

**NHS DERBY AND DERBYSHIRE CCG
GOVERNING BODY – MEETING IN PUBLIC**

**Date & Time: Thursday 2nd December 2021 – 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/2122/188	Welcome, Apologies & Quoracy Apologies: Dr Robyn Dewis	Verbal	Dr Avi Bhatia	9.30
GBP/2122/189	Questions from members of the public	Verbal	Dr Avi Bhatia	
GBP/2122/190	Declarations of Interest <ul style="list-style-type: none"> • Register of Interests • Summary register for recording any conflicts of interests during meetings • Glossary 	Papers	Dr Avi Bhatia	
CHAIR AND CHIEF OFFICER REPORTS				
GBP/2122/191	Chair's Report	Paper	Dr Avi Bhatia	9.35
GBP/2122/192	Chief Executive Officer's Report	Paper	Dr Chris Clayton	
GBP/2122/193	Joined Up Care Derbyshire Board Update	Paper	Dr Chris Clayton	
FOR DECISION				
GBP/2122/194	Remuneration Committee Terms of Reference	Paper	Helen Dillistone	10.00
FOR DISCUSSION				
GBP/2122/195	Closedown of CCG GB and Committees and transition to shadow ICB arrangements	Presentation	Helen Dillistone	10.05

CORPORATE ASSURANCE				
GBP/2122/196	2021/22 H2 Operational Planning Update	Paper	Zara Jones	10.10
GBP/21221197	Finance Report – Month 7	Paper	Richard Chapman	
GBP/2122/198	Finance Committee Assurance Report – November 2021	Verbal	Andrew Middleton	
GBP/2122/199	Audit Committee Assurance Report – November 2021	Paper	Ian Gibbard	
GBP/2122/200	Clinical and Lay Commissioning Committee Assurance Report – November 2021	Paper	Dr Ruth Cooper	
GBP/2122/201	Derbyshire Engagement Committee Assurance Report – November 2021	Paper	Martin Whittle	
GBP/2122/202	Governance Committee Assurance Report – November 2021	Paper	Jill Dentith	
GBP/2122/203	Primary Care Commissioning Committee Assurance Report – November 2021	Verbal	Professor Ian Shaw	
GBP/2122/204	Quality and Performance Committee Assurance Report – November 2021	Paper	Dr Buk Dhadda	
GBP/2122/205	CCG Risk Register – November 2021	Paper	Helen Dillistone	
FOR INFORMATION				
GBP/2122/206	Joined Up Care Derbyshire Board ratified minutes – 16.9.2021	Paper	Dr Chris Clayton	10.40
GBP/2122/207	Ratified Minutes of Corporate Committees: <ul style="list-style-type: none"> • Audit Committee – 16.9.2021 • Engagement Committee – 19.10.2021 • Governance Committee – 23.9.2021 • Primary Care Commissioning Committee – 27.10.2021 • Quality and Performance Committee – 28.10.2021 	Papers	Committee Chairs	
GBP/2122/208	South Yorkshire and Bassetlaw Integrated Care System CEO Report – November 2021	Paper	Dr Chris Clayton	

GBP/2122/209	Safeguarding Children, Looked After Children, named GP and Adults Annual Reports 2020/21	Papers	Brigid Stacey	
MINUTES AND MATTERS ARISING FROM PREVIOUS MEETING				
GBP/2122/210	Minutes of the Governing Body Meeting in Public held on 4th November 2021	Paper	Dr Avi Bhatia	10.50
GBP/2122/211	Matters arising from the minutes not elsewhere on agenda: <ul style="list-style-type: none"> • Action Log – November 2021 	Paper	Dr Avi Bhatia	
GBP/2122/212	Forward Planner	Paper	Dr Avi Bhatia	
GBP/2122/213	Any Other Business	Verbal	All	

Date and time of next meeting: Thursday 13th January 2022 from 9.30am to 11am – via Microsoft Teams

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



*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 GP Parter at Erewash Health Partnership Spouse works for Nottingham University Hospitals in Gynaecology Part landlord/owner of premises at College Street Medical Practice, Long Eaton, Nottingham	✓ ✓ ✓			✓	2000 April 2018 Ongoing Ongoing	Ongoing Ongoing Ongoing Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
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 GP partner at Hannage Brook Medical Centre, Wirksworth. Interests in Drug misuse GP lead for Shared Care Pathology, Derbyshire Pathology Clinical advisor to the board of Sinfonia Viva, a professional orchestra	✓ ✓ ✓	✓ ✓ ✓			Feb 2019 Oct 2010 2011 1 Apr 2021	Ongoing Ongoing Ongoing Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
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 Group and provides private medical services in the East Midlands (including patients who are not eligible for NHS funded treatment according to CCG guidelines) Employed by Nottingham University Hospital NHS Trust which is commissioned by the CCG to provide services to NHS patients. Founder Member, Shareholder and Director of Clinical Services for Alliance Surgical plc which is a company that bids for NHS contracts. 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. Honorary Associate Professor, University of Nottingham, involved in clinical research activity in the East Midlands. Medical Director of Independent Healthcare Group which provides local anaesthetic services to NHS patients in Leicestershire, Gloucestershire, Wiltshire and Somerset. Chief Medical Officer for Circle Harmony Health Limited which is part owned by Circle Health Group who run BMI and Circle Hospitals	✓ ✓ ✓ ✓ ✓ ✓		✓ ✓		Aug 2014 Aug 2000 July 2007 Aug 1992 Aug 2009 Oct 2020 Aug 2020	Ongoing Ongoing Ongoing Ongoing Ongoing Ongoing Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair Declare interest in relevant meetings Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair No action required No action required Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair 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 North East Derbyshire & Bolsover Place Alliance Group Derbyshire Primary Care Leadership Group CRHFT Clinical Quality Review Group GP Workforce Steering Group Conditions Specific Delivery Board	Locum GP at Staffa Health, Tibshelf Shareholder in North Eastern Derbyshire Healthcare Ltd 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 Fundraising Activities through Staffa Health to support Ashgate Hospice and Blythe House	✓ ✓ ✓ ✓				Dec 2020 2015 3 Feb 2021 Ongoing	Ongoing Ongoing Ongoing 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
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 Providing part-time, short term corporate governance support to Rotherham NHS Foundation Trust Director of Jon Carr Structural Design Ltd Providing part-time, short term corporate governance support to Sheffield Teaching Hospitals NHS Foundation Trust	✓ ✓ ✓ ✓				2012 6 Oct 2020 6 Apr 2021 7 Jun 2021	Ongoing 8 April 2021 Ongoing End date tbc	Declare interests at relevant meetings

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 Meryll	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	Nil							No action required

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		

Governing Body Meeting in Public

2nd December 2021

Item No: 191

Report Title	Chair's Report – November 2021
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

It is likely that this will be the last CCG Governing Body in its existing form as we seek to make new arrangements to pave the way for the new Integrated Care Board once it is legally established from April 2022. The CCG Governing Body will operate alongside the shadow ICB from January 2022. Reviewing the achievements and legacy of the CCG will follow on at a meeting before April, but I wanted to use this month's report to reflect on the way the CCG and system has evolved the involvement of clinicians and other care professionals in recent years and point towards how this will continue to develop in the ICB.

Previously, the Clinical and Professional Reference Group (CPRG) met to provide clinical guidance and steer on policy developments which were put before the group. It was a successful model in galvanising a broad range of clinical representatives to provide scrutiny and constructive challenge to developments within our system. The CPRG role was that of a group, or meeting, with its business largely dictated by the issues of the day and its reach didn't stretch far beyond the monthly meetings. CPRG also built on the excellent clinical engagement we had seen across the four predecessor CCGs, where in many areas specific clinical roles had been identified and funded to provide dedicated time and support to programmes. This often involved primary care, but many programmes also saw involvement from secondary care, mental health and community care clinicians.

We have learned from these approaches and have been revisiting the requirement and role that clinicians and care professionals can play in policy development, but also in acting as a coherent leadership group on behalf of the system. This has now evolved into a new Clinical and Professional Leadership Group (CPLG), which is

now meeting and aims to develop thinking to ensure the core objective of building a distributed clinical and professional leadership model for JUCD is created by April 2022. The aim is to embed clinical and care professional leadership in all aspects of system decision making and for the group to be available to all elements of system clinical and care development as a reference group.

This is a very complex and challenging undertaking, but crucially important if we are to achieve our ambition on clinical and care leadership across our system. Five principles have been established to guide the work of the group:

- Principle 1: Ensure that the full range of clinical and care professional leaders from diverse backgrounds are integrated into system decision-making at all levels, supporting this with a flow of communications and opportunities for dialogue.
- Principle 2: Creating a culture that systematically embraces shared learning, supporting clinical and care professional leaders to collaborate and innovate with a wide range of partners, including patients and local communities.
- Principle 3: Support clinical and care professional leaders throughout the system to be involved and invested in ICS planning and delivery, with appropriate protected time, support and infrastructure to carry out this work
- Principle 4: Create a support offer for clinical and care professional leaders at all levels of the system, one which enables them to learn and develop alongside non-clinical leaders
- Principle 5: Adopt a transparent approach to identifying and recruiting leaders which promotes equity of opportunity and creates a professionally and demographically diverse talent pipeline that reflects the community served and ensures that appointments are based on ability and skillset to perform the intended function

CPLG has commenced participation in a series of Action Learning Sets, through a programme run from NHS England/Improvement. As we develop our new ICS governance arrangements, CPLG will play a role as a strategic decision-making group for key decisions that affect population health outcomes, as well as acting as the 'glue' that binds clinical and professional leadership together through stronger connections and acting as the facilitators to enable this.

Planning is now underway to consider how best to run the proposed workshops and focus groups to secure widescale input and buy in to the developments. We fully recognise that timing wise this is difficult for all parts of the system and we are cognisant of the system pressures, plus various other regional support programmes which may call on the same people to be involved. Taking this into account and whilst aiming for strong inclusivity in the developments, we are making every effort to be flexible in the approach and the intention is to utilize existing forums/meetings where possible. There is a strong recognition of the need to manage interdependencies and connectivity with other ICS developments to ensure CPLG are firmly embedded and connected within each aspect and as such part of decision making processes; this is important in setting consistent approaches and messages and to avoid duplication/contradiction.

Dr Avi Bhatia, Clinical Chair and CPLG 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

Governing Body Meeting in Public

2nd December 2021

Item No: 192

Report Title	Chief Executive Officer's Report – November 2021
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

November felt like a milestone month for the Joined Up Care Derbyshire Integrated Care System (JUCD ICS). JUCD has been on a clear pathway to work as health and care partners to make improvements to the health and wellbeing of local people. That is now a well-established, central principle of our ICS. Establishing the method of setting priorities, ensuring the partnership pulls from an ideologically-agreed centre that is based on cooperation, and which seeks to find common ground on which to make necessary improvements has been at the heart of our progress. Delivering such a well-coordinated response to the Covid-19 pandemic is evidence in itself of how Derby and Derbyshire works well together.

The Health and Care Bill which is currently passing through the parliamentary process - with the likelihood of becoming law from April 2022 - has further enabled these developments and given us both direction and permission to take the arrangements to the next level and formalise the arrangements in legislation. This has no doubt helped to accelerate some of the conversations and deliberations during 2021 and has ensured that system leaders have found time to consider the priority setting and governance of our ICS at a time when we have also been managing significant service pressures and a major public health challenge.

It is though fair to say that we were on the money with our own thinking and is one of the reasons why our system has been earmarked as requiring a reduced level of regulatory scrutiny as we progress. During November, we held a very constructive workshop in which we tested out the thinking of a very wide range of system partners, including partners currently outside of the JUCD Board membership from district and borough councils, the voluntary sector and Healthwatch. It was an excellent discussion, but crucially it was a discussion of broad agreement, where our partners demonstrated that we are all pulling in the same direction as we seek to implement the proposed new legislation. The actual output from that discussion was our submission to NHS England/Improvement on the membership and formation of our Integrated Care Board, a major milestone, but also a token of our system collaboration.

I have frequently briefed CCG staff on the developments with our ICS journey, the latest during a Team Talk session in the last week of November. The questions and

feedback I am receiving from teams is very encouraging and while there is still a lot of answers to provide on the future roles and responsibilities of staff across the CCG, I sense that there is growing confidence that we will be making meaningful improvements to the lives of local people.

On a personal note, I am very honoured to have been offered, and to accept, the appointment to the role of Chief Executive Designate for the new NHS Derby and Derbyshire Integrated Care Board. This follows on from John MacDonald's appointment as Chair Designate of the ICB earlier in the year. The advertisements for the ICB's Non-Executive Director roles ran throughout November, and we will be interviewing selected candidates during December, with a view to making appointments before the holiday season. I am currently working through the requirements for my Executive Team and expect to be issuing advertisements for those roles in January.

Of course, the backdrop to these developments is an ongoing picture of high demand across frontline health and care services, and the CCG and system is managing the triple priorities of 1) maintaining and managing services through the pandemic and through winter, 2) recovering services and service backlogs that have occurred and 3) taking forward the system transformation programme outlined above. Staff from all partner organisations remain under pressure and it remains of the utmost importance that we continue to recognise these efforts and keep our staff's welfare at the forefront of our priorities. I would once again like to express my gratitude to all the health and social care colleagues across our system who continue to go above and beyond, day after day, to deliver excellent care to the people of Derby and Derbyshire.

Chris Clayton
Accountable Officer and Chief Executive

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

Meeting and purpose	Attended by	Frequency
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
Accelerating our System Transformation	CCG/System/KPMG	Ad Hoc
2021/22 Planning – Derbyshire System	CCG/System/NHSE	Monthly
LRF/Derbyshire MPs	Members and MPs	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
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
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

JUCD Development Session	CCG/System	Ad Hoc
ICS Shared Services Workshop	Regional AOs/NHSE	Ad Hoc
Advisory System Remuneration and Appointments Committee	System/CCG	Ad Hoc
JUCD Executive Leadership Programme (Cohort 1 - Workshop 1)	System/CCG	Ad Hoc
Creating Derbyshire's Integrated Care Board & Integrated Care Partnership Workshop	System/CCG	Ad Hoc
Strategic Intent Executive Group	CCG/System	Monthly

3.0 National developments, research and reports

3.1 [NHS chief announces next steps for local health systems](#)

The NHS will set out the next steps for how primary care networks will work with partners across newly formed integrated care systems to meet the health needs of people in their local areas.

3.2 [NHS responds to highest number of 999 calls on record](#)

NHS 999 services had their busiest ever month in October as staff answered a record 1,012,143 calls. Ambulance staff responded to more than 82,000 life threatening call-outs, an increase of more than 20,000 on the previous high for October in 2019 (61,561), as well as dealing with the surge in 999 calls.

3.3 [New campaign to help public get NHS advice quickly ahead of 'winter like no other'](#)

The NHS is encouraging the public to use NHS 111 online to get urgent medical advice quickly – in addition to existing services – ahead of what England's top doctor says will be a 'winter like no other'.

3.4 [New campaign to help public get NHS advice quickly ahead of 'winter like no other'](#)

The NHS is encouraging the public to use NHS 111 online to get urgent medical advice quickly – in addition to existing services – ahead of what England's top doctor says will be a 'winter like no other'.

3.5 [HPV vaccine cutting cervical cancer by nearly 90%](#)

The human papillomavirus, or HPV, vaccine is cutting cases of cervical cancer by nearly 90%, the first real-world data shows.

3.6 [NHS chief urges people to take up 'evergreen' vaccine offer as people of all ages come forward for first jab](#)

The head of the NHS has urged anyone who has not had a COVID-19 jab to join the thousands flocking to take up the 'evergreen' offer as winter approaches. More than a half a million adults have come forward for a first dose since the beginning of September, an average of around 9,000 a day over the past four and a half months.

[3.7 People aged 40-49 become eligible for COVID-19 booster vaccine](#)

People aged 40 to 49 are now able to book their booster vaccine, and 16 and 17-year-olds their second jabs. People can book their booster appointment on the National Booking Service a month before they become eligible, which means they can get their top-up jabs as soon as they reach the six month mark.

[3.8 NHS offers residents in every eligible care home a COVID booster jab](#)

COVID-19 booster vaccines have been delivered or booked in at every older adult care home in England where safe to do so.

4.0 Local developments

4.1 Joined Up Care Derbyshire rated well by NHS England

NHS England (NHSE) has informed all Integrated Care Systems and NHS Trusts of their first performance rating, issued under the new [System Oversight Framework \(SOF\)](#) which commences this year.

NHSE has said that SOF ratings will be determined by assessing the level of support required based on a combination of objective criteria and judgement. The decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 4).

Joined Up Care Derbyshire is pleased to have been placed in segment 2, which is defined as a system that is "on a development journey, but demonstrates many of the characteristics of an effective, self-standing ICS, with plans that have the support of system partners in place to address areas of challenge."

[4.2 Appointment of Chief Executive Designate for NHS Derby and Derbyshire Integrated Care Board](#)

The Chief Executive of NHS Derby and Derbyshire Clinical Commissioning Group, Chris Clayton, has been appointed as the Chief Executive Designate of the NHS Integrated Care Board for Derby and Derbyshire, subject to the new organisation coming into being on 1 April 2022.

4.3 Establishing NHS Integrated Care Boards

In October we invited partners for their views on the establishment of NHS Integrated Care Boards and the formation of Derbyshire's health and care Integrated Care Partnership. We held a workshop on Friday 5 November to discuss the themes that had emerged from this period of engagement. The workshop was well attended and aided meaningful conversations which will support our submission to NHS England later this month outlining our proposed approach.

[4.4 National investment creates new mental health services for the people of Derbyshire](#)

Significant national investment of £80m is paving the way for the development of new mental health facilities across Derbyshire. New hospitals will be built to support adults who require acute support for their mental health needs in both Derby and Chesterfield.

[4.5 Vaccination team wins top award for keeping children safe](#)

Derbyshire Community Health Services' School Age Immunisation Team have

been named winners in the national Nursing Times Awards 2021, showcasing the most innovative approaches to nursing during the pandemic.

[4.6 Annual health check resources for people with a learning disability](#)

People with a learning disability often have poorer physical and mental health than other people. This does not need to be the case. Annual health checks are for adults and young people aged 14 or over with a learning disability. More information about the provision of annual health checks in Derby and Derbyshire is available [here](#). Further information about why it's important to get an annual health check if you or someone you care about has learning disabilities is available in [this video](#).

[4.7 Vaccination programme calls for more volunteers](#)

Joined Up Careers Derbyshire is calling for more volunteers to help with the ongoing Covid-19 vaccination programme. Susan Spray, programme lead for Joined Up Careers Derbyshire, said: "This is a chance for more people to take part in a crucial aspect of the country's ongoing response to the coronavirus pandemic."

[4.8 Latest vaccination statistics](#)

NHS England and Improvement publishes data on the vaccination programme at system level [here](#).

[4.9 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

Governing Body Meeting in Public

2nd December 2021

Item No: 193

Report Title	Joined Up Care Derbyshire Board
Author(s)	Sean Thornton, Assistant Director Communications and Engagement
Sponsor (Director)	Chris Clayton, Chief Executive

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

The Governing Body is requested to **NOTE** the update provided from the Joined Up Care Derbyshire Board meeting held on 18th November 2021.

Report Summary

Patient Story

The Board heard the story of a gentleman who had been living at home supported by his son and had an established diagnosis of alcohol related dementia. Having been an upstanding member of the community throughout his life, this patient had received a brain injury which has resulted in cognitive impairment and subsequent challenging behaviour, which had put he and his family at risk in the community.

The patient was admitted to the Walton Unit under Section 2 of the MHA. The unit is commissioned for support for adults aged 65+, and therefore not fully geared to provide care for someone younger. Following admission, the patient displayed a wide range of challenging behaviour, including trying to set fires, trying to escape and intimidating staff which resulted in a move to an isolated unit with additional security support. The multi-disciplinary team had differences of opinion on the best course of action, with a clear acknowledgement that this patient's condition didn't fit neatly into existing care pathways. It was also felt that the Covid-19 lockdown and the increase in alcohol consumption may have contributed to this case and may also be a factor in other care requirements in the future.

The Board acknowledged that this wasn't an isolated case and heard that the Mental Health, Learning Disability and Autism Delivery Board has continued to seek solutions to this type of challenge. DCHS, DHcFT and commissioners are working together on managing these challenging situations with such clinical presentations, including at a regional level as this isn't a challenge contained within our area.

Current System Position

1. Activity and performance

Frontline services across Derby and Derbyshire continue to experience high demand and services across Derbyshire - primary care, emergency response, mental health, community and acute – continue to work closely to ensure a robust system response and further improve signposting and referrals between services. The school immunisation team, operated by Derbyshire Community Health Services NHS Foundation Trust, has administered the most jabs to 12 to 15-year-olds of all the providers in the Midlands. The Derby and Derbyshire team has now carried out COVID-19 vaccine sessions at 48 out of the 78 secondary schools in the city and county and have been offering appointments through half-term for those children who were unable to have them when they visited their schools. Derbyshire's Covid booster campaign continues to perform well and has contributed to the national programme which stands at over five million boosters having been delivered so far: over one million of those being in the Midlands region.

The number of hospital beds occupied by confirmed COVID-19 cases (as at 8am 15/11/21) reported to NHS England is at 86 across the system – down from 119 a month ago and a reduction of 2 in the last week. There are 30 cases at Chesterfield Royal Hospital (CRH) with five in an Intensive Care Unit (ICU), 42 at University Hospitals of Derby and Burton (UHDB) with five patients in ICU, one in a facility operated by Derbyshire Healthcare and seven in facilities operated by Derbyshire Community Health Services. Sadly, there have been ten COVID-19 deaths in Derby and Derbyshire over the last week.

2. Latest planning to address the challenge

The system has been compiling its operational delivery plan across all our core services and against the expectations set out by NHSE. What is emerging is an extremely challenging but realistic plan, which sets out a stark position in the system's ability to meet the national targets given the constraints we've got on capacity, backlogs and workforce pressures.

The plan identifies where our risks lie in achieving national expectations and rightly takes full consideration of the need to maintain high quality care as we attempt to deliver against targets. The key issues identified are:

- primary care, where there are complex capacity and demand pressures, balancing the vaccination programme, routine business and urgent care
- mental health, increasing demand in presentations with higher levels of acuity, along with demand on community services to avoid admission remains critically high
- elective care – long waits will continue with current growth in 52ww+ waits
- cancer – increasing demand and therefore continuing 62d+ waits – 60% above target level despite reduction in year
- urgent care – continued 12-hr and ambulance handover delays. Increasing NEL attendances while the community response embeds. Currently there is a deteriorating length of stay, which puts our plan at risk.

3. System Financial Position

Month 6 monitoring shows JUCD finished the first half of the year with a small surplus of £5m, with cautious optimism that we will finish the financial year in a breakeven position. We do still know that the system carries an underlying financial deficit of £41.4million, which has been covered so far by non-recurrent measures and we continue to work to address as a system to resolve on a recurrent and therefore sustainable basis.

Our development journey towards a statutory ICS

1. Creating our Integrated Care Board and Integrated Care Partnership

An engagement process including a half day workshop to inform the development, roles responsibilities and composition of the Integrated Care Board took place on 5 November. The outputs of written feedback and the workshop have informed the proposal submitted to NHS E/I for approval and is available for review as part of [the Board papers on the JUCD website](#).

Based on the JUCD ICS forward plan, the expectation is to commence the ICB Board and Integrated Care Partnership from January 2022 in shadow form. As a result, the current JUCD ICS formal and developmental Board meetings will cease to run from the end of the year. The formal JUCD ICS Board meeting in November was therefore the final meeting, with a clear plan in place to ensure a smooth transition into the shadow Integrated Care Board. JUCD is also making excellent progress in having a robust Integrated Care Partnership mechanism in place in shadow form from January. Final conversations are being held with key partners on the composition of the partnership, including colleagues in the Health and Wellbeing Boards.

The recruitment process for the ICB CEO designate has progressed. Interviews took place on 13 October 2021, and following a recommendation made to NHS E/I nationally, formal approval has now been received that Chris Clayton be appointed the Chief Executive Designate of the Integrated Care Board (ICB). The process for appointing to the non-executive director roles of the anticipated ICB has commenced with JUCD ICS seeking candidates with skills in community engagement, people, and culture (including diversity and inclusion), quality/performance assurance, financial assurance, audit, and commissioning.

JUCD finance lead Lee Outhwaite will step back from the system role now he has taken up an additional Chief Finance Officer position with DCHS, alongside his role at Chesterfield Royal Hospital. Rich Chapman, Chief Finance Officer at the CCG, will take on the system finance lead role with immediate effect. The Board expressed its thanks to Lee for his work across the system over the last four years.

2. ICS Naming

The ICS Naming Convention was published on 13 October 2021. In discussion with key partners as part of broader ICS development sessions the proposed names outlined below were agreed to most accurately reflected the emerging parts of our system and would be recognised by partners:

- ICB Legal name: NHS Derby and Derbyshire Integrated Care Board
- ICB public name: NHS Derby and Derbyshire
- ICS: Joined Up Care Derbyshire
- ICP: Derby and Derbyshire Integrated Care Partnership

3. NHS Integrated Commissioning Board Constitution

Each Integrated Care Board (ICB) must set out its governance and leadership arrangements in a constitution formally agreed by NHS England and NHS Improvement (NHSE/I). We will submit our first draft Constitution to NHSEI on 3rd December 2021, with iterations over the coming months before submitting our final draft Constitution on 11th March 2022

4. Clinical and Professional Leadership

The Clinical and Professional Leadership Group continues to develop thinking to ensure the core objective of building a distributed clinical and professional leadership model for JUCD is created by April 2022. The aim is to embed clinical leadership in all aspects of system

decision making and for the group to be available to all elements of system clinical development as a reference group.

This is a very complex and challenging undertaking, but crucially important if we are to achieve our ambition on clinical leadership across our system. Five principles have been established to guide the work of the group:

- **Principle 1:** Ensure that the full range of clinical and professional leaders from diverse backgrounds are integrated into system decision-making at all levels, supporting this with a flow of communications and opportunities for dialogue.
- **Principle 2:** Creating a culture that systematically embraces shared learning, supporting clinical and care professional leaders to collaborate and innovate with a wide range of partners, including patients and local communities.
- **Principle 3:** Support clinical and care professional leaders throughout the system to be involved and invested in ICS planning and delivery, with appropriate protected time, support and infrastructure to carry out this work
- **Principle 4:** Create a support offer for clinical and care professional leaders at all levels of the system, one which enables them to learn and develop alongside non-clinical leaders
- **Principle 5:** Adopt a transparent approach to identifying and recruiting leaders which promotes equity of opportunity and creates a professionally and demographically diverse talent pipeline that reflects the community served and ensures that appointments are based on ability and skillset to perform the intended function

5. People and Culture

The People and Culture Group used its September meeting to explore what the notion of “One Workforce”, as referenced in the ICS design Framework and People Operating Model, means to us in Derby and Derbyshire. Suggestions for what this might contain included:

- as a patient or service user I want to see the ICS manifest itself as Healthy Derbyshire so wherever I have contact I can seamlessly move between offers with disclosure of my needs and choices knowing that standards are universally high
- our staff are our greatest asset and voice.
- our staff say they work for the Derbyshire health and care system, and say it with pride and passion
- to genuinely see our whole workforce as a system asset to be deployed where they can have the biggest impact on prevention, health inequalities and wider determinants of health.
- common workforce planning, integrated system level approach to developing future workforce, coherent engagement with Schools, Higher Education and Further Education
- joined up recruitment and ease of movement around the system, avoiding inter recruitment and exit within the system as far as possible
- career paths which are organisationally agnostic.
- the teams of people that people see/receive care from reflect diversity in its broadest sense and it feels inclusive

This discussion will continue, with a draft vision for our One Workforce close to agreement.

6. NHS system oversight framework segmentation

NHS England and NHS Improvement (NHSEI) recently consulted on the new NHS System Oversight Framework (SOF) 2021/22, which introduced a new approach to provide focused assistance to organisations and systems. Following feedback from local leaders and others, this new SOF is now being implemented. Following consideration by the NHSEI Midlands

Regional Support Group, it has been agreed that Joined Up Care Derbyshire ICS should be placed into SOF segment 2, with segment 1 meaning systems require no additional regulatory support, segment 4 being systems where significant regulatory support is required. The following NHS providers are rated as follows:

- Chesterfield Royal Hospital – segment 2
- University Hospitals of Derby and Burton - segment 3
- Derbyshire Community Health Services - segment 1
- Derbyshire Healthcare – segment 2

7. Digital and Data Programme

The health and care system in Derbyshire is undergoing a fundamental transformation of service provision. Emphasis is moving from a traditional posture of treating conditions that are already established in the patient to a proactive approach of working to prevent avoidable conditions wherever possible. The current health and care system is typically reactive and characterised by organisation and role boundaries; it must be replaced by a system that is centred on people and communities.

Digital transformation is necessary to support the shift in care from 'illness to wellness provide the tools and technologies required to transform to new models of care delivery and help address some of the challenges faced across the system. As a health, wellbeing and care system we must make many complex and challenging decisions on who, on what and how we best utilise our resources and provide optimal services for our population. The value of effectively utilising data, intelligence and insight, gives us the best chance of making the best possible decisions that are informed, defensible and transparent.

It is important that data and intelligence, converted to knowledge, is available to support decision-making at different levels and for different purposes. To do this effectively, decisions need to be adequately informed. We must enable knowledge-led decision-making, supporting us to deliver the health and care system quadruple aim. Delivery of the aims will also support progress in other domains identified for improvement within JUCD, including reduction of health inequalities and achievement of maximum impact with population health management programmes.

Outlining a series of 'I' statements within the strategy, from the perspective of citizens, practitioners, service planners, strategic leaders and data professionals helps to articulate how the digital approach will deliver the improvements desired across our system.

Overall, our vision arising from the digital strategy is:

- We will use technology and data to facilitate system transformation and empower our citizens to take control of their health and care, reduce inequalities and improve outcomes.
- We will ensure appropriate and accurate data and intelligence is available and accessible to our citizens and their professional care providers, supporting them to make informed, reasonable and transparent decisions in the delivery of joined-up care

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

None as a result of this report.

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 to this report.
Have any Conflicts of Interest been identified/ actions taken?
Not applicable to this report.
Governing Body Assurance Framework
To support the development of a sustainable health and care economy that operates within available resources, achieves statutory financial duties and meets NHS Constitutional standards.
Identification of Key Risks
Not applicable to this report.

Governing Body Meeting in Public

2nd December 2021

Item No: 194

Report Title	Remuneration Committee – Updated Terms of Reference
Author(s)	Suzanne Pickering, Head of Governance
Sponsor (Director)	Helen Dillistone, Executive Director of Corporate Strategy and Delivery

Paper for:	Decision	<input checked="" type="checkbox"/>	Assurance	<input type="checkbox"/>	Discussion	<input type="checkbox"/>	Information	<input type="checkbox"/>
Assurance Report Signed off by Chair					N/A			
Which committee has the subject matter been through?					Remuneration Committee – 26.11.2021 (virtually)			
Recommendations								
The Governing Body is requested to APPROVE the Remuneration Committee Terms of Reference.								
Report Summary								
The Remuneration Committee Terms of Reference has been reviewed to include the additional responsibility of the Committee to oversee the transition of the Committee and its assurance functions to the Integrated Care Board.								
This is in line with the addition made the other corporate Committee Terms of References approved by Governing Body in October 2021.								
The amendments and additions to the Terms of Reference have been agreed virtually by the Remuneration Committee and are highlighted in tracked changes for information.								
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

Remuneration Committee

Terms of Reference

1. PURPOSE

- 1.1 The Remuneration Committee (the “Committee”) is established by NHS Derby and Derbyshire Clinical Commissioning Group (the “CCG”). In accordance with section 14M and 14L(3) of the NHS Act.
- 1.2 Subject to any restrictions set out in the relevant legislation, the Remuneration Committee has the function of making recommendations to the governing body about the exercise of its functions under section 14L(3)(a) and (b), i.e. its functions in relation to:
- determining the remuneration, fees and allowances payable to employees of the CCG and to other persons providing services to it; and
 - determining allowances payable under pension schemes established by the CCG.
- 1.3 The Remuneration Committee is accountable to the Governing Body. The purpose of the Committee is to make recommendations to Governing Body on the appropriate remuneration and terms of service for the Accountable Officer, Directors, other Very Senior Managers, Clinicians and Lay Members. The Committee will have delegated powers to act on behalf of the CCG within the approved Terms of Reference.
- 1.4 The Committee shall adhere to all relevant laws, regulations and policies in all respects including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate executive directors and senior staff whilst remaining cost effective.

2. ROLES AND RESPONSIBILITIES

The Committee will incorporate the following duties:

- 2.1 with regard to the Accountable Officer, Directors and other Very Senior Managers, make recommendations to Governing Body all aspects of salary (including any performance-related elements, bonuses);
- 2.2 make recommendations to Governing Body contractual arrangements for clinicians engaged to support the CCG Governing Body;
- 2.3 make recommendations on provisions for other benefits, including pensions and cars for all staff;
- 2.4 make recommendations for arrangements for termination of employment and other contractual terms for all staff (decisions requiring dismissal shall be referred to the Governing Body);

- 2.5 ensure that officers are fairly rewarded for their individual contribution to the organisation – having proper regard to the organisation’s circumstances and performance and to the provisions of any national arrangements for such staff;
- 2.6 ensure proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate, advising on and overseeing appropriate contractual arrangements for such staff. This will apply to all CCG staff;
- 2.7 ensure proper calculation and scrutiny of any special payments.

2.8 The Committee will oversee the transition of the committee and its assurance functions to the Integrated Care Board.

3. CHAIR ARRANGEMENTS

The Committee will be chaired by a Lay Member other than the Audit Chair, and only Lay Members of the Governing Body shall be members of the Committee. It is recommended that the Committee shall be chaired by the Lay Member for Patient and Public Involvement and Lay Vice Chair of Governing Body.

4. MEMBERSHIP

- 4.1 Members of the Committee must be appointed from the CCG Governing Body.
- 4.2 To maintain the independence of members, the committee will comprise of four Lay members:
 - Lay Member Patient and Public Involvement (Lay Vice Chair of GB and Chair of Remuneration Committee);
 - Lay Member Audit;
 - Lay Member Finance; and
 - Lay Member Governance.
- 4.3 Only members of the Committee have the right to attend meetings, however, individuals such as the Accountable Officer, Chief Finance Officer, Clinical Governing Body Chair, HR Advisor and external advisors may be invited to attend for all or part of a meeting as and when appropriate but shall not have voting rights. No member or attendee shall be party to discussions about their own remuneration or terms of service.

5. DECLARATIONS OF INTEREST, CONFLICTS AND POTENTIAL CONFLICTS

- 5.1 The provisions of Managing Conflicts of Interest: Statutory Guidance for CCGs¹ or any successor document will apply at all times.
- 5.2 Where a member of the committee is aware of an interest, conflict or potential conflict of interest in relation to the scheduled or likely business of the meeting, they will bring

¹ <https://www.england.nhs.uk/wp-content/uploads/2017/06/revised-ccg-conflict-of-interest-guidance-v7.pdf>

this to the attention of the Chair of the meeting as soon as possible, and before the meeting where possible.

- 5.3 The Chair of the meeting will determine how this should be managed and inform the member of their decision. The Chair may require the individual to withdraw from the meeting or part of it. Where the Chair is aware that they themselves have such an interest, conflict or potential conflict of interests they will bring it to the attention of the Committee, and the Deputy Chair will act as Chair for the relevant part of the meeting.
- 5.4 Any declarations of interests, conflicts and potential conflicts, and arrangements to manage those agreed in any meeting of the Committee, will be recorded in the minutes.
- 5.5 Failure to disclose an interest, whether intentional or otherwise, will be treated in line with the Managing Conflicts of Interest: Revised Statutory Guidance and may result in suspension from the Committee.
- 5.6 All members of the Committee shall comply with, and are bound by, the requirements in the CCG's Constitution, Standards of Business Conduct and Managing Conflicts of Interest Policy, the Standards of Business Conduct for NHS staff (where applicable) and NHS Code of Conduct.
- 5.7 In order to avoid any conflict in respect of the Lay Members who constitute the majority of the membership of the Remuneration Committee, their own remuneration and terms of service shall be set directly by the Governing Body.

6. QUORACY

- 6.1 The quorum necessary for the transaction of business shall be two Lay Members.
- 6.2 A duly convened meeting of the Committee at which quorum is present at the meeting, are contactable by telephone conference call or by other virtual medium, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

7. DECISION MAKING AND VOTING

- 7.1 The Committee will use its best endeavours to make decisions by consensus. Exceptionally, where this is not possible the Chair (or Deputy) may call a vote.
- 7.2 Only members of the Committee set out in section 4 have voting rights. Each voting member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.
- 7.3 If a decision is needed which cannot wait for the next scheduled meeting or it is not considered necessary to call a full meeting, the Committee may choose to convene a telephone conference or conduct its business on a 'virtual' basis through the use of email communication or other virtual medium. Minutes will be recorded for telephone conference and virtual meetings in accordance with relevant sections of the Derby and Derbyshire CCG Governance Handbook.

8. ACCOUNTABILITY

For the avoidance of doubt, in the event of any conflict the Standing Orders, the Standing Financial Instructions and the Scheme of Reservation and Delegation of the CCG will prevail over these Terms of Reference.

8.1 Review Role

8.1.1 The Committee may investigate, monitor and review activity within its terms of reference. It is authorised to seek any information it requires from any committee, group, clinician or employee (including interim and temporary members of staff), contractor, sub-contractor or agent, who are directed to co-operate with any request made by it.

8.1.2 The Committee will apply best practice in the decision making process. For example, when considering individual remuneration the Committee will:

- comply with current disclosure requirements for remuneration;
- on occasion, and where appropriate, seek independent advice about remuneration for individuals; and
- ensure that decisions are based on clear and transparent criteria and be able to withstand public scrutiny and audit.

8.1.3 The Committee will have authority to commission reports or surveys it deems necessary to help fulfil its obligations.

9. REPORTING ARRANGEMENTS

The Committee will provide an appropriate form of report of the meeting to the CCG Governing Body following each meeting, confirming all recommendations of decisions made.

10. FREQUENCY AND NOTICE OF MEETINGS

Meetings will be held at least four times a year and when required and may be called at any other such time as the Committee Chair may require.

11. ADMINISTRATIVE SUPPORT

The Governing Body Executive Assistant shall be secretary to the Committee and shall attend to provide appropriate support to the Chair and Remuneration Committee members. The secretary will be responsible for supporting the Chair in the management of the Committee's business and for drawing the Remuneration Committee's attention to best practice, national guidance and other relevant documents, as appropriate. The secretary will either take minutes or make arrangements for minutes to be taken.

12. REVIEW OF TERMS OF REFERENCE

These terms of reference and the effectiveness of the Committee will be reviewed at least annually or sooner if required. The Committee will recommend any changes to the terms of reference to the Governing Body and will be approved by the Governing Body.

Reviewed by Remuneration Committee: 26th November 2021

Approved by Governing Body: 2nd December 2021

Review Date: Close of CCG on 31st March 2022

Governing Body Meeting in Public

2nd December 2021

		Item No: 195
Report Title	Closedown of CCG Governing Body and Committees and transition to shadow ICB arrangements	
Author(s)	Chrissy Tucker, Director of Corporate Delivery	
Sponsor (Director)	Helen Dillistone, Executive Director of Corporate Strategy and 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 DISCUSS the proposal for the closure of the CCG Governing Body and its Committees and arrangements for transition to the shadow ICB, as discussed in the in accompanying slides.					
Report Summary					
<p>As part of the formal and legal closure of the CCG, there are some technical aspects which must be completed and submitted to NHSEI for assurance. The CCG has been provided with guidance and a template to undertake a due diligence process which will achieve this. However, the template does not take into account either the sharing of the learning gained over the years since the CCG's inception, nor the practical aspects of any matters in progress that will need to transfer, for example outstanding items on the action log and ongoing risks.</p> <p>The attached slides propose a process for this broader handover which the Governing Body is requested to discuss.</p>					
Are there any Resource Implications (including Financial, Staffing etc)?					
None identified.					
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
This report supports all of the CCG's objectives.
Identification of Key Risks
This report references risk management.

Proposed handover process CCG GB to ICB

Context

- Technical requirements are in place via the Due Diligence checklist – to go to Feb 2022 Audit Committee. These cover the statutory elements of transition.
- The CCG Governing Body and its committees have work in progress that will need to be handed over to the ICB for completion.
- The CCG has matured over the years since its inception, including its role as part of the wider Derbyshire system, and has valuable learning and experience to share with the ICB.
- Create an opportunity for the CCG and shadow ICB to work more formally together during the latter stages of transition.

These slides describe a potential process to share learning.

Proposal for joint working and shared learning

- A formal meeting in common of the CCG GB and Shadow ICB to be established in January, February and March.
- In addition, joint development sessions to be established in January, February and March with GB and new ICB members to discuss and agree content of formal handover and to enable a number of themed development discussions.

Development Sessions could include:

- Learning and reflections from the GB from the perspective of each of the categories of membership (Chair, LMs, GPs, CEO, Other Executives, Secondary Care Clinicians, and DPHs)
 - Review of successes and areas that could have been improved
 - Understanding health need challenges
 - Status of the current commissions and performance
 - Quality and safety
 - Financial position
 - Other live matters and risks to transfer to the opening ICB
 - Process and plan for committee closure
- Other topics/themes that could be covered?

Proposal for committees

- Existing system Committees (Finance, Quality and Performance, People and Culture) will need to report for assurance purposes and it is proposed this could be at the January GB, pending establishment of Shadow ICB.
- Each CCG and system committee to prepare a joint report from its clinical lead, executive lead and lay member(s) as part of the formal handover to the ICB.
- Report should include successes and learning points along with previous self-assessments or audit reports completed, open risks, actions and agenda items for follow-up between closing CCG committee and opening shadow ICB committee.
- First ICB Board meeting, and relevant ICB committee meetings to formally receive and note content in April.

Next Steps

- If accepted, the Corporate team will develop a schedule and timetable of key “asks” of each of the CCG and system committees for close down and transfer.
- The Corporate team will work with the CCG Chair and CEO, and ICB Chair and CEO to develop a schedule of joint meetings in quarter 4

Governing Body Meeting in Public

2nd December 2021

	Item No: 196
Report Title	2021/22 H2 Operational Planning Update
Author(s)	Helen Wilson, Deputy Director of Contracting and Performance
Sponsor (Director)	Zara Jones, Executive Director of Commissioning Operations

Paper for:	Decision	Assurance	x	Discussion	Information	x
Assurance Report Signed off by Chair			N/A			
Which committee has the subject matter been through?			JUCD Planning and Co-ordination Cell, JUCD SLT, JUCD Board			
Recommendations						
The Governing Body is requested to NOTE the summary content of the H2 plan submission which was submitted to NHSEI on 18 th November as required.						
Report Summary						
<p>The recently published NHS England <i>2021/22 Priorities and Operational Planning</i> document describes a set of specific asks relating to NHS provision – set across 3 main themes:</p> <ul style="list-style-type: none"> • Supporting the health and wellbeing of staff and taking action on recruitment and retention • Restoring full operation of cancer services • Restoring and increasing access to primary care services • Transforming community services and improving discharge <p>In addition, there are also expectations in relation to a number of cross-sectional themes, but these were covered in the earlier submission in H1 are therefore not included in this plan:</p> <ul style="list-style-type: none"> • Promoting the health and wellbeing of our staff • Maintaining focus on reducing health inequalities • Working collaboratively across systems to deliver on these priorities <p>This JUCD plan submission covers all the areas required and meets the targets required by NHSEI with the exception of targets for elective care recovery which are not seen as resolvable over the winter period due to the continuing constraints of the COVID pandemic and the restoration of demand to higher than pre-COVID levels in many areas.</p>						

Details of the specific targets required by NHSEI are included in the paper with a summary narrative on the JUCD submission against them.
Are there any Resource Implications (including Financial, Staffing etc)?
A full JUCD workforce plan has been submitted and a financial plan has been submitted both for the system and for the individual providers.
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 identified
Governing Body Assurance Framework
Strategic Risk 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. 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

2021/22 H2 Plan NHSEI Submission

Submission Summary – CCG Governing Body
2/12/21



Key Messages

- A realistic yet challenging plan which focuses on achieving maximum elective recovery but reflects the continuing constraints the system will face over the winter period.
- Good levels of compliance across many areas with the NHSE expectation, however there are clear risks and variables for which robust Quality Monitoring processes are in place.
- This is a 'live' plan and the reality of its described challenges are already being lived now.
- Our elective and cancer position is most challenging and is dependent on the management of urgent care activity and potential impact on elective bed capacity.
- We will utilise our developing system architecture (Delivery Board's, SODB, SORG, Planning Group etc) to continue the work set out here following our submission to NHSE last month.

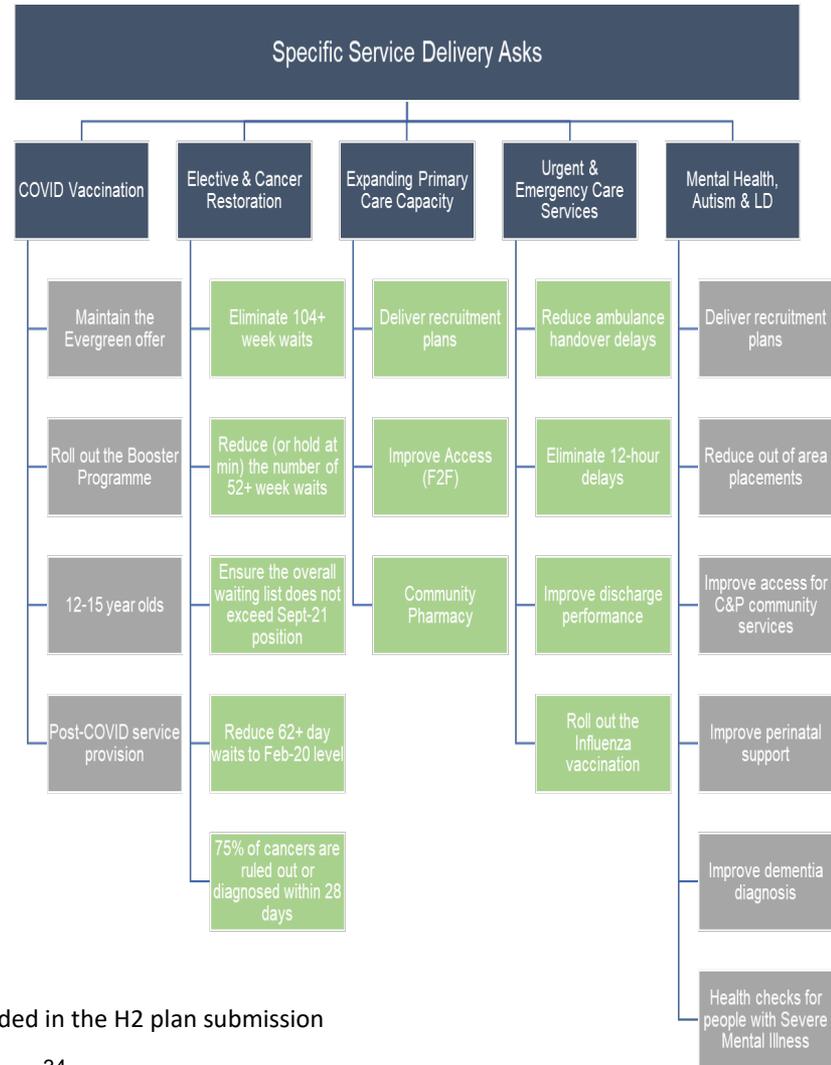


H2 Plan Inclusion Overview

The recently published NHS England *2021/22 Priorities and Operational Planning* document describes a set of specific asks relating to NHS provision – set across the 5 themes shown in the diagram.

In addition, there are also expectations in relation to a number of cross-sectional themes but these were covered in the earlier submission in H1 are therefore not included in this plan:

- Promoting the health and wellbeing of our staff;
- Maintaining focus on reducing health inequalities; and
- Working collaboratively across systems to deliver on these priorities.



Included in the H2 plan submission
 Covered in other plan submissions

H2 Overarching Priorities

Planning guidance was released for H2 by NHSE on Thursday 29th September. The following items are highlighted in the 21/22 Priorities and Operational Planning Guidance Oct21-Mar22 document as the priority for H2 and a brief summary of the JUCD plan is included below.

Health Inequalities - the 5 priority areas are the same, there will be more information coming on how Health Inequality data will be provided across systems. All NHS Board performance reports are now required to include reporting by deprivation and ethnicity.

JUCD position – Work has begun on a system strategy for tackling Health Inequalities which will include work on developing reports for system governance and development.

Staff health and wellbeing – as before with focus on delivery of workforce plans that support elective recovery and winter resilience; continue to move to whole system workforce planning. Full narrative required.

JUCD position – H1 plan achieved in substantive staff although not in bank/agency. Good progress made towards whole system workforce planning, workforce in place to support priorities. Risk areas MHNs and Psychiatrists and some Primary Care staff. Work is underway to mitigate those risks.

Deliver COVID vaccine programme and meet needs of patients – boosters - PCNS prioritising older adult care home residents and care home staff, co-administer covid and flu where expedient, evergreen offer for the unvaccinated, 12-15 year olds. Data to be gathered on long COVID waits.

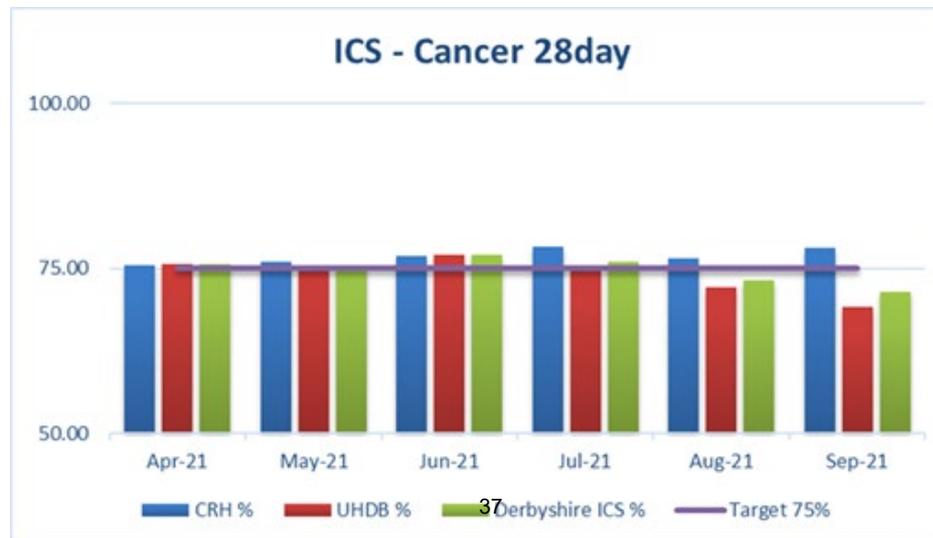
JUCD position – plans in place to meet requirements, achievement to date ahead of average. No requirement to submit narrative or metrics as part of H2 plan.

H2 Focus – Elective

Planning Priority	JUCD position
Eliminate 104 week waits (except P5/6)	<ul style="list-style-type: none"> UHDB long waiters in Bariatrics and Complex Orthopaedics are not seen as resolvable over the winter with predicted 117 104+ week waits still on list by end March 2022. Significant work has achieved a reduction in waiters and further possibilities for support are being explored.
Hold the 52+ week wait number at September 2021 position	<ul style="list-style-type: none"> UHDB forecast an increase in long-waiters of 25% against the September position following H1 improvement of position.
Stabilise waiting lists at Sept 21 level	<ul style="list-style-type: none"> CRH forecast a 2.6% reduction but UHDB are forecasting a 13% increase in waiting list size due to continued capacity challenges and increasing referrals over the winter period
Optimise referrals, deliver 12% Advice & Guidance or equivalent, improvement evidenced via the Elective Recovery dashboard	<ul style="list-style-type: none"> CRH at 32% (due to inclusion of RAS), UHDB at 8.8%, system figure 14.7% so target is forecast to be achieved.
Ensure Patient-Initiated-Follow-Up (PIFU) is in place for 5 specialties, 1.5% OP to PIFU by Dec 21 and 2% by March 22	<ul style="list-style-type: none"> PIFU as proportion of all OPA does not achieve target levels at CRH (1.4 Dec, 1.6 Mar) but overachieves at UHDB (4.1 Dec 4.4 Mar). Therefore system figures achieve target.
Remote outpatient attendances to be at least 25% of total	<ul style="list-style-type: none"> Current submission virtually compliant at 25.1% for CRH and 24.6% for UHDB. However, there is no growth planned during the year.

H2 Focus - Cancer

Planning Priority	JUCD position
>62 day waits restored to Feb 2020 levels	The system is forecasting a significant reduction on the current waiting list but the figure is expected to remain at 365 at end March, against a target figure of 226. This is due to increased referrals as cancer activity exceeds pre-pandemic levels in many specialties. However, both Trusts have achieved the H1 trajectory for recovery of cancer services, achieving full recovery of cancer service delivery.
Meet the Faster Diagnosis Standard from Q3	The system has met the target since April 21 with the exception of August and September when operational pressures resulted in UHDB dipping below the target for the first time. The system are however forecasting full achievement in Q3.



H2 Focus – Primary Care

Planning Priority	JUCD position
Restoration of appointment levels to pre-COVID levels.	<ul style="list-style-type: none"> Appointment levels in August 2021 restored to 3% above August 2019
Recruitment of additional FTE by 21/22	<ul style="list-style-type: none"> Full workforce plans submitted to NHSE confirming recruitment plan Plans to recruit temporary staff support to maintain winter capacity Risks around deliverability and ‘amber’ in relation to PCNs.
Systems support practices with access challenges	<ul style="list-style-type: none"> Working with practices and patients to agree how best to improve access Have submitted a plan to NHSE setting out how system will improve PCN level access sourcing additional capacity from other providers. Awaiting feedback. Some risks around locum recruitment.
Systems to support practices with continued use of remote technologies	<ul style="list-style-type: none"> A proportion of remote appointments will continue to be offered to meet the needs of patients. Where remote appointments are not suitable, face-to-face appointments will continue to be provided Telephony improvements are under consideration to support these patients to access practices more easily.
Scale up referrals to community pharmacy under the CPCS and from hospitals into DMS	<ul style="list-style-type: none"> 16 practices are fully implemented and live. More work to do across all 112 practices. Communication is going out to encourage stage 1 and 2 practices to complete the process and go live in December.

H2 Focus – Urgent Care

Planning Priority	JUCD position
Ensure Hospital Discharge and Community Support policy and operating model are fully implemented, reducing length of stay (particularly over 21 days)	<ul style="list-style-type: none"> Discharge to Assess embedded but further work required with system partners on full policy implementation Additional step down beds commissioned Provider actions in place to support reduced LoS but risks remain
2-hr community crisis response teams providing consistent national cover (8-8, 7/7) by April 2022	<ul style="list-style-type: none"> Funding secured to support capacity expansion but capacity not yet fully in place Work begun to implement acute home visiting at scale support
Reduce number and duration of ambulance to hospital handover delays within system	<ul style="list-style-type: none"> Full acute trust plans in place but ambulance handover delays still occurring currently A&E DB focus and governance
Eliminate 12-hr waits in EDs	<ul style="list-style-type: none"> Delay focus at both Trusts with use of Chaser and Shift Leader New escalation and rota processes and focus on discharge support Impact of plans not yet complete
Consistently submit ECDS 7 days a week by end of Q3	<ul style="list-style-type: none"> Both Acute Trusts compliant with current dataset and working towards meeting new dataset required from Q4
Achieve the flu vaccine uptake standards in national flu letter	<ul style="list-style-type: none"> Target set to exceed last year's high delivery, on track with strong support in place despite vaccine shortages

Timeline we worked to for Submission Requirements

Date	Requirement
29 September	Planning guidance published
14 October 12pm	Submit Elective/Winter Capacity and TIF
20 October	Virtual approval of plan and narrative by PCDB
21 October 12pm	Submit Elective/Winter narrative
29 October 12pm	TIF proposals > £5m Submission Deadline
11 th November	Planning & Co-ordination Group Review
12 th November	JUCD SLT approval to submit to JUCD Board
15 th November	JUCD Board final approval - virtual
18 November 12pm	Final numeric and narrative submission incl activity, performance and workforce Final finance submission – system <i>NB date amended on 11/11 to allow inclusion of TIF bid info.</i>
25 November 12pm	Final finance submission - provider

Recommendations

- Governing Body are asked to note the content of the plan submission and the governance detailed below.
- JUCD Board approved the submission of the plan to NHSEI on 18th November.

JUCD Senior Leadership Team have agreed to:

1. Support the work of the System Oversight and Delivery Board (SODB) to co-ordinate through Delivery Boards, the system performance improvement and delivery of the H2 plan.
2. Receive further updates in December and January to support the above work.
3. Note SODB oversight of delivery of the plan and agreed reporting mechanisms to provide support to delivery with Delivery Boards and workstreams on an ongoing basis.



Governing Body Meeting in Public

2nd December 2021

Item No: 197

Report Title	Finance Report – Month 7
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 – 25.11.2021		
Recommendations					
The Governing Body is requested to NOTE the following:					
<ul style="list-style-type: none"> • 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 half 1 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 £0.702m for April to September. 					
Report Summary					
The report describes the month 6 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 7, October 2021

Statutory Duty/ Performance	Target	Result	Achieved	Key	Comments/Trends
Forecast outturn achievement of expenditure to plan	H1 - £1,038.412m	H1 - £1,038.405m		Green <1%, Amber 1-5% Red >5%	The Covid forecast for H2 is £8.769m which will be retrospectively funded leading to a current forecasted favourable variance of £9.34m.
	H2 - £1,035.448m	H2 - £1,034.883m			
	Total - £2,073.860m	Total - £2,073.288m			
Remain within the Delegated Primary Care Co-Commissioning Allocation	H1 - £ 78.693m	H1 - £ 78.221m		Green <1%, Amber 1-5% Red >5%	The £0.604m overspend is due to offsetting income for expenditure relating to The Impact and Investment Fund and Additional Roles Reimbursement Scheme expected to be received in future allocations.
	H2 - £ 78.166m	H2 - £ 79.242m			
	Total - £156.859m	Total - £157.463m			
Remain within the Running Cost Allowance	H1 - £ 9.739m	H1 - £ 8.781m		Green <1%, Amber 1-5% Red >5%	Running costs are £1.43m underspent against plan. This is attributable to a combination of staff vacancies and the Finance Reserve.
	H2 - £ 9.112m	H2 - £ 8.644m			
	Total - £18.851m	Total - £17.425m			
Remain within cash limit	Greatest of 1.25% of drawdown or £0.25m	0.77%		Green <1.25%, Amber 1.25-5% Red >5%	Closing cash balance of £1.330m against drawdown of £172.0m
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

H1 finalised at £1,038.405m expenditure against £1,035.624m budget with an additional expected reimbursement of £2.801m Covid and offset of £0.676m Non NHS backpay funding resulting in £0.696m surplus.

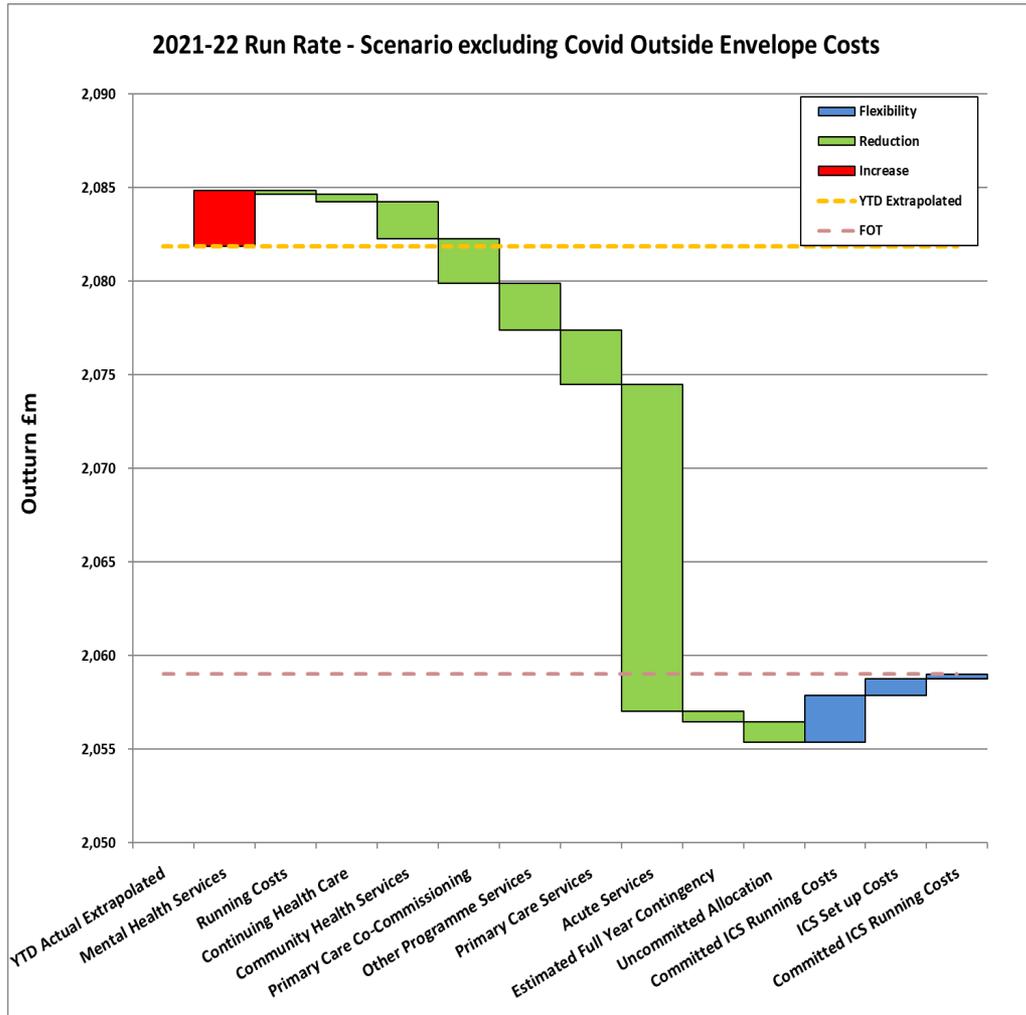
During H1 allocations of £2.789m were received relating to H2 which have been added to the H1 target, however a full year forecast outturn was not recorded in H1 leaving an increased budget against the previously reported YTD H1 expenditure.

Comparison of Month 6 and Month 7 Actual Expenditure

- 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.
- The impact of the backdated pay award relating to H1 and paid in month 7 has been removed to normalise the comparison.
- Continuing Health Care includes £0.625m expenditure for the Hospital Discharge Programme, allocations covering this are anticipated to be received in month 10.
- There has been a reduction in expenditure from month 6 to month 7 where the majority of changes sits in allocations to be distributed and risk contingency where the H1 balance has been accrued to carry forward into H2.

	Month 6 Actual	Month 7 Actual	H1 NHS Pay Award Paid in Month 7	Month 7 Pay Award Removed	Movement from Month 6 to Month 7
	£'000's	£'000's	£'000's	£'000's	£'000's
Acute Services	90,956	95,601	7,213	88,388	(2,568)
Mental Health Services	20,522	22,336	1,139	21,197	674
Community Health Services	14,483	14,323	1,284	13,039	(1,444)
Continuing Health Care	10,689	8,809	-	8,809	(1,880)
Primary Care Services	19,945	17,879	-	17,879	(2,066)
Primary Care Co-Commissioning	12,711	15,024	-	15,024	2,313
Other Programme Services	9,852	6,831	-	6,831	(3,021)
Total Programme Resources	179,157	180,801	9,636	171,165	(7,993)
Allocations	1,559	-	-	0	(1,559)
In-Year 0.5% Risk Contingency	3,920	-	-	0	(3,920)
Running Costs	1,779	1,348	7	1,340	(438)
Total	186,415	182,148	9,643	172,505	(13,910)

Annual Run Rate



£22.9m reduction between the position to date continuing at its current rate and the forecast outturn for the full financial year, excluding Covid outside envelope costs.

- **Mental Health Services** – An additional £4.5m forecast for MHIS which is not currently in the year to date expenditure.
- **Running Costs** – Vacancies expected to be filled reducing underspends on pay costs.
- **Continuing Health Care** – Reduced costs expected based on phasing of caseloads across the year.
- **Community Health Services** – The H2 Ophthalmology expenditure has been transferred to Acute Services but remains in H1 costs.
- **PC Co-Commissioning** – Additional Roles Reimbursement Scheme payments expected to be incurred later in the year. Offsetting this additional expected costs in H2 for additional DES services.
- **Other Programme Services** – NHS 111 and SDF allocations for Maternity and Diabetes received in H1.
- **Primary Care Services** – Prescribing trends decrease and Cat M Q3 cost reduction. Enhanced Services with a different spending profile in H2. Covid costs incurred in H1 not expected to continue in H2.
- **Acute Services** – £8.5m of provider ERF not expected to continue and £12.5m lower costs System top up payments in H2. Partly offset by inflation payments and £9.2m of H2 SDF of which only 1 month is included in the YTD actuals.
- **Estimated Full Year Contingency** – Balance of H1 contingency funding plus H2 estimated amount.
- **Uncommitted Allocations** – Allocations received still awaiting distribution to areas.
- **ICS Running Costs and ICS Set up Costs** – One off expected expenditure.

H2 Allocations and Forecast

CCG Allocation Total for H2	£'m
Programme Allocation	796.2
Top up	57.7
Covid	56.8
Growth	13.5
Running Costs Allocation	9.9
PCCC Allocation	78.2
	<u>1,012</u>

SDF Allocations	
Mental Health	6.4
Other Allocations	20.4
Less SDF received in H1 for H2 planning	(2.5)

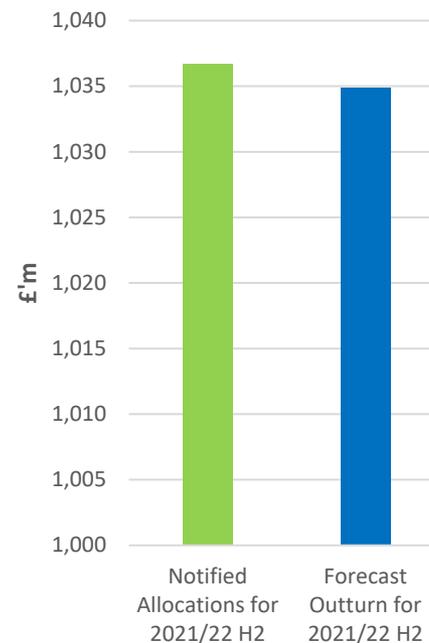
Total Allocations Including SDF	1,036.7
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Forecast Outturn for 2021/22 H2	£'m
Acute Services	532.8
Mental Health Services	123.4
Community Health Services	79.1
Continuing Health Care	60.7
Primary Care Services	104.3
Primary Care Co-Commissioning	79.2
Other Programme Services	46.7
Running Costs	8.6
Total	1,034.9

The advised allocations for planning differ from the allocations received due to the following

	£'m
M7 allocations	1,035.4
Additional Allocations not in Planning	(0.8)
Q2 Covid Reimbursement HDP and Vaccine	(2.8)
H2 Indicative Allocations	4.8
H2 planning allocations	1,036.7

H2 Allocations and Forecast Outturn



Governing Body Meeting in Public

2nd December 2021

Item No: 199

Report Title	Audit Committee Assurance Report – November 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 – 18.11.2021		

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 18th November 2021 meeting of the Audit Committee. This report provides a brief summary of the items transacted for assurance.

External Audit

Health Sector Technical Update: November 2021

The Audit Committee RECEIVED and NOTED the KPMG External Audit Health Sector Technical Update for November 2021. The report highlighted the main risks facing the Health Sector in 2021/22.

The Committee discussed the Better Care Fund planning requirements for 2021/22, which was submitted by the CCG on 16th November. It was agreed that the CCG's Finance Committee would hold a deep-dive on this area to discuss the governance route and expenditure accountability.

Internal Audit

360 Assurance Progress Report

The Committee discussed the impact the Covid-19 pandemic is having on the CCG's delivery of the support it provides to the primary care sector in Derbyshire, and that guidance continues to be issued by NHSE in respect of the new structure of the ICB. Both of these issues are impacting on delivery of the Internal Audit Plan and have been the subject of ongoing discussions with CCG management. Audit Committee NOTED the following affected audits in the original Internal Audit Plan and APPROVED the proposed treatment:

- Primary Care Networks Review – audit to be removed from the Plan and the time is to be used to partly fund a vaccination team secondment

- Investments/Disinvestments – allocation to be used to undertake an assurance review of the CCG’s compliance with the adjustments made to its financial decision-making arrangements
- Data Quality & Performance Management Framework – allocation to be used to undertake a review of waiting list coding which is currently being explored
- ICS Transition Programme Assurance – 360 Assurance will be involved in the Project Board being set up with SBS to create a new ledger using data from the legacy ledgers by the go-live data of 1st April 2022, and carry out a controlled closure of the legacy CCG ledger

Primary Medical Care Services – Finance Final Internal Audit Report

The Committee NOTED the outcome of 'full assurance' for the Primary Medical Care Services – Finance Final Internal Audit Report. Appropriate arrangements are in place within the Primary Care Contracts Team reflecting that many of the duties previously undertaken by NHSE through the General Medical Advisory Support Team have now transitioned to the CCG. No audit recommendations were made.

Finance

Finance Report

The Committee NOTED and GAINED ASSURANCE from the verbal update of the Finance Report.

IFRS16 Report

The Committee NOTED the contents of the IFRS16 Report for assurance over the procedures in place to ensure the CCG's readiness for the deferred implementation of IFRS 16 on 1st April 2022.

Aged Debt Report

The Audit Committee NOTED the report contents regarding the level of debt owed to the CCG and the number of days this has been outstanding.

Single Tender Waivers

The Committee NOTED the Single Tender Waivers approved by the Chief Finance Officer from September to November 2021.

Governance

Freedom to Speak Up Report

The Audit Committee NOTED the update provided following the recruitment of CCG Freedom to Speak Up Ambassadors within the CCG.

National Audit Office Guide on Climate Change Risk Assessment

The Committee NOTED the National Audit Office Good Practice Guide and completed risk assessment checklist for assurance. Risks will be transposed onto the CCG and system risk registers, which will be reported to Governing Body.

Updated National Audit Office Guide on Cyber Security – October 2021

The Audit Committee NOTED the National Audit Office Good Practice Guide for Cyber and Information Security, with a completed risk assessment checklist for

assurance. The Committee highlighted the need at year-end for a Service Auditor Report from North East Commissioning Support Unit for 2021/22.

Governing Body Assurance Framework 2021/22 Quarter 2

The Committee NOTED and GAINED ASSURANCE of the Quarter 2 Governing Body Assurance Framework (GBAF). The Quarter 3 GBAF is currently under review and will be reported to Governing Body in January.

Risk Register

The Audit Committee RECEIVED and NOTED the CCG Risk Register Report for risks during October 2021.

Committee Meeting Business Log

The Audit Committee NOTED the CCG's Committee Meeting Log for information.

Conflicts of Interest Report

Audit Committee NOTED the Conflicts of Interest Update Report for assurance and RECEIVED the following:

- Conflicts of Interest Forward Planner 2021/22
- Decision Makers' Register of Interests
- Governing Body & Committee Members' Register of Interests
- Confidential Register of Interests – no further updates since last meeting
- Summary Register for Recording Any Interests During Meetings
- Gifts & Hospitality Register
- Procurement Register
- Breach Register – no further updates since last meeting

Forward Plan

The Audit Committee RECEIVED and AGREED the relevant changes to the forward planner.

Any Other Business

The Committee will be holding an extraordinary meeting on 17th December to receive the draft Due Diligence Report and Materials ahead of the CCG submitting it to NHSE/I.

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.

Governing Body Meeting in Public

2nd December 2021

Item No: 200

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 – 11.11.2021			

Recommendations

The Governing Body is requested to **RATIFY** the decisions made by the Clinical and Lay Commissioning Committee (CLCC) on the 11th November 2021.

Report Summary

CLC/2122/131 Approval to initiate procurement – Learning Disability & Autism VCSE sector 'lead organisation'

CLCC were asked to:

- Endorse a new, 'proof of concept' approach to enabling the Voluntary, Community & Social Enterprise (VCSE) sector organisations which provide support for children &/or adults with a learning disability and / or autism spectrum condition (people with LD&ASC) and their families).
- Approve for the Clinical Commissioning Group (CCG) to initiate procurement of a 'Lead Organisation' to, in collaboration with partners across Joined Up Care Derbyshire (JUCD), oversee this new 'proof of concept' approach. This Lead Organisation will:
 - Embed co-design, co-production and partnership working in addressing the gaps in community-based, preventative care and support for people with LD&ASC and their families.
 - Commission high quality VCSE sector services for people with LD&ASC through a blended approach of sub-contracting and grants.
 - Provide assurance to JUCD that health and wellbeing outcomes are being delivered and that value for money is being achieved.

- The initial investment through the Lead Organisation, with confirmation of availability from CCG Finance, will total £121,000 of non-recurrent funding during the 2021/22 financial year – £50,000 for infrastructure and implementation and £71,000 focused funding to support innovations in ASC post-diagnostic support through the VCSE sector.

CLCC were also asked to agree to receive an update report, including an initial evaluation and recommend next steps, eight months from implementation.

A query was raised in relation to the possibility of increased demand with the higher functioning autistic patients where there was unmet demand. It was explained that one of the benefits of putting the design element into the hands of those who deliver the support and see people on a day-to-day basis ensures that the support is going to those that need it.

Following a question around inequity the Committee were assured regarding the overall plan to cover the whole of Derbyshire.

CLCC unanimously SUPPORTED this proposal.

The following papers were circulated to the Committee for their virtual approval

CLC/2122/139 Clinical Policies

CLCC RATIFIED the following updated Clinical Policies:

- Policy for Lycra body suits for postural management of cerebral palsy and other musculoskeletal/neurological conditions Policy
- Policy for Cataract Surgery

Areas of 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 September 2021.

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

Implications of NICE Guideline 202 – Obstructive Sleep Apnoea/hypopnoea syndrome and obesity hypoventilation syndrome in over 16s

- CLCC NOTED the publication of [NICE Guideline 202](#) - Obstructive sleep and that CPAG is assured that the Derby and Derbyshire CCG policies are current and applicable.

