NHS DERBY AND DERBYSHIRE CCG

GOVERNING BODY – MEETING IN PUBLIC

Date & Time: Thursday 2nd September 2021 – 9.30am to 11am
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/ 120	**Welcome, Apologies & Quoracy** Apologies: Dean Wallace, Dr Merryl Watkins, Dr Bruce Braithwaite, Dr Steve Lloyd	Verbal	Dr Avi Bhatia	9.30
GBP/2122/ 121	**Questions from members of the public**	Verbal	Dr Avi Bhatia	
GBP/2122/ 122	**Declarations of Interest** • Register of Interests • Summary register for recording any conflicts of interests during meetings • Glossary	Papers	Dr Avi Bhatia	
CHAIR AND CHIEF OFFICER REPORTS				
GBP/2122/ 123	**Chair's Report – September 2021**	Paper	Dr Avi Bhatia	9.35
GBP/2122/ 124	**Chief Executive Officer's Report – September 2021**	Paper	Dr Chris Clayton	
GBP/2122/ 125	**Derby and Derbyshire CCG's Annual Accounts and Report for 2020/21** **Link to Annual Accounts and Report:** **https://www.derbyandderbyshireccg.nhs.uk/publications/annual-report-accounts/**	Link/ Paper	Dr Chris Clayton / Richard Chapman	
GBP/2122/ 126	**Proposal to supplement the Joint Committee's CCG Manual to expand the Scope of the Joint Committee Delegation and put in place additional arrangements for the transition to Integrated Care Boards 2021/22 (Schedule 3)**	Paper	Dr Chris Clayton	10.05

CORPORATE ASSURANCE				
GBP/2122/ 127	**Finance Report – Month 4**	**Paper**	**Richard Chapman**	**10.15**
GBP/2122/ 128	**Finance Committee Assurance Report – August 2021**	**Verbal**	**Andrew Middleton**	
GBP/2122/ 129	**Clinical and Lay Commissioning Committee Assurance Report – August 2021**	**Paper**	**Dr Ruth Cooper**	
GBP/2122/ 130	**Derbyshire Engagement Committee Assurance – August 2021**	**Paper**	**Martin Whittle**	
GBP/2122/ 131	**Primary Care Commissioning Committee Assurance Report – August 2021**	**Verbal**	**Professor Ian Shaw**	
GBP/2122/ 132	**Quality and Performance Committee Assurance Report – August 2021**	**Paper**	**Dr Buk Dhadda**	
GBP/2122/ 133	**CCG Risk Register – August 2021**	**Paper**	**Helen Dillistone**	
FOR INFORMATION				
GBP/2122/ 134	**Update on the Derbyshire Integrated Care System Boundary**	**Paper**	**Dr Chris Clayton**	**10.45**
GBP/2122/ 135	**Derbyshire County Council Health and Wellbeing Board Minutes - 8.7.2021**	**Papers**	**Dr Chris Clayton**	
GBP/2122/ 136	**Ratified Minutes of Corporate Committees:** • Derbyshire Engagement Committee – 20.7.2021 • Primary Care Commissioning Committee – 28.7.2021 • Quality and Performance Committee – 29.7.2021	**Papers**	**Committee Chairs**	
GBP/2122/ 137	**South Yorkshire and Bassetlaw Integrated Care System CEO Report – August 2021**	**Paper**	**Dr Chris Clayton**	
MINUTES AND MATTERS ARISING FROM PREVIOUS MEETING				
GBP/2122/ 138	**Minutes of the Governing Body Meeting in Public held on 5th August 2021**	**Paper**	**Dr Avi Bhatia**	**10.55**
GBP/2122/ 139	**Matters arising from the minutes not elsewhere on agenda:** • Action Log – August 2021	**Paper**	**Dr Avi Bhatia**	
GBP/2122/ 140	**Forward Planner**	**Paper**	**Dr Avi Bhatia**	

GBP/2122/ 141	**Any Other Business**	**Verbal**	**All**	

Date and time of next meeting: **Thursday 7th October 2021 from 9.30am to 11.15am – 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 Derbyshire Place Board Joined Up Care Derbyshire Long Term Conditions Workstream	GP Partner at Moir Medical Centre	✓				2000	Ongoing	Withdraw from all discussion and voting if organisation Is potential provider unless otherwise agreed by the meeting chair
				GP Parter at Erewash Health Partnership	✓				April 2018	Ongoing	
				Spouse works for Nottingham University Hospitals in Gynaecology				✓	Ongoing	Ongoing	
				Part landlord/owner of premises at College Street Medical Practice, Long Eaton, Nottingham	✓				Ongoing	Ongoing	
Blackwell, Dr Penny	Governing Body GP	Governing Body	Derbyshire Primary Care Leadership Group Gastro Delivery Group Derbyshire Place Board Dales Health & Wellbeing Partnership Dales Place Alliance Group Joined Up Care Derbyshire Long Term Conditions Workstream	Director of Flourish Derbyshire Dales CIC, which aims to provide creative arts and activity projects and to support others in this activity for the Derbyshire Dales		✓			Feb 2019	Ongoing	Withdraw from all discussion and voting if organisation Is potential provider unless otherwise agreed by the meeting chair
				GP partner at Hannage Brook Medical Centre, Wirksworth. Interests in Drug misuse	✓				Oct 2010	Ongoing	
				GP lead for Shared Care Pathology, Derbyshire Pathology		✓			2011	Ongoing	
				Clinical advisor to the board of Sinfonia Viva, a professional orchestra		✓			01/04/2021	Ongoing	
Braithwaite, Bruce	Secondary Care Specialist	Governing Body	Audit Committee Clinical & Lay Commissioning Committee	Shareholder in BD Braithwaite Ltd, which provides clinical services to Independent Healthcare Groupand provides private medical services in the East Midlands (including patients who are not eligible for NHS funded treatment according to CCG guidelines)	✓				Aug 2014	Ongoing	Withdraw from all discussion and voting if organisation Is potential provider unless otherwise agreed by the meeting chair
				Employed by Nottingham University Hospital NHS Trust which is commissioned by the CCG to provide services to NHS patients.	✓				Aug 2000	Ongoing	Declare interest in relevant meetings
				Founder Member, Shareholder and Director of Clinical Services for Alliance Surgical plc which is a company that bids for NHS contracts.	✓				July 2007	Ongoing	Withdraw from all discussion and voting if organisation Is potential provider unless otherwise agreed by the meeting chair
				Fellow of the Royal College Of Surgeons of England and Member of the Vascular Society of Great Britain and Ireland. Advisor to NICE on an occasional basis.		✓			Aug 1992	Ongoing	No action required
				Honorary Associate Professor, University of Nottingham, involved in clinical research activity in the East Midlands.		✓			Aug 2009	Ongoing	No action required
				Medical Director of Independent Healthcare Group which provides local anaesthetic services to NHS patients in Leicestershire, Gloucestershire, Wiltshire and Somerset.	✓				Oct 2020	Ongoing	Withdraw from all discussion and voting if organisation Is potential provider unless otherwise agreed by the meeting chair
				Chief Medical Officer for Circle Harmony Health Limited which is part owned by Circle Health Group who run BMI and Circle Hospitals	✓				Aug 2020	Ongoing	Withdraw from all discussion and voting if organisation Is potential provider unless otherwise agreed by the meeting chair

Chapman, Richard	Chief Finance Officer	Governing Body	Clinical & Lay Commissioning Committee Finance Committee Primary Care Commissioning Committee	Nil							No action required
Clayton, Dr Chris	Chief Executive Officer	Governing Body	Clinical & Lay Commissioning Committee Primary Care Commissioning Committee	Spouse is a partner in PWC				✓	2019	Ongoing	Declare interest at relevant meetings
Cooper, Dr Ruth	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Finance Committee 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 03/02/2021 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 07.06.2021	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 Conditions Specific Delivery Board 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	GP Partner at St. Lawrence Road Surgery Clinical sessions at St. Lawrence Road Surgery Shareholder in premises of Emmett Carr Surgery, Renishaw; and St. Lawrence Road Surgery, North Wingfield	✓ ✓ ✓				2012 2012 Ongoing	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 be
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	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	✓ ✓ ✓	✓		✓	2009 2016 2009 18.03.20 2015	Ongoing	Withdraw from all discussion and voting if organisation Is potential provider unless otherwise agreed by the meeting chair INR service interest is to be noted at Governance Committee due to the procurement highlight report, which refers to, for information only, the INR service reprocurement. No further action is necessary as no decisions will be made at this meeting and the information provided does not cause a conflict.
Wallace, Dean	Director of Public Health, Derbyshire County Council	Governing Body	Derbyshire Place Board	Nil							No action required
Watkins, Dr Merryl	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Quality & Performance Committee	GP Partner at Vernon Street Medical Centre Husband is Anaesthetic and Chronic Pain Consultant at Royal Derby Hospital	✓			✓	2008 1992	Ongoing Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Whittle, Martin	Lay Member for Patient and Public Involvement	Governing Body	Engagement Committee Finance Committee Governance Committee Quality & Performance Committee Remuneration Committee	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 September 2021

Item No: 123

Report Title	Chair's Report – August 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

My most recent Governing Body reports have focussed on pressures in the Derbyshire health system, in our primary care services and in our emergency care services. This pressure continues and is covered in the Chief Executive's report and our various communications issued from the CCG and Joined Up Care Derbyshire, so I will not repeat those messages.

The health service has done wonderful things during the pandemic and has rightly been commended throughout the last eighteen months for keeping calm and carrying on in the face of some very challenging conditions. But it is also fair to say that it hasn't been the usual service for some patients, and we fully appreciate that. Despite our GP practices, paramedics, community services and hospital staff performing miracles in adapting to unprecedented conditions, some patients have not been able to receive the care they wanted.

Alongside the work of our system partners in seeking solutions and trying to alleviate pressure and deliver services in a different way as we come to live with covid-19, we have also been speaking with the public about their experiences or perceptions around access to healthcare. We partnered with Britain Thinks and they have been holding focus groups and depth interviews with a range of people, some of whom have used services recently so we can understand their experiences, and some who haven't used services recently, so that we can understand their perceptions of what it might be like and understand their decision-making processes and motivations in using what is a very complex NHS system.

The detailed outcomes of this work are being finalised, but the headlines are straightforward for Derbyshire, and we know from Britain Thinks and the work they have done in other parts of the country, that the Derbyshire position correlates with what is reported elsewhere. Some of our hypotheses about how patients might decide about service choices are accurate, but some are not, and it's important to reflect that in a county such as Derbyshire, with significant range of rural and urban

areas and diversity among the population within them, that we cannot take one set of actions to find solutions and that this will need tailoring, often down to practice level.

What have we learned so far?

- Patients in rural areas have a better experience of getting a GP appointment compared to their urban counterparts.
- When in the system and being cared for, patients tell us that their experiences are good, but access into our system is not so good.
- We must avoid blaming patients in the language we use around service pressures; patients are trying to do the right thing.
- Patients report a 'wait and see' approach before deciding to come for help from the NHS and the choices of the service they seek help from are grounded in good faith. Patients understand the pressure of urgent care services and don't use them lightly. Equally, patients don't come to A&E simply because they struggle to access primary care.
- We must remember that the NHS system is complex, and we don't make it easy, with indistinguishable terms such as 'urgent' and 'emergency' meaning different things from an NHS service perspective, when the dictionary defines them very similarly.
- When children are involved, there are fewer risks taken by their parents when seeking care.

We'll continue to understand the outcomes from the work with Britain Thinks and this will influence our service delivery and communications activity for the future. We have many patients reporting excellent things about their experience of the NHS, with some clear steers on where we can make a difference and we will take these findings into our development plans for the next period.

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 September 2021

Item No: 124

Report Title	Chief Executive Officer's Report – August 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

The last month has again seen some important developments for the NHS both nationally and locally.

John MacDonald has been confirmed as Chair-Designate for the Derbyshire Integrated Care Board (ICB) when it takes on statutory responsibilities as anticipated from April 2022. Mr MacDonald lives in Ashbourne and has worked in and with the NHS in board-level roles for more than 25 years. He has been the independent chair of Joined Up Care Derbyshire since 2019. Advertisements for the 42 ICB Chief Executive posts are expected to go live on 1st September 2021.

Amanda Pritchard has started her role as Chief Executive Officer of NHS England, where she is responsible for an annual budget of more than £130 billion while ensuring that everyone in the country receives high quality care.

"I have always been incredibly proud to work in the health service but never more so than over the last 18 months as nurses, doctors, therapists, paramedics, pharmacists, porters, cleaners and other staff have responded so magnificently to the COVID pandemic. I am honoured to lead the NHS, particularly as the first woman chief executive of an organisation whose staff are more than three quarters female."

Amanda has worked in the NHS for many years and her experience and expertise will be invaluable as the NHS continues its response to the pandemic, prepares for what is expected to be a very difficult winter and embarks on the creation of integrated organisations to bring hospitals and community services closer together. I wish Amanda every success in her new role.

Our health and care system has continued to be stressed during the last month. Despite increasing the volume of elective procedures being undertaken, our waiting lists continue to rise, with over 84,000 patients waiting as at the end of June. Over 27,000 of these had been waiting over 18 weeks and there are still high numbers of patients waiting over 52 weeks at both of our acute providers, not only due to delays

caused by the pandemic but the Trusts report that some of the longest waiters for elective surgery are still reluctant to have their surgery.

For cancer patients the proportion treated within 62 days has shown improvement but performance against the 2 week wait and 31 day standards continues to fluctuate. Our ambulance services continue to experience significant pressure due to the high volume of calls and remain at their highest level of escalation, which is the case for most ambulance services across England.

Our planning for winter is well underway ahead of our submission to NHS England/Improvement by 30th September. Our current challenging activity position is central to that plan to ensure that we are able, where possible, to protect our elective care programme at the same time as dealing with the seasonally predicted rise in activity for our medical beds and other types of care. Modelling for the impact of any rise in Covid-19 cases will also be included in our planning, but we await the national position to help inform our approach. Aligned to this is our planning to support the implementation of the next phase of Covid-19 vaccinations, where we will give boosters to everyone who is double-vaccinated, as well as continuing our 'evergreen' offer for patients who haven't yet taken up the vaccination offer. We await JCVI and NHSE guidance on the delivery model, including the extent to which we are able or expected to deliver the boosters alongside the annual influenza vaccination campaign.

Invitations to get a Covid-19 vaccine have been issued to all 16 and 17 year olds in a further effort to boost take-up in this age group. Derbyshire has already vaccinated 40% of this cohort and we have seen pleasing numbers of young people attending walk-ins for their vaccination, with many citing their desire to protect their relatives as a key reason for attending. Derbyshire continues to perform well with the vaccination programme generally, and we are moving two of our larger vaccination sites this month to reflect the need to open the current venues to usual public activity; Derby Arena's activity will move to Midland House and Chesterfield's Winding Wheel vaccination centre will move to Walton Hospital. Our facilities at Shirebrook Leisure Centre and Sharley Park Leisure Centre in Clay Cross have also now stopped vaccinating for the same reason.

Finally, 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.

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

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

System Transition Assurance Sub-Committee	CCG/System	Monthly
Primary Care Integration Operating Model Options	CCG/NHSE	Ad Hoc
East Midlands ICS Commissioning Board	Regional AOs/NHSE	Monthly
Team Talk	All staff	Weekly
JUCD Finance Sub Committee	NHS/System CEOs	Monthly

3.0 National developments, research and reports

3.1 Nationwide Roll Out of high street heart checks

Thousands of lives will be saved thanks to more blood pressure checks in high street pharmacies. Every NHS pharmacy in England will be able to provide the lifesaving checks to people aged 40 and over from October thanks to a new deal between pharmacies and the NHS.

3.2 Invitation letters sent to one million 16 and 17 year olds

Invitations to get a COVID vaccine are landing on the doormats of all 16 and 17 year olds from today, in a further effort to boost take-up in this age group, as the biggest and most successful vaccination programme in NHS history expands further.

3.3 NHS urges people to come forward for life saving cancer checks in new campaign

The new head of the NHS in England has today encouraged people with potential cancer symptoms to come forward for lifesaving checks. Ahead of a new campaign launching next week, NHS England chief executive, Amanda Pritchard said that the NHS is open and ready to treat people, and urged anyone with potential cancer symptoms to come forward.

3.4 Government launches UK-wide antibody surveillance programme

Thousands of adults a day will be given free access to antibody tests through a new national surveillance programme launched by the UK Health Security Agency, to help improve our understanding of immunity against COVID-19 from vaccination and infection.

3.5 NHS urges students to join health service as thousands collect results

A major drive to boost the NHS workforce is underway as students receive their exam results. The head of the NHS called on students considering their options to take up one of the thousands of places available at university for more than 900 NHS-related courses.

3.6 UK signs deal for 35 million vaccines with Pfizer/BionTech

The UK has agreed a contract for 35 million more doses of the Pfizer/BioNTech vaccine, to be delivered from the second half of next year. The government, through the Vaccine Taskforce, is putting in place preparations to future-proof the country from the threat of COVID-19 and its variants through safe and effective vaccines, as

the UK's world-renowned vaccination programme continues to protect the population.

4.0 Local developments

4.1 Joined Up Care Derbyshire (ICS) Board Updates
Key messages from the Joined Up Care Derbyshire board meetings are available at https://joinedupcarederbyshire.co.uk/news/board-updates.The ICS has also published a suite of guides to help people understand what the ICS is and how it works. These are available at https://joinedupcarederbyshire.co.uk/about/our-plans.

4.2 Derby's vaccination centre to relocate at the end of August
Plans are being finalised to relocate Derbyshire's major vaccination centre from the end of the month, as the Covid-19 vaccination programme moves into its third phase. Derbyshire Community Health Services NHS Foundation Trust (DCHS), in partnership with Derby City Council – the owners of Derby Arena – have agreed to relocate the service when the current lease expires at the end of the month.

4.3 Health and care bosses: help us get your loved ones home from hospital
Health and care leaders are appealing to the public to provide essential help in the process of getting patients out of hospital and back to their homes. The process of discharging patients relies on those patients being able to return to a safe and supportive environment, which benefits their mental and physical wellbeing while also freeing up in-demand hospital beds.

4.4 Buxton's Health and Community Hub – bid for national money
Public sector bosses leading Buxton's proposed new health and community public services hub have confirmed they are compiling a bid for national money under the government's plans to build 40 new hospitals across the country. Back in October 2021, the government named 32 hospitals which will form part of the 40 (total) and is now calling for NHS trusts to submit expressions of interest to be one of the remaining eight sites.

4.5 Friends of Baby Unit celebrate 45 years as a charity
Last week, the Friends of the Baby Unit (FOBU) celebrated their 45th birthday as a charity, raising awareness of baby's receiving care. Situated at the Royal Derby Hospital's Neonatal unit, the Friends of the Baby Unit aim to raise funds for life-saving equipment to use for the intensive care of babies.

4.6 Temporary Changes to Home Birthing Service
Due to current pressures affecting all areas within maternity services, we've made the difficult decision to suspend our home birthing service across Derbyshire and Staffordshire, until 30 August 2021.

4.7 Childhood respiratory infections rise ahead of winter
Parents are being encouraged parents to be aware of the signs of respiratory illnesses in young children, as data from Public Health England (PHE) shows cases are starting to rise in parts of the country. Respiratory illnesses, including colds and respiratory syncytial virus (RSV) are very common in young children and we see them every year.

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 September 2021

Item No: 125

Report Title	NHS Derby and Derbyshire CCG Annual Report and Accounts 2020/21
Author(s)	Suzanne Pickering, Head of Governance
Sponsor (Director)	Dr Chris Clayton, Chief Executive Officer Richard Chapman, Chief Finance Officer Helen Dillistone, Executive Director of Corporate Strategy and Delivery

Paper for:	Decision		Assurance	X	Discussion		Information	X
Assurance Report Signed off by Chair				N/A				
Which committee has the subject matter been through?				The Derby and Derbyshire CCG Annual Report and Accounts 2020/21 were approved by the Audit Committee on the 25th May 2021				

Recommendations

The Governing Body is requested to **RECEIVE** NHS Derby and Derbyshire CCG's Annual Report and Accounts 2020/21 for information and assurance.

Report Summary

Context and Introduction

Clinical Commissioning Groups are required to prepare an Annual Report and Accounts in accordance with NHS England and Improvement directions, as outlined in the National Health Service Act (2006, as amended). The Annual Report and Accounts presented covers the financial year 2020/21.

NHS Derby and Derbyshire CCG's Annual Report and Accounts for the 2020/21 financial year describes our activities, achievements, challenges, and response to the Covid-19 pandemic during that time. It also describes our financial performance and how we met our governance requirements. Our Financial Statements are subject to a rigorous audit process and we are delighted that for 2020/21 the CCG's external auditors, KPMG, provided an unqualified audit opinion of the CCG's financial statements within the report and concluded that there were 'no significant weaknesses' in relation to its use of resources.

On behalf of the entire CCG, the Governing Body we would like to extend our sincere thanks to our CCG staff, GP Practice membership, our public and voluntary sector partners and NHS staff across Derbyshire for their ongoing contribution towards keeping local people healthy and well whilst we continue to respond to the pandemic.

In accordance with the Audit Committee Terms of Reference, the Audit Committee has delegated authority from the Governing Body to review and approve the Annual Report and Accounts on behalf of the Governing Body. The Audit Committee approved the Annual Reports and Accounts on the 25th May 2021.

The Accountable Officer must sign the Annual Report and Accounts to confirm adherence to the reporting framework and these were signed by Dr Chris Clayton on the 25th May 2021.

Due to the implications of the Covid-19 pandemic, NHS England and Improvement nationally extended the submission date, and the signed Annual Report and Accounts were submitted to NHS England and Improvement, and the External Auditors on the 17th June 2021.

NHS Derby and Derbyshire CCG published the Annual Report and Accounts in full on their public website on the 8th July 2021. They can be accessed via the following link:
https://www.derbyandderbyshireccg.nhs.uk/publications/annual-report-accounts/

The CCG is required to present the Annual Report and Accounts at a meeting in public by 30th September 2020. Presentation at today's Governing Body meeting fulfils this requirement.

Summary of the Annual Report and Accounts

CCGs are required to publish a single document, a three part Annual Report and Accounts (ARA) consisting of the:

- Performance Report
- Accountability Report
- Financial Statements

1. The Performance Report

The purpose of the performance section is to provide information on the CCG, its main objectives and strategies and the principal risks that the CCG faces.

The Performance Overview gives a synopsis of the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year, and an overall explanation of how the CCG have discharged its functions.

The key developments of the CCG during 2020/21 were in relation to the following areas:
- Covid-19 Pandemic Response and how the CCG operated
- System Working and Collaboration
- Place Development and Delivery
- Planned Care
- Long Term Conditions

- Urgent Care
- Primary Care
- Integrated Community Care
- Digital Development
- Medicines, Prescribing and Pharmacy
- Ambulance and 111 Commissioning
- Mental Health

The Performance Analysis provides a detailed performance summary of how the CCG measures its performance and meets its mandatory requirements as follows:

- Sustainable Development
- Improving Quality
- Engaging with People and Communities
- Reducing Health Inequality
- Health and Wellbeing Strategy

2. The Accountability Report

The purpose of the accountability section is to meet the key accountability requirements to parliament.

The Corporate Governance Report explains the composition and organisation of the CCG governance structures and how they support the achievement of the CCG objectives. The Corporate Governance Report contains:

- The Members Report
  The report contains the details of the Member Practices, the composition of the Governing Body, Audit Committee membership, Register of Interests, Personal Data Related Incidents and the Statement of Disclosure to the Auditors.

- The Statement of Accountable Officer's Responsibilities
  The Accountable Officer must explain their responsibility for preparing the financial statements and confirm that the ARA as a whole is fair, balanced and understandable and that he takes personal responsibility for the ARA.

- The Governance Statement
  The Governance Statement reflects on the circumstances in which the CCG operated during 2020/21, particularly:
  - The Governing Body and its Committees and Governing Body Performance during the year;
  - Risk management arrangements and effectiveness;
  - Other sources of assurance;
  - Control Issues;
  - Significant Assurance of the Head of Internal Audit Opinion; and
  - Review of effective governance, risk management and internal control.

The Remuneration and Staff Report sets out the CCG's remuneration policy for its directors and senior managers, reports on how the policy was implemented and sets out the amounts awarded to directors and senior managers which are detailed in the Remuneration Report tables. The Staff Report provides an analysis of staff numbers and costs, staff composition and sickness absence data. **The Parliamentary Accountability and Audit Report** – the CCG is not required to produce a Parliamentary Accountability and Audit report. Disclosures on remote contingent liabilities and losses and special payments are included where applicable in the Financial Statements and an Audit Certification is included after the Financial Statements. **3. The Financial Statements** The annual accounts include a set of primary financial statements, and the format of the statement must be followed precisely as per the Department of Health and Social Care Group Accounting Manual 2020/21. The CCG Auditors have reviewed the Accountability Report for consistency with other information in the financial statements and provided an unqualified opinion on the disclosures detailed in the Accountability Report.
Are there any Resource Implications (including Financial, Staffing etc)?
Resource implications have been identified and managed through the merger process.
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?
Not required for this paper. Notwithstanding this, where any issues/risks are identified from Data Protection Impact Assessment (DPIA) then appropriate actions will be taken to manage the associated risks.
Has a Quality Impact Assessment (QIA) been completed? What were the findings?
Not required for this paper. Notwithstanding this, where any issues/risks are identified from Quality Impact Assessment then appropriate actions will be taken to manage the associated risks.
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
Not required for this paper. Notwithstanding this, where any issues/risks are identified from Equality Impact Assessment then appropriate actions will be taken to manage the associated risks.
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 paper

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
The public will be involved in any service changes or developments proposed through the delivery of the Commissioning Strategy.
Have any Conflicts of Interest been identified/ actions taken?
None identified.
Governing Body Assurance Framework
Any corporate risks relating to this agenda and recorded in the Risk Register are aligned to the Governing Body Assurance Framework.
Identification of Key Risks
Any corporate risks relating to this agenda and recorded in the Risk Register are aligned to the Governing Body Assurance Framework.

Governing Body Meeting in Public

2nd September 2021

Item No: 126

Report Title	Proposal to supplement the Joint Committee's CCG Manual to expand the Scope of the Joint Committee Delegation and put in place additional arrangements for the transition to Integrated Care Boards 2021/22 (Schedule 3)
Author(s)	Rob McGough - Hill Dickinson
Sponsor (Director)	Dr Chris Clayton, Chief Executive Officer South Yorkshire & Bassetlaw Accountable Officers and Joint Committee CCGs

Paper for:	Decision	X	Assurance		Discussion		Information	
Assurance Report Signed off by Chair				N/A				
Which committee has the subject matter been through?				South Yorkshire and Bassetlaw Joint Committee of CCGs				

Recommendations

The Governing Body is requested to **REVIEW** the proposal, which seeks agreement from the CCG members of the Joint Committee to this approach and agreement for Schedule (3) enclosed to be added to the Joint Committee's CCG Manual Agreement/Terms of Reference (attached for reference), and specifically **APPROVE** the:

- proposed amendment to the delegation of the Joint Committee for the transition work, but the Joint Committee's Terms of Reference (enclosed for reference) are unchanged; and
- establishment of the Joint Committee sub-committee – the Change and Transition Board – to take forward the transition work between September and March 2022.

Report Summary

Background

NHS Operational Planning Guidance for 2021/22 requires systems to start formally planning for the establishment of the statutory integrated care systems during Q1 of 2021, including setting out plans to operate in shadow form in Q4 of 2021/22. In summary this will involve the establishment of a statutory Integrated Care Board (ICB) and an Integrated Care Partnership (ICP) which together make the Integrated Care Systems (ICSs) of the future. Both statutory functions of current CCGs and some of NHS England will transfer to the ICB, along with existing non-statutory functions of ICSs, including strategic planning, transformation and oversight. The ICB is working towards operating in full shadow form from December 2021.

The five CCGs and ICS wish to put in place arrangements to ensure a smooth transition to the ICB in April 2022. It has been decided that the most practical way of doing this is for the Joint Committee of CCGs (the "Joint Committee") to co-ordinate the taking of preparatory steps for the transition to the ICS on behalf of the CCGs and for the ICS to have visibility of that work.

The boundaries of the ICS mean that NHS Bassetlaw will be moving from the ICS into Nottinghamshire and a neighbouring integrated care system on 1st April 2022. NHS Bassetlaw will continue to have an interest in many of the transitional issues within the remit of the Joint Committee. However, it is recognised that there may also be areas in which NHS Bassetlaw does not have a direct interest, and that NHS Bassetlaw may want to be less involved in discussions on such issues. The transitional operating arrangements take account of this.

Summary of key points

This proposed Schedule (3) sets out that the Joint Committee of the five CCGs is adapted for the transition to the South Yorkshire and Bassetlaw Integrated Care System by:

- expanding the scope of its delegation to include transition work such as the carrying out of due diligence, development of corporate policies, development of the constitution for the new ICB and liaising with NHS England regarding the constitution;

- inviting members of the ICB to its meetings, so that they have a full understanding of the preparatory work being done by the Joint Committee;

- establishing a sub-committee to carry out this preparatory work; and

- having a working arrangement with Bassetlaw CCG that the CCG may choose not to participate in parts of the meeting that are not directly relevant to Bassetlaw, following the move of Bassetlaw from South Yorkshire & Bassetlaw ICS to Nottinghamshire & Nottingham ICS on 1st April 2022.

No changes are made to the Joint Committee's Terms of Reference. In particular, Bassetlaw CCG will continue to be a member of the Joint Committee and attendance of a representative from Bassetlaw CCG will still be required in order for meetings of the Joint Committee to be quorate. If a member from Bassetlaw CCG is in attendance at a Joint Committee meeting and decides not to actively participate in discussions on a particular topic, that will not mean that the meeting is inquorate.

This paper has been supported by Barnsley CCG, Bassetlaw CCG, Doncaster CCG, Rotherham CCG, Sheffield CCG, and Derby and Derbyshire CCG as a variation to the Manual and Delegation. If there is any difference between the provisions of this Schedule 3 and the remainder of the Manual or the Delegation, then the terms of this Paper will take precedence.

As set out above, nothing in this Schedule 3 amends the Joint Committee Terms of Reference (attached for reference).

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?
Not applicable.
Governing Body Assurance Framework
Not applicable.
Identification of Key Risks
Not applicable.

Joint Committee Transition 2021/22

Proposal to add as SCHEDULE 3 to

Joint Committee of CCGs Manual / Terms of Reference

Background

1 NHS Operational Planning Guidance for 2021/22 requires systems to start formally planning for the establishment of the statutory integrated care systems during Q1 of 2021, including setting out plans to operate in shadow form in Q4 of 2021/22. In summary this will involve the establishment of a statutory Integrated Care Board (**ICB**) and an Integrated Care Partnership (**ICP**) which together make the Integrated Care Systems (**ICSs**) of the future. Both statutory functions of current CCGs and some of NHS England will transfer to the ICB, along with existing non-statutory functions of ICSs, including strategic planning, transformation and oversight. The ICB is working towards operating in full shadow form from December 2021.

2 The five CCGs and ICS wish to put in place arrangements to ensure a smooth transition to the ICB in April 2022. It has been decided that the most practical way of doing this is for the Joint Committee of CCGs (**"the Joint Committee"**) to co-ordinate the taking of preparatory steps for the transition to the ICS on behalf of the CCGs and for the ICS to have visibility of that work.

3 The boundaries of the ICS mean that NHS Bassetlaw will be moving from the ICS into Nottinghamshire and a neighbouring integrated care system from the 1st April 2022. NHS Bassetlaw will continue to have an interest in many of the transitional issues within the remit of the Joint Committee. However, it is recognised that there may also be areas in which NHS Bassetlaw does not have a direct interest, and that NHS Bassetlaw may want to be less involved in discussions on such issues. The transitional operating arrangements take account of this.

4 It is anticipated that these arrangements will be in place between September 2021 and 1st April 2022, when CCGs will be dissolved, and ICSs formally established under legislation.

5 In this paper capitalised terms have the same meaning as in the Manual, unless otherwise defined. References to the ICB, ICP and ICS include those organisations operating in shadow form, prior to their legal establishment under the Health & Care Bill.

Transitional arrangements

6 The Joint Committee is adapted for the transition to the South Yorkshire Integrated Care System (**"ICS"**) by:

   a. Expanding the scope of its delegation to include transition work such as the carrying out of due diligence, development of corporate policies, development of the constitution for the new ICB and liaising with NHS England regarding the constitution;

b. Inviting members of the ICB to its meetings, so that they have a full understanding of the preparatory work being done by the Joint Committee;

c. Establishing a sub-committee to carry out this preparatory work; and

d. Having a working arrangement with Bassetlaw CCG that the CCG may choose not to participate in parts of the meeting that are not directly relevant to Bassetlaw, following the move of Bassetlaw from South Yorkshire & Bassetlaw ICS to Nottinghamshire & Nottingham ICS on 1st April 2022.

7 No changes are made to the Joint Committee's Terms of Reference. In particular, Bassetlaw CCG will continue to be a core member of the Joint Committee and attendance of a representative from Bassetlaw CCG will still be required in order for meetings of the Joint Committee to be quorate. If a member from Bassetlaw CCG is in attendance at a Joint Committee meeting and decides not to actively participate in discussions on a particular topic, that will not mean that the meeting is inquorate.

8 This paper has been supported by Barnsley CCG, Bassetlaw CCG, Doncaster CCG, Rotherham CCG, Sheffield CCG and Derbyshire CCG as a variation to the Manual and Delegation. If there is any difference between the provisions of this Schedule 3 and the remainder of the Manual or the Delegation, then the terms of this Paper will take precedence. As set out above, nothing in this Schedule 3 amends the Joint Committee Terms of Reference.

Expanding the Delegation

9 The Delegation is expanded by adding the following paragraph to the end of section B:

*The delegated functions also relate to the preparation for the transition of commissioning responsibilities from CCGs and NHS England to Integrated Care Systems following the introduction of new legislation. The CCGs delegate these functions (regarding the preparation for the transition of commissioning responsibilities) to the Joint Committee, to enable consistent and effective decision-making. Such preparation for future commissioning to be carried out by Integrated Care Boards (**ICBs**) may include (but is not limited to):*

- *The development of draft corporate policies for consideration/ adoption by the ICB once it is formally established e.g. in the areas of HR, conflicts of interest, finance.*

- *Developing the ICB constitution and liaising as appropriate with NHS England to gain approval for the constitution; this may include overseeing support work carried out by the ICB, such as producing drafts of the constitution and co-ordinating engagement.*

- *Producing/ providing input into the transition schemes that will manage the move from CCGs to ICSs and liaising as appropriate with NHS England.*

- *Being the point of contact for any queries from the ICB while it operates in shadow form, including for the provision of information needed to support the ICB's work.*

The development of any ICB plans (such as the Forward Plan and the Capital Plan) will be carried out by the ICB operating in shadow form.

Developing the ICB constitution

10 Under the Health & Care Bill 2021 as currently drafted the CCGs are responsible for the consultation on and submission for approval of the ICB constitution. Under the updated delegation (see section above) this responsibility has been delegated to the Joint Committee.

11 The ICB has offered support to the Joint Committee regarding the constitution, including through preparation of a draft constitution for consideration by the Joint Committee and the co-ordination of any engagement exercise.

12 The Joint Committee may request and obtain assistance from the ICB regarding its responsibilities related to the constitution, in particular regarding any engagement exercise. This may include the ICB carrying out/ co-ordinating activities to support the Joint Committee. The Joint Committee shall be responsible for overseeing any such activity by the ICB and taking any final decisions regarding the CCGs' responsibilities relating to the ICB constitution.

Meeting arrangements for the Joint Committee during the transition period

13 The following arrangements will be put in place to ensure effective working between the Joint Committee and the ICB during the transition period.

Attendance

14 Under its terms of reference (paragraph 5.4) the Joint Committee can invite non-voting members to join the Joint Committee. Non-voting members are invited to all Joint Committee meetings but do not count towards the quorum. The Joint Committee invites the following post holders to join the Joint Committee as non-voting members:

- ICB Chair Designate
- Two individuals nominated by the ICB Chair Designate (the ICB Chair Designate may update these nominations from time to time through informing the Joint Committee Chair of the change)

15 It will be for these invitees to decide whether or not to attend the meeting, informed by the meeting agenda. If the Joint Committee particularly wants a representative from the ICB to attend, this should be highlighted to the ICB Point of Contact at the time that the agenda is circulated.

16 Each ICB non-voting member may nominate a deputy to attend in their place. Such nominations should be made at least three working days in advance of the meeting where possible and should be made by contacting the Joint Committee Point of Contact.

17 The Joint Committee may invite further post holders to join the Joint Committee. If the Joint Committee wishes further ICB officers to join, the Joint Committee Point of Contact should make a request to the ICB Point of Contact. If the ICB wishes further ICB officers

to join, the ICB Point of Contact should make a request to the Joint Committee Point of Contact. The Joint Committee can then decide whether those individuals should be added as non-voting members and whether or not they are able to appoint a deputy if they are unable to attend. To keep meetings manageable, it is envisaged that the total number of non-voting members from the ICB will not exceed four.

18 The Joint Committee can also invite additional experts to attend its meetings on an ad hoc basis. If the Joint Committee wishes an expert from the ICB to attend, then they should make this request to the ICB Point of Contact. If the ICB wishes an ad hoc expert to attend then the ICB Point of Contact should make a request to the Joint Committee Point of Contact at least five working days prior to the meeting.

Communications

19 To ensure clear lines of communication both the ICB and the Joint Committee will have a dedicated **Point of Contact**. The Chair of the Joint Committee will nominate the Joint Committee point of contact and the Chair Designate of the ICB will nominate the ICB point of contact. Nominations may be updated from time to time. At the time of writing the points of contact are:

Joint Committee Point of Contact – Lisa Kell, Director of Commissioning at the ICS,

lisa.kell@nhs.net

ICB Point of Contact – Will Cleary-Gray, Chief Operating Officer at the ICS,

will.cleary-gray@nhs.net

20 Communications regarding the administration of Joint Committee meetings should go through these points of contact.

Meeting administration

21 Administration of the meeting shall continue to be the responsibility of the Joint Committee. It will therefore be the responsibility of the Joint Committee to ensure that:

- Meeting invitations are sent out to the appropriate people (including non-voting members from the ICB)
- Meeting agendas and papers are circulated in advance
- Minutes of the meeting are taken.
- Minutes of the meeting are circulated

22 If the ICB wants a matter to be added to the Joint Committee meeting agenda then the ICB Point of Contact should notify the Joint Committee Point of Contact at least 5 working days before the meeting and provide any relevant papers within the timescales requested by the Joint Committee Point of Contact. The Joint Committee will then consider whether to include the item in accordance with its Terms of Reference.

Meeting papers

23 The agenda and minutes for each meeting will clearly set out:

23.1 The voting members from the Joint Committee who are attending

23.2 The non-voting members from the ICB who are attending

23.3 Any other non-voting members

23.4 Anyone attending as an ad hoc expert

23.5 Who is leading on each agenda item

24 Technically, the minutes will be approved by voting members of the Joint Committee attending the following meeting. However, the voting members will take account of the views of non-voting members in attendance at the relevant meeting before approving the minutes.

Establishing sub-committees

25 The Joint Committee establishes a sub-committee (the Change and Transition Board) to assist it with transition work.

26 The sub-committee will prepare proposals and carry out preparatory work for approval/ adoption by the Joint Committee. The sub-committee will not itself make decisions.

27 The Change and Transition Board sub-committee will operate in accordance with its terms of reference, set out below.

Terms of Reference	
Group or meeting	**Change and Transition Board sub-committee, a sub-committee of the Joint Committee of CCGs ("Joint Committee")**
Roles and responsibilities	To assist the Joint Committee with the preparation for the transition of commissioning responsibilities from the CCG and NHS England to the ICS. The Joint Committee will ask the sub-committee to complete particular tasks on a case by case basis. The sub-committee will make proposals to the Joint Committee. It will then be for the Joint Committee to discuss and adopt these as appropriate. The sub-committee cannot make any decisions on behalf of the Joint Committee.
Membership	**Voting members** One individual nominated by Barnsley CCG One individual nominated by Bassetlaw CCG One individual nominated by Doncaster CCG One individual nominated by Rotherham CCG One individual nominated by Sheffield CCG A CCG Director of Finance from one of the core member CCGs nominated by the Chair of the Joint Committee Each of these members may nominate a deputy to attend in their place. Each CCG may update their nominations from time to time through informing the sub-committee Chair of the change. **Observers** Four individuals nominated by the ICB Chair Designate (the ICB Chair Designate may update these nominations from time to time through informing the sub-committee Chair of the change). It is anticipated that the initial nominees will be the ICS Lead, the ICS Deputy Lead, the ICS Chief Operating Officer and the ICS Director of HR. The Joint Committee Point of Contact, as described in Schedule 3 of the Manual. Each of these observers may nominate a deputy to attend in their place.

	The voting members may invite such other observers to join the sub-committee provided the total number of observers does not exceed 7. The term **“Members”** refers to both voting members and observers of the sub-committee. **Other attendees** The voting members may invite other individuals with subject matter expertise to join its meetings on an ad hoc basis to inform discussions Note that the membership of the sub-committee may flex (through the CCGs and ICB updating their nominations) according to the subject matter of the sub-committee’s work.
Sub-committee points of contact	The Point of Contact for the voting members shall be the Joint Committee Point of Contact; the Point of Contact for the observers is the ICB Point of Contact both Points of Contact as described in Schedule 3 of the Manual.
Chair	The sub-committee will be chaired jointly by two joint Chairs: (1) The Chair of the Joint Committee of CCGs; and (2) The ICB Chair Designate will select one of his nominees to be the other joint chair. It is anticipated that the ICS Lead will be the first such appointment. References to “Chair” in these terms of reference are to the two joint Chairs acting together.
Quorum	The sub-committee is considered quorate if there is at least one representative from Barnsley CCG, Bassetlaw CCG, Doncaster CCG, Rotherham CCG and Sheffield CCG present save that a meeting may be quorate without a representative from Bassetlaw CCG if Bassetlaw CCG has indicated that they do not want to participate in the relevant agenda item. If a meeting is not quorate it may continue but any work or decisions will need to be adopted by a subsequent quorate meeting before being referred to the Joint Committee.
Meetings	Meeting schedule The sub-committee will determine its schedule of meetings at its first meeting and may amend that schedule from time to time.

	The Chair may determine that the sub-committee needs to meet on an urgent basis, in which case the notice period shall be as specified by the Chair acting reasonably. Urgent meetings may be held virtually, using any of the means specified above. <u>Participation by video-link/ phone</u> The Chair may agree that Members may participate in meetings by means of telephone, video or computer link or other live and uninterrupted conferencing facilities provided every Member participating is able to be heard by every other Member. Participation in a meeting in this manner shall constitute presence in person at such meeting. <u>Meetings in private</u> Given that the sub-committee will not be making any decisions on behalf of the Joint Committee, it will meet in private.
Decision-making	Ideally, decisions made by the sub-committee should have the support of all voting members, save that the support of Bassetlaw CCG is not needed if it has stated that it does not have an interest in the matter. If this is not possible then decisions may be made by the majority of voting members present and voting. If the sub-committee refers a matter to the Joint Committee that does not have consensus support as outlined above, this should be made clear and reasons for the lack of consensus given. The Joint Committee shall also be informed of any concerns raised by observers.
Conduct of business	If a Member wishes to add an item to the agenda they must notify the Joint Committee Point of Contact. Requests for agenda items will be passed to the sub-committee Chair who will decide the content and order of the agenda. Circulation of the meeting agenda and papers via email will take place at least five working days prior to the meeting where possible. The sub-committee will have administrative support from the ICS Project Management Office to: - Collate items for the agenda - Circulate the agenda and any papers - take and circulate action points from meetings - maintain a record of actions and action owners
Conflicts of interest	The rules on conflicts of interest that apply to the Joint Committee shall also apply to the sub-committee.

	Observers will comply with their organisation's rules on conflicts of interest. Members will be transparent about any interest their organisation has in matters being discussed by the sub-committee. References to organisation include the ICB and Integrated Care Partnership operating in shadow form.
Accountability and reporting	The sub-committee is accountable to the Joint Committee. Action points from sub-committee meetings will be sent to Board Members within 10 working days of each meeting. Members are also accountable to their host organisation.
Review	It is not anticipated that these terms of reference will be reviewed as it is expected that CCGs will be dissolved in April 2022. However, the Joint Committee may review these Terms of Reference as it considers appropriate.

Manual Agreement and Terms Of Reference

Of

Joint Committee of Clinical Commissioning Groups

South Yorkshire and Bassetlaw

2019/20

Final Version

July 2019

Start Date: 24 July 2019

Review date: 1st December 2019

Chapter	Content	Detail	Page
1.	Introduction and Overview	Short Introduction setting out:- • Background to creating Joint Commissioning of Clinical Commissioning Groups (JC CCGss). • Context for decision making and purpose. • Overview of role in local health system. • Purpose of this agreement/manual.	
2.	Commissioning intentions and statutory duties	Set out:- • Regional/Local commissioning intentions. • Application of existing arrangements. • Complying with the Statutory Duties of CCGs (should include those relating to procurement and competition as well). • Governance, including provision of assurance to members, for JC CCGss.	
3.	Delegation	Delegation pursuant to section 14Z3:- • State purpose of delegation, what it means and the CCGs who have made it. • Set out minute and resolution [separately drafted] of delegation. • Explain terms of delegation in context of joint commissioning approach.	
4.	Terms of reference of joint committee : setting out the role and operation of the committee	Provisions setting out:- • Role • Delegated decisions [defined list as set out in terms] • Reserved decisions [All other than defined list] • Meetings and frequency	

		• Agenda and Minutes • Voting • Electronic meetings • Resolutions [form] • Quorum • Ability to create sub-committees and further delegate (as set out in terms)	
5.	Additional terms supplementing the terms of reference	Matters to be addressed:- • Guiding Principles for JC CCGss. • Definitions and interpretation [especially delegated decisions and reserved decisions] and how to deal with disputes on definitions. • Approach to Conflicts of Interest. • Liability and indemnities. • Disputes and process to be followed to resolve. [This section may also go on to consider ability for members to revoke the delegation. • Information Sharing and General Data Protection Regulation (GDPR) • Approach to Freedom of Information Requests (FOIA) requests. • Compliance with procurement and competition law obligations (to extent not dealt with in statutory duties section) • List of any other relevant protocols • Clarification and/or additional commercial terms • Process to make variations to Delegation, ToR and/or agreement/manual • Explanation of how ratification works and process to apply. • JC CCGss reporting obligations to members and form of such reports. • Set out how finance for the programme will be dealt with, including issues such as pooled	

		funding. • Process and form for issuing Notices by JC CCGss. • What happens if a member leaves the JC CCGss • Supporting the JC CCGss and how the Programme Management Office (PMO) will operate. • Implementing change through NHS Standard Contract and variations to it. • Workforce and Staffing considerations within decision making.	
6.	Appendices	• JC CCGss Terms of Reference (ToR), • statutory duties checklist and all protocols which the JC CCGss need to follow. • Clinical engagement and assurance process • Communications and Engagement assessment and assurance process	

Manual/Agreement for JC CCGss

Chapter 1 - Introduction and Overview

1. Background

1.1 The purpose of the Handbook/Agreement is to set out in practical terms how the local health system will work together in both commissioning and providing health services to the public, as well as how it will interact with the delivery of social care.

1.2 The local health commissioners have created a joint committee, through which they can both consider and undertake system wide commissioning decisions.

1.3 The CCG members of the joint committee ('**the JC CCGs**) are:

- NHS Barnsley Clinical Commissioning Group;
- NHS Bassetlaw Clinical Commissioning Group;
- NHS Doncaster Clinical Commissioning Group;
- NHS Rotherham Clinical Commissioning Group;
- NHS Sheffield Clinical Commissioning Group;
- NHS England Specialised Commissioning;

and Associate* Member CCG

- NHS Derby and Derbyshire Clinical Commissioning Group;

*Associate CCG is a partner CCG outside of the SYB footprint with commissioned patient flows into SYB for acute provider secondary and tertiary care services. Derby and Derbyshire CCG is also a member of the SYB and North Derbyshire Cancer Alliance. Our Associate CCG is involved in the commissioning arrangements, decisions and voting managed through the JC CCGs where their patients are affected by any proposed change as appropriate. Associate CCGs are <u>non-voting members</u> of the JC CCGs where they do not have a patient interest in a proposed change overseen by the JC CCGs.

1.4 In terms of the legal basis on which the CCGs have agreed to jointly exercise a group of their functions through delegating them to the JC CCGs, this has been done using their powers under section 14Z3 of the NHS Act 2006 (as amended) ('**the Act**'), which provides:

"(1) Any two or more clinical commissioning groups may make arrangements under this section.

(2) The arrangements may provide for—

(a) one of the clinical commissioning groups to exercise any of the commissioning functions of another on its behalf, or

(b) all the clinical commissioning groups to exercise any of their commissioning functions jointly.

(2A) Where any functions are, by virtue of subsection (2)(b), exercisable jointly by two or more clinical commissioning groups, they may be exercised by a joint committee of the groups….

(7) *In this section, "commissioning functions" means the functions of clinical commissioning groups in arranging for the provision of services as part of the health service (including the function of making a request to the Board for the purposes of section 14Z9)."*

1.5 The JC CCGs exercises both commissioning functions and those related to commissioning, according to those set out in each CCGs delegation to it. The **actual Delegations from each CCG are set out in Appendix 1 and the Terms of Reference are in Appendix 2**. This should enable and support a more integrated system approach to support the SYB Integrated Care System (ICS).

2. Purpose of the JC CCGs

2.1 The JC CCGs has the primary purpose of enabling the CCG members to work effectively together, to collaborate and take joint decisions in the areas of work that they agree, by exercising the Joint Functions.

2.2 A guiding principle for any changes to commissioning and/or joint decision making through the JC CCGs must be that it demonstrates added value, including improvement in outcomes and population health, standardisation of care, financial efficiency, better use of resources including scarce workforce and avoids unnecessary duplication. Unintended significant risks for a CCG, place or ICS should be avoided.

2.3 The Joint Functions are those set out in the Delegation, appended in Appendix 1 (*Delegation*) and summarised. below.

2.4 In agreement with CCG Governing Bodies the purpose of the JC CCGs may expand to support implementation of the ICS strategic plan in addition to the delivery of the JC CCGs priorities.

