legally and operationally established.

Our ability to fully realise the objectives set out in this document is linked to the ongoing level of healthcare demand from COVID-19. Given the immediate priorities and anticipated pressures, we are not expecting you or your teams to engage with specific planning asks now. The planning timetable will be extended to the end of April 2022, and we will keep this under review.

On behalf of myself and the whole NHS leadership team I want to thank you for the way you are continuing to support staff, put patients first and rise to the challenges we face.

With best wishes

Amanda Pritchard
NHS Chief Executive

Introduction

In 2022/23 we will continue to rise to the challenges of restoring services, meeting the new care demands and reducing the care backlogs that are a direct consequence of the pandemic. While the future pattern of COVID-19 transmission and the resulting demands on the NHS remain uncertain, we know we need to continue to increase our capacity and resilience to deliver safe, high quality services that meet the full range of people's health and care needs. We will:

- accelerate plans to grow the substantive workforce and work differently as we keep our focus on the health, wellbeing and safety of our staff
- use what we have learnt through the pandemic to rapidly and consistently adopt new models of care that exploit the full potential of digital technologies
- work in partnership as systems to make the most effective use of the resources available to us across acute, community, primary and social care settings, to get above pre-pandemic levels of productivity as the context allows
- use the additional funding government has made available to us to increase our capacity and invest in our buildings and equipment to support staff to deliver safe, effective and efficient care.

Our goal is that these actions will support a significant increase in the number of people we are able to treat and care for in a timely way. Our ability to fully realise this goal is linked to the ongoing level of healthcare demand from COVID-19. The new Omicron variant reminds us that we will need to remain ready to rise to new vaccination challenges and significant increases in COVID-19 cases. We are not able to predict the timing or impact of new variants and must develop ambitious plans for what we can achieve for patients and local populations in a more favourable context. The objectives for 2022/23 set out in this document are therefore based on COVID-19 returning to a low level. We will keep these objectives under review as the pandemic evolves.

Effective partnership is critical to achieving the priorities set out in this document. After several years of local development, we have established 42 integrated care systems (ICSs) across England with four strategic purposes:

- improving outcomes in population health and healthcare
- tackling inequalities in outcomes, experience and access

- enhancing productivity and value for money
- supporting broader social and economic development.

To underpin these arrangements, the Health and Care Bill, which intends to put ICSs on a statutory footing and create integrated care boards (ICBs) as new NHS bodies, is currently being considered by Parliament.

To allow sufficient time for the remaining parliamentary stages, a new target date of 1 July 2022 has been agreed for new statutory arrangements to take effect and ICBs to be legally and operationally established. This replaces the previously stated target date of 1 April 2022. This new target date will provide some extra flexibility for systems preparing for the new statutory arrangements and managing the immediate priorities in the pandemic response, while maintaining our momentum towards more effective system working.

The establishment of statutory ICSs, and timing of this, remains subject to the passage of the Bill through Parliament. An implementation date of 1 July would mean the current statutory arrangements would remain in place until then, with the first quarter of 2022/23 serving as a continued preparatory period.

Joint working arrangements have been in place at system level for some time, and there has already been significant progress in preparing for the proposed establishment of statutory ICSs, including recruitment of designate ICB chairs and chief executives. Designate ICB leaders should continue to develop system-level plans for 2022/23 and prepare for the formal establishment of ICBs in line with the guidance previously set out by NHS England and NHS Improvement and the updated transition timeline (this is set out more fully in section J).

The NHS's financial arrangements for 2022/23 will continue to support a system-based approach to planning and delivery and will align to the new ICS boundaries agreed during 2021/22. We will shortly issue one-year revenue allocations for 2022/23 and three-year capital allocations to 2024/25. We intend to publish the remaining two-year revenue allocations to 2024/25 in the first half of 2022/23. It is in this context that we are asking systems to focus on the following priorities for 2022/23:

A. Invest in our workforce – with more people (for example, the additional roles in primary care, expansion of mental health and community services, and tackling

substantive gaps in acute care) and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care.

B. Respond to COVID-19 ever more effectively – delivering the NHS COVID-19 vaccination programme and meeting the needs of patients with COVID-19.

C. Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards.

D. Improve the responsiveness of urgent and emergency care (UEC) and build community care capacity– keeping patients safe and offering the right care, at the right time, in the right setting. This needs to be supported by creating the equivalent of 5,000 additional beds, in particular through expansion of virtual ward models, and includes eliminating 12-hour waits in emergency departments (EDs) and minimising ambulance handover delays.

E. Improve timely access to primary care – maximising the impact of the investment in primary medical care and primary care networks (PCNs) to expand capacity, increase the number of appointments available and drive integrated working at neighbourhood and place level.

F. Improve mental health services and services for people with a learning disability and/or autistic people – maintaining continued growth in mental health investment to transform and expand community health services and improve access.

G. Continue to develop our approach to population health management, prevent ill-health and address health inequalities – using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities.

H. Exploit the potential of digital technologies to transform the delivery of care and patient outcomes – achieving a core level of digitisation in every service across systems.

I. Make the most effective use of our resources – moving back to and beyond pre-pandemic levels of productivity when the context allows this.

J. Establish ICBs and collaborative system working – working together with local authorities and other partners across their ICS to develop a five-year strategic plan for their system and places.

Across all these areas we will maintain our focus on preventing ill-health and tackling health inequalities by redoubling our efforts on the five priority areas for tackling health

inequalities set out in guidance in March 2021. ICSs will take a lead role in tackling health inequalities, building on the Core20PLUS5 approach introduced in 2021/22 to support the reduction of health inequalities experienced by adults, children and young people, at both the national and system level.

Improved data collection and reporting will drive a better understanding of local health inequalities in access to, experience of and outcomes from healthcare services, by informing the development of action plans to narrow the health inequalities gap. ICBs, once established, and trust board performance packs are therefore expected to be disaggregated by deprivation and ethnicity.

We will also continue to embed the response to climate change into core NHS business. Trusts and ICBs, once established, are expected to have a board-level Net Zero lead and a Green Plan, and are asked to deliver carbon reductions against this, throughout 2022/23.

ICS footprints represent the basis of strategic and operational plans for 2022/23 and beyond. Designate ICB leadership teams are asked to work with partners in their ICS to develop plans that reflect these priorities and are triangulated across activity, workforce and money. The immediate focus should remain on the priorities set out in Preparing the NHS for the potential impact of the Omicron variant and we have extended the planning timetable to reflect this.

A. Invest in our workforce – with more people and new ways of working, and by strengthening the compassionate and inclusive culture needed to deliver outstanding care

During the pandemic the focus has rightly been on the health, wellbeing and safety of our staff; this will continue. To support the restoration and recovery of services we need more people, working differently in a compassionate and inclusive culture where leaders at all levels inspire, empower and enable them to deliver high quality care in the most effective and efficient way.

We are therefore asking systems to accelerate work to transform and grow the substantive workforce and make the NHS a better place to work for all our staff. The actions to achieve this should be set out in whole system workforce plans that build on the progress made in delivering local people plans and reflect the ambitions to:

Look after our people:

- improve retention by delivering the NHS People Promise to improve the experience of our staff, through a focus on flexible working, early/mid/late career conversations and enabling staff to understand their pensions
- continue to support the health and wellbeing of our staff, including through effective health and wellbeing conversations and the mental health hubs
- improve attendance by addressing the root causes of non COVID-related sickness absence and, where appropriate, supporting staff to return to work.

Improve belonging in the NHS:

- improve the Black, Asian and minority ethnic disparity ratio, delivering the six high impact actions to overhaul recruitment and promotion practices
- implement plans to promote equality across all protected characteristics.

Work differently:

- accelerate the introduction of new roles, such as anaesthetic associates and first contact practitioners, and expanding advanced clinical practitioners
- develop the workforce required to deliver multidisciplinary care closer to home, including supporting the rollout of virtual wards and discharge to assess models
- ensure the highest level of attainment set out by the ‘meaningful use standards’ for e-job planning and e-rostering is met to optimise the capacity of the current workforce
- establish, or become part of, volunteer services such as the NHS cadets and NHS reservists.

Grow for the future:

- expand international recruitment through ongoing ethical recruitment of high quality nurses and midwifes

- leverage the role of NHS organisations as anchor institutions/networks to widen participation and create training and employment opportunities, including through expanding apprenticeships as a route into working in health and care
- make the most effective use of temporary staffing, including by expanding collaborative system banks and reducing reliance on high-cost agency staff
- ensure training of postgraduate doctors continues, with adequate time in the job plans of supervisors to maintain education and training pipelines
- ensure sufficient clinical placement capacity to enable students to qualify and register as close to their initial expected date as possible.

Health Education England (HEE) and NHS England and NHS Improvement regional teams will support systems to develop and deliver their workforce plans. We will support systems to deliver through:

- investment to expand the national nursing international recruitment programme and support to recruit more allied health professionals
- the national healthcare support worker (HCSW) recruitment and retention programme
- continued funding of mental health hubs to enable staff access to enhanced occupational health and wellbeing and psychological support
- a suite of national GP recruitment and retention initiatives to enable systems to support their PCNs to expand the GP workforce and make full use of the digital locum pool
- the Additional Roles Reimbursement Scheme (ARRS) to deliver 26,000 roles in primary care, to support the creation of multidisciplinary teams.

B. Respond to COVID-19 ever more effectively – delivering the NHS COVID vaccination programme and meeting the needs of patients with COVID-19

The NHS has been asked to offer every eligible adult over the age of 18 a booster vaccination by 31 December 2021 and the immediate next steps for deployment were set out in the recent letter to services. Delivery of the vaccine programme is expected

to remain a key priority as we look ahead to 2022/23 and systems are asked to plan to maintain the infrastructure that underpins our ability to respond as needed. We will set out further details as future requirements become clearer.

A number of new treatment options, including neutralising monoclonal antibodies and oral antivirals, are now available for non-hospitalised NHS patients at greater risk from COVID-19. These treatments are in addition to COVID-19 vaccines, which remain the most important intervention for protecting people from COVID-19 infection.

These new treatments, which reduce the risk of hospitalisation and death, are being rolled out initially for a targeted cohort of highest-risk patients and should continue to be prioritised. In parallel, the government has also launched a study to assess the efficacy of antivirals in the UK's predominately vaccinated population. Dependent on the results of that study, we will develop plans for wider access to antivirals from the spring.

The Office for National Statistics (ONS) estimates around one million people are living with post-COVID syndrome (long COVID) in England. The NHS in England has responded by establishing 90 specialist post-COVID clinics to assess, diagnose and help people recover from long COVID, as well as 14 paediatric hubs to provide expert advice to local services treating children and young people.

While good progress has been made, there is still wide local variation in referral rates, waiting times and access to the clinics across diverse demographic groups. Systems are asked to:

- increase the number of patients referred to post-COVID services and seen within six weeks of referral
- decrease the number of patients waiting longer than 15 weeks, to enable their timely placement on the appropriate management or rehabilitation pathway.

£90 million is being made available to support this work in 2022/23.

C. Deliver significantly more elective care to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards

C1: Maximise elective activity and reduce long waits, taking full advantage of opportunities to transform the delivery of services

The pandemic has had a significant impact on the delivery of elective care and, as a result, on the lives of many patients who are waiting for treatment. Over the next three years, we will rise to the challenge of addressing the elective backlogs that have grown during the pandemic through a combination of expanding capacity, prioritising treatment and transforming delivery of services. Every system is required to develop an elective care recovery plan for 2022/23, setting out how the first full year of longer-term recovery plans will be achieved.

As in the COVID-19 wave last winter, it is crucial that we continue to deliver elective care and ensure that the highest clinical priority patients – including patients on cancer pathways and those with the longest waits – are prioritised. Once again, clinical leadership and judgement about prioritisation and risk will be essential. Wherever possible over winter, we need systems and providers to continue to separate services and to maintain maximum possible levels of inpatient, day case, outpatient and diagnostic activity, recognising the requirement to release staff to support the vaccination programme and respond to the potential increase in COVID-19 cases. This should include the independent sector as separate green pathway capacity.

The ongoing uncertainties and challenges of COVID-19 and demand make it particularly hard to predict how quickly we will be able to recover elective services, but we have set an ambitious goal to deliver around 30% more elective activity by 2024/25 than before the pandemic, after accounting for the impact of an improved care offer through system transformation, and specialist advice, including advice and guidance. We will continue to work to return to pre-pandemic performance as soon as possible with an ambition in 2022/23 for systems to deliver over 10% more elective activity than before the pandemic and reduce long waits. Treatment should continue to be prioritised based on clinical urgency and steps should be taken to address health

inequalities. Systems should make use of alternative providers if people have been waiting a long time for treatment. Systems are asked to:

- eliminate waits of over 104 weeks as a priority and maintain this position through 2022/23 (except where patients choose to wait longer)
- reduce waits of over 78 weeks and conduct three-monthly reviews for this cohort of patients, extending the three-monthly reviews to patients waiting over 52 weeks from 1 July 2022
- develop plans that support an overall reduction in 52-week waits where possible
- accelerate the progress we have already made towards a more personalised approach to follow-up care in hospitals or clinics, reducing outpatient follow-ups by a minimum of 25% against 2019/20 activity levels by March 2023 and going further where possible. We will agree specific targets with systems through the planning process.

Our ability to fully deliver on the objectives is linked to the ongoing level of healthcare demand from COVID-19 and will depend on:

- holding elective activity through the winter
- systems eliminating the loss in productivity caused by the operating constraints resulting from the pandemic.

A more personalised approach to outpatient follow-up appointments will ensure people who require a follow-up appointment receive one in a timely manner – protecting clinical time for the most value adding activity. The opportunity to reduce outpatient follow-ups will differ by trust and specialty and local planning should inform how the ambition will be delivered across the system, supported through a combination of:

- patient initiated follow-up (PIFU) – expanding the uptake of PIFU to all major outpatient specialties, moving or discharging 5% of outpatient attendances to PIFU pathways by March 2023
- effective discharge, particularly of those patients for whom clinical interventions have been exhausted
- more streamlined diagnostic pathways
- referral optimisation, including through use of specialist advice services to enhance patient pathways – delivering 16 specialist advice requests, including

advice and guidance (A&G), per 100 outpatient first attendances by March 2023.

Systems are asked to plan how the redeployment of the released capacity (including staff) is used to increase elective clock-stops or reduce clock-starts proactively.

£2.3 billion of elective recovery funding has been allocated to systems to support the recovery of elective services in 2022/23. We will set out further details in additional guidance.

£1.5 billion of capital above that funded within core envelopes has been made available to the NHS over three years to support new surgical hubs, increased bed capacity and equipment to help elective services recover. Systems are asked to demonstrate how their capital proposals support a material quantified increase in elective activity, eg through schemes that enable the separation of elective and non-elective activity, the setting up or expansion of elective hub sites, day case units or increased bed capacity. Further detail on these requirements and the process will be set out in additional guidance.

Systems are asked to rapidly draw up delivery plans across elective inpatient, outpatient and diagnostic services for adults and children (including specialised services) for April 2022 to March 2023. These plans should set out how:

- systems will meet the ambitions set out above, reflecting the additional revenue and capital funding being made available. We will set out further details in additional guidance
- services will be organised and delivered to maximise productivity opportunities and secure the best possible outcomes for patients
- local independent sector capacity is incorporated as a core element to deliver improved outcomes for patients and reduce waiting times sustainably
- the updated UK Health Security Agency (UKHSA) guidance will be implemented, ensuring safety concerns are appropriately balanced.
- systems will ensure inclusive recovery and reduce health inequalities where they are identified
- elective care, UEC, social care and mental health will be managed in a way that ensures elective recovery can be protected and any disruptions minimised.

C2: Complete recovery and improve performance against cancer waiting times standards

The number of patients seen following an urgent suspected cancer referral has remained at a record high since March 2021. However, backlogs remain for those who have been referred for treatment, and we would have expected at least 36,000 more patients to have come forward to start treatment during the pandemic than have done so. Systems should therefore, as a priority, complete any outstanding work on the post-pandemic cancer recovery objectives set out in the 2021/22 H2 planning guidance, to:

- return the number of people waiting for longer than 62 days to the level in February 2020 (based on the national average in February 2020)
- meet the increased level of referrals and treatment required to reduce the shortfall in number of first treatments.

Priority actions should centre on ensuring there is sufficient diagnostic and treatment capacity to meet recovering levels of demand, with a particular focus on the three cancers making up two-thirds of the national backlog (lower GI, prostate and skin), including:

- provision of sufficient commissioned capacity so that every urgent suspected lower GI cancer referral is accompanied by a faecal immunochemical test (FIT) result
- delivery of the optimal timed pathway for prostate cancer, including ensuring mpMRI prior to biopsy to eliminate the need for biopsy wherever possible
- making teledermatology available as an option for clinicians in all providers receiving urgent cancer referrals.

Systems are asked to work with Cancer Alliances to develop and implement a plan to:

- improve performance against all cancer standards, with a focus on the 62-day urgent referral to first treatment standard, the 28-day faster diagnosis standard and the 31-day decision-to-treat to first treatment standard
- make progress against the ambition in the NHS Long Term Plan to diagnose more people with cancer at an earlier stage, with a particular focus on disadvantaged areas where rates of early diagnosis are lower.

Delivery of these plans is expected to support:

- Timely presentation and effective primary care pathways including:
  - working with PCNs to support implementation of cancer early diagnosis as set out in the Network Contract Directed Enhanced Service (DES)
  - running local campaigns to complement national advertising to raise public awareness of cancer symptoms and encourage timely presentation.
- Faster diagnosis, including:
  - extending coverage of non-specific symptom pathways – with at least 75% population coverage by March 2023
  - ensuring at least 65% of urgent cancer referrals for suspected prostate, colorectal, lung, oesophago-gastric, gynaecology and head and neck cancer meet timed pathway milestones.
- Targeted case finding and surveillance, including:
  - maximising the uptake of targeted lung health checks (TLHC) and the effective delivery of follow-up low dose CT scans, to meet trajectories agreed with the national team. From 2022/23, all Cancer Alliances will have at least one TLHC project
  - ensuring that every person diagnosed with colorectal and endometrial cancer is tested for Lynch syndrome (with cascade testing offered to family members), and patients who qualify for liver surveillance under National Institute for Health and Care Excellence (NICE) guidance are identified and invited to surveillance.

The national cancer team will provide data and guidance to Cancer Alliances to support the development of their plans. Plans will form the basis of Cancer Alliance funding agreements.

ICBs and Cancer Alliances are also asked to work with trusts to:

- ensure they have fully operational and sustainable patient stratified follow-up (PSFU) pathways for breast, prostate, colorectal and one other cancer by the end of the first quarter of 2022/23; and for two further cancers (one of which should be endometrial cancer) by March 2023
- for systems participating in colon capsule endoscopy and cytosponge projects, deliver agreed levels of activity

- increase the recruitment and retention of clinical nurse specialists, cancer support workers and pathway navigators, and promote take up of clinical training opportunities for the cancer workforce.

Maintaining and restoring cancer screening programmes is critical to our efforts to fully restore cancer services. For breast cancer screening in particular, any systems that have not restored compliance with the three-year cycle by the end of March 2022 are expected to have done so by the end of June 2022.

C3: Diagnostics

Recovery of the highest possible diagnostic activity volumes is critical to providing responsive, high quality services and supporting elective recovery and early cancer diagnosis. This will be supported by the timely implementation of new community diagnostic centres (CDCs). Systems are asked to:

- increase diagnostic activity to a minimum of 120% of pre-pandemic levels across 2022/23 to support these ambitions and meet local need
- develop investment plans that lay the foundations for further expansion of capacity through CDCs in 2023/24 and 2024/25.

Three-year capital funding allocations will be included in system envelopes for this purpose. National investment through HEE is planned to facilitate training and supply of the workforce to support these goals. Systems will be able to access dedicated revenue funding to support set up and running of CDCs, subject to the necessary business case approvals. Revenue will be allocated to align with the programmes of work or agreed capital business cases.

Systems are asked to utilise targeted capital allocations to:

- increase the number of endoscopy rooms, levelling up to a guide level of 3.5 rooms per 100,000 population over 50 years of age. Systems should consider using this funding to locate endoscopy services in CDCs and supplement available CDC funding allocations, seeking to co-locate endoscopy and imaging services where possible. Funding will also be available to units that have yet to meet Joint Advisory Group (JAG) on Gastrointestinal Endoscopy Endoscopy accreditation to upgrade their services

- invest in CT capacity to support expansion the Target Lung Health Checks programme from 2023/24, with target coverage to be agreed between Cancer Alliances and the National Cancer Programme team. Cancer Alliances will receive this targeted funding on the basis of their remaining unscreened population and existing CT capacity and should coordinate with ICSs.
- develop additional digitally connected imaging capacity and ensure that acute sites have a minimum of two CT scanners
- procure new breast screening units to deliver the 36-month cycle.

Operational capital resources should continue to be used to reduce the backlog of diagnostic equipment replacement over 10 years old.

Pathology and imaging networks are asked to complete the delivery of their diagnostic digital roadmaps as part of their digital investment plans. National funding will be provided that is broadly consistent with these roadmaps, taking account of progress to date. Refreshed roadmaps need to include specific plans setting out how pathology and imaging networks and CDCs will with their systems support artificial intelligence (AI) research and innovation, and the scalable and sustainable integration of AI-driven diagnostics. The implementation of digital diagnostic investments is expected to deliver at least a 10% improvement in productivity by 2024/25, in line with the best early adopters.

Systems should ensure that pathology networks reach, as a minimum, the 'maturing' status for delivery of pathology services on the pathology network maturity framework by 2024/25. They should also meet the requirements of all national data collections for diagnostic services and support the work to scope creation of endoscopy and clinical physiology networks.

Programme funding of £21 million is available to support pathology and imaging networks to deliver on these priorities in 2022/23 alongside the implementation of CDCs.

C4 Deliver improvements in maternity care

Systems working through local maternity systems (LMSs) are asked to continue to work towards delivering a range of transformation objectives to make maternity and neonatal care safer, more personalised and more equitable. ICSs should undertake

formal, structured and systematic oversight of how their LMS delivers its functions and there should be a direct line of sight to the LMS board.

Providers are asked to continue to embed and deliver the seven immediate and essential actions identified in the interim Ockenden report, along with any future learning shared in the second Ockenden report and East Kent review (when published). LMSs should continue to oversee quality in line with Implementing a revised perinatal quality surveillance model.

LMSs are asked to support providers to prioritise reopening any services suspended due to the pandemic, ensuring women can take somebody with them to all maternity appointments and supporting work to increase vaccination against COVID-19 in pregnancy. LMSs should implement local maternity equity and equality action plans in line with Equity and equality: Guidance for local maternity systems.

LMSs are also asked to continue to work with providers to implement local plans to deliver Better Births, the report of the national maternity review, including:

- delivering local plans for midwifery continuity of carer (MCoC) in line with Delivering midwifery continuity of carer at full scale, prioritising MCoC so that most Black, Asian and mixed ethnicity women and most women from the most deprived areas receive it once the building blocks are in place
- offering every woman a personalised care and support plan in line with the Personalised care and support planning guidance
- fully implement Saving Babies' Lives. Providers should have a preterm birth clinic and act so that at least 85% of women who are expected to give birth at less than 27 weeks' gestation are able to do so in a hospital with appropriate on-site neonatal care.

Funding of c£93 million to support the implementation of Ockenden actions through investment in workforce will go into baselines from 2022/23. Programme funding will also be made available to support the delivery of the Better Births priorities.

D. Improve the responsiveness of urgent and emergency care and build community care capacity– keeping patients safe and offering the right care, at the right time, in the right setting

Sustaining UEC performance has been very challenging due to the pandemic. We need to continue reforms to community and urgent and emergency care to deliver safe, high quality care by preventing inappropriate attendance at EDs, improving timely admission to hospital for ED patients, reducing length of stay and restoring ambulance response times. An essential requirement is to increase the capacity of the NHS by the equivalent of at least 5,000 G&A beds and return, as a minimum, to pre-pandemic levels of bed availability through a combination of:

- national funding for the further development of virtual wards (including hospital at home)
- system capital plans to increase physical bed capacity as part of elective recovery plans
- re-establishing bed capacity consistent with latest UKHSA IPC guidance.

D1: Urgent and emergency care

The urgent and emergency care system continues to be under significant pressure ahead of what is expected to be an extremely challenging winter. These pressures are exacerbated by delayed ambulance handovers and ambulance response times. A longer term improvement approach is required for the full recovery of urgent and emergency care services. Expected performance levels in 2022/23 therefore represent a first step towards recovery.

Systems are therefore asked to:

- reduce 12-hour waits in EDs towards zero and no more than 2%
- improve against all Ambulance Response Standards, with plans to achieve Category 1 and Category 2 mean and 90th percentile standards

- minimise handover delays between ambulance and hospital, allowing crews to get back on the road and contribute to achieving the ambulance response standards. This includes:
  - eliminating handover delays of over 60 minutes
  - ensuring 95% of handovers take place within 30 minutes
  - ensuring 65% of handovers take place within 15 minutes
- ensure stability of services and have planned contingency in advance of next winter.

Systems are asked to build on the work already commenced, as indicated in the UEC 10 Point Action Recovery Plan. This should incorporate:

- Increasing capacity within NHS 111 to ensure the service is the credible first option for patients, enabling their referral to the most appropriate care setting, including:
  - call handling capacity to meet growing demand
  - clinical capacity within the clinical assessment service to support decision-making, with >15% of calls received having clinical input
  - ensuring there is a full range of available options in the Directory of Services to meet local need
  - adopting the new regional/national route calling technology.
- Expanding urgent treatment centre (UTC) provision and increasingly moving to a model where UTCs act as the front door of ED, to enable emergency medicine specialists to focus on higher acuity need within the ED.

Systems are asked to put in place integrated health and care plans for children and young people's services that include a focus on urgent care; building on learning from pilots placing paediatric staff within NHS 111 services; better connections between paediatric health services; joining up children's services across the NHS and local authorities; improving transitions to adult services; and supporting young people with physical and mental health needs within acute and urgent care settings.

Systems are asked to consistently submit timely Emergency Care Data Set (ECDS) data, now seven days a week.

D2: Transform and build community services capacity to deliver more care at home and improve hospital discharge

The transformation of out-of-hospital services is a key element of the NHS recovery. National funding, alongside additional growth within core allocations for community services funding, will support systems to increase overall capacity of community services to provide care for more patients at home and address waiting lists, develop and expand new models of community care and support timely hospital discharge.

Community care models

Virtual wards

The NHS has already had considerable success in implementing virtual wards, including Hospital at Home services. Over 53 virtual wards are already providing over 2,500 ‘beds’ nationwide, enabled by technology. In addition to managing patients with COVID, they also support patients with acute respiratory infections, urinary tract infections (UTIs), chronic obstructive pulmonary disease (COPD) and complex presentations, such as those who are frail as well as having a specific medical need.

The scope for virtual wards is far greater. Given the significant pressure on acute beds we must now aim for their full implementation as rapidly as possible. We are therefore asking systems to develop detailed plans to maximise the rollout of virtual wards to deliver care for patients who would otherwise have to be treated in hospital, by enabling earlier supported discharge and providing alternatives to admission. These plans should be developed across systems and provider collaboratives, rather than individual institutions, based on partnership between secondary, community, primary and mental health services. Systems should also consider partnerships with the independent sector where this will help grow capacity.

By December 2023, we expect systems to have completed the comprehensive development of virtual wards towards a national ambition of 40–50 virtual wards per 100,000 population. Successful implementation will require systems to:

- maximise their overall bed capacity to include virtual wards
- prevent virtual wards becoming a new community-based safety netting service; they should only be used for patients who would otherwise be admitted to an NHS acute hospital bed or to facilitate early discharge
- maintain the most efficient safe staffing and caseload model

- manage length of stay in virtual wards through establishing clear criteria to admit and reside for services
- fully exploit remote monitoring technology and wider digital platforms to deliver effective and efficient care.

Up to £200 million will be available in 2022/23 and up to £250 million in 2023/24 (subject to progress of systems) to support the implementation of these plans. We expect plans to cover two years. The scale of funding awarded in 2022/23 will depend on credible ambition for delivery of virtual wards by December 2022 to provide capacity for next winter. Systems will want to consider approaches that address patients with lower intensity and higher intensity needs (ie Hospital at Home services). We will set out further guidance on the virtual ward model, the support available and the funding criteria.

Urgent community response

By April 2022 all parts of England will be covered by 2 hour urgent community response services and over 2022-23 providers and systems will be required to:

- Maintain full geographic rollout and continue to grow services to reach more people extending operating hours where demand necessitates and at a minimum operating 8am to 8pm, 7 days a week in line with national guidance
- Improve outcomes through reaching patients in crisis in under 2 hours where clinically appropriate. Providers will be required to achieve, and ideally exceed in the majority of cases, the minimum threshold of reaching 70% of 2 hour crisis response demand within 2 hours from the end of Q3.
- Increase the number of referrals from all key routes, with a focus on UEC, 111 and 999, and increase care contacts
- Improve capacity in post urgent community response services to support flow and patient outcomes including avoiding deterioration into crisis again or unnecessary admission
- Ensure workforce plans support increasing capacity and development of skills and competencies in line with service development
- Improve data quality and completeness in the Community Services Dataset (CSDS) as this will be the key method to monitor outcomes, system performance and capacity growth

Anticipatory care

Anticipatory care (AC) is a Long-Term Plan commitment focused on provision of proactive care in the community for multimorbid and frail individuals who would benefit most from integrated evidence-based care. ICSs should design, plan for and commission AC for their system. Systems need to work with health and care providers to develop a plan for delivering AC from 2023/24 by Q3 2022, in line with forthcoming national operating model for AC.

Enhanced Health in Care Homes

Ensure consistent and comprehensive coverage of Enhanced Health in Care Homes in line with the national framework.

Community service waiting lists

Systems must develop and agree a plan for reduction of community service waiting lists and ensure compliance of national sitrep reporting. Specifically, systems are asked to:

- develop a trajectory for reducing their community service waiting lists
- significantly reduce the number of patients waiting for community services
- prioritise patients on waiting lists
- consider transforming service pathways and models to improve effectiveness and productivity.

Hospital discharge

As outlined in the H2 2021/22 planning guidance, the additional funding for the Hospital Discharge Programme will end in March 2022. As part of preparing the NHS for the potential impact of the Omicron variant and other winter pressures, we have asked systems to work together with local authorities and partners, including hospices and care homes, to release the maximum number of beds, as a minimum this should be equivalent to half of current delayed discharges. Systems should seek to sustain the improvement in delayed discharges in 2022/23 working with local authority partners and supported by the Better Care Fund and the investment in virtual wards.

Digital

Digital tools and timely, accurate information are key to delivering on these aims and systems are asked to:

- identify digital priorities to support the delivery of out-of-hospital models of care through the development of system digital investment plans, ensuring community health services providers are supported to develop robust digital strategies to support improvements in care delivery
- ensure providers of community health services, including ICS-commissioned independent providers, can access the Local Care Shared Record as a priority in 2022/23, to enable urgent care response and virtual wards
- deliver radical improvements in quality and availability against national data requirements and clinical standards, including the priority areas of urgent care response and musculoskeletal (MSK).

E. Improve timely access to primary care – expanding capacity and increasing the number of appointments available

The NHS Long Term Plan commits to increasing investment in primary medical and community services (PMCS) by £4.5 billion real terms investment growth by 2023/24. We expect systems to maximise the impact of their investment in primary medical care and PCNs with the aim of driving and supporting integrated working at neighbourhood and place level. Systems are asked to look for opportunities to support integration between community services and PCNs, given they are an integral part of solutions to key system challenges that require a whole system response, including elective recovery and supporting more people in their own homes and local communities. Systems should also consider how community pharmacy can play a greater role in local plans as part of these integrated approaches.

Expanding the primary care workforce remains a top priority to increase capacity. Systems are expected to:

- support their PCNs to have in place their share of the 20,500 FTE PCN roles by the end of 2022/23 (in line with the target of 26,000 by the end of 2023/24) and

to work to implement shared employment models, drawing on more than £1 billion of Additional Roles Reimbursement Scheme (ARRS) funding across system development funding (SDF) and allocations

- expand the number of GPs towards the 6,000 FTE target, with consistent local delivery of national GP recruitment and retention initiatives, thereby continuing to make progress towards delivering 50 million more appointments in general practice by 2024.

In line with the principles outlined in the October 2021 plan, systems are asked to support the continued delivery of good quality access to general practice through increasing and optimising capacity, addressing variation and spreading good practice. Every opportunity to secure universal participation in the Community Pharmacist Consultation Service should be taken. Systems should drive the transfer of lower acuity care from both general practice and NHS 111 under this scheme, supported by a new investment and impact fund indicator for PCNs which incentivises contributions to a minimum of two million appointments in 2022/23. Performance at the rate of the best early implementers of 50 referrals a week would move more than 15 million appointments out of general practice. Systems will need to implement revised arrangements for enhanced access delivered through PCNs from October 2022.

Systems are asked to support practices and PCNs to ensure the commitment that every patient has the right to be offered digital-first primary care by 2023/24 is delivered. By ‘digital-first primary care’ we mean a full primary care service that patients can access easily and consistently online, that enables them to quickly reach the right service for their needs (whether in person or remotely), that is integrated with the wider health system, and that enables clinicians to provide efficient and appropriate care.

2022/23 will see the implementation of GP contract changes, including those to the DES. In addition to the five services already being delivered by PCNs, from April 2022 there will be a phased introduction of two new services – anticipatory care and personalised care – and an expanded focus on cardiovascular disease (CVD) diagnosis and prevention.

Systems are asked to support their PCNs to work closely with local communities to address health inequalities. Practices should continue the critical job of catching up on the backlog of care for their registered patients who have ongoing conditions, to

ensure the best outcomes for them and to avoid acute episodes or exacerbations that may otherwise result in avoidable hospital admissions or even premature mortality.

Systems are asked to take every opportunity to use community pharmacy to support this; for example, in the delivery of care processes such as blood pressure measurement under new contract arrangements. This will drive detection of hypertension across our communities, address backlogs in care and deliver longer-term transformation in integrated local primary care approaches. Systems should also optimise use of pharmacy services around smoking cessation on hospital discharge, the expanded new medicines service and the discharge medicines service.

For dental services, the focus is on maximising clinically appropriate activity in the face of ongoing IPC measures, and targeting capacity to meet urgent care demand, minimise deterioration in oral health and reduce health inequalities.

Subject to the passage of the Health and Care Bill, ICBs will become the delegated commissioners for primary medical services and, in some cases, also dental, community pharmacy and optometry services, during 2022/23 – the target date now being 1 July 2022. Once established, ICBs should develop plans, working with NHS England regional commissioning teams to take on effective delegated dental, community pharmacy and optometry commissioning functions from 2023/24.

F. Grow and improve mental health services and services for people with a learning disability and/or autistic people

F1: Expand and improve mental health services

The complexity of needs for those requiring mental health services has risen because of the pandemic. In addition to a pre-existing treatment gap within mental health, this is increasing pressures within community services, mental health UEC and inpatient pathways across all ages. To address these pressures and continue to make progress against the NHS Long Term Plan ambitions, systems are asked to:

- Continue to expand and improve their mental health crisis care provision for all ages. This includes improving the operation of all age 24/7 crisis lines, crisis resolution home treatment teams and mental health liaison services in acute

hospitals. Systems are also asked to increase the provision of alternatives to A&E and admission, and improve the ambulance mental health response. Over the next three years £150 million targeted national capital funding will be made available to support improvements in mental health UEC, including mental health ambulances, extending Section 136 suites, safe spaces in or near A&E.

- Ensure admissions are intervention-focused, therapeutic and supported by a multidisciplinary team, utilising the expansion of mental health provider collaboratives across the whole mental health pathway where systems plan such developments. These collaboratives will support systems to transform services and reduce reliance on hospital-based care delivered away from people's local area.
- Continue the expansion and transformation of mental health services, as set out in the NHS Mental Health Implementation Plan 2019/20–2023/24, to improve the quality of mental healthcare across all ages. The mental health LTP ambitions tool will support systems to understand their delivery requirements for expanding access, as well as the Mental Health Delivery Plan 2022/23.
- Continue to grow and expand specialist care and treatment for infants, children and young people by increasing the support provided through specialist perinatal teams for infants and their parents up to 24 months and through continuing to expand access to children and young people’s mental health services.
- Subject to confirmation, encourage participation in the first phase of the national Quality Improvement programme to support implementation of the Mental Health Act reforms.

We ask that systems maintain a focus on improving equalities across all programmes, noting the actions and resources identified in the Advancing Mental Health Equalities Strategy.

Delivery of the Mental Health Investment Standard (MHIS) remains a mandatory minimum requirement, ensuring appropriate investment of baseline funding and SDF to deliver the mental health NHS Long Term Plan objectives by 2023/24. Where SDF funding supports ongoing services, these will continue to be funded beyond 2023/24. This will support the continued expansion and transformation of the mental health workforce. For this:

- systems are asked to develop a mental health workforce plan to 2023/24 in collaboration with mental health providers, HEE and partners in the voluntary, community and social enterprise (VCSE) and education sectors
- PCNs and mental health trusts are asked to continue to use the mental health practitioner ARRS roles to improve the care and treatment for adults, children and young people in line with NHS Long Term Plan ambitions.

Capital funding made available through system allocations is expected to support urgent patient safety projects for mental health trusts, such as those that address ligature points and other infrastructure concerns that pose immediate risks to patients. Funding to eradicate mental health dormitories will continue in 2022/23 and 2023/24.

Systems are asked to work with the Mental Health Provider Collaboratives to produce a clear plan of requirements for CYPMH general adolescent and psychiatric intensive care in-patient beds to meet the health needs of their population, strengthen local services and eliminate out of area placements for the most vulnerable young people. These bed plans should be an integral part of the overall plan for CYP mental health services to ensure a local, whole patient pathway for patients with mental health, learning disability and/or autism needs. The plans should be complete by the end of Q1 2022/23 and should be funded through system operational capital. Investing in this way is expected to reduce operating costs as a direct result of improving access to local services and reducing out of area patient flows. Further guidance on the development of these plans will be issued before the start of 2022/23.

All NHS commissioned services must flow data to the national datasets and relevant bespoke collections. Provision for this must be included and agreed in commissioning arrangements planned for 2021/22, as part of this process.

F2: Meeting the needs of people with a learning disability and autistic people

The pandemic has highlighted and exacerbated the significant health inequalities experienced by people with a learning disability and autistic people. As we recover from the pandemic, we must ensure that people with a learning disability and autistic people are not further disadvantaged in fair access to healthcare. As digital healthcare develops, this means making sure there are reasonable adjustments and tailored responses, including consideration of the ongoing need for face-to-face appointments. Systems are asked to:

- Increase the rate of annual health checks for people aged 14 and over on a GP learning disability register towards the 75% ambition in 2023/24. Every annual health check should be accompanied by a health action plan to identify actions to improve the person's health.
- Continue to improve the accuracy of GP learning disability registers so that the identification and coding of patients is complete, and particularly for under-represented groups such as children and young people and people from ethnic minority groups.
- Maintain a strong commitment to reducing reliance on inpatient care for both adults and children with a learning disability and/or who are autistic, consistent with the ambition set out in the NHS Long Term Plan, and to develop community services to support admission avoidance and timely discharge.
- Build on the investment made in 2021/22 to develop a range of care and diagnostic services for autistic people delivered by multidisciplinary teams. This includes access to community mental health services; support for autistic children and young people and their families; and access to the right support and housing. Systems should adopt best practice to improve local diagnostic pathways to minimise waiting times for diagnosis, improve patient experience and ensure that there is accurate and complete reporting of diagnostic data.
- Implement the actions coming out of Learning Disability Mortality Reviews (LeDeRs), including following deaths of people who are autistic, to tackle the inequalities experienced by people with a learning disability; these have been exacerbated by the pandemic.

Service development funding support of £75 million is being made available in 2022/23 to achieve the above ambitions.

G. Continue to develop our approach to population health management, prevent ill-health and address health inequalities

Working alongside local authorities and other partners we will continue to develop our approach to population health management and prevention so that people can play a more proactive role in promoting good health. ICSs will drive the shift to population

health, targeting interventions at those groups most at risk, supporting health prevention as well as treatment. ICSs will take a lead role in tackling health inequalities by building on the Core20PLUS5 approach introduced in 2021/22.

The safe and effective use of patient data is key to this. Systems are asked to develop plans by June 2022 to put in place the systems, skills and data safeguards that will act as the foundation for this. By April 2023, every system should have in place the technical capability required for population health management, with longitudinal linked data available to enable population segmentation and risk stratification, using data and analytics to redesign care pathways and measure outcomes with a focus on improving access and health equity for underserved communities. Systems are encouraged to work together to share data and analytic capabilities.

To support this, we will:

- continue to operate national data platforms for key, individually identified clinical data driven national programmes (eg the COVID pass, vaccine registries)
- provide a clear set of technical requirements and standards.

We are asking systems to develop robust plans for the prevention of ill-health, led by a nominated senior responsible officer (SRO). These plans should reflect the primary and secondary prevention deliverables as outlined in the NHS Long Term Plan, and the key local priorities agreed by the ICS. Plans should set out how system allocations will be deployed to:

- Support the rollout of tobacco dependence treatment services in all inpatient and maternity settings, in line with agreed trajectories and utilising £42 million of SDF funding.
- Improve uptake of lifestyle services, the Diabetes Prevention Programme, Low Calorie Diets, the new Digital Weight Management Programme and digitally supported self-management services.
- Restore diagnosis, monitoring and management of hypertension, atrial fibrillation and high cholesterol and diabetes, as well as asthma and COPD registers and spirometry checks for adults and children, to pre-pandemic levels in 2022/23, as per the Quality and Outcomes Framework (QOF), Integrated Investment Fund and Direct Enhanced Service targets.

- Progress against the NHS Long Term Plan high impact actions to support respiratory, stroke and cardiac care, implementing new models of care and rehabilitation, including remote and digital models, and increasing respiratory, hypertension, atrial fibrillation and high cholesterol detection and monitoring/control to pre-pandemic levels. This should include how systems plan to implement national procurements and population health agreements such as those in place for inclisiran and direct oral anticoagulants (DOACs). NHS England's new DOAC framework agreement will make treatment more affordable, allowing the NHS to provide DOACs to 610,000 additional patients. Uptake of DOAC treatment at this level will help prevent an estimated 21,700 strokes and save 5,400 lives over the next three years
- Reduce antibiotic use in primary and secondary care through early identification and treatment of bacterial infections, and support reduced lengths of hospital stays by ensuring that intravenous antibiotics are only used for as long as clinically necessary, with a switch to oral antibiotics as soon as appropriate.

There is strong evidence that people from socio-economically deprived populations and certain ethnic minority groups experience poorer health than the rest of the population, so it is particularly important to focus preventative services on these groups. Smoking is the single largest driver of health disparities between the most and least affluent quintiles. Obesity is the next biggest preventable risk factor and obesity in children has seen a major increase during the pandemic, especially in the least well off.

Systems are also asked to:

- renew their focus on reducing inequalities in access to and outcomes from NHS public health screening and immunisation services
- continue to adopt culturally competent approaches to increasing vaccination uptake in groups that have a lower than overall average uptake as of March 2022
- continue to deliver on the personalised care commitments set out in the NHS Long Term Plan – social prescribing referrals, personal health budgets, and personalised care and support plans are key enablers of population health and prevention.

H. Exploit the potential of digital technologies to transform the delivery of care and patient outcomes

During the pandemic digital technologies transformed the delivery of care. The opportunity now is for the health and care sector to build on this and use the potential of digital to help the NHS address both its long-term challenges and the immediate task of recovering from the pandemic. In practice this means better outcomes for patients, better experience for staff and more effective population health management.

We will support health and care systems to 'level-up' their digital maturity, and ensure they have a core level of infrastructure, digitisation and skills.

A core level of digitisation in every service within a system is essential. Acute, community, mental health and ambulance providers are required to meet a core level of digitisation by March 2025, in line with the NHS Long Term Plan commitment. By March 2022, systems should develop plans that set out their first year's priorities for achieving a core level of digitisation across all these settings (as set out by the Frontline Digitisation minimum viable product, which will be published by 31 December).

Costed three-year digital investment plans should be finalised by June 2022 in line with What Good Looks Like (WGLL). We will fund systems to establish dedicated teams to support the development and delivery of their plans, which should:

- include provisions for robust cyber security across the system. We will continue to provide and further enhance centralised cyber security capabilities systems; however, local organisations are responsible for managing their own cyber risk
- reflect ambitions to consolidate purchasing and deployment of digital capabilities, such as electronic patient records and workforce management systems, at system level where possible
- set out the steps being taken locally to support digital inclusion
- consider how digital services can support the NHS Net Zero Agenda.

Capital will be available to systems for three years from 2022/23, to support digitisation of acute, mental health, ambulance and community services. £250 million will initially

be allocated to systems for 2022/23 while they develop their digital investment plans. This funding will be directed towards those services and settings that are the least digitally mature.

A digitised, interoperable and connected health and care system is a key enabler of delivering more effective, integrated care. Systems are asked to ensure that:

- by March 2023, all systems within a Shared Care Record collaborative can exchange information across the whole collaborative, with a view to national exchange by March 2024. Standards will be published to support this
- local authorities with social service responsibilities within their footprint are connected to their local Shared Care Record solution by March 2023, and that all social care providers can connect within six months of them having an operational digital social care record system
- suppliers comply with interoperability standards as these are finalised by April 2022
- general practice promotes the NHS App and NHS.UK to reach 60% adult registration by March 2023
- plans are developed to support skilling up the workforce to maximise the opportunities of digital solutions.

The ambition is for the NHS e-Referral Service (e-RS) to become an any-to-any health sector triage, referral and booking system by 2025. This will support two-way digital advice and guidance between clinical teams, ensuring patients are managed safely, and the referral is triaged and processed according to clinical priority. We will support systems with adoption as this functionality is made available to support triage, bookings and referrals. Mental health and other additional services are being evaluated for inclusion in 2022/23.

I. Make the most effective use of our resources

The 2021 Spending Review (SR21) provided the NHS with a three-year revenue and capital settlement covering 2022/23 to 2024/25. The government committed to spend an additional £8 billion to support tackling the elective backlog over the next three

years, from 2022/23 to 2024/25. This allows us to prioritise £2.3 billion in 2022/23 to support elective recovery.

SR21 also confirmed that the NHS will receive total capital resources of £23.8 billion over the next three years, including £4.2 billion of funding to support the building of 40 new hospitals and to upgrade more than 70 hospitals; £2.3 billion to transform diagnostic services; £2.1 billion for innovative use of digital technology; and £1.5 billion to support elective recovery.

We will shortly issue one-year revenue allocations to 2022/23 and three-year capital allocations to 2024/25. We intend to publish the remaining two-year revenue allocations to 2024/25 in the first half of 2022/23.

I1: Use of resources

With this funding, the NHS is expected to fully restore core services and make significant in-roads into the elective backlog and NHS Long Term Plan commitments. The SR21 settlement assumes the NHS takes out cost and delivers significant additional efficiencies, on top of the NHS Long Term Plan requirements, to address the excess costs driven by the pandemic response, moving back to and beyond pre-pandemic levels of productivity when the context allows this.

The scale of the efficiency requirement will be sustained throughout the SR21 period and systems should ensure they develop plans that deliver the necessary exit run-rate position to support delivery of future requirements.

We will continue to provide tools, information and support to help systems work together to deliver cost improvement plans that maximise efficiency and productivity opportunities, and reduce unwarranted variation. We will set out additional information on the support programmes available in additional guidance.

I2: Financial framework

The COVID-19 pandemic necessitated simplified finance and contracting arrangements that supported systems to dedicate maximum focus to responding to immediate operational challenges. To support the next phase of service restoration, the financial and contracting frameworks need to evolve to enable systems to take the appropriate funding decisions for their populations.

The future financial framework will continue to support system collaboration with a focus on financial discipline and management of NHS resources within system financial balance. Partner organisations should work together to deliver the new duties on ICBs and trusts.

Advice and guidance on the establishment of ICB financial management and governance arrangements is available as part of the ongoing support offer for ICB establishment. Regional teams are working with clinical commissioning groups (CCGs) and designate ICB board appointees to ensure that ICBs are ready to operate as statutory bodies from 1 July 2022, subject to the passage of legislation. ICBs and the boards of their constituent partners must be clear on the lines of financial accountability in managing NHS resources. This includes meeting core principles for managing public money, statutory responsibilities and other national expectations.

The 2022/23 financial and contracting arrangements are summarised as:

- A glidepath from current system revenue envelopes to fair share allocations. ICB revenue allocations will be based on current system funding envelopes, which continue to include the funding previously provided to support financial sustainability. In addition to a general efficiency requirement, we will apply a convergence adjustment to bring systems gradually towards their fair share of NHS resources. This will mean a tougher ask for systems consuming more than their relative need.
- Increased clarity and certainty over capital allocations, with multi-year operational capital allocations set at ICB level, building on the approach taken in the last two years, and greater transparency over the allocation of national capital programmes.
- A collective local accountability and responsibility for delivering system and ICB financial balance. The Health and Care Bill includes provisions which are designed to ensure that ICBs and trusts are collectively held responsible for their use of revenue and capital resources. Each ICB and its partner trusts will have a financial objective to deliver a financially balanced system, namely a duty on breakeven.
- A return to signed contracts and local ownership for payment flows under simplified rules. To restore the link between commissioning and funding flows, commissioners and trusts will have local ownership for setting payment values on simplified terms, supported by additional guidance from NHS England and

NHS Improvement. While written contracts between commissioners and all providers (NHS and non-NHS) will be needed to cover the whole of the 2022/23 financial year, systems and organisations should continue to take a partnership approach to establishing payment terms and contract management such that focus on delivery of operational and financial priorities can be maximised. We are separately publishing an updated draft of the NHS Standard Contract for 2022/23 for consultation; the final version of the contract, to be used in practice, will be published in February 2022.

- A commitment to support systems to tackle the elective backlog and deliver the NHS Long Term Plan. Additional revenue and capital funding will be provided to systems to support elective recovery, with access to additional revenue where systems exceed target levels. Provider elective activity plans will be funded as per the aligned payment and incentive approach, with payment linked to the actual level of activity delivered. ICBs will continue to be required to deliver the MHIS, as well as to meet other national investment expectations. We will set these out in additional guidance.
- A continued focus on integration of services to support the transition for future delegations. For those services that continue to be commissioned by NHS England in 2022/23, mechanisms to strengthen joint working with ICBs will be established.

J. Establish ICBs and collaborative system working

The establishment of ICBs, and everything that follows regarding the process and timing for this, remains subject to the passage of the Health and Care Bill through Parliament.

The continued development of ICSs during 2022/23 will help to accelerate local health and care service transformation and improve patient outcomes. As stated in the introduction to this document, a new target date of 1 July 2022 has been agreed for new statutory arrangements for ICSs to take effect and ICBs to be legally and operationally established. National and local plans for ICS implementation will now be adjusted to reflect this timescale, with an extended preparatory phase from 1 April 2022 up to the point of commencement of the new statutory arrangements. During this period:

- CCGs will remain in place as statutory organisations. They will retain all existing duties and functions and will conduct their business (collaboratively in cases where there are multiple CCGs within an ICS footprint) through existing governing bodies.
- CCG leaders will work closely with designate ICB leaders in key decisions that will affect the future ICB, notably commissioning and contracting.
- NHS England and NHS Improvement will retain all direct commissioning responsibilities not already delegated to CCGs.

During Q4 2021/22, NHS England and NHS Improvement will consult a small number of CCGs on changes to their boundaries, to align with the ICS boundary changes decided by the Secretary of State in July 2021. Those CCG boundary changes coming into effect from 1 April 2022 would support the smooth transition from CCGs to ICBs at the implementation date. Arrangements for people affected will be discussed directly with the relevant CCG and designate ICB leaders.

We do not plan to implement any further CCG mergers before the establishment of ICBs.

Next steps

CCG leaders and designate ICB leaders should continue with preparations for the closure of CCGs and the establishment of ICBs, working toward the new target date. NHS England and NHS Improvement will support CCG and designate ICB leaders to reset their implementation plans, to ensure the safe transfer of people, property (in its widest sense) and liabilities from CCGs to ICBs from their establishment. The national programme team will work closely with colleagues in systems and in regional teams to identify what support is needed to manage the new timetable.

We will work with national partners, including trade unions, to communicate the changed target date and any implications for the transfer process. Systems should also ensure they have clear and effective plans for local communications and engagement with the public, staff, trade unions and other stakeholders.

ICB designate chairs and chief executives should continue to progress recruitment to their designate leadership teams, adjusting their timelines as necessary while managing immediate operational demands. Current/planned recruitment activities for designate leadership roles should continue where this is the local preference, but

formal transition to the future leadership arrangements should now be planned for the new target date of 1 July 2022.

Regional teams will work with CCG leaders to agree arrangements that ensure that:

- CCGs remains legally constituted and able to operate effectively, working in partnership with the designate ICB leadership
- individuals' roles and circumstances are clear during the extended preparatory phase.

The employment commitment arrangements for other affected staff and the talent-based approach to people transition previously set out will be extended to reflect the new target date.

The requirements for ICB Readiness to Operate and System Development Plan submissions currently due in mid-February 2022 will be revised to reflect the extended preparatory period. Further details of these plans along with specific implications for financial, people or legal arrangements during the extended preparatory period will be developed with systems and set out in January 2022.

Designate ICB leaders, CCG accountable officers and NHS England and NHS Improvement regional teams will be asked to agree ways of working for 2022/23 before the end of March 2022. This will include agreeing how they will work together to support ongoing system development during Q1, including the establishment of statutory ICSs and the oversight and quality governance arrangements in their system.

Planning during 2022/23

The Health and Care Bill before Parliament will require each ICB to publish a five-year system plan before April each year. This plan must take account of the strategy produced by the integrated care partnership (ICP), and the joint strategic needs assessments and joint health and wellbeing strategies produced by the relevant health and wellbeing board(s).

We expect to require ICBs' refreshed five-year system plans in March 2023. This will give each ICB and its local authority partners sufficient time to agree a strategy for the ICP that has broad support, and to develop a plan to support its implementation, including the development of place based integration. ICBs will undertake preparatory work through 2022/23 to ensure that their five-year system plans:

- match the ambition for their ICS, including delivering specific objectives under the four purposes to:
  - improve outcomes in population health and healthcare
  - tackle inequalities in outcomes, experience and access
  - enhance productivity and value for money
  - support broader social and economic development
- reflect the national priorities and ambitions for the NHS
- take account of the responsibilities that they will be taking on for commissioning services that are currently directly commissioned by NHS England, such as primary care and some specialised services.

Plan submission

The planning timetable will be extended to the end of April 2022, with draft plans due in mid-March. We will keep this under review and publish further guidance setting out the requirements for plan submission.

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

Publishing approval reference: PAR1160

NHS
Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

13th January 2022

Item No: 220

Report Title	Update to Transition Timeline and implications for consideration
Author(s)	Chrissy Tucker, Director of Corporate Delivery
Sponsor (Director)	Helen Dillistone, Executive Director of Corporate Strategy & Delivery

Paper for:	**Decision**		**Assurance**		**Discussion**	x	**Information**	
Assurance Report Signed off by Chair				N/A				
Which committee has the subject matter been through?				N/A				

Recommendations

The Governing Body is requested to **NOTE** the contents of this paper and letter, and consider the issues outlined in the slide pack which highlights some of the implications that need to be worked through as a consequence of the delay.

Report Summary

Guidance relating to 2022/23 priorities and operational planning was released on Christmas Eve and included a change in the implementation date of the establishment of the ICB from 1st April 2022 to 1st July 2022, meaning that the CCG would retain its statutory duties and arrangements until 30th June 2022, effectively providing an extended period in which to plan and prepare whilst allowing the necessary time for the Bill to pass through Parliament.

NHSEI colleagues are currently working on a revised timeline which will be reviewed, and transition plans updated accordingly. Further updates and information will be shared with the Governing Body when available.

Are there any Resource Implications (including Financial, Staffing etc)?

No further resource implications in the delivery of the transition.

Has a Privacy Impact Assessment (PIA) been completed? What were the findings?

Not applicable to this report.

Has a Quality Impact Assessment (QIA) been completed? What were the findings?

Not applicable to this report.

Has an Equality Impact Assessment (EIA) been completed? What were the findings?
Not applicable to this report.
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
Not applicable to this report.
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Not applicable.
Have any Conflicts of Interest been identified / actions taken?
None identified.
Governing Body Assurance Framework
The successful establishment of the ICB supports all of the strategic aims of the CCG.
Identification of Key Risks
Risks are identified within the transition risk register and will be updated as appropriate.

Classification: Official
Publication approval reference: B1275

Skipton House
80 London Road
London
SE1 6LH

24 December 2021

To:

- CCG AOs
- CCG Chairs

Dear colleague

I am writing to confirm that a revised target date of 1 July 2022 has been agreed for Integrated Care Boards (ICBs) to be legally and operationally established in order to allow sufficient time for the remaining parliamentary stages of the Health and Care Bill. This means that the current statutory arrangements will remain in place until then.

I am mindful that as individuals this transition is impactful on you all and the news about the changes to the implementation date has added uncertainty to this. I can confirm that we expect appointment and selection processes to continue as we are confident that the revised ICB implementation timelines do not change the direction of travel, nor the ambitious work needed to be done by the NHS and partners across Integrated Care Systems to improve care for our patients. This also means that we will have a longer transition period and it is important that we continue to maintain stability of Clinical Commissioning Groups (CCGs) and our systems until the establishment date of the ICBs. The attached briefing indicates what is said in the 2022/23 planning guidance on this including the adjustment to recruitment timelines for ICB leadership roles.

I expect you will want to discuss what this means for you with your regional colleagues and I have proposed that we take a supportive approach to retain and develop our talent across our NHS during this transitional period. I am aware that there will also be many questions from both yourselves and staff which we will need to provide responses to early in the new year. I appreciate what you are all doing to support colleagues through this and hope that where possible your system will continue to benefit from your valuable skills and expertise during this period.