Removal of Interim IFR policy and TOR following the closure of Risk 36 by CLCC

- CLCC NOTED the closure of Risk 36 by CLCC the Interim IFR policy and Terms of Reference will be removed from the Clinical Policies Website.

CLCC NOTED the CPAG Bulletin for September 2021.

CLC/2122/140 GBAF Risk 3

CLCC were asked to **REVIEW** for October the Quarter 3 (July to September) Governing Body Assurance Framework Strategic Risk 3 owned by the Clinical and Lay Commissioning Committee.

CLCC VIRTUALLY RECEIVED and NOTED GBAF 3. No changes were made.

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

Governing Body Meeting in Public

2nd December 2021

Item No: 201

Report Title	Derbyshire Engagement Committee Assurance Report – November 2021
Author(s)	Sean Thornton, Deputy Director Communications and Engagement
Sponsor (Director)	Martin Whittle, Vice Chair/Lay Member for PPI

Paper for:	Decision	Assurance	X	Discussion	Information
Assurance Report Signed off by Chair		Martin Whittle, Vice Chair/Lay Member for PPI			
Which committee has the subject matter been through?		Engagement Committee			

Recommendations

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

Report Summary

This report provides the Governing Body with highlights from the meeting of the Engagement Committee, held on 16th November 2021. This report provides a summary of the items transacted for assurance.

Older People's Mental Health Consultation

The Committee had received previous updates relating to the likely consultation on the relocation of older adult mental health wards from London Road Community Hospital to Kingsway in Derby. This proposal remains; however, the consultation has now been expanded to include a similar transfer of services in north Derbyshire, from Pleasley Ward on the Chesterfield Royal Hospital-based Hartington Unit to Walton Hospital.

The consultation would seek views on the proposals, which would enable services to align with national guidance that indicates that adults and older adults should no longer be supported through shared facilities, as well as be provided in more modern accommodation. The Committee reviewed the draft consultation document, providing feedback, and took assurance in the plan for consultation, which will run for two months from 1st December 2021 to 1st February 2022.

Potential Health Development in Sinfin

The Committee received a verbal update on the latest engagement planning for the proposed new community health facility in Sinfin. Previous updates had highlighted that a range of partners were working in collaboration to develop a new facility in the area, which would take account of the growing population and need for larger

premises. A detailed engagement plan is in place, with the project now awaiting confirmation of the potential availability of earmarked sites prior to progressing further.

Florence Nightingale (formerly London Road) Community Hospital Reconfiguration

The Committee was provided with a verbal update on the engagement work planned with citizens in Derby and surrounding areas as the health and care system seeks to make permanent the temporary changes to bedded care in Derby, with the associated provision of new community pathways for rehabilitation and dementia support. Work continues on the collection of detailed information about the proposals, and this will inform an engagement programme to take place in 2022.

Newholme Hospital – Service Move

Since the end of the Better Care Close to Home consultation progress has been made around the change to services and the situation with services at Newholme have been considered. We continue to actively work with our partner organisations to secure alternative long-term accommodation for the teams and services currently located at Bakewell's Newholme Hospital. It is proposed that there is a change in location for some mental health services from Newholme Hospital to Deepdale Business Park. Services affected include:

- North Dales Community Mental Health Team for Adults of Working Age and Older People – where Deepdale will be used as a satellite base and for outpatient appointments and nurse consultation.
- IAPT (Improving Access to Psychological Therapies) will also have use of consulting rooms and office space at Deepdale.

There are currently 293 patients (at any time) who use the services that are relocating to Deepdale. Deepdale will become the office base for other clinical teams, but they will not provide any patient facing/clinical services from the new location. This includes the High Peak and North Dales Dementia Rapid Response Team and Inreach and Home Treatment Team.

The new facilities at Deepdale are the same distance from the centre of Bakewell as Newholme Hospital, roughly a 2-minute drive or 5 minute journey by bus, with more buses to Deepdale from the centre of Bakewell than to Newholme, and more parking is available on the Deepdale site.

The Committee agreed that a programme of direct engagement with affected patients was appropriate, with a letter being issued directly to all those affected by the move in services. In addition, all local Patient Participation Groups and GP Practice Managers whose patients use the services that are proposed to move to Deepdale Business Park will be written to seeking their feedback and any questions or concerns. It is proposed that this engagement commences as soon as possible to fit in with required timescales.

Exception Risk Report and Governing Body Board Assurance Framework

There were no changes to the scores of the single risk currently being managed by the Engagement Committee. This relates to a current 2x4=8 risk on the adherence

to engagement legislation when undertaking service commissioning. The developing engagement model and governance guide will provide necessary assurance in due course to achieve the target risk score of 2x3=6.

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

None identified.

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 but describes a range of patient, public communications and engagement activity across the breadth of CCG work.

Have any Conflicts of Interest been identified/ actions taken?

None identified.

Governing Body Assurance Framework

Risks assigned to the Engagement Committee are reviewed monthly and changes noted within this assurance report.

Identification of Key Risks

Noted as above.

Governing Body Meeting in Public

2nd December 2021

Item No: 202

Report Title	Governance Committee Assurance Report – November 2021
Author(s)	Frances Palmer, Corporate Governance Manager Suzanne Pickering, Head of Governance
Sponsor (Director)	Jill Dentith, Governance Lay Member & Chair of Governance Committee

Paper for:	Decision	Assurance	x	Discussion	Information
Assurance Report Signed off by Chair				Jill Dentith, Governance Lay Member and Chair of Governance Committee	
Which committee has the subject matter been through?				Governance Committee – 11.11.2021	
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 11 th November 2021 meeting of the Governance Committee. This report provides a brief summary of the items transacted for assurance.					
<u>Derby and Derbyshire CCG Procurement Highlight Report</u>					
The Governance Committee RECEIVED and NOTED the Highlight report for Derby and Derbyshire CCG. The Committee REVIEWED the key issues and activities over the current period.					
<u>Human Resources Policies & Procedures for Approval</u>					
<u>Raising Concerns at Work (Whistleblowing) Policy</u>					
The Governance Committee APPROVED IN PRINCIPLE the Raising Concerns at Work (Whistleblowing) Policy. The newly established Freedom to Speak Up Ambassadors role was recently promoted on team talk and the Governance Committee requested that more clarity on the role is included in the policy – in terms of it being voluntary, and that ambassadors are there to listen and sign post the individuals 'speaking up'.					
<u>Corporate Governance Policies for Approval</u>					
<u>Incident Reporting Policy</u>					
The Committee APPROVED the Incident Reporting Policy.					

Incident Management Plan

Governance Committee APPROVED the Incident Management Plan.

Violence Prevention and Reduction Standards Strategy and Policy

The draft Violence Prevention and Reduction Standards Strategy and Policy were presented at the Governance Committee meeting in September, for information. Comments were taken on board and reflected within both documents. Governance Committee APPROVED the Violence Prevention and Reduction Standards Strategy and Policy.

The committee discussed the management of policies for the transition to the ICB. It was confirmed that a number of essential CCG policies would be updated for immediate use, on establishment of the ICB. Other policies would then be managed through the use of a Policy Management Framework and forward planner once the ICB is in operation.

Ratification of virtual approval decisions during October 2021

The Committee FORMALLY RATIFIED the decisions made by the Committee virtually during October 2021.

Procurement Decisions in ICS Transition

The Committee RECEIVED the Procurement Decisions in ICS Transition report, which details how conflicts of interest are being managed in decision making at system-level meetings.

Contract Oversight Group Update

The Committee NOTED the verbal update and the progress being made.

CCG Estates update

The Committee NOTED the verbal update and the work being done and progress being made in regards to staff returning to work at office bases. The committee also discussed the NHS Property Services Lease for Cardinal Square and Scarsdale.

Freedom of Information Act – Quarterly Performance Report for Q2: July - September 2021

The Committee RECEIVED the quarterly report on the CCG's performance in meeting their statutory duties in responding to requests made under the Freedom of Information Act.

Complaints Report Quarter 2 (2021-22)

The Committee NOTED the Complaints Report for Quarter 2.

Business Continuity, Emergency Planning Resilience and Response

The first draft positions for compliance against the National Core Standards for Provider organisations and the CCG were reported to the September meeting. The final position has yet to be agreed and will be finalised when the 'confirm and challenge' meetings have taken place during November 2021.

This year the EPRR team within NHSEI Midlands have adopted a different approach and the CCG has worked closely with the Regional Head of EPRR. The CCG was

required to reassess the core standards and as a result will be reporting a 'substantial level of assurance' compared to 'full assurance' in previous years. 2 out of 29 core standards have been rated partially compliant in relation to Mutual Aid agreements and Mass Casualty arrangements. Actions are currently being progressed.

The Committee NOTED the contents of the report for information and assurance.

ICB Constitution Update

The Committee NOTED the progress and timetable for the completion of the ICB Constitution for assurance purposes.

Health & Safety Report

The Committee RECEIVED ASSURANCE that the CCG is coordinating work to meet its health and safety obligations to remain compliant with health and safety legislation, and is responding effectively and appropriately to the changes in working practices because of the Covid-19 pandemic.

Reprocurement of Health & Safety Contract

The Committee NOTED the update provided on the reprocurement of the Health & Safety Contract, which is due to expire in July 2022.

Information Governance and GDPR Update Report

The Committee APPROVED the items approved at the August Information Governance Assurance Forum meeting and RECEIVED an update regarding actions and compliance activities.

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

The Committee also discussed how the CCG will ensure it meets its Data Security training targets for 2021/22.

Digital Development Update

The Committee RECEIVED and NOTED the positive Digital Development and IT Update report for the Corporate and GP Estates.

Risk Register Exception Report – October 2021

The Committee RECEIVED the assigned Governance risks, as at October 2021; and NOTED the virtual approval received on 26th October 2021 by Governance Committee to decrease the risk score of risk 40 relating to contract extensions. The risk decreased in score from a high 12 (probability 3 x impact 4) to a moderate score of 6 (probability 2 x impact 3).

Governance Committee Governing Body Assurance Framework Risks Quarter 2

The Governance Committee NOTED the 2021/22 Quarter 2 (July to September 2021) Governing Body Assurance Framework (GBAF).

Governance Committee Quarter 3 GBAF Risks Review

The Committee REVIEWED and DISCUSSED the Quarter 3 (October 2021) Strategic Risks 7 and 8. Virtual approval will be sought from members for the Quarter 3 Governing Body Assurance Framework before it is presented at Governing Body in January for approval.

Non-Clinical Adverse Incidents

No incidents were reported to the Committee.

Minutes of the Governance Committee 23rd September 2021

The minutes of the 23rd September 2021 meeting were **APPROVED** as a true and accurate record.

Any Other Business

Workforce Review

The Committee made a recommendation to hold a discussion with the Governing Body in the regards to workforce in the context of understanding the impact of workforce in the coordination of the winter plan and obtaining a clear picture of staffing issues across the system that the CCG can influence.

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

None identified.

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

Going forward any risks highlighted and assigned to the Governance Committee will be linked to the Derby and Derbyshire CCG Board Assurance Framework.
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Identification of Key Risks

Noted as above.

Governing Body Meeting in Public

2nd December 2021

Item No: 204

Report Title	Quality and Performance Assurance Report – November 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 Q&PC	
Which committee has the subject matter been through?				Quality and Performance Committee – 25.11.2021	
Recommendations					
The Governing Body is requested to NOTE the contents of the report for assurance purposes.					
Report Summary					
Performance:					
Urgent and Emergency Care:					
<ul style="list-style-type: none"> • The A&E standard was not met at a Derbyshire level at 75.2% (YTD 79.3%). CRH did not achieve the standard achieving 88.7% (YTD 92.7%). UHDB achieved 67.0% during October (YTD 71.4%). • UHDB had 72 x 12-hour trolley breaches during October – 69 were due the availability of medical beds and 3 were due to the unavailability of a suitable mental health bed. CRH had 1 x 12-hour trolley breaches due to the lack of mental health bed availability. • EMAS were non-compliant for all 6 of their standards for Derbyshire during October 2021, reflecting the significant pressures experienced throughout the month. 					
Planned Care:					
<ul style="list-style-type: none"> • 18 Week Referral to Treatment (RTT) for incomplete pathways continues to be non-compliant at a CCG level at 61.9% (YTD 66.3%). • CRHFT performance was 68.1% (YTD 68.9%) and UHDB 61.9% (YTD 61.5%). • Derbyshire had 5,781 breaches of the 52-week standard across all trusts – the first time in five months there has been an increase. • Diagnostics – The CCG performance was 35.33%, a slightly better position than the previous month. Neither CRH (19.64%) or UHDB (41.56%) have achieved the standard. 					
Cancer:					
During September 2021, Derbyshire was compliant in 2 of the 9 Cancer standards:					
<ul style="list-style-type: none"> • 31-day Subsequent Radiotherapy – 95.8% (94% standard) – Compliant at all trusts except NUH> • 31-day Subsequent Drugs – 99.5% (98% standard) – Compliant for all Trusts. 					

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

- **2-week Urgent GP Referral – 87.6%** (93% standard) – Compliant for Stockport.
- **2 week Exhibited Breast Symptoms – 90.3%** (93% standard) – Compliant at Derby & Burton, Nottingham, and Sherwood Forest.
- **28-day Faster Diagnosis – 74.00%** (75% standard) – Compliant for Chesterfield and Nottingham.
- **31 day from Diagnosis – 88.1%** (96% standard) – Compliant for Chesterfield and Stockport.
- **62-day Urgent GP Referral – 60.3%** (85% standard) – Noncompliant for all trusts.
- **62-day Screening Referral – 50%** (90% standard) – Noncompliant for all trusts.
- **104 day wait** – Data unavailable at a CCG level.

Quality

Chesterfield Royal Hospital FT

Staffing remains an issue in Maternity Services. There has been several recruitment drives across the region but there has been poor uptake of vacancies from these. In relation to Elective Surgery and increased waits, elective surgeries are found to require more complex interventions. All long waiters continue to be reviewed by a Consultant and the level of need reassessed. There is regular contact between the Trust and the patients who are on the waiting list. Incident reporting has reduced but CRH are not concerned with current level.

University Hospitals of Derby and Burton FT

The Maternity Home Birth Service is suspended currently due to safety around staffing. Home births that have occurred have been reviewed and no harm has been found. In ED Concerns remain around staffing, length of stays within department and the ambulance handover time. A paper on the challenges, action plan and update on position will be presented at the December CQRG.

Derbyshire Community Health Services FT

Sickness continues to increase between. This is in the context of escalated Opel levels and system pressures. Managers are reporting a myriad of reasons for absence and pressures occurring for the workforce inside and outside of work. Promoted Counselling Support, over recruitment of registered staff where able and team cohesion. Progress will be monitored at CQRG.

Derbyshire Healthcare Foundation Trust

The Trust have several 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. The number of reported incidents involving physical restraint have remained within common cause variation throughout the reporting period. The use of seclusion was within common cause variation, however increased in July. In further investigating this trend, there appears to be a linked to a small number of patients who have been placed in seclusion on more than one occasion. This data will be monitored for patterns and further support needs for individual areas.

East Midlands Ambulance Trust

Nine Serious Incidents (SIs) were reported in September/October 2021 compared to five reported in the same period of 2020. This brings the total reported at the end of October 2021 to 29. Of the reported cases, six were related to delayed responses. These cases are

currently under investigation. Immediate supportive actions have been taken to reduce the risk of recurrence. All counties are conducting Delayed Response Reviews which will be fed back to the EMAS Quality Assurance Group.

Update from Quality and Performance Committee 25th November 2021

The number of patients waiting over 52 weeks has increased due to increases at CRH. The two week wait list has also increased, there has been a 38% increase in two week waits over one month. The conversion rate for people with cancer remains the same, there is no evidence of inappropriate referrals. The committee was reassured by this.

There is a validation team at both Trusts that reviews the waiters regularly to ensure the patient still requires the surgery. Due to the numbers the teams are reviewing the longest waits. Communications and engagement with patients remain in place.

An update on the cancer waits will be presented at the next committee, to review the processes across the pathway given the continuing increase in numbers.

The Integrated Quality and Performance report was approved by the Committee.

The GBAFs were reviewed and agreed by the Committee. There were no changes to the Committee risk register.

The Safeguarding and Looked After Children reports were noted. The excellent work undertaken by the teams was noted and the Committee was assured. The Chair gave his thanks to teams.

The EMAS report shows continued high patient acuity. Handover delays were discussed. There have been two Serious Incidents linked to delays. The A&E Delivery Board are being asked to commit to no handovers over sixty minutes. The Committee noted the increased performance on alternative pathways by EMAS. The Committee discussed the increasing pressure on EMAS and the actions being put in place to improve flow. The EMAS Quality Assurance Group have undertaken a review of patient safety and local reviews of cases are being undertaken at CCG level.

The Medicines Management papers were noted.

The Committee was assured that the risk stratification of long wait patients is being undertaken at operational level to ensure patients are reviewed and prioritised if needed. This includes waiting well approaches.

The DHU Health Care CIC Out Of Hours Terms of Reference were approved. The role of the Patient Safety Specialist was noted.

The minutes of the Meeting Held on 28th October 2021 were approved.

The assurance questions were agreed.

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.

Month 06

Quality & Performance Report

2021/22

November 2021

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EXECUTIVE SUMMARY

Key Messages	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> The A&E standard was not met at a Derbyshire level at 75.2% (YTD 79.3%). CRH did not achieve the standard achieving 88.7% (YTD 92.7%). UHDB achieved 67.0% during October (YTD 71.4%). UHDB had 72 x 12 hour trolley breaches during October – 69 were due the availability of medical beds and 3 were due to the unavailability of a suitable mental health bed. CRH had 1 x 12 hour trolley breaches due to the lack of mental health bed availability. EMAS were non-compliant for all 6 of their standards for Derbyshire during October 2021, reflecting the significant pressures experienced throughout the month.
Planned Care	<ul style="list-style-type: none"> 18 Week Referral to Treatment (RTT) for incomplete pathways continues to be non-compliant at a CCG level at 61.9% (YTD 66.3%). CRHFT performance was 68.1% (YTD 68.9%) and UHDB 61.9% (YTD 61.5%). Derbyshire had 5,781 breaches of the 52 week standard across all trusts – the first time in five months there has been an increase. Diagnostics – The CCG performance was 35.33%, a slightly better position than the previous month. Neither CRH (19.64%) or UHDB (41.56%) have achieved the standard.
Cancer	<p>During September 2021, Derbyshire was compliant in 2 of the 9 Cancer standards:</p> <ul style="list-style-type: none"> 31 day Subsequent Radiotherapy – 95.8% (94% standard) – Compliant at all trusts except NUH> 31 day Subsequent Drugs – 99.5% (98% standard) – Compliant for all Trusts. <p>During September 2021, Derbyshire was non-compliant in 7 of the 9 Cancer standards:</p> <ul style="list-style-type: none"> 2 week Urgent GP Referral – 87.6% (93% standard) – Compliant for Stockport. 2 week Exhibited Breast Symptoms – 90.3% (93% standard) – Compliant at Derby & Burton, Nottingham and Sherwood Forest. 28 day Faster Diagnosis – 74.00% (75% standard) – Compliant for Chesterfield and Nottingham. 31 day from Diagnosis – 88.1% (96% standard) – Compliant for Chesterfield and Stockport. 62 day Urgent GP Referral – 60.3%(85% standard) – Non compliant for all trusts. 62 day Screening Referral – 50% (90% standard) – Non compliant for all trusts. 104 day wait – Data unavailable at a CCG level.

Executive Summary

Trust	
Chesterfield Royal Hospital FT	Staffing remains an issue in Maternity Services. There has been several recruitment drives across the region but there has been poor uptake of vacancies from these. In relation to Elective Surgery and increased waits, elective surgeries are found to require more complex interventions. All long waiters continue to be reviewed by a Consultant and the level of need reassessed. There is regular contact between the Trust and the patients who are on the waiting list. Incident reporting has reduced but CRH are not concerned with current level.
University Hospitals of Derby and Burton NHS FT	The Maternity Home Birth Service is suspended currently due to safety around staffing. Home births that have occurred have been reviewed and no harm has been found. In ED Concerns remain around staffing, length of stays within department and the ambulance handover time. A paper on the challenges, action plan and update on position will be presented at the December CQRG.
Derbyshire Community Health Services FT	Sickness continues to increase between. This is in the context of escalated Opel levels and system pressures. Managers are reporting a myriad of reasons for absence and pressures occurring for the workforce inside and outside of work. Promoted Counselling Support, over recruitment of registered staff where able and team cohesion. Progress will be monitored at CQRG.
Derbyshire Healthcare Foundation Trust	The Trust have a number of 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. The number of reported incidents involving physical restraint have remained within common cause variation throughout the reporting period. The use of seclusion was within common cause variation, however increased in July. In further investigating this trend, there appears to be a linked to a small number of patients who have been placed in seclusion on more than one occasion. This data will be monitored for patterns and further support needs for individual areas.
East Midlands Ambulance Trust	Nine Serious Incidents (SIs) were reported in September/October 2021 compared to five reported in the same period of 2020. This brings the total reported at the end of October 2021 to 29. Of the reported cases, six were related to delayed responses. These cases are currently under investigation. Immediate supportive actions have been taken to reduce the risk of recurrence. All counties are conducting Delayed Response Reviews which will be fed back to the EMAS Quality Assurance Group.

PERFORMANCE OVERVIEW MONTH 7 – URGENT CARE

NHS Derby & Derbyshire CCG Assurance Dashboard

Key:	Performance Meeting Target	Performance Improved From Previous Period	↑
	Performance Not Meeting Target	Performance Maintained From Previous Period	→
	Indicator not applicable to organisation	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
Urgent Care	Area	Indicator Name	Standard	Latest Period	NHS Derby & Derbyshire CCG			Chesterfield Royal Hospital FT			University Hospitals of Derby & Burton FT			NHS England			
		Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	Oct-21	↑	75.2%	79.3%	73	88.7%	92.7%	2	67.0%	71.4%	73	76.2%	80.9%
A&E 12 Hour Trolley Waits			0	Oct-21					1	14	2	72	147	15	7059	19599	73

NHS Derby & Derbyshire CCG Assurance Dashboard

Key:	Performance Meeting Target	↑ Performance Improved From Previous Period
	Performance Not Meeting Target	→ Performance Maintained From Previous Period
	Indicator not applicable to organisation	↓ Performance Deteriorated From Previous Period

EMAS Dashboard for Ambulance Performance Indicators					Direction of Travel	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	Area	Indicator Name	Standard	Latest Period	East Midlands Ambulance Service Performance (NHSD&DCCG only - National Performance Measure)			EMAS Performance (Whole Organisation)			EMAS Completed Quarterly Performance 2021/22				NHS England			
		Ambulance System Indicators	Ambulance - Category 1 - Average Response Time	00:07:00	Oct-21	→	00:09:12	00:08:32	16	00:09:31	00:08:37	15	00:07:54	00:09:05			00:09:20	00:08:14
Ambulance - Category 1 - 90th Percentile Respose Time			00:15:00	Oct-21	→	00:16:11	00:14:43	2	00:17:05	00:15:28	4	00:14:06	00:16:29			00:16:23	00:14:37	4
Ambulance - Category 2 - Average Response Time			00:18:00	Oct-21	↓	00:46:12	00:37:37	15	00:59:13	00:43:59	16	00:33:40	00:49:29			00:53:54	00:36:23	15
Ambulance - Category 2 - 90th Percentile Respose Time			00:40:00	Oct-21	↓	01:38:06	01:17:18	15	02:07:02	01:33:04	15	01:10:09	01:46:26			01:56:13	01:17:11	7
Ambulance - Category 3 - 90th Percentile Respose Time			02:00:00	Oct-21	↓	07:52:10	05:40:47	15	09:43:11	06:30:19	15	04:30:11	07:17:52			07:47:15	05:10:30	7
Ambulance - Category 4 - 90th Percentile Respose Time			03:00:00	Oct-21	↓	05:56:46	05:08:45	7	06:06:09	05:51:08	7	04:43:53	06:45:03			08:01:16	06:07:43	7

PERFORMANCE OVERVIEW MONTH 6 – 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

Area	Indicator Name	Standard	Latest Period	Direction of Travel	Current Month	YTD	consecutive months non-compliance	NHS Derby & Derbyshire CCG			Chesterfield Royal Hospital FT			University Hospitals of Derby & Burton FT			NHS England		
								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	Referrals to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Sep-21	↓	66.6%	66.3%	44	68.1%	68.9%	29	61.9%	61.5%	45	66.5%	67.2%	67		
		Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Sep-21	↓	5781	37853	20	1129	6897	18	5692	41669	19	300566	1912832	173		
	Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Sep-21	↓	35.33%	29.74%	40	19.64%	14.36%	18	41.56%	33.79%	19	26.09%	24.26%	97		
	2 Week Cancer Waits	All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	Sep-21	↓	87.6%	86.6%	13	Cancer 2 Week Wait Pilot Site - not currently reporting			78.0%	81.1%	13	84.1%	85.3%	16		
		Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	Sep-21	↓	90.3%	68.3%	1				94.8%	68.4%	0	83.6%	72.2%	16		
	28 Day Faster Diagnosis	Diagnosis or Decision to Treat within 28 days of Urgent GP, Breast Symptom or Screening Referral	75%	Sep-21	↓	74.0%	75.2%	1	78.1%	76.9%	0	69.2%	74.1%	2	71.7%	73.0%	6		
	31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	96%	Sep-21	↓	88.1%	92.6%	9	82.3%	94.8%	1	92.3%	92.6%	14	92.6%	94.2%	9		
		Subsequent Surgery Within 31 Days Of Decision To Treat	94%	Sep-21	↓	75.0%	80.6%	22	95.7%	96.3%	0	72.5%	84.5%	4	83.7%	86.0%	38		
		Subsequent Drug Treatment Within 31 Days Of Decision To Treat	98%	Sep-21	↓	99.5%	99.2%	0	100.0%	100.0%	0	99.5%	99.1%	0	98.9%	99.1%	0		
		Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	Sep-21	↑	95.8%	95.3%	0				94.0%	92.4%	0	95.0%	96.5%	0		
	62 Days Cancer Waits	First Treatment Administered Within 62 Days Of Urgent GP Referral	85%	Sep-21	↓	60.3%	67.5%	31	64.6%	71.4%	26	54.0%	65.7%	41	68.0%	72.0%	69		
		First Treatment Administered - 104+ Day Waits	0	Sep-21	↑	N/A	110	66	6	27	41	37	127	66	1128	5591	69		
		First Treatment Administered Within 62 Days Of Screening Referral	90%	Sep-21	↓	50.0%	71.1%	29	8.0%	60.0%	29	81.0%	80.7%	10	70.8%	73.9%	42		
		First Treatment Administered Within 62 Days Of Consultant Upgrade	N/A	Sep-21	↓	73.8%	81.8%		100.0%	89.5%		81.3%	90.8%		78.2%	81.6%			

PERFORMANCE OVERVIEW MONTH 6 – 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
Area	Indicator Name	Standard	Latest Period	NHS Derby & Derbyshire CCG			Chesterfield Royal Hospital FT			University Hospitals of Derby & Burton FT			NHS England			
Patient Safety	Healthcare Acquired Infection (HCAI) Measure: MRSA Infections	0	Sep-21	↔	0	0	0	Cancer 2 Week Wait Pilot Site - not currently reporting			0	1	0	53	313	30
	Incidence of healthcare associated Infection	Healthcare Acquired Infection (HCAI) Measure: C-Diff Infections	Plan	Sep-21	↓		120					60		7433		
		Actual				120	1		8	0		30	0			
		Healthcare Acquired Infection (HCAI) Measure: E-Coli	-	Sep-21	↓	73	447		24	134		44	313		73	447
	Healthcare Acquired Infection (HCAI) Measure: MSSA	-	Sep-21	↓	23	134		6	39		16	95		968	5976	

PERFORMANCE OVERVIEW MONTH 6 – MENTAL HEALTH

G Dashboard for NHS Constitution Indicators

Area	Indicator Name	Standard	Latest Period	NHS Derby & Derbyshire CCG				Derbyshire Healthcare FT			NHS England			Trent PTS (D&DCCG only)			Insight Healthcare (D&DCCG only)			Vita Health (D&DCCG only)		
				Direction of Travel	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure
Early Intervention In Psychosis	Early Intervention In Psychosis - Admitted Patients Seen Within 2 Weeks Of Referral	60.0%	Aug-21	↑	40.0%	54.8%	2	40.0%	54.0%	2				62.4%	67.3%	0						
	Early Intervention In Psychosis - Patients on an Incomplete Pathway waiting less than 2 Weeks from Referral	60.0%	Aug-21	↓	25.0%	50.0%	2	33.3%	61.5%	2				26.5%	28.1%	28						
Mental Health	Dementia Diagnosis Rate	67.0%	Sep-21	↓	64.6%	64.9%	15							62.0%	62.8%	18						
	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		Aug-21	↓	435	2945																
	Physical Health Checks for Patients with Severe Mental Illness	25%	2021/22 Q2	↑	23.9%	29.6%	6															
Improving Access to Psychological Therapies	IAPT - Number Entering Treatment As Proportion Of Estimated Need In The Population	Plan	Sep-21	↑	2.10%	12.60%																
		Actual			2.77%	16.06%	0															
	IAPT - Proportion Completing Treatment That Are Moving To Recovery	50%	Sep-21	↓	50.5%	53.2%	0	50.9%	54.2%	0	49.2%	53.3%	1	56.0%	47.9%	0	54.9%	57.4%	0			
	IAPT Waiting Times - The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment	75%	Sep-21	↓	90.1%	94.8%	0	82.4%	89.8%	0	91.8%	96.2%	0	99.2%	97.9%	0	98.4%	97.9%	0			
	IAPT Waiting Times - The proportion of people that wait 18 Weeks or less from referral to entering a course of IAPT treatment	95%	Sep-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			
Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Sep-21	↓	72.8%	85.2%	4															
	Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Sep-21	↔	0	0	0															

Quality Overview

QUALITY OVERVIEW M6

Trust	Key Issues
Chesterfield Royal Hospital FT	<p>Pressures</p> <ul style="list-style-type: none"> • Maternity Services: Staffing is an issue currently due to Covid isolation guidance. CRH have accepted out of area patients in support of neighbouring Trusts. There has been several recruitment drives across the region but there has been poor uptake of vacancies from these. • Elective Surgery: Due to the longer waiting lists, elective surgeries are found to require more complex interventions. All long waiters have been reviewed by a Consultant and the level of need reassessed. There is regular contact between the Trust and the patients who are on a long waiting list. <p>Patient Safety</p> <ul style="list-style-type: none"> • Incident reporting has reduced but CRH happy with current level. They are looking at improving timeliness and action plans from the reports. • CRH are starting to work through the PSIRF priorities for next year and looking at staffing framework to support this. • PALS in now fully open and a review of the Patient Experience and Complaints process is underway. <p>CQC</p> <ul style="list-style-type: none"> • CRH are developing a good and open relationship with their new CQC Lead. • CRH are looking at internal CQC communications to highlight good areas of practice. • CQC will carry out an inspection in the new calendar year and the focus will be on Maternity and the Emergency Department
University Hospitals of Derby and Burton NHS FT	<p>Pressures</p> <ul style="list-style-type: none"> ▪ Emergency Department: Concerns remain around staffing, length of stays within department and the ambulance handover time. A paper on the challenges, action plan and update on position will be presented at the December CQRG. ▪ Maternity Services: The Home Birth Service is suspended currently due to safety around staffing. Home births that have occurred have been reviewed and no harm has been found. This service is to be reviewed with regards to risk over next 2 weeks. ▪ Elective Surgery: Due to the longer waiting lists, elective surgeries are found to require more complex interventions. An issue with incorrect equipment was highlighted which in turn led to some surgical procedures being cancelled. This has now been resolved. <p>Patient Safety</p> <ul style="list-style-type: none"> • A Patient Safety Specialist is now in post and ready to develop the role. • A review is currently underway of the PSIRF process which includes a questionnaire for staff. DDCCG has requested that the findings be shared when review completed. • A syllabus of Patient Safety training is now available to staff. <p>CQC</p> <ul style="list-style-type: none"> • The Well-led TMA is underway and interviews and focus groups are happening over the next week. • No further feedback or information has been requested with regards to the Maternity Service TMA.

QUALITY OVERVIEW M6 continued

Trust	Key Issues
Derbyshire Community Health Services FT	<p>Covid Vaccination: Phase 3 vaccination programme underway. Data has identified c75 staff who are not vaccinated. Managers are carrying out 1:1 meetings to verify data and support way forward.</p> <p>Staff Flu Campaign: Flu vaccines were delivered in September with the Campaign commencing 4 October 2021. Progress will be monitored at CQRG.</p> <p>Sickness Absence: Continued to increase between 0.2-0.5%. This is in the context of escalated Opel levels and system pressures. Managers are reporting a myriad of reasons for absence and pressures occurring for the workforce inside and outside of work. Promoted Counselling Support, over recruitment of registered staff where able and team cohesion. Progress will be monitored at CQRG.</p>
Derbyshire Healthcare Foundation Trust	<p>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.</p> <p>Prone restraint: The Trust have a number of 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.</p> <p>Physical restraint: The number of reported incidents involving restraint have remained within common cause variation throughout the reporting period.</p> <p>Seclusion: The use of seclusion was within common cause variation, however increased in July. In further investigating this trend, there appears to be a linked to a small number of patients who have been placed in seclusion on more than one occasion. This data will be monitored for patterns and further support needs for individual areas.</p> <p>Delayed transfers of care: The increased number of care homes and care settings in outbreak and demonstrating staffing issues has resulted in high numbers of delays in transfers from inpatient settings, increasing the number of delayed transfers of care at times.</p> <p>Complaints: The number of complaints increased with a particular theme around both concerns and complaints of access to services. The recent results from the Mental Health Community Survey have presented similar themes, with service users and carers feeling they have struggled with the reduction in face to face contact with services. during the COVID-19 Pandemic.</p>
East Midlands Ambulance Trust	<p>COVID Outbreak: As at 18 October 2021 the Trust had no active COVID-19 outbreaks.</p> <p>Serious Incidents: Nine Serious Incidents (SIs) were reported in September/October 2021 compared to five reported in the same period of 2020. This brings the total reported at the end of October 2021 to 29. Of the reported cases, six were related to delayed responses. These cases are currently under investigation. Immediate supportive actions have been taken to reduce the risk of recurrence. All counties are conducting Delayed Response Reviews which will be fed back to the EMAS Quality Assurance Group.</p>

QUALITY OVERVIEW M6

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				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
Section	Area	Indicator Name	Standard	Chesterfield Royal Hospital FT				University Hospitals of Derby & Burton FT				Derbyshire Community Health Services				Derbyshire Healthcare FT			
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%	2019/20 Q2	↑	2.7%	21.7%	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%	2019/20 Q2	↑	50.4%	70.5%	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	Sep-21	↑	18	146	Sep-21	↑	4	34	Sep-21	↓	20	99
		% of formal complaints responded to within agreed timescale	N/A	Sep-21	↑	76.0%	68.0%	Sep-21	↑		58.8%	Sep-21	↔	60.0%	90.6%	Sep-21	↑	100.0%	98.13%
		Number of complaints partially or fully upheld by ombudsman	N/A	Sep-21	↔	0	0	19-20 Q2	↔	1	2	Sep-21	↔	0	0	Sep-21	↔	0	0
	Pressure Ulcers	Category 2 - Number of pressure ulcers developed or deteriorated	N/A	Sep-21	↓	12	34	Sep-21	↓	25	126	Sep-21	↑	74	508	Sep-21	↔	0	1
		Category 3 - Number of pressure ulcers developed or deteriorated	N/A	Sep-21	↑	0	11	Sep-21	↔	6	29	Sep-21	↓	35	190	Sep-21	↔	0	1
		Category 4 - Number of pressure ulcers developed or deteriorated	N/A	Sep-21	↔	0	0	Sep-21	↔	0	0	Sep-21	↓	7	26	Sep-21	↔	0	0
		Deep Tissue Injuries(DTI) - numbers developed or deteriorated		Sep-21	↓	8	24	Sep-19	↑	16	94	Sep-21	↓	66	410	Sep-21	↔	0	0
		Medical Device pressure ulcers - numbers developed or deteriorated						Sep-19	↓	4	20	Sep-21	↓	16	76	Sep-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	Sep-21	↔	0	0
	Falls	Number of falls	N/A	Sep-21	↓	102	543	Data Not Provided in Required Format				Sep-21	↑	11	111	Sep-21	↓	35	161
		Number of falls resulting in SI criteria	N/A	Sep-20	↑	0	8	Sep-19	↑	0	19	Sep-21	↑	0	2	Sep-21	↔	0	0
	Medication	Total number of medication incidents	?	Sep-21	↓	70	457	Data Not Provided in Required Format				Sep-21	↑	0	1	Sep-21	↓	99	505
Serious Incidents	Never Events	0	Sep-21	↔	0	0	Sep-21	↔	0	0	May-19	↔	0	0	Sep-21	↔	0	0	
	Number of SI's reported	0	Sep-20	↑	4	26	Sep-19	↑	7	115	Dec-20	↔	1	34	Sep-21	↓	2	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 M6

Part B: Acute & Non-Acute Provider Dashboard for Local Quality Indicators cont.				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	
Section	Area	Indicator Name	Standard	Chesterfield Royal Hospital NHS Foundation Trust				University Hospitals of Derby & Burton FT				Derbyshire Community Health Services				Derbyshire Healthcare FT				
Adult	VTE	Number of avoidable cases of hospital acquired VTE		Mar-20	↓	0	15	Feb-21	↔	0	TBC					Sep-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		Jun-21	↑	0.954		Jun-21	↓	0.914										
		Crude Mortality		Sep-21	↓	1.66%	1.46%	Sep-21	↓	1.30%	1.04%									
Maternity	FFT	Antenatal service: 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												Sep-21	↔	0	0		
Workforce	Staff	Staff turnover (%)		Sep-21	↑	8.9%	8.9%	Sep-21	↓	11.0%	10.5%	Sep-21	↓	9.1%	8.9%	Sep-21	↓	11.17%	10.80%	
		Staff sickness - % WTE lost through staff sickness		Sep-21	↓	4.6%	4.4%	Sep-21	↓	6.1%	5.6%	Sep-21	↓	6.3%	5.0%	Sep-21	↓	6.77%	6.39%	
		Vacancy rate by Trust (%)		Sep-17	↓	1.9%	1.3%	Data Not Provided in Required Format				Sep-21	↑	3.5%	2.8%	Sep-21	↑	13.1%	13.7%	
		Agency usage	Target Actual													Sep-21	↑	1.96%	2.38%	
		Agency nursing spend vs plan (000's)		Sep-21	↓	£233	£1,234	Oct-18	↑	£723	£4,355	Sep-21	↓	£99	£506					
		Agency spend locum medical vs plan (000's)		Sep-21	↑	£657	£4,463													
	Training	% of Completed Appraisals	90%	Sep-21	↑	91.8%	68.3%	Sep-21	↑		84.2%	Sep-21	↓	85.2%	87.7%	Sep-21	↓	75.2%	76.4%	
Mandatory Training - % attendance at mandatory training		90%	Sep-21	↓	83.2%	84.2%	Sep-21	↑		87.8%	Sep-21	↓	95.7%	96.1%	Sep-21	↓	84.4%	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																	

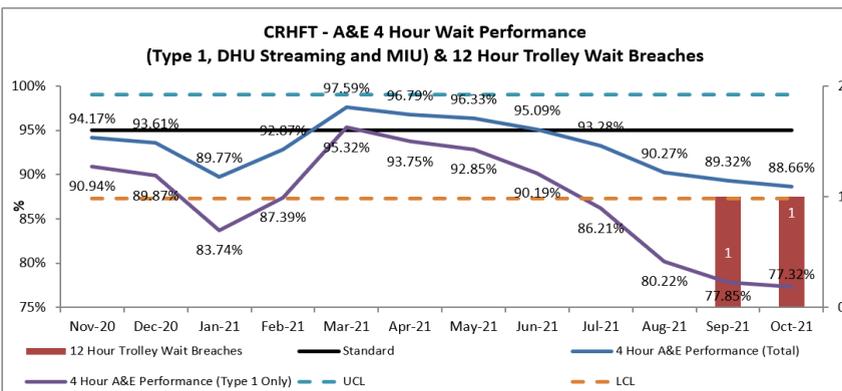
Urgent & Emergency Care

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

Performance Analysis

During October 2021 the trust did not meet the 95% standard, achieving 88.7% and the Type 1 element achieving 77.3%, a decline on last month's performance.

There was 1x12 hour trolley breaches during October due to a delay with patient transport.



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 Type 1 attendances are at pre-pandemic levels, with an average of 202 attendances per day. By October 2021 the volume of Type 1 & streamed attendances were 1.7% higher than October 2019 levels.
- There were surges of Covid19 admissions & outbreaks in the middle and end of the month, with as many as 47 positive inpatients at one point, including 8 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.
- 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?

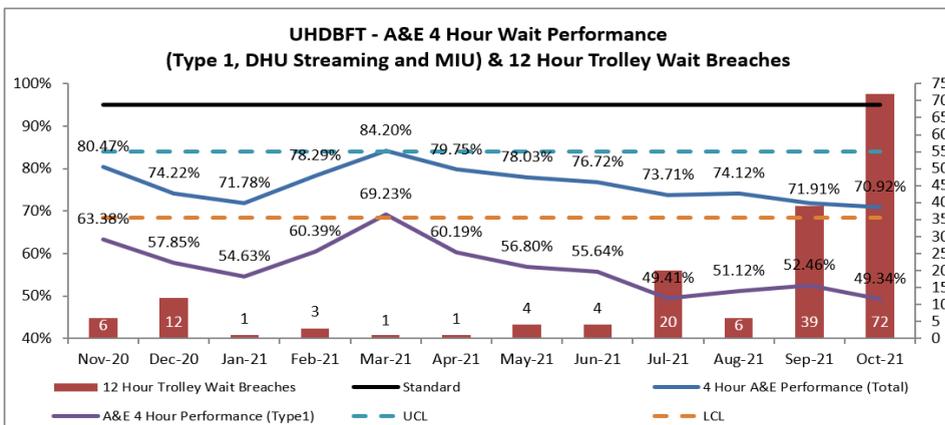
- Escalation of the Packages Of Care shortage to the System Organisational Resilience Group (SORG) which includes councils and community trusts. This group meets twice weekly to solve problems collaboratively, in addition to focussed meetings & communications to secure more capacity.
- The opening of additional space in an adjoining ward to provide more physical capacity.
- 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.
- Increased public communications regarding 111First and Urgent Treatment Centres as alternatives to automatic A&E attendances.
- Streamlining of front door and booking-in processes to support more timely clinical review.

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

Performance Analysis

During October 2021, performance overall did not meet the 95% standard, achieving 70.9% (Network figure) and 49.3% for Type 1 attendances. These continue the deterioration since March 2021.

There were 72 x 12 hour breaches during September 2021 due to the availability of suitable Mental Health beds (3) and medical capacity issues (69).



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

What are the next steps?

- Enacting the Winter Plan, with the first action being to change an Orthopaedic ward over to non-elective emergency care.
- 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.
- Extending the opening hours of the Discharge Assessment Unit at Florence Nightingale Community Hospital, to improve patient flow.
- Development of Bed Meetings to focus on action allocation and tracking.
- Reinstating the Geriatrician Of The Day role with an aim to make it more substantive rather than ad-hoc according to availability.
- 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 is very high, with an average of 514 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 are 6% higher than pre-pandemic levels (October 2021 compared to October 2019).
- The acuity of the attendances was high, seeing an average of 13 Resuscitation patients & 190 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 138 per day during October 2021 (compared to 99 per day in October 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.
- ED and Assessment areas are still separated into red/green areas according to Covid19 symptoms to ensure infection control. This limits physical space and therefore flexibility of patient flow.

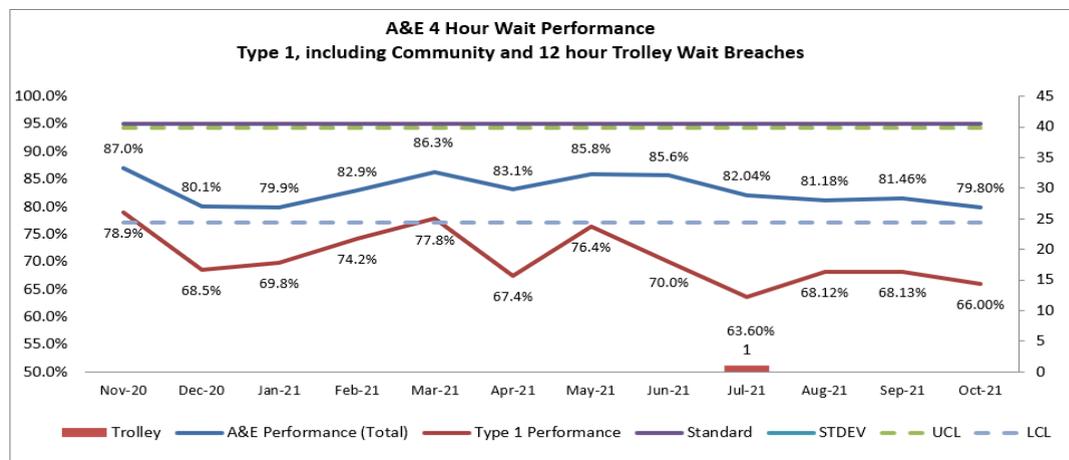
What actions have been taken?

- The opening of the co-located UTC remains the most significant recent action, 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.
- Engaging clinicians throughout the Trust on the importance of ED flow, through internal Professional Standards Forums.

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

Performance Analysis

During October 2021, performance overall did not meet the 95% standard, achieving 66.0% for the Burton A&E and 79.8% including community hospitals. Performance has been fluctuating since winter. There were no 12 hour breaches during October 2021.



What are the next steps?

- Once the Burton Treatment Centre is open there will be some elective beds freed up for the potential use of non-elective emergency patients.
- 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 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 178 Type 1 attendances per day.
- The acuity of the attendances is high, with an average of 119 Resuscitation/Major patients per day (67% of Type 1s).

What actions have been taken?

- Opening an Acute Medical Triage Unit to assess patients away from ED and enabling patients to bypass ED by direct referral to this are by GPs.
- 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.
- Implemented a new working model which enables closer consultant working with ED doctors.
- The development of a Diagnostic Hub at Samuel Johnson Community Hospital, releasing capacity at the acute site.
- A Data Quality Review to ensure that the recorded times (and other information) are accurate.
- The development of a Community Hospitals Plan to enable improved patient flow processes.

DHU111 Performance Month 6 (September 2021)

Performance Summary

DHU achieved three out of the five contractual Key Performance Indicators (KPIs) due for reporting in September 2021. The KPI's that were not met were:

1. The Average speed of answer which had a 47 second deterioration in September at 1 minute and 47 seconds from August's performance which was 1 minute.
2. The abandonment rate which increased by 2.3% from 3.1% in August 2021 to 5.4% in September 2021.

Regional Performance Year Five - Key Performance Indicators (KPI's)													
		Quarter One (October – December)			Quarter Two (January – March)			Quarter Three (April - June)			Quarter Four (July- September)		
Contractual KPI's	Standard	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Abandonment rate (%)	≤5%	0.5%	0.1%	0.2%	0.2%	0.2%	1.0%	1.0%	0.7%	0.9%	1.1%	3.1%	5.4%
Average speed of answer (seconds)	≤27s	00:00:09	00:00:06	00:00:06	00:00:10	00:00:09	00:00:18	00:00:15	00:00:13	00:00:19	00:00:26	00:01:00	00:01:47
Call Transfer to a Clinician	≥50%	66.0%	66.7%	69.6%	71.6%	70.4%	68.7%	66.5%	68.0%	66.5%	64.5%	66.0%	65.2%
Self Care	≥17%	26.2%	23.6%	20.9%	20.6%	20.1%	20.4%	17.3%	17.1%	18.1%	19.0%	17.2%	17.4%
Patient Experience	≥85%	88.0%	This data is updated on a six monthly basis					88.0%	This data is updated on a six monthly basis				
C3 Validation	≥50%	98.0%	98.9%	92.0%	98.9%	98.8%	98.4%	95.9%	98.7%	98.6%	98.2%	98.0%	98%

Activity Summary

- Activity was below plan throughout the contractual year (Year 5, October 2020 to September 2021). This was due to a combination of factors including the NHS111 First activity not materialising as anticipated, and a reduction in usual winter illness seen between December 2020 – February 2021 in particular.
- Calls offered were 17.1% below plan for Year 5. Due to the contractual +5% threshold agreement in place, a credit of £1,753,497 is due to commissioners.
- Clinical Calls were also below plan for Year 5, at 11.9%. Due to the contractual +5% threshold agreement in place, a credit of £511,738 is due to commissioners.
- There were 8,177 Category 3 Ambulance Validations in September, with an associated cost of £147,431. This is a decrease on August, when there were 12,995 validations with a cost of £234,300.
- The regional cost of COVID-19 activity for September was £111,869. COVID-19 calls have increased from 10,022 in August to 11,951 calls in September.

DHU111 Performance Month 6 (September 2021)

What are the issues?

- DHU111 continue to identify changes within the distribution of activity, with a significant increase in weekday and daytime calls, particularly on a Monday.
- DHU111 have experienced challenges in relation to recruitment and retention of call takers which is causing pressure.
- DHU111 continue to receive activity from other providers as a result of them entering national contingency and due to the unpredictability of this activity, it is difficult to anticipate and staff up for.
- Despite the challenges being faced and non achievement of two KPIs, DHU111 continue to perform significantly better than other 111 providers across the country. Where DHU111 average speed of answer was 1 minutes and 47 seconds during September, the national average figure was 9 minutes and 17 seconds.

Activity		Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Year to date (Contract Year runs Oct -Sep)
Calls Offered	Actual	148,098	146,417	146,590	135,746	119,595	145,732	162,043	171,605	149,659	160,685	150,433	160,561	1,797,157
	Plan	152,299	153,848	203,460	199,210	177,571	188,612	188,704	186,048	177,330	192,078	178,427	170,069	2,167,656
	Variance	-2.8%	-4.8%	-28.0%	-31.9%	-32.6%	-22.7%	-14.1%	-7.8%	-15.6%	-16.3%	-15.7%	-5.6%	-17.1%
Clinical Calls	Actual	30,215	30,687	32,894	31,929	27,493	32,072	29,965	34,287	30,426	29,568	26,594	25,470	361,600
	Plan	29,898	30,333	39,528	36,350	31,639	35,140	36,518	35,809	34,529	35,256	33,100	32,402	410,504
	Variance	1.1%	1.2%	-16.8%	-12.2%	-13.1%	-8.7%	-18.0%	-4.3%	-11.9%	-16.1%	-19.7%	-21.4%	-11.9%

What actions have been taken?

- Initiatives are being implemented to improve the recruitment process which include a more streamlined approach to processing successful applicants and offering incentives to encourage more applicants and retain staff.
- NHSE have released the H2 Funding Guidance which states additional funding will be provided to NHS 111 Services to support additional capacity and performance. Commissioners are awaiting further detail on the value of the additional funding and how it will be split. We will work through this with the DHU 111 when further details are available.
- Despite a reduction in staff the new pilot scheme which extends the Category 3 validation timeframe from 30 minutes to 60 minutes has been implemented and appears to be working well, with an increased percentage of calls avoiding an ambulance dispatch.
- The Year 6 Contract has been agreed between DHU111 and Commissioners and a Contract Variation is to be agreed and inserted into the contract imminently.

Covid-19 Activity - Actual	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Non-Clinical	9,371	9,142	7,413	9,122	5,652	2,943	2,322	5,637	6,495	8,666	7,875	9,334
Clinical (total)	2,208	2,435	2,392	3,259	1,809	995	740	1,851	1,984	2,423	2,347	2,617

What are the next steps?

- DHU111 are to provide Commissioners with an update as to how they could utilise the additional funding from NHSE/I to improve capacity and performance.
- With regards to the pilot scheme which extends the Category 3 validation calls from 30 minutes to 60 minutes, DHU111 are monitoring the impact of this and providing a monthly update to Contract Management Board Meeting.
- The Year 6 Contract Variation will go to the November Contract Management Board Meeting for formal sign off.

NB: the contract year runs Oct–Sept for the DHU111 contract as per contract award in Sept 2016. We are currently in year five of a six year contract.

AMBULANCE – EMAS PERFORMANCE M6 (September 2021)

What are the issues?

The contractual standard is for the Derbyshire division to achieve national performance on a quarterly basis. For Quarter two, Derbyshire did not meet any of the six national standards. The variation to meeting the national standards was as follows:

- C1 mean +1 minute and 57 seconds from the national standard.
- C1 90th Centile +35 seconds from the national standard.
- C2 mean +24 minutes and 54 seconds from the national standard.
- C2 90th Centile +48 minutes and 36 seconds from the national standard.
- C3 90th Centile +4 hours, 36 minutes and 36 seconds from the national standard.
- C4 90th Centile +2 hours, 24 minutes and 6 seconds from the national standard.

- There is a regional level trajectory for performance which is linked to the receipt of additional national funding, and EMAS was not able achieve any of these performance trajectories during September 2021. The trajectories were built upon a range of assumptions including demand and acuity. Although demand was below the assumed level, acuity also remained much higher than the assumed figure with an average of 80% of incidents categorised at C1 or C1 against a regional assumption of 75% the same acuity.

- Average Pre hospital handover times during September 2021 continued to be above the 15 minute National Standard across Derbyshire at 24 minutes and 28 seconds which was a within a minute of August 2021 performance at 23 minutes and 34 seconds.

- Average Post handover times during September 2021 remained above the 15 minute national standard across Derbyshire with the exception of Macclesfield District (12 minutes and 14 seconds). Overall the post handover time in September 2021 was 19 minutes and 21 seconds which was similar to August 2021 performance at 19 minutes.

- Incidents in Derbyshire in September 2021 saw a decrease when compared to August 2021 (12,857 compared to 13,248) although remained above the indicative activity plan

- S&C to ED as a percentage of incidents is middle of the pack across the region at 52.6%.

- The percentage of calls being classed as a duplicate call during September was comparable to August at 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 – September	00:09:28	00:17:01	00:52:54	01:53:36	08:00:52	09:15:05
Derbyshire Actual - September	00:09:21	00:16:14	00:44:22	01:32:45	06:36:22	05:37:28
Derbyshire Actual - Quarter Two	00:08:57	00:15:35	00:42:54	01:28:36	06:36:06	05:24:06

September 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	00:27:09	85:13:08	00:17:20	34:16:45	00:44:29	104:51:42
Chesterfield Royal	00:23:02	323:22:15	00:18:35	227:26:09	00:41:37	469:43:13
Macclesfield District General Hospital	00:23:30	6:08:49	00:12:14	0:37:55	00:35:45	4:59:03
Royal Derby	00:25:13	719:55:09	00:20:18	496:02:34	00:45:31	1078:57:44
Sheffield Northern General Hospital	00:31:31	35:24:05	00:20:06	17:52:50	00:51:37	46:06:29
Stepping Hill	00:18:59	32:12:05	00:15:55	22:41:15	00:34:54	44:27:10
Derbyshire TOTAL	00:24:28	1202:15:31	00:19:21	798:57:28	00:43:49	1749:05:21

AMBULANCE – EMAS PERFORMANCE M6 (September 2021)

What actions have been taken?

- The deteriorating performance position is being seen across the country, with all ambulance services operating at REAP level 4. NHSE/I Executives are aware of the current pressures and briefings on the current pressures have been given to Ministers.
- EMAS have plans in place to utilise the additional £3.7m from NHSE/I which includes an increase in capacity across the Emergency Operations Centre (EOC), increase operational capacity on the front line and the provision of Hospital Ambulance Liaison Officers (HALO's) in Lincoln and Leicester. With the exception of the HALO's all other areas are on track with the 10 point plan.
- Strategic Delivery Board members have been invited to participate in the Regional Ambulance ED Avoidance, Right Care, Right Place, Collaboration where best practice can be shared.
- The Clinical Quality Review Group provided an update to the Strategic Delivery Board in relation to the impact of Operational Performance on Quality and it was agreed that EMAS were doing everything within their capacity to mitigate risk and optimise quality. Key issues that were discussed at the meeting include; Sources of quality assurance – reporting, the stress and pressure that EMAS staff are experiencing, particularly those in the Emergency Operations Centre, the increase in patient complaints and patient feedback due to wait times, the decrease in compliance against time critical Ambulance Clinical Quality Initiatives e.g., Return of Spontaneous Circulation, (ROSC) and Stroke, the increase in Serious Incidents where the root cause is a 'Delayed Response', hospital handover delays and actions for addressing risks in the short and long term.
- Work is taking place around the Winter Plan with a focus on resources, clinical triage and reducing conveyance.
- From 1st September 2021, DHU111 extended their C3 validation timeframe from 30 minutes to 60 minutes. This provided the DHU111 clinicians with more time to clinically validate C3 dispositions via 111. The DHU 111 C3 Validation is being run as a pilot with the intention that it will initially run for up to three months. It is anticipated the pilot should reduce the number of C3 calls being passed through to EMAS and it should reduce overall incident numbers for EMAS. It is however acknowledged that the C3 validation could increase the percentage of activity being categorised as C1 and C2 by EMAS. Initial data showed a percentage reduction in the number of calls passed through to EMAS from 111 with 22.2% of total incidents in September compared to 23.6% in August.
- EMAS have worked with the Derbyshire system to finalise the local Winter Plan which considers further actions which could be taken to improve performance over the coming months. The actions link back to the Urgent and Emergency Care 10 point plan and covers all providers across Derbyshire. Proposed actions include increasing resources, reducing conveyances, reducing ambulance turnaround times which should release crew capacity, and delivering same day emergency care.

What are the next steps

- As part of the winter planning actions, there is a National review of three chief complaint codes which are currently a C2 with the potential to move them into a C3 category. The data will be reviewed nationally once all Ambulance Trust data has been submitted, with recommendations then being presented to ECPAG for formal approval.
- An updated version of the National Managing Conveyances Policy is due to be reissued to systems. The policy promotes a proactive approach to managing hospital conveyances through activity monitoring in ambulance Emergency Operations Centres. In the event of delays and no ambulance being available to respond to life threatening 999 calls, then rapid handovers should take place, this must be enacted in conjunction with system escalation processes.
- NHSE/I will be publishing the Paramedic Referral to Same Day Emergency Care (SDEC) document shortly which will enable other systems to refer into SDEC.
- Work is also taking place to maximise the utilisation of IUC CAS capacity and the transfer of work from 999 into the IUC CAS. The NHSEI National team are currently undertaking some work around this, with an update due shortly.
- Work is taking place with the EMAS Reducing Conveyance Lead to refresh the alternative pathways and determine next steps.
- The Pathways Clinical Consultation Support (PaCCS) system is due to be installed in October 2021 to allow EMAS teams to have up to date access to local service information and referrals.
- EMAS will be live with Service Finder from 1st October to enable crews to access alternative services whilst on scene.

Derbyshire	Quarter One 2021-2022	July	August	September	Quarter Two 2021-2022
Calls (Total)	59,214	23,342	21,271	21,463	66,076
Total Incidents	42,043	14,155	13,248	12,857	40,260
Total Responses	37,900	12,608	11,873	11,505	35,986
Duplicate Calls	11,841	5,500	4,471	4,559	14,530
Hear & Treat (Total)	9,473	5,234	4,927	5,399	15,560
See & Treat	12,959	4,617	4,223	4,198	13,038
See & Convey	24,941	7,991	7,650	7,307	22,948
Duplicates as % Calls	20.0%	23.6%	21.0%	21.2%	22.0%
H&T ASI as % Incidents	9.9%	10.9%	10.4%	10.5%	10.6%
S&T as % Incidents	30.8%	32.6%	31.9%	32.7%	32.4%
S&C as % Incidents	59.3%	56.5%	57.7%	56.8%	57.0%
S&C to ED as % of incidents	54.8%	51.8%	53.6%	52.6%	52.7%

Planned Care

DERBYSHIRE COMMISSIONER – INCOMPLETE PATHWAYS (92%)

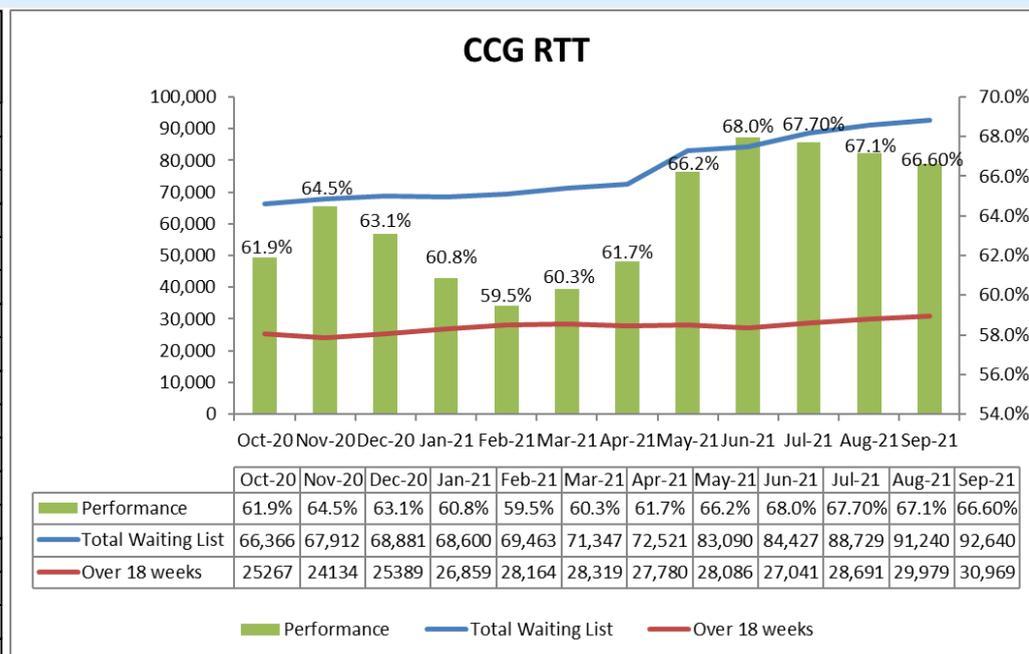
Performance Analysis

Performance for September 2021 was 66.6%, a slight reduction on the 67.1% in August.

The total incomplete waiting list for DDCCG was 92,640 an increase of £1,400 on the previous month. As mentioned previously those patients who are now on the ASI list at UHDB, awaiting an appointment, are now included in the overall figure.

The number of referrals across Derbyshire during September showed an increase of 22% for urgent referrals but a reduction of 25% for routine referrals when compared with the average weekly referral of the previous 51 weeks. (Urgent referrals are 15% higher and the routine referrals 21% lower than the same month during 2019.)

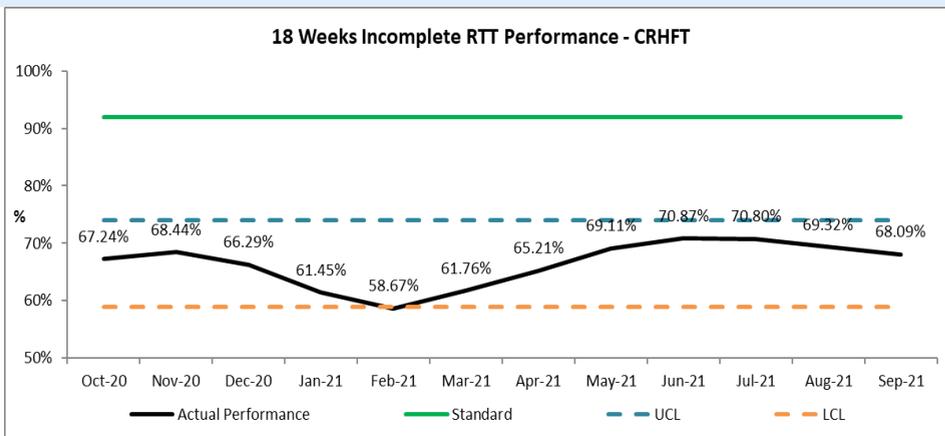
Treatment Function	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Total 52 plus weeks
General Surgery Service	5,000	2,578	51.6%	837
Urology Service	4,227	3,061	72.4%	264
Trauma and Orthopaedic Service	13,823	7,306	52.9%	1,770
Ear Nose and Throat Service	5,972	3,845	64.4%	453
Ophthalmology Service	12,926	7,675	59.4%	822
Oral Surgery Service	24	14	58.3%	1
Neurosurgical Service	537	337	62.8%	16
Plastic Surgery Service	595	397	66.7%	48
Cardiothoracic Surgery Service	209	120	57.4%	16
General Internal Medicine Service	290	223	76.9%	0
Gastroenterology Service	4,530	3,523	77.8%	116
Cardiology Service	2,392	1,874	78.3%	36
Dermatology Service	6,820	4,909	72.0%	117
Respiratory Medicine Service	1,545	1,261	81.6%	4
Neurology Service	2,431	1,928	79.3%	5
Rheumatology Service	1,785	1,302	72.9%	13
Elderly Medicine Service	282	245	86.9%	1
Gynaecology Service	6,639	4,471	67.3%	305
Other - Medical Services	6,331	5,120	80.9%	65
Other - Mental Health Services	350	305	87.1%	0
Other - Paediatric Services	6,860	4,638	67.6%	322
Other - Surgical Services	8,041	5,638	70.1%	546
Other - Other Services	1,031	901	87.4%	24
Total	92,640	61,671	66.6%	5,781



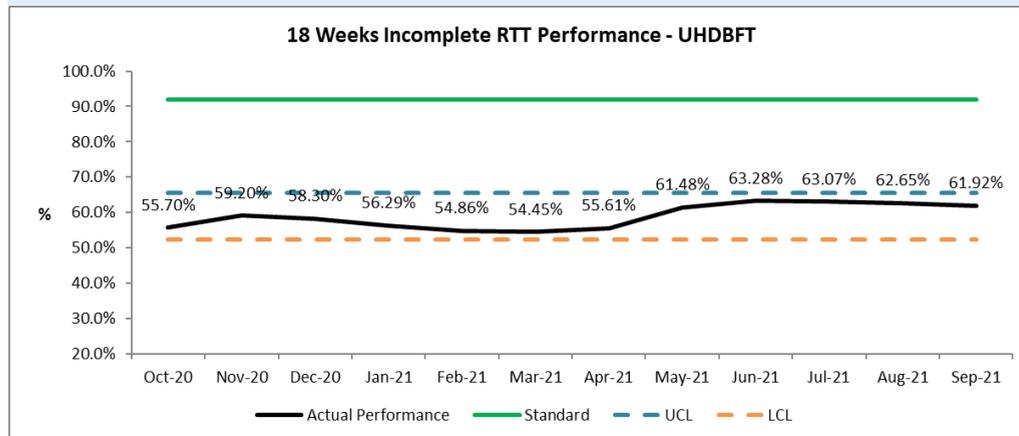
- The Derbyshire CCG position is representative of all of the patients registered within the CCG area attending any provider nationally.
- 70% of Derbyshire patients attend either CRHFT (25%) or UHDB (45%). The RTT position is measured at both CCG and provider level.
- The RTT standard of 92% was not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

Referral to Treatment – Incomplete Pathways (92%).

CRH – During September the trust achieved 68.1%, a slight reduction on the August figure of 69.3%. The incomplete waiting list at the end of August was 19,955 (August – 19,775).



UHDB - During September the trust achieved a standard of 61.9%, a slight reduction on the August figure of 62.7%. The incomplete waiting list at the end of September was 86,349 (August - 85,931).



Treatment Function	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Total 52 plus weeks
General Surgery Service	1,212	519	42.8%	261
Urology Service	1,162	931	80.1%	16
Trauma and Orthopaedic Service	1,949	1,068	54.8%	164
Ear Nose and Throat Service	1,467	968	66.0%	92
Ophthalmology Service	2,251	1,305	58.0%	160
Oral Surgery Service	1,296	733	56.6%	96
General Internal Medicine Service	261	204	78.2%	0
Gastroenterology Service	1,285	958	74.6%	10
Cardiology Service	520	389	74.8%	1
Dermatology Service	1,853	1,518	81.9%	7
Respiratory Medicine Service	547	399	72.9%	0
Rheumatology Service	386	286	74.1%	3
Gynaecology Service	1,572	1,059	67.4%	164
Other - Medical Services	1,000	764	76.4%	17
Other - Paediatric Services	1,169	962	82.3%	21
Other - Surgical Services	2,024	1,523	75.2%	117
Other - Other Services	1	1	100.0%	0
Total	19,955	13,587	68.1%	1,129

Treatment Function	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Total 52 plus weeks
General Surgery Service	4,903	2,683	54.7%	568
Urology Service	3,721	2,348	63.1%	336
Trauma and Orthopaedic Service	14,417	7,254	50.3%	1,952
Ear Nose and Throat Service	6,906	4,074	59.0%	315
Ophthalmology Service	11,195	5,707	51.0%	842
Oral Surgery Service	3,150	1,622	51.5%	319
Neurosurgical Service	114	67	58.8%	0
Plastic Surgery Service	345	250	72.5%	21
Cardiothoracic Surgery Service	7	6	85.7%	0
General Internal Medicine Service	16	13	81.3%	0
Gastroenterology Service	3,419	2,818	82.4%	10
Cardiology Service	1,854	1,589	85.7%	9
Dermatology Service	6,358	3,905	61.4%	147
Respiratory Medicine Service	780	711	91.2%	1
Neurology Service	2,124	1,638	77.1%	2
Rheumatology Service	1,686	1,234	73.2%	8
Elderly Medicine Service	393	300	76.3%	5
Gynaecology Service	6,634	4,238	63.9%	222
Other - Medical Services	6,311	4,984	79.0%	41
Other - Mental Health Services	3	3	100.0%	0
Other - Paediatric Services	4,372	2,655	60.7%	289
Other - Surgical Services	6,552	4,448	67.9%	568
Other - Other Services	1,089	919	84.4%	37
Total	86,349	53,466	61.9%	5,692

DERBYSHIRE COMMISSIONER – OVER 52 WEEK WAITERS

52 Week Waits

September figures show that there were 5,781 Derbyshire patients waiting over 52 weeks for treatment in Derbyshire. Of these 4,493 were waiting for treatment at our two main providers UHDB and CRH, the remaining 1,288 were waiting at various trusts around the country as outlined in the table on the following slide.

The number has shown an increase for the first time since March 2021. It is expected that the number may increase further.

CCG Patients – Trend – 52 weeks													
	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug	Sept
DDCCG	2,107	2,658	3,388	4,245	5,903	7,554	8,261	7,490	6,859	6,199	5,897	5,627	5,781

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
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
CRH	308	438	594	797	1,202	1,475	1,471	1,278	1,179	1,095	1,098	1,118	1,129

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 September 2021 at associate providers are as follows:

Provider	Total	Provider	Total
ASPEN - CLAREMONT HOSPITAL	20	SPIRE REGENCY HOSPITAL	5
BARTS HEALTH NHS TRUST	3	STOCKPORT NHS FOUNDATION TRUST	390
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	4	TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	2
BMI - THE ALEXANDRA HOSPITAL	4	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	1
BMI - THE PARK HOSPITAL	3	THE ONE HEALTH GROUP LTD	3
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	5	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	1
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	8	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	2
EAST AND NORTH HERTFORDSHIRE NHS TRUST	1	THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FT	5
EAST CHESHIRE NHS TRUST	21	THE ROTHERHAM NHS FOUNDATION TRUST	1
EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	1	THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	1
GEORGE ELIOT HOSPITAL NHS TRUST	1	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	1
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	1	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	3
LEEDS TEACHING HOSPITALS NHS TRUST	6	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	31
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	2	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	3
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	9	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	63
MID YORKSHIRE HOSPITALS NHS TRUST	1	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	8
NEWMEDICA COMMUNITY OPHTHALMOLOGY - BARLBOROUGH TREATMENT CENTRE	3	WEST SUFFOLK NHS FOUNDATION TRUST	1
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	1	WOODTHORPE HOSPITAL	5
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	292	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	2
NUFFIELD HEALTH, DERBY HOSPITAL	50	HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST	5
NUFFIELD HEALTH, NORTH STAFFORDSHIRE HOSPITAL	1	LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	7
PENNINE ACUTE HOSPITALS NHS TRUST	1	SOUTH TYNESIDE AND SUNDERLAND NHS FOUNDATION TRUST	1
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	1	BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	1
ROYAL FREE LONDON NHS FOUNDATION TRUST	4	PORTSMOUTH HOSPITALS UNIVERSITY NATIONAL HEALTH SERVICE TRUST	1
SALFORD ROYAL NHS FOUNDATION TRUST	13	SPAMEDICA DERBY	32
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	2	PRACTICE PLUS GROUP HOSPITAL - BARLBOROUGH	18
SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	41	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	1
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	56	UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST	1
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	135	YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUS	1
SPIRE NOTTINGHAM HOSPITAL	2	Total	1288

Actions:

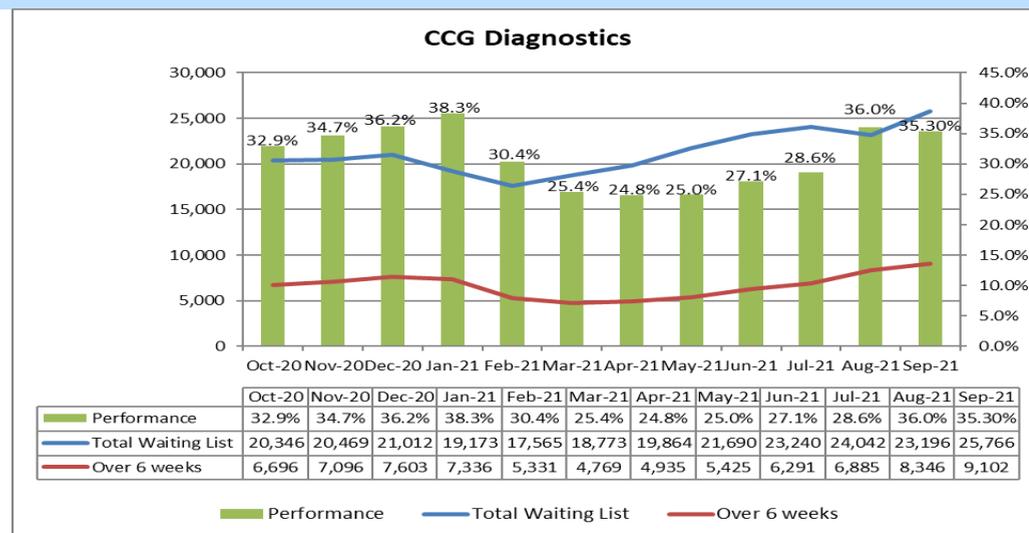
- The performance team make enquiries of the relevant CCGs and responses received back are that these patients are not clinically urgent but are being reviewed. We have not been informed of any TCI dates.