2.5 The role of the JC CCGs, as set out in Clause 3.1 of the Terms of Reference is:

- 2.5.1 Development of collective strategy and commissioning intentions;
- 2.5.2 Development of co-commissioning arrangements with NHS England;
- 2.5.3 Joint contracting with Foundation Trusts and other service providers;
- 2.5.4 System transformation, including the development and adoption of service redesign and best clinical practice across the area – which may include the continuation or establishment of clinical networks in addition to those nationally established;
- 2.5.5 Representation and contribution to Alliances and Networks including clinical networks nationally prescribed;
- 2.5.6 Work with NHS England and Improvement on the outcome and implication of national or regional service reviews;
- 2.5.7 Work with the NHS England on system management and resilience;
- 2.5.8 Collaboration and sharing best practice on Quality Innovation Productivity and Prevention (QIPP) initiatives; and Cost Improvement Plans (CIP)
- 2.5.9 Mutual support and aid in organisational development.

2.6 Generally, the JC CCGs will work across the system to develop a strategic approach to commissioning sustainable, efficient services that are patient centred and focussed on

improving population health outcomes. Further, it will enable the development of integrated working with social care and wider community and voluntary sector partners so that the patients receive a more seamless service.

3. Role in local health and care system

3.1 As indicated above, the JC CCGs will support the development of a clear system strategic plan for the SYB ICS. In bringing commissioning leaders together, it will support strategic planning and provide an interface with both providers of health services and social care. The work which it can do with places and local authorities on creating better integrated health and social care services will support meeting the sustainability, quality and financial challenges in the coming years.

3.2 In terms of looking at strategic issues across the ICS footprint the JC CCGs will feed in to the work on such as:

- Leadership and governance and the best ways to set up joint working, taking account of the ability of providers and commissioners to set up shared governance structures. Some key issues to work through are conflicts and procurement, as well as good governance using the Handbook approach and assurance.
- Working out how best to play in your ongoing integrated care programmes and vanguards, especially in looking to implement change to benefit patients.
- Engagement and consultation strategies, both overall and when changes are needed to improve services.
- Productivity strategies, especially around joint and integrated working proposals.

4. Status of this Manual and Interpretation

4.1 This Manual sets out the arrangements that apply in relation to the exercise of the Joint Functions of the JC CCGs. If there is any conflict between the provisions of this Manual and the provisions of the Terms of Reference, the provisions of the Terms of Reference will prevail. This Manual is to be interpreted in accordance with Schedule 1 (*Definitions and Interpretation).*

5. Term

5.1 The Manual has effect from the date of the Terms of Reference and will remain in force unless terminated in accordance with Clause (*Termination of the Manual*).

5.2 Individual Member CCG(s) may terminate their membership of the JC CCGs and so no longer be obliged to work in accordance with this Manual under Clause (*Leaving the Joint Committee*).

Chapter 2- Commissioning Intentions and Statutory Duties

6. System / local commissioning intentions

6.1 Commissioning intentions relating to Hyper Acute Stroke services and Children's Surgery and Anaesthesia and the 2019/20 JCCCG priorities requiring delegated authority set out below:

2019/20 JCCCG Priorities requiring delegated authority	**Requested delegation to the JC CCGs to:**
System Contracting • 999 system lead contractor (YAS) for 4 SYB CCGs • 111 system lead contractor (YAS) for 5 SYB CCGs	• develop and agree a financial threshold of contract value against contract baseline for the lead contractor to negotiate on behalf of each CCG during 19/20 contract negotiations.
Outpatients • Review of outpatient follow ups across SYB by specialty, develop clinical protocols to standardise practice and reduce unwarranted variation * • Review of outpatient first appointments (as above) *	• identify and agree the specialities in scope of the OP review • develop and sign off clinical protocols developed with SYB clinical engagement from both commissioners and providers and patients/ public as necessary • implement clinical protocols in Providers standard NHS contracts 2019/20
Commissioning Outcomes • Commissioning for Outcomes – new stage 2	• identify and agree the clinical priorities in the policy • sign off 19/20 policy ensuring public consultation /engagement has taken place • implementation of protocols and included formally in standard NHS contracts 2019/20
IVF • Explore options for a SYB approach to the number of IVF cycles	• develop IVF options appraisal and financial modelling for consideration by CCG Governing Bodies
Cancer • Standard implementation of national cancer pathways across SYB tom improve outcomes and equity of access*	• implement standard cancer pathways in NHS provider contracts and across the 5 SYB places

Medicines and Prescribing • Medicines optimisation – standardisation of policies across SYB	• Identify opportunities for medicines standardisation • develop and sign off policies developed with SYB clinical engagement from clinicians, patients / public as necessary
Hospital Services Programme • Governing Bodies agreeing next steps on the work programme of the Hospital Services Programme,	• The conclusions on next steps on transformation and reconfiguration and implementation of these

* *Consistent with Long Term Plan Requirements*

6.2 A clinical engagement and assurance process has been developed by the Joint Committee Sub Group to provide assurance to the JC CCGs and Governing Bodies that the work to take forward and deliver the JC CCGs 2019/20 priorities is clinically led (appendix 4).

6.3 A communications and engagement Assessment Process for Section 14Z2 Duty for Public Involvement has also been agreed to provide assurance and support the work of the JC CCGs priorities (appendix 5).

7. Any existing arrangements

7.1 Commissioning intentions relating to Hyper Acute Stroke services and Children's Surgery and Anaesthesia agreed by the JCCCG in 2017.

8. Complying with the Statutory Duties of CCGs

8.1 The JC CCGs will need to be clear that is exercising functions it meets the statutory obligations of the CCGs which are its members. A failure to do so could lead to challenge to decisions made and an inability to assure the CCG Governing Bodies that their delegated functions are being properly exercised. Such an inability would impact on a CCG's ability to assure NHS England and Improvement that it was operating in accordance with the CCG Improvement and Assessment Framework.

8.2 The statutory duties which need to be taken into account are summarised in the Checklist in Appendix 3.

8.3 Further, each CCG should note that under s.14Z3(6) of the Act "*any delegation of functions to a joint committee of CCGs do not affect the liability of a clinical commissioning group for the exercise of any of its functions.*"

8.4 The result of this is that:

a) the Member CCGs need to ensure that the JC CCGs is complying with the CCGs' statutory duties, as the Member CCGs continue to be responsible if there are any failings in decision making; and

b) the Member CCGs need to ensure that an appropriate reporting mechanism from the JC CCGs to them is in place. This will allow the Member CCGs to maintain effective oversight of the JC CCGs processes and decision making.

8.5 In effect, the JC CCGs will stand in the place of the multiple CCGs who are its members for decision making, <u>but those individual CCGs will continue to have liability for those</u>

decisions. It is therefore essential that the JC CCGs understand the statutory framework within which it will make decisions.

9. Governance

9.1 It is important that CCGs maintain effective oversight of the activities of the JC CCGs.

- The JC CCGs will make a quarterly written report to the Member CCG governing bodies. This will cover, as a minimum summary of key decisions.
- The JC CCGs will review aims, objectives, strategy and progress and will publish quarterly reports on progress made.
- As to conducting business the JC CCGs will operate in accordance with the Terms of Reference approved by each CCG member when delegating functions to it. It shall also adopt the Standing Financial Order (SFO) and Standing Instructions (Sis) of Sheffield CCG in respect to the operation of committees, with all CCG members assuring themselves that will enable their own constitution, SFIs and SOs to be met.
- Regular reporting will take place with all member CCGs to include formal decisions and minutes.
- Decisions and minutes will be made public and will be posted onto the SYB ICS website.
- Reports will be prepared by the SYB ICS secretariat.
- Reports from any JC CCGs sub-committee will be shared with CCGs by agreement or request of the JC CCGs as appropriate.

Chapter 3 – Delegation

10. Purpose of delegation

10.1 The Member CCGs have agreed to delegate functions to the JC CCGs in order to enable the Member CCGs to work effectively together, to collaborate and to take joint decisions in those areas of work delegated.

10.2 The Member CCGs also consider that the delegation of functions will help the CCGs more easily collaborate and take joint decisions with NHS England in respect of those services which are directly commissioned by NHS England for example specialised services.

10.3 This will also link in to the work that each ICS needs to undertake to support the delivery of the NHS Long Term Plan within the South Yorkshire and Bassetlaw ICS Strategic Plan.

10.4 The JC CCGs forms a critical element of the interim governance arrangements agreed by the SYB ICS executive and the mechanism by which future collective commissioning decisions can be made.

11. The delegation

11.1 The delegation of functions from each CCG to the JC CCGs is set out in the delegation document at Appendix A (*Delegation*). A summary of what that means is:-

> Under s.14Z3 of the NHS Act 2006 each CCG delegates a range of its commissioning functions to a joint committee, in particular to allow the joint committee to take decisions on current and future transformation programmes which involve all, or a sub-set, of the CCGs.

11.2 The delegated functions are referred to in this Manual as the **"Joint Functions".**

11.3 As is noted above, the JC CCGs needs to also comply with statutory duties which the CCGs have. As a result, the Delegation also delegates the requirement to comply with statutory requirements relevant to the delegated functions.

12. Terms of delegation in context of joint commissioning

12.1 The JC CCGs will work with NHS England on ensuring commissioning is joined up and collaborative across such as primary and specialist care under existing agreements.

Chapter 4 - Terms of reference of joint committee

13. Terms of Reference of the JC CCGs

13.1 The CCGs have established the JC CCGs in accordance with the Terms of Reference, see Appendix 2. The JC CCGs and each member will act at all times in accordance with the Terms of Reference and that means the decisions of the JC CCGs will be binding on the Member CCGs.

13.2 The JC CCGs may at any time agree to make a decision or decisions through a common process with a CCG that is not a member of the JC CCGs. The common process would include the non-member CCG being in the same room as the JC CCGs, with the same papers and making a decision at the same time as the JC CCGs but as a separate CCG.

13.3 In determining those matters on which they want to share decision making, the CCGs have also agreed a number of areas in which they are not planning to make joint decisions. The following are functions which have not been delegated to the JC CCGs:

14. Reserved Functions

14.1 All functions are reserved for statutory organisations that are not specifically stated in the scheme of delegation.

14.2 It will be important for the JC CCGs to be cognisant of the above Reserved Functions and to engage with member CCGs if any of those arise in the context of the functions which the JC CCGs are to exercise.

14.3 **Exercise of the Joint Functions**

The JC CCGs must exercise the Joint Functions in accordance with:

- the Terms of Reference;
- the terms of this Manual;
- all applicable law, see framework in Appendix 3;
- all applicable Guidance issued by health system regulators; and
- good Practice.

Chapter 5- Additional terms supplementing the Terms of Reference

15. Key Objectives and Guiding Principles for JC CCGs

15.1The JC CCGs shall work towards achieving the Key Objectives of the JC CCGs and all members of the JC CCGs shall act in good faith to support achievement of the Key Objectives.

15.2The Key Objectives of the JC CCGs are:

15.2.1To achieve better patient experience, better outcomes and more efficient service delivery through the Member CCGs collaborating in the commissioning of services, by:

15.2.1.1 working together on contractual and service issues with providers several or all of the Member CCGs use, due to patient flows;

15.2.1.2 sharing clinical expertise, best practice and management resource in service redesign, enabling more focussed commissioning capacity and leadership;

15.2.1.3 working together on patient and public participation in commissioning health and care, taking into account updated guidance.

15.2.1.4 leading transformation change where working together is necessary to ovate change;

15.2.1.5 achieving economies of scale through shared representation and input to clinical networks, specialised commissioning and primary care commissioning (where CCGs will wish to influence primary and tertiary commissioned pathways, and specialised and primary care commissioners will wish to influence secondary care and enhanced care pathways);

15.2.1.6 coordinate work with NHS England, particularly on specialised and primary care, where this improves experience for patients, giving consistency along pathway interfaces and avoiding duplication;

15.2.1.7 resolving cross boundary issues, where the action of one Member CCG could have an impact on a neighbour Member CCG;

15.2.1.8 providing leadership to the health system in the area covered by the Member CCGs; and

15.2.1.9 ensuring equity of access to services collaboratively commissioned; and

15.2.1.10 To support ongoing effective working of the Member CCGs.

15.3 The JC CCGs shall adopt and follow the JC CCGs Guiding Principles and all members of the JC CCGs shall act in good faith to follow the Guiding Principles.

15.4 The Guiding Principles of the JC CCGs are set out in the Terms of Reference and are:

- To collaborate and co-operate. Do it once rather than repeating or duplicating actions and increasing cost across the CCGs. Establish and adhere to the governance structure set out in the Terms of Reference and in this Manual, to ensure that activities are delivered and actions taken as required;
- To be accountable. Take on, manage and account to each other for performance of the respective roles and responsibilities set out in the Terms of Reference and in this Manual;
- To be open. Communicate openly about major concerns, issues or opportunities relating to the functions delegated to the JC CCGs, as set out in Appendix 1 (*Delegation)*;
- To learn, develop and seek to achieve full potential. Share information, experience, materials and skills to learn from each other and develop effective working practices, work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost whilst ensuring quality is maintained or improved across all the Member CCGs;
- To adopt a positive outlook. Behave in a positive, proactive manner;
- To adhere to statutory requirements and best practice. Comply with applicable laws and standards including EU procurement rules, data protection and freedom of information legislation.
- To act in a timely manner. Recognise the time-critical nature of the functions delegated to the JC CCGs as set out in Appendix 1 (*Delegation*), and respond accordingly to requests for support;
- To manage stakeholders effectively;
- To deploy appropriate resources. Ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in the Terms of Reference and in this Manual; and
- To act in good faith to support achievement of the Key Objectives and compliance with these Principles.
- The JC CCGs has a commitment to ensuring that in pursuing its Key Objectives it does not increase inequalities or worsen health outcomes for any local populations.
- Where one of the partners voted in a different way to others on any issue the committee would take the time to discuss and understand the reasons why.

16. Sub committees of the JC CCGs

16.1 The JC CCGs shall be able to appoint sub-committees, which shall include:

16.1.1 **Joint Committee Sub Group**

17. Finances/ Pooled Funding

17.1 The Member CCGs may, for the purposes of exercising the Joint Functions under this Manual, establish and maintain a pooled fund in accordance with section 14Z3 of the

NHS Act 2006. Specifically, member CCGs may want to look at how to support the implementation of the decisions they make from service reconfiguration processes through to enabling strategic system change across the region. Pooling funds for use across the region for the overall benefit of all patients would ensure that best use of limited resources is achieved. It will also mean that implementation of decisions is less likely to stall due to financial challenges in that a pooled fund provides greater regional support options than CCGs seeking to implement change individually.

In some instances, consideration can also be given to getting better value for money by consolidating purchasing/commissioning power in a pooled fund.

18. Secretariat

18.1 SYB ICS will provide the secretariat to the JC CCGs

18.2 JC CCGs associated ICS staffing resource are hosted by Sheffield CCG

19. Staffing

19.1 See 18 above

20. Conflicts of Interest.

20.1 The Member CCGs must comply with their statutory duties set out in Chapter A2 of the NHS Act 2006, including those relating to the management of conflicts of interest as set out in section 14O of the Act.

20.2 Each member of the JC CCGs must abide by NHS England's guidance *Managing conflicts of interest – statutory guidance for CCGs a*s updated from time to time *(https://www.england.nhs.uk/commissioning/pc-co-comms/coi/)* and all relevant Guidance and policies of their appointing body in relation to conflicts of interest.

20.3 In addition, the JC CCGs shall operate a register of interests and has a Conflicts of Interest Policy. Members of the JC CCGs shall comply with the JC CCGs's conflicts of interest policy and shall disclose any potential conflict; where there is any doubt or where there is a divergence between the terms of the conflicts of interest policy of a member's appointing CCG and that of the JC CCGs, the member should always err on the side of disclosure of any potential conflict.

20.4 Where any member of the JC CCGs has an actual or potential conflict of interest in relation to any matter under consideration by the JC CCGs, that member must not participate in meetings (or parts of meetings) in which the relevant matter is discussed, or make a recommendation in relation to the relevant matter. The relevant appointing body may send a suitable deputy to take the place of the conflicted member in relation to that matter.

20.5 Any breaches of the JC CCGs conflicts of interest policy or NHS England guidance on managing conflicts of interest shall be reported to the Member CCGs promptly and in any event within 5 business days of the breach having come to light.

21. General Data Protection Regulation (GDPR) 2018

21.1The Member CCGs shall all comply with GDPR requirements.

21.2 The GDPR introduces a principle of *'accountability'*. This requires that CCGs and organisations must be able to *demonstrate compliance*. The key obligations to support this include:

- the recording of all data processing activities with their lawful justification and data retention periods
- routinely conducting and reviewing data protection impact assessments where processing is likely to pose a high risk to individuals' rights and freedoms
- assessing the need for data protection impact assessment at an early stage, and incorporating data protection measures by default in the design and operation of information systems and processes
- ensuring demonstrable compliance with enhanced requirements for transparency and fair processing, including notification of rights
- ensuring that data subjects' rights are respected (the provision of copies of records free of charge, rights to rectification, erasure, to restrict processing, data portability, to object, and to prevent automated decision making)
- notification of personal data security breaches to the Information Commissioner
- the appointment of a suitably qualified and experienced Data Protection Officer.

21.3 The Member CCGs agree that, in relation to information sharing and the processing of information for the purposes of the Joint Functions, they must comply with:

21.3.1 all relevant Information Law requirements including the common law duty of confidence and other legal obligations in relation to information sharing including those set out in the NHS Act 2006 and the Human Rights Act 1998;

21.3.2 Good Practice; and

21.3.3 relevant Guidance (including guidance given by the Information Commissioner).

22. IT inter-operability

22.1The Member CCGs will aim to develop inter-operable IT systems (where necessary for the exercise of the Joint Functions) in line with national Information Governance (IG) rules to enable data to be transferred between systems securely, easily and efficiently.

23. Confidentiality

23.1 Where information is shared with the JC CCGs of a confidential or commercially sensitive nature information will be treated under the confidential policy of the host CCG.

24. Freedom of Information

24.1 Each Member CCG acknowledges that the other Member CCGs are a public authority for the purposes of the Freedom of Information Act 2000 (**"FOIA"**) and the Environmental Information Regulations 2004 (**"EIR"**).

24.2 Each Member CCG may be statutorily required to disclose information about the Agreement and the information shared or generated by the Member CCGs pursuant to this Agreement and the Terms of Reference, in response to a specific request under FOIA or EIR, in which case:

24.2.1 each Member CCG shall provide the others with all reasonable assistance and co-operation to enable them to comply with their obligations under FOIA or EIR;

24.2.2 each Member CCG shall consult the others regarding the possible application of exemptions in relation to the information requested, giving them at least 5 working days within which to provide comments. Such consultation shall be effected by contacting [the CCG Representative named in Column 2 of Schedule 2 (*Member CCGs*)]; and

24.2.3 each Member CCG acknowledges that the final decision as to the form or content of the response to any request is a matter for the Member CCG to whom the request is addressed.

25. Procurement

25.1 Commissioners are required to ensure that their decisions to procure services, which relates to many commissioning decisions , comply with the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013. Key questions are set out under each heading below to assist you when considering whether you are meeting these requirements. Commissioners are also required to comply with EU/UK general procurement law but this is not covered in the list below.

The real procurement objective is to -

'*To secure the needs of patients and improve quality and efficiency of services*'

Therefore, part of considering how robust your decision is in terms of meeting procurement obligations is to look at:

- What have you done to assess patient need and do you have evidence to support your findings?
- How are you assessing the quality of services and the performance of the current providers? How have you assessed whether the service is offering value for money?
- Have you reviewed the current service specification to ensure it is working well and whether there is scope for further improvement? In particular, it would be helpful to have a schedule of all existing contracts and relationships, including performance monitoring on contracts.
- What steps have you taken to assess equitable access to services by all patient groups?

25.2 In achieving the main objective, the regulations contain three general requirements, which are:

25.2.1 To act transparently and proportionately and in a non-discriminatory way.

- What steps have you taken to make providers and stakeholders aware of your plans? Have you provided reasons to support your decisions?
- Are you publishing details in a timely manner and have you kept records of decision making, e.g. board minutes and briefing papers?
- Do providers understand the selection criteria you are using and are they able to express an interest in providing the services? Can you show that you have not favoured one provider over the other?
- Is your approach proportionate to the nature of the services in relation to the value, complexity and clinical risk associated with the provision of the services in question?

25.2.2 To contract with providers who are most capable of meeting the objectives and provide best value for money

- How have you identified existing and potential providers and objectively evaluated their relative ability to deliver the service specification, improve quality and meet the needs of patients?
- Are you satisfied providers are capable and robust enough to deliver a safe and efficient service and provide the best value for money in doing so?

25.2.3 Consider ways of improving services through integration, competition and patient choice

- What evidence do you have to show the steps you taken to determine whether it might be better for patients if the services are integrated with other health care services?
- Have you asked providers, patients, and other stakeholders for their views?
- Does your specification or performance monitoring process incentivise delivery of care in a more integrated manner?
- Have you considered whether competition or choice would better incentivise providers to improve quality and efficiency? Do you have evidence to support your findings?

25.3 Advertisements and expressions of interest

To ensure providers are able to express an interest in in providing any services which includes the requirement to publish opportunities and awards on a website

- How have you gathered evidence about the existing and potential providers on the market?
- Have you published your intentions to the market by way of commissioning intentions or publication on a website?

25.4 Award of a new contract without a competition

A new contract may be awarded without publishing a contract notice where the commissioner is satisfied that the services in question are capable of being provided only by that provider, e.g. A&E services in a particular area or where it is not viable for providers to provide one service without also providing another service.

- What steps have you taken and what evidence are you relying on to satisfy yourself that there is only one capable provider?

25.5 Conflict of Interests

Commissioners are prohibited from awarding a contract where conflicts, or potential conflicts, between the interests of Commissioners in commissioning services and the interests involved in providing the services affect, or appear to affect, the integrity of the award of the contract.

- Have you recorded how you have managed any conflict or potential conflict?

This will be an issue over which the ICS needs to be sensitive given the collaborative working between commissioners and providers. Further information and guidance is available in section 20 above.

25.6 Anti-competitive behaviour

Not to engage in anti-competitive behaviour unless to do so would be in the interests of people who use NHS services

- Are you acting in an anticompetitive manner – for instance have you prevented new providers from entering the market or caused a provider to exit the market?
- If so, is it objectively justifiable as being in the interests of users and stakeholders? What evidence do you have to support this?

26 Competition Issues

26.1 Requirement to Notify the Competition and Markets Authority (CMA)

The obligation to notify the CMA sits with the provider and guidance is set out below on when that duty bites. It should also be noted that if a provider has given any undertakings to the CMA or its predecessor, the Competition Commission, then they may prohibit a statutory transaction and should be checked. A brief overview of the merger regime is set out below:

26.2 Merger control rules

The merger control regime may apply to NHS service reconfigurations where two or more services are merged and the transaction meets the jurisdictional tests.

26.3 Jurisdictional Tests

The CMA has jurisdiction to examine a merger where:

26.3.1 Two or more enterprises cease to be distinct (change of control)

26.3.2 and either

- the UK turnover of the acquired enterprise exceeds £70 million; or
- the enterprises which cease to be distinct together supply or acquire at least 25% of all those particular services of that kind supplied in the UK or in a substantial part of it. The merger must also result in an increment to the share of supply, i.e. the merging providers must supply or acquire the same category of services.

[**Enterprise**: NHS foundation trusts and NHS trusts controlling hospital, ambulance services, mental health service, community services or individual services or specialities may be enterprises for the purpose of merger control.

Change in control: Two enterprises (or services) cease to be distinct if they are brought under common ownership or control. There must be a change in the level of control over the activities of one or more enterprises (or services) for merger control to apply.]

26.4 Competition test

The CMA assesses qualifying mergers to decide whether they are likely to lead to a substantial lessening of competition (‘SLC’). An SLC occurs when competition is substantially less after the merger.

26.5 SLC assessment

The CMA will require detailed information about the reconfiguration. This will include:

- service overlaps;
- GP referral data / catchment area analysis; and
- Hospital share of GP practice referrals.

26.6 CMA merger assessment timetable

The process is divided into two stages:

- Phase I: an initial 40 working day investigation; and

- Phase II: a possible 24 weeks in-depth investigation, which can be extended if the CMA considers it necessary.

27 Liability and indemnities.

27.1 In accordance with section 14Z3 of the NHS Act 2006, the Member CCGs retain liability in relation to the exercise of the Joint Functions.

28 Breach of this Manual and Remedies

28.1 Any breach of this manual will be raised by the Chair and identified senior officer. Disputes will be dealt with under 29 below.

29 Dispute Resolution

29.1 Where any dispute arises within the JC CCGs in connection with this Manual, the relevant Member CCGs must use their best endeavours to resolve that dispute on an informal basis within the JC CCGs.

29.2 Where any dispute is not resolved under clause on an informal basis, any CCG Representative (as set out in Column 2 of Schedule 2 (*Member CCGs*) may convene a special meeting of the JC CCGs to attempt to resolve the dispute.

29.3 If any dispute is not resolved under clause , it will be referred by the [Chair] of the JC CCGs to the Accountable Officers of the relevant Member CCGs, who will co-operate in good faith to resolve the dispute within ten (10) days of the referral.

29.4 Where any dispute is not resolved under clauses , or , any CCG Representative may refer the matter for mediation arranged by an independent third party to be appointed by [the Chair of the JC CCGs] [CEDR], and any agreement reached through mediation must be set out in writing and signed by and the relevant Member CCGs.

30 Leaving the JC CCGs

30.1 Should this joint decision making arrangement prove to be unsatisfactory, the governing body of any of the Member CCGs can decide to withdraw from the arrangement, but has to give a minimum of six months' notice to partners, with consideration by the JC CCGs of the impact of a leaving partner - a maximum of 12 months' notice could apply.

30.2 The Member CCG who wishes to withdraw from the JC CCGs will work together with the other Member CCGs to ensure that there are suitable alternative arrangements in place in relation to the exercise of the Joint Functions.

30.3 After leaving the JC CCGs, that CCG shall no longer be a Member CCG but shall remain bound by Clauses 23 (confidentiality)

31 Termination of the Manual

31.1 This Manual shall no longer apply if the JC CCGs is terminated.

31.2 Such termination shall be effective if all Member CCGs agree in writing that the JC CCGs shall end and withdraw the delegation of their functions to the JC CCGs.

32 Notices

32.1 Any notices given under this Manual must be in writing, must be marked for the [CCG Representative noted in Column 2 to Schedule 2 (*Member CCGs")].*

32.2 Notices sent:

32.2.1 by hand will be effective upon delivery;

32.2.2 by post will be effective upon the earlier of actual receipt or five (5) working days after mailing; or

32.2.3 by email will be effective when sent (subject to no automated response being received).

33 Variations

33.1 Any variation to the Delegation, Terms of Reference or this Manual will only be effective if it is made in writing and signed by each of the Member CCGs.

33.2 All agreed variations to the Delegation, Terms of Reference or this Manual must be appended as a Schedule to this Manual.

34 Counterparts

This Manual may be executed in any number of counterparts, each of which when executed and delivered shall constitute an original of this Manual, but all the counterparts shall together constitute the same agreement.

35 Applicable Law

This Manual shall be interpreted in accordance with the laws of England and Wales and each party to this Manual submits to the exclusive jurisdiction of the courts of England and Wales.

Schedule 1
Definitions and Interpretation

In this Manual, the following words and phrases will bear the following meanings:

Manual	means this agreement between the Member CCGs comprising the body of the Manual and its Schedules;
Data Controller	shall have the same meaning as set out in the GDPR;
Delegation	means the delegation of functions set out in Appendix 1 to this Manual;
Good Practice	means using standards, practices, methods and procedures conforming to the law, reflecting up-to-date published evidence and exercising that degree of skill and care, diligence, prudence and foresight which would reasonably and ordinarily be expected from a skilled, efficient and experienced commissioner;
GDPR	means the General Data Protection Regulation 2018;
Guidance	means any applicable health and social care guidance, guidelines, direction or determination, framework, standard or requirement issued by NHS England or any other regulatory or supervisory body, including the Information Commissioner, to the extent that the same are published and publicly available;
Information Law	The, GDPR, DPA, the EU Data Protection Directive 95/46/EC; regulations and guidance made under section 13S and section 251 of the NHS Act; guidance made or given under sections 263 and 265 of the Health and Social Care Act 2012; the Freedom of Information Act 2000; the common law duty of confidentiality; the Human Rights Act 1998 and all other applicable laws and regulations relating to processing of Personal Data and privacy including General Data Protection Regulation requirements;
JC CCGs	means the joint committee of the Member CCGs established on the terms set out in the Terms of Reference;
Joint Functions	means the functions jointly exercised by the Member CCGs through the decisions of the JC CCGs in accordance with the Terms of Reference and as set out in detail in clause [add] of the Delegation;

Law	means: (i) any applicable statute or proclamation or any delegated or subordinate legislation or regulation; (ii) any enforceable EU right within the meaning of section 2(1) European Communities Act 1972; or (iii) any applicable judgment of a relevant court of law which is a binding precedent in England and Wales, in each case in force in England and Wales;
Member CCG	means the CCGs which are part of the JC CCGs and are set out in the Terms of Reference and Column 1 of Schedule 2 (*Member CCGs*) to this Manual.
NHS Act 2006	means the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012 or other legislation from time to time);
NHS England	means the National Health Service Commissioning Board established by section 1H of the NHS Act, also known as NHS England;
Non-member CCG	means a CCG which is not a member of the JC CCGs
Non-Personal Data	means data which is not Personal Data;
Personal Data	shall have the same meaning as set out in the DPA and shall include references to Sensitive Personal Data where appropriate;
Sensitive Personal Data	shall have the same meaning as in the DPA; and
Terms of Reference	means the terms of reference for the JC CCGs agreed between the CCG(s).

Schedule 2
Member CCGs

Column 1 Clinical Commissioning Groups
NHS Barnsley Clinical Commissioning Group; NHS Bassetlaw Clinical Commissioning Group; NHS Doncaster Clinical Commissioning Group; NHS Rotherham Clinical Commissioning Group; NHS Sheffield Clinical Commissioning Group; NHS England Specialised Commissioning And associate CCG: NHS Derby and Derbyshire Clinical Commissioning Group;

Appendix 1

Delegation by CCGs to JC CCGs

A. The CCG functions at B will be delegated to the JC CCGs by the member CCGs in accordance with their statutory powers under s.14Z3 of the NHS Act 2006 (as amended) (**"the NHS Act"**). Section 14Z3 allows CCGs to make arrangements in respect of the exercise of their commissioning functions and includes the ability for two or more CCGs to create a Joint Committee to exercise functions.

B. The delegated functions relate to the health services provided to the member CCGs by all providers they commission services from in the exercise of their functions. The CCGs delegate their commissioning functions so far as such functions are required for the Joint Committee to carry out its role, as set out in the Terms of Reference (appendix 2).

The CCGs delegate the functions to enable the Joint Committee to take decisions around future transformation projects, specifically and limited to transformation and redesign of Hyper Acute Stroke services and Children's Surgery and Anaesthesia services and the specific delegation requirements for JC CCGs set out in the agreed 2019/20 JCCCG priorities which are summarised below:

2019/20 SYB System Commissioning Priorities requiring delegated authority	Requested delegation to the JC CCGs to:
System Contracting • 999 system lead contractor (YAS) for 4 SYB CCGs • 111 system lead contractor (YAS) for 5 SYB CCGs	• develop and agree a financial threshold of contract value against contract baseline for the lead contractor to negotiate on behalf of each CCG during 19/20 contract negotiations.
Outpatients • Review of outpatient follow ups across SYB by specialty, develop clinical protocols to standardise practice and reduce unwarranted variation * • Review of outpatient first appointments (as above) *	• identify and agree the specialities in scope of the OP review • develop and sign off clinical protocols developed with SYB clinical engagement from both commissioners and providers and patients/ public as necessary • implement clinical protocols in Providers standard NHS contracts 2019/20
Commissioning Outcomes • Commissioning for Outcomes – new stage 2	• identify and agree the clinical priorities in the policy • sign off 19/20 policy ensuring public

	consultation /engagement has taken place • implementation of protocols and included formally in standard NHS contracts 2019/20
IVF • Explore options for a SYB approach to the number of IVF cycles	• develop IVF options appraisal and financial modelling for consideration by CCG Governing Bodies
Cancer • Standard implementation of national cancer pathways across SYB tom improve outcomes and equity of access*	• implement standard cancer pathways in NHS provider contracts and across the 5 SYB places
Medicines and Prescribing • Medicines optimisation – standardisation of policies across SYB	• Identify opportunities for medicines standardisation • develop and sign off policies developed with SYB clinical engagement from clinicians, patients / public as necessary
Hospital Services Programme • Governing Bodies to agree next steps on the work programme of the Hospital Services Programme,	• The conclusions on next steps on transformation and reconfiguration and implementation of these

C. Each member CCG shall also delegate the following functions to the JC CCGs so that it can achieve the purpose set out in (B) above:

1. Acting with a view to securing continuous improvement to the quality of commissioned services. This will include outcomes for patients with regard to clinical effectiveness, safety and patient experience to contribute to improved patient outcomes across the NHS Outcomes Framework
2. Promoting innovation, seeking out and adopting best practice, by supporting research and adopting and diffusing transformative, innovative ideas, products, services and clinical practice within its commissioned services, which add value in relation to quality and productivity.
3. The requirement to comply with various statutory obligations, including making arrangements for public involvement and consultation throughout the process and taking into account updated guidance on patient and public participation in commissioning health and care. That includes any determination on the viability of models of care pre-consultation and during formal consultation processes, as set out in s.13Q, s.14Z2 and s.242 of the NHS Act.
4. The requirement to ensure process and decisions comply with the four key tests for service change introduced by the Secretary of State for Health, which are:
    - Support from GP commissioners;
    - Strengthened public and patient engagement;
    - Clarity on the clinical evidence base; and

- Consistency with current and prospective patient choice.

5. The requirement to comply with the statutory duty under s.149 of the Equality Act 2010 i.e. the public sector equality duty.
6. The requirement to have regard to the other statutory obligations set out in the new sections 13 and 14 of the NHS Act. The following are relevant but this is not an exhaustive list:

   ss.13C and 14P - Duty to promote the NHS Constitution
   ss.13D and 14Q - Duty to exercise functions effectively, efficiently and economically
   ss.13E and 14R – Duty as to improvement in quality of services
   ss.13G and 14T - Duty as to reducing inequalities
   ss.13H and 14U – Duty to promote involvement of each patient
   ss.13I and 14V - Duty as to patient choice
   ss.13J and 14W – Duty to obtain appropriate advice
   ss.13K and 14X – Duty to promote innovation
   ss.13L and 14Y – Duty in respect of research
   ss.13M and 14Z - Duty as to promoting education and training
   ss.13N and 14Z1- Duty as to promoting integration
   ss.13Q and 14Z2 - Public involvement and consultation by NHS England/CCGs
   s.13O - Duty to have regard to impact in certain areas
   s.13P - Duty as respects variations in provision of health services
   s.14O – Registers of Interests and management of conflicts of interest
   s.14S – Duty in relation to quality of primary medical services

7. The JC CCGs must also have regard to the financial duties imposed on CCGs under the NHS Act and as set out in:

   - s.223G – Means of meeting expenditure of CCGs out of public funds
   - s.223H – Financial duties of CCGs: expenditure
   - s.223I - Financial duties of CCGs: use of resources
   - s.223J - Financial duties of CCGs: additional controls of resource use

8. Further, the JC CCGs must have regard to the Information Standards as set out in ss.250, 251, 251A, 251B and 251C of the Health & Social Care Act 2012 (as amended).
9. The expectation is that CCGs will ensure that clear governance arrangements are put in place so that they can assure themselves that the exercise by the JC CCGss of their functions is compliant with statute.
10. The JC CCGs will meet the requirement for CCGs to comply with the obligation to consult the relevant local authorities under s.244 of the NHS Act and the associated Regulations.
11. To continue to work in partnership with key partners e.g. the local authority and other commissioners and providers to take forward plans so that pathways of care are seamless and integrated within and across organisations.
12. The JC CCGs will be delegated the capacity to propose, consult on and agree future service configurations that will shape the medium and long terms financial plans of the constituent organisations. The JC CCGs will have no contract negotiation powers meaning that it will not be the body for formal annual contract negotiation between commissioners and providers. These processes will continue to be the responsibility of Clinical Commissioning Groups (and NHS England) under national guidance, tariffs and contracts during the pre-consultation and consultation periods.

Appendix 2

JC CCGs Terms of Reference

1. Introduction

.1 The NHS Act 2006 (as amended) (‘**the NHS Act**’), was amended through the introduction of a Legislative Reform Order (“**LRO**”) to allow CCGs to form joint committees. This means that two or more CCGs exercising commissioning functions jointly may form a joint committee as a result of the LRO amendment to s.14Z3 (CCGs working together) of the NHS Act.

1.2 Joint committees are a statutory mechanism which gives CCGs an additional option for undertaking collective strategic decision making and can include NHS England, who may also make decisions collaboratively with CCGs.

1.3 Individual CCGs and NHS England will still always remain accountable for meeting their statutory duties. The aim of creating a joint committee is to encourage the development of strong collaborative and integrated relationships and decision-making between partners.

1.4 The Joint Committee of Clinical Commissioning Groups (‘**JC CCGs**’) is a joint committee of:

(1) NHS Barnsley Clinical Commissioning Group;

(2) NHS Bassetlaw Clinical Commissioning Group;

(3) NHS Doncaster Clinical Commissioning Group;

(4) NHS Rotherham Clinical Commissioning Group;

(5) NHS Sheffield Clinical Commissioning Group;

(6) NHS England Specialised Commissioning; Non voting

And *Associate CCG members:

(6) NHS Derby and Derbyshire Clinical Commissioning Group;

***Associate CCG** is a partner CCG outside of the SYB footprint with commissioned patient flows into SYB for acute provider secondary and tertiary care services. Derby and Derbyshire CCG is also a member of the SYB and North Derbyshire Cancer Alliance. Our Associate CCG is involved in the commissioning arrangements and decisions managed through the JC CCGs where their patients are affected by any proposed change as appropriate. Associate CCGs are non-voting members of the JC CCGs where they do not have a patient interest in a proposed change overseen by the JC CCGs. The involvement of the associate CCG in the JC CCGs work (where voting rights would be appropriate for that specific priority) is clarified on the list of JC CCGs work priorities.

It has the primary purpose of enabling the CCG members to work effectively together, to collaborate and take joint decisions in the areas of work that they agree.

1.5 In addition the JC CCGs will meet collaboratively with NHS England to make integrated decisions in respect of those services which are directly commissioned by NHS England.

1.6 Guiding principles:

- Collaborate and co-operate. Do it once rather than repeating or duplicating actions and increasing cost across the CCGs. Establish and adhere to the governance structure set out in these Terms of Reference and in the JC CCGs Manual (as updated from time to time), to ensure that activities are delivered and actions taken as required;
- Be accountable. Take on, manage and account to each other for performance of the respective roles and responsibilities set out in these Terms of Reference and in the JC CCGs Manual (as updated from time to time);
- Be open. Communicate openly about major concerns, issues or opportunities relating to the functions delegated to the JC CCGs, as set out in Schedule 1; ensuring our collective decisions are based on the *best* available evidence, that these are fully articulated, heard, and understood.
- Learn, develop and seek to achieve full potential. Share information, experience, materials and skills to learn from each other and develop effective working practices, work collaboratively to identify solutions, eliminate duplication of effort, mitigate risk and reduce cost whilst ensuring quality is maintained or improved across all the CCGs;
- Adopt a positive outlook. Behave in a positive, proactive manner;
- Adhere to statutory requirements and best practice. Comply with applicable laws and standards including EU procurement rules, data protection and freedom of information legislation.
- Act in a timely manner. Recognise the time-critical nature of the functions delegated to the JC CCGs as set out in Schedule 1, and respond accordingly to requests for support;
- Manage stakeholders effectively;
- Deploy appropriate resources. Ensure sufficient and appropriately qualified resources are available and authorised to fulfil the responsibilities set out in these Terms of Reference and in the JC CCGs Manual Agreement (as updated from time to time);
- Act in good faith to support achievement of the Key Objectives as set out in the JC CCGs Manual and compliance with these Principles.
- The JC CCGs has a commitment to ensuring that in pursuing its Key Objectives it does not increase inequalities or worsen health outcomes for any local populations.
- From time to time programmes boards may be established to oversee individual programmes of work. Where these are established under the direction of the JC CCGs these will be accountable to the JC CCGs.
- Where one of the partners voted in a different way to others on any issue the committee would take the time to discuss and understand the reasons why.

2. Statutory Framework

2.1 The NHS Act which has been amended by LRO 2014/2436, provides at s.14Z3 that where two or more clinical commissioning groups are exercising their commissioning functions jointly, those functions may be exercised by a joint committee of the groups.

2.2 The CCGs named in paragraph 1.5 above have delegated the functions set out in Schedule 1 to the JC CCGs.

3. Role of the JC CCGs

3.1 The role of the JC CCGs shall be:

- Development of collective strategy and commissioning intentions;
- Development of co-commissioning arrangements with NHS England;
- Joint contracting with Foundation Trusts and other service providers;
- System transformation, including the development and adoption of service redesign and best clinical practice across the area – which may include the continuation or establishment of clinical networks in addition to those nationally established;
- Representation and contribution to Alliances and Networks including clinical networks nationally prescribed;
- Work with NHS England and Improvement on the outcome and implication of national or regional service reviews;
- Work with the NHS England Area on system management and resilience;
- Collaboration and sharing best practice on Quality Innovation Productivity and Prevention initiatives; and
- Mutual support and aid in organisational development.

3.2 At all times, the JC CCGs, through undertaking decision making functions of each of the member CCGs, will act in accordance with the terms of their constitutions. No decision outcome shall impede any organisation in the fulfilment of its statutory duties.

4. Geographical coverage

4.1 The JC CCGs will comprise those CCGs listed above in paragraph 1.5, NHSE/I specialised commissioning covering the South Yorkshire and Bassetlaw, Derby and Derbyshire areas (associate members).

5. Membership

5.1 Membership of the committee will combine both Voting and Non-voting members and will comprise of: -

5.2 Voting members:

- Two decision makers from each of the five SYB member CCGs: the Clinical Chair and Accountable Officer. Each CCG has one vote.

5.3 Non-voting attendees:

- Two Lay Members
- One Director of Finance chosen from the member CCGs.
- A Healthwatch representative nominated by the local Healthwatch groups
- SYB ICS Chief Executive or deputy
- SYB ICS Director of Commissioning
- SYB ICS Communications and Engagement lead
- NHSE Specialised Commissioning lead
- Associate CCG member (where no or minimal patient interest in proposed changes, see para 1.4)

5.4 The JC CCGs may invite additional non-voting members to join the JC CCGs to enable it to carry out its duties

5.5 Committee members may nominate a suitable deputy when necessary and subject to the approval of the Chair of the JC CCGs. All deputies should be fully briefed and the secretariat informed of any agreement to deputise so that quorumum can be maintained.

5.6 No person can act in more than one role on the JC CCGs, meaning that each deputy needs to be an additional person from outside the JC CCGs membership.

5.7 The SYB ICS will act as secretariat to the JC CCGs to ensure the day to day work of the JC CCGs is proceeding satisfactorily. The membership will meet the requirements of the constitutions of the CCGs named above at paragraph 1.4.

5.8 The JC CCGs will be Chaired by a respective CCG Clinical Chair and vice clinical Chair. For 2019/20 the chair is Doncaster CCG Clinical Chair, Deputy Chair is Rotherham CCG Clinical chair. The tenure of the role is 12 months.

6. Meetings

6.1 The JC CCGs shall adopt the standing orders of NHS Sheffield Clinical Commissioning Group insofar as they relate to the:

a) notice of meetings;

b) handling of meetings;

c) agendas;

d) circulation of papers; and

e) conflicts of interest.

7. Voting

7.1 The JC CCGs will aim to make decisions by consensus wherever possible. Where this is not achieved, a voting method will be used. The JC CCGs has five CCG members and 1 vote for each CCG. The voting power of each individual present will be weighted so that each party (CCG) possesses 20% of total voting power.

7.2 It is proposed that recommendations can only be approved if there is approval by more than 80%.

8. Quorum

8.1 At least one full voting member from each CCG must be present for the meeting to be quorate. The Healthwatch representative must also be present.

9. Frequency of meetings

9.1 Frequency of meetings will usually be monthly, but the Chair has the power to call meetings of the JC CCGs as and when they are required.

9.2 Meetings may be held by telephone or video conference, JC CCGs members can participate and included as quorum in a face to face meeting, by telephone or by video link.

10 Meetings of the JC CCGs

10.1 Meetings of the JC CCGs shall be held in public unless the JC CCGs considers that it would not be in the public interest to permit members of the public to attend a meeting or part of a meeting. Therefore, the JC CCGs may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.

10.2 The Chair shall set the agenda and arrange papers to be circulated 5 working days prior to the JC CCGs meeting

10.3 Members of the JC CCGs have a collective responsibility for the operation of the JC CCGs. They will participate in discussion, review evidence and provide objective expert input to the best of the knowledge and ability, and endeavour to reach a collective view.

10.4 The JC CCGs may call additional experts to attend meetings on an ad hoc basis to inform discussions.

10.5 Each JCCCG member must abide by all policies in relation to conflicts of interests. Where any JC CCGs member has an actual or potential conflict of interest in relation to any matter under consideration at any meeting , the Chair (in their discretion) shall decide, having regard to the nature of the potential or actual conflict of interest, whether or not that member of the JC CCGs can participate / vote in the meeting or part of the meeting where the item is discussed

10.6 The JC CCGs has the power to establish sub groups and working groups and any such groups will be accountable directly to the JC CCGss.

10.7 Members of the JC CCGs shall respect confidentiality requirements as set out in the Standing Orders referred to above unless separate confidentiality requirements are set out for the JC CCGs, in which event these shall be observed.

10.8 The right of attendance at meetings by members of the public as referred to in paragraph 10.1 does not give the right to such members of the public to ask questions or participate in that meeting, unless invited to do so by the Chair.

10.9 Members of the public or press may not record proceedings in any manner whatsoever, other than in writing, or make any oral report of the proceedings as they take place, without the prior written agreement of the Chair.

10.10 Questions must be submitted in writing to the JC CCGs secretariat by noon on the Monday before the meeting.

10.11 Answers to submitted questions relating to the agenda received in advance of the meeting will be published on the JCCCG section of the South Yorkshire and Bassetlaw Integrated Care System website prior to the meeting. Up to 15 minutes will be set aside at the beginning of the meeting in public for questions and/or statements to be made by members of the public. The chair reserves the right to not answer questions or statements that are not deemed appropriate to the JC CCGs agenda.

10.12 Confidential items will be considered in a closed private meeting of the JC CCGs.

10.13 The Chair may exclude any member of the public from a meeting of the JC CCGs if they are interfering with or preventing the proper or reasonable conduct of that meeting.

11. Secretariat provisions

The secretariat to the JC CCGs will:

a) Take and circulate the minutes, conflicts, matters arising action notes and decisions of the JC CCGs meeting to all members; and

b) Present the minutes, conflicts, matters arising, action notes and decisions to the governing bodies of the CCGs set out in paragraph 1.4 above.

12. Reporting to CCGs

The JC CCGs will make a quarterly written report to the CCG member governing bodies and the SYB ICS and hold at least annual engagement events to review aims, objectives, strategy and progress and publish an annual report on progress made.

13. Decisions

13.1 The JC CCGs will make decisions within the bounds of the scope of the functions delegated.

13.2 The decisions of the JC CCGs shall be binding on all member CCGs.

13.3 All decisions undertaken by the JC CCGs will be published by the Clinical Commissioning Groups set out in paragraph 1.4 above.

13.4 The JC CCGs agrees to make decisions by a common process for decision making with a non-member CCG. This process will apply where a non-member CCG has delegated the functions within the scope of the JC CCGs to an individual or member or employee of the non-member CCG.

15. Attendance

14.1 Voting members of the JC CCGs shall attend a minimum of at least 75% of meetings during the financial year.

15. Review of Terms of Reference

These terms of reference will be formally reviewed in **6 months** by Clinical Commissioning Groups set out in paragraph 1.4 and may be amended by mutual agreement between the CCGs at any time to reflect changes in circumstances as they may arise.

15. Withdrawal from the JC CCGs

15.1 Should this joint commissioning arrangement prove to be unsatisfactory, the governing body of any of the member CCGs can decide to withdraw from the arrangement, but has to give a minimum six months' notice to partners, with consideration by the JC CCGs of the impact of a leaving partner - a maximum of 12 months notice could apply.

16. **List of Members from each CCG and non-voting members**

Column 1 **Organisation or nomination**	**Column 2** **Representatives**
Voting members	
NHS Barnsley Clinical Commissioning Group;	The Clinical Chair, The Accountable Officer
NHS Bassetlaw Clinical Commissioning Group;	The Clinical Chair, The Accountable Officer
NHS Doncaster Clinical Commissioning Group;	The Clinical Chair, The Accountable Officer
NHS Rotherham Clinical Commissioning Group;	The Clinical Chair, The Accountable Officer
NHS Sheffield Clinical Commissioning Group;	The Clinical Chair, The Accountable Officer
Non-voting members	
JC CCGs Lay Members	Lay members X2
Nominated Director of Finance	NHS Sheffield CCG Director of Finance
Nominated Healthwatch member	Healthwatch Doncaster
South Yorkshire and Bassetlaw ICS	ICS Chief Executive or Deputy ICS Director of Commissioning ICS Communications & Engagement Lead
NHS England	Specialised Commissioning
Associate CCG member	NHS Derby and Derbyshire CCG

Appendix 3

Checklist of Statutory Duties and Protocols

Public Law Issues (including for service change)

1. Case For Change

The starting point is to have established a clear Case for Change that both commissioners and providers agree is clinically and financially sound.

2. Engagement with Public and Patients

You must comply with various statutory obligations to engage with and consult the public and patients throughout the process. That includes any determination on the viability of models of care pre-consultation and during formal consultation processes. – see s.13Q, s.14Z2 and s.242 of the NHS Act 2006 (as amended) ('the Act') and statutory guidance for CCGs and NHS England (May 2017).

3. Four Key Tests

It is important throughout the reconfiguration process to have in mind the four key tests introduced by the last Secretary of State for Health, which are:

(i) strong public and patient engagement;

(ii) consistency with current and prospective need for patient choice;

(iii) a clear clinical evidence base; and

(iv) support for proposals from clinical commissioners.

Decision makers will need to show compliance when making a final decision on service change.

4. Equality

All NHS statutory bodies must also ensure compliance with their duty under s.149 of the Equality Act 2010 that is their public sector equality duty.