In the meantime I wanted to thank you for your hard work especially over the past few months as we have seen increased pressures from another wave of COVID, elective and emergency pressures and the renewed push on vaccines. I am very grateful for your efforts tackling these issues whilst making impressive progress on preparing for the establishment of statutory Integrated Care Systems.

Yours sincerely

Mark Cubbon
Chief Delivery Officer
NHS England and NHS Improvement

NHS
Derby and Derbyshire
Clinical Commissioning Group

Implications of Changes to Transition Timeline

Helen Dillistone
Executive Director of Corporate Strategy and Delivery

ICS Transition

- NHSEI confirmed through the 2022/23 Priorities and Operational Planning Guidance released on 24th December and subsequently through correspondence to CCG and ICS leads, a 3 month slippage from 1st April 2022 to 1st July 2022 for the establishment of the new ICB, and the close down of the CCG.

- The transition plan, close down arrangements and associated risks will now therefore be revised to reflect the change. NHSEI are working on a revised version of the establishment timeline.

- However, there will be implications that need further consideration to ensure business continuity and the safe transfer of functions to the new ICB.

- The GB are therefore asked to note and consider the implications of the change.

Areas for consideration

The CCG must now continue to operate until 30th June 2022 including ensuring all statutory functions and responsibilities are delivered. These include

- **Preparation for ICB establishment** – revision of plans for ICB establishment and CCG closure
- **Corporate Governance processes** including Governing Body and its committees, board assurance, risk management, annual report timetable etc
- **Financial planning,** allocations, on going management including audit plans
- **HR matters** eg staff health and wellbeing, transition arrangements
- **Operational and technical matters** eg DSPT, contracting arrangements
- **Boundary change** bringing Glossop into Derbyshire and associated activities to support the change.

NHS
Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

13th January 2022

	Item No: 221

Report Title	Finance Report – Month 8
Author(s)	Georgina Mills, Senior Finance Manager
Sponsor (Director)	Richard Chapman, Chief Finance Officer

Paper for:	**Decision**		**Assurance**	x	**Discussion**		**Information**	
Assurance Report Signed off by Chair				N/A				
Which committee has the subject matter been through?				Finance Committee – 23.12.2021				

Recommendations

The Governing Body is requested to **NOTE** the following:

- Allocations have been received for the full year at £2.079bn
- The YTD reported underspend at month 8 is £0.730m
- Retrospective allocations received for half 1 Covid spend on the Hospital Discharge Programme were £5.498m further funding is expected of £1.358m relating to month 7 and 8.
- The Elective Recovery Fund has been reimbursed £0.756m for April to November with an additional £5k anticipated.
- The year-end position is forecast at £0.03m underspent.

Report Summary

The report describes the month 8 position. The key points are listed in the recommendations section above.

Are there any Resource Implications (including Financial, Staffing etc)?

N/A

Has a Privacy Impact Assessment (PIA) been completed? What were the findings?

N/A

Has a Quality Impact Assessment (QIA) been completed? What were the findings?

N/A

Has an Equality Impact Assessment (EIA) been completed? What were the findings?
None identified
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
No
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
No
Have any Conflicts of Interest been identified/ actions taken?
None identified
Governing Body Assurance Framework
Any risks highlighted and assigned to the Finance Committee will be linked to the Derby and Derbyshire CCG Board Assurance Framework
Identification of Key Risks
As detailed in the report

Financial Performance Summary
Month 8, November 2021

NHS
Derby and Derbyshire
Clinical Commissioning Group

Statutory Duty/ Performance	Target	Result	Achieved	Key	Comments/Trends
Achievement of expenditure to plan	£1392.484m	£1393.117m		Green <1%, Amber 1-5% Red >5%	Expected reimbursements of £1.358m for Covid and £0.005m for Elective Recovery Fund, resulting in a YTD favourable variance of £0.730m.
Remain within the Delegated Primary Care Co-Commissioning Allocation	£105.603m	£105.603m		Green <1%, Amber 1-5% Red >5%	Breakeven position for YTD. This is due to Co-Commissioning being on plan with minor variances offsetting each other across the service.
Remain within the Running Cost Allowance	£12.576m	£11.497m		Green <1%, Amber 1-5% Red >5%	Running costs are £1.079m underspent against plan attributed to staff vacancies and the running cost reserve.
Remain within cash limit	Greatest of 1.25% of drawdown or £0.25m	0.54%		Green <1.25%, Amber 1.25-5% Red >5%	Closing cash balance of £0.820m against drawdown of £153.0m
Achieve BPPC (Better Payment Practice Code)	>95% across 8 areas	Pass 8/8		Green 8/8 Amber 7/8 Red <6/8	In month and YTD payments of over 95% for invoices categorised as NHS and non NHS assessed on value and volume

Operating Cost Statement For the Period Ending: November 2021

	YTD Budget	YTD Actual	YTD Variance	YTD Variance as a % of YTD Budget	Annual Budget	Annual Forecast Outturn	Forecast Variance	FOT Variance as a % of Annual Budget
	£'000's	£'000's	£'000's	%	£'000's	£'000's	£'000's	%
Acute Services	732,296	729,720	2,575	0.35	1,095,957	1,092,659	3,297	0.30
Mental Health Services	157,490	156,738	753	0.48	239,772	238,367	1,405	0.59
Community Health Services	106,471	106,685	(214)	(0.20)	158,382	159,716	(1,333)	(0.84)
Continuing Health Care	73,258	76,833	(3,574)	(4.88)	108,630	119,534	(10,905)	(10.04)
Primary Care Services	141,629	143,168	(1,539)	(1.09)	210,366	211,958	(1,593)	(0.76)
Primary Care Co-Commissioning	105,603	105,603	(0)	(0.00)	159,630	165,300	(5,670)	(3.55)
Other Programme Services	57,591	58,700	(1,109)	(1.93)	80,819	85,148	(4,329)	(5.36)
Total Programme Resources	**1,374,337**	**1,377,447**	**(3,110)**	**(0.23)**	**2,053,555**	**2,072,683**	**(19,128)**	**(0.93)**
Running Costs	12,576	11,497	1,079	8.58	18,851	17,976	875	4.64
Total before Planned Deficit	**1,386,913**	**1,388,944**	**(2,031)**	(0.15)	**2,072,407**	**2,090,659**	**(18,253)**	(0.88)
In-Year Allocations	1,559	1,559	0	0.00	3,543	3,543	0	0.00
In-Year 0.5% Risk Contingency	4,244	2,613	1,631	38.42	4,244	0	4,244	100.00
In year Planned Deficit (Control Total)	(232)	0	(232)	100.00	(696)	0	(696)	100.00
Total Incl Covid Costs	**1,392,484**	**1,393,117**	**(633)**	(0.21)	**2,079,498**	**2,094,202**	**(14,705)**	(0.71)
Expected Covid Reimbursement in Future Months	**5,498**	**6,856**	**(1,358)**		**5,498**	**14,163**	**(8,665)**	
Expected Elective Recovery Fund Allocation	**756**	**761**	**(5)**		**756**	**1,067**	**(311)**	
ARRS Funding Above Baseline	**0**	**0**	**0**		**0**	**5,759**	**(5,759)**	
Total Including Reclaimable Covid Costs and Pay award	**1,386,230**	**1,385,500**	**730**	0.05	**2,073,244**	**2,073,214**	**30**	0.00

The reported position at month 8 is an underspend of £0.730m and favourable FOT underspend of £0.03m.

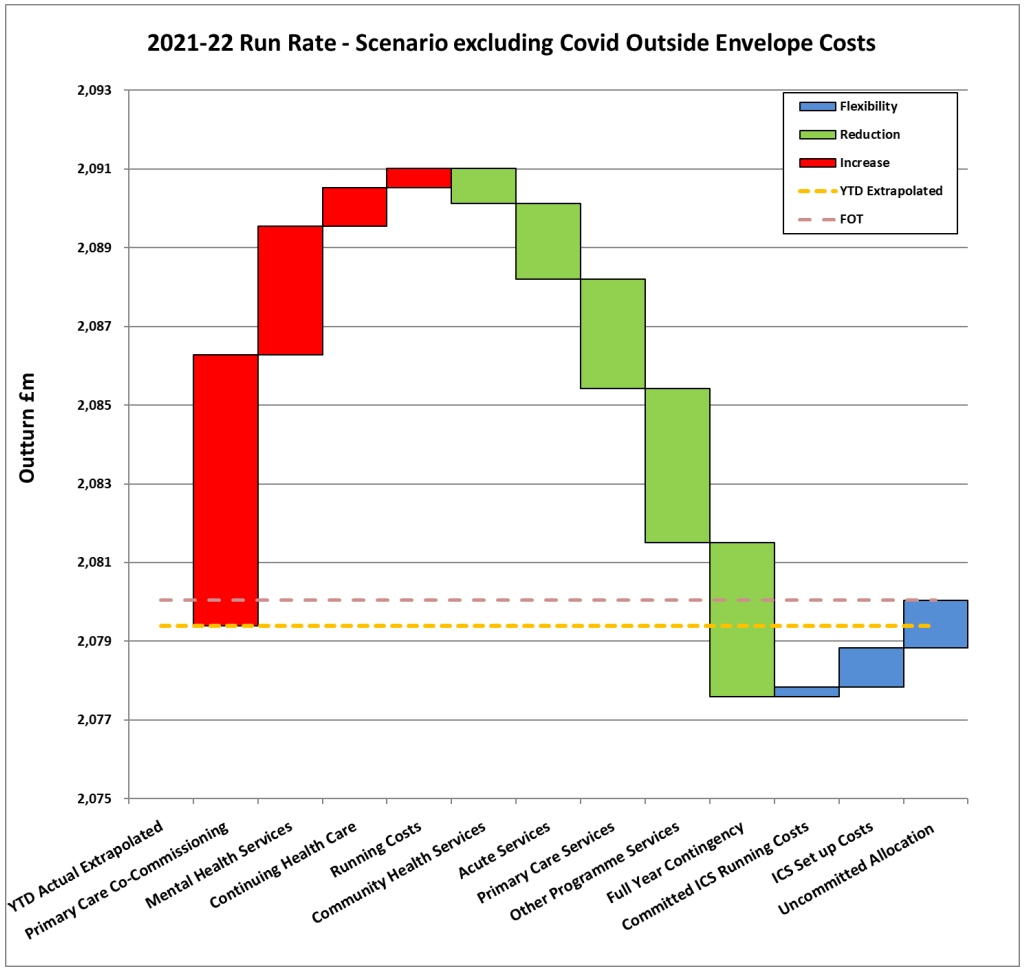
This position includes an expected reimbursement of £1.358m YTD and £8.665m FOT relating to Covid expenditure for the Hospital Discharge and Vaccine Inequalities Programmes. Allocations totalling £5.498m for out of envelope covid expenditure have been received relating to quarter 1 and 2. Quarter 3 funding is anticipated to be received in month 10.

The underspend includes £0.005m YTD relating to an Elective Recovery Fund (ERF) allocation which is expected to be reimbursed by NHSEI, this is an estimate and has not yet been validated. An ERF allocation relating to Independent Sector expenditure of £0.043m was received in month relating to H2.

Primary Care Co-Commissioning has a £5.670m forecast overspend. This includes expenditure of £5.759m relating to Additional Roles Reimbursement Scheme (ARRS) costs above the baseline funding received in H1, this amount is expected to be funded.

The CCG has released £1.631m of the H1 £4.244m contingency into the month 8 position.

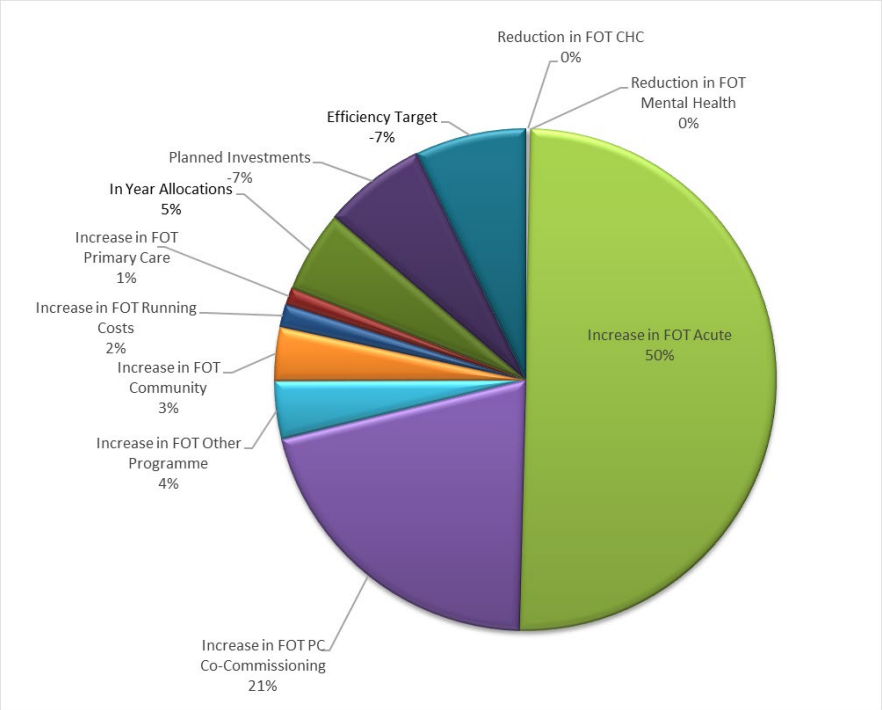
Run Rate based on Year to Date Expenditure



£0.648m variation between the position to date continuing at its current rate and the forecast outturn for the full financial year.

- **PC Co-Commissioning** – Costs relating to ARRS and allocations received expected to be spent later in the year.
- **Mental Health Services** –MHIS Investments growth due to increased allocations in H2. Other increases include complex care costs in CAMHS and Learning Disabilities, growth in High Cost Patients and Section 117, and increased activity for Improving Access to Psychology Therapies.
- **Continuing Health Care** –Additional PHB costs expected later in the year and an estimation for discharge to access costs for patients discharged at the end of March.
- **Running Costs** – Vacancies expected to be filled reducing underspends on pay costs.
- **Community Health Services** – Reduction in costs with transfer of ophthalmology providers to acute services offset by increased H2 payments to NHS providers including impact of pay award.
- **Acute Services** – ERF allocations received in H1 and paid to NHS providers off set by an increase for NHS payments relating to inflation and pay award, service development funding and non-recurrent support.
- **Primary Care Services** – Expenditure against allocations received for H1 only, a reduction in Enhance Services due to a change in schemes and prescribing costs based on historic trends.
- **Other Programme Services** – 3% efficiency target savings expected to be achieved in H2.
- **Full Year Contingency –** Balance of H1 contingency funding to be utilised in H2.
- **ICS Running Costs and ICS Set up Costs –** One off expected expenditure mainly in H2.
- **Uncommitted Allocations –** Allocations received still awaiting distribution to areas.

Main Changes in Forecast Outturn – Month 7 to Month 8



		£m	£m
Month 7 Annual Forecast Outturn excluding Contingency			2,067.12
Reduction in FOT	CHC	(0.10)	
	Mental Health	(0.03)	
Increase in FOT	Acute	18.89	
	PC Co-Commissioning	7.84	
	Other Programme	1.42	
	Community	1.29	
	Running Costs	0.55	
	Primary Care	0.43	
In Year Allocations		1.98	
Planned Investments		(2.50)	
Efficiency Target		(2.70)	
Total Movement			27.08
Month 8 Annual Forecast Outturn			2,094.20

- **Acute** – Increase in NHS payments for non-recurrent system support and additional costs relating to service development funding.
- **PC Co-Commissioning** – Predominantly the ARRS forecast increase due to changed guidance requesting expected costs above allocations to be estimated. Non-recurrent allocations received for winter access fund and increased costs for enhanced services and premises.
- **Other Programme** – NHS 111 service development funding received in H2.
- **Community** – Covid costs for Hospital Discharge Programme relating to additional beds in H2 together with an expected increase in orthotics activity and a hospice support payment.
- **Running Costs** – Committed running cost allocations in H2.
- **Primary Care** – Prescribing costs due to higher volumes than planned.
- **In Year Allocations –** Non-recurrent allocations received in H2 awaiting distribution to areas.
- **Planned Investments** – Investment funding which have been used to support the system financial position.
- **Efficiency Target** –Efficiency savings expected to be made by end of financial year.

Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

13th January 2022

Item No: 223

Report Title	Audit Committee Assurance Report – December 2021
Author(s)	Frances Palmer, Corporate Governance Manager
Sponsor (Director)	Ian Gibbard, Audit Lay Member and Audit Committee Chair

Paper for:	**Decision**		**Assurance**	x	**Discussion**		**Information**	
Assurance Report Signed off by Chair				Ian Gibbard, Audit Committee Chair				
Which committee has the subject matter been through?				Audit Committee – 17.12.2021				

Recommendations

The Governing Body is requested to **NOTE** the contents of this report for information and assurance.

Report Summary

This report provides the Governing Body with highlights from the Extraordinary 17th December 2021 meeting of the Audit Committee. This report provides a brief summary of the items transacted for assurance.

CCG Closedown – draft Due Diligence Checklist

The Audit Committee NOTED the contents of the Due Diligence Checklist, which had been reviewed by all relevant functions within the CCG. Audit Committee were ASSURED of the checklist and APPROVED its submission on 31st December 2021. The Committee will review the Due Diligence Checklist again in February 2022.

Financial Transition Project

The Audit Committee:

- were ASSURED on and NOTED the actions taken to date, and the size and scope of the proposed project to ensure the smooth transition of financial systems and banking arrangements;
- were ASSURED on and NOTED the proposed approach to ensuring the ICB's financial systems and banking arrangements are in place and tested by 31st March 2022; and
- CONFIRMED that updates will be presented at the January 2022 and February 2022 Audit Committee meetings to ensure the committee is satisfied with progress.

Has a Privacy Impact Assessment (PIA) been completed? What were the findings?

A PIA is not found applicable to this update. This report is for assurance and information.

Has a Quality Impact Assessment (QIA) been completed? What were the findings?
A QIA is not found applicable to this update. This report is for assurance and information.
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
An EIA is not found applicable to this update. This report is for assurance and information.
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
Not applicable to this update. This report is for assurance and information.
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Not applicable to this update. This report is for assurance and information.
Have any Conflicts of Interest been identified/ actions taken?
None identified.
Governing Body Assurance Framework
Any risks highlighted and assigned to the Audit Committee will be linked to the Derby and Derbyshire CCG GBAF and risk register
Identification of Key Risks
Noted as above.

Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

13th January 2022

Item No: 224

Report Title	Clinical and Lay Commissioning Committee Assurance Report
Author(s)	Zara Jones, Executive Director of Commissioning Operations
Sponsor (Director)	Zara Jones, Executive Director of Commissioning Operations

Paper for:	**Decision**	x	**Assurance**	x	**Discussion**		**Information**	
Assurance Report Signed off by Chair					Dr Ruth Cooper, Chair of the CLCC			
Which committee has the subject matter been through?					CLCC – 9.11.2021			

Recommendations

The Governing Body is requested to **RATIFY** the decisions made by the Clinical and Lay Commissioning Committee (CLCC) on the 9th December 2021.

Report Summary

CLC/2122/152 Clinical Policies to be ratified

CLCC RATIFIED the following updated policies:

1.a Dilatation and Curettage (D & C) for Heavy Menstrual Bleeding in women Policy
1.b Dupuytren's Contracture Policy
1.c Ganglion Cysts Policy

Areas for Service Development:

CLCC NOTED that the Clinical Policy Advisory Group (CPAG) have reviewed Individual Funding Request (IFR) cases submitted and Interventional Procedures Guidance (IPGs), Medtech Innovation Briefings (MIBs), Medical Technology Guidance (MTGs) and Diagnostic Technologies (DTs) for October 2021.

CLCC were assured that no areas for service developments were identified.

CLCC NOTED the following:

IFR Decision making process for Glossop residents from 1st April 2022

- To inform CLCC of the IFR Decision Making process for Glossop residents from 1st April 2022.

CLCC NOTED the CPAG Minutes and Bulletin for October 2021.

CLC/2122/154 GBAF Risk 3

CLCC were asked to:

- **DISCUSS** and **REVIEW** the Quarter 3 (October to December) Governing Body Assurance Framework Strategic Risk 3 owned by CLCC
- **REVIEW** and **UPDATE** any further mitigating actions and assurances
- **REVIEW** and **UPDATE** the current risk score.

CLCC reviewed and NOTED GBAF Risk 3. There were no amendments.

CLC/2122/156 BCF Guidance 21/22

CLCC were asked to note that BCF Plans have been submitted for Derby and Derbyshire for 2021/22 and are undergoing NHSE/I assurance.

CLCC NOTED the BCF Plans.

Are there any Resource Implications (including Financial, Staffing etc)?
N/A
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?
N/A
Has a Quality Impact Assessment (QIA) been completed? What were the findings?
N/A
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
N/A
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
N/A
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
N/A

Have any Conflicts of Interest been identified/ actions taken?
N/A
Governing Body Assurance Framework
N/A
Identification of Key Risks
N/A

NHS
Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

13th January 2022

Item No: 226

Report Title	Quality and Performance Assurance Report – December 2021
Author(s)	Jackie Carlile, Head of Performance and Assurance Helen Hipkiss, Director of Quality
Sponsor (Director)	Zara Jones, Executive Director for Commissioning Operations Brigid Stacey, Chief Nurse.

Paper for:	**Decision**		**Assurance**	x	**Discussion**		**Information**	
Assurance Report Signed off by Chair					Dr Buk Dhadda, Chair of Quality and Performance Committee			
Which committee has the subject matter been through?					Quality and Performance Committee – 23.12.2021			

Recommendations

The Governing Body is requested to **NOTE** the paper for assurance purposes.

Report Summary

Performance:

Urgent and Emergency Care:

- The A&E standard was not met at a Derbyshire level at 73.0% (YTD 78.5%). CRH did not achieve the standard achieving 85.7% (YTD 91.9%). UHDB achieved 64.6% during November (YTD 70.5%).
- UHDB had 106 x 12-hour trolley breaches during November – 102 were due the availability of medical beds and 4 were due to the unavailability of a suitable mental health bed.
- EMAS were non-compliant for all 6 of their standards for Derbyshire during November 2021, reflecting the continuing significant pressures being experienced by the trust.

Planned Care:

- 18 Week Referral to Treatment (RTT) for incomplete pathways continues to be non-compliant at a CCG level at 66.3% (YTD 66.3%). An improvement on last month's figure of 61.9%
- CRHFT performance was 67.3% (YTD 67.3%) and UHDB 61.9% (YTD 61.6%).
- Derbyshire had 5,705 breaches of the 52-week standard across all trusts – the same figure as last month.
- Diagnostics – The CCG performance was 36.19%, a similar figure to last month. Neither CRH (22.33%) or UHDB (40.93%) have achieved the standard.

Cancer:

During October 2021, Derbyshire was compliant in 2 of the 9 Cancer standards:

- **31-day Subsequent Radiotherapy – 97.8%** (94% standard) – Compliant at all trusts except UHDB.

- **31-day Subsequent Drugs – 98.9%** (98% standard) – Compliant for all Trusts except UHDB.

During October 2021, Derbyshire was non-compliant in 7 of the 9 Cancer standards:

- **2-week Urgent GP Referral – 79.7%** (93% standard) – Compliant for Stockport.
- **2 week Exhibited Breast Symptoms – 47.5%** (93% standard) – Compliant at NUH and Sherwood Forest.
- **28-day Faster Diagnosis – 73.40%** (75% standard) – Compliant for Chesterfield, NUH and Sherwood Forest
- **31 day from Diagnosis – 91.9%** (96% standard) – Compliant for East Cheshire and Stockport.
- **62-day Urgent GP Referral – 60.3%** (85% standard) – Noncompliant for all trusts.
- **62-day Screening Referral – 53.1%** (90% standard) – Noncompliant for all trusts.
- **104 day wait –** Data unavailable at a CCG level.

Quality

Chesterfield Royal Hospital FT
The Maternity service remains pressurised; NHSEI have been invited to review services, including LMNS representatives. In relation to Stroke, the Trust's SSNAP audit score has improved from a C to a B, however an increase in mortality has been noted and a deep dive is being undertaken; this is to be monitored via CQRG. An increase in mortality in relation to hip fracture has been highlighted via the hip fracture database. A number of actions around hip fractures are in place and work is on-going. A structured judgement review of patients is going through a mortality review; monitoring is via CQRG. An unannounced ED visit was undertaken and was positive and reassuring; no concerns were noted.

University Hospitals of Derby and Burton FT
ED pressures are ongoing, the Trust are working with EMAS and WMAS to implement the role of the Hospital Ambulance Liaison Officer and are exploring funding options. The Maternity service remains pressurised, with the Home Birth Service suspended. Improvements with regards to Stroke pathways have been noted in improving the SSNAP audit rating to C from D.

Derbyshire Community Health Services FT
A weekly flu planning group is it place which is implementing the 16-week organisational plan to ensure, as a minimum, the 85% flu vaccination target is achieved. Current Flu Vaccination figures for the 22.11.2021 was 43%. The Trust's sickness absence rate has shown a month on month increase since June and is currently 6.35%. The impact of Covid is still evident with 0.74% of this month's absence being attributed to Covid sickness. A task and finish group focusing on Stress Related Absence has commenced. The CCG Head of Inspection/Hospitals (Mental Health and Community Health Services) visited services in the Trust on the 18th October; feedback following the visit has been positive.

Derbyshire Healthcare Foundation Trust
There are ongoing work streams to support the continuing need to reduce restrictive practice, including the introduction of body worn cameras and monitoring of restrictive practice within the "reducing restrictive practice forum". Data analysis and review has shown that even where restraint and seclusion has increased, the use of prone restraint has continued to reduce. In relation to in-patient falls April to July 2021 remain below the mean and demonstrated the ongoing falls reduction work being developed and implemented within Older adult services. However, August and September saw an increase

in falls. A further review is ongoing to understand this pattern and will be monitored through CQRG.

East Midlands Ambulance Trust
There continues to be challenges with demand with EMAS being in Clinical Safety Plan 4 (CSP4) Clinical Safety Plan 4 Avoidance (CSP4A) for a significant amount of time. Seven out of the nine serious incidents reported between September 2021 and October 2021 were categorised as delays in care/response. Delays in response was now the most prevalent type of serious incident reported by EMAS. Harm reviews were conducted between October and November to provide further assurance regarding if patients were coming to harm due to delays in care. The Harm reviews did not identify any harm because of delays in care. The Delayed Hospital Handovers impact assessment of patient harm was also published on the 15th November 2021. The CQRG will review the findings of the report and the increase in serious incidents at its extraordinary meeting in December 2021.

Quality and Performance Committee 23rd December 2021

The Integrated Report was noted and approved by the Committee.

The Committee received a presentation on cancer waits which showed an increase in referrals by both Trusts, particularly at UHDBFT who saw an increase of 18%. The delays currently being experienced are at the front end of the pathway however the Committee were assured that once the patient is diagnosed the performance from diagnosis to treatment is good. The number of patients on the 62-day backlog is increasing and the Trust are required to reduce this figure by March 2022. As a system we are seen as an outlier in the recovery of our cancer backlog, but it is accepted that this is due to an unusually high increase in cancer referrals. Other systems are seeing 100-115% of prior levels whereas we are seeing 130%. The Committee were assured of the actions being taken by the providers however asked the Risk Stratification Group to provide assurance that patients were being seen in clinical priority. A further update will be provided to the February Quality and Performance Committee.

The Committee received an update on the Derby Breast Pain clinics and were assured of progress.

Workforce - A general theme throughout the meeting was the challenge of insufficient workforce to deliver many of the operational challenges to the system. It was agreed to ask Linda Garnett, Workforce lead for JUCD, to attend the next Quality and Performance Committee meeting to undertake a deep dive into workforce challenges.

Written Statement Of Action (WSOA) - The Committee received the outcome of the reinspection of SEND in Derby City. The previous inspection two years ago showed significant areas of concern and resulted in the requirement to provide a WSOA to address those areas. The reinspection in October 2021 resulted in the inspectors stating that the system had made sufficient progress in all the key areas of the WSOA. This is the highest level of attainment that could be achieved. However, there are still areas of work that need to be addressed for example ND pathway waits improvements still not being seen on the ground. Psychologists and nurses who have the right training is a challenge. The Mental Health Delivery Board has approved the slippage investment of £1.7m to manage the waiting list. The Committee praised the work of both the Childrens team and the Nursing and Quality team on the amount of work undertaken to achieve this result.

The Committee received and update on the progress of the System Quality Architecture and noted examples of system working for the benefit of patients e.g., Complex Children in ED. Clive Treacy Review - The Committee received the report and noted the extensive number of recommendations, particularly for commissioners. They were assured regarding the quality oversight of Independent Hospitals undertaken by the Derbyshire team.
Are there any Resource Implications (including Financial, Staffing etc)?
No
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?
N/A
Has a Quality Impact Assessment (QIA) been completed? What were the findings?
N/A
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
N/A
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
N/A
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
N/A
Have any Conflicts of Interest been identified/ actions taken?
None
Governing Body Assurance Framework
The report covers all of the CCG objectives
Identification of Key Risks
The report covers GBAFs 1, 2 and 6

NHS
Derby and Derbyshire
Clinical Commissioning Group

Month 07
Quality & Performance Report
2021/22

December 2021

Contents Page

EXECUTIVE SUMMARY

Key Messages	• The tables on slides 5-8 show the latest validated CCG data against the constitutional targets. A more detailed overview of performance against the specific targets and the associated actions to manage performance is included in the body of this report.
Urgent & Emergency Care	• The A&E standard was not met at a Derbyshire level at 73.0% (YTD 78.5%). CRH did not achieve the standard achieving 85.7% (YTD 91.9%). UHDB achieved 64.6% during November (YTD 70.5%). • UHDB had 106 x 12 hour trolley breaches during November – 102 were due the availability of medical beds and 4 were due to the unavailability of a suitable mental health bed. • EMAS were non-compliant for all 6 of their standards for Derbyshire during November 2021, reflecting the continuing significant pressures being experienced by the trust.
Planned Care	• 18 Week Referral to Treatment (RTT) for incomplete pathways continues to be non-compliant at a CCG level at 66.3% (YTD 66.3%). An improvement on last months figure of 61.9% • CRHFT performance was 67.3% (YTD 67.3%) and UHDB 61.9% (YTD 61.6%). • Derbyshire had 5,705 breaches of the 52 week standard across all trusts – the same figure as last month. • Diagnostics – The CCG performance was 36.19%, a similar figure to last month. Neither CRH (22.33%) or UHDB (40.93%) have achieved the standard.
Cancer	During October 2021, Derbyshire was compliant in 2 of the 9 Cancer standards: • **31 day Subsequent Radiotherapy – 97.8%** (94% standard) – Compliant at all trusts except UHDB. • **31 day Subsequent Drugs – 98.9%** (98% standard) – Compliant for all Trusts except UHDB. During October 2021, Derbyshire was non-compliant in 7 of the 9 Cancer standards: • **2 week Urgent GP Referral – 79.7%** (93% standard) – Compliant for Stockport. • **2 week Exhibited Breast Symptoms – 47.5%** (93% standard) – Compliant at NUH and Sherwood Forest. • **28 day Faster Diagnosis – 73.40%** (75% standard) – Compliant for Chesterfield, NUH and Sherwood Forest • **31 day from Diagnosis – 91.9%** (96% standard) – Compliant for East Cheshire and Stockport. • **62 day Urgent GP Referral – 60.3%**(85% standard) – Non compliant for all trusts. • **62 day Screening Referral – 53.1%** (90% standard) – Non compliant for all trusts. • **104 day wait –** Data unavailable at a CCG level.

Executive Summary

Trust	
Chesterfield Royal Hospital FT	Maternity service remain pressurised; NHSEI have been invited to review services, including LMNS representatives. In relation to Stroke, the Trust's SSNAP audit score has improved from a C to a B, however an increase in mortality has been noted and a deep dive being undertaken, this is to be monitored via CQRG. An increase in mortality in relation to hip fracture has being highlighted via the hip fracture database. A number of actions around hip fractures are in place and work is on-going. A structured judgement review of patients is going through mortality review. Monitoring is via CQRG. An unannounced ED visit wan undertaken and was positive and reassuring. No concerns were noted.
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Derbyshire Community Health Services FT	A weekly flu planning group is it place which is implementing the 16 week organisational plan to ensure as a minimum the 85% flu vaccination target is achieved. Current Flu Vaccination figures for the 22/11/21 was 43%. The Trust's sickness absence rate has shown a month on month increase since June and is currently 6.35%. The impact of Covid is still evident with 0.74% of this month's absence being attributed to Covid sickness. A task and finish group focusing on Stress Related Absence has commenced. The CCG Head of Inspection/Hospitals (Mental Health and Community Health Services), visited services in the Trust on the 18th October. Feedback following the visit has been positive.
Derbyshire Healthcare Foundation Trust	There are ongoing work streams to support the continuing need to reduce restrictive practice; including the introduction of body worn cameras and monitoring of restrictive practice within the "reducing restrictive practice forum". Data analysis and review has shown that even where restraint and seclusion has increased, the use of prone restraint has continued to reduce. In relation to in-patient falls April to July 2021 remain below the mean and demonstrated the ongoing falls reduction work being developed and implemented within Older adult services. However, August and September saw an increase in falls. A further review is ongoing to understand this pattern and will be monitored through CQRG.
East Midlands Ambulance Trust	There continues to be challenges with demand with EMAS being in Clinical Safety Plan 4 (CSP4) Clinical Safety Plan 4 Avoidance (CSP4A) for a significant amount of time. Seven out of the nine serious incidents reported between September 2021 and October 2021 were categorised as delays in care/response. Delays in response was now the most prevalent type of serious incident reported by EMAS. Harm reviews were conducted between October and November to provide further assurance regarding if patients were coming to harm due to delays in care. The Harm reviews did not identify any harm as a result of delays in care. The Delayed Hospital Handovers impact assessment of patient harm was also published on the 15th of November 2021. The CQRG will review the findings of the report and the increase in serious incidents at its extraordinary meeting in December 2021.

PERFORMANCE OVERVIEW MONTH 8 – URGENT CARE

NHS Derby & Derbyshire CCG Assurance Dashboard

Key:	
	Performance Meeting Target
	Performance Not Meeting Target
	Indicator not applicable to organisation

Performance Improved From Previous Period	↑
Performance Maintained From Previous Period	→
Performance Deteriorated From Previous Period	↓

Part A - National and Local Requirements

CCG Dashboard for NHS Constitution Indicators

					Direction of Travel	NHS Derby & Derbyshire CCG			Chesterfield Royal Hospital FT			University Hospitals of Derby & Burton FT			NHS England		
	Area	Indicator Name	Standard	Latest Period		Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance
Urgent Care	Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	Nov-21	↑	73.0%	78.5%	74	85.7%	91.9%	3	64.6%	70.5%	74	76.3%	80.3%	74
		A&E 12 Hour Trolley Waits	0	Nov-21					0	14	0	106	253	16	10646	30245	74

NHS Derby & Derbyshire CCG Assurance Dashboard

Key:	
	Performance Meeting Target
	Performance Not Meeting Target
	Indicator not applicable to organisation

↑	Performance Improved From Previous Period
→	Performance Maintained From Previous Period
↓	Performance Deteriorated From Previous Period

EMAS Dashboard for Ambulance Performance Indicators

					Direction of Travel	East Midlands Ambulance Service Performance (NHSD&DCCG only - National Performance Measure)			EMAS Performance (Whole Organisation)			EMAS Completed Quarterly Performance 2021/22				NHS England		
	Area	Indicator Name	Standard	Latest Period		Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22	Current Month	YTD	consecutive months non-compliance
Urgent Care	Ambulance System Indicators	Ambulance - Category 1 - Average Response Time	00:07:00	Nov-21	↑	00:09:12	00:08:37	17	00:09:19	00:08:43	16	00:07:54	00:09:05			00:09:10	00:08:21	7
		Ambulance - Category 1 - 90th Percentile Respose Time	00:15:00	Nov-21	→	00:15:43	00:14:50	3	00:16:23	00:15:35	5	00:14:06	00:16:29			00:16:04	00:14:48	5
		Ambulance - Category 2 - Average Response Time	00:18:00	Nov-21	→	00:42:05	00:38:11	16	00:55:03	00:45:22	17	00:33:40	00:49:29			00:46:37	00:37:40	16
		Ambulance - Category 2 - 90th Percentile Respose Time	00:40:00	Nov-21	→	01:28:20	01:18:41	16	01:59:24	01:36:22	16	01:10:09	01:46:26			01:40:57	01:20:09	8
		Ambulance - Category 3 - 90th Percentile Respose Time	02:00:00	Nov-21	→	06:51:32	05:49:37	16	07:59:54	06:41:31	16	04:30:11	07:17:52			06:23:03	05:19:34	8
		Ambulance - Category 4 - 90th Percentile Respose Time	03:00:00	Nov-21	↓	07:21:54	05:25:24	8	07:15:18	06:01:39	8	04:43:53	06:45:03			07:32:38	06:18:20	0

PERFORMANCE OVERVIEW MONTH 7 – PLANNED CARE

NHS Derby & Derbyshire CCG Assurance Dashboard

Key:	
	Performance Meeting Target
	Performance Not Meeting Target
	Indicator not applicable to organisation

Performance Improved From Previous Period	↑
Performance Maintained From Previous Period	→
Performance Deteriorated From Previous Period	↓

Part A - National and Local Requirements

CCG Dashboard for NHS Constitution Indicators

						Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance
Planned Care	Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Oct-21	↓		66.3%	66.3%	45	67.3%	68.7%	30	61.9%	61.6%	46	65.6%	67.0%	68
		Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Oct-21	↓		5705	43558	21	1133	8030	19	5659	47328	20	312665	2225497	174
	Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Oct-21	↑		36.19%	30.79%	41	22.33%	15.54%	19	40.93%	34.97%	20	24.98%	24.36%	98
	2 Week Cancer Waits	All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	Oct-21	↓		79.7%	85.5%	14	Cancer 2 Week Wait Pilot Site - not currently reporting			70.4%	79.6%	14	81.3%	84.8%	17
		Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	Oct-21	↓		47.5%	65.3%	2				43.2%	65.2%	1	67.6%	71.5%	17
	28 Day Faster Diagnosis	Diagnosis or Decision to Treat within 28 days of Urgent GP, Breast Symptom or Screening Referral	75%	Oct-21	↓		73.4%	74.9%	2	77.5%	77.0%	0	69.8%	73.5%	3	73.5%	73.1%	7
	31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	96%	Oct-21	↑		91.9%	92.5%	10	95.4%	94.9%	2	91.1%	92.4%	15	93.5%	94.1%	10
		Subsequent Surgery Within 31 Days Of Decision To Treat	94%	Oct-21	↑		81.1%	80.7%	23	100.0%	96.6%	0	83.3%	84.3%	5	85.7%	85.9%	39
		Subsequent Drug Treatment Within 31 Days Of Decision To Treat	98%	Oct-21	↓		98.9%	99.1%	0	100.0%	100.0%	0	97.6%	98.9%	1	99.1%	99.1%	0
		Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	Oct-21	↑		97.0%	95.5%	0				93.5%	92.5%	1	95.5%	96.3%	0
	62 Days Cancer Waits	First Treatment Administered Within 62 Days Of Urgent GP Referral	85%	Oct-21	↓		60.3%	66.3%	32	81.5%	73.1%	27	48.9%	63.2%	42	67.8%	71.4%	70
		First Treatment Administered - 104+ Day Waits	0	Oct-21	↔		N/A	110	67	9	35	42	32	159	67	1184	6775	70
		First Treatment Administered Within 62 Days Of Screening Referral	90%	Oct-21	↑		53.1%	68.3%	30	31.8%	54.7%	30	83.3%	81.1%	11	73.2%	73.8%	43
		First Treatment Administered Within 62 Days Of Consultant Upgrade	N/A	Oct-21	↓		66.7%	80.1%		87.5%	88.9%		78.4%	89.1%		76.2%	80.8%	

PERFORMANCE OVERVIEW MONTH 7 – PATIENT SAFETY

NHS Derby & Derbyshire CCG Assurance Dashboard

Key:	
	Performance Meeting Target
	Performance Not Meeting Target
	Indicator not applicable to organisation

Performance Improved From Previous Period	↑
Performance Maintained From Previous Period	→
Performance Deteriorated From Previous Period	↓

Part A - National and Local Requirements

CCG Dashboard for NHS Constitution Indicators

					Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance
Patient Safety	Incidence of healthcare associated Infection	Healthcare Acquired Infection (HCAI) Measure: MRSA Infections	0	Oct-21	↔	0	0	0	0	0	0	0	1	0	40	358	31
		Healthcare Acquired Infection (HCAI) Measure: C-Diff Infections	Plan	Oct-21	↓		140			21			70				
			Actual				153	2		9	0		39	0		8691	
		Healthcare Acquired Infection (HCAI) Measure: E-Coli	-	Oct-21	↓	74	521		22	156		48	361		74	521	
		Healthcare Acquired Infection (HCAI) Measure: MSSA	-	Oct-21	↑	17	151		8	47		6	101		1008	7023	

PERFORMANCE OVERVIEW MONTH 7 – MENTAL HEALTH

CCG Dashboard for NHS Constitution Indicators

Mental Health

Area	Indicator Name	Standard	Latest Period	Direction of Travel	NHS Derby & Derbyshire CCG Current Month	NHS Derby & Derbyshire CCG YTD	NHS Derby & Derbyshire CCG consecutive months of failure	Derbyshire Healthcare FT Current Month	Derbyshire Healthcare FT YTD	Derbyshire Healthcare FT consecutive months of failure				NHS England Current Month	NHS England YTD	NHS England consecutive months of failure			
Early Intervention In Psychosis	Early Intervention In Psychosis - Admitted Patients Seen Within 2 Weeks Of Referral	60.0%	Sep-21	↑	47.8%	52.9%	3	45.8%	51.7%	3				69.4%	67.6%	0			
	Early Intervention In Psychosis - Patients on an Incomplete Pathway waiting less than 2 Weeks from Referral	60.0%	Sep-21	↑	50.0%	50.0%	3	33.3%	56.3%	3				35.8%	29.3%	29			
Mental Health	Dementia Diagnosis Rate	67.0%	Oct-21	↓	64.3%	64.9%	16							61.9%	62.8%	19			
	CYPMH - Eating Disorder Waiting Time % urgent cases seen within 1 week		2021/22 Q2	↓	87.6%	74.6%													
	CYPMH - Eating Disorder Waiting Time % routine cases seen within 4 weeks		2021/22 Q2	↓	82.1%	83.9%													
	Perinatal - Increase access to community specialist perinatal MH services in secondary care	4.5%	2021/22 Q1	↑	3.1%	3.9%	6												
	Mental Health - Out Of Area Placements		Sep-21	↑	475	3420													
	Physical Health Checks for Patients with Severe Mental Illness	25%	2021/22 Q2	↑	23.9%	29.6%	6												
Area	**Indicator Name**	**Standard**	**Latest Period**		**NHS Derby & Derbyshire CCG**			**Talking Mental Health Derbyshire (D&DCCG only)**			**Trent PTS (D&DCCG only)**			**Insight Healthcare (D&DCCG only)**			**Vita Health (D&DCCG only)**		
Improving Access to Psychological Therapies	IAPT - Number Entering Treatment As Proportion Of Estimated Need In The Population	Plan	Oct-21	↓	2.10%	14.70%													
		Actual			2.38%	18.48%	0												
	IAPT - Proportion Completing Treatment That Are Moving To Recovery	50%	Oct-21	↓	50.2%	52.9%	0	53.5%	54.1%	0	48.6%	52.7%	2	47.8%	47.9%	1	54.3%	56.9%	0
	IAPT Waiting Times - The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment	75%	Oct-21	↑	90.2%	94.2%	0	86.4%	89.4%	0	89.8%	95.4%	0	99.4%	98.1%	0	98.1%	98.0%	0
	IAPT Waiting Times - The proportion of people that wait 18 Weeks or less from referral to entering a course of IAPT treatment	95%	Oct-21	↔	100.0%	100.0%	0	100.0%	100.0%	0	100.0%	100.0%	0	100.0%	100.0%	0	100.0%	100.0%	0
Area	**Indicator Name**	**Standard**	**Latest Period**		**Derbyshire Healthcare FT**														
Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Oct-21	↓	67.9%	82.3%	5												
	Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Oct-21	↑	1	1	1												

Quality Overview

QUALITY OVERVIEW M09

Trust	Key Issues
Chesterfield Royal Hospital FT	**Pressures** • **Maternity Services**: Pressure continues, with increase in births and acuity. A review of Maternity Services has been requested by the Trust to be carried out by NHSEI and the LMNS, this is taking place on the 17th and 18th January 2022.Oversight continues via the LMNS. • **Stroke:** Due to the increase in mortality for Stroke, a deep dive has been done into the pathways and early identification, this is to be monitored via CQRG. SNNAP report shows CRH now improved to B status • **Staff:** Staff are tired, and absences are still being seen due to covid. CRH are still engaging with Ashgate Hospice for support and confidential and group sessions are still on-going for staff. • **Mortality:** An increase in mortality in relation to hip fracture has being highlighted via the hip fracture database. A number of actions around hip fractures are in place and work is on-going. A structured judgement review of patients is going through mortality review. Monitoring is via CQRG • **Unannounced ED Visit:** An unannounced ED visit was carried out by the CCG and was positive and with no concerns reported. It was highlighted that there has been an increase in middle grades and consultants in ED. • **Patient Safety** • A lot of learning has been taken from PSIRP, but there is a backlog and this is being discussed internally. The Trust have proposed that PSIRP is suspended with use of SWARM methodology to ensure action is taken in relation to incidents. This is to be reviewed monthly as to when it would be re-implemented.
University Hospitals of Derby and Burton NHS FT	**Pressures** ▪ **Emergency Department:** Bed availability and discharges into social care continue to have significant impact on the flow through ED. UHDB are working with EMAS and West Midlands to implement the HALO Process and are funding this themselves. • **Maternity Services:** Workforce pressure continues. At present there are 25 WTE vacancies. They are involved in robust recruitment drive and is lead on the collaboration for the International Recruitment Plan. Home Birth Service is still suspended and will be reviewed mid-January. An increase in induced births has seen a number of women diverted to other hospitals. A review of vaccinated staffs shows that 16 out of 423 workforce are not vaccinated. Clarification with regard to staffs that are exempt will be undertaken. Oversight continues via the LMNS. • **Stroke Services:** Improvements with regards to Stroke pathways have been noted in improving the SSNAP audit rating to C from D. There are staffing constraints amongst almost every department: Stroke Consultants, Clinical Nurse Specialists, Occupational Therapists and Speech and Language Therapists • **Patient Safety:** UHDB has just had the 1 year anniversary of the implantation of PSIRF. Overall, they have had positive feedback from staffs with regards to process, although the templates are a challenge to complete. This was feedback to NHSE/I and so they are awaiting a new template. A review of Never Events is being undertaken and the PSR for Maternity is still under review for learning opportunities. A mapping exercise into Duty of Candour pathways is being carried to understand the challenges that are faced. All Duty of Candour actions are raised at the Quality Review Group. A Band 7 is starting in January to support the PSIRF with regards to governance and training. Human Factors and HSIB training is being implemented in the New Year to support staffs within the PSIRF. • **CQC:** The 3rd TMA has just been completed and so far, they have reviewed C&YP Services, Maternity Services and if organisation is Well Led. TMA for Imaging is planned for Dec/Jan and Outpatients is planned for Feb/March.

QUALITY OVERVIEW M6 continued

Trust	Key Issues
Derbyshire Community Health Services FT	**Flu Vaccination:** A weekly flu planning group is it place which is implementing the 16 week organisational plan to ensure as a minimum the 85% flu vaccination target is achieved. Current Flu Vaccination figures for the 22/11/21 was 43%. **Sickness:** The Trust's sickness absence rate has shown a month on month increase since June and is currently 6.35%. This is 1.76% higher than the average sickness rate for September over the last 9 years (4.59%). September 2020 absence was 4.54% and 4.74% in 2019. The impact of Covid is still evident with 0.74% of this month's absence being attributed to Covid sickness. A five pronged approach to supporting staff at work remains a priority. In addition a task and finish group focusing on Stress Related Absence has commenced. The midlands region are collaborating across 11 Integrated Care Systems to scope and test out Trust's Health and Wellbeing offers. **CQC**: CQC leads attended private and public Board on the 7th October 2021. This is the first time the new inspectors have attended Board. The Head of Inspection/Hospitals (Mental Health and Community Health Services), visited services in the Trust on the 18th October. Feedback following the visit has been positive.
Derbyshire Healthcare Foundation Trust	**Covid Vaccination:** 93% of people working for the Trust have received their first vaccination and 90% have now received both vaccinations. Booster vaccinations have commenced. **Prone restraint:** There are ongoing work streams to support the continuing need to reduce restrictive practice; including the introduction of body worn cameras and monitoring of restrictive practice within the "reducing restrictive practice forum". Data analysis and review has shown that even where restraint and seclusion has increased, the use of prone restraint has continued to reduce. **Falls on inpatient wards:** April to July 2021 remained below the mean line and demonstrated the ongoing falls reduction work being developed and implemented within Older adult services. However, August and September saw an increase in falls. A further review is ongoing to understand this pattern and will be monitored through CQRG.
East Midlands Ambulance Trust	**Serious Incidents:** There continues to be challenges with demand with EMAS being in Clinical Safety Plan 4 (CSP4) Clinical Safety Plan 4 Avoidance (CSP4A) for a significant amount of time. Seven out of the nine serious incidents reported between September 2021 and October 2021 were categorised as delays in care/response. Delays in response was now the most prevalent type of serious incident reported by EMAS. Harm reviews were conducted between October and November to provide further assurance regarding if patients were coming to harm due to delays in care. The Harm reviews did not identify any harm as a result of delays in care. The Delayed Hospital Handovers impact assessment of patient harm was also published on the 15th of November 2021. The CQRG will review the findings of the report and the increase in serious incidents at its extraordinary meeting in December 2021.

QUALITY OVERVIEW M7

Derbyshire Wide Integrated Report

Part B: Provider Local Quality Indicators

Dashboard Key:	CCG assured by the evidence	Performance Improved From Previous Period	↑
	CCG not assured by the evidence	Performance Maintained From Previous Period	↔
		Performance Deteriorated From Previous Period	↓

Part B: Acute & Non-Acute Provider Dashboard for Local Quality Indicators

Section	Area	Indicator Name	Standard	Chesterfield Royal Hospital FT				University Hospitals of Derby & Burton FT				Derbyshire Community Health Services				Derbyshire Healthcare FT			
				Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD
Ratings	CQC Ratings	Inspection Date	N/A	Aug-19				Mar-19				May-19				May-18			
		Outcome	N/A	Good				Good				Outstanding				Requires Improvement			
Adult	FFT	Staff 'Response' rates	15%	2019/20 Q2	↑	7.6%	8.6%	2019/20 Q2	↑	10.1%	10.1%	Sep-21	↓	86.5%	89.9%	2019/20 Q2	↑	3.2%	18.1%
		Staff results - % of staff who would recommend the organisation to friends and family as a place to work		2019/20 Q2	↑	56.0%	64.1%	2019/20 Q2	↑	70.2%	70.2%	Sep-21	↑	72.0%	72.0%	2019/20 Q2	↑	57.3%	66.7%
		Inpatient results - % of patients who would recommend the organisation to friends and family as a place to receive care	90%	Sep-21	↓	93.6%	97.7%	Sep-21	↓	91.9%	96.4%	Jul-20	↔	100.0%	98.6%				
		A&E results - % of patients who would recommend the organisation to friends and family as a place to receive care	90%	Sep-21	↓	79.7%	77.8%	Sep-21	↑	81.9%	80.3%	Jul-20	↓	N/A	99.3%				
	Complaints	Number of formal complaints received	N/A	Sep-21	↓	17	94	Oct-21	↓	31	177	Oct-21	↓	5	39	Oct-21	↑	19	118
		% of formal complaints responded to within agreed timescale	N/A	Sep-21	↑	76.0%	68.0%	Oct-21	↑		64.9%	Oct-21	↑	80.0%	89.0%	Oct-21	↓	100.0%	98.39%
		Number of complaints partially or fully upheld by ombudsman	N/A	Sep-21	↔	0	0	19-20 Q2	↔	1	2	Oct-21	↔	0	0	Oct-21	↔	0	0
	Pressure Ulcers	Category 2 - Number of pressure ulcers developed or deteriorated	N/A	Sep-21	↓	12	34	Oct-21	↓	52	178	Oct-21	↓	81	589	Oct-21	↔	0	1
		Category 3 - Number of pressure ulcers developed or deteriorated	N/A	Sep-21	↑	0	11	Oct-21	↓	21	50	Oct-21	↑	17	207	Oct-21	↔	0	1
		Category 4 - Number of pressure ulcers developed or deteriorated	N/A	Sep-21	↔	0	0	Oct-21	↔	0	0	Oct-21	↑	4	30	Oct-21	↔	0	0
		Deep Tissue Injuries(DTI) - numbers developed or deteriorated		Sep-21	↓	8	24	Sep-19	↑	16	94	Oct-21	↑	57	467	Oct-21	↔	0	0
		Medical Device pressure ulcers - numbers developed or deteriorated						Sep-19	↓	4	20	Oct-21	↑	12	88	Oct-21	↔	0	0
		Number of pressure ulcers which meet SI criteria	N/A	Sep-20	↑	0	3	Sep-19	↔	0	4	Apr-21	↓	1	1	Oct-21	↔	0	0
	Falls	Number of falls	N/A	Sep-21	↓	102	543	Data Not Provided in Required Format				Oct-21	↓	27	138	Oct-21	↓	37	198
		Number of falls resulting in SI criteria	N/A	Sep-20	↑	0	8	Sep-19	↑	0	19	Oct-21	↓	1	3	Oct-21	↔	0	0
	Medication	Total number of medication incidents	?	Sep-21	↓	70	457	Data Not Provided in Required Format				Oct-21	↑	0	1	Oct-21	↑	76	581
	Serious Incidents	Never Events	0	Sep-21	↔	0	0	Oct-21	↔	0	2	May-19	↔	0	0	Oct-21	↔	0	0
		Number of SI's reported	0	Sep-20	↑	4	26	Sep-19	↑	7	115	Dec-20	↔	1	34	Oct-21	↑	0	7
		Number of SI reports overdue	0	Apr-21	↔	0	0	May-19	↓	19	28	May-19	↔	0	0				
		Number of duty of candour breaches which meet threshold for regulation 20	0	Sep-20	↑	0	3	May-19	↔	0	0	Dec-20	↔	0	0				

QUALITY OVERVIEW M7

Part B: Acute & Non-Acute Provider Dashboard for Local Quality Indicators cont.

Section	Area	Indicator Name	Standard	Chesterfield Royal Hospital NHS Foundation Trust				University Hospitals of Derby & Burton FT				Derbyshire Community Health Services				Derbyshire Healthcare FT			
				Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD
Adult	VTE	Number of avoidable cases of hospital acquired VTE		Mar-20	↓	0	15	Feb-21	↔	0	TBC					Oct-21	↔	0	0
		% Risk Assessments of all inpatients	90%	2019/20 Q3	↓	96.9%	97.4%	2019/20 Q3	↓	95.9%	96.1%	2019/20 Q3	↓	99.5%	99.7%				
	Mortality	Hospital Standardised Mortality Ratio (HSMR)	Not Higher Than Expected	Sep-21	↔	102.6		Nov-20	↔	107.4									
		Summary Hospital-level Mortality Indicator (SHMI): Ratio of Observed vs. Expected		Jul-21	↓	0.967		Jul-21	↓	0.922									
		Crude Mortality		Sep-21	↓	1.66%	1.46%	Oct-21	↓	1.80%	1.15%								
Maternity	FFT	Antenatal serivce: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Jul-21	↑	98.3%	98.5%	Jun-21	↔	N/A	95.1%								
		Labour ward/birthing unit/homebirth: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Jun-21	↓	N/A	98.9%	Jun-21	↓	100.0%	98.1%								
		Postnatal Ward: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Sep-21	↓	100.0%	98.4%	Sep-21	↓	100.0%	98.0%								
		Postnatal community service: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Jun-21	↔	N/A	98.8%	Jun-21	↔	N/A	97.8%								
Mental Health	Dementia	Dementia Care - % of patients ≥ 75 years old admitted where case finding is applied	90%	Feb-20	↑	100.0%	98.9%	Feb-20	↑	92.1%	90.9%								
		Dementia Care - % of patients identified who are appropriately assessed	90%	Feb-20	↔	100.0%	100.0%	Feb-20	↑	89.4%	85.4%								
		Dementia Care - Appropriate onward Referrals	95%	Feb-20	↔	100.0%	100.0%	Feb-20	↔	100.0%	99.3%								
	Inpatient Admissions	Under 18 Admissions to Adult Inpatient Facilities	0													Oct-21	↔	0	0
Workforce	Staff	Staff turnover (%)		Sep-21	↑	8.9%	8.9%	Oct-21	↓	10.4%	10.5%	Oct-21	↓	9.2%	9.0%	Oct-21	↓	11.38%	10.88%
		Staff sickness - % WTE lost through staff sickness		Sep-21	↓	4.6%	4.4%	Oct-21	↑	5.8%	5.6%	Oct-21	↓	6.5%	5.2%	Oct-21	↓	7.49%	6.60%
		Vacancy rate by Trust (%)		Sep-17	↓	1.9%	1.3%	Data Not Provided in Required Format				Oct-21	↔	3.5%	2.8%	Oct-21	↑	11.5%	13.4%
		Agency usage	Target													Oct-21	↓		
			Actual															2.09%	2.33%
		Agency nursing spend vs plan (000's)		Sep-21	↓	£233	£1,234	Oct-18	↑	£723	£4,355	Oct-21	↑	£72	£578				
		Agency spend locum medical vs plan (000's)		Sep-21	↑	£657	£4,463												
	Training	% of Completed Appraisals	90%	Sep-21	↑	91.8%	68.3%	Oct-21	↓		81.9%	Oct-21	↓	83.4%	87.1%	Oct-21	↓	74.5%	76.2%
		Mandatory Training - % attendance at mandatory training	90%	Sep-21	↓	83.2%	84.2%	Oct-21	↓		87.0%	Oct-21	↓	95.2%	96.0%	Oct-21	↓	83.8%	84.1%
Quality Schedule		Is the CCG assured by the evidence provided in the last quarter?	CCG assured by the evidence																
CQUIN		CCG assurance of overall organisational delivery of CQUIN	CCG not assured by the evidence																

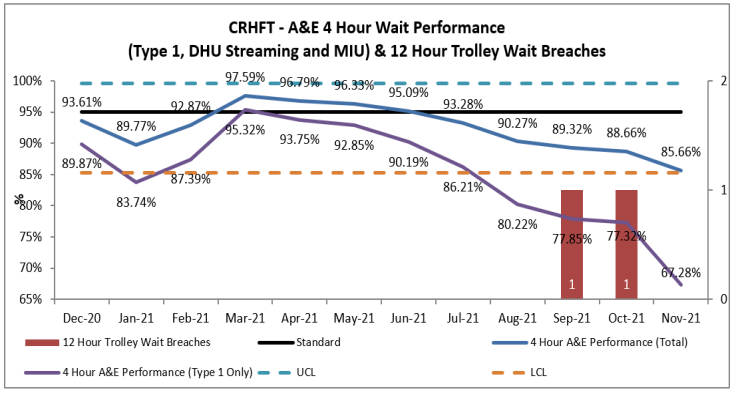
Urgent & Emergency Care

CRHFT A&E PERFORMANCE – PERCENTAGE OF PATIENTS SEEN WITHIN 4 HOURS (95%)

Performance Analysis

During November 2021 the trust did not meet the 95% standard, achieving 85.7% and the Type 1 element achieving 67.3%, a sharp decline on last month's performance.