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

Performance Analysis

Derbyshire CCG Diagnostic performance at the end of September was 36.0% waiting over six weeks, a slight decrease on the 35.3% waiting at the end of August.

The total number of Derbyshire patients waiting for diagnostic procedures increased during September. 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.



Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Percentage waiting 6+ weeks
Magnetic Resonance Imaging	4,739	1,393	421	29.4%
Computed Tomography	3,219	963	397	29.9%
Non-obstetric Ultrasound	9,184	3,403	802	37.1%
Barium Enema	2	0	0	0.0%
DEXA Scan	851	205	32	24.1%
Audiology - Audiology Assessments	1,190	437	103	36.7%
Cardiology - Echocardiography	3,459	1,719	307	49.7%
Neurophysiology - Peripheral Neurophysiol	331	3	0	0.9%
Respiratory physiology - Sleep Studies	171	48	11	28.1%
Urodynamics - Pressures & Flows	126	59	27	46.8%
Colonoscopy	894	333	250	37.2%
Flexi Sigmoidoscopy	360	116	64	32.2%
Cystoscopy	273	61	33	22.3%
Gastroscopy	967	362	234	37.4%
Total	25,766	9,102	2,681	35.3%

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%	0.6%	8.2%	2.1%	1.1%	69.1%	0.0%
Computed Tomography	37.1%	1.5%	23.3%	20.8%	38.2%	11.2%	1.2%
Non-obstetric Ultrasound	50.1%	1.0%	0.4%	11.6%	14.0%	9.1%	0.0%
Barium Enema	0.0%						0.0%
DEXA Scan	31.5%	0.4%	51.4%	27.5%	15.7%	58.7%	
Audiology - Audiology Assessments	28.5%	46.8%	49.5%	1.4%	3.3%	29.3%	44.5%
Cardiology - Echocardiography	46.0%	54.6%	25.5%	21.6%	32.3%	33.3%	66.7%
Peripheral Neurophysiology	0.9%		0.0%			1.4%	5.0%
Respiratory physiology - Sleep Studies	29.3%		8.1%	3.2%	16.8%	26.3%	0.0%
Urodynamics - Pressures & Flows	50.0%	59.3%	22.2%	61.9%	4.0%	38.7%	
Colonoscopy	10.0%	34.7%	84.7%	31.0%	28.9%	46.6%	49.5%
Flexi Sigmoidoscopy	12.2%	27.8%	81.4%	58.9%	39.0%	44.4%	12.2%
Cystoscopy	23.6%	0.0%	0.0%	30.8%	39.0%	9.1%	18.2%
Gastroscopy	13.5%	37.3%	82.3%	43.3%	27.9%	53.7%	18.9%
Total	41.6%	19.6%	41.4%	16.9%	20.0%	44.7%	28.2%

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

Performance Analysis

Performance during September was 19.6%, an improvement on the August figure of 22.1%.

The numbers on the waiting list have increased overall. The number waiting over 6 weeks have decreased slightly but the number waiting over 13 weeks continues to increase.

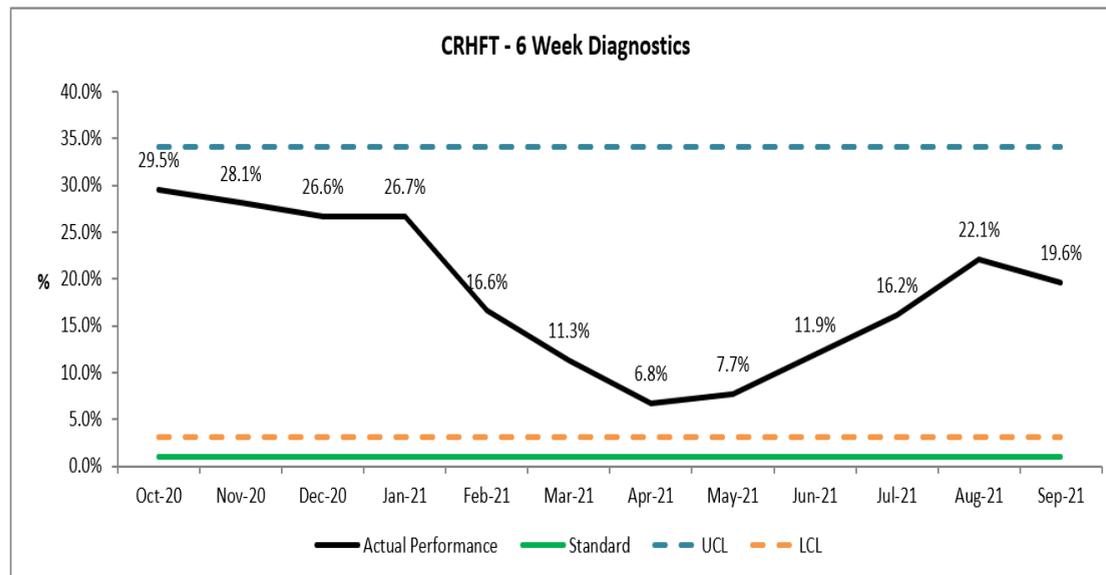
What are the issues?

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 41.6%, a further deterioration of the August position.

The overall numbers on the waiting list have increased during September, as have the number waiting over 6 weeks and the number waiting over 13 weeks.

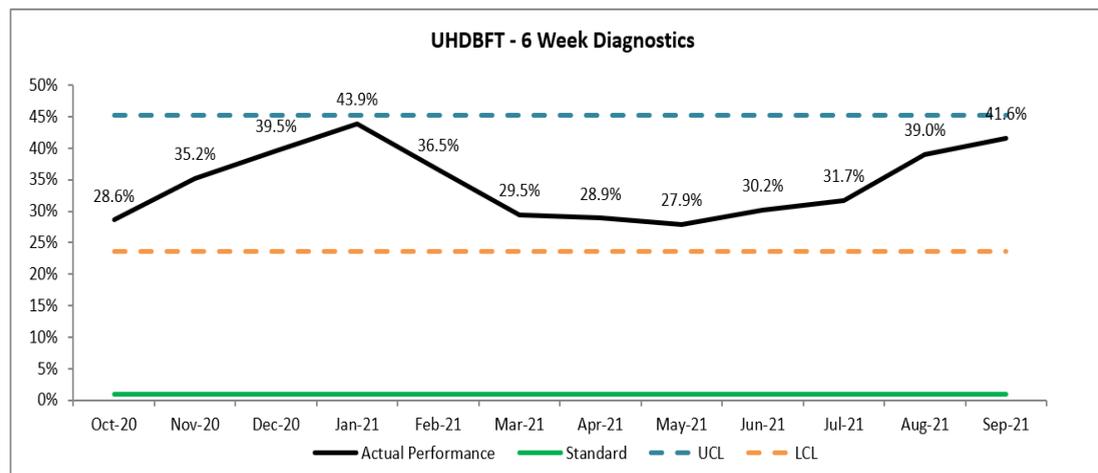
Non Obstetric ultrasounds and Urodynamics are experiencing the highest waits proportionally.

Issues

- Continued limited MRI capacity mainly due to staff shortages but also due to the scanner at Florence Nightingale Community Hospital remaining closed.
- Echocardiology capacity has been sought from external suppliers but there is a high demand for this nationally.
- Endoscopy waiting list initiatives are not being picked up by staff who are already stretched in their usual roles.
- 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

- Infection Control have allowed turnaround times between patients to be relaxed by 5 minutes in some areas.
- Seven radiographers have been recruited from abroad.
- Seven newly-qualified sonographers have been recruited to increase Ultrasound capacity.
- The bid for a Rapid Diagnostics Site at the Trust was successful, which will enhance patient flow.
- Expanding endoscopy services at the Sir Robert Peel Hospital.



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%

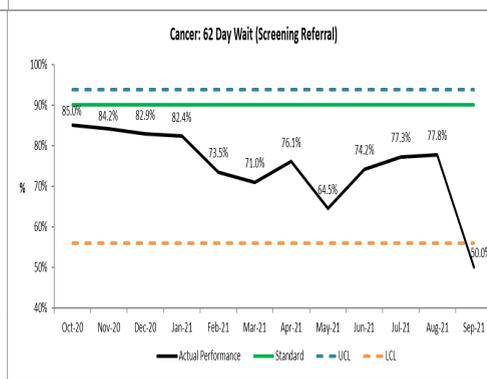
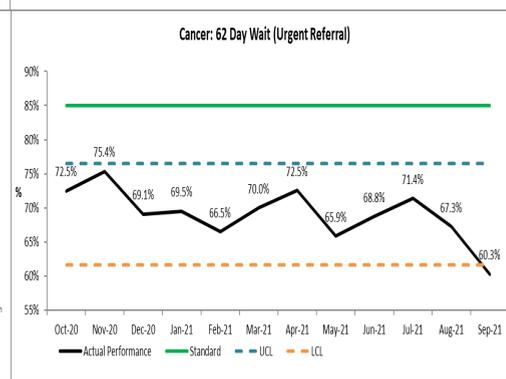
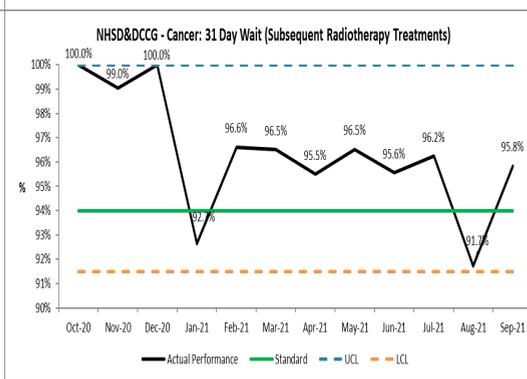
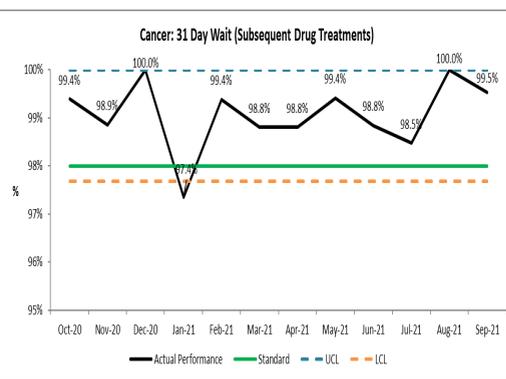
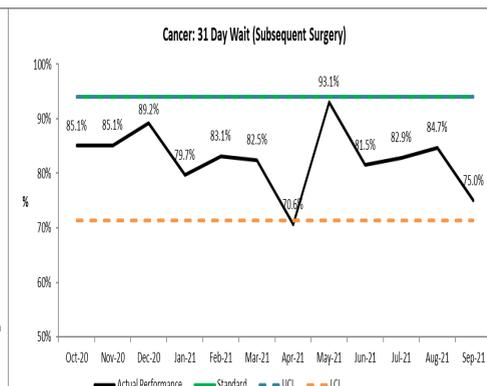
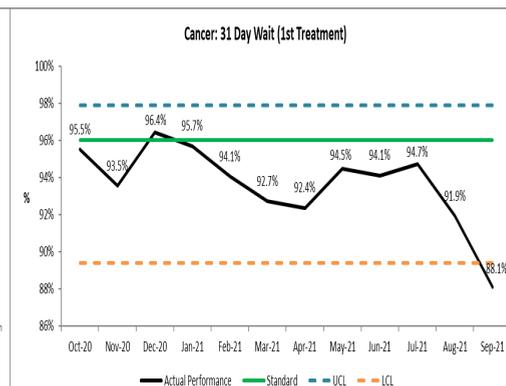
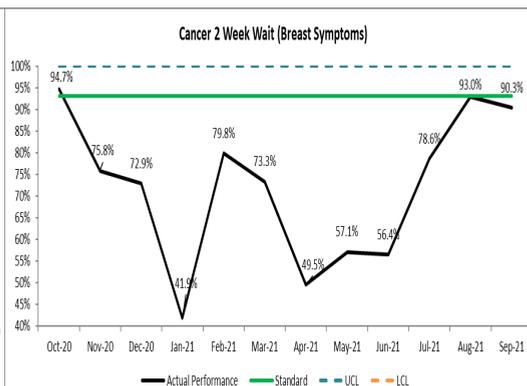
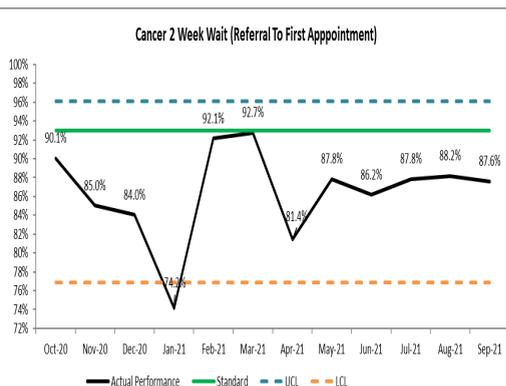
DERBYSHIRE COMMISSIONER – CANCER WAITING TIMES

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

- **31 day Subsequent Radiotherapy – 95.8%** (94% standard) – Compliant at all trusts except NUH>
- **31 day Subsequent Drugs – 99.5%** (98% standard) – Compliant for all Trusts.

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

- **2 week Urgent GP Referral – 87.6%** (93% standard) – Compliant for Stockport.
- **2 week Exhibited Breast Symptoms – 90.3%** (93% standard) – Compliant at Derby & Burton, Nottingham and Sherwood Forest.
- **28 day Faster Diagnosis – 74.00%** (75% standard) – Compliant for Chesterfield and Nottingham.
- **31 day from Diagnosis – 88.1%** (96% standard) – Compliant for Chesterfield and Stockport.
- **62 day Urgent GP Referral – 60.3%** (85% standard) – Non compliant for all trusts.
- **62 day Screening Referral – 50%** (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 September for first treatment within 62 days of urgent referral has reduced to 64.6%, remaining non-compliant against the standard of 85%.

There were 99 patients treated along this pathway in September with 64 of those patients treated within the 62 day standard, resulting in 35 breaches which is an increase from the 20.5 reported in August.

Of the 35 breaches 20 of the patients were treated by day 76, 9.5 treated by day 104 and 5.5 treated after 104days. The tumour sites reporting the breaches include Breast(12), Lower GI(7.5), Lung(3.5), Skin(1), Urology(7) and Other(4).

Current Issues

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

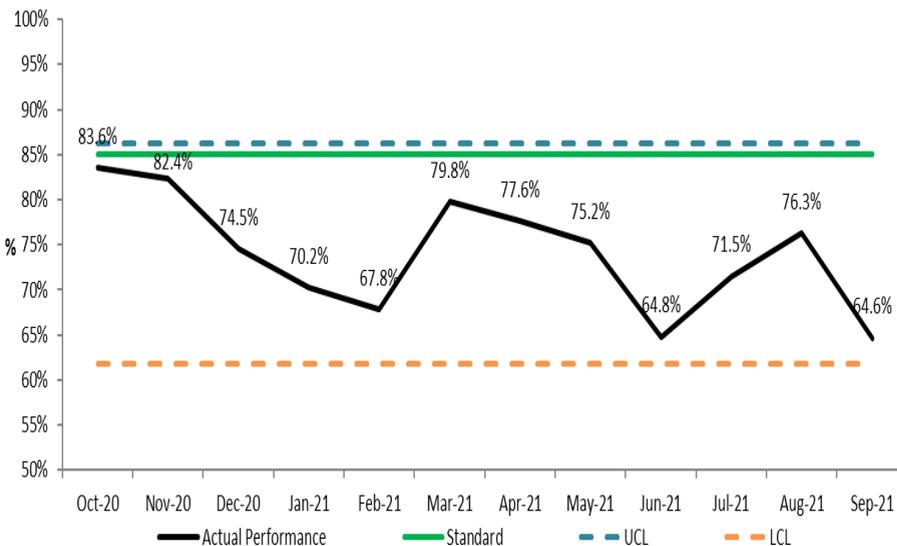
Actions Being Taken

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

What are the next steps

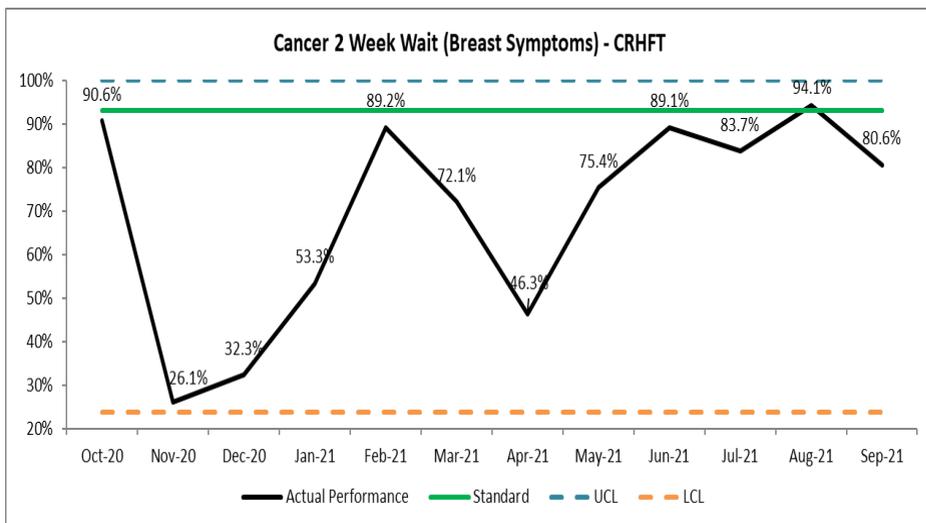
- Continued focus on those patients over 62 day and 104 day on the PTL.
- H2 Operational Plan for 21/22 requires the trust to reduce their PTL of patients waiting over 63 days for treatment to the February 2020 figure or lower.

CRHFT - Cancer: 62 Day Wait (Urgent Referral)



Tumour Type	Total Patients Seen	Seen Within 62 Days	Breaches of 62day Standard	% Seen Within 62 Days
Breast	2397	1863	12	35.14%
Lower Gastrointestinal	1515	671	7.5	42.31%
Lung	899	534	3.5	30.00%
Other	3381	1928	4	68.00%
Skin	3476	3019	190	96.88%
Urological (Excluding Testicular)	3198	2094	7	61.11%
Total	14866	10109	35	64.65%

CRHFT - CANCER WAITING TIMES – Breast Symptomatic



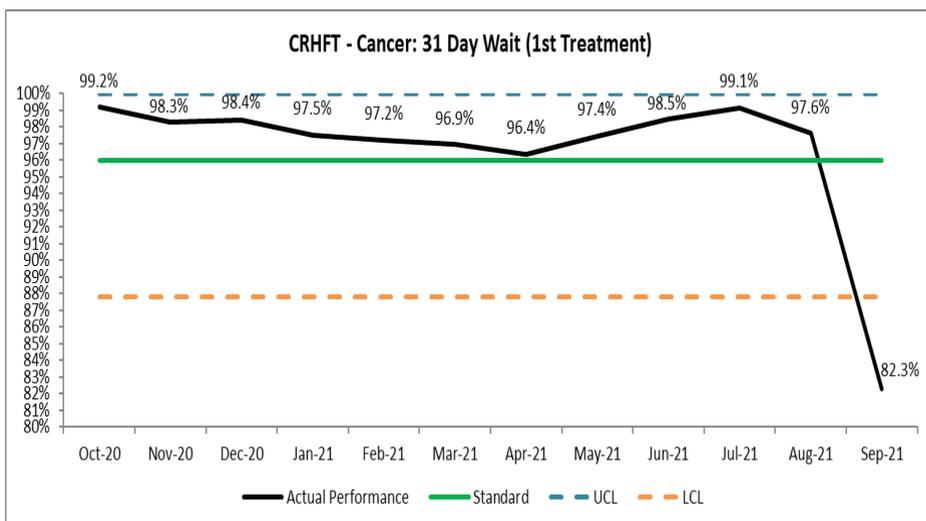
Performance Analysis

Performance in September at CRH for the Breast Symptomatic standard has reduced to 80.6% resulting in the Trust being non-compliant against the standard of 93%.

There were 36 patients seen via the Breast Symptomatic pathway in September with 29 of those patients being seen within the 14day standard resulting in 7 breaches.

Out of the 7 breaches 4 of the patients were seen by day 21 with the remaining 3 seen by day 28.

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



Performance Analysis

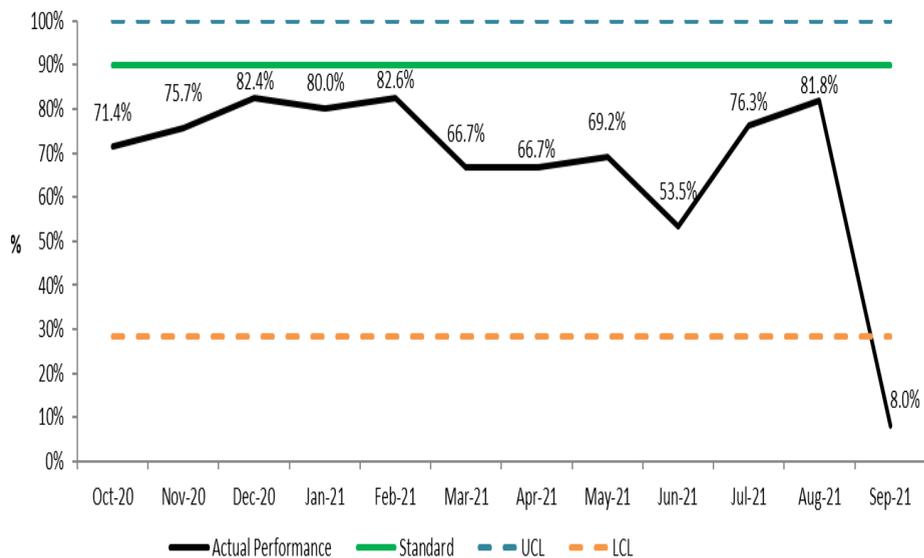
Performance in September at CRH for 31 day from diagnosis to first treatment has reduced to 82.3%, resulting in the Trust being non-compliant against the standard of 96%.

There were a total number of 147 patients treated in September along this pathway with 121 of those patients being treated within the 31day standard resulting in 26 breaches. The tumour sites reporting the breaches include Breast(17), Lower GI(4), Skin(3), Urology(1) and Other(1).

Out of the 26 breaches 18 of them were treated by day 48 with the remaining 8 being treated by 62days.

CRHFT - CANCER WAITING TIMES – 62day Screening Referral

CRHFT - Cancer: 62 Day Wait (Screening Referral)



Performance Analysis

Performance in September for the 62day screening standard has deteriorated to 8% and continues to remain non-complaint against the standard of 90%.

The number of patients treated via screening referral were 12.5 with only 1 of those patients being treated within the 62day screening standard resulting in 11.5 breaches.

Of the 11.5 breaches there were 7 of those patients treated by 76 days, 3.5 by 104days and 1 after 104days. The tumour sites reporting the breaches include Breast(10) and Lower GI(2).

The reasons for the delay include Elective Capacity(9), Patient Choice(1), Complex Pathway(1) and Admin Delay(1).

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

Performance Analysis

UHDB performance during September for first treatment within 62 days has reduced slightly to 54%, remaining non-compliant against the standard of 85%.

There were a total of 194.5 patients treated along this pathway in September with 105 of those patients being within the 62 standard resulting in 89.5 breaches, an increase from the 73.5 reported in August.

Out of the 89.5 breaches there were 14.5 patients treated by 76days, 38.5 treated by day 104 and 36.5 treated over 104days. The tumour sites reporting the breaches include Breast(6), Lower GI(14), Lung(5.5), Skin(2), Urology(34) and Other(28).

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

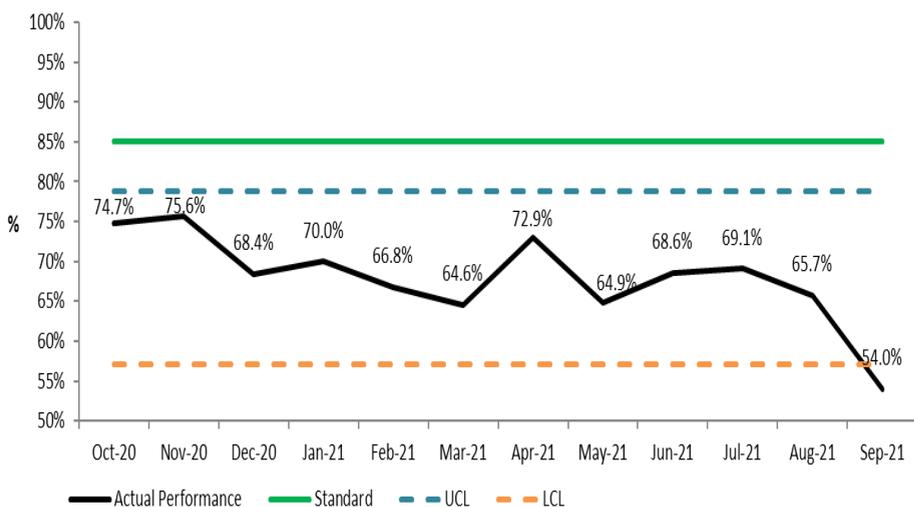
Actions Being Taken

- 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.

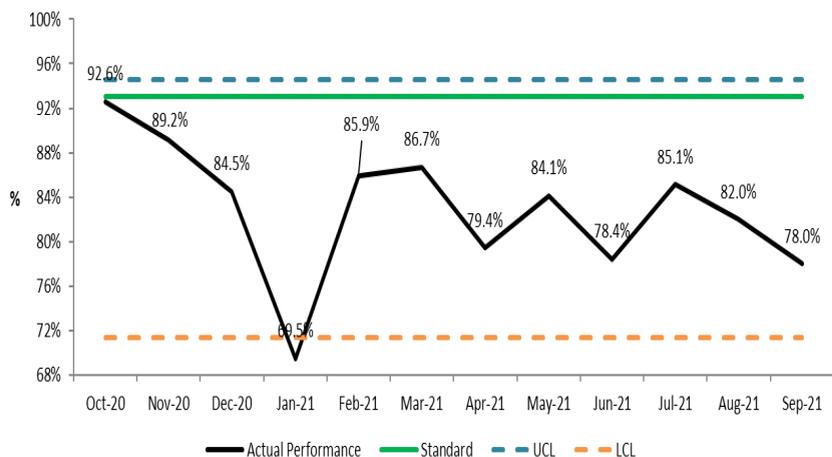
UHDBFT - Cancer: 62 Day Wait (Urgent Referral)



Tumour Type	Total Patients Seen	Seen Within 62 Days	Breaches of 62day Standard	% Seen Within 62 Days
Breast	2397	1863	6	81.82%
Lower Gastrointestinal	1515	671	14	12.50%
Lung	899	534	5.5	38.89%
Other	3381	1928	28	47.66%
Skin	3476	3019	2	93.55%
Urological (Excluding Testicular)	3198	2094	34	34.62%
Total	14866	10109	89.5	53.98%

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

Cancer 2 Week Wait (Referral To First Appointment) - UHDBFT



Performance Analysis

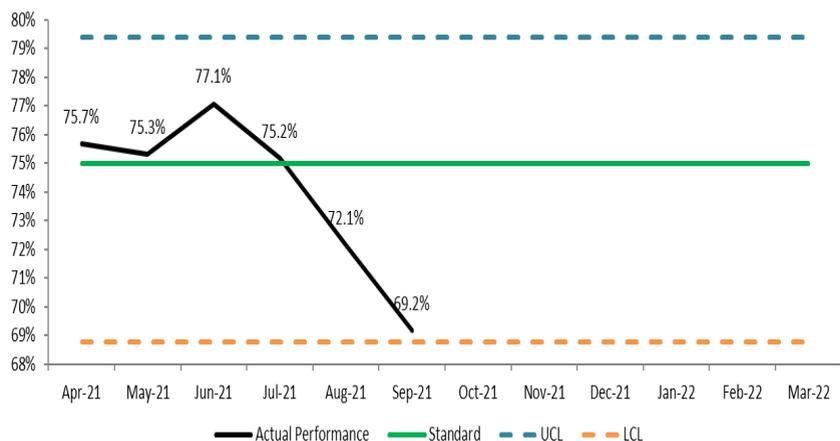
September performance at UHDB for 2 week wait has reduced slightly to 78% and continues to remain non-compliant against the standard of 93%. The main challenges for 2ww performance this month has been associated with Gynaecology and Lower GI.

There were a total number of 3,451 patients seen in September by way of GP Urgent referral to first appointment which is an increase on the 3,049 reported in August. Nearly 60% of the referrals related to Breast, Lower GI and Skin. Of the 3,451 patients seen in September, 2,691 of these patients were seen within the 2 week wait standard, resulting in 760 breaches which is an increase on the 550 reported in August.

The 760 breaches occurred in Brain(1), Breast (27), Children (2), Gynaecology (179), Haematology (3), Head and Neck (13), Lower GI (307), Lung (2), Skin(44), Testicular(1), Upper GI (74) and Urology (107).

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

UHDBFT - Cancer: 28 Day Faster Diagnosis Standard



Performance Analysis

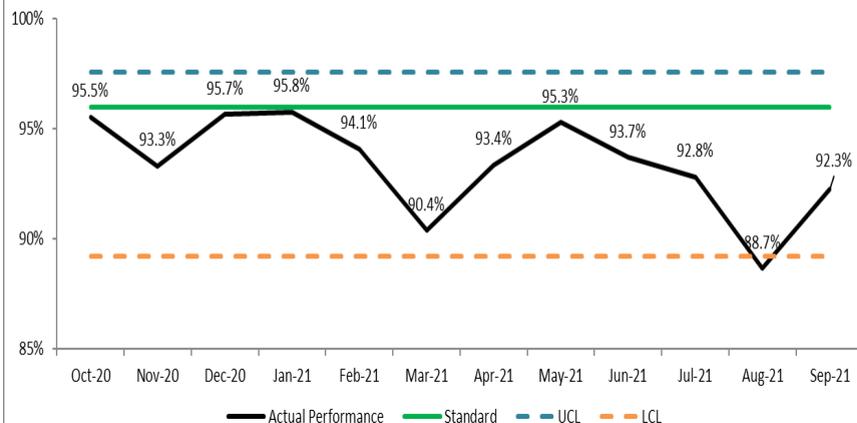
Performance in September at UHDB for the 28day Faster Diagnostic Standard is 69.2% and for only the second month is reporting non-Compliant against the 75% standard.

There were a total of 3365 patients seen via the 28 day faster diagnosis pathway in September with 2327 of those patients being informed of a cancer diagnosis or not within the 28 day standard, resulting in 1038 breaches. This is an increase from the 841 breaches reported in August.

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

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

UHDBFT - Cancer: 31 Day Wait (1st Treatment)



Performance Analysis

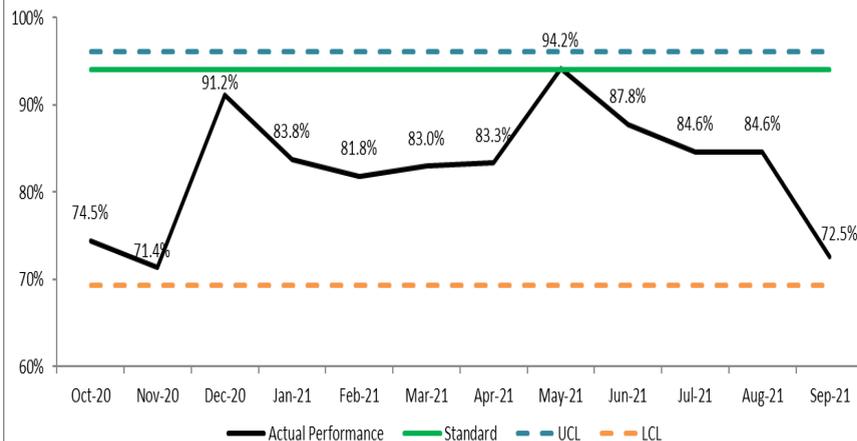
September performance at UHDB for 31 day from diagnosis to first treatment has improved to 92.3%, however, it still remains non-compliant against the standard of 96%.

There were a total number of 362 patients treated in September along this pathway with 334 of those being treated within the 31day standard, resulting in 28 breaches. The 28 breaches is an improvement this month when compared to the 42breaches reported in August.

The 28 breaches occurred in Breast(6), Lower GI(6), Lung(1), Skin(8), Urology(4) and Other(3).

UHDB - CANCER WAITING TIMES – 31day to Subsequent Surgery

UHDBFT - Cancer: 31 Day Wait (Subsequent Surgery)



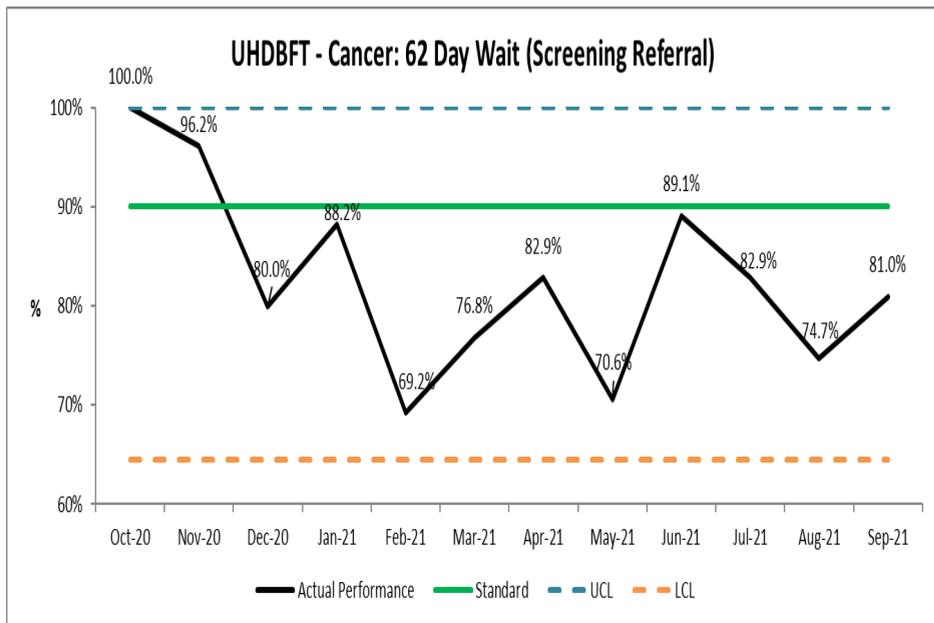
Performance Analysis

September performance at UHDB for 31 day to subsequent surgery has reduced to 72.5%, continuing to be non-compliant against the standard of 94%.

There were a total number of 51 patients treated along the subsequent surgery pathway in September with 37 of those patients being treated within the 31day standard, resulting in 14 breaches.

Of the 14 breaches, 7 of those patients were treated by day 38, 4 by day 48, 1 by 62days and 2 over 62days.

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



Performance Analysis

Performance in September at UHDB has improved to 81%, however, it continues to remain non-compliant against the standard of 90%.

There were a total of 42 patients treated in September who were referred from a screening service with 34 of those patients being treated within 62 days, resulting in 8 breaches.

Of the 8 breaches there were 3 of those patients treated by 76 days, 2 by 90days, 2 by 104days and 1 after 104days. The tumour sites reporting the breaches include Breast(2) and Lower GI(6).

The reasons for the delay include Medical Reasons, Theatre Capacity and Complex Diagnostics.

Appendix

PERFORMANCE OVERVIEW M6 – ASSOCIATE PROVIDER CONTRACTS

Provider Dashboard for NHS Constitution Indicators				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	Area	Indicator Name	Standard	Latest Period	East Cheshire Hospitals			Nottingham University Hospitals			Sheffield Teaching Hospitals FT			Sherwood Forest Hospitals FT			Stockport FT								
	Urgent Care	Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	Oct-21	↓	62.2%	62.3%	40	A&E pilot site - not currently reporting 4 hour breaches			↑	71.0%	74.1%	66	↑	82.6%	87.2%	12	↑	62.4%	71.3%	17	
A&E 12 Hour Trolley Waits			0	Oct-21	↓	54	98	7	↑	108	461	4	↓	14	30	8	↑	2	18	3	↓	4	9	3	
Planned Care	Referral to Treatment for non-urgent consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Sep-21	↑	66.7%	56.4%	49	↓	66.6%	68.2%	24	↓	78.0%	80.7%	20	↑	72.1%	68.5%	49	↓	55.7%	57.6%	44	
		Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Sep-21	↑	365	3770	21	↑	3525	20265	18	↑	816	5057	18	↓	1040	7251	18	↑	3745	23411	41	
	2 Week Cancer Waits	Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Sep-21	↓	28.16%	53.82%	19	↑	44.65%	41.89%	19	↓	16.90%	15.60%	19	↓	20.02%	22.50%	21	↓	41.37%	44.69%	27
		All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	Sep-21	↓	92.7%	90.1%	1	↓	89.7%	88.4%	6	↑	91.4%	82.6%	6	↓	90.3%	91.9%	4	↑	97.4%	97.3%	0	
	28 Day Faster Diagnosis	Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	Sep-21	↓	79.1%	76.4%	7	↓	94.8%	76.1%	0	↑	83.7%	31.0%	6	↓	92.6%	94.4%	1	↔	N/A	N/A	0	
			Diagnosis or Decision to Treat within 28 days of Urgent GP, Breast Symptom or Screening Referral	75%	Sep-21	↓	61.2%	68.3%	6	↓	80.8%	80.2%	0	↓	67.9%	65.4%	6	↓	73.7%	77.2%	2	↓	55.5%	58.2%	6
		31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	96%	Sep-21	↑	98.1%	92.1%	0	↓	89.5%	89.3%	30	↑	89.9%	91.2%	6	↓	91.9%	94.2%	4	↓	95.5%	97.4%	1
			Subsequent Surgery Within 31 Days Of Decision To Treat	94%	Sep-21	↓	80.0%	92.3%	1	↓	66.0%	69.1%	41	↑	70.2%	78.9%	10	↑	100.0%	93.5%	0	↓	77.8%	92.2%	1
	Subsequent Drug Treatment Within 31 Days Of Decision To Treat		98%	Sep-21	↔	N/A	100.0%	0	↓	96.9%	98.7%	1	↔	100.0%	99.3%	0	↔	100.0%	91.8%	0	↓	100.0%	100.0%	0	
	62 Days Cancer Waits	Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	Sep-21					↑	93.6%	93.3%	2	↑	95.5%	96.4%	0									
First Treatment Administered Within 62 Days Of Urgent GP Referral		85%	Sep-21	↓	68.2%	63.0%	24	↑	69.2%	69.4%	18	↓	59.1%	60.9%	73	↓	61.4%	69.0%	21	↑	79.8%	77.0%	29		
First Treatment Administered - 104+ Day Waits		0	Sep-21	↓	0.5	32.0	13	↑	21.5	116.5	66	↓	13.5	121.5	66	↑	6.5	38.0	41	↔	1.0	10.5	29		
First Treatment Administered Within 62 Days Of Screening Referral		90%	Sep-21	↑	87.5%	75.8%	10	↓	69.2%	71.4%	10	↑	78.3%	70.6%	10	↑	80.0%	77.5%	4	↓	0%	42.9%	4		
Patient Safety	Incidence of healthcare associated Infection	First Treatment Administered Within 62 Days Of Consultant Upgrade	N/A	Sep-21	↓	78.9%	86.9%		↑	75.4%	75.9%		↑	74.4%	78.0%		↓	70.6%	76.2%		↓	75.8%	83.2%		
		Healthcare Acquired Infection (HCAI) Measure: MRSA Infections	0	Sep-21	↓	1	2	1	↔	0	0	0	↔	0	0	0	↔	0	0	0	↑	0	1	0	
		Healthcare Acquired Infection (HCAI) Measure: C-Diff Infections	Plan		Sep-21	↑		15			60			↓		84			42			↓		27	
			Actual				4	0			40	0				59	0			26	0			15	0
		Healthcare Acquired Infection (HCAI) Measure: E-Coli	-	Sep-21	↑	10	123		↓	71	348		↓	59	272		↑	27	179		↓	17	118		
Healthcare Acquired Infection (HCAI) Measure: MSSA	-	Sep-21	↑	2	46		↓	25	123		↓	17	97		↑	3	48		↑	3	29				

Governing Body Meeting in Public

2nd December 2021

ITEM NO: 205

Report Title	CCG Risk Register Report at 30 th November 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 – 11.11.2021 Primary Care Commissioning Committee – 24.11.2021 Quality and Performance Committee – 25.11.2021 Finance Committee – 25.11.2021			

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 30th November 2021;
- Appendix 2 which summarises the movement of all risks in November 2021.

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 30th November 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 30 th November 2021 detailed in Appendix 1.

NHS DERBY AND DERBYSHIRE CCG GOVERNING BODY MEETING

RISK REPORT AS AT 30TH NOVEMBER 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 – NOVEMBER 2021

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

Risk Register as at 30th November 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 November 2021	6	13	6	0	25
New Risks	0	0	0	0	0
Increased Risks	0	0	0	0	0
Decreased Risks	0	0	0	0	0
Closed Risks	0	0	0	0	0

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 – NOVEMBER 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.

October performance:

- CRH reported 88.7% (YTD 92.7%) and UHDB reported 67.0% (YTD 71.4%).
 - CRH - The volume of Type 1 attendances are approaching pre-pandemic levels, with an average of 202 attendances per day. By October 2021 the volume of Type 1 and streamed attendances were 1.7% higher than October 2019 levels.
 - UHDB - The volume of attendances is high, with an average of 514 attendances per day at Derby (Type 1 and co-located Urgent Treatment Centre) and 213 at Burton (Type 1 and Primary Care Streaming). As a Network the numbers of attendances are 6% higher than pre-pandemic levels (October 2021 compared to October 2019).
 - The acuity of the attendances was high, with Derby seeing an average of 13 Resuscitation patients and 190 Major patients per day and Burton seeing 119 Major/Resus patients per day.
 - Attendances at the 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 138 per day during October 2021 (compared to 99 per day in October 2019) .
 - SORG manages operational escalations and issues if required. The meeting frequency has been stepped up from weekly to twice per week.
 - GP Connect roll out complete enabling direct booking of GP appointments via 111.
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.

November update

Current bed position:

- CCG beds = 31 (Q3 2021/22 target 21).
- Adult Specialised Commissioning = 18 (Q3 2021/22 target 15).

- Children and Young People (CYP) specialised commissioning = 6 (Q3 2021/22 target 3).
 - The substantive Band 7 Commissioning Manager vacancy that primarily leads on the delivery of Care, Education and Treatment Reviews C(E)TRs is currently being advertised with a closing date of 21st November and interviews scheduled for 29th November. There is currently no admin support within the team, block booking of a Band 4 agency admin post is being prioritised to enable coordination of C(E)TRs and support with admin 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 17 individuals during October. The remaining patient reporting on the platform will be concise ahead of the national report being run on 28th November. A robust system is now in place to maintain this moving forward.
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.

No further changes for November.

October update:

- Monthly groups are in place with all four providers represented.
- Completion of assurance framework quarterly is undertaken by all providers and reports to Planned Care Delivery Board (PCDB) quarterly, and to System Quality Group (SQG).
- Identified harm is reported on STEIS and all providers are monitoring this.
- A risk stratification tool is being piloted by providers.

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.

November 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 31st 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.

November update:

- The blood tube shortage has stabilised.
- There is an 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.

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.

November update

October 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 and long term financial position and deliver a balanced in-Year position.
- As at Month 6 the CCG are not seeing any major financial pressures against planned expenditure with the exception of CHC

and we continue to work with Midlands & Lancashire Commissioning Support Unit and providers to rectify this.

- The CCG is due to submit its plans for the H2 period in 2021/22 on 16th November. As a result, at the end of Month 7 the CCG Governing Body had not approved the H2 budgets but the CCG expects to remain within its allocated resources although there remains a substantial underlying deficit in the System that will need to be addressed moving into 2022/23.

4. **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 30th November 2021;
- Appendix 2 which summarises the movement of all risks in November 2021.

Risk Reference	Year	Risk Description	Responsible Committee	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	Link to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner							
				Probability	Impact				Rating	Rating	Rating												
				Probability	Impact				Rating	Rating	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 Aiden & GEM CSJ 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	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. Remember: The CCG contracting team continues to monitor and manage all contracts due for expiry including plans to extend or reprocure.	2	3	6	2	3	1	4	4	May 22	ICS	Nov-21	Dec-21	Helen Dillstone - Executive Director of Corporate Strategy and Delivery	Chrisay Tudor - Director of Corporate Delivery

Appendix 2 - Movement during November 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	↔	GP Connect roll out complete enabling direct booking of GP appointments via 111.	Zara Jones Executive Director of Commissioning Operations	Quality & Performance	Craig Cook Director of Contracting and Performance / Deputy Director of Commissioning Operations Jackie Carlile Claire Hinchley 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	↔	The CSU have been asked if they can transfer a worker to assist in the Re X applications for the CHC cohort	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	↔	In order to ensure timely and concise reporting to NHSE/I mapping of required reporting and associated timeframes has been undertaken	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	<u>Contracting:</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	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	<p>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.</p> <p>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</p>	4	5	20	4	5	20	↔	Issue around the impact of the recent government announcement on the mandatory COVID vaccination of NHS staff.	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	↔	Slippage identified and schemes to support waiting times agreed by MH,LDA,CYP Board and being initiated.	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	3	4	12	↔	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.	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	2	3	6	↔	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.	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	↔	Continuing work with NHSEI to finalise EPRR submissions for CCG and Derbyshire Providers.	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 CCG is due to submit it's plans for the H2 period in 2021/22 on 16th November.	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	↔	Milestone plan for the Short Breaks review is going to be considered by System Delivery Board.	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	↔	The Governance Guide is progressed and submitted for approval at November Engagement Committee.	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 remain on track as per previous report, potential savings quantified over next quarter still.	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	↔	Project group to recommence review of HR files with a view to scanning into an electronic filing system.	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	↔	Mid-year review conversations focussing on health & wellbeing & support required by staff taking place during October & November.	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	1	4	4	↔	Number of redeployments has significantly reduced.	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	↔	No progress update. Advise to keep the risk on the tracker due to forthcoming winter pressures and the spread of COVID variants.	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	↔	Agreed to develop two rehab centres at CRH and Florence Nightingale.	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	↔	Continued pressures on paediatric units and in 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	3	4	12	↔	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.	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	↔	A risk stratification tool is being piloted by providers.	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	↔	Independent Panel is now due to meet virtually on 13th December.	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	↔	If completed by December review this risk will be proposed to be closed in December.	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 reproced. 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 CCG contracting team continues to monitor and manage all contracts due for expiry including plans to extend or reprocedure.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Chrissy Tucker - Director of Corporate Delivery

Joined Up Care Derbyshire Board
Minutes of the Meeting held in PUBLIC on
Thursday 16 September 2021 (0900-1300 hours)
Via Microsoft Teams

UNCONFIRMED

Present:		Designation:	Organisation:	
Helen Phillips	HP	Chair	Chesterfield Royal Hospital NHSFT	
Angie Smithson	ASm	Chief Executive	Chesterfield Royal Hospital NHSFT	
Avi Bhatia	AB	GP & Clinical Chair	Derby & Derbyshire CCG	
Penny Blackwell	PB	Place Board Chair & Governing Body GP	Derby & Derbyshire CCG	
Chris Clayton	CC	Chief Executive & ICS Executive Lead	Derby & Derbyshire CCG	
Brigid Stacey	BS	Chief Nurse	Derby & Derbyshire CCG	
Sean Thornton	ST	Assistant Director Communications & Engagement	Derby & Derbyshire CCG JUCD	
Martin Whittle Left 1230	MW	Chair of the System Engagement Committee	Derby & Derbyshire CCG	
Kath Markus	KM	Chief Executive	Derby & Derbyshire LMC	
Robyn Dewis Left 1000-1100	RD	Director of Public Health	Derby City Council	
Andy Smith (late joining)	AS	Strategic Director of People Services	Derby City Council	
Roy Webb	RW	Councillor	Derby City Council	
Carol Hart	CH	Councillor & Cabinet Member for Health & Communities	Derbyshire County Council	
Helen Jones	HJ	Executive Director of Adult Social Care & Health	Derbyshire County Council	
Dean Wallace Left 1000-1100	DW	Director of Public Health	Derbyshire County Council	
Prem Singh Left 1230	PS	Chair	Derbyshire Community Health Services NHSFT	
Ifti Majid	IM	Chief Executive	Derbyshire Healthcare NHSFT	
Selina Ullah Joined 1045	SU	Chair	Derbyshire Healthcare NHSFT	
Richard Wright	RWr	Non-Executive Director & Interim Chair of Finance & Estates Assurance Committee	Derbyshire Healthcare NHSFT	
Stephen Bateman	SB	Chief Executive	DHU Health Care	
John MacDonald (Chair)	JM	ICS Chair	Joined Up Care Derbyshire	
Sukhi Mahil	SKM	ICS Assistant Director	Joined Up Care Derbyshire	
Vikki Ashton Taylor	VT	ICS Director	Joined Up Care Derbyshire	
Gavin Boyle Left 1230	GB	Chief Executive	University Hospitals Derby & Burton NHSFT	
Kathy Mclean Left 1030	KMc	Chair	University Hospitals Derby & Burton NHSFT	
In Attendance:		Designation:	Organisation:	Deputy on behalf of/Item No:
Helen Cooke	HC	PA to Chief Executive (JUCD Quality Assurance Committee & Planned Care Delivery Board)	Chesterfield Royal Hospital NHSFT	
Maria Riley	MR	Director of Transformation and PMO	Chesterfield Royal Hospital NHSFT	
Richard Chapman	RC	Chief Finance Officer	Derby & Derbyshire CCG	Deputy for Lee Outhwaite
Helen Dillistone	HD	Executive Director of Corporate Strategy and Delivery	Derby & Derbyshire CCG	CCG Exec Lead Rep

Kate Brown	KB	Director of Joint Commissioning & Community Development	Derby & Derbyshire CCG	Item 10
Will Jones	WJ	Chief Operating Officer	Derbyshire Community Health Services NHSFT	Deputy for Tracy Allen
Carolyn Green	CG	Director of Nursing & Patient Experience	Derbyshire Healthcare NHSFT	Patient Story
Trevor Wright	TW	Chair of EQUAL Autism group	Supporting Derbyshire Healthcare NHSFT	Patient Story
Karen Tomlinson	KT	Non-Executive Director	EMAS	Deputy for Pauline Tagg
Jackie Counsell	JC	ICS Executive Assistant	Joined Up Care Derbyshire	Note taking
Linda Garnett	LG	ICS Workforce & OD Lead	Joined Up Care Derbyshire	
Sarah Draper	SD	Assistant Director of Strategic Transformation, NHSE/I, North Midlands	NHS E/I – Midlands	Deputy for Fran Steele
Elaine Andrews	EA	Deputy Director Strategy, Planning & Assurance	University Hospitals Derby & Burton NHSFT	
Gino Distefano	GD	Director of Strategy	University Hospitals Derby & Burton NHSFT	

Members of the Public in Attendance:

Scott Davies, Business Consultant, First Care
Susan Applegarth, Partnership Development Manager, Elysium Healthcare
Marcus Latham
Marc Goddard

Apologies:		Designation:	Organisation:
Lee Outhwaite	LO	JUCD Finance Lead & Director of Finance	Chesterfield Royal Hospital NHSFT
Tracy Allen	TA	Chief Executive	Derbyshire Community Health Services NHSFT
Paddy Kinsella	PK	Exec of GP Alliance	Derbyshire GP Alliance
Riten Ruparelia	RR	GP Alliance Provider Representative	Derbyshire GP Alliance
Phil Cox	PC	Non-Executive Director	DHU Health Care
William Legge	WL	Director of Strategy & Transformation	EMAS NHSFT
Pauline Tagg	PT	Chair	EMAS NHSFT
Rachel Gallyot	RG	Clinical Chair	East Staffordshire CCG
Fran Steele	FS	Director of Strategic Transformation, North Midlands	NHS E/I – Midlands

160921/1	Welcome, Apologies and Minutes of Previous Meeting	Action
	<p><i>As per the Agenda, members were reminded that the meeting was being recorded purely for the purpose of minute accuracy.</i></p> <p>The Chair welcomed Board members to the meeting and apologies for absence were noted as reflected above; the meeting was confirmed as being quorate.</p> <p>The minutes of the last meeting held in public on 15th July 2021 were noted to be an accurate record. Today's meeting was confirmed as being held in public.</p>	
160921/2	Action Log	
	VT advised there were no outstanding actions requiring an update as there were either closed or covered on the agenda for today's meeting.	
160921/3	Declarations of Interest	
	The Chair asked for any changes to the Declarations of Interest to be identified in the meeting. The purpose was to record any conflicts of interest and note any other conflicts in relation to the meeting agenda. No changes were noted.	

The Chair welcomed CG to the meeting. CG is lead Director supporting the DHcFT service users and carers forum which is called EQUAL (to reflect working in a way where there is equal knowledge and equal influence of the strategic direction within DHcFT).

CG set the context that at a DHcFT Trust Board a few months ago a colleague agreed to share their lived experience where it was recognised that outcomes for individuals living with Autism and their families were less than optimal. This lived experience example corresponded with various feedback through the autism sub-group, Healthwatch and stories previously shared anonymously with the DHcFT Trust Board (with individuals subsequently feeling more empowered to share publicly). CG handed over to TW to talk through his story.

TW explained that he lived locally in Derby and was diagnosed in 2014 with autism and his teenage daughter was diagnosed 2 years ago when she was in school. From talking to other parents/autistic individuals, many of the points he was raising today were common experiences.

Assessment and support: Although the point of diagnosis was brilliant, subsequent assessment/ support was patchy. The problem is that whilst there are many committed teams/individuals across the locality, the good examples are not systematic and provision for autistic people/families was not always comprehensive. When TW was diagnosed it was a very quick, productive and positive experience which helped him enormously. However, now waiting lists are over 2 years, possibly longer, as the situation has been exacerbated by covid. This delayed diagnosis means that people on waiting lists don't get any support for presenting needs as they need a confirmed diagnosis before they get any help. Lots of autistic people have issues around anxiety, attention issues, demand avoidance etc and without any support there are increased chances of them going into crisis.

Lack of sensory assessment: The biggest gap for TW personally is those co-occurring conditions around the attention issues he has and demand avoidance (avoiding everyday expectations), including sensory needs. Sensory issues can relate to sensitivity to light, sound, balance, muscle sense and having a sense of your own physical/mental wellbeing. TW was never offered assessment for those needs. Sensory assessments do happen for some children but not routinely for adults and there is a significant impact when senses are being overloaded; some people shut down, but many explode outwards. The lack of sensory assessment is key. He never received any assessment for anxiety either, and had a long history of high blood pressure which was linked to his anxiety issues. TW felt, as well as being a cost to himself, there was a cost to the system/GP/health service in general because of the subsequent physical impact.

Education/support: TW learnt a lot through his own work/research, but in order to find a decent support group for basic knowledge, information and support post diagnosis, he had to travel to Nottinghamshire as although there is a parent support group in Derby it's quite stretched. When his daughter was diagnosed, it was a 3-year battle, even though he worked within health and social care and knew a bit about the system.

During those 3 years they got passed around different teams/individuals (community paediatricians, psychology teams and CAMHS) in Derby/Belper who seemed to work with different systems. This resulted in having to repeat information over again, not having up to date information stored in different locations and diaries not joining up; simple things that could be resolved.

Fantastic support was received from a nurse, who then unfortunately went off long term sick and it took 3 months for someone to step back in; by which point his daughter was in the middle of her GCSEs and at that time said "if they can't be bothered why should I". Consequently, her school performance dropped, her teenage attitude got worse which had a

damaging effect on the family. She struggled in 6th Form and had to go back to Derby College to re-sit A 'Levels, consequently she is c. 1½ years behind her peers.

Transition issues from Child/Adult: A positive point with CAMHS input is that his daughter did recover a bit, but that support stops at 18 and then there were no checks or processes to enable her transition across to adult support which happened during covid; this had a big impact/struggle with isolation. It was a lot of family effort to try and keep her mental health levels topped up daily.

TW didn't think this was a one off; many families tell the same stories, with one of the main gaps being around sensory needs and co-occurring conditions/behaviours which many families are left without educational support to cope with and those behaviours have big impacts on lives, as it can limit access to social opportunities. This in turn can also have a big impact on healthcare system in terms of costs and inefficiencies. Quite often those people who struggle then go on to have challenging behaviours need higher levels of support/care.

The following key summary discussion points were highlighted:

- JM thanked TW for sharing his story and highlighting these important points.
- So many people supported as adults in social care are those that have somehow been 'failed' elsewhere in the system; there is so much more we need to do as society to understand neurodiversity. We need to look at those leaders within our organisations who have lived experiences of neurodiversity and family experience and bring them together to provide leadership to help facilitate positive changes (HJ). CG added that DHcFT also had colleagues that would be willing to do that.
- In terms of what difference diagnosis made for TW individually; TW said that it was a positive experience helping him to understand why he does things, but crucially why he didn't do things he always wanted to do, e.g. write/sing. Once he understood why, he could then work out some strategies with some help and in doing this he had joined writing groups (since had 2 poetry collections published) and joined a community choir. This helped raise his self-esteem and to develop skills to reduce anxieties that unless you learn how to self-manage can lead to reliance on the mental health system. TW did receive some support through community mental health and as a result now feels unlikely to need it again, as he feels he is a much more rounded person now and feels he can do a lot more and contribute more.
- IM added that he had heard TW's story a couple times and it was really impactful. Both this story and others with lived experiences were real drivers in making a significant shift in how we think about delivery of services for people with autism. He added there is a real danger we simply put this in the MH&LDA Delivery Board space, when it's wider and covers all aspects of how we deliver health and social care services to give people with autism best outcomes. As co-chair of the work within the Anchor institutions this was an area where we can think about how we support employment opportunities for people with autism. In addition, we had also invested in prevention as part of our new model, we need to ensure support at local level (including high intensity support) for people and families living with autism are embedded within the new model.
- CH referred to an observation where a family close to her was experiencing real problems with an adopted daughter, where lots of people wanted to help but there was no coordination and things were falling through gaps/overlapping. It would be good to have an overarching lead to help with co-ordination of services.
- The story highlights the big differences that can be made by working on behaviours, attitudes, understanding and caring; not simply relying on plans/written documents (PB)
- Insightful story with interesting points about diagnosis in later life. In terms of delayed diagnosis in young people, there is a contribution educational establishment can make. (RW).

The Chair thanked CG and TW on behalf of the Board for sharing the insightful lived experience story of our services, which led to some rich conversation and recognition of areas

	<p>that need attention, including the need for strategic coordination not just within health, but across social care and education. Within the ICS that sits with the Mental Health & Learning Disability Autism (MH&LDA) delivery board to lead and to make connections with other parts of the system. Many important ideas/comments had been made which will help with further conversations to tackle these issues.</p>	
160921/5	Chair and ICS Executive Lead Update (JM, CC)	
	<p>The Chair noted his recognition, in addition to the content in the Chair and Executive Lead Report, of the pace to develop the ICB and ICP whilst balancing this with the day job and the huge pressures the system continues to experience. There was an immense amount of guidance coming through and it is a very challenging time; thanks, were put on record to all for the continued hard work; noting the good relationships that exist continued to help get us through this difficult time.</p> <p>CC highlighted the following salient points:</p> <ul style="list-style-type: none"> • The patient story this morning demonstrates how much more we need to do, and it will be a continual development process to get the improvements we are striving for. • There was recognition of the need to consider the balance between competing pressures and needs, in the short, medium and longer term. • The system is currently in Opel 3 (lower grading to few weeks ago when it was escalated to Opel 4). We are incredibly busy from an urgent and emergency care perspective, not just in A&E but including 111/999 teams, GPs, EMAS. However, the coordination across system is a very good marker of an Integrated Care System. It was noted that the pressures extend to all services (planned care, maternity, cancer, MH&LDA) who continue to deal with the pandemic that is not over and are working hard to restore services to pre-pandemic levels. In addition, the system was progressing the rollout of phase 3 of the covid vaccine programme as a protective measure. <p>The JUCD Board NOTED the report.</p>	
160921/6	System Leadership Team Report (ASm)	
	<p>ASm advised the report provided a brief summary of the System Leadership Team (SLT) meeting held on 13 August 2021 (previously circulated). There were good discussions focusing on digital, data and information. The key decisions made were:</p> <ul style="list-style-type: none"> • Recruiting to a system Chief Data Officer • Procurement of the digital tool and continuing to progress the Population Health Management (PHM) programme. A further meeting had taken place last week and all areas were progressing. There was some really good work to pull together all the programmes through the digital tool, so that there was no duplication in effort in reporting and ensuring we are clear on outcomes to prioritise and focus our energy more effectively <p>The JUCD Board NOTED the report.</p>	
160921/7	JUCD ICS System Development: Transition Assurance Subcommittee Report (AB, VT)	
	<p>AB updated the Board that the Transition Assurance Committee (TAC), continued to meet on a regular basis and were aware the workload will increase towards the establishment of the ICS.</p> <p>TAC was taking a pragmatic approach and had reviewed the critical success factors mentioned in the report. AB likened it to a job description with essential/desirable characteristics/functions; those considered essential being the actions required to allow the CCG to close and for the ICB to be established to take the necessary statutory duties. TAC also remained mindful of the desirable functions and the building blocks of the ICS in order to make this as good an ICS as it possibly can be. He assured the Board that there was progression in all areas; noting there were a selection of risks, but TAC was continually reviewing them whilst remaining cognisant of the pressures the system is currently under, plus the added pressures going into winter.</p>	

VT highlighted that in both the Chair/Executive Lead report and the TAC report a significant number of national publications were referenced that had been issued recently to help support the development of the ICS. One of those documents is the Readiness to Operate Statement (ROS), which will be used as a measure by the NHSEI regional team to provide assurance that our system is progressing as expected between now and April 2022. Thus, we are in the process of aligning the ROS with our system transition plan and will highlight any areas where we feel additional work or focus is required.

The following points were highlighted:

- KM asked about Glossop, where there were 6 practices covering c. 30K patients, who had a multitude of questions around the pace of change, funding, what resource was being given to this and when/if there were plans to give the opportunity to both LMCs/GPs involved about how the transition will happen and what will happen for things such as shared care records, pathology, medicines management, wound care, and enhanced services (amongst other things). KM sensed that many GPs in Glossop/ High Peak were feeling unsettled and were seeking clarity.
- CC advised that Helen Dillistone is the Executive Lead for the system, working with our partners in Greater Manchester to work through all the possible areas that need to be considered to enable a safe legal transition. HJ and CC had a call with council leaders in the high peak last night, who had similar questions and CC gave them broad assurance that we would be taking a sensible and pragmatic approach to this. Firstly, there was a need to understand all aspects, there will be no hasty changes, it will be a considered approach to ensure a smooth transition.
- From a GP perspective CC had a call scheduled with the PCN clinical director there, to discuss the integration of GPs through the PCN into the Place model and how we engage further on this.
- KMc asked for clarification on the status of reporting progress on items, which things were further ahead than others and what were the things causing more concern when on the face of it they are rated the same (e.g. amber)? Also where were discussions taking place about how we connect everything being done to the ICS core purposes and ensure we keep the focus on Place, Provider Collaboratives and coming together as an ICP; there was a need to, hear more about what this means for our population as we set this up and the difference it would make to our people. Finally, was there a method for seeking views of the membership of both the ICB and the ICP and how it will link with HWB and sought assurance that we will be addressing these things.
- CC as accountable officer for the transition, asked the Board to hold its nerve over the next couple of months, when we'll have the ability to answer urgent, immediate and important questions whilst holding true to the purpose. CC's anecdotal view based on experience was we have a lot of work to do on integrated care, between our different services, organisations and communities; it's such a big agenda and a change from how the NHS has been constituted over many years and how it will work with colleagues from social care and public health in the future. The focus is on the safe legal transfer and establishment of the ICB; this will continue to be worked through in an open and transparent way, but our collective energy needed to be on the integrated care model in and out of hospital; whilst the mission critical elements continue to progress.
- PB advised that Place discussions had reflected that some of this is simply about a disconnect between senior strategic leadership and what's happening on the ground in the Local Place Alliances. There was a need to look at behaviours, attitudes, cultures, changing how things are done, working differently, questioning our purpose and connecting with the emerging functions of the ICB and ICP. PB felt progress was being made with conversations regarding how system leads think agnostically outside our organisation/ and the behaviours needed to change to become more integrated.
- AB agreed to work with VT/HD to look at how we can get more detail on the assurance of the progress on items (amber). He also reminded the Board that TAC's role was not to design the ICS and as things progress TAC will be able to provide more assurance.

	<ul style="list-style-type: none"> • VT added we can develop our previously agreed system milestones to become an ICS to show the critical path. • KMc set a challenge to the Board asking whether form genuinely does follow function and if so, how our time as leaders should be used i.e. focus on purpose and allow the form to happen in the background? • JM asked TAC to sense check if we had the capacity to implement the volume of detailed work required which would ramp up as we get nearer to establishing the ICB? • AB assured the Board that those discussions had already commenced to ensure this was factored in our roadmap. • JM formally updated the Board that as with all ICSs we had gone out to advert for the ICS CEO role for the ICB and interviews were scheduled to take place on 13th October 2021. As part of the recruitment process there would be a number of stakeholder sessions, to ensure wide engagement; information for these would be coming out shortly. He added that the Interview Panel would include NHS, LA and external representatives. <p>ACTIONS:</p> <ul style="list-style-type: none"> • JM noted that everything can't move at same pace and requested AB, VT, HD look at devising a critical path to highlight the key things that the Board needs to focus its attention on. • As the guidance is published it looks like a structured ICB from a national perspective that we need to put in place, but it's important we don't lose focus on partnership working, local perspectives and the important point made earlier in relation to purpose. CC/JM agreed the need to consider how those people not as fully involved in some of the discussions happening in the background are kept updated and engaged in developments. Over the next few months, we need to be explicit about our purpose as there is a danger of slipping into bureaucracy too much. <p>The JUCD Board NOTED the assurance report and progress being made.</p>	<p>AB, VT, HD</p> <p>CC/JM</p>
160921/8	<p>Developing ICS Operating Model (CC)</p>	
	<p>JM took the opportunity to formally welcome SU to the Board (who had just joined the meeting), SU had taken over from CM as Chair (DHcFT).</p> <p>CC went through the presentation (previously circulated) recapping on the functions of the ICB and ICP and previous discussions held with the Board during July/August 2021. CC updated that the ICP engagement document was published last night which now needed to be worked through to consider the local possibilities through ongoing discussions with the LA (both upper tier and districts/ boroughs). CC was hopeful that by November there would be a firmer view based on those conversations.</p> <p>CC highlighted the different roles and duties of both the ICP and ICB, with the ICB having very clear accountability and duties as a statutory organisation and employing people. CC talked through the presentation shared; outlining the composition of the ICS Model to demonstrate how everything links together:</p> <ul style="list-style-type: none"> • ICP is a partnership between the NHS/LA (Public Health & Social Care) • ICB principal input is NHS, plus statutory provider organisations (including Provider Collaborative at Scale and Place). The ICS host and support but collective input was required • Relationship between the ICP and HWBB would be via Place • There was a need to consider whether wider determinants of health are undertaken through the ICP or HWBBs. Current thinking was that the HWBBs would keep the global eye on JUCD (NHS, PH&SC), Built Environment (environmental quality/built environment); and Socioeconomic Factors (education, employment, income, family/social support). • Outcomes on the NHS side will be set by the ICB; these will need to be managed collectively via the NHS Executive Team. 	

The following key summary discussion points were highlighted:

- JM asked CC to think about the engagement processes to provide clarity for Board members; ensuring greater awareness of the key issues and where some of these discussions were taking place.
- KMc outlined a few thoughts; if the ICP did nothing else in year one, it would be responsible for creating the system strategy which had regard to health and wellbeing strategies and the JSNAs; there was a question how the system would best do that and how an inclusive approach would be created to ensure engagement with all partners including the VCSE. The ICP will be pivotal in setting the priorities for both the LA/ICB through this strategy. In terms of the diagrams, they should not be hierarchical; this was a partnership of equals and the current presentation did not reflect the primacy of place and communities.
- KMc asked if there were plans for a development session, if capacity and timing allowed for this, to work through this important aspect together rather than by having individual/small group discussions.
- PB concurred that VCSE were partners needed to be involved as they are key partners in all Local Place Alliances and Place Board.
- CC advised that the October JUCD Board would be a development session where we can bring forward a proposal on how we start to develop the Integrated Care strategy, recognising we need wider discussions.
- Pragmatically JM advised that the core ICP membership would be reflective of the current JUCD Board membership, but we may need to add others as required to ensure education/local people are also engaged.
- HJ gave her reflections on the ICP engagement document and felt it takes us back to the fundamental question or whether the ICP is a place where HWBBs come together or if that's part of its purpose. In 2020 there was consideration locally about both HWBBs coming together and it was agreed it was sensible to make those connections and share priorities. That piece of work hasn't progressed and now perhaps there was an opportunity for this to be housed in the ICP; recognising HWBBs will continue to exist with statutory responsibilities. The key now was about how we move forward without creating duplication and understanding the distinct purpose of the ICP and HWBBs. HJ added, the ICP engagement document doesn't differentiate between the upper tier and lower tier LAs. There was a session planned with district Cllrs/CEOs later this month, where the intention is to work through this and until those discussions take place there was a need to hold off reaching any firm conclusions as it was important to have their involvement and seek their views. We are required to have partnership and makes sense to us all locally to help shape our thinking.
- GB thanked CC for trying to make sense of all the guidance. GB agreed that cocreation and conversations are important; this was a good starter for 10 but it was vital that there was the opportunity to give more consideration collectively.
- IM thought the diagrams were a good way to start to crystallise what we are trying to create through the different component parts. He added a note of caution, in terms of how we connect operational delivery and performance management in the new system; duplication must be avoided and this included managing upwards to influence how NHSEI relinquish some of their control/performance management to enable us to do it ourselves; without this there will be continued challenges with capacity.
- IM added in terms of wider engagement, there were lessons from the anchor work. There is a real difference in engaging with and giving influence to external voices and there was a need to consider how the wider socioeconomic system can have a real impact; it is not just about having conversations but to genuinely cocreate with partners.

The Chair summarised JUCD Board **SUPPORT** for the recommendations made in the slides, noting that although there was some frustration of where we are and that some of these conversations still needed to happen, there was no general decent to points raised. There was agreement that we need to look at wider engagement and it would be helpful if CC could send a note out to Board members outlining what the process of engagement for engaging

	<p>with people in the development of the ICP. JM reiterated, when co-creating there was a need to maintain focus on the 'why', ensuring primacy of place, whilst noting this is journey with April 2022 being a key stage so there was also a need to maintain a balance with the fact that the ICB will be directly responsible and accountable to NHSEI from that point. As a system we were facilitating the partnership and we need a system that will allow both upward accountability for the money and care we provide as well as locally shaping how things happen, hence codesign is important.</p>	
<p>160921/9</p>	<p>Derbyshire System Financial Delivery (CC)</p>	
	<p>CC introduced RC. He advised that although we were talking principally about NHS finances today that doesn't preclude broader finance discussions continuing in the future.</p> <p>The System Finance & Estates Assurance Committee had shaped thinking to enable looking at finance as a system rather than individual organisational positions. CC reiterated the ICB will allocate funds for NHS delivery and we need to decide how best to spend that money.</p> <p>For context CC described the Derbyshire position. Noting, we currently allocate more money to providers than we receive as a system, and in turn actual spend is higher than the allocation; resulting in an overall deficit position. If we continue to deliver care in the same way as present, it would far exceed both our allocation and spend further. Therefore, there is a need to look at how we can improve this position and review finance in the next phase of our development. CC handed over to RC who went through his presentation (<i>ppt circulated post meeting</i>).</p> <p>The following key summary discussion points were highlighted:</p> <ul style="list-style-type: none"> • RW recognised NHS investment in smoking cessation, obesity, drugs/ alcohol, but flagged a disconnect as there is no transfer of funds or support directly into LAs; he felt this was one of the issues, as LA won't benefit from additional NHS funding and it would be helpful when looking at partner organisations/solutions that this is looked at as an ongoing issue. JM pointed out that although the focus is on NHS money, it is not for the ICB/ICP to manage LA money. JM agreed however, that it was important that there is visibility and understanding of the totality of the resources available and allocated in the system which included LAs. • IM reminded the group of examples in MH&LDA, where Long Term Plan money has been transferred into LAs to increase capacity in social care e.g. employing social workers. DW agreed and added there is also funding via the NHS into LAs for suicide prevention activity, an obesity post hosted by the City council and a population health management post hosted by the County. This was positive although recognised there was more to be done. • CC added that joint strategic intentions would go beyond the NHS which would facilitate decisions around how we jointly commission, agree budgets and commit resources collectively and equally with LA partners who will also need to commit. In terms of some of the efficiency programmes there will also be a need to capture some efficiencies that may traditionally be outside the NHS space, for example investments in housing which may impact positively on A&E attendances due to reduced respiratory infections. There was a need to work out how to capture such benefits in an efficiency programme which had a broader angle than the NHS. • PS pointed out that the STAR board had an informative this week based on sustainable financial and resource management and where to focus energy in terms of clinical processes. It highlighted that 66% of demand was driven by clinical practice and innovation not the aging population (which was c. 10%). Testing in Primary Care had gone up exponentially adding to demand and pressure on services. Much of the 66% was considered lower value/waste and persistent inequity was also evident. Recognising resource allocation along with upward accountability; there was a need to consider how we create a culture whereby primacy of place with devolution of resources was the crux of delivery so those clinicians making decisions closer to communities are accountable for resource commitments. PS suggested this could be an OD area of learning going forward. 	<p>JC</p>

	<ul style="list-style-type: none"> • JM concurred that the STAR Board presentation was very good, which echoed some of the approach RC had outlined and agreed we should be considering this further alongside the approach RC described. VT to share with Board member. • To aid with the cultural shift and clinical and professional decision making at all levels, SKM suggested that CPLG should be involved/sighted on the framework to help get this socialised within the system. • HJ said there is a strong link to a person-centred approach, where value is defined by the individual not the professionals, and suggested we need to be more explicit in the definitions and that this is a person-centred approach, as well as an asset based/outcome-based approach to focus on what matters to the individuals. • IM stated that in terms of ICB allocations to providers based on cost, there was a worry about traditional bilateral contracting arrangements. He was keen to have one ICB contract for the whole MH&LDA spectrum which DHcFT holds as the host organisation; DHcFT could then hold the contracts in the alliance in a new way of working. There was a need to think about these new alternative approaches as opposed to traditional ways of bilateral contracting. • JM added moving to this approach would not be an overnight change and will take 2-3 years before the real benefits are observed, as much of this will require fundamental changes as to how we work as a system to achieve this. There was a need to map out what can be delivered immediately via traditional financial means; how we develop the culture and systems and when we'll see an impact. He suggested joint thinking was required with OD colleagues and Clinical leaders early on as much of the care currently delivered was led by clinical practice yet considered low value in terms of patient outcomes and there was a need to work through the issues raised. • RWr suggested there was a need to develop and empower our Delivery Boards more, as that's where good clinical decisions are made for example in relation to allocation of resources, investment in prevention etc. There were also wider implications of such decisions in terms of how we develop our estates to support integration. • CC reiterated the importance of our integrated care model and that our clinicians don't think they're doing things with low value when initiating things, they are acting with good intent and it will require a significant change and looking at what we can do instead to gain better value. • It's important to ensure we take our citizens along with us on the journey if we are looking at a different way of planning how we fund our health services and we need to have a conversation with our population, as such ST would link in with RC (ST). • A collaborative financial management/ financial flows regime supported by a collaborative performance management was needed and should be thought through carefully to support integration, so it becomes the facilitator for the transformation we need. <p>The Chair summarised the need to consider how we take this forward/socialise this without slowing down pace on progress. We need to take into consideration patient, public, clinical and professional involvement and OD work/cultural changes that would be required. He suggested an update in the New Year on this.</p> <p>The Board NOTED the report and SUPPORTED the direction of travel described.</p> <p>ACTION: Agenda a further Derbyshire System Financial Delivery workshop item in the New Year to update on progress and review next steps.</p>	<p>VT</p> <p>CC, RWr</p>
<p>160921/10</p>	<p>Place Partnerships & Provider Collaboration at Scale (PB, KB, SB)</p> <p>Place Partnerships PB introduced KB to go through the paper (previously circulated). KB updated that further work had taken place on developing the components of the operating model in advance of the national guidance, which had recently been received and following review confirmed it endorsed the approach being taken locally which was supportive of building on existing work. In terms of the vision/purpose, functions and scope, there was a strong consensus of those</p>	

elements noting there were things that would need to be tested more formally, and there was more work to do around the wider functions in place partnerships and the work ongoing with communities (largely under the HWB structures) to ensure we are integrating, as the functions of place are much broader than joining up the health and social care. Similarly, discussions around membership and governance all relied on form following function, thus when the likely degree of delegated responsibility ambition is determined, this will heavily inform the recommendations we make. The next phase will be to firm up those proposals and feed into those discussions taking place in the system.