5. Statutory obligations

Commissioners must also have regard to the other statutory obligations set out in the new sections 13 and 14 of the Act. In looking at CCG duties the following, amongst others, are relevant:

- 14P – Duty to promote NHS Constitution
- 14Q – Duty as to effectiveness, efficiency etc
- 14R – Duty as to improvement in quality of services
- 14T – Duty as to reducing inequalities

- 14V – Duty as to patient choice
- 14X - Duty to promote innovation
- 14Z1 – Duty as to promoting integration
- 14Z2 – Public involvement and consultation by CCGs (see above)

6. Government Consultation Principles Updated 2018

All consulting NHS bodies should consider and comply with government principles on Consultation on what needs to be done to undertake a lawful public consultation exercise.

7. Principles for consultation (2018)

- **Consultations should be clear and concise**

  Use plain English and avoid acronyms. Be clear what questions you are asking and limit the number of questions to those that are necessary. Make them easy to understand and easy to answer. Avoid lengthy documents when possible and consider merging those on related topics.

- **Consultations should have a purpose**

  Do not consult for the sake of it. Ask departmental lawyers whether you have a legal duty to consult. Take consultation responses into account when taking policy forward. Consult about policies or implementation plans when the development of the policies or plans is at a formative stage. Do not ask questions about issues on which you already have a final view.

- **Consultations should be informative**

  Give enough information to ensure that those consulted understand the issues and can give informed responses. Include validated impact assessments of the costs and benefits of the options being considered when possible; this might be required where proposals have an impact on business or the voluntary sector.

- **Consultations are only part of a process of engagement**

  Consider whether informal iterative consultation is appropriate, using new digital tools and open, collaborative approaches. Consultation is not just about formal documents and responses. It is an on-going process.

- **Consultations should last for a proportionate amount of time**

  Judge the length of the consultation on the basis of legal advice and taking into account the nature and impact of the proposal. Consulting for too long will unnecessarily delay policy development. Consulting too quickly will not give enough time for consideration and will reduce the quality of responses.

- **Consultations should be targeted**

  Consider the full range of people, business and voluntary bodies affected by the policy, and whether representative groups exist. Consider targeting specific groups if appropriate. Ensure they are aware of the consultation and can access it. Consider how to tailor consultation to the needs and preferences of particular groups, such as older people, younger people or people with disabilities that may not respond to traditional consultation methods.

- **Consultations should take account of the groups being consulted**

  Consult stakeholders in a way that suits them. Charities may need more time to respond than businesses, for example. When the consultation spans all or part of a holiday period, consider how this may affect consultation and take appropriate mitigating action, such as prior discussion with key interested parties or extension of the consultation deadline beyond the holiday period.

- **Consultations should be agreed before publication**

  Seek collective agreement before publishing a written consultation, particularly when consulting on new policy proposals. Consultations should be published on gov.uk.

- **Consultation should facilitate scrutiny**

  Publish any response on the same page on gov.uk as the original consultation, and ensure it is clear when the government has responded to the consultation. Explain the responses that have been received from consultees and how these have informed the policy. State how many responses have been received.

- **Government responses to consultations should be published in a timely fashion**

  Publish responses within 12 weeks of the consultation or provide an explanation why this is not possible. Where consultation concerns a statutory instrument publish responses before or at the same time as the instrument is laid, except in very exceptional circumstances (and even then publish responses as soon as possible). Allow appropriate time between closing the consultation and implementing policy or legislation.

- **Consultation exercises should not generally be launched during local or national election periods**.

  If exceptional circumstances make a consultation absolutely essential (for example, for safeguarding public health), departments should seek advice from the Propriety and Ethics team in the Cabinet Office. This document does not have legal force and is subject to statutory and other legal requirements.

8. Governance

As to decision making it is important that clear governance arrangements are put in place that are compliant with statute.

9. Local authorities

Equally you must comply with your obligation to consult the relevant local authorities under s.244 of the Act and the associated Regulations.

10. Clear plan

As to consulting you need to have a clear plan in place which ensures that you give the public sufficient information for them to provide informed responses.

11. Analysis and report

Once the public consultation is complete, you must be able to collate and analyse responses for the decision makers to consider, often in the form of a consolidated report. Equally, you need a clear analysis of compliance with your obligations under the public sector equality duty.

12. Compliance with statutory obligations and four Key Tests

Commissioners will also want to ensure that decisions comply with their other statutory obligations and the four Key Tests, as set out above.

13. IRP

Consideration should be given to those issues which the IRP have indicated in annual reviews cause the most concern to the public an patients. (See separate note for a list of the issues).

Procurement Issues

Commissioners are required to ensure that their decisions to procure services comply with the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013. Key questions are set out under each heading below to assist you when considering whether you are meeting these requirements. Commissioners are also required to comply with EU/UK general procurement law but this is not covered in the list below.

1. Procurement objective

'To secure the needs of patients and improve quality and efficiency of services'.

- What have you done to assess patient need and do you have evidence to support your findings?
- How are you assessing the quality of services and the performance of the current providers? How have you assessed whether the service is offering value for money?
- Have you reviewed the current service specification to ensure it is working well and whether there is scope for further improvement? In particular, it would be helpful to have a schedule of all existing contracts and relationships, including performance monitoring on contracts.
- What steps have you taken to assess equitable access to services by all patient groups?

2. Three general requirements

I. To act transparently and proportionately and in a non-discriminatory way.

- What steps have you taken to make providers and stakeholders aware of your plans? Have you provided reasons to support your decisions?
- Are you publishing details in a timely manner and have you kept records of decision making, e.g. board minutes and briefing papers?
- Do providers understand the selection criteria you are using and are they able to express an interest in providing the services? Can you show that you have not favoured one provider over the other?
- Is your approach proportionate to the nature of the services in relation to the value, complexity and clinical risk associated with the provision of the services in question?

II. To contract with providers who are most capable of meeting the objectives and provide best value for money

- How have you identified existing and potential providers and objectively evaluated their relative ability to deliver the service specification, improve quality and meet the needs of patients?
- Are you satisfied providers are capable and robust enough to deliver a safe and efficient service and provide the best value for money in doing so?

III. Consider ways of improving services through integration, competition and patient choice

- What evidence do you have to show the steps you taken to determine whether it might be better for patients if the services are integrated with other health care services?
- Have you asked providers, patients, and other stakeholders for their views?
- Does your specification or performance monitoring process incentivise delivery of care in a more integrated manner?
- Have you considered whether competition or choice would better incentivise providers to improve quality and efficiency? Do you have evidence to support your findings?

3. Advertisements and expressions of interest

To ensure providers are able to express an interest in in providing any services which includes the requirement to publish opportunities and awards on a website

- How have you gathered evidence about the existing and potential providers on the market?
- Have you published your intentions to the market by way of commissioning intentions or publication on a website?

4. Award of a new contract without a competition

A new contract may be awarded without publishing a contract notice where the commissioner is satisfied that the services in question are capable of being provided only by that provider, e.g. A&E services in a particular area or where it is not viable for providers to provide one service without also providing another service.

- What steps have you taken and what evidence are you relying on to satisfy yourself that there is only one capable provider?

5. Conflict of Interests

Commissioners are prohibited from awarding a contract where conflicts, or potential conflicts, between the interests of Commissioners in commissioning services and the interests involved in providing the services affect, or appear to affect, the integrity of the award of the contract.

- Have you recorded how you have managed any conflict or potential conflict?

6. Anti-competitive behaviour

Not to engage in anti-competitive behaviour unless to do so would be in the interests of people who use NHS services

- Are you acting in an anticompetitive manner – for instance have you prevented new providers from entering the market or caused a provider to exit the market?
- If so, is it objectively justifiable as being in the interests of users and stakeholders? What evidence do you have to support this?

Competition Issues

1. Requirement to Notify to the Competition and Markets Authority (CMA)

Any undertakings given to the CMA or its predecessor, the Competition Commission, may prohibit a statutory transaction and should be checked. They may not apply to a merger by reconfiguration but the merger regime set out below will still apply.

2. Merger control rules

The merger control regime may apply to NHS service reconfigurations where two or more services are merged and the transaction meets the jurisdictional tests.

3. Jurisdictional Tests

The CMA has jurisdiction to examine a merger where:

1. two or more enterprises cease to be distinct (change of control)

2. and either

- the UK turnover of the acquired enterprise exceeds £70 million; or

- the enterprises which cease to be distinct together supply or acquire at least 25% of all those particular services of that kind supplied in the UK or in a substantial part of it. The merger must also result in an increment to the share of supply, i.e. the merging providers must supply or acquire the same category of services.

[**Enterprise**: NHS foundation trusts and NHS trusts controlling hospital, ambulance services, mental health service, community services or individual services or specialities may be enterprises for the purpose of merger control.

Change in control: Two enterprises (or services) cease to be distinct if they are brought under common ownership or control. There must be a change in the level of control over the activities of one or more enterprises (or services) for merger control to apply.]

4. Competition test

The CMA assesses qualifying mergers to decide whether they are likely to lead to a substantial lessening of competition (‘SLC’). An SLC occurs when competition is substantially less after the merger.

5. SLC assessment

The CMA will require detailed information about the reconfiguration. This will include:

- service overlaps;
- GP referral data / catchment area analysis; and
- Hospital share of GP practice referrals.

6. CMA merger assessment timetable

The process is divided into two stages:

- Phase I: an initial 40 working day investigation; and
- Phase II: a possible 24 weeks in-depth investigation, which can be extended if the CMA considers it necessary.

Appendix 4

South Yorkshire and Bassetlaw JC CCGs Clinical Engagement and Assurance Process

The SY&B system commissioning priorities for 2019/20 have been developed by the JC CCGs, members of SYB CCG Governing Bodies and Directors of Commissioning. Individual CCGs will be responsible for leading specific priorities of work to be adopted across the ICS in order to standardise access, improve outcomes and quality of care for patients across SY&B.

It is important that JC CCGs priorities are clinically developed using best practice and evidence based and are locally clinically led to ensure an agreed SYB consensus to pathways, policies and protocols. Assurance will be sought through the JC CCGs that all SYB priorities being developed are underpinned by a robust locally managed process in each place for clinicians to engage, influence, develop and agree the work and is supported by CCG memberships.

Wider involvement of clinicians and professionals from across the system including; primary and community care, secondary care, tertiary care, mental health, cancer and specialised services will be engaged in the relevant work priorities as appropriate to inform the clinical consensus. The lead CCG will ensure that wider SYB clinical engagement has been undertaken as required.

Each CCG currently has a forum to ensure this clinical assurance takes place locally through their place:

- Doncaster CCG – Clinical Reference Group
- Barnsley – Clinical Forum
- Sheffield CCG – Clinical Reference Group
- Rotherham CCG – Clinical Referral Management Committee
- Bassetlaw CCG – Service Delivery Committee

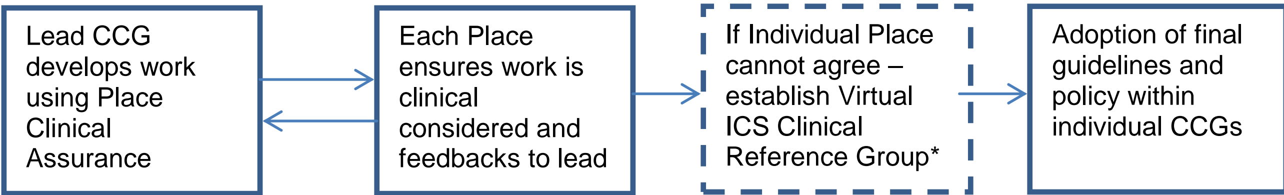
These respective groups all have the remit to ensure clinical debate and assurance is undertaken at place enabling a clinical consensus in each place for SYB system commissioning priorities throughout the work that cover the following requirements:

- Patient centred and quality driven decision making
- Local ownership and implementation of recommendations

- Consistency of guidelines and clinical pathways across the ICS
- Timely decision making to ensure implementation within agreed timeframes

SYB Clinical Engagement and Assurance Process:

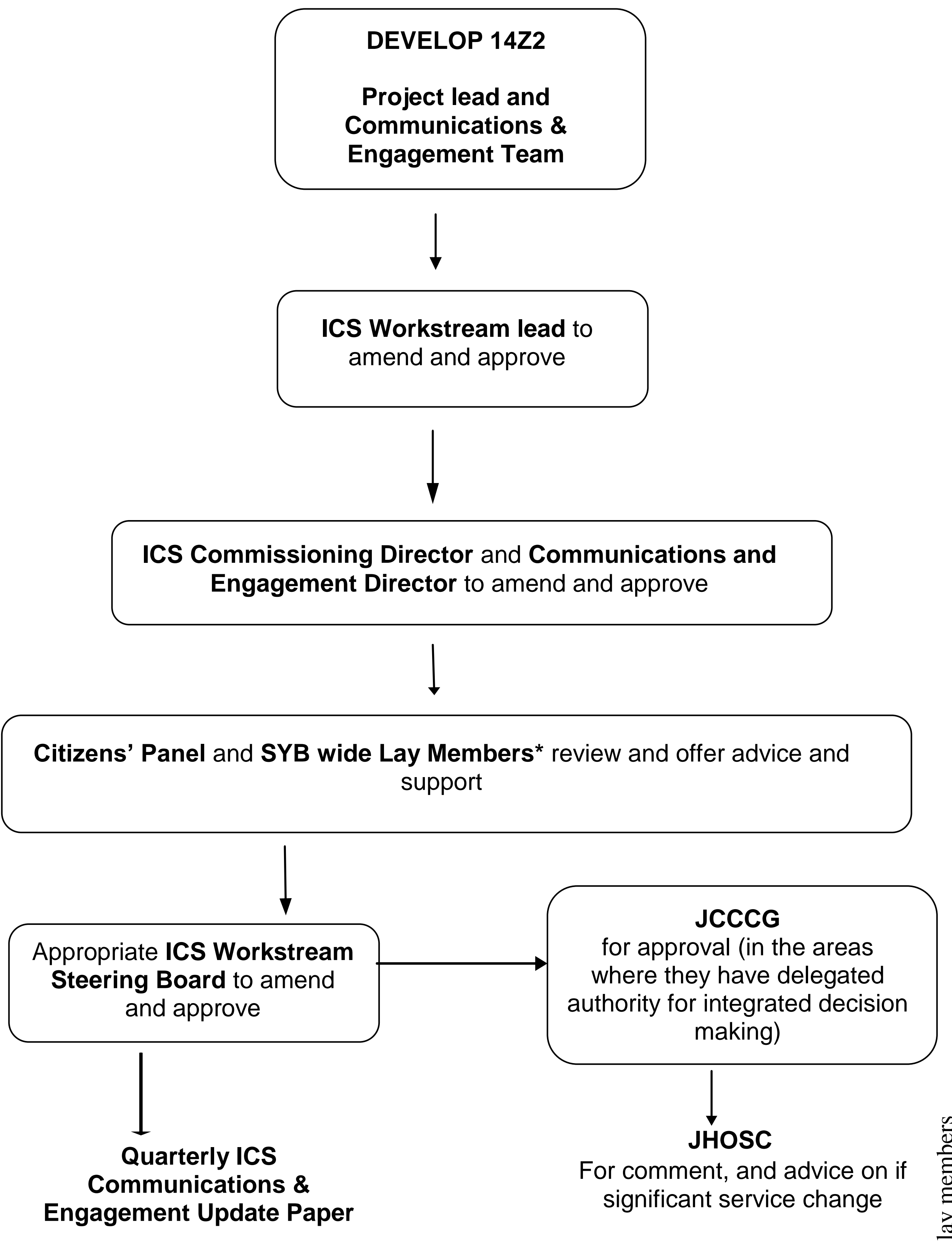
Lead CCG liaises with individual places to ensure clinical reference and agreement takes place during development of work:



*A virtual ICS Clinical Reference Group would be created to debate and reconcile clinical opinion and confirm final clinical sign off in each place. This group would be clinically tailored to the priority subject matter and have authority of clinical decision making from the ICS and place.

Appendix 5

South Yorkshire and Bassetlaw ICS Assessment Process for Section 14Z2 Duty for Public Involvement



Governing Body Meeting in Public

2nd September 2021

Item No: 127

Report Title	Finance Report – Month 4
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 – 26.8.2021				

Recommendations

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

- Allocations have been received for H1 at £1.029bn
- The YTD reported underspend at month 3 is £0.401m
- Retrospective allocations received for quarter 1 Covid spend on the Hospital Discharge Programme were £2.697m further expected funding is £0.799m relating to month 4.
- The Elective Recovery Fund has been reimbursed £0.289m for April and 90% May a further YTD estimate and H1 forecast of £0.093m is expected to be reimbursed.
- H1 is forecast to conclude at a breakeven position.

Report Summary

The report describes the Month 4 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

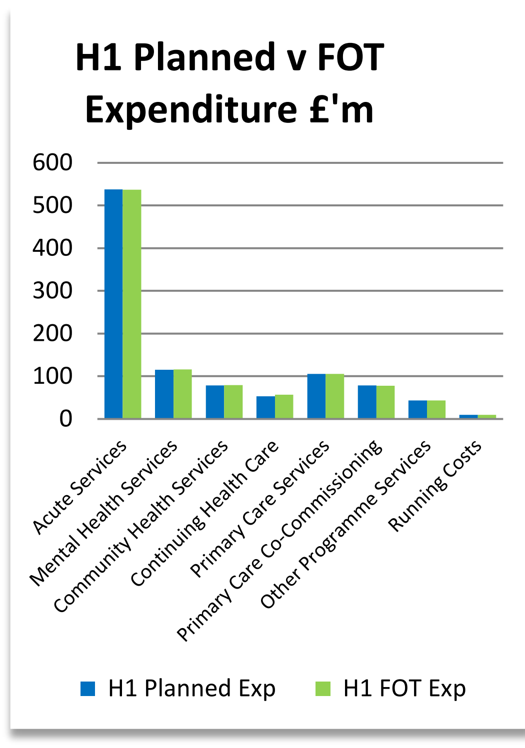
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
None identified
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
No
Has there been involvement of Patients, Public and other key stakeholders? 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 4, July 2021

Statutory Duty/ Performance	Target	Result	Achieved	Key	Comments/Trends
Achievement of expenditure to plan	£680.677m	£681.168m	✓	Green <1%, Amber 1-5% Red >5%	The expected reimbursement of £0.799m Covid HDP and £0.093m Elective Recovery Fund results in a YTD favourable variance of £0.401m.
Remain within the Delegated Primary Care Co-Commissioning Allocation	£52.017m	£51.913m	✓	Green <1%, Amber 1-5% Red >5%	£0.104m favourable variance, this is due to locum costs being lower than expected.
Remain within the Running Cost Allowance	£5.963m	£5.617m	✓	Green <1%, Amber 1-5% Red >5%	Running costs are £0.346m underspent against plan, attributed to staff vacancies and travel
Remain within cash limit	Greatest of 1.25% of drawdown or £0.25m	0.17%	✓	Green <1.25%, Amber 1.25-5% Red >5%	Closing cash balance of £0.27m against drawdown of £159.0m
Achieve BPPC (Better Payment Practice Code)	>95% across 8 areas	Pass 8/8	✓	Green 8/8 Amber 7/8 Red <6/8	In month and YTD payments of over 95% for invoices categorised as NHS and non NHS assessed on value and volume

Operating Cost Statement For the H1 Period Ending: July 2021

	YTD Budget	YTD Actual	YTD Variance	YTD Variance as a % of YTD Budget	H1 Budget	H1 Forecast Outturn	Forecast Variance	FOT Variance as a % of Annual Budget
	£'000's	£'000's	£'000's	%	£'000's	£'000's	£'000's	%
Acute Services	360,645	359,950	695	0.19	537,852	536,988	864	0.16
Mental Health Services	76,327	76,717	(389)	(0.51)	114,888	115,993	(1,106)	(0.96)
Community Health Services	51,642	51,647	(6)	(0.01)	78,759	79,102	(343)	(0.44)
Continuing Health Care	35,840	38,342	(2,502)	(6.98)	52,832	57,099	(4,267)	(8.08)
Primary Care Services	69,260	69,289	(30)	(0.04)	105,450	105,329	121	0.11
Primary Care Co-Commissioning	52,017	51,913	104	0.20	78,166	77,975	191	0.24
Other Programme Services	27,627	27,693	(66)	(0.24)	43,509	43,676	(167)	(0.38)
Total Programme Resources	**673,358**	**675,551**	**(2,193)**	**(0.33)**	**1,011,455**	**1,016,162**	**(4,707)**	**(0.47)**
Running Costs	5,963	5,617	346	5.80	9,912	9,510	402	4.06
Total before Planned Deficit	**679,321**	**681,168**	**(1,847)**	(0.27)	**1,021,367**	**1,025,671**	**(4,304)**	(0.42)
In-Year Allocations	0	0	0	0.00	3,073	3,073	0	0.00
In-Year 0.5% Risk Contingency	1,356	0	1,356	100.00	4,244	2,210	2,034	47.93
Total Incl Covid Costs	**680,677**	**681,168**	**(491)**	(0.07)	**1,028,684**	**1,030,955**	**(2,270)**	(0.22)
Expected Covid Reimbursement in Future Months	2,697	3,496	(799)		2,697	4,875	(2,178)	
Expected Elective Recovery Fund Allocation	289	382	(93)		289	382	(93)	
Total Including Reclaimable Covid Costs	**677,691**	**677,290**	**401**	0.06	**1,025,698**	**1,025,698**	**0**	0.00



The reported position as at month 4 is a YTD underspend of £0.401m and a breakeven forecast position.

This position includes £0.799m YTD and £2.178m FOT relating to Covid expenditure for Hospital Discharge Programme which is expected to be reclaimed in full. An allocation of £2.697m to fund quarter 1 Covid expenditure was received in month 4.

The underspend also includes £0.093m YTD and FOT relating to Elective Recovery Fund which is expected to be reimbursed, although this is an estimate and has not yet been validated. An allocation of £0.289m was received in month 4 to fund April and the majority of May’s activity.

To balance the month 4 position the CCG has committed £2.034m of the H1 £4.244m contingency, with £1.356m being reflected in the year to date position.

Run Rate based on H1 Expenditure

Derby and Derbyshire
Clinical Commissioning Group

2021-22 Run Rate - Scenario excluding Outside Envelope Covid costs and other normalisation adjustments

Outturn £m

1,026
1,024
1,022
1,020
1,018
1,016

Flexibility
Reduction
Increase
YTD Extrapolated
FOT

YTD Actual Extrapolated
Community Health Services
Primary Care Services
ICS Set up Costs
Mental Health Services
Running Costs
Primary Care Co-Commissioning
Uncommitted Allocation
Continuing Health Care
Other Programme Services
Acute Services
Uncommitted Running Costs
Investments as yet Uncommitted
Contingency

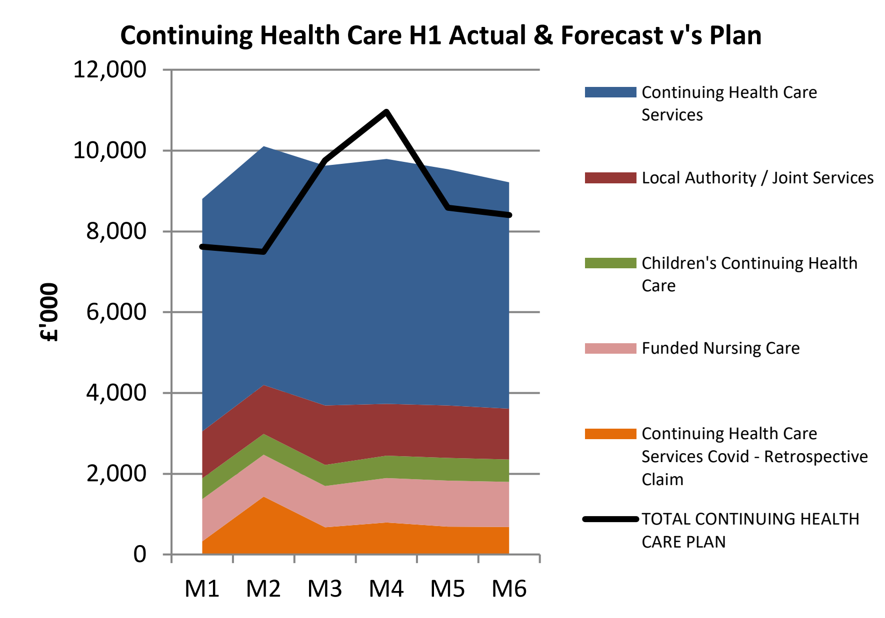
£9.572m variation between the H1 position to date continuing at its current rate and the H1 forecast.

- **Community Health Services** – Ageing Well expenditure to be incurred in months 4 to 6.
- **Primary Care Services** – Enhanced services and GPFV allocations with higher expenditure expected in later months.
- **ICS Set up Costs –** One off expected expenditure to cover ICS set up.
- **Mental Health Services**– MHIS investments and allocations expenditure expected in months 4 to 6.
- **Running Costs** – Pay underspends not continuing at same rate due to vacancies being filled.
- **PC Co-Commissioning** – Small movement relating to phasing of prescribing costs.
- **Uncommitted Allocation** –Non-recurrent allocations received not yet distributed to areas.
- **Continuing Health Care**– Expectation that fast track numbers will fall from month 5 onwards.
- **Other Programme Services** – 111 First expenditure relating to allocation received for quarter 1 and Staff vacancies will be filled.
- **Acute Services** – System ERF funds received and distributed to providers in month 4.
- **Uncommitted Running Costs-** Expected to be utilised within patient care.
- **Uncommitted Investments**–Funding currently in reserves expected to be used by end of H1.
- **Contingency** – 0.5% H1 contingency of £4.244m with £2.210m forecast expenditure and £2.034m balance committed against financial position.

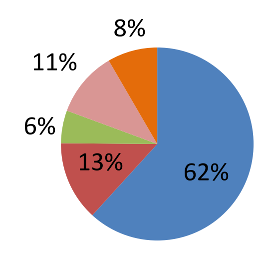
Derby and Derbyshire
Clinical Commissioning Group

Continuing Health Care

	YTD Budget	YTD Actual	YTD Variance		H1 Budget	H1 Forecast Outturn	Forecast Variance	
	£'000's	£'000's	£'000's	%	£'000's	£'000's	£'000's	%
Continuing Health Care								
Continuing Health Care Services	22,269	23,685	(1,416)		33,606	35,138	(1,532)	
Local Authority / Joint Services	4,705	5,118	(413)		7,055	7,679	(624)	
Children's Continuing Health Care	2,078	2,106	(28)		3,120	3,226	(107)	
Funded Nursing Care	4,359	4,214	145		6,621	6,457	164	
Continuing Health Care Services Covid - Retrospective Claim	2,429	3,219	(790)		2,429	4,598	(2,168)	
	35,840	**38,342**	(2,502)		**52,832**	**57,099**	(4,267)	



Continuing Health Care Year to Date Actual Expenditure



- Continuing Health Care Services
- Local Authority / Joint Services
- Children's Continuing Health Care
- Funded Nursing Care
- CHC Services Covid - Retrospective Claim

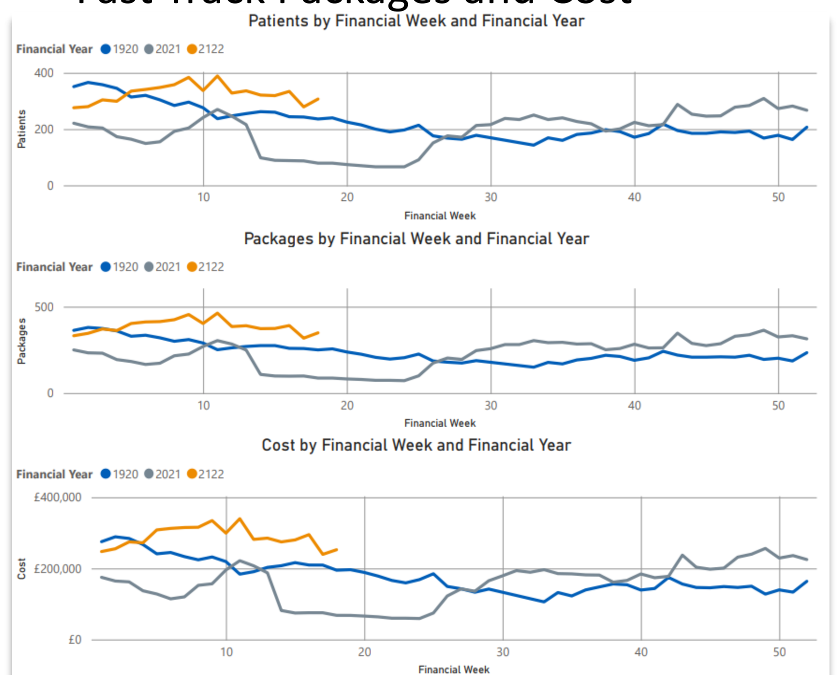
£0.790m (FOT £2.168m) of the reported overspend is due to Covid related costs for the Hospital Discharge Programme and these costs are expected to be reclaimed in full. An allocation was received in month 4 to fund the quarter 1 expenditure and this is the £2.429m YTD budget.

The main pressures relate to Fully Funded Adult CHC, Fast Track and Joint Funded CHC.

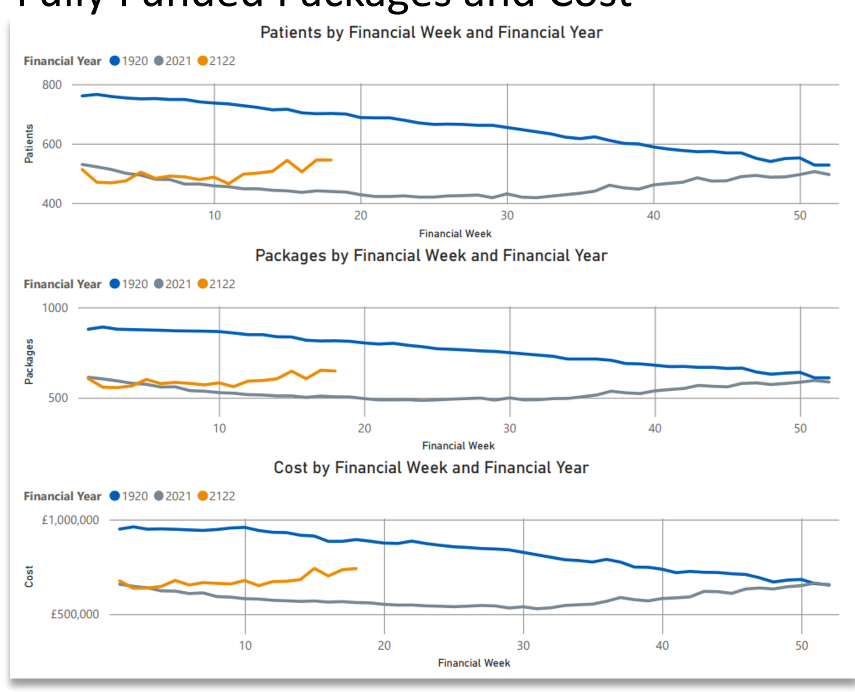
Derby and Derbyshire
Clinical Commissioning Group

Continuing Health Care

Fast Track Packages and Cost



Fully Funded Packages and Cost



Fast track costs at M4 have reduced significantly to a £0.456m overspend year to date with a forecast overspend of £0.065m. The latest data shows a slight increase in the last two weeks although it is still on a downwards trajectory.

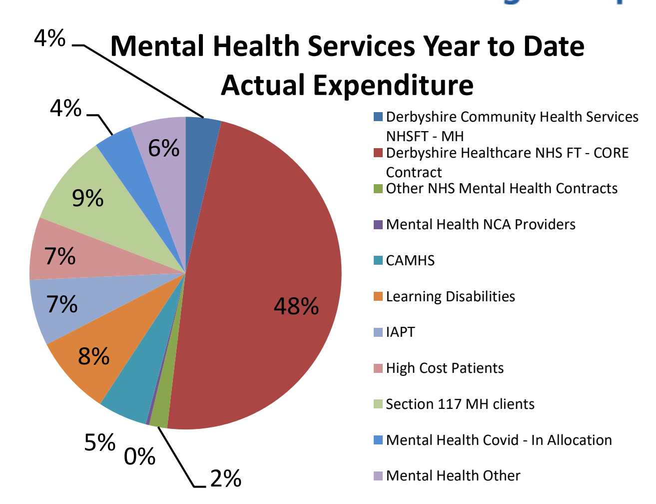
In contrast the Fully Funded packages are reporting a £1.014m overspend and a £1.423m FOT above plan. This is expected due to the actions taken by colleagues in the Nursing and Quality team and the CSU to reduce the fast track packages, with a number of them converting to a more appropriate fully funded package of care.

The arrangements put in place to reduce fast track packages continue including increased quality assurance, prioritisation of assessment and reviews. There is also ongoing communication from the Pathways Operations Group with the highest referring organisations supporting the correct utilisation of the fast track path way.

Derby and Derbyshire
Clinical Commissioning Group

Mental Health Services

	YTD Budget	YTD Actual	YTD Variance		H1 Budget	H1 Forecast Outturn	Forecast Variance	
	£'000's	£'000's	£'000's	%	£'000's	£'000's	£'000's	%
Mental Health Services								
Derbyshire Community Health Services NHSFT - MH	2,848	2,848	0		4,272	4,272	0	
Derbyshire Healthcare NHS FT - CORE Contract	37,218	36,958	260		55,884	55,518	365	
Other NHS Mental Health Contracts	1,433	1,432	2		2,150	2,146	4	
Mental Health NCA Providers	269	269	(0)		403	406	(3)	
CAMHS	3,941	3,926	14		5,917	5,885	32	
Learning Disabilities	5,847	6,321	(474)		8,437	9,065	(628)	
IAPT	5,487	5,255	232		7,932	7,852	80	
High Cost Patients	4,913	4,991	(78)		6,775	7,227	(452)	
Section 117 MH clients	6,584	7,245	(661)		10,162	11,037	(875)	
Mental Health Services Additional Efficiency Requirement with non-NHS	0	0	0		0	0	0	
Mental Health Covid - In Allocation	3,200	3,064	136		4,800	4,624	176	
Mental Health Other	4,588	4,407	181		8,156	7,962	194	
	76,327	**76,717**	(389)		**114,888**	**115,993**	(1,106)	

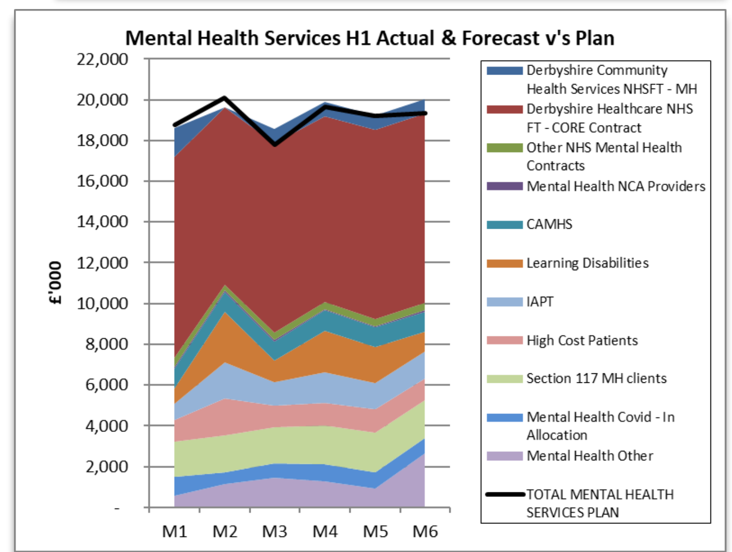


Mental Health Services has a total overspend to date of £0.389m and a H1 forecast of £1.106m.

Section 117 has an overspend of £0.661m to date (FOT £0.875m) relating to activity growth and learning disabilities has an overspend of £0.474m (FOT £0.628m) to date relating to plan differences.

High Cost Patients costs are expected to increase in PICU due to anticipated increased caseload in August and September compared to year to date, in line with previous trends.

The variances are partly offset by year to date underspends in other areas including IAPT with activity at a lower level than planned, however this is expected to pick up during the latter part of H1.



System Year to Date and Forecast Outturn

JUCD YTD and forecast by organisation

Month 04 Position	2021/22 Financial Year						
Surplus/(Deficit)	Plan YTD Month 04 £m's	Actual Month 04 £m's	Variance Month 04 £m's	H1 Plan £m's	H1 Forecast £m's	Forecast Variance £m's	Notes
NHS Derby and Derbyshire CCG	0.0	0.4	0.4	0.0	0.0	0.0	
Chesterfield Royal Hospital	0.1	1.4	1.3	0.0	0.0	0.0	The key drivers of the YTD financial position are an underspend against the Covid funding and a margin on the elective recovery work, this is partly offset by unscheduled care demand, medical staffing pressures and additional drugs costs. NB forecast reduced to break even due to additional in month costs on drugs and DPATH.
Derbyshire Community Health Services	0.0	(0.2)	(0.2)	0.0	0.7	0.7	
Derbyshire Healthcare	0.0	0.0	0.0	0.0	0.0	0.0	
East Midlands Ambulance Service	0.0	(0.5)	(0.5)	0.0	(0.8)	(0.8)	
University Hospitals Of Derby And Burton	3.1	5.9	2.8	0.0	0.0	0.0	
Intra System Reconciliation							
JUCD Total	**3.2**	**7.0**	**3.9**	**0.0**	**(0.1)**	**(0.1)**	

Note - All Number Above Assumed to be Based on NHS E Control Total Number, excluding impairments etc.

Governing Body Meeting in Public

2nd September 2021

Item No: 129

Report Title	Clinical and Lay Commissioning Committee Assurance Report - August 2021
Author(s)	Zara Jones, Executive Director of Commissioning Operations
Sponsor (Director)	Zara Jones, Executive Director of Commissioning Operations

Paper for:	Decision		Assurance	x	Discussion		Information	x
Assurance Report Signed off by Chair				Dr Ruth Cooper – CLCC Chair				
Which committee has the subject matter been through?				CLCC – 12.8.2021				

Recommendations

The Governing Body is requested to **RATIFY** the decisions made by the Clinical and Lay Commissioning Committee (CLCC) on 12th August 2021.

Report Summary

The following items had been circulated to CLCC previously for their virtual approval:

CLC/2122/75 Clinical Policies

CLCC were asked to approve the following updated Policies:

- 1a. Removal of Benign Skin Lesions Policy
- 1b. Surgical Removal of Lipomas
- 1c. Surgical Removal of Epidermoid and Pilar Cysts Policy

Areas for Service Development

CLCC NOTED that CPAG have reviewed IFR cases submitted and IPGs, MIBs, MTGs and DGs for June 2021. The Committee were assured that no areas for service developments were identified.

Clinical Policy Advisory Group - EBI2 Interventions – updates for ratification and information

CLCC were asked to note the following for information:

Evidence Based Interventions (EBI2) Guidance

CLCC NOTED the progress to date regarding the EBI2 interventions

<u>Evidence-Based Interventions (EBI2) Guidance – review of Section 3 – pathways (part 1)</u> **CLCC NOTED that the interventions included in section 3.1 required no further action by CPAG as we have been assured that providers are compliant and form part of a clinical pathway.** **CLCC NOTED the CPAG bulletin for June 2021.** <u>CLC/2122/78 CLCC Risk Tracker Emerging Risks</u> **CLCC RECEIVED AND NOTED the updated Emerging Risk Tracker. There were no additional risks added.**
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 September 2021

Item No: 130

Report Title	Derbyshire Engagement Committee Assurance Report – August 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	x
Assurance Report Signed off by Chair				Martin Whittle, Vice Chair/Lay Member for PPI				
Which committee has the subject matter been through?				Engagement Committee – 17.8.2021				

Recommendations

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

Report Summary

This report provides the Governing Body with highlights from the meeting of the Engagement Committee, held on 17th August 2021. This report provides a brief summary of the items transacted for assurance.

Insight into GP and Urgent Care Access

An update on the recent period of insight collection was given by Britain Thinks, who have been commissioned to obtain independent views from patients in Derbyshire about their perceptions are realities of accessing GP and urgent care services in the area. Britain Thinks had concluded their fieldwork and were drawing the themes and conclusions from that work to inform next steps for the system. The Committee heard the interim findings, which were subject to further and ongoing analysis. The final report would be received by the Accident and Emergency Delivery Board at the end of August, with findings used to inform communications and service winter planning.

London Road Community Hospital Reconfiguration

The Committee agreed an engagement programme to commence in Derby to better understand the impact of the temporary changes made to the provision of community hospital beds at the start of the Covid-19 pandemic, to support an informed decision on whether to make those changes permanent.

In response to the Covid-19 pandemic the Derbyshire system agreed to temporarily repurpose Wards 4, 5 and 6 at the London Road Community Hospital site and relocate staff back into the acute site to prepare for the anticipated Covid-19 surge. These 74 beds have not been replaced like for like and instead resources have been utilised better so more people are going home or being supported in lower level

residential beds. This is in line with findings experienced in Belper, Buxton, Bolsover and Ilkeston where the model of care has seen inpatient beds at community hospitals replaced with a range of community support.

The Committee heard that Local Authority scrutiny committees agree in principle with the programme, Healthwatch Derby have signed up to help with the engagement work and NHSEI have now agreed with the approach. The plan is to engage for 12 weeks collecting the views of local people on the change.

Integrated Care System Communications and Engagement
The Committee received an update on progress with the ICS communications and engagement plan. While a wide-reaching plan was ever evolving, work has continued with laying foundations and taking forward the agreed programme. Developments have included:

- The latest 'ICS Explained' chapter was soon to be published, covering the history of the ICS. A further chapter was in development on the voluntary sector, building on the work done with the voluntary sector leadership programme.
- Work was underway with Place partnerships, who were clear they wish to engage extensively with local communities around the purpose of the care partnership.
- There is a new weekly stakeholder bulletin for the ICS, repurposing the Covid-19 stakeholder bulletin.
- The Joined Up Care Derbyshire newsletter is to become bi-monthly rather than quarterly due to the amount of information that needs communicating.
- The latest Derbyshire Dialogue session had over 200 people attend, covering the latest developments with the ICS.
- An online engagement platform was due to be launched during August.

Winter Communications and Engagement Plan
A comprehensive communications and engagement plan to support the system's approach to winter was being progressed. As in previous years, this was being coordinated by communications colleagues in all partner organisations and would track the development of the systems operational Winter/Surge Plan, which is required to be submitted to NHS England/Improvement by the end of September.

Engagement on Patient Reluctance to Access Services
Following discussion at a recent Quality and Performance Committee, insight is to be collected from cancer patients to seek to understand their views and behaviours in accessing services during the pandemic. This is in the context of the system being aware of fewer referrals during the pandemic and to identify any messaging or service interventions that may benefit. The insight collection will be discussed with Healthwatch Derby.

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 Committee heard that an engagement governance guide was in progress which, once cascaded across teams with related training, would serve 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 September 2021

Item No: 132

Report Title	Quality and Performance Committee Assurance Report – August 2021
Author(s)	Jackie Carlile, Head of Performance and Assurance Alison Cargill, Assistant Director of Quality
Sponsor (Director)	Zara Jones, Executive Director for Commissioning Operations Brigid Stacey, Chief Nurse Officer

Paper for:	Decision		Assurance	x	Discussion		Information	x
Assurance Report Signed off by Chair				Not applicable.				
Which committee has the subject matter been through?				Quality and Performance Committee				

Recommendations

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

Report Summary

Performance:

Urgent and Emergency Care:

- The A&E standard was not met at a Derbyshire level at 78.7% (YTD 81.6%). CRH did not achieve the standard achieving 93.3% (YTD 95.3%). UHDB achieved 69.9% during July (YTD 73.7%), which is a deterioration.
- UHDB had 20 x 12-hour trolley breaches during July – 10 were due to the unavailability of suitable mental health beds and 10 were due to unavailable capacity in the trust.
- EMAS were non-compliant in all their standards for Derbyshire during July 2021 reflecting the increase in activity experience.

Planned Care

- 18 Week Referral to Treatment (RTT) for incomplete pathways continues to be non-compliant at a CCG level at 68.0% (YTD 65.5%). CRHFT performance was 70.9% (YTD 68.4%) and UHDB 63.3% (YTD 60.4%) Both our main provider improved slightly so the reduction in CCG performance is due to our associate providers.
- Derbyshire had 6,199 breaches of the 52-week standard across all trusts – there were 6,859 and 7,490 for the previous two months
- Diagnostics – The CCG performance was 27.07%, a deterioration from the previous month. Neither CRH (11.88%) or UHDB (30.18%) have achieved the standard.

Cancer

During June 2021, Derbyshire was compliant in 2 of the 8 Cancer standards:

- **31-day Subsequent Drugs** – 98.8% (98% standard) – Compliant all Trusts except Sherwood Forest.

- **31-day Subsequent Radiotherapy** – 95.6% (94% standard) – Compliant for Derby & Burton and Sheffield, but not for Nottingham.

During June 2021, Derbyshire was non-compliant in 6 of the 8 Cancer standards:

- **2-week Urgent GP Referral** – 86.2% (93% standard) – Compliant for Sherwood Forest and Stockport.
- **2 week Exhibited Breast Symptoms** – 56.4% (93% standard) – Noncompliant for all trusts.
- **31 day from Diagnosis –** 94.1% (96% standard) – Compliant for Chesterfield and Stockport.
- **31-day Subsequent Surgery** – 81.5% (94% standard) - Compliant for Chesterfield, East Cheshire, and Stockport.
- **62-day Urgent GP Referral** – 68.8% (85% standard) – Noncompliant for all trusts.
- **62-day Screening Referral** – 74.2% (90% standard) – Noncompliant for all trusts.

Additional standards include:

- **28-day Diagnosis or Decision to Treat** – 76.5% (75% standard) – Compliant for Derby & Burton, Chesterfield, Nottingham & Sherwood Forest.
- **104 day wait** – 28 CCG patients waited over 104 days for treatment.

Quality

Chesterfield Royal Hospital FT
Emergency Department: The department is under significant pressure and the Trust have improved systems to ensure all service managers are appraised of the pressures, the aim being to give an overview and encourage flexibility with bed management and staff movement. A quality and safety visit has been carried out which was a positive visit and provided evidence of services adapting to the pressures. It was noted that the staff feedback was one of fatigue and increased sickness. A formal report will be shared with Trust via CGRG.

University Hospitals of Derby and Burton FT
Emergency Department: There are continued pressures within the department, with concerns regarding quality and safety raised. As result of this an ED quality and safety visit was conducted. The visit showed adaptation and improvement to patient pathways; however, staff ‘burnout’, stress, and increased sickness was a feature. A formal report will be shared with Trust via CQRG.

Derbyshire Community Health Services FT
COVID-19: As of 22nd July 2021, 40 Covid-19 related deaths. As of 10th August 2021, for 1st vaccination it is 96.3% and for both vaccinations it is 93.2%. Sickness absence rate remains static. With evidence of increasing Covid-19 related absence due to direct sickness and isolation. Underlying rate is comparatively better than peer organisations and pre-pandemic rate. Absence is higher in Nursing and Additional Clinical Services (HCAs) and is particularly related to anxiety/stress/depression. The Derbyshire COVID Vaccination programme will extend into 2022 to support a booster programme and a plan for those aged 12 – 18 years. A new flexible staffing model is under development. Monitoring continues at CQRG.

Derbyshire Healthcare Foundation Trust
Covid-19 Vaccination: As of 9th August 2021, 93% of staff were dual vaccinated.

Waiting Lists: CAMHS continue to utilise telephone and Attend Anywhere as vehicles to support clinical contacts; face to face appointments are offered only when clinically indicated. This is having a positive impact on the size of the waiting list and for the last 12 months the waiting list has been significantly lower than expected. The number of patients on the waiting list for psychology was significantly lower than expected in May 2021, with the average wait to be seen returning to common course variation for the last 4 months, following a sustained period of longer waits than expected, because of the pandemic. Waiting lists will continue to be monitored at CQRG.

East Midlands Ambulance Trust
Performance: Derbyshire matched the regional position during June 2021 achieving C1 90th centile. For Derbyshire this is the same performance as seen in May 2021. As a County Prehospital handover delays were slightly above modelled in June to 4% compared to 3% in May. Work continues locally between EMAS, Commissioners and the Acute Trusts to look at how pre-hospital handover delays can be reduced. Hours lost to post hospital handover delays remain higher than modelled in June, with an actual time in Derbyshire of 4 minutes and 36 seconds. The percentage of post handovers greater than 60 minutes remains stable at 2% but is showing a slight increasing trend overall. This continues to be monitored at CQRG.

Committee Update 26th August 2021

Differences between the two Acute Trusts was highlighted as a concern in terms of health inequalities. Variation has been reviewed; this is predominantly down to UHDBFT having more specialities. Where variation is identified this is addressed through the performance team. The new ICS performance structure is being constructed. It was agreed that the transition work will need oversight from the committee.

Breast performance will be reviewed to understand if the new pathway is having an impact on performance. The August and September data will be used to establish the impact. The performance team have attended the long waiter meetings at UHBD, P2 and P3 are being prioritised. Theatre occupancy is reviewed by the performance team. Theatre staffing is the main concern, the cohort of staff is being expanded.

Staff morale was identified as quality concern across all organisations. Staff are not being asked to cancel leave as they need this time to recover.

Neurodevelopmental work is being expanded, for example the schools pilot to support teachers working with children who have neurodevelopmental concerns. General practice referrals to CAMHS are monitored, SEND navigators will be available to direct referrals to other services such as short breaks.

The Integrated report was signed off by the Chair.

The assurance items were presented and noted. Safeguarding quarterly reports were received.

EMAS performance was examined. There are three areas of concern demand, workforce and handover. Demand for C1/2, high acuity is 84%. In July, 300 patients were awaiting an allocation, this has a huge pressure of the staff in the call centre. Over sixty-minute waits are between 4-6%. The midlands region has the highest level of patients waiting outside a hospital. EMAS are looking at the waits to ensure patients are staff, a deep dive has been undertaken on safeguarding referrals. C1/2 validation is undertaken, the number of patients

deemed as unconscious has increased, EMAS are assessing how many are C1/2 when the crews arrive. Enhance clinical validation for C2 is in place, whereby patients can be moved to a C3 where clinically appropriate. Transforming Care Partnership performance and the increased work being undertaken by the team was noted. The assurance questions were fulfilled.
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 1-3.