There were no 12 hour trolley breaches during November.



What are the next steps?

- Implementing a recurrent increase to the level of P1 capacity from December 2021 with the County increasing its new start capability by 20%.
- The official Winter Plan will see increased bed capacity over the pressured season.
- The acute frailty service will continue to operate over the winter – with a geriatrician led team located in ED.
- Creating a discharge lounge to improve flow through acute and elective care beds and ED/assessment units
- Broadening the Same Day Emergency Care (SDEC) pathway offer following a Perfect Week exercise, especially for surgical and Gynaecological conditions.

What are the issues?

- There continued to be severely delayed discharges for patients requiring Packages Of Care, due to capacity for these in the county. This has led to the medical bed base being full (at times there have been enough Medically Fit For Discharge patients to fill whole inpatient wards), therefore reducing the beds available for those in A&E who need them.
- The combined Type 1 & streamed attendances are close to pre-pandemic levels, with an average of 272 attendances per day. By November 2021 the volume of Type 1 & streamed attendances were at 99.5% of November 2019 levels.
- There were surges of Covid19 admissions & outbreaks in the middle and end of the month, with as many as 39 positive inpatients at one point, including 7 in ICU. This added more pressure to a trust with an escalated critical care position.
- The trust has seen an increase in children presenting with eating disorders that require medical intervention. In addition there have been more presentations at ED of children with issues relating to their mental health.
- Heavy snowfall impacted on staff being able to attend for work and the cold weather has led to more temperature related attendances.
- The trust are still taking precautions against COVID-19 and still have these preventative measures in place to include streaming of patients at the physical front door and additional time between seeing patients to turnaround the physical space ensuring increased strict infection control.

What actions have been taken?

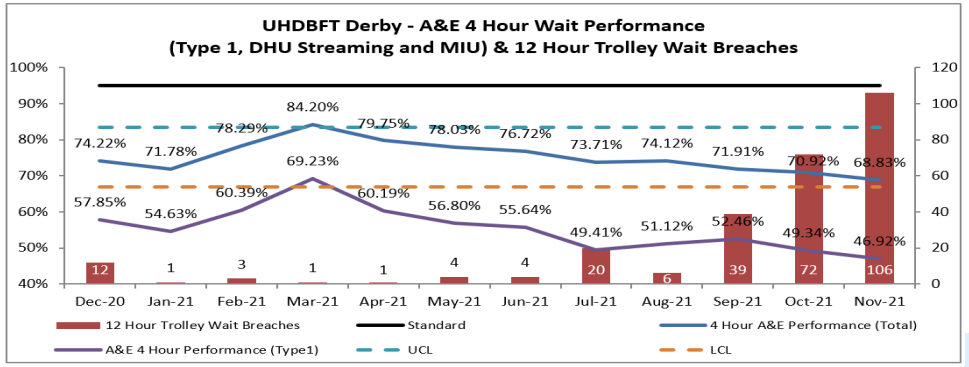
- Escalation of the Packages Of Care shortage to the System Organisational Resilience Group (SORG) which includes councils and community trusts. This group meets twice weekly to solve problems collaboratively, in addition to focussed meetings & communications to secure more capacity.
- Expanding the physical footprint of the Majors area in order to accommodate more of these patients and to asses and/or treat them more quickly.
- The cancellation of the least urgent elective procedures to free up critical care capacity and inpatient beds.
- Agreed actions with EMAS to increase utilisation of the 999 Medicine Direct Referral Pathway so that suitable patients will bypass ED.
- Implemented actions recommended by the Missed Opportunities Audit, including other pathway alterations, increased access to diagnostics and alternative streaming options.

UHDBFT – ROYAL DERBY HOSPITAL A&E - PERCENTAGE OF PATIENTS SEEN WITHIN 4 HOURS (95%)

Performance Analysis

During November 2021, performance overall did not meet the 95% standard, achieving 68.8% (Network figure) and 46.9% for Type 1 attendances. These continue the deterioration since March 2021.

There were 106 x 12 hour breaches during November 2021 due to the availability of suitable Mental Health beds (4) and medical capacity issues (102).



The 12hour trolley breaches in the graph relate to the Derby ED only.

What are the next steps?

- Repurposing a ward at Florence Nightingale Community Hospital to treat Nursing Home and End Of Life patients in a more appropriate setting.
- A further constructive peer review by Chris Morrow-Frost (NHSEI) to gain advice about further improvements now that the UTC has been established at his suggestion. Long-term contractual work to ensure consistent staffing is also taking place.
- Launch of a Professional Standards campaign to influence medical practice across the Trust and therefore improve patient flow.
- Improving the Discharge Assessment Unit to increase capacity and to improve the patient experience, enabling patients to go there sooner.
- Developing an Action Plan based on the Empowering Voices project, which actively listens to ED staff and enacts their suggestions.
- Creating 3 new bays in CED for paediatric acute assessment - creating capacity to meet increasing demand, address CED overcrowding and improve quality and dignity of paediatric assessments.
- The development of a Diagnostic Hub at Florence Nightingale Community Hospital, releasing capacity at the acute site.

What are the issues?

- The volume of attendances were very high, with an average of 478 attendances per day at Derby. These comprise both Type 1 and co-located Urgent Treatment Centre (UTC) numbers, as the UTC sees patients who would otherwise have been classed as minors. However, staff shortages have reduced the capacity of the UTC at times.
- As a Network the numbers of attendances were at 98% of pre-pandemic levels (November 2021 compared to November 2019).
- The acuity of the attendances was high, seeing an average of 13 Resuscitation patients & 176 Major patients per day.
- Attendances at Children's ED continue to be high, with concerns about RSV and Bronchiolitis being major factors. Children's Type 1 attendances at Derby have averaged at 137 per day during November 2021 (compared to 109 per day in November 2019) .
- Critical Care pressures continued to affect the whole region, with Derby taking transfers from Nottingham, which affects capacity as these patients tend not to be transferred back due to maintain safety & quality of care.

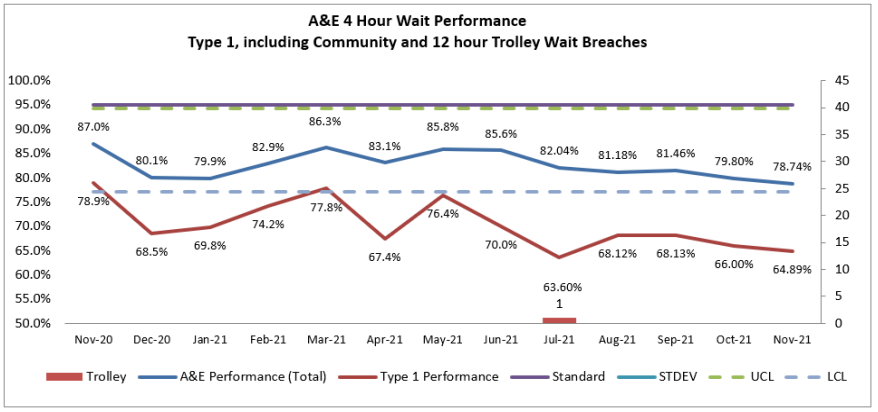
What actions have been taken?

- Early implementation of the Winter Plan, with an Orthopaedic ward given over to non-elective emergency care. Some of the elective Orthopaedic patients are now being seen in the Burton Treatment Centre, to free up emergency capacity.
- The doctor hours worked in ED have been increased, thanks to strategic recruitment. This enables speedier clinical assessment at a senior level.
- Reinstatement of a Frailty Geriatrician Of The Day, enabling speedier and more specialised care for patents attending due to frailty related conditions.
- Continued use of the co-located UTC (with 24/7 opening) meaning that more minor cases can be seen, reducing unnecessary Type 1 ED attendances.
- The UTC has been developed to improve communications, escalation procedures, flow processes and referrals straight to inpatient wards or assessment areas.
- Pre-emptive escalation of potential 12hour trolley breaches to trigger immediate actions to admit the patients sooner.
- Improved consistency in Team Huddles (3x daily), with dashboards introduced and more defined escalation/chaser roles within the department.
- Agreed actions with EMAS to increase utilisation of the 999 Medicine Direct Referral Pathway so that suitable patients will bypass ED.
- Increased 'Every Day Counts' accreditation for wards to increase their focus on discharge planning to improve patient flow.

UHDB – BURTON HOSPITAL A&E - PERCENTAGE OF PATIENTS SEEN WITHIN 4 HOURS (95%)

Performance Analysis

During November 2021, performance overall did not meet the 95% standard, achieving 64.9% for the Burton A&E and 78.7% including community hospitals. Performance has been fluctuating since winter. There were no 12 hour breaches during November 2021.



What were the issues?

- Critical Care pressures continue to affect the whole region, with Burton taking transfers from Stoke, Walsall & Birmingham which affects capacity as these patients tend not to be transferred back due to maintain safety & quality of care.
- The department have experienced a high volume of activity with an average of 181 Type 1 attendances per day.
- The acuity of the attendances is high, with an average of 121 Resuscitation/Major patients per day (67% of Type 1s).

What are the next steps?

- Launch of a Professional Standards campaign to influence medical practice across the Trust and therefore improve patient flow.
- The acute frailty service will continue to operate over the winter – with a geriatrician led team located in ED.
- The continuation of the red-hub and red-home visiting service for Derbyshire patients through to the end of March 2022 given that these services are currently being utilised and relieving pressure of 'normal' general practice capacity.
- Increased Point of Care Testing (flu & covid) capacity – sourcing more 'ID Now' analysers & consumables.
- Devising an Action Plan following a departmental Critical Friend Review by Chris Morrow-Frost (NHSEI).
- A major capital programme to increase the number of Assessment Unit beds and increasing Majors bed capacity is continuing.

What actions have been taken?

- Opening an Acute Medical Unit Triage (AMUT) to assess patients away from ED as GPs refer directly into the unit or patients are 'pulled' there from the ED waiting room.
- Every walk-in patient is now streamed by Clinical Navigators to ascertain whether ED is the most appropriate setting for their assessment or care.
- The Surgical Assessment Unit (SAU) now operates for 12 hours a day (9am-9pm) with 9 trolleys available for specialised assessment away from ED.
- Increased use of the Burton Treatment Centre to see elective patients and therefore release beds for emergency activity.
- The Discharge Team now have weekend cover, enabling speedier discharges for medically appropriate patients over the weekend and improving flow over the whole hospital.
- Further improvements to the discharge process to include earlier input to the discharge process and increased in-reach.
- Increased 'Every Day Counts' accreditation for wards to increase their focus on discharge planning to improve patient flow.
- Development of the 'In-Department Pathway' project to include alternative navigation/streaming process and the 'pulling' of patients into Same Day Emergency Care (SDEC) pathways.
- The addition of a modular building to house GP Streaming services.
- The opening of a 2nd Ultrasound Room has increased availability of scanning capacity and increasing patient flow.

DHU111 Performance Month 7 (October 2021)

Performance Summary

- DHU achieved three of the five contractual Key Performance Indicators (KPIs) during October 2021. The following two KPIs were not achieved:
    1. Abandonment rate which was 2.0% higher than the contractual KPI, at 7.0%.
    2. The Average speed of answer which was 1 minute and 56 seconds above the contractual KPI, at 2 minutes and 23 seconds.
- It is worth noting that 111 providers across the country continue to experience high levels of demand and although there has been a deterioration in DHU111's performance, it remains good comparative to the national position which shows an abandonment rate of 27.8% and an average speed of answer of 6 minutes and 57 seconds.

Regional Performance Year Six - Key Performance Indicators (KPI's)							
		Quarter Four (July- September)			Quarter One (October – December)		
Contractual KPI's	Standard	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Abandonment rate (%)	≤5%	1.1%	3.1%	5.4%	7.0%		
Average speed of answer (seconds)	≤27s	00:00:26	00:01:00	00:01:47	00:02:23		
Call Transfer to a Clinician	≥50%	64.5%	66.0%	65.2%	69.2%		
Self Care	≥17%	19.0%	17.2%	17.4%	19.0%		
Patient Experience	≥85%	84.0%			This data is updated on a six monthly basis		
C3 Validation	≥50%	98.2%	98.0%	98.0%	98.2%		

Activity Summary

- During October, calls offered were 8.8% above the newly negotiated indicative activity plan (IAP) for Year 6 and clinical calls were 15.1% below the IAP. Please note that, as per the agreements made as part of the Year 6 contract, COVID activity is now included within the core activity lines.
- A total of 10,382 Category 3 validations were carried out during October, this was a slight increase compared to the previous month where 9,361 validations took place, however remains lower than the levels seen throughout Year 5 of the contract, an average of 14,436 per month. Staffing pressures are contributing to the number of validations DHU111 are able to carry out.
- Commissioners will work with DHU to understand the difference between calls offered and clinical calls in terms of their variance from IAP.

DHU111 Performance Month 7 (October 2021)

What are the issues?

- DHU111 continue to experience a change in the distribution of activity, with a significant increase being seen across Monday to Friday calls, activity is 59% up during the daytime when compared to 2019. DHU have also reported that dental related activity continues to increase. *Due to Covid, 2021 activity has been compared to 2019 rather than 2020.*
- DHU111 continue to experience challenges in relation to recruitment and retention of call takers which is causing additional pressure throughout the service. The Clinical Quality Review Group (CQRG) are assured that DHU111 are doing everything possible to recruit staff and acknowledge that DHU111 are in the same position as other providers nationally in that it remains a challenge.

What actions have been taken?

- The pilot scheme which extended the Category 3 validation timeframe from 30 minutes to 60 minutes has not shown the desired outputs. A recent review of the scheme across all pilot sights has determined that the extended timeframe will not continue or be rolled out further, and providers should revert back to the 30 minute timeframe for validation.

Activity		Year Five (Contract Year runs Oct 2020 to Sep 2021)	Oct-21	Nov-21	Dec-21
Calls Offered	Actual	1,797,157	172,735		
	Plan	2,167,656	158,694		
	Variance	-17.1%	8.8%		
Clinical Calls	Actual	361,600	30,000		
	Plan	410,504	35,337		
	Variance	-11.9%	-15.1%		

What are the next steps?

- Commissioners are currently working through the H2 Funding available to Integrated Urgent Care (IUC) systems to support short term increases in capacity to cope with increased demand over winter. The amounts being allocated to DHU111 will be confirmed at the December CMB meeting.
- With regards to Year 7, the Commissioning Governing bodies have agreed to enact the second year of the optional two year extension to the Contract, the Coordinating Commissioning Team are currently working through how this could be structured and will write to DHU111 formally setting out the proposal for Year 7.

Please note that the contract year runs October – September for the DHU 111 contract as per contract award in September 2016. We are currently in year five of a six year contract.

AMBULANCE – EMAS PERFORMANCE M7 (October 2021)

What are the issues?

- The contractual standard is for the Derbyshire division to achieve national performance on a quarterly basis. For Quarter three to date, Derbyshire are not meeting any of the six national standards. The variation to the national standards was as follows:
  - C1 mean +2 minute and 12 seconds
  - C1 90th Centile +1 minute and 11
  - C2 mean +28 minutes and 12 seconds
  - C2 90th Centile +58 minutes and 6 seconds
  - C3 90th Centile +5 hours, 52 minutes and 10 seconds
  - C4 90th Centile +2 hours, 56 minutes and 46 seconds
- There is a regional level trajectory for performance which is linked to the receipt of additional national funding. During October, EMAS did not achieve any of the performance trajectories, and performance against all trajectories except C1 90th Centile has deteriorated when compared to the previous month. The trajectories were built upon a range of assumptions including demand and acuity, whilst demand remained below the assumed level, acuity also remained much higher than assumed.
- Within Derbyshire demand from NHS111 is the highest in the region at 27%
- There continues to be challenges with demand with EMAS being in CSP4/CSP4A for a significant amount of time. This has had an adverse effect on patient safety as is evidenced by delayed harm serious incidents reported.
- Average Pre hospital handover times during October 2021 continued to be above the 15 minute National Standard across Derbyshire at 24 minutes and 28 seconds which was the same as September 2021 performance.
- Average Post handover times during October 2021 remained above the 15 minute national standard across Derbyshire with the exception of Macclesfield District (12 minutes and 16 seconds). Overall the post handover time in October 2021 was 19 minutes and 26 seconds which was similar to September 2021 performance at 19 minutes and 21 seconds.
- Incidents in Derbyshire in October 2021 saw an increase when compared to September 2021 (13,505 compared to 12,857) and remained above the indicative activity plan
- S&C to ED as a percentage of incidents is middle of the pack across the region at 54.0%.
- The percentage of calls being classed as a duplicate call during October 2021 was slightly higher (21.9%) when compared to September (21.2%), and these remain above the contractual threshold of 17.9%.

Performance	Category 1		Category 2		Category 3	Category 4
	Average	90th centile	Average	90th centile	90th centile	90th centile
National standard	00:07:00	00:15:00	00:18:00	00:40:00	02:00:00	03:00:00
EMAS Actual – October	00:09:30	00:17:01	00:59:14	02:07:06	09:43:04	06:06:09
Derbyshire Actual - October	00:09:12	00:16:11	00:46:12	01:38:06	07:52:10	05:56:46
Derbyshire Actual – Quarter Three to date	00:09:12	00:16:11	00:46:12	01:38:06	07:52:10	05:56:46

October 2021	Pre Handovers		Post Handovers		Total Turnaround	
	Average Pre Handover Time	Lost Hours	Average Post Handover Time	Lost hours	Average Total Turnaround	Lost hours
Burton Queens	00:32:14	119:47:25	00:17:14	33:51:09	00:49:28	139:09:24
Chesterfield Royal	00:20:57	268:50:55	00:19:53	269:42:07	00:40:50	464:07:21
Macclesfield District General Hospital	00:36:33	18:20:43	00:12:16	1:28:26	00:48:49	16:42:20
Royal Derby	00:25:22	781:59:37	00:19:51	516:10:01	00:45:13	1146:37:56
Sheffield Northern General Hospital	00:32:55	31:58:30	00:19:00	11:43:11	00:51:55	39:35:08
Stepping Hill	00:23:03	58:30:55	00:15:33	24:58:41	00:38:36	69:31:52
Derbyshire TOTAL	00:24:28	1279:28:05	00:19:26	857:53:35	00:43:54	1875:44:01

AMBULANCE – EMAS PERFORMANCE M7 (October 2021)

What actions have been taken?

- The EMAS Clinical Quality Review Group (CQRG) are working closely with EMAS in relation to the increase in demand and CSP4A. EMAS have put a process in place to share the CSP daily report updates with associates.
- It was agreed at the November CQRG that all were assured EMAS were taking all the necessary actions and mitigations to provide as safe a service as possible, and the CQC have reported that EMAS is not performing any worse to other ambulance providers. Harm reviews were conducted to provide further assurance regarding delays in care and these have not identified any harm as a result of delays in care.
- EMAS have concerns with regards staff welfare due to the current demand being seen, however they have measures in place to address this.
- DHU111 continued to work to an extended timeframe for clinical validation of C3/C4 activity (60 minutes rather than 30 minutes). However following an evaluation of the pilot, it has been determined that the timeframe will revert back to 30 minutes as the pilot did not show the intended benefits across the pilot sites.
- Call handling continues to be a challenge, and to overcome this EMAS continue to recruit additional call handlers to reduce the length of time callers are waiting. There is also a National initiative with British Telecom to screen callers to help reduce the number of duplicate calls where callers are wanting an update on arrival time but the patients condition has not changed. The National NHSEI team are also leading a national recruitment campaign for call handlers within ambulance services to support.
- Progress continues in relation to the delivery of the Urgent and Emergency Care 10 point plan which covers all providers across Derbyshire.

What are the next steps

- Since the November CQRG meeting, commissioners have been notified of a further twelve delayed response serious incidents reported. The Delayed Hospital Handovers impact assessment of patient harm was also published on the 15th of November 2021. A decision has been taken to hold an extraordinary CQRG in December 2021, where the group will discuss the findings of the report and the increase in serious incidents.
- As part of winter planning ambulance providers have been asked to ensure there is sufficient call handler capacity in place and to prioritise call handler recruitment in order to prepare for an anticipated 25% uplift on 2019 call volumes. NHSE/I have confirmed that additional funding will be available to support this recruitment and EMAS continue to recruit at pace.
- Chesterfield Royal Hospital are introducing a process to speed up the check-in process of patients arriving via ambulance which should in turn reduce handover delays and therefore release ambulances more quickly for responding to further calls.

EMAS Activity - 2021 to 2022						
Derbyshire	July	August	September	Quarter Two 2021 -2022	October	Quarter Three to date
Calls (Total)	23,342	21,271	21,463	66,076	22,150	22,150
Total Incidents	14,155	13,248	12,857	40,260	13,505	13,505
Total Responses	12,608	11,873	11,505	35,986	12,251	12,251
Duplicate Calls	5,500	4,471	4,559	14,530	4,842	4,842
Hear & Treat (Total)	5,234	4,927	5,399	15,560	5,057	5,057
See & Treat	4,617	4,223	4,198	13,038	4,405	4,405
See & Convey	7,991	7,650	7,307	22,948	7,846	7,846
Duplicates as % Calls	23.6%	21.0%	21.2%	22.0%	21.9%	21.9%
H&T ASI as % Incidents	10.9%	10.4%	10.5%	10.6%	9.3%	9.3%
S&T as % Incidents	32.6%	31.9%	32.7%	32.4%	32.6%	32.6%
S&C as % Incidents	56.5%	57.7%	56.8%	57.0%	58.1%	58.1%
S&C to ED as % of incidents	51.8%	53.6%	52.6%	52.7%	54.0%	54.0%

Planned Care

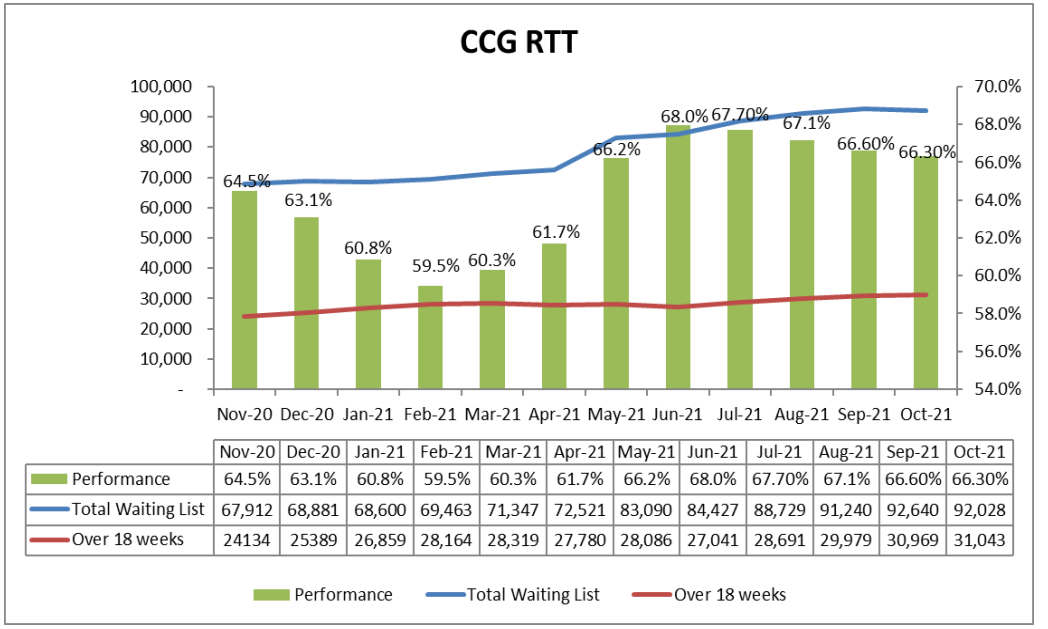
DERBYSHIRE COMMISSIONER – INCOMPLETE PATHWAYS (92%)

Performance Analysis

Performance for September 2021 was 66.3%, a slight reduction on the 66.6% in August.

The total incomplete waiting list for DDCCG was 92,048 a decrease of 612 on the previous month. .
The number of referrals across Derbyshire during October showed the same weekly average for urgent referrals but a reduction of 38% for routine referrals when compared with the average weekly referral of the previous 51 weeks. (Urgent referrals are at the same level and routine referrals 38% lower than the same month during 2019.

Treatment Function	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Total 52 plus weeks
General Surgery Service	4,945	2,527	51.1%	815
Urology Service	4,054	2,940	72.5%	266
Trauma and Orthopaedic Service	13,708	7,391	53.9%	1,709
Ear Nose and Throat Service	6,213	4,066	65.4%	429
Ophthalmology Service	12,884	7,501	58.2%	863
Oral Surgery Service	7	6	85.7%	0
Neurosurgical Service	563	364	64.7%	17
Plastic Surgery Service	640	441	68.9%	52
Cardiothoracic Surgery Service	203	117	57.6%	16
General Internal Medicine Service	249	190	76.3%	0
Gastroenterology Service	4,489	3,486	77.7%	107
Cardiology Service	2,314	1,771	76.5%	40
Dermatology Service	6,631	4,631	69.8%	90
Respiratory Medicine Service	1,435	1,175	81.9%	3
Neurology Service	2,426	1,970	81.2%	8
Rheumatology Service	1,795	1,375	76.6%	25
Elderly Medicine Service	260	225	86.5%	2
Gynaecology Service	6,566	4,428	67.4%	327
Other - Medical Services	6,347	5,130	80.8%	69
Other - Mental Health Services	345	303	87.8%	1
Other - Paediatric Services	7,002	4,728	67.5%	268
Other - Surgical Services	7,924	5,340	67.4%	567
Other - Other Services	1,028	880	85.6%	31
Total	**92,028**	**60,985**	**66.3%**	**5,705**



	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Performance	64.5%	63.1%	60.8%	59.5%	60.3%	61.7%	66.2%	68.0%	67.70%	67.1%	66.60%	66.30%
Total Waiting List	67,912	68,881	68,600	69,463	71,347	72,521	83,090	84,427	88,729	91,240	92,640	92,028
Over 18 weeks	24134	25389	26,859	28,164	28,319	27,780	28,086	27,041	28,691	29,979	30,969	31,043

- *The Derbyshire CCG position is representative of all of the patients registered within the CCG area attending any provider nationally.*
- *70% of Derbyshire patients attend either CRHFT (25%) or UHDB (45%). The RTT position is measured at both CCG and provider level.*
- *The RTT standard of 92% was not achieved by any of our associate providers during April.*

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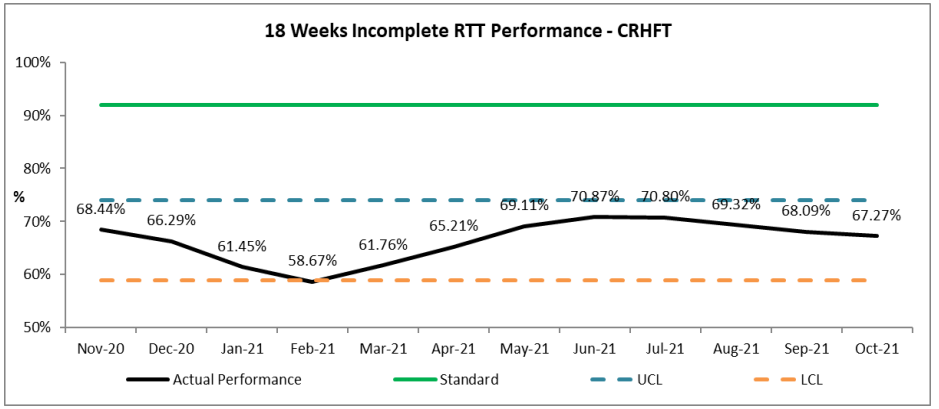
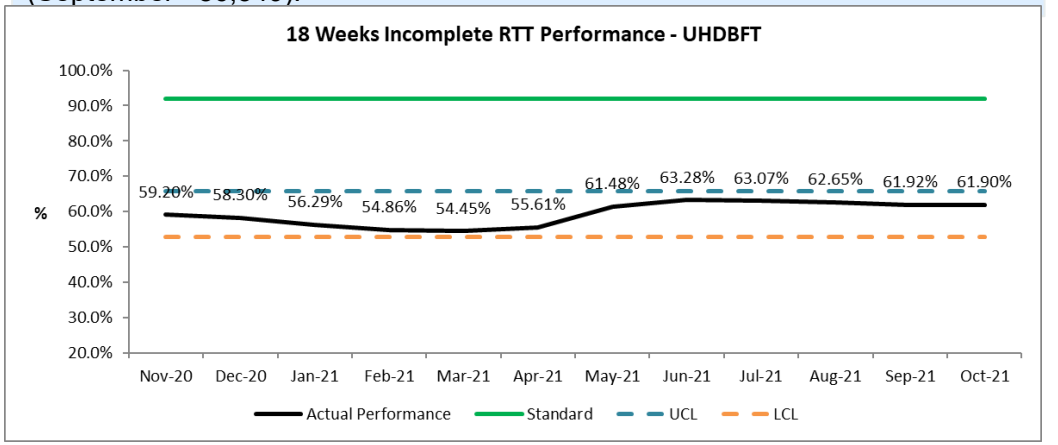
Referral to Treatment – Incomplete Pathways (92%).

CRH – During October the trust achieved 67.3%, a slight reduction on the September figure of 68.1%. The incomplete waiting list at the end of October was 19,921 (September - 19,955).



UHDB - During October the trust achieved a standard of 61.9%, the same figure as September. The incomplete waiting list at the end of October was 85,487 (September - 86,349).



Treatment Function	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Total 52 plus weeks
General Surgery Service	1,283	560	43.6%	264
Urology Service	1,033	820	79.4%	16
Trauma and Orthopaedic Service	2,008	1,053	52.4%	188
Ear Nose and Throat Service	1,579	1,086	68.8%	93
Ophthalmology Service	2,295	1,357	59.1%	159
Oral Surgery Service	1,356	785	57.9%	92
General Internal Medicine Service	222	170	76.6%	0
Gastroenterology Service	1,236	931	75.3%	6
Cardiology Service	530	410	77.4%	5
Dermatology Service	1,916	1,489	77.7%	0
Respiratory Medicine Service	510	375	73.5%	0
Rheumatology Service	348	269	77.3%	3
Gynaecology Service	1,514	1,008	66.6%	179
Other - Medical Services	979	746	76.2%	13
Other - Paediatric Services	1,191	958	80.4%	22
Other - Surgical Services	1,921	1,383	72.0%	93
Total	**19,921**	**13,400**	**67.3%**	**1,133**

Treatment Function	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Total 52 plus weeks
General Surgery Service	4,912	2,742	55.8%	516
Urology Service	3,627	2,366	65.2%	306
Trauma and Orthopaedic Service	14,095	7,291	51.7%	1,861
Ear Nose and Throat Service	6,948	4,156	59.8%	289
Ophthalmology Service	11,448	5,688	49.7%	935
Oral Surgery Service	3,089	1,507	48.8%	338
Neurosurgical Service	107	58	54.2%	0
Plastic Surgery Service	354	265	74.9%	20
Cardiothoracic Surgery Service	10	9	90.0%	0
General Internal Medicine Service	18	16	88.9%	0
Gastroenterology Service	3,388	2,731	80.6%	9
Cardiology Service	1,758	1,432	81.5%	8
Dermatology Service	6,172	3,694	59.9%	166
Respiratory Medicine Service	721	656	91.0%	1
Neurology Service	2,076	1,630	78.5%	4
Rheumatology Service	1,759	1,368	77.8%	19
Elderly Medicine Service	322	256	79.5%	6
Gynaecology Service	6,627	4,317	65.1%	246
Other - Medical Services	6,172	4,887	79.2%	65
Other - Mental Health Services	2	2	100.0%	0
Other - Paediatric Services	4,252	2,633	61.9%	229
Other - Surgical Services	6,559	4,320	65.9%	600
Other - Other Services	1,071	890	83.1%	41
Total	**85,487**	**52,914**	**61.9%**	**5,659**

DERBYSHIRE COMMISSIONER – OVER 52 WEEK WAITS

52 Week Waits
At the end of October there were 5,705 Derbyshire patients waiting over 52 weeks for treatment in Derbyshire. Of these 4,396 were waiting for treatment at our two main providers UHDB and CRH, the remaining 1,309 were waiting at various trusts around the country as outlined in the table on the following slide.

The number is a slight decrease on the September 2021 figure.

CCG Patients – Trend – 52 weeks													
	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sept-21	**Oct-21**
DDCCG	2,658	3,388	4,245	5,903	7,554	8,261	7,490	6,859	6,199	5,897	5,627	5,781	**5,705**

Main Providers:
In terms of Derbyshire's the two main acute providers the 52ww monthly position up until July at UHDB and CRH is as follows:

	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sept-21	**Oct- 21**
UHDB	2,367	2,968	3,751	4,706	6,629	8,767	9,728	8,605	7,573	6,806	6,206	5,755	5,692	**5,659**
CRH	308	438	594	797	1,202	1,475	1,471	1,278	1,179	1,095	1098	1,118	1,129	**1,133**

NB: *UHDB/CRH figures are all patients at that trust irrespective of Commissioner.*

The Surgery Division are following national Royal College of Surgeon guidance on prioritisation of surgical patients which was issued in October 2020. This identifies patients who are clinically appropriate to delay for periods and those who will need to be prioritised. This will aid the teams to use the limited elective capacity on the patients who are most at risk of harm, allowing trusts to tackle the growing backlog of long waiters. The priority levels are 1-4, P5 (treatment deferred due to Covid concerns) and P6 (deferred for other reason).

Actions:
- System Planned Care Group are leading on the plans for restoration and recovery across the system.
- Patients are being treated in priority order and a number of patients currently waiting over 52 weeks are low priority.
- There is an increased focus by the National team at NHS England around the long waiters across Derbyshire. The CCG are working with the trusts reviewing those patients who have been waiting the longest time as there are a number over 104 weeks. Trusts will be expected to eliminate 104+ weeks patients by end of March 2022 (except for those identified as P5 or P6, which is due to patient choice).

DERBYSHIRE COMMISSIONER – OVER 52 WEEK WAITERS

Associate Providers – Derbyshire Patients waiting over 52 weeks in October 2021 at associate providers were 1309 compared to 1288 during September 2021.

Provider	Total	Provider	Total
ASPEN - CLAREMONT HOSPITAL	15	SPIRE REGENCY HOSPITAL	8
BARTS HEALTH NHS TRUST	5	STOCKPORT NHS FOUNDATION TRUST	388
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	3	TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	2
BMI - THE ALEXANDRA HOSPITAL	5	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	1
BMI - THE PARK HOSPITAL	2	THE ONE HEALTH GROUP LTD	5
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	5	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	1
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	1	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	1
DERBYSHIRE HEALTHCARE NHS FOUNDATION TRUST	1	THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FT	5
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	9	THE ROTHERHAM NHS FOUNDATION TRUST	2
EAST AND NORTH HERTFORDSHIRE NHS TRUST	2	THE ROYAL WOLVERHAMPTON NHS TRUST	1
EAST CHESHIRE NHS TRUST	25	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	3
GEORGE ELIOT HOSPITAL NHS TRUST	1	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	34
HARROGATE AND DISTRICT NHS FOUNDATION TRUST	1	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	4
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	1	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	60
LEEDS TEACHING HOSPITALS NHS TRUST	6	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	11
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	2	WEST SUFFOLK NHS FOUNDATION TRUST	1
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	7	WOODTHORPE HOSPITAL	4
MID YORKSHIRE HOSPITALS NHS TRUST	1	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	1
NEWMEDICA COMMUNITY OPHTHALMOLOGY - BARLBOROUGH TREATMENT CENTRE	3	HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST	3
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	1	LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	6
NORTH BRISTOL NHS TRUST	1	BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	1
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	310	PORTSMOUTH HOSPITALS UNIVERSITY NATIONAL HEALTH SERVICE TRUST	1
NUFFIELD HEALTH, DERBY HOSPITAL	50	SPAMEDICA DERBY	36
NUFFIELD HEALTH, LEICESTER HOSPITAL	1	PRACTICE PLUS GROUP HOSPITAL - BARLBOROUGH	18
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	1	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	1
ROYAL FREE LONDON NHS FOUNDATION TRUST	5	SPAMEDICA SHEFFIELD	1
SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	36	SPAMEDICA MANCHESTER	1
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	61	UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST	1
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	122	YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUS	1
SPIRE NOTTINGHAM HOSPITAL	4	NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	20
		Total	1309

Actions:

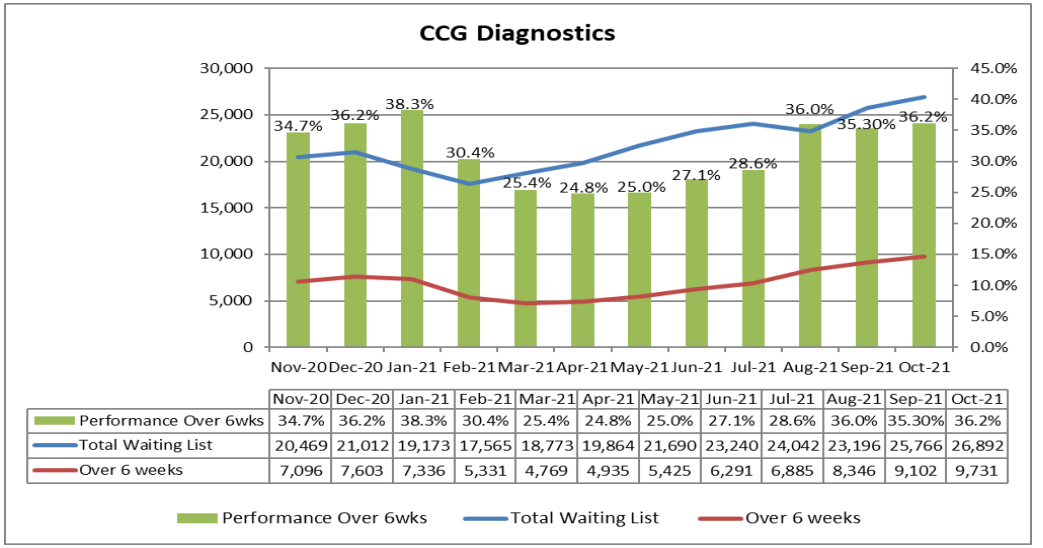
- The performance team make enquiries of the relevant CCGs and responses received back are that these patients are not clinically urgent but are being reviewed. We have not been informed of any TCI dates.

DERBYSHIRE COMMISSIONER – 6 WEEK DIAGNOSTIC WAITING TIMES (Less than 1%)

Performance Analysis

Derbyshire CCG Diagnostic performance at the end of October was 36.2% waiting over six weeks, a deterioration on the 35.3% waiting at the end of September.

The total number of Derbyshire patients waiting for diagnostic procedures increased during October. The number of patients waiting over 6 weeks and over 13 weeks have both increased. All of our associates are showing non compliance for the diagnostic standard.



	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Performance Over 6wks	34.7%	36.2%	38.3%	30.4%	25.4%	24.8%	25.0%	27.1%	28.6%	36.0%	35.30%	36.2%
Total Waiting List	20,469	21,012	19,173	17,565	18,773	19,864	21,690	23,240	24,042	23,196	25,766	26,892
Over 6 weeks	7,096	7,603	7,336	5,331	4,769	4,935	5,425	6,291	6,885	8,346	9,102	9,731

Diagnostic Test Name	University Hospitals of Derby & Burton	Chesterfield Royal Hospital	Stockport	Sheffield Teaching Hospitals	Sherwood Forest Hospitals	Nottingham University Hospitals	East Cheshire
Magnetic Resonance Imaging	42.4%	0.2%	4.4%	2.1%	1.7%	67.3%	0.0%
Computed Tomography	37.1%	1.0%	17.3%	16.8%	38.8%	10.4%	0.0%
Non-obstetric Ultrasound	49.9%	0.2%	0.3%	14.2%	18.3%	10.5%	0.0%
DEXA Scan	25.8%	0.8%	39.0%	5.4%	14.7%	57.8%	
Audiology - Audiology Assessments	29.9%	53.5%	31.4%	5.4%	0.0%	25.6%	21.7%
Cardiology - Echocardiography	39.9%	60.8%	28.3%	10.2%	22.1%	35.5%	59.9%
Peripheral Neurophysiology	0.2%		0.0%	35.1%		0.6%	
Respiratory physiology - Sleep Studies	19.9%		9.5%	5.1%	23.2%	21.9%	12.5%
Urodynamics - Pressures & Flows	63.6%	64.3%	13.3%	39.2%	3.6%	28.6%	
Colonoscopy	12.1%	22.5%	82.7%	26.9%	28.1%	43.2%	42.3%
Flexi Sigmoidoscopy	18.3%	18.5%	84.5%	54.4%	28.7%	40.6%	14.0%
Cystoscopy	20.6%	7.7%	0.0%	21.6%	35.5%	10.9%	50.0%
Gastroscopy	16.0%	23.5%	76.3%	45.9%	22.6%	49.9%	13.2%
Total	**40.9%**	**22.3%**	**38.0%**	**16.1%**	**19.7%**	**43.8%**	**22.8%**

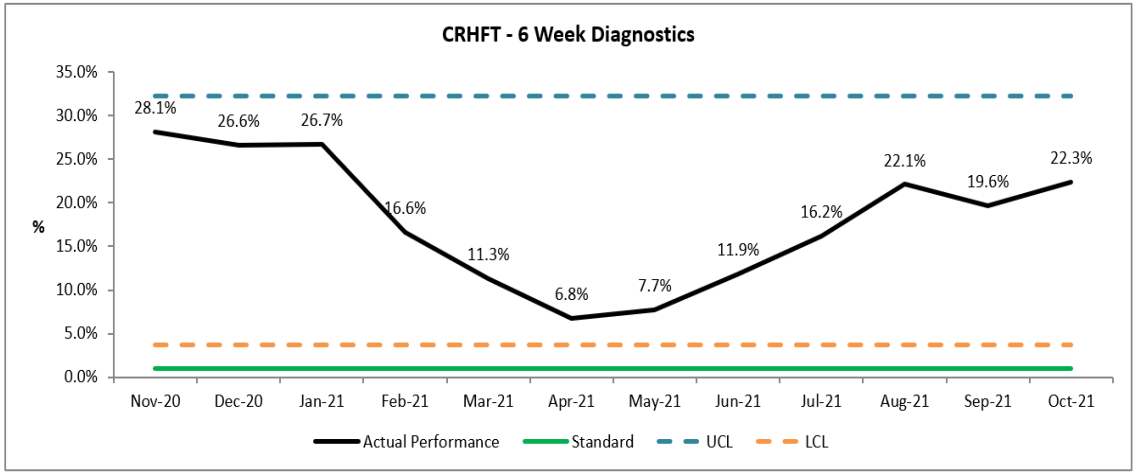
Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Percentage waiting 6+ Weeks
Magnetic Resonance Imaging	5,398	1,941	836	36.0%
Computed Tomography	3,102	822	314	26.5%
Non-obstetric Ultrasound	9,300	3,614	1,104	38.9%
DEXA Scan	791	134	37	16.9%
Audiology - Audiology Assessments	1,176	462	56	39.3%
Cardiology - Echocardiography	3,623	1,771	379	48.9%
Peripheral Neurophysiology	510	15	1	2.9%
Respiratory physiology - Sleep Studies	189	57	13	30.2%
Urodynamics - Pressures & Flows	132	73	34	55.3%
Colonoscopy	952	324	219	34.0%
Flexi Sigmoidoscopy	400	129	59	32.3%
Cystoscopy	273	55	31	20.1%
Gastroscopy	1,046	334	205	31.9%
Total	**26,892**	**9,731**	**3,288**	**36.2%**

CRHFT DIAGNOSTICS - 6 WEEK DIAGNOSTIC WAITING TIMES (Less than 1% of pts should wait more than six weeks)

Performance Analysis

Performance during October was 22.3%, a deterioration on the September figure of 19.6%.

The numbers on the waiting list have decreased overall. The number waiting over 6 weeks have remained the same but the number waiting over 13 weeks have seen the bulk of the decrease.



Issues

- Staff absence due to sickness remains high and affects Radiology in particular.
- The high demand due to higher outpatient referrals and increased non-elective activity continues.
- TRUSS and TP capacity planning is dependant on the number of patients that opt for a TP over TRUSS biopsy, which varies from week to week.

Actions

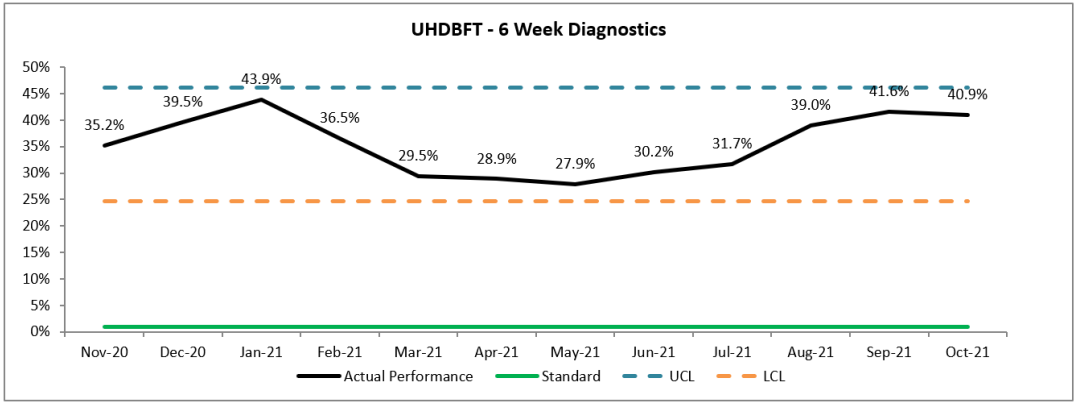
- Increased imaging capacity through the use of Mobile CT and Mobile MRI scanners.
- Immediate booking of Endoscopy dates to enable forward planning.
- The prioritisation of Imaging and Endoscopy activity for those patients on a cancer pathway.
- Further development of the clinical triage set and CAB.

Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Percentage waiting 6+ weeks
Magnetic Resonance Imaging	828	5	0	0.6%
Computed Tomography	614	9	0	1.5%
Non-obstetric Ultrasound	1,960	20	0	1.0%
DEXA Scan	235	1	0	0.4%
Audiology - Audiology Assessments	566	265	49	46.8%
Cardiology - Echocardiography	1,309	715	150	54.6%
Urodynamics - Pressures & Flows	27	16	5	59.3%
Colonoscopy	216	75	66	34.7%
Flexi Sigmoidoscopy	54	15	8	27.8%
Cystoscopy	42	0	0	0.0%
Gastroscopy	161	60	34	37.3%
Total	6,012	1,181	312	19.6%

UHDB DIAGNOSTICS - 6 WEEK DIAGNOSTIC WAITING TIMES (Less than 1% of pts should wait more than six weeks)

Performance Analysis

Performance during September was 40.9%, a slight improvement on the September position.
The overall numbers on the waiting list have increased during October, with the number waiting over 6 weeks decreasing but the number waiting over 13 weeks increasing.
Non Obstetric ultrasounds, Urodynamics and Echocardiography are experiencing the highest waits proportionally.



Issues

- There has been limited ability to accommodate General Anaesthetic patients in Endoscopy, leading to higher waits for these patients.
- Continued limited MRI capacity mainly due to staff shortages but also due to the scanner at Florence Nightingale Community Hospital remaining closed.
- The high demand due to higher outpatient referrals and increased non-elective activity continues. The high emergency demand is particularly impacting Imaging service including Non Obstetric ultrasounds.

Actions

- Imaging have recruited 12 additional CT & MRI Radiographers from abroad, therefore not drawing away from other local labour pools.
- Additional CT & MRI vans have been sourced, however these won't be available until March 2022.
- Increased outsourcing of Echocardiography and Non-Obstetric Ultrasound activity.
- A temporary CT scanner has been retained for a further 6 months.
- Infection Control have allowed turnaround times between patients to be relaxed by 5 minutes in some areas.
- The bid for a Rapid Diagnostics Site at the Trust was successful, which will enhance patient flow.

Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Percentage waiting 6+ weeks
Magnetic Resonance Imaging	5,351	2,269	578	42.4%
Computed Tomography	3,263	1,209	490	37.1%
Non-obstetric Ultrasound	9,846	4,931	1,319	50.1%
Barium Enema	26	0	0	0.0%
DEXA Scan	663	209	43	31.5%
Audiology - Audiology Assessments	956	272	67	28.5%
Cardiology - Echocardiography	2,860	1,316	386	46.0%
Peripheral Neurophysiology	427	4	0	0.9%
Respiratory physiology - Sleep Studies	184	54	7	29.3%
Urodynamics - Pressures & Flows	106	53	27	50.0%
Colonoscopy	558	56	8	10.0%
Flexi Sigmoidoscopy	263	32	0	12.2%
Cystoscopy	225	53	30	23.6%
Gastroscopy	646	87	18	13.5%
Total	25,374	10,545	2,973	41.6%

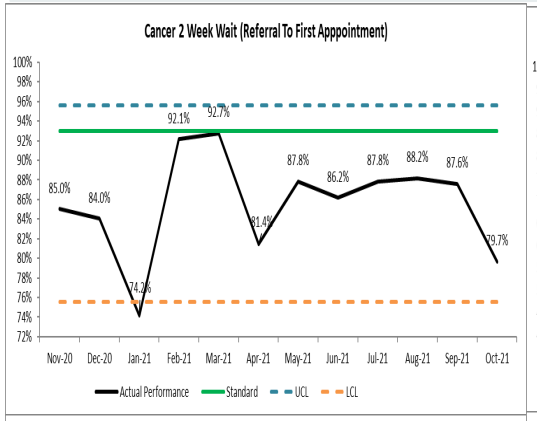
DERBYSHIRE COMMISSIONER – CANCER WAITING TIMES

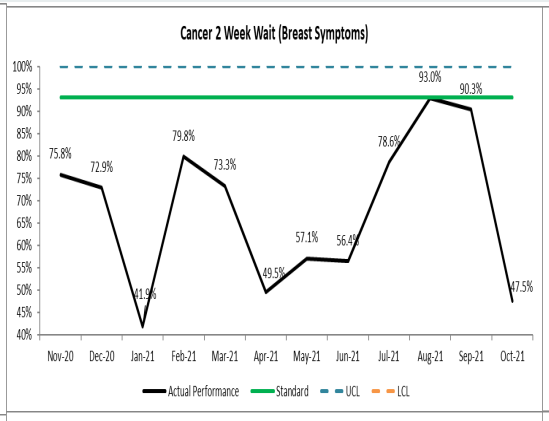
During October 2021, Derbyshire was compliant in 2 of the 9 Cancer standards:

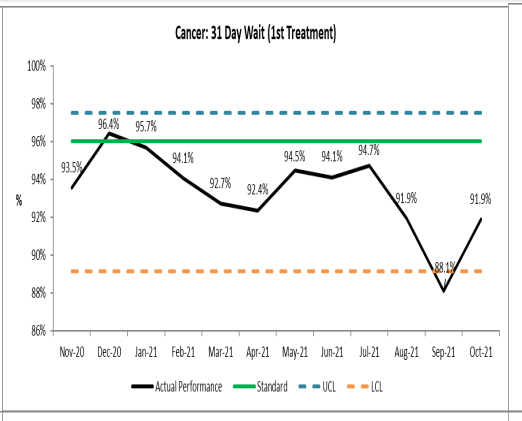
- **31 day Subsequent Radiotherapy – 97.8%** (94% standard) – Compliant at all trusts except UHDB.
- **31 day Subsequent Drugs – 98.9%** (98% standard) – Compliant for all Trusts except UHDB.

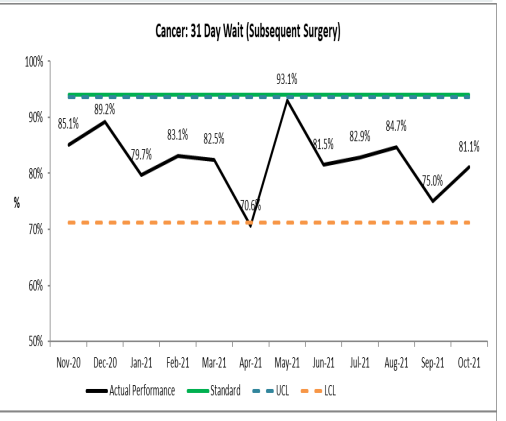
During October 2021, Derbyshire was non-compliant in 7 of the 9 Cancer standards:

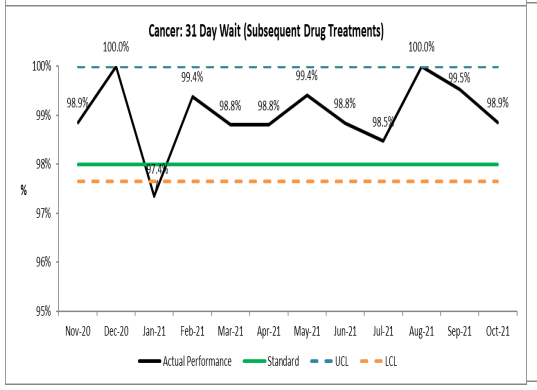
- **2 week Urgent GP Referral – 79.7%** (93% standard) – Compliant for Stockport.
- **2 week Exhibited Breast Symptoms – 47.5%** (93% standard) – Compliant at NUH and Sherwood Forest.
- **28 day Faster Diagnosis – 73.40%** (75% standard) – Compliant for Chesterfield, NUH and Sherwood Forest
- **31 day from Diagnosis – 91.9%** (96% standard) – Compliant for East Cheshire and Stockport.
- **62 day Urgent GP Referral – 60.3%**(85% standard) – Non compliant for all trusts.
- **62 day Screening Referral – 53.1%** (90% standard) – Non compliant for all trusts.
- **104 day wait –** Data unavailable at a CCG level.

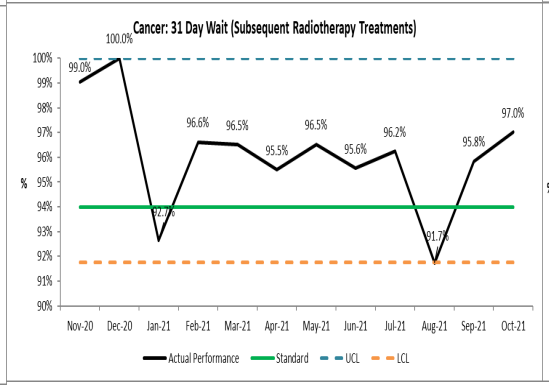


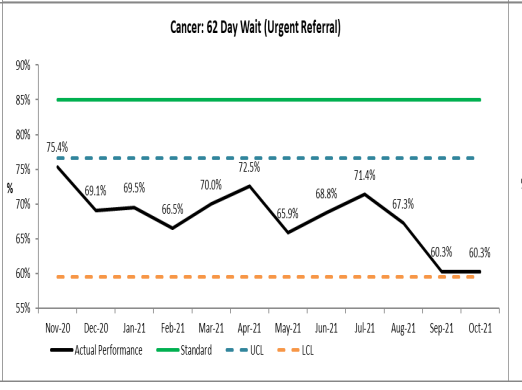


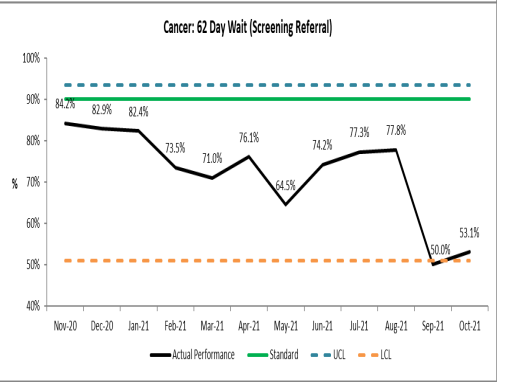












CCG performance data reflects the complete cancer pathway which for many Derbyshire patients will be completed in Sheffield and Nottingham.