The subgroup is working with the voluntary sector who brought a recommendation of how to build that citizen voice as an ongoing process, using existing networks. Discussions had also been held around how we develop the workforce that will be needed to deliver place on an operational level including leadership/capability. The next step is to align the building blocks and transition work, whilst not losing sight of the need to drive/support delivery through those local place alliances and focussing on some major transformation pieces of work/feeding into place board to ensure its influencing/delivering on those programmes of work. This also included Glossop working with the subgroup mapping what we've got and how we are currently working to ensure a smooth transition.

PB added that Place were looking at new/emerging ways of thinking at Place board and had good engagement from all organisations who are key to the transformation. It had focussed on changing the culture/involvement of people/communities, whilst progressing the work as required. The voluntary sector was well embedded at place and place alliances and a task group had been established including members from the voluntary sector, Healthwatch, public health, GP leads, etc, looking at how we involve people/communities in place partnership and join up services and incorporate quality conversations, understanding of lived experience which can affect change to our services and resonates with ICS guidance. Work had also commenced with the King's Fund regarding an integration measure to identify how good we are at truly integrating services and putting what we say into practice. PB noted that place leads are mostly GPs who are great at leading across systems and thinking agnostically.

The following key summary discussion points were highlighted:

- If we have meaningful engagement with the voluntary sector at Place what additionality do, we need to do at ICP level. Need to understand the NHS accountability into Place and how does that work in a broad partnership model that's wider (CC).
- Public engagement work and engaging with both patients/the public voice is great and needs to happen at different levels both local/strategic and develop a golden thread that runs through the different tiers of system (MW).
- JM suggested some development time over the next 6 months to understand the relationships between the different parts of the ICS/what it looks like. In terms of keeping purpose at the forefront of our minds, he suggested; alongside the patient story having a story about how we are working differently in a meaningful way/making a difference to people.
- PB added that it can be difficult to measure impact on some things/hard to make it tangible, thus putting narrative in around this can be helpful.

The JUCD Board **NOTED** the Place Partnerships Update.

PC at Scale

SB updated the board on the PC at Scale report and recapped that PC at scale and place teams had been working together, since April when the PC at scale subcommittee had been set up under the NED chair of HP and had good representation across the system. The programme of work focussed on 3 mandatory areas: Acute collaboration (Planned Care under ASm leadership), urgent and emergency critical care (under GB's leadership), MH&LDA (under

IM's leadership). It also included the ambulance programme, 999/111 collaboration, plus in/out of hours primary care. Today's update will primarily focus on primary care.

He added that the national guidance was received in August and endorsed the work we are doing to date and reinforces our proposals. As a result of that a development session was held (August) and we have landed on a provider leadership model to drive forward the PC at scale work, bringing all NHS partners together across Derby/Derbyshire with plans to review membership as other collaboratives form, including LA. The work in August looked primarily at the positive work around MH&LDA and looking at forming a PC model working towards an alliance proposal. Other work being progressed was through Duncan Gooch's leadership on GP alliance and work with TA on the community services side, which was looking at two areas: General Practice provider collaborative as an organisation that is the voice of GP at scale. Tremendous progress had been made bringing together the work of the LMC, all practices and GP alliance work and that group is also looking to endorse the work of a primary and community care collaborative which brings together partners from across primary care, including optometry/dentistry/ pharmacy, the community services element and DHU out of hours. This group had started to look at a programme of work, looking at areas around primary care, strategy and community services and had made really good progress.

SB noted that there was an SLT development session planned for the 4th October to focus on PC at scale/Place partnership to understand it from a system leadership perspective to add further context to our thinking and the OD programme work will also add value to the work we're doing on provider collaboratives. SB/WL were also presenting to a system leadership conference next week to socialise this programme of work across the system further.

The following key summary discussion points were highlighted:

- We need to take a decision about the construct of the Provider Collaborative to help manage colleagues' expectations around the choices we've got/timescales we are working to (HP).
- In response, SB advised that we need a model form within the Derby/Derbyshire ICS by 31 March 2022. On 4th October we are focussing on looking at a provider leadership board for the NHS providers. It was the preferred model agreed by the subcommittee who thought it was the most sensible option from a governance point of view and has a clear purpose to oversee the various collaboratives that will be formed in Derby/Derbyshire to drive those transformation programmes, primarily via the delivery boards (SB).
- It was a big ask for provider organisations to think internally what it means for them, i.e., changes to commissioning, changes to ICB, what does it mean in terms of integrated care provision, timescales. There will be a report in a month on the integrated care strategy and we need to include how far we've got, including Place, PC at scale and delivery boards and how they start to connect. (CC).
- JM thanked colleagues for the really good work here. He suggested the following 4/5 key questions were important for the board to understand in terms of the integrity of the system:
 - The construct/timings
 - What is the relationship between place and provider collaboratives and how we ensure we're looking right across the system
 - Financial flows
 - Delegation of authority and decision making across place and PC
 - What does it mean for how the statutory organisations change the way they work

The JUCD Board **NOTED** the Provider Collaborative at Scale progress update.

160921/11 People & Culture Strategic Oversight Group (PS)

PS reminded the board that the relationship between PCSOG/the P&C Board was to ensure no duplication. The P&C Board would escalate matters of concern to PCSOG as required, with

	<p>PCSOG providing assurance to JUCD Board. He summarised the PCSOG report, advising that the 2nd meeting had reported on 3 key areas of discussion/actions to take forward:</p> <ul style="list-style-type: none"> • 4 key pillars of the NHS People Plan – assured that good progress is being made with a couple of areas requiring further attention in terms of new ways of working/true integration. Output/action was to look at few key aspirational metrics PCSOG should be looking at and how to connect with P&C Board to prevent a repetitive assurance mechanism. • System OD - a lot of good OD work had already been done previously, plus excellent Quality Conversations and the Growth model/how we can apply to the leadership model/embed going forward in addition to the anchor institution charter that we have signed up to. There will be various strands to the OD work plan, including discussions around finance/clinicians, change management process, place and how it will be modelled around our thinking. One area we need to embed OD further is into our organisations, where we can generally be guilty of focussing on structures in terms of ICS discussions rather than why we are doing it. • One workforce – one of the ICS strands is to develop a one workforce. SOG felt it was an important developmental strand and as such have arranged a session next week to consider what it means for the Derbyshire aspirations and approach for one workforce. <p>LG added that the framework underway with the Place team does have a much wider application and all those elements around shifting culture/mindsets, understanding what we mean by value, etc, could all be picked up in that framework. Thus, if the Board was happy that could be used to begin to structure our work across the different programmes of work.</p> <p>The following key summary discussion points were highlighted:</p> <ul style="list-style-type: none"> • JM suggested moving towards a single system leadership development programme across the system rather than as individual organisations. Importantly it would give people the opportunity to meet others from across system and would require pooling of resources. The Board were SUPPORTIVE of a single system leadership development approach. • PB added that this is what place had been trying to do, via the Place Alliance Leadership Meetings (PALM), which was about system leadership and how we do it. • LG thanked the board for the helpful steer on this. She updated that we do currently have several system leadership offers for instance Mary Seacole local (a programme for first line leaders, delivering on a system basis using our OD team across the system. Currently we had people from primary care, voluntary sector, LA and health sectors and this formed part of their introduction to leadership. Thus far, it had received excellent/powerful feedback. The only area where any push back had been experienced was on the middle management leadership development programmes where organisations currently run the programmes and feel protective about them, thus the Board's steer is helpful to enable this to be revisited. <p>The JUCD Board NOTED the report.</p>	
160921/12	Finance & Estates Assurance Committee (RWr)	
	<p>RWr updated the board on the F&EAC report, noting 2 meetings had been held. The group was chaired previously by CM, with membership also from CC/RC. Discussions had been a mix of topics pertinent to both NHS ICB and the wider system. The latest draft of the system estates plan was reviewed and included greater consideration around community facilities. There are several ongoing schemes at various stages of approval covering both acute and community facilities. It is an active programme with active expenditure. The system is limited to what can be spent on capital each year and the number of schemes is pushing against that limit, so JUCD ICS will have to prioritise capital expenditure going forward.</p>	

	<p>The committee discussion also focused on our financial position within the NHS, which although detailed the individual Trust positions, the discussion had been around the total NHS numbers and single deficit as NHS bodies in system. Based on what we know, the system is spending £200m more than allocated. Also discussed, was around a system efficiency improvement PMO tool for the whole of the system to collate/understand the efficiency programmes that will deliver that 3%.</p> <p>The following key summary discussion points were highlighted:</p> <ul style="list-style-type: none"> • CC advised we will start a conversation in October with the CCG Governing Body with AB’s permission regarding how a system F&E Committee could also give assurance on the CCG’s position and a mirror question to our provider partners, in terms of releasing capacity and having a single agenda. These are questions our provider colleagues will need to have with their own boards. We are starting on the commissioning side but need to consider how the ICB will have assurance on its allocation and spend. This will be picked up again in October/November as the ICB develops. <p>JUCD Board NOTED the report and the chair thanked RWr/RC for their hard work on this.</p>	
160921/13	Quality Assurance Committee (ASm)	
	<p>ASm (on KMc’s behalf) updated the board, advising that discussions had focussed on the need for system oversight from both a health and LA perspective and not to duplicate what we are doing in individual organisations.</p> <p>ASm reported on good progress being made with a joined up approach. These included:</p> <ul style="list-style-type: none"> • Children and Young People in EDs – significant difference had been made through senior leadership from social care being involved in regular discussions which had resulted in a reduced length of stay for those young people in EDs. • Maternity - Focus on Ockenden and broadened the discussion to focus on the whole range of maternity impacts and outcomes for our population. To give the board some assurance with maternity services currently being very high profile, BS advised that during September a robust assurance exercise had been completed with both maternity units. The reports received this morning were reassuring; these will be further reviewed by QAC and feedback to this board in November. • Risk Stratification for patients on waiting lists – linking in Quality Conversations with the health impacts and looking at the wider perspective so that the approach was trying to maintain assurance around the quality of health for our patients on waiting lists. <p>The following key summary discussion points were highlighted:</p> <ul style="list-style-type: none"> • JM advised the National Chief Nursing Officer was looking to meet with different systems on maternity and it would be useful for them to have a wider understanding of how much has been done locally; it would be helpful for a brief summary of all the assurances that have been undertaken over the past couple of years to be prepared which would support this. • JM added that in terms of the implications of how the QAC adds value to individual organisations quality governance and not duplicating efforts, it would be helpful for the JUCD Board to understand the benefits of the working QAC is doing which add value over and above what individual organisations are doing and/or what individual organisations are changing in light of having a system QAC. He placed on record thanks to all the work on this. <p>The JUCD Board NOTED the report.</p>	
	For Information	
	No Items.	
160921/14	Any Other Business	

	<p>No items were raised. The Chair thanked the Board for the good meaningful discussion at today's meeting. He was grateful for Board members continued commitment.</p> <p>It was confirmed the key messages to be drafted following the meeting would cover:</p> <ul style="list-style-type: none"> • Patient Story – Improving Autism Services in Derbyshire • Current System Position • Our journey towards a statutory ICS • System Financial Position • Place and Provider Collaboration • System Leadership and Organisational Development 	
160921/15	Questions from members of the public	
	No questions had been received from members of the public.	
	Date of Next Meeting	
	The next formal JUCD Board meeting was scheduled to take place on Thursday 18 November 2021; to be held via MS Teams.	All to Note

**MINUTES OF DERBY AND DERBYSHIRE AUDIT COMMITTEE
HELD ON 16 SEPTEMBER 2021**

VIA MS TEAMS AT 9.30AM

Present:

Ian Gibbard Lay Member (Audit) Chair
Andrew Middleton Lay Member (Finance)

In Attendance:

Andrew Cardoza Director, KPMG
Debbie Donaldson EA to Chief Finance Officer (minute taker)
Darran Green Associate Chief Finance Officer
Donna Johnson Head of Finance
Ian Morris Counter Fraud, 360 Assurance
Frances Palmer Corporate Governance Manager
Suzanne Pickering Head of Governance
Kevin Watkins Business Associate, 360 Assurance

Apologies:

Richard Chapman Chief Finance Officer
Jill Dentith Lay Member (Governance)
Helen Dillistone Executive Director of Corporate Strategy and Delivery
Richard Walton Senior Manager, KPMG
Tim Thomas Director, 360 Assurance
Chrissy Tucker Director of Corporate Delivery

Item No	Item	Action
AC/2021/401	Welcome and Apologies The Chair welcomed members to the Derby and Derbyshire Audit Committee. Apologies were received from Richard Chapman, Jill Dentith, Helen Dillistone, Chrissy Tucker, Tim Thomas and Richard Walton.	
AC/2021/402	Declarations of Interest The Chair 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.	

	<p>Declarations made by members of the Derby and Derbyshire Audit Committee were listed in the CCG's Register of Interests and included with the meeting papers. The Register was also available either via the Corporate Secretary to the Governing Body or the CCG's website at the following link:</p> <p>www.derbyandderbyshireccg.nhs.uk</p> <p><u>Declarations of interest from today's meeting</u></p> <p>There were no declarations of interest made.</p> <p>The Chair declared that the meeting was quorate.</p>	
AC/2021/403	<p>Minutes of the Derby and Derbyshire Audit Committee held on 25 May 2021</p> <p>The Minutes of the Derby and Derbyshire Audit Committee held on 25 May 2021 were presented.</p> <p>The Minutes from the Derby and Derbyshire Audit Committee held on 25 May 2021 were agreed and signed by the Chair.</p>	
AC/2021/404	<p>Matters Arising Matrix</p> <p>The Matters Arising Matrix was reviewed and updated.</p> <p>There were no further matters arising.</p>	
AC/2021/405	<p>Terms of Reference</p> <p>Suzanne Pickering reported that the Audit Committee Terms of Reference were to be reviewed by members as part of their mid-year review.</p> <p>There had been one amendment to the document, which was the inclusion of paragraph 2.1.4 to Section 2 (Roles and Responsibilities), which detailed the role of Audit Committee in overseeing the transition of the existing Audit Committee to the Integrated Care Board.</p> <p>Andrew Middleton felt that the wording of the TOR was clear and cogent but asked what it would mean by way of our agendas, and activity lists in the next six months. He understood that the Transition Committee had a list of transition tasks to perform over the next six months and asked whether each of the Committees responsible for those tasks had discussed how they might shape those handover components.</p> <p>Suzanne Pickering reported that the responsible Committees for those areas were not aware of their transition tasks as yet. Further detail was currently being added to the transition plans, and guidance had been received during August. It was noted that we were currently having discussions in relation to the transfer and integration of the System Finance Committee and the CCG's</p>	

	<p>Finance Committee, and System and CCG's Quality and Performance Committee; there would be a further conversation around that at the CCG's November Governing Body. There would also hopefully be more information with regard to the appointment process of the Chief Executive Officer.</p> <p>Andrew Middleton referred to p70 Internal Audit's 2020/21 JUCD System Decision Making Review. Kevin Watkins reported that 360 Assurance had been doing some horizon scanning which had highlighted a number of interesting questions that had been posed that the CCG may want to get further assurance on from JUCD, in addition to their management responses to those questions in that report.</p> <p>Kevin Watkins went on to highlight another observation, the extent to which it specifically related to the Audit Committee making sure that it handed over all the Audit Committee functions properly, and the wider aspect of the Audit Committee's overall oversight role in ensuring that the transition process went well. 360 Assurance hoped to be able to guide the Audit Committee in this process and would be bringing a report regarding what that would mean in terms of the work that needed to be done.</p> <p>Kevin Watkins suggested that the CCG request a paper around what a due diligence checklist would look like in order that it could satisfy itself that it was going to be completed; adding it was a good idea for the Audit Committee to maintain that oversight role.</p> <p>The Chair felt that it was slightly wider than overseeing the transition of the Audit Committee, adding that it maybe the transition of the Committee and its assurance functions. The Chair felt that there was a very well-established governance mechanism round the transition work and that assurance for the Audit Committee had to be more than just transferring the Committee.</p> <p>The Chair asked Suzanne Pickering if we could refer to the Audit Committees assurance functions within the amended paragraph also. Suzanne Pickering agreed to make that amendment, in order that the Terms of Reference could be approved by Governing Body at its next meeting.</p> <p>The Committee APPROVED the amendments to the Audit Committee Terms of Reference in relation to overseeing the Committee's assurance functions to the Integrated Care Board.</p>	SP
AC/2021/406	<p>Audit Committee Annual Report</p> <p>The Chair reported that it was a requirement for Committees of the CCG to produce an Annual Report each financial year, as set out in the Terms of Reference. This report provided the Audit Committee with a review of the work that it had completed during the period 1 April 2020 to 31 March 2021.</p>	

	<p>It was noted that the Audit Committee Annual Report would be presented at October's Public Governing Body meeting for assurance.</p> <p>The Chair thanked Frances Palmer for her assistance in compiling this Annual Report.</p> <p>Andrew Middleton reported that he had no concerns regarding the Annual Report.</p> <p>Audit Committee NOTED the contents of the Audit Committee Annual Report for 2020/21.</p>	
AC/2021/407	<p>External Audit Technical Update – September 2021</p> <p>Andrew Cardoza presented the External Audit Technical update and highlighted the following:</p> <ul style="list-style-type: none"> • A good Audit had been undertaken with great assistance from Darren Green and the Finance Team, and the Audit had been delivered by the due date. • KPMG were focusing nationally on the risks facing the NHS going forwards and starting to think about what they planned to focus their Audit resources on for this coming year 2021-22. • A health sector update had been produced • IFRS16 had not been included, but KPMG were expecting it to happen this year and that it would not be delayed any further. • Turning to p49 of the pack, second page of the report there was a summary about where KPMG thought those risks were at this moment, together with some of the main things going on within the health sector. • Climate change was something that all organisations were having to think about and work through. KPMG were offering a climate change presentation if required. • The Health and Care Bill would introduce a huge amount of change, eg the special severance payments, together with an organisation in transition, all of which KPMG would pay due attention to as part of the audit. • H2 allocation was still awaited. • P63/64 referred to digital futures Andrew Cardoza reported on KPMG's use of Babylon Health, where GP healthcare was provided online for their staff. • Andrew Middleton reported that he had a clear role within the System space with regard to Estates; he had a general concern, as did the organisation, about the return-to-work model the CCG would be adopting and the increase in transport emissions as a result. • Andrew Middleton asked if he could be invited to the relevant Committee where the Green Plan was being discussed. Suzanne Pickering agreed to arrange. • It was noted that KPMG had succeeded in the first year of the pandemic with its Audit work by utilising MS Teams. The second year had also been successful, but people were 	SP

	<p>beginning to get tired of MS Teams and not seeing people face to face.</p> <ul style="list-style-type: none"> • KPMG were currently reviewing hybrid working models, as it had been difficult to train and coach juniors virtually; they had missed human interaction. • Darran Green reported that regarding the 3% pay rise, the CCG was within its running costs allocation this year and as a result, we were able to set a contingent, and that contingency had allowed the CCG to cover the pay rise comfortably in either H1 or H2. <p>Audit Committee NOTED the KPMG Technical Update presented.</p>	
<p>AC/2021/408</p>	<p>Internal Audit Progress Report</p> <p>Kevin Watkins presented the Internal Audit Progress Report and highlighted the following key messages:</p> <ul style="list-style-type: none"> • Issued the final report summarising the findings of the System Shared Decision-Making report for JUCD (the final review delivered from the 2020/21 Internal Audit Plan). • Issued the report summarising the annual review of the CCG's arrangements for managing conflicts of interest, providing a Substantial Assurance in respect of the control environment examined. • Issued the Contracting for Continuing Healthcare report, providing Significant Assurance. • Completed Stage 1 of the HOIA Opinion work. • Continued to meet with CCG and JUCD Directors to discuss delivery of the CCG's Internal Audit Plan in the context of the ongoing pandemic and the CCG's transition to the ICB statutory body. It was anticipated that there would be some required adjustments to the Plan and this paper summarised current proposals. • 360 had been liaising with Lee Outhwaite, the JUCD Chief Finance Officer, to agree how time in Internal Audit Plans of JUCD partners for system-wide work would be utilised. It was proposed that two reviews be undertaken in 2021/22. The first exercise would examine arrangements being put in place to manage the delivery of transformation and efficiency schemes at a system level. The Nottingham & Nottinghamshire ICS had also requested that a review of this area be undertaken in 2021/22 and agreement in principle had been reached to develop a joint Terms of Reference covering both reviews to provide opportunity for learning and sharing best practice. The exercise would commence in the latter part of Q3. • The second exercise would focus on developing arrangements for the delivery of the People Management function at a system level and its links to HR functions within system partners. A preliminary meeting had been held with the JUCD Workforce 	

	<p>and OD Lead to discuss the potential scope of the review and a draft Terms of Reference was being prepared.</p> <ul style="list-style-type: none"> • 360 Assurance had been discussing utilisation of the allocation for ICS Transition Programme Assurance with the Director of Corporate Delivery. It had been agreed that, with immediate effect, 360 would be joining the internal CCG group which focused on actions required by the CCG to transition into the ICB to provide an ongoing project assurance role. Options to join a second group which were operating as part of the JUCD governance structure were still to be finalised. • 360 Assurance were meeting regularly with the Associate Director of Finance and the Director of Corporate Delivery to discuss implications of the pandemic, NHSE guidance and utilisation of the contingency allocation. At the most recent meeting (held on 27/8/21) it was agreed that some preliminary work would be undertaken to explore the potential for the Performance and Information (PI) Team to undertake a benchmarking exercise focusing on areas of spend where the CCG was either an outlier or where recent trends showed an increase in expenditure. Possible areas that could be scrutinised in this exercise included CHC, Section 117 expenditure and prescribing. The PI Team were meeting with relevant CCG staff and colleagues across the TIAN network of NHS Internal Audit providers to scope the exercise and develop a proposal for Audit Committee's approval. • Also discussed at the meeting on the 27th of August was the potential for deferring the review of the development of Primary Care Networks (PCNs) in Derbyshire. The required, ongoing response by primary care to the pandemic had meant that PCNs had not been able to develop to the extent originally envisaged. It was therefore proposed that this exercise be deferred for consideration by the ICB for inclusion in its Strategic Internal Audit Plan. • 360 had commenced the Primary Medical Care Services mandated review. • Undertaken follow-up work in response to updates provided by Management in respect of the implementation of actions. • It was noted that Tim Thomas was due to retire shortly, and the Chair wished to place on record the committee's thanks for his contribution over the years. Leanne Hawkes had been appointed into an interim role on 1 September 2021 as his replacement. • The Audit Committee still owned the CCG's Annual Audit Plan, and if assignments were added or changed in the Plan, the Chair requested that Audit Committee members be made aware of this. • The Chair expressed his concern with regard to the 14% completion of the overall Audit Plan at this stage, which he felt was low, and the fact that 360 Assurance were recruiting extra contracting staff; the Chair asked whether that was signalling a capacity issue. Kevin Watkins reported that he was still confident that 360 Assurance would be able to deliver this plan; 	
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	<p>there was also still 45 days of contingency left. It was noted that 360 Assurance had also started a recruitment drive to obtain extra bank members of staff, this was due in part to them thinking about the shape of their organisation post 1st April 2022, after which their client base would look a little different to the way it did now.</p> <ul style="list-style-type: none"> • Andrew Middleton was pleased that 360 Assurance were reviewing the People Management Plan, as he had had an unease for some time about staff shortages. He felt the NHS, was, relatively unimaginative in this area and we were not leveraging through scale the concept of one workforce across the NHS or the Health and Care Sector. Recent discussions at Governing Body revealed that we were not on the best trajectory for ensuring that we had the right people in place. • Andrew Middleton reported that he was the Chair on Commissioning for Individuals Panel, which dealt with very complex mental health and brain injury cases. He was very mindful of the fact that we struggled to provide the services required in this area. It was noted that we often had to go out to the private sector and pay extortionate prices for these services that were not necessarily fully reassuring on quality, and beneath that was the fact that we struggled to recruit people of the right calibre in these areas. • Andrew Middleton felt that the CHC report had been timely, because we were currently reappointing the management contract. He asked whether 360 Assurance could feed back any pertinent comments from this report to Kathryn Brown if they felt it would be helpful. • Andrew Middleton felt that we must not lose sight of the fact that the CCG was still the statutory body for another six months, and beyond that, we had got a moral and professional duty to hand over a going concern. • Andrew Middleton raised his concerns with regard to the abnormal funding regime during Covid, where we had been reporting balanced budgets, and the Finance Committee had been properly challenging and asking about what had happened to £180m resource gap. The reality was, it had not gone away, he went onto add that he was pleased that the System Finance and Estates Committee was increasingly gripping this issue. • Andrew Middleton referred to the Due Diligence report; this had given him a lot of assurance. Each of the parent Committees needed to be sighted on their section of that due diligence. Andrew highlighted the listed questions within that report (page 116) and reported that he had not seen any for Finance and Estates within that list. He suggested including the following within the list: <ul style="list-style-type: none"> ▪ Systems and procedures for developing, designing, and measuring comparative values of the range of ICS services, ▪ A decision-making mechanism for deciding the priorities and the resource allocations, ▪ Decision making arrangements for ensuring that system resource expenditure was controlled and linked back to ICS's Strategic Plan. 	
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	<ul style="list-style-type: none"> ▪ How would you measure health inequalities? <ul style="list-style-type: none"> • Andrew Middleton reported that the new Office for Health Improvement Disparities was starting life, its brief was to hold us accountable for delivering on health inequalities. • Andrew Middleton had a 15-month involvement in the System Finance and Estates Committee and was acutely conscious of his current statutory responsibility. He would be happy to be part of any discussions on how to take System Finance and Estates functions forward. Kevin Watkins reported that he would welcome further discussions with Andrew Middleton. <p>Audit Committee NOTED the progress report.</p> <p>From 2021/22</p> <p>Continuing Healthcare – 2122/DDCCG/01</p> <p>Kevin Watkins presented the Continuing Healthcare report and highlighted the following:</p> <ul style="list-style-type: none"> • It was good timing to review the quality schedule and to make sure that it contained everything that was needed. • It was noted that there were appropriate processes in place to monitor CHC expenditure, which was not necessarily the same as monitoring the contract; this was included in this piece of work. • It was noted that spend levels were being properly debated and discussed at Finance Committee. • The Chair reported that Finance Committee had spent a lot of time discussing the CHC fast track process and the overspending of that process. He did not see a reference to that in this report and asked whether this had been reviewed? • Kevin Watkins reported that they had looked at the process for making sure that the expenditure was being monitored. In other words, the role of the Finance Committee was to get information and demand actions in terms of a detailed analysis of what fast track was doing; the overspending of that process had not been part of this review. • Andrew Middleton reported on that point, Finance Committee had pressured Bridget Stacey, who was the owner of CHC, and members had received assurance both in Finance Committee and Governing Body that it's number 1, 2 and 3 on the priority list and the right people were all working on it. It was noted that we were somewhat assured with the trajectory as it had started to turn the way it should. But in addition, we had also received assurance from the Associate CFO that we had sufficient contingency to cover the worst-case scenario. • Bridget Stacey had also taken up the challenge to re-educate people about the correct use of fast-track and protocols. • Finance team were being kept in touch on a monthly basis. • It was noted that fast-track was a special process for people in a discrete group who may have limited time left in their lives, but it appeared that this process may have been used 	
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	<p>inappropriately to discharge patients because of the pressure on hospital beds. As a result, we were showing, or had been showing, an overspending pattern.</p> <ul style="list-style-type: none"> • The Chair reported that we needed to watch this area and there may be a need to widen the scope of that audit. • It was noted that Primary Care Services report, was a standard mandated piece of work that all CCGs had been required to have done by NHSE. <p>Conflicts of Interest – 2122/DDCCG/02</p> <p>Kevin Watkins presented the Conflicts of Interest Report which had achieved Significant Assurance. As part of this work 360 Assurance had done some counter fraud proactive work testing, which had not identified any concerns.</p> <p>Frances Palmer reported that we had now been able to close the one action contained within this report.</p> <p>Audit Committee NOTED the Conflicts of Interest Report.</p> <p>Stage 1 HOIAO – 2122/DDCCG/03</p> <p>Kevin Watkins presented the Head of Internal Audit Opinion Stage 1 report. It was noted that there were no major concerns to be brought to the Committee's attention. It was noted that Kevin Watkins had observed some of the recorded Governing Body meetings to see how risks were being reported and challenged through the process, which he had found to be very interesting.</p> <p>Audit Committee NOTED the Stage 1 Head of Internal Audit Opinion.</p> <p>From 2020/21</p> <p>JUCD Decision Making report</p> <p>Kevin Watkins presented the JUCD Decision Making Report and highlighted the following:</p> <ul style="list-style-type: none"> • This was a challenging report to put together and was an attempt to do some horizon scanning. • When the Terms of Reference for this piece of work had been put together and agreed, we had no idea that we were going to be in this situation we were now with CCG's disappearing at the end of this year and the timescales of the emergence of ICB's; latest guidance indicated that they would be in place by the 1st of April 2022. This had happened as 360 Assurance were still putting this report together, so they had tried to incorporate that into the report. • The report covered a range of different issues, that was intentional in the sense that the kind of key approach to the work was to try to interview as many people as they could from the 	
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	<p>various System partners, including the Local Councils, which had also been helpful.</p> <ul style="list-style-type: none"> • It was noted that on the subject of what needed to take place in order for the ICS to be able to take decisions, 360 Assurance had been able to do more traditional Audit work, in that they had done a walkthrough test on a decision, and observations had been made as a result. • Given the length of this report 360 Assurance had been asked to identify 3 key messages that emerged from the work completed on decision making arrangements and from interviews conducted with organisation leaders, which were: <p>Develop a formal process for ratifying decisions made the ICS Partnership Board.</p> <p>Develop and implement a decision-making framework at Place level.</p> <p>Ensure sufficient resources are invested in the prevention of ill health and health promotion agendas.</p> <ul style="list-style-type: none"> • It was noted that 360 Assurance had raised a lot of questions and reflected on the results of the interviews and Lee Outhwaite had coordinated a JUCD response to those questions, which had been included as a management response to this report. • It was noted that this was not a traditional Audit report with agreed actions and implementation target dates, but Kevin Watkins hoped to speak with Lee Outhwaite about how they could feed back to partners on how those questions had been responded to. • The Chair felt that it was important that we had that loop back from conversations with Lee Outhwaite which indicated what the concerns were about, and we could then make sure they feed into our own governance processes within the remaining time we had got as a CCG. It also needed to go into our Governing Body if there were concerns, and it needed to flow into the transition work that was being managed by both sides. • Andrew Middleton reported that Dr Clayton had been attending System Finance and Estates Subcommittee, and as a result there had been a new energy behind that Committee. <p>Audit Committee NOTED the ongoing work with JUCD partners in terms of the impact of the proposed legislation changes and looked forward to getting a further update in due course.</p> <p>Counter Fraud</p> <p>2020-21 Annual Report</p> <p>Ian Morris presented 2020-21 Annual Report and highlighted the following:</p> <ul style="list-style-type: none"> • Appendix A of the Annual Report was the Counter Fraud functional standard return. This had been done at the end of 	
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	<p>May, and there had been quite a lot of discussion in the March Audit Committee meeting regarding the scoring process, and the fact that if we were scoring ourselves low it was a result of the standards being new.</p> <ul style="list-style-type: none"> • Appendix A gave a full rundown of where we felt we were, and this had been discussed with the Audit Committee Chair and Richard Chapman. • It felt wrong that we were having to mark ourselves down on new standards that we had not had an opportunity to meet, but it was important that we scored ourselves honestly, we were now in a good position to move ourselves forward. The work plan was going to be fluid moving forwards in order to achieve compliance with the standards; and the CCG was a good position to do that. • The Chair asked Andrew Cardoza whether KPMG had any concerns about a statutory body posting up fraud reports with red flags all over them; it was clearly something they would want to take into account when formulating a view. • Andrew Cardoza reported that from KPMG's point of view, he had read the mitigation, and this had been taken into consideration; this situation was not uncommon. • Andrew Middleton reported that it did give him a degree of discomfort to have reds on an assessment like this, but he understood the rationale and reasons why. He asked what a realistic timescale would be to get the CCG to at least amber, or some greens? • Ian Morris responded that we were well in the process of doing that already. He went onto add that he needed a conversation with Darran Green and Richard Chapman in terms of where to pinpoint the work moving forward with regard to the ICB, as he did not want to complete work and then find when it came to March next year there was not going to be any significant benefit. He went onto add that that he was in constant discussion in terms of where the CCG wanted him to focus his time and work. • With regard to Risk 1, the new standard in terms of using the Government methodology (which had only just come into place). Ian Morris reported that it was impossible to be anything other than red. It was noted that Counter Fraud were doing a significant amount of work on that now. • The Counter Fraud Benchmarking Report had highlighted risk areas and would be addressed with the CCG. • The Chair asked whether there was an interim assessment that we could look at in Q4 before we get to the point where we had to declare? • Ian Morris reported that currently Counter Fraud were in the process of developing a new progress report for Audit Committees, where progression would be mapped and discussed with Richard Chapman and members if required. <p>Progress Report:</p> <p>Ian Morris presented the progress report and highlighted the following:</p>	
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	<ul style="list-style-type: none"> • In June the Counter Fraud Managers Group, who had 156 clients across numerous organisations, had got together to produce a report in terms of referrals. • This had brought up several questions in terms of low referral rates; having low referral rates could sometimes be a negative thing, it was making sure that people had the right places to come to and that they felt safe to do that. • The Counter Fraud Authority had predominantly, since they had been established, concentrated on preventing fraud, raising awareness of fraud, and raising awareness to staff. Significant focus was now being put on detection, so much of Ian Morris's work moving forward would be put into detection. • Darran Green reported that we had strengthened the CCG's side by getting Donna Johnson more involved in Counter Fraud and had made her a CCG Counter Fraud Champion. • Ian Morris reported that in the past the Counter Fraud Authority had not provided significant guidance in terms of the role of Fraud Champion, but the fact that the CCG had put two people forward for that role showed a real willingness and desire by the organisation to take the role seriously. <p>The Audit Committee NOTED the progress report and NOTED the Annual Report from 2020-21, and specifically the outcome of the self-assessed functional standard.</p>	
AC/2021/409	<p>Finance and Performance Update Report</p> <p>Darran Green gave a verbal Finance and Performance Update and highlighted the following:</p> <ul style="list-style-type: none"> • In terms of financial performance, the M5 position had not been to Finance Committee yet, but there had been no significant changes from M4. If anything, the position had improved and there were no significant unmitigated risks. • The CCG expected to live within its resources for H1, as did the System; the System was reporting a more/less breakeven with a very small overspend position. • We were confident with the mitigations being carried, both with the CCG and other providers, and that position could be managed relatively safely. • The CCG was still awaiting guidance for H2, the full guidance was due imminently along with the planning guidance, it appeared that plans for H2 did not need to be submitted until November. • The Chair reported that both he and Andrew Middleton kept a close eye on the numbers and were both members of Finance Committee. He did feel that it was helpful for Audit Committee's assurance to note the above, and that they were kept informed of any specific challenges that we may face by year end. • The Chair reported that there had been some guidance documents and checklists that had been issued from the centre in terms of what was expected about the end of year Audit process. It was noted that the ICB would have responsibility for overseeing the end of year Audit process. Quite how that 	

	<p>worked in terms of the planning and individual sign offs was not clear.</p> <ul style="list-style-type: none"> • Darran Green reported that it would be different at year end, as we would need to close the organisation, and obviously the Audit Committee that signed the accounts off would be a couple of months after that period end. There had been mixed approaches to that in the past, but it did appear that it would be the ICB that would take that role on; how that would happen, was still being worked through. • In terms of the process, the CCG was still locally planning to do what we had always done. Which was to have a very detailed plan, the plan would be shared very early with colleagues at KPMG and with this Committee. The CCG had got the same team on board, we did not envisage bringing in people to strengthen the team; we were confident that we could manage that process within the existing team • The challenge for us now was around the fact that when we did become an ICB we would be a different sized organisation with the inclusion of Glossop. • Work needed to be done between now and the 31st of March to ensure that we were clearly sighted on the assets and liabilities that would transfer from our CCG into the ICB. But the real challenge would be the assets and liabilities in Glossop that would also transfer into the ICB. We had already started contacting colleagues in Tameside and Glossop to understand what that process would be. • The Chair acknowledged that that would be one of the risk factors, and Andrew Middleton had mentioned earlier in the week we believed that we were also going to bring in IFRS16. This would add to the to the workload and he asked whether we fully understood what that was going to mean in terms of the work that needed to be done in April and May. • Darran Green reminded the Chair that approx. two years ago he had done a presentation to himself and Andrew Middleton. It was when we first thought IFRS16 was coming in, and we had kept the work going in anticipation of the fact it would come in. Darran Green offered to bring a paper to next Audit Committee, to assure the Committee of the work that had been done during that period. • The Chair felt that this was helpful and asked Darran Green to put this on the forward planner. <p>The Audit Committee NOTED the finance and performance update given by Darran Green.</p>	DG
AC/2021/410	<p>Finance Staff Journal Limits</p> <p>Darran Green presented the Finance Staff Journal Limits report and highlighted the following:</p> <ul style="list-style-type: none"> • It was explained that the finance team had put this process in place previously at Months 4, 8 and 12 where we adjust the journal limits so that journals of significant values over £100k could only be authorised by Richard Chapman, Niki Bridge or 	

	<p>Darran Green; this provided an additional confirm and challenge to those.</p> <ul style="list-style-type: none"> • This had been brought about as a result of a comment made by KPMG around the fluctuating levels of accruals made throughout the year. It was reported that this had just been done in M4 successfully, at M5 the journal limits were returned to normal. Nothing was found in that process that needed to be brought to this Committee's attention. • Every month, as a result of the suggestions made by KPMG, a process was undertaken where Georgina Mills and Darran Green reviewed all the accruals that had been done, and compared them to the previous month, the previous quarter and that particular month the previous year. This was analysed and recorded as an audit trail. As a result, we would then be able to fully understand why we had accrued for a different amount from one month to the next. • Hopefully, this would give this Committee assurance that there was a high level of scrutiny placed on the accruals done. • The Chair felt that this was good practice, and was best practice, and he felt assured that the journals were being well managed. <p>Audit Committee NOTED the Staff Journal Limits report.</p>	
<p>AC/2021/411</p>	<p>Losses and Special Payments Financial Policy and Procedures</p> <p>Darran Green presented the updated Losses and Special Payments Financial Policy and Procedures and highlighted the following:</p> <ul style="list-style-type: none"> • The policy had been scrutinised in some detail at Finance Committee recently and had been approved. • Finance Committee had made a couple of recommendations/amendments to the policy and procedures which had now been incorporated into the document. • It was the intention of the Financial Control team to publish these policies and procedures on the Intranet to make them widely available for reference. <p>The Audit Committee NOTED the Updated Losses and Special Payments Financial Policy and Procedures.</p>	
<p>AC/2021/412</p>	<p>Aged Debt Report</p> <p>Darran Green presented the Aged Debt Report and highlighted the following:</p> <ul style="list-style-type: none"> • It was noted that there were a small number of debts over 90 days. • There were a couple of large invoices and credits related to the same issues around the STP recharges, but these had subsequently been resolved. • Credit values on the accounts payable system against small values were being well managed by the team. 	

	<ul style="list-style-type: none"> • With regard to the two largest balances on the report, £37k of the £46k in total were clearing this month. • It was noted that the team had regular contact with suppliers and providers where needed in order to close these amounts off • The Chair referred to the tables on p 205-207 which had headings showing £0 and asked whether this was a mistake. Darran Green apologised and reported that this was a mistake, which he would adjust after the meeting. <p>Audit Committee NOTED the aged debt report.</p>	DG
AC/2021/413	<p>Single Tender Waivers</p> <p>The Chair highlighted his concerns with regards to the long list of STW's, with a lot of them referring to neuro rehab, which we knew was a difficult area. The Chair reported that this gave him some concerns about the extent to which we were taking the right route through the competition laws in terms of determining that the patients' families could tell us where they wanted to go.</p> <p>Darran Green agreed that there were a lot of STW's in this report, but in mitigation the report did go back to April of this year, and highlighted the following:</p> <ul style="list-style-type: none"> • It was noted that there was a mixture of reasons why these STW's had been raised; there had been quite a few to do with GPIT and this was as a result of not receiving the full guidance needed, and the need to extend certain contracts for a further 12-month period in some instances. • The STW's had all initially been scrutinised in great detail by Donna Johnson before they went to Richard Chapman for sign off. • It was noted that colleagues were becoming much more aware of this process, so it may be that rather than doing more STW's than we had previously, it was that we were efficiently recording them. • Andrew Middleton reported that he had had a hand in some of the STW's via the commissioning for individuals panel, who had agreed to take a discharge from a secure mental health facility, and we had no alternative but to use a private sector provider. • Andrew Middleton reported that the panel was not swayed that much by family choice, it was the fact that the Midlands and Lancs programme managers contact care homes and Intense Care Homes on our framework, and they all decline to take patients with aggressive behaviour etc. • Andrew Middleton reported that some patients were not bad enough to be reasonably detained under the Mental Health Act, but there were a cadre of patients who fall between residential home residents with dementia and acute psychotic secure placements, and at the moment it was the niche private sector provider that was the only provider of a safe place. • Andrew Middleton felt that the takeaway message, and it was helpful that we are seeing these emphatically stated on a report like this, was that there needed to be a provider development 	

	<p>discussion with the Mental Health Trust about how they were going to help us out on this, and/or provide alternative solutions within the System.</p> <ul style="list-style-type: none"> • It was noted that we could not escape the duty to make provision for these patients, and we quite often did not like the price, or that it had to be short notice and subject to a STW, but we had no alternatives due to the lack of long-term investment in developing the supply side for this challenging cohort. • Andrew Middleton reported that Mental Health Development Boards were aware of it, but he felt that there was a falling between the cracks between Brigid Stacey's care home responsibilities and the Mental Health Development Board, which tended to focus on the more extreme end of patients. • The Chair referred to the two placements, one through Finegreen and the other through Michael Page, which were both looking to contract for positions that had not filled through normal recruitment, and then obviously the IR35 question. He asked whether these placements would be pay rolled or PAYE, and whether we were confident, given that we had described them as backfilling officer posts, that we were going to be compliant with the current PAYE rules? • Darran Green reported that he could give Audit Committee assurance that we had scrutinised all the STW's before signing off. It was noted that Donna Johnson was our IR35 Champion, and she had scrutinised the paperwork for the backfill placements, and Darran Green was confident that we were compliant with regards to the process. • The Chair referred to the STW on p215 of the papers for Richmond Fellowship of £182k, which did not state what that was for; the form had not been filled in correctly. The Chair requested that Darran Green investigate why they had been given a STW and email members with the details after the meeting. <p>Audit Committee NOTED the report of Single Tender Waivers approved by the Chief Finance Officer since April 2021.</p>	DG
AC/2021/414	<p>Contracts Oversight Project</p> <p>Darran Green informed members that the CCG had got some real traction on this now. This had been something that Finance, and Governance colleagues had been very keen to establish, but had limited opportunity to deliver without the help of contracting colleagues.</p> <p>Darran Green highlighted the following:</p> <ul style="list-style-type: none"> • The Contracts Oversight Group met on a regular basis. • There was a plan for a single repository of information for all our contracts. • This would hopefully help with STW's and a reduction in the need for them. • When we came to the dissolution of the CCG, we would be fully sighted on all the contracts we had, what needed to be carried forward, and what needed novating. 	

	<ul style="list-style-type: none"> • There would be a challenge with regard to Glossop and the contracts that would come in from them. • The final product would be brought to Committee when the work had been completed. • The Chair reported that the risk assessment did not suggest that there were any risks around this, and asked whether capacity was a risk – had we got enough people, time and focus in order to get this done in the timescale required? • Darran Green responded that previously the risk had been not getting the buy in from the rest of the organisation, but he felt we had got that now. Helen Wilson, Head of Contracts, could see the benefit of it and she was confident that we could deliver it. <p>Audit Committee NOTED the progress made in producing a contracts database under the Contracts Oversight Project Group. The Chair thanked the teams concerned for their work in helping to produce this.</p>	
AC/2021/415	<p>Freedom to Speak Up Report</p> <p>Suzanne Pickering, on behalf of Jill Dentith, presented the Freedom to Speak Up verbal report and highlighted the following:</p> <ul style="list-style-type: none"> • This month was a nil report. • In mid-July Jill Dentith had given a presentation at the full CCG team talk on the importance of the Freedom to Speak Up Guardian. • Jill Dentith had explained her role, what the requirements, expectations and responsibilities were, which had been well received. • The CCG had put out the requirement to recruit some Freedom to Speak Up Ambassadors, and it was noted that we had received 9 expressions of interest and that we had now recruited 3 members of staff. • These 3 members of staff were undergoing training and within the next month or so, would be in place and able to support the organisation. • Andrew Middleton reported that he had been anointed as the Freedom to Speak Up Champion in another CCG, and he had discovered that under e-learning for health there were two training modules, one for all staff and one for managers which had been very interesting (both 25 mins long). He agreed to pass the details of the courses to Suzanne Pickering in order that she could put this forward to HR. <p>The Audit Committee NOTED the verbal Freedom to Speak Up Report.</p>	

AC/2021/416	<p>GBAF 2021/22 Quarter 1</p> <p>Suzanne Pickering presented Q1 Governing Body Assurance Framework (GBAF) which had been reported to Governing Body at the beginning of August and highlighted the following:</p> <ul style="list-style-type: none"> • On 6th May Governing Body had reviewed its strategic objectives and its strategic risks. • As a result of the new strategic objectives, we had also identified 3 new strategic risks for the GBAF, two of those were owned by the Governance Committee, Risks 7 and 8 and Risk 6 an additional one for Quality and Performance Committee. • Updates to the GBAF were highlighted in red. • We were moving forwards with Q2 GBAF, which was currently being agreed and challenged by the Committees during September and would be reported to Governing Body on 7th October. • The Chair felt that some of the conversations we had earlier in this meeting highlighted the interlinkage between some of the assurances that we were taking on transition, particularly from groups that had been dedicated to this. • Andrew Middleton reported that on first sight, the sea of reds on the GBAF was a bit depressing, but he understood why, as we were being anticipatory in respect of System responsibilities and there were a lot of uncertainties. For instance, the efficiency programme was in suspension currently. • Andrew Middleton asked whether JUCD/putative System Board had a GBAF, if so, what did it look like and how much reconciliation was there between theirs and ours? • Suzanne Pickering reported that JUCD System Board did not currently have a GBAF, they did not have the same governance arrangements that the CCG had in place. In terms of the transition into the ICB, this was a key action in terms of due diligence and readiness to operate statement and was a key action that we were already starting to progress. • It was noted that the CCG would be recommending that we continued with a similar or same format that we had within the CCG and its governance arrangements. • Andrew Middleton reported that that was assuring. <p>Audit Committee NOTED the Governing Body Assurance Framework for Q1. NOTED that work was almost concluded in terms of producing Q2 and looked forward to future updates in due course.</p>	
AC/2021/417	<p>Risk Report as at end August 2021</p> <p>Suzanne Pickering presented the Risk Report as at end August 2021 which detailed the actions and transition from the last report at end of May, and highlighted the following:</p> <ul style="list-style-type: none"> • Section 3 detailed the very high risks overview for the organisation and the responsible Committees with key updates. 	

	<ul style="list-style-type: none"> • Section 4 was the May to August overview, there had been some key changes in those months • In terms of the decreased scores in May, one risk was decreased (Risk 28), in June a further two risks were decreased, Risk 24 and Risk 30. • In terms of increased scores, in July we had one increase (Risk 6) around PICU beds, which was increased to a high score of 12. • Section 4.3 new risks, there had been one new risk in June (Risk 38) in relation to CHC and the impact in relation to Covid. In July (Risk 40) in terms of the transition from the CCG to the ICS and the proportion of contracts being extended (which in line with the earlier conversation around STW's). • Section 4.4, closed risks, one risk was closed in June in relation to data security protection toolkit and the contract management, again part of the contracts oversight work, and then one risk in July new risk in relation to safeguard referrals during lockdown, which had been managed very closely by the Quality and Performance Committee. • The Chair was pleased to see that the Risk Register was being managed dynamically and that an intelligent approach had been taken in moderating these. • The Chair reported that the Finance Committee had reduced its assessment of the fraud risk from probability 2 to probability 1 and asked whether Ian Morris was happy with this decision. • Ian Morris reported that the fraud risk on the standard return was something that Counter Fraud were looking significantly at. This would tie into future conversations as we needed to be even more mindful of the risk going forwards into the ICB. Ian Morris confirmed that rather than say yes to the Chair's questions, he would keep this under consideration. <p>The Audit Committee RECEIVED and NOTED:</p> <ul style="list-style-type: none"> • The Risk Register Report • Appendix 1 as a reflection of the risks facing the organisation as at 31st August 2021; and • Appendix 2 which summarised the movement of all risks during May to August 2021. 	
AC/2021/418	<p>Committee Meeting Business Log</p> <p>Frances Palmer presented the Committee Meeting Log which summarised discussions and approved items at the following NHS Derby and Derbyshire CCG's committees, that have been formally ratified and not yet presented to the Audit Committee:</p> <ul style="list-style-type: none"> • Clinical & Lay Commissioning Committee • Engagement Committee • Finance Committee • Governance Committee (Confidential & Public) • Primary Care Commissioning Committee (Confidential & Public) 	

	<ul style="list-style-type: none"> Quality and Performance Committee <p>Audit Committee NOTED the NHS Derby and Derbyshire CCG's Committee Meeting Log.</p>	
AC/2021/419	<p>Conflicts of Interest Update</p> <p>Frances Palmer presented the Conflicts of Interest (COI) update. This report summarised the activity that the CCG had undertaken since May 2021 to fulfil its obligations regarding managing its conflicts of interest. A forward planner for 2021/22 was provided at Appendix 1, to assure the Committee further on the work that was planned for the year. The following was highlighted:</p> <ul style="list-style-type: none"> We had distributed COI forms to all staff for this financial year; last year we were at 76% of forms received back and today we were at 74%. In previous years we had sent out reminders for those forms to be returned, and this would be done again. It was noted that NHSE did not require any CCGs to submit quarterly returns anymore. The expectation was that we continued to manage COI internally and report these through Audit Committees. Andrew Middleton highlighted training at 92%, that meant that there were still about 46 staff who had not done it; that was 46 too many. He asked whether we were using the strength of the line manager route efficiently, we need to make it very difficult for a member of any team to avoid doing it? Frances Palmer reported that she would be getting in touch with the line managers of the individuals concerned. It was noted that the figure had gone up to 94% since this report had been issued. She reported that there were a few individuals that had been outstanding for a considerable number of months, and she would take this piece of work forward. The Chair reported that there may be sensitive issues in some cases, where people were helping out with the pandemic, so he asked Frances Palmer to be mindful of that, but the message from the Audit Committee was that this training was mandatory, and we expected people to comply. <p>Audit Committee NOTED the report and RECEIVED the following:</p> <ul style="list-style-type: none"> Conflicts of Interest Forward Planner 2021/22 Decision Makers' Register of Interests Governing Body & Committee Members' Register of Interests Confidential Register of Interests Summary Register for Recording Any Interests During Meetings Gifts & Hospitality Register Procurement Register Breach Register – no further updates since last meeting 	FP

AC/2021/420	<p>Any Other Business</p> <p>There was no further business.</p>	
AC/2021/421	<p>Forward Planner:</p> <p>Audit Committee NOTED the Forward Plan.</p>	
AC/2021/422	<p>Assurance Questions</p> <p>1. Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance processes?</p> <p>Yes.</p> <p>2. Were the papers presented to the Committee of an appropriate professional standard, did they incorporate a detailed report with sufficient factual information and clear recommendations?</p> <p>Yes.</p> <p>3. Were papers that have already been reported on at another committee presented to you in a summary form?</p> <p>Some were.</p> <p>4. Was the content of the papers suitable and appropriate for the public domain?</p> <p>Not entirely.</p> <p>5. Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow Committee members to review the papers for assurance purposes?</p> <p>Yes.</p> <p>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?</p> <p>Audit Plan, which would indicate in more detail, other areas which we needed to go into more detail.</p> <p>7. What recommendations does the Committee want to make to the Governing Body following the assurance process at today's Committee meeting?</p> <p>Governing Body would be supplied with a standard Assurance Report from the meeting today.</p>	IG

AC/2021/423	Date of Next Meeting: Thursday 18 November 2021, 9.30-12.30 Dates for future meetings: Thursday 20 January 2022, 9.30-12.30	
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Signed: Dated:
(Chair)

RATIFIED MINUTES OF DERBYSHIRE ENGAGEMENT COMMITTEE MEETING HELD ON
21 SEPTEMBER 2021 VIA MICROSOFT TEAMS
11:15 TO 13:15

Present:		
Martin Whittle – Chair	MW	Governing Body Lay Member, DDCCG
Helen Dillistone	HD	Executive Director Corporate Strategy and Delivery, DDCCG
Maura Teager	MT	Lead Governor, University Hospitals of Derby and Burton NHS Foundation Trust
Margaret Rotchell	MR	Public Governor, CRH
Sean Thornton	ST	Assistant Director Communications and Engagement DDCCG and JUCD
Beth Soraka	BSO	Health Watch Derby
Jocelyn Street	JS	Lay Representative
Steven Bramley	SB	Lay Representative
Ian Shaw	IS	Lay Member for Primary Care Commissioning
Vikki Taylor	VT	ICS Director Lead, Joined Up Care Derbyshire
In Attendance:		
Lucinda Frearson	LF	Executive Assistant, DDCCG (Administration)
Rebecca Johnson	RJ	Health Watch Derby
Claire Haynes	CH	Engagement Manager, DDCCG
Apologies:		
Carole Riley	CR	Public Governor, Derbyshire Healthcare NHS Foundation Trust
Helen Henderson-Spoors	HHS	Chief Executive Officer, Healthwatch Derbyshire
Beverley Smith	BSm	Director Corporate Strategy & Development, DDCCG
Karen Lloyd	KL	Head of Engagement, Joined Up Care Derbyshire
Lynn Walshaw	LW	Deputy Lead Governor, DCHS
Paul Ram	PR	Derbyshire County Council Representative
Simon McCandlish	SMc	Governing Body Lay Member, DDCCG (Deputy Chair)
Tim Peacock	TP	Lay Representative

Item No.	Item	Action
EC/21/22-68	<p>WELCOME APOLOGIES AND QUORACY</p> <p>MW welcomed all to the meeting, noting the apologies as above and declaring the meeting quorate.</p> <p>MW acknowledged Rebecca Johnson (RJ) thanking her for joining the meeting advising that RJ would be shadowing BS and attending future Committees on behalf of BS who was due to go on maternity leave.</p>	
EC/21/22-69	<p>DECLARATIONS OF INTEREST</p> <p>MW 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.</p> <p>Declarations declared by members of the Engagement 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</p>	

	<p><u>Declarations of Interest from today's meeting</u> MT declared an expression of interest not a conflict with Item 72 on the agenda. MW recorded no decisions were being made therefore no action was required.</p> <p>No further declarations were made.</p>	
<p>EC/21/22-70</p>	<p>GP AND URGENT CARE ACCESS INSIGHT - UPDATE</p> <p>ST gave a verbal update informing Committee that he had a meeting planned with Clive Newman, CCG Director of Primary Care Development and Emma Prokopiuk, Head of Primary Care Development, to look at the action plan prior to presenting a draft plan to a Primary and Community Service Group this week. The plan will be formally presented to the group by Britain Thinks and will be the first time the report will get a detailed airing in the community</p> <p>ST emphasised there was a set of messaging that required to be put out to the public in various ways around how general practice was operating today including post pandemic and pre pandemic which had not changed. Another element was around access to GP appointments with a rise of aggression and violence against practices. ST had also arranged a meeting with colleagues from the hospital primarily to discuss and try to factor in a message to the public around what was acceptable in terms of the use of services and the way healthcare and support staff were being treated.</p> <p>Action: ST to provide update of the action plan at the next meeting detailing what has been agreed and proposed actions.</p> <p>Engagement Committee offered the following comments and questions:</p> <ul style="list-style-type: none"> • MW asked whether there were any takeaways from the Accident and Emergency Board. ST felt the report had been received positively and felt it was a good piece of work but difficult to argue about as it was based on public feedback. • SB reiterated concerns previously raised regarding the struggle to get access to GP appointments at his practice. SB disagreed with the public being abusive but could understand why as he felt the whole system needed to get back on track and get peoples trust back. • IS highlighted a variation in practice and mode of practice, and models seem to be declining and other forms of models coming up such as the new GP locum scheme brought in by NHSE advising the risk of GP practices falling over at the moment was high. The other high risk was the provision of services through GP practices and practices getting loaded through new building programmes, patients were increasing but not the number of practices. ST clarified the research did show a variation amongst practices, buddying up and learning across practices was being encouraged. • IS felt some of the dissatisfaction was coming through mainstream media. • JS noted that PPGs had stood down but the difference in attitude between practices to their PPGs was indicative to the way they think about patient involvement and participation. 	<p>ST</p>

	<p>MW summarised that there was clearly lots of pressure through the system but there was work in progress. Feedback will be received next month and noted some targeting may be needed.</p> <p>The Engagement Committee NOTED the verbal update and progress of work undertaken.</p>	
EC/21/22-71	<p>WINTER COMMUNICATIONS AND ENGAGEMENT PLAN</p> <p>ST explained that the plan could not be shared as it was still in production, therefore provided a verbal update. A Winter Comms and Engagement Group had been convened which met for the first-time last week and included all system partners including Local Authorities, to start to work on the approach for this year. ST had discussed with colleagues at UHDB around how to engage the broadcast media in giving more airtime on promoting how the system was trying to work. ST will share virtually once finalised as submission date is the 30 September.</p> <p>Action: ST to circulate with specific questions for members to provide comments.</p> <p>The Engagement Committee NOTED the verbal update</p>	ST
EC/21/22-72	<p>FLORENCE NIGHTINGALE COMMUNITY HOSPITAL RECONFIGURATION: LONDON ROAD WARDS 4/5/6 - UPDATE</p> <p>ST had now done more detailed work on the comms and engagement plan to begin to set a timeline to when the activities may take place. Timescales are reliant on the quality and equality impact assessment being presented to QEIA Panel on 5 October. Subject to the document going to Panel the engagement period would then follow beginning on 11 November with a 3-month engagement phase. The plan sets out a presentation to Engagement Committee in October to enable Committee to review and shape before launching on 11 November.</p> <p>The Engagement Committee NOTED progress to gather feedback, APPROVED the engagement approach and was ASSURED of progress.</p>	
EC/21/22-73	<p>ICS GOVERNANCE REQUIREMENTS AND FUTURE COMMITTEES</p> <p>HD provided an update for information. Members were aware of the work underway to close down the CCG ready for next year; in parallel was the establishment of the ICS for which the ICB, the Integrated Care Board, would be part of. Specifically relating to the work of this committee was how will the system gain its assurance in all the different areas of work and areas of responsibility that the ICS will be responsible for and clearly engagement and patient and public involvement.</p> <p>MW commented this was a work in progress with a need to try to take learning from what was felt had gone well and could be even better if something different was done. The ICS will be different from the CCG, the way of working will be very different and will be happening at different tiers in the system. A small group were meeting later in the week to discuss and would feedback comments at the next meeting.</p> <p>The Engagement Committee NOTED the verbal update.</p>	

<p>EC/21/22-74</p>	<p>ENGAGEMENT MODEL AND GOVERNANCE GUIDE:</p> <ul style="list-style-type: none"> • ICS Working with People and Communities • Understanding Integration 2021 Guide <p>Clare Haynes (CH), Engagement Manager, presented an update on the engagement model which had originally been brought to Committee in May 2019 and since then had been implemented. There had been progress with some very good links and systems, but it was recognised with the changes to ICS there was a requirement to look at making sure the systems were more robust, looking at a system approach. All new guidance received had been reviewed and it was pleasing to find the new guidance was the direction of travel anticipated.</p> <p>Engagement Committee offered the following comments/questions:</p> <ul style="list-style-type: none"> • TP was impressed and asked if he could use for his PPG. ST agreed but there was a need to ensure that there remained just one version. • SB gave an observation. He liked the whole paper but had recently been involved with North Derbyshire PLACE and moving into next phase of mental health changes and champions were requested, SB put himself forward but unfortunately as the meetings were Wednesdays, could not attend highlighting that if lay people are going to be at the centre then there needed to be more flexibility for involvement. • JS felt this was a really good piece of work with regard to principle 1 where PCNs were going to have lay representation. Secondly it was crucial to keep the across system lines of working and not to move back and loose speed of response. Thirdly, all the provisions for engagement and the requirement for it was fine but time needs must be factored in so performing the engagement does not become a delaying tactic. ST was conscious there was an engagement approach forming around PCNs in Erewash but there was not a system approach to how to facilitate in PCNs and there will not be a one size fits all approach. This was work in progress and PCNs are a fundamental part of PLACE. • BS had been invited to a PCN in Derby City which was a PCN in its own right as the population was so large, this had patient representation, which gives patients a better insight and helps breakdown stereotypes. Health Watch has been able to feed in when talking about projects and believed that particular PCN to be quite progressive and very insightful. • ST advised next steps were to look at the model and guidance and carry out a gap analysis to ensure everything was in place, and a draft of the governance guide would be brought back to the next meeting. <p>Action: CH to provide a further update next month when the Governance Guide may also be available.</p> <ul style="list-style-type: none"> • MT flagged that the guide states system quality groups should include 2 lay members. MW felt this was something that needed following up and offered to speak to Brigid Stacey, Chief Nursing Officer, DDCCG. VT advised that work was underway at the moment to think about what the sub committees of the ICB will look like and who the constituent members will be but unlikely to be confirmed until after the appointment of the CEO and the non-exec directors into the ICB. 	<p>CH</p>
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	<p>ACTION: MW to arrange to discuss with Brigid Stacey, DDCCG</p> <p>The Engagement Committee NOTED the update and discussed the approach and NOTED the recently released guidance.</p>	MW
EC/21/22-75	<p>GLOSSOP WORKSTREAM – UPDATE</p> <p>Communication and engagement workstream had been established to work through the transition of Glossop into Derbyshire ICS with the first meeting taking place on the 1st October. ST felt it would be helpful to have lay representation in the group but needed to ensure the needs of both Glossop and Derbyshire were met and would come back to the group on that item.</p> <p>The Engagement Committee NOTED the verbal update.</p>	
EC/21/22-76	<p>PLACE ENGAGEMENT APPROACH</p> <p>ST presented this paper reporting conversations had taken place with Penny Blackwell, Chair of the Place Board and Tracy Allen, Chief Executive of Derbyshire Community Health Services and Executive SRO for the PLACE collaboration workstream, along with Kate Brown, CCG Director of Joint Commissioning, to try to understand how to take forward.</p> <p>The paper sets out the proposed approach and pilot taking place in Amber Valley which had been derived from a decision from voluntary sector representation, Public Health, and the CCG. Guidance was clear this should be delivered through PLACE and PCNs. The paper is not about how to inform people of change but more how engagement could take place on a less formal level.</p> <p>The Engagement Committee offered the following comments and questions:</p> <ul style="list-style-type: none"> • MW wished to know how people get involved. ST explained that the plan was not yet at that stage. <p>The Engagement Committee NOTED the Plan and NOTED the ownership was at PLACE Sub Committee level.</p>	
EC/21/22-77	<p>ENGAGEMENT COMMITTEE TERMS OF REFERENCE</p> <p>MW informed members that the Terms of Reference were being presented for their mid-year approval. If members were happy to approve the changes, these would be forwarded on to Governing Body for their formal ratification.</p> <p>The Engagement Committee AGREED the Terms of Reference and APPROVED changes up to end of March 2022.</p>	
EC/21/22-78	<p>S14Z2 LOG</p> <p>ST advised that there had been no new items lodged therefore nothing new to report. An enhanced version of the Florence Nightingale Community Hospital Wards 4/5/6 project had been received; this was the only change noted.</p> <p>The Engagement Committee REVIEWED the report and were ASSURED they were being completed appropriately.</p>	

<p>EC/2122-79</p>	<p>DDCCG EXCEPTION RISK REPORT</p> <p>HD reported 1 risk around the standardising of processes across the CCG to ensure meeting S14Z2 statutory duties, with no change to the risk score of 8.</p> <p>The Engagement Committee RECEIVED and DISCUSSED the report, NOTING no changes to risk scores.</p>	
<p>EC/2122-79a</p>	<p>GBAF</p> <p>ST advised of a couple of minor updates on the descriptions on the risk form and guidance being published. Score remains the same with all actions being taken in other areas hopefully assisting to bring the score down.</p> <p>The Engagement Committee RECEIVED the report, after reviewing the log the Committee were ASSURED it had been updated appropriately.</p>	
<p>EC/2122-80</p>	<p>MINUTES OF THE MEETING HELD ON: 17 AUGUST 2021</p> <p>The Engagement Committee ACCEPTED the Minutes of the previous meeting as a true and accurate record.</p>	
<p>EC/2122-81</p>	<p>MATTERS ARISING</p> <p>No additional matters were raised.</p>	
<p>EC/2122-82</p>	<p>ACTION LOG FROM THE MEETING HELD ON: 17 AUGUST 2021</p> <p>The Engagement Committee reviewed the action log and updated accordingly.</p>	
<p>EC/2122-83</p>	<p>ENGAGEMENT COMMITTEE FORWARD PLANNER 2021/22 FOR REVIEW AND AGREEMENT.</p> <p>The Engagement Committee REVIEWED and AGREED the Forward Planner.</p>	
<p>EC/2122-84</p>	<p>ANY OTHER BUSINESS</p> <p>MW extended the Committee's best wishes to BS for the future and thanking BS for her commitment and contribution. BS thanked Committee and looked forward to an exciting way forward. Over the last couple of years, from a Health Watch point of view, it was good to see the system working together and taking patients' experiences forward.</p>	
<p>EC/2122-85</p>	<p>FUTURE MEETINGS IN 2021/22 Time: 11:15 – 13:15 Meetings will be held as virtual meetings until further notice</p> <p>Tuesday 19 October 2021 Tuesday 16 November 2021 Tuesday 21 December 2021 Tuesday 18 January 2022 Tuesday 15 February 2022 Tuesday 15 March 2022</p>	

EC/2122-86	<p>ASSURANCE QUESTIONS</p> <ol style="list-style-type: none"> 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 5 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 do the Committee want to make to Governing Body following the assurance process at today's Committee meeting? None, there was felt to be no specific recommendation at this stage. 	
DATE AND TIME OF NEXT MEETING		
Date: Tuesday 19 October 2021		
Time: 11:15 – 13:15		

DRAFT

**RATIFIED MINUTES OF GOVERNANCE COMMITTEE MEETING HELD ON
23 SEPTEMBER 2021 AS A VIRTUAL MEETING VIA MICROSOFT TEAMS
AT 13:00 TO 15:00**

Present:		
Jill Dentith (Chair)	JED	Governing Body Lay Member – Governance, DDCCG
Dr Emma Pizzey	EP	Governing Body GP, DDCCG
Dr Greg Strachan	GS	Governing Body GP, DDCCG
Ian Gibbard	ICG	Governing Body Lay Member – Audit, DDCCG
Martin Whittle	MW	Governing Body Lay Member – Patient and Public Involvement, DDCCG
Helen Dillistone	HD	Executive Director of Corporate Strategy and Delivery, DDCCG
In Attendance:		
Chrissy Tucker	CT	Director of Corporate Delivery, DDCCG
Ged Connolly-Thompson	GCT	Head of Digital Development, DDCCG
James Lunn	JL	Head of Human Resources and Organisational Development, DDCCG
Lisa Innes	LI	Head of Procurement, NHS Arden and GEM CSU (part meeting)
Suzanne Pickering	SP	Head of Governance, DDCCG
Lucinda Frearson (Admin)	LF	Executive Assistant, DDCCG

Item	Subject	Action
GC/2122/53	<p>WELCOME, APOLOGIES & QUORACY</p> <p>JED welcomed members to the meeting and confirmed the meeting to be quorate.</p> <p>No apologies had been received.</p>	
GC/2122/54	<p>DECLARATIONS OF INTEREST</p> <p>JED 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 Clinical Commissioning Group (CCG).</p> <p>Declarations made by members of the Governance 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</p> <p>No declarations of interest were made for today's meeting.</p>	
GC/2122/55	<p>DERBY AND DERBYSHIRE CCG PROCUREMENT HIGHLIGHT REPORT</p> <p>LI presented the procurement highlight report requesting Committee to note the new format which identified three different types of risk, processes risk being timelines and resource, contract risk in terms of whether out of contract, expired or within contract and compliance in terms of regulation and process</p>	

	<p>being undertaken. Committee were also asked to note name change from pipeline projects to future projects.</p> <p>In progress services identified risks were Continuing Healthcare (CHC) Domiciliary Care and IVF fertility services, both are due to tight timelines but are running to time and should be completed in contracted time scale.</p> <p>The CHC Domiciliary Care service risk was due to a number of contracts issued with conditions and possibility of losing the providers if they did not meet the requirements, the majority have now all been concluded and progressing as planned.</p> <p>Future projects include Occupational Therapy (OT), the Derby Urgent Care Centre (DUCC) and INR-Anti-coagulation services and Phlebotomy. INR and Phlebotomy services are due to start moving forward in Quarter 3 and are on track. The DUCC contract was being extended in line with other integrated care services and a paper on OT services will be going to Committees to request a further extension.</p> <p>Where risks are highlighted in amber or red there is mitigation and contingency.</p> <p>Governance Committee offered the following comments and questions:</p> <ul style="list-style-type: none"> • JED asked about capacity in terms of the progression into the Integrated Care System (ICS) and the Covid situation. LI informed members that things were returning to normal, however there were some resource issues with the quality team as they were still being affected but are managing and this was not hindering or delaying projects. • JED asked about the inclusion of Glossop in the ICS and the planning and contracting processes. LI advised that they were working with the Commissioners and ICS partners in novating contracts into the new system architecture. • HD explained that in relation to the Glossop contracts Greater Manchester had agreed to extend some of the contracts to allow continuity of some services so there should not be a situation where contracts need to be renewed during the transition phase. <p>The Governance Committee RECEIVED the Highlight report for Derby and Derbyshire CCG, NOTED status of projects, and NOTED the change in format.</p>	
<p>GC/2122/56</p>	<p>CORPORATE POLICIES AND PROCEDURES</p> <p>Flexible Working Policy: JL reported that in March the Governance Committee had approved changes to the flexible working policy in line with the NHS People Plan. It was noted that since then there had been a revision to Section 33 of the NHS terms and conditions that had mandated some contractual changes for staff. The new guidance places a requirement for centralised oversight of the processes to ensure greater consistency and access to flexible working including an escalation stage.</p>	

	<p>The central oversight will be achieved by the request form being sent to Human Resources (HR) team and this being entered onto a spreadsheet to track all requests and outcomes. The form has been amended so that it is optional to enter the reasoning for flexible working.</p> <p>The contractual changes are effective from the 13th September 2021 in England and will support the commitments made in the NHS People Promise around moving to flexibility by default. The Flexible Working Policy has been updated to reflect these new contractual requirements.</p> <p>IG asked about transferability of arrangements when moving positions. JL confirmed that it would only relate to the individual's current role and not transferable to a new post so further discussions would be required with regard to a move. JL would ensure this was clear in the policy and was communicated along with the policy.</p> <p>The Committee APPROVED the NHS Derby and Derbyshire CCG's updated Flexible Working Policy.</p>	<p>JL</p>
<p>GC/2122/57</p>	<p>GOVERNANCE COMMITTEE TERMS OF REFERENCE</p> <p>JED advised there were minor changes with the inclusion of the section to oversee the transition of the committee and its assurance functions to the Integrated Care Board and a removal of the paragraph regarding the recovery and restoration plan.</p> <p>Governance Committee offered the following comments and questions:</p> <ul style="list-style-type: none"> • IG commented that the conflicts of interest (COI) link in the footer was possibly out of date and the link was not working so required updating. • EP had a general query with regard to transition to the Integrated Care Board (ICB) and the role of the Governance Committee in the new system. HD advised there was not a system Governance Committee at the moment but the ICB may require one and discussions were taking place. <p>The Governance Committee AGREED the Terms of Reference following repair to link within the footer.</p>	<p>SP</p>
<p>GC/2122/58</p>	<p>CONTRACTS OVERSIGHT GROUP - UPDATE</p> <p>SP gave a verbal update advising progress was continuing to identify suitable software to maintain the database and it is likely we will use Microsoft Access. Agreement has been reached on the regular monitoring and update of the database. Training was being provided currently with contract managers to facilitate the IFRS16 Assessment of the contracts with Chloe Foreman and Ruth Lloyd undertaking the training.</p> <p>The Governance Committee NOTED the verbal update.</p>	
<p>GC/2122/59</p>	<p>HUMAN RESOURCES PERFORMANCE REPORT Q1 2020/21</p> <p>JL highlighted key items within the report, taking the report as read.</p>	