Month 03
Quality & Performance Report
2021/22

August 2021

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EXECUTIVE SUMMARY

Key Messages	• The tables on slides 5-8 show the latest validated CCG data against the constitutional targets. A more detailed overview of performance against the specific targets and the associated actions to manage performance is included in the body of this report.
Urgent & Emergency Care	• The A&E standard was not met at a Derbyshire level at 78.7% (YTD 81.6%). CRH did not achieve the standard achieving 93.3% (YTD 95.3%). UHDB achieved 69.9% during July (YTD 73.7%), which is a deterioration. • UHDB had 20 x 12 hour trolley breaches during July – 10 were due to the unavailability of suitable mental health beds and 10 were due to unavailable capacity in the trust. • EMAS were non-compliant in all of their standards for Derbyshire during July 2021 reflecting the increase in activity experience.
Planned Care	• 18 Week Referral to Treatment (RTT) for incomplete pathways continues to be non-compliant at a CCG level at 68.0% (YTD 65.5%). CRHFT performance was 70.9% (YTD 68.4%) and UHDB 63.3% (YTD 60.4%) Both our main provider improved slightly so the reduction in CCG performance is due to our associate providers. • Derbyshire had 6,199 breaches of the 52 week standard across all trusts – there were 6,859 and 7,490 for the previous two months • Diagnostics – The CCG performance was 27.07%, a deterioration from the previous month. Neither CRH (11.88%) or UHDB (30.18%) have achieved the standard.
Cancer	During June 2021, Derbyshire was compliant in 2 of the 8 Cancer standards: • **31 day Subsequent Drugs** – 98.8% (98% standard) – Compliant all Trusts except Sherwood Forest. • **31 day Subsequent Radiotherapy** – 95.6% (94% standard) – Compliant for Derby & Burton and Sheffield, but not for Nottingham. During June 2021, Derbyshire was non-compliant in 6 of the 8 Cancer standards: • **2 week Urgent GP Referral** – 86.2% (93% standard) – Compliant for Sherwood Forest and Stockport. • **2 week Exhibited Breast Symptoms** – 56.4% (93% standard) – Non compliant for all trusts. • **31 day from Diagnosis –** 94.1% (96% standard) – Compliant for Chesterfield and Stockport. • **31 day Subsequent Surgery** – 81.5% (94% standard) - Compliant for Chesterfield, East Cheshire and Stockport. • **62 day Urgent GP Referral** – 68.8% (85% standard) – Non compliant for all trusts. • **62 day Screening Referral** – 74.2% (90% standard) – Non compliant for all trusts. Additional standards include: • **28 day Diagnosis or Decision To Treat** – 76.5% (75% standard) – Compliant for Derby & Burton, Chesterfield, Nottingham & Sherwood Forest. • **104 day wait** – 28 CCG patients waited over 104 days for treatment.

Executive Summary

Trust	
Chesterfield Royal Hospital FT	Emergency Department: The department is under significant pressure and the Trust have improved systems to ensure all service managers are appraised of the pressures, the aim being to give an overview and encourage flexibility with bed management and staff movement. A quality and safety visit has been carried out which was a positive visit and provided evidence of services adapting to the pressures. It was noted that the staff feedback was one of fatigue and increased sickness. A formal report will be shared with Trust via CGRG.
University Hospitals of Derby and Burton NHS FT	Emergency Department: There are continued pressures within the department, with concerns regarding quality and safety raised. As result of this an ED quality and safety visit was conducted. The visit showed adaptation and improvement to patient pathways, however staff 'burnout', stress, and increased sickness was a feature. A formal report will be shared with Trust via CQRG.
Derbyshire Community Health Services FT	COVID-19: As at 22nd July 2021, 40 COVID-19 related deaths. As at 10th August 2021 for 1st vaccination it is 96.3% and for both vaccinations it is 93.2%. Sickness absence rate remains static. With evidence of increasing COVID-19 related absence due to direct sickness and isolation. Underlying rate is comparatively better than peer organisations and pre-pandemic rate. Absence is higher in Nursing and Additional Clinical Services (HCAs) and is particularly related to anxiety/stress/depression. The Derbyshire COVID Vaccination programme will extend into 2022 to support a booster programme and a plan for those aged 12 – 18 years. A new flexible staffing model is under development. Moinitoring continues at CQRG.
Derbyshire Healthcare Foundation Trust	COVID-19 Vaccination: As at 09th August 2021, 93% of staff were dual vaccinated. Waiting Lists: CAMHS continue to utilise telephone and Attend Anywhere as vehicles to support clinical contacts; face to face appointments are offered only when clinically indicated. This is having a positive impact on the size of the waiting list and for the last 12 months the waiting list has been significantly lower than expected. The number of patients on the waiting list for psychology was significantly lower than expected in May 21, with the average wait to be seen returning to common course variation for the last 4 months, following a sustained period of longer waits than expected, as a result of the pandemic. Waiting lists will continue to be monitored at CQRG.
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PERFORMANCE OVERVIEW MONTH 4 – URGENT CARE

NHS Derby & Derbyshire CCG Assurance Dashboard

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

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

Part A - National and Local Requirements

CCG Dashboard for NHS Constitution Indicators

	Area	Indicator Name	Standard	Latest Period	NHS Derby & Derbyshire CCG				Chesterfield Royal Hospital FT			University Hospitals of Derby & Burton FT			NHS England		
					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	Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	Jul-21	↑	78.7%	81.6%	70	93.3%	95.3%	1	69.9%	73.7%	70	79.7%	83.5%	70
		A&E 12 Hour Trolley Waits	0	Jul-21					7	7	1	20	29	12	2215	4721	70

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

	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		
					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	Ambulance System Indicators	Ambulance - Category 1 - Average Response Time	00:07:00	Jul-21	↓	00:09:00	00:08:10	13	00:09:09	00:08:11	12	00:07:54				00:08:33	00:07:43	3
		Ambulance - Category 1 - 90th Percentile Respose Time	00:15:00	Jul-21	↓	00:15:45	00:13:59	1	00:16:33	00:14:38	1	00:14:06				00:15:15	00:13:43	1
		Ambulance - Category 2 - Average Response Time	00:18:00	Jul-21	↓	00:45:19	00:33:28	12	00:52:00	00:38:04	13	00:33:40				00:41:04	00:29:09	12
		Ambulance - Category 2 - 90th Percentile Respose Time	00:40:00	Jul-21	↓	01:33:33	01:07:36	12	01:51:28	01:19:27	12	01:10:09				01:27:44	01:00:25	4
		Ambulance - Category 3 - 90th Percentile Respose Time	02:00:00	Jul-21	↓	06:58:50	04:46:07	12	07:37:00	05:20:28	12	04:30:11				06:20:48	04:08:36	4
		Ambulance - Category 4 - 90th Percentile Respose Time	03:00:00	Jul-21	→	04:36:23	04:30:04	4	06:06:08	05:08:56	4	04:43:53				06:52:02	05:29:16	4

PERFORMANCE OVERVIEW MONTH 3 – 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	NHS Derby & Derbyshire CCG Current Month	NHS Derby & Derbyshire CCG YTD	NHS Derby & Derbyshire CCG consecutive months non-compliance	Chesterfield Royal Hospital FT Current Month	Chesterfield Royal Hospital FT YTD	Chesterfield Royal Hospital FT consecutive months non-compliance	University Hospitals of Derby & Burton FT Current Month	University Hospitals of Derby & Burton FT YTD	University Hospitals of Derby & Burton FT consecutive months non-compliance	NHS England Current Month	NHS England YTD	NHS England consecutive months non-compliance
Planned Care	Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Jun-21	↑	68.0%	65.5%	41	70.9%	68.4%	26	63.3%	60.4%	42	68.8%	67.0%	64
		Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Jun-21	↑	6199	20548	17	1095	3552	15	6806	24016	16	304803	1027026	170
	Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Jun-21	↑	27.07%	25.70%	37	11.88%	8.95%	15	30.18%	29.02%	16	22.38%	22.89%	94
	2 Week Cancer Waits	All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	Jun-21	↓	86.2%	85.2%	10	Cancer 2 Week Wait Pilot Site - not currently reporting			78.4%	80.5%	10	84.9%	85.9%	13
		Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	Jun-21	↓	56.4%	54.4%	8				49.8%	49.9%	7	68.8%	66.2%	13
	28 Day Faster Diagnosis	Diagnosis or Decision to Treat within 28 days of Urgent GP, Breast Symptom or Screening Referral	75%	Jun-21	↑	76.5%	75.4%	0	76.9%	76.2%	0	77.1%	76.1%	0	73.0%	73.4%	3
	31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	96%	Jun-21	↓	94.1%	93.6%	6	98.5%	97.4%	0	93.7%	94.1%	11	94.6%	94.6%	6
		Subsequent Surgery Within 31 Days Of Decision To Treat	94%	Jun-21	↓	81.5%	80.4%	19	100.0%	95.3%	0	87.8%	88.7%	1	86.9%	86.7%	35
		Subsequent Drug Treatment Within 31 Days Of Decision To Treat	98%	Jun-21	↓	98.8%	99.0%	0	100.0%	100.0%	0	98.6%	99.1%	0	99.3%	99.1%	0
		Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	Jun-21	↓	95.6%	95.8%	0				94.2%	93.9%	0	97.5%	97.0%	0
	62 Days Cancer Waits	First Treatment Administered Within 62 Days Of Urgent GP Referral	85%	Jun-21	↑	68.8%	69.0%	28	64.8%	72.6%	23	68.6%	68.8%	38	73.3%	73.9%	66
		First Treatment Administered - 104+ Day Waits	0	Jun-21	↑	28	76	63	5	16	38	17	49	63	878	2600	66
		First Treatment Administered Within 62 Days Of Screening Referral	90%	Jun-21	↑	74.2%	72.7%	26	53.5%	61.9%	26	89.1%	82.6%	7	73.2%	73.9%	39
		First Treatment Administered Within 62 Days Of Consultant Upgrade	N/A	Jun-21	↑	92.5%	85.4%		100.0%	83.3%		100.0%	97.0%		82.3%	83.0%	

PERFORMANCE OVERVIEW MONTH 3 – 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	↓

CCG Dashboard for NHS Constitution Indicators

	Area	Indicator Name		Standard	Latest Period	Direction of Travel	NHS Derby & Derbyshire CCG Current Month	NHS Derby & Derbyshire CCG YTD	NHS Derby & Derbyshire CCG consecutive months non-compliance	Chesterfield Royal Hospital FT Current Month	Chesterfield Royal Hospital FT YTD	Chesterfield Royal Hospital FT consecutive months non-compliance	University Hospitals of Derby & Burton FT Current Month	University Hospitals of Derby & Burton FT YTD	University Hospitals of Derby & Burton FT consecutive months non-compliance	NHS England Current Month	NHS England YTD	NHS England consecutive months non-compliance
Patient Safety	Incidence of healthcare associated Infection	Healthcare Acquired Infection (HCAI) Measure: MRSA Infections		0	Jun-21	↔	0	0	0	0	0	0	0	1	0	64	144	27
		Healthcare Acquired Infection (HCAI) Measure: C-Diff Infections	Plan		Jun-21	↑		60			9			30				
			Actual					50	0		4	0		13	0		3480	
		Healthcare Acquired Infection (HCAI) Measure: E-Coli		-	Jun-21	↓	79	233		27	65		45	159		79	233	
		Healthcare Acquired Infection (HCAI) Measure: MSSA		-	Jun-21	↑	11	69		5	18		13	52		975	2981	

PERFORMANCE OVERVIEW MONTH 3 – MENTAL HEALTH

CCG Dashboard for NHS Constitution Indicators

Mental Health

Area	Indicator Name	Standard	Latest Period	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
Area	Indicator Name	Standard	Latest Period	NHS Derby & Derbyshire CCG				Derbyshire Healthcare FT						NHS England		
Early Intervention In Psychosis	Early Intervention In Psychosis - Admitted Patients Seen Within 2 Weeks Of Referral	60.0%	May-21	↓	80.0%	84.2%	0	88.9%	83.3%	0				71.9%	71.7%	0
Early Intervention In Psychosis	Early Intervention In Psychosis - Patients on an Incomplete Pathway waiting less than 2 Weeks from Referral	60.0%	May-21	↑	100.0%	66.7%	0	50.0%	75.0%	1				29.3%	29.8%	25
Mental Health	Dementia Diagnosis Rate	67.0%	Jun-21	↓	65.1%	65.1%	12							61.9%	62.8%	15
Mental Health	CYPMH - Eating Disorder Waiting Time % urgent cases seen within 1 week		2021/22 Q1	↓	90.8%	74.6%										
Mental Health	CYPMH - Eating Disorder Waiting Time % routine cases seen within 4 weeks		2021/22 Q1	↓	94.6%	83.9%										
Mental Health	Perinatal - Increase access to community specialist perinatal MH services in secondary care	4.5%	2020/21 Q4	↓	2.6%	3.9%	5									
Mental Health	Mental Health - Out Of Area Placements		May-21	↓	625	1295										
Mental Health	Physical Health Checks for Patients with Severe Mental Illness	25%	2021/22 Q1	↑	22.2%	29.6%	5									
Area	Indicator Name	Standard	Latest Period	NHS Derby & Derbyshire CCG				Talking Mental Health Derbyshire (D&DCCG only)			Trent PTS (D&DCCG only)			Insight Healthcare (D&DCCG only)		
Improving Access to Psychological Therapies	IAPT - Number Entering Treatment As Proportion Of Estimated Need In The Population	Plan	Jun-21	↑	2.10%	6.30%										
Improving Access to Psychological Therapies		Actual			2.81%	8.13%	0									
Improving Access to Psychological Therapies	IAPT - Proportion Completing Treatment That Are Moving To Recovery	50%	Jun-21	↑	54.1%	53.7%	0	57.1%	55.2%	0	52.7%	53.8%	0	47.4%	47.7%	2
Improving Access to Psychological Therapies	IAPT Waiting Times - The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment	75%	Jun-21	↓	96.0%	97.6%	0	91.7%	95.5%	0	97.4%	98.4%	0	98.7%	98.0%	0
Improving Access to Psychological Therapies	IAPT Waiting Times - The proportion of people that wait 18 Weeks or less from referral to entering a course of IAPT treatment	95%	Jun-21	↔	100.0%	100.0%	0	100.0%	100.0%	0	100.0%	100.0%	0	100.0%	100.0%	0
Area	Indicator Name	Standard	Latest Period	Derbyshire Healthcare FT												
Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Jun-21	↓	91.5%	93.9%	1									
Referral to Treatment for planned consultant led treatment	Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Jun-21	↔	0	0	0									

Quality Overview

QUALITY OVERVIEW M3

Trust	Key Issues
Chesterfield Royal Hospital FT	**CQC** Discussions with CQC happened on 5/8/2021 with regards to Maternity Service review. There was good attendance from the Trust and the feedback was very positive. Still awaiting formal decision from meeting but CRH optimistic of outcome. **Emergency Department** – The department is under significant pressure and the Trust have adopted an open and transparent alert system to all service managers with regards to beds in A&E. This is hoped to give an overview and encourage flexibility with bed management and staff movement. – DDCCG carried out visit to E.D. Overall very positive visit and evidence of services adapting to meet needs can be seen. It was noted that the staff feedback was one of fatigue and increased sickness. CCG will be sharing formal report with Trust. **Stroke Update** – CRH continue to score B on SNAPP and a KPI dashboard is now in place and visible to staff. – The 3 areas of action that continue are: Senior input at start of pathway Increasing nursing input within HASU Swallow Screening within 4 hrs **12 hour DTA breaches** Nil for CRH.
University Hospitals of Derby and Burton NHS FT	**ED Performance** DDCCG carried out an announced quality and safety visit to both Derby and Burton Emergency Departments. Similar findings to that of CRH's visit and a formal report will be shared across the system. **Waiting lists and winter planning** Continued focus on balancing increasing capacity against a background of increased demand to reduce waiting list backlogs, alongside ensuring winter planning incorporates a focus on continued work on reductions. The Trust are working closely with the System around these areas. **12 hour DTA breaches** For July there were 21 breaches in total, 20 at Derby and 1 at Burton. 11 due to mental health bed availability and 10 due to MAU capacity. Most of the mental health breaches occurred towards the end of the month and 5 medical capacity issues occurred on the same day (15th July) We have continued to support the harm review process on each occasion.

QUALITY OVERVIEW M3 continued

Trust	Key Issues
Derbyshire Community Health Services FT	**COVID-19:** As at 22nd July 2021, 40 COVID-19 related deaths. No current outbreaks. This will be monitored at CQRG **COVID-19 Vaccinations:** As at 10th August 2021 for 1st vaccination it is 96.3% and for both vaccinations it is 93.2%. This will be monitored at CQRG. **COVID sickness** rate in June 2021 remains unchanged from May 2021 at 0.3%. **LOS**: Inpatient length of stay in June 2021 was 17.4 days against a target of 16 days. **Sickness absence** Sickness absence rate remains static. With evidence of increasing COVID-19 related absence due to direct sickness and isolation. Underlying rate is comparatively better than peer organisations and pre-pandemic rate. Absence is higher in Nursing and Additional Clinical Services (HCAs) and is particularly related to anxiety/stress/depression. This will be monitored at CQRG. **Derby Vaccination Programme:** The programme will extend into 2022 as there will be a booster programme and a plan for those aged 12 – 18 years. So as to respond to this a new flexible staffing model is in development. This will be monitored at CQRG.
Derbyshire Healthcare Foundation Trust	**COVID-19 Vaccination:** As at 09th August 2021, 93% of staff were dual vaccinated. **Waiting list for Child and Adolescent Mental Health Services (CAMHS):** CAMHS continue to utilise telephone and Attend Anywhere as vehicles to support clinical contacts; face to face appointments are offered only when clinically indicated. This is having a positive impact on the size of the waiting list and for the last 12 months the waiting list has been significantly lower than expected. This will be monitored at CQRG. **Waiting list for psychology:** The number of patients on the waiting list was significantly lower than expected in May 21, with the average wait to be seen returning to common course variation for the last 4 months, following a sustained period of longer waits than expected, as a result of the pandemic. This will be monitored at CQRG.
East Midlands Ambulance Trust	**Performance:** Derbyshire matched the regional position during June 2021 achieving C1 90th centile. For Derbyshire this is the same performance as seen in May 2021. This will be monitored at CQRG. **Pre-handover Delays**: As a County Pre hospital handover delays were slightly above modelled in June to 4% compared to 3% in May. Work continues locally between EMAS, Commissioners and the Acute Trusts to look at how pre-hospital handover delays can be reduced. This will be monitored CQRG. **Post handover delays:** Hours lost to post hospital handover delays remain higher than modelled in June, with an actual time in Derbyshire of 4 minutes and 36 seconds. The percentage of post handovers greater than 60 minutes remains fairly stable at 2% but is showing a slight increasing trend overall. This will be monitored at CQRG.

QUALITY OVERVIEW M3

Derbyshire Wide Integrated Report

Part B: Provider Local Quality Indicators

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

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

Section	Area	Indicator Name	Standard	Chesterfield Royal Hospital FT				University Hospitals of Derby & Burton FT				Derbyshire Community Health Services				Derbyshire Healthcare FT			
				Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD
Ratings	CQC Ratings	Inspection Date	N/A	Aug-19				Mar-19				May-19				May-18			
		Outcome	N/A	Good				Good				Outstanding				Requires Improvement			
Adult	FFT	Staff 'Response' rates	15%	2019/20 Q2	↑	7.6%	8.6%	2019/20 Q2	↑	10.1%	10.1%	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%	Jun-21	↓	N/A	97.7%	Jun-21	↑	93.1%	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%	Jun-21	↓	N/A	77.8%	Jun-21	↑	85.4%	80.3%	Jul-20	↓	N/A	99.3%				
	Complaints	Number of formal complaints received	N/A	Jun-21	↑	15	47	May-21	↑	23	75	Jun-21	↔	3	11	Jun-21	↑	11	51
		% of formal complaints responded to within agreed timescale	N/A	Jun-21	↓	60.0%	75.3%	May-21	↓		69.2%	Jun-21	↑	100.0%	94.3%	Jun-21	↔	100.0%	97.92%
		Number of complaints partially or fully upheld by ombudsman	N/A	Jun-21	↔	0	0	19-20 Q2	↔	1	2	Jun-21	↔	0	0	Jun-21	↔	0	0
	Pressure Ulcers	Category 2 - Number of pressure ulcers developed or deteriorated	N/A	Jun-21	↓	7	10	May-21	↑	19	55	Jun-21	↓	86	255	Jun-21	↔	0	1
		Category 3 - Number of pressure ulcers developed or deteriorated	N/A	Jun-21	↓	4	7	May-21	↑	5	19	Jun-21	↑	24	97	Jun-21	↔	0	0
		Category 4 - Number of pressure ulcers developed or deteriorated	N/A	Jun-21	↔	0	0	May-21	↔	0	0	Jun-21	↓	6	14	Jun-21	↔	0	0
		Deep Tissue Injuries(DTI) - numbers developed or deteriorated		Jun-21	↓	3	8	Sep-19	↑	16	94	Jun-21	↑	54	203	Jun-21	↔	0	0
		Medical Device pressure ulcers - numbers developed or deteriorated						Sep-19	↓	4	20	Jun-21	↓	15	41	Jun-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	Jun-21	↔	0	0
	Falls	Number of falls	N/A	Jun-21	↑	85	262	Data Not Provided in Required Format				Jun-21	↑	18	58	Jun-21	↓	23	70
		Number of falls resulting in SI criteria	N/A	Sep-20	↑	0	8	Sep-19	↑	0	19	Jun-21	↑	0	1	Jun-21	↔	0	0
	Medication	Total number of medication incidents	?	Jun-21	↑	81	230	Data Not Provided in Required Format				Jun-21	↔	0	0	Jun-21	↓	80	230
	Serious Incidents	Never Events	0	Jun-21	↔	0	0	May-21	↓	2	2	May-19	↔	0	0	Jun-21	↔	0	0
		Number of SI's reported	0	Sep-20	↑	4	26	Sep-19	↑	7	115	Dec-20	↔	1	34	Jun-21	↑	0	5
		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 M3

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

Section	Area	Indicator Name	Standard	Chesterfield Royal Hospital NHS Foundation Trust: Latest Period	Direction of travel	Current Period	YTD	University Hospitals of Derby & Burton FT: Latest Period	Direction of travel	Current Period	YTD	Derbyshire Community Health Services: Latest Period	Direction of travel	Current Period	YTD	Derbyshire Healthcare FT: Latest Period	Direction of travel	Current Period	YTD
Adult	VTE	Number of avoidable cases of hospital acquired VTE		Mar-20	↓	0	15	Feb-21	↔	0	TBC					Jun-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	May-21	↓	109		Nov-20	↔	107.4									
		Summary Hospital-level Mortality Indicator (SHMI): Ratio of Observed vs. Expected		Mar-21	↓	0.961		Mar-21	↓	0.908									
		Crude Mortality		Jun-21	↑	1.25%	1.33%	May-21	↑	0.90%	1.10%								
Maternity	FFT	Antenatal serivce: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Jun-21	↔	N/A	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?		Jun-21	↓	N/A	98.4%	Jun-21	↓	98.4%	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													Jun-21	↔	0	0
Workforce	Staff	Staff turnover (%)		Jun-21	↓	9.1%	8.6%	May-21	↓	10.2%	9.6%	Jun-21	↓	8.9%	8.8%	Jun-21	↓	10.72%	10.56%
		Staff sickness - % WTE lost through staff sickness		Jun-21	↑	4.3%	4.2%	May-21	↓	5.6%	5.2%	Jun-21	↑	4.3%	4.3%	Jun-21	↓	6.55%	5.95%
		Vacancy rate by Trust (%)		Sep-17	↓	1.9%	1.3%	Data Not Provided in Required Format				Jun-21	↓	2.8%	2.2%	Jun-21	↑	13.4%	13.8%
		Agency usage	Target													Jun-21	↑		
			Actual															2.43%	2.61%
		Agency nursing spend vs plan (000's)		Jun-21	↓	£167	£561	Oct-18	↑	£723	£4,355	Jun-21	↑	£48	£254				
		Agency spend locum medical vs plan (000's)		Jun-21	↓	£793	£2,281												
	Training	% of Completed Appraisals	90%	Jun-21	↑	68.9%	46.2%	May-21	↑		85.9%	Jun-21	↓	88.9%	89.0%	Jun-21	↓	74.7%	76.5%
		Mandatory Training - % attendance at mandatory training	90%	Jun-21	↑	85.4%	85.1%	May-21	↑		87.9%	Jun-21	↓	96.0%	96.2%	Jun-21	↑	84.5%	83.4%

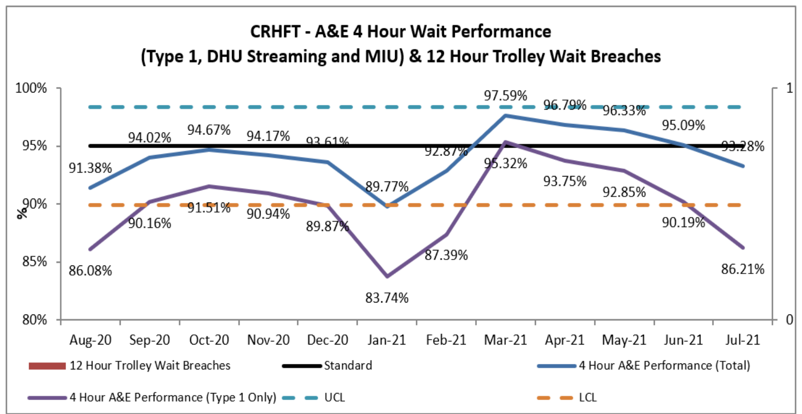
	Indicator	Standard	Chesterfield Royal Hospital NHS Foundation Trust	University Hospitals of Derby & Burton FT	Derbyshire Community Health Services	Derbyshire Healthcare FT
Quality Schedule	**Is the CCG assured by the evidence provided in the last quarter?**	CCG assured by the evidence				
CQUIN	**CCG 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 July 2021 the trust did not meet the 95% standard being slightly under at 93.3%, and the Type 1 element achieving 86.21%, a decline on last month's performance. There were no 12 hour trolley breaches during July.



What are the next steps?

- Broadening the Same Day Emergency Care (SDEC) pathway offer following a Perfect Week exercise, especially for surgical and Gynaecological conditions.
- Working with EMAS to improve virtual communications with crews to ensure that patients are directed to the appropriate treatment area and bypassing ED if possible.
- Continue to implement actions recommended by the Missed Opportunities Audit. These could include 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.

What are the issues?

- Staff absence due to sickness is high, with around a third of sickness being due to Covid related sickness or isolation.
- The volume of Type 1 attendances are approaching pre-pandemic levels, with an average of 202 attendances per day. However, July 2021 volumes were still around 93% of the July 2019 levels.
- Decreased bed capacity due to the high number of children attending the hospital with suspected RSV.
- A high volume of patients attending at the front door following GP phone consultations.
- A shortage of Covid-specific community beds.
- A temporary shortage of physical space during work to physically expand ED.

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.

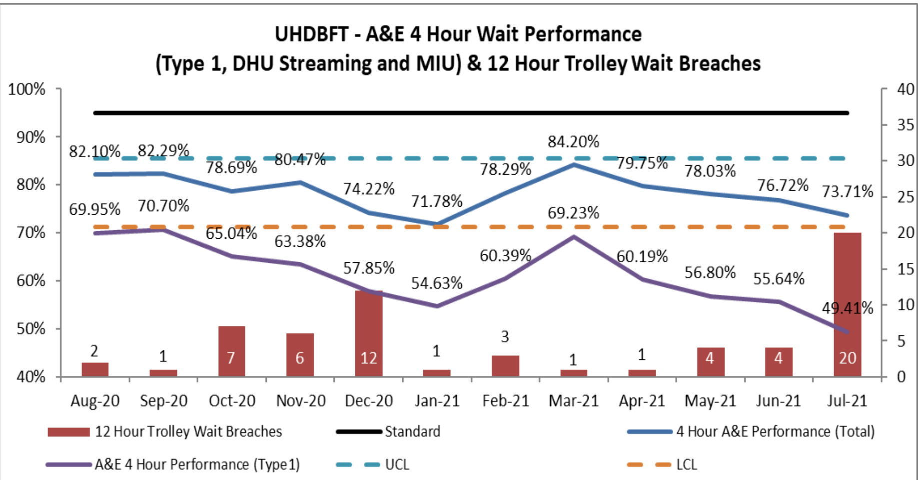
What actions have been taken?

- Streamlining of front door and booking-in processes to support more timely clinical review.
- Escalation of the shortage of Covid-specific community beds issue to the System Organisational Resilience Group (SORG) which includes councils and community trusts.
- AN NHSI critical friend visit was undertaken during June 2021, with a focus on urgent & emergency care. The Trust are awaiting written feedback.
- RSV Surge accommodation plans have been enacted to include increased oxygen provision across the site, equipment/consumables provision and detailed communications with relevant staff.
- Close working with EMAS to avoid unnecessary conveyances and to reduce Turnaround Times for those arriving this way.
- Established 24 hour access to the Assessment Units for relevant Medical, Surgical and Gynaecological patients.
- The implementation of the 111First project, whereby patients only access ED via 999 calls or booked appointments – to reduce unnecessary attendances.
- The implementation of new urgent care pathways including improved High Peak rapid response access, Dementia, Palliative Care, early pregnancy assessment, Urology, TIA and an additional route into the Mental health Safe Haven.

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

Performance Analysis

During July 2021, performance overall did not meet the 95% standard, achieving 73.71% (Network figure) and 49.41% for Type 1 attendances. This is following a continued decline.
There were 20 x 12 hour breaches during June 2021 due to the availability of suitable Mental Health beds (10) and medical capacity issues (10).



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

What are the next steps?

- Chief Nurses within the Derbyshire system are due to conduct a Peer Review of the department during August 2021.
- Further development of the Urgent Treatment Centre, to reduce unnecessary ED attendances.
- Developing Frailty pathways in the Discharge Assessment Unit and improving access to SystemOne for primary and community care.
- Developing the Every Day Counts project to improve discharges, which is now fully established in Divisions and Wards.
- Improving the shared Pitstop area for patients arriving by ambulance.
- Increased public communications regarding 111First and Urgent Treatment Centres as alternatives to automatic A&E attendances.

What are the issues?

- Staff absence due to sickness is high, with around a third of sickness in the trust being due to Covid related sickness or isolation. This also affected DHU, resulting in the Urgent Treatment Centre (UTC) being unable to operate 24 hours every day.
- The volume of Type 1 attendances is high, with an average of 348 attendances per day. As a Network the numbers of attendances are at 95% of pre-pandemic levels by (July 2021 compared to July 2019).
- The acuity of the attendances was high, with an average of 17 Resuscitation patients and 196 Major patients per day.
- Attendances at Children's ED have rapidly increased, with concerns about RSV and Broncheolitis being major factors. Children's Type 1 attendances have averaged at 125 per day during July 2021 (compared to 94 per day in July 2019) with as many as 163 attending on one particular day (8th July).
- 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. The recent increase in the proportion of red capacity (to reflect greater need) was a large undertaking.

What actions have been taken?

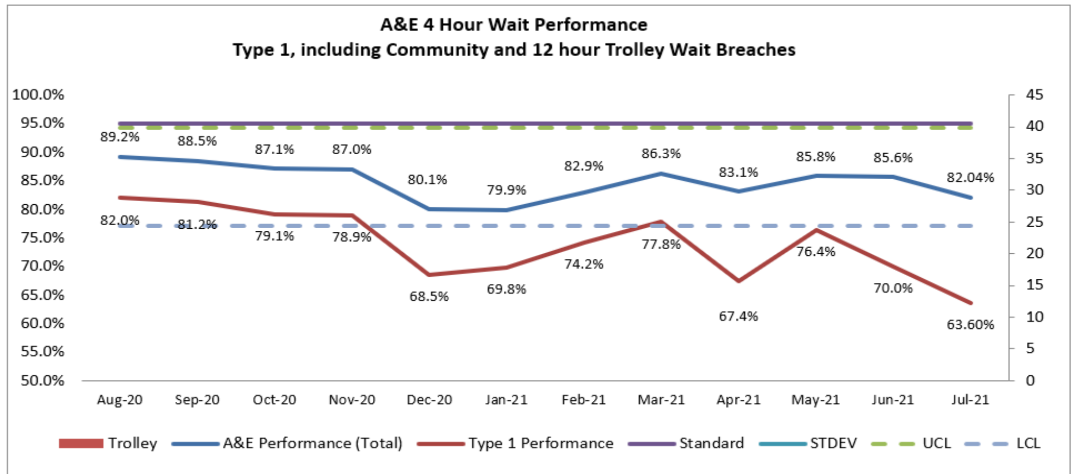
- The improved access to imaging for ED has been extended to Assessment Units. This includes more on-the-day scanning as part of the Same Day Emergency Care (SDEC) programme.
- The trust's Transformation Team are attending Team Huddles to identify potential communication improvements.
- The opening of a co-located Urgent Treatment Centre (UTC), in collaboration with DHU. There is a commitment to open 24/7 (previously closed between 2am-7am so this will provide support throughout the night) from August 2021. As an enhanced form of streaming this has been significant in reducing the number of patients attending the ED department unnecessarily. During July 2021 they saw an average of 134 patients per day.
- The UTC has established direct access for requesting diagnostic pathology testing which can be done through Lorenzo.
- Development of the Discharge Assessment Unit, with more morning discharges meaning that beds are released for patients attending through the day.

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

Performance Analysis

During July 2021, performance overall did not meet the 95% standard, achieving 63.6% for the Burton A&E and 82.0% including community hospitals. Performance has been fluctuating since winter.

There were no 12 hour breaches during July 2021.



What are the next steps?

- A major capital programme to increase the number of Assessment Unit beds and increasing Majors bed capacity is continuing.
- The addition of a modular building to house GP Streaming services.
- Continued development of the Every Day Counts programme, focussing on engagement and working behaviours.
- Extending the use of the Meditech IT system to community hospitals to enable improved patient flow processes.
- The Non-Elective Improvement Group (NELIG) continue to work on improvements, currently focussing on overall bed capacity at the Queens Hospital site.

What were the issues?

- The trust had been experiencing a decrease in attendances but now the attendances exceed the previous year by 39%, with an average of 175 Type 1 attendances per day.
- The acuity of the attendances is high, with an average of 119 Resuscitation/Major patients per day (68% of total attendances).

What actions have been taken?

- The opening of a 2nd Ultrasound Room has increased availability of scanning capacity and increasing patient flow.
- Action Plans have been devised, following a peer review by Chris Morrow-Frost (Regional Clinical Manager) which will led to suggestions for transformation.
- Implemented a new working model which enables closer consultant working with ED doctors.
- The implementation of the Staffordshire 111First project, whereby patients only access ED via 999 calls or booked appointments – to reduce unnecessary attendances and improve capacity management for those who do attend.
- Improved data analysis support inform transformation.
- The implementation of revised Same Day Emergency Care (SDEC) pathways for Thunderclap Headaches, Dementia and Palliative Care.
- The GP Connect service now includes Frailty as a condition, whereby GPs can connect with UHDB Geriatricians before deciding whether a patient needs hospital support.
- The Meditech can now flag Medically Fit For Discharge patients, to speed their discharge and improve patient flow.
- The standardisation of discharge processes in inpatient wards.
- Twice-weekly multi-disciplinary team meetings in community hospitals with a focus on patients medically fit for discharge.

DHU111 Performance Month 3 (June 2021)

Performance Summary

- DHU achieved all six contractual Key Performance Indicators (KPIs) in June 2021.
- Activity has been below plan throughout the contractual year (Year 5, October 2020 to date). This is due to a combination of factors; Think 111 First activity not materialising as anticipated, and a significant reduction in the usual winter illnesses as a result of social distancing measures in particular flu and respiratory illnesses.

Activity Summary

- Calls offered are 18.5% below plan year to date (October 2020 – June 2021). Due to the contractual +5% threshold agreement in place, a credit at the end of quarter three is due to commissioners for £1,473,418*.
- Clinical Calls are also below plan for the year to date by 9.6%. Due to the contractual +5% threshold agreement in place, a credit at the end of quarter three is due to commissioners for £257,713*.
- There were 14,295 Category 3 Ambulance Validations in June, with an associated cost of £235,237. This is a decrease on May, when there were 14,316 validations with a cost of £258,117.
- The regional cost of COVID-19 activity for June was £80,782. COVID-19 calls have increased from 7,488 in May to 8,479 calls in June, due to the increase in cases being seen and the rise of the Delta variant.

Regional Performance Year Five - Key Performance Indicators (KPI's)											
			Quarter One (October – December)			Quarter Two (January – March)			Quarter Three (April - June)		
KPI's		Standard	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Contract	Abandonment rate (%)	≤5%	0.50%	0.10%	0.20%	0.20%	0.20%	1.00%	1.00%	0.7%	0.9%
Contract	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
Contract	Call Transfer to a Clinician	≥50%	66.00%	66.70%	69.60%	71.60%	70.40%	68.70%	66.5%	68.0%	66.5%
Contract	Self Care	≥17%	26.20%	23.60%	20.90%	20.60%	20.10%	20.40%	17.3%	17.1%	18.1%
Contract	Patient Experience	≥85%	88.00%	This data is updated on a six monthly basis					88.00%	This data is updated on a six monthly basis	
Contract	C3 Validation	≥50%	98.00%	98.90%	92.00%	98.90%	98.8%	98.4%	95.90%	98.7%	98.6%

** The agreement reached between all associate commissioners in relation to transacting the underperformance position is as follows:*

- *Reconcile and transact the underactivity position at the end of Q3 within Leicester, Leicestershire and Rutland only*
- *Delay the reconciliation of funds for the remaining four counties until the end of Q4*
- *A year end reconciliation taking account of the full year position and any funds paid will be made as agreed in the contract.*

DHU111 Performance Month 3 (June 2021)

What are the issues?

- Activity remained below plan for calls offered (-15.6%) and clinical calls (-11.9%) during June 2021, although June activity was lower than that seen in May 2021. However actual calls answered and therefore demand on the service has seen a significant increase on the levels seen last year.
- This is not unique to DHU111, nor the 111 service. Demand is up when compared with last year across the country.
- One of the issues being experienced by DHU111 is national contingency. When a 111 provider is experiencing significant operational pressure, they are able to enter national contingency and a proportion of their calls (or all calls dependent on the issue) are redirected to other 111 services across the country whilst they get their operations back up and running. National contingency has been invoked multiple times on a daily basis, by multiple providers over the past couple of months. Since it is unpredictable in its nature and therefore difficult to resource for, there are occasions where DHU111 performance is impacted and it takes a period of time to recover. Despite this DHU111 are still performing very well and continue to achieve their contractual KPI’s.
- EMAS have previously expressed concerns with increasing levels of activity being passed through from 111 to 999.

What actions have been taken?

- A deep dive has taken place between DHU111 and EMAS to explore pass through activity and presented at the July EMAS Strategic Delivery Board meeting. The key findings were that demand into 111 has seen significant growth and this is therefore reflected in the numbers being passed through to EMAS, with C2 and C3 seeing the biggest increases. Whilst the percentage of calls resulting in an ambulance referral has increased compared to last year, they remain slightly lower than pre-pandemic levels, and the numbers being validated through the C3 validation service delivered by 111 continues to grow.

What are the next steps?

- Discussions are taking place between DHU111 and EMAS regarding the high levels of activity and how this can be reduced when safe and appropriate. A piece of work focusing on extending the Category 3 validation calls being passed over to EMAS from 30 minutes to 60 minutes will take place. Commissioners are also considering a proposal for DHU to validate C3 validations via the online route to reduce demand into EMAS.
- DHU111 have taken the decision to continue adhering to strict COVID-19 guidance within their call centres following the relaxing of restrictions on 19th July to prevent transmission.
- Discussions in relation to Year 6 contract negotiations are due to commence next month.

Activity		Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Year to date (Contract Year Oct 2020-Sep 2021)
Calls Offered	Actual	148,098	146,417	146,590	135,746	119,595	145,732	162,043	171,605	149,659	1,325,478
	Plan	152,299	153,848	203,460	199,210	177,571	188,612	188,704	186,048	177,330	1,627,082
	Variance	-2.80%	-4.80%	-28.00%	-31.90%	-32.6%	-22.70%	-14.10%	-7.80%	-15.6%	-18.5%
Clinical Calls	Actual	30,215	30,687	32,894	31,929	27,493	32,072	29,965	34,287	30,426	279,968
	Plan	29,898	30,333	39,528	36,350	31,639	35,140	36,518	35,809	34,529	309,746
	Variance	1.10%	1.20%	-16.80%	-12.20%	-13.10%	-8.70%	-18.00%	-4.30%	-11.9%	-9.6%

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

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

AMBULANCE – EMAS PERFORMANCE M3 (June 2021)

What are the issues?

- The contractual standard is for the division to achieve national performance on a quarterly basis. In Quarter one, Derbyshire achieved one of the six national standards, C1 90th Centile. C1 mean was not achieved by 56 seconds, C2 mean was not achieved by 9 minutes and 43 seconds, C2 90th Centile was not achieved by 21 minutes and 1 second, C3 90th Centile was not being achieved by 1 hour, 59 minutes and 27 seconds and C4 90th Centile was not achieved by 1 hour, 20 minutes and 56 seconds.

- Average Pre hospital handover times during June 2021 remained above the 15 minute national standard across Derbyshire (22 minutes) which was a deterioration compared to May 2021 (20 minutes and 46 seconds).
- Average Post handover times during June 2021 remained above the 15 minute national standard across Derbyshire with the exception of Macclesfield District (11 minutes and 4 seconds). Overall the post handover time in June 2021 (18 minutes and 10 seconds) was comparable to April 2021 (18 minutes and 14 seconds)

- Incidents in June 2021 saw a decrease when compared to May 2021 (13,905 compared to 14,588).
- H&T and S&T as a percentage of incidents saw an increase, where total S&C as a percentage of incidents saw a decrease.
- Duplicate calls increased again in June 2021, 22.6%, and this remains above the contractual threshold of 17.9%.
- S&C to ED specifically saw a further decrease in June 2021, with S&C incidents to ED being 52.8% compared to 55.5% in May 2021.
- Derbyshire had the joint highest level, with Leicestershire, of on scene demand passed from NHS 111 during June 21 at 27%.
- There has been a increase in C1 and C2 demand in recent months and this is a significant driver of the declining performance position.

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 – June	00:08:21	00:14:46	00:41:34	01:25:55	05:54:44	06:13:13
Derbyshire Actual - June	00:08:21	00:14:07	00:37:48	01:16:20	05:21:59	05:32:49
Derbyshire Actual - Quarter One	00:07:56	00:13:34	00:29:43	01:01:01	03:59:27	04:20:56

June 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	00:21:34	52:56:34	00:18:23	41:16:06	00:39:57	81:14:53
Chesterfield Royal	00:21:40	300:40:13	00:17:42	211:11:39	00:39:22	425:21:34
Macclesfield District General Hospital	00:27:41	12:52:33	00:11:04	0:32:55	00:38:45	10:32:33
Royal Derby	00:22:11	566:39:31	00:18:50	445:01:09	00:41:01	869:15:38
Sheffield Northern General Hospital	00:31:58	41:48:34	00:16:54	13:48:38	00:48:52	47:27:29
Stepping Hill	00:17:41	30:17:36	00:15:04	22:31:37	00:32:45	40:01:36
Derbyshire TOTAL	00:22:00	1005:15:01	00:18:10	734:22:04	00:40:10	1473:53:43

AMBULANCE – EMAS PERFORMANCE M3 (June 2021)

What actions have been taken?

- The increase in C1 and C2 demand is being seen across the country and NHSE/I have recognised there is a need for immediate and substantial action in order to ensure all patients are being reached as soon as possible and therefore £55m of additional non-recurrent funding is being made available across the ambulance sector in order to support improved performance.
- Following an increase in demand impacting on poor performance, EMAS called an extraordinary Strategic Delivery Board (SDB) meeting on 7th July to discuss the need for further demand initiatives with commissioners.
- EMAS have previously expressed concerns with increasing levels of activity being passed through from 111 to the 999 service. A deep dive has taken place to explore this activity and was presented at the SDB meeting in July. The key findings were that demand into 111 has seen significant growth and this is therefore reflected in the numbers being passed through to EMAS, with C2 and C3 seeing the biggest increases. Whilst the percentage of calls resulting in an ambulance referral has increased compared to last year, they remain slightly lower than pre-pandemic levels, and the numbers being validated through the C3 validation service delivered by 111 continues to grow.
- Two dedicated senior transformation leads (one for the East Midlands, one for the West Midlands) have been jointly appointed by NHSEI and CCGs and are now in post to support the work in relation to; pre-hospital pathways, reducing crowding and unwarranted variation within UEC, reduce variability of pathway options for the ambulance service and 111 clinicians.

What are the next steps

- In order to access the funding being made available nationally, a performance trajectory is required from ambulance trusts and EMAS are now working with the coordinating commissioner to agree both the trajectory and use of the additional funds (c.£3.7m for EMAS).
- Following on from the extraordinary SDB meeting in early July, local commissioners are currently exploring options within local Clinical Assessment Units (CAS) and current pathways to help reduce demand into EMAS.
- In relation to handover delays, there are a number of focus areas at Chesterfield Royal hospital in relation to handover delays; use of the 'Think SDEC' pathways for EMAS and GPs to avoid direct attendance at ED, reduce duplication of booking in through utilisation of ePRF for inbound ambulances, piloting a receptionist within the ED pitstop, there will be a refresh of the EMAS and Chesterfield Royal joint improvement plan to identify missed opportunities, and a perfect week is being planned for August, the exact date is to be confirmed.
- In relation to handover delays, there are also a number of focus areas at Royal Derby hospital in relation to handover delays; monthly ambulance turnaround meetings are now in place with representatives from the acute trust, EMAS and the CCG, there will be a joint ambulance turnaround Recovery Action Plan (RAP) to be signed off by A&E Delivery Board, the trust are looking to extend 'team nursing' for majors into the Pitstop with crews potentially taking patients directly to their bay for handover with the nursing team, the pitstop reception is being altered to allow space for additional reception staff, there will be a re-launch of notify screens, and introduction of the ability for direct admission from EMAS into specific wards rather than via ED.

Derbyshire	Quarter Four 2020/2021	April	May	June	Quarter One
Calls (Total)	53,290	17,643	20,461	21,110	59,214
Total Incidents	40,622	13,550	14,588	13,905	42,043
Total Responses	36,905	12,321	13,189	12,390	37,900
Duplicate Calls	9,018	2,936	4,129	4,776	11,841
Hear & Treat (Total)	7,367	2,386	3,143	3,944	9,473
See & Treat	13,306	4,134	4,433	4,392	12,959
See & Convey	23,599	8,187	8,756	7,998	24,941
Duplicates as % Calls	*16.9%*	16.6%	20.2%	22.6%	20.0%
H&T ASI as % Incidents	9.2%	9.4%	*9.6%*	10.9%	9.9%
S&T as % Incidents	*32.8%*	*31.9%*	*30.4%*	31.6%	30.8%
S&C as % Incidents	*58.1%*	*58.7%*	*60.0%*	57.5%	59.3%
S&C to ED as % of incidents	53.9%	56.2%	55.5%	52.8%	54.8%

Planned Care

DERBYSHIRE COMMISSIONER – INCOMPLETE PATHWAYS (92%)

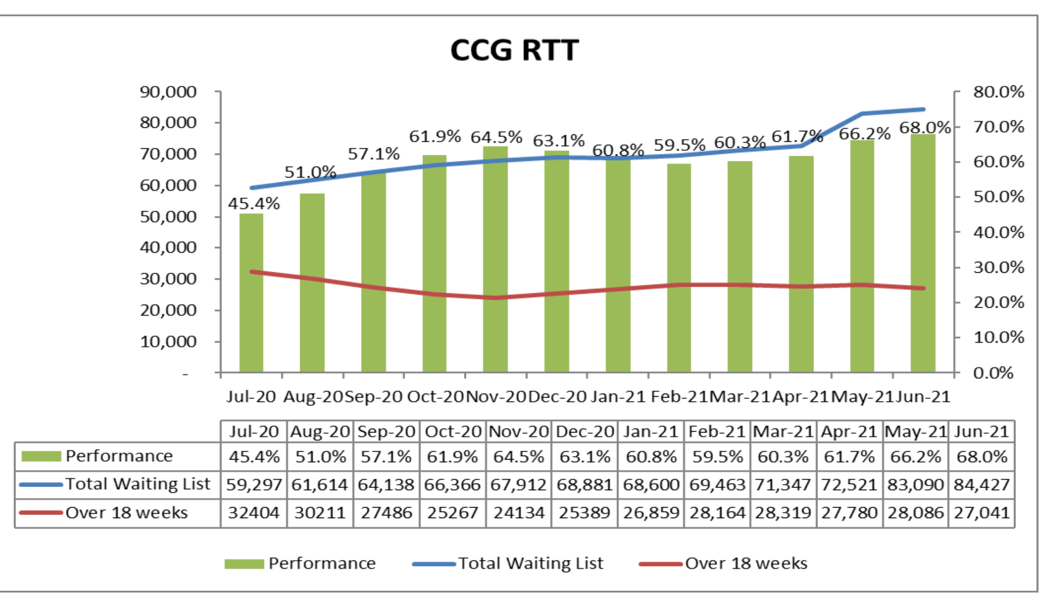
Performance Analysis

Performance for June 2021 was 68.0%, against a figure of 66.2% in May 2021, which is a slight improvement on the percentage of patients now waiting over 18 weeks.