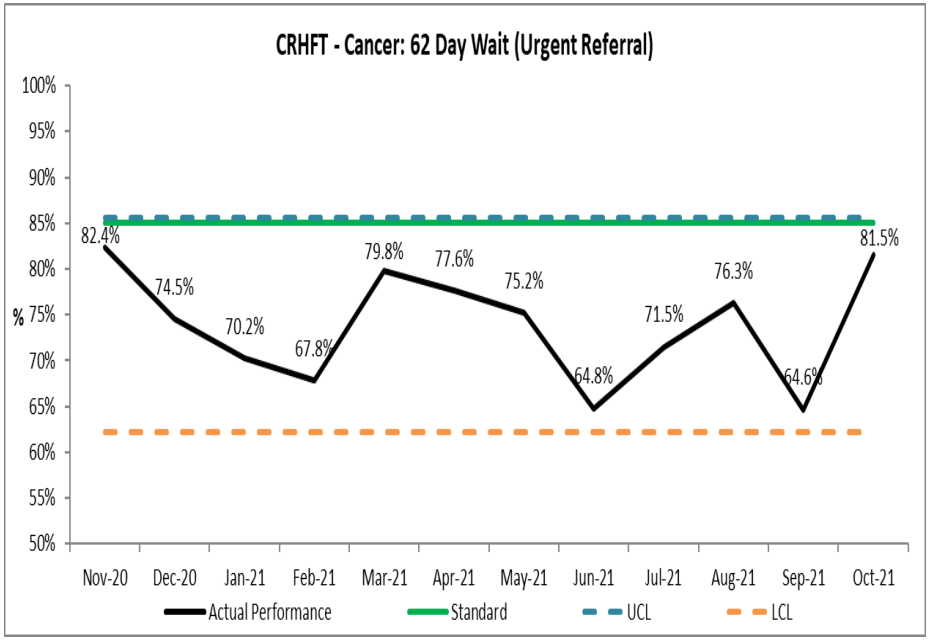
CRHFT - CANCER WAITING TIMES (First Treatment Administered within 62 Days of Urgent Referral)

Performance Analysis

CRH performance during October for first treatment within 62 days of urgent referral has improved to 81.5%, however, it remains non-compliant against the standard of 85%.

There were 94.5 patients treated along this pathway in October with 77 of those patients treated within the 62 day standard, resulting in 17.5 breaches which is an improvement on the 35 breaches reported in September.

Of the 17.5 breaches 5 of the patients were treated by day76, 4 treated by day 104 and 8.5 treated after 104days. The tumour sites reporting the breaches include Breast(2), Lower GI(4), Lung(1.5), Skin(1), Urology(6) and Other(3).



Current Issues

- Increase in Breast Referrals
- Workforce issues – impacted upon by Covid and Isolation
- PTL increasing
- ASI in Lower GI

Actions Being Taken

- Additional Breast Clinics, creating extra capacity.
- Monthly Tumour site Improvement meetings.
- Focus on reducing longest waits.

What are the next steps

- Continued focus on those patients over 62 day and 104 day on the PTL.
- H2 Operational Plan for 21/22 requires the trust to reduce their PTL of patients waiting over 63 days for treatment to the February 2020 figure or lower.

Tumour Type	Total Patients Seen	Seen Within 62 Days	Breaches of 62day Standard	% Seen Within 62 Days
Breast	5.5	3.5	2	63.64%
Lower Gastrointestinal	10.5	6.5	4	61.90%
Lung	6.5	5	1.5	76.92%
Other	22.5	19.5	3	86.67%
Skin	28	27	1	96.43%
Urological (Excl. Testicular)	21.5	15.5	6	72.09%
Total	**94.5**	**77**	**17.5**	**81.48%**

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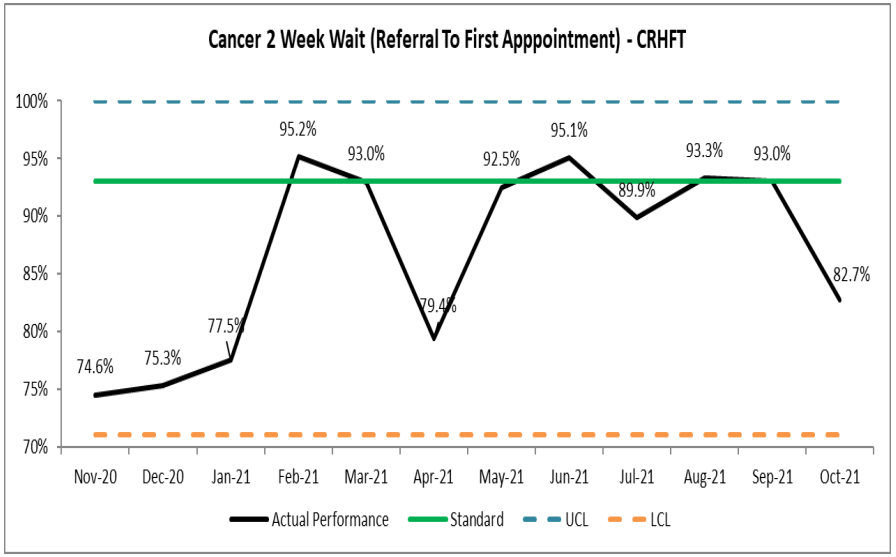
CRHFT - CANCER WAITING TIMES – 2 Week Wait - Urgent Referral to First Appointment



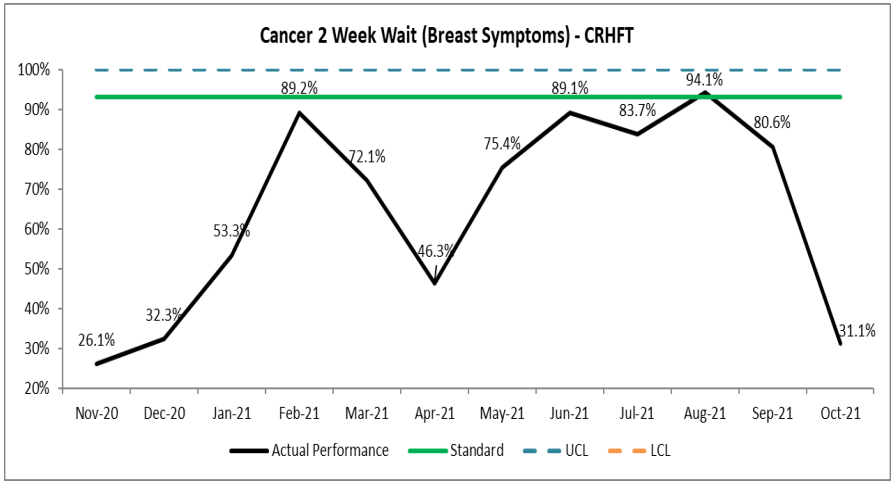
Performance Analysis

October performance at CRH for 2 week wait has reduced to 82.7% and continues to be non-compliant against the standard of 93%. The main challenges for 2ww performance this month has been associated with Breast which has continued to receive a high number of referrals.

There were a total number of 1060 patients seen in October by way of GP Urgent referral to first appointment which is a slight decrease on the 1128 reported in September. Over 65% of the referrals related to Breast, Lower GI and Skin. Of the 1060 patients seen in October 877 of these patients were seen within the 2 week wait standard, resulting in 183 breaches which is an increase on the 79 reported in September.

The 183 breaches occurred in Breast (124), Gynaecology (1), Head and Neck (7), Lower GI (23), Skin(17), Upper GI (9) and Urology (2).

CRHFT - CANCER WAITING TIMES – Breast Symptomatic



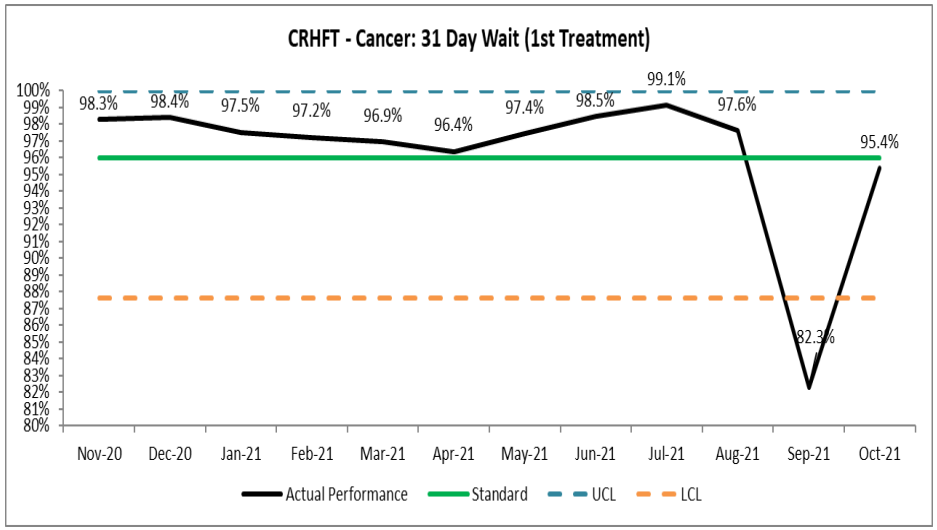
Performance Analysis

Performance in October at CRH for the Breast Symptomatic standard has reduced to 31.1% resulting in the Trust being non-complaint against the standard of 93%.

There were 45 patients seen via the Breast Symptomatic pathway in October which is more than usual, with 14 of those patients being seen within the 14 day standard resulting in 31 breaches which is an increase on the 7 breaches reported in September.

Out of the 31 breaches 5 of the patients were seen by day16, 17 patients were seen by day21 with the remaining 9 seen by day 28.

CRH - CANCER WAITING TIMES – First Treatment administered within 31 days of Diagnosis



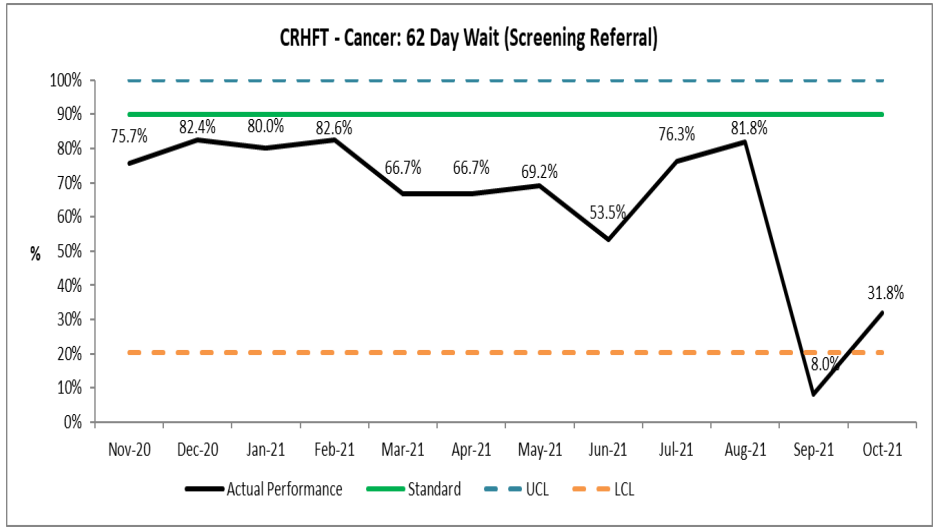
Performance Analysis

Performance in October at CRH for 31 day from diagnosis to first treatment has improved to 95.4%, resulting in the Trust being marginally non-compliant against the standard of 96%.

There were a total number of 151 patients treated in October along this pathway with 144 of those patients being treated within the 31day standard resulting in just 7 breaches. The tumour sites reporting the breaches are breast (6) and Lower GI (1).

Out of the 7 breaches 6 of them were treated by day 48 after diagnosis with the remaining 1 being treated by 62 days.

CRHFT - CANCER WAITING TIMES – 62day Screening Referral



Performance Analysis

Performance in October for the 62day screening standard has improved to 31.8% however, it continues to remain non-complaint against the standard of 90%.

The number of patients treated via screening referral were 22 with 7 of those patients being treated within the 62day screening standard resulting in 15 breaches which is a slight increase on the 11.5 breaches reported in September.

Of the 15 breaches there were 11.5 of those patients treated by day76, 2 by day104 and 1.5 after 104days.

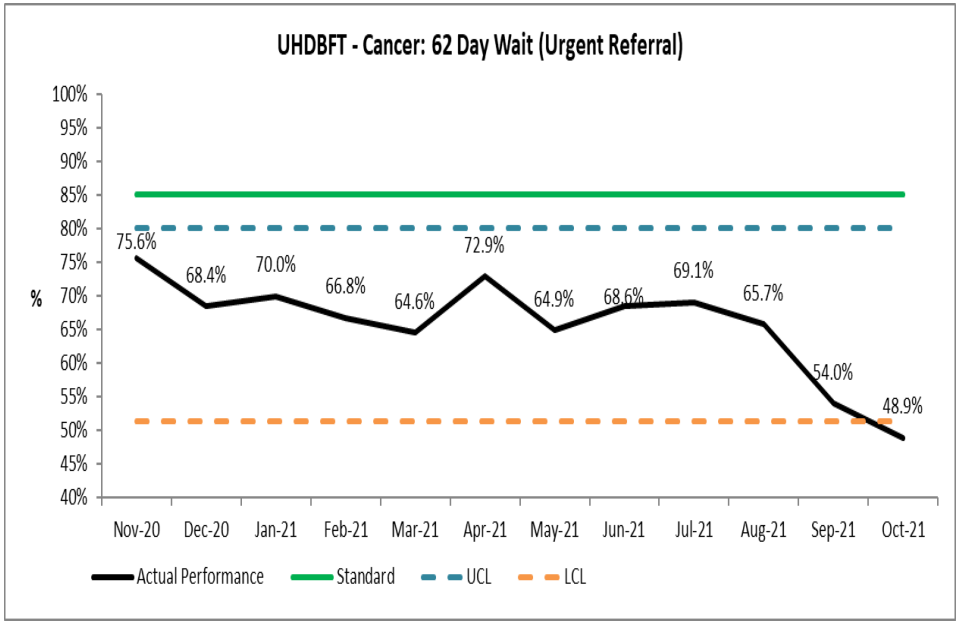
UHDB - CANCER WAITING TIMES (First Treatment Administered within 62 Days of Urgent Referral)

Performance Analysis

UHDB performance during October for first treatment within 62 days has reduced slightly to 48.9%, remaining non-compliant against the standard of 85%.

There were a total of 202.5 patients treated along this pathway in October with 99 of those patients being within the 62 standard resulting in 103.5 breaches, an increase from the 89.5 reported in September.

Out of the 103.5 breaches there were 32 patients treated by day76, 39.5 treated by day104 and 32 treated over 104days. The tumour sites reporting the breaches include Breast(10), Lower GI(12), Lung(4), Skin(6.5), Urology(36) and Other(35).



Current Issues

- Increase in Breast Referrals
- Workforce issues – impacted upon by Covid and Isolation
- Limited workforce to schedule additional capacity.
- Capacity issues are particular high in lower GI

Actions Being Taken

- Additional clinics where possible in particular to support Breast referrals
- Work with specific tumour sites and CCG where inappropriate referrals are received, pressure points and what actions we can take.

What are the next steps

- Continued focus on those patients over 62 day and 104 day on the PTL.
- H1 Operational Plan for 21/22 requires the trust to reduce their PTL of patients waiting over 63 days for treatment to the February 2020 figure or lower.

Tumour Type	Total Patients Seen	Seen Within 62 Days	Breaches of 62day Standard	% Seen Within 62 Days
Breast	34	24	10	70.59%
Lower Gastrointestinal	17	5	12	29.41%
Lung	9.5	5.5	4	57.89%
Other	58.5	23.5	35	40.17%
Skin	41.5	35	6.5	84.34%
Urological (Excl. Testicular)	42	6	36	14.29%
Total	202.5	99	103.5	48.89%

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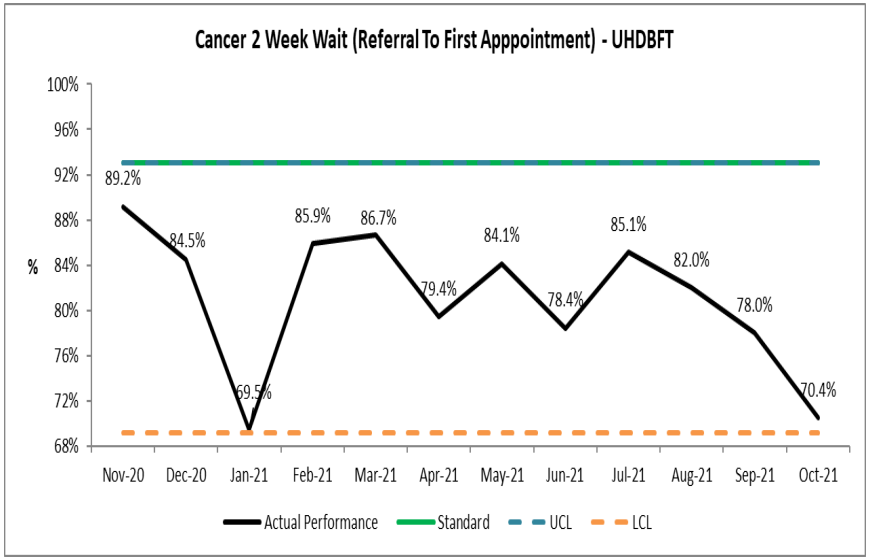
UHDB - CANCER WAITING TIMES – 2 Week Wait – Urgent Referral to First Appointment



Performance Analysis

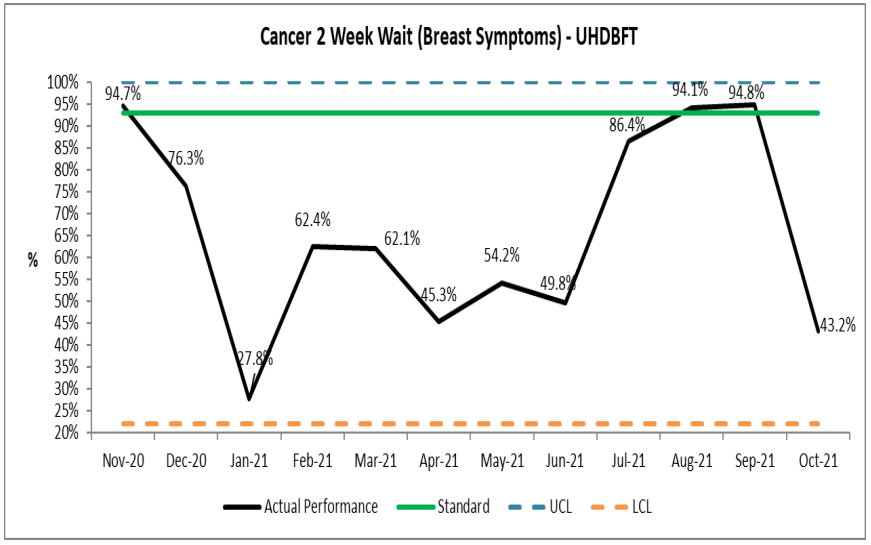
October performance at UHDB for 2 week wait has reduced to 70.4% and continues to remain non-compliant against the standard of 93%. The main challenges for 2ww performance this month has been associated with Breast, Gynaecology and Lower GI. Breast and Gynae referrals have continued to increase.

There were a total number of 3,194 patients seen in October by way of GP Urgent referral to first appointment which is an decrease on the 3,451 reported in September but it is to be noted is 10% than were seen in the same month during 2019.

Over 60% of the numbers seen relate to Breast, Lower GI and Skin. Of the 3,194 patients seen in October, 2,250 of these patients were seen within 14 days, resulting in 944 breaches.

The breaches occurred in Breast (306), Children (2), Gynaecology (195), Haematology (9), Head and Neck (17), Lower GI (284), Lung (1), Skin(51), Upper GI (42) and Urology (37).

UHDB - CANCER WAITING TIMES – Breast Symptomatic



Performance Analysis

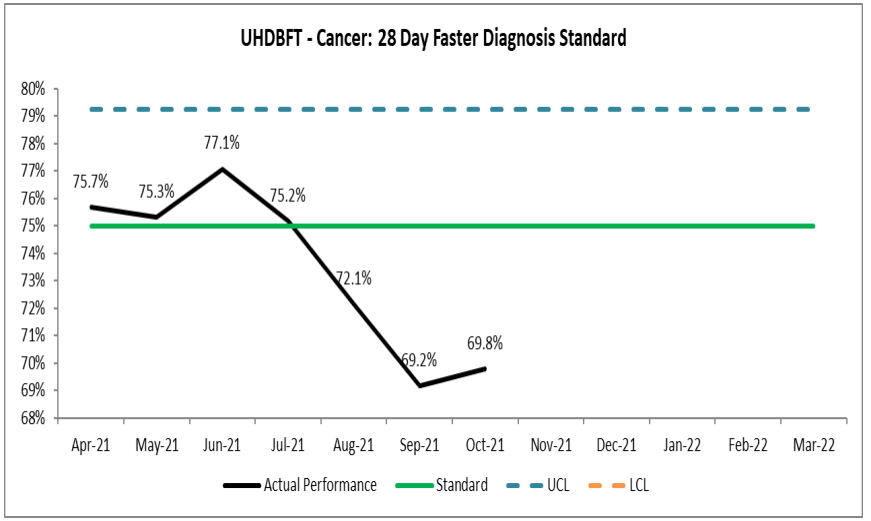
Performance in October at UHDB for the Breast Symptomatic standard has reduced to 43.2% resulting in the Trust being non-complaint against the standard of 93%.

There were 162 patients seen via the Breast Symptomatic pathway in October with 70 of those patients being seen within 14 days resulting in 92 breaches.

Out of the 92 breaches 35 of the patients were seen by day 16, 46 by day 21, 9 seen by day 28 and 2 over 28 days.

It is to be noted that the polling range for breast appointments has been increased to 35 days to enable all referrals to have an appointment booked.

UHDB - CANCER WAITING TIMES – 28 Day Wait Faster Diagnosis Standard



Performance Analysis

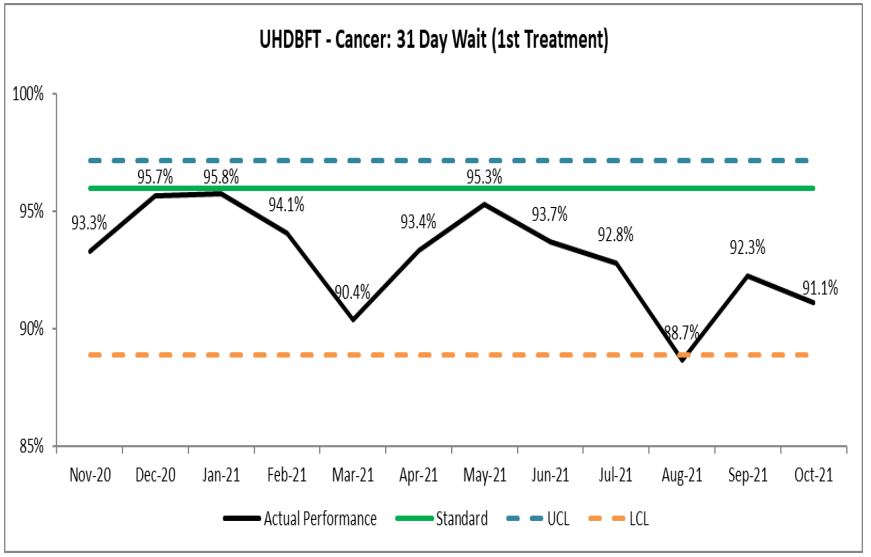
Performance in October at UHDB for the 28 day Faster Diagnostic Standard is 69.8% remaining non-Compliant against the 75% standard.

There were a total of 3200 patients through this part of the pathway in October with 2233 of those patients being informed of a cancer diagnosis or not within the 28 day standard, resulting in 967 breaches.

As there continues to be a high level of 2WW referrals, a number of patient are being seen after 2 weeks which then affects the ability of the teams to be able to diagnose or rule out a diagnosis of cancer within 28 days.

Over half of the breaches related to Gynaecology and Lower GI.

UHDB - CANCER WAITING TIMES – First Treatment administered within 31 days of Diagnosis



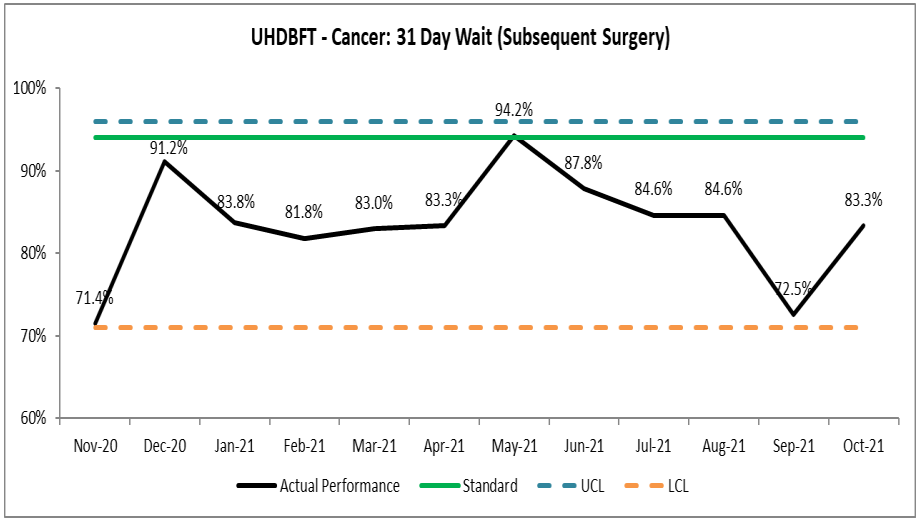
Performance Analysis

Performance in October at UHDB for 31 day from diagnosis to first treatment has reduced slightly to 91.1%, resulting in the Trust remaining non-compliant against the standard of 96%.

There were a total number of 371 patients treated in October along this pathway with 338 of those patients being treated within the 31day standard resulting in 33 breaches. The tumour sites reporting the breaches include Breast(7), Lower GI(3), Lung(1), Skin(10), Urology(7) and Other(5).

Out of the 33 breaches 11 of them were treated by day 38, 12 by day 48, 4 by day 62 and 6 being treated over 62 days.

UHDB - CANCER WAITING TIMES – 31day to Subsequent Surgery



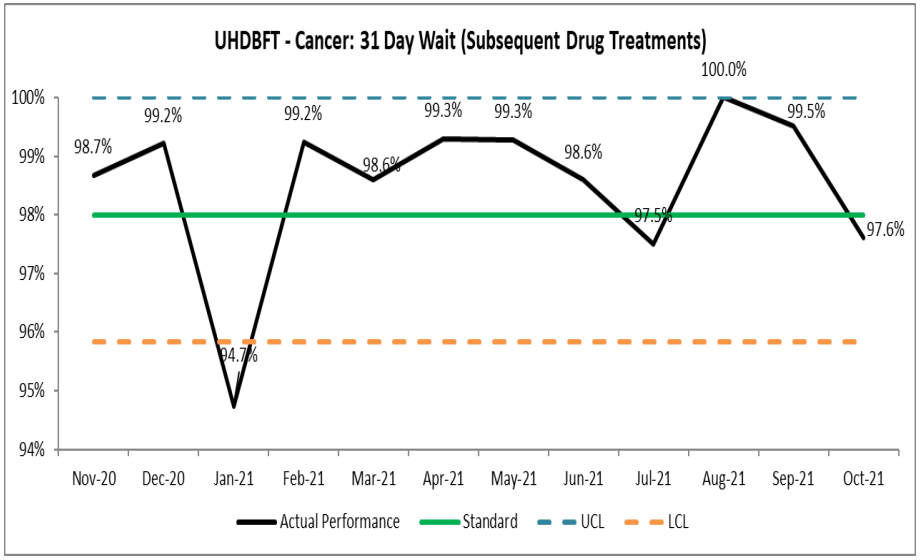
Performance Analysis

October performance at UHDB for 31 day to subsequent surgery has improved to 83.3%, continuing to be non-compliant against the standard of 94%.

There were a total number of 42 patients treated along the subsequent surgery pathway in October with 35 of those patients being treated within the 31 day standard, resulting in 7 breaches.

Of the 7 breaches, 3 of those patients were treated by day 38, 3 by day 62, and 1 over 62 days.

UHDB - CANCER WAITING TIMES – 31day Subsequent Drug Treatment



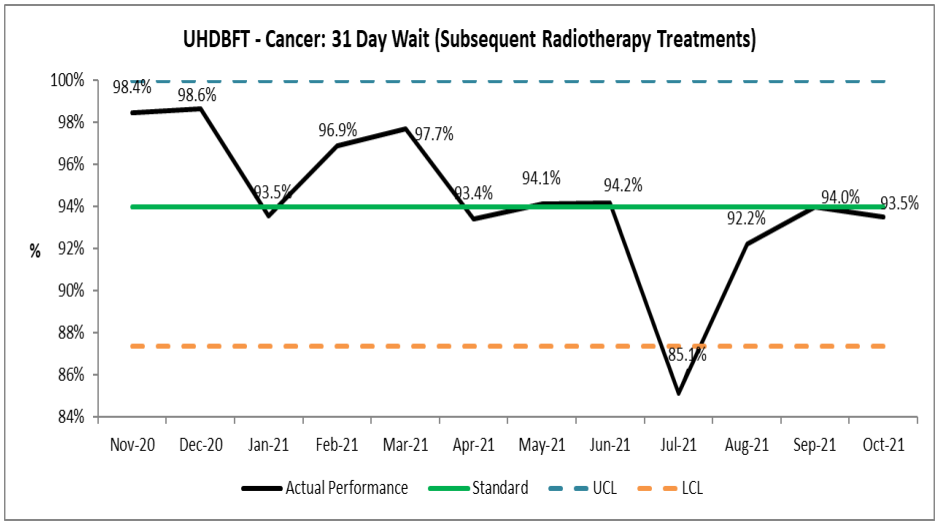
Performance Analysis

October performance at UHDB for 31 day to subsequent drug treatment has reduced slightly to 97.6%, just missing the standard of 98%.

There were a total number of 167 patients treated along the subsequent drug pathway in October with 163 of those patients being treated within the 31 day standard, resulting in 4 breaches.

Out of the 4 breaches, 2 of those patients were treated by day 38 and 2 by day 62.

UHDB - CANCER WAITING TIMES – 31day Subsequent Radiotherapy Treatment



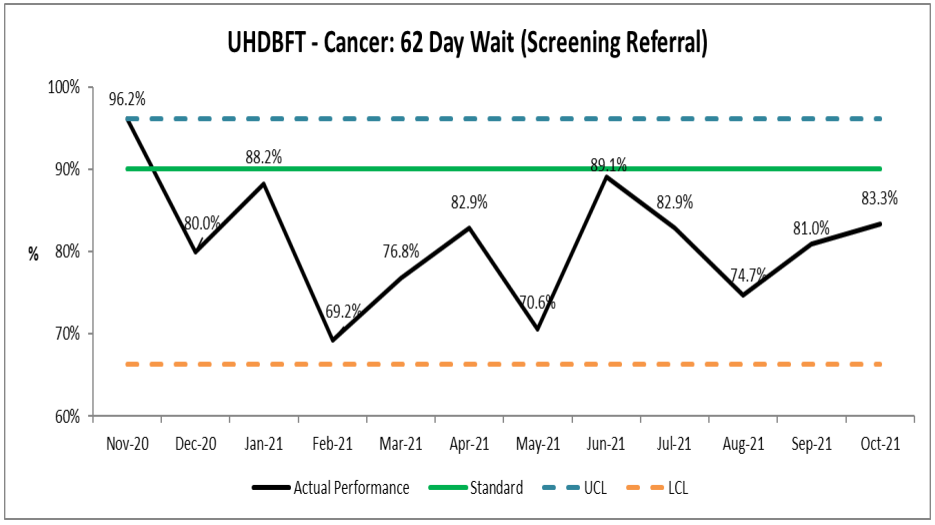
Performance Analysis

October performance at UHDB for 31 day to subsequent radiotherapy treatment has reduced slightly to 93.5%, continuing to be marginally non-compliant against the standard of 94%.

There were a total number of 77 patients treated along the subsequent drug pathway in October with 72 of those patients being treated within the 31 day standard, resulting in 5 breaches.

Out of the 5 breaches, 3 of those patients were treated by day 38, 1 by day 62 and 1 being treated over 62 days.

UHDB - CANCER WAITING TIMES – 62 Day Wait – Screening Referral



Performance Analysis

Performance in October at UHDB for 62day wait via Screening Referral has slightly improved to 83.3%, however, it continues to remain non-compliant against the standard of 90%.

There were a total of 42 patients treated in October who were referred from a screening service with 35 of those patients being treated within 62 days, resulting in 7 breaches.

Out of the 7 breaches 1 of those patients were treated by day 76, 4 by day 104 and 2 after 104 days.

Appendix

PERFORMANCE OVERVIEW M7 – ASSOCIATE PROVIDER CONTRACTS

Provider Dashboard for NHS Constitution Indicators					East Cheshire Hospitals				Nottingham University Hospitals				Sheffield Teaching Hospitals FT				Sherwood Forest Hospitals FT				Stockport FT			
	Area	Indicator Name	Standard	Latest Period	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance
Urgent Care	Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	Nov-21	↑	61.0%	62.1%	41	A&E pilot site - not currently reporting 4 hour breaches				↓	72.0%	73.8%	67	↓	84.3%	86.9%	13	↓	62.5%	70.3%	18
		A&E 12 Hour Trolley Waits	0	Nov-21	↓	106	204	8	↓	425	886	5	↑	8	38	9	↓	23	41	4	↓	6	15	4
Planned Care	Referral to Treatment for non-urgent consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Oct-21	↑	67.7%	56.4%	50	↓	65.6%	67.8%	25	↓	76.9%	80.1%	21	↓	71.6%	69.0%	50	↓	54.6%	57.1%	45
		Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Oct-21	↑	387	3770	22	↑	3782	24047	19	↑	885	5942	19	↓	928	8179	19	↓	3736	27147	42
	Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Oct-21	↓	22.84%	53.82%	20	↓	43.82%	42.18%	20	↓	16.14%	15.69%	20	↓	19.71%	22.12%	22	↓	37.99%	43.86%	28
	2 Week Cancer Waits	All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	Oct-21	↓	67.1%	90.1%	2	↓	88.6%	88.4%	7	↓	91.0%	83.9%	7	↑	91.2%	91.8%	5	↑	98.7%	97.6%	0
		Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	Oct-21	↓	36.4%	76.4%	8	↓	93.6%	78.5%	0	↓	64.4%	35.3%	7	↑	94.1%	94.3%	0	↔	N/A	N/A	0
	28 Day Faster Diagnosis	Diagnosis or Decision to Treat within 28 days of Urgent GP, Breast Symptom or Screening Referral	75%	Oct-21	↓	58.9%	67.1%	7	↑	82.3%	80.5%	0	↑	73.3%	66.5%	7	↑	78.2%	77.3%	0	↑	60.7%	58.6%	7
	31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	96%	Oct-21	↓	97.9%	92.1%	0	↑	90.3%	89.5%	31	↓	89.6%	91.0%	7	↓	91.9%	93.9%	5	↑	97.1%	97.4%	0
		Subsequent Surgery Within 31 Days Of Decision To Treat	94%	Oct-21	↑	100.0%	92.3%	0	↑	73.1%	69.5%	42	↓	66.3%	77.1%	11	↓	87.5%	92.3%	1	↑	100.0%	93.5%	0
		Subsequent Drug Treatment Within 31 Days Of Decision To Treat	98%	Oct-21	↔	N/A	100.0%	0	↓	96.3%	98.5%	2	↓	99.5%	99.3%	0	↔	100.0%	93.2%	0	↔	100.0%	100.0%	0
		Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	Oct-21					↑	97.4%	94.3%	0	↑	98.9%	96.8%	0								
	62 Days Cancer Waits	First Treatment Administered Within 62 Days Of Urgent GP Referral	85%	Oct-21	↑	75.4%	63.0%	25	↓	65.8%	68.9%	19	↑	61.6%	61.0%	74	↑	62.4%	68.0%	22	↓	65.0%	75.0%	30
		First Treatment Administered - 104+ Day Waits	0	Oct-21	↔	0.5	32.0	14	↑	23.5	140.0	67	↑	20.0	141.5	67	↑	9.0	47.0	42	↑	5.5	16.0	30
		First Treatment Administered Within 62 Days Of Screening Referral	90%	Oct-21	↓	81.3%	75.8%	11	↑	70.7%	71.3%	11	↓	68.9%	70.3%	11	↓	70.0%	76.9%	5	↔	0%	40.0%	5
		First Treatment Administered Within 62 Days Of Consultant Upgrade	N/A	Oct-21	↓	42.1%	86.9%		↓	70.2%	75.2%		↓	68.6%	76.7%		↓	69.2%	75.3%		↓	72.2%	81.2%	
Patient Safety	Incidence of healthcare associated Infection	Healthcare Acquired Infection (HCAI) Measure: MRSA Infections	0	Oct-21	↑	0	2	0	↔	0	0	0	↔	0	0	0	↔	0	0	0	↔	0	1	0
		Healthcare Acquired Infection (HCAI) Measure: C-Diff Infections	Plan	Oct-21	↔		17		↑		70		↑		98		↓		49		↔		31	
			Actual				4	0			45	0			71	0			34	1			18	0
		Healthcare Acquired Infection (HCAI) Measure: E-Coli	-	Oct-21	↓	13	123		↑	65	413		↑	41	313		↑	25	204		↓	18	136	
		Healthcare Acquired Infection (HCAI) Measure: MSSA	-	Oct-21	↓	4	46		↓	30	153		↔	17	114		↓	6	54		↔	3	32	

NHS
Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

13th January 2022

Item No: 227

Report Title	Governing Body Assurance Framework 2021/22 Quarter 3
Author(s)	Rosalie Whitehead, Risk Management & Legal Assurance Manager
Sponsor (Director)	Helen Dillistone, Executive Director of Corporate Strategy and Delivery

Paper for:	**Decision**	x	**Assurance**	x	**Discussion**		**Information**	

Recommendations

The Governing Body are requested to **AGREE** the 2021/22 Quarter 3 (October to December 2021) Governing Body Assurance Framework.

Report Summary

The Governing Body Assurance Framework (GBAF) provides a structure and process that enables the organisation to focus on the strategic and principal risks that might compromise the CCG in achieving its corporate objectives. It also maps out both the key controls that should be in place to manage those objectives and associated strategic risks, and confirms that the Governing Body has sufficient assurance about the effectiveness of the controls.

Strategic Objectives 2021/22

On the 6th May 2021, the Governing Body reviewed and agreed the 2021/22 CCG Strategic Objectives. These are managed through the GBAF to support the delivery and management of organisational risk.

Further work was undertaken on the objective descriptions following feedback from Governing Body. The final 2021/22 strategic objectives are reflective of our final year of operation as a CCG and recognises the transition into the ICS and are as follows:

1. Safely and legally transition the statutory functions of the CCG into the ICS, and safely deliver the disestablishment of the CCG.
2. Deliver the commitments made in response to the Operating Plan, with a focus on reducing health inequalities and improving outcomes for the people of Derbyshire, and continuing to support the system during transition to maintain a strategic focus on overall health outcomes / health inequalities.
3. Continue with the roll out of the Covid-19 vaccination programme and ensure a sustainable planning and operational model is in place.
4. Support the development of a recovering and sustainable health and care economy that operates within available resources, achieves statutory financial duties and meets NHS Constitutional standards.
5. Support our staff in the delivery of the above and transition into an ICS, through continued health and wellbeing programmes and effective communication and engagement.
6. Continue to further develop and implement new and transformational ways of working that have been developed in response to Covid.
7. Work in partnership with stakeholders and engage with our population to achieve the above objectives where appropriate.

Governing Body Assurance Framework Quarter 3

The following strategic risks have changed in risk score during quarter 3, October to December 2021.

Strategic Risk 7: CCG staff retention and morale during the transition will be adversely impacted due to uncertainty of process and implications of the transfer to the ICS, despite the NHSEI continuity of employment promise.

The responsible Committee is the Governance Committee.

The risk score has **increased** from a moderate 6 to a high score of 12.

The reason for the increase in score is:

- The CCG has concerns about losing staff and the impact of that is higher than the current probability score of 2.
- The risk score increase also aligns the with the ICB Transition risk 1 within the register.

Strategic Risk 8: If the CCG is not ready to transfer its functions or has failed to comprehensively and legally close down the organisation, or if the system is not ready to receive the functions of the CCG, the ICS operating model cannot be fully established.

The responsible Committee is the Governance Committee.

The risk score has **reduced** from a very high 16 to a high score of 10.

The reason for the reduction in score is:

- Version 2 of the Due Diligence update is received and being incorporated into project plans.
- 360 Audit have joined the CCG Transition Project Group which will provide assurance on the management of the project.
- The Draft Due Diligence Checklist was presented to CCG Audit Committee on 17th December and subsequently submitted as part of the regional submission due by the end of December 21 and uploaded 20th December 21.
- The GBAF risk is now aligning with the score for risk 7 on the Transition Risk Register.

The corporate committees proactively take the responsibility and ownership of their GBAF risks to scrutinise and develop them further. The Quality and Performance Committee GBAF Task and Finish Group meets monthly to review their GBAF risks thoroughly and is a dynamic group. The other committees are following a similar approach which is most appropriate for the Committee.

The corporate committees responsible for their assigned strategic risks have scrutinised and approved their GBAF Strategic Risks at their committee meetings held during October to December 2021.

The GBAF Quarter 3 can be found at appendix one to this report and updates to the strategic risk extract documents are detailed in red text.

Are there any Resource Implications (including Financial, Staffing etc)?
The Derby and Derbyshire CCG attaches great importance to the effective management of risks that may be faced by patients, members of the public, member practices and their partners and staff, CCG managers and staff, partners and other stakeholders, and by the CCG itself.
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?
Not required for this paper. Notwithstanding this, where any issues/risks that have been identified from Data Protection Impact Assessment (DPIA) appropriate actions will be taken to manage the associated risks.
Has a Quality Impact Assessment (QIA) been completed? What were the findings?
Not required for this paper. Notwithstanding this, where any issues/risks that have been identified from a Quality Impact Assessment) appropriate actions will be taken to manage the associated risks.
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
An EIA is not found applicable to this update on the basis that the GBAF is not a decision making tool; however, addressing risks will impact positively across the organisation as a whole.
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
Due Regard is not found applicable to this update on the basis that the GBAF is not a decision making tool; however, addressing risks will impact positively across the organisation as a whole.
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Not applicable to this update.
Have any Conflicts of Interest been identified/ actions taken?
Not applicable to this update.
Governing Body Assurance Framework
As detailed in appendix one, this paper provides Governing Body with assurance of the 2021/22 Quarter 3 GBAF for agreement.
Identification of Key Risks
The GBAF identifies the strategic/ principal risks which are linked to the corporate/ operational risks identified in the Corporate Risk Register.

NHS Derby and Derbyshire CCG: Summary Governing Body Assurance Framework
Quarter 3 – October to December 2021/22

NHS Derby & Derbyshire Clinical Commissioning Group

The Governing Body Assurance Framework (GBAF) aims to identify the strategic/principal risks to the delivery of the Derby and Derbyshire CGGs strategic objectives. It sets out the controls that are in place to manage the risks and the assurances that show if the controls are having the desired impact. It identifies the gaps in control and hence the key mitigating actions required to reduce the risks towards the target or appetite risk score. It also identifies any gaps in assurance and what actions can be taken to increase assurance to the Derby and Derbyshire CCG. The table below sets out the Derby and Derbyshire CCG strategic objectives; lists the strategic/principal risks that relate to them. Further details can be found on the extract pages for each of the strategic/ principal Risks.

The 2021/22 Strategic Objectives of Derby and Derbyshire CCG are reflective of our final year of operation as a CCG and recognises the transition into the ICS:

1. Safely and legally transition the statutory functions of the CCG into the ICS, and safely deliver the disestablishment of the CCG.
2. Deliver the commitments made in response to the Operating Plan, with a focus on reducing health inequalities and improving outcomes for the people of Derbyshire, and continuing to support the system during transition to maintain a strategic focus on overall health outcomes / health inequalities.
3. Continue with the roll out of the Covid-19 vaccination programme and ensure a sustainable planning and operational model is in place.
4. Support the development of a recovering and sustainable health and care economy that operates within available resources, achieves statutory financial duties and meets NHS Constitutional standards.
5. Support our staff in the delivery of the above and transition into an ICS, through continued health and wellbeing programmes and effective communication and engagement.
6. Continue to further develop and implement new and transformational ways of working that have been developed in response to Covid.
7. Work in partnership with stakeholders and engage with our population to achieve the above objectives where appropriate.

	Strategic Risk(s)	Current Rating	Executive Lead
1	Lack of timely data, insufficient system ownership and ineffective commissioning may prevent the ability of the CCG to improve health and reduce health inequalities. This is of particular concern during the COVID pandemic where some people may not be able to access usual services or alternatives.	15	Steve Lloyd
2	The CCG is unable to identify priorities for variation reduction and reduce or eliminate them.	20	Steve Lloyd
3	Ineffective system working may hinder the creation of a sustainable health and care system by failing to deliver the scale of transformational change needed at the pace required.	12	Zara Jones
4A	The Derbyshire health system is unable to manage demand, reduce costs and deliver sufficient savings to enable the CCG to move to a sustainable financial position.	16	Richard Chapman
4B	The Derbyshire health system is unable to manage demand, reduce costs and deliver sufficient savings to enable the system to move to a sustainable financial position	16	Richard Chapman
5	The Derbyshire population is not sufficiently engaged to identify and jointly deliver the services that patients need.	9	Helen Dillistone

6	The CCG does not achieve the national requirements for the Covid-19 Vaccination Programme and have robust operational models in place for the continuous sustainable delivery of the Vaccination Programme	**20**	Steve Lloyd
7	CCG staff retention and morale during the transition will be adversely impacted due to uncertainty of process and implications of the transfer to the ICS, despite the NHSEI continuity of employment promise.	**12**	Helen Dillistone
8	If the CCG is not ready to transfer its functions or has failed to comprehensively and legally close down the organisation, or if the system is not ready to receive the functions of the CCG, the ICS operating model cannot be fully established.	**10**	Helen Dillistone

Strategic Objective: 2	GBAF RISK 1	Executive Lead: Steve Lloyd Assigned to Committee: Quality and Performance
Deliver the commitments made in response to the Operating Plan, with a focus on reducing health inequalities and improving outcomes for the people of Derbyshire, and continuing to support the system during transition to maintain a strategic focus on overall health outcomes / health inequalities.		

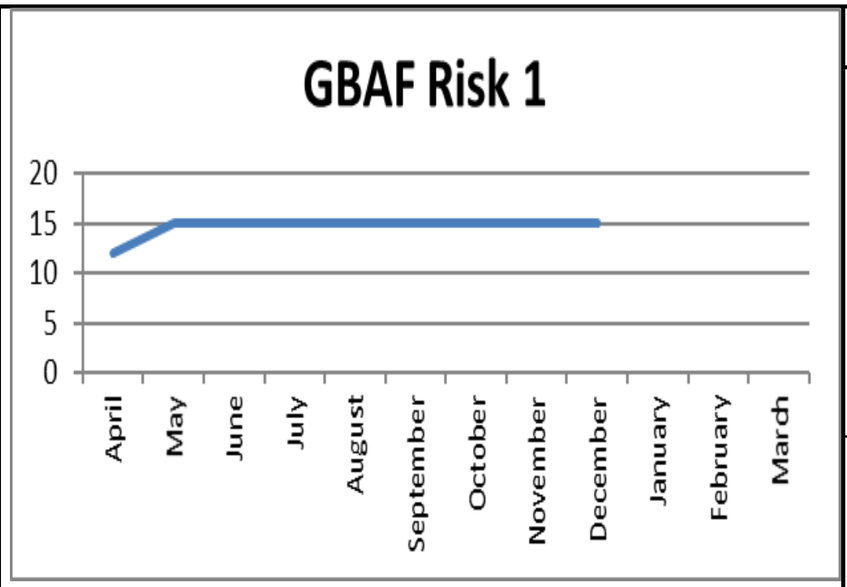
What would success look like and how would we measure it?

- Agreement and commitment to agenda at JUCD Board with inequalities in the Terms of Reference.
- New ICS governance structure to include addressing inequalities.
- Strategic Long Term Conditions Programme Board to be established with a clear remit to reduce unwarranted variation in services.
- Commissioning to focus on particular patient cohorts, with measures around services to be put in place to support reduction of inequalities.
- Covid risk stratification work should cover health and social care inequality, as well as mental health not just physical health.
- System Q&P dashboard to include inequality measures
- Patient experience and engagement feedback will be gathered at an early stage to inform all service change / development projects. This will be evidenced in business cases and project initiation documents.
- Feedback about the experience of Derby and Derbyshire end of life care will be gathered and analysed to provide intelligence to support the development of services that are driven by those who use services.
- A Quality and Equality Impact Assessment (QEIA) will be part of all service change / development projects and programmes. This will be a document that changes as benefits and risks along with mitigating actions are realised.
- The QEIA will also include evidence to demonstrate compliance with legislative requirements in respect of public engagement.
- Increase Patient Experience feedback and engagement.

Risk Description

Lack of timely data, insufficient system ownership and ineffective commissioning and the impact of COVID-19 may prevent the ability of the CCG to improve health and reduce health inequalities. This is of particular concern during the COVID pandemic where some people may not be able to access usual services or alternatives.

Risk rating	Likelihood	Consequence	Total
Initial	3	3	9
Current	5	3	15
Risk Appetite	**Level**	**Category**	**Target Score**
	Moderate	Commissioning and Contracting	8
	2	4	



Date reviewed	December 2021

Rationale for risk rating (and any change in score):

- The Derby and Derbyshire population are unable to access their usual service or an alternative due to the impact of the Covid pandemic,
- The CCG is unable to meets its strategic aim as above due to the impact of the Covid pandemic.
- Capacity in commissioning has improved.
- PLACE areas are now supported by a CCG Functional Director.
- QIA/EIA process in place.
- Recovery and Restoration plan and process in place.

Link to Derby and Derbyshire Risk Register

1,2,3,4,5,6,7,9,12,14,17,19,21,22,24,25,26,27,28

KEY CONTROLS TO MITIGATE RISK

Internal

- QIPP and Service Benefit Reviews challenge process.
- Prioritisation tool.
- Clinical & Lay Commissioning Committee providing clinical oversight of commissioning and decommissioning decisions.
- Robust QIA process for commissioning/ decommissioning schemes and System QIA now in place
- Clinical Quality Review Group (CQRG) measures built into all contracts
- Recovery and Restoration (R&R) Action Plan
- R&R progress and assurance reported monthly to Governing Body through the Quality & Performance Assurance report
- 2020/2021 Commissioning Intentions published and on website
- 2020/2021 Contracting approach and objectives developed
- Chief Nurse of DDCCG is the Chair of the System Quality and Performance Group
- Quality and Performance Committee meetings reinstated from June 20. As a result of the COVID 19 pandemic.
- CCG Escalated to Business Continuity Level 4 in December 2020 due to Covid 19 pandemic.
- Corporate Committees and Governing Body Meetings have not been stood down and continue to meet monthly.
- Functions continue to operate at BC level 3 and are reviewed regularly.
- Winter Planning Cell established and in place to manage the impact of winter pressures and

External

- NHSE and NHSI assurance arrangements
- CQC inspections and associated commissioner and provider action plans
- Programme Boards
- STP Oversight
- Meetings with Local Authority to identify joint funding opportunities.
- System wide efficiency planning has commenced for 2020/2021 showing commitment to joint system working
- System Quality and Performance Group has been established and monthly meetings in place.
- System ownership of the health inequalities agenda.
- Daily System Escalation Cell (SEC) meetings established to support the management of COVID 19 across the Derbyshire System.
- Winter Planning Cell established.
- STP/ ICS Interim Accountable Officer appointed.
- Strategic Long Term Conditions Programme Board to be established or system to collate and triangulate data and agree actions.
- ICS guidance published November 2020.
- Derby and Derbyshire formally approved as an ICS.
- ICS White Paper was published in February 2021.
- JUCD system moved from Gold Command to Silver Command.
- SEC meetings were stood down in February 2021, and operational issues being fully managed by the System Operational Resilience Group (SORG)
- Transition Assurance Committee (TAC)

SOURCES OF ASSURANCE

Internal

- Quality & Performance Committee
- Risk management controls and exception reports on clinical risks to Quality & Performance Committee
- Performance reporting framework in place
- Lay representation within Governing Bodies and committee in common structures.
- System NHSE assurance meetings to provide assurance.
- Recovery and Restoration (R&R) Action Plan and Highlight Report owned by Quality & Performance Committee
- Joined Up Care 5 Year Strategy Delivery Plan 19/20 - 23/24
- STP Refresh Summary
- R&R progress and assurance reported monthly to Governing Body through the Quality & Performance Assurance report
- Measurement of performance targets
- System Quality and Performance Group minutes
- System Phase 3 Plan approved by Governing Body and Submitted to NHSE.
- Monthly Winter Plan Report provided to JUCD Board.
- SOC and SVOC update provided weekly to System Escalation Cell (SEC) until it was stood down in February. Now provided to SORG.
- Vaccine hesitancy updates reported to weekly Gold Call meetings
- Plan on a page for each cohort.

External

- Quality Surveillance Group
- Recovery Action Plans
- Commissioning Boards
- Health and Well-being Boards
- Legal advice where appropriate
- NHSE System Assurance Letters
- System Quality and Performance Group minutes.
- Agreement and commitment to the Health Inequalities agenda at JUCD Board.
- SEC/SORG Agendas and Papers.
- SEC/SORG Action Logs.
- System Phase 3 Plan agreed and submitted to NHSE and is a work in progress plan.
- 2021/22 JUCD Operational Plan
- ICS Transition Plan
- Transition Assurance Committee (TAC), agenda, papers and minutes
- NHSEI Net Zero Carbon Strategy
- NHS Midlands Greener NHS Board agenda and minutes
- Derbyshire ICS NHS Greener Delivery Group agenda and minutes

COVID-19. • System Operational Centre established and include the System Vaccination Operational Centre (SVOC) • JUCD system moved from Gold Command to Silver Command February 2021. • Covid-19 Vaccination Inequalities Group established and in place to support tackling vaccine hesitancy in high risk and transient communities. The first meeting was held in February 2021. • JUCD 2021/22 Operational Plan submitted to NHSE 14th May 2021. • Transition Assurance Committee (TAC) established and inaugural meeting took place end April and meeting monthly. • CCG GB Chair is the Transition Assurance Committee (TAC) Chair and ICS CCG Transition Working Group Chair. • CCG ICS Transition Working Group established and meets monthly. First meeting took place 6th May. • Dr Robyn Dewis, Director of Public Health Derby City is Chair of Health Inequalities Group across the System. • Helen Dillistone is SRO lead for NHS Greener/ Sustainability Programme for the Derbyshire ICS.	established and inaugural meeting took place end April and meeting monthly. • Health Inequalities is priority focus of JUCD Board and Strategic Intent. • Health inequalities programme of work will be supported by the strategic intent function of the ICS, the anchor institution and the future plans for data and digital management. • ICS Design Framework published 16th June 2021 • Health and Care Bill ordered by The House of Commons 6th July 2021. • Further ICS/ ICB Guidance published August 2021 • John MacDonald appointed as ICB Designate Chair. • Dr Chris Clayton appointed as Chief Executive Designate of NHS Derby and Derbyshire ICB • Greener NHS National Programme published Net Zero Carbon Strategy, cites multiple links between climate change, sustainable development, and health inequalities. • Improving health and patient care and reducing health inequalities is one of the top three priorities of the Greener NHS National Programme. • NHS Midlands Greener NHS Board • Derbyshire ICS NHS Greener Delivery Group • Joined Up Improvement Derbyshire Efficiency and Productivity PMO in place. • Craig Cook appointed as interim Chief Digital and Intelligence Officer.	• Vaccination Inequalities Group Terms of Reference and Action Plan. • 2021/22 JUCD Operational Plan • ICS Transition Plan • Transition Assurance Committee (TAC), agenda, papers and minutes • CCG ICS Transition Working Group agenda, papers and minutes	

GAPS IN CONTROL		GAPS IN ASSURANCE	
Internal	**External**	**Internal**	**External**
• Commissioning the specific needs to meet the demands of the Covid Pandemic • CCG patient experience function stood down in response to COVID.	• CCG does not currently have an evidence-based strategy to address inequalities. • Programme of work for appropriate interventions, informed by public health data and incorporating the wider determinants of health.	• CCG patient experience function stood down in response to COVID.	• Understanding health data and implications of Covid including disparities of outcomes. • Understanding direct impacts and long-term implications of Covid. Triangulating through system. • Development of Derbyshire ICS NHS Greener Plan • Development of ICS Health Inequalities Plan

ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)			
Internal	**Timeframe**	**External**	**Timeframe**
• Post COVID Syndrome Pathway meeting established in November and has been meeting fortnightly until w/c 15.03.21. Now meeting on a monthly basis, due to the launch of a monthly clinical forum. • Addressing health inequalities is a key priority in the ICS System Development Plan currently being drafted for submission to NHSEI • JUCD quality group is undertaking a review of the system quality strategies and a joint strategy will be developed in the next six months. Health inequalities will form part of that strategy.	• Ongoing, monthly • Ongoing • December 2021	• Long Term Conditions Strategy. • Long Term Conditions Board to identify groups for focus (prioritisation work started) • Derbyshire ICS NHS Greener Plan to be approved by ICB Board • ICS Health Inequalities Plan to be approved by Shadow ICB Board March 2022	• Ongoing • Ongoing • April 2022 • March 2022

Strategic Objective: 2	GBAF RISK 2	Executive Lead: Steve Lloyd Assigned to Committee: Quality and Performance
Deliver the commitments made in response to the Operating Plan, with a focus on reducing health inequalities and improving outcomes for the people of Derbyshire, and continuing to support the system during transition to maintain a strategic focus on overall health outcomes / health inequalities.		