	<p>The report covers 1st April 2021 to 13 June 2021 and showed a small increase in leavers, sickness absent levels continue to reduce and during this period the vacancy levels slightly reduced across the CCG. The report provided a summary of the vacancies as of 14 July 2021 by Directorate and an overview of staff redeployed in support of the vaccination programme.</p> <p>JL gave a brief update on changes since the report highlighting a slight increase in the number of leavers, increasing vacancies to 56, which are regularly discussed and reviewed at the Senior Leadership Team (SLT) meetings.</p> <p>HR are continuing to promote the health and wellbeing initiatives and recently enabled staff to access virtual exercise classes run by provider colleagues.</p> <p>On 14 July it had been reported the vaccination rate for staff was 72.2% in terms of double vaccinated. JL could now report that just over 90% of CCG staff have been double vaccinated with a further 3% having had their first jab. Covid booster vaccinations are being promoted for those having had their second vaccination over 6 months ago with access via NHS booking system. Flu vaccinations are also being promoted with a target of 85% within the CCG. Staff are being encouraged to take advantage of the NHS booking system or Occupational Health. As last year, staff are also able to use their local provider and claim back expenses via Epay.</p> <p>Governance Committee offered the following comments and questions:</p> <ul style="list-style-type: none"> • EP asked about the top three causes of staff sickness which were stress, anxiety, and mental health. She asked if these had been identified as work related and if so, was there anything that could be done to improve the situation. JL advised that there was a further category breakdown, so HR were aware if work related. He also advised of a number of initiatives to support staff. • MW noted that the report showed that most staff leaving the organisation had identified positive reasons such as promotion for their departure. JL advised that the staff survey had identified the majority of people were content, however, there were some concerns around workload and the ICS/ICB transition which was causing some uncertainty. • JED asked if there was anything in the return-to-work policy around non-vaccinated staff returning to the workplace. JL replied at the moment there were low numbers returning to base and as part of the Standard Operating Procedure (SOP) individuals have the discussion with their line manager and go through a risk assessment prior to booking but it has not been stated that those not vaccinated cannot come into the office, so it is considered but not prevented. <p>The Governance Committee RECEIVED the report and NOTED the contents of the report for information and assurance.</p>	
<p>GC/2122/60</p>	<p>MANDATORY TRAINING UDPATE</p> <p>CT presented the report which showed the levels of mandatory training as at the end of August with levels of compliance broadly similar to the last report</p>	

	<p>presented. Modules 2 and 3 of the conflicts of interest had been removed, as these were not mandatory, to reflect more accurate figures.</p> <p>The Governance Committee NOTED the report.</p>	
GC/2122/61	<p>BUSINESS CONTINUITY, EMERGENCY PLANNING RESILIENCE AND RESPONSE (EPRR) UPDATE</p> <p>SP presented on behalf of RH and began by giving an update in terms of business continuity. The CCG are still working at Business Continuity level 4. An Extraordinary Governance Committee had been held on 10 September during which the new operating model was approved. A staff briefing took place during CCG team talk and managers briefings were taking place. The CCG is currently working in an amber status, where it is not mandated to return to the office and hot desk are at a reduced level.</p> <p>On 26 August notification was received of a blood specimen collection disruption, a review will be taking place on the 17 September.</p> <p>Regarding EPRR and the Derbyshire Resilience Forum, there had been meetings since July for the Risk Assessment Group to agree the Terms of Reference and to agree who would lead on which area of the risk.</p> <p>The Governance Committee NOTED the contents of the report for information and assurance.</p>	
GC/2122/62	<p>EPRR CORE STANDARDS SELF-ASSESSMENT SUBMISSION FOR 2020/21</p> <p>SP presented on behalf of RH informing members that further to the update provided at July's meeting the standards were circulated with a deadline of 31 August. All submissions were received by NHSEI except Derbyshire Healthcare Foundation Trust, but this has since been submitted. Attached to the report are the CCG's core standards and self-assessment, for information, demonstrating full compliance.</p> <p>A table included in the report detailed the position of Derbyshire providers against the standards. It was noted that all Derbyshire providers were either fully or substantially compliant with a plan to achieve full compliance. Since submission at the 31 August there has been some confirm and challenge from NHSEI. Derbyshire now have a new NSHEI EPRR lead, and each Derbyshire Provider organisation has been given a list of 10-20 questions to provide further details and evidence to support the standards. There will be a further confirm and challenge process in November with NHSEI which will result in confirmation of the status of each provider against the standards.</p> <p>The Governance Committee NOTED the contents of the report for information and assurance.</p>	
GC/2122/63	<p>HEALTH AND SAFETY REPORT</p> <p>SP presented the paper on behalf of RH, taking the report as read and informing members that on 20 September the hybrid operating model for return to offices was implemented. The Estates team were working to produce</p>	

	<p>presentations for team talk and line manager briefings. There had been a lot of work undertaken to get offices ready to adhere to guidelines for the new operating model.</p> <p>Governance Committee offered the following comments and questions:</p> <ul style="list-style-type: none"> JED queried the Action Plan which was dated 20/21. SP advised the plan had now rolled over and the date will be amended accordingly. <p>The Governance Committee was ASSURED that Derby and Derbyshire CCG was coordinating work to meet its health and safety obligations to remain compliant with health and safety legislation and was ASSURED that Derby and Derbyshire CCG was responding effectively and appropriately to the changes in working practices as a consequence of the COVID-19 pandemic.</p>	SP
GC/2122/64	<p>VIOLENCE PREVENTION AND REDUCTION STANDARDS UPDATE</p> <p>SP presented on behalf of RH advising that work with 360 Assurance has enabled the CCG to produce a draft strategy and policy for information and assurance. There are still highlighted sections that require further work and SP would like to bring both back to the November meeting for final approval.</p> <p>Governance Committee offered the following comments and questions:</p> <ul style="list-style-type: none"> JED asked if the documents were in a national format and would this affect the wording. SP advised this was a master document, but any amendments required could be implemented. IG believed that overall, the policy was helpful. He noted that section 1.3 was the view of the executives but felt that the document should also state that it was a legal requirement. JED queried Section 6, roles and responsibilities, it states the Chief Executive Officer (CEO) and executive team are accountable when usually it is the CEO accountable and executive team should implement and some cross referencing was required within the table. <p>The Governance Committee provided comments and NOTED the contents of the report for information and assurance and looked forward to receiving the updated version, with the above comments included, at the next committee meeting.</p>	
GC/2122/65	<p>INFORMATION GOVERNANCE UPDATE REPORT</p> <p>SP took the report as read providing highlight of main points which were that the Control of Patient Information (COPI) Notice had been extended again to 31 March 2022 and had been published on the Government website.</p> <p>The Hold Notice had been received for the Covid 19 enquiry, the notice has been shared with all staff via the IG Newsletter and the CCG are engaged in the national Data Protection Officer (DPO) calls.</p>	

	<p>Organisation Data Service (ODS) code changes for the ICB are being facilitated by NHS Digital and currently there is no requirement at this point for any action from the CCG in respect of data flows and the DOS requirements.</p> <p>In terms of IG compliance, a further four face to face sessions have taken place and more virtual sessions are being arranged. Staff that are not compliant are being followed up.</p> <p>In terms of national guidance, the information governance framework for the integrated health and care for social care records has been reviewed and are in line with the work required.</p> <p>Governance Committee offered the following comments and questions:</p> <ul style="list-style-type: none"> JED asked regarding the data security and protection tool kit and questioned whether the CCG or ICS would submit. SP advised that discussions were underway as of 30 June it would be ICB's responsibility in terms of compliance, but it was the CCG's intention to submit 31 March. The CCG are working with 360 Assurance for internal audit as there is still the mandated data security and protection tool kit audit to be completed by the end of the financial year for the Head of Internal Audit Opinion. <p>The Governance Committee APPROVED and RECEIVED the update of actions and activities.</p>	
<p>GC/2122/66</p>	<p>DIGITAL DEVELOPMENT AND CYBER SECURITY UPDATE</p> <p>GCT provided a summary of key issues from the report presented, advising that the team are considering re-procurement of services within primary care. This included understanding what the Primary Care Networks (PCNs) are evolving into, how to support digitally and continue relationships with the ICS and new models of working. Approval had been received from Primary Care Commissioning Committee (PCCC) for re-procurement of AccuRX Plus online consultation tools and clinical information systems but with a request for appropriate assurance around the use of single tender waives which will be considered for future procurement phases.</p> <p>Initial meeting had taken place with Tameside and Glossop CCG which was very positive agreeing on a number of issues and these will be fed into the workstreams. Primary focus was avoiding disruption to patients and staff whilst agreeing timescales for aligning services and contract renewals.</p> <p>Discussions are continuing regarding the electronic eye care referral system and whether a clinical safety officer is required, and if so whether the role should be outsourced. As the digital agenda develops it is increasingly important there is dedicated clinical oversight of any tools, services or products being put into the ICS and access to a qualified Commissioning Support Officer (CSO). The E-Referral Service (ERS) Project Board raised concerns around additional workload therefore the project looked outside Derbyshire for support.</p> <p>CCG are pleased with the service NECS are providing especially around the fix-it sessions. NECS have been proactive with engineers arranging to attend</p>	

	<p>GP practices for a particular date and time to pick up any issues the practice wishes to identify.</p> <p>Cyber security infrastructure remains stable and as agreed at PCCC a number of shared sites are being migrated from Arden and Gem onto NECS platform.</p> <p>There will be some older devices within primary care that are not being regularly connected to the network which is a concern as an ongoing resource cost and also a security concern. As part of the fix-it sessions practices will be encouraged to handover any equipment no longer required.</p> <p>CCG have now begun attending a reconvened Local Resilience Forum group looking specifically at cyber security.</p> <p>Governance Committee offered the following comments and questions:</p> <ul style="list-style-type: none"> • EP asked regarding 'away from my desk' technology and smart card access. GCT advised that various virtual desktop infrastructure (VDI) solutions were being looked at currently. • GS commented on the digitisation of Lloyd George. As this will be a scan and demand model so would the CCG or NHSEI be responsible for the secure storage. GCT believed the responsibility will be for NHSEI, there will be a national contract that will be put in place the CCG may have to provide some storage prior to that. • MW raised a question regarding the Glossop area and whether they were using different equipment that may cause issues. GCT replied that current services will continue in the short term as their network was provided through the Local Authority and they would look to move over during contract renewals. <p>Governance Committee offered the following comments regarding the Digital and Data Delivery Board Terms of Reference:</p> <ul style="list-style-type: none"> • JED asked if someone specific would be required on the group in terms of Glossop if not what assurance was there that Glossop would be represented. • Quorum states 70% and JED suggested it would be more appropriate to specify key skill from those forming the quorum. <p>GCT would action above comments.</p> <p>The Governance Committee NOTED the contents of the report for information and assurance also providing comments regarding the Terms of Reference.</p>	<p>GCT</p>
<p>GC/2122/67</p>	<p>RISK REGISTER EXCEPTION REPORT</p> <p>SP presented the Governance Committee Risk Report as of September 2021. All risks had been reviewed and amended being highlighted in red where there are any changes in terms of mitigating action and progress.</p>	

	<p>Risk 9 had been reduced in score from a high 8 to a moderate 6, in relation to the CCG and General Practice.</p> <p>Governance Committee offered the following comments and questions:</p> <ul style="list-style-type: none"> • IG stated that the National Audit Office had released a good practice guide on how the Board should manage the climate change risk and asked if this was being looked at in terms of risk. SP advised that there was no risk at the moment but this was currently being considered in terms of actions and risks. JED asked if this would be added as a risk to the CCG's register or if it would be something for the ICS. SP advised that CT and colleagues were considering this and would advise. JED asked if there would be a risk this year or something ICS/ICB would be picking up. SP believed there would be a presentation at the next Audit Committee and CT would be taking up as part of her risk team review. • GS asked GCT if system printers could be set to double sided printing as a default as they are currently set to single. It was noted that all script printing is done from SystemOne or EMIS with patient information or forms being printed separately. <p>Action: GCT to follow up on possibility to set printers to double sided printing as default.</p> <p>Action: CT to look at climate risk as part of her risk team review.</p> <p>The Governance Committee RECEIVED the Governance risks assigned to the Committee as of September 2021.</p> <p>The Committee APPROVED the decrease in risk score for Risk 09.</p>	<p>GCT</p> <p>CT</p>
<p>GC/2122/68</p>	<p>GOVERNANCE COMMITTEE GBAF RISKS REVIEW</p> <p>SP presented the newly identified strategic risks for Governing Body Assurance Framework (GBAF) assigned to Governance Committee. There had been a conversation during the last meeting in July when both risks had been discussed and it was felt they could be reduced in score, these reductions had now taken place. Both were open for discussion and review prior to present to Governing Body on 7 October in Q2 GBAF.</p> <p>Risk 07 had been reduced in score to a moderate 6. JED felt that the figures were increasing slightly which may impact on the score. JL believed that the current score was reflective of the situation and SP offered to include more detail with regard to Thrive to the information presented. It was agreed to keep the score for Risk 07 as proposed at this stage.</p> <p>Risk 08 had been reduced to a risk score 16. Further guidance had been received at the end of August and John McDonald had been appointed as ICB Designated Chair. It was noted that further guidance is awaited in addition to the Bill to be passed through Parliament. Details with regard to Glossop require inclusion prior to presentation to Governing Body.</p>	

	<p>The Governance Committee NOTED the Quarter 2 Governing Body Assurance Framework and RECEIVED GBAF Risks 7 and 8 owned by the Governance Committee and APPROVED the change in score for Risk 7 and Risk 8.</p>	
GC/2122/69	<p>NON-CLINICAL ADVERSE INCIDENTS</p> <p>CT informed Committee that there were no incidents to report.</p>	
GC/2122/70	<p>MINUTES OF THE MEETING HELD ON: 22 JULY 2021</p> <p>The Governance Committee APPROVED the Minutes of the meeting on 22 JULY 2021 as a true and accurate record of the meeting.</p>	
GC/2122/71	<p>MATTERS ARISING</p> <p>No further matters were identified.</p>	
GC/2122/72	<p>ACTION LOG FROM THE MEETING HELD ON: 22 JULY 2021</p> <p>All actions completed except one which will be added to the forward planner with monthly updates.</p> <p>The Governance Committee REVIEWED the action log and updated.</p>	
GC/2122/73	<p>GOVERNANCE COMMITTEE FORWARD PLANNER 2021/22 (FOR DISCUSSION/AGREEMENT)</p> <p>Ongoing work through the CCG Transition Working Group (TWG) and Project Group item from the action log to be added to the Forward Planner with monthly updates.</p> <p>The Governance Committee APPROVED the Forward Planner 2021/22</p>	LF
GC/2122/74	<p>ANY OTHER BUSINESS</p> <p><u>Extra Ordinary Governance Committee Meeting – 10 September 2021</u> The Minutes from the Extraordinary Governance Committee will be brought to the next confidential session on 11 November 2021.</p>	
GC/2122/75	<p>FUTURE MEETINGS DATES</p> <p>Time: 13:00 – 15:00 <u>NB. The meetings will be held as virtual meetings until further notice.</u></p> <p>Thursday 11 November 2021 Papers due: Tuesday 2 November 2021</p> <p>Thursday 10 February 22 Papers due: Tuesday 2 February 2022</p> <p>Thursday 24 March 2022 Papers due: Tuesday 15 March 2022</p>	

	<p>ASSURANCE QUESTIONS</p> <ol style="list-style-type: none"> 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 5 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, not at this point. 7. What recommendations do the Committee want to make to Governing Body following the assurance process at today's Committee meeting? The Committee felt that good progress was being made regarding the transition to ICS from a governance perspective. 	
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**MINUTES OF PRIMARY CARE COMMISSIONING COMMITTEE
PUBLIC MEETING
HELD ON
Wednesday 27th October 2021**

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

PRESENT

Simon McCandlish (Chair)	SMc	Deputy Chair, 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
Clive Newman	CN	Director of GP Development 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
Judy Derricott	JDe	AD of Nursing & Quality Derby & Derbyshire CCG
Kath Markus	KM	Chief Executive Derby & Derbyshire LMC
Jean Richards (Part of Meeting)	JR	Senior GP Commissioning Manager DDCCG
Pauline Innes	PI	Executive Assistant to Dr Steven Lloyd DDCCG

APOLOGIES

Richard Chapman	RC	Chief Finance Officer
Ged Connolly-Thompson	GCT	Head of Digital Development
Abid Mumtaz	AM	Service Commissioning Manager Public Health, Derbyshire County Council
Ian Shaw	IS	Lay Member Derby & Derbyshire CCG
Brigid Stacey	BS	Chief Nurse Derby & Derbyshire CCG

ITEM NO.	ITEM	ACTION
PCCC/2122/142	<p>WELCOME AND APOLOGIES</p> <p>The Chair (SMc) 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.</p> <p>The Chair confirmed that the meeting was quorate.</p>	
PCCC/2122/143	<p>DECLARATIONS OF INTEREST</p> <p>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.</p>	

	<p>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:</p> <p style="text-align: center;">www.derbyandderbyshireccg.nhs.uk</p> <p><u>Declarations of interest from today's meeting</u> There were no declarations of interest made</p> <p>The Chair declared that the meeting was quorate.</p>	
FOR DECISION		
	No items for decision	
FOR DISCUSSION		
	No Items for discussion	
FOR ASSURANCE		
PCCC/2122/144	<p>FINANCE UPDATE</p> <p>Niki Bridge (NB) presented an update from the shared paper. The paper was taken as read and the following points of note were made.</p> <p>The Month 5 finance position has been received at the Finance Committee and Governing Body.</p> <p>Key points of interest:</p> <ul style="list-style-type: none"> • All statutory duties have been met. At Month 5 the CCG are reporting a year-to-date favorable position of £0.128m with a favorable variance against the Primary Care Co-commissioning allocation of £0.107m which is due to lower activity levels for enhanced services and reduced locum costs. • At Month 4 £2m of the £4m contingency fund was used which was set aside for H1, however, none of the contingency fund for month 5 has been used • There are several hot spots being reported for complex health care however, this is an improving position as the actions that are being taken to improve the fast tracks are starting to have a positive impact. There remains to be some pressures, however with the actions taken this potentially will be brought back in line with 2019/20 activity. • The underspends are mainly due to slippage in Mental Health investments and in the acute independent sector where an underspend is being seen against activity which is due to capacity constraints within the independent sector to help support and achieve reductions. • The system report as at Month 5 shows a £3.2m surplus year to date above the plan and at year end it is expected that there will be a £2.2m surplus. <p>Jill Dentith (JeD) queried the locum costs which were lower than anticipated which appears unusual bearing in mind the difficulties that practices are under in terms of delivery objectives, asking if further detail could be provided. NB explained that this is around availability and having the resource to deliver, stating that this concern is not just in Primary Care it is across the Board.</p> <p>Steve Lloyd (SL) reiterated NB comments stating that a significant element of</p>	

	<p>this area of concern is around locum availability which is not there for several practices.</p> <p>Kath Markus reported that locum availability has been a concern for some time now stating that GPs are not putting themselves forward to undertake additional sessions due to pressures of work.</p> <p>Hannah Belcher (HB) reported of timings for claims that are submitted stating that quite often there is a bit of a delay in the claims for locum reimbursement which may also have an impact. HB echoed the comments made in that there are overall workforce challenges for locums at the moment.</p> <p>Simon McCandlish (SMc) enquired as to whether surplus monies would be used to help clear backlogs or alternatively would this mean the organisation would start from scratch in the new financial year. NB explained that H2 guidance has made it clear that CCGs will be expected to breakeven at the end of the financial year. If a surplus was to be declared this would be under the business rules of the CCG. If the Committee recall the CCG was running at a slight deficit on carry forward therefore if there is a surplus this would wipe off the deficit.</p> <p>The Primary Care Commissioning Committee NOTED and RECEIVED the update on the DDCCGs financial position for Month 5.</p>	
<p>PCCC/2122/145</p>	<p>RISK REGISTER EXCEPTION REPORT</p> <p>Hannah Belcher (HB) presented an update from the shared paper. The paper was taken as read and the following points of note were made.</p> <p><u>Risk 04A: Contracting:</u> 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</p> <p>HB reported that there are no changes in scores since the last report in September from a contracting point of view. Practices still remain under significant pressure with challenges around the delivery of the COVID and Flu vaccine along with an increased number of staff being absent through various illnesses as well as COVID which is causing pressures under Primary Care. The Committee noted that there is no recommendation to change the current risk rating at this moment in time.</p> <p>Jill Dentith (JeD) referred to the winter plan enquiring if this will have any impact with regards to risks as we move into the next couple of months. HB reported that this will have an impact due to practices returning to business as usual there will undoubtedly be a change, stating that this concern will be monitored closely. The Committee noted that an update on the winter plan will be provided at the November meeting.</p> <p><u>Risk 04B: Quality:</u> 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</p> <p>Marie Scouse (MS) reported that Primary Care are seeing from the SITREP reports that practices continue to have concerns with workloads and staffing and recommended to the Committee that the risk remains the same.</p> <p>The Primary Care Commissioning Committee NOTED and RECEIVED the update on the two outstanding risks and:</p> <ul style="list-style-type: none"> • AGREED that the scores remain unchanged • REQUESTED that the scores are reviewed monthly. 	<p>Fwd Agenda</p>

FOR INFORMATION

There were no items for Information

MINUTES AND MATTERS ARISING

PCCC/2122/146 Minutes of the Primary Care Commissioning Committee meeting held on 22nd September 2021

The minutes from the meeting held on 22nd September 2021 were agreed to be an accurate record of the meeting.

PCCC/2122/147 MATTERS ARISING MATRIX

There are no outstanding actions on the Action Matrix.

PCCC/2122/148 ANY OTHER BUSINESS

There were no items of any other business

PCCC/2122/149 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 24th November 2021, 10:00-10:30am via Microsoft Teams Meeting

**MINUTES OF QUALITY AND PERFORMANCE COMMITTEE
HELD ON 28TH OCTOBER 2021,
9AM TO 10.00AM
MS TEAMS**

Present:		
Dr Buk Dhadda (Chair)	BD	Chair, Governing Body GP, DDCCG
Brigid Stacey	BS	Chief Nurse Officer, DDCCG
Niki Bridge	NB	Deputy Director of Finance
Alison Cargill	AC	Asst Director of Quality, DDCCG
Simon McCalandish	SMcC	Lay Member, Patient Experience
Sarah MacGillivray	SMacG	Head of Patient Experience, DDCCG
Andrew Middleton	AM	Lay Member, Finance
Lisa Falconer	LF	Head of Clinical Quality (Acute) DDCCG
Dan Merrison		Snr Performance and Assurance Manager DDCCG
Dr Greg Strachan	GS	Governing Body GP, DDCCG
Rosalie Whitehead	RW	Risk Management & Legal Assurance Manager DDCCG
Dr Merryl Watkins	MWa	Governing Body GP, DDCCG
Helen Wilson	HW	Deputy Director Contracting and Performance - 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:		
Jackie Carlile	JC	Head of Performance and Assurance -DDCCG
Dr Steve Lloyd	SL	Medical Director - DDCCG
Craig Cook	CC	Deputy Director of Commissioning DDCCG
Helen Henderson-Spoors	HHS	Healthwatch Derbyshire
Suzanne Pickering	SP	Head of Governance- DDCCG
Phil Sugden	PS	Asst Director of Quality & Named Patient Safety Specialist
Dr Emma Pizzey	EP	GP South
Zara Jones	ZJ	Executive Director of Commissioning Operations, DDCCG

Item No.	Item	Action
QP2122 /123	<p>WELCOME, APOLOGIES & QUORACY</p> <p>Apologies were received as above. BD declared the meeting quorate.</p>	
QP2122 /124	<p>DECLARATIONS OF INTEREST</p> <p>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.</p> <p>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</p> <p><u>Declarations of interest from sub-committees</u> No declarations of interest were made.</p> <p><u>Declarations of interest from today's meeting</u> No declarations of interest were made.</p>	
	<p>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.</p>	

<p>QP2122 /125</p>	<p>Integrated Report</p> <p>The report was taken as read. BD explained to the Committee that the report included in the pack will be updated following receipt of recent data around breast performance and 12-hour breaches. Therefore, the report that is submitted to GB will reflect those changes.</p> <p>DM highlighted the changes. Page 22 of the report states there were two 12-hour trolley breaches during September for CRHFT. The correct figure was 1 and was due to the lack of availability of a MH bed. Page 23 of the report states there were 46 12-hour trolley breaches for UHDBFT, and this figure was actually 39.</p> <p>There have been concerns around breast performance but despite this both trusts achieved their targets for 2 week waits and breast symptomatic in August. DM noted that there have been spikes in referrals on a national scale. There is also a renewed focus on 62 day wait patients and this could show as a decrease in the reporting figures.</p> <p>GS requested assurance on the waiting list blitz being carried out by the CAMHS team. HH confirmed that the CAMHS team have stood down the usual routine work to focus solely on assessments. It is hoped that the waiting list should reduce to around six weeks.</p> <p>AM referred to the recent announcement around the immediate cessation of handover delays from the ambulance service and asked how achievable this might be. BS gave assurance that the 999 Quality Assurance Committee had undertaken a piece of work with EMAS to look at the quality and safety of patients in terms of these delays. All of the pressures and mitigating actions were considered and the 999 QAC were assured that EMAS were consistently ensuring the quality and safety of patients. A piece of work has been initiated with systems that are experiencing vast pressures to look at the whole patient pathway to identify where any harm occurred.</p> <p>Activity Report</p> <p>The report was taken as read. HW explained that there is a weekly COVID modelling meeting for which trusts submit data on ICU COVID occupancy. For 3-4 consecutive weeks there had been increases which was quite worrying, however last week this decreased in line with the rest of the country.</p> <p>MW referred to the cancer referrals increasing following non presentation during COVID. HW confirmed that the Cancer Alliances have been focussing on this over the last 12 months by pushing new initiatives and communications as well as pushing their outpatient first appointments and outpatient follow ups to</p>	
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	<p>ensure patients on the elective pathway are moving through the system. BD referred to the non-urgent elective backlog and asked how many of these patients have been converted to urgent due to the patient approaching the GP with worsening symptoms and whether this data was recorded anywhere. HW agreed to follow this up and update at a future meeting. MWa added it would be useful to know how the consultants deal with the letters that are received from the GP with a request to expedite a patient. ACTION - BS confirmed that Alison Cargill would explore this with the relevant quality leads in the Trusts and provide feedback to the Committee.</p> <p>HW explained that a piece of work around understanding the inequalities built into the elective pathways is being carried out with colleagues from CRHFT and UHDBFT and is feeding into the Planned Care Delivery Board. HW agreed to bring an update to Quality and Performance Committee when appropriate. ACTION – Add to the forward planner.</p> <p>HH gave assurance to the Committee that the winter plan has been designed across the system. There are a number of mitigations included around patient flow from acute into community and ultimately into their homes, the strapline is "home first". The winter plan has been approved by SORG and the A&E Delivery Board is meeting to review the winter plan.</p> <p>BD APPROVED the Integrated Report.</p>	<p>AC</p> <p>JP</p>
<p>QP2122 /126</p>	<p>GBAF Q3</p> <p>The paper was taken as read.</p> <p>The Quality and Performance Committee Task and Finish Group met recently. The group reviewed and challenged the risks and updated them to include the NHS Greener Plan. There have been no changes to the risk scores for Q3.</p> <p>The Committee noted the contents and approved the paper.</p>	
<p>QP212 /127</p>	<p>RISK REGISTER</p> <p>The paper was taken as read.</p> <p>The Committee were asked to approve the following recommendations.</p> <p>Approve the decrease in risk score for risk 38 relating to the risk of quality of care being impacted by patients not receiving a care needs review in a timely way as a result of the COVID pandemic.</p> <p>Approve closure of risk 14 relating to on-going non-compliance of</p>	

	<p>completion of initial health assessments (IHA's).</p> <p>MWA spoke about an emerging risk around notice being given in relation to the vaccination service. BS confirmed that the Vaccination Operations Centre (VOC) would need to discuss what mitigations need to be put in place with Dr Steve Lloyd and if it is felt the mitigations are insufficient then it would be raised as a risk to be included on the risk register at the most appropriate Committee. ACTION - BS will discuss with Dr Steve Lloyd to confirm whether this issue needs to be raised as a formal risk.</p> <p>The Committee noted the contents and the approved the recommendations in the paper.</p>	<p>BS</p>
<p>QP2122 /128</p>	<p>PATIENT SAFETY UPDATE</p> <p>BD confirmed that this will be moved into the confidential session of the meeting.</p>	
<p>QP2122 /129</p>	<p>PATIENT SAFETY SPECIALIST LETTER</p> <p>The paper was taken as read.</p> <p>LF explained there is an NHSEI request for a discussion to take place between the Board and the Patient Safety Specialist to agree the expectations of the Patient Safety Specialist role and responsibilities in patient safety in the CCG/ICS. NHSEI will be assuring themselves that the board discussion has taken place.</p> <p>BS asked the Committee members if</p> <ol style="list-style-type: none"> 1. The discussion should take place at quality and performance Committee with a report to Governing Body. 2. The discussion should take place at Governing Body. 3. Have an in-depth discussion at Quality and Performance Committee followed by a brief presentation to Governing Body to give Board members an overview and a say in that piece of work. <p>Committee members agreed on option 3. ACTION – Add to the forward planner for the November meeting.</p> <p>There were no questions raised by the committee members.</p> <p>The Committee noted the contents and approved the paper.</p>	<p>JP</p>

<p>QP2122 /130</p>	<p>JUCD QEIA</p> <p>The paper was taken as read. There were no questions raised by the Committee members.</p> <p>The Committee noted the contents and approved the paper.</p>	
<p>QP2122 /131</p>	<p>END OF LIFE CARE PROJECT</p> <p>The paper was taken as read. There were no questions raised by the committee members.</p> <p>The Committee noted the contents and approved the paper.</p>	
<p>QP2122 /132</p>	<p>CONTINUING HEALTH CARE (CHC)</p> <p>The paper was taken as read. There were no questions raised by the Committee members.</p> <p>The Committee noted the contents and approved the paper.</p>	
<p>QP2122 /133</p>	<p>IPC</p> <p>The paper was taken as read. There were no questions raised by the Committee members.</p> <p>The Committee noted the contents and approved the paper.</p>	
<p>QP2122 /134</p>	<p>CARE HOMES</p> <p>The paper was taken as read. There were no questions raised by the Committee members.</p> <p>The Committee noted the contents and approved the paper.</p>	

<p>QP2122 /135</p>	<p>MINUTES FROM SUB COMMITTEES</p> <p>The Committee noted the minutes from the following sub-Committees:</p> <p>Updates from Trust CQRG meetings. UHDBFT CRHFT</p>	
<p>QP2122 /136</p>	<p>MINUTES FROM THE MEETING HELD ON 30TH SEPTEMBER 2021.</p> <p>The minutes were approved as a true and accurate record. JP will amend the minutes to state an update will be brought back to Quality and Performance Committee around the Mental Health pathway.</p>	
<p>QP2122 /137</p>	<p>MATTERS ARISING AND ACTION LOG</p> <p>The action log was reviewed and updated.</p>	
<p>QP2122 /138</p>	<p>AOB</p> <p>There were no matters raised under AOB.</p>	
<p>QP2122 /139</p>	<p>FORWARD PLANNER</p> <p>The Forward Planner was reviewed. No updates were made.</p>	
<p>QP2122 /140</p>	<p>ANY SIGNIFICANT SAFETY CONCERNS TO NOTE</p> <p>None raised.</p>	
	<p>ASSURANCE QUESTIONS</p> <ul style="list-style-type: none"> • 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 	

	<ul style="list-style-type: none"> • 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: 25 th November 2021		
Time: 9am to 10.30am		
Venue: MS Teams		

APPROVED



Chief Executive Report

Health Executive Group

9th November 2021

Author(s)	Andrew Cash	
Sponsor		
Is your report for Approval / Consideration / Noting		
For noting and discussion		
Links to the ICS Five Year Plan (please tick)		
Developing a population health system	Strengthening our foundations	
<input checked="" type="checkbox"/> Understanding health in SYB including prevention, health inequalities and population health management	<input checked="" type="checkbox"/> Working with patients and the public	
<input checked="" type="checkbox"/> Getting the best start in life	<input checked="" type="checkbox"/> Empowering our workforce	
<input checked="" type="checkbox"/> Better care for major health conditions	<input checked="" type="checkbox"/> Digitally enabling our system	
<input checked="" type="checkbox"/> Reshaping and rethinking how we flex resources	<input checked="" type="checkbox"/> Innovation and improvement	
Building a sustainable health and care system	Broadening and strengthening our partnerships to increase our opportunity	
<input checked="" type="checkbox"/> Delivering a new service model	<input checked="" type="checkbox"/> Partnership with the Sheffield City Region	
<input checked="" type="checkbox"/> Transforming care	<input checked="" type="checkbox"/> Anchor institutions and wider contributions	
<input checked="" type="checkbox"/> Making the best use of resources	<input checked="" type="checkbox"/> Partnership with the voluntary sector	
	<input checked="" type="checkbox"/> Commitment to work together	

Where has the paper already been discussed?

Sub groups reporting to the HEG:

- Quality Group

- Strategic Workforce Group

- Performance Group

- Finance and Activity Group

- Transformation and Delivery Group

System governance groups:

- Joint Committee CCGs

- Acute Federation

- Mental Health Alliance

- Place Partnership

Are there any resource implications (including Financial, Staffing etc)?

N/A

Summary of key issues

This monthly paper from the System Lead of the South Yorkshire and Bassetlaw Integrated Care System provides a summary update on the work of the South Yorkshire and Bassetlaw health and care partners for the month of October 2021.

Recommendations

The SYB ICS Health Executive Group (HEG) partners are asked to note the update and Chief Executives and Accountable Officers are asked to share the paper with their individual Boards, Governing Bodies and Committees.

Chief Executive Report

SOUTH YORKSHIRE AND BASSETLAW INTEGRATED CARE SYSTEM

Health Executive Group

9th November 2021

1. Purpose

This paper from the South Yorkshire and Bassetlaw (SYB) Integrated Care System (ICS) System Lead provides an update on the work of the South Yorkshire and Bassetlaw health and care partners for the month of October 2021.

2. Summary update for activity during October

2.1 Coronavirus (COVID-19): The South Yorkshire and Bassetlaw position

After a slight reduction in new Covid cases over recent weeks there are now signs of small increases detected across SYB. This coincides with the end of the Half-Term Holiday as children return to schools and colleges combined with the resumption of regular Covid testing.

The majority of Covid cases remain across younger age groups (under 18s) but there are signs that cases in the over 70s are flattening and declining in some areas. There is a rise within the 50-69 year-old age group which could translate into more hospitalisations.

Regionally, SYB remains in the middle of the pack across the wider region - South West, North East, South East, East of England all showing higher cases – and within Yorkshire and The Humber with County Durham, North Yorkshire/York and Cumbria are all showing higher rates.

Public health teams continue to provide robust support to prevent large-scale outbreaks which are typically confined and isolated to smaller group settings. It is highly likely that Covid cases will continue to rise as we head into the Winter and contingency plans are being developed with our health and care partners to manage system pressures, promote public health messaging and support the Covid vaccination and booster campaign.

SYB's Covid Vaccination Programme continues to provide oversight for the regional roll-out of both the boosters and the primary vaccination offer, including third doses for eligible groups. The focus remains on protecting care homes, the health and care workforce and supporting the School Age Immunisation Service (SAIS) with the 12-15 year-old single vaccination offer. The SYB programme is progressing well against the deadlines for these priority areas.

2.2 Regional update

2.2.1 Leaders meeting

The North East and Yorkshire (NEY) Regional ICS Leaders meet weekly with the NHS England and Improvement Regional Director. During October, discussions focused on emergency care and winter resilience, planning and recovery, health inequalities and ICS development and the ongoing response to Covid..

2.3 National update

2.3.1 Comprehensive Spending Review

The Comprehensive Spending Review (Autumn Budget 2021) outlined a range of new investments that will support SYB's health and care system to improve waiting lists, reduce health inequalities and invigorate SY's transport infrastructure.

Our health and care system will receive a share of £5.9 billion of new funding which is being allocated to support the NHS' COVID-19 (Covid) recovery. With the main aim of reducing waiting lists and speeding up diagnostics, the Spending Review committed towards the purchasing of new hospital beds, equipment, estate developments, improving digital technology/connectivity and the launch of new community-based diagnostic 'hubs' (as recently reported for The Glass Works in Barnsley and the Montagu Hospital site in Mexborough).

The Spending Review also announced a range of investments that will provide a boost towards levelling-up across SYB; a planned increase of 6.6 per cent on the National Living Wage (up to £9.50 an hour), a Covid recovery fund of £2 billion pounds for schools/colleges and £640m annual funding to be allocated to address rough sleeping and homelessness. Regionally, £570 million will also be made available to fast-track transport infrastructure projects including active and green travel schemes in South Yorkshire.

2.3.2 Winter preparedness funding

SYB health and care partners have been allocated £8 million pounds of dedicated new funding to directly address winter preparedness plans.

The NHS continues to experience significant levels of pressure. The continued impact of managing Covid, plus the recovery of services and return to usual activity levels has led to a challenging summer; especially in the context of constrained capacity due to Covid related infection prevention and control (IPC) and workforce issues.

As partners move into the winter months with more unknowns than usual, we need to plan to manage capacity to respond to demand that may be fuelled by further waves of Covid and/or severe outbreaks of respiratory and other illness. Resilience over winter can only be achieved through taking a system led approach and through detailed scenario planning, at both system and Place, we are developing robust strategies to alleviate system pressures.

Partners are continuing to work collaboratively on the consistent and coordinated deployment of public health messaging, led through South Yorkshire's Local Resilience Forum (LRF) - which includes the NHS, local authorities, public health teams and police, fire and rescue services.

Thanks are extended to all colleagues in the health and care system for their ongoing hard work and dedication through this very busy time

2.4 Integrated Care System update

There have been a number of developments relating to our transitional journey into becoming the South Yorkshire Integrated Care Board (SYICB) by April 2022.

At the end of September, colleagues across our four Clinical Commissioning Groups (CCGs) in Barnsley, Doncaster, Rotherham and Sheffield alongside our current ICS-based teams, were given letters that provided greater clarity over future employment statuses.

We shortly hope to have appointed SY's future designate Chief Executive Officer (CEO) for the SYICB. The designate Chair, Pearse Butler, has been overseeing the selection process alongside a system-representative panel, including colleagues from Healthwatch, Local Authorities and the

NHS.

We have been working on the refreshed System Development Plan and working with our regional NHS team in the North East and Yorkshire (NEY) to develop a '4+1' process to review our systems' Readiness to Operate Statement (ROS) assessments; this is a structured framework that requires evidence of SYB's ability to start working as an ICB. The checklist criteria include the appointment of leadership roles, financial planning requirements and information governance processes, to name a few. The expectation is that the ROS outputs will be agreed with the regional team and shared with the National Director of System Transformation in November.

A wide-range of published guidance about the development of national integrated care systems continues to be uploaded to the NHS Futures website. Most recently, partners have been discussing our transition and development journey and starting to put a structure around the future board/core requirements as we move closer towards the national deadline in April 2022.

This has included engaging with partners on two key aspects of the ICB Constitution - its composition and how partners will be nominated. This work is being led by SYB's designate leaders, Pearse Butler, Independent Chair and Chair Designate of the future SY ICB organisation. It is hoped that the Chief Executive Officer (CEO), which is now in the latter stages of the interview process, will join the ICB development work shortly.

South Yorkshire's four clinical commissioning groups (CCGs) in Barnsley, Doncaster, Rotherham and Sheffield, will present the final proposals for the future board make up and process for appointment to it at the Joint Committee of Clinical Commissioning Groups (JCCCG).

2.5 Launch of Digital North Accelerator Programme

A new digital accelerator programme, co-developed by four regional Academic Health Science Networks (AHSN's), has been launched with the aim to support national health challenges exacerbated by the pandemic.

Yorkshire & Humber AHSN, Health Innovation Manchester, Innovation Agency (AHSN for the North West Coast) and AHSN North East and North Cumbria are leading the new programme, enabling the most successful regional solutions to be guided towards national adoption through the Innovation Exchange programme.

The 2021 "Restore, Reset and Recover" programme will deliver digital innovations which meet the recovery priorities of our NHS partners as they respond to the continuing impact of Covid.

2.6 Children's Hospital Charity

Outstanding fundraising efforts by colleagues at The Children's Hospital Charity's has raised more than £750,000 from the Bears of Sheffield auction. This successfully completes their three-year appeal to transform the Cancer and Leukaemia ward at Sheffield Children's Hospital NHS Foundation Trust.

2.7 Partner organisation appointments

Dr Graeme Tosh has been appointed as the new Executive Medical Director of the Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) and will replace the current Medical Director, Dr Nav Ahluwalia, in spring next year.

Tracey Wrench, the Executive Director of Nursing and Allied Health Professionals and Deputy Chief Executive, has also announced her retirement and will leave RDaSH on March 22 next year.

2.8 British Medical Association recognition for SYB health equality and prevention schemes

The British Medical Association (BMA) has referenced a number of SYB's health equality and prevention schemes as exemplary case studies in its most recent toolkit for clinicians; the QUIT Programme (treating tobacco addiction) with Yorkshire Cancer Research, The SOAR community regeneration project (chronic pain support group, North Sheffield) and Page Hall Medical Centre's translated public health videos (into different languages).

3. Finance

The revenue surplus at Month 6 (H1 – first half of the year) is £26.6m which is an increase of £4.1m on the forecast surplus reported at Month 5 of £22.5m. This surplus relates to Providers only. CCGs have reported a break even position at Month 6. Capital spend reported at Month 6 is £28.4m which is £1.9m under spend against plan at Month 6.

Plans are currently being agreed for the second half of 2021/22 now that the system envelope has been announced. Submission of the system plan is due on 16th November.

Andrew Cash
System Lead, South Yorkshire and Bassetlaw Integrated Care System

Date: 4th November 2021

Governing Body Meeting in Public

2nd December 2021

Item No: 209

Report Title	2020/21 Annual reports for: <ul style="list-style-type: none"> • Safeguarding Children, • Looked after Children • Named GP for Safeguarding Children
Author(s)	<p>Safeguarding Children annual report 2020/21 <i>Michelina Racioppi</i> Assistant Director for Safeguarding Children / Lead Designated Nurse for Safeguarding Children <i>Juanita Murray</i> -Designated Nurse for Safeguarding Children <i>Dr Sebastian Yuen</i> – Designated Doctor for Safeguarding Children</p> <p>Looked after children annual report 2020/21 <i>Heather Peet</i>, Designated Nurse for Looked after Children <i>Alison Robinson</i>, Designated Nurse for Looked after Children <i>Dr Agnes Lakner</i>, Designated Doctor for Looked after Children <i>Dr Corina Teh</i>, Designated Doctor for Looked after Children</p> <p>DDCCG Named GPs for Safeguarding Children annual report 2020/21 Dr Ruth Bentley Dr Jeremy Gibson Dr Sandra Ives</p>
Sponsor (Director)	Brigid Stacey – DDCCG Chief Nurse

Paper for:	Decision	Assurance	x	Discussion	Information	x
Assurance Report Signed off by Chair				N/A		
Which committee has the subject matter been through?				DDCCG Quality and Performance Committee – 25.11.2021		
Recommendations						
The Governing Body is requested to NOTE the three reports.						
The Governing Body are requested to ENDORSE the content of the three reports and the objectives set for 2021/2022. DDCCG Safeguarding children and Looked after Children team will continue to work collaboratively with our partners, continue						

to engage in workstreams to improve quality and strengthen our safeguarding children's and looked after children arrangements and were necessary raise any risks or areas of concerns to the DDCCG Quality and Performance Committee and Governing Body.

Report Summary

- The reports provide a summary of how DDCCG is fulfilling its safeguarding children and looked after children statutory functions and responsibilities.
- Provide a summary of the governance and accountability arrangements within DDCCG and the CCG role and functions in the Derby and Derbyshire Safeguarding Children Partnership and its subgroups and the Corporate Parenting Boards.
- Provide a summary of how DDCCG has gained safeguarding children and Looked after Children assurance from its Commissioned services.
- Provide assurance that the safeguarding children and Looked after children 2020/2021 objectives were completed.
- Specify DDCCG 2021/2022 safeguarding children's and Looked after Children's objectives

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

As of the end of July 2021 there is a vacancy in the Designated Dr for Safeguarding Children (Derby City)- 3 pa sessions. This vacancy has been out for advert three times with no interest being shown and whilst it is vacant it is being supported by the Designated Doctor for Safeguarding Children (County). NHS England are aware of this as there is a national problem in recruiting into these roles.

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

Not required for this report

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

Not required for this report

Has an Equality Impact Assessment (EIA) been completed? What were the findings?

Not required for this report

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below

Not required for this report

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below

Not required for this report

Have any Conflicts of Interest been identified / actions taken?

Non raised

Governing Body Assurance Framework

This report supports Derby and Derbyshire CCG objectives of Safeguarding /patient safety / quality.

Identification of Key Risks

- From the end of July 2021 - Designated Doctor for Safeguarding Children Vacancy – Derby City – 3 PA sessions a week.
- Ensuring that Safeguarding Children, looked after Children and CDOP statutory functions are smoothly transferred and firmly embedded within the new ICS structure.
- Looked after Children numbers increasing above the national average rates – year on year which may result in Health Providers and/or Local Authority reaching a point where service provision within the statutory timescales are compromised on a consistent basis. All health performance is monitored on a monthly/quarterly basis and any sustained drift will be escalated as required.

Derby and Derbyshire Safeguarding Children Annual Report 2020-2021



Authors:

Michelina Racioppi	Assistant Director for Safeguarding Children / Lead Designated Nurse for Safeguarding Children
Juanita Murray	Designated Nurse for Safeguarding Children
Dr Sebastian Yuen	Designated Dr for Safeguarding Children
Dr Jeremy Gibson	Named GP for Safeguarding Children
Dr Ruth Bentley	Named GP for Safeguarding Children
Dr Sandra Ives	Named GP for Safeguarding Children

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1. Introduction

- 1.1 Welcome to the Derby and Derbyshire Clinical Commissioning Group (DDCCG) 2020/2021 annual report. The report describes the range of activities and developments that the safeguarding team have supported in designing and delivering effective safeguarding arrangements across the Derby and Derbyshire Footprint.
- 1.2 This report provides an overview of Derby and Derbyshire Clinical Commissioning Group (DDCCG) Safeguarding Children team performance and activity during the period of April 2020 to the end of March 2021. The report provides assurance to the Governing body and to members of the public that DDCCG as a commissioner of provider services has fulfilled its statutory duties in collaboration with local multiagency safeguarding children partnerships to protect the welfare of children in accordance with the Children Act 1989, 2004, Health and Social Care Act 2012 and the NHS England and Improvement (NHSE/I) Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework 2019.
- 1.3 In addition to this annual report the safeguarding team have produced quarterly reports for the DDCCG Quality and Performance Committee which has provided the committee regular updates and assurance during this reporting period.
- 1.4 This report reflects that DDCCG Safeguarding Children team remains highly committed to ensuring that the population of Derby and Derbyshire are safe and that they work in close partnership with our Partner agencies to continuously improve systems and processes to safeguard children in our community.
- 1.5 The report concludes by looking forward to the year ahead identifying key priorities for 2021/2022.
- 1.6 The DDCCG Governing Body and the Quality & Performance Committee are asked to receive this report as evidence to support assurance that DDCCG is meeting its statutory responsibilities in relation to safeguarding children.

2. Safeguarding children and young people legislation, mandatory reporting, and national frameworks

- 2.1 Responsibilities for safeguarding children are enshrined in legislation, supported by statutory guidance issued by HM Government. All CCG's have a statutory responsibility to ensure that the organisations which they commission services from have safe and effective systems in place that safeguard children and young people at risk of abuse, neglect, or exploitation.

All Health organisations are required to adhere to the following arrangements and safeguarding children legislation- ***please note this is not an exhaustive list.***

- The Children Act 1989 and 2004
- Working Together to Safeguard Children Statutory Guidance 2018
- Care Act 2014
- Domestic Abuse Act 2021
- Children and Social Work Act 2017
- United Nations Convention on the Rights of the child 1992
- Human Rights Act 1998
- Safeguarding Vulnerable Groups Act 2006
- Serious Crime Act 2015
- Counter Terrorism and Security Act 2015 / Prevent Duty
- Modern Slave Act 2015

- Children and Families Act 2014
- Female Genital Mutilation Act 2003
- The Crime and Disorder Act 1998
- Safeguarding Children and Young People: Roles and Competences for Health care 2019
- Promoting the Health of Looked after Children statutory Guidance

2.2 The key document outlining the statutory duties to safeguard children is Working Together to Safeguard Children (2018). This sets out how all agencies and professionals should work together to promote children welfare and protect them from harm.

Safeguarding and promoting the welfare of children is defined as:

- Protecting children from maltreatment
- Preventing impairment of children’s health and development
- Ensuring that children grow up in circumstances consistent with the provision of safe and effective care
- Taking action to enable all children to reach their best outcomes

Effective safeguarding arrangements in every local area should be underpinned by two key principles:

- Safeguarding is everyone’s responsibility. For services to be effective each professional and organisation should play their full part
- A child centred approach. For services to be effective, they should be based on a clear understanding of the needs and views of children.

2.3 The Section 11 of the Children Act (2004) outlines the responsibilities and duties of organisations such as CCGs to ensure they, as well as those who they commission carry out their duties in such a way as to safeguard and promote the welfare of children. There is more detail on our Provider safeguarding arrangement assurance in section 6.

2.4 Based on the Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework (2019) all NHS Organisations including CCGs should have in place arrangements that reflect the importance of safeguarding and promoting the welfare of children. In regard to DDCCG these are reflected in the table below.

Table 1

Safeguarding Children Assurance Measures – self assessment	DDCCG Compliance for 2020/21	RAG Rating/ compliance
<p>1. A clear line of accountability for safeguarding properly reflected in the CCG governance arrangements, i.e., a named executive lead to take overall leadership responsibility for the organisations safeguarding arrangements.</p>	<p>There are clear governance and accountability arrangements, which include the Safeguarding team reporting to the Governing body via the CCG Quality Assurance and Performance Committee on a quarterly basis and having regular meetings with the Executive lead for Safeguarding Children.</p>	

	<p>The Chief Nurse remains CCG Executive Lead for both safeguarding children and adults.</p> <p>The overall responsibility for safeguarding rests ultimately with the CCG Chief Executive Officer</p>	
<p>2. Clear policies setting out their commitment, and approach, to safeguarding, including safe recruitment practices and arrangements for dealing with allegations against people who work with children and adults, as appropriate</p>	<p>Safeguarding Children Policy and other policies and guidance documents available on the intranet and internet websites for staff to access</p> <p>Multiagency Safeguarding Children Procedures are also available for all staff to access. www.ddscp.org.uk</p>	
<p>3. Training their staff in recognising and reporting safeguarding issues, appropriate supervision, and ensuring that their staff are competent to carry out their responsibilities for safeguarding</p>	<p>DDCCG Training programme and strategy is accessible via the DDCCG intranet site. The Multiagency Safeguarding Children Partnership training programme is available for all staff to access courses ranging from level 1-4</p> <p>Advice and supervision are available for staff to access. www.ddscp.org.uk</p>	
<p>4. Equal system leadership between LA children's services, the Police and the CCG as specified in Working Together to Safeguard Children Statutory Guidance (2018)</p>	<p>The CCG are equal partners with the Police and Local Authorities as specified in Working Together to Safeguard Children (2018)</p>	
<p>5. Effective inter-agency working with LAs, the Police and third sector organisations, including appropriate arrangements to co-operate with LAs in the operation of safeguarding children's partnerships, Corporate Parenting Boards, SABs and Health and Wellbeing Boards</p>	<p>There are good and effective working relationship with Providers and partners and there is very strong evidence of partnership working and CCG representation at boards and subgroups.</p>	
<p>6. Ensuring effective arrangements for information sharing</p>	<p>Effective information sharing arrangements are in place.</p> <p>The CCG cooperate and adhere to information sharing requests in line with legislation.</p>	
<p>7. Employing the expertise of Designated professionals for safeguarding children, children in care, safeguarding adults and a Designated Paediatrician for Child Death which includes advising on the Sudden Unexpected Deaths in Childhood (SUDIC) processes and pathways</p>	<p>Designated Nurses and Doctors for Safeguarding Children are in post. During this reporting period the Designated Doctor Derby City vacancy is being covered on an interim arrangement until the end of July 2021. The post will be advertised again.</p>	

	<p>Designated Nurses are directly employed full time by the CCG's and the Designated Doctors are contracted to undertake the PA sessions via an agreement with one of our health Providers.</p> <p>DDCCG also have a Designated Doctor for Child Death – 2 pa sessions a week.</p> <p>The Designated Nurses are directly accountable to the Chief Nurse and the Designated Doctors are directly accountable to the Medical Director. The Designated Professionals have direct access to the CCG Chief Executive Officer and the Executive Lead for Safeguarding Children as required.</p> <p>Named GPs are in post covering the DDCCG Footprint.</p>	
<p>8.</p> <p>CCGs need to demonstrate that their Designated professionals are involved in the safeguarding decision-making of the organisation, with the authority to work within local health economies to influence local thinking and practice.</p>	<p>The CCG can demonstrate that their Designated Professionals are involved in decision making of the organisation and have a strong voice and representation at a number of health and multiagency forums which influence local thinking and development of services, policies, and strategies.</p>	
<p>9.</p> <p>CCGs should ensure that adult and children's services work together to commission and provide health services that ensure a smooth transfer for young people and children in care, including a planned period of overlap to avoid the abruptness of a sudden change in clinicians, culture, frequency of appointments and environment.</p>	<p>The Designated Professionals work closely with Children Commissioning and Contract team in the commissioning of services and development of service specifications.</p>	

2.5 In March 2021 DDCCG received confirmation from the NHS England Regional Safeguarding team that we were fully compliant in our Midlands Safeguarding Development Framework (MSDF) return for 2020/21. NHS England asked each Sustainability & Transformation Partnership /Integrated Care System (STP/ICS), to review their position in relation to the MSDF to demonstrate assurance against the NHS Safeguarding Assurance and Accountability Framework (SAAF) (2019) of which the MSDF is based on. Midlands Safeguarding Team reviewed all returns based on the four levels of support described within the NHS Oversight Framework and alongside that attributed

a red/amber/green rating to it. In the table below is the rating that NHS England Regional team have provided based on our 2020/21 self-assessment return.

Table 2

STP/ICS	Assurance Oversight Category	Level of support offered	Rating
Derby and Derbyshire	1 (Maximum autonomy)	Universal (voluntary)	
Assurance level 1	Maximum autonomy: No actual support needs identified across. Maximum autonomy and lowest level of oversight appropriate. Level of Support offer – Universal (Voluntary)		x
Assurance level 2	Targeted support: Support needed but mandated action is not considered needed. Level of Support offer - Universal + targeted support as agreed with the CCG to address issues identified and help move the provider to Assurance level 1		
Assurance level 3	Mandated support: The CCG has significant support needs and is placed in the dedicated support regime. Level of support offer - Universal targeted + mandated support as determined by the regional team to address specific issues and help move the CCG to Assurance level 2 or 1		
Assurance level 4	Special measures for providers; legal directions for CCGs: The CCG is failing or at risk of failure with very serious/ complex issues that mean it is placed under legal directions. Level of support offer - Universal targeted + mandated support as determined to minimise the time the CCG is under legal direction.		

2.6 It is planned that in Quarter 2 2021/2022, a national version of the MSDF is going to be launched to seek assurance and to support improvement and development. This will be known as the Safeguarding Commissioning Assurance Tool (Safeguarding-CAT).

3. Safeguarding children team structure and governance & accountability arrangements

3.1 The DDCCG Safeguarding Children team consists of the following members of staff as illustrated in the table below.

Table 3

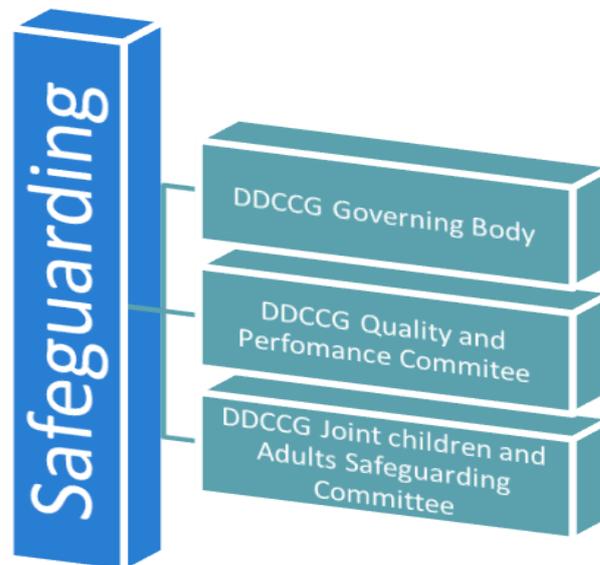
<p>DDCCG Safeguarding Children team</p> <ul style="list-style-type: none"> • Assistant Director for Safeguarding Children/Lead Designated Nurse for Safeguarding Children - Michelina Racioppi (Full time) • Designated Nurse for Safeguarding Children – Juanita Murray (Full time) • Designated Doctor for Safeguarding Children (Derby City) Dr Patricia Field (2 PA sessions) <i>Until end of July 2021</i> • Designated Dr for Safeguarding Children (County) Dr Sebastian Yuen (3 PA sessions) <p><u>Named GPs</u></p> <ul style="list-style-type: none"> • Dr Jeremy Gibson (2 PA Sessions) • Dr Ruth Bentley (4 PA Sessions) • Dr Sandra Ives (3 PA sessions) <p>DDCCG Looked after Children team</p> <ul style="list-style-type: none"> • Designated Nurse Looked after Children (Derby City) Heather Peet (Full time) • Designated Doctor for Looked after Children – Dr Corina Teh (Derby City) (1 PA session) • Designated Nurse for Looked after Children (Derbyshire) Alison Robinson (Part time) • Designated Doctor for Looked after Children (Derbyshire) - Dr Gail Collins- (2 PA sessions)
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3.2 There is clear and robust governance and reporting processes within DDCCG. The safeguarding team have direct access to the Executive Safeguarding Children and Adults Lead for the CCG, in addition when required they have direct access to the Chief Officer. When the COVID 19 lockdown commenced, and the CCG introduced remote working, in order to keep in regular contact, the Chief Nurse commenced daily meetings with the senior

managers from the Nursing and Quality team. This is another forum where the Chief Nurse and the senior managers from the N & Q team can raise any concerns/ issues / escalations directly to the Chief Nurse and Deputy Chief Nurse.

3.3 DDCCG Governance reporting process demonstrated in the table below.

Table 4:



3.4 Quarterly safeguarding reports are produced that are submitted to the Quality and Performance Committee and annual reports are submitted to the DDCCG Governing Body. There are also reports that are produced that are submitted to the Executive team as and when they are required to raise any specific issues that need the Executive team to be made aware of.

3.5 On a bi-monthly basis a joint Safeguarding Children, looked after Children and Adults Assurance Committee is held which directly reports to the DDCCG Quality and Performance Committee.

3.6 On a bi-monthly basis the Designated Professionals lead on the Named and Designated Professionals & health assurance group. This is a clinical network that brings together the designated professionals for both safeguarding children and looked after children and the Named Professionals from our health providers to discuss local and national safeguarding themes and issues and identify any local safeguarding improvement / development priorities. During 2020/21 the forum has continued to meet via MS teams and has remained a strong and supportive network for safeguarding professionals within our geographical footprint.

4 Designated Professionals for Safeguarding Children functions and activity

4.1 The table below provides an overview of the key roles and responsibilities of the Designated Professionals. The CCG Governing Body can be assured that the CCG Safeguarding Children team have fulfilled these areas of responsibilities during 2020/21.

Table 5

The Designated Professionals roles and responsibilities during 2020/21:	
➤	Provision of expert advice to ensure the range of services commissioned takes account of the need to safeguard and promote the welfare of children and meet statutory requirements

➤ Development and monitoring of safeguarding children standards in Provider contracts and in Primary Care
➤ Provision of expert advice and support to Partnership leads for safeguarding in each NHS Provider Organisations
➤ Provision of expert advice, support, and supervision to Named Nurses, Midwives and Doctors in each provider organisation and Primary Care
➤ Lead on safeguarding quality assurance and improvement across the health systems, monitoring services adherence to legislation, policy, and key statutory and non-statutory guidance
➤ Provision of expert advice to the Derby and Derbyshire Safeguarding Children Partnership and all its subgroups
➤ Take a lead role in conducting the health component of the Local Safeguarding Children Partnership rapid reviews.
➤ Disseminate / share the learning from reviews and gain assurance that service improvement / development has taken place
➤ Key members of forums listed: (Not an exhaustive list) Derby and Derbyshire Safeguarding children Executive Board and all its subgroups Domestic abuse and Sexual violence Strategic Governance Board, Drive Strategic and operational groups Named and Designated Professionals Group Derbyshire self-harm & suicide Prevention Partnership, Derby and Derbyshire Joint interagency meeting Derbyshire Children Partnership, Joined up Care Derbyshire Children STP Derby and Derbyshire Predicting demand group Derby and Derbyshire Strategic Multiagency Obesity Group Derbyshire PAUSE Strategic group Derbyshire Cybercrime and online safety Derby and Derbyshire Domestic homicide action planning group Starting Point Strategic Board Safeguarding Committees for the four main providers Members of the City and County Child protection conference dissent meetings
Attendance to a range of NHS England Safeguarding meetings: Meetings include: <ul style="list-style-type: none"> • Community of Practice • Safeguarding and SEND meetings • Regional Safeguarding Steering Group meeting • East Midlands Tackling serious violence group • Midlands safeguarding Lead's meeting • Preventing Harm forum • Safeguarding senate meetings

5. Named GP for Safeguarding Children update

Please find attached in appendix 1 the Named GP for Safeguarding Children annual report which provides a summary of their performance & activity for 2020/21 and their priorities for 2021/2022.

6. Safeguarding children assurance

- 6.1 The Safeguarding Children team have worked with our 6 main Providers in gaining assurance regarding their safeguarding arrangements. The DDSCP approved Section 11 self-

assessments tool was completed by our providers and MS team meetings held with our providers to go through their self-assessment return. Despite the pressures and challenge of pandemic the Safeguarding team gained good assurance from our Providers and where required actions were agreed to address any areas of non-compliance. **Table 6**

Post Quality Review meeting - 2020/21 - Section 11 Progress Report																													
Providers (Derby City & Derbyshire County)	Standard 1 - Accountability Structure											Standard 2 - A culture of listening to children, young people, carers and to staff				Standard 3: Information Sharing		Standard 4: Safe Recruitment and Dealing with Allegations Against People Working With Children					Standard 5 – Effective appropriate supervision and support for staff, including safeguarding training						
	1.1	1.2	1.3	1.4	1.5	1.6	1.7	1.8	1.9	1.10	1.11	2.1	2.2	2.3	2.4	3.1	3.2	4.1	4.2	4.3	4.4	4.5	5.1	5.2	5.3	5.4			
1	Derbyshire Healthcare NHS F/T (DHcFT)																												
2	University Hospitals of Derby and Burton NHS F/T (UHDB)																												
3	Chesterfield Royal Hospital NHS F/T (CRHFT)																												
4	Derbyshire Community Health Services NHS F/T (DCHS)																												
5	East Midlands Ambulance Service NHS Trust (EMAS)																												
6	DHU Healthcare (DHU H/C)																												

6.2 In December 2020, all 112 Derbyshire GP surgeries were invited to complete the Safeguarding Children & Adults Assessment Framework (JSAF) which is a framework to guide GP practices regarding the safeguarding arrangements that they are required to have in place in order to be able to provide a level of assurance to DDCCG. The JSAF is based on key national and local priorities and drivers (e.g., Care Quality Commission standards). It also focused on the NHS England, Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (NHS England, 2019) and Section 11 requirements of the Children Act (2004). The self-assessment has seven main standards/ areas of compliance, as follows:

- *Clear lines of accountability for safeguarding adults and children who are vulnerable or at risk of harm and/ or neglect.*
- *Governance arrangements/ quality assurance.*
- *Safeguarding policies, procedures, and systems.*
- *Information sharing.*
- *People are treated with dignity, respect, and compassion at all times*
- *Safe recruitment practices.*
- *Advice and support, training and continuing professional development for staff*

6.3 DDCCG have received 98% return rate. Most practices included specific actions planned to address any areas of non-compliance. The Safeguarding Children team have offered their advice and support on any of the standard's requirements that they need support with. In this year JSAF, GP practices were also asked to reflect on the impact of Covid 19 on their safeguarding practice and measures they took to mitigate this. The annual report produced in regard to the JSAF is presented to the Derbyshire Primary Care Quality & Performance Review Sub Committee (PCQPRSC) Meeting. Please see appendix 4 for a fuller report on the JSAF.

6.4 In regard to our independent providers the safeguarding children and adults' team have worked with our N & Q and Contract team to gain safeguarding arrangement assurance from these services. Depending on the size of the contract the provider was requested to complete either a self-assessment checklist based on 7 questions or a more in-depth self-assessment tool based on 6 standards with sub-sections.

6.5 The table below provides a brief breakdown of the number of providers who were requested to complete the relevant assurance tool. The safeguarding team are working closely with the Nursing & Quality and Contract team to follow up Providers who are outstanding with their self-assessment return.

Table 7

Independent providers who were asked to complete the safeguarding children and adult's checklist	55 providers	10 outstanding / awaiting return
Independent providers who were requested to complete the in-depth safeguarding children and adult's self-assessment tool	21 Providers	5 outstanding / awaiting return

7. Multi-agency safeguarding arrangements – Derby and Derbyshire Safeguarding Children Partnership (DDSCP)

7.1 The new local safeguarding children's arrangements were introduced on the 29th September 2019. The two previous Safeguarding Children Boards were merged into a single partnership arrangement with the two Local Authorities, Derbyshire Police, DDCCG and Tameside and Glossop being the key agencies. Derby and Derbyshire is one of only a few areas nationally that has chosen to establish multi-agency safeguarding arrangements which span two local authority boundaries. The three Safeguarding partners are required to:

- Agree on ways to coordinate their safeguarding services.
- Act as a strategic leadership group in supporting and engaging others.
- Implement local and national learning including from serious child safeguarding incidents.

7.2 The purpose Derby and Derbyshire Safeguarding Children Partnership is to support and enable organisations and agencies across Derby and Derbyshire to work together so that:

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

7.3 The Derby and Derbyshire Safeguarding Children Partnership and its subgroups have excellent DDCCG and provider representation. The Executive Chief Nurse/ Deputy Chief Nurse and the Designated Nurses and Doctors are members of the Executive Board. The Chief Nurses or their Deputies attend the Executive Board from the following health providers:

- Derbyshire Community Health Services NHS Foundation Trust
- University Hospitals of Derby and Burton NHS Foundation Trust
- Derbyshire Healthcare NHS Foundation Trust
- Chesterfield Royal Hospital NHS Foundation Trust
- East Midlands Ambulance Service (EMAS)
- DHU Healthcare / NHS 111

7.4 DDCCG not only makes a significant contribution to the work of the Partnership and all its subgroups, but the CCG also make an equal financial contribution on behalf of health to the functioning of the Partnership.

7.5 DDCCG commitment to the work of DDSCP and its subgroups is outlined in the table below. All the DDSCP subgroups take place on a quarterly basis and generate a significant amount of work which the Designated Professionals and Named GP's who are very active members of these subgroups contribute to. The Chairs of the subgroups report back the activities of these forums to the quarterly DDSCP Executive Board meetings. Any specific areas of concerns / risk are added to the DDSCP risk log and the Chief Officers of the DDSCP are informed of the risks and actions being taken to address the risks highlighted. DDCCG Governing Body can be assured that CCG has effectively discharged its function as a core member of the Safeguarding Children Partnership and its subgroups during 2020/21 through membership and active engagement in the activity and funding of the Partnership.

Table 8

<u>Derby and Derbyshire Safeguarding Children Partnership - DDCCG representative/ membership in 2020/21</u>	
Meeting/ subgroup	DDCCG Representative
Chief Officers' Group of the DDSCP	Accountable Officer/ Chief Executive
Core Business Group of the DDSCP	Assistant Director for Safeguarding Children / Lead Designated Nurse for Safeguarding Children
Derby and Derbyshire Safeguarding Children Partnership – Executive Board	Chief Nurse / Executive Lead/ Deputy Chief Nurse Designated Nurses Designated Doctors
Derby and Derbyshire Child Practice Review (CPR) Panels and CPR action plan group	Designated Doctors and Designated Nurses, Named GPs
Quality Assurance Group – Derby and Derbyshire	Designated Nurses and Designated Doctors
Policies and Procedures Group	Designated Nurse & Named GP
Derby and Derbyshire Exploitation and vulnerable young people's group	Designated Nurses and Designated Dr
Learning and Development Group	Designated Nurse & Named GP

7.6 The agreed DDSCP Strategic Priorities for 2021-2022 are:

Table 9

Promote emotional health and wellbeing and reduce the impact of Adverse Childhood Experiences (ACE's)
Safeguard children at risk of exploitation reflecting additional features such contextual safeguarding and our understanding of emerging vulnerabilities
Reduce the vulnerability of Electively Home Educated Children (EHE), Children excluded from school and Children who are Missing (from home, school, and care)
Reduce the adverse impact of Parental Substance Misuse and Parental Mental Health
Promote and obtain assurance of Early Help arrangements (including responding to neglect) and response to requests for services
Reduce the adverse impact of Domestic Abuse and family conflict
Promote and Improve the safety and welfare of babies
<p>Other priorities identified via review processes and the multiagency priority matrix:</p> <ul style="list-style-type: none"> • Thresholds / escalation • Keeping babies safe / vulnerability of babies • Neglect • Child sexual abuse • Think family • Quality of assessments • Management oversight and supervision • Agency contribution to strategy meetings

7.7 In the table below is an extract from the national review led by Sir Alan Wood of the safeguarding children's arrangements. This was Sir Alan Wood summary of the Derby and Derbyshire arrangements.

Table 10

The Sir Alan Wood Report: Sector expert review of new multi-agency safeguarding arrangements included the following commentary on the DDSCP partnership arrangements:

“The new Derby and Derbyshire Safeguarding Children Partnership covers two local authorities, two CCGs and the constabulary for the area. The partnership is led by a Chief Officers Group - including the two lead members - which directs and scrutinises the work of an executive board charged with assuring high quality coordinated services to protect and safeguard children, through its subgroups, which are voluntarily merging across the two authority areas, where appropriate. Both the COG and executive board have the same independent chair. The independent chair has identified a number of outcomes, which indicate the partnership has improved the leadership and scrutiny of safeguarding arrangements, developed the coordination and impact of work across the safeguarding partnership and minimised duplication of effort. This includes focused involvement of young people in safeguarding, more effective dissemination, and transparency of learning from serious incidents, robust inter agency challenge and strengthening of the professional expertise and experience, through a cross-partnership collaborative approach. The Partnership team is clear that it supports the Safeguarding Partnership, not the individual agencies, and receives equal funding from all the statutory partners. This approach has shown its worth during the pandemic, with effective cross- agency working to identify and protect vulnerable children.” (2021)

7.8 Brief overview of some of the key achievements of the Derby and Derbyshire Safeguarding children partnership and its subgroups during 2020/21 – *This is not an exhaustive list*

- Fully embedded the new local Safeguarding Children Partnership and its subgroup arrangements
- Maintained the effective functions of the Partnership and its subgroups via virtual meetings during the Covid Pandemic
- Provided the Chief Officers assurance of the local safeguarding arrangements through the work of the DDSCP subgroup activities.
- The DDSCP have analysed trends in social care contacts and referrals during COVID-19, to understand changing patterns and whether unmet need could lead to increased vulnerability and higher demand for social care services following the end of lockdown. This has led to action being taken by partner agencies and both Local Authorities to ensure that thresholds for referral are well understood and consistently applied within their organisations.
- A scoping exercise was carried out during the first lockdown to obtain assurance of whether vulnerable children that were known to services were being seen, and that the support provided by schools and early help was in place. The assertive outreach report produced identified that there was limited visibility of pre-school children and it helped the partnership identify opportunities for all agencies to strengthen oversight of vulnerable children.
- Updates of multiagency policies, procedures, and guidance documents such as the prebirth protocol, graded care profile, Fabricated and Induced Illness, self-harm and suicide prevention guidance, modern slavery and Safeguarding Children at Risk of Abuse

Through Female Genital Mutilation (FGM) all available on the [DDSCP website](#) have been made.

- The production of a Performance framework which concentrates on the key issues for families/ services across Derby and Derbyshire, providing oversight on the trends and changes to safeguarding activity.
- The production of monthly briefings for local counsellors/ MP and for the public keeping them updated on safeguarding children.
- The production of a Quality Assurance strategy and Quality Assurance matrix.
- The completion of a range of single and multiagency audits and key findings shared.
- The production of contingency / mitigation plans produced by Partners of their COVID19 arrangements.
- The update of DDSCP training courses and delivery of multiagency training via MS teams.
- The progression and completion of rapid reviews and child practice reviews and receiving commendation from the National Child Practice Review panel of the quality of the rapid reviews completed and submitted to the National panel.
- The partnership has established a clearer understanding of the breadth and range of issues that present a risk to young people and forged strong links with the education subgroups to strengthen awareness of emerging risks and issues.
- An increasing understanding of the complexities around child criminal exploitation which has led to the development of effective responses to this particularly vulnerable cohort of young people, especially those who have special education needs and disabilities (SEND).
- In response to COVID-19 pandemic, briefing documents on Responding to Safeguarding Concerns and Vulnerable Children and Domestic Abuse were published to help practitioners to take appropriate safeguarding action at a very difficult time for children and their families.
- The completion of new and extensive guidance for practitioners Working with Intra-familial Child Sexual Abuse which includes commentary from young people involved in local reviews that promotes learning and fills a notable gap in available guidance on the complex topic.