The total incomplete waiting list for DDCCG was 84,427, which is an increase of 1,337 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 June showed an increase of 14% of urgent referrals and a reduction of 6% for routine referrals when compared with the average weekly referral of the previous 51 weeks. (Urgent referrals are 8% higher and routine referrals 15% lower than the same month during 2019)

Treatment Function	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Total 52 plus weeks
General Surgery Service	4,546	2,439	53.7%	741
Urology Service	3,697	2,697	73.0%	243
Trauma and Orthopaedic Service	12,654	6,394	50.5%	2,015
Ear Nose and Throat Service	6,249	3,862	61.8%	539
Ophthalmology Service	11,768	7,414	63.0%	780
Oral Surgery Service	34	27	79.4%	1
Neurosurgical Service	449	315	70.2%	27
Plastic Surgery Service	637	398	62.5%	76
Cardiothoracic Surgery Service	197	137	69.5%	12
General Internal Medicine Service	351	282	80.3%	1
Gastroenterology Service	4,406	3,629	82.4%	119
Cardiology Service	2,316	1,854	80.1%	32
Dermatology Service	5,781	4,274	73.9%	126
Respiratory Medicine Service	1,406	1,158	82.4%	3
Neurology Service	2,205	1,763	80.0%	10
Rheumatology Service	1,570	1,226	78.1%	11
Elderly Medicine Service	244	226	92.6%	1
Gynaecology Service	6,047	4,342	71.8%	294
Other - Medical Services	5,654	4,909	86.8%	60
Other - Mental Health Services	290	267	92.1%	0
Other - Paediatric Services	6,219	4,252	68.4%	503
Other - Surgical Services	6,801	4,769	70.1%	565
Other - Other Services	906	752	83.0%	40
Total	**84,427**	**57,386**	**68.0%**	**6,199**



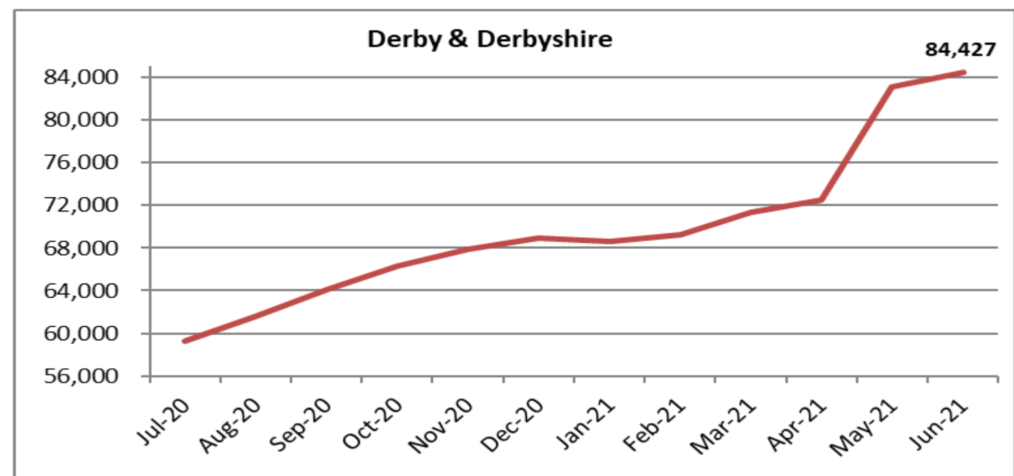
	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Performance	45.4%	51.0%	57.1%	61.9%	64.5%	63.1%	60.8%	59.5%	60.3%	61.7%	66.2%	68.0%
Total Waiting List	59,297	61,614	64,138	66,366	67,912	68,881	68,600	69,463	71,347	72,521	83,090	84,427
Over 18 weeks	32404	30211	27486	25267	24134	25389	26,859	28,164	28,319	27,780	28,086	27,041

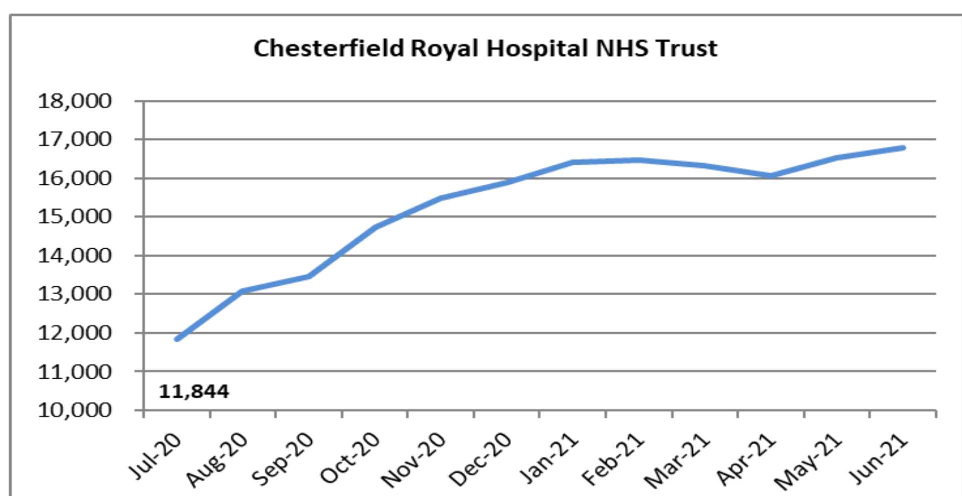
- *The Derbyshire CCG position is representative of all of the patients registered within the CCG area attending any provider nationally.*
- *70% of Derbyshire patients attend either CRHFT (25%) or UHDB (45%). The RTT position is measured at both CCG and provider level.*
- *The RTT standard of 92% was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

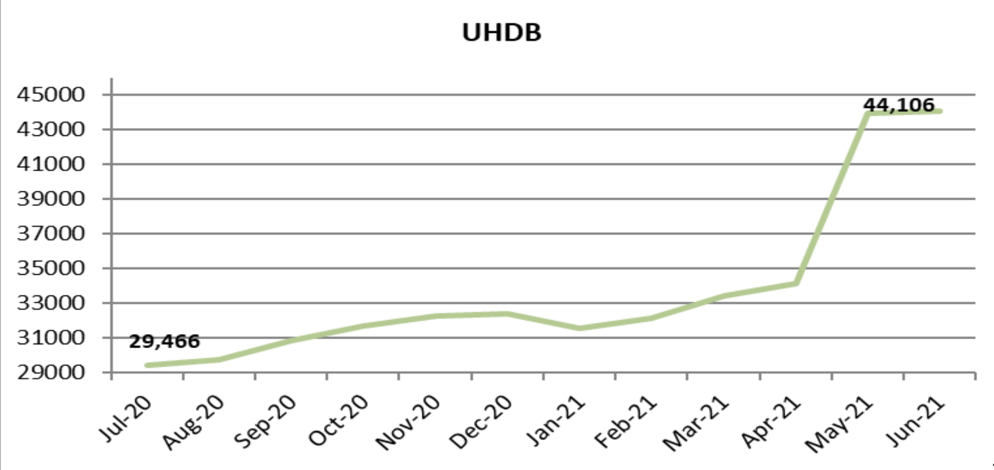
ELECTIVE CARE – DDCCG Incomplete Pathways

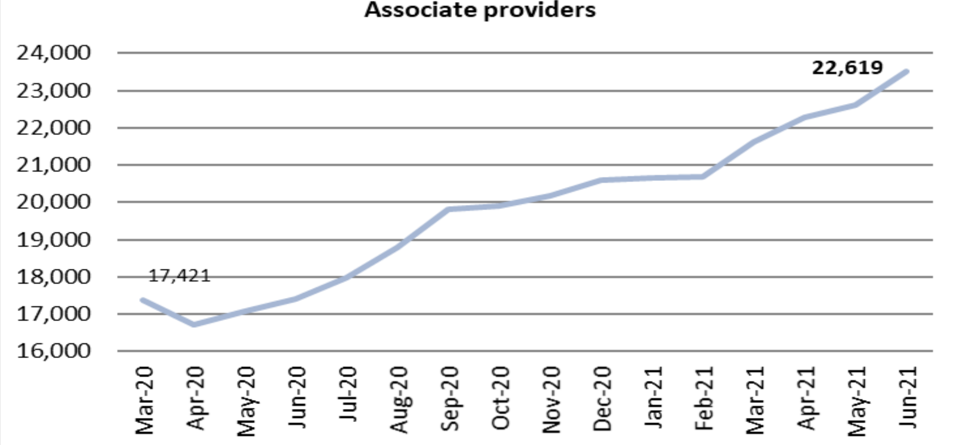
Derbyshire CCG incomplete waiting list at the end of June 2021 is 84,427, another increase on the previous month.

Of this number 60,904 Derbyshire patients are currently awaiting are at our two main acute providers CRH (16,798) and UHDB (44,106). The remaining 23,523 Derbyshire residents are on an incomplete pathways at other trusts out of Derbyshire. The graphs below show the current position and how this has changed over the last few months.





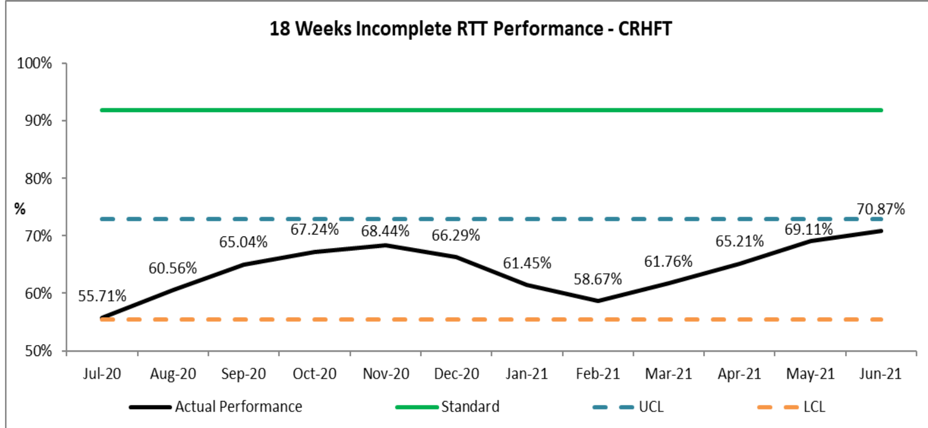


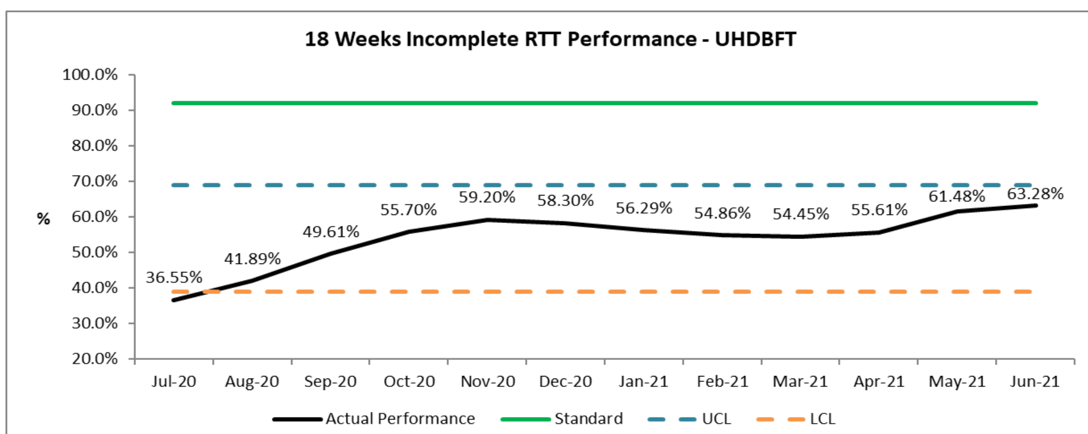


Referral to Treatment – Incomplete Pathways (92%).

CRH – During June 2021 the trust achieved 70.9%, a small further improvement compared to 69.1% for May. The waiting list at the end of May is now 18,496.

UHDB
During June the trust achieved a standard of 63.3%, an improvement on the May figure of 61.5%. The waiting list at the end of June was 79,410.





CRH - Treatment Function	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Total 52 plus weeks
General Surgery Service	1,013	508	50.1%	166
Urology Service	1,149	925	80.5%	20
Trauma and Orthopaedic Service	1,737	1,021	58.8%	155
Ear Nose and Throat Service	1,601	1,039	64.9%	156
Ophthalmology Service	2,088	1,335	63.9%	129
Oral Surgery Service	1,195	743	62.2%	118
General Internal Medicine Service	264	207	78.4%	0
Gastroenterology Service	1,222	909	74.4%	15
Cardiology Service	620	452	72.9%	0
Dermatology Service	1,449	1,343	92.7%	18
Respiratory Medicine Service	473	366	77.4%	1
Rheumatology Service	444	323	72.7%	2
Gynaecology Service	1,546	1,045	67.6%	154
Other - Medical Services	934	752	80.5%	8
Other - Paediatric Services	1,025	883	86.1%	21
Other - Surgical Services	1,736	1,257	72.4%	132
Total	18,496	13,108	70.9%	1095

UHDB - Treatment Function	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Total 52 plus weeks
General Surgery Service	4,239	2,519	59.4%	591
Urology Service	3,153	2,021	64.1%	352
Trauma and Orthopaedic Service	13,672	6,496	47.5%	2380
Ear Nose and Throat Service	6,821	4,077	59.8%	386
Ophthalmology Service	10,304	5,442	52.8%	926
Oral Surgery Service	3,324	1,832	55.1%	446
Neurosurgical Service	124	84	67.7%	2
Plastic Surgery Service	403	239	59.3%	58
Cardiothoracic Surgery Service	9	9	100.0%	0
General Internal Medicine Service	507	450	88.8%	1
Gastroenterology Service	3,202	2,971	92.8%	8
Cardiology Service	1,624	1,491	91.8%	10
Dermatology Service	5,657	3,550	62.8%	126
Respiratory Medicine Service	549	515	93.8%	3
Neurology Service	2,015	1,539	76.4%	8
Rheumatology Service	1,374	1,108	80.6%	4
Elderly Medicine Service	334	262	78.4%	2
Gynaecology Service	6,002	4,053	67.5%	261
Other - Medical Services	5,590	4,917	88.0%	52
Other - Mental Health Services	4	4	100.0%	0
Other - Paediatric Services	4,063	2,236	55.0%	514
Other - Surgical Services	5,464	3,656	66.9%	616
Other - Other Services	976	780	79.9%	60
Total	79,410	50,251	63.3%	6806

DERBYSHIRE COMMISSIONER – OVER 52 WEEK WAITERS

52 Week Waits
June figures show that there were 6,199 Derbyshire patients waiting over 52 weeks for treatment in Derbyshire. Of these 4,955 were waiting for treatment at our two main providers UHDB and CRH, the remaining 1,244 were waiting at various trusts around the country as outlined in the table on the following slide.

Although the number of patients waiting has decreased this month it is expected that numbers will increase as the decrease is reflective of the reduction in referrals during Spring/Summer of last year.

CCG Patients – Trend – 52 weeks													
	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	**Jun-21**
DDCCG	527	934	1,519	2,107	2,658	3,388	4,245	5,903	7,554	8,261	7,490	6,859	**6,199**

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

	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	**Jun-21**
UHDB	580	1,011	1,667	2,367	2,968	3,751	4,706	6,629	8,767	9,728	8,605	7,573	**6,806**
CRH	53	117	212	308	438	594	797	1,202	1,475	1,471	1,278	1,179	**1,095**

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

Main Provider Actions:
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.

DERBYSHIRE COMMISSIONER – OVER 52 WEEK WAITERS

Associate Providers – Derbyshire Patients waiting over 52 weeks in June 2021 at associate providers are as follows:

Provider	Total	Provider	Total
AIREDALE NHS FOUNDATION TRUST	1	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	116
ASPEN - CLAREMONT HOSPITAL	38	SPIRE NOTTINGHAM HOSPITAL	2
BARTS HEALTH NHS TRUST	3	SPIRE REGENCY HOSPITAL	8
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	5	STOCKPORT NHS FOUNDATION TRUST	390
BMI - THE ALEXANDRA HOSPITAL	5	TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FT	2
BMI - THE PARK HOSPITAL	1	THE ONE HEALTH GROUP LTD	4
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	1	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FT	1
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	12	THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FT	2
EAST CHESHIRE NHS TRUST	23	THE ROYAL WOLVERHAMPTON NHS TRUST	1
EAST LANCASHIRE HOSPITALS NHS TRUST	1	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	3
LEEDS TEACHING HOSPITALS NHS TRUST	9	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	24
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	1	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	2
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	3	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	50
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	20	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	5
NEWMEDICA COMMUNITY OPHTHALMOLOGY - BARLBOROUGH TREATMENT	1	WOODTHORPE HOSPITAL	8
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	1	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	4
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	260	HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST	8
NUFFIELD HEALTH, DERBY HOSPITAL	79	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	1
PENNINE ACUTE HOSPITALS NHS TRUST	1	LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	8
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	1	BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	1
ROYAL BERKSHIRE NHS FOUNDATION TRUST	1	PORTSMOUTH HOSPITALS UNIVERSITY NATIONAL HEALTH SERVICE TRUST	2
ROYAL FREE LONDON NHS FOUNDATION TRUST	4	PRACTICE PLUS GROUP HOSPITAL - BARLBOROUGH	18
SALFORD ROYAL NHS FOUNDATION TRUST	12	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	1
SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	52	UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST	1
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	47	**Total**	**1244**

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 June was 27.07% waiting over six weeks, another slight deterioration on the 25.0% waiting at the end of May.

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

CCG Diagnostics

	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Performance	40.7%	40.2%	35.8%	32.9%	34.7%	36.2%	38.3%	30.4%	25.4%	24.8%	25.0%	27.1%
Total Waiting List	20,601	20,616	21,415	20,346	20,469	21,012	19,173	17,565	18,773	19,864	21,690	23,240
Over 6 weeks	8,393	8,282	7,673	6,696	7,096	7,603	7,336	5,331	4,769	4,935	5,425	6,291

Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Percentage waiting 6+ Weeks
Magnetic Resonance Imaging	4,286	817	352	19.1%
Computed Tomography	2,962	567	182	19.1%
Non-obstetric Ultrasound	8,305	2,601	542	31.3%
Barium Enema	8	1	0	12.5%
DEXA Scan	758	120	33	15.8%
Audiology - Audiology Assessments	931	316	16	33.9%
Cardiology - Echocardiography	2,678	815	75	30.4%
Peripheral Neurophysiology	317	6	0	1.9%
Respiratory physiology - Sleep Studies	142	17	8	12.0%
Urodynamics - Pressures & Flows	127	65	36	51.2%
Colonoscopy	979	390	243	39.8%
Flexi Sigmoidoscopy	403	121	59	30.0%
Cystoscopy	218	41	25	18.8%
Gastroscopy	1,126	414	251	36.8%
Total	**23,240**	**6,291**	**1,822**	**27.1%**

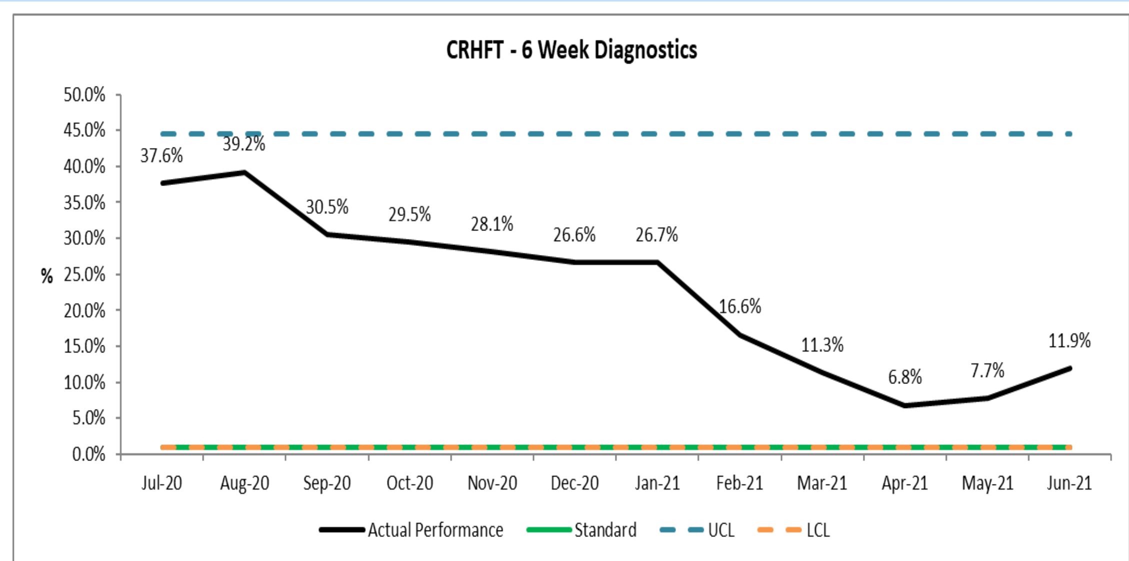
Diagnostic Test Name	University Hospitals of Derby & Burton	Chesterfield Royal Hospital	Stockport	Sheffield Teaching Hospitals	Sherwood Forest Hospitals	Nottingham University Hospitals	East Cheshire
Magnetic Resonance Imaging	21.0%	0.3%	13.9%	2.6%	1.9%	64.5%	0.0%
Computed Tomography	26.2%	0.2%	2.8%	3.8%	31.6%	8.8%	0.0%
Non-obstetric Ultrasound	45.6%	0.2%	9.6%	0.0%	1.6%	33.4%	0.0%
DEXA Scan	6.5%	0.7%	68.2%	65.7%	0.5%	57.7%	
Audiology - Audiology Assessments	18.6%	49.6%	23.6%	46.8%	2.8%	12.3%	34.9%
Cardiology - Echocardiography	20.0%	31.1%	13.1%	35.6%	56.2%	0.0%	69.0%
Peripheral Neurophysiology	0.3%			13.7%		0.0%	
Respiratory physiology - Sleep Studies	0.0%		15.9%	8.0%	2.5%	3.6%	0.0%
Urodynamics - Pressures & Flows	59.3%	47.6%	25.9%	78.1%	4.4%	12.9%	
Colonoscopy	5.7%	30.6%	88.2%	29.9%	25.7%	16.1%	50.9%
Flexi Sigmoidoscopy	11.0%	27.4%	86.6%	37.2%	22.9%	14.3%	31.6%
Cystoscopy	21.6%	1.9%		8.3%	31.3%	7.1%	25.0%
Gastroscopy	5.9%	28.2%	81.8%	22.5%	37.0%	21.4%	46.3%
Total	**30.2%**	**11.9%**	**44.1%**	**14.2%**	**20.1%**	**39.2%**	**32.7%**

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

Performance Analysis

Performance during June was 11.9%, a deterioration on the May figure of 7.7%..

The numbers on the waiting list have again increased – this month by nearly 600, However, the number waiting over 13 weeks continue to decrease.



What are the issues?

Issues

- Staff absence due to sickness is high, with around a third of sickness in the trust being due to Covid related sickness or isolation.
- The high demand due to higher outpatient referrals and increased non-elective activity continues.
- Echocardiology have reduced capacity due to staff shortages.
- Audiology are running on reduced capacity due to IPC guidance, which will continue until IPC is lifted or additional accommodation is found.
- Although Urodynamics have a low volume of patients the specialist nature of the area means that the cancellation of just 1 list can have a significant impact.

Actions

- A mobile CT Scanner is being deployed from August to provide extra scanning capacity.
- Endoscopy dates are now booked immediately to prevent recurrence of the booking issues.
- Imaging and Endoscopy activity for those patients on a cancer pathway is prioritised.
- Further development of the clinical triage set and CAB.
- Local diagnostic departments continue to validate waiting lists to ensure data quality.

Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Percentage waiting 6+ weeks
Magnetic Resonance Imaging	763	2	0	0.3%
Computed Tomography	654	1	0	0.2%
Non-obstetric Ultrasound	1,974	3	0	0.2%
DEXA Scan	287	2	0	0.7%
Audiology - Audiology Assessments	401	199	3	49.6%
Cardiology - Echocardiography	832	259	0	31.1%
Urodynamics - Pressures & Flows	21	10	5	47.6%
Colonoscopy	304	93	23	30.6%
Flexi Sigmoidoscopy	106	29	11	27.4%
Cystoscopy	54	1	0	1.9%
Gastroscopy	259	73	26	28.2%
Total	**5,655**	**672**	**68**	**11.9%**

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

Performance Analysis

Performance during June was 30.18% a deterioration of the May figure.

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

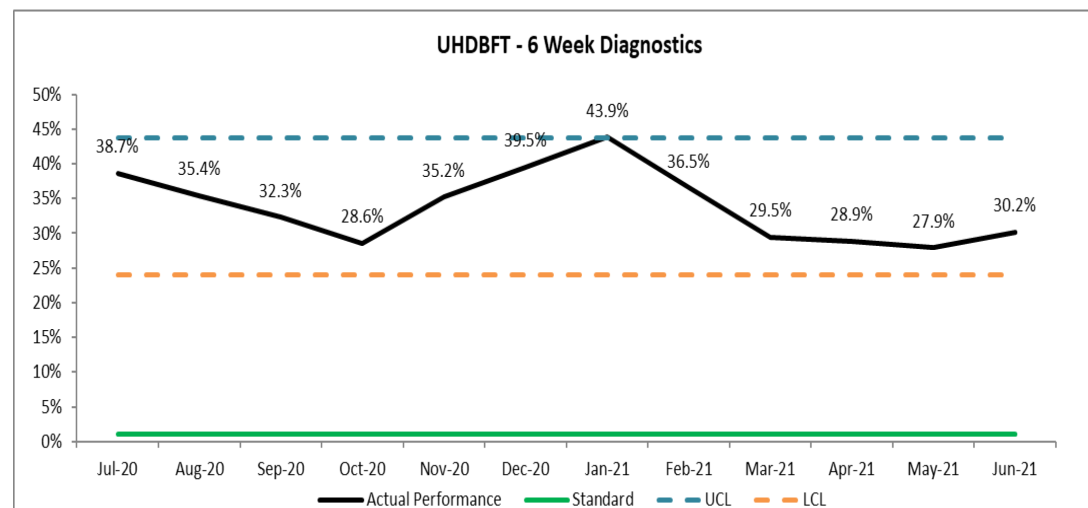
Non Obstetric ultrasounds , CT and MRI are experiencing the highest waits proportionally.

Issues

- Staff absence due to sickness is high, with around a third of sickness in the trust being due to Covid related sickness or isolation.
- The high demand due to higher outpatient referrals and increased non-elective activity continues.
- MRI out-of-hours staffing issues continue, affecting their capacity.
- More intense cleaning of equipment between patients has reduced capacity in all areas

Actions

- An additional 7 Sonographers have been recruited in order to increase capacity.
- A 2nd Ultrasound Room has now been opened at Burton, increasing the capacity for these scans.
- The bid for a Rapid Diagnostics Site at the Trust continues, with negotiations taking place to secure funding beyond Year 1.
- MRI are attempting to recruit locums to address the staffing issues.
- Waiting list validation continues, to ensure that patients are not shown as waiting unnecessarily.



Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	% waiting 6+ weeks
Magnetic Resonance Imaging	3,749	788	107	21.0%
Computed Tomography	2,584	676	191	26.2%
Non-obstetric Ultrasound	8,495	3,874	736	45.6%
Barium Enema	30	1	0	3.3%
DEXA Scan	474	31	14	6.5%
Audiology - Audiology Assessments	763	142	20	18.6%
Cardiology - Echocardiography	1,821	365	6	20.0%
Neurophysiology	395	1	0	0.3%
Respiratory physiology - Sleep Studies	184	0	0	0.0%
Urodynamics - Pressures & Flows	113	67	31	59.3%
Colonoscopy	489	28	10	5.7%
Flexi Sigmoidoscopy	282	31	1	11.0%
Cystoscopy	185	40	23	21.6%
Gastroscopy	573	34	13	5.9%
Total	**20,137**	**6,078**	**1,152**	**30.2%**

DERBYSHIRE COMMISSIONER – CANCER WAITING TIMES

During June 2021, Derbyshire was compliant in 2 of the 8 Cancer standards:
- **31 day Subsequent Drugs** – 98.8% (98% standard) – Compliant all Trusts except Sherwood Forest.
- **31 day Subsequent Radiotherapy** – 95.6% (94% standard) – Compliant for Derby & Burton and Sheffield, but not for Nottingham.

During June 2021, Derbyshire was non-compliant in 6 of the 8 Cancer standards:
- **2 week Urgent GP Referral** – 86.2% (93% standard) – Compliant for Sherwood Forest and Stockport.
- **2 week Exhibited Breast Symptoms** – 56.4% (93% standard) – Non compliant for all trusts.
- **31 day from Diagnosis –** 94.1% (96% standard) – Compliant for Chesterfield and Stockport.
- **31 day Subsequent Surgery** – 81.5% (94% standard) - Compliant for Chesterfield, East Cheshire and Stockport.
- **62 day Urgent GP Referral** – 68.8% (85% standard) – Non compliant for all trusts.
- **62 day Screening Referral** – 74.2% (90% standard) – Non compliant for all trusts.

Additional standards include:
- **28 day Diagnosis or Decision To Treat** – 76.5% (75% standard) – Compliant for Derby & Burton, Chesterfield, Nottingham & Sherwood Forest.
- **104 day wait** – 28 CCG patients waited over 104 days for treatment.

Cancer 2 Week Wait (Referral To First Appointment)

Cancer 2 Week Wait (Breast Symptoms)

Cancer: 31 Day Wait (1st Treatment)

Cancer: 31 Day Wait (Subsequent Surgery)

Cancer: 31 Day Wait (Subsequent Drug Treatments)

Cancer: 31 Day Wait (Subsequent Radiotherapy Treatments)

Cancer: 62 Day Wait (Urgent Referral)

Cancer: 62 Day Wait (Screening Referral)

Actual Performance | Standard | UCL | LCL

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

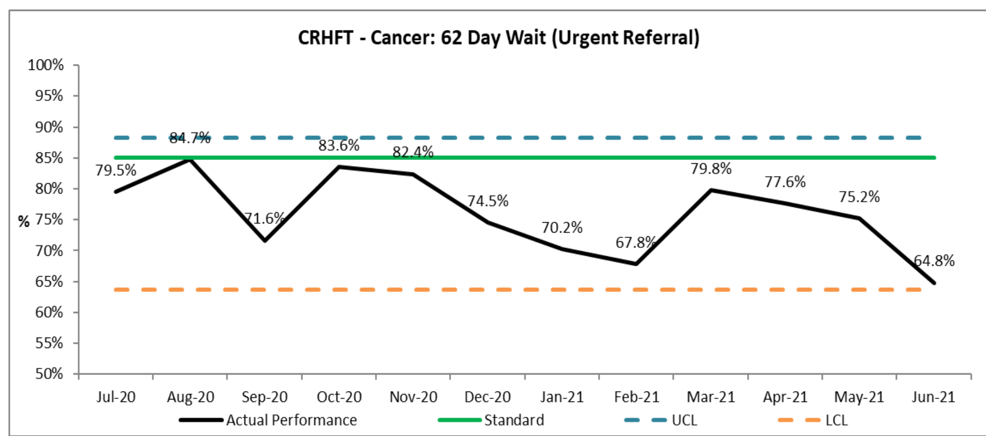
CRHFT - CANCER WAITING TIMES (First Treatment Administered within 62 Days of Urgent Referral)

Performance Analysis

CRH performance during June for first treatment within 62 days of urgent referral has deteriorated to 64.8%, remaining non-compliant against the standard of 85%.

There were 71 patients treated along this pathway in June with 46 of those patients being treated within the 62 day standard, resulting in 25 breaches.

Of the 25 breaches 7 patients were treated after day 104 days, 6 of these were within Urology and 1 within Haematology. The reasons for the delay were Complex Diagnostics (some diagnostics impacted upon by Covid), Outpatient Capacity and Healthcare Initiated Treatment Plan.



Current Issues

- Diagnostic Capacity, in particular Truss Biopsies which were reporting 6-8 week appointment delays. More recently this has reduced to 2 weeks.
- Theatre Capacity to accommodate demand.
- Workforce issues.
- Tertiary Referrals – referral processes from Chesterfield to Sheffield.
- Limited space to implement additional clinics.
- Restoration of all hospital services as part of the Covid recovery - all impacting on Cancer Performance.

Actions Being Taken

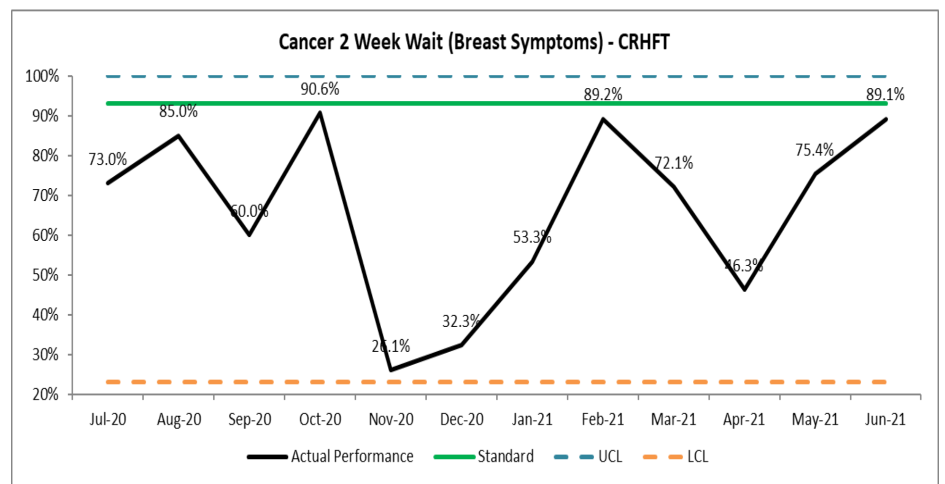
- Mobile CT Scan to be in place from August.
- Interviews for Urology nurse associate role and Macmillan AHP role
- Breast Diagnostic pathway under review.
- Derbyshire Community Breast Pain Pathway went 'live' in June. It is expected to help manage the level of referrals. The impact of this is under close review.

What are the next steps

- Continued focus on those patients over 62 day and 104 day on the PTL. The 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.

CRH Tumour Type	Total referrals seen during the period	Seen Within 62 Days	Breaches of 62 Day Standard	% Performance
Breast	10	4	6	40.00%
Gynaecological	1.5	0.5	1	33.33%
Haematological (Excluding Acute Leukaemia)	7	4	3	57.14%
Head and Neck	6	3.5	2.5	58.33%
Lower Gastrointestinal	12	7	5	58.33%
Lung	2	2	0	100.00%
Sarcoma	2	0	2	0.00%
Skin	14	14	0	100.00%
Upper Gastrointestinal	5.5	4.5	1	81.82%
Urological (Excluding Testicular)	11	6.5	4.5	59.09%
Totals	**71.0**	**46**	**25**	**64.79%**

CRHFT - CANCER WAITING TIMES – Breast Symptoms



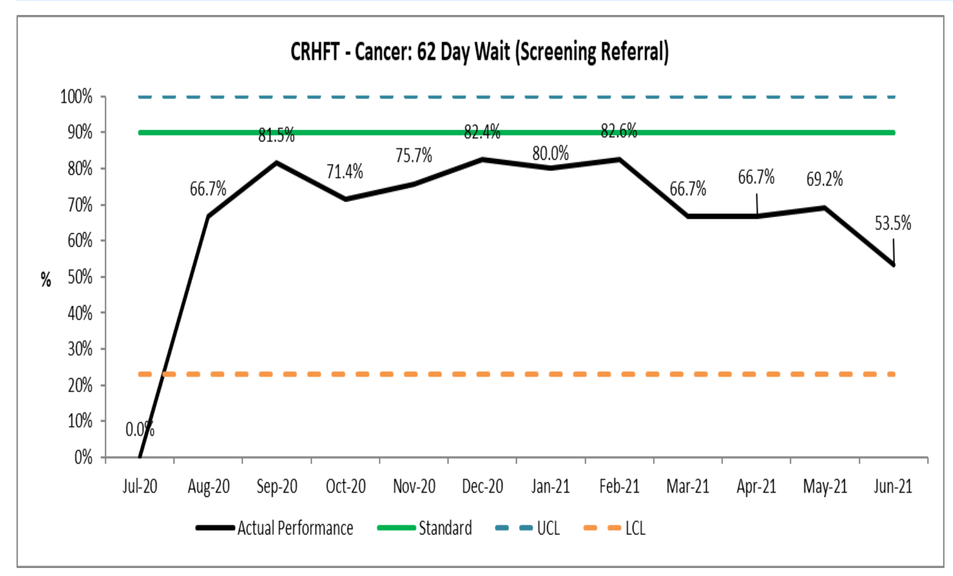
Performance Analysis

June performance at CRH for 2 Week Wait Breast Symptomatic has continued to improve to 89.1% when compared to May which reported 75.4%. However, it continues to remain non-compliant against the standard of 93% as Breast referrals continue to increase which is a national issue.

The total number of patients seen under this standard during June was 46, a decrease on the 65 seen in May. Of the 46 patients 41 were seen within the 14 day standard resulting in 5 breaches. A significant improvement to the 16 breaches reported in May.

Out of the 5 breaches 3 of those were due to Patient Choice with the remaining 2 being as a result of Outpatient Capacity.

CRHFT - CANCER WAITING TIMES – 62day Screening Referral



Performance Analysis

Performance in June has reduced to 53.5% when compared to the 69.2% reported in May, remaining non-complaint against the standard of 90%.

The number of patients treated via referral through screening has increased in June to 21.5, compared to 13 treated in May.

Of the 21.5 patients treated there were 11.5 treated within the 62 day standard resulting in 10 breaches (relating to 11 patients). The tumour sites include Breast(6) and Lower GI(5).

The reasons were Elective Capacity(2), Healthcare Initiated Treatment Plan(4), Outpatient Capacity (2) and Patient Choice(3). Those reported as waiting the longest were as a result of Patient Choice.

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

Performance Analysis

June Performance for first treatment within 62 days has reduced slightly to 68.6%, remaining non-compliant against the standard of 85%.

There were a total of 203.5 patients treated along this pathway in June which is an increase from the 178 treated in May. Of the 203.5 patients there were 139.5 who were treated within the 62 standard resulting in 64 breaches.

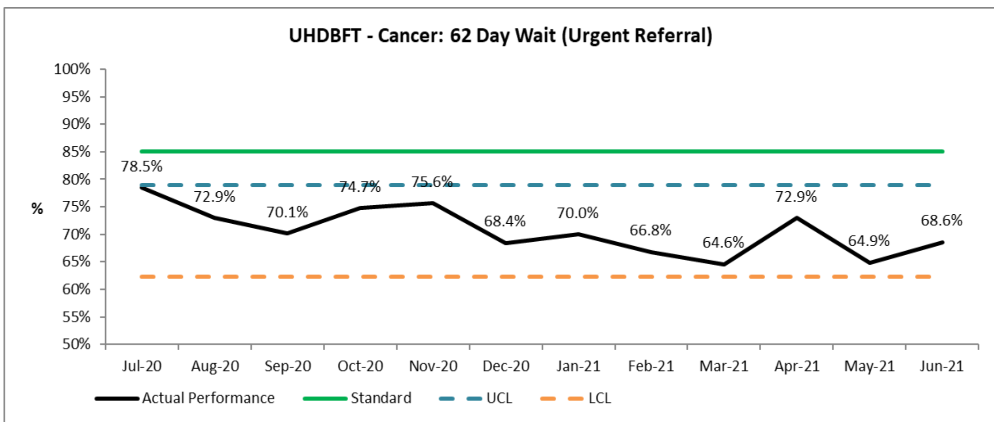
Out of the 64 breaches 17 patients were treated after day 104 which were delayed due to Elective Capacity, Outpatient Capacity, Medical Reasons and Healthcare Initiated Treatment Plan. The tumour sites reporting over 104 day include Gynaecology, Lower GI and Urology.

Actions Being Taken

- Derbyshire Community Breast Pain Pathway went 'live' in June and is expected to help manage the level of referrals. The impact of this is under close review.
- Additional Clinics accommodating increasing referrals where possible.
- Inappropriate skin referrals under review.
- Out to agency for Consultant in Urology at Burton site.

What are the next steps

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

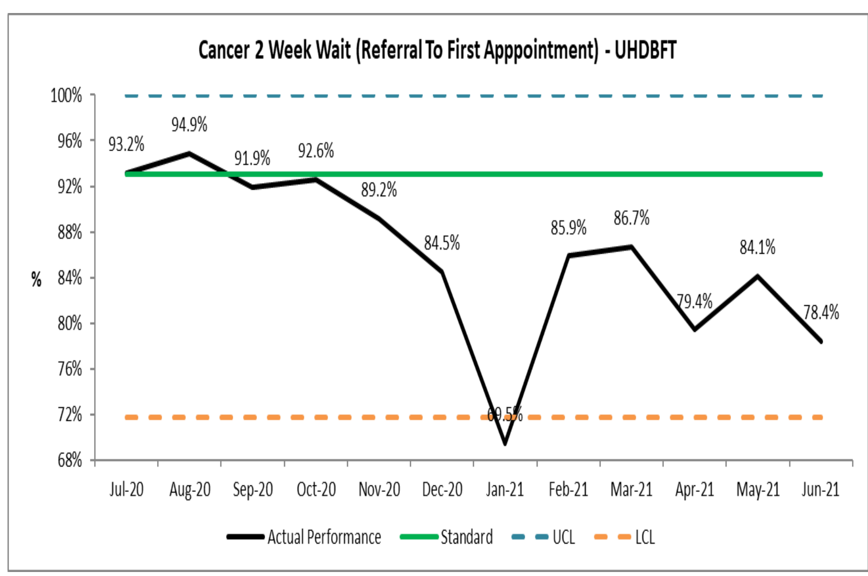


Tumour Type	Total referrals seen during the period	Seen Within 62 Days	Breaches of 62 Day Standard	% Performance
Breast	45	34	11	75.56%
Gynaecological	17.5	2.5	15	14.29%
Haematological (Excluding Acute Leukaemia)	15	8	7	53.33%
Head and Neck	18	15.5	2.5	86.11%
Lower Gastrointestinal	37	18	19	48.65%
Lung	10	8	2	80.00%
Other	3	3	0	100.00%
Sarcoma	3.5	1	2.5	28.57%
Skin	59	58.5	0.5	99.15%
Testicular	3	3	0	100.00%
Upper Gastrointestinal	18.5	13.5	5	72.97%
Urological (Excluding Testicular)	45	20.5	24.5	45.56%
Totals	**274.5**	**185.5**	**89**	**67.58%**

Current Issues

- Increase in referrals across the majority of tumour sites in particular Breast, Gynaecology and Skin.
- Inappropriate GP referrals identified in Skin.
- Haematology Locum to support Derby has withdrawn.
- Colorectal associate Consultant on long term absence, impacting on appointment capacity.
- Restoration of all hospital services as part of the Covid recovery are all impacting on Cancer Performance.

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

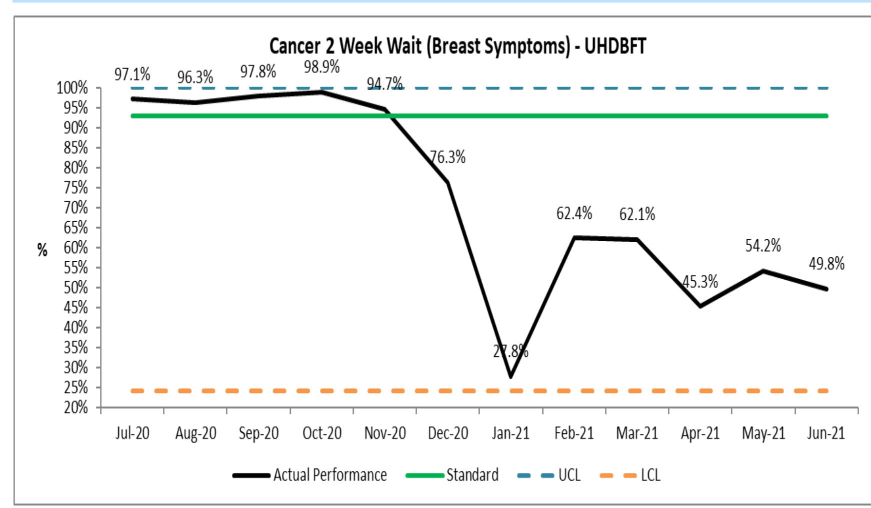


Performance Analysis
June performance at UHDB for 2 week wait has reduced to 78.4%, and continues to be non-compliant against the standard of 93%. The main challenges for 2ww performance have been associated with Breast, Gynaecology, Lower GI, Upper GI and more recently Skin.

There were a total number of 3481 patients seen this month by way of GP Urgent referral to first appointment which is a significant increase on the 2970 reported in May. June also continued with nearly 60% of the referrals being in Breast, Lower GI and Skin. Of the 3481 patients seen in June, 2730 of these patients were seen within the 2 week wait standard, resulting in 751 breaches which is a significant increase on the 472 breaches reported in May.

The 751 breaches occurred in Breast (322), Children (2), Gynaecology (150), Haematology (2), Head and Neck (23), Lower GI (106), Lung (1), Skin (60), Testicular (1), Upper GI (71) and Urology (13). The majority of the breach reasons were due to Outpatient Capacity, followed by Patient Choice then a small few being due to Administrative delay.

UHDB - CANCER WAITING TIMES – 2 Week Wait – Breast Symptoms

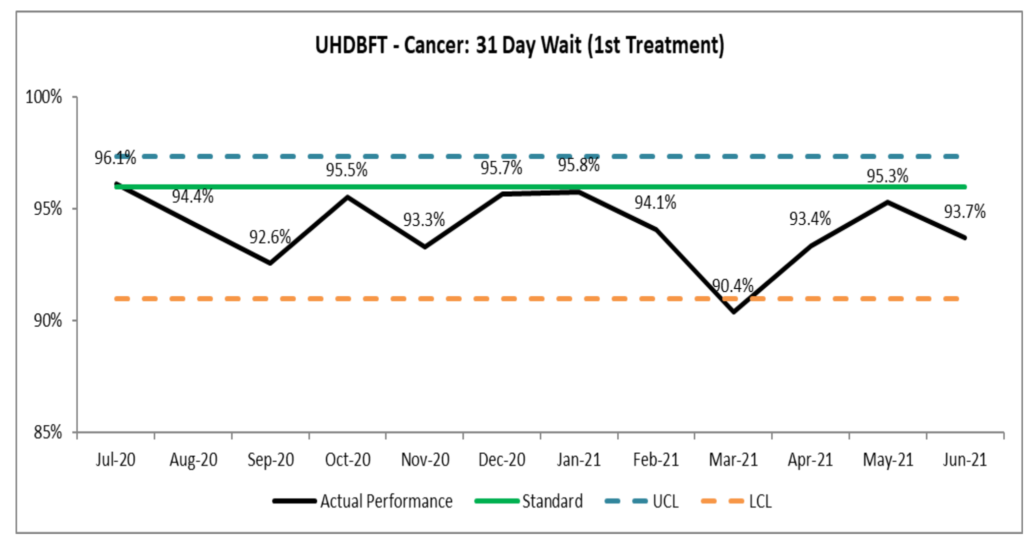


Performance Analysis
June performance at UHDB for 2 week wait Breast Symptomatic has reduced slightly to 49.8%, remaining non-compliant against the standard of 96%.

Breast referrals polling range on Choose and Book, for both 2WW and symptomatic, was extended to more than 14 days to enable patients to book, even though the appointment would be after 14 days and although this has now stopped this has affected those patients seen in June.

The total number of patients seen this month by way of referral to Breast Symptomatic was 207 with 103 of those patients being seen within 2 weeks, resulting in 104 breaches. Of the 104 breaches 97 of the patients were seen within 21 days, 5 waiting up to 28 days and 2 waiting 35 days. The majority of the breach reasons were due to outpatient capacity(96), with the remaining being as a result of Patient Choice(8).

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



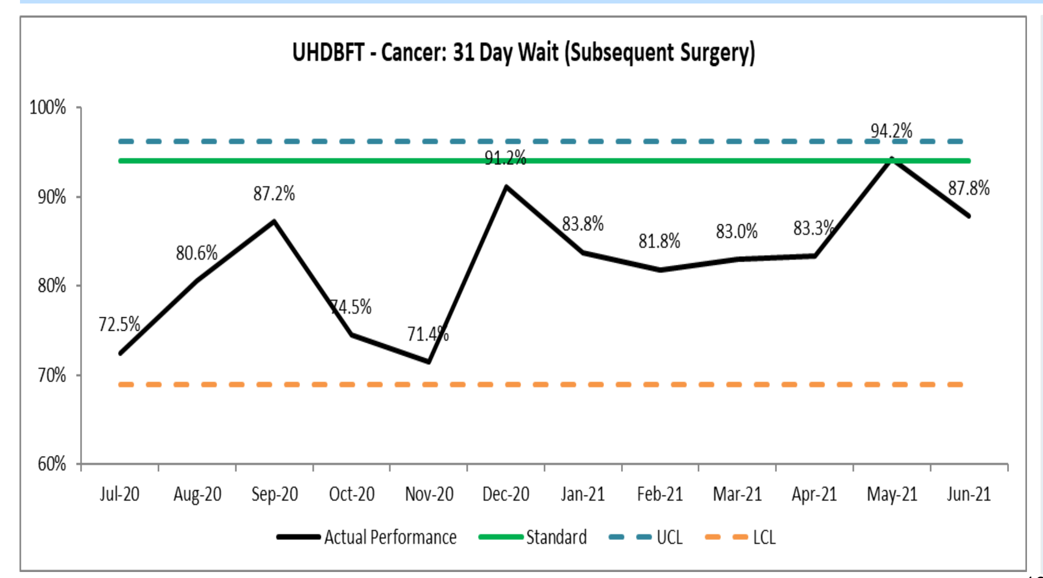
Performance Analysis

June performance at UHDB for 31 day from diagnosis to first treatment has reduced slightly to 93.7%, remaining non-compliant against the standard of 96%.

There were a total number of 397 patients treated in June along this pathway, increasing from the 340 treated in May. Of the 397 patients there were 372 patients treated within 31 days, resulting in 25 breaches.

The 25 breaches occurred in Breast(3), Gynaecology(5), Lower GI (5), Skin(2), Upper GI(1) and Urology(9). The majority of the breach reasons were due to Elective Capacity.

UHDB - CANCER WAITING TIMES – 31day to Subsequent Surgery



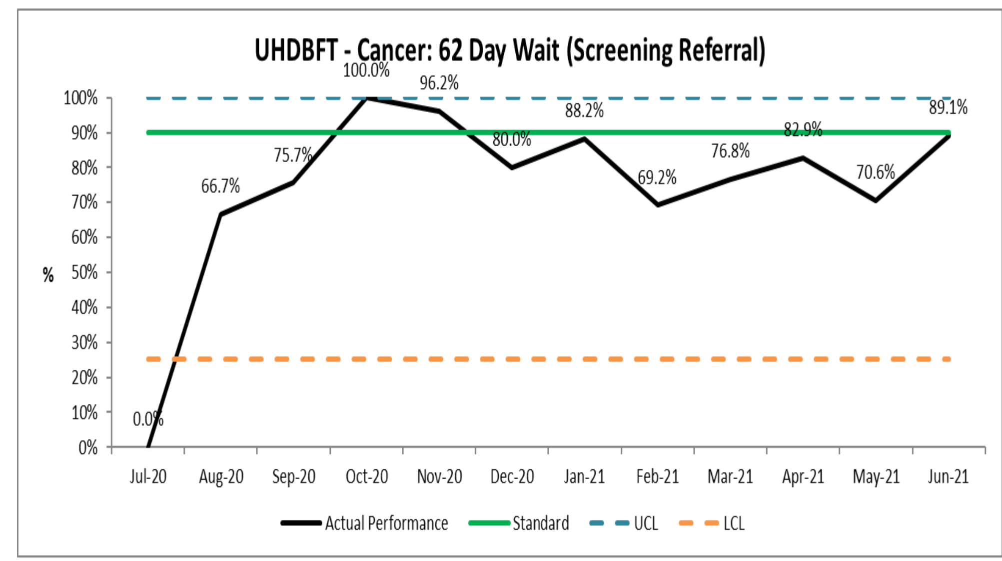
Performance Analysis

June performance at UHDB for 31 day to subsequent surgery has reduced to 87.8%, remaining non-compliant against the standard of 96%.