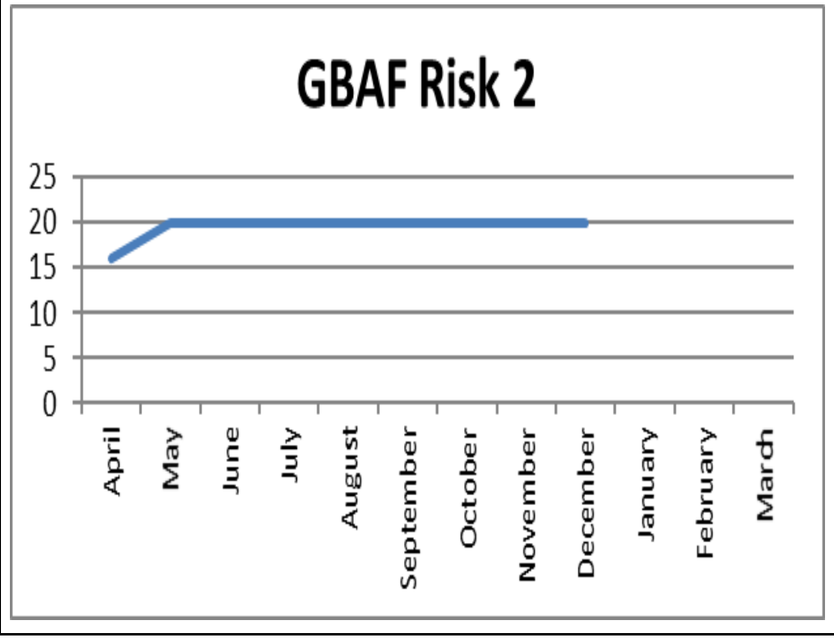
What would success look like and how would we measure it?

- Agreement and commitment to agenda at JUCD Board with unwarranted variation in quality in the Terms of Reference.
- JUCD to take a disease management approach to variation, rather than individual services.
- New ICS governance structure to include addressing unwarranted variation in quality.
- CCG to understand the variations in services across JUCD and if these are unwarranted.
- Quality to work with commissioning teams to ensure contracts address the inequalities.
- System Q&P dashboard to used to identify the variations at system level.
- System Q&P to address the unwarranted variation identified from the dashboard, through the JUCD Programme Boards.
- Improve Patient experience and engagement feedback and how it will be gathered to understand how varying of services is impacting on the people of Derbyshire.

Risk Description

The CCG is unable to identify priorities for variation reduction and reduce or eliminate them.

Risk rating	Likelihood	Consequence	Total
Initial	3	4	12
Current	5	4	20
Risk Appetite	Level	Category	Target Score
	Moderate	National Quality and Direction	8
	2	4	



Date reviewed	December 2021

Rationale for risk rating (and any change in score):

- CCG unable to identify priorities for variation reduction due to the impact of the Covid pandemic.
- Increase in risk score as a result in losing Clinical and Medical Staff to prioritise Covid patients.
- The STP Clinical leadership group is becoming established.
- The Systems saving group is bringing key partners together to deliver the financial priorities and has increased joint ownership of priorities.
- PLACE commissioning is developing.

Link to Derby and Derbyshire Risk Register
1,2,3,4,5,6,7,9,12,14,17,21,22,23,24,25,26,27,28,29

KEY CONTROLS TO MITIGATE RISK		SOURCES OF ASSURANCE	
Internal	External	Internal	External
• Clinical & Lay Commissioning Committee providing clinical oversight of commissioning and decommissioning decisions • Robust QIA process for commissioning/ decommissioning schemes and new System QIA panel in place • Clinical Quality Review Group (CQRG) measures built into all contracts • Executive Team and Finance Committee oversight. • Contract Management Board (CMB) oversight • Quality & Performance Committee • Recovery and Recovery (R&R) Plan • R&R progress and assurance reported monthly to Governing Body through the Quality & Performance Assurance report • Brigid Stacey, Chief Nurse of Derby and Derbyshire CCG is the Chair of the System Quality & Performance Group • Internal resource planning work led by HR • Quality and Performance Committee meetings reinstated from June 20 as a result of the COVID 19 pandemic. • Winter Planning Cell established and in place to manage the impact of winter pressures and COVID-19 • CCG Escalated to Business Continuity Level 4 in December 2020 due to Covid 19 pandemic. • Corporate Committees and Governing Body Meetings have not been stood down and continue to meet monthly. • Functions continue to operate at BC level 3 and are reviewed regularly. • JUCD system moved from Gold Command to Silver Command February 2021. • Covid-19 Vaccination Inequalities Group established and in place to support tackling vaccine hesitancy in high risk and transient communities. • JUCD 2021/22 Operational Plan submitted to NHSE 14th May 2021. • Transition Assurance Committee (TAC) established and inaugural meeting took place end April and meeting monthly. • CCG GB Chair is the Transition Assurance Committee (TAC) Chair and CCG ICS Transition Working Group Chair. • CCG ICS Transition Working Group established and meets monthly. First meeting took place 6th May. • Dr Robyn Dewis, Director of Public Health Derby City is Chair of Health Inequalities Group across	• NHSE System assurance arrangements • Provider Governance arrangements are clear and include any subcontracting responsibilities. • CQC inspections and associated commissioner and provider action plans • STP Oversight • System Quality & Performance Group established and meets on a monthly basis • Winter Planning Cell established • STP/ ICS Interim Accountable Officer appointed • System Quality and Performance Group meetings stood down from March 2020 to July 2020 due to COVID 19 pandemic. • ICS guidance published November 2020. • Derby and Derbyshire formally approved as an ICS. • System Quality and Performance Group meetings continue to meet and are not stood down at level 4 • ICS White Paper was published in February 2021. • JUCD system moved from Gold Command to Silver Command. • SEC meetings were stood down in February 2021, and operational issues being fully managed by the System Operational Resilience Group (SORG). • Transition Assurance Committee (TAC) established and inaugural meeting took place end April and meeting monthly. • Health Inequalities is priority focus of JUCD Board and Strategic Intent. • Health inequalities programme of work will be supported by the strategic intent function of the ICS, the anchor institution and the future plans for data and digital management. • ICS Design Framework published 16th June 2021 • Health and Care Bill ordered by The House of Commons 6th July 2021. • Health and Care Bill ordered by The House of Commons 6th July 2021. • Further ICS/ ICB Guidance published August 2021 • John MacDonald appointed as ICB Designate Chair. • Dr Chris Clayton appointed as Chief Executive Designate of NHS Derby and Derbyshire ICB • Greener NHS National Programme published Net Zero Carbon Strategy, cites multiple links between climate change, sustainable development, and health inequalities. • Improving health and patient care and reducing health inequalities is one of the top three priorities	• Quality & Performance Committee • Risk management controls and exception reports on clinical risk to Quality & Performance • Performance reporting framework • Lay and Council representation within Governing Bodies and committees structure. • Clinical Committee established at Place, • Quality assurance visits • NHSE system assurance meetings to provide assurance. • R&R Plan and Highlight Report owned by Quality & Performance Committee • Joined Up Care 5 Year Strategy Delivery Plan 19/20 - 23/24 • STP Refresh Summary • R&R progress and assurance reported monthly to Governing Body through the Quality & Performance Assurance report • Brigid Stacey, Chief Nurse of Derby and Derbyshire CCG is the Chair of the System Quality & Performance Group. • Daily System Escalation Cell meetings established to support the management of COVID 19 across the Derbyshire System. • System Phase 3 Plan approved by Governing Body and Submitted to NHSE. • Monthly Winter Plan Report provided to JUCD Board. • Vaccine hesitancy updates reported to weekly Gold Call meetings • Plan on a page for each cohort. • Vaccination Inequalities Group Terms of Reference and Action Plan. • Decision making principles to be applied to each cohort to ensure consistent approach. • 2021/22 JUCD Operational Plan • ICS Transition Plan • Transition Assurance Committee (TAC), agenda, papers and minutes • CCG ICS Transition Working Group agenda, papers and minutes	• Collaboration with Healthwatch • Health and Well-being Boards • NHSE/I assurance meetings • CQC Inspections and action plans • Quality Surveillance Group • Minutes of System Quality & Performance Group • System Phase 3 Plan agreed and submitted to NHSE and is a work in progress plan • 2021/22 JUCD Operational Plan • ICS Transition Plan • Transition Assurance Committee (TAC), agenda, papers and minutes • System Outcomes Based Accountability Steering Group has commenced work looking at health outcomes. • NHSEI Net Zero Carbon Strategy • NHS Midlands Greener NHS Board agenda and minutes • Derbyshire ICS NHS Greener Delivery Group agenda and minutes

the System. • Helen Dillistone is SRO lead for NHS Greener/ Sustainability Programme for the Derbyshire ICS	of the Greener NHS National Programme. • NHS Midlands Greener NHS Board • Derbyshire ICS NHS Greener Delivery Group • Joined Up Improvement Derbyshire Efficiency and Productivity PMO in place. • Craig Cook appointed as interim Chief Digital and Intelligence Officer		
GAPS IN CONTROL		**GAPS IN ASSURANCE**	
Internal • CCG unable to identify priorities for variation reduction due to the impact of the Covid pandemic. • CCG patient experience function stood down in response to COVID.	External • Identify variation caused through system processes and work with system partners to eliminate or reduce. • Priorities which carry the most significant at-scale benefits for early action.	Internal • Development of STP planning and refresh. • CCG patient experience function stood down in response to COVID.	External • Differentiate which variation is appropriate for elimination and which is not; develop a prioritised plan for the former. • Agree dataset to measure improvement in outcomes and patient experience. • Development of Derbyshire ICS NHS Greener Plan • Development of ICS Health Inequalities Plan

ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)			
Internal • Establishment of Quality & Performance Committee Task & Finish Group to provide scrutiny and challenge. • Addressing health inequalities is a key priority in the ICS System Development Plan currently being drafted for submission to NHSEI • JUCD quality group is undertaking a review of the system quality strategies and a joint strategy will be developed in the next six months. Health inequalities will form part of that strategy.	Timeframe • Ongoing monthly • Ongoing • December 2021	External • Increased system working with system partners to deliver transformation change. • Refer issues to System Quality and Performance Group. • Strategic Long Term Conditions Programme Board to address variation. (Working on risk stratification with BI / Board are reviewing priorities) • Right Care Evidence and Data (awaiting updated data packs) • Working with the LTC Board to agree Priorities at System Event. • Working with the LTC Board to agree Strategic Long Term Conditions Programme Board to agree dataset measurement. • Derbyshire ICS NHS Greener Plan to be approved by ICB Board • ICS Health Inequalities Plan to be approved by Shadow ICB Board March 2022	Timeframe • Ongoing • Monthly System Quality & Performance Group • Ongoing • Ongoing • TBC • Ongoing • April 2022 • March 2022

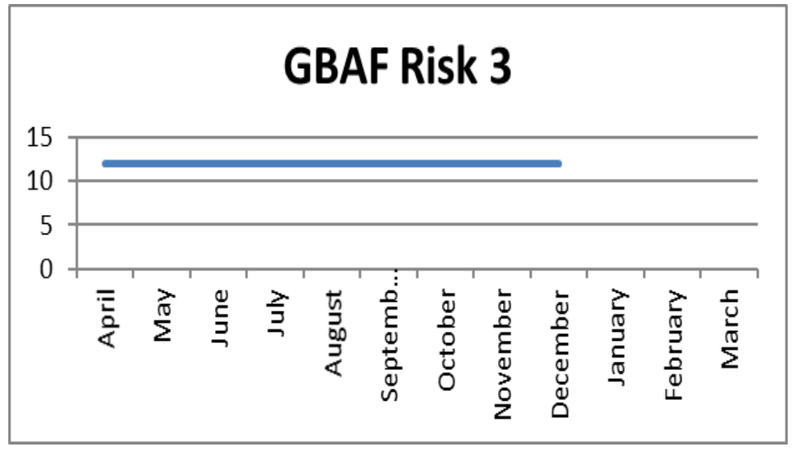
NHS
Derby & Derbyshire
Clinical Commissioning Group

Strategic Objective: 6 **Continue to further develop and implement new and transformational ways of working that have been developed in response to Covid.**	**GBAF RISK 3**	**Executive Lead: Zara Jones** **Assigned to Committee: Clinical & Lay Commissioning**

What would success look like and how would we measure it?	**Risk Description**
Safe delivery of our Phase 3 and winter plan through effective system oversight of delivery and escalation and resolution of issues. Retaining the benefits of learning and transformation through wave 1 COVID-19. Improved / sustained relationships with system partners – increased collaboration and strengthened planning and delivery, less duplication and more shared accountability for delivery.	**Ineffective system working may hinder the creation of a sustainable health and care system by failing to deliver the scale of transformational change needed at the pace required.**

Risk rating	Likelihood	Consequence	Total
Initial	3	4	**12**
Current	3	4	**12**

Risk Appetite	Level	Category	Target Score
	Moderate	Collaborative working	**8**
	2	4	



Date reviewed	December 2021

Rationale for risk rating (and any change in score):

- System working through the last few months remains at the same level in terms of collaboration and mutual support.
- Measures are not easily measurable making the score more subjective.

Link to Derby and Derbyshire Risk Register
1,2,3,4,5,6,9,10,12,14,17,19,22,23,24,25,26,27,28,29

KEY CONTROLS TO MITIGATE RISK

Internal

- Senior members of staff are fully involved in STP/ ICS workstreams
- Link with STP
- Strong CEO lead and influence on STP
- Good clinical engagement i.e. Medical Director a key player in CPRG
- CPAG and new Clinical Pathways Forum
- Commissioning Intentions 20/21 finalised and agreed with Providers and published on website
- Clinical Leadership Framework in place
- Deep Dives on areas of poor performance involving provider partners e.g. Q&P deep dives
- Lessons learned application to 20/21 planning and delivery through Finance Committee and shared with GB and system
- Clinical and Lay Commissioning Committee meetings reinstated June 2020 a result of the COVID 19 pandemic.
- Clinical Cell established to manage COVID 19 issues, Steve Lloyd Medical Director is the lead

External

- Governance structure embedded
- Good CEO/DoF system engagement
- JUCD Board now fully functioning as a group of system leaders and meeting in public since January 2021.
- Systems Savings Group
- Future in Mind Plan agreed by the CCG, Derby City Council and Derbyshire County Council
- System Quality and Performance Group established to support in-year delivery strategically, linked to the transformation agenda
- System Planning leads oversight of contracting and planning for 20/21, linked to DoFs group to ensure we set the right framework for delivery of our transformation as a system.
- System Clinical and Professional Reference Group established and meets monthly.
- System intelligence – one version of the truth
- Winter Planning Cell established
- STP/ ICS Executive Lead appointed
- ICS guidance published November 2020.
- Derby and Derbyshire formally approved as an ICS.

SOURCES OF ASSURANCE

Internal

- Clinical & Lay Commissioning Committee meetings
- Governing Body
- Executive Team
- Recovery and Restoration Action Plan
- Recovery and Restoration Plan Highlight Report owned by Clinical & Lay Commissioning Committee
- Clinical & Lay Commissioning Assurance Report provided to Governing Body.
- STP System Refresh
- Draft Joined Up Care 5 Year Delivery Plan 19/20 – 23/24
- Commissioning Intentions 20/21 published and available on the CCGs website.
- System Phase 3 Plan approved by Governing Body and Submitted to NHSE.
- Winter Planning Cell established and in place to manage the impact of winter pressures and COVID-19.

External

- JUCD Board
- System Forums including delivery boards, planning leads
- CEO/DoF meetings
- CPRG meetings
- NHSE/I reviews
- Derby City Council
- Derbyshire County Council
- Future in Mind Plan published on Derby City Council website
- Future in Mind Plan published on Derbyshire County Council website
- STP refresh
- System Clinical and Professional Reference Group Minutes
- System Phase 3 Plan agreed and submitted to NHSE and is a work in progress plan.

for the cell. • Zara Jones, Executive Director of Commissioning and Operations is the lead for the System Planning Cell. • Daily System Escalation Cell meetings established to support the management of COVID 19 across the Derbyshire System (currently stood down) • System Planning and Operations Cell established to manage and determine recovery plans and future planning. • Established intelligence and baseline data on finance, activity and workforce to enable scenario modelling to inform decision making. • CCG Escalated to Business Continuity Level 4 in December 2020 due to Covid 19 pandemic. • Corporate Committees and Governing Body Meetings have not been stood down and continue to meet monthly. • Functions continue to operate at BC level 3 and are reviewed regularly. • JUCD system moved from Gold Command to Silver Command February 2021 • JUCD 2021/22 Operational Plan submitted to NHSE 14th May 2021. • System Transition Assurance Committee established and inaugural meeting took place end April and meeting monthly. • CCG GB Chair is the System Transition Assurance Committee Chair. • CCG Governing Body received Derbyshire ICS Boundary Update at their meeting in public 2nd September 2021. • Joint Derby Derbyshire CCG and Tameside and Glossop CCG Transition Steering Group established to lead four main workstreams. • Four workstreams comprising of specialist leads across both systems for Communications and Engagement, Finance IT and Contracting, Neighbourhood Development and Statutory Duties, Risks and People Impact Assessment.	• ICS White Paper was published in February 2021. • JUCD system moved from Gold Command to Silver Command. • SEC meetings were stood down in February 2021, and operational issues being fully managed by the System Operational Resilience Group (SORG) • System Transition Assurance Committee established, and inaugural meeting took place end April and meeting monthly. • Secretary of State for Health and Social Care decision taken in August 2021 to amend the ICS boundary so that Glossop will move from the Greater Manchester ICS into the Derbyshire ICS • Dr Chris Clayton appointed as Chief Executive Designate of NHS Derby and Derbyshire ICB • John MacDonald appointed as ICB Designate Chair. • Joined Up Improvement Derbyshire Efficiency and Productivity PMO in place	• SOC and SVOC update provided weekly to System Escalation Cell (SEC) until it was stood down in February. Now provided to SORG. • 2021/22 JUCD Operational Plan • System Transition Assurance Committee, agenda, papers and minutes • CCG submitted its Engagement Report to NHSEI in June 2021. • Joint Transition Steering Group minutes and action log. • Derbyshire ICS Transition Plan	• SEC/SORG Agendas and Papers. • SEC/SORG Action Logs • 2021/22 JUCD Operational Plan • System Transition Assurance Committee, agenda, papers and minutes • Joint Transition Steering Group minutes and action log. .

GAPS IN CONTROL		GAPS IN ASSURANCE	
Internal	**External**	**Internal**	**External**
• Not able to influence decisions • Limited CCG capacity to contribute to all meetings Clinical and Lay Commissioning Committee meetings stood down from March 2020 to June 2020 due to CCG operating at level 4 Business Continuity Escalation as a result of the COVID 19 pandemic. • Withdrawal of Turnaround approach • Development of communications and engagement plan with stakeholders, patients and public. • Contracting and Commissioning implications on broader geography and population • Place/ PCN planning and Primary Care development to include Glossop	• National directives • 'Club v's country' i.e. organisational sovereignty over system • System Clinical and Professional Reference Group meetings stood down due to COVID 19 pandemic. • Workforce plans to be established across the system to provide the necessary competency and capacity to deliver healthcare, including contingency plans for staff reductions due to Covid-19. • Suspension of operational planning • Suspension of Systems Savings Group and PMO • Necessary delays in some transformation work		• System Clinical and Professional Reference Group Minutes not available due to current Position. • Quantify residual health need resulting from Covid infection and factor into capacity and demand planning.

ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)			
Internal	**Timeframe**	**External**	**Timeframe**
• System savings work in place and ongoing • Joined Up Care Derbyshire Workstream Delivery Boards / Assurance • Strategic commissioner and ICS / ICP development • Virtual urgent decisions can be made by CLCC as per the Terms of Reference as required. • Weekly 30 minute Confidential GB Virtual Meetings established, with focused agenda have been established for urgent decision making and any urgent committee business. • Clinical Cell established to manage COVID 19 issues, Steve Lloyd Medical Director is the lead for the cell. • Zara Jones, Executive Director of Commissioning and Operations is the lead for the System Planning Cell. • Glossop transition Communications and Engagement Plan with stakeholders, patients and public. • Contracting and Commissioning Plan to include broader geography and population • Place/ Primary Care Network (PCN) Plan and Primary Care Plan to include Glossop	• Monthly review • Ongoing • Ongoing • Ongoing • Ongoing • Ongoing • Since March 2020 and ongoing • Ongoing • Ongoing • Ongoing	• Continued work with system partners to develop and deliver transformation plans • Development of Direct Enhanced Services during 2021/22 through PCCC. • System Escalation Cell/ SORG meetings established to support the management of COVID 19 across the Derbyshire System. • System Planning and Operations Cell established to manage and determine recovery plans and future planning.	• Monthly review • June 2021 • Ongoing • Ongoing

Strategic Aim: 4 **Support the development of a recovering and sustainable health and care economy that operates within available resources, achieves statutory financial duties and meets NHS Constitutional standards.**	**GBAF RISK 4A**	**Executive Lead: Richard Chapman** **Assigned to Committee: Finance Committee**

What would success look like and how would we measure it?

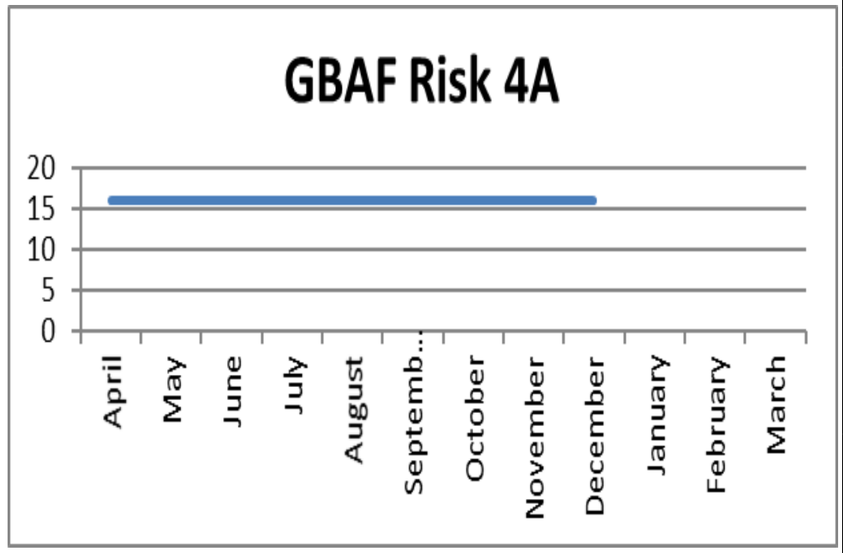
- Delivery of agreed 2021/22 financial position.

Risk Description

The Derbyshire health system is unable to manage demand, reduce costs and deliver sufficient savings to enable the CCG to move to a sustainable financial position.

Risk rating	Likelihood	Consequence	Total
Initial	5	5	**25**
Current	4	4	**16**

Risk Appetite	Level	Category	Target Score
	Low	Financial Statutory Duties	**10**
	2	5	



Date reviewed	December 2021

Rationale for risk rating (and any change in score):

- Identify underlying system position, current and forward-looking
- The risk score for GBAF risk 4A has been increased to a very high score of 16. Work remains ongoing to monitor and manage the 2020/21 position, but also to understand the recurrent expenditure position as the CCG and system partners begin planning for 2021/22. The CCG is working with system partners to understand the recurrent underlying position and early work suggests there is a considerable system financial challenge moving into 2021/22.
- The Derbyshire NHS system has a gap of c. £43m between expenditure assessed as required to meet delivery plans and notified available resource. The CCG is working with system partners to agree how these resources are used and what remaining financial risk there is, where this risk will be held and how it can be mitigated.

Link to Derby and Derbyshire Risk Register
11,30

KEY CONTROLS TO MITIGATE RISK		SOURCES OF ASSURANCE	
Internal	**External**	**Internal**	**External**
• Contract management incl. validation of contract information, coding and counting challenges etc. • Internal management processes – monthly confirm and challenge by Executive Team & Finance Committee. • Recovery and Restoration (R&R) Plan. • R&R progress and assurance reported monthly to Governing Body through the Finance Committee Assurance report. • Finance Committee meetings reinstated from June 2020 • Temporary financial regime in place within the CCG for the 6 month period 1st April to 30th September 2020 as a result of COVID-19. • NHSEI have provided guidance of a new financial for the period to March 2021. The allocations	• Standardised contract governance in line with national best practice. • System Finance Oversight Group (SFOG) established. • Daily System Escalation Cell meetings established to support the management of COVID 19 across the Derbyshire System • System Savings Group established and in place • System Finance Oversight Group in place and reinstated and continuing to meet at BC level 4. • The Derbyshire NHS system has a gap of c. £43m between expenditure assessed as required to meet delivery plans and notified available resource. The CCG is working with system partners to agree how these resources are used and what remaining financial risk there is, where	• Monthly reporting to NHSE/NHSI, Finance Recovery Group and Finance Committee. • Internal Audit 20/21 Integrity of the general ledger, financial reporting and budgetary control Audit giving significant assurance. • Recovery and Restoration Action Plan. • R&R progress and assurance reported monthly to Governing Body through the Finance Committee Assurance report • Finance Committee Minutes • Service Development Funding received end September 20. • SOC and SVOC update provided weekly to System Escalation Cell (SEC) until it was stood down in February. Now provided to	• Regulator review and oversight of monthly financial submissions • System Finance Oversight Group Minutes • 2021/22 JUCD Operational Plan • ICS Transition Plan • System Transition Assurance Committee, agenda, papers and minutes

have been based on the first 6 months of the financial year and includes additional system allocations for COVID-19, Top-up and Growth. • CCG Escalated to Business Continuity Level 4 in December 2020 due to Covid 19 pandemic. • Corporate Committees and Governing Body Meetings have not been stood down and continue to meet monthly. • Functions continue to operate at BC level 3 and are reviewed regularly. • JUCD system moved from Gold Command to Silver Command February 2021. • JUCD 2021/22 Operational Plan submitted to NHSE 14th May 2021. • System Transition Assurance Committee established, and inaugural meeting took place end April and meeting monthly. • CCG GB Chair is the System Transition Assurance Committee Chair and ICS CCG Transition Working Group Chair. • CCG ICS Transition Working Group established and meets monthly. First meeting took place 6th May. • CCG Finance Committee integrated with System and Finance Estates Committee from January 2022.	this risk will be held and how it can be mitigated. • ICS guidance published November 2020. • Derby and Derbyshire formally approved as an ICS. • ICS White Paper was published in February 2021. • JUCD system moved from Gold Command to Silver Command. • SEC meetings were stood down in February 2021, and operational issues being fully managed by the System Operational Resilience Group (SORG) • System Transition Assurance Committee established and inaugural meeting took place end April and meeting monthly. • Dr Chris Clayton appointed as Chief Executive Designate of NHS Derby and Derbyshire ICB • John MacDonald appointed as ICB Designate Chair. • Joined Up Improvement Derbyshire Efficiency and Productivity PMO in place	SORG. • 2021/22 JUCD Operational Plan • ICS Transition Plan • System Transition Assurance Committee, agenda, papers and minutes • CCG ICS Transition Working Group agenda, papers and minutes	

GAPS IN CONTROL		GAPS IN ASSURANCE	
Internal	**External**	**Internal**	**External**
• Consistent and regular reporting of timely, accurate and complete activity data with associated financial impact.	• Absence of integrated system reporting of the health financial position. • System Finance Oversight Group meetings to be reinstated September 2020. • Establish common system objective to deliver financial sustainability on a system-wide basis. • Identify underlying system position, current and forward-looking. • Establish system-wide monitoring, efficiency and transformational delivery process.	• Regularisation of integrated activity, finance and savings reporting incorporating activity trajectoried matched to provider capacity to deliver and associated commissioner financial impact	• Absence of commitment to open-book reporting with clear risk identification. • System Finance Oversight Group Minutes

ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)

Internal	Timeframe	External	Timeframe
• Strengthening of activity data reporting to ensure improved business intelligence to support decision making. • Development of an integrated Activity Finance & Savings report in place	• Ongoing • Ongoing	• Transparency of open book reporting through System Savings Group • Output from Demand & Capacity Workstream on waiting list growth (reduction) and consider in financial sustainability terms.	• Ongoing • May 2021

Derby & Derbyshire Clinical Commissioning Group

Strategic Aim: 4	GBAF RISK 4B	Executive Lead: Richard Chapman Assigned to Committee: Finance Committee
Support the development of a recovering and sustainable health and care economy that operates within available resources, achieves statutory financial duties and meets NHS Constitutional standards.		

What would success look like and how would we measure it?

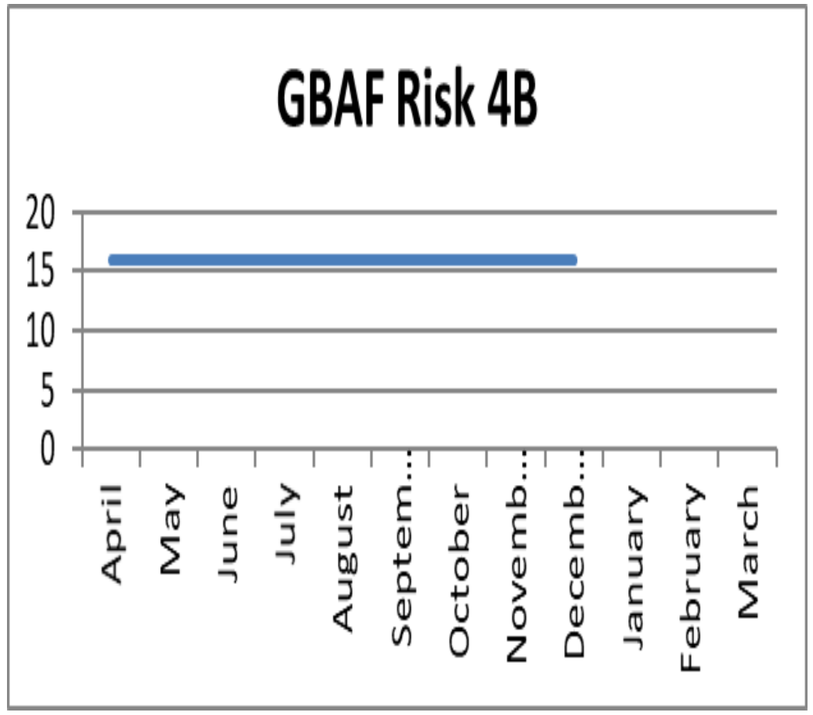
- Delivery of agreed 2021/22 financial position on a system basis.

Risk Description

The Derbyshire health system is unable to manage demand, reduce costs and deliver sufficient savings to enable the system to move to a sustainable financial position.

Risk rating	Likelihood	Consequence	Total
Initial	5	4	**20**
Current	4	4	**16**

Risk Appetite	Level	Category	Target Score
	Low	Financial Statutory Duties	**10**
	2	5	



Date reviewed	December 2021

Rationale for risk rating (and any change in score):

- Identify underlying system position, current and forward-looking.
- The system does not currently have a functional efficiency programme or agreed structures to implement such a programme.
- The risk score for GBAF risk 4B has been increased to a very high score of 16. Work remains ongoing to monitor and manage the 2020/21 position, but also to understand the recurrent expenditure position as the CCG and system partners begin planning for 2021/22. The CCG is working with system partners to understand the recurrent underlying position and early work suggests there is a considerable system financial challenge moving into 2021/22.
- The likelihood was increased based on initial assessment that the NHS system has a gap of c. £43m between expenditure assessed as required to meet delivery plans and notified available resource. Since this initial risk the CCG is working with system partners and we have, as a result of a much-improved CCG position, been able to report that the system are forecasting a break-even position, with the providers reporting a combined £5.0m surplus against the CCGs £5.0m deficit. Work remains ongoing to monitor and manage this position, particularly in relation to where the risks are and how these can be mitigated.

Link to Derby and Derbyshire Risk Register
11,30

KEY CONTROLS TO MITIGATE RISK		SOURCES OF ASSURANCE	
Internal	**External**	**Internal**	**External**
• Internal management processes – monthly confirm and challenge by Executive Team and Finance Committee • Integrated financial reporting incorporating I&E and savings positions and risk • Recovery and Restoration (R&R) Plan. • Clinical Leadership Framework in place across the system to support governance and clinical workstreams. • R&R Plan progress and assurance reported monthly to Governing Body through the Finance Committee Assurance report • Finance Committee meetings reinstated from June 2020 • NHSEI have provided guidance of a new financial for the period to March 2021. The allocations have been based on the first 6 months of the financial year and includes additional system allocations for COVID-19, Top-up and Growth. • CCG Escalated to Business Continuity Level 4 in December 2020 due to Covid 19 pandemic. • Corporate Committees and Governing Body Meetings have not been stood down as continue to meet monthly. • Functions continue to operate at BC level 3 and are reviewed regularly. • JUCD system moved from Gold Command to Silver Command February 2021. • JUCD 2021/22 Operational Plan submitted to NHSE 14th May 2021. • System Transition Assurance Committee established and inaugural meeting took place end April and meeting monthly. • CCG GB Chair is the System Transition Assurance Committee Chair and ICS CCG Transition Working Group Chair. • CCG ICS Transition Working Group established and meets monthly. First meeting took place 6th May. • CCG Finance Committee integrated with System and Finance Estates Committee from January 2022.	• Standardised contract governance in line with national best practice. • System Finance Oversight Group (SFOG) established • Requirement to agree a multi-year system recovery plan with regulator in order to mitigate impact score • The Derbyshire NHS system has a gap of c. £43m between expenditure assessed as required to meet delivery plans and notified available resource. The CCG is working with system partners to agree how these resources are used and what remaining financial risk there is, where this risk will be held and how it can be mitigated. • ICS guidance published November 2020. • Derby and Derbyshire formally approved as an ICS. • SFOG continue to meet at BC Level 4, December • ICS White Paper was published in February 2021. • JUCD system moved from Gold Command to Silver Command. • SEC meetings were stood down in February 2021, and operational issues being fully managed by the System Operational Resilience Group (SORG) • 2020 onwards. • System Transition Assurance Committee established and inaugural meeting took place end April and meeting monthly. • Dr Chris Clayton appointed as Chief Executive Designate of NHS Derby and Derbyshire ICB • John MacDonald appointed as ICB Designate Chair. • Joined Up Improvement Derbyshire Efficiency and Productivity PMO in place	• Monthly reporting to NHSE/NHSI, Executive Team and Finance Committee. • Recovery and Restoration Plan. • Clinical Leadership Framework in place across the system to support governance and clinical workstreams. • Recovery and Restoration Programme progress and assurance reported monthly to Governing Body through the Finance Committee Assurance Report • Finance Committee Minutes • SOC and SVOC update provided weekly to System Escalation Cell (SEC) until it was stood down in February. Now provided to SORG. • 2021/22 JUCD Operational Plan. • ICS Transition Plan. • System Transition Assurance Committee, agenda, papers and minutes. CCG ICS Transition Working Group agenda, papers and minutes.	• Regulator review and oversight of monthly financial submissions • System Finance Oversight Group Minutes • 2021/22 JUCD Operational Plan • ICS Transition Plan • System Transition Assurance Committee, agenda, papers and minutes

GAPS IN CONTROL		GAPS IN ASSURANCE	
Internal	**External**	**Internal**	**External**
• Consistent and regular reporting of timely, accurate and complete activity data with associated financial impact.	• Absence of a single system view of activity data which is timely, accurate and complete. • Absence of a system planning function on which partners place reliance. • Absence of integrated system reporting of the health financial position. • Regulatory and statutory financial duties mitigate against system collaboration and cooperation to reduce health cost. • System Activity Finance & Savings report • System Savings Group established and in place • System Finance Oversight Group in place • System Finance Oversight Group reinstated September 20 and continues to meet at BC Level 4 from December 20, • Establish common system objective to deliver financial sustainability on a system-wide basis. • Identify underlying system position, current and forward-looking. • Establish system-wide monitoring, efficiency and transformational delivery process.	• Regularisation of integrated activity, finance and savings reporting incorporating activity trajectoried matched to provider capacity to deliver and associated commissioner financial impact	• Absence of commitment to open-book reporting with clear risk identification. • Provider rules only allow reforecasting on a quarterly basis, unable to influence this • Provider Sustainability Fund rules incentivise delay in risk recognition meaning forecasting may not be fully objective, unable to influence this • System Finance Oversight Group minutes not available due to current position

ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)			
Internal	**Timeframe**	**External**	**Timeframe**
• Development of new System Activity Finance & Savings report	• Ongoing	• Establish greater system working across finance teams • Transparency of open book reporting through System Savings Group • System Escalation Cell/ SORG meetings established to support the management of COVID 19 across the Derbyshire System • Output from Demand & Capacity Workstream on waiting list growth (reduction) and consider in financial sustainability terms.	• Ongoing • Ongoing • Ongoing • May 2021

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Strategic Aim: 7 Work in partnership with stakeholders and engage with our population to achieve the above objectives where appropriate.	**GBAF RISK 5**	Executive Lead: Helen Dillistone Assigned to Committee: Engagement Committee

What would success look like and how would we measure it?

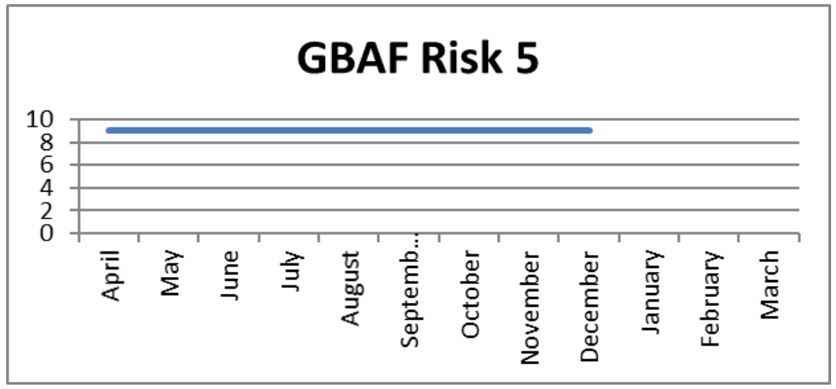
Output and delivery of comprehensive engagement programme, with % increase to Citizen's Panel membership and agreed % population engaged in planning in Yr1. Fully populated and network engagement structure, with permanent membership of Engagement Committee confirmed.

Risk Description

The Derbyshire population is not sufficiently engaged to identify and jointly deliver the services that patients need.

Risk rating	Likelihood	Consequence	Total
Initial	4	3	**12**
Current	3	3	**9**

Risk Appetite	Level	Category	Target Score
	Low	Commissioning	**6**
	2	3	



Date reviewed	December 2021

Rationale for risk rating (and any change in score):

- The CCG recognises the risk of operating in a complex and financially challenged environment and the need to balance decision making with appropriate engagement and involvement.
- The risk likelihood was reduced from 4 to 3 in October to reflect the appetite and development to implement the Derbyshire Dialogue programme.

Link to Derby and Derbyshire Risk Register
4,5,6,7,9,12,14,16,24,25,26,27,28

KEY CONTROLS TO MITIGATE RISK

Internal

- Clearly defined system strategy which identifies key health priorities and forward planning to ensure public engagement can be embedded.
- Engagement function with clearly defined roles and agreed priorities.
- Engagement Committee to provide challenge and internal scrutiny; the Committee has broad representation from provider Governors, members of the public, Local Government, Healthwatch and the Voluntary Sector.
- Alignment of CCG and JUCD communications and engagement agendas where necessary to provide streamlined and coherent approach.
- Identified involvement of communications and engagement lead involvement in all projects.

External

- Engagement Committee has dual responsibility for the alignment of JUCD and CCG communications and engagement agendas where necessary to provide streamlined and coherent approach.
- Relationship development with local parliamentary and council politicians.
- Structured approach to broader stakeholder engagement.
- Proactive formal and informal Engagement with Overview & Scrutiny Committees, with clear business plan.
- Co-production approach to planning utilising existing local experts by experience (Lay Reference Groups)
- Joined Up Care Derbyshire Comms and Engagement collaboration and planning.
- Legal/Consultation Institute advice on challenging issues.

SOURCES OF ASSURANCE

Internal

- Confirm and challenge and outputs for Engagement Committee providing assurance to GBs.
- Governing Body assurance of Engagement Committee evidence from training and development.
- Commissioning cycle to involve patient engagement.
- EIA and QIA process.
- QIA/EIA panel.
- Communications & Engagement Team aligned to programme boards to maintain understanding of emerging work and implications
- Systematic completion of S14Z2 forms will provide standardised assurance against compliant decision making and recording of decisions at project level.

External

- Membership (and other stakeholder) feedback via annual 360 survey.
- Approval of commissioning strategy and associated decisions by the Clinical Lay Commissioning Committee.
- Approval of engagement and consultation processes from Overview and Scrutiny Committees.
- NHS England CCG Assurance Rating.
- INHS England Assurance on winter communications and engagement plan
- NHS England assurance on NHS 111 First communications and engagement plan
- 2021/22 JUCD Operational Plan
- ICS Transition Plan
- System Transition Assurance Committee, agenda, papers and minutes

• Clearly defined offer and ownership of communications channels to support consistency of approach and clarity of message. • QEIA panel now includes review of S14Z2 (engagement review) forms to provide early sighting on engagement requirements • Simple engagement model now approved to support project flow through consistent process. • Strengthening of CCG committee cover sheets to ensure committees making implementation decisions have full assurance that duties have been met. • 2020/21 Commissioning Intentions finalised and agreed with Providers. • Population Health Management in development • Recovery and Restoration Plan • Governing Body • Commissioning Intentions 2020/21 published and on website. • Engagement Committee meetings reinstated from June 2020. • Zara Jones, Executive Director of Commissioning and Operations is the lead for the System Planning Cell. • Daily System Escalation Cell meetings established to support the management of COVID 19 across the Derbyshire System • System Planning and Operations Cell established to manage and determine recovery plans and future planning • Communications and Engagement Strategy- outline proposal of the strategy ready for January 2021 and final version in March 2021 asserting ambition for measuring success. CCG Escalated to Business Continuity Level 4 in December 2020 due to Covid 19 pandemic. • Corporate Committees and Governing Body Meetings have not been stood down and Engagement Committee meets bi-monthly. • Functions continue to operate at BC level 3 and are reviewed regularly. • JUCD system moved from Gold Command to Silver Command February 2021 • JUCD 2021/22 Operational Plan submitted to NHSE 14th May 2021. • System Transition Assurance Committee established and inaugural meeting took place end April and meeting monthly. • CCG GB Chair is the System Transition Assurance Committee Chair and ICS CCG Transition Working Group Chair. • CCG ICS Transition Working Group	• Derbyshire Dialogue launched in September 2020 to begin process of continuous engagement with local people. Subjects covered to date include the pandemic response, primary care and mental health, with future sessions planned on UEC and cancer. • Derby and Derbyshire formally approved as an ICS. • ICS White Paper was published in February 2021. • JUCD system moved from Gold Command to Silver Command. • System Transition Assurance Committee established and inaugural meeting took place end April and meeting monthly. • Health Inequalities is priority focus of JUCD Board during May and June 2021. • Joined up Care Derbyshire Communications and Engagement Strategy approved at JUCD Board 15th July 2021. • Further ICB guidance published in August 2021. • Awaiting Health & Social Care Bill to be passed in parliament. • Dr Chris Clayton appointed as Chief Executive Designate of NHS Derby and Derbyshire ICB • John MacDonald appointed as ICB Designate Chair.	• Training for Engagement Committee membership to ensure robust understanding and application of guidance and statutory responsibility. • 2020/21 Commissioning Intentions finalised and agreed with Providers. • Population Health Management supported by Public Health Directors and Governing Body. • Establishment of Strategic Advisory Group. • Governing Body developing CCG Strategy. • Commissioning Intentions published and on website • Significant community engagement programme in progress to support vaccine inequalities agenda. • 2021/22 JUCD Operational Plan • ICS Transition Plan • System Transition Assurance Committee, agenda, papers and minutes CCG ICS Transition Working Group agenda, papers and minutes	

established and meets monthly. First meeting took place 6th May. • Dr Robyn Dewis, Director of Public Health Derby City is Chair of Health Inequalities Group across the System.			
GAPS IN CONTROL		**GAPS IN ASSURANCE**	
Internal • A robust engagement programme that supports the health inequalities and commissioning agendas at the planning stage, with full population analysis to support reaching seldom heard groups. • Finalise construct of engagement mechanisms from PPG level, through PCN, Place, ICP to Engagement Committee level, subject to system structure agreement. • Embed clear and robust statements and processes relating to the desire to engage in CCG strategic policies. • Communication and Engagement not appropriately funded to ensure effectiveness in crowded public sector messaging space.	**External** • Multiple public sector messages resulting in CCG cut through being a challenge	**Internal** • Embed insight gathering processes into BAU for health service commissioning, with programme support identification of behaviours and issues that affect service commissioning and health inequalities • CCG Communications and Engagement Strategy requires refresh, including alignment with JUCD approach	**External** • CCG Communications and Engagement Strategy requires refresh, including alignment with JUCD approach
ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)			
Internal	**Timeframe**	**External**	**Timeframe**
• Training support for project managers in development on commissioning cycle to standardise processes, building on recent project management training. • Fully populated and network engagement structure, with permanent membership of Engagement Committee confirmed. • Funding proposal developed to support implementation and ambition of Communications and Engagement Strategy	• Q4 2021/22 (paused during Level 4 Business Continuity arrangements) • Ongoing • Q4 2021/22 (in line with national and system financial planning processes for 21/22)	• Engagement Committee re-established bi-monthly. • Insight programme in progress but requires longer-term funding model • Funding proposal developed to support implementation and ambition of Communications and Engagement Strategy	• Bi-monthly 2021/22 • Q4 2021/22 • Q4 2021/22 (in line with national and system financial planning processes for 21/22)

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Strategic Objective: 3	GBAF RISK 6	Executive Lead: Steve Lloyd Assigned to Committee: Quality and Performance Committee
Continue with the roll out of the Covid-19 vaccination programme and ensure a sustainable planning and operational model is in place.		

What would success look like and how would we measure it?

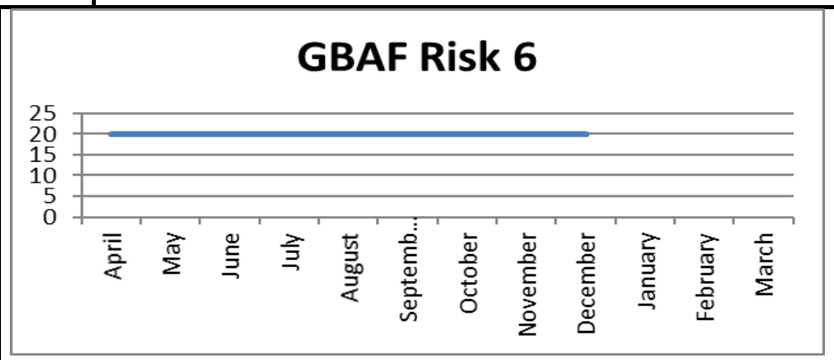
- 95% of the Derby and Derbyshire CCG population receive 1st and 2nd doses of a Covid-19 vaccination
- Phase 3 of Vaccination Programme is implemented from September 2021

Risk Description

The CCG does not achieve the national requirements for the Covid-19 Vaccination Programme and have robust operational models in place for the continuous sustainable delivery of the Vaccination Programme.

Risk rating	Likelihood	Consequence	Total
Initial	4	5	20
Current	4	5	20

Risk Appetite	Level	Category	Target Score
	5	Clinical Quality & Patient Safety	5



Date reviewed	December 2021

Rationale for risk rating (and any change in score):

VOC on the rise within Derbyshire requiring significant surge planning amidst workforce shortages and constrained vaccine supply.

Link to System Wide Risk Register
Risk 10

KEY CONTROLS TO MITIGATE RISK

Internal

- Vaccination Operations Cell (VOC) established and in place to coordinate and oversee the JUCD Covid-19 vaccination programme
- Permanent recruitment to vaccination programme underway as instructed by NHSEI
- Fully established VOC rota to manage and deliver the vaccination programme.
- Dr Steve Lloyd, Medical Director is the SRO for the Vaccination Programme.
- Senior Leadership, Lead Provider and Workstream leads managing the VOC and vaccination programme.
- Silver and Gold Command Operation Group
- JUCD 2021/22 Operational Plan submitted to NHSE 14th May 2021.
- Linda Syson-Nibbs is Chair of Health Inequalities Group across the System which also reviews hesitancy within groups of patients
- Vaccination sites across Derby and Derbyshire to deliver vaccination programme
- Health Protection Board actions for early warning of delta variants and other VOC's.
- Modelling of further cohorts in Phase 3 for booster

External

- System Escalation Cell
- System Operational Resilience Group
- System Demand and Capacity Group

SOURCES OF ASSURANCE

Internal

- VOC email inbox and dedicated phone line
- Standing Operating Procedure (SOP) for the VOC
- VOC draft structure developed
- Fully established Governance cycle of vaccination meeting to support delivery of the programme
- 2021/22 JUCD Operational Plan
- VOC Risk register
- Gold report being revised to include all elements of Phase 3 performance reporting to enable targeted uptake where necessary
- Health Protection Board
- Development of the vaccine programme as a strategic delivery board within the ICS structure, signed off by JUCD leadership
- Weekly Phase 3 planning meeting now stood down as implemented. Fortnightly Flu cell remains for operational issues, reporting into Silver Operational Group.
- QEIA in development for Phase 3
- DPH and LA engagement in schools

External

- 2021/22 JUCD Operational Plan
- Weekly demand and capacity briefing
- NHSE regular returns for Health and Social Care Worker uptake across health and social care systems
- Weekly plan submitted to NHSE
- Weekly stocktakes submitted to NHSE
- Phase 3 planning return submitted monthly with revisions
- JUCD representation across all NHSEI Phase 3 planning meetings
- JUCD representation at national level on children's programme
- National Maternity Board representation by Dr Steve Lloyd
- JUCD SAIS representation at C & YP NHSEI meetings

being undertaken, including vaccinating of 5-11 year olds to understand the impact on workforce and vaccine requirements. • Planning for phase 4 to begin imminently to assess estate and workforce requirements		programme, working closely with SAIS team	
GAPS IN CONTROL		**GAPS IN ASSURANCE**	
Internal • Influence and impact on system planning regarding restoration and recovery and co-delivery of the vaccination programme • Infrastructure to support new model to deliver suggested Phase 3 including Flu and sustainable delivery as a programme of work including operational delivery i.e. site leads • Any changes made in relation to phase 3 guidance giving very short notice affecting decisions/priorities and impact of opt-in/out of vaccine delivery	**External** • Community Pharmacy contracting • National guidance including JCVI and Green Book publications • NHSEI financial model for vaccinations does not cover the costs incurred against low vaccine uptake, as an example SAIS • Pfizer vaccine supply has been capped	**Internal** • Do not have access to booking information for local booking services	**External**
ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)			
Internal • Enhanced communications approach looking at new and innovative ways to reduce hesitancy within cohorts of patients not receiving first or second vaccinations. • Surge planning being undertaken in areas with variants of concern (VOC) delta variant, in partnership with PH. • Call to arms for staffing shortages • Reviewing allocation at site level to make best use of Pfizer allocations to under achieving areas • Phase 3 planning guidance published. Expressions of interest continue for Community Pharmacies to address any gaps in delivery • Reviewing published PCN Enhanced Service guidance for Phase 3, providing JUCD system support to PCNs where required to support continuation of opt-in. • Gap analysis undertaken to ensure geographical coverage of vaccination sites. • Process established to understand system stock and forward bookings of patients. System email to all sites circulated to increase uptake of Moderna assured sites to cover off Pfizer supply issues.	**Timeframe** • Ongoing • Immediate/ ongoing • Ongoing • Ongoing • Ongoing • Ongoing	**External** • Escalating to NHSEI regional team regarding vaccine supply and surge planning issues with supply • Escalation to NHSEI regional team regarding financial modelling for vaccinations against low vaccine uptake	**Timeframe** • Weekly and daily as required • Weekly and daily as required

Strategic Objective: 5	GBAF RISK 7	Executive Lead: Helen Dillistone Assigned to Committee: Governance Committee
Support our staff in the delivery of the above and transition into an ICS, through continued health and wellbeing programmes and effective communication and engagement		

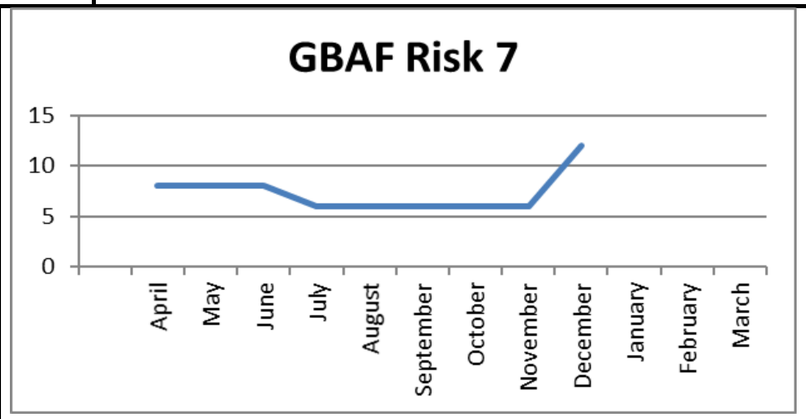
What would success look like and how would we measure it?

- The CCG workforce will transition over to the Integrated Care System (ICS).
- All employees to have effective communication on developments and structures within the ICS.
- Having robust health and well-being programmes in place to support staff.

Risk Description

CCG staff retention and morale during the transition will be adversely impacted due to uncertainty of process and implications of the transfer to the ICS, despite the NHSEI continuity of employment promise.

Risk rating	Likelihood	Consequence	Total
Initial	2	4	**8**
Current	3	4	**12**
	Level	**Category**	**Target Score**
Risk Appetite	Low	Statutory and mandatory compliance and governance	**5**



Date reviewed	December 2021

Rationale for risk rating (and any change in score):

The CCG has concerns about losing staff and the impact of that is higher than the previous score of 2. The score then aligns the with the ICB Transition risk 1 within the register.

Link to Derby and Derbyshire Risk Register

The ICS Transition Programme has a Risk Register managed at CCG and system level. Risk is a standing agenda item for the Transition Working Group who report up to the Governing Body each month

KEY CONTROLS TO MITIGATE RISK

Internal

- JUCD 2021/22 Operational Plan submitted to NHSE 14th May 2021.
- Transition Assurance Committee (TAC) established and inaugural meeting took place end April and meeting monthly.
- CCG GB Chair is the Transition Assurance Committee (TAC) Chair and ICS CCG Transition Working Group Chair.
- CCG ICS Transition Working Group established and meets monthly. First meeting took place 6th May.
- Governance Committee has oversight of the NHS People Plan and ICS transition.
- Comprehensive communications and engagement plan which places staff knowledge, information and ability to be involved at the heart of the transition.

External

- Transition Assurance Committee (TAC) established and inaugural meeting took place end April and meeting monthly
- ICS Design Framework published 16th June 2021
- Health and Care Bill ordered by The House of Commons 6th July 2021.
- Final HR Framework published August including commitment of employment guarantee.
- Further ICS/ ICB Guidance published August 2021
- John MacDonald appointed as ICB Designate Chair.
- Dr Chris Clayton appointed as Chief Executive Designate of NHS Derby and Derbyshire ICB

SOURCES OF ASSURANCE

Internal

- 'People Matter' HR newsletter emailed to all CCG staff.
- 2021/22 JUCD Operational Plan
- ICS/CCG Transition Plan
- CCG ICS Transition Working Group agenda, papers and minutes
- CCG Team Talks
- CCG Staff Bulletins
- Bespoke communications activity in relation to the transition
- CCG Turnover and sickness absence statistics
- Health and Wellbeing information available o the CCG Intranet for all CCG Staff.

External

- 2021/22 JUCD Operational Plan
- ICS Transition Plan
- Transition Assurance Committee (TAC), agenda, papers and minutes

• THRIVE Mental Health Provider providing briefing sessions to support CCG staff through the transition to ICB.			
GAPS IN CONTROL		**GAPS IN ASSURANCE**	
Internal • Further ICS Guidance to be published	**External** • Health and Care Bill still to be passed in Parliament	**Internal** • Communications content limited in detail while awaiting Bill.	**External**
ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)			
Internal • Communications and Engagement Plan to be finalised • Attendance at all national ICS communications briefings to keep track of timescales and emerging guidance.	**Timeframe** January 22 Ongoing	**External**	**Timeframe**

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Strategic Objective: 1	GBAF RISK 8	Executive Lead: Helen Dillistone Assigned to Committee: Governance Committee
Safely and legally transition the statutory functions of the CCG into the ICS, and safely deliver the disestablishment of the CCG		

What would success look like and how would we measure it?

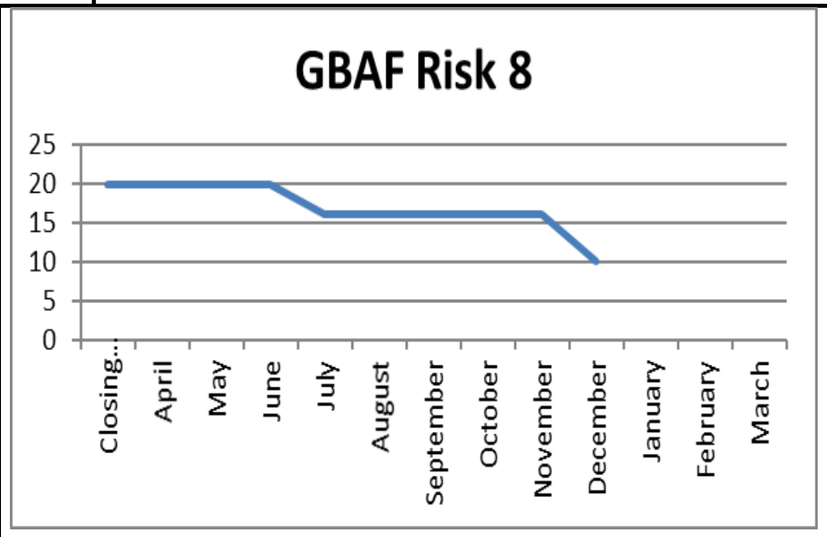
The CCG would meet all critical timescales as described in the programme plan in readiness for the ICS to launch as a statutory organisation in April 2022 and would receive the appropriate confirmation of a safe and legal transfer of duties and closure of the CCG from NHSEI.