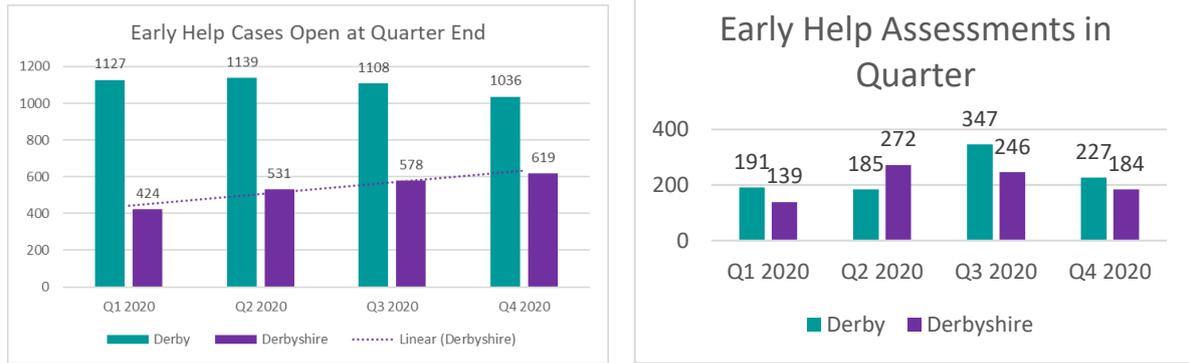
8. Safeguarding children performance and activity data

8.1 The below tables provide a breakdown of the Derby and Derbyshire early help and safeguarding children activity. It does not include data on looked after children or care leavers as this information is reported on in the DDCCG Looked after Children annual report 2020/21. The DDSCP Quality Assurance Groups analyse the performance activity reports that are produced for both the City and the County and agree on any further actions required to be taken to address any themes / trends or areas of concern.

8.2 It is important to note that there has been changes with the Early Help services in the Derbyshire area which has led to a drop in the number of early help cases. In light of the changes there has been a raising awareness process of the new early help arrangements in Derbyshire particularly with education and health which has led to a slow but steady increase. The number of early help cases has also been impacted by the fact that children and young

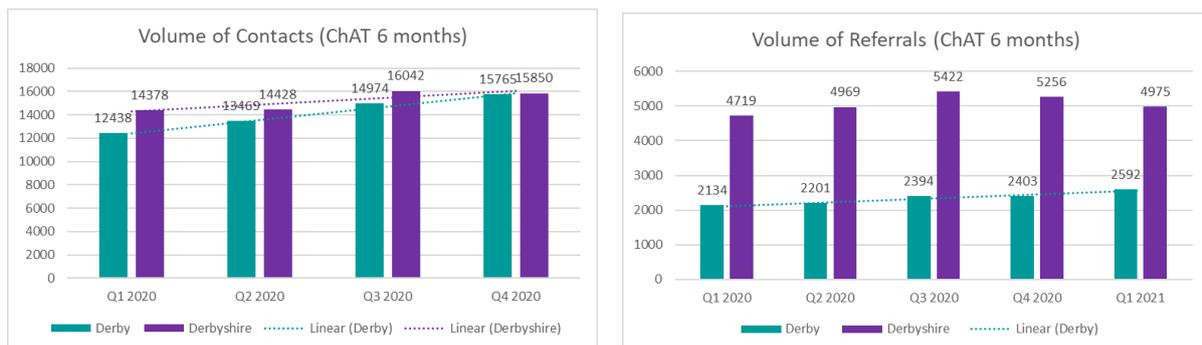
people were not being seen as they ordinarily would be due to the Covid 19 lockdown restrictions.

Table 11



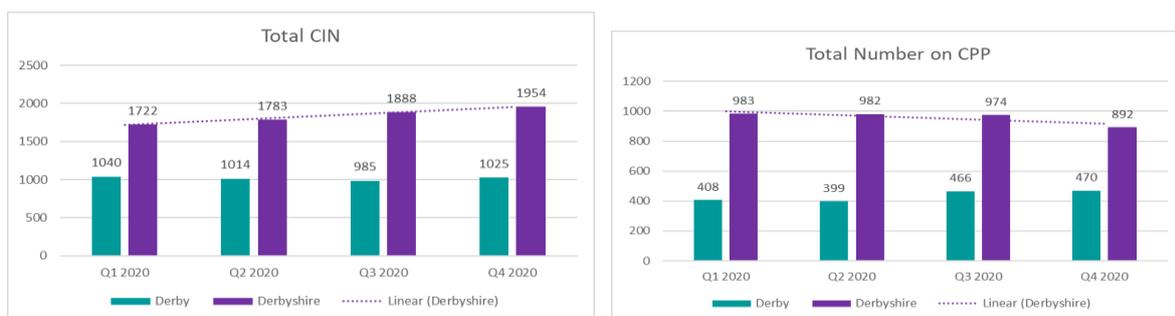
8.3 The two tables below provide an overview of the number of cases that are recorded as Social Care contacts and how many of the cases convert to Social Care referrals. Due to the high number of cases that result in threshold not met/ no further action a Derby and Derbyshire Predicting Demand Multiagency Group has been set up chaired by the Independent Chair of the DDSCP. This group was established to analyse potential future services demands and priorities so that children would receive the right support at the right time and critically analyse what is leading to the number of contacts that result in no further action or threshold not met.

Table 12



8.4 The tables below provide an overview of the number of children who have child in need plans and child protection plans in Derby and Derbyshire. When the COVID Pandemic commenced to enable safeguarding meetings to continue and safeguarding and child in need plans to be reviewed / progressed meetings took place via virtual mechanisms involving professionals and families. This has proven to be an effective process in professionals and families managing to meet virtually to discuss new cases and review plans previously agreed.

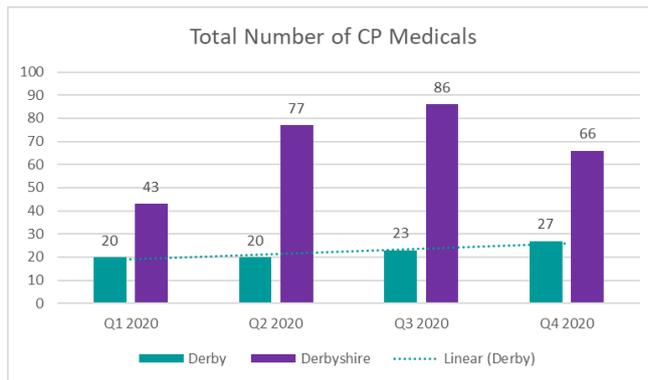
Table 13



8.5 The table below provides an overview of the number of Child protection medicals carried out for physical abuse and neglect in the Derby and Derbyshire area. The two Local Authorities

have reviewed cases that have been referred to Social Care due to safeguarding concerns and are assured that the number of medicals requested for physical abuse or neglect medical assessments are the appropriate numbers during this reporting period.

Table 14 for Physical and Neglect medicals only



9. Inspection activity

9.1 During this reporting period OFSTED and CQC paused their single and Joint Safeguarding children's inspections due statutory agencies needing to focus on managing the pressures / challenges of the Covid 19 pandemic. Single and multiagency safeguarding inspection activity will be resuming in late 2021 and DDCCG will be working together with partners in ensuring that they are inspection ready.

10. Safeguarding Children training

10.1 Due to the Covid 19 Pandemic DDCCG Named GP's have adapted their face-to-face safeguarding children training and delivered level three safeguarding children training to General Practice via MS teams. This training has been very well attended and evaluated positively. A narrated Level 1 and Level 2 PowerPoint presentation was also produced by the Named GPs for use in training "in house" for General Practice. Level 1 and 2 safeguarding training for CCG staff has been accessed via ESR training during the COVID pandemic .

Please see further details on training and presentations delivered to General Practice within the Named GP for Safeguarding Children annual report in appendix 1

Table 15

Level 3 Safeguarding children training during April 2020 – March 2021:

Training date for level 3 training :	No of Attendees:
8 July 2020	49
11 August 2020 Derbyshire educational network - Core L3 session	72
9 September 2020 (N.E Derbyshire)	38
16 September 2020	12
14 October 2020	30
21 October 2020	29

11 November 2020 (Erewash QUEST Clinicians also)	140
13 January 2021	57
10 February 2021	63
10 March 2021	23
17 March 2021	13
Total:	526

10.2 In addition to the above training the DDCCG Safeguarding team arranged the following training with funding gratefully received from NHS England Regional team. This training was made available to our health providers and partner agencies.

Table 16

11th Sept 2020 - Safeguarding children Advanced Supervision Training	19 attendees
4th Nov 2020 - Trauma Informed training	41 attendees
21st Jan 2021 - DDCCG Safeguarding children and adult annual conference	Between 177 – 197 attendees
26th February 2021 - Foetal alcohol spectrum disorder training	46 attendees

10.3 In addition to the in-house training available, Health Professionals have also been able to access the Safeguarding Children Partnership multi-agency training, which provides a wide range of safeguarding courses ranging from level 1 - 4.

10.4 In line with the Intercollegiate Document (2019) training requirements the Designated Professionals and Named GPs have kept themselves up to date professionally and have attended relevant Safeguarding children training (level 4 and 5). The team have also completed the required professional body revalidation processes and have had yearly appraisals.

11. Child Safeguarding Practice Reviews (CSPR)

11.1 During this reporting period the Derby and Derbyshire Child Safeguarding Practice review panels have been meeting via MS teams and have ensured that the serious case reviews, rapid reviews, and Child Safeguarding practice reviews have continued to progress. There is also a DDSCP CSPR action planning group that reviews the progress of the recommendations/ actions agreed.

Both sub-groups are responsible for:

- Commissioning and completing rapid reviews on cases where notifications are made by local authorities in response to serious child safeguarding incidents.
- Commissioning, facilitating, and publishing local child safeguarding practice reviews.
- Completing serious case reviews and local learning reviews which started prior to 29 September 2019.

- Co-operating and supporting the work of the panel to complete national child safeguarding practice reviews.
- Publishing, promoting, and embedding learning from local child safeguarding practice reviews in a way that local services for children and families can become more reflective and implement changes to practice.

11.2 There have been some delays in some of the reviews being able to be published but this has been due to ongoing police/ criminal investigations or awaiting the outcome of coroner's inquest. Cases that have been published are available on the [DDSCP website](#). Of the cases that are not able to be published an executive summary or briefing document has been produced to ensure that learning from the reviews can be widely disseminated and shared to enable service development / improvements.

11.3 Some key learning from the Derby and Derbyshire reviews completed:

- The need to raise awareness regarding the completion of the Pre-Birth Protocol
- Understanding signs and indicators of abuse and use of approved risk assessments
- Raising awareness regarding bruising in pre-mobile babies
- Raising awareness regarding hidden men
- The need to raise further awareness regarding the escalation process
- The importance of post-natal parental advice – Safe sleep and Don't shake the baby.
- The importance of professional curiosity and assertiveness -respectful and authoritative.
- The importance of Information sharing (Cross Border and Inter-Agency).
- The importance of identifying parental vulnerability – Mental Ill Health, Learning Needs, and Substance Misuse (alcohol and drugs).
- The importance of Inter-Agency understanding.
- The importance of early identification of parental stress points (triggers for harmful behaviour).
- The importance of supervision - regularity and quality.
- The importance of strong positive leadership and manager development.
- The importance of sharing and understanding of multi-agency plans.
- The importance of the role of the education sector in multi-agency safeguarding children work.
- Understanding the effects of criminality in the family home.
- The importance of recognising disguised compliance.
- The importance of understanding and addressing Adverse Childhood Experiences (ACES's)
- The importance of supporting Young Carers.

12. Keeping Babies Safe

12.1 The Keeping Babies Safe steering group in Derby and Derbyshire is a subgroup of the Child Death Overview Panel (CDOP). The Terms of reference of this group have been strengthened due to the importance of learning from Child Practice Reviews. The group has been identified as supporting the keeping baby's safe agenda and the work will be sighted by the Derby and Derbyshire Safeguarding Children's Partnership. The group is a multi-agency forum including all multi-agency partners. The focus of the group is to consider the vulnerabilities of babies and how the group can support practitioners to provide researched based information, share learning from Child Practice Reviews and CDOP and advise families to ensure that babies are cared for safely and protected from abuse and neglect.

12.2 Keeping Babies Safe Strategy – The Three Steps for Baby Safety

The Designated Nurse Safeguarding Children and Lead Nurse for Child Death Review have written and published a Keeping Babies Safe Strategy for Derby and Derbyshire - The Three Steps for Baby Safety, with the contributions and support of the wider group. The strategy will be the focus of the work of the Keeping Babies Safe Steering Group and a priority of the Derby and Derbyshire Safeguarding Childrens Partnership for the next year.

Aims of the Strategy:

- Derby and Derbyshire Safeguarding Children Partnership (DDSCP) and the Child Death Overview Panel (CDOP) encourage and support partners in all agencies who care for or support families with babies under a year old to utilise this strategy and deliver the clear consistent messages regarding baby safety to families, including all fathers and wider family members, and to their colleagues within their own organisation.
- All practitioners in Derby and Derbyshire should have access to research-based practice and information to educate and support parents and carers so that they are able to make safe choices when caring for their baby.
- DDSCP aims to reduce the numbers of babies who die or are seriously injured following unsafe sleep practice, unsafe handling and those that die accidentally.

12.3 The Keeping Babies Safe Champions

An important element of the strategy is to train and support some Keeping Babies Safe Champions. The vision for Derby and Derbyshire is to have Champions across the partnership including all health providers, Childrens Social Care and Police. Champion's training commenced in February this year and will continue across the next year.

The role and responsibility of the Baby Safe Champions:

- Be a resource regarding baby safety within their team and agency
- Attend training and updates on baby safety
- Disseminate any learning from child practice reviews and CDOP regarding baby safety
- Raise the awareness of the importance of Safe Sleep, Safe Handling and Safe Space and the use of the strategy and toolkit to support families with babies

The Baby Safe Champions will continue be supported and updated by the Keeping Babies Safe Steering Group for Derby and Derbyshire

12.4 Keeping Babies Safe steering group governance arrangements

The governance arrangements for this group are through CDOP. The group has an action plan which is reported to and monitored by CDOP. The progress of the action plan was reported to the Child Death Review Partners through the quarterly reporting.

13. Child Death Review and Child Death Overview Panel (CDOP)

13.1 The necessary response to the COVID 19 pandemic fundamentally changed the way all professionals involved in the child death review process were able to meet the statutory requirements set out in Working Together (2018) and Child Death Review: Statutory and Operational Guidance (2018).

It became clear that most members of the Child Death Review Team and CDOP are frontline practitioners or are senior managers or strategic leads in health, the Police or Children's Social Care.

- 13.2** There were no changes or additions made to the statutory guidance for child death review to take into account the COVID 19 pandemic. The National Child Mortality Database (NCMD) team continued to lead on behalf of NHSE on the communications with professionals involved in child death review and CDOP.
- 13.3** The NCMD informed the child death review teams that the statutory timeframes remained in place (6 months to review a death) however there was an expectation that timeframes would lapse during the COVID 19 pandemic which may well influence the CDOP figures during this reporting year. NHSE have produced some guidance on the changes to the Joint Agency Response (JAR) taking into account some additional requirements during the COVID 19 pandemic.
- 13.4** The Notifications of Death were strengthened and now include some mandatory questions related to COVID 19. The NCMD required any information where COVID 19 was a factor in the child's death to be reported either on the Notification Form or later through ECDOP. The NCMD are collating the data and will be reporting the national picture on child deaths where COVID 19 is the cause or a factor in the future.
- 13.5** A contingency plan for Child Death Review (CDR) and CDOP was developed in April 2020. This was agreed by the Child Death Review Partners and was reviewed and reported on quarterly. The contingency plan had a final review in March 2021 with all actions having been completed.

The aim of the contingency plan was to enable the Child Death Review Team to continue to review the deaths of children in a timely way and within the statutory timescales where possible. The contingency plan made arrangements for:

- Notifications of death
- COVID 19 reporting in line with the NCMD
- Management of the Joint Agency Response (JAR)
- Enhance support for agencies to complete the Reporting Forms
- Monitoring and supporting the Child Death Review meetings
- RAG rating of child deaths to ensure clarity on the status of the process of reviewing for each death
- Preparation of cases to be heard at CDOP
- Managing the CDOP meeting
- Reporting to the Child Death Review Partners

There were particular challenges related to the child death review process and CDOP which were mitigated for within the contingency plan:

13.6 RAG rating of child deaths

The team RAG rated all cases to allow an understanding of the progress of the process and any delay to ensure that the CDR partners had a clear understanding of the picture of CDR across Derby and Derbyshire. This tool has been effective and is part of the CDOP quarterly reporting.

Table 17

Green	Ready to be Reviewed
Amber	Awaiting Further Information or the CDRM needs to be held
Red	Awaiting Coronial or other Investigations

13.7 Information gathering and Child Death Review Meetings

This was extremely challenging particularly in the early months of the pandemic and when there were additional waves of the pandemic. Practitioners who complete reporting forms and the Mortality Leads who are Paediatricians all work on the frontline and were unable to complete analysis forms within timeframes due to the pressures of the pandemic and redeployment.

Also all health Trusts cancelled all meetings initially and this included the Child Death Review meetings. This created a backlog which was a challenge to overcome. It took some time for child death review meetings (CDRM) to be re-established.

13.8 Child Death Overview Panel Meetings

CDOP became a virtual meeting via Microsoft Teams and has remained so in this reporting year. Some meetings were cancelled due to not enough cases being ready to heard, none were cancelled due to poor attendance which shows a real commitment to this process despite pressures on all services.

13.9 Reporting to Child Death Review Partners

The Chair of CDOP commenced quarterly reporting to the Child Death Review Partners to ensure assurance was given around the progress on cases, management of the CDR process and the CDOP meetings.

13.10 Child Death Review and CDOP Activity

Number of Child Deaths between April 2020 and March 2021

There have been 58 deaths of children in this reporting year this is a decrease from the previous year. It is unclear why this is the case as the drop in numbers is in the neonatal deaths. Sudden and unexpected death occurred for 14 children and 13 of those families received a Joint Agency Response (JAR) in line with local guidance.

Table 18

Child Deaths- Age	Number
0 - 28 days - Neonates	23
28 days – 1 year	11
1 – 4 years	7
5 – 17 years	17
Total	58

Reviews of Deaths at CDOP April 2020 to March 2021

The work of CDOP for this year includes reviewing child deaths that may not have occurred within this reporting year as the panel reviews any outstanding deaths from previous years. The CDOP review should be the last point at which a child’s death is discussed and reviewed. Reviews can be significantly delayed for several reasons including the serious case review process, criminal or coronial investigation and coronial inquests.

Any delays in reviewing deaths of children are reported to the Child Death Review Partners and to the Derby and Derbyshire Safeguarding Children Partnership.

CDOP have reviewed 50 child deaths within this reporting year

13.11 The numbers of child deaths reviewed has reduced this year from 64 to 50 this is a direct impact of the Covid 19 pandemic. The child death review process is reliant on clinicians being able to complete reporting forms and holding Child Death Review Meetings. For some time, all meetings were cancelled due to the national requirement of all clinicians being available to work on the frontline, many were redeployed, and others were taking on additional duties. The swift introduction of social distancing and working from home increased the need for additional

technology across the partnership to enable information sharing and the ability to hold meetings online.

13.12 Cases RAG rated red were mainly Coronial cases some of which remained with the Coroner for an extensive period due to the pandemic.

13.13 The outcome of the child death review process not being completed was a reduced number of cases being ready to be heard at CDOP. Three CDOP meetings were cancelled due to a lack of cases being ready to discuss and review.

13.14 Voices of families in CDOP

The views of families and experiences of children is important to CDOP. As part of our process, we offer families the opportunity to share a photograph of their child and any specific information they would like us to know. This may include information about their character, likes and dislikes or the child's story surrounding their death. CDOP have observed over the year that more families are sharing photographs and their stories. This adds the personal information about a child's life and makes the CDOP process more meaningful. CDOP continue to write to all families who request feedback information following the completion of the child death review process.

13.15 Significant Learning themes obtained from reviews completed

- Scooter and car seat safety
- The requirement to commission a 24-hour palliative care service to support children who wish to die at home is a recurring theme
- The impact of domestic abuse in pregnancy
- COVID 19 and delays created in seeking medical advice, GP registration, delays in investigations
- Smoking in pregnancy and a think family approach to household smoking
- The need for a neonatal palliative care pathway

13.16 Learning from the Themed Panel for Sudden and Unexpected Deaths in Infants

- Unsafe sleep practice was a factor in all cases
- The importance of ensuring that parents/cares understand the safe sleep messages and practice safe sleep when caring for their babies
- The need to reinforce the message that 'Every Sleep Counts'
- The message that the risk to babies increases when co sleeping is unplanned.
- Alcohol use was a factor in most of the cases and is often minimised by parents
- Evidence on post-mortem of signs of viral illness
- Evidence of Vitamin D deficiency on post-mortem
- The need for parents/carers to be aware of the difference in sleep practices for babies whilst on Neonatal Intensive Care Unit and when babies go home.

13.17 Challenges for the Child Death Review Process

Most challenges this year are related to the COVID 19 pandemic:

- Information sharing and completion of the analysis forms from provider organisations
- Delay in the Child Death Review meetings being held
- Coronial delays
- Establishing the CDOP meeting on Microsoft Teams to ensure all partners and members could take part
- Ensuring that the Joint Agency Response could take place taking into account PPE and social distancing

- The CDOP seminar planned for June 2020 was postponed due to COVID 19
- Numbers of deaths sitting with the coroner
- The delay in CDRM meetings being restored following the 2nd wave of COVID 19
- The delay in Perinatal Mortality Review Tool (PMRT) being completed and shared with CDOP

13.18 CDOP achievements

- Contingency Plan was developed quickly in April 2020 for Child Death Review and CDOP regarding the COVID 19 Pandemic
- Quarterly reporting to the Child Death Review Partners in line with the Governance and Accountability document
- Sudden Unexplained Death in Infancy (SUDI) Themed Panel was held in November and report written and widely disseminated
- Pathway has been developed and agreed between Child Death Review and Child Practice Review
- LeDeR pathway with CDOP reviewed and agreed
- Voices of families and their children are heard at CDOP
- Development of five CDOP Newsletters
- The Designated Doctor for Child Death attended the JUCD End of Life Programme Board to share Imogen's Story and discuss end of life provision for children wishing to die at home
- Recommended the commissioning of a 24-hour community palliative care services in line with NICE Guidelines

13.19 CDOP Priorities for 2021-2022

- To support UHDBFT midwifery and neonatal professionals in the development of processes and pathways to ensure timely information sharing particularly around the PMRT's to allow for the preparation of the neonatal cases for CDOP
- To monitor the restoration of CDRM's and information sharing with CDOP to prevent further delays
- To monitor the progress of the commissioning of a 24-hour palliative care service for children wishing to be cared for and die at home
- Create guidance for CDOP regarding Modifiable Factors in line with the NCMD
- To plan for a Themed Panel on the Sudden and Unexpected Deaths in Teenagers in May 2021
- To plan the Child Death Review Seminar to be a virtual experience in the next reporting year

13.20 Despite the number of changes, challenges, and developments for the Child Death Review and CDOP what has remained constant in this most difficult of years is strong commitment to review each child's death and where possible to identify learning and make recommendations to reduce future deaths in Derby and Derbyshire.

14. Impact of COVID 19 on safeguarding

14.1 2020/21 has been an unprecedented year due to the Covid 19 pandemic, the pandemic has had an impact on each and everyone of us in some form or other. Due to the lockdown restrictions our most vulnerable in our society were at risk of not being seen by professionals, friends and families placing them at increased vulnerability. Throughout the pandemic DDCCG remained highly committed in keeping our safeguarding arrangements robust and ensuring our statutory functions were fulfilled, in order to ensure this, the safeguarding children team were not redeployed from the CCG. The team worked closely with our health providers and partner agencies to understand and respond appropriately to emerging issues, concerns

and challenges formulating mitigation and contingency plans that were regularly reviewed. The Safeguarding team also reported regularly to the NHS England Regional Safeguarding team keeping them informed of local arrangements and areas of concern/ challenges being experienced during this unprecedented time. During the peak of the pandemic members of the CCG Safeguarding team met on a fortnightly basis with our main provider safeguarding adult and children leads to receive regular updates on the children and adult services being provided during his period and to offer peer support, sharing mitigation and contingency plans during this challenging period.

- 14.2** Despite the significant challenges that the CCG and Health providers experienced during the pandemic the CCG Quality and Performance Committee and Governing Body can be assured that all appropriate measures and steps were taken to ensure that safeguarding functions were fulfilled and that where required mitigations and measures were put in place.

15. Priorities 2021/2022

- 15.1** DDCCG Safeguarding Children Team will continue to work collaboratively, to engage in work streams to improve quality, strengthen safeguarding children's arrangements and where necessary mitigate organisational and partnership risks.

Below is a table of key priorities that the Safeguarding Children team will be working to achieve in 2021/2022.

Table 19

Safeguarding Children 2021/22 team priorities
<ul style="list-style-type: none"> • Continue to strengthen and maintain DDCCG Safeguarding children's robust arrangements by ensuring full compliance with the NHS England and Improvement Safeguarding Assurance Framework
<ul style="list-style-type: none"> • To ensure that Safeguarding Children holds a strong position within the new Derby and Derbyshire Integrated Care System / Board
<ul style="list-style-type: none"> • To continue to work collaboratively with our health providers and safeguarding partners, to engage in work streams to improve quality, strengthen safeguarding arrangements and where necessary mitigate organisational and partnership risks.
<ul style="list-style-type: none"> • To continue to meet the CCG statutory safeguarding responsibilities as a key and equal partner of the Derby and Derbyshire safeguarding children partnership arrangements.
<ul style="list-style-type: none"> • To continue to provide regular quality and performance assurance reports to the CCG Quality and Performance Committee and Senior Management Team, highlighting any areas of concern or risk.
<ul style="list-style-type: none"> • To continue to advise the CCG commissioners to ensure that safeguarding responsibilities/ requirements are firmly embedded within contracts approved.
<ul style="list-style-type: none"> • To continue to develop and embed robust safeguarding children assurance processes with our Health Providers and Independent contractors.
<ul style="list-style-type: none"> • To continue to be available to provide advice and support to health staff and offer expert advice to partner agencies when required.

<ul style="list-style-type: none"> • To continue to offer safeguarding supervision to provider Safeguarding Children Leads/Named Professionals.
<ul style="list-style-type: none"> • The Designated Doctor to set up action learning sets for the Named Doctors and Named GP for Safeguarding children
<ul style="list-style-type: none"> • To continue to develop safeguarding arrangements within Primary Care.
<ul style="list-style-type: none"> • To continue to develop, deliver, and evaluate the safeguarding children training to all staff within the CCG and across Independent Contractor settings.
<ul style="list-style-type: none"> • To continue to meet the statutory requirements of the Child Death review arrangements
<ul style="list-style-type: none"> • To continue to have a presence on all Provider Trust's Safeguarding Committees and provide strategic direction and leadership for health in relation to safeguarding children.
<ul style="list-style-type: none"> • To continue to take an active role in rapid reviews & child practice reviews, monitor the progress of action plans and gain assurance that that learning has been embedded into clinical practice.
<ul style="list-style-type: none"> • To work in partnership with key agencies in being inspection ready for the CQC and Ofsted (single and joint) Inspections taking place in 2021-22.
<ul style="list-style-type: none"> • To continue to raise awareness regarding key priority areas such as Keeping babies safe, Children at risk of exploitation, Contextual Safeguarding/ Place Based risk, Adverse childhood experiences, Improving the Emotional health & wellbeing of children and young people and domestic abuse.

16. Conclusion

16.1 The purpose of this report is to demonstrate and provide assurance to DDCCG Quality and Performance Committees and Governing Body that DDCCG take seriously their duty to ensure that its safeguarding children functions are effectively discharged. The priorities listed above will aim to continue to strengthen the CCG safeguarding arrangements and promote the safety and wellbeing of children, young people, and families within our community.

16.2 The Designated Professionals and Named GPs for Safeguarding Children will continue to work collaboratively with our Providers and partner agencies to ensure that safeguarding children arrangements remain robust and that Children and Young people in our community are safeguarded effectively.

16.3 Derby and Derbyshire CCG Quality and Performance Committee and the Governing Body are asked to acknowledge the work undertaken during the reporting period and agree on the 2021/22 safeguarding children's priorities

17. References

Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework NHS England (2019)

The Children Act (1989) and (2004)

Department of Health (2018) Working Together to Safeguard Children: A guide to interagency working to safeguard and promote the welfare of children

Intercollegiate Document (2019) Safeguarding Children and Young People: Roles and Competences for health care staff.

Appendix 1

Named GP Annual Report 1st April 2020 to 31st March 2021

Named GP team structure

During 2020-21 the Named GP Team experienced some staff changes in that Dr Woodcock retired in May 2020 leaving a vacancy of three sessions. This post has been filled in March 2021 so at the end of this reporting year all Named GP for Safeguarding Children sessions were filled.

Sessions allocated

- Dr Ruth Bentley two days a week (4 sessions or 16 hours).
- Dr Jeremy Gibson one day a week (2 sessions or 8 hours)
- Dr Sandra Ives 1.5 days a week (3 sessions or 12 hours)

The Named GPs are supported by the Designated Doctors for Safeguarding Children. Dr Sebastian Yuen took up the post of Designated Doctor for Safeguarding Children in the County in early 2020. The Designated Doctor for Safeguarding Children in the City post was filled temporarily by Dr Patricia Field on one day a week following the resignation of the previous Designated Doctor. Day to day advice and support is also available from the Assistant Director for Safeguarding Children/ Lead Designated Nurse for Safeguarding Children – Michelina Racioppi.

Challenges for 2020-21:

The main challenge for 2020-21 has been the global Coronavirus Pandemic. The country was put in the first lockdown in March 2020, and this continued through much of the period covered by this annual report. Due to the restrictions on working, the team had to adapt quickly to new ways of working.

Initially meetings and training were suspended until virtual options were made available. The options that were made available was the use of MS Teams which was deemed as the most appropriate and safe/ secure way of delivering training to the workforce.

Positives for 2020-21:

The use of technology for virtual meetings has hugely reduced the traveling time and carbon footprint of the team. The technology is becoming easier to use with practice and in the longer term, continued use of virtual meetings will free up time for the Named GPs and make it easier for Safeguarding Children leads and other GPs to attend meetings and training. The team have also noticed that the attendance rate at safeguarding training has increased since introducing this style of training and the team have received positive feedback/ evaluations.

Overview of 2020-21 following the previous annual report priorities:

To hold quarterly GP Safeguarding Leads meetings. Due to Covid 19 measures these will be held virtually via Microsoft Teams.

The safeguarding leads meetings were restarted after the initial pause at the start of lockdown. A rolling three-month programme covering all the areas was established. All the PCN's were split into one of three groups:

1. High Peak and Derbyshire Dales
2. Chesterfield and Dronfield, North and South Hardwick and Bolsover and North East Derbyshire
3. Belper, Erewash and Heanor, Alfreton and Ripley.

The first run of meetings in June, July and August were a general catch up and test of using MS teams for the group. General discussions around Initial Child Protection Conference (ICPC) reports, safeguarding meetings in practice and the new Safeguarding template for S1 were held and relevant issues fed back to other agencies via Dr Bentley.

The second round of meetings in September, October and November was joined by Karen Barden (since retired) from Derbyshire Children Social Care to discuss ICPC reports and meetings. Feedback was given regarding the outcome of the yearlong ICPC audit undertaken by Dr Bentley.

The third round of meetings in December, January and February was joined by Ann Coverley, Service Manager from Derbyshire Starting Point to discuss the role of Starting Point and the referral processes.

In March 2021 the fourth round of meetings was held and we were joined by Derbyshire Local Authority Debbie Peacock (now retired) and Chris Caley to discuss Early Help and the role of schools in Early help process.

Verbal feedback from the meeting suggested that participants found the meetings very helpful, both from the Safeguarding Children Leads and from the speakers who were able to attend the sessions.

Derby City and Swadlincote usually have quarterly GP Safeguarding Leads meetings. These were paused at the beginning of the pandemic but have now resumed virtually.

On 9th September 2020, we had three presentations on:

- Update on safeguarding template by Ross Naylor, SystemOne Trainer
- Domestic Abuse during COVID-19 by Dr Jeremy Gibson, Named GP for Safeguarding Children
- Contextual safeguarding by Dr Jeremy Gibson, Named GP for Safeguarding Children

On 20th November 2020, we had had presentations on:

- Safeguarding template - update
- Looked After Children by Dr Jeremy Gibson, Named GP for Safeguarding Children.

Meetings

- 🚩 *To continue to hold meetings virtually and continue to ask external speakers to join us on specific topics.*

- ✚ *To arrange an annual meeting to discuss processes between the leads and share good practice.*

To provide quarterly Named GP newsletter updates.

These have been provided quarterly via email. Topics covered and documents shared include and range of documents and advice. *(full list at the end of this report)*

- ✚ *To continue to provide quarterly newsletters with relevant information to General Practice.*

To continue to provide Level 3 Safeguarding Children training to professionals outlined in the Intercollegiate Document 2019 as requiring Level 3 training. Due to Covid 19 measures, we have developed and have started to deliver online learning modules using Microsoft Teams. This may allow future training to be delivered in a more flexible and accessible way.

After an initial pause at the start of lockdown, training was delivered throughout 2020-21 virtually via MSTeams. Zoom was used if needed by other agencies such as the GP training scheme. The training was redesigned to accommodate a virtual approach. 10 dates were held from July to March 2020, as well as three additional sessions for the GP registrars at the request of the local training schemes. One session was delivered for the Derbyshire Educational Network at the request of the LMC.

The total number attending training was harder to capture exactly from attendance lists of MSTeams, but the total number trained was more than 700 participants. This is an increase from the previous year of some 300+ (previous year saw 374 people attending). This includes GP registrar training.

Over 95% of attendees rated us in their evaluation feedback 4 or 5 out of 5 for content and delivery.

65% of those giving feedback identified their job role as a GP.

17% were practice nurses and 2.5% were Advance Nurse Practitioners.

- ✚ *To continue to expand the training offer taking advantage of the online delivery to expand the portfolio.*
- ✚ *To update the Level 1 and Level 2 training for use in practice as part of ongoing rolling programme of updates to training.*

To contribute to Rapid Reviews and Child Safeguarding Practice Reviews.

The team have contributed to rapid reviews as they have come up by completing a rapid review and then attending practitioner and manager events as appropriate. Dr Bentley has contributed to three CSPR's and one DHR and one rapid review that did not proceed to CSPR. Dr Gibson has contributed to three rapid reviews.

- ✚ *To continue to respond to rapid review requests and involvement with Child Practice Reviews' and Domestic Homicide Review's as required.*

To improve the quantity and quality of GP Initial Child Protection Conferences (ICPCs) reports.

Audit work has been ongoing for the ICPC reports. Dr Bentley's yearlong audit of ICPC reports returned in the County ended in March 2020 and was covered in last year's annual report.

In December 2020 Dr Bentley undertook a quality audit of the reports being submitted looking at 10 consecutive reports. The results show that the template was only used in 4 of 10 reports. Areas consistently completed included immunisations and when the child was last seen as

well as which family members were registered. Areas poorly completed included the voice of the child and information around learning disabilities in adults or children. (full results in appendix 2). Jeremy Gibson also has completed ICPC quality audit for Derby City (appendix 3).

- ✚ To undertake further short audits planned to review the numbers of reports produced and the quality of reports for ICPC from GPs through 2021-22.
- ✚ To offer further training/ guidance for GPs in report writing for ICPC.
- ✚ To continue with ongoing liaison with Children Social Care and GPs around improvements to process.

To develop, in partnership with the SystemOne Trainers, an electronic safeguarding template to standardise the way GPs record and code safeguarding information on electronic records.

The Safeguarding Template for Systemone is now embedded with in the Pathfinder main page. Pathfinder is an overarching template which in time will incorporate all that is required by way of referral forms and information for the whole range of specialities across the City and County. The Safeguarding Template has been updated this year to be in line with the aesthetic of the other templates and the information streamlined. It continues to be updated in response to queries and observations from GPs about what would be useful. This is an ongoing process that will continue in the long-term as we gain feedback. The same information is available to EMIS practices, but there has been a delay in some software that would allow fuller integration of pathfinder into EMIS. This is beyond our control at this point, but we continue to monitor this through our contacts in the S1 team at the CCG.

- ✚ *To continue to update the template as needed.*
- ✚ *To try to incorporate some of the safeguarding documents that we share, and the newsletters into the SharePoint site associated with Pathfinder. (Currently on hold as there may be a web-based solution being considered -continued liaison with the relevant IT people regarding this).*

Other areas of Named GP work:

Practice visits

There have been no practice visits through this year due to Coronavirus restrictions. In the previous year, visits were only made following the Joint Safeguarding Assurance Framework (JSAF) if concerns were raised, or at the specific request of practices. There have been some MS Teams meetings with individual Safeguarding Leads held during 2020-21 if requested to discuss any specific queries about the role or process.

- ✚ *To continue to offer MSTeams meetings on request to safeguarding leads who have a specific issue to discuss or feel they need further support.*

Team communication and wider meetings attended.

The Named GPs meet with the Designated Doctors for regular supervision meetings to help co-ordinate their work and to ensure adequate peer review of any advice they have given to local GPs. The Named GPs also attend the Derbyshire Named and Designated Professionals meetings. A Named GP representative sits on a number of other relevant meetings, including the Child Death Overview Panel (CDOP), the Child Practice Review, the Learning and Organisational Development and Policies and Procedures which are (all apart from CDOP) subgroups of the Derby and Derbyshire Safeguarding Children Partnership (DDSCP).

In 2020 NHSE developed a regional support network for Named GPs which is now becoming more established.

- ✚ To continue to provide representation at local multi agency meetings, and continued involvement in regional NHSE Safeguarding Forum.

Documents developed by the Named GPs for Safeguarding Children:

Dr Bentley has developed a Guide to Social Care for General Practice which outlines the pathways through social care and how the process works. This was completed with input from Children Social Care in the City and County to ensure that it was compliant with the DDSCP threshold document



Structure and
Pathways through soci

Dr Bentley has developed a one-page summary of the Threshold Guidance as an aide to making threshold informed decisions when referring.



Safeguarding
thresholds Summary F

- ✚ To continue to develop supporting documents to aid decision making and understanding of safeguarding.

Audit work completed in 2020-21:

- Audit of the numbers of reports returned for ICPC from GPs audited for the County and City
- ICPC quality audits have been undertaken in County and City.
- Quality audit of GP referrals made to Derbyshire Starting Point

National safeguarding publications

Jeremy C Gibson and Heather Peet. – Looking out for looked after children - *Community Practitioner* 2020; November/ December: 29-31

Named GP for Safeguarding Children Priorities for 2021/2022

- ✚ To continue to hold Safeguarding Leads meetings virtually and continue to ask external speakers to join us on specific topics.
- ✚ To arrange an annual meeting to discuss processes between the leads and share good practice.
- ✚ To continue to provide quarterly newsletters with relevant information to General Practice.
- ✚ To expand the training offer taking advantage of the online delivery to expand the portfolio.
- ✚ To update the Level 1 and Level 2 training for use in practice as part of ongoing rolling programme of updates to training.
- ✚ To continue to respond to rapid review requests and involvement with CPR's / DHR's as required.
- ✚ To undertake further short audits planned to review the numbers of reports produced and the quality of reports for ICPC from GPs through 2021-22.
- ✚ To offer further training/ guidance for GPs in report writing for ICPC.
- ✚ To continue with ongoing liaison with Children Social Care and GPs around improvements to process.
- ✚ To continue to update the safeguarding children ICPC template as needed.
- ✚ To try to incorporate some of the safeguarding documents that we share, and the newsletters into the SharePoint site associated with Pathfinder.
- ✚ To continue to offer MS Teams meetings on request to safeguarding leads who have a specific issue to discuss or feel they need further support.
- ✚ To continue to provide representation at local multi agency meetings, and continued involvement in regional NHSE Safeguarding Forum.
- ✚ To continue to develop supporting documents to aid decision making and understanding of safeguarding will be developed according to demand.

List of documents shared in Named GP newsletters in 2020-21

- Training dates for CCG and DDSCP.
- Level 1 and 2 training packages for practices to use.
- Notification that local Safeguarding App no longer recommended as not updated.
- Threshold and Escalation documents (shared twice).
- Operation Liberty Form. New S1 Safeguarding Template – now to find and use.
- Early Help briefing document for General Practice (Derbyshire GPs) (shared twice).
- Initial Child protection conference report templates and how to complete (shared twice).
- How to make a referral to Childrens social care.
- Child not brought to appointment document. Fabricated Induced Illness guidance.

- Joint Agency response (JAR) to child deaths during the covid 19 pandemic.
- Prebirth protocol. Covid-19 and Domestic Abuse. Adverse Childhood Experiences
- JSAF report for the previous year. Marking events not visible in the online record.
- Mental health support for Derby and Derbyshire children, young people and carers.
- DDSCP – reminder about policy and procedures, how to find them.
- Allegations against staff, carers, and volunteers. Primary Care Contact leaflet updated in March 2021.
- Management of Genital Herpes Simples in Children and Young people.
- Pathway for Ano-Genital warts in children and young people.
- Guidance for the management of subconjunctival haemorrhage in the neonatal period.
- Self-harm and suicidal behaviour guidance working with children and young people in Derby City and Derbyshire. CAMHS Specialist community advisors leaflet for North and South.
- CDOP newsletter (August 2020 and December 2020).
- Safeguarding during virtual consultations.
- Finalised pathway for suspected FII with perplexing presentations within primary care.
- Catch 22 referral form. Children who may have left a GP practice pathway.
- CSEQR4 Questionnaire. Prevention programme Covid-19 guidance. Social care area email list.

Appendix two. Derbyshire ICPC Quality Audit Feb 2021

Methods:

This audit was completed to investigate the quality of reports returned for Initial Child Protection Conferences from General Practice in Derbyshire County. It was completed jointly by Karen Barden (title) and Dr Ruth Bentley (Named GP for Safeguarding Children DDCCG).

Karen identified 10 consecutive submissions from General Practice. One was actually for a review child protection conference, so this was discounted, and the next consecutive report was used instead giving a total of 10 reports considered.

Karen and Ruth independently assessed the quality using a tool produced by Dr Jeremy Gibson (Named GP for Safeguarding Children DDCCG) following the publication of his article outlining what constitutes a good report for initial child protection conference (What makes a good-quality GP report for an Initial Child Protection Conference? British Journal of General Practice Nov 2019 69:577-578).

Results:

The results are as follows:

Question	Number where information completed.
How long has the child been registered with the practice?	5
Medical conditions (in lay language), indications for and concordance with treatments.	8
Behavioural issues in the child	4
Physical or learning disability	2
Is there a history of abuse or neglect?	4

Are immunisations up to date of have they been delayed?	10
When was the child last seen in the practice?	10
What is the frequency and appropriateness of the child's attendances at the GP surgery, emergency department and NHS out –of-hours services?	6
Alcohol or substance misuse in the child	4
Which family members are registered with the practice?	8
Biological and non-biological link of household adults to child (e.g., if they have PR)	6
Ethnicity of child and family members	4
Parental employment status	4
Number of children in the family home	8
Domestic abuse	4
Substance misuse in the parent	4
Alcohol misuse in the parent	6
Mental illness in the parent	6
If a parent has problems with substance misuse/alcohol misuse/mental illness are they having treatment for this and are they compliant with treatment?	2
Parental physical or learning disability	2
Child not brought to appointments	6
Capture the voice of the child	0
Complete on ICPC form (either typed or handwritten).	4

The results show that the ICPC form which has been developed and circulated is not as yet in widespread use. The team at DCC are happy to receive letters, but the letter needs to cover the same information as is requested in the form and this is rarely the case. It is noted that letters are not conference reports and cannot therefore be tabled in the meeting or shared whereas reports using the template can be and this makes the focus clearer on the risks, giving the GP an opportunity to contribute.

The voice of the child was not captured in any of the forms. While a description of the situation was considered, the impact of this on the child directly or their views were not given.

Areas that performed well were immunisations being up to date and when the child was last seen in the practice. This is likely because this information is readily available in the records. Medical conditions (where mentioned) were usually explained in lay language. The number of family members registered with the practice and the number of children in the home were recorded in most cases.

Other areas which are less well documented within the record were more infrequently completed such as ethnicity.

Conclusions:

It is clear that there is still some way to go to improve the quality of reports for Initial Child Protection Conferences in Derbyshire County.

During the course of evaluating the responses it was discussed that, although not included in this sample, it is not uncommon for DCC to receive a copy of the records rather than a formal report.

Future plans:

Karen and Ruth to produce a joint letter to return to practices who have submitted a copy of the records to explain why this is not suitable.

It is planned to produce a training package that will be made available to GPs to provide instruction on the type of information that is required and how to complete the form accurately.

Appendix three. ICPC Quality Audit in Derby City Feb/ Mar 2021

Introduction

Under the Children Act 1989, when safeguarding concerns arise in England, local authorities (LAs) have a statutory responsibility to carry out a Section 47 Enquiry. This may lead to an Initial Child Protection Conference (ICPC), which relies on collating pertinent information from relevant agencies. Because GPs are a key health representative, who may hold crucial information in their records, they should be invited to submit a written report for and, if able, attend the ICPC. Despite the important role the ICPC plays in safeguarding children, historically, GPs have rarely attended¹ and infrequently submitted reports². Having implemented changes to increase the number of GP ICPC reports³, in an effort to optimise the health information being fed into local ICPCs, where decisions are made on behalf of children who are potentially suffering from or at risk of significant harm, we audited the quality of all reports submitted during February and March 2019 and then February and March 2021.

Methods

The United States National Incidence Study (NIS) is a congressionally mandated, periodic effort to provide updated estimates of the incidence of child abuse and neglect. On the basis of NIS-4⁴ (the most recently conducted, 2010), we developed a standard dataset against which to audit local GP ICPC reports.⁵

All Derby City GP ICPC reports for February-March 2019. JG, MR, and JN-F independently reviewed and scored each report. On 27th November 2019 JG, MR and JN-F met to review their scoring, discuss differences, and agree scoring for each report. The February-March 2021 reviewed and scored by JG alone. Because of the failure to have showed consistent improvement in quality throughout domains, at this stage MR and JN-F did not also score.

Change implemented: new GP ICPC report template developed, promoted and payment introduced

Prior to September 2019, there were two Local Safeguarding Children Boards (LSCB), one for the city and one for the county. Each had their own ICPC GP report template. After September 2019, when, in response to the Wood Report⁶, the two LSCB were replaced with one Derby and Derbyshire Safeguarding Children Partnership (DDSCP), we developed one new ICPC GP report template for city and county, which, if completed fully, would capture all necessary information.

This template was uploaded onto the DDSCP website. An electronic self-populating version was also embedded into a safeguarding view in the electronic medical record. This safeguarding view is an area in the electronic medical record where all relevant safeguarding issues are pulled together. The self-populating facility, which we believe facilitates the completion process, automatically fills in standard information such as demographics, current medication, immunisation history, if the child was not brought to an appointment, etc. The form requires comment on, for example, whether the immunisation history is up to date and whether the patient takes their medication effectively.

We publicised the new template in the July 2020 Local Medical Committee (LMC) bulletin and autumn 2020 safeguarding newsletter (which goes to all GP Safeguarding leads in Derby City and County). We promoted its use through a series of online learning events during which more than 600 GPs, GP trainees, and practice nurses from Derby City and County attended.

From October 2020, DDCCG introduced payments for completing ICPC reports.

Results – round one: Feb-Mar 2019

In Derby City, February-March 2019, 30 (68.2%) GP reports were submitted for 44 ICPCs. We could only obtain 26 of these reports. Results are in the table below. Although most GP reports listed the child's immunisation history few commented on whether they were up to date or whether they were delayed. Whether the GP had captured the voice of the child or not was subject to our individual interpretation, which we discussed and came to agreement on a case-by-case basis. For instance, some GPs had reflected in their reports how the child presented at the GP Surgery. In some reports information from strategy discussions and meetings was simply copied into the report, which we felt inappropriate. Only one of the 26 reports had been shared with a parent/ carer.

Results – round two: Feb-Mar 2021

In Derby City, February-March 2021, 46 (63.9%) GP reports were submitted for 72 ICPCs. We obtained all 46 of these reports. JG reviewed and scored these (results tabulated below). The self-populating template failed to add date of registration. IT was contacted about this who rectified this centrally. Twelve (26.1%) used the old template. All of these twelve were from one GP practice which was contacted and asked to start using the new template. Fourteen (30%) used a letter rather than completing the template. Three (6.5%) used an email rather than a template. Seventeen (37%) used the new template. Of these only five (10.9% of total) fully completed the new template.

Every GP practice which had submitted a letter or email, or only partly completed the new template were emailed and asked to audit their reports against the audit tool and encouraged to fully complete the new template for future ICPC reports.

All GP safeguarding leads in the city and county were also emailed (as follows), with the same paragraphs being included in the Summer Safeguarding newsletter.

"Thank you for your continued support in completing and submitting ICPC reports when requested. The number of submitted GP ICPC reports remains good at almost 70%. However, we're now aiming to optimize their quality. I attach the audit tool we're using to measure this, which is based on the BJGP article: Jeremy Gibson, Michelina Racioppi and Jasmine Nembhard-Francis. What makes a good-quality GP report for an Initial Child Protection Conference? BJGP 2019; 69 (688): 577-578. It is available here: <https://bjgp.org/content/69/688/577>

We have noticed that several practices have not been using the new template and some of those who have done so have not completed it fully. Please consider self-scoring any reports

which your practice has submitted against the audit tool and for future ICPC reports using the standardised template that we highly recommend all GPs complete. It's relatively straightforward and if you open it on the pathfinder safeguarding template many of the areas self-populate. You need to complete one generic template for the index child (or, if there are more than one, for one of them) and then a child and adult profile for each additional household member.”

We are also planning to hold two virtual workshops on how to complete the ICPC reports.

Results – round three: Feb-Mar 2022

We plan re-audit all reports in February and March 2022 to review progress.

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CSC data relating to GP report submission for ICPCs

ICPC	February/ March 2016	February/ March 2017	February/ March 2019	February/ March 2021
Total number of ICPCs held	34	53	44	72
GP not invited as registered practice unknown	14 (42.4%)	18 (34.0%)	3 (6.8%)	5 (6.9%)
GP invited to submit a report and attend ICPC	19 (57.6%)	26 (49.1%)	41 (93.2%)	64 (88.9%)
GP submitted report	9 (27.3%)	3 (5.7%)	30 (68.2%)	46 (63.9%)
GP attended	0	0	0	-

Results table

Identify health-related risk factors	Feb-Mar 2019 (n=26)	Feb-Mar 2021 (n=46)
--------------------------------------	------------------------	------------------------

Child's developmental needs	How long has the child been registered with the practice?	1 (3.8%)	8 (17.4%)
	Medical conditions (in lay language), indications for and concordance with treatments	20 (76.9%)	23 (50%)
	Behavioural issues in the child	5 (19.2%)	21 (45.6%)
	Physical or learning disability	3 (11.5%)	21 (45.6%)
	Is there a history of abuse or neglect?	8 (30.8%)	25 (54.3%)
	Are immunisations up to date or have they been delayed?	11 (42.3%)	29 (63%)
	When was the child last seen in the practice?	24 (92.3%)	32 (69.6%)
	What is the frequency and appropriateness of the child's attendances at the GP surgery, emergency department and NHS out-of-hours services?	14 (53.8%)	27 (58.7%)
	Alcohol or substance misuse in the child	0 (0%)	14 (30.4%)
	Family environmental factors	Which family members are registered with the practice?	21 (80.8%)
Biological and non-biological link of household adults to child (e.g. if they have parental responsibility)		20 (76.9%)	25 (54.3%)
Parenting capacity	Ethnicity of child and family members	0 (0%)	14 (30.4%)
	Parental employment status	2 (7.7%)	7 (15.2%)
	Number of children in family home	19 (73.1%)	31 (67.4%)
	Domestic abuse	11 (42.3%)	24 (52.2%)
	Substance misuse	11 (42.3%)	20 (43.5%)
	Alcohol misuse	8 (30.8%)	20 (43.5%)
	Mental illness	16 (61.5%)	31 (67.4%)
	If a parent has problems with substance misuse/ alcohol misuse/ mental illness are they having treatment for this and are they compliant with treatment?	13 (50%)	22 (47.8%)
	Parental physical or learning disability	0 (0%)	6 (13%)
	Child not brought to appointments	10 (38.5)	18 (39.1%)
Capture the voice of the child	0 (0%)	4 (8.7%)	
Clearly explain and critically analyse health information – THINK FAMILY	6 (23.15)	7 (15.2%)	
If safe to do so, have you shared the details of this report with the child's parents?	1 (3.8%)	0 (0%)	

Introduction/ context

Section 11 of the Children Act 2004 places a duty on a range of organisations (including the NHS England and CCGs) to ensure their functions and any services they commission or contract out to others are discharged as having regard to the need to safeguard and to promote the welfare of children.¹ Section 42 of the Care Act 2014, the most significant reform to Adult Social Care for more than sixty years, has brought a clear legal framework in relation to Safeguarding Adults.² While safeguarding is firmly embedded within the wider duties of all organisations across the health economy there is a distinction between providers' responsibilities to provide safe and high quality care and support, and commissioners' responsibilities to assure themselves of the safety and effectiveness of the services they have commissioned.³

In April 2015 CCGs began to co-commission GP services with NHS England. Under delegated arrangements, the CCGs became responsible for ensuring that the GP Services commissioned have effective safeguarding arrangements in place. The NHS England document, 'Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (2019)' explains that this assurance may consist of assurance visits, Section 11 (Children Act 2004) audits and the attendance at provider safeguarding committees as means of gaining such assurance; however, it lacks further detail on a standardised measuring tool; nor does it give any explanation of how CCGs should respond to non-compliance. To guide GP practices regarding what safeguarding arrangements they should have in place and to give some assurance to the CCG that their GP practices had robust safeguarding processes in place, the CCG Safeguarding Children and Adults teams developed the Joint Safeguarding Assurance Framework (JSAF).

Since its development, the JSAF has been repeatedly updated to reflect the latest local and national guidance. Following the Joint Targeted Area Inspection (JTAI) in March 2019 the inspectors provided a view that the self-reporting nature of the JSAF precluded it from being termed an assurance tool. It was, therefore, updated and renamed the Joint Safeguarding children and adults Self-Assessment Framework.

Findings for 2020/ 2021 returns

In December 2020, all 112 Derbyshire GP surgeries were invited to complete the JSAF. Due to the pressures and demands of the Covid Pandemic the GP practices were provided with an extended return date.

The practices that did not return their self-assessment were sent a reminder. The current return rate is 97.3% (which pertains to 109 JSAF self-assessments returns). Most of the self-assessment ratings within the JSAF were green – fully compliant. Of the 79 amber self-assessment ratings, most of these related to updating policies and staff training. None of the GP practices self-assessed themselves as a red rating.

In this year's JSAF self-assessment we asked GP practices to provide a summary of what they perceived the impact Covid-19 has had upon their safeguarding activities/ functions. For

¹ http://www.workingtogetheronline.co.uk/chapters/chapter_two.html#section_eleven

² <http://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted>

³ The Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework NHS England, 2019

example, patient contact, home visits, or increase in child protection concerns, self-neglect or domestic abuse, etc. and what measures/ contingencies had their practice put in place to safeguard children and adults during the pandemic.

As part of the JSAF process we also cross referenced what CQC inspections had taken place and the GP practice ratings; of the GP practices in Derbyshire and Derby City CQC rated 87 of them as good, nineteen of them as outstanding, four of them as needing improvement; two were registered as inadequate.

How GP practices have responded to COVID-19, in relation to safeguarding

Patient contact

Fewer face-to-face consultation, more telephone and video consultations.

When making telephone calls, checks were made that patient was free and safe to speak.

Most practices reported fewer home visits, though they continued home visits for the most vulnerable/ housebound.

Immunisation continued, which enabled babies to be seen.

Weekly, remote care-home ward-rounds.

Continued Learning Difficulties and Mental Health checks, and eight-week baby checks.

Safeguarding meetings/ training

Regular, virtual multi-disciplinary team (MDT) safeguarding meetings took place. Many practices reported difficulty in getting health visitors, and especially midwives and school nurses to attend during the pandemic period.

Virtual safeguarding training events, including highlighting the impact of parental mental health on children and impact of Adverse Childhood Experiences (ACEs).

Safeguarding GP leads continued to attend GP leads meetings with the Named GPs for Safeguarding children.

Safeguarding GP leads hosted internal safeguarding training so that practice staff maintained their training compliance.

Safeguarding workload - general

While several practices reported no increase in safeguarding concerns/ self-neglect/ DA, many others noted an increase in child protection cases, requests for child protection conference reports, cases of self-neglect, DA cases (and MARAC reports), alcohol abuse, Police reports highlighting mental health issues, and East-Midlands Ambulance Service safeguarding alerts (especially related to the frail, elderly patients with social care issues).

Practices acknowledged that they found it easier to attend virtual child protection conferences, compared to when they were face-to-face meetings.

Safeguarding workload – case examples

Two cases of self-neglect detected.

One practice, which detected a concealed pregnancy, by liaising with an out of area authority uncovered child trafficking.

Difficult family situations came to light – for example which parent should a child stay with if self-isolating.

Mental health

There has been an increase in mental health issues in adults and children identified, with more children appearing to be suffering from behavioural and emotional issues, anxiety, self-harm, suicidal thoughts, etc.

More adults appear to have had more problems with alcohol and drug misuse

Innovation

Monthly Emergency Department (ED) auditing to identify children who attend regularly, discussed at safeguarding meetings.

Monthly reports for children who missed immunisations – parents were contacted.

Regular review of children subject to child protection plans.

Adult patients where there are concerns about self-neglect were monitored by the care co-ordinator and discussed at the multidisciplinary team meetings, where referrals were made to relevant agencies/ social prescribing.

Concerns regarding local care homes addressed.

High risk/ vulnerable patients/ families/ children on child protection plan/ children on child in need plan/ people with Learning disability were contacted during lockdown for safe and well checks.

Staff training on recognising domestic abuse (DA) on telephone and its increased risk during lockdown delivered.

Video conferencing and intimate digital imaging policy in place and adhered to.

Continued monitoring/ follow up if children not brought to appointments.

Social prescriber supported vulnerable adult patients and patients with long-term mental health problems.

Staff being more aware of difficulties in identifying safeguarding issues via telephone/ video tips circulated on how to address this.

Practice website updated with information for self-referrals and support for domestic abuse.

One practice created an electronic resource to support families/ individuals with mental health and other vulnerabilities (e.g., DA, self-neglect, alcohol/ drug misuse, eating disorders etc).

Password-protected log of patients with concerns (including details of actions completed), to allow easy access to overview the safeguarding concerns of patients.

Any child (<18 years-of-age) with a safeguarding alert who presented with genito-urinary symptoms provided a same day telephone appointment.

Processes put in place to monitor all safeguarding communication coming into practice, a recall system to ensure concerns discussed in multidisciplinary team meetings, and status markers to alert clinicians in consultations of any concerns/ vulnerabilities.

One practice put up domestic abuse posters that patients could see from outside the surgery.

One practice employed two mental health practitioners.

In summary and actions

- During the COVID-19 pandemic, Derbyshire GP practices appear to have worked hard, and innovatively, to maintain high standards of safeguarding practice for adults and children.
- The Named GPs plan to make contact with the practices which did not submit a JSAF return this year and work alongside the CCG Primary Care Team.
- The Named GPs plan to liaise with Children Social Care regarding informing GPs when children come off a Child in Need plan.
- For further conversations to take place with DCHS and DHCFT 0-19 service providers regarding the absence of school nurses attending GP practice Safeguarding meetings and strengthening the GP 0-19 service link role.
- To share the report with the Derbyshire Primary Care Quality & Performance Review Sub Committee and the Joint Safeguarding children and adults committee.
- To share key findings of the report with safeguarding GP leads.
- To review the JSAF report for 2021/22

ANNUAL REPORT FOR LOOKED AFTER CHILDREN

REPORTING PERIOD: 2020/2021

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The report has been compiled in collaboration with Derbyshire Healthcare NHS Foundation Trust,
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Section 1: Introduction and context

Introduction

- 1.1 The purpose of this report is to provide Derby and Derbyshire Clinical Commissioning Group (DDCCG) an overview of the progress, challenges, opportunities and future plans to support and improve the health and wellbeing of looked after children in Derby and Derbyshire. This includes all cohorts of looked after children that Derby and Derbyshire Local Authorities are responsible for, no matter where they live (see **Appendix 1** for explanation of the differing cohorts).
- 1.2 The report will outline how Commissioners, Designated Professionals, Local Authority and Health Providers have worked together in partnership to meet the health needs of children in care in Derby City and Derbyshire; in line with the statutory guidance 'Promoting the health and wellbeing of looked after children' (DH, 2015).
It will summarise key improvements, service performance; along with setting out the objectives and priorities for the next financial year (2021/22) for looked after children in Derby and Derbyshire.
- 1.3 This report has been compiled in partnership with Designated Nurses & Designated Doctors for Looked after Children for Derby and Derbyshire and the Looked after Children health teams across the Health Providers.
- 1.4 The report contains and analyses the compliance to the statutory framework in respect of timeliness and quality of health assessments and is obtained by the use of clinical audits and on-going quality assurance work.
- 1.5 Within all national and local policies and guidance the service is known as Looked after Children, however within Providers service provision is known as Children in Care.

Context

1.6 Definition of a looked after child / child in care

A child that is being looked after by the Local Authority, they might be living with:

- Foster parents
- At home with their parents under the supervision of Children's Social Care
- In residential children's homes
- Other residential settings like schools or secure units

They might have been placed in care voluntarily by parents struggling to cope, or Children's Social Care may have intervened because a child was at significant risk of harm.

Health and wellbeing of looked after children

- 1.7 It is well recognised that children's early experiences have a significant impact on their development and future life chances. As a result of their experiences and blended effects of poverty, poor parenting, chaotic lifestyles, abuse and neglect, looked after children often are at greater risk and have poorer health than their peers (DfE, DH, 2015).

Ref: Promoting the health and well-being of looked-after children, March 2015, Department for Education and Department of Health

1.8 The Royal College of Paediatrics and Child Health (2020) states that looked after children and young people have greater mental health problems, along with developmental and physical health concerns such as speech and language problems, bedwetting, coordination difficulties and sight problems. Furthermore, the Department for Education and Department of Health (2015) argue that almost half of children in care have a diagnosable mental health disorder and two thirds have special educational needs. When there are delays in identifying or meeting the emotional and mental health needs this can have a detrimental effect on all aspects of their lives leading to unhappy unhealthy lives as adults.

Ref: Promoting the health and well-being of looked-after children, March 2015, Department for Education and Department of Health

Ref: Looked after children: Knowledge, skills and competencies of health care staff, Intercollegiate Role Framework, December 2020, Royal College of Paediatrics and Child Health

Section 2: Statutory Framework, Legislation and Guidance

The statutory guidance focused around Looked after Children is in abundance; the key documents and legislation are outlined as follows:

2.1 Children Act (1989)

Under this Act a child is defined as being 'looked after' by the local authority if the child or young person is in their care for a continuous period of more than 24 hours by the authority.

There are four main groups:

- **Section 20** children who are accommodated under a voluntary agreement with their parents
- **Section 31 and 38** children who are subject to an interim care order or care order
- **Section 44 and 46** children are subject to emergency orders
- **Section 21** children who are compulsory accommodated including children remanded to the care of the local authority or subject to criminal justice supervision with a residence requirement.

2.2 Adoption and Children Act (2002)

This Act modernised the law regarding adoptive parenting in the UK and international adoption. It also enabled more people to be considered by the adoption agency as prospective adoptive parents. This Act also places the needs of the child being adopted above all else.

2.3 Children and Young People's Act (2008)

The purpose of the Act is to extend the statutory framework for children in care in England and Wales and to ensure that such young people receive high quality care and services which are focused on and tailored to their needs.

2.4 Children and Families Act (2014)

This Act strengthens the timeliness of processes in place to ensure children are adopted sooner. Due regard is given to the greater protection of vulnerable children including those with additional needs

2.5 Promoting the health and wellbeing of looked after children (March 2015)

This guidance was issued by the Department of health and Education. It is published for Local Authorities, Clinical Commissioning Groups, Service Providers and NHS England.

2.6 **Looked after children: Knowledge, skills and competences of health care staff intercollegiate role framework (December 2020)**

This document sets out specific knowledge skills and competencies for professionals working in dedicated roles for looked after children

2.7 **The Children and Social Work Act (2017)**

Improves decision making and support for looked after and previously looked after children in England and Wales

- Improve joint work at local level to safeguard children and enabling enhanced learning to improve practice in child protection
- Enabling the establishment of new regulatory regime for the social work profession
- Improve the provision of relationship and sex education in schools

Section 3: Looked after children data and profile

National and local data

3.1 The number of looked after children has increased steadily over the past nine years. There were 80,080 looked after children on 31 March 2020, an increase of 2.5%, compared to 31 March 2019. The most up to date national figures for 2020/21 are not yet available from the Department for Education (Stats: Looked after Children, Department for Education, 2018), the usual publication date being December 2021.

3.2 **Number of children looked after in England at 31 March 2013 to 2020**

2013	68,080
2014	68,800
2015	69,540
2016	70,440
2017	72,670
2018	75,420
2019	78,150
2020	80,080

Ref: Data made available from Department for Education publications

3.3 **Number of children looked after in Derby at 31 March 2014 to 31 March 2021**

Year	Derby City	Derbyshire
2014	445	627
2015	470	609
2016	452	586
2017	448	631
2018	491	719
2019	565	805
2020	588	869
2021	642	905

Ref: Data made available from Derby City and Derbyshire Local Authority Informatics Department

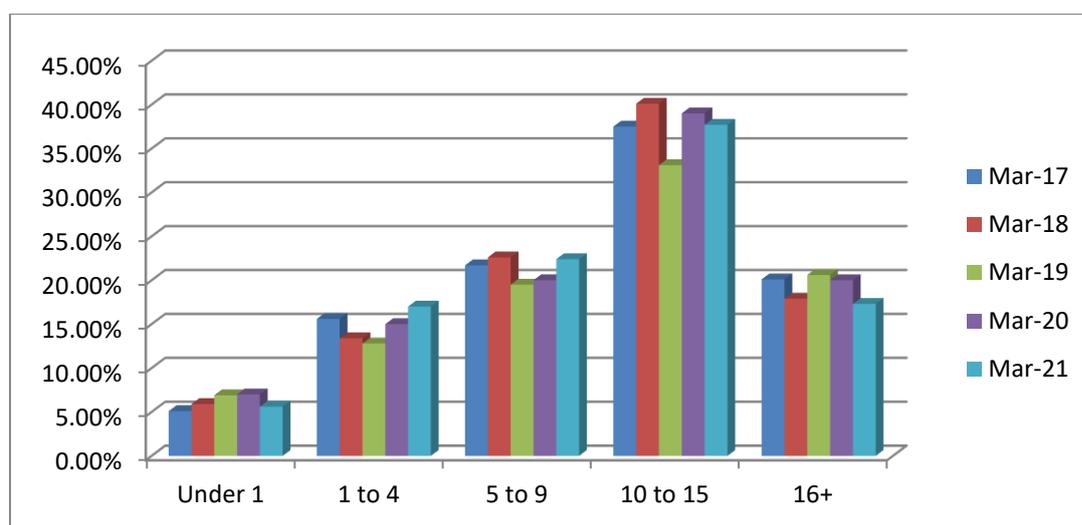
As the figures above indicate the numbers of Looked after Children continue to increase year on year for both Derby City and Derbyshire. Over this last financial year there has been a 9%

increase for Derby City and an 4% increase for Derbyshire. These figures are higher than the national average increase of 2.5%. The reasons for this are complex and to some extent unknown, however there may be a link potentially to the austerity of the local area, impact of Covid-19 pandemic, increase in Social Care cases overall and the complexities of children / young people due to their adverse childhood experiences.

Profile of looked after children in Derby and Derbyshire

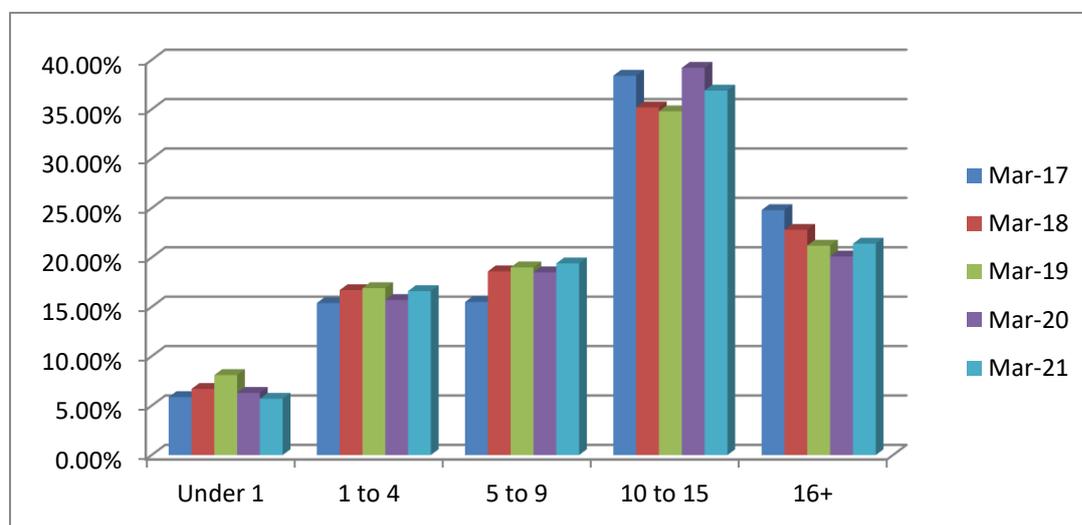
3.4 Age comparisons over the last five years for Derby and Derbyshire:

Derby City:



Ref: Data made available from Derby City Local Authority Informatics Department

Derbyshire:



Ref: Data made available from Derbyshire Local Authority Informatics Department

In comparing the data for the past four years, the 10 to 15 year old age group consistently remain the highest number of children/young people coming into care (for both Derby and Derbyshire). It is difficult to determine the definitive reasons for this but it may be linked to the increase in socially unacceptable behaviour, impacts of the Covid-19 pandemic, abuse/neglect, and acute stress within the family home vocalised by children/young people and family dysfunction identified as a reason for coming into care.

3.5 The percentage of children under the age of one coming into care has increased year by year (for Derby City) up to March 2020 and March 2019 (Derbyshire). This previous trend may be due to robust pre-birth assessments by Social Care and the adherence to Derby and Derbyshire Safeguarding Procedures. The Derby/Derbyshire data for 2021 indicates an increased level of children aged 1-4 years, which may be as a result of the delays seen during the financial year within the family courts and adoption decisions, as a direct result of Covid-19 pandemic.

3.6 **Reasons for children coming into care**

Abuse or neglect remains the most dominant reason for children/young people coming into care, with the figures remaining relatively stable (for this reason) over the last few years for both Derby and Derbyshire. On further analysis on the reasons of children coming into care: parental illness/disability, family in acute stress and family dysfunction are the other most common reasons. This may in some circumstances be associated to the financial climate within England, changes in benefit systems which is then reflected in family pressures and the wider impact of Covid-19 pandemic; this is difficult to confirm.

3.7 The increase for Derby City in absent parenting (Unaccompanied Asylum Seeking Children UASC) has stabilised over this last financial year; this may be related to changes in policy within the Immigration Service at the point of entry. This change ensures that if any young person states to the Immigration Service they are under 18 years old and who look under 25 years of age; there is a window of doubt, therefore they are accommodated as if they are a child initially. Another contributing factors may be due to the restricted movement of Asylum Seekers from the point of entry to other parts of the country due to lockdowns and restrictions posed by Government during the pandemic.

Ref: Data made available from Derby City and Derbyshire Local Authority Informatics Department

Section 4: Summary of Achievements 2020/2021 (in line with plans set out in the Annual Reports from 2019/2020)

4.1 **Derby and Derbyshire**

- The launch of the child/young person held health record called 'My Health Passport' across Derby/Derbyshire has been delayed due to the continued Covid-19 restrictions. The graduated roll out will be a priority for the financial year 2021/22
- Development and implementation of streamlining processes (where possible) across Derby and Derbyshire CCG and the Health Providers, in relation to out of area invoices for Looked after Children Health Assessments, quality assurance, pathways and quarterly reporting
- A collaborative approach between the Health Providers, Local Authority and CCG has been embedded to improve, maintain and monitor the compliance of timeliness for statutory health assessments for Looked after Children living in and out of the area (as per statutory responsibilities)
- Support given to the Health Providers in their development and implementation of virtual Health Assessments upon the onset of the Covid-19 pandemic; prioritising any face to face follow ups as required. Health Providers using and acting on the voices of children/young people in this innovation and service development
- Learning event held virtually for the Derby and Derbyshire Looked after Children health team, in order to improve knowledge of a Looked after Child related topic across the health community (gender and sexual identity, Changing Lives programme, understanding commissioning)

4.2 **Derby**

- Support given to the Health Team to develop and implement an on-going Health Promotion programme within the Local Authority Children's Homes (including healthy eating/lifestyle). Successfully bid for sexual health community funds to develop resources for young people, residential workers and other Local Authority staff within the financial year 2021/22
- Continuation of the Children in Care action learning sets (via virtual methods) which focused on current issues that face the children and young people in care to ensure the skills and competencies of staff is maintained and developed
- Continuation of the Foster Carer training (via virtual methods) in conjunction with the Fostering team, Learning and Development team (Health, DDSCP and Local Authority), Independent Fostering Agencies and the Local Authority.