There were a total number of 41 patients treated along the subsequent surgery pathway in June. Of the 41 patients there were 36 patients treated for subsequent surgery within 31 days, resulting in 5 breaches.

The 5 patients waiting for treatment were treated within a range of 35 - 55 days. The breaches that occurred were as a result of Elective Capacity(2), Medical Reasons(2) and Patient Choice(1).

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



Performance Analysis

Performance in June at UHDB has improved to 89.1%, marginally being non-compliant against the standard of 90%. Had one more patient been treated the standard would have been achieved.

There were a total of 46 patients treated in June who were referred from a screening service with 41 of those patients being treated within 62 days, resulting in 5 breaches.

Of the 5 breaches, 1 occurred in in Gynaecology and 4 occurred in Lower GI. The breaches occurred as a result of Elective Capacity(2), Outpatient Capacity(1), Complex Diagnostics(1) and Healthcare Initiated Treatment Plan(1).

The number of days the patients breached ranged between 70 and 114 days.

Appendix

APPENDIX 1: PERFORMANCE OVERVIEW M3 – ASSOCIATE PROVIDER CONTRACTS

Provider Dashboard for NHS Constitution Indicators

	Area	Indicator Name	Standard	Latest Period	East Cheshire Hospitals: Direction of Travel	Current Month	YTD	consecutive months non-compliance	Nottingham University Hospitals: Direction of Travel	Current Month	YTD	consecutive months non-compliance
Urgent Care	Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	Jul-21	↑	59.3%	65.0%	37	A&E pilot site - not currently reporting 4 hour breaches			
		A&E 12 Hour Trolley Waits	0	Jul-21	↓	6	20	4	↓	74	79	1
Planned Care	Referral to Treatment for non-urgent consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Jun-21	↑	60.7%	56.4%	46	↑	70.3%	68.1%	21
		Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Jun-21	↓	422	3770	18	↓	3200	10390	15
	Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Jun-21	↓	32.71%	53.82%	16	↓	39.18%	41.33%	16
	2 Week Cancer Waits	All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	Jun-21	↓	62.4%	90.1%	4	↑	87.7%	85.9%	3
		Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	Jun-21	↑	31.5%	76.4%	4	↑	72.3%	60.5%	3
	28 Day Faster Diagnosis	Diagnosis or Decision to Treat within 28 days of Urgent GP, Breast Symptom or Screening Referral	75%	Jun-21	↓	67.2%	67.9%	3	↑	81.4%	80.0%	0
	31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	96%	Jun-21	↑	84.2%	92.1%	6	↓	86.3%	89.0%	27
		Subsequent Surgery Within 31 Days Of Decision To Treat	94%	Jun-21	↑	100.0%	92.3%	0	↑	70.8%	68.6%	38
		Subsequent Drug Treatment Within 31 Days Of Decision To Treat	98%	Jun-21	↔	N/A	100.0%	0	↓	98.3%	98.6%	0
		Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	Jun-21					↓	92.9%	94.0%	2
	62 Days Cancer Waits	First Treatment Administered Within 62 Days Of Urgent GP Referral	85%	Jun-21	↑	59.5%	63.0%	21	↓	70.0%	72.1%	15
		First Treatment Administered - 104+ Day Waits	0	Jun-21	↓	0.5	32.0	10	↑	21.0	57.5	63
		First Treatment Administered Within 62 Days Of Screening Referral	90%	Jun-21	↑	60.0%	75.8%	7	↑	70.4%	66.4%	7
		First Treatment Administered Within 62 Days Of Consultant Upgrade	N/A	Jun-21	↓	75.0%	86.9%		↑	79.5%	77.0%	
Patient Safety	Incidence of healthcare associated Infection	Healthcare Acquired Infection (HCAI) Measure: MRSA Infections	0	Jun-21	↔	0	2	0	↔	0	0	0
		Healthcare Acquired Infection (HCAI) Measure: C-Diff Infections	Plan	Jun-21	↑		9		↓		30	
			Actual				1	0			14	0
		Healthcare Acquired Infection (HCAI) Measure: E-Coli	-	Jun-21	↑	12	123		↓	56	168	
		Healthcare Acquired Infection (HCAI) Measure: MSSA	-	Jun-21	↑	5	46		↑	12	59	

Indicator Name	Sheffield Teaching Hospitals FT: Direction of Travel	Current Month	YTD	consecutive months non-compliance	Sherwood Forest Hospitals FT: Direction of Travel	Current Month	YTD	consecutive months non-compliance	Stockport FT: Direction of Travel	Current Month	YTD	consecutive months non-compliance
A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	↑	68.6%	74.0%	63	↑	86.2%	89.8%	9	↑	67.6%	73.0%	14
A&E 12 Hour Trolley Waits	↑	2	9	5	↑	0	5	0	↑	0	2	0
Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	↑	83.0%	82.1%	17	↑	68.9%	66.3%	46	↑	59.3%	58.1%	41
Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	↓	794	2671	15	↓	1142	3979	15	↓	3819	12107	38
Diagnostic Test Waiting Times - Proportion Over 6 Weeks	↑	14.16%	13.13%	16	↓	20.08%	22.73%	18	↓	44.11%	45.75%	24
All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	↑	82.0%	80.8%	3	↓	89.9%	93.2%	1	↓	97.4%	97.6%	0
Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	↓	2.7%	15.2%	3	↓	77.3%	94.3%	1	↔	N/A	N/A	0
Diagnosis or Decision to Treat within 28 days of Urgent GP, Breast Symptom or Screening Referral	↓	62.4%	63.1%	3	↓	80.2%	79.6%	0	↓	58.6%	59.1%	3
First Treatment Administered Within 31 Days Of Diagnosis	↑	93.0%	92.8%	3	↓	91.9%	95.1%	1	↑	98.0%	97.2%	0
Subsequent Surgery Within 31 Days Of Decision To Treat	↓	84.7%	84.4%	7	↔	100.0%	90.9%	0	↑	100.0%	93.5%	0
Subsequent Drug Treatment Within 31 Days Of Decision To Treat	↑	99.1%	98.8%	0	↓	66.7%	83.3%	3	↑	N/A	100.0%	0
Subsequent Radiotherapy Within 31 Days Of Decision To Treat	↓	97.9%	97.6%	0								
First Treatment Administered Within 62 Days Of Urgent GP Referral	↑	65.2%	60.8%	70	↑	71.8%	71.7%	18	↑	77.0%	77.9%	26
First Treatment Administered - 104+ Day Waits	↓	22.0	67.0	63	↑	6.0	18.5	38	↓	1.0	6.5	26
First Treatment Administered Within 62 Days Of Screening Referral	↑	80.9%	75.9%	7	↓	76.9%	82.7%	1	↓	50%	50.0%	1
First Treatment Administered Within 62 Days Of Consultant Upgrade	↓	81.6%	82.6%		↑	82.2%	78.9%		↑	89.6%	88.2%	
Healthcare Acquired Infection (HCAI) Measure: MRSA Infections	↔	0	0	0	↔	0	0	0	↔	0	0	0
Healthcare Acquired Infection (HCAI) Measure: C-Diff Infections (Plan)	↑		42		↔		21		↑		15	
Healthcare Acquired Infection (HCAI) Measure: C-Diff Infections (Actual)			26	0			8	0			9	0
Healthcare Acquired Infection (HCAI) Measure: E-Coli	↓	40	119		↑	24	84		↓	24	62	
Healthcare Acquired Infection (HCAI) Measure: MSSA	↑	17	48		↑	8	26		↓	7	18	

Governing Body Meeting in Public

2nd September 2021

ITEM NO: 133

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

Paper for:	Decision		Assurance	X	Discussion		Information	
Assurance Report Signed off by Chair				N/A				
Which committee has the subject matter been through?				Engagement Committee – 17.8.2021 Primary Care Commissioning Committee – 25.8.2021 Quality and Performance Committee – 26.8.2021 Finance Committee – 26.8.2021				

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 31st August 2021
- Appendix 2 which summarises the movement of all risks in August 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 31st August 2021.

The RR is a live management document which enables the organisation to understand its comprehensive risk profile, and brings an awareness of the wider risk environment. All risks in the Risk Register are allocated to a Committee who review new and existing risks each month and agree removal of fully mitigated risks.

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

The Derby and Derbyshire CCG attaches great importance to the effective management of risks that may be faced by patients, members of the public, member practices and their partners and staff, CCG managers and staff, partners and other stakeholders, and by the CCG itself.

All members of staff are accountable for their own working practice and have a responsibility to co-operate with managers in order to achieve the objectives of the CCG.
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?
Not applicable to this update
Has a Quality Impact Assessment (QIA) been completed? What were the findings?
Not applicable to this update
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
Not applicable to this update; however, addressing risks will impact positively across the organisation as a whole
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
Not applicable to this update
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Not applicable to this update
Have any Conflicts of Interest been identified/ actions taken?
Not applicable to this update
Governing Body Assurance Framework
The risks highlighted in this report are linked to the Derby and Derbyshire CCG Board Assurance Framework
Identification of Key Risks
The paper provides a summary of the very high scoring risks as at 31st August 2021 detailed in Appendix 1

NHS DERBY AND DERBYSHIRE CCG GOVERNING BODY MEETING

RISK REPORT AS AT 31ST AUGUST 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 – AUGUST 2021

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

Risk Register as at 31st August 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 August 2021	6	17	4	0	27
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, the movement in score and the rationale for the movement.

3. COMMITTEES – AUGUST VERY HIGH RISKS OVERVIEW

3.1 Quality & Performance Committee

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

1. Risk 001: *The Acute providers may breach thresholds in respect of the A&E operational standards.*

   The current risk score is 20.

   July performance:

   - CRH reported 93.3% (YTD 95.3%) and UHDB reported 69.9% (YTD 73.7%).
   - CRH - The volume of Type 1 attendances are approaching pre-pandemic levels, with an average of 202 attendances per day. However, July 2021 volumes were still around 93% of the July 2019 levels.
   - UHDB - Staff absence due to sickness is high, with around a third of sickness in the trust being due to Covid related sickness or isolation. This also affected DHU, resulting in the Urgent Treatment Centre (UTC) being unable to operate 24 hours every day.
   - The volume of Type 1 attendances is high, with an average of 348 attendances per day. As a network the numbers of attendances are at 95% of pre-pandemic levels by (July 2021 compared to July 2019).
   - The acuity of the attendances was high, with an average of 17 Resuscitation patients and 196 Major patients per day.
   - Attendances at Children's ED have rapidly increased, with concerns about RSV and bronchiolitis being major factors. Children's Type 1 attendances have averaged at 125 per day during July 2021 (compared to 94 per day in July 2019) with as many as 163 attending on one particular day (8th July).
   - SORG manages operational escalations and issues if required.
   - Meeting frequency has been stepped down from twice per week to weekly.
   - 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.

   July update:

   Current bed position:

   - CCG beds = 29 (Q2 2021/22 target 25).
   - Adult Specialised Commissioning = 17 (Q2 2021/22 target 17).
   - Children and Young People (CYP) specialised commissioning = 2 (Q2 2021/22 target 3).
   - The outcomes of the Derbyshire Learning Disability Autism Programme Diagnostic Review were presented to the Mental Health, Learning Disability & Autism Board. The key areas are:
     - Consensus on strategic vision and priorities
     - Project and Programme Management capability
     - Operating model and resource capacity
     - Workforce strategy, recruitment and retention
     - Engagement with Community Mental Health
     - Shift from intervention to preventative care
   - Chair & Senior Responsible Officer Mental Health, Learning Disability & Autism Board to write out to Derbyshire TCP System to provide support with additional capacity to core TCP team through establishment of a virtual team.

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.

   August update:

   - Three monthly assurance framework submissions continue and all providers are working to support increasing numbers of patients on the waiting lists.

- Twice weekly regional NHSEI meetings are in place.
- Communications strategy is in progress.
- The risk score remains the same.

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.

   The position for August mirrors the July update:

   July update:

   - There is an increasing demand and pressure General Practice are facing as lockdown measures are being relaxed and removed.

- Appointment levels are already higher than pre pandemic levels as well as Primary Care delivering 75% of the COVID vaccination programme to date largely through the existing workforce.
- A meeting with the CCG, LMC and GP Alliance took place in July which highlighted the significant concerns being reported in General Practice, the CCG were asked to reinstate the weekly sitrep that reports staff absences and RAG rating. The sitrep will provide an accurate picture of the situation in General Practice that can be reported into the wider system meetings to enable partners have a clear understanding of what is happening in general practice and how it can be supported. It will also support requests for additional funding and resources in Primary Care.
- No changes 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*

The current risk score is 20.

August update:

- JUCD FLU Planning cell set up to plan and provide oversight of the Flu Programme.
- JUCD moving into Phase 3 of the Covid Vaccination Programme/FLU programme whilst General Practice also working as business as usual. Demand on general practice is above pre pandemic levels.
- Risk description updated to include 2021/22 Flu Programme.

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.

August update:

July 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 4 the CCG is not experiencing any major financial pressures against planned expenditure with the exception of Continuing Health Care and the CCG continues to work with Midlands & Lancs Commissioning Support Unit and providers to rectify this.
- The CCG is reporting at month 4 a year to date surplus of £0.401m and have used £1,356m of the 0.5% contingencies.
- The forecast position is breakeven and uses £2.210m of contingencies along with anticipated allocations for retrospective Covid and Elective Recovery Fund.
- The CCG is also working with system partners to understand the recurrent underlying position and early work suggests there is a significant recurrent deficit.

4. RECOMMENDATION

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

- The Risk Register Report;
- Appendix 1 as a reflection of the risks facing the organisation as at 31st August 2021;
- Appendix 2 which summarises the movement of all risks in August 2021.

Derby & Derbyshire Clinical Commissioning Group

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

Risk Reference	Year	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk Rating: Probability	Initial Risk Rating: Impact	Initial Risk Rating: Rating	Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating: Probability	Previous Rating: Impact	Previous Rating: Rating	Residual/ Current Risk: Probability	Residual/ Current Risk: Impact	Residual/ Current Risk: Rating	Target Risk: Probability	Target Risk: Impact	Target Risk: Rating	Target Date	Link to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
01	21/22	The Acute providers may breach thresholds in respect of the A&E operational standards of 95% to be seen, treated, admitted or discharged within 4 hours, resulting in the failure to meet the Derby and Derbyshire CCGs constitutional standards and quality statutory duties.	Quality and Performance	Constitutional Standards/ Quality	3	4	12	Governance: - The CCG are active members of the Derbyshire A&E Delivery Board which has oversight and ownership of the operational standards. A performance dashboard has been produced to allow greater scrutiny of performance and any areas of concern to be highlighted and acted upon accordingly. - Providers update the OPEL reporting website daily by 11am and can escalate concerns and requests for support via the CCG urgent care team in hours, or the on-call director out of hours. - All providers participate in the COVID System Escalation Calls. - A robust Derbyshire System Winter Plan has been developed, and there will be an agreed process in order for this to be monitored and actioned throughout the Winter period - This will feed into the Derbyshire A&E Delivery Board. - Providers across the Derbyshire Health and Social Care System have now started to meet twice weekly as part of the System Operational Resilience Group. The purpose of this silver command level group is to co-ordinate and deliver the actions necessary to respond to significant issues which are affecting, or likely to affect, the functioning of an effective operation at a intra and inter sector level across the Health and Social Care System. This group reports into the System Escalation Group (SEC) which represents Gold Command.	Actions taken: - Review of the Directory of Services to ensure all appropriate patients go to UTCs rather than EDs - Imminent launch of the 111 First programme to move unheralded ED patients to more appropriate settings and embed a culture of patients calling 111 first - Work ongoing to develop digital consultations as part of the urgent care pathway - Enabling the direct booking of GP appointments via 111, when clinically appropriate and roll out of GP Connect to support this. - Increased Clinician to Clinician contact availability to assist EMAS clinical decision making and avoid unnecessary conveyances. - Identifying other failed pathway referrals that lead to unnecessary ambulance conveyances, forming a plan to remedy these. - Proactively manage High Intensity Users of urgent care to avoid their need to use emergency services. - Providing PCN-based enhanced care in Care Homes to improve quality and reduce unwarranted referrals. - Improving ambulance handover times through increased senior ownership within EDs and applying Releasing Time To Care principles in EMAS. - Expanding the mental health Crisis Service and enhancing the home treatment offer to improve gatekeeping. - Increasing A&E Mental Health Liaison team capacity to speed up response times. - Taking a system-wide approach to Same Day Emergency Care working to increase same-day discharges to improve patient flow. - Establishing an Orthopaedic Assessment Unit at RDH to treat patients in a more appropriate setting and improve flow. - Establishing a Surgical Assessment Unit at CRH to treat patients in a more appropriate setting and improve flow. - Increased GP Streaming at UHDB through commissioning changes and staff upskilling. - Embedding a weekly review process for patients with a length of stay of 21+ days in acute trusts. - Understanding Community demand and capacity to support the Improving Flow D2A pathways in South and City. - Increase OPAT capacity to enable more patients to be discharged from acute hospitals on IV antibiotics. - Altered handovers to enable more timely transfers from MAU/AAC to base wards at UHDB. - Same day emergency care (SDEC) and urgent treatment centre (UTC) pathways have been developed and in the process of increasing for EMAS to access, in order to reduce the number of patients directed to ED. - EMAS to undertake monthly audits with CRH and UHDB on patients that did not need to be conveyed to ED - in the process of starting to collate this data and then a system action plan will be developed, in order to make any necessary changes to reduce the number of unnecessary conveyances. - The SORG are currently reviewing the OPEL dashboard to support their operational discussion and to give a full picture on their operational resilience, which supports the system to understand where the pressures are, the impact this has and actions required to support. SEC stood down. SORG manages operational escalations and issues if required.	July 2021 performance CRH reported 93.3% (YTD 95.3%) and UHDB reported 69.9% (YTD 73.7%). CRH - The volume of Type 1 attendances are approaching pre-pandemic levels, with an average of 202 attendances per day. However, July 2021 volumes were still around 93% of the July 2019 levels. UHDB - Staff absence due to sickness is high, with around a third of sickness in the trust being due to Covid related sickness or isolation. This also affected DHU, resulting in the Urgent Treatment Centre (UTC) being unable to operate 24 hours every day. The volume of Type 1 attendances is high, with an average of 348 attendances per day. As a Network the numbers of attendances are at 95% of pre-pandemic levels by (July 2021 compared to July 2019). The acuity of the attendances was high, with an average of 17 Resuscitation patients and 196 Major patients per day. Attendances at Children's ED have rapidly increased, with concerns about RSV and Broncheolitis being major factors. Children's Type 1 attendances have averaged at 125 per day during July 2021 (compared to 94 per day in July 2019) with as many as 163 attending on one particular day (8th July). SORG manages operational escalations and issues if required. Meeting frequency has been stepped down from twice a week to weekly. GP Connect roll out complete enabling direct booking of GP appointments via 111.	5	4	20	5	4	20	3	3	9	On going	Linked to Strategic Aims 1, 2, 3, 4, 5	Aug-21	Sep-21	Zara Jones Executive Director of Commissioning Operations	Craig Cook Director of Contracting and Performance / Deputy Director of Commissioning Operations Jackie Carlile Catherine Bainbridge, Head of Urgent Care Dan Merrison Senior Performance & Assurance Manager
02	21/22	Changes to the interpretation of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) safeguards, results in greater likelihood of challenge from third parties, which will have an effect on clinical, financial and reputational risks of the CCG	Quality and Performance	Statutory/ Financial	3	3	9	•The implementation date for LPS to replace DoL has been deferred until April 2022. The new code of practice is not expected until mid 2021. Midlands and Lancs CSU continue to re-review and identify care packages that potentially meet the 'Acid Test' and the MCA/DoLS staff member is preparing the papers for the CCG to take to the Court of Protection as workload allows. • CCG DoL policy will be updated when the LPS Code of Practice is available. • The CCG is required to submit 100% health funded packages of care that meet the DoL threshold to the Court of Protection (CoP) authorisation, there is an agreement with the LA for the joint funded cases which the LA submit on both our behalves and charge the CCG 50% of the submission fee. There is a reputational risk to CCG if found guilty of an unauthorised DoL for someone in receipt of CHC funding with associated compensation costs. • Due to the delay in the implementation of LPS until April 2022 the CCG will continue to make applications under the existing Re X process. There is still a large backlog of cases that the Court of Protection have not yet processed. • The Designated Nurse for Safeguarding Adults continues to meet once a fortnight with Midlands and Lancs to discuss ongoing management of cases. •The Designated Nurse for Safeguarding Adults sits on the CSU Operational Group where any issues in relation to this work are raised.	The Re X DoLS Options Paper was agreed by the December Governing Body meeting and is now being implemented. A further paper was taken Q & P to seek permission for the Safeguarding Adults Team and the CSU MCA/DoLS worker to submit Re X DoLS applications that are 100% funded directly to the CoP. This has been agreed and a framework for this to happen is being developed. The Safeguarding Adults Team continue to develop a framework for this to happen. This has been agreed and a framework for this to happen is being developed and an account with the COP has been set up.	January 2021: There is a current back log of Re X applications. February 2021: No change to the position for February. March 2021 Additional funding has been allocated from the CHC budget to allow recruitment of a band 6 nurse and an admin post to support the clearing of the backlog of Re X applications. Posts will be effective from April 2021 08.04.21 Risk still the same at the moment as new staff not yet in post. 17.05.21 Band 6 and Band 3 posts recruited to. June: There is no change to the risk grading the rationale being that it is an ongoing piece of work. Later in the year when we have more applications made there is the possibility that the risk grading can be reduced, but not currently. July: The CSU has received additional funding from the CCG to assist in clearing the backlog of Re X cases that we have that need to go to the CoP. The risk grading is stagnant as there is not enough movement in relation to this yet to be able to bring the risk down. August - No change	3	4	12	3	4	12	3	3	9	October 2021	Linked to Strategic Aims 1, 2, 3, 4, 5	Aug-21	Sep-21	Brigid Stacey - Chief Nursing Officer	Bill Nicol, Head of Adult Safeguarding Michelle Grant, Designated Nurse Safeguarding Adults/MCA Lead
03	21/22	TCP unable to maintain and sustain performance, pace and change required to meet national TCP requirements. The Adult TCP is on a recovery trajectory and rated amber with confidence, whilst CYP TCP is rated green. The main risks to delivery are within market resource and development with workforce provision as the most significant risk for delivery.	Quality and Performance	Quality/ Reputational	3	4	12	• System leadership group meets bi-monthly to review performance and address system issues, chaired by DHcFT SRO. • System wide plan developed identifying priorities for joint action and delivery • Additional funding and capacity in place for crisis response and forensic • Quality standards in place within contracts for NHS providers monitored quarterly at CQRG • Investment in Speech and Language Therapist for mental health wards to improve formulation in mental health care. • System Recovery & Restoration Plan implemented and ongoing • Weekly Discharge Review meeting to seek assurance against agreed trajectories • LD,MH,Autism delivery group have established a Provider development task and finish group to oversee the work to improve the capacity and resilience of local providers. - LD-A (Learning Disability and Autism) Delivery Group Meeting meet bi-weekly to monitor implementation of the seven 'lanes' on the improvement plan, with leads identified for the each workstream. - Weekly reconciliation meetings with DHcFT to ensure that admissions are appropriate with regards to confirmed diagnosis. - Mental health in-reach secondment: Funding agreed to establish a temporary in-reach post to acute mental health wards from Dec 2020 – May 2021. - Proposal to enhance the Derbyshire Autism offer: The System Delivery Board (via TCP SRO and Director of Quality) has requested a costed options proposal. This will go to the December meeting - Interim services to support Autistic people scoped and provided. The temporary secondment post and Case Managers will enhance oversight for people admitted with an ASD diagnosis. - Monthly NHSE/I regional Escalation assurance meetings - Weekly DDCCG TCP meeting • Derby and Derbyshire all-age Dynamic Support Register (DSR) for people with a formally diagnosed Learning Disability and/or Autistic Spectrum Disorder implemented • Weekly 1:1 – TCP Programme manager and NHSE TCP Lead Nurse • Covid-19 – impacting on transitions from Locked Rehab hospitals into community placements causing delays in discharges. Alternative transition planning being explored, • Case Managers redeployed to support DHcFT services – each Case Manager redeployed for 2 days per week to ensure they are able to continue to support case load.	TCP Recovery Action plan developed and monitored weekly: - Revised assurance systems and processes led by new TCP Programme Manager (Discharge Review Meeting (DRM), weekly NHS Provider meetings, appointment of two CCG Case Managers) - Mental health in-reach role: establish a temporary in-reach post to acute mental health wards from November 2020 – May 2021. - Weekly procurement updates: Multi agency weekly meetings with providers developing new services in Derbyshire led by Local Authority. - NHSE training sessions and case reviews for Ministry of Justice (MoJ) cases with Christine Hutchinson. - 1:1 support for TCP Programme Manager Admission avoidance - Proposal to enhance the Derbyshire Autism offer: The System Delivery Board (via TCP SRO and Director of Quality) has requested a costed options proposal is submitted to the group in December 2020. - Local Area Emergency Protocol (LAEP) notifications: It is an expectation that LAEPS are requested as part of meeting national and contractual expectations to notify about potential admissions. - Strengthen management of people in distress: These will focus on detailed review of care plans and provision for people with previous high levels of admissions & development of the Dynamic Support Register - Review of short breaks provision. - New Strategic Commissioner posts	Current bed position: CCG beds = 29 (Q2 2021/22 target 25) Adult Specialised Commissioning = 17 (Q2 2021/22 target 17) Children and Young People (CYP) specialised commissioning = 2 (Q2 2021/22 target 3) The outcomes of the Derbyshire LDA Programme Diagnostic Review were presented to the MH, LD&A Board. Key areas: - Consensus on strategic vision and priorities - Project and Programme Management capability - Operating model and resource capacity - Workforce strategy, recruitment and retention - Engagement with Community Mental Health - Shift from intervention to preventative care Chair & SRO MH, LD&A Board to write out to Derbyshire TCP System to provide support with additional capacity to core TCP team through etablishment of a virtual team TCP remains on national escalation with regular calls with NHSE. Whilst a lot of work is being done there won't be a significant impact until the IST teams are recruited into for the revised autism offer. This is due to commence August this year. Therefore the risk score will remain the same.	5	4	20	5	4	20	2	3	6	tbc	Linked to Strategic Aims 1, 2, 3, 4, 5	Aug-21	Sep-21	Brigid Stacey - Chief Nursing Officer	Helen Hipkiss, Deputy Director of Quality / Phil Sugden, Assistant Director Quality, Community & Mental Health, DCHS
04A	21/22	Contracting: Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care. There are 112 GP practices in Derbyshire all with individual Independent Contracts GMS, PMS, APMS to provide Primary Medical Services to the population of Derbyshire. Six practices are managed by NHS Foundation Trusts and one by an Independent Health Care Provider. The majority of Derbyshire GP practices are small independent businesses which by nature can easily become destabilised if one or more core components of the business become critical or fails. Whilst it is possible to predict and mitigate some factors that may impact on the delivery of care the elements of the unknown and unexpected are key influencing dynamics that can affect quality and care outcomes. Nationally General Practice is experiencing increased pressures which are multi-faceted and include the following areas: *Workforce - recruitment and retention of all staff groups *COVID-19 potential practice closure due to outbreaks *Recruitment of GP Partners *Capacity and Demand *Access *Premises *New contractual arrangements *New Models of Care *Delivery of COVID vaccination programme	Primary Care Commissioning	Primary Care	5	4	20	Early warning systems: CCG works with LMC and other partners to systematically identify and support practices that may be in trouble, including: reviewing information on practice performance via an internal, cross directorate review of practices looking at a range of data sources; linking with the LMC to pool soft intelligence on practice 'health' and to jointly support struggling practices; directly approaching practices identified as at risk CCG support: CCG commissions and funds a range of supportive measures designed to increase the resilience of General Practice, in line with the GP Forward View and GP Contract. Key working groups and committees have been established to support the delivery of the work programmes, these include: *Primary Care Leadership Committee *Primary Care Workforce Steering Group - sub group GPN 10 Group *Primary Care Estates Steering Group *General Practice Digital Steering Group The groups have a wide range of objectives and outcomes to mitigate this corporate risk, these include , managing allocation and monitoring of additional funding to support the PC workforce (recruitment and retention, new roles) Funding of practice nurses to promote the National GPN , work with CCG nursing team. Identification and delivery of training to support and improve GP practice resilience; funding increased capacity; supporting practices to manage workload, development of leadership[p roles. Utilisation of the GP Task Force and Health Education Derbyshire to support the delivery of these objectives Peer support: the Primary Care Networks will provide a way that practices can support each other in smaller groups. Over time this will provide a safe forum for practices to seek help from peers and another route for help for struggling practices who are not willing to approach the CCG directly Strategy: implementation of the CCG's primary care strategy will bring additional resources, capacity and support to General Practice, and develop its role at the centre of an integrated system, thus increasing resilience and mitigating against individual practice failure. The CCG has financially supported the development of the GP alliance, who have supported the development of the PC strategy and are also undertaking a review of PC demand and capacity in order to have a understanding of access to Primary Care in Derbyshire .	The Derbyshire wide Primary Care Strategy agreed and in place. Primary Care Networks (PCNs) established county wide. PCNs undertaking self-diagnostic to establish current position and development needs. Funding identified to support development. First cross directorate review meeting of practice data set for September. Primary Care Team to continue to work closely with practices to understand and respond to early warning signs including identification of support/resources available including practice support in discussions around workload transfer from other providers. Derbyshire wide Primary Care Commissioning Committee to oversee commissioning, quality and GPFV work streams. Assurance provided to NHS England/JUCD through monthly returns and assurance meetings.	19.10.20 Increasing COVID-19 activity in primary care. National portal now live for practice orders for PPE. From 1 October 2020, CCG continuing to reimburse additional cleaning costs and also COVID19 absence in practices where backfill is required for face to face appointments and roles. OPEL reporting being developed for primary care. Winter plan submitted for additional resource to support red hubs / activity. Risk remains the same and will be reviewed at PCCC on 28th October 2020 9.11.20 Letter from NHSE/I to outline draft enhanced service for COVID vaccine. In addition, £1.3million funding allocated to the CCG to support General Practice in additional capacity which will also support COVID vaccine rollout. Practice outbreaks are starting to be seen with business continuity plans enacted. Risk mitigated through the additional staffing to cover COVID absence. December - There are no changes to the existing levels of risk for this month. The pressures on Primary Care and General Practice remain the same along with the challenges of COVID-19 vaccine programme and whilst there are mitigations around the additional funding for general practice the risks remain the same as reported in November 2020. February 2021 - There are no changes to the existing levels of risk for this month. CCG letter and guidance issued 8th January 2021 which summarised the CCG position and support available to practices, locally, nationally and from the Derbyshire system. This included a comprehensive guidance document detailing all the available funding streams, income protections and additional resource available to our practices. NHS E/I issued a letter dated 7th January 2021 which recognises the pressure this puts practices and PCNs under and sets out the steps to be taken to free up practices to enable prioritisation of the Covid-19 vaccination programme. July no change to risk score. There is an increasing demand and pressure General Practice are facing as lockdown measures are being relaxed and removed. Appointment levels are already higher than pre pandemic levels as well as Primary Care delivering 75% of the COVID vaccination programme to date largely through the existing workforce. Following a meeting with the CCG, LMC and GP Alliance in July highlighting the significant concerns being reported in General Practice the CCG were asked to reinstate the weekly sitrep that reports staff absences and RAG rating. The sitrep will provide 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. It will also support requests for additional funding and resources in Primary Care. The CCG has also recommenced the 'battle box service' that was available through previous waves of Covid to provide temporary loans of equipment to GP Practices who need a rapid response to enable their staff to work remotely. No changes to the existing levels of risk this month. August - No change this month.	4	4	16	4	4	16	4	3	12	On going	Linked to Strategic Aims 1, 2, 3, 4, 5	Aug-21	Sep-21	Dr Steve Lloyd - Medical Director	Hannah Belcher, Head of GP Commissioning and Development (Primary Care)
04B	21/22	Quality: Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care. There are 112 GP practices in Derbyshire all with individual Independent Contracts GMS, PMS, APMS to provide Primary Medical Services to the population of Derbyshire. Six practices are managed by NHS Foundation Trusts and one by an Independent Health Care Provider. The majority of Derbyshire GP practices are small independent businesses which by nature can easily become destabilised if one or more core components of the business become critical or fails. Whilst it is possible to predict and mitigate some factors that may impact on the delivery of care the elements of the unknown and unexpected are key influencing dynamics that can affect quality and care outcomes. Nationally General Practice is experiencing increased pressures which are multi faceted and include the following areas: *Workforce - recruitment and retention of all staff groups *COVID-19 potential practice closure due to outbreaks *Recruitment of GP Partners *Capacity and Demand *Access *Premises *New contractual arrangements *New Models of Care *Delivery of COVID vaccination programme *Restoration and Recovery *2021/22 FLU Programme	Primary Care Commissioning	Primary Care	4	5	20	Primary Care Quality Team: team providing monitoring of and support to practices county wide, proactive and reactive, direct contact available to practices to clinical team members, via telephone and email, for advice and support of any clinical queries and patient safety issues. Communication pathways established including membership bulletin, Information Handbook, web site development and direct generic inbox Primary Care Quality and Performance Committee: The Committee will oversee monitoring support and action plans for the delivery of Primary Medical Services, gain assurance regarding the quality and performance of the care provided by GP practices, identifying risks to quality at an early stage. Monthly meetings established. Cross directorate internal review (hub) process - Primary Care Quality dashboard and matrix developed, discussed monthly at Hub meeting, integration, sharing and triangulation of PC data from Primary Care Quality, Contracting and Transformation. Provides the opportunity to oversee multiple data sources and gain information from wider CCG teams in order to gain collective view on quality of care offered and to identify areas of best practice and areas of concern where support or intervention is needed. Provides the opportunity to review and create action plans to support practices who may be experiencing / demonstrating difficulty or signs of potential deficit in quality or unwarranted variation of care provision. Supporting Quality Improvement visits:18 month rolling programme of practice visits with a focus on quality and support is being delivered, this provides the opportunity of direct clinical face to face discussion between individual GP practices and CCG. Provides an safe opportunity to discuss individual practice quality metrics and for the practices to highlight / raise any issues or concerns directly to the CCG. Clinical Governance leads meetings: Established and held quarterly across Derbyshire PCN footprint, provides the interface between CCG and individual practices, opportunity to share best practice, practice concerns, learning and recommendations, support the implentation of GP practice governance. Quality Schedule: being developed as part of the enhanced service review to provide a formal mechanism to contract for improved quality standards in areas such as sepsis and safeguarding - following model developed with acute and other provider organisations. Primary Care Quality Schedule Included (October 2021) to DCCG Commissioned Primary Care Contracts, to maintain and support the delivery of continuous quality improvement in Primary Care. JUCD FLU Planning cell set up to plan and provide oversight of the Flu Programme.	Primary Care Quality Team now fully recruited to and delivering on quality programme including SQI visits. Continuing work to track and support quality of General Practice - Primary Care Quality and Performance Committee established and functioning well. Work is ongoing on development of quality schedule. Production of a Primary Care dashboard being finalised, review of quality reporting methodology and governance structures to PCCC being undertaken. Primary Care Dashboard and Matrix established. Supporting Governance Framework implemented. July: Continuing work to track and support quality of General Practice - Primary Care Quality and Performance Matrix in place and reviewed monthly. Primary Care Quality and Performance Sub Committee re established June following return to BC3, supported by an escalation methodology to ensure consistency and timeliness of response. Hub (pre meet) also established and working well to support the identification of concerns/ triangulate information across the CCG/ national data.	• A range of mitigations have been put in place both Nationally and Locally to support general practice; Local services include • Red hubs and red home visiting service; • DHU support for practices to provide cover Long COVID pathway development System support to deliver COVID vaccination programme Intelligence both qualitative and quantitative continues to be captured to both support and monitor care provided by general practice from both a contractual and quality perspective Whilst the Primary Care Quality and Performance committee has been stepped down due to the level four CCG pandemic response a monthly meeting to determine / highlight any new risks / emerging themes continues. Any actions from this will be addressed with individual practices as required . Reporting arrangement will be undertaken directly to PCCC March - no change 08.04.21 GP services are moving towards recovery and restoration including reinstatement of CQC inspections, the risk will continue to be reviewed and amended as required. May update: Primary Care Performance and Quality Committee and monthly PC Hub meetings re starting June Practice Quality Visits re commencing July Clinical Governance Leads Meetings re starting July / August CQC Inspections commenced April June - No changes this month. July - Quality Assurance visits planned to re commence in September, practices in the process of being booked in, visiting GPs in place and new supporting agenda in place to reflect restoration/ recovery and available data. Clinical Governance leads meetings restarting July. CQC Refresh events delivered July to support general practice awareness of new visiting regime and preparation for CQC inspections. August - JUCD moving into Phase 3 of the Covid Vaccination Programme/ FLU programme whilst General Practice also working as BAU. Demand on general practice is above pre pandemic levels	4	5	20	4	5	20	4	4	16	On going	Links to Strategic Aims 1, 2, 3, 4, 5	Aug-21	Sep-21	Dr Steve Lloyd - Medical Director	Marie Scouse, Assistant Director of Nursing & Quality - Primary Care 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.	Quality and Performance	Patient Experience/ Quality	4	3	12	A national mandated programme of community delivery with specific recommendations for psychological therapies is expected. This will change how DDCCG commissions current services and stopped the planned STP Psychological therapies review. . For children there are growing waits from assessment to psychological treatment .Some investment is being made through core CAHMS investment in 2019 and 2020 in both CRH and DHCFT CAHMS linked to waiting times. A newly commissioned targeted intervention service was introduced in June 19 and digital offer for cyp in September 19 (KOOTH) . Funding for wave 2 Transformation from NHSE to support MH in school was successful with an intended start date of may 2020. A service for Looked after children was due to start in May 2020. These initiatives are intended to provide support without CAHMS being required to help manage waits. COVID 19 has reduced face to face therapies and increased waits delayed recruitment and investments and wait times have become longer. This is a concern raised by safeguarding board and partners and children's commissioner for England.	Once national research and guidance released recommission DHCFT to deliver services to new model. Continue to monitor within contract meetings once these are restarted. For children introduce increased digital offer during pandemic . Consider Further services to manage expected demand when schools return in September 20202. Progress CAHMS review to a JUCD plan of improvement with if necessary provider improvement plans. report to safeguarding board and JUCD in September 20. Report to CLC on COVID19 arrangement analysis and potential mitigations .	May update The pathway to Helios is being finalised and CBT pathway incorporated. CYP transformation plan submitted and signed off . This supports psychological therapy wait times as without this support, wait times would have increased for adults still further. The expected delivery of a significant reduction of wait times has been put back to April22. This is because for CYP the COVID impact of increased referral rates and COVID delayed impact of wait time initiatives in 2020. For adults the impact of Community Mental Health Framework on psychological therapies will take a 3 year period to be realised in LTP. June update -Overall situation as described in May . Helios initiative has started , significant investment in CYP crisis developments agreed in financial return. Workforce will be a significant issue in delivery. Regional review of sexual violence services has been commissioned by NHSE&I that will help inform our Derbyshire approach. Expressions of interest in regional resource to review waiting lists for CYP neurodevelopment and look to alternative pathways is being pursued. July Update as June but note Helios unable to provide as much CBT intensively over 6month period as initially planned due to national demand. August ,DHcFT have produced outline plan for reducing waiting list for CAHMS . Being considered in CYP MH planning sub group. recommendations to MH,LDA AND CYP Board in September.	4	3	12	4	3	12	3	3	9	Sept 21	Links to Strategic Aims 1, 2, 3, 4, 5	Aug-21	Sep-21	Zara Jones Executive Director of Commissioning Operations	Dave Gardner Assistant Director, Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning
06	21/22	Demand for Psychiatric intensive Care Unit beds (PICU) has grown substantially over the last five years. This has a significant impact financially with budget forecast overspend, in terms of poor patient experience , Quality and Governance arrangements for uncommissioned independent sector beds. The CCG cannot currently meet the KPI from the Five year forward view which require no out of area beds to be used from 2021.	Quality and Performance	Commissioning	5	3	15	Beds commissioned on block and to be extended for a further year. STP developing a plan for Derbyshire PICU. Use has escalated during COVID19 and funding recoverable from COVID funding this therefore has resulted in no change to the financial risk despite numbers doubling to 24 from 12. However plans will need to be in place to ensure numbers return to agreed baseline. 07.08.20 Length of stay rising is a factor in increased use mitigated by reduced use of additional observations. DHCFT have submitted 250M capital funding Bid to national capital scheme. this includes a new build PICU for men. Options for Women will need to be considered within the estate changes made possible if the bid is successful.	Continue to Explore regional options for bed optimisation being taken forward with clinical network DHcFT to take a lead provider role . OOA bed reduction plan to include PICU and manages through STP. Report on Options for Derbyshire PICU and controls to be brought back to DDCCG in September, Ensure plan in place to reduce PICU usage post COVID. Ensure that DHCFT returns patients back to Derby as soon as possible. Maintain reduced additional observation costs with continued provider challenge. 07.08.20 Issue raised in MH recovery Cell . short life group formed to address . Report on Options for future dependent on outcome of 250Mcapital bid. Subgroup of recovery cell to produce plan to reduce numbers . Finance teams to discuss how COVID funding arrangements can be taken forward with DHcFT as "top up funding" announced in phase 3 arrangements may be linked to provider costs not CCG costs. This is being investigated further.	April update. PICU bed use is within expected trends . All beds are still classed as out of area and will be until procurement is completed in June 21 and contract mobilised. DDCCG and JUCD will not meet Kpi for no OOA beds until contract mobilisation. DHcFT proceeding with plans for Derbyshire PICU unit on Kingsway site. Risk rating reduced to 6 ,as financial risk reduced and patient care is sub optimal in terms of OOA but numbers reduced and pathway being managed with improved monitoring of LOS and repatriation. May Update - procurement window closed for PICU block beds and framework. Limited market response unlikely to resolve OOA PICU without an alternative sourcing strategy for PICU to be drawn up during MAY. NHSE/I will probably need a RAP June update As suspected the provider market has changed since the market test in part due to NHSE&I policy. We have met with NHSE&I and agreed we will seek closest possible bed to Derbyshire that meets quality requirements as an interim measure. Options on how to take this forward are being explored but further procurement is likely. Remains a risk against delivery of no beds by last quarter 2022 which is revised objective -for delivery from NHSE&I July - July Update as June .Options to take forward PICU following the market response in procurement being considered. Risk score increased to reflect the increased risk against KPI for no out of area PICU for last quarter following procurement .The risk has increased as a consequence of procurement not meeting our needs as desired and therefore possibility increasing of failing to meet the national requirement by quarter 4 which is on the risk scale a 4 now 12 not 9. August update Papers on procurement outcome and proposals for next steps to come to CLCC. Concerns remain as for July depending on outcome of search for provider who can meet quality requirements .	3	4	12	3	4	12	2	3	6	Dec 21	Links to Strategic Aims 1, 2, 3, 4, 5	Aug-21	Sep-21	Zara Jones Executive Director of Commissioning Operations	Dave Gardner Assistant Director, Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning

Risk Reference	Year	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk Rating: Probability	Initial Risk Rating: Impact	Initial Risk Rating: Rating	Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating: Probability	Previous Rating: Impact	Previous Rating: Rating	Residual/ Current Risk: Probability	Residual/ Current Risk: Impact	Residual/ Current Risk: Rating	Target Risk: Probability	Target Risk: Impact	Target Risk: Rating	Target Date	Link to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
09	21/22	Sustainable digital performance for CCG and General Practice due to threat of cyber attack, network outages and the impact of migration of NHS Mail onto the national shared tenancy. The CCG is not receiving the required metrics to provide assurance regarding compliance with the national Cyber Security Agenda, and is not able to challenge any actual or perceived gaps in assurance as a result of this.	Governance	Corporate	3	4	12	• NECS receive and acts on CareCERT alerts, received in response to NHS Digital monitoring of threats to the external system. Actions taken are reported via the NECS contract management meetings, and escalated to the Digital Lead where required. • The network infrastructure is proactively monitored and anti-virus signatures are maintained adequately. • NECS actively provide compliance evidence for the DSPT and provides assurance to the CCG regarding network security. • The Governance Committee has responsibility to oversee the arrangements for ensuring that technology is secure and up-to-date and IT systems are protected from cyber threats. • The NECS contract management board receives routine assurance reports regarding cyber security preparedness and resilience. • Hygiene reports (progress against technical security measures) are provided to the NECS contract management board The CCG has agreed a local policy for the shared tenancy and Microsoft Office 365 that seeks to prevent the introduction of new functionality into Microsoft Teams and other associated software until the business case has been proven that this functionality would be beneficial and until such time as the Governance is in place. Where changes are known in advance, these are communicated to staff appropriately including the effect of the change. The CCG are also working with NECS to develop system policies at the local level to allow as much local control over changes as is feasible while feeding back to the national teams. Our CCG is also two/three weeks behind the rollout in other NECS Customers to enable us to learn lessons from their experiences and adjust accordingly.	CCG proposes to work closely with cyber awareness training provider / Cyber Resilience Support team which may include identification and recommendations of cyber issues that may impact on cyber security, for example developing and implementing further strategies and policies - and identification of practical opportunities where necessary to support operational awareness. Development of local policies and working with the national team to devolve as much responsibility as possible to the local level thereby allowing us to have more control over the deployment, removal and changes to functionality within the Microsoft Teams and other environments linked to the NHS shared tenancy and Microsoft Office 365. Additionally, the migration of the CCG and colleagues within General Practice away from the previous NHS Mail system and onto the NHS' national shared tenancy brings both benefits and risks. While there are economies of scale and additional functionality available, there is a lack of control over the launch of new functionality and removal of existing functionality. This has been reflected in the configuration issues between settings at the national and local level, leading to a temporary pause in the deployment of Microsoft Office 365 within Derby & Derbyshire until these are remedied.	11.03.21 - We are assured that recent CareCERT that have been issued by the NHS Digital Data Security Centre have been implemented in an appropriate timescale and we await the completion of the rollout of Microsoft Office (N)365, Cisco ISE and the NHS Digital tools. As these systems begin to deploy, we will be able to reduce the risk, but until that point we suggest these remain in their current position. 21.04.21 - Preparatory work has begin for the upgrade to the CheckPoint system; this was due to be implemented last week, but required further change which had not previously been within scope. Full deployment of Microsoft Office 365 has begun with the Corporate estate, removing the risks relating to Microsoft Office 2010, but this is not yet complete. As with the previous update, deployment is more advanced than the last update, but are not yet fully implemented and hence the scores remain the same. 18.05.21 - CheckPoint VPN upgrade is underway and over 50% complete; the Cisco ISE endpoint protection has also been procured and deployment is starting. GP Practices are being booked in for their Microsoft Office 365 upgrade and currently around 40% of CCG devices have been updated. There are no Windows 7 devices left - all devices are Windows 10 and running advanced threat protection. There are no specific additional risks, but will look to reduce the score once all of the mitigation has been implemented. 14.06.21 - CheckPoint VPN upgrade has been completed and a timetable for Cisco ISE endpoint protection agreed. Deployment of Office 365 continues across GP and CCG devices and the CCG is going through the process of re-accreditation for Cyber Essentials with a view to securing Cyber Essentials Plus. We are aware of extended support arrangements that have been put in place with Microsoft for additional Windows 10 support and the local NECS team are in the process of upgrading all Windows 10 devices to the latest version of the applicable by the end of June 2021. 12.07.21 - No evidence of the recent (and ongoing) distributed denial of service attack penetrating any of our networks or devices and NECS has confirmed that geo-blocking is in place to prevent connections from countries and areas known to be active in attacks such as these. We are continuing to work with NECS on the 'PrintNightmare' vulnerability and we have tracked this from initially being of low significance to requiring action. NECS has mitigated the risk by removing the printing function from all unnecessary devices, but to fully resolve the issue we would need to suspend all printing from all devices which is impractical. We therefore continue to scan all devices connected to the network for any signs of the vulnerability being utilised - if found, the device will automatically be isolated from the network and NECS alerted. To date, there have been no exploitations identified within the CCG or Primary Care. Risk remains the same, as there is the risk of exploitation, but no evidence of this being exploited - similar to the scenario with Microsoft Office 2010. 17.08.21 - We have agreed an initial reporting procedure with NECS for the communication of any high level or escalating CareCERT alerts accompanied by appropriate assurances and mitigations; this allows the CCG to be aware of all potential threats and to manage those risks in tandem with NECS and assurances that alerts are being appropriately responded to. We have also subscribed to the NHS Digital CareCERT data feed to ensure that we also receive any low level or for information alerts so that these can be assessed and raised with NECS and/or through appropriate internal routes as appropriate. The risk continues to be low.	2	4	8	2	4	8	1	4	4	No target date added as Cyber Security is a continuing risk/threat and will need to be reviewed constantly	Links to Strategic Aim 4	Aug-21	Sep-21	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Ged Connolly-Thompson - Head of Digital Development / Chrissy Tucker - Director of Corporate Delivery
10	21/22	If the CCG does not review and update existing business continuity contingency plans and processes, strengthen its emergency preparedness and engage with the wider health economy and other key stakeholders then this will impact on the known and unknown risks to the Derby and Derbyshire CCG, which may lead to an ineffective response to local and national pressures.	Governance	Corporate	4	4	16	• CCG active in Local Health Resilience Partnership (LHRP) and relevant sub groups • On-call staff are required to receive Met Office Weather Alerts. These will be cascaded to relevant teams who manage vulnerable groups • Executive attendance at multi agency exercises. • Internal Audits have evaluated Business Continuity preparedness. • Derbyshire-wide Incident Plan in existence • Joint Emergency Services Interoperability Protocol (JESIP) training made available to on-call staff • Staff member trained in Business Continuity and member of professional body • Staff member competent to train Loggists internally and there are sufficient number now trained • Derby and Derbyshire CCG represented on LHRP and LRF sub-groups including, HEPOG, Training and Exercising sub-group. Risk Assessment Working Group, LRF Tactical, Human Aspects and Derbyshire Health Protection Response Group. • On-call rota being revised to introduce two tier system with improved resilience • Comprehensive training undertaken for On-call staff to National Standards Accountable Emergency Office and Deputy AEO attended EU Exit conference 17th September 2019 • On Call Forum has been established and has held productive meetings sharing knowledge and experience • Table top exercise took place in December 2019 to test the robustness of the CCG response to IT and Telephony failure and to Fuel Shortage leading to improvements in processes and procedures • CCG participating in local response to Coronavirus risks as part of the Derbyshire LHRP system following national guidance from PHE. • The Director of Corporate delivery and the Business Resilience manager took part in a national seminar Effective Communication Around Major Incidents Digital Forum on Friday 16 October, 2020. • The Director of Corporate Delivery and the Business Resilience Manager took part in a national seminar EU Exit End of Transition period workshop on 04 November 2020. This has resulted in key areas of work being identified and CCG Leads mobilised to provide a response • Senior Responsible Officer for EU Exit designated for the CCG and contact details made available to NHSEI • EU Exit now a standing item on weekly SEC Meetings	• Practices updating Business Continuity Plans to include consistent contact details for CCG in-hours and out of hours. • Business Resilience Manager developed a single operational Business Continuity Plan. This will now be reviewed in the light of learning from the COVID pandemic. • Confirm and challenge meeting with Providers and NHSEI took place on 2nd October 2019 and agreement reached with Providers on final level of assessment against the core standards. • CCG on call arrangements reviewed and CCG is operating a 2 tier on call system. Training has been provided to all on call staff from November to March 19. • Accountable Emergency Office and Deputy AEO attended EU Exit conference 17th September 2019, to gain assurance on EU Exit assurance • CCG took part in daily SitRep reporting to NHSE until stood down on 28 October 19. • CCG provided exception reports on EU Exit through Local Resilience Forum. • Derbyshire System wide EU Exit Plan developed and distributed to Providers • Two "dry runs" at preparing for EU Exit date puts the CCG in a stronger position • Business Impact Assessments for each function within the CCG have been completed and approved the Governance Committee in March 2020. • Lessons learned from Toddbrook Reservoir will be incorporated into the Business Continuity plan when the EPRR review becomes available. • A review of the recent power outage situation at Cardinal Square is scheduled this month (November) and lessons learned incorporated into the Business Continuity Plan. • The On Call Forum has met regularly and has provided an opportunity to share experience and knowledge • The CCG has fully participated in the response to the COVID pandemic and submitted evidence to NHSEI as part of the 2020/21 EPRR National Core Standards • Continued collaborative working with Provider organisations and other stakeholders including the LRF and NHSEI Regional teams	• CCG and Derbyshire Provide Annual Assurance 20/21 lessons learnt during first wave of COVID -19 and preparedness for Winter Planning process currently being undertaken, deadline for submission to NHSE is 31st October 2020. • CCG is working with members of SEC to design a Derbyshire wide system escalation process to enable swift and collective action regarding winter pressures and other key issues including EU Exit. • The CCG submitted the annual EPRR response for the National Core Standards to NHSE for itself and Derbyshire Provider organisations ahead of the deadline of 31 October 2020. The results showed a positive approach across all organisations in relation to response, evaluation and preparedness for winter pressures. Attended the End of Transition webinar where actions undertaken by NHSEI workstreams were shared and organisational actions recommended, and the CCG is currently working through those. Future webinars are planned and the CCG EU Exit team will be in attendance. Due to the uncertainty around EU End of Transition and what will transpire the probability is recommended to increase from 2 to 3 • The CCG is working with Provider organisations to identify any supplier contracts in place that fall outside national provisions ahead of EU Exit • CCG is complying with NHSEI request to submit a daily EU Exit Transition return via the NHSEI Data Collection Portal • CCG is undertaking a review of its functions to determine how best to support the COVID-19 vaccine roll out with CCG staff The risk score has been reduced due to our Business Continuity arrangement being enacted and embedded over the past year and the further development of strengthened partnership working with health colleagues and other key stakeholders. 25.02.21 Updated Business Continuity Plan, Policy and EPRR Policy Statement was approved by January Governance Committee. March update: • EU Exit SitREP to NHSEI over 7 days • EU Exit SitREP now submitted each weekday and by exception at the weekend April Update • EU Exit SitREP stood down with effect from 1 April 2021. July Update • Business Resilience Manger attended x2 days training in June 2021 facilitated by the Emergency Planning College to enhance contribution to LRF Risk Sub Group. First meeting of the group to be held 21 July 21. • EU Exit Learning the Lessons report compiled at to be presented to Governance Committee The score is proposed to remain as it is due to how the risk is described. To reduce it any further would weaken the case for continued development internally and with wider stakeholders. August Update • EPRR Core Standards have been received from NHSE and the deadline for completion by the CCG and Derbyshire Providers is 31st August 2021. DDCCG core standards and full compliancy will be presented to the September 2021 Governance Committee. The score is proposed to remain as it is due to how the risk is described. To reduce it any further would weaken the case for continued development internally and with wider stakeholders.	2	4	8	2	4	8	2	2	4	On going	Links to Strategic Aims 3, 4	Aug-21	Sep-21	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Chrissy Tucker - Director of Corporate Delivery / Richard Heaton, Business Resilience Manager
11	21/22	Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the CCG to move to a sustainable financial position.	Finance	Finance	4	4	16	Internal management processes – monthly confirm and challenge by Finance Committee Monthly reporting to NHSEI Development of system I&E reporting including underlying positions by organisation and for the system as a whole	Due to the uncertainty of the financial regime in the NHS it remains unclear what the impact on the CCG of failure to live within agreed resources for the 2021/22 financial year would be.	The Derbyshire NHS system has a significant gap between expenditure assessed as required to meet delivery plans and notified available resource. The CCG is working with system partners to establish a sustainable a long term financial position and deliver a balanced in-Year position. As at M4 the CCG are not seeing any major financial pressures against planned expenditure with the exception of CHC and we continue to work with M&CSU and providers to rectify this. We are reporting at M4 a YTD surplus of £0.401m and have used £1.356m of the 0.5% contingencies. The forecast position is breakeven and uses £2.210m of contingencies along with anticipated allocations for Retrospective Covid and Elective Recovery Fund. The CCG is also working with system partners to understand the recurrent underlying position and early work suggests there is a significant recurrent deficit.	4	4	16	4	4	16	2	3	6	On going	Links to Strategic Aims 1, 2, 3, 4, 5	Aug-21	Sep-21	Richard Chapman, Chief Finance Officer	Darran Green- Assistant Chief Finance Officer
12	21/22	Inability to deliver current service provision due to impact of service review. The CCG has initiated a review of NHS provided Short Breaks respite service for people with learning disabilities in the north of the county without recourse to eligibility criteria laid down in the Care Act. Depending on the subsequent actions taken by the CCG fewer people may have access to the same hours of respite, delivered in the same way as previously. There is a risk of significant distress that may be caused to individuals including carers, both during the process of engagement and afterwards depending on the subsequent commissioning decisions made in relation to this issue. There is a risk of organisational reputation damage and the process needs to be as thorough as possible. There is a risk of reduced service provision due to provider inability to retain and recruit staff. There is a an associated but yet unquantified risk of increased admissions – this picture will be informed by the review.	Quality and Performance	Quality / Reputational	3	4	12	• Joint working in place with Derbyshire County Council to quantify the potential impact on current service users. • Joint working in place with Derbyshire Community Health Services NHS Trust to ensure business continuity plans in place and operational risks mitigated • Communications and engagement teams are being involved throughout to manage consultation process and ensure information is shared within public domain to enable a balanced view. • Project team meeting weekly to monitor progress and resolve issues - Task and finish group has been established with representation from local authority, CCG, DCHS and DHFCT Action plan has been developed and sent to the BRS Delivery Group for comment. Task and finish group will now take the action plan forward The crisis element of respite has been discussed in the wider system and agreement has been reached The original short break review - a position statement paper has been produced and will be discussed with Director to agree on next steps. Work to be carried out by the Strategic Commissioners	• Working closely with Comms and Engagement Team. • Assurance of process received from Consultation Institute.	Covid-19 restrictions – impacting on discharge planning, inconsistent policies across different providers. - Orchard Cottage maintained significant damage by a patient unable to be used at moment,; This will not be re-opened until 2021 - Amberleigh - previously closed. Discussions have taken place to re-open to provide an urgent provision for transforming care patients. Discussions continue. - The third unit remains closed as not currently fit for purpose. The crisis element of respite has been discussed in the wider system and agreement has been reached Ownership of 'Crisis' Lane as part of the Three Year LD/A Road Plan changed to DDCCG Strategic Commissioner. BRS LD A Delivery Group Extraordinary Meeting scheduled for the 21st April. Progress to be reviewed against: 1.The expansion of IST 2.Commissioning of crisis accommodation 3.Commissioning of crisis in reach 4.Review of approach to respite June update - CCG Specialised Commissioners developing Governing Board paper for short breaks The CCG Strategic Commissioners are writing a paper for GB which will provide an update and options. Therefore the risk remains the same at present. August update: - Expansion of IST - Recruitment progressing & SOP in development, with strategic alignment taking place. - Commissioning of crisis accommodation implementation delayed due to COVID but work now been accelerated - The Short Breaks paper which was due at the previous Delivery Board was postponed due to awaiting further information from partners – deferred to September meeting.	3	3	9	3	3	9	2	3	6	December 21	Links to Strategic Aims 1, 2, 3, 4, 5	Aug-21	Sep-21	Brigid Stacey - Chief Nursing Officer	Mick Burrows Director for Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning, Helen Hipkiss, Deputy Director of Quality /Phil Sugden, Assistant Director Quality, Community & Mental Health, DCHS
14	21/22	On-going non-compliance of completion of initial health assessments (IHAs) within statutory timescales for children in care due to the increasing numbers of children/young people entering the care system. This may have an impact on children in care not receiving their initial health assessment as per the statutory framework.	Quality and Performance	Corporate	5	3	15	The CIC Collaborative Operational Meeting in Derbyshire (commenced March 2020) - meet on a - bi monthly basis - which continues to review the statutory IHA pathway and which works & delivers from a multi agency perspective (Health - CCG Designated Nurse & Doctor for CIC - CRH FT - DCHS FT and the LA - DCC), in order to address the IHA compliance issues and improve compliance (the reasons for non compliance are multi faceted and complex because of the nature and complexity of children and young people who are placed in care and this is why there has not been a speedy resolution to this risk. 'Back Stories' of all CIC who are not bought for their IHA within the 20 day statutory period are being collated by health and social care). The CIC Collaborative Operational Meeting has a RAG Rated Work plan in place and IHA Compliance is included within said work plan and will be reviewed at every meeting for progress. Assurance work is on-going as a collaborative approach between CCG, CRHFT and Local Authority - overseen by the CIC Collaborative Operational Group, CCG Quality meetings and Corporate Parenting Board. Remedial work and actions are on-going for the partners to ensure any obstacles and/or process issues are resolved in a timely manner. All breaches that occur - the children continue to have their health needs met within primary and secondary care as required and the vast majority of breaches are by a few days. It has to be acknowledged that CIC and the legislation surrounding them (eg: parental responsibility and the legal pathway) are complex and there will always be delays that Health or LA cannot control or mitigate against. CRHFT continue to monitor sickness rates and priorities/flex work plans accordingly, in the remaining CIC Health Provider Team but this can be difficult to do due to other clinical commitments/work plans & increasing numbers of children being bought into care by LA's (a noted 4.14%. increase in DCC numbers March 2020 - March 2021). **August 2021 Update**: The health data continues to indicate that the majority of IHAs are completed in Derbyshire by the Medical Advisor within the statutory 20 working days but there remain, ongoing complex LA (at the beginning of the 20 work day pathway) and Health Provider issues (at the end of the 20 working day pathway) where the IHA is not always received back by the LA by 20 statutory working days. There is generally a delay for children in care living out of area whereby the IHA is completed by an external Health Provider late and DDCCG have no control over their performance. This has been discussed previously at CPB as being a concern for all externally placed CIC and this will continue to impact on timeliness of health assessments. IHAs continue to be reviewed by the CIC Collaborative Operational Meeting, The Improving Health Outcomes Meeting and by Children in Care Strategic Partnership (CICSP) & by Derbyshire CPB (next meeting 16/09/21 - where a verbal update & PowerPoint presentation will be given by the new Designated Dr for CIC who has taken on the responsibility (in her Designated role) for the delivery and reporting of IHA timeliness. Extensive partnership working continues to improve the IHA timeliness issue, which includes appropriate health and LA escalations, when required. The ability to escalate IHA issues early between both organisations, remains a real strength, in terms of collaborative partnership working, with the express intention of continuously improving IHA timeliness overall for all CIC living within the Derbyshire footprint (wherever they originate from).	Completion of Multi-agency IHA Action Plan. Increasing numbers of children/young people entering care & increasing numbers of Derbyshire CIC being placed externally by the Local Authority has been acknowledged at Derbyshire Corporate Parenting Board. The Designated Nurse CIC has highlighted the risk of external health provision (of IHA's & RHA's) being the responsibility of the external health provider and not with CRHFT or DDCCG (as stated by NHSE). Ongoing, sustained, multi-agency compliance with timescale pathway. Monthly and quarterly analysis of 'finer' IHA performance continues at this time by CRH FT CIC health provider and Designated CIC Professionals on behalf of the CCG. Review and Monitoring of the whole pathway/process via RAG Rated Action Plan, via multi-agency meeting - CIC Collaborative Operation Meeting - which meets on a bi monthly basis. Ongoing review by Derbyshire Corporate Parenting Board & the DDCCG Safeguarding Assurance Committee. Will be reviewed again at CPB in September 2021. Monthly review of figures/data from CRH FT & Quarterly Reporting of IHA progress by the Designated Nurse CIC (Derbyshire). Designated Doctor CIC (Derbyshire) remains responsible for IHA Quality Assurance and for liaison with external health providers who are identified to be providing late IHAs consistently. Performance of external health providers/CCG's delivering untimely IHA's (for Derbyshire Children placed externally outside of Derbyshire) remains the responsibility & risk of external health providers; to ensure that they are adhering to Statutory Guidance, as defined in Promoting the Health & Wellbeing of Looked After Children - March 2015) & as highlighted by NHSE. administration/medical tasks prioritised/re-allocated where possible. There is on-going progress with the implementation of SystmOne processes for Admin, Nursing and Medics which moving forwards should help to assist with the timeliness of returns to the LA. The risk score, remains the same at the current time .This will need to be sustained and continued increases in compliance seen before the risk can be lowered and eventually removed. Extensive ongoing work continues from a multi-agency perspective, with ongoing overview & review of a number of very complex issue's associated with IHA compliance; including ongoing review of individual breach reporting by both health (CCG & Provider) and the LA. This work is reviewed on an ongoing basis by Derbyshire Corporate Parenting Board, Improving Health Outcomes Group, CIC Strategic Partnership & the CIC Collaborative Operational Group & associated work plan. **August 2021 Update**: With regard to the proportion of identified breaches, the majority of children have actually been seen within the 20 working days but the appt is so close to the deadline that statutory timescale is breached due to report writing and admin time required to send the report back to the LA but usually only by a few days. CRHFT have been under pressure for the past few months due to staff absences because of sickness – both admin and medical teams but this has now resolved and a new Designated Dr CIC has just been appointed into post, who is already looking closely at the health pathways to ensure timely, statutory compliance. From a medical perspective the team are responding by planning additional clinics to try and adhere to the statutory timescales, although this is complex due to other work plan commitments. Administration & Medical sickness cover is reviewed & monitored by the provider (CRH FT) daily and administration/medical tasks prioritised/re-allocated where possible to fit in with numbers of IHAs required. There is on-going progress with the implementation of SystmOne processes for Admin, Nursing and Medics which moving forwards should help to assist with the timeliness of returns to the LA. DCC LA IHA Data shows a slow upward trajectory of an increase in compliance (Jan to July 2021 standing at 61% rolling compliance (based on 147 IHAs due within this period – DCC LA Data) there are differences in health and LA data reporting due to two different systems used & the Designated Dr CIC has already begun some work with CRHFT CIC Admin Team to streamline and enhance health data set reporting, to try to align it with LA reporting processes, this remains work in progress at the current time.	Extensive ongoing work continues from a multi-agency perspective, with ongoing overview & review of a number of very complex issue's associated with IHA compliance; including ongoing review of individual breach reporting by both health (CCG & Provider) and the LA. This work is reviewed on an ongoing basis by Derbyshire Corporate Parenting Board, Improving Health Outcomes Group, CIC Strategic Partnership & the CIC Collaborative Operational Group & associated work plan. Target date extended to October 2021, given the slow, upward trajectory of improvement in the timeliness of IHAs (despite ongoing extensive work).Recent health breaches have highlighted that these have been caused by provider CIC Health Team admin and medical advisor sickness issues (some pandemic related), which have caused delay in returning completed IHA's (completed within statutory timescales) back to the LA within 20 working days. Mitigation: Sickness absence rates and workload prioritisation are monitored on a daily basis by the CRH FT CIC Health Provider Service. Quarter 4 2020/2021 Summary Compliance (January, February & March 2021) IHAs completed within timescales = 53.0% average a slight decrease of 0.33% from the previous Q3 (Previous Q1 2020/2021 = 63.33%, Q2 2020/2021 = 62.33% & Q3 2020/2021 = 53.33%). Q1 2021/2022, Month 1 April 2021/2022 = 50% overall IHA compliance (completed and returned to the LA within 20 working days). Q1 2021/2022 Month 2 May 2021/2022 = 69% seen and returned to the LA within 20 working days (a continuing upward trajectory of compliance noted) Quarter 1 Month 3 June 2021 = 33 % completed and returned to the LA within 20 working days. Quarter 1 2021 overall compliance 50.66% – CRH FT Data – Recorded Manually. Overall CRH FT CIC Health Provider yearly 2020/2021 IHA 20 working day statutory timeliness compliance stands at 58.0% overall (end of year Q4 2020/2021), 8.25% down on the previous year 2019/2020, which stood at 66.25%-year end & up 10.5% on year end 2018/2019, which stood at 47.5%. the score remains the same as the percentage of compliance has not improved overall due to the added pressures of ongoing MA sickness within CRHFT, the complexities surrounding CIC, impact of Covid (particularly on external Health Providers) and timely notifications from LA (SW workload capacity). However it has to be noted the vast majority of the delays are by a few days only and not on children having their health needs met. Extensive multi-agency work continues to address the IHA timeliness issues. **August 2021 Update**: June 2021 IHA Summary (latest available data):•18 Children seen in total for their IHA at CRHFT •9 Children seen within 20 working days (50%) •9 Children seen over 20 working days (50%) •6 IHA's completed within full Statutory Timescale (IHA Completed & returned to the LA within 20 working days (33%) Of the 9 children seen out of the timescale •7 (78%) – Their IHA Appointment was arranged late by the LA •1 (11%) – The IHA was late because the CIC Was Not Bought (WNB) to the previous appointment •1 (11%) – The IHA was delayed due to the CIC being hospital (at the time of the planned IHA) •0 (0%) – CRHFT Clinic Capacity Issues Identified •3 (33%) – CIC seen for IHA within 20 working days but the completed report returned to the LA out of 20 working day statutory timescale Q1 2021/2022, Month 1 April 2021/2022 = 50% overall IHA compliance (completed and returned to the LA within 20 working days). Q1 2021/2022 Month 2 May 2021/2022 = 69% seen and returned to the LA within 20 working days (a continuing upward trajectory of compliance noted) Quarter 1 Month 3 June 2021 = 33 % completed and returned to the LA within 20 working days. **Quarter 1 2021 overall compliance 50.66%** Several complicating factors have been identified from the health breach reporting that have affected the timeliness of IHA completion during this reporting period, which includes delay at the beginning of the IHA pathway by the LA and also at the end of the IHA pathway by health. The main complicating health provider factor, during this reporting period is identified as a lack of ability of the CIC health provider MA and Admin teams to return IHAs, completed within the 20 working day timescale by the CIC Medical Team, back to the LA in a timely manner. Additional clinic capacity has been arranged at CRH Hospital and Littlewick Medical Centre in Erewash to meet statutory requirements. The team are also looking to deliver extra IHA clinics in the South of the County (Willington Surgery) & at Buxton Health Centre in High Peak from September 2021 onwards and the new addition of a further Medical Advisor to undertake the increase in IHAs (anticipated due to the delivery of the new CIC Service Specification (from 1st July 2021) which covers all DCC LA CIC up to 20 miles over the border (of Derbyshire). All appointments for IHAs that were booked out of timescale have also been bought forward, wherever possible. CRH FT CIC Team have worked extremely hard to monitor the IHA clinic capacity and adjust it to the increase in demand during this period. CRH FT CIC Administration Team is also currently under review, to ensure that it has sufficient capacity to ensure that all IHA/RHA work is managed in a timely manner and that appropriate systems and processes are in place to support this, within the provider organisation. Improvements have been evidenced in IHA timeliness compliance, but this will need to be sustained into the future and the newly implemented CIC Service Specification notes a KPI of 85% compliance for IHA timeliness. NB A DCC LA ILACS inspection is due (anytime between September 2021 - Easter 2022) and IHA timeliness will no doubt be reviewed as part of that inspection process, therefore this need to remain on the Risk Register at this time to evidence the substantial ongoing quality assurance work undertaken by the Designated CIC Professionals (Dr & Nurse) & by DDCCG Nursing and Quality Team. Extensive multi-agency work continues to take place to improve IHA timeliness provision from a multi-agency perspective and in turn improve health outcomes for all CIC.	4	3	12	4	3	12	3	1	3	September 21	Links to Strategic Aims 1, 2, 3, 4, 5	Aug-21	Sep-21	Brigid Stacey - Chief Nursing Officer	Alison Robinson, Designated Nurse for Looked After Children
16	21/22	Lack of standardised process in CCG commissioning arrangements. CCG and system may fail to meet statutory duties in S14Z2 of Health and Care Act 2012 and not sufficiently engage patients and the public in service planning and development, including restoration and recovery work arising from the COVID-19 pandemic.	Engagement	Communications/ Engagement/ Statutory	3	4	12	Systematic completion of S14Z2 forms will provide standardised assurance against compliant decision making and recording of decisions at project level. Engagement Committee established to strengthen assurance and risk identification.	PMO processes are not being applied to restoration and recovery projects, therefore there are no checks and balances as projects proceed to ensure that they have completed either the S14Z2 or EIA forms. An equality and engagement policy is being developed to address this gap in part, for proposed adoption by all JUCD partners. EIA/QIA process adopted by JUCD. Not all projects follow a systematic project management/commissioning/transformation process to ensure standardisation of process and application of legal duties. June update: Engagement Governance Guide and training being developed to support consistency of approach for officers involved with transformational change. Meeting with new ICS Director of Transformation to be arranged to ensure processes embedded in future project management approaches.	Engagement Committee re-established in June 2020 following pause during peak of COVID-19 pandemic. Training for Engagement committee members on consultation law completed. Replacement lay members recruited to ensure sufficient lay voice on Engagement Committee following recent resignations. S14Z2 log reviewed regularly by Engagement Committee. CCG planning approach under review to identify potential annual commissioning business cycle, thus enabling rolling engagement programme in commissioning development and activity. July: Consultation Law refresher training undertaken for engagement team to support governance process review and strengthen our approach to planning and delivery of engagement, including additional context of engagement requirements in a virtual world. Will feed Governance Guide production this month, to be reviewed by Engagement Committee in August 2021. August: Meeting with ICS Director of Transformation taken place 17.8.21; meeting with QEIA panel leads on 18.8.21. Governance Guide remains in development, aligned to revision of Engagement Model. Will also align with emerging JUCD transformation processes, with agreement that that S14Z2 check will be included in documentation and digital tool. Further strengthening of S14Z2 process also agreed with QEIA Panel process, to improve quality and timeliness of submissions of S14Z2 forms. These actions combined will serve to achieve the target score this risk during Q3.	2	4	8	2	4	8	2	3	6	30.09.21	Links to Strategic Aims 1, 2, 3, 4, 5	Aug-21	Sep-21	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Sean Thornton Assistant Director Communications and Engagement
17	21/22	S117 package costs continue to be a source of high expenditure which could be positively influenced with resourced oversight, this growth across the system, if unchecked, will continue to outstrip available budget	Quality & Performance	Corporate	3	4	12	Although not overspent to budget at this time the rising cost of care under s117 is around 38m to the system. The CCG is investing in additional case managers, re-introducing S117 work stream under MHSDB when this is possible. It is anticipated that both of these measures will positively affect outturn at system level. 17.09.20 The CCG have agreed to employ a number of case ,managers, which will cover s117 packages of Care. This is being negotiated with the CSU to start in October. The Commissioning for Individuals panel is now in place. This includes s117 cases. Although not overspent to budget at this time the rising cost of care under s117 is around 38m to the system. The CCG is investing in additional case managers, re-introducing S117 work stream under MHSDB when this is possible. It is anticipated that both of these measures will positively affect outturn at system level.	There is slippage in the introduction of case managers, so the savings have slipped from October 2020 to January 2021. Further re-design of specification now means delivery start date now Q1 21-22	Recruitment challenges Investment is being made in additional case managers via CSU , re-introducing the S117 work stream under the MHDB to enhance the oversight will also help. 05.02.21 Recruitment ongoing, remains on track for commencement Q1 21-22 10.03.21 Posts now recruited and CV to main CCG CSU Contract being finalised, remains on track to commence Q1 21-22 08.04.21 CV discussed in CHC OPs Group last week, final tweaks in process then final sign off to be sought. Service now going live in Q1. The risk score needs to remain at 9 until the caseload has been reviewed. 18.05.21 Service now live, risk score unchanged until caseload review has been completed 15.06.21 Risk score unchanged pending completion of case load review 16.07.2021 Risk score remains unchanged pending completion of case load review, CSU asked to confirm timescale now second member of staff recruited 17.08.21 Risk remains unchanged pending case load review, CSU have not yet confirmed timeline.	3	3	9	3	3	9	2	2	4	tbc	Links to Strategic Aims 1, 2, 3, 4, 5	Aug-21	Sep-21	Zara Jones, Executive Director of Commissioning Operations	Helen Hipkiss, Director of Quality / Dave Stevens, Head of Finance
20	21/22	Failure to hold accurate staff files securely may result in Information Governance breaches and inaccurate personal details. Following the merger to Derby and Derbyshire CCG this data is not held consistently across the sites.	Governance	Corporate	4	3	12	• Staff files from Scarsdale site are to be moved to a locked room at the TBH site. This is interim until the new space in Cardinal is available. There are still staff files at Scarsdale and Cardinal Square they are safely secured. Due to Covid-19 the work has been placed on hold as staff are all working from home. • EA's/PA's at Cardinal Square have been contacted and a list is being pulled together of names and files (current or leavers) held ensuring that these are all securely saved in locked filing cabinets. Work is being completed at Cardinal Square by staff who do regularly attend site to compile the list and confirm who may be missing. • Consider an electronic central document management system (DMS) This action remains once we are in a position to move the project forward.	• A project team has been organised to work on the risks, ensuring that a standardised format and tick list is developed of the relevant paperwork to keep in HR files. This piece of work will take a significant amount of time before the CCG can even consider looking at a document management system. • Information Governance are currently working to secure a contract for archiving, this will ensure that staff leavers files are securely archived with the correct paperwork. • Project team are obtaining guidance with other NHS organisations to consider a document management system.	15.07.20 update: This risk is still open, and valid for 20/21, the files are currently being collated and this is actively being worked on. Work was paused with the COVID 19 pandemic. Progress is now underway. 12.08.20 The files from Toll Bar House have now been relocated to Cardinal Square. To reduce the transmission of Covid-19 and mitigate health and safety risks, the majority of our staff are continuing to work from home. As the review and weeding of the hard copy HR files requires a physical presence in the workplace, this aspect of the project has been temporarily paused. 14.09.20 Project still paused due to staff working from home. 13.11.20 No further update due to home working December - No further update due to continued home working. January - No change due to continued home working. February - No change due to continued home working, paused.	3	3	9	3	3	9	1	2	2	On going tbc	Links to Strategic Aim 4	Aug-21	Sep-21	Beverley Smith, Director of Corporate Strategy & Development	Sam Robinson, Service Development Manager

Risk Reference	Year	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk Rating			Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating			Residual/ Current Risk			Target Risk			Target Date	Link to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
					Probability	Impact	Rating				Probability	Impact	Rating	Probability	Impact	Rating	Probability	Impact	Rating						
22	21/22	The mental health of CCG staff and delivery of CCG priorities could be affected by remote working and physical staff isolation from colleagues.	Governance Committee	Corporate/Clinical	3	3	9	Daily Team Meetings/catch up's held between Managers and their staff. Weekly All Staff virtual meeting held, led by Dr Chris Clayton, to update and inform CCG staff of developments etc. Weekly Staff Bulletin email from Dr Chris Clayton outlining the CCG activity which has occurred during the week, with particular focus on the people aspect of the CCG. Twice daily COVID-19 Staff update emails issued outlining all progress, news and operational developments. CCG employees trained as Mental Health First Aiders available for all CCG staff to contact for support and to talk to. This is promoted through the daily COVID-19 Staff updates. Included in the Staff update emails is the link to the Joined Up Care Derbyshire website staff support area which is available and continues to be updated. This now also includes a new section for leaders and a section for parents or carers of children. This also offers wellbeing, leadership advice and support for health, social care and community staff in relation to the Covid-19 virus. For confidential support and counselling the CCG employee assistance programme provider (EAP) can be accessed by all CCG colleagues and family members in the same household and is available 365 days a year, 24 hours a day. They have also launched a 25 minute web based "Working from Home and Resilience" seminar details of which have been included in the CCG Staff update email. 1 to 1 wellbeing checklist introduced for line-managers to facilitate support for members of their team. Virtual tea breaks and initiatives to promote social connectivity introduced and ongoing.	08.04.20 A range of ideas to support the wellbeing of staff working from home will be launched shortly, with a toolkit to help staff all maintain a positive outlook and ensure interaction with colleagues 'off topic' to maintain spirits during the working week. Staff are encouraged that they should all take time to remember that they are not "working from home", but "at home, during a crisis, trying to work". 17.04.20 continue to monitor and assess sickness returns for trends and patterns and good practice for staff H&WB e.g. NHS Employer, Social Partnership Forum etc. 12.05.20 The CCG will develop and run briefings for line managers to support them in undertaking 1 to 1 wellbeing checks with their team (to include wellness action plan, display screen equipment review and risk assessments for vulnerable staff).	All staff have the use of Microsoft Teams video conferencing on their remote device. This application has been rolled out throughout the NHS in England, This enables face to face meetings to take place and encourage interaction between colleagues and good working relationships. 09.06.21 - Continuation of wellbeing communication and initiatives for staff, including flexible working, social connectivity, relaxation sessions, Thrive app etc. 13.07.21 - All staff requested to meet with line manager to complete a new ways of working: Individual preferences and risk assessment pro-forma, which combines wellbeing discussion with exploring individual preferences for working arrangements moving forwards. Continuation of wellbeing communication and initiatives for staff, including flexible working, social connectivity, relaxation sessions. Repeat of Thrive: Mental Wellbeing and Avoiding Burnout session. 12.08.21 - 90% of staff have reviewed and submitted an updated risk assessment pro-forma and individual preferences. From the pro-formas, 86.3% of CCG staff are fully vaccinated with a further 4.4% who have received the first does only. Continuation of wellbeing communication and initiatives for staff, including flexible working, social connectivity, relaxation sessions.	2	3	6	2	3	6	1	3	3	On going	Links to Strategic Aims 1, 2, 3, 4, 5	Aug-21	Sep-21	Beverley Smith, Director of Corporate Strategy & Development	Beverley Smith, Director of Corporate Strategy & Development James Lunn, Head of People and Organisational Development
23	21/22	CCG Staff capacity compromised due to illness or other reasons. Increased numbers of CCG staff potentially unable to work due to COVID 19 symptoms / Self isolation.	Governance Committee	Corporate	3	4	12	Staff asked to complete Skills Survey for redeployment. Detailed analysis of deployment within and outside of the CCG completed. Backup rota compiled for Incident Control Centre (ICC). Majority of CCG staff working from home. Business Continuity Plan escalation level increased to 4 allows for pausing of functions within the CCG.	Running a mixed model of remote/base work Possible shadowing of staff working in the ICC by backup rota staff. General capacity issues in covering staff absences. Staff illness could compromise the operation of the ICC. Develop a resilient rota for the ICC, PPE and Testing Cells over 7 days	16.4.21 - National level of escalation reduced from level 4 to level 3. Review of priorities across system & CCG , vaccination programme continues to be main priority. Bi-weekly monitoring of the deployment of CCG staff against the system priorities by Functional Directors. 17.5.21 - SLT review of CCG business continuity levels. The COVID-19 Vaccination Programme remains both a national and JUCD's priority and there is a requirement for our staff to continue the essential roll out of the Vaccine programme and to ensure the programme is not de stabilised by loss of expertise and experience. A review of existing redeployments has also been undertaken on a case by case basis with risks to business critical functions/delivery within the CCG and vaccination delivery identified. Where possible discussions have taken place with the respective managers to identify alternative solutions, such as commencing recruitment to back fill roles to enable staff to remain within the Vaccine Operations Cell or vaccination sites. Ongoing review of redeployments at SLT. 09.06.21 - Continuing review of existing redeployments and consideration of alternative solutions, including back filling roles via recruitment and/or interim/agency. At the current time we are seeking through regular discussions with the FDs and seeking approval for temporary agency staff to backfill roles within the CCG. 13.07.21 - Arrangements in place to backfill two key roles for staff redeployed to the vaccine operational cell with interim/agency. Ongoing review of existing redeployments and consideration of alternative solutions. 12.08.21 - Ongoing review of existing redeployments and consideration of alternative solutions.	1	4	4	1	4	4	1	3	3	On going	Links to Strategic Aims 1, 2, 3, 4, 5	Aug-21	Sep-21	Beverley Smith, Director of Corporate Strategy & Development	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.	Quality & Performance	Clinical	5	4	20	National and local campaigns across all media platforms to promote access and availability of health services. Weekly performance brief to monitor patient attendance across providers (A&E, 111, NEL, Elective Care, Cancer etc.) Primary Care agreed to prioritise LTC reviews for all priority (red) patients and have agreed to see all amber patients by 31st March 2021. Includes messages to voluntary sector to strengthen messages to patients. COVID vaccination roll out to commence in December, based on a prioritisation framework.	On-going public communication campaigns regarding service provision as we move across each phase. To support winter pressures, PCN's are developing contingency plans to support patients that display COVID/ Flu symptoms. Learnings to be taken from the red hub concept. Proposals to restore services and reintroduce appointments by utilising digital technology and reviewing provision of service (acute v community) e.g. rehab services, diagnostics, phlebotomy, MDT's etc. System Cell leading on the co-ordination of vaccine roll out, commencing in early December.	14/06/21- To commence vaccinations for people aged 25-29, which will see us further add to the 1.2million vaccinations we have delivered in Derbyshire so far. 14/06/21- GP practices have seen an increase in appointments of between 10% and 20% than before the pandemic. March 2021 saw an average 9% increase or 40,000 more GP appointments than the same month in 2020 and 2019. We are seeing an increasing expectation for more face to face appointments. As we move forward, our plan is to reach a balance of face to face and other channels for delivering consultations which works for both our patients and our practices but we know this will require a process of adjustment. In the meantime, the CCG is delivering a campaign to raise awareness on how we can all help to support our practices as we work through this readjustment to new ways of working. The core purpose of the campaign is to inform our patients and the overriding message is that "your GP is open for business and we are here when you need us. Evidence and data across the Health system identifies that patients 'in the main' are no longer deferring medical advice due to the belief that COVID takes presidence. Another discussion is required regarding reducing the probability to a '2" that will reduce the rating to a 6, the target rating. If the reduction in risk is accepted, we would advise to keep the risk on the tracker due to forthcoming winter pressures and the spread of COVID variants. 16/7/21- Target rating agreed at the last Board meeting. Advise to keep the risk on the tracker due to forthcoming winter pressures and the increasing spread of COVID variants. Since the unlocking of lockdown measures COVID infection rates have risen to January 21 levels. On 19th July almost all legal restrictions on social contact will be removed, risking a further increase in infections. Despite the increase cases the number of COVID patients within the Acute Trusts is below 30. However this figure has doubled in the past week. 13/8/21- Vaccinations rolled out to 16-18 age group. Booster jabs for over 50's•, adults aged 16-49 who are in a flu or Covid-19 at-risk group and those living in the same house as people who are immunosuppressed. 13/08/21- Our system is currently under significant pressure. Not only are our Emergency Departments filling up, but our ambulance service, general practice, urgent treatment centres, mental health units and our discharge support teams are all experiencing unprecedented demand. This 'perfect storm' is now also being exacerbated by increasing numbers of staff needing to self-isolate having either had a positive test for Covid-19, having to self-isolate because of an alert from the NHS Covid-19 app or having to take time off work to look after their children.	2	3	6	2	3	6	2	3	6	On going	Links to Strategic Aims 1, 2, 3, 4, 5	Aug-21	Sep-21	Dr Steve Lloyd, Medical Director	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster Head of Strategic Clinical Conditions and Pathways
25	21/22	Patients diagnosed with COVID 19 could suffer a deterioration of existing health conditions which could have repercussions on medium and long term health.	Quality & Performance	Clinical	4	4	16	Derbyshire-wide Condition Specific Boards continue to review information, guidance, evidence and resources to understand the repercussions e.g. NHSE After-care needs of inpatients recovering from COVID-19, BTS Guidance. System working to co-ordinate and implement guidance. Primary Care agreed to prioritise LTC reviews for all priority (red) patients and have agreed to see all amber patients by 31st March 2021. NHSE have launched the 'Your COVID Recovery' service to provide advice and guidance (self-care) online, and a national COVID rehab service is in development Post COVID rehab pathways for admitted and non-admitted patients being developed, and criteria for referral to secondary care if patients have ongoing needs. vMDTs set up across the county in respiratory between Acute and Community Respiratory Teams. Working towards implementation with Acute and Primary Care. Post COVID Syndrome Assessment Clinic service implemented to support patients suffering with post/long COVID symptoms. MDT approach to provide physical and psychological assessments, to ensure patients access the required service and treatment.	Review COVID inpatient data to identify pre-existing LTCs to proactively support patients. Derbyshire-wide Condition Specific Boards to amend/ develop pathways through embedding new guidance and good practice to allow effective follow-up of patients. Keep virtual consultations / on-line support (amplify). Proposals to restore services and reintroduce appointments by utilising digital technology and reviewing provision of service (acute v community) e.g. rehab services, diagnostics, phlebotomy, MDT's etc. To support the roll out of the 'Your COVID Recovery Service' throughout Derbyshire as required. To include communications and implementation of rehab service. Review and scoping of pan-Derbyshire end to end rehab pathway Develop and implement a Post COVID Assessment Clinic to ensure patients are referred to appropriate services. Post COVID integrated pathway (system) and Post COVID Assessment Clinic to be communicated across the health system. Including culturally relevant communications to raise awareness amongst patients and the public.	12/02/21- The Post COVID Syndrome Assessment Clinic MDT is continuously being strengthened with input from specialists such as Respiratory Consultants, Chronic Fatigue Services, Children's services etc. The MDT will continue to develop and broaden in expertise as we learn more about the condition. 12/02/21- A Derbyshire Dialogue event (12/02/21- 120 attendees) was held with the public to discuss Post COVID Syndrome and the Derbyshire response to this condition. Feedback utilised to enhance services. Risk score reduced to 9 in line with target rating. This is due to the Post COVID Assessment Service being launched and embedded into system pathways. Strategic Clinical Conditions & Pathways Team (SCCP) are monitoring the impact of services and patient outcomes hence the risk remaining on the register. 08/03/21- £18.5m government funding to support research projects to better understand the causes, symptoms and treatment of the condition. 08/03/2- NHSE have confirmed PCS Assessment Clinic funding for 21/22 to support service continuity and to enhance the service offer. 16/04/21- 21/22 NHSE funding announced for Post COVID Assessment Clinic. CCG and DCHS undertaking workforce modelling, with funding to be utilised to enhance provision and clinical input. 17/05/21- CCG and DCHS continue to develop new PCS workforce model. Aim to finalise this month and commence recruiting additional capacity into the team. Includes additional GP/ AHP capacity to target 6/7 week waiting list. 17/05/21- Refreshed PCS Assessment Clinic Guidance launched by NHSE. DCHS and CCG have undertaken service review to ensure new guidance is embedded in SOP and pathways. 14/06/21- PCS Workforce model has been agreed by Execs. The service will be bolstered by additional GP input, a Clinical Psychologist, Nurse, and Service Co-ordinator. Funding will also be utilised to reduce the waiting list from 6 to 2 weeks by agreeing short-term additional GP hours. 14/06/21- Press release was launched w/c 7th July. Lead GP was interviewed by BBC Radio Derby. 16/07/21- £1.8m funding ringfenced for JUCD to support the ongoing treatment and rehabilitation of patients. Plans to develop a Long COVID Rehab pathway to support patients with Post COVID Syndrome are being worked up. A total of 600 patients have been referred to the Post Covid Assessment Clinic to date. 13/08/21- NHSE agree in principle to JUCD Post COVID Rehab pathway which will see the establishment of four rehab centres based within the community. A seamless process for both GP's and the assessment clinic to refer to the Post COVID Rehab Centre. Mild symptoms will be referred directly to the Rehab Centre, moderate/severe symptoms will continue to the Post COVID Assessment Clinic and then be referred on where applicable to the Rehab Centre, this will help to reduce the ever increasing backlog and strain on the other existing services such as Pulmonary Rehab and Chronic Fatigue. System stakeholders are working up the detail of the rehab offer.	3	3	9	3	3	9	3	3	9	On going	Links to Strategic Aims 1, 2, 3, 4, 5	Aug-21	Sep-21	Dr Steve Lloyd, Medical Director	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster Head of Strategic Clinical Conditions and Pathways
26	21/22	New mental health issues and deterioration of existing mental health conditions for adults, young people and children due to isolation and social distancing measures implemented during COVID 19.	Quality & Performance	Clinical	5	3	15	o Derbyshire Healthcare NHS Foundation Trust have developed a 24 / 7 crisis helpline for people of all ages and their carers to seek advice regarding MH difficulties including those arising or being exacerbated by Covid-19. Helpline is accessible via 111 warm transfer. o Multi-agency approach in place collating all sources of support and advice that will also support the help line in terms of where people can be triaged to get the most appropriate help. o Working with Communications teams to ensure that information is disseminated effectively across all stakeholders and the system. o Actively working with providers to understand their business continuity measures and how they are planning for fluctuations in demand and capacity, e.g. to meet and respond to reduction in referrals and/or anticipated surge in demand going forward. o CYP services, targeted intervention predominantly online. CAMHS RAG rating and prioritising urgent cases. Digital offer Kooth and Qwell uplift continue until March 21. Ongoing CYP communications strategy with partners to send information out across the system. o IAPT providers fully operational and accepting referrals - Attend Anywhere utilised across the trust for online consultations Mental Health System Delivery Board to provide Covid oversight recovery and planning	o To further recruit and upskill clinical triage & assessment team staff responding to the helpline in CYP, LD & Autism o Additional community based LD beds -there needs to be an agreed list of identified staff that can be called on this responsibility lies with LA not CCG. Building needs to be furnished and cleaned. o Re above – need to develop a training programme for staff working in the specialised unit- being actioned via LD delivery group. o Need to finalise the LD & Mental Health All Age COVID Recovery Planning Group process to feed into LRF across providers. o Wellbeing in education training to all schools Sept - March to include local MH resources and pathways . Close monitoring of service demand to be prepared to respond to any anticipated surge in referrals now CYP returned to school o IAPT providers are funded on AQP basis so there is no cap on activity - frontline staff vaccinations will support increase in face to face capacity and engagement in care and improve resilience of staff capacity reducing absences	April Update Urgent care work stream taking forward work on crisis cafe and alternatives to ED .CYP crisis plan has been developed and approved at Mental Health,LD,ASD,delivery Board. Plans for 3 year road map for ASD developed ,Transforming care summit held and actions agreed. Investment plans will be coming through DDCCG governance process in April. Digital offer for support in procurement and further engagement on adult offer in process .Funding for workforce Hubs received from NHSE and Hub continued to be developed by workforce leads. MH planning submission due 6 May with focus on areas impacted by Pandemic. May Update - IAPT continues to increase capacity and access including training for long COVID. June Update. Delivery of LTP is seen as approach to restoration for MH in operating framework and 12 months finance and workforce return for MH reflected investments in full. Road map Strategy for LD/ASD approved. July update -as June but CYP plan is being refreshed and sent out to strategic partners as draft .Additional funding streams applied for ,with success Noted in working with Nottinghamshire to deliver improved autism support in schools Project(100k each) .Proposals to support the delivery of the ambitious transformation requirements of LTP are being developed. August update - increased programme / commissioning capacity agreed to deliver the LTP priorities at Pace. The impact of RSV a particular concern for bed capacity at paediatric acutes which has potential to impact when also an increase in CYP with MH / challenging behaviours - mtgs held with agreed escalation routes ,data flow ,and system response.	4	3	12	4	3	12	2	2	4	Aug-21	Links to Strategic Aims 1, 2, 3, 4, 5	Aug-21	Sep-21	Zara Jones, Executive Director of Commissioning Operations	Mick Burrows, Director of Commissioning for MH, LD, ASD, and CYP Helen O'Higgins, Head of All Age Mental Health Tracy Lee, Head of Mental Health - Clinical Lead Helen Van Ristell TCP Programme Manager Jenn Stothard Head of Mental Health
27	21/22	Increase in the number of safeguarding referrals linked to self neglect related to those who are not in touch with services. These initially increased immediately following COVID lockdown. The adult safeguarding processes and policy are able to respond to this type of enquiry once an adult at risk has been identified. Numbers are difficult to predict but are predicted to increase as COVID restrictions ease.	Quality & Performance	Clinical	5	4	20	Key statutory partners such as Health , Local Authority, Police and Voluntary Sector are working closely together to ascertain who are at enhanced risk. Safeguarding meetings and assessments are continuing to take place via virtual arrangements. Families and individuals are being signposted to relevant support services.	Domestic Abuse is likely to increase as family groups are forced to be together for extended periods of time, children are at home on a full time basis, there are financial pressures due to restrictions upon employment, and adults at risk from abusive partners become socially isolated. It remains at an early stage. Referrals are expected to increase with another sharp spike in activity predicted when COVID restrictions are eased and victims feel safer in making disclosures Self Neglect. Individuals are finding it problematic to obtain aids to daily living and basic essentials. They do not have the motivation or ability to access sources to access or replenish essential items. Scamming. Individuals are targeted due to their physical or cognitive vulnerability and persuaded and cajoled to trust unscrupulous individuals During the COVID19 pandemic the number of referrals to adult social care services has increased but not as yet at the rates envisaged and predicted at the outset of lockdown and enforced isolation. Ongoing close partnership working is required. The Derby and Derbyshire Safeguarding Adult Boards are continuing to work collaboratively to gather information / intelligence and data regarding domestic abuse and adult abuse prevalence during the COVID 19 pandemic to formulate relevant action / contingency plans. Police are undertaking safe and well checks as appropriate and will use powers of entry if deemed necessary and proportionate.	Marked increase in domestic abuse referrals (30)%. This is likely due to families being forced together for extended periods of time, children being at home due to schools closure, financial pressures due to furloughing, victims being isolated from support systems and extended family, and dysfunctional partnerships. Increase in staff requesting advice and assistance due to abuse within their personal domestic relationship Marked increase (34%)in self-neglect concerns as people have withdrawn from social contact. Many families have been unable to maintain relationships and adults at risk have become isolated. Many individuals have been unable to access community care and their living conditions have deteriorated as a consequence. It is likely that referral rates will continue to increase as lockdown restrictions are eased and isolated individuals are once again able to seek support and assistance. Both Safeguarding Adult Boards, and their respective sub structures, have continued to meet on a regular basis. Business has been influenced by the impact of Covid upon service provision, family relationships, and partnership arrangements. The SABs 3 priorities (Making Safeguarding Personal, Section 42 Enquiries, and Quality Assurance) have been maintained. Safeguarding Adult Training has re-commenced using Teams as a delivery method. This has been successful in attracting large numbers of attendees and is likely to be maintained as a future option. Since the recent easing of lock down arrangements both of the Local Authorities have seen an increase in Safeguarding Adult enquiries and referrals. The monthly increase is on average 16% although this has on occasion risen to over 30% . As predicted, and recognised previously, the increase in operational activity predominantly concerns Domestic Abuse and also Self-Neglect allegations. Although under pressure, the safeguarding systems have managed to respond and inter-agency communication and joint-working remains both effective and robust. DDCCG and Safeguarding Adult Boards have continued to implement their governance and assurance arrangements and have continued to fulfil their statutory arrangements This has included the auditing of case files and the recommencement of staff training programmes.	4	3	12	4	3	12	3	3	9	Dec-21	Links to Strategic Aims 1, 2, 3, 4, 5	Aug-21	Sep-21	Brigid Stacey, Chief Nursing Officer	Bill Nicol, Head of Adult Safeguarding
30	21/22	There is an ever present risk of fraud and cybercrime; the likelihood of which may increase during the COVID emergency response period.	Finance	Corporate	4	5	20	The CCG is constantly exposed to fraud risk and cybercrime and works with 360 Assurance and NHS Counter Fraud to minimise and manage this risk. There has been a noticeable increase in the reported instances of fraud and cybercrime in recent months and the CCG must remain vigilant in this period working closely with our partners. Should the CCG be subject to a successful attempt at fraud or cybercrime information and assets could be taken that exposes us to Information Governance breaches, financial and reputational risk.	The CCG continue to work closely with 360 Assurance and NHS Counter Fraud to minimise and manage this risk. The CCG also has an accredited NHS Counter Fraud Authority 'Champion' who receives regular correspondence and training.	11.03.21 - There is evidence of increased activity at the perimeter of the network, but there is no evidence of penetration by third parties and CareCERT and other high profile security vulnerabilities are appropriately managed. We are assured that the system is secure and propose reducing the risk on this basis with a view to further reducing the risk following the Cyber Essentials and Cyber Essentials Plus exercises in which the CCG is currently engaged with the West Midlands Ambulance Service as auditors. 21.04.21 - The CCG has come to an agreement with NECS to support the Cyber Essentials re-accreditation process and work is ongoing to agree the process for Cyber Essentials Plus. This involves re-using some of the information captured as part of the NECS CE+ accreditation process to reduce the scope of the work and subsequently the cost. A revised KPI report is expected at the next Contract Management Board which provides additional information on cyber issues which picks up themes from the CORS report and provides greater detail. As per previous updates, scores remain the same until work progresses on CE/CE+. 18.05.21 - Cyber Essentials re-accreditation for the CCG is underway, currently awaiting technical information from NECS to complete the process. More detailed information is now being shared by NECS as part of the Contract Management Board which provides greater granularity on the design of the security systems and provides additional assurance of the various layers through which a malevolent third party would need to progress. There are no indications of the recent cyber attack in Ireland having any impact on any of our systems. Will consider reducing the risk when the NHS Digital tools are in place to allow us to monitor vulnerabilities through a third party tool. 14.06.21 - The CCG recently worked with NHS Digital to run a simulated phishing attack on 471 CCG email addresses with the result that only 1% of those contacted opened the email, clicked the link and attempted to enter credentials to access the document. We are assured by this result and the 84% of people that ignored the email entirely. There has also been work undertaken between IG, HR and Digital regarding the leavers/joiners process and ensuring appropriate closure of all aspects of a user account when an individual leaves the CCG's employment or moves roles. Recommend reduce the probability of this risk, as there is no evidence of an active threat, additional risk analysis has been undertaken and work done to address these. 12.07.21 - Cyber Essentials re-accreditation can progress now that we have confirmation of the removal of unsupported Microsoft Windows 10 devices from the network and there are not expected to be any further issues preventing this from being successfully completed. Work continues on ensuring the appropriate closure of all aspects of a user's account(s) following the triggering of the leavers/joiners process with the potential to automate some of the stages to provide assurances. 17.08.21 - There remain no identified vulnerabilities with the perimeter network and work is progressing with colleagues and with NECS around the leavers/joiners process including internal moves. The CCG has invested in improved reporting capability for NECS to allow them to more easily assimilate logs files from disparate sources into a single report and also into immutable (offline) storage to provide additional protection for data loss resulting from an issue with the physical environment within a data centre. Risk remains on the register as the CCG transitions into the ICB.	1	4	4	1	4	4	1	3	3	On going	Links to Strategic Aim 4	Aug-21	Sep-21	Richard Chapman, Chief Finance Officer	Darran Green- Assistant Chief Finance Officer / Ged Connolly-Thompson, Head of Digital Development
32	21/22	Risk of exploitation by malevolent third parties if vulnerability is identified within any of the Microsoft Office 2010 applications after October 14th 2020 and not patched, due to support for Microsoft Office 2010 officially ending, after which point Microsoft will cease to issue updates and patches for vulnerabilities found within this suite of applications	Governance	Corporate	4	4	16	Replace all instances of Microsoft Office 2010 with Microsoft Office 365; Additional Cyber Security communications to all CCG and Primary Care staff to raise awareness of the potential for increased phishing emails, suspicious attachments and downloading documents from unfamiliar web sites; Reinforce the message that devices should be connected to the network every two weeks to ensure that anti-virus and other system management software updates accordingly; Identify other mitigation which NECS have put in place to prevent the execution and spread of any malicious code or exploitation of any vulnerability;	Task and finish group has been established with NECS to develop the programme of work which removes the risk, but also ensure continuity of service across commissioning and Primary Care; Already under development as part of the response to the CORS report; information will be cascaded through the CCG Comms team for CCG and Primary Care colleagues and also shared with the LMC;	18.05.21 - CCG has begun migration onto Microsoft Office 365; GP Practices have begun to book in for their upgrades. Both programmes will be completed by the end of July, three months before the mandated deadline to allow for any unforeseen anomalies. Concerns have been raised with NHS Digital regarding the suitability of their policy based security systems, with users able to access functionality which is turned off locally and nationally. Therefore, while the Office 365 project is progressing, there are a number of concerns with the way in which NHS Digital has chosen to implement Microsoft Office 365 within the NHS Shared Tenancy, the amount of local control that we have and the tools that are being provided nationally to allow us to manage local variation. Scores will be reduced when the rollout programme is complete and again further when NHSD can evidence the issues identified have been addressed. 14.06.21 - There are no indications of any vulnerabilities that have been exploited and the implementation of Microsoft Office 365 continues across the GP and CCG devices. There are concerns over some variants of the Windows 10 operating system that were out of active support, but we understand that has now been rectified. NECS Engineers are continuing to upgrade devices to the latest version of Windows 10 to ensure that all devices are appropriately supported when this temporary extension ends. Once all of this work has been completed, the risk will be fully mitigated, but attacks on the infrastructure remain a possibility. 12.07.21 - All unsupported versions of Microsoft Windows 10 have now been removed from all devices currently connected to the network. There are three devices outstanding, but these are with colleagues not currently at work and the device will be required to be upgraded prior to re-connecting to the network. The installation of Microsoft Office 365 has been mandated across all CCGs as of 4pm on July 9th with personal follow-up from NECS for any outstanding. There are around 700 devices yet to be upgraded onto Microsoft Office 365 across Primary Care - NECS continue to work with Practice Managers to resolve and Engineer visits will be arranged where more convenient. Risk remains the same. 17.08.21 - All remaining CCG devices yet to upgrade to Microsoft Office 365 are having the installation forced when the device first starts up. A communication has been sent to GP Practices informing them that the forced upgrade will be introduced in Primary Care on August 17th; any devices not upgraded by September 8th will have their network accounts disabled and will require all outstanding upgrades and updates to be carried out prior to being allowed back onto the network. This allows a three week period for any engineer visits or remedial actions to take place prior to the deadline of October 2021.	3	4	12	3	4	12	2	1	2	Dec-21	Links to Strategic Aim 4	Aug-21	Sep-21	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Ged Connolly-Thompson - Head of Digital Development, Chrissy Tucker - Director of Corporate Delivery