Risk Description

If the CCG is not ready to transfer its functions or has failed to comprehensively and legally close down the organisation, or if the system is not ready to receive the functions of the CCG, the ICS operating model cannot be fully established.

Risk rating	Likelihood	Consequence	Total
Initial	4	5	**20**
Current	2	5	**10**

Risk Appetite	Level	Category	Target Score
	Low	Statutory and mandatory compliance and governance	**5**



Date reviewed	December 2021

Rationale for risk rating (and any change in score):

Version 2 of Due Diligence update now received and being incorporated into project plans. 360 Audit have joined the CCG Transition Project Group which will provide assurance on the management of the project.
Draft Due Diligence Checklist was presented to CCG Audit Committee on 17th December and subsequently submitted as part of the regional submission due by end December 21 and uploaded 20th December 21.
The risk is now aligning with the score for risk 7 on the Transition Risk Register.

Link to Derby and Derbyshire Risk Register

The ICS Transition Programme has a Risk Register managed at CCG and system level. Risk is a standing agenda item for the Transition Working Group who report up to the Governing Body each month.

KEY CONTROLS TO MITIGATE RISK

Internal

- Chris Clayton CCG CEO is the interim Chief Executive of JUCD
- JUCD 2021/22 Operational Plan submitted to NHSE 14th May 2021.
- Transition Assurance Committee (TAC) established and inaugural meeting took place end April and meeting monthly. CCG represented.
- CCG GB Chair is the Transition Assurance Committee (TAC) Chair and ICS CCG Transition Working Group Chair.
- CCG ICS Transition Working Group established

External

- Transition Assurance Committee (TAC) established and inaugural meeting took place end April and meeting monthly.
- JUCD / ICS Governance Structure in Place
- JUCD Senior Leadership Team
- ICS Engine Room Team comprising of System Leaders
- JUCD Board meeting in public
- System Quality and Performance Committee in place
- System Finance and Estates Committee in place
- People and Culture Committee in place

SOURCES OF ASSURANCE

Internal

- 2021/22 JUCD Operational Plan
- ICS Transition Plan
- Transition Assurance Committee (TAC), agenda, papers and minutes
- CCG ICS Transition Working Group agenda, papers and minutes.
- Governing Body public and confidential minutes
- Governing Body ICS Development session notes
- ICS Programme Group minutes and meeting

External

- 2021/22 JUCD Operational Plan
- ICS Transition Plan
- Transition Assurance Committee (TAC), agenda, papers and minutes
- JUCD Senior Leadership Team minutes
- Minutes of System Quality Committee
- Minutes of System Finance & Estates Committee
- Minutes of System People and Culture Committee

and meets monthly. First meeting took place 6th May. • ICS Project Group established to manage the operational ICS Transition Plan. • Helen Dillistone, Executive Director of Corporate Strategy and Development is the CCG SRO for the ICS Transition. • Governing Body supports the transition to ICS • Governing Body ICS Development Sessions • Executive Team • Senior Leadership Team • Programme Management Office support for management ICS Transition Plan • Derbyshire Engagement Committee in place • ICS Risk Register in place incorporating both CCG and system level risks, reviewed weekly by the Core Project Team and monthly by the CCG Transition Working Group and Transition Assurance Committee (TAC). • Joint Derby Derbyshire CCG and Tameside and Glossop CCG Transition Steering Group established to lead four main workstreams. • Four workstreams comprising of specialist leads across both systems for Communications and Engagement, Finance IT and Contracting, Neighbourhood Development and Statutory Duties, Risks and People Impact Assessment.	• White Paper consultation published in November 2020 • ICS Design Framework published 16th June 2021 • Health and Care Bill ordered by The House of Commons 6th July 2021 • Final HR Framework published August • Further ICS/ ICB Guidance published August 2021 • John MacDonald appointed as ICB Designate Chair. • Dr Chris Clayton appointed as Chief Executive Designate of NHS Derby and Derbyshire ICB. • Secretary of State for Health and Social Care decision taken in August 2021 to amend the ICS boundary so that Glossop will move from the Greater Manchester ICS into the Derbyshire ICS • Draft ICB Constitution submitted to NHSEI 3rd December, • Readiness to Operate Statement RAG rating and evidence submitted to NHSE by 31st December • Due Diligence checklist approved by Audit Committee 17th December 2021 and submitted to NHSEI	papers • ICS Risk Register • Mapping of CCG Functions • PMO system to support ICS Transition • Derbyshire Engagement Committee Minutes	

GAPS IN CONTROL		GAPS IN ASSURANCE	
Internal • Potential planning gaps due to delays in passing the bill through Parliament and publication of guidance materials. • Further ICS Guidance to be published	**External** • Health and Care Bill still to be passed in Parliament	**Internal**	**External**

ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)			
Internal	**Timeframe**	**External**	**Timeframe**
• Project Team will review guidance and HR framework to assess risks to delivery and ensure alignment to programme plan.	• Monthly, ongoing		

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Governing Body Meeting in Public

13th January 2022

ITEM NO: 228

Report Title	CCG Risk Register Report at 31st December 2021
Author(s)	Rosalie Whitehead, Risk Management & Legal Assurance Manager
Sponsor (Director)	Helen Dillistone, Executive Director of Corporate Strategy and Delivery

Paper for:	**Decision**	x	**Assurance**	x	**Discussion**		**Information**	
Assurance Report Signed off by Chair	N/A							
Which committee has the subject matter been through?	Governance Committee *(by virtual approval)* – 04.01.22 Primary Care Commissioning Committee – 22.12.21 Quality and Performance Committee – 23.12.21 Finance Committee – 23.12.21							

Recommendations

The Governing Body is requested to **RECEIVE** and **NOTE**:

- The Risk Register Report;
- Appendix 1 as a reflection of the risks facing the organisation as at 31st December 2021;
- Appendix 2 which summarises the movement of all risks in December 2021;
- The decrease in risk score for:
  - Risk 06 relating to the demand for Psychiatric intensive Care Unit beds (PICU)
  - Risk 32 relating to the risk of exploitation by malevolent third parties If vulnerability is identified within any of the Microsoft Office 2010 applications after 14th October 2020 and not patched
- The increase in risk score for:
  - Risk 09 relating to sustainable digital performance
  - Risk 23 relating to CCG staff capacity compromised
- New risk 42 relating to climate change.

And to **APPROVE** the closure of risk 38 relating to the quality of care potentially being impacted by patients not receiving a care needs review in a timely way as a result of the COVID pandemic and the requirement for some of the Midland and Lancashire Commissioning Support Unit (MLCSU) Individual Patient Activity / Continuing Health Care (CHC) services to redirect service delivery to support system wide pressures.

Report Summary

This report presented to the Governing Body is to highlight the areas of organisational risk that are recorded in the Derby and Derbyshire CCG Corporate Risk Register (RR) as at 31st December 2021.

The RR is a live management document which enables the organisation to understand its comprehensive risk profile and brings an awareness of the wider risk environment. All risks in the Risk Register are allocated to a Committee who review new and existing risks each month and agree removal of fully mitigated risks.
Are there any Resource Implications (including Financial, Staffing etc.)?
The Derby and Derbyshire CCG attaches great importance to the effective management of risks that may be faced by patients, members of the public, member practices and their partners and staff, CCG managers and staff, partners and other stakeholders, and by the CCG itself. All members of staff are accountable for their own working practice and have a responsibility to co-operate with managers in order to achieve the objectives of the CCG.
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?
Not applicable to this update.
Has a Quality Impact Assessment (QIA) been completed? What were the findings?
Not applicable to this update.
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
Not applicable to this update; however, addressing risks will impact positively across the organisation as a whole.
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
Not applicable to this update.
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Not applicable to this update.
Have any Conflicts of Interest been identified/ actions taken?
Not applicable to this update.
Governing Body Assurance Framework
The risks highlighted in this report are linked to the Derby and Derbyshire CCG Board Assurance Framework.
Identification of Key Risks
The paper provides a summary of the very high scoring risks as at 31st December 2021 detailed in Appendix 1.

NHS DERBY AND DERBYSHIRE CCG GOVERNING BODY MEETING

RISK REPORT AS AT 31ST DECEMBER 2021

1. INTRODUCTION

This report describes all the risks that are facing the organisation.

In order to prepare the monthly reports for the various committees who own the risks, updates are requested from the Senior Responsible Officers (SRO) for that period, who will confirm whether the risk:

- remains relevant, and if not may be closed;
- has had its mitigating controls that are in place reviewed and updated;
- has been reviewed in terms of risk score.

All updates received during this period are highlighted in red within the Risk Register in Appendix 1.

2. RISK PROFILE – DECEMBER 2021

The table below provides a summary of the current risk profile.

Risk Register as at 31st December 2021

Risk Profile	Very High (15-25)	High (8-12)	Moderate (4-6)	Low (1-3)	Total
Total number on Risk Register reported to GB for December 2021	7	13	6	0	26
New Risks	0	1	0	0	1
Increased Risks	0	0	2	0	2
Decreased Risks	0	2	0	0	2
Closed Risks	0	0	1	0	1

Appendix 1 to the report details the full risk register for the CCG. Appendix 2 to the report details all the risks for the CCG, any movement in score and the rationale for the movement.

3. COMMITTEES – DECEMBER VERY HIGH RISKS OVERVIEW

3.1 Quality & Performance Committee

Three Quality & Performance risks are rated as very high (15 to 25).

1. Risk 01: *The Acute providers may breach thresholds in respect of the A&E operational standards.*

   The current risk score is 20.

   November performance:

   - CRH reported 85.7% (YTD 91.9%) and UHDB reported 64.6% (YTD 70.5%).
   - CRH: The combined Type 1 and streamed attendances are close to pre-pandemic levels, with an average of 272 attendances per day. By November 2021 the volume of Type 1 and streamed attendances were at 99.5% of November 2019 levels.
   - There were surges of COVID 19 admissions and outbreaks during the middle and towards the end of the month, with as many as 39 positive inpatients at one point, including 7 of these in the Intensive Care Unit (ICU). This added more pressure to a Trust with an escalated critical care position.
   - UHDB: The volume of attendances is high, with an average of 478 attendances per day at Derby (Type 1 and co-located Urgent Treatment Centre) and 181 at Burton (Type 1 and Primary Care Streaming). As a Network the numbers of attendances were at 98% of pre-pandemic levels (November 2021 compared to November 2019).
   - The acuity of the attendances was high, with Derby seeing an average of 13 Resuscitation patients and 121 Major patients per day and Burton seeing 119 Major/Resus patients per day.
   - Attendances at Children's Emergency Department continue to be high, with concerns about RSV and Bronchiolitis being major factors. Children's Type 1 attendances at Derby have averaged at 137 per day during November 2021 (compared to 109 per day in November 2019).

2. Risk 03: *TCP Unable to maintain and sustain performance, pace and change required to meet national TCP requirements. The Adult TCP is on recovery trajectory and rated amber with confidence whilst CYP TCP is rated Green, main risks to delivery are within market resource and development with workforce provision as the most significant risk for delivery.*

   The current risk score is 20.

December update

Current bed position:

- CCG beds = 32 (Q3 2021/22 target 21).
- Adult Specialised Commissioning = 17 (Q3 2021/22 target 15).
- Children and Young People (CYP) specialised commissioning = 6 (Q3 2021/22 target 3).
- The substantive 1.0 wte Band 7 Commissioning Manager vacancy that primarily leads on the delivery of Care Treatment Reviews (CTRs) has been recruited to.
- The provider Trust has funded the substantive appointment of an additional 1.0 wte Band 7 Commissioning Manager post to provide additional capacity to the Transforming Care Partnership (TCP) Team.
- There continues to be no administrative support within the team, block booking of agency administrative support is being prioritised to enable coordination of C(E)TRs and support with administration within the team.
- In order to ensure timely and concise reporting to NHSE/I, mapping of required reporting and associated timeframes has been undertaken.
- Data cleansing and refreshing of the Assuring Transformation Clinical Audit Platform was completed for all inpatients ahead of the national report being run on 28th November.
- A robust system is now in place to maintain compliance including Safe and Wellbeing reviews (previously five eyes).
- Derby and Derbyshire have 31 of the regional 91 red RAG rated reviews. However, as a system we have demonstrated most progress in achieving completion of red RAG rated reviews.

3. Risk 33: *There is a risk to patients on waiting lists as a result of their delays to treatment as a direct result 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.*

   The current risk score is 16.

   December update

   - Provider Governance processes have been reviewed and strengthened regarding oversight.

3.2 Primary Care Commissioning Committee – Very High Risks

Two Primary Care Commissioning Committee risks are rated as very high.

1. Risk 04A: *Contracting: Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care. There are 112 GP practices in Derbyshire all with individual Independent Contracts GMS, PMS, APMS to provide Primary Medical Services to the population of Derbyshire. Six practices are managed by NHS Foundation Trusts and one by an Independent Health Care Provider. The majority of Derbyshire GP practices are small independent businesses which by nature can easily become destabilised if one or more core components of the business become critical or fails. Whilst it is possible to predict and mitigate some factors that may impact on the delivery of care the elements of the unknown and unexpected are key influencing dynamics that can affect quality and care outcomes.*

   Nationally General Practice is experiencing increased pressures which are multi- faceted and include the following areas:

   **Workforce - recruitment and retention of all staff groups*
   **COVID-19 potential practice closure due to outbreaks*
   **Recruitment of GP Partners*
   **Capacity and Demand*
   **Access*
   **Premises*
   **New contractual arrangements*
   **New Models of Care*
   **Delivery of COVID vaccination programme*

   The current risk score is 16.

   December update

   - There continues to be increasing demand and pressure that General Practice are facing.
   - The regular sitrep report is providing an accurate picture of the situation in General Practice that can be reported into the wider system meetings so partners have a clear understanding of what is happening in general practice and how it can be supported. Winter Access plans were submitted to NHSE/I for consideration to provide additional support and capacity for increased number of GP appointments until 31 March 2022 and feedback is awaited.
   - There are no changes recommended to the existing levels of risk this month.

2. Risk 04B: *Quality: Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care. There are 112 GP practices in Derbyshire all with individual Independent Contracts GMS, PMS, APMS to provide Primary Medical Services to the population of Derbyshire. Six practices are managed by NHS Foundation Trusts and one by an Independent Health Care Provider. The majority of Derbyshire GP practices are small independent businesses which by nature can easily become destabilised if one or more core components of the business become critical or fails. Whilst it is possible to predict and mitigate some factors that may impact on the delivery of care the elements of the unknown and unexpected are key influencing dynamics that can affect quality and care outcomes.*

   Nationally General Practice is experiencing increased pressures which are multi-faceted and include the following areas:

   **Workforce - recruitment and retention of all staff groups*
   **COVID-19 potential practice closure due to outbreaks*
   **Recruitment of GP Partners*
   **Capacity and Demand*
   **Access*
   **Premises*
   **New contractual arrangements*
   **New Models of Care*
   **Delivery of COVID vaccination programme*
   **Restoration and Recovery*
   **2021/22 Flu Programme*
   **Becton Dickinson Blood Tube shortage*

   The current risk score is 20.

   December update:

   - Improving Access in General Practice has begun, this will support an increase in appointment capacity.

3.3 Finance Committee – Very High Risks

One Finance Committee risk is rated as very high.

1. Risk 11: *Risk of 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.*

   The current risk score is 16.

December update

November position:

- The Derbyshire NHS system has a significant gap between expenditure assessed as required to meet delivery plans and notified available resource.
- The CCG is working with system partners to establish a sustainable long term financial position and deliver a balanced in-Year position.
- As at Month 8 the CCG are not seeing any major financial pressures against planned expenditure with the exception of CHC and we continue to work with Midland &Lancs Commissioning Support Unit and providers to rectify this.
- The CCG are reporting a year to date underspend of £0.730m against total allocations of £1,392.484m for the period covering April to November 2021.
- Against total resources available in 2021/22 of £2,073.224m the CCG is forecasting a surplus of £0.030m.

4. DECEMBER OVERVIEW

4.1 Decreased risks since last month

Two risks have decreased in score.

1. Risk 06: *Demand for Psychiatric intensive Care Unit beds (PICU) has grown substantially over the last five years. This has a significant impact financially with budget forecast overspend, in terms of poor patient experience, Quality and Governance arrangements for uncommissioned independent sector beds. The CCG cannot currently meet the KPI from the Five year forward view which require no out of area beds to be used from 2021.*

   This risk has decreased in score from a high score of 12 (probability 3 x impact 4) to a moderate score of 6 (probability 2 x impact 3).

   This decrease was approved at Quality & Performance Committee on 23rd December 2021.

   - The reason for the proposed decrease is that contracts are now agreed with providers for block funded beds. The mobilisation period has commenced and actions have been agreed. The risk score has been decreased to reflect the actions taken.
   - The risk will be kept under review for a further two months by which time the CCG will be clear that the actions required by

NHSE have been completed and the risk can then be recommended to be closed.

2. Risk 32: *Risk of exploitation by malevolent third parties If vulnerability is identified within any of the Microsoft Office 2010 applications after October 14th 2020 and not patched, due to support for Microsoft Office 2010 officially ending, after which point Microsoft will cease to issue updates and patches for vulnerabilities found within this suite of applications.*

   This risk has decreased in score from a high 12 (probability 3 x impact 4) to a moderate score of 4 (probability 1 x impact 4).

   This decrease was approved virtually by Governance Committee members on 5th January 2022.

   - The reason for the reduction is that NECS have affirmed the upgrade or removal of all unsupported devices from the NECS managed network.
   - The risk score has been reduced with this assurance in place, to a probability 1, reducing the overall risk to moderate score of 4.

4.2 Increased risks since last month

Two risks have increased in score.

1. Risk 09: *Sustainable digital performance for CCG and General Practice due to threat of cyber attack, network outages and the impact of migration of NHS Mail onto the national shared tenancy. The CCG is not receiving the required metrics to provide assurance regarding compliance with the national Cyber Security Agenda, and is not able to challenge any actual or perceived gaps in assurance as a result of this.*

   This risk has increased in score from a moderate score of 6 (probability 2 x impact 3) to a very high score of 16 (probability 4 x impact 4).

   This increase was approved virtually by Governance Committee members on 5th January 2022.

   - The reason for the increase is that there is currently a high severity CareCert in place for a vulnerability within the Log4j component which is to be found in a number of different systems including Apple's iCloud and a number of systems in use across Derbyshire. This vulnerability can lead to remote agents taking control of a host system and as a result NECS has already identified Internet facing systems which cause a potential threat and has taken steps to suspend these pending further investigations.
   - There is currently no evidence to suggest any breaches of any NHS organisations within Derbyshire including the CCG or in

Primary Care. Mitigations also include local business recovery plans.

However, given the severity of the vulnerability, the current status of not knowing all affected systems and the duration that this situation is likely to be ongoing, it seems prudent to raise the probability significantly to identify this increased risk.

2. Risk 23: *CCG Staff capacity compromised due to illness or other reasons. Increased numbers of CCG staff potentially unable to work due to COVID 19 symptoms / Self isolation.*

This risk has increased from a moderate score of 4 (probability 1 x impact 4) to a high score of 12 (probability 3 x impact 4).

This increase was approved virtually by Governance Committee members on 5th January 2022.

- There are an increasing number of redeployments away from the CCG, due to requirements to support the system with the COVID booster and vaccination programme.
- The risk probability score is proposed to be increased accordingly from 1 to 3.
- A permanent structure has been developed for the VOC to support continuity and deployment and this has been submitted to the Executive Team for consideration.
- Additional interim resource is being brought in to boost capacity in the short-term (until 31 March 2021) from underspend on both running and programme costs.

4.3 New risks since last month

One new risk has been identified.

1. Risk 42: *If the CCG does not prioritise the importance of climate change it will have a negative impact on its requirement to meet the NHS's Net Carbon Zero targets and improve health and patient care and reducing health inequalities and build a more resilient healthcare system that understands and responds to the direct and indirect threats posed by climate change.*

This new risk is scored at a high 12 (probability 4 x impact 3).

The new risk is owned by the Governance Committee and was approved virtually by Governance Committee members on 5th January 2022.

4.4 Closed risks since last month

One risk is proposed to be closed.

1. Risk 38: *The quality of care could be impacted by patients not receiving a care needs review in a timely way as a result of the COVID pandemic and the requirement for some of the Midland and Lancashire Commissioning Support Unit (MLCSU) Individual Patient Activity /Continuing Health Care (CHC) services to redirect service delivery to support system wide pressures. This has had an impact on core CHC and Funded Nursing Care (FNC) service delivery in relation to care needs reviews.*

   This risk is currently scored at a moderate score of 6 (probability 3 x impact 2).

   This risk is now recommended to be closed as the outstanding reviews have been completed other than four remaining, which are booked for completion before the end of December.

   The closure of this risk has been approved by Quality & Performance Committee on 23rd December 2021.

5. RECOMMENDATION

The Governing Body is requested to:

- **RECEIVE** and **NOTE**:
  - The Risk Register Report;
  - Appendix 1 as a reflection of the risks facing the organisation as at 31st December 2021;
  - Appendix 2 which summarises the movement of all risks in December 2021;
  - The decrease in risk score for:
    - Risk 06 relating to the demand for Psychiatric intensive Care Unit beds (PICU)
    - Risk 32 relating to the risk of exploitation by malevolent third parties If vulnerability is identified within any of the Microsoft Office 2010 applications after October 14th 2020 and not patched
  - The increase in risk score for:
    - Risk 09 relating to sustainable digital performance
    - Risk 23 relating to CCG staff capacity compromised
  - New risk 42 relating to climate change.

- **APPROVE** the closure of risk 38 relating to the quality of care potentially being impacted by patients not receiving a care needs review in a timely way as a result of the COVID pandemic and the requirement for some of the Midland and Lancashire Commissioning Support Unit (MLCSU) Individual Patient Activity /Continuing Health Care (CHC) services to redirect service delivery to support system wide pressures.

Appendix 1 - Derby and Derbyshire CCG Risk Register - as at December 2021

NHS
Derby & Derbyshire
Clinical Commissioning Group

Risk Reference	Year	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk Rating: Probability	Initial Risk Rating: Impact	Initial Risk Rating: Rating	Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating: Probability	Previous Rating: Impact	Previous Rating: Rating	Residual/ Current Risk: Probability	Residual/ Current Risk: Impact	Residual/ Current Risk: Rating	Target Risk: Probability	Target Risk: Impact	Target Risk: Rating	Target Date	Link to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
01	21/22	The Acute providers may breach thresholds in respect of the A&E operational standards of 95% to be seen, treated, admitted or discharged within 4 hours, resulting in the failure to meet the Derby and Derbyshire CCGs constitutional standards and quality statutory duties.	Quality and Performance	Constitutional Standards/ Quality	3	4	12	Governance: - The CCG are active members of the Derbyshire A&E Delivery Board which has oversight and ownership of the operational standards. A performance dashboard has been produced to allow greater scrutiny of performance and any areas of concern to be highlighted and acted upon accordingly. - Providers update the OPEL reporting website daily by 11am and can escalate concerns and requests for support via the CCG urgent care team in hours, or the on-call director out of hours. - All providers participate in the COVID System Escalation Calls. - A robust Derbyshire System Winter Plan has been developed, and there will be an agreed process in order for this to be monitored and actioned throughout the Winter period - This will feed into the Derbyshire A&E Delivery Board. - Providers across the Derbyshire Health and Social Care System have now started to meet twice weekly as part of the System Operational Resilience Group. The purpose of this silver command level group is to co-ordinate and deliver the actions necessary to respond to significant issues which are affecting, or likely to affect, the functioning of an effective operation at a intra and inter sector level across the Health and Social Care System. This group reports into the System Escalation Group (SEC) which represents Gold Command.	Actions taken: - Review of the Directory of Services to ensure all appropriate patients go to UTCs rather than EDs - Imminent launch of the 111 First programme to move unheralded ED patients to more appropriate settings and embed a culture of patients calling 111 first - Work ongoing to develop digital consultations as part of the urgent care pathway - Enabling the direct booking of GP appointments via 111, when clinically appropriate and roll out of GP Connect to support this. - Increased Clinician to Clinician contact availability to assist EMAS clinical decision making and avoid unnecessary conveyances. - Identifying other failed pathway referrals that lead to unnecessary ambulance conveyances, forming a plan to remedy these. - Proactively manage High Intensity Users of urgent care to avoid their need to use emergency services. - Providing PCN-based enhanced care in Care Homes to improve quality and reduce unwarranted referrals. - Improving ambulance handover times through increased senior ownership within EDs and applying Releasing Time To Care principles in EMAS. - Expanding the mental health Crisis Service and enhancing the home treatment offer to improve gatekeeping. - Increasing A&E Mental Health Liaison team capacity to speed up response times. - Taking a system-wide approach to Same Day Emergency Care working to increase same-day discharges to improve patient flow. - Establishing an Orthopaedic Assessment Unit at RDH to treat patients in a more appropriate setting and improve flow. - Establishing a Surgical Assessment Unit at CRH to treat patients in a more appropriate setting and improve flow. - Increased GP Streaming at UHDB through commissioning changes and staff upskilling. - Embedding a weekly review process for patients with a length of stay of 21+ days in acute trusts. - Understanding Community demand and capacity to support the Improving Flow D2A pathways in South and City. - Increase OPAT capacity to enable more patients to be discharged from acute hospitals on IV antibiotics. - Altered handovers to enable more timely transfers from MAU/AAC to base wards at UHDB. - Same day emergency care (SDEC) and urgent treatment centre (UTC) pathways have been developed and in the process of increasing for EMAS to access, in order to reduce the number of patients directed to ED. - EMAS to undertake monthly audits with CRH and UHDB on patients that did not need to be conveyed to ED - in the process of starting to collate this data and then a system action plan will be developed, in order to make any necessary changes to reduce the number of unnecessary conveyances. - The SORG are currently reviewing the OPEL dashboard to support their operational discussion and to give a full picture on their operational resilience, which supports the system to understand where the pressures are, the impact this has and actions required to support. SEC stood down. SORG manages operational escalations and issues if required.	November 2021 performance: CRH reported 85.7% (YTD 91.9%) and UHDB reported 64.6% (YTD 70.5%). CRH: The combined Type 1 & streamed attendances are close to pre-pandemic levels, with an average of 272 attendances per day. By November 2021 the volume of Type 1 & streamed attendances were at 99.5% of November 2019 levels. There were surges of Covid19 admissions & outbreaks in the middle and end of the month, with as many as 39 positive inpatients at one point, including 7 in ICU. This added more pressure to a trust with an escalated critical care position. UHDB: The volume of attendances is high, with an average of 478 attendances per day at Derby (Type 1 & co-located UTC) and 181 at Burton (Type 1 & Primary Care Streaming). As a Network the numbers of attendances were at 98% of pre-pandemic levels (November 2021 compared to November 2019). The acuity of the attendances was high, with Derby seeing an average of 13 Resuscitation patients & 121 Major patients per day and Burton seeing 119 Major/Resus patients per day. Attendances at Children's ED continue to be high, with concerns about RSV and Bronchiolitis being major factors. Children's Type 1 attendances at Derby have averaged at 137 per day during November 2021 (compared to 109 per day in November 2019).	5	4	20	5	4	20	3	3	9	On going	Linked to Strategic Aims 1, 2, 3, 4, 5	Dec-21	Jan-21	Zara Jones Executive Director of Commissioning Operations	Craig Cook Director of Contracting and Performance / Deputy Director of Commissioning Operations Jackie Carlile Catherine Bainbridge, Head of Urgent Care Dan Merrison Senior Performance & Assurance Manager
02	21/22	Changes to the interpretation of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) safeguards, results in the greater likelihood of challenge from third parties, which will have an effect on clinical, financial and reputational risks of the CCG	Quality and Performance	Statutory/ Financial	3	3	9	•The implementation date for LPS to replace DoL has been deferred until April 2022. The new code of practice is not expected until mid 2021. Midlands and Lancs CSU continue to re-review and identify care packages that potentially meet the 'Acid Test' and the MCA/DoLS staff member is preparing the papers for the CCG to take to the Court of Protection as workload allows. • CCG DoL policy will be updated when the LPS Code of Practice is available. • The CCG is required to submit 100% health funded packages of care that meet the DoL threshold to the Court of Protection (CoP) authorisation, there is an agreement with the LA for the joint funded cases which the LA submit on both our behalves and charge the CCG 50% of the submission fee. There is a reputational risk to CCG if found guilty of an unauthorised DoL for someone in receipt of CHC funding with associated compensation costs. • Due to the delay in the implementation of LPS until April 2022 the CCG will continue to make applications under the existing Re X process. There is still a large backlog of cases that the Court of Protection have not yet processed. • The Designated Nurse for Safeguarding Adults continues to meet once a fortnight with Midlands and Lancs to discuss ongoing management of cases. •The Designated Nurse for Safeguarding Adults sits on the CSU Operational Group where any issues in relation to this work are raised.	The Re X DoLS Options Paper was agreed by the December Governing Body meeting and is now being implemented. A further paper was taken Q & P to seek permission for the Safeguarding Adults Team and the CSU MCA/DoLS worker to submit Re X DoLS applications that are 100% funded directly to the CoP. This has been agreed and a framework for this to happen is being developed. The Safeguarding Adults Team continue to develop a framework for this to happen. This has been agreed and a framework for this to happen is being developed and an account with the COP has been set up.	September: The CSU will take over the ReX applications to the COP on behalf of the CCG once the SOP has been approved. This should ensure that the CCG has no outstanding ReX applications by the time LPS replaces the current DoL legislation. October 21 - Re X applications are slowly being processed. The risk remains the same as the numbers of Re X applications the CSU are making are not significant enough at the moment to reduce the risk. November 21: The CSU have been asked if they can transfer a worker to assist in the Re X applications for the CHC cohort because these numbers are far higher than the TCP cohort, yet have the same number of staff allocated to process. December: An LPS implementation group will be established in the New Year to take this work forward across health providers who will become responsible bodies under the new framework.	3	4	12	3	4	12	3	3	9	March 2022	Linked to Strategic Aims 1, 2, 3, 4, 5	Dec-21	Jan-21	Brigid Stacey - Chief Nursing Officer	Bill Nicol, Head of Adult Safeguarding Michelle Grant, Designated Nurse Safeguarding Adults/MCA Lead
03	21/22	TCP unable to maintain and sustain performance, pace and change required to meet national TCP requirements. The Adult TCP is on a recovery trajectory and rated amber with confidence, whilst CYP TCP is rated green. The main risks to delivery are within market resource and development with workforce provision as the most significant risk for delivery.	Quality and Performance	Quality/ Reputational	3	4	12	• System leadership group meets bi-monthly to review performance and address system issues, chaired by DHcFT SRO. • System wide plan developed identifying priorities for joint action and delivery • Additional funding and capacity in place for crisis response and forensic • Quality standards in place within contracts for NHS providers monitored quarterly at CQRG • Investment in Speech and Language Therapist for mental health wards to improve formulation in mental health care. • System Recovery & Restoration Plan implemented and ongoing • Weekly Discharge Review meeting to seek assurance against agreed trajectories • LD,MH,Autism delivery group have established a Provider development task and finish group to oversee the work to improve the capacity and resilience of local providers. • LD-A (Learning Disability and Autism) Delivery Group Meeting meet bi-weekly to monitor implementation of the seven 'lanes' on the improvement plan, with leads identified for the each workstream. • Weekly reconciliation meetings with DHcFT to ensure that admissions are appropriate with regards to confirmed diagnosis. • Mental health in-reach secondment: Funding agreed to establish a temporary in-reach post to acute mental health wards from Dec 2020 – May 2021. • Proposal to enhance the Derbyshire Autism offer: The System Delivery Board (via TCP SRO and Director of Quality) has requested a costed options proposal. This will go to the December meeting • Interim services to support Autistic people scoped and provided. The temporary secondment post and Case Managers will enhance oversight for people admitted with an ASD diagnosis. - Monthly NHSE/I regional Escalation assurance meetings - Weekly DDCCG TCP meeting - Derby and Derbyshire all-age Dynamic Support Register (DSR) for people with a formally diagnosed Learning Disability and/or Autistic Spectrum Disorder implemented • Weekly 1:1 – TCP Programme manager and NHSE TCP Lead Nurse • Covid-19 – impacting on transitions from Locked Rehab hospitals into community placements causing delays in discharges. Alternative transition planning being explored, • Case Managers redeployed to support DHcFT services – each Case Manager redeployed for 2 days per week to ensure they are able to continue to support case load.	TCP Recovery Action plan developed and monitored weekly: - Revised assurance systems and processes led by new TCP Programme Manager (Discharge Review Meeting (DRM), weekly NHS Provider meetings, appointment of two CCG Case Managers) - Mental health in-reach role: establish a temporary in-reach post to acute mental health wards from November 2020 – May 2021. - Weekly procurement updates: Multi agency weekly meetings with providers developing new services in Derbyshire led by Local Authority - NHSE training sessions and case reviews for Ministry of Justice (MoJ) cases with Christine Hutchinson. • 1:1 support for TCP Programme Manager Admission avoidance: - Proposal to enhance the Derbyshire Autism offer: The System Delivery Board (via TCP SRO and Director of Quality) has requested a costed options proposal is submitted to the group in December 2020. - Local Area Emergency Protocol (LAEP) notifications: It is an expectation that LAEPS are requested as part of meeting national and contractual expectations to notify about potential admissions. - Strengthen management of people in distress: These will focus on detailed review of care plans and provision for people with previous high levels of admissions & development of the Dynamic Support Register - Review of short breaks provision. - New Strategic Commissioner posts	Current bed position: CCG beds = 32 (Q3 2021/22 target 21) Adult Specialised Commissioning = 17 (Q3 2021/22 target 15) Children and Young People (CYP) specialised commissioning = 6 (Q3 2021/22 target 3) The substantive 1.0 wte Band 7 Commissioning Manager vacancy that primarily leads on the delivery of CTRs has been recruited to. The provider Trust has funded the substantive appointment of an additional 1.0 wte Band 7 Commissioning Manager post to provide additional capacity to the TCP Team. There continues to be no admin support within the team, block booking of a Band 4 agency admin is being prioritised to enable coordination of CJE/CTRs and support with admin per se within the team. In order to ensure timely and concise reporting to NHSE/I mapping of required reporting and associated timeframes has been undertaken. Data cleansing and re-freshing of the Assuring Transformation Clinical Audit Platform was completed for all inpatients ahead of the national report being run on November 28. A robust system is now in place to maintain compliance. Safe and wellbeing reviews (previously five eyes), Derby and Derbyshire have 31 of the regional 91 red RAG rated reviews, however as a system we have demonstrated most progress in achieving completion of red RAG rated reviews. Last week NHSE/I ring fenced monies for four inpatients subject to LTS/CTRs to enable life planning.	5	4	20	5	4	20	2	3	6	tbc	Linked to Strategic Aims 1, 2, 3, 4, 5	Dec-21	Jan-21	Brigid Stacey - Chief Nursing Officer	Helen Hipkiss, Deputy Director of Quality / Phil Sugden, Assistant Director Quality, Community & Mental Health, DCHS
04A	21/22	Contracting: Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care. There are 112 GP practices in Derbyshire all with individual Independent Contracts GMS, PMS, APMS to provide Primary Medical Services to the population of Derbyshire. Six practices are managed by NHS Foundation Trusts and one by an Independent Health Care Provider. The majority of Derbyshire GP practices are small independent businesses which by nature can easily become destabilised if one or more core components of the business become critical or fails. Whilst it is possible to predict and mitigate some factors that may impact on the delivery of care the elements of the unknown and unexpected are key influencing dynamics that can affect quality and care outcomes. Nationally General Practice is experiencing increased pressures which are multi-faceted and include the following areas: *Workforce - recruitment and retention of all staff groups *COVID-19 potential practice closure due to outbreaks *Recruitment of GP Partners *Capacity and Demand *Access *Premises *New contractual arrangements *New Models of Care *Delivery of COVID vaccination programme	Primary Care Commissioning	Primary Care	5	4	20	**Early warning systems**: CCG works with LMC and other partners to systematically identify and support practices that may be in trouble, including: reviewing information on practice performance via an internal, cross directorate review of practices looking at a range of data sources; linking with the LMC to pool soft intelligence on practice "health" and to jointly support struggling practices; directly approaching practices identified as at risk **CCG support:** CCG commissions and funds a range of supportive measures designed to increase the resilience of General Practice, in line with the GP Forward View and GP Contract. Key working groups and committees have been established to support the delivery of the work programmes, these include: *Primary Care Leadership Committee *Primary Care Workforce Steering Group - sub group GPN 10 Group *Primary Care Estates Steering Group *General Practice Digital Steering Group The groups have a wide range of objectives and outcomes to mitigate this corporate risk, these include , managing allocation and monitoring of additional funding to support the PC workforce (recruitment and retention, new roles) Funding of practice nurses to promote the National GPN , work with CCG nursing team. Identification and delivery of training to support and improve GP practice resilience; funding increased capacity, supporting practices to manage workload, development of leadership roles. Utilisation of the GP Task Force and Health Education Derbyshire to support the delivery of these objectives **Peer support:** the Primary Care Networks will provide a way that practices can support each other in smaller groups. Over time this will provide a safe forum for practices to seek help from peers and another route for help for struggling practices who are not willing to approach the CCG directly **Strategy**: implementation of the CCG's primary care strategy will bring additional resources, capacity and support to General Practice, and develop its role at the centre of an integrated system, thus increasing resilience and mitigating against individual practice failure. The CCG has financially supported the development of the GP alliance, who have supported the development of the PC strategy and are also undertaking a review of PC demand and capacity in order to have a understanding of access to Primary Care in Derbyshire .	The Derbyshire wide Primary Care Strategy agreed and in place. Primary Care Networks (PCNs) established county wide. PCNs undertaking self-diagnostic to establish current position and development needs. Funding identified to support development. First cross directorate review meeting of practice data set for September. Primary Care Team to continue to work closely with practices to understand and respond to early warning signs including identification of support/resources available including practice support in discussions around workload transfer from other providers. Derbyshire wide Primary Care Commissioning Committee to oversee commissioning, quality and GPFV work streams. Assurance provided to NHS England/JUCD through monthly returns and assurance meetings.	September no change to risk score. There continues to be increasing demand and pressure General Practice are facing. Appointment levels are already at least 10% higher than pre pandemic levels (additional 50,000 per month appointments across Derbyshire) as well as Primary Care continuing to deliver 75% of the COVID vaccination programme to date largely through the existing workforce. The regular sitrep report is providing an accurate picture of the situation in General Practice that can be reported into the wider system meetings so partners have a clear understanding of what is happening in general practice and how it can be supported. Planning for support for General Practice for the winter period is in progress to support requests for additional funding and resources in Primary Care to increase capacity in Primary Care to support the system. In addition, Primary care will also be starting the flu programme in September and therefore there are no changes recommended to the existing levels of risk this month. October - No change this month. November - There continues to be increasing demand and pressure that General Practice are facing. The regular sitrep report is providing an accurate picture of the situation in General Practice that can be reported into the wider system meetings so partners have a clear understanding of what is happening in general practice and how it can be supported. Winter Access plans were submitted to NHSE/I for consideration to provide additional support and capacity for increased number of GP appointments until 31 March 2022 and feedback is awaited. There are no changes recommended to the existing levels of risk this month. December - No changes this month.	4	4	16	4	4	16	4	3	12	On going	Linked to Strategic Aims 1, 2, 3, 4, 5	Dec-21	Jan-21	Dr Steve Lloyd - Medical Director	Hannah Belcher, Head of GP Commissioning and Development (Primary Care)
04B	21/22	Quality: Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care. There are 112 GP practices in Derbyshire all with individual Independent Contracts GMS, PMS, APMS to provide Primary Medical Services to the population of Derbyshire. Six practices are managed by NHS Foundation Trusts and one by an Independent Health Care Provider. The majority of Derbyshire GP practices are small independent businesses which by nature can easily become destabilised if one or more core components of the business become critical or fails. Whilst it is possible to predict and mitigate some factors that may impact on the delivery of care the elements of the unknown and unexpected are key influencing dynamics that can affect quality and care outcomes. Nationally General Practice is experiencing increased pressures which are multi faceted and include the following areas: *Workforce - recruitment and retention of all staff groups *COVID-19 potential practice closure due to outbreaks *Recruitment of GP Partners *Capacity and Demand *Access *Premises *New contractual arrangements *New Models of Care *Delivery of COVID vaccination programme *Restoration and Recovery *2021/22 FLU Programme *Becton Dickinson Blood Tube shortage	Primary Care Commissioning	Primary Care	4	5	20	**Primary Care Quality Team**: team providing monitoring of and support to practices county wide, proactive and reactive, direct contact available to practices to clinical team members, via telephone and email, for advice and support of any clinical queries and patient safety issues. Communication pathways established including membership bulletin, Information Handbook, web site development and direct generic inbox **Primary Care Quality and Performance Committee**: The Committee will oversee monitoring support and action plans for the delivery of Primary Medical Services, gain assurance regarding the quality and performance of the care provided by GP practices, identifying risks to quality at an early stage. Monthly meetings established. **Cross directorate internal review (hub) process** - Primary Care Quality dashboard and matrix developed, discussed monthly at Hub meeting, integration, sharing and triangulation of PC data from Primary Care Quality, Contracting and Transformation. Provides the opportunity to oversee multiple data sources and gain information from wider CCG teams in order to gain collective view on quality of care offered and to identify areas of best practice and areas of concern where support or intervention is needed. Provides the opportunity to review and create action plans to support practices who may be experiencing / demonstrating difficulty or signs of potential deficit in quality or unwarranted variation of care provision. **Supporting Quality Improvement visits:**18 month rolling programme of practice visits with a focus on quality and support is being delivered, this provides the opportunity of direct clinical face to face discussion between individual GP practices and CCG. Provides an safe opportunity to discuss individual practice quality metrics and for the practices to highlight / raise any issues or concerns directly to the CCG. **Clinical Governance leads meetings:** Established and held quarterly across Derbyshire PCN footprint, provides the interface between CCG and individual practices, opportunity to share best practice, practice concerns, learning and recommendations, support the implentation of GP practice governance. **Quality Schedule**: being developed as part of the enhanced service review to provide a formal mechanism to contract for improved quality standards in areas such as sepsis and safeguarding - following model developed with acute and other provider organisations. Primary Care Quality Schedule Included (October 2021) to DCCG Commissioned Primary Care Contracts, to maintain and support the delivery of continuous quality improvement in Primary Care. JUCD FLU Planning cell set up to plan and provide oversight of the Flu Programme.	Primary Care Quality Team now fully recruited to and delivering on quality programme including SQI visits. Continuing work to track and support quality of General Practice - Primary Care Quality and Performance Committee established and functioning well. Work is ongoing on development of quality schedule. Production of a Primary Care dashboard being finalised, review of quality reporting methodology and governance structures to PCCG being undertaken. Primary Care Dashboard and Matrix established. Supporting Governance Framework implemented. July: Continuing work to track and support quality of General Practice - Primary Care Quality and Performance Matrix in place and reviewed monthly .Primary Care Quality and Performance Sub Committee re-established June following return to BC3, supported by an escalation methodology to ensure consistency and timeliness of response. Hub (pre meet) also established and working well to support the identification of concerns/ triangulate information across the CCG/ national data.	• A range of mitigations have been put in place both Nationally and Locally to support general practice; Local services include • Red hubs and red home visiting service; • DHU support for practices to provide cover Long COVID pathway development System support to deliver COVID vaccination programme Intelligence both qualitative and quantitative continues to be captured to both support and monitor care provided by general practice from both a contractual and quality perspective Whilst the Primary Care Quality and Performance committee has been stepped down due to the level four CCG pandemic response a monthly meeting to determine / highlight any new risks / emerging themes continues. Any actions from this will be addressed with individual practices as required . Reporting arrangement will be undertaken directly to PCCC August - JUCD moving into Phase 3 of the Covid Vaccination Programme/ FLU programme whilst General Practice also working as BAU. Demand on general practice is above pre pandemic levels September - Flu Programme - Delays in delivery of flu vaccine to GP practices. Where flu clinics have already been organised, this is adding additional pressures. Shortage of Becton Dickinson blood tubes is being managed as a system - updates and associated information is being issued to GP practices and there are only four instances where phlebotomy can be undertaken currently, due to the shortage. Therefore, phlebotomy undertaken within GP practices is severely restricted which will have a future impact on QOF prevention. It is expected that the situation will improve from 20.09.21 but pressures will still be felt. From 31.08.21 to 17.09.21 blood tests carried out in GP practices will be only in the four instances. Phase 3 COVID delayed until 22.09.21, planning taking place. October - The risk score remains the same this month but this may increase over the coming months due to the fragility in the system. This is due to the COVID pandemic and as we move into the winter months additional pressures will be experienced. November - The blood tube shortage has stabilised. Issue around the impact of the recent government announcement on the mandatory COVID vaccination of NHS staff. The mitigation in place for this is that the CCG is working with the GP taskforce to understand the impact on Primary Care. The GP taskforce are organising practice feedback to ascertain the numbers affected and the possible impact. December: Improving Access in General Practice has begun, this will support an increase in appointment capacity.	4	5	20	4	5	20	4	4	16	On going	Linked to Strategic Aims 1, 2, 3, 4, 5	Dec-21	Jan-21	Dr Steve Lloyd - Medical Director	Marie Scouse, Assistant Director of Nursing & Quality - Primary Care Judy Dericott, Head of Primary Care Quality
05	21/22	Wait times for psychological therapies for adults and for children are excessive. For children there are growing waits from assessment to psychological treatment. All services in third sector and in NHS are experiencing significantly higher demand in the context of 75% unmet need (right Care). COVID 19 restrictions in face to face treatment has worsened the position.	Quality and Performance	Patient Experience/ Quality	4	3	12	A national mandated programme of community delivery with specific recommendations for psychological therapies is expected. This will change how DDCCG commissions current services and stopped the planned STP Psychological therapies review. For children there are growing waits from assessment to psychological treatment .Some investment is being made through core CAHMS investment in 2019 and 2020 in both CRH and DHCFT CAHMS linked to waiting times. A newly commissioned targeted intervention service was introduced in June 19 and digital offer for cyp in September 19 (KOOTH). Funding for wave 2 Transformation from NHSE to support MH in school was successful with an intended start date of may 2020. A service for Looked after children was due to start in May 2020. These initiatives are intended to provide support without CAHMS being required to help manage waits. COVID 19 has reduced face to face therapies and increased waits delayed recruitment and investments and wait times have become longer. This is a concern raised by safeguarding board and partners and children's commissioner for England.	Once national research and guidance released recommission DHCFT to deliver services to new model. Continue to monitor within contract meetings once these are restarted. For children introduce increased digital offer during pandemic . Consider Further services to manage expected demand when schools return in September 20202. Progress CAHMS review to a JUCD plan of improvement with if necessary provider improvement plans. report to safeguarding board and JUCD in September 20. Report to CLC on COVID19 arrangement analysis and potential mitigations .	October update. Waiting lists for ND pathway all have come down as a consequence of mitigating actions taking effect. However there is now a surge of demand doubling for Psychology CYP 30% up for CAHMS and 40% up for targeted interventions. Eating disorder cases up 70% all pandemic related. Further waiting list initiatives utilising slippage from transformation schemes being taken forwards. November update: Slippage identified and schemes to support waiting times agreed by MH,LDA,CYP Board and being initiated. (CAMHS core, ND pathway, targeted intervention, sexual violence). December update: System MH,LDA,CYP Board approved outline plan to reduce ND wait list for cyp to get to 18 weeks by 2024/5 . work underway across east midlands to support choice agenda and wait times for ADHD adults .Recommended to review and subdivide this risk from April as system risk update with impact of Covid -19 escalation. DHCFT CAMHS ASIST (assessment) team have reported on their targeted waiting list initiative in Oct to reduce the external wait for CAMHS Initial assessment. This has reduced their waiting list to 266 young people on the CAMHS external wait list (down from 444 in August 2021) with the longest wait reducing from 52 weeks to approximately 25 weeks at this time. CAMHS have maintained all critical/essential services and continue to prioritise these. Further waiting list initiatives with Action for Children, DHCFT and CRH underway.	4	3	12	4	3	12	3	3	9	Mar 22	Links to Strategic Aims 1, 2, 3, 4, 5	Dec-21	Jan-21	Zara Jones Executive Director of Commissioning Operations	Dave Gardner Assistant Director, Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning
06	21/22	Demand for Psychiatric intensive Care Unit beds (PICU) has grown substantially over the last five years. This has a significant impact financially with budget forecast overspend, in terms of poor patient experience , Quality and Governance arrangements for uncommissioned independent sector beds. The CCG cannot currently meet the KPI from the Five year forward view which require no out of area beds to be used from 2021.	Quality and Performance	Commissioning	5	3	15	Beds commissioned on block and to be extended for a further year. STP developing a plan for Derbyshire PICU. Use has escalated during COVID19 and funding recoverable from COVID funding this therefore has resulted in no change to the financial risk despite numbers doubling to 24 from 12. However plans will need to be in place to ensure numbers return to agreed baseline. 07.08.20 Length of stay rising is a factor in increased use mitigated by reduced use of additional observations. DHCFT have submitted 250M capital funding Bid to national capital scheme. this includes a new build PICU for men. Options for Women will need to be considered within the estate changes made possible if the bid is successful.	Continue to Explore regional options for bed optimisation being taken forward with clinical network DHcFT to take a lead provider role . OOA bed reduction plan to include PICU and manages through STP. Report on Options for Derbyshire PICU and controls to be brought back to DDCCG in September, Ensure plan in place to reduce PICU usage post COVID. Ensure that DHCFT returns patients back to Derby as soon as possible. Maintain reduced additional observation costs with continued provider challenge . 07.08.20 Issue raised in MH recovery Cell . short life group formed to address . Report on Options for future dependent on outcome of 250Mcapital bid. Subgroup of recovery cell to produce plan to reduce numbers . Finance teams to discuss how COVID funding arrangements can be taken forward with DHcFT as "top up funding" announced in phase 3 arrangements may be linked to provider costs not CCG costs. This is being investigated further.	August update Papers on procurement outcome and proposals for next steps to come to CLCC. Concerns remain as for July depending on outcome of search for provider who can meet quality requirements . September Update use remains stable ,searches underway for suitable providers .Risk level remains unchanged until suitable providers identified. October Update. Providers who can meet quality requirements identified but at a distance from Derby. Direct award for providers being considered in papers to CLCC. November update: Outline Business Cases for the development of 14 bedded Derbyshire Male PICU service have been reviewed by the CCG and JUCD governance and are supported to progress to full business case. Negotiated procedures have been conducted with current contracted providers of PICU services to agree contract terms for the provision of block funded beds until the proposed Derbyshire unit is in place, this will provide an increased level of block funded access and will support the JUCD system in the achievement of no OOAP through the provision of continuity of care arrangements with the contracted providers. Contracts will be agreed by the end of November with full implementation of CoC arrangements to be in place Q4 2021/22. December update: Contracts agreed with providers for block funded beds. Mobilisation period commenced and actions agreed. Risk score amended to reflect actions taken.	3	4	12	2	3	6	2	3	6	Dec 21	Links to Strategic Aims 1, 2, 3, 4, 5	Dec-21	Jan-21	Zara Jones Executive Director of Commissioning Operations	Dave Gardner Assistant Director, Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning

Risk Reference	Year	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk Rating			Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating			Residual/ Current Risk			Target Risk			Target Date	Links to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
					Probability	Impact	Rating				Probability	Impact	Rating	Probability	Impact	Rating	Probability	Impact	Rating						
09	21/22	Sustainable digital performance for CCG and General Practice due to threat of cyber attack, network outages and the impact of migration of NHS Mail onto the national shared tenancy. The CCG is not receiving the required metrics to provide assurance regarding compliance with the national Cyber Security Agenda, and is not able to challenge any actual or perceived gaps in assurance as a result of this.	Governance	Corporate	3	4	12	• NECS receive and acts on CareCERT alerts, received in response to NHS Digital monitoring of threats to the external system. Actions taken are reported via the NECS contract management meetings, and escalated to the Digital Lead where required. • The network infrastructure is proactively monitored and anti-virus signatures are maintained adequately. • NECS actively provide compliance evidence for the DSPT and provides assurance to the CCG regarding network security. • The Governance Committee has responsibility to oversee the arrangements for ensuring that technology is secure and up-to-date and IT systems are protected from cyber threats. • The NECS contract management board receives routine assurance reports regarding cyber security preparedness and resilience. • Hygiene reports (progress against technical security measures) are provided to the NECS contract management board The CCG has agreed a local policy for the shared tenancy and Microsoft Office 365 that seeks to prevent the introduction of new functionality into Microsoft Teams and other associated software until the business case has been proven that this functionality would be beneficial and until such time as the Governance is in place. Where changes are known in advance, these are communicated to staff appropriately including the effect of the change. The CCG are also working with NECS to develop system policies at the local level to allow as much local control over changes as is feasible while feeding back to the national teams. Our CCG is also two/three weeks behind the rollout in other NECS Customers to enable us to learn lessons from their experiences and adjust accordingly. The CCG receives regular automated updates from NHS Digital to enable them to identify any new risks or variations or escalation in existing risks. These are also automatically published into a Microsoft Teams environment which is shared with Primary Care to allow further propagation of the information. NECS has also agreed to provide named contacts within the CCG with regular updates around critical and high priority changes such that the CCG can actively participate in any risk management decisions and remains information of progress. Following discussion and approval at PCCC, the CCG is procuring dedicated connections into currently shared sites to remove the dependency upon AGEM and their supplier chain. This will ensure that NECS own the connection from the desktop to the data centre and out to the Internet.	CCG proposes to work closely with cyber awareness training provider / Cyber Resilience Support team which may include identification and recommendations of cyber issues that may impact on cyber security, for example developing and implementing further strategies and policies - and identification of practical opportunities where necessary to support operational awareness. Development of local policies and working with the national team to devolve as much responsibility as possible to the local level thereby allowing us to have more control over the deployment, removal and changes to functionality within the Microsoft Teams and other environments linked to the NHS shared tenancy and Microsoft Office 365. Additionally, the migration of the CCG and colleagues within General Practice away from the previous NHS Mail system and onto the NHS' national shared tenancy brings both benefits and risks. While there are economies of scale and additional functionality available, there is a lack of control over the launch of new functionality and removal of existing functionality. There are also configuration issues between settings at the national and local level, leading to a temporary pause in the deployment of Microsoft Office 365 within Derby & Derbyshire until these are remedied. Visibility of the NECS responses and strategies to dealing with critical and high priority risks.	12.07.21 - No evidence of the recent (and ongoing) distributed denial of service attack penetrating any of our networks or devices and NECS has confirmed that geo-blocking is in place to prevent connections from countries and areas known to be active in attacks such as these. We are continuing to work with NECS on the 'PrintNightmare' vulnerability and we have tracked this from initially being of low significance to requiring action. NECS has mitigated the risk by removing the printing function from all unnecessary devices, but to fully secure the network we would need to suspend all printing from all devices which is impractical. We therefore continue to scan all devices connected to the network for any signs of the vulnerability being utilised - if found, the device will automatically be isolated from the network and the security team informed. To date, there have been no exploitations identified within the CCG or Primary Care. Risk remains the same, as there is the risk of exploitation, but no evidence of this being exploited - similar to the scenario with Microsoft Office 2010. 17.08.21 - We have agreed an initial reporting procedure with NECS for the communication of any high level or escalating CareCERT alerts accompanied by appropriate assurances and mitigations; this allows the CCG to be aware of all potential threats and to manage those risks in tandem with NECS and assurances that alerts are being appropriately responded to. We have also subscribed to the NHS Digital CareCERT data feed to ensure that we also receive any low level or for information alerts so that these can be assessed and raised with NECS and/or through appropriate internal routes as appropriate. The risk continues to be low. 13.09.21 - Recommend reduction of the impact of the risk, as previously risk mitigation and responses to critical and high-level alerts were provided directly to NHS Digital for assurance with subsequent reporting to the CCG through operational contractual meetings. The revised approach means the CCG are both aware of all risks (not just critical and high-level) and receive more timely reports from NECS on how these are being actively managed. It also allows for the CCG to challenge responses where appropriate and to receive assurance that the risk has been addressed or where risks remain. Reviewing the available information would indicate risks are being appropriately managed and actioned and with the additional investment made in our off-site storage and improvements to the firewall, we feel the impact of the risk should be reduced given these additional mitigating actions. 26.10.21 - Recommendation that the risk remains the same until the additional 12 dedicated and NECS managed connections are installed, as this will then remove the risks to service delivery through the shared sites. 17.11.21 - The risk score remains the same, as we are awaiting a funding decision from NHSX to upgrade existing slower connections and the intention would be to commission both pieces of work together - the additional sites and the upgrades to any sites with lower than 30MB/sec connectivity speeds. 14.12.21 - At the time of writing the update there is currently a high severity CareCert in place for a vulnerability within the Log4j component which is to be found in a number of different systems including Apple's iCloud and a number of systems in use across Derbyshire. This vulnerability can lead to remote agents taking control of a host system and as a result NECS has already identified Internet facing systems which cause a potential threat and has taken steps to suspend these pending further investigation. There is currently no evidence to suggest any breaches of any NHS organisations within Derbyshire including the CCG or Primary Care. Mitigations also include local business recovery plans. However, given the severity of the vulnerability, the current status of not knowing all affected systems and the duration that this situation is likely to be ongoing, it seems prudent to raise the probability significantly to identify this increased risk	2	3	6	4	4	16	1	4	4	No target date as/dod as Cyber security is continually monitored and will need to be reviewed constantly	Links to Strategic Aim 4	Dec-21	Jan-21	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Ged Connolly-Thompson - Head of Digital Development, Chrissy Tucker - Director of Corporate Delivery
10	21/22	If the CCG does not review and update existing business continuity contingency plans and processes, strengthen its emergency preparedness and engage with the wider health economy and other key stakeholders then this will impact on the known and unknown risks to the Derby and Derbyshire CCG, which may lead to an ineffective response to local and national pressures.	Governance	Corporate	4	4	16	• CCG active in Local Health Resilience Partnership (LHRP) and relevant sub groups • On-call staff are required to receive Met Office Weather Alerts. These will be cascaded to relevant teams who manage vulnerable groups • Executive attendance at multi agency exercises. • Internal Audits have evaluated Business Continuity preparedness. • Derbyshire-wide Incident Plan in existence • Joint Emergency Services Interoperability Protocol (JESIP) training made available to on-call staff • Staff member trained in Business Continuity and member of professional body • Staff member competent to train Loggists internally and there are sufficient number now trained • Derby and Derbyshire CCG represented on LHRP and LRF sub-groups including, HEPOG, Training and Exercising sub-group. Risk Assessment Working Group, LRF Tactical, Human Aspects and Derbyshire Health Protection Response Group. • On-call rota being revised to introduce two tier system with improved resilience • Comprehensive training undertaken for On-call staff to National Standards Accountable Emergency Office and Deputy AEO attended EU Exit conference 17th September 2019 On Call Forum has been established and has held productive meetings sharing knowledge and experience • Table top exercise took place in December 2019 to test the robustness of the CCG response to IT and Telephony failure and to Fuel Shortage leading to improvements in processes and procedures • CCG participating in local response to Coronavirus risks as part of the Derbyshire LHRP system following national guidance from PHE. • The Director of Corporate delivery and the Business Resilience manager took part in a national seminar Effective Communication Around Major Incidents Digital Forum on Friday 16 October, 2020. • The Director of Corporate Delivery and the Business Resilience Manager took part in a national seminar EU Exit End of Transition period workshop on 04 November 2020. This has resulted in key areas of work being identified and CCG Leads mobilised to provide a response • Senior Responsible Officer for EU Exit designated for the CCG and contact details made available to NHSEI • EU Exit now a standing item on weekly SEC Meetings	• Practices updating Business Continuity Plans to include consistent contact details for CCG in-hours and out of hours. • Business Resilience Manager developed a single operational Business Continuity Plan. This will now be reviewed in the light of learning from the COVID pandemic. • Confirm and challenge meeting with Providers and NHSEI took place on 2nd October 2019 and agreement reached with Providers on final level of assessment against the core standards. • CCG on call arrangements reviewed and CCG is operating a 2 tier on call system. Training has been provided to all on call staff from November to March 19. • Accountable Emergency Office and Deputy AEO attended EU Exit conference 17th September 2019, to gain assurance on EU Exit assurance. • CCG took part in daily SitRep reporting to NHSE until stood down on 28 October 19. • CDG provided exception reports on EU Exit through Local Resilience Forum. • Derbyshire System wide EU Exit Plan developed and distributed to Providers • Two "dry runs" at preparing for EU Exit date puts the CCG in a stronger position • Business Impact Assessments for each function within the CCG have been completed and approved the Governance Committee in March 2020. • Lessons learned from Toddbrook Reservoir will be incorporated into the Business Continuity plan when the EPRR review becomes available. • A review of the recent power outage situation at Cardinal Square is scheduled this month (November) and lessons learned incorporated into the Business Continuity Plan. • The On Call Forum has met regularly and has provided an opportunity to share experience and knowledge •The CCG has fully participated in the response to the COVID pandemic and submitted evidence to NHSEI as part of the 2020/21 EPRR National Core Standards • Continued collaborative working with Provider organisations and other stakeholders including the LRF and NHSEI Regional teams	December Update • CCG informed by NHSEI Midlands EPRR Team that submission for this years EPRR Nation Core Standards is Substantial compliance subject to final ratification • CCG engaged with LRF in exercises to test system resilience • Engaging with system partners to explore and implement strengthened on-call arrangements over Christmas period • Working with ICS lead and 360 Assurance with regard to violence and aggression reduction	2	4	8	2	4	8	2	2	4	On going	Links to Strategic Aims 3, 4	Dec-21	Jan-21	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Chrissy Tucker - Director of Corporate Delivery / Richard Heaton, Business Resilience Manager
11	21/22	Risk of 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.	Finance	Finance	4	4	16	Internal management processes – monthly confirm and challenge by Finance Committee Monthly reporting to NHSEI Development of system I&E reporting including underlying positions by organisation and for the system as a whole	Due to the uncertainty of the financial regime in the NHS it remains unclear what the impact on the CCG of failure to live within agreed resources for the 2021/22 financial year would be.	The Derbyshire NHS system has a significant gap between expenditure assessed as required to meet delivery plans and notified available resource. The CCG is working with system partners to establish a sustainable a long term financial position and deliver a balanced in-Year position. As at M8 the CCG are not seeing any major financial pressures against planned expenditure with the exception of CHC and we continue to work with M&LCSU and providers to rectify this. The CCG are reporting a year to date underspend of £0.730m against total allocations of £1,392.484m for the period covering April to November 2021. Against total resources available in 2021/22 of £2,073.224m the CCG is forecasting an surplus of £0.030m.	4	4	16	4	4	16	2	3	6	On going	Links to Strategic Aims 1,2, 4, 5	Dec-21	Jan-21	Richard Chapman, Chief Finance Officer	Darran Green-Assistant Chief Finance Officer
12	21/22	Inability to deliver current service provision due to impact of service review. The CCG has initiated a review of NHS provided Short Breaks respite service for people with learning disabilities in the north of the county without recourse to eligibility criteria laid down in the Care Act. Depending on the subsequent actions taken by the CCG fewer people may have access to the same hours of respite, delivered in the same way as previously. There is a risk of significant distress that may be caused to individuals including carers, both during the process of engagement and afterwards depending on the subsequent commissioning decisions made in relation to this issue. There is a risk of organisational reputation damage and the process needs to be as thorough as possible. There is a risk of reduced service provision due to provider inability to retain and recruit staff. There is an associated but yet unquantified risk of increased admissions – this picture will be informed by the review.	Quality and Performance	Quality/ Reputational	3	4	12	• Joint working in place with Derbyshire County Council to quantify the potential impact on current service users. • Joint working in place with Derbyshire Community Health Services NHS Trust to ensure business continuity plans in place and operational risks mitigated • Communications and engagement teams are being involved throughout to manage consultation process and ensure information is shared within public domain to enable a balanced view. • Project team meeting weekly to monitor progress and resolve issues - Task and finish group has been established with representation from local authority, CCG, DCHS and DHFCT Action plan has been developed and sent to the BRS Delivery Group for comment. Task and finish group will now take the action plan forward The crisis element of respite has been discussed in the wider system and agreement has been reached The original short break review - a position statement paper has been produced and will be discussed with Director to agree on next steps. Work to be carried out by the Strategic Commissioners	• Working closely with Comms and Engagement Team. • Assurance of process received from Consultation Institute.	Covid-19 restrictions – impacting on discharge planning, inconsistent policies across different providers. - Orchard Cottage maintained significant damage by a patient unable to be used at moment,,. This will not be re-opened until 2021 - Amberleigh - previously closed. Discussions have taken place to re-open to provide an urgent provision for transforming care patients. Discussions continue. - The third unit remains closed as not currently fit for purpose. The crisis element of respite has been discussed in the wider system and agreement has been reached Ownership of 'Crisis' Lane as part of the Three Year LD/A Road Plan changed to DDCCG Strategic Commissioner. BRS LD A Delivery Group Extraordinary Meeting scheduled for the 21st April. Progress to be reviewed against: 1.The expansion of IST 2.Commissioning of crisis accommodation 3.Commissioning of crisis in reach 4.Review of approach to respite December Update: System Delivery Board have endorsed proposal for Short Breaks programme reinitiation First phase focused on understanding need or Short Breaks service users any potential impact of changes on individuals, families and wider stakeholders. Comms and engagement plan to be developed and implemented Risk assessment the same whilst project in initiation.	3	3	9	3	3	9	2	3	6	December 21	Links to Strategic Aims 1, 2, 3, 4, 5	Dec-21	Jan-21	Brigid Stacey - Chief Nursing Officer	Mick Burrows Director for Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning, Helen Hipkiss, Deputy Director of Quality /Phil Sugden, Assistant Director Quality, Community & Mental Health, DCHS
16	21/22	Lack of standardised process in CCG commissioning arrangements. CCG and system may fail to meet statutory duties in S14Z2 of Health and Care Act 2012 and not sufficiently engage patients and the public in service planning and development, including restoration and recovery work arising from the COVID-19 pandemic.	Engagement	Communications/ Engagement/ Statutory	3	4	12	Systematic completion of S14Z2 forms will provide standardised assurance against compliant decision making and recording of decisions at project level. Engagement Committee established to strengthen assurance and risk identification.	PMO processes are not being applied to restoration and recovery projects, therefore there are no checks and balances as projects proceed to ensure that they have completed either the S14Z2 or EIA forms. An equality and engagement policy is being developed to address this gap in part, for proposed adoption by all JUCD partners. EIA/QIA process adopted by JUCD. Not all projects follow a systematic project management/commissioning/transformation process to ensure standardisation of process and application of legal duties. June update: Engagement Governance Guide and training being developed to support consistency of approach for officers involved with transformational change. Meeting with new ICS Director of Transformation to be arranged to ensure processes embedded in future project management approaches. September: Completion of Engagement Governance Guide in October and alignment with transformation/PMO processes.	Engagement Committee re-established in June 2020 following pause during peak of COVID-19 pandemic. Training for Engagement committee members on consultation law completed. Replacement lay members recruited to ensure sufficient lay voice on Engagement Committee following recent resignations. S14Z2 log reviewed regularly by Engagement Committee. CCG planning approach under review to identify potential annual commissioning business cycle, thus enabling rolling engagement programme in commissioning development and activity. July: Consultation Law refresher training undertaken for engagement team to support governance process review and strengthen our approach to planning and delivery of engagement, including additional context of engagement requirements in a virtual world. Will feed Governance Guide production this month, to be reviewed by Engagement Committee in August 2021. August: Meeting with ICS Director of Transformation taken place 17.8.21; meeting with QEIA panel leads on 18.8.21. Governance Guide remains in development, aligned to revision of Engagement Model. Will also align with emerging JUCD transformation processes, with agreement that that S14Z2 check will be included in documentation and digital tool. Further strengthening of S14Z2 process also agreed with QEIA Panel process, to improve quality and timeliness of submissions of S14Z2 forms. These actions combined will serve to achieve the target score this risk during Q3. September/October: Engagement Model refresh to September Engagement Committee, governance guide sits behind this as a resource for teams undertaking service change. Planning for guide to be completed in October 2021, with parallel alignment into Transformation/PMO processes. Target risk score achievable by October/November 2021. November:The Governance Guide is progressed and submitted for approval at November Engagement Committee. December: Governance Guide verbal update given at November Committee - final amendments required prior to approval that could not be completed in time for the meeting due to team capacity challenge. To be reviewed at January 2022 Engagement Committee.	2	4	8	2	4	8	2	3	6	Dec 21	Links to Strategic Aims 1, 2, 3, 4, 5, 6	Dec-21	Jan-21	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Sean Thornton Assistant Director Communications and Engagement
17	21/22	S117 package costs continue to be a source of high expenditure which could be positively influenced with resourced oversight, this growth across the system, if unchecked, will continue to outstrip available budget	Quality & Performance	Corporate	3	4	12	Although not overspent to budget at this time the rising cost of care under s117 is around 38m to the system. The CCG is investing in additional case managers, re-introducing S117 work stream under MHSDB when this is possible. It is anticipated that both of these measures will positively affect outturn at system level. 17.09.20 The CCG have agreed to employ a number of case ,managers, which will cover s117 packages of Care. This is being negotiated with the CSU to start in October. The Commissioning for Individuals panel is now in place. This includes s117 cases. Although not overspent to budget at this time the rising cost of care under s117 is around 38m to the system. The CCG is investing in additional case managers, re-introducing S117 work stream under MHSDB when this is possible. It is anticipated that both of these measures will positively affect outturn at system level.	There is slippage in the introduction of case managers, so the savings have slipped from October 2020 to January 2021. Further re-design of specification now means delivery start date now Q1 21-22	Recruitment challenges 17.08.21 Risk remains unchanged pending case load review, CSU have not yet confirmed timeline. 12.10.21 Discussed with MLCSU today, she confirms that reviews are now ongoing and that potential savings will be quantified over the next quarter. The risk remains high due to the ongoing issues that need resolving with systems partners. 17.11.21 Reviews remain on track as per previous report, potential savings quantified over next quarter still. 13.12.21 Reviews continuing as per previous updates, potential savings to be quantified in Q4	3	3	9	3	3	9	2	2	4	tbc	Links to Strategic Aims 1, 2, 3, 4, 5	Dec-21	Jan-21	Zara Jones, Executive Director of Commissioning Operations	Helen Hipkiss, Director of Quality / Dave Stevens, Head of Finance
20	21/22	Failure to hold accurate staff files securely may result in Information Governance breaches and inaccurate personal details. Following the merger to Derby and Derbyshire CCG this data is not held consistently across the sites.	Governance	Corporate	4	3	12	• Staff files from Scarsdale site are to be moved to a locked room at the TBH site. This is interim until the new space in Cardinal is available. There are still staff files at Scarsdale and Cardinal Square they are safely secured. Due to Covid-19 the work has been placed on hold as staff are all working from home. • EKs/PAs at Cardinal Square have been contacted and a list is being pulled together of names and files (current or leavers) held ensuring that these are all securely saved in locked filing cabinets. Work is being completed at Cardinal Square by staff who do regularly attend site to compile the list and confirm who may be missing. • Consider an electronic central document management system (DMS) This action remains once we are in a position to move the project forward.	• A project team has been organised to work on the risks, ensuring that a standardised format and tick list is developed of the relevant paperwork to keep in HR files. This piece of work will take a significant amount of time before the CCG can even consider looking at a document management system. • Information Governance are currently working to secure a contract for archiving, this will ensure that staff leavers files are securely archived with the correct paperwork. • Project team are obtaining guidance with other NHS organisations to consider a document management system.	December - No further update due to continued home working, January - No change due to continued home working, February - No change due to continued home working, paused. 14.09.21 - Trial of flexible/hybrid model of working commences on 20.9.21 with staff able to book desks at CCG sites. Project group to recommence review of HR files with a view to scanning into an electronic filing system. Files to be reviewed ahead of transition to ICS on 1 April 2022. 13.10.21 - New operating model in place from 20.9.21. Project group to recommence review of HR files with a view to scanning into an electronic filing system. Files to be reviewed ahead of transition to ICS on 1 April 2022.. 15.11.21 - Project group to recommence review of HR files with a view to scanning into an electronic filing system. Meeting to be held on 17.11.2021 - Files to be reviewed ahead of transition to ICS on 1 April 2022. 10.12.21 - Project group met on17.11.2021 - agreed that work can commence on current personal files as all the paperwork was agreed previously, with a front sheet added to everyone's HR folder. At this stage any that are required to be archived will remain in a separate filing cabinet clearly marked with meta data. Files to be reviewed ahead of transition to ICS on 1 April 2022.Update 13.12.2021 - Government advice to work from home wherever possible will temporarily pause project.	3	3	9	3	3	9	1	2	2	On going/ tbc	Links to Strategic Aim 4	Dec-21	Jan-21	Beverley Smith, Director of Corporate Strategy & Development	Sam Robinson, Service Development Manager
22	21/22	The mental health of CCG staff and delivery of CCG priorities could be affected by remote working and physical staff isolation from colleagues.	Governance Committees	Corporate/Clinical	3	3	9	Daily Team Meetings/catch up's held between Managers and their staff. Weekly All Staff virtual meeting held, led by Dr Chris Clayton, to update and inform CCG staff of developments etc. Weekly Staff Bulletin email from Dr Chris Clayton outlining the CCG activity which has occurred during the week, with particular focus on the people aspect of the CCG. Twice daily COVID-19 Staff update emails issued outlining all progress, news and operational developments. CCG employees trained as Mental Health First Aiders available for all CCG staff to contact for support and to talk to. This is promoted through the daily COVID-19 Staff updates. Included in the Staff update emails is the link to the Joined Up Care Derbyshire website staff support area which is available and continues to be updated. This now also includes a new section for leaders and a section for parents or carers of children. This also offers wellbeing, health advice and support for health, social care and community staff in relation to the Covid-19 virus. For confidential support and counselling the CCG employee assistance programme provider (EAP) can be accessed by all CCG colleagues and family members in the same household and is available 365 days a year, 24 hours a day. They have also launched a 25 minute web based "Working from Home and Resilience" seminar details of which have been included in the CCG Staff update email. 1 to 1 wellbeing checklist introduced for line managers to facilitate support for members of their team. Virtual tea breaks and initiatives to promote social connectivity introduced and ongoing.	08.04.20 A range of ideas to support the wellbeing of staff working from home will be launched shortly, with a toolkit to help staff all maintain a positive outlook and ensure interaction with colleagues 'off topic' to maintain spirits during the working week. Staff are encouraged that they should all take time to remember that they are not "working from home", but "at home, during a crisis, trying to work". 17.04.20 continue to monitor and assess sickness returns for trends and patterns and review good practice for staff H&WB e.g. NHS Employer, Social Partnership Forum etc. 12.05.20 The CCG will develop and run briefings for line managers to support them in undertaking 1 to 1 wellbeing checks with their team (to include wellness action plan, display screen equipment review and risk assessments for vulnerable staff).	14.09.21 - Majority of staff have reviewed and submitted an updated risk assessment pro-forma and individual preferences. 90% of CCG staff are fully vaccinated with a further 3.4% who have received the first does only. Continuation of wellbeing communication and initiatives for staff, including flexible working, social connectivity, relaxation sessions. Anticipate that the probability of health risks from remote working will reduce (probability of 1) when the CCG introduces the flexible model/hybrid working with effect from 20. 9.21 whereby staff will be able to choose to attend and work at a CCG base. Briefing for all staff at Team Talk on 14.9.21 regarding the flexible model linked to virus transmission rates (red/amber/green) and an overview of the standard operating procedure (e.g. amber - 80 desks bookable, social distancing, requirement to wear mask and max 2 people in a meeting). 13.10.21 - Continuation of wellbeing communication and initiatives for staff, including flexible working, social connectivity, relaxation sessions. CCG has introduced the new operating model (hybrid working) and staff are able to choose to attend and work at a CCG base. Mid-year review conversation to focus on health & wellbeing & support required by staff. 15.11.21 - Mid-year review conversations focussing on health & wellbeing & support required by staff taking place during October & November .Continuation of wellbeing communication and initiatives for staff, including flexible working, social connectivity, relaxation sessions. Also promoting access to virtual exercise classes and MSK exercises. Staff remain able to book a desk and work from a CCG base. 10.12.21 - Majority of mid-year review conversations focussing on health & wellbeing & support required by staff have now taken place. All staff webinar held on personal resilience and change by Thrive psychologists Promotion of virtual exercise classes and exercises to undertake whilst working to maintain good MSK health. Continuation of wellbeing communication and initiatives for staff, including flexible working, social connectivity, relaxation sessions. From 13.12.2021 staff will no longer be able to book a desk to work from a CCG location, however, exceptions will be looked at for health and wellbeing grounds as previously.	2	3	6	2	3	6	1	3	3	On going	Links to Strategic Aims 1, 2, 3, 4, 5	Dec-21	Jan-21	Beverley Smith, Director of Corporate Strategy & Development	Beverley Smith, Director of Corporate Strategy & Development James Lunn, Head of People and Organisational Development
23	21/22	CCG Staff capacity compromised due to illness or other reasons. Increased numbers of CCG staff potentially unable to work due to COVID 19 symptoms / Self isolation.	Governance Committees	Corporate	3	4	12	Staff asked to complete Skills Survey for redeployment. Detailed analysis of deployment within and outside of the CCG completed. Backup rota compiled for Incident Control Centre (ICC). Majority of CCG staff working from home. Business Continuity Plan escalation level increased to 4 allows for pausing of functions within the CCG.	Running a mixed model of remote/base work Possible shadowing of staff working in the ICC by backup rota staff. General capacity issues in covering staff absences Staff illness could compromise the operation of the ICC. Develop a resilient rota for the ICC, PPE and Testing Cells over 7 days	12.08.21 - Ongoing review of existing redeployments and consideration of alternative solutions. 14.09.21 - CCG staff continue to provide support in the vaccine operational cell (VOC) and at the vaccination centres. The number of CCG staff/ time commitment has reduced from 1 September 2021 with the move away from the mass vaccination centre. There is an ongoing review of existing redeployments and consideration of alternative solutions. 13.10.21 - Ongoing review of existing redeployments and consideration of alternative solutions. The Vaccine Operational Cell (VOC) currently has vacancies and SLT discussions around how these can be filled are being carried out. Sickness absence rates continue to be below pre-covid levels (3.16%) but have increased in the last 6 months from (2.16% in April to 2.34%). 15.11.21 - Number of redeployments has significantly reduced. CCG has agreed to fund additional external resource to boost capacity in the short-term (until 31 March 2021) from underspend on both running and programme costs. 20.12.21 - Increasing number of redeployments away from the CCG, due to requirements to support the system with the COVID booster and vaccination programme. Risk probability score increased accordingly from 1 to 3. Permanent structure developed for VOC to support continuity & deployment and submitted to Executive Team for consideration. Additional interim resource being brought in to boost capacity in the short-term (until 31 March 2021) from underspend on both running and programme costs.	1	4	4	3	4	12	1	3	3	On going	Links to Strategic Aims 1, 2, 3, 4, 5	Dec-21	Jan-21	Beverley Smith, Director of Corporate Strategy & Development	Beverley Smith, Director of Corporate Strategy & Development James Lunn, Head of People and Organisational Development

Risk Reference	Year	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk Rating: Probability	Initial Risk Rating: Impact	Initial Risk Rating: Rating	Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating: Probability	Previous Rating: Impact	Previous Rating: Rating	Residual/ Current Risk: Probability	Residual/ Current Risk: Impact	Residual/ Current Risk: Rating	Target Risk: Probability	Target Risk: Impact	Target Risk: Rating	Target Date	Links to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
24	21/22	Patients defering seeking medical advice for non COVID issues due to the belief that COVID takes precedence. This may impact on health issues outside of COVID 19, long term conditions, cancer patients etc.	Quality & Performance	Clinical	5	4	20	National and local campaigns across all media platforms to promote access and availability of health services. Weekly performance brief to monitor patient attendance across providers (A&E, 111, NEL, Elective Care, Cancer etc.) Primary Care agreed to prioritise LTC reviews for all priority (red) patients and have agreed to see all amber patients by 31st March 2021. Includes messages to voluntary sector to strengthen messages to patients. COVID vaccination roll out to commence in December, based on a prioritisation framework.	On-going public communication campaigns regarding service provision as we move across each phase. To support winter pressures, PCN's are developing contingency plans to support patients that display COVID/ Flu symptoms. Learnings to be taken from the red hub concept. Proposals to restore services and reintroduce appointments by utilising digital technology and reviewing provision of service (acute v community) e.g. rehab services, diagnostics, phlebotomy, MDT's etc. System Cell leading on the co-ordination of vaccine roll out, commencing in early December.	13/8/21- Vaccinations rolled out to 16-18 age group. Booster jabs for over 50's+, adults aged 16-49 who are in a flu or Covid-19 at-risk group and those living in the same house as people who are immunosuppressed. 13/08/21- Our system is currently under significant pressure. Not only are our Emergency Departments filling up, but our ambulance service, general practice, urgent treatment centres, mental health units and our discharge support teams are all experiencing unprecedented demand. This 'perfect storm' is now also being exacerbated by increasing numbers of staff needing to self-isolate having either had a positive test for Covid-19, having to self-isolate because of an alert from the NHS Covid-19 app or having to take time off work to look after their children. 10/09/21- The pressures on our health and social care system continue to intensify and urgent talks took place to see what measures were needed to support and bolster our local NHS network against unprecedented demand. System leaders are monitoring the live situation and will make changes to relieve capacity where possible and we're also asking the public to work with us by accessing the right NHS service. 13/10/21- No progress update. Advise to keep the risk on the tracker due to forthcoming winter pressures and the spread of COVID variants. 13/11/21- No progress update. Advise to keep the risk on the tracker due to forthcoming winter pressures and the spread of COVID variants. 10/12/21- Concern over Omicron variant and national measures have been introduced to tackle the spread. Booster jab roll out for all 40+ commenced. Advise to keep the risk on the tracker due to forthcoming winter pressures and the spread of COVID variants.	2	3	6	2	3	6	2	3	6	On going	Links to Strategic Aims 1, 2, 3, 4, 5	Dec-21	Jan-21	Dr Steve Lloyd, Medical Director	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster Head of Strategic Clinical Conditions and Pathways
25	21/22	Patients diagnosed with COVID 19 could suffer a deterioration of existing health conditions which could have repercussions on medium and long term health.	Quality & Performance	Clinical	4	4	16	Derbyshire-wide Condition Specific Boards continue to review information, guidance, evidence and resources to understand the repercussions e.g. NHSE After-care needs of inpatients recovering from COVID-19, BTS Guidance. System working to co-ordinate and implement guidance. Primary Care agreed to prioritise LTC reviews for all priority (red) patients and have agreed to see all amber patients by 31st March 2021. NHSE have launched the 'Your COVID Recovery' service to provide advice and guidance (self-care) online, and a national COVID rehab service is in development Post COVID rehab pathways for admitted and non-admitted patients being developed, and criteria for referral to secondary care if patients have ongoing needs. MDTs set up across the county in respiratory between Acute and Community Respiratory Teams. Working towards implementation with Acute and Primary Care. Post COVID Syndrome Assessment Clinic service implemented to support patients suffering with post/long COVID symptoms. MDT approach to provide physical and psychological assessments, to ensure patients access the required service and treatment.	Review COVID inpatient data to identify pre-existing LTCs to proactively support patients. Derbyshire-wide Condition Specific Boards to amend/ develop pathways through embedding new guidance and good practice to allow effective follow-up of patients. Keep virtual consultations / on-line support (amplify). Proposals to restore services and reintroduce appointments by utilising digital technology and reviewing provision of service (acute v community) e.g. rehab services, diagnostics, phlebotomy MDT's etc. To support the roll out of the 'Your COVID Recovery Service' throughout Derbyshire as required. To include communications and implementation of rehab service. Review and scoping of pan-Derbyshire end to end rehab pathway Develop and implement a Post COVID Assessment Clinic to ensure patients are referred to appropriate services. Post COVID integrated pathway (system) and Post COVID Assessment Clinic to be communicated across the health system. Including culturally relevant communications to raise awareness amongst patients and the public.	14/06/21- Press release was launched w/c 7th July. Lead GP was interviewed by BBC Radio Derby. 16/07/21- £1.8m funding ringfenced for JUCD to support the ongoing treatment and rehabilitation of patients. Plans to develop a Long COVID Rehab pathway to support patients with Post COVID Syndrome are being worked up. A total of 600 patients have been referred to the Post Covid Assessment Clinic to date. 13/08/21- NHSE agree in principle to JUCD Post COVID Rehab pathway which will see the establishment of four rehab centres based within the community. A seamless process for both GP's and the assessment clinic to refer to the Post COVID Rehab Centre. Mild symptoms will be referred directly to the Rehab Centre, moderate/severe symptoms will continue to be Post COVID Assessment Clinic and then be referred on where applicable to the Rehab Centre, this will help to reduce the ever increasing backlog and strain on the other existing services such as Pulmonary Rehab and Chronic Fatigue. System stakeholders are working up the detail of the rehab offer. 10/09/21- Held a stakeholder workshop to commence development of the Post COVID Rehab Centres. Currently working closely with multi-agency providers to develop the workforce model. Funding agreed to appoint a Long COVID Project Manager to lead the programme. Interviews scheduled for w/c 20/09. 15/10/21- Project Manager appointed, with a phased start date agreed as the 18th October. The system is working on developing two initial Post COVID Rehab centres. 12/11/21- Agreed to develop two rehab centres at CRH and Florence Nightingale. Recruitment to the workforce has commenced and system wide partners are dialogue to develop the patient pathway. 12/11/21- Concern over waiting lists and recruitment at the Assessment Clinic. Funding being utilised to recruit additional clinician time to eradicate backlog by Dec 21. 10/12/21- Ongoing development of the rehab service, and DCHS are implementing a revised plan to reduce the assessment clinic waiting list.	3	3	9	3	3	9	3	3	9	On going	Links to Strategic Aims 1, 2, 3, 4, 5	Dec-21	Jan-21	Dr Steve Lloyd, Medical Director	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster Head of Strategic Clinical Conditions and Pathways
26	21/22	New mental health issues and deterioration of existing mental health conditions for adults, young people and children due to isolation and social distancing measures implemented during COVID 19.	Quality & Performance	Clinical	5	3	15	o Derbyshire Healthcare NHS Foundation Trust have developed a 24 / 7 crisis helpline for people of all ages and their carers to seek advice regarding MH difficulties including those arising or being exacerbated by Covid-19. Helpline is accessible via 111 warm transfer. o Multi-agency approach in place collating all sources of support and advice that will also support the help line in terms of where people can be triaged to get the most appropriate help. o Working with Communications teams to ensure that information is disseminated effectively across all stakeholders and the system. o Actively working with providers to understand their business continuity measures and how they are planning for fluctuations in demand and capacity, e.g. to meet and respond to reduction in referrals and/or anticipated surge in demand going forward. o CYP services, targeted intervention predominantly online. CAMHS RAG rating and prioritising urgent cases. Digital offer Kooth and Qwell uplift continue until March 21. Ongoing CYP communications strategy with partners to send information out across the system. o IAPT providers fully operational and accepting referrals - Attend Anywhere utilised across the trust for online consultations Mental Health System Delivery Board to provide Covid oversight recovery and planning	o To further recruit and upskill clinicial triage & assessment team staff responding to the helpline in CYP, LD & Autism o Additional community based LD beds -there needs to be an agreed list of identified staff that can be called on this responsibility lies with LA not CCG. Building needs to be furnished and cleaned. o Re above – need to develop a training programme for staff working in the specialised unit- being actioned via LD delivery group. o Need to finalise the LD & Mental Health All Age COVID Recovery Planning Group process to feed into LRF across providers. o Wellbeing in education training to all schools Sept - March to include local MH resources and pathways Close monitoring of service demand to be prepared to respond to any anticipated surge in referrals now CYP returned to school o IAPT providers are funded on AQP basis so there is no cap on activity - frontline staff vaccinations will support increase in face to face capacity and engagement in care and improve resilience of staff capacity reducing absences	August update - increased programme / commissioning capacity agreed to deliver the LTP priorities at Pace. The impact of RSV a particular concern for bed capacity at paediatric acutes which has potential to impact when also an increase in CYP with MH / challenging behaviours - mtgs held with agreed escalation routes ,data flow ,and system response. September update - progressing recruitment to increase programme capacity, bronze, silver, gold escalation routes for CYP with MH / challenging behaviours insitu to facilitate flow. October 21. Improvement in numbers of CYP admitted to paediatric wards. Severe pressure in community. System identification of opportunities for short term accommodation being sought. Use of slippage in CYP to support increased demand and manage wait times . Winter pressure plan developed. November 21 - Additional CYP crisis staff starting to come in to post i.e. in CAMHS Eating Disorder urgent care team . Continued pressures on paediatric units and in community. Working up / reviewing opportunities for CYP short term accommodation. December update - Continuing to recruit to Crisis, Liaison and Intensive Home treatment team. Ongoing pressures affecting flow across in tier 4, paediatric units and community	4	3	12	4	3	12	2	2	4	Oct-21	Links to Strategic Aims 1, 2, 3, 4, 5	Dec-21	Jan-21	Zara Jones, Executive Director of Commissioning Operations	Mick Burrows, Director of Commissioning for MH, LD, ASD, and CYP Helen O'Higgins, Head of All Age Mental Health Tracy Lee, Head of Mental Health - Clinical Lead Helen Van Rstell TCP Programme Manager Jenn Stothard Head of Mental Health
27	21/22	Increase in the number of safeguarding referrals linked to self neglect related to those who are not in touch with services. These initially increased immediately following COVID lockdown. The adult safeguarding processes and policy are able to respond to this type of enquiry once an adult at risk has been identified. Numbers are difficult to predict but are predicted to increase as COVID restrictions ease.	Quality & Performance	Clinical	5	4	20	Key statutory partners such as Health , Local Authority, Police and Voluntary Sector are working closely together to ascertain who are at enhanced risk. Safeguarding meetings and assessments are continuing to take place via virtual arrangements. Families and individuals are being signposted to relevant support services.	Domestic Abuse is likely to increase as family groups are forced to be together for extended periods of time, children are at home on a full time basis, there are financial pressures due to restrictions upon employment, and adults at risk from abusive partners become socially isolated, it remains at an early stage. Referrals are expected to increase with another sharp spike in activity predicted when COVID restrictions are eased and victims feel safer in making disclosures Self Neglect. Individuals are finding it problematic to obtain aids to daily living and basic essentials. They do not have the motivation or ability to access sources to access or replenish essential items. Scamming. Individuals are targeted due to their physical or cognitive vulnerability and persuaded and cajoled to trust unscrupulous individuals. During the COVID19 pandemic the number of referrals to adult social care services has increased but not as yet at the rates envisaged and predicted at the outset of lockdown and enforced isolation. Ongoing close partnership working is required. The Derby and Derbyshire Safeguarding Adult Boards are continuing to work collaboratively to gather information / intelligence and data regarding domestic abuse and adult abuse prevalence during the COVID 19 pandemic to formulate relevant action / contingency plans. Police are undertaking safe and well checks as appropriate and will use powers of entry if deemed necessary and proportionate.	September: The Safeguarding Adult Boards and their Quality and Performance Committees have taken a view that the risk of escalating adult safeguarding activity remains an unknown quantity. Referrals have continued to rise every quarter as more adults at risk are in contact with families and service providers. Self-Neglect and Domestic Abuse, particularly within those aged 65 plus have increased. It would be fair to say that systems are under increasing pressure and it would be optimistic and naive to amend the risk factors and threats at this time. As stated previously we are only likely to begin to understand the impact of Covid upon adults at risk when we have had a sustained and consistent period of normality. This has been exacerbated by a heightened alert around Prevent and anti-terrorist activity particularly within extreme right wing groups. This is in itself linked to the Black Lives Matter strategy and the recent Afghan migration to the UK No further update to add for October. November - Safeguarding Adult referrals have increased by 16% over the last Quarter. This was anticipated due to an easing of lockdown restrictions began to take effect. These referral rates and types are monitored through the Safeguarding Adult Boards and also via case file audit. There should be little doubt that systems and resource ex are stretched and challenged but at the time of writing there are no particular areas of concern requiring escalation. Suggest that we continue with the risk levels as they currently stand until completing a root and branch review during March 2022. December - No changes this month.	4	3	12	4	3	12	3	3	9	Dec-21	Links to Strategic Aims 1, 2, 3, 4, 5	Dec-21	Jan-21	Brigid Stacey, Chief Nursing Officer	Bill Nicol, Head of Adult Safeguarding
32	21/22	Risk of exploitation by malevolent third parties If vulnerability is identified within any of the Microsoft Office 2010 applications after October 14th 2020 and not patched, due to support for Microsoft Office 2010 officially ending, after which point Microsoft will cease to issue updates and patches for vulnerabilities found within this suite of applications	Governance	Corporate	4	4	16	Replace all instances of Microsoft Office 2010 with Microsoft Office 365; Additional Cyber Security communications to all CCG and Primary Care staff to raise awareness of the potential for increased phishing emails, suspicious attachments and downloading documents from unfamiliar web sites; Reinforce the message that devices should be connected to the network every two weeks to ensure that anti-virus and other system management software updates accordingly; Identify other mitigation which NECS have put in place to prevent the execution and spread of any malicious code or exploitation of any vulnerability;	Task and finish group has been established with NECS to develop the programme of work which removes the risk, but also ensure continuity of service across commissioning and Primary Care; Already under development as part of the response to the CORS report; information will be cascaded through the CCG Comms team for CCG and Primary Care colleagues and also shared with the LMC;	12.07.21 - All unsupported versions of Microsoft Windows 10 have now been removed from all devices currently connected to the network. There are three devices outstanding, but these are with colleagues not currently at work and the device will be required to be upgraded prior to re-connecting to the network. The installation of Microsoft Office 365 has been mandated across all CCGs as of 4pm on July 9th with personal follow-up from NECS for any outstanding. There are around 700 devices yet to be upgraded onto Microsoft Office 365 across Primary Care - NECS continue to work with Practice Managers to resolve and Engineer visits will be arranged where more convenient. Risk remains the same. 17.08.21 - All remaining CCG devices yet to upgrade to Microsoft Office 365 are having the installation forced when the device first starts up. A communication has been sent to GP Practices informing them that the forced upgrade will be introduced in Primary Care on August 17th; any devices not upgraded by September 8th will have their network accounts disabled and will require all outstanding upgrades and updates to be carried out prior to being allowed back onto the network. This allows a three week period for any engineer visits or remedial actions to take place prior to the deadline of October 2021. 13.09.21 - There remain around 300 devices yet to be migrated onto the latest version of Microsoft Office with around 4 of these still on older versions of Microsoft Windows 10 - these are primarily within the GP estate including a specific GP Practice which has been undergoing a number of operational issues. Communications have been issued to Practice Managers reminding them of the need to engage with the project which re-enforces messages sent directly to the devices. The decision was taken on Friday Sept 10th to instigate the action to disable the computer accounts of all devices not updated by cop Wednesday Sept 15th. This will also be picked up by engineers routinely visiting sites. Risk score remains the same until all devices are disabled or updated. 26.10.21 - There are currently 2 devices in the CCG (99.6% complete) and 43 devices in Primary Care (99.1% complete) outstanding. Further comms have been distributed to reduce this number, but the majority of these devices appear to be dormant. NECS Engineers have been asked to uncover all dormant devices and return to the CCG if not in active use. All older versions of Windows 10 have now been removed and there are no examples of exploitation of any unpatched vulnerabilities within older versions of Microsoft Office. Suggestion is the risk remains the same until all devices upgraded or blocked. 17.11.21 - The risk score remains the same. The project will be reviewed again in the operational meeting which takes place on 19.11.21 at which time assurance can be given that the risk has been eliminated from CCG and Primary Care estates. 14.12.2021 - NECS have affirmed the upgrade or removal of all unsupported devices from the NECS managed network. The proposal is to reduce the risk score with this assurance in place, to a probability 1, reducing the overall risk to 4.	3	4	12	1	4	4	2	1	2	Dec-21	Links to Strategic Aims 4	Dec-21	Jan-21	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Ged Connolly-Thompson - Head of Digital Development, Chrissy Tucker - Director of Corporate Delivery
33	21/22	There is a risk to patients on waiting lists as a result of their delays to treatment as a direct result 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.	Quality & Performance	Clinical	4	4	16	• Risk stratification of waiting lists as per national guidance • Work is underway to attempt to control the growth of the waiting lists – via MSK pathways, consultant connect, ophthalmology, reviews of the waiting lists with primary care etc. • Providers are providing clinical reviews and risk stratification for long waiters and prioritising treatment accordingly.	• An assurance group is in place to monitor actions being undertaken to support these patients which reports to PCDB and SQP • Providers are capturing and reporting any clinical harm identified as a result of waits as per their quality assurance processes • An assurance framework has been developed and completed by all providers the results of which will be reported to PCDB • A minimum standard in relation to these patients is being considered by PCDB • Work to control the addition of patients to the waiting lists is ongoing	• Monthly groups are in place with all 4 providers represented • Completion of assurance framework quarterly is undertaken by all providers and reports to PCDB quarterly, and to SQG • Identified harm is reported on STEIS and all providers are monitoring this • A risk stratification tool is being piloted by providers November: Nothing further to add this month. December: Provider Governance processes have been reviewed and strengthened regarding oversight.	4	4	16	4	4	16	3	2	6	Feb-22	Links to Strategic Aims 1, 2, 3, 4	Dec-21	Jan-21	Brigid Stacey, Chief Nursing Officer	Alison Cargill Assistant Director of Quality
37	21/22	The Royal College of Physicians identified that there is a risk to the sustainability of the Hyper Acute Stroke Unit at CRHFT and therefore to service provision for the population of North Derbyshire.	Quality & Performance	Clinical	4	5	20	Short term work has been undertaken and assurance re the safety of services has been provided by the Medical and Nursing Director at CRHFT, however the long term sustainability of the service now needs to be addressed. March update: CRH Stroke Service Contingency Plan has been implemented, with sign-off from impacted surrounding trusts (Kings Mill, Hallamshire, UHDB, and Stepping Hill). Short-term mitigations in place to support service continuity, reducing the risk of service suspension and patient divert.	• Locum Consultant cover is in place • Clinical Leadership support is being provided by Liverpool Consultant • Trust to go out for advert to recruit new Stroke Lead consultant & work being done to make advert attractive • CCG , NHSE & System working with Trust Medical Director to contact other organisations and the Stroke Network for support. • Trust reviewing staff daily and escalating as per safer staffing policy as required, including red flag acuity reporting • CRHFT and Integrated Stroke Delivery Network (ISDN) leads to develop service contingency plan to understand internal measures, mutual aid options, and patient divert impact. • SOP to operationalise the contingency plan. • A task and finish group to commence a service review of the HASU, including options appraisal. All options to be reviewed with the aim of providing a sustainable service.	June-21- HASU service review is on-going. The T&F group have agreed to review 4 options that includes: Continuation of HASU with consultant workforce, conveyance and repatriation model, alternative workforce models or closure and conveyance to surrounding trust. Jo Keogh (CRH Divisional Director) is leading the review with support from CCG colleagues. July 21- HASU service review update- 5 options have been identified by the group that include:- 1.HASU provision continues as is delivered by the existing substantive Consultant, locum support and telemedicine. 2.The current HASU service is strengthened by redesign. 3.The Trust introduces a review and convey (drip and ship) model. 4.Decommission the CRH HASU element of the Stroke Service pathway, if workforce sustainability issues cannot be resolved, with either a single HASU provider or multiple providers.5.Review of the CRH HASU as part of a wider East Midlands review to rationalise sites; continuing to provide the service 'as is' at CRH. To support the identification of the preferred option and to provide transparency on decision making, the task and finish group have requested that an outcome matrix and criteria is developed and is to be presented at the August meeting for review. August 21- Workshop to be delivered in Sept 21, to allow all stakeholders to review the options and gain consensus on the preferred service delivery option. CRH are in discussion with Sheffield Teaching Hospitals to develop a joint staffing model for consultants to work across both sites. If agreed the proposal will be added to the consultation options. Sept 21- Workshop has been rescheduled for Oct 21. The workshop will be utilised to enable stakeholders to work-up the options only. The decision on the future service option will be made by an Independent Panel appointed by the CCG. Oct 21- HASU options appraisal workshop to take place on 25th November. CRH are in the process of developing information packs for the workshop and independent panel. CCG are reviewing the independent panel process to be assured by the Committee. It is expected that the independent panel will take place w/c 6th December to review the options and provide recommendations. Expected one month slippage to the programme of work caused by workshop delays. 12/11/21- Independent Panel is now due to meet virtually 13th December. The recommendations identified by the independent panel will be required to be presented to CCG, CRH and wider governance committees throughout Jan 2022. 10/12/21 HASU workshop was delivered on 25/11/21 and all outcomes/ information has been written up in preparation for the Independent Panel on 13th December. For each service option the panel is required to provide recommendations as to whether the option will be shortlisted, discounted, or could proceed for further review subject to caveats. The Clinical Senate has also been approached to undertake a desk top review of the process and outputs.	3	4	12	3	4	12	3	3	9	Jan-22		Dec-21	Jan-21	Dr Steve Lloyd, Medical Director	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster Head of Strategic Clinical Conditions and Pathways
38	21/22	The quality of care could be impacted by patients not receiving a care needs review in a timely way as a result of the COVID pandemic and the requirement for some of the Midland and Lancashire Commissioning Support Unit (MLCSU) Individual Patient Activity /Continuing Health Care (CHC) services to redirect service delivery to support system wide pressures. This has had an impact on core CHC and Funded Nursing Care (FNC) service delivery in relation to care needs reviews.	Quality & Performance	Clinical	4	2	8	A prioritisation matrix was put in place to ensure the most high risk/complex case reviews were prioritised.	A service Proposal has been presented and agreed by the CCG. MLCSU will schedule and complete care reviews of all individuals who have a review that was due between 19th March 2020 and 31st March 2021. These will all be completed within 6 months	May 2021 - 600 overdue reviews. Recovery action plan in place and review activity commenced. July 2021 -Trajectory in place to complete all 600 reviews by November 2021. Workforce in place and 220 reviews completed in June so on target. August 2021 -Remain on trajectory to complete the backlog by November. reduction in the number of reviews completed in July but still remain on target. September 2021 - No further additional narrative this month. October 2021 - remain on trajectory to complete overdue review activity by the end of November 2021. Probability of risk score reduced accordingly. November 2021 - remain on trajectory to complete by end of November - 44 outstanding reviews within this review project. If completed by December review this risk will be proposed to be closed in December. December 2021 update: Outstanding reviews have been completed other than 4 which are booked for completion before the end of December. Risk recommended to be closed.	3	2	6	3	2	6	3	2	6	Nov-21	tbc	Dec-21	Jan-21	Brigid Stacey Chief Nursing Officer	Nicola MacPhail Assistant Director of Quality

Risk Reference	Year	Risk Description	Responsible Committee	Type: Corporate or Clinical	Initial Risk Rating			Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating			Residual/ Current Risk			Target Risk			Target Date	Link to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
					Probability	Impact	Rating				Probability	Impact	Rating	Probability	Impact	Rating	Probability	Impact	Rating						
40	21/22	In the period of transition from CCG to ICS, it is likely that a larger proportion of contracts will be extended on expiry rather than reprocured. The CCG is advised by Arden & GEM CSU on best practice for our procurement activity, but in some circumstances, the CCG may decide to proceed against best practice in order to give sufficient time for review of services within the framework of movement to an ICS. Proceeding against advice, carries a small risk of challenge from any providers who may have felt excluded from the process.	Governance	Corporate	4	4	16	All healthcare contract extensions or renewals are reviewed via SLT, Execs, CLCC and then Governing Body for larger contracts. Any procurements issues and risks are highlighted as part of that process and the risk is accepted when agreement is given to proceed with the extension. Risks of challenge are small in most markets and the size of the risk will have been factored in to decision-making. Healthcare contracts expiring within 12 months are reviewed at Commissioning Ops Directorate SMT to ensure that timely action is taken before expiry. Where any challenge occurred from a provider, if the challenge were valid the risk could usually be mitigated by including the provider in future stages of procurement. Legislation is currently going through parliament to remove the requirement for NHS bodies to comply with the Public Sector Procurement Regulations for the procurement of healthcare services. This requirement will be replaced with a Provider Selection Regime which requires adherence to a decision-making framework but removes the right of legal challenge from providers except by judicial review.	A monthly meeting has been established between AGEM and the contracting team to review the procurement report and ensure that any issues around risk, progress or lack of engagement are escalated appropriately. The redesign of the procurement report has reduced the number of contracts of concern.	A monthly meeting has been established between AGEM and the contracting team to review the procurement report and ensure that any issues around risk, progress or lack of engagement are escalated appropriately. August Update: The Governance Committee will provide the oversight to decision-making processes in relation to the Provider Selection for the 20 services to give assurance that procurement processes are being followed and Conflicts of Interests are appropriately managed. September update: The CCG contracting team is monitoring and managing all contracts due for expiry including plans to extend or reprocure and identifying the governance path for decision-making. This is refreshed regularly and presented to SLT every two weeks. October update: With oversight described above the CCG continues to agree against advice for pragmatic reasons with a number of contracts. This will continue until the new procurement regulations come into force. The risk score is reduced due to the likelihood of challenge being small and impact also being small. November: The CCG contracting team continues to monitor and manage all contracts due for expiry including plans to extend or reprocure. December: The CCG contracting team continues to monitor and manage all contracts due for expiry including plans to extend or reprocure. The risk score cannot be decreased until the Provider Selection Regime comes into force.	2	3	6	2	3	6	1	4	4	Mar-22	SoC	Dec-21	Jan-21	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Chrissy Tucker - Director of Corporate Delivery
NEW RISK 42	21/22	If the CCG does not prioritise the importance of climate change it will have a negative impact on its requirement to meet the NHS's Net Carbon Zero targets and improve health and patient care and reducing health inequalities and build a more resilient healthcare system that understands and responds to the direct and indirect threats posed by climate change	Governance	Corporate	4	4	16	Helen Dillistone, Net Zero Executive Lead for Derbyshire ICS NHSE Memorandum of Understanding in place NHSE Midlands Greener Board established and meets monthly Derbyshire ICS Greener Delivery Group established and meets bi monthly NHSE Midlands regional priorities identified Derbyshire Provider Trust Green Plans in place	Helen Dillistone, Net Zero Executive Lead for Derbyshire ICS NHSE Memorandum of Understanding in place NHSE Midlands Greener Board established and in place Derbyshire ICS Greener Delivery Group established and in place NHSE Midlands regional priorities identified Derbyshire Provider Green Plans in place	Derbyshire Provider Trust Green plans to be submitted to ICS by 14th January 22. Derbyshire ICS Green plan in development and will be approved March 2022. NHSE Midlands Green Delivery Board Terms of Reference NHSE Midlands Green Delivery Board Agenda and Minutes Derbyshire ICS Greener Delivery Board Terms of Reference Derbyshire ICS Greener Delivery Board Agenda and Minutes Communications and Staff Engagement toolkits published by NHSE Nitrous Oxide Medicine Toolkit published by NHSE Net Zero – One year on Staff Communication from Helen Dillistone, Net Zero Lead CCG Team Talk staff engagement session on the Greener NHS and Derbyshire arrangements in place – November 2021 Derbyshire ICS Green Plan workshop 16th December 2021 Medicines Executive Lead is a member of the Derbyshire ICS Delivery Group Medicines Management Lead is a member of the Derbyshire ICS Delivery Group Climate Change National Audit Office best practice risk assessment presented to Audit Committee November 2021				4	3	12	3	3	9	Mar-22	SoC	Dec-21	Jan-21	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Suzanne Pickering Head of Governance

Appendix 2 - Movement during December 2021

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
01	**21/22**	The Acute providers may breach thresholds in respect of the A&E operational standards of 95% to be seen, treated, admitted or discharged within 4 hours, resulting in the failure to meet the Derby and Derbyshire CCGs constitutional standards and quality statutory duties.	5	4	**20**	5	4	**20**	⟷	The volume of attendances is high.	Zara Jones Executive Director of Commissioning Operations	Quality & Performance	Craig Cook Director of Contracting and Performance / Deputy Director of Commissioning Operations Jackie Carlile Catherine Bainbridge, Head of Urgent Care Dan Merrison Senior Performance & Assurance Manager
02	**21/22**	Changes to the interpretation of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) safeguards, results in greater likelihood of challenge from third parties, which will have an effect on clinical, financial and reputational risks of the CCG	3	4	**12**	3	4	**12**	⟷	An LPS implementation group will be established in the New Year to take this work forward across health providers who will become responsible bodies under the new framework.	Brigid Stacey - Chief Nursing Officer	Quality & Performance	Bill Nicol, Head of Adult Safeguarding
03	**21/22**	TCP unable to maintain and sustain performance, Pace and change required to meet national TCP requirements. The Adult TCP is on recovery trajectory and rated amber with confidence whilst CYP TCP is rated green, main risks to delivery are within market resource and development with workforce provision as the most significant risk for delivery.	5	4	**20**	5	4	**20**	⟷	A robust system is now in place to maintain compliance. Safe and wellbeing reviews (previously five eyes),	Brigid Stacey - Chief Nursing Officer	Quality & Performance	Helen Hipkiss, Deputy Director of Quality / Phil Sugden, Assistant Director Quality, Community & Mental Health, DCHS
04A	**21/22**	Contracting: Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care. There are 112 GP practices in Derbyshire all with individual Independent Contracts GMS, PMS, APMS to provide Primary Medical Services to the population of Derbyshire. Six practices are managed by NHS Foundation Trusts and one by an Independent Health Care Provider. The majority of Derbyshire GP practices are small independent businesses which by nature can easily become destabilised if one or more core components of the business become critical or fails. Whilst it is possible to predict and mitigate some factors that may impact on the delivery of care the elements of the unknown and unexpected are key influencing dynamics that can affect quality and care outcomes. Nationally General Practice is experiencing increased pressures which are multi-faceted and include the following areas: *Workforce - recruitment and retention of all staff groups *COVID-19 potential practice closure due to outbreaks *Recruitment of GP Partners *Capacity and Demand *Access *Premises *New contractual arrangements *New Models of Care *Delivery of COVID vaccination programme	4	4	**16**	4	4	**16**	⟷	Winter Access plans were submitted to NHSE/I for consideration to provide additional support and capacity for increased number of GP appointments until 31 March 2022 and feedback is awaited.	Dr Steve Lloyd - Medical Director	Primary Care Commissioning	Hannah Belcher, Head of GP Commissioning and Development (Primary Care)

04B	**21/22**	<u>Quality:</u> Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care. There are 112 GP practices in Derbyshire all with individual Independent Contracts GMS, PMS, APMS to provide Primary Medical Services to the population of Derbyshire. Six practices are managed by NHS Foundation Trusts and one by an Independent Health Care Provider. The majority of Derbyshire GP practices are small independent businesses which by nature can easily become destabilised if one or more core components of the business become critical or fails. Whilst it is possible to predict and mitigate some factors that may impact on the delivery of care the elements of the unknown and unexpected are key influencing dynamics that can affect quality and care outcomes. Nationally General Practice is experiencing increased pressures which are multi faceted and include the following areas: *Workforce - recruitment and retention of all staff groups *COVID-19 potential practice closure due to outbreaks *Recruitment of GP Partners *Capacity and Demand *Access *Premises *New contractual arrangements *New Models of Care *Delivery of COVID vaccination programme *Restoration and Recovery +C30	4	5	**20**	4	5	**20**	⟺	Improving Access in General Practice has begun, this will support an increase in appointment capacity.	Dr Steve Lloyd - Medical Director	Primary Care Commissioning	Judy Derricott, Head of Primary Care Quality
05	**21/22**	Wait times for psychological therapies for adults and for children are excessive. For children there are growing waits from assessment to psychological treatment. All services in third sector and in NHS are experiencing significantly higher demand in the context of 75% unmet need (right Care). COVID 19 restrictions in face to face treatment has worsened the position.	4	3	**12**	4	3	**12**	⟺	Work underway across the East Midlands to support choice agenda and wait times for ADHD adults.	Zara Jones Executive Director of Commissioning Operations	Quality & Performance	Dave Gardner Assistant Director, Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning
06	**21/22**	Demand for Psychiatric intensive Care Unit beds (PICU) has grown substantially over the last five years. This has a significant impact financially with budget forecast overspend, in terms of poor patient experience , Quality and Governance arrangements for uncommissioned independent sector beds. The CCG cannot currently meet the KPI from the Five year forward view which require no out of area beds to be used from 2021.	3	4	**12**	2	3	**6**	↓	Contracts agreed with providers for block funded beds. Mobilisation period commenced and actions agreed. Risk score amended to reflect actions taken.	Zara Jones Executive Director of Commissioning Operations	Quality & Performance	Dave Gardner Assistant Director, Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning
09	**21/22**	Sustainable digital performance for CCG and General Practice due to threat of cyber attack and network outages. The CCG is not receiving the required metrics to provide assurance regarding compliance with the national Cyber Security Agenda, and is not able to challenge any actual or perceived gaps in assurance as a result of this.	2	3	**6**	4	4	**16**	↑	There is currently a high severity CareCert in place for a vulnerability within the Log4j component which is to be found in a number of different systems including Apple's iCloud and a number of systems in use across Derbyshire.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Ged Connolly-Thompson - Head of Digital Development, Chrissy Tucker - Director of Corporate Delivery
10	**21/22**	If the CCG does not review and update existing business continuity contingency plans and processes, strengthen its emergency preparedness and engage with the wider health economy and other key stakeholders then this will impact on the known and unknown risks to the Derby and Derbyshire CCG, which may lead to an ineffective response to local and national pressures.	2	4	**8**	2	4	**8**	⟺	CCG engaged with LRF in exercises to test system resilience.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Chrissy Tucker - Director of Corporate Delivery / Richard Heaton, Business Resilience Manager

11	**21/22**	Risk of 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.	4	4	**16**	4	4	**16**	⟷	The Derbyshire NHS system has a significant gap between expenditure assessed as required to meet delivery plans and notified available resource.	Richard Chapman, Chief Finance Officer	Finance	Darran Green-Assistant Chief Finance Officer
12	**21/22**	Inability to deliver current service provision due to impact of service review. The CCG has initiated a review of NHS provided Short Breaks respite service for people with learning disabilities in the north of the county without recourse to eligibility criteria laid down in the Care Act. Depending on the subsequent actions taken by the CCG fewer people may have access to the same hours of respite, delivered in the same way as previously. There is a risk of significant distress that may be caused to individuals including carers, both during the process of engagement and afterwards depending on the subsequent commissioning decisions made in relation to this issue. There is a risk of organisational reputation damage and the process needs to be as thorough as possible. There is a risk of reduced service provision due to provider inability to retain and recruit staff. There is a an associated but yet unquantified risk of increased admissions – this picture will be informed by the review.	3	3	**9**	3	3	**9**	⟷	System Delivery Board have endorsed proposal for Short Breaks programme reinitiation.	Brigid Stacey - Chief Nursing Officer	Quality & Performance	Mick Burrows Director for Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning, Helen Hipkiss, Deputy Director of Quality /Phil Sugden, Assistant Director Quality, Community & Mental Health, DCHS
16	**21/22**	Lack of standardised process in CCG commissioning arrangements. CCG and system may fail to meet statutory duties in S14Z2 of Health and Care Act 2012 and not sufficiently engage patients and the public in service planning and development, including restoration and recovery work arising from the COVID-19 pandemic.	2	4	**8**	2	4	**8**	⟷	Governance Guide verbal update given at November Committee - final amendments required prior to approval that could not be completed in time for the meeting due to team capacity challenge.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Engagement	Sean Thornton Assistant Director Communications and Engagement
17	**21/22**	S117 package costs continue to be a source of high expenditure which could be positively influenced with resourced oversight, this growth across the system, if unchecked, will continue to outstrip available budget	3	3	**9**	3	3	**9**	⟷	Reviews continuing.	Zara Jones, Executive Director of Commissioning Operations	Quality & Performance	Helen Hipkiss, Director of Quality / Dave Stevens, Head of Finance
20	**21/22**	Failure to hold accurate staff files securely may result in Information Governance breaches and inaccurate personal details. Following the merger to Derby and Derbyshire CCG this data is not held consistently across the sites.	3	3	**9**	3	3	**9**	⟷	Government advice to work from home wherever possible will temporarily pause project.	Beverley Smith, Director of Corporate Strategy & Development	Governance	Sam Robinson, Service Development Manager
22	**21/22**	The mental health of CCG staff and delivery of CCG priorities could be affected by remote working and physical staff isolation from colleagues.	2	3	**6**	2	3	**6**	⟷	Majority of mid-year review conversations focussing on health & wellbeing & support required by staff have now taken place.	Beverley Smith, Director of Corporate Strategy & Development	Governance	Beverley Smith, Director of Corporate Strategy & Development James Lunn, Head of People and Organisational Development

23	**21/22**	CCG Staff capacity compromised due to illness or other reasons. Increased numbers of CCG staff potentially unable to work due to COVID 19 symptoms / Self isolation.	1	4	**4**	3	4	**12**		Increasing number of redeployments away from the CCG, due to requirements to support the system with the COVID booster and vaccination programme.	Beverley Smith, Director of Corporate Strategy & Development	Governance	Beverley Smith, Director of Corporate Strategy & Development James Lunn, Head of People and Organisational Development
24	**21/22**	Patients deferring seeking medical advice for non COVID issues due to the belief that COVID takes precedence. This may impact on health issues outside of COVID 19, long term conditions, cancer patients etc.	2	3	**6**	2	3	**6**		Concern over Omicron variant and national measures have been introduced to tackle the spread.	Dr Steve Lloyd, Medical Director	Quality & Performance	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster Head of Strategic Clinical Conditions and Pathways
25	**21/22**	Patients diagnosed with COVID 19 could suffer a deterioration of existing health conditions which could have repercussions on medium and long term health.	3	3	**9**	3	3	**9**		Ongoing development of the rehab service, and DCHS are implementing a revised plan to reduce the assessment clinic waiting list.	Dr Steve Lloyd, Medical Director	Quality & Performance	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster Head of Strategic Clinical Conditions and Pathways
26	**21/22**	New mental health issues and deterioration of existing mental health conditions for adults, young people and children due to isolation and social distancing measures implemented during COVID 19.	4	3	**12**	4	3	**12**		Ongoing pressures affecting flow across in tier 4, paediatric units and community	Zara Jones, Executive Director of Commissioning Operations	Quality & Performance	Mick Burrows, Director of Commissioning for MH, LD, ASD, and CYP Helen O'Higgins, Head of All Age Mental Health Tracy Lee, Head of Mental Health - Clinical Lead
27	**21/22**	Increase in the number of safeguarding referrals linked to self neglect related to those who are not in touch with services. These initially increased immediately following COVID lockdown. The adult safeguarding processes and policy are able to respond to this type of enquiry once an adult at risk has been identified. Numbers are difficult to predict but numbers are predicted to increase as COVID restrictions ease.	4	3	**12**	4	3	**12**		Safeguarding Adult referrals have increased by 16% over the last Quarter. This was anticipated due to an easing of lockdown restrictions began to take effect.	Brigid Stacey, Chief Nursing Officer	Quality & Performance	Bill Nicol, Head of Adult Safeguarding
32	**21/22**	Risk of exploitation by malevolent third parties If vulnerability is identified within any of the Microsoft Office 2010 applications after October 14th 2020 and not patched, due to support for Microsoft Office 2010 officially ending, after which point Microsoft will cease to issue updates and patches for vulnerabilities found within this suite of applications	3	4	**12**	1	4	**4**		NECS have affirmed the upgrade or removal of all unsupported devices from the NECS managed network.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Ged Connolly-Thompson - Head of Digital Development, Chrissy Tucker - Director of Corporate Delivery

33	**21/22**	There is a risk to patients on waiting lists as a result of their delays to treatment as a direct result 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.	4	4	**16**	4	4	**16**		Provider Governance processes have been reviewed and strengthened regarding oversight.	Brigid Stacey, Chief Nursing Officer	Quality & Performance	Laura Moore, Deputy Chief Nurse
37	**21/22**	The Royal College of Physicians identified that there is a risk to the sustainability of the Hyper Acute Stroke Unit at CRHFT and therefore to service provision for the population of North Derbyshire.	3	4	**12**	3	4	**12**		HASU workshop was delivered on 25/11/21 and all outcomes/ information has been written up in preparation for the Independent Panel.	Dr Steve Lloyd, Medical Director	Quality & Performance	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster Head of Strategic Clinical Conditions and Pathways
38	**21/22**	The quality of care could be impacted by patients not receiving a care needs review in a timely way as a result of the COVID pandemic and the requirement for some of the Midland and Lancashire Commissioning Support Unit (MLCSU) Individual Patient Activity /Continuing Health Care (CHC) services to redirect service delivery to support system wide pressures. This has had an impact on core CHC and Funded Nursing Care (FNC) service delivery in relation to care needs reviews.	3	2	**6**	3	2	**6**	**Risk recommended to be closed.**	Risk recommended to be closed.	Brigid Stacey Chief Nursing Officer	Quality & Performance	Nicola MacPhail Assistant Director of Quality
40	**21/22**	In the period of transition from CCG to ICS, it is likely that a larger proportion of contracts will be extended on expiry rather than reprocured. The CCG is advised by Arden & GEM CSU on best practice for our procurement activity, but in some circumstances, the CCG may decide to proceed against best practice in order to give sufficient time for review of services within the framework of movement to an ICS. Proceeding against advice, carries a small risk of challenge from any providers who may have felt excluded from the process.	2	3	**6**	2	3	**6**		The risk score cannot be decreased until the Provider Selection Regime comes into force.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Chrissy Tucker - Director of Corporate Delivery
NEW RISK 42	**21/22**	If the CCG does not prioritise the importance of climate change it will have a negative impact on its requirement to meet the NHS's Net Carbon Zero targets and improve health and patient care and reducing health inequalities and build a more resilient healthcare system that understands and responds to the direct and indirect threats posed by climate change.				4	3	**12**	NEW RISK	NEW RISK	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Suzanne Pickering - Head of Governance

NHS
Derby and Derbyshire
Clinical Commissioning Group

MINUTES OF PRIMARY CARE COMMISSIONING COMMITTEE

PUBLIC MEETING

HELD ON

Wednesday 24th November 2021

Microsoft Teams Meeting 10:00am – 10:30am

PRESENT

Ian Shaw (Chair)	**IS**	Lay Member Derby & Derbyshire CCG
Niki Bridge	**NB**	Deputy Chief Finance Officer, DDCCG (for CFO)
Jill Dentith	**JeD**	Lay Member Derby & Derbyshire CCG
Steve Lloyd	**SL**	Executive Medical Director Derby & Derbyshire CCG
Simon McCandlish	**SMc**	Deputy Chair, Lay Member, Derby & Derbyshire CCG
Marie Scouse	**MS**	AD of Nursing & Quality Derby & Derbyshire CCG (for CNO)

IN ATTENDANCE

Hannah Belcher	**HB**	AD GP Commissioning & Development Derby DDCCG
Ged Connolly-Thompson	**GCT**	Head of Digital Development
Clive Newman	**CN**	Director of GP Development Derby & Derbyshire CCG
Dr Peter Williams	**PW**	Derby & Derbyshire LMC
Jean Richards	**JR**	Senior GP Commissioning Manager DDCCG
Pauline Innes	**PI**	Executive Assistant to Dr Steven Lloyd DDCCG

APOLOGIES

Richard Chapman	**RC**	Chief Finance Officer
Judy Derricott	**JDe**	Head of Primary Care Quality Derby & Derbyshire CCG
Abid Mumtaz	**AM**	Service Commissioning Manager Public Health, Derbyshire County Council
Brigid Stacey	**BS**	Chief Nurse Derby & Derbyshire CCG

ITEM NO.	ITEM	ACTION
PCCC/2122/150	**WELCOME AND APOLOGIES** The Chair (IS) welcomed Committee Members to the meeting, there were no members of the Public present at today's meeting. Apologies were received and noted as above. The Chair confirmed that the meeting was quorate.	
PCCC/2122/151	**DECLARATIONS OF INTEREST** The Chair informed members of the public of the committee members' obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG.	