4.3 **Derbyshire**

- Ongoing, positive multi-agency working around the delivery and timeliness of Initial Health Assessments, which have continued to improve steadily over the course of 2020/21 for all Children in Care living/residing in Derbyshire
- Designated Nurses (City & County) have supported CRH FT Children in Care Nursing Team with their SystemOne development, improving their skills and understanding on caseload management, data recording and fully utilising the system to its fullest potential
- Completion of clinical quality audits that informed the service of continued quality, improvements made (post previous audits) and as a mechanism for quality assurance to ensure Looked after Children receive the highest quality service
- Embedded the Children in Care Collaborative Operational Meeting across the partnership (the meetings now taking place via virtual means)
- Development and agreements reached by all parties for the newly aligned Children in Care Derbyshire Service Specification. The Designated Nurses to continue to support and work in partnership with the CRH FT CIC Team to ensure effective implementation and development of the service.

Section 5: Provider and Partnership Working

- 5.1 Partnership working between the Health Providers and DDCCG is well established and remains robust with the local Health Community. Collaboration and co-operation between the Provider and the Designated Professionals has proved essential in the ability to improve the health and well-being of Looked after Children in Derby/Derbyshire and those placed out of county.
- 5.2 The Health Providers and DDCCG have liaised on a regular basis with the Local Authority, attended the relevant Looked after Children focussed meetings, are fully engaged and always strive to achieve the best outcomes for looked after children.

Section 6: Service provision for Looked after Children

- 6.1 The Children in Care health teams and the 0-19 Public Health Nursing Service have core competencies, specialist skills, knowledge and attitudes to act as advocates, undertake health assessments, identify and manage health needs and provide support/training to Foster Carers and Children's homes, where appropriate (in line with the Intercollegiate Role Framework, RCN, RCGP, 2015). The teams also contribute to health care plans for all looked after children including children with special educational needs and/or disabilities.

6.2 Following the Covid-19 restrictions the Health Providers swiftly adapted and developed their Health Assessment offer to ensure that the statutory service continued during the periods of lockdown. Follow up face to face assessments were clinically and needs led, utilising allied health professionals where appropriate.

6.3 Derby City

Derby City's service provision has been maintained over this last financial year despite the Covid-19 restrictions by including virtual delivery (when required) of; focussed health promotion to children and young people, focussed training for Foster Carers, support for care leavers via the Care Leavers team, embedding of a robust system to collate health histories and continued provision for children who have special needs and/or disability.

6.4 Derbyshire

The Looked after Children team in Derbyshire have worked proactively and collaboratively with the CCG to align the Service Specifications between Derby City and Derbyshire. This alignment has secured increased funds via the National Tariff, for the Looked after Health team upon completion of Health Assessments for external children placed into Derbyshire and when the team complete an assessment across the border. This arrangement will improve continuity for children/young people, improved quality and timeliness of service provision.

Section 7: Health data and performance

7.1 Derby and Derbyshire

Health data and Local Authority performance is a mandated submission to the Department for Education on a yearly basis and the table below summarises the performance over the last three years:

Health Data Indicator	Year 2017/18		Year 2018/19		Year 2019/20		Year 2019/20 Comparative Data	Year 2020/21 PROVISIONAL	
	Derby	Derbyshire	Derby	Derbyshire	Derby	Derbyshire	England	Derby	Derbyshire
Annual health assessments	92.7%	89.9%	96.1%	89.2%	93.5%	91.3%	90%*	93.8%	88.1%
Dental checks	87.6%	85.1%	91.4%	81.6%	92.3%	91.3%	86%*	29.2%	41.3%
Imms up to date	93.9%	95.4%	92.8%	85.9%	92.3%	97.5%	88%*	93.1%	95.7%
Development checks (two RHAs in the 12 months for under 5 years old)	87.5%	85.2%	91.9%	81.2%	90.2%	96.2%	88%*	96.6%	85.9%
SDQ completion rate	93.5%	90.6%	92.7%	79.2%	92.5%	86.7%	78%*	91.8%	87.8%
SDQ score	15.9	15.4	14.8	16.1	14.7	16.8	14.1*	15.0	16.8

NB: the data is only mandatory for those children/young people in care for a period of 12 months or more

* The comparative data is from the financial year 2019/20 and does not take into account the impact of Covid-19 restrictions – in particular with access to dental care

Derby City

- 7.2 Overall performance of the Health Provider's provision remains consistently high, with the support of both the clinical and administration team and has been acknowledged within the Clinical Commissioning Group, DHcFT and Local Authority.
- 7.3 The majority of the performance parameters are higher than the national figures and the comparative Local Authority. The current dental care uptake rate for the forthcoming year will be a focus, particularly in light of the Covid-19 Pandemic whereby the access to NHS routine dental care was placed on hold for some time. It is evident through liaison with neighbouring Local Authorities that this level of compliance is not an 'outlier' in comparison to regional or national figures.
- 7.4 The Year 2020/21 comparative data is not yet available so the data has been rated according to the Local Authority targets, all but dental care have exceeded the local targets.

Derbyshire

- 7.5 Overall performance of the Health Provider's (CRH FT) provision remains consistently high, with the support of both the clinical and administration team. This has been acknowledged within the Clinical Commissioning Group, CRH FT and the Local Authority (DCC).
- 7.6 The SDQ performance parameter remains higher than the national average and the comparative Local Authority Data. Local Authority area aware of this higher average score and hope that the newly commissioned emotional health/wellbeing service will have an impact on the SDQ scores for children/young people. Derbyshire County Council Local Authority, DDCCG & Emotional Health and Wellbeing Providers continue to work together via two specific SDQ working parties (one looking at specific carer and professional SDQ training requirements/guidance and another looking at how SDQ scores translate into meaningful emotional health and wellbeing service delivery (for CIC with high SDQ scores).
- 7.7 The majority of the other performance parameters are higher than the national average and the comparative Local Authority Data. The current dental care uptake rate for the forthcoming year will be a focus, particularly in light of the Covid-19 Pandemic whereby the access to NHS routine dental care was placed on hold for some time. (see above for additional information)
- 7.8 All performance parameters will continue to be monitored closely by the multi-agency CIC Collaborative Operational Group.

Section 8: Markers of Good Practice

- 8.1 In February 2021 the Health Providers who provide statutory health assessments for Looked after Children submitted the Markers of Good Practice – self assessment tool for Looked after Children. The Markers of Good Practice tool, which is 'RAG' rated, provides the Health Providers with a productive opportunity to showcase their service to the Clinical Commissioning Group and Designated Professionals.
- 8.2 With the submission of evidence and 'RAG' rating, the tool supports the health teams to highlight progress, any gaps or improvements that are required to assure the commissioners

our service is working towards a 'gold standard' delivery and that the needs of the Looked after Children are being met and identified in line with the statutory guidance.

- 8.3 Unfortunately due to the continued Covid-19 Pandemic the planned annual MOGP visits to the Health Providers were unable to take place face to face, so a paper review and virtual approach was agreed. These reviews were completed in March and April 2021 by the Designated Professionals for the Health Providers (Chesterfield Royal NHS Foundation Trust, Derbyshire Community Health Services and Derbyshire Healthcare NHS Foundation Trust).
- 8.4 During the MOGP process the following was identified:
- The tool aided all parties to be 'inspection ready' with regard to CQC
 - The MOGP process continues to be an opportunity to reflect, evaluate progress and plan for future improvements
 - The MOGP gave the Health Providers opportunity to showcase their achievements, be open and transparent about their challenges and allowed the Designated Professionals to support where necessary
 - The Health Providers gave a wealth of evidence to demonstrate progress, improvements made over this last financial year and also brought 'alive' some children's journeys through case studies.
- 8.5 Strengths and challenges have been identified and action plans will be developed for the organisation to work through within the next year, to achieve compliance or improvements in the areas that were not yet rated as green. The Markers of Good Practice action plan will be mutually agreed and progress will be discussed with the Designated Nurse LAC on a regular basis to ascertain that sufficient progress is made.
- 8.6 The Clinical Commissioning Group have been assured that the Looked after Children service provision is overall at a good standard and the Health Providers are working in partnership in all areas that have been identified as requiring further progression or improvement

Section 9: Quality Assurance Processes

- 9.1 The Designated Professional role for Looked after Children has a statutory responsibility to promote the health and welfare of looked after children (Statutory Guidance: Promoting the health and well-being of looked after children, March 2015). This role is intended to be strategic at a Commissioning level (working in partnership with the Local Authority and Health Providers) and ensuring the voice of the child is heard and acted upon in the relevant arena.
- 9.2 The Designated Nurses are directly employed by DDCCG, which enables a level of independence to the Health Provider. A key element of the Designated Nurse and Doctor roles is one of quality assuring the service provision of health assessments within Derby/Derbyshire and out of area, to ensure the placement for the child in no way disadvantages them in healthcare provision and outcomes; in comparison to those Looked after Children living in Derby/Derbyshire and provide assurance to the DDCCG that the service that it commissions is of a high standard.
- 9.3 The Designated Professionals undertake an on-going audit programme throughout the year and findings are given as feedback to the Health Provider and Local Authority as appropriate (**see Appendix 2 for an example**). Any concerning issues found are escalated as appropriate via the contracting and quality routes within the relevant agency and within the Clinical Commissioning Group. The aim of the audit programme is to ensure quality, timeliness of assessments is maintained, systems and processes in place ensure Looked after Childrens

needs are met, to ensure robust record keeping with the health team and explore improvements / innovations.

9.4 Health assessment quality assurance

Over the year 2020/2021, the Designated Professionals for Looked after Children have continued the robust system to ascertain the quality and timeliness of health assessments (Initial and Reviews) undertaken, which is now aligned across the footprint. Quality assurance of the Initial Health Assessment is a requirement of the Designated Doctor and the provision of feedback is part of the service specification key performance indicators. However the quality assurance for Review Health assessments is the responsibility of the Designated Nurses within the CCG.

9.5 There is a robust process in place that if a Health Assessment is deemed to be of sub-standard quality, it is returned to the relevant Health Provider for further amendments and improvements prior to being accepted and paid for by Derby and Derbyshire CCG.

9.6 Additional work and responsibilities of the Designated Doctors is detailed within section 10.

Section 10: Designated Doctor

10.1 The Designated Doctor (and Nurse) role is to assist service planning and in England to advise Clinical Commissioning Groups in fulfilling their responsibilities as commissioner of services to improve the health and well-being of looked after children. The CCG have arrangements in place for Derby and Derbyshire in ensure the role of Designated Doctor for Looked after Children is fulfilled across the footprint.

10.2 The job descriptions/contracts for the Designated Doctors have been jointly agreed by the CCG, the Health Provider from which the doctor is employed and the local authority. It should be noted that the Named and Designated professional are distinct roles and as such should ideally be separate post holders to avoid potential conflict of interest. The designated role is intended to be a strategic one, separate from any responsibilities for individual children or young people who are looked (RCPCH December, 2020).

Derby City

10.3 The Designated Doctor currently has 4 hours (1 Programmed Activity - 1PA) per week to undertake the role within Derby City.

Within this, the following achievements have been achieved over the year 2020/21:

- Attendance/contribution at the bimonthly local Derby City CIC Commissioning Group meeting led by Local Authority Director of Early Help and Children's Social Care
- Advocate for Looked after Children and support to the Corporate Parent responsibilities
- Involvement in the Derby/Derbyshire Markers of Good Practice for Looked After Children health service
- Involvement in the preparation of the annual health report together with the Designated Nurse
- Interval professional supervision of Designated Nurse
- Interval snap-shot audits of health assessments
- In-house training and regular clinical supervision of medical staff to improve quality of assessments (1-1 and peer group supervision)
- Involvement in DATIX adverse events/ Inspection outcomes to improve local health provision
- Collaboration with Designated Nurse to successfully have evidence-based publications within the Adoption and Fostering journal and within the RCPCH annual conference (see further details in section 10.5 and 10.6)

- 10.4 As detailed in last year's annual report, the Designated Doctor and Nurse supported a Medical Student to undertake a 'deep dive' audit which explored the centile change of body mass index following admission into residential care. During 2020/21 this audit has been prepared for publication in the Adoption and Fostering journal and will be published during the Autumn of 2021.
- 10.5 The Designated Professionals completed a detailed and analytical review of the potential impact of Covid-19 pandemic on the entrants into care within Derby City. This reviewed the probable reasons for the exponential increase in number of children entering care, the changes seen in the reasons for entry into care and the differing demographics within quarter one in 2020/21 in comparison to the same quarter 2019/20. The review was published within the Adoption and Fostering journal in the Winter 2020.

Reference: Teh, C. & Peet, H. (2020) 'The impact of the Covid-19 pandemic on children who become looked after in Derby City', *Adoption and Fostering*, First published: December 2020.

- 10.6 A longitudinal study of the health outcomes for Looked after Children (in care for six years or more) was collated by the Designated Professionals and presented within the RCPCH annual conference in July 2020. The study clearly evidenced that the health outcomes for the cohort had significantly improved during their time in care but did highlight the need for on-going help and support for Looked after Children and those who have experienced care as they enter adulthood, especially for their emotional health and wellbeing. (see **Appendix 3** for the e-poster presentation)
- 10.7 A quality assurance audit for Initial Health assessments completed as a Medical Advisor peer group demonstrated that the quality of IHAs has been maintained in comparison to the previous years audit. This outcome highlights the success of the newer style documentation back in 2018 has been maintained, although the audit highlights areas that could improve further, in particular the voice of the child. Following this peer audit the Medical Team have spent some time reflecting and sharing practice to improve this aspect within 2021/22. The audit will be repeated with this next financial year and indeed on an annual basis. (see **Appendix 4** for further details of the audit)
- 10.8 Priorities for 2021/22 include:
- Supporting the Designated Nurse and the CICA develop a film to ensure children entering care understand what happens at an Initial and Review Health Assessment and as a means to reduce their anxiety or misunderstanding about the assessments
 - Provide guidance in the development of a publication or article about the CICA Nurse-led sexual health project planned within the forthcoming year

Derbyshire

- 10.9 The Children in Care Health Team's activity was particularly affected by the COVID-19 Pandemic last year and adaptation of the way of working was required in line with change of regulations. In the 1st lockdown the Initial Health Assessments were undertaken exclusively via telephone consultation and children were triaged for physical examination after relaxation of the regulations.

We have learnt a lot from the first lockdown and in order to avoid building up a big backlog of physical examinations we have offered face to face assessment for all IHAs from September

2020. Children and Young people have been triaged for virtual or face to face RHA. For the first RHA a clinic appointment or home visit has been arranged as feasible.

10.10 In the period of 1 April 2020 to 31 March 2021 the number of children in care increased from 861 to 897 (4.2% increase). The ongoing large variation of number of monthly admissions (19 – 54) and high number of External Authority children placed into Derbyshire requiring Initial Health Assessment, have had a significant impact on the Medical Team.

10.11 In view of timeliness, a steady improvement has been made over the year and 69.6% of children have had their Initial Health Assessment within the 20 working days timescale by 31st March 2021. Timeliness of IHAs on the work plan remains a top priority and the CIC Health Team continues working with Social Care collaboratively to improve the statutory IHA compliance. The Children in Care Health Team is dedicated to identify any gaps in health provision and make reasonable changes to meet children and young people's needs and improve their health outcome.

10.12 Audits – summary of outcome:

10.12 (I) IHA Quality assurance audit (Appendix 5)

The quality of IHAs undertaken between 1st April 2020 and 31st March 2021 improved compared to the previous year. This outcome is presumably the result of individual feedback to the Assessors on the quality of the IHAs and also due to implementation of the new, user friendly Derbyshire IHA form, which provides more structure and avoids unnecessary repetitions.

10.12.(II) BMI audit (Appendix 6)

Based on the relatively small audit sample this year we found that at admission, significantly less children presented with excess weight than in the general childhood population. However after at least 6 months in care the percentage of children with excess weight increased (higher than in the previous year) and in 2020/21 the percentage was close to the estimated percentage in the general childhood population. The findings were based on the small audit sample may not be representative of the whole children in care population, however the outcome suggests that regular food availability in care combined with lack of opportunity for physical activity (like during lockdown) can lead to excess weight.

10.12 (III) Unaccompanied Asylum Seeking Children (UASC) audit (Appendix 7)

The outcome of the audit clearly shows the benefit of screening UASC for commonly encountered health needs as soon as possible after arrival to the UK. Early identification of the health problem is equally beneficial to the individuals and to public health point of view.

Managing the screenings and IHA in one clinic appointment is convenient for the patient and professionals and cost effective as well. However, young people need more support to understand the importance of compliance with medical advice for their own health benefit and protection of others.

10.12.(IV) Patient feedback audit (Appendix 8)

Due to limited face to face contact with children and young people in the COVID-19 pandemic we have received much less feedback forms than in the previous years.

We hope that the positive feedback from 19 children and young people represents the opinion of the whole Children in Care population we serve.

Children and young people should be encouraged to complete the feedback form with comment and let us know if we need to change our practice to improve their health assessment experience.

The young people's positive feedback in relation to acceptance / preference of venue for the next health assessment, give us confidence to develop our service towards expanding the Clinic Based Model for Review Health Assessments.

We plan to continue with the Patient Feedback Audit in 2021-2022 and shape our service to become more suitable for children and young people's needs.

10.13 Looking ahead to the current year, the CCG have agreed a new contract with CRH for provision of health services to children in care which means that more of our children can be seen by our local service rather than out of area.

Priorities for 2021/22 include:

- Support the medical team with expansion of capacity and new ways of working
- timely completion of IHA within the 20 day statutory timeframe
- Monitoring the quality of the healthcare plans
- to explore what opportunities there may be to improve timeliness of access to health services for Children in Care

Section 11: Voice of the Child

11.1 The voice of the child/young person is embedded in all aspects of service development and delivery within the Health Providers and CCG. It is essential that children and young people are listened to and their views responded to in order to promote and respect the rights of children.

11.2 The voice of the child is obtained through a variety of mechanisms (dependent on their age, capacity, levels of understanding, analysis of non-verbal cues and body language):

- The child/young person is offered the opportunity where age appropriate to be seen alone during their health assessments
- At each appointment confidentiality is explained to the child or young person
- Identification in collaboration with the child/young person of their own strengths, wishes, feelings and their needs
- Use of the evaluation form after health assessments or any individual contact with a child or young person (variety of styles of the form is available)
- Clear documentation of the child's voice by using direct speech quotes or agreed summary of conversations, which is now embedded within the new Review Health assessment documentation
- Audits completed by the Designated Nurses focusing on the voice of the child

11.3 Unfortunately during the year 2020/21 there has been little opportunity for the Looked after Children Specialist Nurses, Named Nurses and Designated Nurses to attend the Children in Care Council due to the continued Covid-19 pandemic. Despite this, liaison has been maintained between the Children in Care Councils Leads, members and the health teams as required.

- 11.4 Within the Corporate Parent Committee the Health Provider and Designated Nurse (representing the CCG) are held to account and asked to respond to any presentations, concerns raised or submissions to the Committee. Within Derby City and Derbyshire County Council there is always child representation at the Corporate Parent Committee meetings and any responses are given in a child's language.
- 11.5 The Children in Care teams have gained feedback from children and young people about their experience of virtual assessments which were instigated as part of the continuation of services during the Covid-19 pandemic.
- 11.6 As part of the Derby and Derbyshire Children in Care Development Day there had been some focus on how to obtain the voice of the child despite the virtual delivery; this resulted on some improvements and alternative methods on capturing the voice within health assessments.

Section 12: Special Educational Needs / Disability

- 12.1 The Health Providers and Designated Nurse have worked exceptionally hard, in partnership with the Local Authority to improve the service provision for Looked after Children with additional needs and/or disability.

Derby City: Changes and achievements over the year 2020/21 are:

- 12.2 Audits are regularly completed by the Designated Nurse to ensure that copies of Education, Health Care Plans (EHCPs) for children living in and out of the city are available within the health record. Following the Ofsted led local area inspection focusing on SEN/D in June 2019 and Written Statement of Action, there has been further work on the compliance of the Initial Health Assessments which was highlighted as an area for improvement. Unfortunately there has been little progress with the alignment / flow of the child's Review Health Assessment, Looked after Child Review, Education reviews and the annual review of the child's EHCP due to the Covid-19 pandemic and reduced capacity with the Local Authority and partners.
- 12.3 Virtual School continue to send monthly reports to the Designated Nurse – indicating the support required for all school age looked after children. Any changes in between months have been noted and sent to the Named Nurse to amend the clinical child's health record accordingly.
- 12.4 Improved communication and clear pathways have continued between Special Educational Needs / Disability Clinical Lead and the Looked after Children health team. This ensures that the Looked after Children team are made aware of when there is a request for health information to contribute to the Education Health Care Plan and liaison between professionals as appropriate.
- 12.5 Work has continued on improving services across the local area following the SEN/D inspection and the Looked after Children service is firmly linked to this on-going work.

Derbyshire

- 12.6 The Children in Care Health Team work in collaboration with Social Care and Education to ensure that Children in Care have their needs appropriately identified and are given the support they require, their educational experience is a positive one and they achieve their full potential.
- 12.7 Since the Ofsted inspection on SEN/D process, the Children in Care Health Team's contribution to the assessment has been streamlined. The Children in Care Health Team has

been informed (via communication within CRHFT, not directly from Local Authority) about the Educational Local Authority's decision, when a child requires an assessment for EHCP. The School Doctors at CRHFT (who are also Children in Care Medical Advisers) provide the medical report for the assessment and later on for the annual reviews. The report includes up-to-date information from the holistic statutory Health Assessment and provides the relevant information for developing the EHCP, which then works in harmony with the child's care plan.

- 12.8 Notification regarding the outcome of the assessment will be received by the Children in Care Health Team and then the final EHCP report becomes accessible on the hospital's electronic record. Currently we are working on developing a process for uploading the EHCP reports onto SystmOne and flag children with SEN/D in order to give easier access to health professionals to the relevant information.

Section 13: Priorities for year 2021/22

13.1 Derby and Derbyshire

- Designated Professionals, Derby City/Derbyshire Health Teams to continue to work closely with DDCCG and Local Authorities to effectively work towards the Joined-up Care Derbyshire Approach and in readiness for the newly formed Integrated Care Systems/Partners in 2022
- Submission of the Markers of Good Practice Assurance Tool by all three Health Providers for the financial year 2021/22 to gain assurance of service quality, improvements made and explore innovations for the future
- Maintain the local area collaborative approach (Health Providers, Local Authorities, DDCCG and Designated Professionals) to maintain and improve the adherence to the statutory timescales and maintain health performance parameters
- Maintain the regional collaborative approach (regional CIC Designated Professionals and Named Professionals & NHSE/I East & West Midlands regional leads) to maintain and improve adherence to existing statutory guidance and CIC health pathways and to also help to identify and action (as required) emerging key themes and CIC lines of enquiry

13.2 Derby

- Designated Professionals to support and guide the Health Provider to deliver health promotion within the Local Authority Residential Children's Homes focusing on Healthy Eating initially and then subsequent health related topics (as identified by young people)
- Designated Professionals and the wider Health Team to continue the support and delivery of the Derby City foster carer learning and support sessions held bi-monthly
- To continue to develop and deliver quarterly action learning sets for all Children in Care Nurses/Doctors in collaboration with the Designated Nurse/Doctor for Looked after Children
- Designated Nurse to support the development of training resources for foster carers and residential children care workers to use when supporting children and young people with sexual health

13.3 Derbyshire

- Designated Professionals to continue to support CRHFT CIC Health Team with the roll out and delivery of the newly aligned CIC Service Specification delivery, which encompasses 20-mile cross border radius IHA/RHA delivery
- Designated Professionals to continue to support delivery of the Derbyshire CIC Collaborative Operational Meeting and maintain and action the associated workplan; which continues to identify key health themes for CIC and Care Leavers in Derbyshire

- Designated Nurse to continue to deliver 6/12 CIC Clinical Supervision & CIC Leadership to the whole CIC Nursing Team
- Designated Professionals to offer ongoing support and Leadership to the Band 7 Named Nurse for CIC, once recruited into post (as part of the newly aligned CIC Service Specification delivery)
- Designated Professionals to support and guide the Health Provider to deliver health promotion within the Local Authority Residential Children's Homes focusing on health-related topics (as identified by young people and themed audit outcomes)
- Designated Doctor and Nurse to consider, plan, develop and deliver action learning sets for all CIC Doctors and Nurses (as a CIC Whole Team Approach) to support/increase CIC knowledge, skills, and competencies within the wider CIC team; to ensure the best health outcomes possible for all CIC & Care Leavers

Section 14: References

Promoting the health and well-being of looked-after children, March 2015, Department of Health and Department of Education

Looked after children: Knowledge, skills and competencies of health care staff, Intercollegiate Role Framework, December 2020, Royal College of Paediatrics and Child Health

Stats: looked after children, Department for Education, 2020

[Children looked after in England including adoptions, Reporting Year 2020 – Explore education statistics – GOV.UK \(explore-education-statistics.service.gov.uk\)](https://www.gov.uk/explore-education-statistics)

Section 15: Appendices

Appendix 1 – Looked after Children cohorts explanation

BORN IN, LIVES IN – Looked after Children born in Derby City and reside within the City.

BORN IN, LIVES OUT (placed near home) – Looked after Children that were born in Derby City but reside within approximately 20 miles away from Derby City in another Local Authority area.

BORN IN, LIVES OUT (at a distance) – Looked after Children that were born in Derby City but reside in another Local Authority area over 20 miles away from Derby City.

BORN OUT, LIVES IN – Looked after Children that were born in another area outside of Derby City but reside in Derby City.

Appendix 2: Sample of a quality audit completed by the Designated Nurse

Audit template – Looked after Children

Dates of audit: October – December 2020	Date of completion: January 2021
Completed by: Heather Peet – Designated Nurse for LAC	
Title:	
Assessment and snap shot audit of the quality of the review health assessments for Looked after Children within the cohort 'born in, lives in' and 'born in, live out, close to home' and to assess/compare the quality of Review Health Assessments conducted via non face to face methods. NB: The Children in Care Health team have adapted significantly in order to continue the delivery of statutory health assessments during the Covid-19 pandemic; using non face to face methods where appropriate to maintain safety.	
Purpose:	
To ensure all Looked after Children's review health assessments are timely and high quality standard. This ensures that Looked after Children and Young People have their health needs met and being in care has no detrimental impact on their health outcomes.	
Method:	
<ul style="list-style-type: none">• SystemOne clinical records randomly selected for each Specialist Nurse – 12 records in total (3 RHAs per Specialist Nurse)• Once the clinical records are selected the health assessment documentation was graded using the standardised quality matrix (quality standards: unsatisfactory, satisfactory, good, outstanding)• Summary of any trends, omissions and good practice collated	
Findings:	

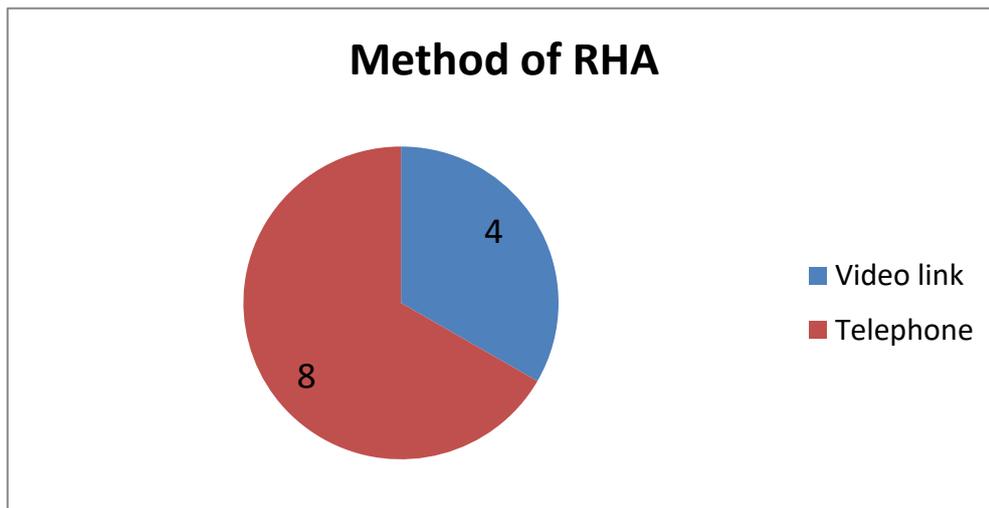
The detailed analysis is presented within a separate document due to the level of information gained.

- 0 review health assessments were found to be of a quality level of unsatisfactory
- 0 review health assessments were found to be of a quality level of satisfactory
- 3 review health assessments were found to be of a quality level of good
- 9 review health assessments were found to be of a quality level of **outstanding**

Timeliness:

100% of the review health assessments were within the statutory timescales.

All the Review Health assessments within the audit were completed non face to face:



Omissions within the documentation which resulted in a 'GOOD' standard:

- Actions for child development – left blank
- Poor capture of the voice of the child eg: 'preverbal child' with no further comment made
- Section on Culture, faith and diversity – left blank or 'none'
- Health care plan actions without a specified time for completion
- Impact of family contact for the child – left blank

The following elements have been noted but have not impacted on the overall quality standard of the assessment.

Key missing elements or not documented within the review health assessments:

- BMI category – left blank on some records reviewed (where growth measurements obtained)
- Last Health Assessment measurements not included / compared
- Inconsistency in the spelling of the child's first name throughout the documentation

The quality of review health assessments has been maintained at a good or outstanding quality since the roll-out of the newly developed documentation in 2019. It is clearly evident that Review Health assessments undertaken through a virtual method demonstrate some difficulties in capturing the voice of the child and interactions between carer and child.

Action taken / or to be taken:

- Named Nurse for CICA – DHcFT to receive the analysis and outcome of the audit
- Named Nurse for CICA – DHcFt to share the audit findings and any improvements that can be made with the team
- Designated Nurse to undertake a re-audit in the Summer time 2021 to ensure the quality has been maintained and with a vision to gain an 'outstanding' standard for all (even if the virtual method continues for some children).

Feedback to Provider:
Designated Nurse and Named Nurse to meet to discuss the audit, any suggested improvements and plans to re-audit in the future. Suggested actions: <ul style="list-style-type: none"> • Named Nurse to hold a meeting with Derby/Derbyshire Specialist Nurses to discuss the documentation, findings of the audit and any improvements on how to capture the voice of the child • CiCA nurses to consider completion of the peer record keeping audits as part of their clinical supervision sessions. The findings to be given to Named Nurse on a regular basis, summarised, in order to monitor the quality of health assessments on an on-going basis • Named Nurse to encourage the CiCA nurse (via management supervision) to reflect on their own practice, documentation, learn and share best practice with other team members.
Feedback to Local Authority:
A summary of this audit will be referenced within the annual report 2020/21 to indicate the impact of Covid-19 pandemic and the complexities of undertaking virtual Review Health Assessments. No detailed analysis of the audit is to be presented to the Local Authority.
Summary:
This audit identified that the quality of the review health assessments undertaken by the Specialist Nurses within Derbyshire Healthcare NHS Foundation Trust is at 75% of 'outstanding' quality and 25% of 'good' quality. There some minor improvements that can be made for some Review Health Assessments however it was evident that more consideration is required to support the Specialist Nurses on how to capture the voice of the child (when the assessment is conducted virtually). It would be appropriate to complete some peer record keeping audits in the near future so the Specialist Nurses can learn from each other on alternative methods of capturing the voice and will hopefully highlight quality as a team. This audit is not a reflection on the consistent, sustained hard work and flexibility that the Specialist Nurses have portrayed during the Covid-19 pandemic (and continue to); however it demonstrates the need to be more creative techniques on capturing the voice of the child when a face to face assessment is not possible.
Future plans:
<ul style="list-style-type: none"> • Designated Nurse to re-audit in Summer time 2021, with the same methodology to review the quality and timeliness of review health assessments.

Audit template – Looked after Children

Dates of audit: September 2019 – March 2020	Date of completion: April 2020
Completed by: Heather Peet – Designated Nurse for LAC	
Title:	
Assessment and snap shot audit of the quality of the review health assessments for Looked after Children undertaken by the Chesterfield Royal Hospital NHS Foundation Trust Specialist Nurse team	
Purpose:	

<p>To ensure all Looked after Children’s review health assessments are timely and high quality standard. This ensures that Looked after Children and Young People have their health needs met and being in care has no detrimental impact on their health outcomes.</p>
<p>Method:</p>
<ul style="list-style-type: none"> • SystemOne clinical records randomly selected for each Specialist Nurse – 24 records in total (4 RHAs per nurse) • Once the clinical records are selected the health assessment documentation was graded using the standardised quality matrix (quality standards: unsatisfactory, satisfactory, good, outstanding)
<p>Findings:</p>
<p>The detailed analysis is presented within a separate document due to the level of information gained.</p> <ul style="list-style-type: none"> • 0 review health assessments were found to be of a quality level of unsatisfactory • 0 review health assessments were found to be of a quality level of satisfactory • 19 review health assessments were found to be of a quality level of good • 5 review health assessments were found to be of a quality level of outstanding <p>Timeliness:</p> <p>83% of the review health assessments were within the statutory timescales; however there was a clear reason for the lateness within the clinical record. Reasons: previous was not brought, non-engagement of young people and appointment being rebooked.</p> <p>There was clear evidence within the audit that the nurse team try their utmost to engage young people even after initial non-engagement on the young person’s part and will often eventually successfully engage those harder to reach.</p> <p>Key missing elements or not documented within the review health assessments:</p> <p>Please note: this is a summary of all of the documents reviewed and not an indication of the actual face to face consultation quality. The missing detail may have only seen once within the audit.</p> <ul style="list-style-type: none"> • Sections within the RHA documentation left blank (eg: GP/OOH/A&E attendance, other professionals involved, section on culture/faith/diversity, BMI category) • Good analysis of the impact of any contact with birth family • Lack of analysis with SDQ scores (when available) • Lack of discussions documented about culture, faith and diversity • Lack of discussions documented about sexual health • Lack of consideration regarding young people reaching 16yrs (and above) and introductions about the concept of Health Histories and health independence • Lack of discussions regarding education • Actions within the Health Care Plan not ‘SMART’ <p>The quality of review health assessments should be at least of a ‘good’ standard as a minimum, which all of the health assessments were of this standard or above. The service should have a vision for ‘outstanding’ quality for all review health assessments that are undertaken by the Specialist Nurses at Chesterfield Royal Hospital NHS Foundation Trust.</p>
<p>Action taken:</p>
<ul style="list-style-type: none"> • The findings of the audit to be discussed with Jayne Duly (Service Improvement Lead – CRH) and Alison Robinson (Designated Nurse for LAC, aligned to Derbyshire) to ascertain how best to support the nurse team in further improving the standard in order to reach ‘outstanding’ quality consistently.

<ul style="list-style-type: none"> • Designated Nurses are available and willing to support a quality workshop for the Specialist Nurses. This workshop to concentrate on the themes and trends from the audit findings and shared anonymously to the team • Designated Nurses are happy to offer individual feedback for staff members if they so wish (either via Designated Nurse, Jayne Duly or via email)
<p>Feedback to Provider:</p>
<p>Designated Nurse and Service Improvement Lead to meet to discuss the audit, quality workshop and how to maintain quality in the future.</p> <p>Actions suggested:</p> <ul style="list-style-type: none"> • Email the audit result to all the Specialist Nurses • Audit individual feedback is available if requested (which ever mechanism suits the individual) • Specialist Nurses to engage in some quality improvement workshop (or alternative) • Specialist Nurses to consider completion of peer record keeping audits as part of their clinical supervision sessions. The findings to be given to Service Improvement Lead on a regular basis, summarised, in order to monitor the quality of health assessments on an on-going basis • Designated Nurse to undertake a re-audit in Quarter 4 (2020/21) to ensure the quality has improved and maintained • Service Improvement Lead to encourage the Specialist Nurses (via management supervision) to reflect on their own practice, documentation, learn and share best practice with other team members.
<p>Feedback to Local Authority:</p>
<p>Designated Nurse to inform the Local Authority that the Specialist Nurses and Service Improvement Lead are aiming to improve quality of review health assessments over the year 2020/21.</p> <p>A summary of this audit will be referenced within the annual report 2019/20 and included within the improvements identified for the financial year 2020/21.</p> <p>No detailed analysis of the audit are to be presented to the Local Authority.</p>
<p>Summary:</p>
<p>This audit identified that the quality of the review health assessments undertaken by the Specialist Nurses within Chesterfield Royal Hospital NHS Foundation Trust is at 100% of 'good' or 'outstanding' quality, yet it is fair to indicate further improvements can be made. The improvement actions indicated above will be considered but some of the plans may have to be put on hold due to the current climate in relation to Covid-19.</p> <p>It has to be acknowledged that the quality of health assessments can have a significant impact on meeting the child's health needs, Local Authority partners understanding the complexities of health and for young people to learn health promotion and self-management of their own health and well-being as they approach adulthood. The Designated Nurses continue to support for Health Providers to strive for excellence and are keen to work in partnership to address and improve the quality of review health assessments.</p>
<p>Future plans:</p>
<ul style="list-style-type: none"> • Designated Nurse to re-audit in Quarter 4 (2020/21), with the same methodology to review the quality of review health assessments and any of the training/support provided for the nurses has resulted in a change of practice

Appendix 3: e-poster of the longitudinal study of the health outcomes for Looked after Children (presented at the RCPCH annual conference)



Longi eposter.pptx

Appendix 4: Peer quality audit findings – Initial Health Assessments

IHA QUALITY AUDIT 2020/21

Introduction

In line with national and local statistics, the numbers of children and young people entering Looked After Children (LAC) care status in Derby City has continued to rise significantly year on year. The service was set up in 2002 for approximately 350 locally originating LAC. By 2010, this number was around 420. This continued to rise to 450 by 2015 with a local “promise” of a top cap number of 470. However, by mid-2018, this number had risen to 500. Currently, as at end February 2020, the number is 574.

In accordance to the current Statutory Guidance for Looked After Children 2015, all children entering “looked after children” legal status requires an Initial Health Assessment (IHA) with a registered medical practitioner within 20 working days.

Locally, in 2018, in discussion with Children’s service management and additional recruitment and redesigning community paediatrics medical configuration , a plan was put in place to increase medical capacity to meet this demand since September 2018. Currently, we run approximately 25 IHA clinic slots per month.

We continue to have ongoing supernumerary clinics that paediatric trainees support (0-4 extra slots /month) depending on the number of trainees who join the team every 6 months

Over the past 5 years , there has also been an ongoing increased demand for large sibling groups (of x3 or more children) which continues to have a considerable knock –on effect on the timeliness of IHAs for children who had to wait longer as the service tried to accommodate all the sibling groups.

Since August 2018, the new local IHA document has been implemented to ease overall documentation of important aspects such as consent clearly recorded, ensuring the “ voice of the child” is featured and recorded effectively , prevention/ screening , diagnostics and clear Health Care Plans (HCP) are all documented better. In tandem with this a new single one page “consent” form was proposed for Social workers to provide all necessary consent more efficiently and in a timely fashion. This consent form has now been in use since January 2019.

2020, due to the unprecedented Covid-19 global pandemic which is ongoing, has been a stand out year for a different delivery of statutory IHAs but it remains important that IHAs remain of good quality and continues to reflect all the above parameters. The IHAs from end March 2020- August 2020 had to be conducted via telephone due to the national lockdown. With Covid- secure premises more readily available from end August 2020 ,50% of our clinicians opted to re-start face to face IHA assessments.

In 2020, another audit of a random sample of twelve IHAs with the above design IHA document which has been in use since August 2018 (x10 from September 2019) has been conducted to look at various outcomes as follows:

- 1) The basic demographics of the population (age, sex, ethnicity and UASC status) and the legal status upon entering care.
- 2) The timeliness of the IHA appointment from the date of the child entering LAC status as per the current Statutory Guidance of within 20 working days (ie 4 weeks)including timeliness of receipt of “new” design consent document from Social Services. (this audit has been done on a monthly basis by the Designated Nurse, Heather Peet and not repeated here for 2020. (see separate summary from H Peet)
- 3) Completion of the in house electronic LAC audit template by all clinicians conducting the IHA which impacts on accurate reporting output.
- 4) Capturing consent clearly within the IHA document.
- 5) Capturing the “voice of the child” appropriately and ensuring “voices” of the child and carer are clearly heard - evidence of satisfactory / good recording under the EMOTIONAL ASSESSMENT section of the IHA document by the clinicians
- 6) Completion of the IHA documentation and HCP ready to be sent back to Social Workers on time within 5 working days (H Peet, Designate Nurse has also been doing a monthly report on this)

Appendix 5: Quality Assurance Audit of Initial Health Assessments

Derbyshire Children in Care

1st April 2020 - 31st March 2021

The Children in Care Health team strives to ensure that Health Assessments are consistent to high standards for every child / young person in care placed within or outside Derbyshire. An audit has been undertaken to evidence the quality of the Initial Health Assessments undertaken by the Derbyshire Children in Care Medical Team and identify areas that need improvement.

The Health Assessment for Looked After Children checklist tool (Pay by Result) has been used with some additional criteria relevant to our practice.

32 Initial Health Assessments were randomly selected and included in the audit sample, completed by 4 Medical Advisers between 1st April 2020 and 31st March 2021.

Additional Criteria / Findings	
Number of IHA's audited	32
Source of written information listed / completed forms	32
Source of verbal information recorded	32
Mother & Baby Form was available at IHA (under 6's)	4 (16)
Implication of the family health history fully recorded	32

Height and Weight centile recorded	32
BMI calculated / recorded (over 2's)	27 (29)
Risk of BBI considered and documented / number of forms	32
Due date of Review Health Assessment recorded	32
List of immunisations received - recorded from 2 months old	30 (30)
Emotional state assessed/recorded (Adolescent wellbeing Q completed from 11y)	32 (32)

Analysis:

- Availability of documents as source of information (such as Derbyshire A form, M&B form, PH form, SystemOne record etc) and consent availability - recorded in all forms.
- The list of attendees - recorded in all forms.
- The M&B forms were available at the time of IHA only in 4 cases (out of 16 under 6s) therefore an update of these reports required after receipt of the forms
- Possible implications of the family health history/lifestyle - recorded on all forms
- BMI was calculated and the identified issue addressed in the Health Plan in 27 cases out of 29 over 2 years.
- Risk of Blood Borne Infection was considered / recorded on all forms
- The identified health issues have been addressed in the Health Plan in all audited cases and communication with GP, specialist clinics has been evidenced
- All forms have been typed - which is in line with National Standard for Health Assessments (forms typed by the Medical Advisers)
- All forms were signed and appropriately dated
- All audited IHAs were found compliant with IHA standards /Pay by Result criteria

Action:

A pathway for completion of the M&B forms should be developed in order to ensure the availability of the forms for Initial Health Assessment.

Health professionals with responsibility of completion of the forms have now been identified in birth hospitals of the region. The list of Health Professionals available for SC Business Services, making it possible to send the forms for completion directly to the right person and then receive them without delay.

Overall evaluation

The quality of IHAs undertaken between 1st April 2020 and 31st March 2021 has improved compared to the previous year. This outcome is presumably the result of individual feedback to the Assessors on the quality of the IHAs and also due to implementation of the new, user

friendly Derbyshire IHA form, which provides more structure and avoids unnecessary repetitions.

Plan

- We will continue with the IHA Audit in 2021-22.
- Ongoing feedback to the Assessors individually.
- Initial Health Assessment standards and additional audit criteria will be part of the Induction program for Trainees in Community Paediatrics.

*Dr Agnes Lakner
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Children in Care Health Team
Derbyshire
21.08.2021*

Appendix 6: BMI Audit - Derbyshire Children in Care

2020 - 2021

INTRODUCTION

Unhealthy weight and lifestyles are significant issues for children and young people in care, whether living at home with parents under the supervision of social services, with foster carers or in residential homes, as there is a close relationship between food, nutrition and family connectedness.

The fundamental cause of obesity and unhealthy weight is an energy imbalance between calories consumed and calories expended. Children who are taken into Care often have a history of abuse and neglect which could lead to unhealthy BMI (underweight, overweight, obese).

The aim of the audit is to find out whether children remaining in care are protected from the national problem of increasing weight gain and obesity.

BMI

- Body mass index (BMI) is a measurement of weight adjusted for height and varies with body proportions, age and body status.
- It is calculated by the equation:
$$\frac{\text{weight (kg)}}{\text{length /height (m}^2\text{)}}$$
- In the UK **Overweight** is defined as a **BMI between the 91st and 98th centile**.
- **Obesity** is defined as a **BMI above the 98th centile**.
- **Healthy BMI** defined as a **BMI between the 9th and 91st centile**

METHOD

- To identify the percentage of children under or overweight /obese - .
- To see whether the BMI improved after a period of time in care.

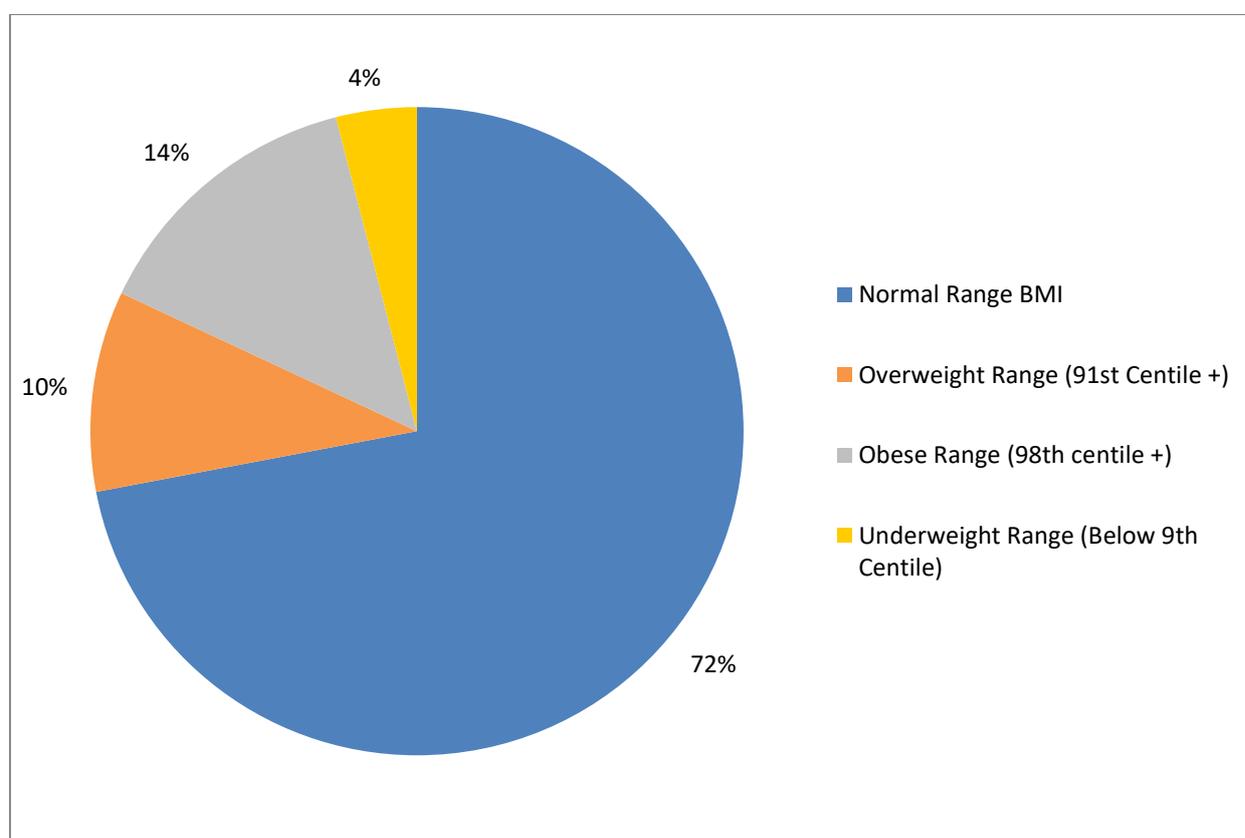
AUDIT SAMPLE

- We included the BMI of the Derbyshire Children in Care (**2-18years**) admitted between **1st April 2020 and 31st March 2021**.
- BMI data collection from the Initial Health Assessments and Review Health Assessments - using clinical percentiles.
- The audit sample is smaller than in the previous year as some children had virtual Initial Health Assessment and most of the Review Health Assessments were undertaken virtually due to the COVID -19 Pandemic.

BMI DATA from INITIAL HEALTH ASSESSMENTS

The Graph below shows the number of Derbyshire Children in Care whose BMI recordings were taken at the time of their Initial Health Assessment and met the inclusion criteria of the audit.

Total number of children in the Audit: 145



FINDINGS

- Number of children with BMI in normal range: 103 (72 %)
- Number of overweight children with BMI above 91st centile: 15 (10 %)
- Number of obese children with BMI above 98th centile: 21 (14 %)
- Number of underweight children: 6 (4 %)

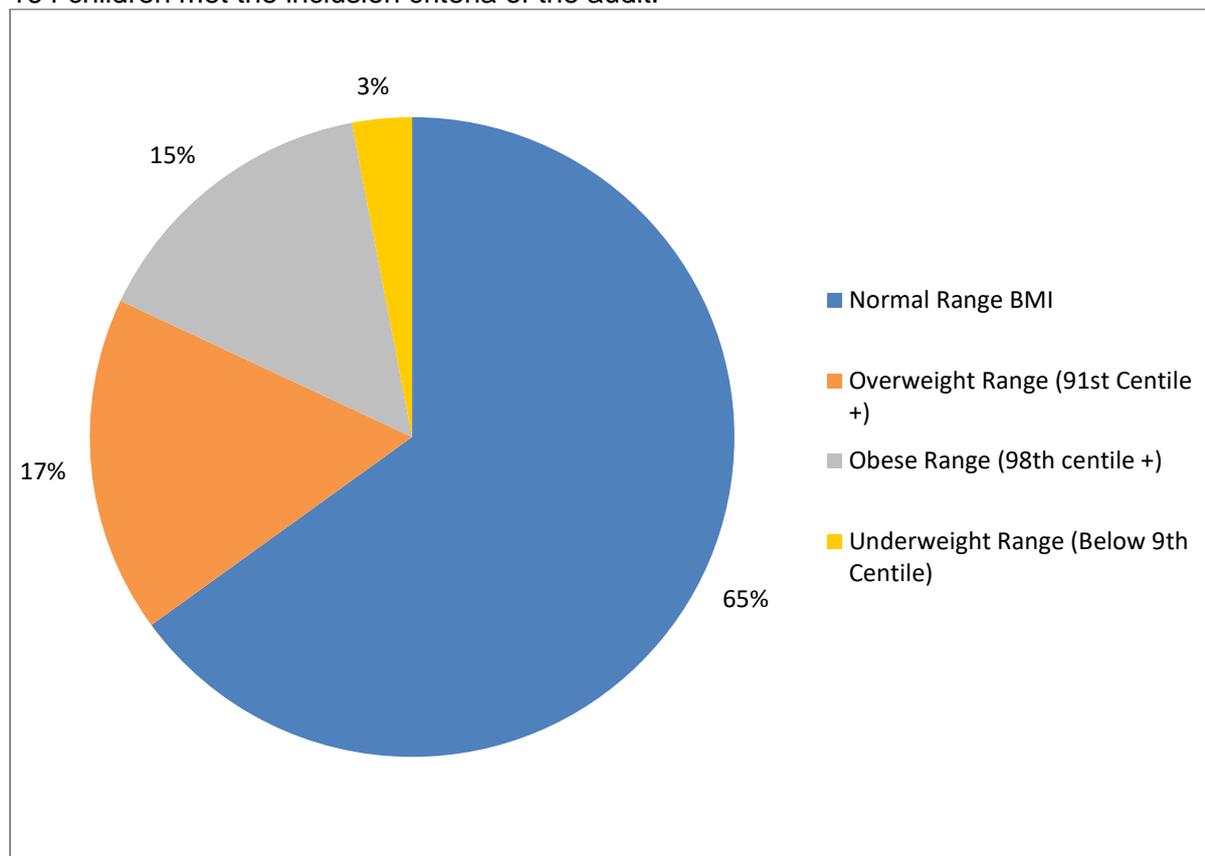
In 2020/21 at the Initial Health Assessment 3% more children had normal BMI than in 2019/20. The percentage of children with excess weight at admission to care has decreased slightly from 2019/20 (25%) to 24%. The percentage of underweight children has decreased as well from 6% to 4% in 2020/21.

Based on our data it is more likely that children coming from deprived areas present with excess weight at admission to care than with lower than normal weight. However the percentage of children with excess weight at admission to care (24%) is far below the percentage of children with excess weight in the general population (33%).

BMI DATA from REVIEW HEALTH ASSESSMENTS

The Graph below shows the number of Derbyshire children who continued to be in care and their BMI recordings taken at the time of their Review Health Assessment.

164 children met the inclusion criteria of the audit.



FINDINGS

- Number of children with BMI in normal range: 107 (65%)
- Number of overweight children with BMI above 91st centile: 28 (17%)
- Number of obese children with BMI above 98th centile: 24 (15%)
- Number of underweight children: 5 (3%)

ANALYSIS

At the Review Health assessment slightly less children had normal BMI (65%) than in the previous year (67%). The percentage of children presented with excess weight has increased (32%) compared with outcome at the Review Health Assessment in 2019/20 (29%). This is due to increase of percentage of obese children (from 12% to 15%). The percentage of overweight children remained the same (17%).

At admission 24 % of children had excess weight which increased to 32% after at least 6 months in care.

The percentage of underweight children has decreased (from 4% to 3%).

REFLECTION

There is no national BMI data available for the age range of 2-18 years, therefore no comparison can be made with our data above. However it is believed that one third of the general childhood population is overweight or obese.

Based on the relatively small audit sample we found, that at admission significantly less children presented with excess weight than in the general childhood population. However after at least 6 months in care the percentage of children with excess weight increased (higher than in the previous year) and in 2020/21 the percentage was close to the estimated percentage in the general childhood population.

The findings based on the small audit sample may not be representative of the whole children in care population, however the outcome suggests that regular food availability in care combined with lack of opportunity for physical activity (like during lockdown) can lead to excess weight.

RECOMMENDATIONS

- More work needs to be done to help children in care to tackle obesity and achieve their healthy weight.
 - Advice should be given to carers and children on healthy diet, regular meal times, age appropriate meal portions and regular exercise
- Encourage children to go to the gym (free pass is available for all CiC in Derbyshire).
- Review BMI in 6 month time when identified a child as obese/underweight.
- Monitor BMIs during the child's journey in care.
- Record of BMI on SystmOne at all Statutory Health Assessments could help to get a clearer picture of the impact of foster care on the BMI.

***Note** – The difference between our and DCC percentages could be explained by the difference in BMI recording and also by the fact that DCC percentages are based on total number of RHAs conducted and not on the number of children having BMI calculated.*

*Dr Agnes Lakner
Medical Adviser for Adoption and Fostering
Children in Care Health Team
Derbyshire
19 August*

Appendix 7: UNACCOMPANIED ASYLUM SEEKING CHILDREN (UASC)

INVESTIGATIONS / FINDINGS 2020 - 21

A Complex Clinic has been set up for UASC at Chesterfield Royal Hospital and within one clinic appointment the Initial Health Assessment, TB check (assessed by a TB nurse) and blood tests for Quantiferon TB Gold, Blood Borne Infection screen, anaemia screen have been

undertaken, in order to rule out the presence of the diseases known to be commonly seen among them.

7 UASC were seen for Initial Health Assessment at the Complex Clinic at **Chesterfield Royal Hospital between 1st April 2020 and 31st March 2021.**

County of origin: Afganistan (2), Sudan (2), Iran (3)

Gender: Male: 7 Female: 0

Tuberculosis Infection Screen:

7 YP - TB check was undertaken by TB nurse at IHA

7 YP - had Chest X-ray

7 YP - had Quantiferon TB test

Results: 2 YP had positive Quantiferon test result and were identified with **latent TB**. They have been referred to the Respiratory Team / CRH for further investigations and management.

Blood Borne Infection (BBI) testing (testing for Hepatitis B, Hepatitis C, HIV, Syphilis):

1YP - had anti HB core antigen positive result – suggesting past but not active hepatitis B infection. He is also under TB related investigation.

6YP - had normal result

Other blood tests (full blood count, film, ferritin, vitamin D, B12, folate, liver function, kidney function)

2 YP - were found to have iron deficiency – required iron supplement

2 YP - were found to have **Vitamin D deficiency** – were started on high dose of Vitamin D treatment and then long term maintenance dose required

1 YP - was found to have insufficient Vitamin D level and advised to take maintenance dose of Vitamin D long term

Referral for further investigations/treatment:

2 YP - with latent TB have been referred to the Respiratory Team for further Investigations / treatment

2 YP - complaint about recurrent abdominal pain - were referred to the GP for further monitoring / investigations.

1YP - had a small sinus in midline of spine and after an US scan

he was referred to Paediatric surgeon and subsequently for a CT scan before surgical intervention

1 YP – referred to ENT with blocked broken (?) nose.

Due to previous exposure to traumatic experiences all YP would benefit from some level of psychological support and their Social Workers have been asked to arrange this for them.

Immunisation status:

2 YP from Afganistan (high prevalence of TB) required BCG vaccination – received from the TB nurse.

All 7 YP were found at IHA as unimmunised for common childhood infections, requiring a full course of immunisations via their GP, in line with Public Health England recommendation.

During the review of the cases at the time of this audit - based on SystmOne record it was found that out of 7 YP only 1 YP completed the course of recommended immunisations and one received the first set of immunisation.

Summary:

The above outcome clearly shows the benefit of screening UASC for commonly encountered health needs as soon as possible after arrival to the UK. Early identification of the health problem is equally beneficial to the individuals and to public health point of view.

Managing the screenings and IHA in one clinic appointment is convenient for the patient and professionals and cost effective as well. However YP need more support to understand the importance of compliance with medical advice for their own health benefit and protection of others.

*Dr Agnes Lakner
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Children in Care
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18th August 2021*

Appendix 8: Patient Feedback Audit about their Health Assessment Experience

Derbyshire Children in Care (2020 – 2021)

Reason for choice of audit:

The Children in Care Health Team are trying to find out if we need to make any changes with our services to help our Children in Care to receive a positive health assessment experience.

Audit tool:

Children in Care feedback questionnaire 5-10 years

Children in Care feedback questionnaire 11-18 years - designed by the Children in Care Team.

Audit sample:

19 forms were completed following Initial and Review Health Assessment between 1st April 2020 and 31st March 2021 (during the COVID-19 Pandemic).

8 forms were completed by Children between 5-10 years

11 forms were completed by Young People between 11-18 years of age

Audit findings:**5 – 10 year olds**

- 8 children completed the questionnaire and all of them found that the health assessment was a positive experience for them.
- 7 children ticked the 'very happy face' on the chart and 1 the 'happy face'
- 1 child was not happy to come to the hospital and wait for the assessment, but ticked the 'very happy face' on the chart
- All children had a chance to ask and received answer
- Children commented: liked being measured, drawing, 'she is very nice' (assessor).
- 2 children were seen by a doctor in the hospital and 6 by a nurse at home (4) or in clinic (2).

11 – 18 year olds

- 11 Young People completed the feedback questionnaire – male: 3, female: 8
- All YP said that they were treated with respect
- All YP said that confidentiality was explained
- All YP said they were given the chance to speak privately.
- All YP found that the health assessment was a good experience
- 1 YP was assessed in clinic, 8 at home (2 did not answer).
- 6 YP said that they would like to be assessed at home in the future. (All of them had their assessment undertaken at home to date). 3 YP would like to be assessed in clinic. (2 YP did not answer).
- Only 1 female has made a comment : 'It was very open and I could speak willingly'

Reflection

Due to limited face to face contact with children and young people in the COVID-19 pandemic we have received much less feedback forms than in the previous years.

We hope that the positive feedback from 19 children and young people represents the opinion of the whole Children in Care population we serve.

Children and young people should be encouraged to complete the feedback form with comment and let us know if we need to change our practice to improve their health assessment experience.

The young people's positive feedback in relation to acceptance / preference of venue for the next health assessment, give us confidence to develop our service towards expanding the Clinic Based Model for Review Health Assessments.

We plan to continue with the Patient Feedback Audit in 2021-2022 and to shape our service to become more suitable for children and young people's needs.

*Dr Agnes Lakner
Medical Adviser for Adoption and Fostering
Children in Care Health Team
Derbyshire
18th August 2021*

Named GPs for Safeguarding Children Annual Report

April 2020-March 2021

Authors:

Dr Ruth Bentley

Dr Jermey Gibson

Dr Sandra Ives

Named GP Annual Report 1st April 2020 to 31st March 2021

Named GP team structure

During 2020-21 the Named GP Team experienced some staff changes in that Dr Woodcock retired in May 2020 leaving a vacancy of three sessions. This post has been filled in March 2021 so at the end of this reporting year all Named GP for Safeguarding Children sessions were filled.

Sessions allocated

- Dr Ruth Bentley two days a week (4 sessions or 16 hours).
- Dr Jeremy Gibson one day a week (2 sessions or 8 hours)
- Dr Sandra Ives 1.5 days a week (3 sessions or 12 hours)

The Named GPs are supported by the Designated Doctors for Safeguarding Children. Dr Sebastian Yuen took up the post of Designated Doctor for Safeguarding Children in the County in early 2020. The Designated Doctor for Safeguarding Children in the City post was filled temporarily by Dr Patricia Field on one day a week following the resignation of the previous Designated Doctor. Day to day advice and support is also available from the Assistant Director for Safeguarding Children/ Lead Designated Nurse for Safeguarding Children – Michelina Racioppi.

Challenges for 2020-21:

The main challenge for 2020-21 has been the global Coronavirus Pandemic. The country was put in the first lockdown in March 2020, and this continued through much of the period covered by this annual report. Due to the restrictions on working, the team had to adapt quickly to new ways of working.

Initially meetings and training were suspended until virtual options were made available. The options that were made available was the use of MS Teams which was deemed as the most appropriate and safe/ secure way of delivering training to the workforce.

Positives for 2020-21:

The use of technology for virtual meetings has hugely reduced the traveling time and carbon footprint of the team. The technology is becoming easier to use with practice and in the longer term, continued use of virtual meetings will free up time for the Named GPs and make it easier for Safeguarding Children leads and other GPs to attend meetings and training. The team have also noticed that the attendance rate at safeguarding training has increased since introducing this style of training and the team have received positive feedback/ evaluations.

Overview of 2020-21 following the previous annual report priorities:

To hold quarterly GP Safeguarding Leads meetings. Due to Covid 19 measures these will be held virtually via Microsoft Teams.

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The safeguarding leads meetings were restarted after the initial pause at the start of lockdown. A rolling three-month programme covering all the areas was established. All the PCN's were split into one of three groups:

1 – High Peak and Derbyshire Dales

2 – Chesterfield and Dronfield, North and South Hardwick and Bolsover and North East Derbyshire

3 – Belper, Erewash and Heanor, Alfreton and Ripley.

The first run of meetings in June, July and August were a general catch up and test of using MS teams for the group. General discussions around Initial Child Protection Conference (ICPC) reports, safeguarding meetings in practice and the new Safeguarding template for S1 were held and relevant issues fed back to other agencies via Dr Bentley.

The second round of meetings in September, October and November was joined by Karen Barden (since retired) from Derbyshire Children Social Care to discuss ICPC reports and meetings. Feedback was given regarding the outcome of the yearlong ICPC audit undertaken by Dr Bentley.

The third round of meetings in December, January and February was joined by Ann Coverley, Service Manager from Derbyshire Starting Point to discuss the role of Starting Point and the referral processes.

In March 2021 the fourth round of meetings was held and we were joined by Derbyshire Local Authority Debbie Peacock (now retired) and Chris Caley to discuss Early Help and the role of schools in Early help process.

Verbal feedback from the meeting suggested that participants found the meetings very helpful, both from the Safeguarding Children Leads and from the speakers who were able to attend the sessions.

Derby City and Swadlincote usually have quarterly GP Safeguarding Leads meetings. These were paused at the beginning of the pandemic but have now resumed virtually.

On 9th September 2020, we had three presentations on:

- Update on safeguarding template by Ross Naylor, SystemOne Trainer
- Domestic Abuse during COVID-19 by Dr Jeremy Gibson, Named GP for Safeguarding Children
- Contextual safeguarding by Dr Jeremy Gibson, Named GP for Safeguarding Children

On 20th November 2020, we had had presentations on:

- Safeguarding template - update
- Looked After Children by Dr Jeremy Gibson, Named GP for Safeguarding Children.

On the 12th of May 2021, we had three presentations on:

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- Child & Adolescent Mental Health Services (CAMHS) Rise Service by Dr Deepa Joseph, consultant child and adolescent psychiatrist
- 'Keeping Baby Safe' by Juanita Murray, Designated Nurse for Safeguarding Children
- Obesity strategy for Children and Young People by Kerry Hodges and Richard Martin, Public Health Managers

Meetings

- ✚ *To continue to hold meetings virtually and continue to ask external speakers to join us on specific topics.*
- ✚ *To arrange an annual meeting to discuss processes between the leads and share good practice.*

To provide quarterly Named GP newsletter updates.

These have been provided quarterly via email. Topics covered and documents shared include and range of documents and advice. *(full list in appendix 1)*

- ✚ *To continue to provide quarterly newsletters with relevant information to General Practice.*

To continue to provide Level 3 Safeguarding Children training to professionals outlined in the Intercollegiate Document 2019 as requiring Level 3 training. Due to Covid 19 measures, we have developed and have started to deliver online learning modules using Microsoft Teams. This may allow future training to be delivered in a more flexible and accessible way.

After an initial pause at the start of lockdown, training was delivered throughout 2020-21 virtually via MTeams. Zoom was used if needed by other agencies such as the GP training scheme. The training was redesigned to accommodate a virtual approach. 10 dates were held from July to March 2020, as well as three additional sessions for the GP registrars at the request of the local training schemes. One session was delivered for the Derbyshire Educational Network at the request of the LMC.

The total number attending training was harder to capture exactly from attendance lists of MTeams, but the total number trained was more than 700 participants. This is an increase from the previous year of some 300+ (previous year saw 374 people attending). This includes GP registrar training.

Over 95% of attendees rated us in their evaluation feedback 4 or 5 out of 5 for content and delivery.

65% of those giving feedback identified their job role as a GP.

17% were practice nurses and 2.5% were Advance Nurse Practitioners.

- ✚ *To continue to expand the training offer taking advantage of the online delivery to expand the portfolio.*
- ✚ *To update the Level 1 and Level 2 training for use in practice as part of ongoing rolling programme of updates to training.*

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To contribute to Rapid Reviews and Child Safeguarding Practice Reviews.

The team have contributed to rapid reviews as they have come up by completing a rapid review and then attending practitioner and manager events as appropriate. Dr Bentley has contributed to three CSPR's and one DHR and one rapid review that did not proceed to CSPR. Dr Gibson has contributed to three rapid reviews.

- ✚ *To continue to respond to rapid review requests and involvement with Child Practice Reviews' and Domestic Homicide Review's as required.*

To improve the quantity and quality of GP Initial Child Protection Conferences (ICPCs) reports.

Audit work has been ongoing for the ICPC reports. Dr Bentley's yearlong audit of ICPC reports returned in the County ended in March 2020 and was covered in last year's annual report.

In December 2020 Dr Bentley undertook a quality audit of the reports being submitted looking at 10 consecutive reports. The results show that the template was only used in 4 of 10 reports. Areas consistently completed included immunisations and when the child was last seen as well as which family members were registered. Areas poorly completed included the voice of the child and information around learning disabilities in adults or children. (full results in appendix 2). Jeremy Gibson also has completed ICPC quality audit for Derby City (appendix 3).

- ✚ To undertake further short audits planned to review the numbers of reports produced and the quality of reports for ICPC from GPs through 2021-22.
- ✚ To offer further training/ guidance for GPs in report writing for ICPC.
- ✚ To continue with ongoing liaison with Children Social Care and GPs around improvements to process.

To develop, in partnership with the SystemOne Trainers, an electronic safeguarding template to standardise the way GPs record and code safeguarding information on electronic records.

The Safeguarding Template for Systemone is now embedded with in the Pathfinder main page. Pathfinder is an overarching template which in time will incorporate all that is required by way of referral forms and information for the whole range of specialities across the City and County. The Safeguarding Template has been updated this year to be in line with the aesthetic of the other templates and the information streamlined. It continues to be updated in response to queries and observations from GPs about what would be useful. This is an ongoing process that will continue in the long-term as we gain feedback. The same information is available to EMIS practices, but there has been a delay in some software that would allow fuller integration of pathfinder into EMIS. This is beyond our control at this point, but we continue to monitor this through our contacts in the S1 team at the CCG.

- ✚ *To continue to update the template as needed.*
- ✚ *To try to incorporate some of the safeguarding documents that we share, and the newsletters into the SharePoint site associated with Pathfinder. (Currently on hold as there may be a web-based solution being considered -continued liaison with the relevant IT people regarding this).*

Other areas of Named GP work:

Joint Safeguarding Assessment framework - JSAF

The JSAF is a Red-Amber-Green (RAG) self-assessment tool, based on key national and local priorities and drivers (e.g., Care Quality Commission standards). It also focused on the NHS England, Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (NHS England, 2019) and Section 11 requirements of the Children Act (2004). The self-assessment has seven main standards/ areas of compliance, as follows:

- 1. Clear lines of accountability for safeguarding adults and children who are vulnerable or at risk of harm and/ or neglect.**
 - 2. Governance arrangements/ Quality Assurance.**
 - 3. Safeguarding policies, procedures, and systems.**
 - 4. Information sharing.**
 - 5. People are treated with dignity, respect, and compassion at all times**
 - 6. Safe recruitment practices.**
 - 7. Advice and support, training and continuing professional development for staff**
- During the COVID-19 pandemic, Derbyshire GP practices appear to have worked hard, and innovatively, to maintain high standards of safeguarding practice for adults and children.**

Practice visits

There have been no practice visits through this year due to Coronavirus restrictions. In the previous year, visits were only made following the Joint Safeguarding Assurance Framework (JSAF) if concerns were raised, or at the specific request of practices. There have been some MS Teams meetings with individual Safeguarding Leads held during 2020-21 if requested to discuss any specific queries about the role or process.

-  *To continue to offer MSTeams meetings on request to safeguarding leads who have a specific issue to discuss or feel they need further support.*

Team communication and wider meetings attended.

The Named GPs meet with the Designated Doctors for regular supervision meetings to help co-ordinate their work and to ensure adequate peer review of any advice they have given to local GPs. The Named GPs also attend the Derbyshire Named and Designated Professionals meetings. A Named GP representative sits on a number of other relevant meetings, including the Child Death Overview Panel (CDOP), the Child Practice Review, the Learning and Organisational Development and Policies and Procedures which are (all apart from CDOP) subgroups of the Derby and Derbyshire Safeguarding Children Partnership (DDSCP).

In 2020 NHSE developed a regional support network for Named GPs which is now becoming more established.

-  To continue to provide representation at local multi agency meetings, and continued involvement in regional NHSE Safeguarding Forum.

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Documents developed by the Named GPs for Safeguarding Children:

Dr Bentley has developed a Guide to Social Care for General Practice which outlines the pathways through social care and how the process works. This was completed with input from Children Social Care in the City and County to ensure that it was compliant with the DDSCP threshold document



Structure and
Pathways through soc

Dr Bentley has developed a one-page summary of the Threshold Guidance as an aide to making threshold informed decisions when referring.



Safeguarding
thresholds Summary F

✚ To continue to develop supporting documents to aid decision making and understanding of safeguarding.

Audit work completed in 2020-21:

- Numbers of reports returned for ICPC from GPs audited for the County and City.
- ICPC quality audits have been undertaken in County and City.
- Quality audit of GP referrals made to Derbyshire Starting Point

National safeguarding publications

Jeremy C Gibson and Heather Peet. – Looking out for looked after children - *Community Practitioner* 2020; November/ December: 29-31

Named GP for Safeguarding Children Priorities for 2021/2022

- ✚ To continue to hold Safeguarding Leads meetings virtually and continue to ask external speakers to join us on specific topics.
- ✚ To arrange an annual meeting to discuss processes between the leads and share good practice.
- ✚ To continue to provide quarterly newsletters with relevant information to General Practice.
- ✚ To expand the training offer taking advantage of the online delivery to expand the portfolio.
- ✚ To update the Level 1 and Level 2 training for use in practice as part of ongoing rolling programme of updates to training.
- ✚ To continue to respond to rapid review requests and involvement with CPR's / DHR's as required.
- ✚ To undertake further short audits planned to review the numbers of reports produced and the quality of reports for ICPC from GPs through 2021-22.
- ✚ To offer further training/ guidance for GPs in report writing for ICPC.
- ✚ To continue with ongoing liaison with Children Social Care and GPs around improvements to process.
- ✚ To continue to update the safeguarding children ICPC template as needed.
- ✚ To try to incorporate some of the safeguarding documents that we share, and the newsletters into the SharePoint site associated with Pathfinder.
- ✚ To continue to offer MS Teams meetings on request to safeguarding leads who have a specific issue to discuss or feel they need further support.
- ✚ To continue to provide representation at local multi agency meetings, and continued involvement in regional NHSE Safeguarding Forum.
- ✚ To continue to develop supporting documents to aid decision making and understanding of safeguarding will be developed according to demand.

Appendix One. List of documents shared in Named GP newsletters in 2020-21

- Training dates for CCG and DDSCP.
- Level 1 and 2 training packages for practices to use.
- Notification that local Safeguarding App no longer recommended as not updated.
- Threshold and Escalation documents (shared twice).
- Operation Liberty Form. New S1 Safeguarding Template – now to find and use.
- Early Help briefing document for General Practice (Derbyshire GPs) (shared twice).
- Initial Child protection conference report templates and how to complete (shared twice).
- How to make a referral to Childrens social care.
- Child not brought to appointment document. Fabricated Induced Illness guidance.
- Joint Agency response (JAR) to child deaths during the covid 19 pandemic.
- Prebirth protocol. Covid-19 and Domestic Abuse. Adverse Childhood Experiences
- JSAF report for the previous year. Marking events not visible in the online record.
- Mental health support for Derby and Derbyshire children, young people and carers.
- DDSCP – reminder about policy and procedures, how to find them.
- Allegations against staff, carers, and volunteers. Primary Care Contact leaflet updated in March 2021.
- Management of Genital Herpes Simples in Children and Young people.
- Pathway for Ano-Genital warts in children and young people.
- Guidance for the management of subconjunctival haemorrhage in the neonatal period.
- Self-harm and suicidal behaviour guidance working with children and young people in Derby City and Derbyshire. CAMHS Specialist community advisors leaflet for North and South.
- CDOP newsletter (August 2020 and December 2020).
- Safeguarding during virtual consultations.
- Finalised pathway for suspected FII with perplexing presentations within primary care.
- Catch 22 referral form. Children who may have left a GP practice pathway.
- CSEQR4 Questionnaire. Prevention programme Covid-19 guidance. Social care area email list.