	Declarations declared by members of the Primary Care Commissioning Committee are listed in the CCG's Register of Interests and included within the meeting papers. The Register is also available either via the corporate secretary to the Governing Body or the CCG website at the following link: www.derbyandderbyshireccg.nhs.uk **Declarations of interest from today's meeting** There were no declarations of interest made The Chair declared that the meeting was quorate.	
FOR DECISION		
	No items for decision	
	FOR DISCUSSION	
	No Items for discussion	
FOR ASSURANCE		
PCCC/2122/152	**FINANCE UPDATE** Niki Bridge (NB) presented an update from the shared paper. The paper was taken as read and the following points of note were made. The Month 6 finance position has been received at the Finance Committee and Governing Body. Key points of interest: • Allocations have been received for H1 at £1.036bn • The H1 reported underspend at month 6 is £0.696m • Retrospective allocations received for quarter 1 Covid spend on the Hospital Discharge Programme were £2.697m further expected funding is £2.801m relating to month 4 to 6. • The Elective Recovery Fund has been reimbursed £0.702m for April to September. The M7 financial position has not yet been reported to the Governing Body and so will be reported to the public session of the PCCC at the next 2021 meeting. **The Primary Care Commissioning Committee NOTED and RECEIVED the update on the DDCCGs financial position for Month 6.**	
PCCC/2122/153	**RISK REGISTER EXCEPTION REPORT** Hannah Belcher (HB) presented an update from the shared paper. The paper was taken as read and the following points of note were made. **Risk 04A**: ***Contracting****: Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care –* ***Risk Score 16*** Jill Dentith (JeD) referred to capacity in Primary Care where it is being described in the report as increasingly difficult for Primary Care querying if Risk 04A should be increased? HB explained that this risk is being monitored on a regular basis through the SITREP reports stressing that there has been no increase in contacts from practices who are struggling financially however it is	

	important for the Committee to note that this may be forthcoming over the next few months. HB recommended that risk 04A remains at a score of 16 due to winter access funding being imminent which will support practices over the winter period. Clive Newman (CN) stressed to the Committee that the immediate risk is around staffing rather than finance. **Risk 04B:** ***Quality:*** *Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care.* ***Risk Score 20*** Marie Scouse (MS) reported Risk 04B is being monitored on a regular basis. Colleagues will be aware of the access project which is looking at access within Primary Care based on a quality perspective and a quality improvement plan however that is mainly linked in to staffing which is one main risks that impacts both on quality and the service provision. MS recommended that the risk remains at a score of 20 given the winter pressures and ongoing challenges of COVID and Flu. **The Primary Care Commissioning Committee NOTED and RECEIVED the update on the two outstanding risks and:** • **AGREED that the scores remain unchanged** • **Were ASSURED that the risk scores are reviewed on a regular basis.**	
PCCC/2122/154	**QUARTER 2 PRIMARY CARE QUALITY AND PERFORMANCE ASSURANCE REPORT** Marie Scouse (MS) presented an update from the shared paper. The paper was taken as read and the following points of note were made. This report covers the period 1st July 2021 to 30th September 2021 and is intended to provide the Primary Care Commissioning Committee with assurance that the Clinical Commissioning Group (CCG) is fulfilling its statutory responsibility under delegated authority to monitor and support primary care quality and performance. Key points of interest: • Care Quality Commission Update • Quality Assurance Visits update • Medicines Management update including vaccinations and Antimicrobial Stewardship **The Primary Care Commissioning Committee NOTED and RECEIVED, the Quarter 2 Primary Care Quality and Performance Assurance update.**	
FOR INFORMATION		
	There were no items for Information	
MINUTES AND MATTERS ARISING		
PCCC/2122/155	**Minutes of the Primary Care Commissioning Committee meeting held on 27th October 2021** The minutes from the meeting held on 27th October 2021 were agreed to be an accurate record of the meeting.	

PCCC/2122/156	**MATTERS ARISING MATRIX** There are no outstanding actions on the Action Matrix.	
PCCC/2122/157	**ANY OTHER BUSINESS** There were no items of any other business	
PCCC/2122/158	**ASSURANCE QUESTIONS** **1.** Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? **Yes** **2.** Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? **Yes** **3.** Were papers that have already been reported on at another committee presented to you in a summary form? **Yes** **4.** Was the content of the papers suitable and appropriate for the public domain? **Yes** **5.** Were the papers sent to Committee members at least five working days in advance of the meeting to allow for the review of papers for assurance purposes? **Yes** **6.** Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? **No** **7.** What recommendations does the Committee want to make to Governing Body following the assurance process at today's Committee meeting? **None**	
	DATE AND TIME OF NEXT MEETING	
Wednesday 22nd December 2021, 10:00-10:30am via Microsoft Teams Meeting		

NHS
Derby and Derbyshire
Clinical Commissioning Group

MINUTES OF QUALITY AND PERFORMANCE COMMITTEE
HELD ON 25th November 2021,
9AM TO 10.00AM
MS TEAMS

Present:		
Dr Buk Dhadda (Chair)	BD	Chair, Governing Body GP, DDCCG
Dr Bruce Braithwaite	BB	Secondary Care Consultant
Jackie Carlile	JC	Head of Performance and Assurance -DDCCG
Liz Chambers	LC	Clinical Quality Manager, DDCCG
Dr. Katherine Bagshaw	KB	Deputy Medical Director
Niki Bridge	NB	Deputy Director of Finance
Alison Cargill	AC	Asst Director of Quality, DDCCG
Helen Hipkiss	HH	Director of Quality, DDCCG
Jackie Jones	JJ	Director of Ambulance and NHS111 Commissioning – East Midlands
Simon McCalandish	SMcC	Lay Member, Patient Experience
Sarah MacGillivray	SMacG	Head of Patient Experience, DDCCG
Bill Nicol	BN	Assistant Director, Safeguarding Adults, DDCCG
Andrew Middleton	AM	Lay Member, Finance
Lisa Falconer	LF	Head of Clinical Quality (Acute) DDCCG
Temi Omorinoye	TO	Senior Medicines Optimisation Pharmacist
Suzanne Pickering	SP	Head of Governance- DDCCG
Dr Emma Pizzey	EP	GP South
Michelina Racioppi	MR	Assist Director Safeguarding Children/Lead Designated Nurse
Dr Greg Strachan	GS	Governing Body GP, DDCCG
Phil Sugden	PS	Asst Director of Quality & Named Patient Safety Specialist
Dr Merryl Watkins	MWa	Governing Body GP, DDCCG
Martin Whittle	MW	Vice Chair and Governing Body Lay Member, Patient and Public Involvement, DDCCG
In Attendance:		
Jo Pearce (Minutes)	JP	Executive Assistant to Chief Nurse, DDCCG
Apologies:		
Brigid Stacey	BS	Chief Nurse Officer, DDCCG
Dr Steve Lloyd	SL	Medical Director - DDCCG
Helen Henderson-Spoors	HHS	Healthwatch Derbyshire
Zara Jones	ZJ	Executive Director of Commissioning Operations, DDCCG

Item No.	Item	Action
QP2122 /141	**WELCOME, APOLOGIES & QUORACY** Apologies were received as above. BD declared the meeting quorate.	
QP2122 /142	**DECLARATIONS OF INTEREST** BD reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG. Declarations declared by members of the Quality and Performance Committee are listed in the CCG's Register of Interests and included with the meeting papers. The Register is also available either via the corporate secretary to the Governing Body or the CCG website at the following link: www.derbyandderbyshireccg.nhs.uk <u>Declarations of interest from sub-committees</u> No declarations of interest were made. <u>Declarations of interest from today's meeting</u> No declarations of interest were made.	
	BD confirmed that the meeting will be conducted in a more abbreviated form. Some of the papers have been listed on the agenda for information only and Committee members were asked to submit questions relating to the papers before the meeting. Responses to the questions were circulated to the Committee members prior to the meeting and are included within these minutes. The questions are being collated for future reference if needed.	
QP2122 /143	**Integrated Report** The report was taken as read. JC noted the key points:	

	Over 52 week waits at CCG level has increased for the first time since March 21. The cancer reports for this month do not include as much tumour site data as they usually would, this is due to losing access to cancer waiting times data and a solution is being explored. 2 week wait responses remain pressured, UHDBFT reported an increase of 38% in September 2021 compared to September 2019. UHDBFT failed the 28-day faster diagnosis standard, this is because of delays in inviting the patient back to inform them of the results of their diagnostic tests regardless of the outcomes. The increase in referrals from 2500 to 4000 was noted and JC confirmed that the conversion rate remains the same at 8-10% and referrals were appropriate. MW asked how often the waiting lists are "cleansed". JC stated that there are validation teams at both Trusts who review the waiting lists regularly. UHDBFT are focusing their efforts on the long waiters and identifying and confirming whether surgery is still required. SMcC questioned whether there is scope for a piece of work for the Communications and Engagement team to highlight the work that is being done around the waiting lists. JC noted the ongoing work that is being done in this area locally and on a national level. EP asked if data is available on advanced cancers and whether numbers are increasing. JC referred to the Urology department at UHDBFT who have recently completed a piece of work looking at the comparisons of Stage 1 & 2 patients in 2019 and 2020. Other departments are aiming to carry out this piece of work. A follow up report on cancer waits was requested which will include a breakdown into specific areas where concerns have been identified. **ACTION** - JP will add to the forward planner and agenda for December. AM referred to a recent HSJ article (22nd November 2021) around elective recovery and questioned whether the Communications team provide responses in the event of a misstatement. HH confirmed that the communications team review the HSJ and NHSEI will contact the CCG directly should they have any concerns around what has been reported in the HSJ. **ACTION** – HH and JC will liaise with the communications team to understand how they deal with HSJ articles in relation to the CCG. **Activity Report** There were no questions raised on the activity report. BD **APPROVED** the Integrated Report.	**JP** **HH/JC**

QP2122 /144	**GBAF Q3** The paper was taken as read. SP confirmed that the Quality and Performance GBAF Task & Finish group has met to review the scores and have agreed that they should remain the same for this month. The Committee noted the contents and approved the paper.	
QP212 /145	**RISK REGISTER** The paper was taken as read. There were no questions raised by the Committee members. The Committee noted the contents and the approved the recommendations in the paper.	
QP2122 /146	**SAFEGUARDING ADULTS UPDATE** **SAFEGUARDING ANNUAL REPORT** The papers were taken as read. BN confirmed that activity continues to be closely monitored with the main demand being around domestic abuse and self-neglect. Police are receiving approx. 100 calls per day. Self-neglect is an ongoing issue, the CCG contribute to a hoarding grant which assists people in dealing with accumulated belongings. Referring to the annual report, BN noted it has been a unique time and repeated what he has stated in past meetings that the impact of COVID would not be fully seen until full measures are lifted. Referrals have increased by 20% this year and work is being carried out to understand the reasons behind the increase. BN commented on his sense of pride around the achievements of the Safeguarding Adults team, noting the staff shortage over the past 20 months. A new member of the team is due to commence in post soon which will make a huge difference. The Committee noted the contents and approved the paper.	
QP2122 /147	**SAFEGUARDING CHILDREN UPDATE** **SAFEGUARDING CHILDREN ANNUAL REPORT** **LOOKED AFTER CHILDRENS UPDATE** The paper was taken as read.	

	MR confirmed that the CCG are fulfilling all of their statutory duties and are gaining assurance from commissioned service providers. The numbers of children coming into care continues to increase which impacts on workload. AM wished for it to be formally noted the significant level of assurance he gets from the contents of the Safeguarding Adult and Children reports and commented on the excellence of the Safeguarding teams. MW referred to the named GP report and the increase in attendance to safeguarding training when it moved to a virtual format. MR and BN confirmed that they intend to continue with a virtual format to deliver training and confirmed attendance has significantly increased and feedback on the virtual training has been extremely positive. BN recognised that in order to provide the best training experience to staff, the Safeguarding team would benefit from further training on using MS Teams. BD thanked the Safeguarding Adult and Childrens teams for the astounding work they have done over the years which has provided assurance to Quality and Performance Committee members. The Committee noted the contents and approved the paper.	
QP2122 /148	**EMAS UPDATE** The paper was taken as read. JJ gave an update on the current position around acuity. EMAS continues to see high acuity of the patients seen by EMAS . 81% of all calls are category 1 and category 2 for Derbyshire and unseen demand continues to increase. JJ referred to handover delays and noted there have been 2 SI in Derbyshire since September. There is a paper being presented at A&E Delivery Board asking the system to commit to zero +60-minute handover delays at the acute Trusts across Derbyshire. MW referred to the £55m funding listed in the paper, asking how much of this would be allocated to Derbyshire. JJ confirmed that £3.2m would be received and will be used to employ additional call handlers, clinical staff within the Emergency Operations Centre to validate and review calls and to employ newly qualified paramedics. EP asked if sickness levels are driving the handover delay figures. JJ confirmed that EMAS are experiencing higher sickness levels than usual, and this is due to either COVID, stress or normal sickness reasons. Statutory mandatory training has also been reinstated and this is having an impact on the number of workforce available.	

	AM asked if the system is focused on doing all in its power to receive a patient within 5-10 minutes of arrival at A&E. JJ confirmed this is an ongoing challenge in this area and one that would need support from various pathways AM then asked if the system is treating these issues seriously. JJ responded to say yes they are taken seriously. AC asked if the use of HALOs (Hospital Ambulance Liaison Officer) has been considered at Royal Derby Hospital. JJ explained that they have struggled to recruit to these posts in other areas of the region and some trusts have used Community First Responders and Nurses to carry out the role. AC also informed the Committee about the unannounced out of hours visit to CRHFT and UHDBFT that will be taking place. HH assured the Committee that a review of all these concerns and a deep dive has been carried out at the EMAS Quality Assurance Group for which Brigid Stacey (CCG CNO) is the Chair. PS informed the Committee that the Trust are carrying out end to end reviews on a random sample of 5 individuals from point of pick up through to discharge, which will assess pathways from a quality perspective. The Committee noted the report and were assured by the contents.	
QP2122 /149	**MEDICINES MANAGEMENT UPDATE** **AMR UPDATE** The paper was taken as read. There were no questions raised by the Committee members.	
QP2122 /150	**RISK STRATIFICATION UPATE** AC explained that the paper had been presented to the last Planned Care Delivery Board and the question that keeps getting raised is around communication with patients. The Risk Stratification Group are now in the process of looking at standardised communications from a system perspective. Communications are taking place at a business level with divisions having an oversight. Trusts are now using tools to risk stratify and prioritise patients and additional work, including weight management and pain management is being carried out to support the risk stratification work. The following comments were noted around communications back to GPs. • Request to keep GPs informed of a patients position on the waiting list.	

	• Communication to GP to state "for information only, no further action required" when appropriate. • Ensure the Consultant secretaries are fully informed. AC will feedback the comments to the Risk Stratification Group. The Committee noted the report and were assured by the contents.	
QP2122 /151	**DHU OUT OF HOURS TOR FOR APPROVAL** The paper was taken as read. There were no questions raised by the Committee members. The Committee **APPROVED** the ToR for DHU Out of Hours.	
QP2122 /152	**ROLE OF THE PATIENT SAFETY SPECIALIST** The paper was taken as read. AM asked if any inappropriate referrals have been received and when would be an appropriate time to submit an interim report on how the Patient Safety Specialist role is developing. PS responded, stating all referrals are taken seriously and are examined from a system perspective. HH highlighted the ongoing work that is taking place to look at where roles may sit within the ICB in preparation for the transition in April 2022. Following that the ICB will be appraised on any areas of important work that are taking place in relation to quality. The Committee noted the contents and approved the paper.	
QP2122 /153	**JUCD QEIA** The paper was taken as read. There were no questions raised by the Committee members. The Committee noted the contents and approved the paper.	
QP2122 /154	**CONTINUING HEALTH CARE (CHC)** The paper was taken as read. There were no questions raised by the Committee members. The Committee noted the contents and approved the paper.	
QP2122 /155	**IPC**	

	The paper was taken as read. There were no questions raised by the Committee members. The Committee noted the contents and approved the paper.	
QP2122 /156	**CARE HOMES** The paper was taken as read. There were no questions raised by the Committee members. The Committee noted the contents and approved the paper.	
QP2122 /157	**MINUTES FROM SUB COMMITTEES** The Committee noted the minutes from the following sub-Committees: Updates from Trust CQRG meetings. UHDBFT CRHFT DCHS	
QP2122 /158	**MINUTES FROM THE MEETING HELD ON 28TH OCTOBER 2021.** The minutes were approved as a true and accurate record.	
QP2122 /159	**MATTERS ARISING AND ACTION LOG** The action log was reviewed and updated.	
QP2122 /160	**AOB** There were no matters raised under AOB.	
QP2122 /161	**FORWARD PLANNER** The Forward Planner was reviewed. No updates were made.	
QP2122 /162	**ANY SIGNIFICANT SAFETY CONCERNS TO NOTE** None raised.	
	ASSURANCE QUESTIONS	

	• Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? Yes • Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? Yes • Were papers that have already been reported on at another committee presented to you in a summary form? Yes • Was the content of the papers suitable and appropriate for the public domain? Yes • Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? Yes • Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? No • What recommendations do the Committee want to make to Governing Body following the assurance process at today's Committee meeting? None	

DATE AND TIME OF NEXT MEETING
Date: 23rd December 2021
Time: 9am to 10.30am
Venue: MS Teams

NHS
Derby and Derbyshire
Clinical Commissioning Group

Derby and Derbyshire CCG Governing Body Meeting in Public
Held on
2nd December 2021 via Microsoft Teams

UNCONFIRMED

Present:

Dr Avi Bhatia	AB	Clinical Chair
Dr Penny Blackwell	PB	Governing Body GP
Dr Bruce Braithwaite	BB	Secondary Care Consultant
Richard Chapman	RCp	Chief Finance Officer
Dr Chris Clayton	CC	Chief Executive Officer (part meeting)
Dr Ruth Cooper	RC	Governing Body GP
Jill Dentith	JD	Lay Member for Governance
Dr Buk Dhadda	BD	Governing Body GP
Helen Dillistone	HD	Executive Director of Corporate Strategy and Delivery
Ian Gibbard	IG	Lay Member for Audit
Zara Jones	ZJ	Executive Director of Commissioning Operations
Dr Steven Lloyd	SL	Medical Director (part meeting)
Simon McCandlish	SM	Lay Member for Patient and Public Involvement
Andrew Middleton	AM	Lay Member for Finance
Dr Emma Pizzey	EP	Governing Body GP
Professor Ian Shaw	IS	Lay Member for Primary Care Commissioning
Brigid Stacey	BS	Chief Nursing Officer
Dr Greg Strachan	GS	Governing Body GP
Dr Merryl Watkins	MW	Governing Body GP
Martin Whittle	MWh	Lay Member for Patient and Public Involvement / Vice Chair

Apologies:

Dr Robyn Dewis	RD	Director of Public Health - Derby City Council
Dean Wallace	DW	Director of Public Health - Derbyshire County Council

In attendance:

Dawn Litchfield	DL	Executive Assistant to the Governing Body/Minute Taker
Fran Palmer	FP	Corporate Governance Manager
Sean Thornton	ST	Deputy Director Communications and Engagement

Item No.	Item	Action
GBP/2122/188	**Welcome, Apologies & Quoracy** Dr Avi Bhatia (AB) welcomed members to the meeting. Apologies were received and noted as above. It was confirmed that the meeting was quorate.	
GBP/2122/189	**Questions received from members of the public** No questions were received from members of the public.	

GBP/2122/ 190	**Declarations of Interest** AB reminded Committee members and visiting delegates of their obligation to declare any interests that they may have on any issues arising at Committee meetings which might conflict with the business of the CCG. Declarations declared by members of the Governing Body are listed in the CCG's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Governing Body or the CCG website at the following link: www.derbyandderbyshireCCG.NHS.uk No further declarations of interest were made, and no changes were requested to the Register of Interests.	
GBP/2122/ 191	**Chair's Report – November 2021** AB presented a report, a copy of which was circulated with the meeting papers; the report was taken as read and the following point of note was made: • The importance of the continuation of clinical leadership in the decision-making process was reiterated. The following question was raised in relation to the report: • It was queried how the new joint CCG Governing Body / Integrated Care Board (ICB) meetings would work next year. AB confirmed that it is hoped to hold some joined up Governing Body meetings with the shadow ICB from January 2022, however this is dependent upon the construction of the ICB. There are already some joint System Committees in situ, with more scheduled to take place in January. Thoughts will be welcomed on the development processes and practicalities of this later in the meeting. **The Governing Body NOTED the content of the report provided**	
GBP/2122/ 192	**Chief Executive Officer's Report – November 2021** Helen Dillistone (HD) presented Dr Chris Clayton's (CC) report, a copy of which was circulated with the meeting papers. The report was taken as read and the following points of note were made: • November has been a busy month with a theme of bringing the Integrated Care System (ICS) together and moving the CCG's functions into the ICB. • The Health and Care Bill is currently passing through the parliamentary process, and the changes will become law from April 2022. The changes will underpin Derbyshire's journey and will help continue the direction of travel already being taken. • November has seen much engagement within the wider System around the proposed changes and structures, ensuring that a broad partnership approach is taken, and voices are heard to help shape and influence the process. An engagement session was held on 5th November, cumulating in a proposal being submitted to NHSE on 15th November setting out initial thoughts around ICB membership and the formation of the ICB. Work is also taking place around the Integrated Care Partnership (ICP), which will be an important part of the infrastructure in the ICS.	

	• CC recently briefed CCG staff on the key developments, providing assurance on the forthcoming changes. • The System pressures currently being experienced form part of the many challenges being faced. • There is huge appreciation for the ongoing work across the System. The following statement was made: • A recent Audit Committee webinar advised that the ICB commencement date of 1st April 2022 would not be delayed. As the majority of ICB Chairs and CEOs are now in place, it would be damaging to have a delay in proceedings now. **The Governing Body NOTED the content of the report provided**	
GBP/2122/193	**Joined Up Care Derbyshire (JUCD) Board Update – November 2021** CC presented an update on the discussions held at the JUCD Board in November, a copy of which was circulated with the meeting papers. The report was taken as read and the following points of note were made: • An important patient story was provided with clear learning for the whole System, signifying the complexity and interfaces between different parts of the System whilst also demonstrating how things have been worked through to break down barriers to solve complex issues. • The System activity and performance was highlighted. • Planning is being undertaken for the challenges ahead over the weeks to capture the various operational priority areas. • Developments of the ICB and ICP and the transition from CCG to ICB will be discussed later in the meeting, including the shadowing process to be undertaken. • The ICS's naming convention has now been formalised, retaining the Derby and Derbyshire nomenclature. • Consideration is being given to clinical and professional leadership across the System and how to embed it into all aspects of care. • Conversations were held around people and culture and digital development. The following concern was raised: • The patient story illustrated the frustration of the Commissioning for Individuals Panel in its wish to make provision for patients within the Derbyshire boundary, as it does not always have the capacity to do this; this is illustrative of a major market development need in the mental health space, particularly with increasing numbers of cases of this type. It is concerning that patients often need to be sent outside of Derbyshire, for which the same quality oversight may not be provided. CC noted these views and shared the support for the Mental Health Delivery Board to continue to work on this. **The Governing Body NOTED the contents of the report provided**	
GBP/2122/194	**Remuneration Committee Updated Terms of Reference – November 2021** HD presented the updated Terms of Reference of the Renumeration Committee which have been reviewed to include the additional responsibility	

	of the Committee to oversee the transition of the Committee and its assurance functions to the ICB, in line with all other Committees. As a statutory Committee of the ICB, a formal process to transfer the roles and responsibilities will be required. The amendment has been virtually approved by Remuneration Committee members. Martin Whittle (MWh), Chair of DDCCG's Remuneration Committee, added that an Advisory System Remuneration Committee has been meeting, which does not have a statutory footing; therefore John MacDonald, the ICS Chair Designate, was keen to anchor it formally in a statutory organisation. Although DDCCG's Remuneration Committee cannot take decisions on behalf of other organisations, it will be able to oversee the work of the new ICB Remuneration Committee. **The Governing Body APPROVED the Remuneration Committee's Updated Terms of Reference.**	
GBP/2122/195	**Closedown of the CCG's Governing Body and Committees and transition to the shadow ICB arrangements** HD gave a presentation on the proposed arrangements, for the close down of the CCG's Governing Body and Corporate Committees and the shadowing arrangements, a copy of which was circulated with the meeting papers. The plethora of technical guidance received has helped to work through the due diligence processes and a checklist will go to the Audit Committee in February 2022 to cover the statutory element of the transition. It was recognised that the Governing Body has matured over the years since its inception and has valuable learning and experience to share with the ICB. It is hoped that there will be an opportunity for the CCG and shadow ICB to work more formally together during the latter stages of the transition. The following proposals were made for joint working and shared learning: • A formal meeting in common of the CCG Governing Body and shadow ICB is to be established in January, February and March 2022. • The establishment of joint development sessions between Governing Body members and new ICB Board members to discuss and agree the content of a formal handover and to enable themed development discussions; topics for discussion at these development sessions were suggested. • The methodology for the transfer of the existing Corporate Committees' responsibilities into the new environment was outlined. • Each CCG and System Committee will be requested to prepare a joint report from its clinical lead, executive lead and lay member(s) as part of the formal handover to the ICB, to include successes and learning points, along with previous self-assessments or audit reports. • Any open risks, actions and agenda items for follow-up between closing the CCG Committees and opening the shadow ICB Committees will need to be well documented for receipt at the first meetings to formally receive and note in April. • The Corporate Team will develop a schedule of the key tasks of each Committee for closedown and transfer. • The practicalities of establishing the joint meetings in Quarter 4 will be worked through by the Corporate Team. The following questions were raised in response to the presentation:	

	• It was enquired how the Governing Body Assurance Framework (GBAF) and the Risk Register will be linked; although this refers to what the CCG has been doing, and not the ICB, it is important that the issues and assurances identified provide a framework for the new organisation. Whilst some Committees fit naturally into the new structure, others are split across a few areas, in particular the Governance Committee which will link into the Audit and Governance Committee and People and Culture Committee in the new arrangements. More work may be required to think things through in this case to prevent anything being lost in transition. HD advised that the GBAF is the architecture being recommended to develop the ICB Board Assurance Framework (BAF). There will be legacy detail in the GBAF that will need to feature in the ICB's BAF. The Board is encouraged by the CCG to have time to develop this by the end of Quarter 1 in 202223 to set the strategic objectives and risks to flow through the System architecture. The CCG is cautious not to impose this on the ICB Board but would highly recommend it. A process is being undertaken to ensure that nothing is lost, and all functions are received appropriately. The proposal for the System Committees is being re-looked at and tested as it does not need to be finally agreed until the new year. • Standard templates for the Committees to provide the right information were requested, particularly around risk register ownership and transferring risks over to the next financial year; it is important that the ICB is sighted on any mitigations. HD confirmed a pack of information will be produced in a standard format for Committees to work to. The Committees will be formally written to setting out the timetable, requesting they undertake this work during Quarter 4. • It would be helpful for each Committee's annual report to be included. HD agreed that this will form part of the work. CC recorded his thanks to Governing Body members for the way in which they are tackling this change, one which they are affected by. They have behaved pragmatically, thoughtfully, and constructively on how to make this happen in a streamline manner, keeping it safe and legal; colleagues have embraced the transition and handover very well. The Corporate Team will start working through the practicalities of the proposals regarding the convening of joint meetings. **The Governing Body NOTED and DISCUSSED the proposal for the closure of the CCG Governing Body and its Committees and the arrangements for transition to the shadow ICB**	
GBP/2122/196	**H2 Operational Planning Update** Zara Jones (ZJ) provided an update on the H2 Operational Plan, which is broader than just the Winter Plan. Many of the risks and challenges have been discussed by the Governing Body previously. It is a realistic picture of the significant challenges that the System is collectively facing which will continue over the winter period. The Plan demonstrates how best the System can comply with the different elements set out by NHSEI for H2. There are some areas which it will be possible to achieve and accelerate, however there are some areas that fall short of national expectations around compliance. The System is doing everything possible to achieve in these areas however, due to the gaps in the Plan, it is important to implement quality monitoring processes to assist with the making of challenging decisions in order to meet the need and demand across the health and care	

	System. There will be constraints around workforce capacity which may require decisions to be made to balance everything out, therefore the quality assessments will need to be robust to monitor impact; this is a key pillar of the Plan itself. Elective Care - A challenging position is presented; there is a growing waiting list position with a number of people waiting a long period of time for treatment. Inroads are being made to deliver activity in a timely manner, however clinical prioritisation decisions are having to be made regarding greatest clinical need and treating in priority order; it is anticipated that these waits will continue over the winter period and beyond. Cancer – This is an important area in which good progress is being made. The Plan sets out a challenging position, particularly for the over 62 day waits. A new standard for faster diagnosis has been implemented and overall, it is centred around the clinical prioritisation of patients. Primary Care – These challenges are well known and have been discussed by the Governing Body frequently in the past. Robust plans have been developed to demonstrate levels of compliance, how winter will be managed, and the challenges addressed around recruitment and demand. It is a challenging position and the ability to deliver the plans is in question as we go through the winter period. Urgent care including community provision and responding to crisis and urgent care needs – The Derbyshire System is struggling with some key priority areas, particularly ambulance handovers, with patients waiting for long periods of time in Emergency Departments. There are plans in place to alleviate pressures wherever possible, however these plans rely on the whole System working together to improve patient flow. Getting people out of hospital is challenging due to social care issues and workforce constraints. Good plans are in place to manage the risks and provide quality assurance. The Plan was submitted to NHSEI on 8th November; the CCG worked closely with the System to ensure this happened and the JUCD Board was appraised of the position. Feedback on the Plan is expected; it is a live document which will continue to be updated to manage the risks in real time. It is presented to the Governing Body for assurance, highlighting the risks and challenges. It will support the System architecture, particularly the Delivery Boards which will help work through the System challenges to provide the best possible care for patients over the winter period. Brigid Stacey (BS) highlighted the quality impact of the Plan. A robust System Quality Review Panel has been implemented which will consider any quality impacts of stopping services. The Panel will look at the risks and mitigations of anything referred to it and feedback to the System on the level of risk that implementing these decisions will cause; the System will then be able to decide what level of risk they are happy to accept. This process was reported to Region, which was very impressed with it, and are planning to implement it across the Region as a good example of managing risks. There is an extraordinary meeting of the System Quality Assurance Committee on 17th December to look at the Winter Plan and the end-to-end risks. From a quality and safety perspective the System will be well assured both on the Plan and any emerging risks. The following questions were raised:	

	• This is a well worked up Plan with the quality aspects being suitably covered under the circumstances. It was enquired if there is a sense emerging of the impact on inequalities on the waiting times. There does not appear to be a lack of pressure in the private system, and the danger is that a two-tier system is emerging, which would undermine the ethos of the NHS. It was asked how well sighted the System is on the inequalities. ZJ responded that an understanding of inequalities is still emerging; targeted pieces of work have been undertaken, particularly from a mental health perspective and the impact seen because of the pandemic. Available data is helping to drive decision making and strategic priorities. There is a new initiative to tackle inequalities through the development of a Health Inequalities Plan. Although things are in train, the priorities are not yet fully understood; this will be done quickly once the information is collated and worked through. There are requirements for planned care to record stats to help understand the inequalities position. The Planned Care Delivery Board is analysing this data and making decisions accordingly. • A lot of work has gone on behind this Plan to reach this position; in terms of assurance, there is a section on the coversheet regarding involving patients, public and key stakeholders, which says 'N/A' however this is not the case, and it was assured that this work has been undertaken. ZJ responded that the coversheet relates to the submission of the Plan to NHSEI. The communications and engagement team are constantly engaging with patients and sending messages on the reality of winter, what to expect and working together. • Regarding MSK, and the treatments undertaken at the independent hospitals i.e., Barlborough Treatment Centre and Nuffield Health a comment was made that this treatment favours those people in the higher socio-economic group who are more likely to fit the strict criteria; it was agreed that this will perpetuate inequities, and work is being undertaken to look at the nationally set criteria. **The Governing Body NOTED the summary content of the H2 plan submission which was submitted to NHSEI on 18th November**	
GBP/2122/197	**Finance Report – Month 7** Richard Chapman (RCp) provided an update on the financial position as at Month 7 (H2). The following points of note were made: • It has not been possible to report against the year-to-date budget, as it was not confirmed in time to be put into the ledger at the time of reporting; therefore Month 7 expenditure was reported against normalised Month 6 expenditure. • A £13.9m reduction in month on month run rate expenditure has been seen. £8m of this reduction relates to programme spend changes, and the remaining £5.9m is in reserves, specific allocations and investments which includes the release of a £3.9m contingency not required in H1, and as previously agreed by the Governing Body, has been committed to balance the H2 System Plan. • The annual run rate extrapolates the year-to-date expenditure rate to year end and is the difference between that and the annual forecast outturn; the run rate is materially impacted by not expecting any elective recovery funding in H2 and the reductions to COVID funding not being available to pass on to providers in the System. • A differential between indicative planning allocations and confirmed allocations was highlighted.	

	The Governing Body NOTED the following: • **Allocations have been received for the full year at £2.074bn** • **In line with NHSE/I guidance, planning for H2 had not been completed for month 7 reporting. As a result, the finance report has been compiled comparing actual monthly expenditure in month 7 with month 6 and overall expenditure against the H2 allocation allowance** • **Retrospective allocations received for H1 Covid spend on the Hospital Discharge Programme were £5.498m; further funding is expected of £0.625m relating to month 7** • **The Elective Recovery Fund has been reimbursed at £0.702m for April to September**	
GBP/2122/198	**Finance Committee Assurance Report – November 2021** Andrew Middleton (AM) provided a verbal update following the Finance Committee meeting held on 25th November 2021. The following points of note were made: • The CCG has moved firmly into maintaining a balanced position for the current year, to ensure it is well positioned to hand over to the ICB from April 2022. The System Finance and Estates Committee (SFEC) will meet as a joint Committee with the CCG's Finance Committee from January 2022 onwards. It has been demonstrated through SFEC that System working is a much better place to be. • The Committee will be pursuing deep dives on the Better Care Fund and the Personal Health Budgets approach strategy. • Restoration of the productivity plan is well established in the System space and was explored by SFEC. • The CCG's running costs are under 1% of its total budget which needs to be acknowledged, as vacancies are being covered by existing staff, with no let up to ensure that the System is prepared for the future. • The Financial Control Team achieved the Better Payment Practice code in October, reaching 100% for first time in some time. • This is a preparatory position, moving at pace, to ensure the System is able to carry it on from April 2022. **The Governing Body NOTED the verbal update provided for assurance purposes**	
GBP/2122/199	**Audit Committee Assurance Report – November 2021** Ian Gibbard (IG) provided an update following the Audit Committee meeting held on 18th November 2021. The report was taken as read and the following points of note were made: • Changes have been made to the Internal Audit Plan; System pressures have required them to refocus some planned assignments to ensure a good focus on the transition work, whilst deferring other things; this was considered to be a sensible and rational approach going forward. • Full assurance was received on an audit of Primary Care Medical Services, particularly the financial aspects of it, which is testament to the work of the Primary Care Team and the functions of the PCCC being discharged effectively.	

	The Governing Body NOTED the update provided for assurance purposes	
GBP/2122/200	**Clinical and Lay Commissioning Committee (CLCC) Assurance Report – November 2021** Dr Ruth Cooper (RC) provided an update following the CLCC meeting held on 11th November 2021. The report was taken as read and the outcomes of discussions were noted. The following point of note was made: • The Committee endorsed the proof of concept to work with the voluntary sector and social enterprises going forward, specifically for autism, however it could be applied to other areas. The concept was to have a lead provider to work directly with the ICB in future and with providers in the community to co-design services. The advantages of this are that lead providers are familiar with all services in the community, particularly the smaller ones, who often provide significant support and are cost effective, but do not have the infrastructure to be able to put forward bids and therefore could be lost to the System. This is a good opportunity to monitor quality more effectively, and therefore received significant support from the Committee. **The Governing Body NOTED the paper for assurance purposes and RATIFIED the decisions made by the CLCC**	
GBP/2122/201	**Derbyshire Engagement Committee Assurance Report – November 2021** Martin Whittle (MWh) provided an update following the Derbyshire Engagement Committee meeting held on 16th November 2021. The report was taken as read and the following points of note were made: • The Committee has started to look at items of engagement which have taken place since the COVID pandemic, for example, the older people mental health consultation for which updates had been received on potential changes for the wards at LRCH; although this is still proposed it is now also being looked at in Chesterfield and Walton to provide more modern accommodation that does not have shared facilities. There was assurance around the consultation plan received; the consultation will be run between December and February and the Committee will receive feedback thereafter. • A change is proposed for some services provided out of Newholme Hospital. The Committee supported the planned engagements with the wider participation groups and General Practice Managers where patient services will move. **The Governing Body NOTED the update provided for assurance purposes**	
GBP/2122/202	**Governance Committee Assurance Report – November 2021** Jill Dentith (JD) provided an update following the Governance Committee meeting held on 11th November 2021. The report was taken as read and the following points of note were made: • The following policies were approved:	

	• Raising Concerns at Work (Whistleblowing) Policy • Incident Reporting Policy • Incident Management Plan • Violence Prevention and Reduction Standards Strategy and Policy • The management of the transition of CCG policies to ICB policies was discussed, to ensure the new organisation is able to pick them up where necessary and have the opportunity to comment on their development. • It was noted that there has been a slight change to the Business Continuity approach taken by NHSEI, resulting in a few standards declaring Substantial Assurance rather than Full Assurance; the Committee was happy that the work being undertaken is appropriate and there are no risks around it. • The following Information Governance policies were approved: • IG01 – Information Governance (IG) Policy • IG02 – Network Internet and Email Acceptable Use Policy • IG03 – Records Management Policy • Information Governance Strategy • Following a discussion at last months' Governing Body on workforce at a strategic System level, the Governance Committee was requested to have a further conversation. A detailed discussion was held and, although HR and people and culture are part of the Governance Committee's remit, the wider System work around workforce fits better in the System space. It was proposed that this be picked up from January onwards as part of the transitional integrated working arrangements. **The Governing Body NOTED the update provided for assurance purposes**	
GBP/2122/203	**Primary Care Commissioning Committee (PCCC) Assurance Report – November 2021** Professor Ian Shaw (IS) provided a verbal update following the PCCC meeting held on 24th November 2021. The following point of note was made: • A concern was raised for both the CCG and ICB around the capacity of the Primary Care Team in meeting its high standards and requirements in the face of an increasing workload, particularly with the pharmacy and optometry responsibilities being phased in over the next two years without any additional resources. AB queried if the Transition Assurance Committee is sighted on this; HD confirmed that this is a risk and is part of the overarching plan being worked through. **The Governing Body NOTED the verbal update provided for assurance purposes**	
GBP/2122/204	**Quality and Performance Committee (Q&PC) Assurance Report – November 2021** Dr Buk Dhadda (BD) provided an update following the Q&PC meeting held on 25th November 2021. The report was taken as read and the following points of note were made:	

	• Challenges are being faced around the 62-day cancer target; the Q&PC is sighted on this and will be relooking at the pathway in greater detail. A significant increase in cancer referrals has been seen by providers, although the conversion rate remains the same it results in a higher number for cancer diagnoses which puts more pressure on an already strained System. • An update was received on EMAS, including the issues around pre / post-handover delays, patient demand and acuity. The A&E Delivery Board is sighted on this and has put a commitment in place that no handovers will take over 60 minutes. EMAS's Quality Assurance Group reviews patient safety and local reviews are undertaken at CCG level. NHSEI has acknowledged the additional pressures facing ambulance services across England and £55m of national funding has been provided, of which Derbyshire will receive a share, to improve performance trajectories. • The Committee received the annual safeguarding reports for both children and adults which provided assurance that the CCG is meeting its statutory commitments around safeguarding. Thanks were placed on record to both safeguarding teams for the excellent work they have done which is apparent in the reports, despite the rising demand and challenges around the pandemic. The Teams also continue to undertake safeguarding training for health care professionals. The following questions were rasied in relation to the report: • The report raises an issue around maternity staff and midwives, which links with the Governance Committee discussions on workforce, on how the CCG and System can ensure sufficient capacity to deliver the set targets. It was queried what assurance there is that maternity services are being managed appropriately within the resources. BD confirmed that the Committee has looked at this and it was discussed at a System level where assurance was provided around maternity provision for the CCG's population. BS added that this is a national problem. The home birth services at UHDBFT were suspended in the summer due to staff pressures and will be reviewed on 17th January 2022. As a result of this, a quality review of maternity services was undertaken in September and October which provided assurance that there are no safety concerns. There is a quality and safety forum for maternity services. • It was queried whether the Committee has had the opportunity to look at balancing capacity across the System in responding to waiting time targets, particularly regarding diagnostics where there are huge variations in waiting times between CRHFT and UHDBFT. For example, the MRI wait at CRHFT is zero, whilst at UHDBFT it is significant. It was asked whether patients are being triaged between centres on this basis based on the criticality of their condition. It was asked if this also applies in other areas. BD responded that this was mentioned at Q&PC. Patient demographics are different between UHDBFT and CRHFT; UHDBFT is more specialised and has a greater demand on its diagnostic services. As well as the issues of staffing, COVID safety has reduced the capacity to carry out the numbers of investigations undertaken pre-pandemic; UHDBFT has implemented measures to increase its MRI scanning capacity. The reporting of test results also puts strain on the department. It is a complex pathway, which will continue to be monitored. In relation to waiting list backlogs, there is a clinical risk stratification process in place, working to a national protocol, to ensure that patients needing to be seen earlier are prioritised. The waiting times are expected to increase due to the referrals coming in.	

	• ZJ added that comparisons are always being made between providers and the possibility of sharing workforce or moving patients between sights, although fraught with logistical challenges, is being looking into. Discussions have been held on having a shared waiting list position; however, it is not sure how much could be done over the winter period given the constraints; when the challenges settle, it may be possible to implement new models of working. • Primary Care providers need to ensure that their referrals are appropriate and decide if non-cancer referrals into imaging are necessary. A video has recently been shared, produced by CRHFT and UHDBFT, to help people understand the waiting times in diagnostics, explaining that the Teams are still working hard and trying to get the waiting lists down and asking for people to be supportive of this. • IT systems are difficult to access between CRHFT and UHBDFT, which causes problems if patients have images or tests at one hospital and are treated at the other. It is frustrating that the IT systems are preventing the use of resources in a joined-up manner – If this could be resolved it would make a big difference. • There is also an issue with eRS allowing consultants to triage referrals; one of the barriers is that eRS does not speak to the hospital computer system. • Understanding between Trusts is increasing, and mutual respect is developing as they work collaboratively together. **The Governing Body NOTED the paper for assurance purposes**	
GBP/2122/205	**CCG Risk Register – November 2021** HD advised that this report highlights areas of organisational risk recorded in DDCCG's Corporate Risk Register as at 30th November 2021. All risks in the Register are allocated to one of the CCG's Corporate Committees which reviews them on a monthly basis. No changes were made to the risk scores this month. During Quarter 4, a formal process of review will be undertaken to reach a year-end position and consider any risks that will need to be transferred into the ICB. **The Governing Body RECEIVED and NOTED:** • **The Risk Register Report** • **Appendix 1 as a reflection of the risks facing the organisation as at 30th November 2021** • **Appendix 2 which summarises the movement of all risks in November**	
GBP/2122/206	**Joined Up Care Derbyshire Board – ratified minutes – 16.9.2021** **The Governing Body RECEIVED and NOTED these minutes**	
GBP/2122/207	**Ratified Minutes of DDCCG's Corporate Committees:** • Audit Committee – 16.9.2021 • Derbyshire Engagement Committee – 21.9.2021 • Governance Committee – 23.9.2021 • Primary Care Commissioning Committee – 27.10.2021 • Quality and Performance Committee – 28.10.2021	

	The Governing Body RECEIVED and NOTED these minutes	
GBP/2122/ 208	**South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) CEO Report – November 2021** CC announced that Gavin Boyle, the CEO of UHDBFT, has been appointed as the CEO Designate of SYB ICS. The Governing Body congratulated Gavin in this new venture and wished him well. **The Governing Body RECEIVED and NOTED this report**	
GBP/2122/ 209	**Safeguarding Children, Looked After Children, Named GP for Children's Safeguarding and Adult Safeguarding Reports – 2020-21** **The Governing Body NOTED and ENDORSED the content of the reports and the objectives set for 2021/2022**	
GBP/2122/ 210	**Minutes of the Governing Body meeting in public held on 4th November 2021** **The minutes of the above meeting were agreed as a true and accurate reflection of the discussions held**	
GBP/2122/ 211	**Matters Arising / Action Log** Action Log – November 2021 – No outstanding items	
GBP/2122/ 212	**Forward Planner** **The Governing Body NOTED the Planner for information**	
GBP/2122/ 213	**Any Other Business** None raised	
DATE AND TIME OF NEXT MEETING – 13th January 2022 at 9.30am via MST		

Signed by: ……. Dated: ……
(Chair)

NHS
Derby and Derbyshire
Clinical Commissioning Group

Derby and Derbyshire CCG Governing Body Forward Planner 2021/22

	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
AGENDA ITEM / ISSUE												
WELCOME/ APOLOGIES												
Welcome/ Apologies and Quoracy	X	X	X	X	X	X	X	X	X	X	X	X
Questions from the Public	X	X	X	X	X	X	X	X	X	X	X	X
Declarations of Interest • Register of Interest • Summary register of interest declared during the meeting • Glossary	X	X	X	X	X	X	X	X	X	X	X	X
CHAIR AND CHIEF OFFICERS REPORT												
Chair's Report	X	X	X	X	X	X	X	X	X	X	X	X
Chief Executive Officer's Report	X	X	X	X	X	X	X	X	X	X	X	X
FOR DECISION												
Review of Committee Terms of References		X					X					
FOR DISCUSSION												
360 Stakeholder Survey												X
Mental Health Update								X				
CORPORATE ASSURANCE												
Finance and Savings Report	X	X	X	X	X	X	X	X	X	X	X	X
Finance Committee Assurance report	X	X	X	X	X	X	X	X	X	X	X	X
Quality and Performance Committee Assurance Report • Quality & Performance Report • Serious Incidents • Never Events	X	X	X	X	X	X	X	X	X	X	X	X
Governance Committee Assurance Report • Business Continuity and EPRR core standards • Complaints	X		X		X		X		X		X	

	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
AGENDA ITEM / ISSUE												
• Conflicts of Interest • Freedom of Information • Health & Safety • Human Resources • Information Governance • Procurement												
Audit Committee Assurance Report	X	X	X				X		X		X	
Engagement Committee Assurance Report	X	X	X	X	X	X	X	X	X	X	X	X
Clinical and Lay Commissioning Committee Assurance Report	X	X	X	X	X	X	X	X	X	X	X	X
Primary Care Commissioning Committee Assurance Report	X	X	X	X	X	X	X	X	X	X	X	X
Risk Register Exception Report	X	X	X	X	X	X	X	X	X	X	X	X
Governing Body Assurance Framework	X	X		X			X			X		X
Strategic Risks and Strategic Objectives		X		X	X							
Annual Report and Accounts			X			X						
AGM						X						
Corporate Committees' Annual Reports					X							
Joined Up Care Derbyshire Board Update	X		X		X		X		X		X	
FOR INFORMATION												
Director of Public Health Annual Report											X	
Minutes of Corporate Committees												
Audit Committee	X	X	X				X		X		X	
Clinical & Lay Commissioning Committee	X	X	X	X	X	X	X	X	X	X	X	X
Engagement Committee	X	X	X	X	X	X	X	X		X	X	X
Finance Committee	X	X	X	X	X	X	X	X	X	X	X	X
Governance Committee			X		X		X		X		X	
Primary Care Commissioning Committee	X	X	X	X	X	X	X	X	X	X	X	X
Quality and Performance Committee	X	X	X	X	X	X	X	X	X	X	X	X

	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
AGENDA ITEM / ISSUE												
Minutes of Health and Wellbeing Board Derby City	X		X		X				X		X	
Minutes of Health and Wellbeing Board Derbyshire County	X		X		X				X		X	
Minutes of Joined Up Care Derbyshire Board	X		X		X		X		X		X	
Minutes of the SY&B JCCCG meetings – public / private	X	X	X	X	X	X	X	X	X	X	X	X
MINUTES AND MATTERS ARISING FROM PREVIOUS MEETNGS												
Minutes of the Governing Body	X	X	X	X	X	X	X	X	X	X	X	X
Matters arising and Action log	X	X	X	X	X	X	X	X	X	X	X	X
Forward Plan	X	X	X	X	X	X	X	X	X	X	X	X
ANY OTHER BUSINESS												

Derby and Derbyshire
Clinical Commissioning Group

GOVERNING BODY MEETING IN PUBLIC
ACTION SHEET – December 2021

Item No.	Item title	Lead	Action Required	Action Implemented	Due Date
2021/22 Actions					
GBP/2122/054	Joined Up Care Derbyshire Board Update – May 2021	Helen Dillistone	It was requested that a Governing Body Development / Transition Session be planned to ensure that Governing Body members are sufficiently sighted on the measures being taken to address the health inequalities in Derbyshire; Dr Robyn Dewis and Dean Wallace will be requested to provide input into this session on the inequalities' strategy.	To be scheduled for the February Session	**February 2022**
GBP/2122/174	Winter Plan Update	Helen Dillistone	It was requested that the Governing Body holds a deep dive on the workforce challenges.	A detailed discussion was held at the Governance Committee and, although HR and people and culture are part of the Governance Committee's remit, the wider System work around workforce fits better in the System space. It was proposed that this be picked up from January onwards as part of the transitional integrated working arrangements.	**February 2022**