Appendix two. Derbyshire ICPC Quality Audit Feb 2021

Methods:

This audit was completed to investigate the quality of reports returned for Initial Child Protection Conferences from General Practice in Derbyshire County. It was completed jointly by Karen Barden (title) and Dr Ruth Bentley (Named GP for Safeguarding Children DDCCG).

Karen identified 10 consecutive submissions from General Practice. One was actually for a review child protection conference, so this was discounted, and the next consecutive report was used instead giving a total of 10 reports considered.

Karen and Ruth independently assessed the quality using a tool produced by Dr Jeremy Gibson (Named GP for Safeguarding Children DDCCG) following the publication of his article outlining what constitutes a good report for initial child protection conference (What makes a

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good-quality GP report for an Initial Child Protection Conference? British Journal of General Practice Nov 2019 69:577-578).

Results:

The results are as follows:

Question	Number where information completed.
How long has the child been registered with the practice?	5
Medical conditions (in lay language), indications for and concordance with treatments.	8
Behavioural issues in the child	4
Physical or learning disability	2
Is there a history of abuse or neglect?	4
Are immunisations up to date or have they been delayed?	10
When was the child last seen in the practice?	10
What is the frequency and appropriateness of the child's attendances at the GP surgery, emergency department and NHS out –of-hours services?	6
Alcohol or substance misuse in the child	4
Which family members are registered with the practice?	8
Biological and non-biological link of household adults to child (e.g if they have PR)	6
Ethnicity of child and family members	4
Parental employment status	4
Number of children in the family home	8
Domestic abuse	4
Substance misuse in the parent	4
Alcohol misuse in the parent	6
Mental illness in the parent	6
If a parent has problems with substance misuse/alcohol misuse/mental illness are they having treatment for this and are they compliant with treatment?	2
Parental physical or learning disability	2
Child not brought to appointments	6
Capture the voice of the child	0
Complete on ICPC form (either typed or handwritten).	4

The results show that the ICPC form which has been developed and circulated is not as yet in widespread use. The team at DCC are happy to receive letters, but the letter needs to cover the same information as is requested in the form and this is rarely the case. It is noted that letters are not conference reports and cannot therefore be tabled in the meeting or shared whereas reports using the template can be and this makes the focus clearer on the risks, giving the GP an opportunity to contribute.

The voice of the child was not captured in any of the forms. While a description of the situation was considered, the impact of this on the child directly or their views were not given.

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Areas that performed well were immunisations being up to date and when the child was last seen in the practice. This is likely because this information is readily available in the records. Medical conditions (where mentioned) were usually explained in lay language. The number of family members registered with the practice and the number of children in the home were recorded in most cases.

Other areas which are less well documented within the record were more infrequently completed such as ethnicity.

Conclusions:

It is clear that there is still some way to go to improve the quality of reports for Initial Child Protection Conferences in Derbyshire County.

During the course of evaluating the responses it was discussed that, although not included in this sample, it is not uncommon for DCC to receive a copy of the records rather than a formal report.

Future plans:

Karen and Ruth to produce a joint letter to return to practices who have submitted a copy of the records to explain why this is not suitable.

It is planned to produce a training package that will be made available to GPs to provide instruction on the type of information that is required and how to complete the form accurately.

Appendix three. ICPC Quality Audit in Derby City Feb/ Mar 2021

Introduction

Under the Children Act 1989, when safeguarding concerns arise in England, local authorities (LAs) have a statutory responsibility to carry out a Section 47 Enquiry. This may lead to an Initial Child Protection Conference (ICPC), which relies on collating pertinent information from relevant agencies. Because GPs are a key health representative, who may hold crucial information in their records, they should be invited to submit a written report for and, if able, attend the ICPC. Despite the important role the ICPC plays in safeguarding children, historically, GPs have rarely attended¹ and infrequently submitted reports². Having implemented changes to increase the number of GP ICPC reports³, in an effort to optimise the health information being fed into local ICPCs, where decisions are made on behalf of children who are potentially suffering from or at risk of significant harm, we audited the quality of all reports submitted during February and March 2019 and then February and March 2021.

Methods

The United States National Incidence Study (NIS) is a congressionally mandated, periodic effort to provide updated estimates of the incidence of child abuse and neglect. On the basis of NIS-4⁴ (the most recently conducted, 2010), we developed a standard dataset against which to audit local GP ICPC reports.⁵

All Derby City GP ICPC reports for February-March 2019. JG, MR, and JN-F independently reviewed and scored each report. On 27th November 2019 JG, MR and JN-F met to review their scoring, discuss differences, and agree scoring for each report. The February-March 2021 reviewed and scored by JG alone. Because of the failure to have showed consistent improvement in quality throughout domains, at this stage MR and JN-F did not also score.

Change implemented: new GP ICPC report template developed, promoted and payment introduced

Prior to September 2019, there were two Local Safeguarding Children Boards (LSCB), one for the city and one for the county. Each had their own ICPC GP report template. After September 2019, when, in response to the Wood Report⁶, the two LSCB were replaced with one Derby and Derbyshire Safeguarding Children Partnership (DDSCP), we developed one new ICPC GP report template for city and county, which, if completed fully, would capture all necessary information.

This template was uploaded onto the DDSCP website. An electronic self-populating version was also embedded into a safeguarding view in the electronic medical record. This safeguarding view is an area in the electronic medical record where all relevant safeguarding issues are pulled together. The self-populating facility, which we believe facilitates the completion process, automatically fills in standard information such as demographics, current medication, immunisation history, if the child was not brought to an appointment, etc. The form requires comment on, for example, whether the immunisation history is up to date and whether the patient takes their medication effectively.

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We publicised the new template in the July 2020 Local Medical Committee (LMC) bulletin and autumn 2020 safeguarding newsletter (which goes to all GP Safeguarding leads in Derby City and County). We promoted its use through a series of online learning events during which more than 600 GPs, GP trainees, and practice nurses from Derby City and County attended.

From October 2020, DDCCG introduced payments for completing ICPC reports.

Results – round one: Feb-Mar 2019

In Derby City, February-March 2019, 30 (68.2%) GP reports were submitted for 44 ICPCs. We could only obtain 26 of these reports. Results are in the table below. Although most GP reports listed the child's immunisation history few commented on whether they were up to date or whether they were delayed. Whether the GP had captured the voice of the child or not was subject to our individual interpretation, which we discussed and came to agreement on a case-by-case basis. For instance, some GPs had reflected in their reports how the child presented at the GP Surgery. In some reports information from strategy discussions and meetings was simply copied into the report, which we felt inappropriate. Only one of the 26 reports had been shared with a parent/ carer.

Results – round two: Feb-Mar 2021

In Derby City, February-March 2021, 46 (63.9%) GP reports were submitted for 72 ICPCs. We obtained all 46 of these reports. JG reviewed and scored these (results tabulated below). The self-populating template failed to add date of registration. IT was contacted about this who rectified this centrally. Twelve (26.1%) used the old template. All of these twelve were from one GP practice which was contacted and asked to start using the new template. Fourteen (30%) used a letter rather than completing the template. Three (6.5%) used an email rather than a template. Seventeen (37%) used the new template. Of these only five (10.9% of total) fully completed the new template.

Every GP practice which had submitted a letter or email, or only partly completed the new template were emailed and asked to audit their reports against the audit tool and encouraged to fully complete the new template for future ICPC reports.

All GP safeguarding leads in the city and county were also emailed (as follows), with the same paragraphs being included in the Summer Safeguarding newsletter.

“Thank you for your continued support in completing and submitting ICPC reports when requested. The number of submitted GP ICPC reports remains good at almost 70%. However, we're now aiming to optimize their quality. I attach the audit tool we're using to measure this, which is based on the BJGP article: Jeremy Gibson, Michelina Racioppi and Jasmine Nembhard-Francis. What makes a good-quality GP report for an Initial Child Protection Conference? BJGP 2019; 69 (688): 577-578. It is available here: <https://bjgp.org/content/69/688/577>

We've noticed that several practices have not been using the new template and some of those who have done so have not completed it fully. Please consider self-scoring any reports which your practice has submitted against the audit tool and for future ICPC reports using the standardised template that we highly recommend all GPs complete. It's relatively

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straightforward and if you open it on the pathfinder safeguarding template many of the areas self-populate. You need to complete one generic template for the index child (or, if there are more than one, for one of them) and then a child and adult profile for each additional household member.”

We are also planning to hold two virtual workshops on how to complete the ICPC reports.

Results – round three: Feb-Mar 2022

We plan re-audit all reports in February and March 2022 to review progress.

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CSC data relating to GP report submission for ICPCs

ICPC	February/ March 2016	February/ March 2017	February/ March 2019	February/ March 2021
Total number of ICPCs held	34	53	44	72
GP not invited as registered practice unknown	14 (42.4%)	18 (34.0%)	3 (6.8%)	5 (6.9%)
GP invited to submit a report and attend ICPC	19 (57.6%)	26 (49.1%)	41 (93.2%)	64 (88.9%)
GP submitted report	9 (27.3%)	3 (5.7%)	30 (68.2%)	46 (63.9%)
GP attended	0	0	0	-

Results table

Identify health-related risk factors		Feb-Mar 2019 (n=26)	Feb-Mar 2021 (n=46)	
Child's developmental needs	How long has the child been registered with the practice?	1 (3.8%)	8 (17.4%)	
	Medical conditions (in lay language), indications for and concordance with treatments	20 (76.9%)	23 (50%)	
	Behavioural issues in the child	5 (19.2%)	21 (45.6%)	
	Physical or learning disability	3 (11.5%)	21 (45.6%)	
	Is there a history of abuse or neglect?	8 (30.8%)	25 (54.3%)	
	Are immunisations up to date or have they been delayed?	11 (42.3%)	29 (63%)	
	When was the child last seen in the practice?	24 (92.3%)	32 (69.6%)	
	What is the frequency and appropriateness of the child's attendances at the GP surgery, emergency department and NHS out-of-hours services?	14 (53.8%)	27 (58.7%)	
	Alcohol or substance misuse in the child	0 (0%)	14 (30.4%)	
	Family and environmental factors	Which family members are registered with the practice?	21 (80.8%)	29 (63%)
Biological and non-biological link of household adults to child (e.g. if they have parental responsibility)		20 (76.9%)	25 (54.3%)	
Ethnicity of child and family members		0 (0%)	14 (30.4%)	
Parental employment status		2 (7.7%)	7 (15.2%)	
Number of children in family home		19 (73.1%)	31 (67.4%)	
Domestic abuse		11 (42.3%)	24 (52.2%)	
Parenting capacity		Substance misuse	11 (42.3%)	20 (43.5%)
		Alcohol misuse	8 (30.8%)	20 (43.5%)
		Mental illness	16 (61.5%)	31 (67.4%)
		If a parent has problems with substance misuse/ alcohol misuse/ mental illness are they having treatment for this and are they compliant with treatment?	13 (50%)	22 (47.8%)
	Parental physical or learning disability	0 (0%)	6 (13%)	
	Child not brought to appointments	10 (38.5)	18 (39.1%)	
Capture the voice of the child	0 (0%)	4 (8.7%)		
Clearly explain and critically analyse health information – THINK FAMILY	6 (23.15)	7 (15.2%)		
If safe to do so, have you shared the details of this report with the child's parents?	1 (3.8%)	0 (0%)		

Appendix four. Safeguarding Children & Adults Assessment Framework (JSAF) Annual Report 2020/2021

Introduction/ context

Section 11 of the Children Act 2004 places a duty on a range of organisations (including the NHS England and CCGs) to ensure their functions and any services they commission or contract out to others are discharged as having regard to the need to safeguard and to promote the welfare of children.¹ Section 42 of the Care Act 2014, the most significant reform to Adult Social Care for more than sixty years, has brought a clear legal framework in relation to Safeguarding Adults.² While safeguarding is firmly embedded within the wider duties of all organisations across the health economy there is a distinction between providers' responsibilities to provide safe and high quality care and support, and commissioners' responsibilities to assure themselves of the safety and effectiveness of the services they have commissioned.³

In April 2015 CCGs began to co-commission GP services with NHS England. Under delegated arrangements, the CCGs became responsible for ensuring that the GP Services commissioned have effective safeguarding arrangements in place. The NHS England document, 'Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework (2019)' explains that this assurance may consist of assurance visits, Section 11 (Children Act 2004) audits and the attendance at provider safeguarding committees as means of gaining such assurance; however, it lacks further detail on a standardised measuring tool; nor does it give any explanation of how CCGs should respond to non-compliance. To guide GP practices regarding what safeguarding arrangements they should have in place and to give some assurance to the CCG that their GP practices had robust safeguarding processes in place, the CCG Safeguarding Children and Adults teams developed the Joint Safeguarding Assurance Framework (JSAF).

Since its development, the JSAF has been repeatedly updated to reflect the latest local and national guidance. Following the Joint Targeted Area Inspection (JTAI) in March 2019 the inspectors provided a view that the self-reporting nature of the JSAF precluded it from being termed an assurance tool. It was, therefore, updated and renamed the Joint Safeguarding children and adults Self-Assessment Framework.

¹ http://www.workingtogetheronline.co.uk/chapters/chapter_two.html#section_eleven

² <http://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted>

³ The Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework NHS England, 2019

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Findings for 2020/ 2021 returns

In December 2020, all 112 Derbyshire GP surgeries were invited to complete the JSAF. Due to the pressures and demands of the Covid Pandemic the GP practices were provided with an extended return date.

The practices that did not return their self-assessment were sent a reminder. The current return rate is 97.3% (which pertains to 109 JSAF self-assessments returns). Most of the self-assessment ratings within the JSAF were green – fully compliant. Of the 79 amber self-assessment ratings, most of these related to updating policies and staff training. None of the GP practices self-assessed themselves as a red rating.

In this year's JSAF self-assessment we asked GP practices to provide a summary of what they perceived the impact Covid-19 has had upon their safeguarding activities/ functions. For example, patient contact, home visits, or increase in child protection concerns, self-neglect or domestic abuse, etc. and what measures/ contingencies had their practice put in place to safeguard children and adults during the pandemic.

As part of the JSAF process we also cross referenced what CQC inspections had taken place and the GP practice ratings; of the GP practices in Derbyshire and Derby City CQC rated 87 of them as good, nineteen of them as outstanding, four of them as needing improvement; two were registered as inadequate.

How GP practices have responded to COVID-19, in relation to safeguarding

Patient contact

Fewer face-to-face consultation, more telephone and video consultations

When making telephone calls, checks were made that patient was free and safe to speak

Most practices reported fewer home visits, though they continued home visits for the most vulnerable/ housebound

Immunisation continued, which enabled babies to be seen

Weekly, remote care-home ward-rounds

Continued Learning Difficulties and Mental Health checks, and eight-week baby checks

Safeguarding meetings/ training

Regular, virtual multi-disciplinary team (MDT) safeguarding meetings took place. Many practices reported difficulty in getting health visitors, and especially midwives and school nurses to attend during the pandemic period

Virtual safeguarding training events, including highlighting the impact of parental mental health on children and impact of Adverse Childhood Experiences (ACEs)

Safeguarding GP leads continued to attend GP leads meetings with the Named GPs for Safeguarding children

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Safeguarding GP leads hosted internal safeguarding training so that practice staff maintained their training compliance

Safeguarding workload - general

While several practices reported no increase in safeguarding concerns/ self-neglect/ DA, many others noted an increase in child protection cases, requests for child protection conference reports, cases of self-neglect, DA cases (and MARAC reports), alcohol abuse, Police reports highlighting mental health issues, and East-Midlands Ambulance Service safeguarding alerts (especially related to the frail, elderly patients with social care issues)

Practices acknowledged that they found it easier to attend virtual child protection conferences, compared to when they were face-to-face meetings.

Safeguarding workload – case examples

Two cases of self-neglect detected

One practice, which detected a concealed pregnancy, by liaising with an out of area authority uncovered child trafficking

Difficult family situations came to light – for example which parent should a child stay with if self-isolating

Mental health

There has been an increase in mental health issues in adults and children identified, with more children appearing to be suffering from behavioural and emotional issues, anxiety, self-harm, suicidal thoughts, etc.

More adults appear to have had more problems with alcohol and drug misuse

Innovation

Monthly Emergency Department (ED) auditing to identify children who attend regularly, discussed at safeguarding meetings

Monthly reports for children who missed immunisations – parents were contacted

Regular review of children subject to child protection plans

Adult patients where there are concerns about self-neglect were monitored by the care co-ordinator and discussed at the multidisciplinary team meetings, where referrals were made to relevant agencies/ social prescribing.

Concerns regarding local care homes addressed

High risk/ vulnerable patients/ families/ children on child protection plan/ children on child in need plan/ people with Learning disability were contacted during lockdown for safe and well checks

Staff training on recognising domestic abuse (DA) on telephone and its increased risk during lockdown delivered

Video conferencing and intimate digital imaging policy in place and adhered to

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Continued monitoring/ follow up if children not brought to appointments

Social prescriber supported vulnerable adult patients and patients with long-term mental health problems.

Staff being more aware of difficulties in identifying safeguarding issues via telephone/ video – tips circulated on how to address this

Practice website updated with information for self-referrals and support for domestic abuse.

One practice created an electronic resource to support families/ individuals with mental health and other vulnerabilities (e.g., DA, self-neglect, alcohol/ drug misuse, eating disorders etc)

Password-protected log of patients with concerns (including details of actions completed), to allow easy access to overview the safeguarding concerns of patients

Any child (<18 years-of-age) with a safeguarding alert who presented with genito-urinary symptoms provided a same day telephone appointment

Processes put in place to monitor all safeguarding communication coming into practice, a recall system to ensure concerns discussed in multidisciplinary team meetings, and status markers to alert clinicians in consultations of any concerns/ vulnerabilities.

One practice put up domestic abuse posters that patients could see from outside the surgery

One practice employed two mental health practitioners

In summary and actions

- During the COVID-19 pandemic, Derbyshire GP practices appear to have worked hard, and innovatively, to maintain high standards of safeguarding practice for adults and children.
- The Named GPs plan to make contact with the practices which did not submit a JSAF return this year and work alongside the CCG Primary Care Team.
- The Named GPs plan to liaise with Children Social Care regarding informing GPs when children come off a Child in Need plan.
- For further conversations to take place with DCHS and DHCFT 0-19 service providers regarding the absence of school nurses attending GP practice Safeguarding meetings and strengthening the GP 0-19 service link role.
- To share the report with the Derbyshire Primary Care Quality & Performance Review Sub Committee and the Joint Safeguarding children and adults committee
- To share key findings of the report with safeguarding GP leads
- To review the JSAF report for 2021/22

Author

Dr Jeremy Gibson, Named GP for Safeguarding Children



Governing Body Meeting in Public

2nd December 2021

	Item No: 209
Report Title	Safeguarding Adults Annual Report 2020/21
Author(s)	Bill Nicol, Asst Director, Safeguarding Adults
Sponsor (Director)	Brigid Stacey, Chief Nurse

Paper for:	Decision	Assurance	Discussion	Information		
Assurance Report Signed off by Chair			N/A			x
Which committee has the subject matter been through?			Q&PC – 25.11.2021			
Recommendations						
The Governing Body is requested to NOTE the Safeguarding Adults Annual Report for 2020/21.						
Report Summary						
The report provides details of the work undertaken on behalf of the CCG by the Safeguarding Adult Team. It highlights the steps taken to ensure that the CCG and NHS providers meet their statutory requirements and responsibilities.						
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

Yes, in part. Principally through the findings from case file audit and the work of the Safeguarding Adult Boards Customer Engagement Group

Have any Conflicts of Interest been identified / actions taken?
--

None identified

Governing Body Assurance Framework

Safeguarding adults from abusive behaviour and practice is a statutory requirement of DDCCG

Identification of Key Risks

Cross reference to risks within GBAF or Risk Registers
--



SAFEGUARDING ADULT ANNUAL REPORT

APRIL 2020 – MARCH 2021

Author: Bill Nicol
Assistant Director for Safeguarding Adults
November 2021

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1. Introduction & Covid

The past year has been unique on many levels. The Covid pandemic presented safeguarding adults with a variety of challenges and demands. As formal and informal support networks withdrew so threats to adults at risk increased. Our principal challenge was to ensure that those adults at risk continued to be shielded and protected from all forms of abusive behaviour and practice. Our statutory responsibilities as care providers and commissioners had to be met no matter how difficult. It was therefore more important than ever to work together, to communicate and share information, to identify and then escalate gaps in care provision, to adapt to these new demanding social pressures and circumstances, and to maintain a high quality of safeguarding adult activities.

By closely monitoring disclosure and referral activity it became apparent that as families were forced together or as individuals became isolated from formal and informal support, we as a safeguarding community, identified an increase in incidences of Domestic Abuse and Self Neglect. Referral activity increased on average by 16%. This, coupled with staff redeployment and increased staff sickness, placed additional demands and pressures upon already stretched resources.

After some much-needed immediate adjustment to working practices I would argue that services and stakeholders rose to this challenge and maintained a professional and skilled response to this new landscape. The Derby and Derbyshire Safeguarding Adult Boards continued to provide strategic leadership whilst their supporting structures met regularly to facilitate their work programmes. Case file audits provided us with assurance that operational activity remained robust and in line with local and national policy and legislation.

Due to the need for consistent inter-agency collaboration Safeguarding Adults arrangements are, in the main, determined and influenced by strategic priorities set by multi – agency Local Safeguarding Adult Boards (SABs).

Derby & Derbyshire Clinical Commissioning Group continue to actively support and participate in adult safeguarding work streams and strategic initiatives at a local, regional, and national level.

From April 2015, as a result of the Care Act (2014) these SABs have now been granted statutory status. The main thrust of this legislation from a safeguarding perspective is to place the well-being and safety of the adult at risk at the heart of the care and support system. This is defined as “Making Safeguarding Personal” and should ensure that the person at risk is consulted with throughout the totality of the safeguarding operational and decision-making process. This should also ensure that, wherever possible, safety planning and outcomes reflect the needs and wishes of the adult in need of support and protection.

Since the publication of No Secrets (2000) both the definition of Safeguarding Adults and its operational remit have grown significantly to encompass a diverse range of patient and public safety work-streams. The core functions of the CCGs Safeguarding Adults Service are detailed within the Memorandum of Understanding (2017).

This annual report therefore is written on behalf of NHS Derby & Derbyshire Clinical Commissioning Group for the year 2020/21.

2. Core Function of the CCG Safeguarding Adults Team

- 2.1 The CCG is committed to safeguarding and promoting the safety and welfare of patients and family carers across all areas of the health economy.

The term Safeguarding Adults encompasses an ever- expanding range of public safety initiatives and disciplines. At its core is the assumption that any intervention assists the adult at risk to live a life that is free from abusive behaviour and practice. For this to be effective it is essential that organisations work collaboratively to ensure that all patient contact promotes safety, independence, self-empowerment, dignity and choice. Any intervention should strive to offer the adult at risk options for halting and preventing a reoccurrence of abuse or mistreatment.

- 2.2 Whilst the lead responsibility for coordinating Safeguarding Adult's arrangements lies with the Local Authority Adult Social Care Department in both Derbyshire and Derby City Councils, truly effective safeguarding can only be effective when based upon the existence of strong multi-agency partnership working arrangements with the existence of consistent operational processes and robust information sharing pathways.

- 2.3 The principal role of the Derby & Derbyshire Clinical Commissioning Groups is to ensure that both their own internal Safeguarding Adults structures and processes, and those within all commissioned services, meet the required standard and are compliant with local and national regulatory drivers. The CCGs adult safeguarding service also provides a key role in promoting awareness and offering an operational consultancy service of safeguarding issues across Primary Care.

- 2.4 The Derby & Derbyshire CCGs are committed to the principles and definitions found within the multi – agency Safeguarding Adult Policy shared by both the County and City Safeguarding Adult Boards.

- 2.5 The purpose of this report is to provide information on the progress being made when safeguarding patients who may be unable to protect themselves from harm or abusive behaviours. The report also provides information on the activity of the CCG's Safeguarding Adults Team and their work in partnership with other key stakeholders. This report will set out the current national and local context and reflect the following themes:

- Governance, quality assurance, and accountability arrangements between the Derbyshire CCGs and NHS provider services
- Key Safeguarding Adults priorities, developments and challenges
- Future objectives, priorities, and developments
- Functions and activities of the CCGs Safeguarding Adults Team
- Staff Training & Development Programmes
- Contribution to local Safeguarding Adults arrangements

3. Key Professionals

3.1 The Derby and Derbyshire CCG Safeguarding Adults Team currently consists of:

Bill Nicol, Assistant Director for Safeguarding Adults

Michelle Grant, Designated Nurse for Safeguarding Adults

Natalie Hall Senior Safeguarding Adults Administrator

3.2 The post holders work in conjunction with the CCG Chief Nurse and in partnership with NHS England. They also work in collaboration with the Derby City & Derbyshire Safeguarding Adults Partnership Boards. There are clear lines of communication and governance to report upon adult safeguarding activities and arrangements across the CCG.

4. Key Roles of the CCG Safeguarding Adults Team Local Strategic Leadership & Governance

4.1 The Assistant Director of Safeguarding Adults is the Vice Chair of both the Derby City & the Derbyshire Safeguarding Adult Boards and is also Chair of both the Derby City & the Derbyshire Safeguarding Adult Boards respective Quality Assurance Performance Improvement Groups. The Designated Nurse for Safeguarding Adults is the Deputy Chair of the DSAB subgroups; MCA/DOL and Operational and Leadership and also the DDCCG Safeguarding Committee

4.2 In 2013 an Adult at Risk Committee – Health (ARCH) was established. This ensures that all NHS providers are given ample opportunity to debate and consider those Safeguarding Adults issues which are particularly relevant to the NHS community. ARC-H members assisted the Safeguarding Adults Team in revising both the Safeguarding Adult Assurance Framework (SAAF) evidence template and the Joint Safeguarding Assurance Framework (JSFAF) template for Primary Care. Attendees also share information regarding challenges, progress, and priorities within their respective organisations.

4.3 The Safeguarding Adults Team also submits activity reports to the CCG's Quality and Performance Committee and their internal DDCCG safeguarding committee on a quarterly basis.

4.4 The CCG Safeguarding Adults Annual Report is presented to the CCG Boards & the Safeguarding Adult Boards for their information and scrutiny.

4.5 The Safeguarding Adults Team are responsible for ensuring that the CCGs and all NHS providers demonstrate strong Safeguarding Adults arrangements and possess effective operational policies, procedures, and staff guidance. NHS provider performance and activity are monitored through both the Safeguarding Adult Boards and the CCG's Safeguarding Adult Assessment Framework (SAAF).

4.6 In 2020-2021 the CCGs Safeguarding Adults, Prevent and Domestic Abuse Policies were reviewed and updated to reflect national developments.

These policies reflect the 6 Care Act (2014) guiding principles of:

- Empowerment – person led decisions and informed consent
- Protection – support and representation for those in need
- Prevention – take proactive action before harm can occur
- Proportionality – least intrusive response
- Partnership – services working with communities
- Accountability – transparency in safeguarding
(Care Act 2014)

5. Safeguarding Adults Inter-Agency Supporting Network

5.1 The Safeguarding Adults Team attend and contribute to several strategic committees and associated sub-groups which support a Safeguarding Adults & Public Protection infrastructure.

These include:

- Domestic Abuse & Sexual Violence Strategic Board
- Domestic Homicide Review Panels
- Dignity Award Steering Group
- Prevent Coordinators Group
- Multi-Agency Public Protection Levels 2, 3, and 4 (MAPPA)
- Mental Capacity & Deprivation of Liberty Committee
- Adult Safeguarding Customer Inclusion Group
- Human Trafficking & Community Safety
- Hate Crime Practitioners Network
- Financial Scamming Task Group
- CQC Information Sharing Forum
- Safeguarding Adult Review Panels
- Vulnerable Adult Risk Management Review Committee (VARM).
- Safeguarding Adult Boards Core Business Group
- Regional & National Adult Safeguarding Committee
- Staff Development Committee
- Homelessness Strategic Board
- Rape Scrutiny Panel
- Quality Assurance & Performance Improvement Committees
- NHS Provider Trust Internal Safeguarding Adult Committees (UHDBFT, CRHFT, DCHSFT, DCHFT, and EMAS)

5.2 The existence of these groups is further evidence of the expanding areas of safeguarding responsibility. Inter-agency and partnership working are essential components in keeping adults safe from abusive behaviour. It is imperative that the CCG's Safeguarding Adults Team contributes and influences the design and implementation of local public protection arrangements, policies, and operational practice.

5.3 Throughout 2020-2021 the CCG Safeguarding Adults Team have been available to provide operational and referral advice across the healthcare economy. This professional consultancy role encompasses all aspects of patient and public safety; including abuse

and neglect, Domestic Abuse, Mental Capacity and Deprivation of Liberty, Hate Crime, Modern Slavery and Prevent.

- 5.4 The last few years have seen a sharp increase in the number of adult safeguarding referrals. A breakdown of activity is available as an attachment to this report. The average increase is 16% per annum. Work is being undertaken to better understand the reasons behind this surge in activity. In 2010 there were 750 referrals to Derby & Derbyshire's respective Adult Care Services in 2019 there were approaching 8,000.

6. Safeguarding Adult Reviews and Domestic Homicide Reviews

- 6.1 The Assistant Director and the Designated Nurse for Safeguarding Adults have represented the CCGs at 5 Domestic Homicide Reviews (DHR). The Safeguarding Adults Team has also produced Independent Management Review Reports on behalf of the relevant GP Practices.
- 6.2 Although there were no immediate issues of concern identified for the CCGs there will always remain a need to ensure the best possible consistent information sharing between the domestic abuse Multi-Agency Risk Assessment Conferences (MARAC) and GPs. MARACs are essential when formulating risk assessments and protection plans for those adults deemed to be at risk of death or life threatening injury as a result of domestic abuse and violence.
- 6.3 Learning from these reviews was disseminated across NHS services.

7. Vulnerable Adult Risk Management

- 7.1 The Safeguarding Adults Team has worked in collaboration with partner agencies to review the Vulnerable Adult Risk Management (VARM) process. The VARM is a multi-agency procedure that is followed in order to identify individuals who are deemed to be at serious risk within their communities due to self-neglect, hoarding, and/or a failure to engage risk reduction and engagement strategy to engage with the adult. Unlike Safeguarding Adults this process is not led by the Local Authority but is the responsibility of any partner agency that identifies an adult deemed to be under threat. The VARM process has generally achieved good results and positive outcomes for people at risk across Derbyshire. A review on the efficacy of the VARM programme took place during 2016-18 and the results and recommendations were presented to the CCGs and the Derbyshire Safeguarding Adult Board. This review resulted in significant amendments to policy, process, staff guidance, and the design of an information leaflet for adults at risk.
- 7.2 An ongoing multi-agency partnership audit of VARM interventions found evidence of strong multi-agency working and cooperation resulting in positive outcomes for those individuals referred for assistance.
- 7.3 The CCGs also make a financial contribution to a Hoarding Grant in partnership with Derbyshire Fire and Rescue, Derbyshire Adult Care, and Environmental Health Services. This funding is used to purchase refuse skips thus enabling house clearances. This has resulted in very positive outcomes for adults at risk. Increasing levels of self-neglect however continues to be a cause for concern with referral rates and themes being closely monitored and audited.

8. Safeguarding Adult Assurance Framework

8.1 During 2020-21 the CCG Safeguarding Adults Team met the following NHS providers on a regular basis as part of the ongoing Safeguarding Adult Assessment Framework (SAAF) process;

- Chesterfield Royal Hospital NHS Foundation Trust
- University Hospital of Derby and Burton NHS Foundation Trust
- East Midlands Ambulance Service
- Derbyshire Health United
- Derbyshire Community Health Services NHS Foundation Trust
- Derbyshire Healthcare NHS Foundation Trust
- Barlborough NHS Treatment Centre.
- Cygnet Hospital
- Ashgate Hospice
- Midlands and Lancashire Clinical Support Unit.

8.2 The CCG Safeguarding Adults Team assess and evaluate the evidence submitted by the NHS providers. The SAAF process identifies evidence, information, and assurance on how the Trusts are performing across the following areas of practice:

- Safeguarding Adults
- Domestic Abuse
- Prevent
- Mental Capacity Act & Deprivation of Liberty
- Inter-Agency Commitment & Contribution to Work Programmes
- Staff Training
- Operational Policy & Procedures
- Internal Governance Arrangements
- Making Safeguarding Personal
- Case Examples & Outcomes
- Implementation of National Statutory Legislation

8.3 The CCG Safeguarding Adults Team meet with the Providers to offer feedback and, where appropriate, to seek further detail and assurance. The Safeguarding Adults Team continues to meet with these NHS providers on a regular basis to confirm progress against agreed actions and priorities. NHS Trusts and healthcare providers provided a raft of evidence and assurance that adult safeguarding continues to enjoy a high, and positive, profile.

The CCG Safeguarding Adults Team also attends the NHS Trust's Internal Safeguarding Adults Committees. This provides an additional opportunity to evaluate the progress being made towards achieving SAAF targets and to promote strong communication between the CCGs and NHS provider settings.

8.4 The CCG Safeguarding Adults Team, in partnership with key Safeguarding Adult Board members, have conducted an audit of over 475 adult safeguarding case files. An audit tool was developed to reflect the adult safeguarding requirements detailed within Section 8 of the Care Act (2014). The audit encompasses an assessment of referral quality, inter-

agency collaboration, recording standards, referral pathways, Section 42 Enquiries, outcomes for adults at risk, and making safeguarding personal.

Evaluation reports have been compiled by the DDCCG Assistant Director of Safeguarding Adults and have been presented directly to the Safeguarding Adult Boards and to the CCGs via their Quality Committees and Joint Commissioning Group. This work will continue and forms an important component of the SABs Strategic Programme.

- 8.5 The purpose of the exercise is therefore to scrutinise levels of inter-agency working, evaluate referral standards, measure the efficacy of operational procedures, and identify any areas for improvement within practice.
- 8.6 In October 2020 the 116 Derbyshire and Derby City GP Surgeries were invited to complete the Joint Safeguarding Assurance Framework. The return rate across all Practices was 100%.

We are of the view that the JSAF is useful both in providing a level of assurance to the CCGs and by supporting Practices when collating evidence in preparation for CQC inspections. The DDCCGs Children & Safeguarding Adults professionals can provide an assessment of the evidence submitted within the JSAF upon request.

- 8.7 The Safeguarding Adults Team in partnership with the Childrens Safeguarding Team now have a programme of Practice visits to provide additional assurance of safeguarding standards whilst also supporting Practice Safeguarding leads in meeting key lines of enquiry and national standards.

9. Mental Capacity Act/Deprivation of Liberty

- 9.1 The Supreme Court Judgement in March 2014 defined what constituted a Deprivation of Liberty (DoL). This is known as the 'Acid Test' and applies to any person ('P') who is deemed to be under constant supervision and control and who is not free to leave. This is the standard which any deprivation of liberty continues to be assessed against. Since this time the Safeguarding Adults Team has been responsible for reviewing and assessing the legal and practice implications for the CCG as new case law develops in respect of those patients in receipt of Continuing Healthcare funding. For other packages of care funded by the CCG which sit outside the CHC Framework other CCG teams within the CCG have responsibility for these. The information below is in respect of these CHC funded patients.
- 9.2 There are two ways in which the current legislation around a Deprivation of Liberty can affect the CCG. For those people that are living in a care home and in receipt of CHC funding their DoL is authorised by the Local Authority. If 'P' (P is used in the legal documents to identify the 'Person' and maintain anonymity) subsequently challenges the DoL stating they wish to live back at home or in another nursing home then section 21A of the Mental Capacity Act is triggered and the CCG must appoint Solicitors to act on our behalf when the challenge is heard in Court and to support the preparation of witness statements. On occasions we require legal representation from a barrister when the case is heard by a Tier 3 judge in court rather than a District Judge.

When 'P' is living in their own home or supported living placement and is in receipt of CHC funding the Local Authority cannot under the current legal framework authorise the DoL. These cases must be done by making an application to the Court of Protection to comply

with the law. If all interested parties (family, carers, advocates professionals all agree the care package is in the best interests of 'P' then this is done using a Re X streamlined application to the Court of Protection and is heard on the papers alone with no requirement to attend court in person for an oral hearing). In both authorisation scenarios the Designated Nurse for Safeguarding Adults works closely with our colleagues in CHC to ensure that all necessary paperwork and attendance at court is covered.

- 9.3 The costs of Re X applications is currently £365 for each one, these are sent directly to the court by the Designated Nurse for Safeguarding Adults on behalf of the CCG now that we have familiarity with what is required. During 20/21 the number and complexity of the s21A challenges has grown and along with long term sickness in the Adult Safeguarding Team the number of Re X applications submitted has been lower than anticipated. This has been escalated and placed on the CCG risk register as a risk to the CCG in relation to a challenge to an unauthorised DoL. The legal fees for the s21A challenges dependent on the number of court hearings required to authorise the application. The CCG now employs Capsticks LLP to act on our behalf. Legal bills can vary dependent on the number of court hearings required to authorise the DoL, the average cost is between £10,000 - £15,000. We have had 7 new Court of Protection DoL applications approved by the Court of Protection in 20/21 and 7 renewals (an authorisation only lasts for 12 months then a further reapplication must be made).

The CCG also incurs legal fees when we have to appoint solicitors to act on our behalf in health and welfare (H&W) decisions these can result when family request access to a member of their family and this is thought not to be in the best interests of 'P'. If we fund the package of care 'P' receives via CHC then we are a respondent to court proceedings and must provide a position statement and attend court to explain why we might object to the applicant's request, these costs too can be variable, there has been only one new one of these in the last 12 months.

- 9.4 There are changes to the DoL legal framework which will be known as Liberty Protection Safeguards (LPS) these were granted royal assent on 16th May 2019. However the new draft Code of Practice and regulations are still awaited. What we do know is that NHS hospitals and CCG's will be granted responsible body status which in principle will mean that the NHS can authorise their own deprivation of liberty under the LPS scheme for those whose care we are responsible. We know that it is intended that the authorisation will 'transportable' within different care settings which is not the case now and that after the initial 2 twelve-month authorisations the third can be for up to 3 years if the care plan is likely to remain the same.

In preparation for the implementation of LPS due in April 2022 work has been ongoing with our CHC staff to identify which care packages would meet the definition of Deprivation of Liberty as per the Cheshire West judgement. Further MCA training has also been rolled out across the CHC clinical team.

9.5 Court of Protection case load for 20/21

Court of Protection Re X Applications for 20/21

New Re X Applications to be submitted to the CoP	Re X reauthorisation reapplications	Re X Applications with the CoP awaiting a hearing	Re X Applications authorised the CoP
7	7	4	7

Court of Protection s21A challenges for 20/21

New s21A challenges	Ongoing s21A challenges	Authorised s21A challenges
8	11	3

Court of Protection S16 Health and Welfare challenges

New H&W challenges	Ongoing H&W challenges	Authorised H&W challenges
1	0	2

10. Dignity in Care

- 10.1 The CCG Safeguarding Adults Team have been key partners in promoting the Dignity in Care Award across a diverse range of care settings and agencies since its inception in 2012. Since the development of the Derby SABs Making Safeguarding Personal subgroup award submissions have increased with some coming from the NHS and we look forward to seeing a further increase in the coming year. The CCG will continue to promote the award and encourage participation across all NHS settings.

11. Safeguarding Adults Operational Activity

- 11.1 Both Derbyshire and Derby City Local Authority Adult Care have collated statistical information to provide details regarding safeguarding adult's referral activity, see Appendices below. This takes the form of an annual return to central Government entitled Safeguarding Adults Collection (SAC).
- 11.2 The Safeguarding Adult Boards and their respective Performance Improvement Sub Groups analyse this data to identify trends, practice priorities and demands. These Appendices demonstrate a variety of factors relating to the referral including gender, age, ethnicity, referral source and physical characteristics of the adult at risk.

12. Some Key Priorities for 2021– 2022

- Ensure ongoing CCG compliance with the Care Act (2014) and the Safeguarding Vulnerable People in the NHS - Accountability and Assurance Framework
- Evaluate the quality assurance programme for Primary Care (JSAF)
- Ensure ongoing CCG compliance with national legislation including Domestic Abuse, Mental Capacity Act, Prevent, and Modern Slavery
- Coordinate, deliver, and evaluate the staff training programme in line with the Intercollegiate Document
- Work with the Safeguarding Children's Team to jointly develop a programme of level 3 training Workshops for the Primary Care Networks
- Continuation of the safeguarding adults case file audit
- Ongoing revision and implementation of the SAAF process
- Collaboration with key stakeholders to achieve the Safeguarding Adults Boards strategic objectives
- Analyse themes and challenges to safeguarding adults in direct response to Covid

- To coordinate and lead on Safeguarding Adult Reviews (SARs), Domestic Homicide Reviews (DHRs) and monitor the implementation of subsequent action plans. To obtain evidence that learning from reviews has been embedded into clinical practice
- Maintain active participation in shaping local partnership strategies, priorities, and arrangements
- Continue to co-ordinate and monitor the Re X cases and S21A challenges to Deprivation of Liberty authorisations
- To monitor the progress of the LPS and be involved as far as possible in planning for the proposed changes to ensure the CCG is prepared to take on the 'responsible body' role.
- Act as a point of reference on Safeguarding Adults casework for colleagues across the NHS.
- Design and implement an adult safeguarding assurance process for Domiciliary Care providers and Nursing Homes

13. CONCLUSION

- 13.1 We have ensured that Derby and Derbyshire Clinical Commissioning Group has been actively represented at a wide and diverse range of safeguarding initiatives and work streams. We have continued to assist partner agencies in implementing the Safeguarding Adult Board strategic priorities and work plans. We have continued to raise the profile of this work across a range of staff groups.

We were assessed by NHSE as providing strong standards of performance and were awarded a "Green" rating. We continue to adapt in order to meet demands from the Covid pandemic. We have worked hard to maintain a "business as usual" approach.

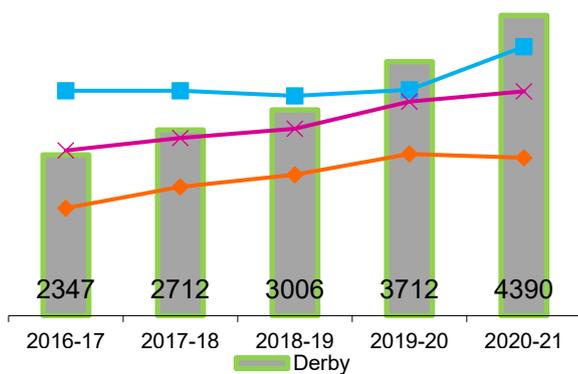
Covid restrictions led to the postponement of our staff training programme. Staff were encouraged to access online alternatives. Information bulletins were also made available.

Bill Nicol
 Assistant Director for Safeguarding Adults
 NHS Derby and Derbyshire CCG
 November 2021

Number of Referrals

Derby City received 4390 referrals from April '20 – March '21. This is an 18% increase on the previous year, as shown in the graph below. Derbyshire received 4318 referrals.

Derby City : 4390 total referrals



Derbyshire : 4318 total referrals



Type of Referral/Category of Abuse

In Derby City the highest category of risk was **neglect/acts of omission at 26%** of all referrals, with physical abuse being second highest at 17%.

In Derbyshire the highest category of risk was also **neglect, at 28%** of all referrals, with physical abuse also being second at 22%.

Location of Abuse

In Derby City the most common location of risk is a person’s own home with 61%. The next largest location of risk is Residential Care Home (12%). In the previous year, 53% were located in Own Home and then 13% Residential Care Home.

For Derbyshire the results are similar with the location of abuse taking place in the adult’s own home (1789 cases). Residential and nursing care homes were the second and third most common locations.

Section 42 Enquiries

In Derby City 53% of safeguarding resulted in further enquiries being undertaken under S.42 of the Care Act 2014, for this 12 month period, this was a decrease on the previous year (62%).

In Derbyshire 39.8% of safeguarding referrals resulted in further enquiries being undertaken under S.42 of the Care Act 2014, for this 12 month period, this was also a decrease on the previous year (48%).

Derby has 22% of individuals involved in Section 42 Enquiries where the individual lacked the capacity to make decisions in 2020-21. This is 11% lower than the previous year (33%).

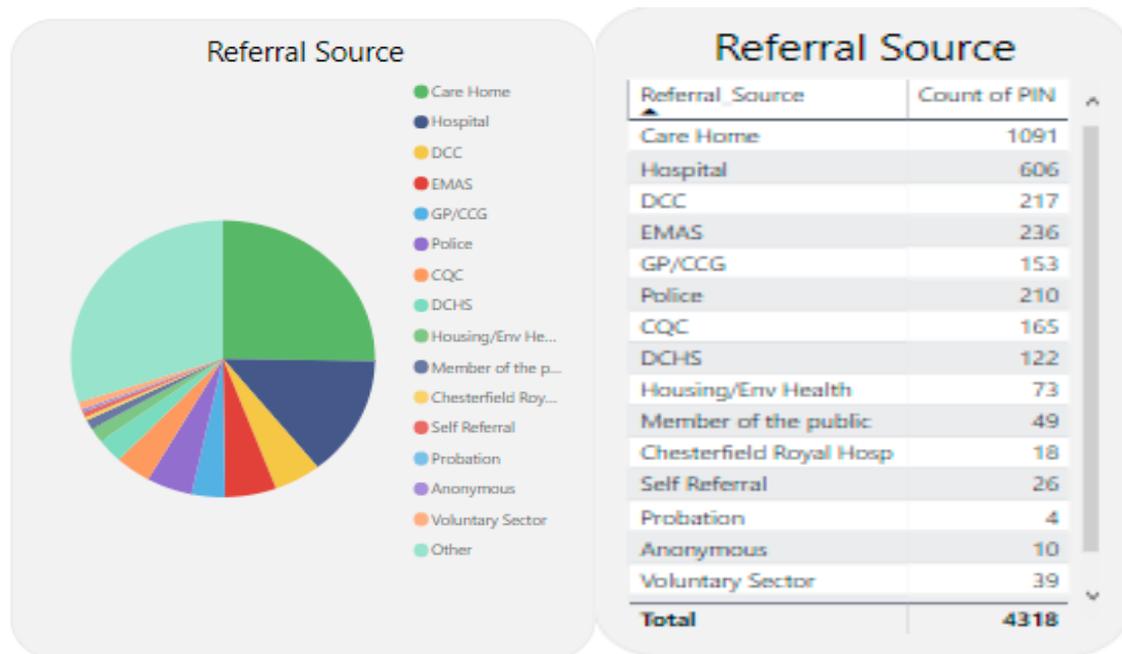
Derbyshire has 33.6 of individuals lacking capacity to make decisions in 2020-21.

Ethnicity

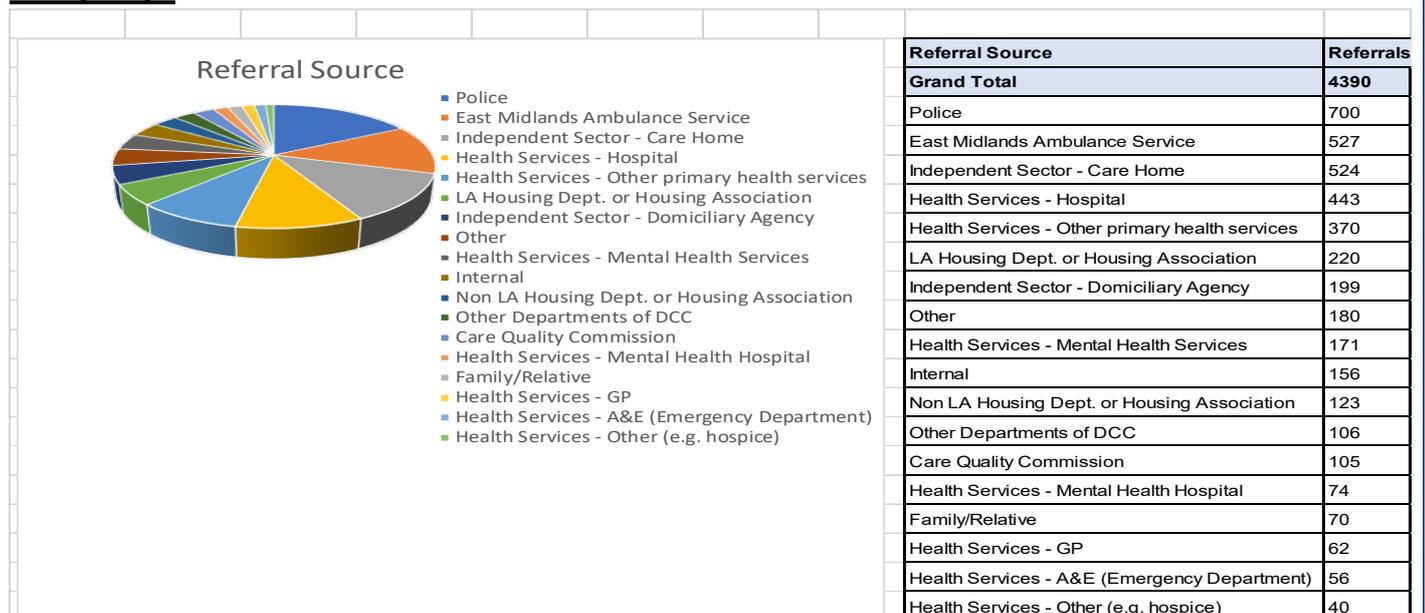
The majority of referrals for Derby City (76%) and Derbyshire (88%) are for adults who are white British.

Referral Source

Derbyshire :



Derby City :



Derby and Derbyshire CCG Governing Body Meeting in Public
Held on
4th November 2021 via Microsoft Teams

UNCONFIRMED

Present:

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
Simon McCandlish	SM	Lay Member for Patient and Public Involvement
Andrew Middleton	AM	Lay Member for Finance
Dr Emma Pizzey	EP	Governing Body GP
Brigid Stacey	BS	Chief Nursing Officer
Dr Greg Strachan	GS	Governing Body GP
Dean Wallace	DW	Director of Public Health - Derbyshire County Council
Dr Merryl Watkins	MW	Governing Body GP
Martin Whittle	MWh	Lay Member for Patient and Public Involvement / Vice Chair (Meeting Chair)

Apologies:

Dr Avi Bhatia	AB	Clinical Chair
Dr Robyn Dewis	RD	Director of Public Health - Derby City Council
Professor Ian Shaw	IS	Lay Member for Primary Care Commissioning

In attendance:

Dawn Litchfield	DL	Executive Assistant to the Governing Body/Minute Taker
Suzanne Pickering	SP	Head of Governance
Andy Harrison	AH	SRO, Acute Care Capital Programme, DHcFT

Item No.	Item	Action
GBP/2122/168	Welcome, Apologies & Quoracy Martin Whittle (MWh) welcomed members to the meeting. Apologies were received and noted as above. It was confirmed that the meeting was quorate.	
GBP/2122/169	Questions received from members of the public No questions were received from members of the public.	

<p>GBP/2122/170</p>	<p>Declarations of Interest</p> <p>MWh 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.</p> <p>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</p> <p><u>Item GBP/2122/187 – Any Other Business – Business as Usual – Capital Finance Plan</u> – All GB GPs declared an interest in this item which related to General Practice funding. The item has previously been considered by the Finance Committee and it was confirmed that GPs were not part of the discussion. All GB GPs left the meeting prior consideration of this item.</p> <p>No further declarations of interest were made, and no changes were requested to the Register of Interests.</p>	
<p>GBP/2122/171</p>	<p>Chair’s Report – October 2021</p> <p>MWh presented Dr Avi Bhatia's (AB) 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:</p> <ul style="list-style-type: none"> • The work being undertaken by the NHS to improve climate change was highlighted. • The clinical trial of blood tests in relation to the diagnosis of cancer will be very helpful and it is good that the Derbyshire population will be participating in it. • The violence and aggression towards our Emergency Department and Primary Care colleagues needs to be minimised; it is very sad that this is even happening at all. <p>The following questions were raised in relation to the report:</p> <ul style="list-style-type: none"> • It was enquired how well sighted the CCG is on the base data that enables progress on the Green agenda to be charted, and when the Green Plan, currently in development, will be made available to Governing Body members. Helen Dillistone (HD) responded that the CCG has been working on the Plan however the regional level data which demonstrates where the region sits against the rest of county, in terms of carbon emission outputs, has only recently been received. The 1990 NHS data was compared to the current data and has shown a significant reduction, which is pleasing. Specific interim targets have been set to help reach net zero by 2030 and 2045 for the remaining targets. CCG staff received a presentation recently highlighting some of the biggest contributing factors in the NHS, including anaesthetic gases and inhalers. A workstream and ICS Green Delivery Group has been established, comprising acute and community Chief Pharmacists and Medicines Leads, to take this issue forward. Other areas of priority include NHS estates, waste management and fleet. There is a good understanding of what the main contributors are. 	

	<p>Benchmarking data demonstrates the current position and the target that needs to be reached, both at an individual organisation level and collectively across the ICS. Each organisation is required to have its own Strategy and Plan by the new year. A Board Level Executive Lead is required to champion the green agenda. This will be overseen by the ICS and best practice shared; an ICS Green Plan is required by March 2022.</p> <ul style="list-style-type: none"> It was enquired how practices are being supported regarding physical infrastructures to help keep their staff safe from violence and aggression. Dr Steve Lloyd (SL) advised that the CCG, LMC and GP Taskforce are working together to support practices and a resource pack issued to provide links to wider training and support. It is hoped to expand premises funding to help improve security arrangements. SL meets with MPs regularly to flag up concerns. There is a need to inform and educate patients on this particularly challenging and vexing issue. <p>The Governing Body NOTED the contents of the report provided</p>	
<p>GBP/2122/172</p>	<p>Chief Executive Officer's Report – October 2021</p> <p>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:</p> <ul style="list-style-type: none"> A series of interviews were undertaken recently by Radio Derby, speaking to all Derbyshire System CEOs about the health challenges currently being faced across the System, and how best to support people through the winter period. The importance of the vaccination programme was highlighted, and people were encouraged to take up the offer of a COVID-19 vaccine and booster, and the flu vaccination, as soon as possible. The public were encouraged to use the NHS 111 On-Line service to access healthcare information and advice. The Integrated Care System (ICS) will come into being from 1st April 2022. The CCG is currently supporting the set up and development of the Derbyshire ICS, in conjunction with the wider System partnership. The new Integrated Care Board (ICB) will come into being and the CCG will cease to operate. Continued engagement with patients and System partners is being undertaken to ensure that their voices are heard on the priorities going forward. Our Glossop CCG colleagues will be joining the Derbyshire ICS from April 2022. On behalf of CC, HD thanked all health and social care staff for their continued support and the work they are undertaking at this difficult time. <p>MWh advised that the recent Derbyshire Dialogue engagement event was very interesting and was well received by all who participated. Many members of the public joined the session to contribute to the discussions and share their knowledge.</p> <p>The following questions were raised:</p> <ul style="list-style-type: none"> The Foundation Trusts all have a membership and elected Governors which is a good route towards engaging with a broad spectrum of the population; it was asked whether it would be possible for the ICS to have a membership to generate more widespread interest. MWh 	

	<p>agreed that working more with FT Governors would be a great opportunity to bolster engagement overall and requires further consideration. HD advised that some of the Trusts' Governors are on the Engagement Committee therefore providing links into the Trusts. Use of the Trusts' membership and Governors would help to create better public partnerships across the health and social care networks.</p> <ul style="list-style-type: none"> • The exhaustion of NHS staff through working long hours and extra shifts was highlighted; there is a need to be conscious of this fact when planning for the winter. Positive, supportive messages need to be conveyed to staff, giving praise for the work being done to counteract the negativity being portrayed within the press. <p>The Governing Body NOTED the contents of the report provided</p>	
<p>GBP/2122/173</p>	<p>DHcFT Acute Mental Health Dormitory Eradication</p> <p>Zara Jones (ZJ) presented the Outline Business Cases (OBCs) relating to the refurbishment of the Radbourne Acute Mental Health Unit in Derby, the provision of a new male Psychiatric Intensive Care Unit (PICU) and the new female acute plus inpatient services in Derby. This links to the previous discussions on the strategic importance of dormitory eradication. The OBCs have already been approved for the two 54-bedded units in the north and south of the county and ZJ was pleased to inform that a national process has approved an £80m award to build those facilities.</p> <p>ZJ confirmed that scrutiny has been undertaken on the capital and revenue requirements: the OBCs were taken through the System Finance and Estates Committee (SFEC) to ensure that they fit with the System's Capital Prioritisation Plan. The Mental Health Delivery Board (MHDB), which is the key System Group overseeing the developments, is taking ownership of the revenue implications, recognising that the revenue costs attributed to this spend would result in revenue not necessarily being available for other initiatives. The System's Oversight and Scrutiny Committees are sighted on the developments, as is the CCG's Engagement Committee and CLCC.</p> <p>Andy Harrison (AH) provided a presentation, a copy of which was circulated to members post meeting, outlining the OBCs for the eradication of dormitories and development of local facilities to reduce out of area placements. When the Full Business Cases (FBC) are submitted for final national approval next year, there will be a need to demonstrate that progress has been made on local developments.</p> <p>ZJ added that the most cost-effective solutions have been developed in order to meet the strategic commissioning intentions for inclusion in local capital plans.</p> <p>The following questions were raised:</p> <ul style="list-style-type: none"> • This initiative has been long awaited; AH was thanked for all the work he has put into this project. • It was enquired how the 14 bed PICU facility has been modelled and whether it would be adequate to prevent patients from being sent out of area, as far as possible. AH confirmed that the numbers of patients requiring PICU over the last 3 years in Derbyshire have been analysed, taking into account potential growth and using national statistical modelling; it was demonstrated that 14 beds will be capable of dealing with the forward projection over the next 3 years. These findings will be 	

confirmed as the FBC is developed, in line with future demand using CCG and national data.

- CC stated that the acknowledgment of the MHDB of the revenue consequences is an important strategic shift for the System. The need to invest, from a revenue basis, in a specialised end of care pathway was also recognised.
- CC took an action from the SFEC meeting to gauge the assurance of the CLCC on the two out of area female PICU patients who may still need to be cared for outside of Derbyshire, and the model intended around that. Dr Ruth Cooper (RC) challenged this at the CLCC meeting and was informed that this was the most cost-efficient solution. ZJ confirmed that, from a clinical perspective, in some circumstances, out of area placements are deemed to be the most appropriate solution if it is not possible to meet patients' needs in-county; it was noted that this is the right approach for these two particular individuals. It was also noted that appropriate governance processes are in place and were utilised effectively by the CLCC, with robust discussions being held; assurance was taken from this process.
- The Commissioning for Individuals Panel often struggles to find suitable in-county provision for specialist patients. The proposed facilities continue the trend to develop more home-grown capacity to support patients. The Panel will be delighted at the prospect of having packages available for patients in-county, for which there are good assurance mechanisms and scrutiny in place. Should the market develop and an upward trend for highly complex cases emerge, assurance was provided at the SFEC that the architectural design of the facilities would allow expandability in the future.
- It was acknowledged that the workforce development is ongoing alongside the build and a watch needs to be kept of numbers to ensure that there will be enough staff to run the new facilities.
- Confirmation of the arrangements for de-canting patients during the refurbishment period was requested, particularly regarding the continuity of service provision. AH advised that the refurbishments will commence early in the next financial year and outlined the three-phase process which will maintain the same number of beds over the refurbishment process, thus having a minimal impact on service provision.
- From a quality and patient safety perspective, this is a much-needed development for Derbyshire.

The Governing Body:

- **NOTED the Outline Business Cases relating to the refurbishment of the Radbourne Acute MH Unit in Derby, the provision of a new male Psychiatric Intensive Care Unit and new female acute plus inpatient services, both to be provided on the Kingsway Hospital campus in Derby**
- **REVIEWED the recommendations from the CLCC**
- **NOTED the approval provided from the JUCD System Finance and Estates Committee**
- **CONFIRMED support for the progress of the Outline Business Cases**
- **APPROVED content of proposed letters of support**
- **NOTED that the final OBC relating to the proposed relocation of the older people's mental health wards in North Derbyshire will be reviewed at future CCG Committees and Governing Body**

GBP/2122/
174

Winter Plan Update

ZJ provided an overview of the Winter Plan which included:

- The operational priorities for the NHS to deliver over the next six months – as per those set out recently by NHS England
- The key challenges that the NHS in Derby and Derbyshire face this Winter
- The headline messages in relation to delivery against the operational priorities set by NHS England – reflecting the current status of planning works across the Derby and Derbyshire NHS
- The work that continues to be done to prepare the NHS for Winter.

A presentation was provided, a copy of which was circulated with the meeting papers, outlining the 2021/22 priorities and operational planning for October 2021 to March 2022.

Every winter is difficult, but this winter seems to be the most challenging one to date. Although there has been a change in the COVID-19 position, it has not provided enough headroom going into winter due to a challenging summer and autumn period. The pressures are being felt across the whole System, from General practice, to community, acute or mental health service providers and the current performance issues are adding to the pressures.

All System partners have contributed to the development of the Urgent and Emergency Care Plan which was broadened out to look at non-emergency care and the pathways aspects. The Plan is currently being finalised in preparation for submission to NHSEI by 16th November 2021.

The following questions were raised:

- Concern was expressed how effective the Winter Plan will be if it is reliant upon staff, most of whom are already stretched to the limit and do not have the capacity to work more sessions; this together with increased sickness levels due to COVID-19, the viruses around at this time of the year, and stress and burnout, will have a profound effect on the delivery of the Plan. ZJ agreed that this was a real challenge. The Winter Plan includes workforce initiatives including wellbeing offers and support. All providers are working to fill the recruitment gaps whilst preventing moving the problem elsewhere. There is a need to support staff and manage expectations, filling shifts through overtime within reasonable parameters. The Plan is probably unbalanced however it includes an honest appraisal of the challenges for which there is not necessarily an easy solution.
- It needs to be ensured that there is a read across from the Winter Plan to the Primary Care Plan confirming continuity between the two, complimenting rather than causing problems for each other.
- Capacity to deliver was also discussed by the PCCC, particularly around DHU colleagues picking up the front-line work which is dependent upon the availability of staff. There is a need to ensure a focus on getting the resources in the right place. Volunteers also have an important role to play; it was asked if anything could be done to create a volunteer cohort to support the Plan. ZJ confirmed that volunteering options are being considered as part of the long-term workforce planning led by the workforce leads.

	<ul style="list-style-type: none"> The workforce is recognised as one of the key risks and mitigations have been implemented as far as possible. It has been agreed that the Winter Plan will be held by the Strategic Operational Review Group (SORG); a process has been established to escalate any matter that SORG considers necessary, due to operational pressures, to a multi-agency panel for a robust EQIA process and advice on any potential risks. It was recognised that there are no easy solutions to this problem; it was requested that the Governing Body holds a deep dive on the workforce challenges. This is one of the most comprehensive Winter Plans ever seen. The Governing Body could gain assurance that it has been through the appropriate CCG Corporate and System Committees where all quality and safety aspects have been considered. However, there is still work to be done and the situation will be kept under review over the next few months. <p>The Governing Body NOTED the progress of the NHS' preparations for winter across Derby and Derbyshire</p>	HD
GBP/2122/175	<p>Finance Report – Month 6</p> <p>Richard Chapman (RCp) provided an update on the financial position as at Month 6 (H1). The following points of note were made:</p> <ul style="list-style-type: none"> All targets have been met. There is a £696k surplus for H1 after accounting for a £2.8m COVID reimbursement for Quarter 2 and a £676k pay award for two non-NHS providers whose staff are on Agenda for Change (A4C) contracts. A chart was presented demonstrating a straight-line extrapolation of current expenditure run rates against forecast outturn. There are forecast reductions in expenditure run rates between the year-to-date position and the year-end, the largest being in acute services; the System will receive a reduced COVID top up allocation in H2 and will therefore be paying less out to providers hence the run rate reduction. Some non-recurrent allocations received in H1 have not yet been confirmed in H2 therefore cannot form part of the forecast outturn. The System received £8.5m elective recovery funding in H1, which was paid to acute providers however this is not included in the H2 returns. This is partially offset by an increased flow of funding for the A4C pay awards and an increased forecast in independent sector activity. Planning for H2 continues in preparation for submission of the Plan on 16th November however the numbers are likely to change before submission. Specific risks include a deterioration in the primary care prescribing position driven by an increase in the numbers of prescriptions issued. A deep dive is to be undertaken to look at the root cause of the activity patterns, with a possible hypothesis that the growth is being driven by increased hospital discharges. There was a £5m System surplus for H1 driven by improvements to plan for UHDBFT, and a reported underspend for the CCG of £696k. The retrospective allocations received for Quarter 1 spend on the hospital discharge programme were £2.7m, and a further £2.8m is expected for months 4-6, which has already been accounted for. Elective Recovery Funding of £702k has been reimbursed to the CCG for April to September 2021. 	

	<p>It was noted that the PCCC held a detailed conversation on the prescribing concerns. It was good to receive RCp's feedback on how the CCG is focusing on this, as it is something that may throw the finances off course.</p> <p>The Governing Body NOTED the following:</p> <ul style="list-style-type: none"> • 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 	
<p>GBP/2122/176</p>	<p>Finance Committee Assurance Report – October 2021</p> <p>Andrew Middleton (AM) provided a verbal update following the Finance Committee meeting held on 28th October 2021. The following points of note were made:</p> <ul style="list-style-type: none"> • The Committee undertook deep dives into CHC and Section 117 funding; good challenges were made by Committee members with good responses received from the presenting teams. It was acknowledged that a deeper understanding of the subjects had been gained due to deep dives. A primary care prescribing deep dive is planned for next month. The purpose of deep dives is to recognise and understand trends that may not have been anticipated and implement necessary actions. • Challenged by the CEO to forge a pathway towards closer financial arrangements across the System, a proposal was put forward to merge the CCG's Finance Committee with SFEC, which was endorsed. The CCG's Finance Committee will join the SFEC meeting to discharge its normal duties in the presence of SFEC members from January 2022 and members are invited to remain for the System element of the meeting to contribute to common issues. This will also provide the System with a better understanding of CCG issues. • The underlying deficit position has not gone away; work is ongoing to address this deficit through the PMO; PMO feedback will be a standing item on the new merged Committee's agenda. <p>It was queried how much longer the COVID money will be provided for and how much this is in the minds of the Finance Team. RCp advised that the COVID allocation has been reduced for H2. In H1 £65.3m was received by the System; in H2 this falls to £56.8m which is still a significant contribution therefore it is still very much in the minds of finance.</p> <p>The Governing Body NOTED the verbal update provided for assurance purposes</p>	
<p>GBP/2122/177</p>	<p>Clinical and Lay Commissioning Committee (CLCC) Assurance Report – October 2021</p> <p>Dr Ruth Cooper (RC) provided an update following the CLCC meeting held on 14th October 2021. The report was taken as read and the outcomes of discussions were noted. The following points of note were made:</p>	

	<ul style="list-style-type: none"> • The Committee noted and was assured by the CYPMH Transformation Plan and agreed to its onward transmission to Governing Body. • The Committee unanimously supported the taking forward of the PICU Outline Business Case to the Governing Body. • The following policies / position statements were ratified by the Committee: <ul style="list-style-type: none"> • Treatment of Congenital Pigmented Lesions on the face • Removal of Benign Skin Lesions Policy – minor amendment • Surgical Removal of Lipoma/Lipomata Policy – minor amendment • Surgical Removal of Epidermoid and Pilar Cyst Policy – minor amendment <p>The Governing Body NOTED the paper for assurance purposes and RATIFIED the decisions made by the CLCC</p>	
<p>GBP/2122/178</p>	<p>Primary Care Commissioning Committee (PCCC) Assurance Report – October 2021</p> <p>Simon McCandlish (SM) provided a verbal update following the PCCC meeting held on 27th October 2021. The following points of note were made:</p> <ul style="list-style-type: none"> • Several projects from the Primary Care Estates Steering Group were approved. • An application to vary the GMS contract was approved. • The collaborative approach to the Government's Access to Primary Care was commended by the Committee, along with the associated pressures that the Primary Care Team had to work under to meet the deadline. • The Month 6 Finance report was approved. <p>The Governing Body NOTED the verbal update provided for assurance purposes</p>	
<p>GBP/2122/179</p>	<p>Quality and Performance Committee (Q&PC) Assurance Report – October 2021</p> <p>Dr Buk Dhadha (BD) provided an update following the Q&PC meeting held on 28th October 2021. The report was taken as read and the following points of note were made:</p> <ul style="list-style-type: none"> • There are early signs of improvement in performance in breast services following a reorganisation in the breast pathway across Derbyshire, although close monitoring continues to be undertaken. • The delays in ambulance response times were discussed by the Committee and assurance was received on the quality and patient safety processes implemented. • The Committee approved the reduction of Risk 38 relating to the CHC backlog, and the closure of Risk 14 relating to the non-compliance of completion of Initial Health Assessments. • A paper was requested for the next Committee meeting on the need to identify patient safety specialists as part of the NHS patient safety strategy for the standard NHS contract for 2021/22. A recommendation will be made to the Governing Body next month. <p>The Governing Body NOTED the paper for assurance purposes</p>	

<p>GBP/2122/180</p>	<p>CCG Risk Register – October 2021</p> <p>HD advised that this report highlights areas of organisational risk recorded in DDCCG’s Corporate Risk Register as at 31st October 2021. All risks in the Register are allocated to one of the CCG’s Corporate Committees which reviews them on a monthly basis. The following request was made:</p> <ul style="list-style-type: none"> • Risk 14, relating to the ongoing compliance of non-completion of Initial Health Assessments, has been on the Risk Register all year, however following a discussion held at the Derby and Derbyshire Safeguarding Committee, it was considered that this risk had been appropriately managed, with mitigations implemented and could therefore be removed from the Register. <p>The Governing Body RECEIVED and NOTED:</p> <ul style="list-style-type: none"> • The Risk Register Report • Appendix 1 as a reflection of the risks facing the organisation as at 31st October 2021 • Appendix 2 which summarises the movement of all risks in October 2021 • The decrease in risk score for risk 38 relating to the risk of quality of care being impacted by patients not receiving a care needs review in a timely way as a result of the COVID pandemic • The decrease in risk score for risk 40 relating to contract extensions <p>And APPROVED the closure of risk 14 relating to on-going non-compliance of completion of initial health assessments (IHAs)</p>	
<p>GBP/2122/181</p>	<p>Children and Young People Mental Health Transformation Plan</p> <p>ZJ presented the Plan for completeness following presentation at last month’s confidential session. It has now been published on websites.</p> <p>The Governing Body NOTED that the CYPMH Transformation Plan is based on the previously agreed Futures in Mind and the CYP Crisis plans and to note for information that:</p> <ul style="list-style-type: none"> • Our Derbyshire ICS Children and Young People Mental Health Transformation plan has been published, as required by NHSEI • A draft of the CYPMH Transformation plan was submitted to NHSEI and feedback received which has been incorporated into the final version • The draft plan has been circulated widely for system engagement, contributions and debate • Associated financial investments have previously been agreed 	
<p>GBP/2122/182</p>	<p>Ratified Minutes of DDCCG’s Corporate Committees:</p> <ul style="list-style-type: none"> • Primary Care Commissioning Committee – 22.9.2021 • Quality and Performance Committee – 30.9.2021 <p>The Governing Body RECEIVED and NOTED these minutes</p>	

GBP/2122/ 183	<p>South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) CEO Report – October 2021 / ICS Development Update</p> <p>The Governing Body RECEIVED and NOTED these reports</p>	
GBP/2122/ 184	<p>Minutes of the Governing Body meeting in public held on 7th October 2021</p> <p>The minutes of the above meeting were agreed as a true and accurate reflection of the discussions held</p>	
GBP/2122/ 185	<p>Matters Arising / Action Log</p> <p><u>Action Log – October 2021</u> – No outstanding items</p>	
GBP/2122/ 186	<p>Forward Planner</p> <p>A deep dive session on workforce planning is to be scheduled following consideration at the Governance Committee as to what it should include.</p> <p>The Governing Body NOTED the Planner for information</p>	
GBP/2122/ 187	<p>Any Other Business</p> <ul style="list-style-type: none"> • <u>Business As Usual Capital Finance Plan</u> <p>All GPs declared an interest in this item and left the meeting at this point</p> <p>RCp advised that the Finance Committee considered the Business-As-Usual (BAU) Capital Finance Plan at its meeting on 28th October 2021 and recommended that the Governing Body:</p> <ol style="list-style-type: none"> 1. RATIFIED the planned use of a £2.11m (BAU) capital allocation that NHSEI has made available for the CCG to use for GPIT, corporate IT and GP premises. 2. NOTED the Finance Committee's ratification of the urgent approval of spend against the draft Capital Plan by the Chief Finance Officer and Medical Director, and the methodology in seeking approval in the absence of the Accountable Officer. <p>The Governing Body APPROVED the recommendations made by the Finance Committee as above</p>	
<p>DATE AND TIME OF NEXT MEETING – Thursday 2nd December 2021 – 9.30am to 11am via Microsoft Teams</p>		

Signed by:
(Chair)

Dated:

**GOVERNING BODY MEETING IN PUBLIC
ACTION SHEET – November 2021**

Item No.	Item title	Lead	Action Required	Action Implemented	Due Date
2021/22 Actions					
GBP/2122/054	<u>Joined Up Care Derbyshire Board Update – May 2021</u>	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/2122/123	<u>Chair's Report – August 2021</u>	Martin Whittle	It was requested that the Britain Thinks Report be presented to the Governing Body in full.	Copy circulated to Governing Body members	Item complete
GBP/2122/130	<u>Derbyshire Engagement Committee Assurance Report – August 2021</u>	Martin Whittle	It was enquired whether there is any evidence which captures the fact that services have improved, and not deteriorated, when changes have been made to them.	The evidence available to demonstrate that more people are being discharged to the places that will best meet their needs is currently being collated	January 2022
GBP/2122/174	<u>Winter Plan Update</u>	Helen Dillistone	It was requested that the Governing Body holds a deep dive on the workforce challenges.	HD agreed to discuss with the Governance Committee, Executive Team and Linda Garnett	February 2022

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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> Quality & Performance Report Serious Incidents Never Events 	X	X	X	X	X	X	X	X	X	X	X	X
Governance Committee Assurance Report <ul style="list-style-type: none"> 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												
<ul style="list-style-type: none"> 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												