Risk Reference	Year	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk Rating			Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating			Residual/ Current Risk			Target Risk			Target Date	Link to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
					Probability	Impact	Rating				Probability	Impact	Rating	Probability	Impact	Rating	Probability	Impact	Rating						
33	21/22	There is a risk to patients on waiting lists as a result of their delays to treatment as a direct result of the COVID 19 pandemic. Provider waiting lists have increased in size and it is likely that it will take significant time to fully recover the position against these.	Quality & Performance	Clinical	4	4	16	• Risk stratification of waiting lists as per national guidance • Work is underway to attempt to control the growth of the waiting lists – via MSK pathways, consultant connect, ophthalmology, reviews of the waiting lists with primary care etc. • Providers are providing clinical reviews and risk stratification for long waiters and prioritising treatment accordingly.	• A task and finish group is in place to monitor actions being undertaken to support these patients which reports to PCDB and SQP • Providers are capturing and reporting any clinical harm identified as a result of waits as per their quality assurance processes • An assurance framework has been developed and completed by all providers the results of which will be reported to PCDB • A minimum standard in relation to these patients is being considered by PCDB • Work to control the addition of patients to the waiting lists is ongoing • Providers are contacting patients via letter	• Monthly reporting of progress against all work to control growth of waiting lists • Two weekly task and finish groups with all 4 providers represented • Completion of assurance framework has been undertaken by all providers and is being collated to go to PCDB for discussion • Identified harm has been reported on STEIS and all providers are monitoring this • All providers have completed the assurance framework and this is being collated to go back to PCDB for discussion re further risk mitigations • Work is ongoing around Consultant Connect, MSK and Ophthalmology 14.05.2021 update - Providers are all in the process of completing the assurance framework again to monitor progress. ToR now agreed and the next 3 meetings will focus on individual aspects of the minimum standard requirements to facilitate sharing and learning as all providers work to achieve this. Risk score to remain. 24.06.2021. Waiting lists remain a system issue and there continue to be significant numbers of patients on them, therefore the risk remains the same. 12.07.21 update - PCDB and System Quality Group have been updated on the current position in relation to the assurance framework. there remains limited assurance overall regarding the ability to prevent harm due to the numbers of patients on the lists. A Derbyshire wide communications strategy is being worked up with Comms leads. Risk score to remain 16.08.21 3monthly assurance framework submissions continue and all providers are working to support increasing numbers of patients on the waiting lists. Twice weekly regional NHSEI meetings are in place. Comms strategy in progress. Risk remains the same	4	4	16	4	4	16	3	2	6	Feb-22	Links to Strategic Aims 1, 2, 3, 4	Aug-21	Sep-21	Brigid Stacey, Chief Nursing Officer	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.	Quality & Performance	Clinical	4	5	20	Short term work has been undertaken and assurance re the safety of services has been provided by the Medical and Nursing Director at CRHFT, however the long term sustainability of the service now needs to be addressed. March update: CRH Stroke Service Contingency Plan has been implemented, with sign-off from impacted surrounding trusts (Kings Mill, Hallamshire, UHDB, and Stepping Hill). Short-term mitigations in place to support service continuity, reducing the risk of service suspension and patient divert.	• Locum Consultant cover is in place • Clinical Leadership support is being provided by Liverpool Consultant • Trust to go out for advert to recruit new Stroke Lead consultant & work being done to make advert attractive • CCG , NHSE & System working with Trust Medical Director to contact other organisations and the Stroke Network for support. • Trust reviewing staff daily and escalating as per safer staffing policy as required, including red flag acuity reporting • CRHFT and Integrated Stroke Delivery Network (ISDN) leads to develop service contingency plan to understand internal measures, mutual aid options, and patient divert impact. • SOP to operationalise the contingency plan. • A task and finish group to commence a service review of the HASU, including options appraisal. All options to be reviewed with the aim of providing a sustainable service.	Feb 21- Stroke admission data has been analysed to support development of CRH Contingency Plan, this includes full , partial and mimic divert data. Feb 21- The CRH Contingency Plan is in its final draft form and conversations have commenced with surrounding impacted trusts to understand CRH's internal measures and mitigations. Medical Director sign off to take place w/c 22/2/21 Mar-21- CRH Stroke Service Contingency Plan has been implemented, with sign-off from impacted surrounding trusts (Kings Mill, Hallamshire, UHDB, and Stepping Hill). SOP being developed to operationalise the plan. Mar-21- The Stroke Delivery Group have appointed a task and finish group to commence a service review of the HASU, including options appraisal. All options to be reviewed with the aim of providing a sustainable service. Risk score reduced to 12 due to implementation of contingency plan and locum cover in place. The reduction in risk was agreed by the Stroke Delivery Group 8/3/21. Apr 21- SOP to operationise the contingency plan is circulated to surrounding Trusts. Apr 21- CRH HASU options appraisal to commence in May-21 and is to be chaired by the NHSE/I National Stroke Clinical Lead Deb Lowe. Membership includes all key stakeholders including surrounding Trusts (Sheffield Teaching Hospitals, Sherwood Forest Hospitals and UHDB). May-21- CRH's SSNAP rating has improved from an overall C rating (July-Sept 20) to B rating (Oct-Dec 20). An 'A' or 'B' SSNAP rating are indicative of first class quality of care and a good or excellent service in many aspects respectively. June-21- HASU service review is on-going. The T&F group have agreed to review 4 options that includes: Continuation of HASU with consultant workforce, conveyance and repatriation model, alternative workforce models or closure and conveyance to surrounding trust. Jo Keogh (CRH Divisional Director) is leading the review with support from CCG colleagues. July 21- HASU service review update- 5 options have been identified by the group that include:- 1.HASU provision continues as is delivered by the existing substantive Consultant, locum support and telemedicine. 2.The current HASU service is strengthened by redesign. 3.The Trust introduces a review and convey (drip and ship) model. 4.Decommission the CRH HASU element of the Stroke Service pathway, if workforce sustainability issues cannot be resolved, with either a single HASU provider or multiple providers.5.Review of the CRH HASU as part of a wider East Midlands review to rationalise sites; continuing to provide the service 'as is' at CRH. To support the identification of the preferred option and to provide transparency on decision making, the task and finish group have requested that an outcome matrix and criteria is developed and is to be presented at the August meeting for review. August 21- Workshop to be delivered in Sept 21, to allow all stakeholders to review the options and gain consensus on the preferred service delivery option. CRH are in discussion with Sheffield Teaching Hospitals to develop a joint staffing model for consultants to work across both sites. If agreed the proposal will be added to the consultation options.	3	4	12	3	4	12	3	3	9	Aug-21		Aug-21	Sep-21	Dr Steve Lloyd, Medical Director	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster Head of Strategic Clinical Conditions and Pathways
38	21/22	The quality of care could be impacted by patients not receiving a care needs review in a timely way as a result of the COVID pandemic and the requirement for some of the Midland and Lancashire Commissioning Support Unit (MLCSU) Individual Patient Activity /Continuing Health Care (CHC) services to redirect service delivery to support system wide pressures. This has had an impact on core CHC and Funded Nursing Care (FNC) service delivery in relation to care needs reviews.	Quality & Performance	Clinical	4	2	8	A prioritisation matrix was put in place to ensure the most high risk/complex case reviews were prioritised.	A service Proposal has been presented and agreed by the CCG. MLCSU will schedule and complete care reviews of all individuals who have a review that was due between 19th March 2020 and 31st March 2021. These will all be completed within 6 months	May 2021 - 600 overdue reviews. Recovery action plan in place and review activity commenced. July 2021 -Trajectory in place to complete all 600 reviews by November 2021. Workforce in place and 220 reviews completed in June so on target. August 2021 -Remain on trajectory to complete the backlog by November. reduction in the number of reviews completed in July but still remain on target.	4	2	8	4	2	8	3	2	6	Sep-21	tbc	Aug-21	Sep-21	Brigid Stacey Chief Nursing Officer	Nicola MacPhail Assistant Director of Quality
40	21/22	In the period of transition from CCG to ICS, it is likely that a larger proportion of contracts will be extended on expiry rather than reprocured. The CCG is advised by Arden & GEM CSU on best practice for our procurement activity, but in some circumstances, the CCG may decide to proceed against best practice in order to give sufficient time for review of services within the framework of movement to an ICS. Proceeding against advice, carries a small risk of challenge from any providers who may have felt excluded from the process.	Governance	Corporate	4	4	16	All healthcare contract extensions or renewals are reviewed via SLT, Execs, CLCC and then Governing Body for larger contracts. Any procurements issues and risks are highlighted as part of that process and the risk is accepted when agreement is given to proceed with the extension. Risks of challenge are small in most markets and the size of the risk will have been factored in to decision-making. Healthcare contracts expiring within 12 months are reviewed at Commissioning Ops Directorate SMT to ensure that timely action is taken before expiry. Where any challenge occurred from a provider, if the challenge were valid the risk could usually be mitigated by including the provider in future stages of procurement. Legislation is currently going through parliament to remove the requirement for NHS bodies to comply with the Public Sector Procurement Regulations for the procurement of healthcare services. This requirement will be replaced with a Provider Selection Regime which requires adherence to a decision-making framework but removes the right of legal challenge from providers except by judicial review.	A monthly meeting has been established between AGEM and the contracting team to review the procurement report and ensure that any issues around risk, progress or lack of engagement are escalated appropriately. The redesign of the procurement report has reduced the number of contracts of concern.	A monthly meeting has been established between AGEM and the contracting team to review the procurement report and ensure that any issues around risk, progress or lack of engagement are escalated appropriately. August Update: The Governance Committee will provide the oversight to decision-making processes in relation to the Provider Selection for the 20 services to give assurance that procurement processes are being followed and Conflicts of Interests are appropriately managed.	3	4	12	3	4	12	4	2	8	Mar-22	tbc	Aug-21	Sep-21	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Chrissy Tucker - Director of Corporate Delivery

Appendix 2 - Movement during August 2021

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
01	**21/22**	The Acute providers may breach thresholds in respect of the A&E operational standards of 95% to be seen, treated, admitted or discharged within 4 hours, resulting in the failure to meet the Derby and Derbyshire CCGs constitutional standards and quality statutory duties.	5	4	**20**	5	4	**20**		The volume of attendances are approaching pre-pandemic levels.	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 risk score remains stable as there is not enough movement in relation to this yet to be able to be able to reduce the risk score	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**		TCP remains on national escalation with regular calls with NHSE.	Brigid Stacey - Chief Nursing Officer	Quality & Performance	Helen Hipkiss, Deputy Director of Quality / Phil Sugden, Assistant Director Quality, Community & Mental Health, DCHS
04A	**21/22**	Contracting: Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care. There are 112 GP practices in Derbyshire all with individual Independent Contracts GMS, PMS, APMS to provide Primary Medical Services to the population of Derbyshire. Six practices are managed by NHS Foundation Trusts and one by an Independent Health Care Provider. The majority of Derbyshire GP practices are small independent businesses which by nature can easily become destabilised if one or more core components of the business become critical or fails. Whilst it is possible to predict and mitigate some factors that may impact on the delivery of care the elements of the unknown and unexpected are key influencing dynamics that can affect quality and care outcomes. Nationally General Practice is experiencing increased pressures which are multi-faceted and include the following areas: *Workforce - recruitment and retention of all staff groups *COVID-19 potential practice closure due to outbreaks *Recruitment of GP Partners *Capacity and Demand *Access *Premises *New contractual arrangements *New Models of Care *Delivery of COVID vaccination programme	4	4	**16**	4	4	**16**		There is an increasing demand and pressure General Practice are facing as lockdown measures are being relaxed and removed.	Dr Steve Lloyd - Medical Director	Primary Care Commissioning	Hannah Belcher, Head of GP Commissioning and Development (Primary Care)

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
04B	**21/22**	Quality: Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care. There are 112 GP practices in Derbyshire all with individual Independent Contracts GMS, PMS, APMS to provide Primary Medical Services to the population of Derbyshire. Six practices are managed by NHS Foundation Trusts and one by an Independent Health Care Provider. The majority of Derbyshire GP practices are small independent businesses which by nature can easily become destabilised if one or more core components of the business become critical or fails. Whilst it is possible to predict and mitigate some factors that may impact on the delivery of care the elements of the unknown and unexpected are key influencing dynamics that can affect quality and care outcomes. Nationally General Practice is experiencing increased pressures which are multi faceted and include the following areas: *Workforce - recruitment and retention of all staff groups *COVID-19 potential practice closure due to outbreaks *Recruitment of GP Partners *Capacity and Demand *Access *Premises *New contractual arrangements *New Models of Care *Delivery of COVID vaccination programme *Restoration and Recovery *2021/22 FLU Programme	4	5	**20**	4	5	**20**		JUCD moving into Phase 3 of the Covid Vaccination Programme/ FLU programme whilst General Practice also working as BAU. Demand on general practice is above pre pandemic levels	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**		DHcFT have produced outline plan for reducing waiting list for CAHMS. This is being considered in Children and Young People Mental Health planning sub group.	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**		Papers on procurement outcome and proposals for next steps to be submitted to CLCC.	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	4	**8**	2	4	**8**		Initial reporting procedure agreed with NECS for the communication of any high level or escalating CareCERT alerts.	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**		The score is proposed to remain as it is due to how the risk is described. To reduce it any further would weaken the case for continued development internally and with wider stakeholders.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Chrissy Tucker - Director of Corporate Delivery / Richard Heaton, Business Resilience Manager

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
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 working with system partners to establish a sustainable and long term financial position and deliver a balanced in-Year position.	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**		Expansion of IST - Recruitment progressing & SOP in development, with strategic alignment taking place.	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
14	**21/22**	On-going non-compliance of completion of initial health assessments (IHAs) within statutory timescales for Children in Care due to the increasing numbers of children/young people entering the care system. This may have an impact on Children in Care not receiving their initial health assessment as per statutory framework.	4	3	**12**	4	3	**12**		Extensive multi-agency work continues to take place to improve IHA timeliness provision from a multi-agency perspective and in turn improve health outcomes for all CIC.	Brigid Stacey - Chief Nursing Officer	Quality & Performance	Alison Robinson, Designated Nurse for Looked After Children
16	**21/22**	Lack of standardised process in CCG commissioning arrangements. CCG and system may fail to meet statutory duties in S14Z2 of Health and Care Act 2012 and not sufficiently engage patients and the public in service planning and development, including restoration and recovery work arising from the COVID-19 pandemic.	2	4	**8**	2	4	**8**		Governance Guide remains in development, aligned to revision of Engagement Model. Will also align with emerging JUCD transformation processes, with agreement that that S14Z2 check will be included in documentation and digital tool.	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**		Risk remains unchanged pending case load review, CSU have not yet confirmed timeline.	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**		No change due to continued home working, paused.	Beverley Smith, Director of Corporate Strategy & Development	Governance	Sam Robinson, Service Development Manager

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
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	↔	90% of staff have reviewed and submitted an updated risk assessment pro-forma and individual preferences. From the pro-formas, 86.3% of CCG staff are fully vaccinated with a further 4.4% who have received the first does only.	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	↔	Ongoing review of existing redeployments and consideration of alternative solutions.	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	↔	All services are currently oversubscribed which indicates that patients in the main feel that they can come forward to seek healthcare.	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	↔	NHSE agree in principle to JUCD Post COVID Rehab pathway which will see the establishment of four rehab centres based within the community.	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	↔	Increased programme/ commissioning capacity agreed to deliver the LTP priorities at pace.	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	↔	Since the recent easing of lock down arrangements both of the Local Authorities have seen an increase in Safeguarding Adult enquiries and referrals.	Brigid Stacey, Chief Nursing Officer	Quality & Performance	Bill Nicol, Head of Adult Safeguarding

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
30	**21/22**	There is an ever present risk of fraud and cybercrime; the likelihood of which may increase during the COVID emergency response period.	1	4	**4**	1	4	**4**		There remain no identified vulnerabilities with the perimeter network and work is progressing with colleagues and with NECS around the leavers/joiners process including internal moves.	Richard Chapman, Chief Finance Officer	Finance	Darran Green- Assistant Chief Finance Officer / Ged Connolly-Thompson, Head of Digital Development
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**		All remaining CCG devices yet to upgrade to Microsoft Office 365 are having the installation forced when the device first starts up.	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**		Three monthly assurance framework submissions continue and all providers are working to support increasing numbers of patients on the waiting lists.	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**		Workshop to be delivered in Sept 21, to allow all stakeholders to review the options and gain consensus on the preferred service delivery option.	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.	4	2	**8**	4	2	**8**		Remain on trajectory to complete the backlog by November. Reduction in the number of reviews completed in July but still remain on target.	Brigid Stacey Chief Nursing Officer	Quality & Performance	Nicola MacPhail Assistant Director of Quality
40	**21/22**	In the period of transition from CCG to ICS, it is likely that a larger proportion of contracts will be extended on expiry rather than reprocured. The CCG is advised by Arden & GEM CSU on best practice for our procurement activity, but in some circumstances, the CCG may decide to proceed against best practice in order to give sufficient time for review of services within the framework of movement to an ICS. Proceeding against advice, carries a small risk of challenge from any providers who may have felt excluded from the process.	3	4	**12**	3	4	**12**		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.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Chrissy Tucker - Director of Corporate Delivery

Governing Body Meeting in Public

2nd September 2021

	Item No: 134

Report Title	Update on the Derbyshire ICS Boundary
Author(s)	Helen Dillistone, Executive Director of Corporate Strategy & Delivery
Sponsor (Director)	Helen Dillistone, Executive Director of Corporate Strategy & Delivery

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 attached report.

Report Summary

The Government White Paper "Working Together to Improve Health and Social Care for All", published on 11th February 2021, provided an opportunity to review geographical local authority boundaries alignment in relation to the development of the Derbyshire ICS, in particular for ICSs to be coterminous with upper tier local authorities.

The CCG, acting as a neutral party, obtained views from key stakeholders in Derbyshire and Greater Manchester including local authorities to borough level, MPs, NHS regulators, Integrated Care Systems, Clinical Commissioning Groups, NHS providers, Primary Care Networks, Local Medical Committees, Place Alliances and voluntary networks and presented a report to NHSE for consideration as part of their report to the Secretary of State.

Following review by the Secretary of State, a decision has been made that Glossop should form part of the Derbyshire ICS from April 2022 and the CCG will be working closely with its Manchester and Glossop colleagues to effect a smooth transition, with a Steering Group and associated workstreams currently being established.

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

CCG staff resources will be required from across our functions to support the transition.

Has a Privacy Impact Assessment (PIA) been completed? What were the findings?
This will be undertaken as part of the transition work.
Has a Quality Impact Assessment (QIA) been completed? What were the findings?
This will be undertaken as part of the transition work.
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
This will be undertaken as part of the transition work.
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
This will be undertaken as part of the transition work.
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
This will be undertaken as part of the transition work.
Have any Conflicts of Interest been identified / actions taken?
None identified at this stage.
Governing Body Assurance Framework
This paper supports all of the CCG's strategic objectives.
Identification of Key Risks
Risks around challenge from the public have been identified. Any further risks will be identified as the programme of work develops.

Derbyshire ICS Boundary
Update to Derby and Derbyshire CCG Governing Body
2nd September 2021

1. National Context

Earlier this year, the Department of Health and Social Care (DHSC) asked NHS England to set out options for boundary alignment in Integrated Care Systems (ICS) in specific geographies where upper-tier local authorities currently have to work across more than one ICS footprint and to assess the impact of changes to deliver alignment in each case. Over the last 6 months NHS England has worked with stakeholders to develop advice and analysis for each of the affected areas to inform the Secretary of State for Health and Social Care's decision.

This work has now concluded, with advice provided to the Secretary of State for Health and Social Care. A final decision has been taken for the six areas in scope, one of which was Glossop, Derbyshire.

2. Coterminosity

This work has been underpinned by the principle that coterminous boundaries deliver clear benefits in integration between local authorities and NHS organisations. As approaches to integrated care develop it is crucial that systems support closer working both across NHS organisations and between the NHS and local government.

It is envisaged that local authorities, subject to the passage of the Health and Care Bill through parliament, will have a statutory seat on NHS Integrated Care Boards (ICB) and will play a key role in establishing and leading Integrated Care Partnerships (ICP). As such it is important that once established in legislation, ICBs and ICPs have the best opportunities to build strong relationships between NHS and local authority stakeholders.

3. ICS Boundary Review Process

Since the initial request, NHS England asked NHS Derby and Derbyshire CCG to engage with local stakeholders to seek views on the proposal to move Glossop from the Greater Manchester ICS into the Derbyshire ICS boundary. Glossop is geographically already part of Derbyshire, with local authority service provided by Derbyshire County Council and High Peak Borough Council but has been part of the Manchester NHS system via Tameside and Glossop CCG.

The CCG submitted its engagement report to NHSE in June 2021. DHSC has also engaged at ministerial level with parliamentarians as well as national organisations such as NHS Providers and the Local Government Association to ensure their views were reflected in the final advice to the Secretary of State and they had an opportunity to feed into the development of this work.

4. Final Decision Process

The Secretary of State for Health and Social Care's decision process has involved careful consideration of a wide range of issues, perspectives and interests and a careful weighing up of risks and benefits, outlined in the analysis provided by NHS England for each area. These have been considered on a case-by-case basis for each area. Where NHS England has made a recommendation based on broad (not universal) local consensus, including a recommendation to retain the status quo, the Secretary of State has listened and has accepted these recommendations.

Where there was not a broad local consensus within this review, no recommendations were made by NHS England and a balanced judgement was taken by the Secretary of State, weighing up the risks and benefits of a change in boundaries and having regard to his legal duties including his public sector equalities duty.

5. Glossop

The decision has been taken to amend the ICS boundary so that Glossop will move from the Greater Manchester ICS into the Derbyshire ICS.

The Secretary of State has outlined that there was no local consensus in this area and while the historic partnership and strong relationships developed in Tameside and Glossop were noted, the decision was taken based on a consideration that the benefits of coterminous boundaries outweighed the challenges. The benefits of the decision are that alignment enables more opportunities for joined-up working with the local authority and the creation of joined-up plans for prevention and population health to improve provision for local people as well as greater alignment between community, mental health and ambulance service provision which provide a county-wide service.

It is important to stress that this decision will not impact any individual patient's right to choose or use services outside of their ICS, nor do ICS changes mean any local services to patients and residents will change. It will also be important that all parties work together in the region to implement this change in a way that retains the learning and relationships developed as part of Greater Manchester ICS and incorporates all mitigations required to ensure a smooth transition.

NHS England has made an employment commitment for colleagues impacted by the legislative changes.

The HR framework developed by NHS England will also provide guidance on the process to follow for CCGs affected by boundary changes to ensure the appropriate transfer of people in line with this employment commitment. This guidance is designed for leaders and HR colleagues and is due to be published in due course.

6. Next Steps

It is crucial that partners work together on this transition and a Joint Transition Steering Group has been established, jointly chaired by DDCCG and T&G CCG Executives and leading four main workstreams comprising specialist leads from across both systems:

- Communications and Engagement
- Finance, IT and Contracting
- Neighbourhood Development
- Statutory Duties, Risks and People Impact Assessment

The groups will coordinate and oversee the following key areas of work:

- Development of a communications and engagement plan with key stakeholders and with the local patients and public.
- HR implications and potential CCG staff transferring into the Derbyshire system.
- Contracting and commissioning implications to include broader geography and population.
- Incorporation of Glossop into Place/PCN planning/Primary Care development.
- Financial impacts of the above.
- Incorporation of this proposal into the overall Derbyshire ICS Transition planning.

Joined Up Care Derbyshire

PUBLIC

Agenda Item

MINUTES of a meeting of the **DERBYSHIRE HEALTH AND WELLBEING BOARD** held as a Microsoft Teams Live Event on 08 July 2021.

PRESENT

Councillor C Hart (Derbyshire County Council)
(In the Chair)

C Clayton	Derby & Derbyshire CCG
M Dooley	Bolsover District Council
C Hart	Derbyshire County Council
H Henderson-Spoors	Healthwatch Derbyshire
L Hickin	Bolsover District Council
N Hoy	Derbyshire County Council
H Jones	Derbyshire County Council
J Patten	North East Derbyshire District Council
T Slater	East Midlands Ambulance Service
D Wallace	Derbyshire County Council

Also in attendance – S Bachelor (Active Derbyshire), and D Peet (Office of the Police and Crime Commissioner).

Apologies for absence were submitted on behalf of I Majid (NHS), C Prowse (Tameside & Glossop CCG), A Smithson (Chesterfield Royal Hospital), and V Taylor (Joined Up Care Derbyshire).

11/21 **MINUTES** **RESOLVED** that the minutes of the meeting of the Board held on 01 April 2021 be confirmed as a correct record.

12/21 **'UNITING THE MOVEMENT' IN DERBYSHIRE** In January, Sport England launched ‘Uniting the Movement’. A 10-year vision to transform lives and communities through sport and physical activity, with a mission to tackle deep-rooted inequalities and unlock the advantage of being active for everyone.

While the pandemic had made it more important than ever to keep being active, it had made it more difficult. In Derbyshire 1 in 4 people were inactive, and with the widening inequality driven by COVID-19, that number was growing. The approach was to get behind Sport England’s vision and work out, together, how Derbyshire could play their part and set out a local plan that would create lasting change.

The start of this process had been to consider all the insight and learning from the previous strategy, Towards An Active Derbyshire, together with the

impact of covid. An evidence review had been undertaken and outlined within the report.

Over the Summer period the contributions gained from the engagement sessions would be collated and analysed and form the basis of the strategic direction that would be taken. This would then form the basis of the new Strategy/Plan and prepare the opportunity for 'how' to then deliver the change that was required to embed physical activity in people's lives.

RESOLVED to (1) engage in the 'Joining the Movement' conversation and encourage their organisations and partners to add their voice; and (2) receive a future report on the engagement findings and the draft strategy and how this would be delivered.

13/20 DERBYSHIRE COUNTY COUNCIL LOCALITIES PROGRAMME UPDATE The Public Health Locality Programme was made up of eight partnerships across the county that aligned to the district/borough boundaries and contributed to improving health, wellness and reducing health inequalities at a local level. These partnerships were sub-groups of the Health and Wellbeing Board.

The Locality Programme as a whole had recently undergone a review and one of the recommendations was to strengthen the profile and performance management of the programme by establishing regular reporting arrangements to the Health and Wellbeing Board.

The programme facilitated the involvement of local partners through a collaborative approach to identify and address local health issues that impact on public health outcomes related to Housing, Leisure, Health, Children's Services, Physical Activity and Mental Wellbeing. The partnerships worked closely with statutory partners, CVS/Infrastructure organisations, other local VCSE organisations and local communities directly.

It was important to maintain a consistent approach across the county, whilst being mindful of locally identified needs and priorities, varying partnership arrangements and diverse local infrastructure. This was done by maintaining the common principles.

RESOLVED to (1) note the content of the report; (2) agree to receive an initial presentation in September setting out the work of the 8 Health and Wellbeing Partnerships in more detail as a starting point for more regular reporting to the Board; and (3) agree to a discussion about the future potential of the programme as part of the Integrated Care System (ICS) at the September Board.

14/20 HEALTH AND WELLBEING STRATEGY REFRESH UPDATE The Derbyshire 'Our Lives, Our Health' Health and Wellbeing Strategy shaped the work and actions of the Health and Wellbeing Board and wider system actions. The strategy was scheduled to be reviewed in 2023.

At the April Board meeting it had been agreed that a light touch review of the strategy took place to reflect the following:

a) The impact of COVID-19 on the health and wellbeing of the population, both directly and indirectly;
b) The launch of the Derbyshire Integrated Care System;
c) Changes to the Public Health landscape;
d) The opportunity to work with Derby City Council to align or join up the approach to health and wellbeing;
e) Opportunities to incorporate emerging themes in the Health White Paper and other strategic documents;
f) An outcomes-based accountability approach would continue to underpin the Health and Wellbeing Strategy.

A high-level timeline had been proposed within the report.

RESOLVED to (1) note the update on the Derbyshire Health and Wellbeing Strategy and proposals to revise and refresh the document to outline the impact of and recovery from COVID-19 and other system changes over the past 12 months; and (2) agree the indicative timeline in relation to refreshing the Health and Wellbeing Strategy.

15/20 SECTION 75 UPDATE REPORT The Health and Wellbeing Board were provided with an update in relation to the Strategic Governance's Boards oversight of the Section 75 Partnership Agreement since the Covid-19 pandemic. An overview of services delivered had been outlined as part of the Section 75 including the 0-19 Public Health Nursing Service as well as the Early Help delivery in Children's Centre's. As well as an overview in relation to the changes to vision and hearing screening, and the impact the COVID-19 pandemic had on the ability to promote these changes. The report sought the support of the Health and Wellbeing Board in relation to communicating the changes for school entry vision and hearing screening across the county.

RESOLVED to note the update in relation to the Strategic Governance's Boards oversight of the Section 75 Partnership Agreement since the start of the Covid-19 pandemic, including the overview of services delivered as part of the Section 75 including the 0-19 Public Health Nursing Service and the Early Help delivery in Children's Centre's; (2) note the changes to vision and hearing screening, and the impact the COVID-19 pandemic has had on the ability to promote these changes; and (3) support the communication of the changes to vision and hearing screening for school age children across the county.

16/20 **IMPACT OF COVID-19** A detailed explanation of the impact of Covid-19 had been given at the last meeting. There was ongoing work being completed and a further report would be brought to the next meeting of the Board in September.

The update would focus on the move into Autumn and Winter and what impact that would have on the public and broadly. It would be discussed how Derby and Derbyshire would react to minimise the impact. As well as try to mitigate the future and the impacts of long Covid.

17/20 **VACCINE HESITANCY REPORT: ATTITUDES TOWARDS THE COVID-19 VACCINE** Whilst the majority of the public had embraced the vaccine, others had been hesitant to get vaccinated. Healthwatch Derbyshire had carried out a piece of work to gain an understanding of why some people were not taking up the offer of the Covid-19 vaccine or were not wanting to do so. The report summarised the findings from an online survey which ran from 18 March 2021 to 25 April 2021. A total of 517 responses were received.

RESOLVED to note the report.

18/20 **HWB ROUND UP** HJ had provided HWB members with a written report containing a round-up of key progress in relation to Health and Wellbeing issues and projects not covered elsewhere on the agenda.

RESOLVED to note the information contained in the round-up report.

MINUTES OF DERBYSHIRE ENGAGEMENT COMMITTEE MEETING HELD ON 20 July 2021 VIA MICROSOFT TEAMS 11:15 TO 13:15

Present:		
Martin Whittle – Chair	MW	Governing Body Lay Member, DDCCG
Beverley Smith	BSm	Director Corporate Strategy & Development, 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
Jocelyn Street	JS	Lay Representative
Lynn Walshaw	LW	Deputy Lead Governor, DCHS
Margaret Rotchell	MR	Public Governor, CRH
Sean Thornton	ST	Assistant Director Communications and Engagement DDCCG and JUCD
Beth Soraka	BSo	Health Watch Derby
Simon McCandlish	SMc	Governing Body Lay Member, DDCCG (Deputy Chair)
Steven Bramley	SB	Lay Representative
Andrew Middleton	AM	Lay Representative
In Attendance:		
Lucinda Frearson (Admin)	LF	Executive Assistant, DDCCG
Jean Richards	JR	Primary Care Commissioning Manager, DDCCG
Julie Barton	JB	Senior Officer GP Commissioning & Development, DDCCG
Sukhi Mahil	SM	ICS Assistant Director Derbyshire Healthcare NHS Foundation Trust
Raki Raya	RR	Project Manager, DDCCG
Apologies:		
Vikki Taylor	VT	ICS Director Lead Joined Up Care Derbyshire
Karen Lloyd	KL	Head of Engagement Joined Up Care Derbyshire
Tim Peacock	TP	Lay Representative

Item No.	Item	Action
EC/21/22-32	**WELCOME APOLOGIES AND QUORACY** MW welcomed everyone to the meeting and noted apologies as above. MW declared the meeting quorate.	**MW**
EC/21/22-33	**Standing Item: DECLARATIONS OF INTEREST** 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. 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 **DECLARATIONS OF INTEREST**	

	SB advised his involvement with the Information Governance Workstream and the Derbyshire County Council Stakeholder Engagement Board, these were not deemed as conflicts of interest but are to be entered on the register for completeness.	
EC/21/22-34	**PROPOSED SINFIN HEALTH CENTRE** **The Committee is asked to note progress to date with the development of a business case for a new health centre at Sinfin, for information and awareness at this stage.** JR advised a feasibility study had taken place of South West Derby following the South and West areas being identified as having primarily high population growth, Sinfin was seen as the pinch point and the location for a new health centre. The original health centre was to be redeveloped until approached by the national health team and was now part of a national pilot program. JR explained the building would be system owned with flexibility to bring in different services and provides more flexibly in line with the needs of the community. Funding had now been received to begin development of a business case but was still in the early stages. Next steps were to engage with the local population, attendance at local groups and engagement with local elected members. SB queried why the health centre was different from other health centres around Derbyshire that had several different services happening within them and not understanding the background it would be very difficult to know what engagement would be required to be carried out. JR highlighted the main difference was flexibility over time, being tailored to the local population and changing as their needs change. SMc wished to see more specifics and benefits to the local population, what was being improved that was different and thinking from an engagement point of view if not clear of the outcome it would be difficult to engage people especially this early in the process. MW summarised that the project was in its early days with a lot of work to be done in terms of working on a business case to give more detail. The Committee was now aware of the scheme but required sight of the engagement plan currently being developed as part of their role to enable checking and oversight. **The Engagement Committee NOTED the progress with a further update requested.** **Action: ST to present the Sinfin Engagement Plan at the next meeting**	**JR** **ST**
EC/21/22-35	**ST THOMAS ROAD SURGERY** **Committee is requested to note that the St Thomas Road Surgery (part of One Medical Group, Leeds) Alternative Provider Medical Services contract (APMS) was due to expire on 30 September 2021. In August 2020, Primary Care Commissioning Committee agreed to extend the current contract for 1 year to 30 September 2022 to enable feedback from patients**	**JB**

	and stakeholder engagement prior to the commencement of the procurement process. JB advised a letter had been sent to 3000+ patients explaining the procurement process, along with a questionnaire to allow feedback on current services. A communication and engagement plan was in place and two engagement meetings arranged, patients could also contact the communications team directly. Further letters were being sent to Stakeholders, Clinical Directors, MPs and the Local Authority. An online survey was live with 12 responses already received; this was being pushed with assistance from the surgery and reminders. The Practice has a very diverse patient population with all 5 languages within the area being made available. Healthwatch were also supporting with getting the message out to as many patients as possible. **Action: LF to circulate patient letter and questionnaire with Minutes.** **The Engagement Committee NOTED the contract expiry date and 1-year extension to September 2022.** **The Engagement Committee NOTED progress to gather feedback and was ASSURED of progress.**	**LF**
EC/21/22-36	INTEGRATED CARE SYSTEM TRANSITION SM verbally updated the Derbyshire Dialogue had taken place earlier in July with over 200 people attending and had been well received. There were also carers and users explainers on the JUCD website which had been found to be helpful and simple to understand. Now beginning to receive additional guidance following the second reading of the Bill with the ICS Design Framework received and HR Framework due imminently. The Transition Assurance Committee are overseeing the transition plan on behalf of the system. The key purpose was around the dialogue which had commenced and would continue throughout the process. ST advised the second reading had taken place in Parliament prior to their summer recess which was good news meaning steps could start to be taken for example looking to begin the appointment process for ICS Chairs and Accountable Officers. These positions had already been appointed following a matter of process within Derbyshire so there was uncertainty whether ratification was required or a full recruitment process. ST also gave an update on an AOB from a previous meeting, the CCG had been acting on behalf of NHSE as neutral broker around engagement on boundaries related to Glossop and a decision was expected imminently. **Post meeting note**: The Secretary of State has determined that Glossop will form part of the Derbyshire ICS; an update will be provided at the next meeting. **The Engagement Committee NOTED the verbal update.**	**SM**

EC/21/22-37	**DRAFT COMMUNICATIONS AND ENGAGEMENT PERFORMANCE REPORTING SCHEDULE** **The Committee is asked to REVIEW the draft performance schedule for communications and engagement activity and COMMENT on the proposed metrics. NOTE that information collected can be utilised to develop the public-facing dashboard of communications and engagement activity and NOTE that further iterations of the metrics are required to include: Measurements of success in implementing the JUCD Communications and Engagement Strategy and Measurements of success in system partnership working for the developing Integrated Care System.** ST presented the communication and engagement strategy advising of the undertaking of the strategic approach for the future and how this will grow. The draft performance schedule presented showed a mixture of the engagement and communication measures; set out in a table was the metric and units used to measure. Integration was the key with a need not to lose sight of the communication and engagement collaboratively, in the meantime, individual organisations were continuing to do individually until brought together. **Action: ST to bring updated performance report/dashboard to the next meeting.** BS advised there were 2 angles to the engagement activity with staff, the wider workforce items around ICS and the impact and the statutory employer responsibilities to staff. All HRDs from partner organisations were holding weekly meetings and feeding into the People and Culture Board so it was clear that this committee did not need to be sighted but to be aware where it was being reported. ***The Engagement Committee RECEIVED and ACCEPTED the performance schedule for communications and engagement activity.*** The meeting was adjourned for a comfort break.	**ST** **ST**
EC/21/22-38	**S14Z2 LOG** **The Committee is asked to review the current S14Z2 log providing assurance that S14Z2 forms are being completed appropriately.** ST advised two forms had been reviewed since the last Committee and both had been presented today as part of the agenda: - • Proposed Sinfin Health Centre • St Thomas Road Surgery Two further forms had been received which were awaiting review and would be presented at the next meeting. **The Engagement Committee APPROVED the papers and were ASSURED they were being completed appropriately.**	**ST**

EC/2122-39	**DDCCG EXCEPTION RISK REPORT** **The Committee is asked to RECEIVE and DISCUSS the risk assigned to the Committee as at July 2021.** BS advised Committee one risk had been assigned in the July update (page 20). The team had undertaken their consultation and refresher training, but there was no intention to alter the risk as the impact and likelihood would remain the same. **The Engagement Committee RECEIVED and APPROVED and to be recorded accordingly.**	**BS**
EC/2122-39a	**GBAF** **The Committee are asked to DISCUSS and REVIEW the Quarter 2 Governing Body Assurance Framework Strategic Risk owned by the Engagement Committee. REVIEW and UPDATE the mitigating actions and assurances and REVIEW and UPDATE the current risk score** BS advised the Q2 strategic risk stemmed from the strategic aim 7, and GBAF risk 5, which was the Derbyshire population were not sufficiently engaged to identify and jointly deliver the services patients need. Mitigations and controls were updated in the report along with details of actions that had been undertaken over the last month giving assurance that progress was being made to mitigate the risk. MW believed the metric discussed earlier would assist with the population of the GBAF and as metrics are measured would bring the GBAF to life. Now the communication and engagement strategy had been to JUCD Board a change in action was proposed on the log. **The Engagement Committee gave APPROVAL to change and reviewing the log was ASSURED it had been updated accordingly.**	**BS**
EC/2122-40	**COMMITTEE ANNUAL REPORT** **Committee is asked to NOTE the contents of the Engagement Committee Public Annual Report for 2020/21.** The report was produced as part of the annual reporting process summarising Committee activities throughout the year and expanding on the Committee's role and membership; the report was brought to Committee for information. **The Engagement Committee NOTED the contents of the report and APPROVED sharing of the report with wider networks.**	**MW**
EC/2122-40b	**Terms of Reference (TOR)** Last month the removing of the recovery and restoration topic had been discussed due to no longer being involved in that specific workstream. The	**MW**

	CCG's formal programme and reporting processes now required removal from the TOR. **Action: Page 37, Section 2.16 of the TOR to be removed.** ***The Engagement Committee ACCEPTED the TOR following outlined amendment.***	**ST**
EC/2122-41	**MINUTES OF THE MEETING HELD ON 15/06/2021** **The Engagement Committee ACCEPTED the Minutes of the previous meeting as a true and accurate record.**	**MW**
EC/2122-42	**ACTION LOG FROM THE MEETING HELD ON 15/06/2021** The Engagement Committee reviewed the action log and updated accordingly.	**ALL**
EC/2122-43	**ENGAGEMENT COMMITTEE FORWARD PLANNER 2021/22 FOR REVIEW AND AGREEMENT.** **The Engagement Committee REVIEWED and AGREED the Forward Planner.**	**ALL**
EC/2122-44	**ANY OTHER BUSINESS** Lifting of Covid Restrictions: BSo raised the number of documents being shared around organisations regarding the lifting of Covid restrictions but not within a healthcare setting, this was good practice and showed shared support across the system. ST advised that all system partners had tried to convey the message that things were not changing in the healthcare setting regarding the lifting of restrictions and the message was very much out there.	
EC/2122-45	**HEALTH AND CARE BILL – RESOURCES AND BRIEFINGS** **The Committee was asked to NOTE the development of resources on the JUCD website relating to the transition towards a statutory Integrated Care System.** **The Engagement Committee NOTED the contents of the report.**	**ST**
EC/2122-46	**DERBYSHIRE DIALOGUE SLIDES – 24.06.21 – INTEGRATED CARE SYSTEM** **The Engagement Committee NOTED the contents of the presentation.**	**ST**
EC/2122-47	**FUTURE MEETINGS IN 2021/22** **Time: 11:15 – 13:15**	

	Meetings will be held as virtual meetings until further notice Tuesday 17 August 2021 Tuesday 21 September 2021 Tuesday 19 October 2021 Tuesday 16 November 2021 Tuesday 21 December 2021 Tuesday 18 January 2022 Tuesday 15 February 2022 Tuesday 15 March 2022	
EC/2122-48	**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 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? **Yes** 6. Is the Committee assured on progress regarding actions assigned to it within the Recovery & Restoration plan? **Yes** 7. 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** **8.** 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 specific recommendation at this stage.**	

DATE AND TIME OF NEXT MEETING
Date: Tuesday 17 August 2021
Time: 11:15 – 13:15

MINUTES OF PRIMARY CARE COMMISSIONING COMMITTEE

PUBLIC MEETING

HELD ON

Wednesday 28th July 2021

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

PRESENT		
Ian Shaw (Chair)	**IS**	Lay Member Derby & Derbyshire CCG
Kath Bagshaw	**KB**	Deputy Medical Director (for Executive Medical Director)
Niki Bridge	**NB**	Deputy Chief Finance Officer, DDCCG (for CFO)
Jill Dentith	**JeD**	Lay Member Derby & Derbyshire CCG
Simon McCandlish	**SMc**	Deputy Chair, Lay Member, Derby & Derbyshire CCG
Clive Newman	**CN**	Director of GP Development Derby & Derbyshire CCG

IN ATTENDANCE		
Hannah Belcher	**HB**	AD GP Commissioning & Development Derby DDCCG
Jean Richards	**JR**	Senior GP Commissioning Manager DDCCG
Pauline Innes	**PI**	Executive Assistant to Dr Steven Lloyd

APOLOGIES		
Judy Derricott	**JDe**	Head of Primary Care Quality Derby & Derbyshire CCG
Steve Lloyd	**SL**	Executive Medical Director Derby & Derbyshire CCG
Kath Markus	**KM**	Chief Executive Derby & Derbyshire LMC
Adam Norris	**AN**	Service Commissioning Manager Public Health, Derbyshire County Council
Marie Scouse	**MS**	AD of Nursing & Quality Derby & Derbyshire CCG (for CNO)
Brigid Stacey	**BS**	Chief Nurse Derby & Derbyshire CCG

ITEM NO.	ITEM	ACTION
PCCC/2122/113	**WELCOME AND APOLOGIES** The Chair (IS) welcomed Committee Members to the meeting. Apologies were received and noted as above. The Chair confirmed that the meeting was quorate.	
PCCC/2122/114	**DECLARATIONS OF INTEREST** The Chair informed members of the public of the committee members' obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG. Declarations declared by members of the Primary Care Commissioning Committee are listed in the CCG's Register of Interests and included within the meeting papers. The Register is also available either via the corporate	

	secretary to the Governing Body or the CCG website at the following link: www.derbyandderbyshireccg.nhs.uk There were no Declarations of Interest made. The Chair declared that the meeting was quorate.	
FOR DECISION		
	No items for decision	
	FOR DISCUSSION	
	No Items for discussion	
FOR ASSURANCE		
PCCC/2122/115	**FINANCE UPDATE** Niki Bridge (NB) presented an update from the shared paper. The paper was taken as read and the following points of note were made. The finance report for Month 2 has been through the Finance Committee and Governing Body. • All targets have been met. As of Month 2 the organisation was showing a slight underspend position of £478k with a forecast of £1.87m underspend. The underspends are due to the inclusion of the elective recovery funding that has been received against elective activity recovery; • Primary Care Co-commissioning has a s light overspend of £41k however this is expected to correct itself once further allocations are received • Concerns are still being seen with Continuing Healthcare and fast-tracks where there are issues with the discharge processes not being followed however there is a national plan in place to attempt to bring this back in-line. **The Primary Care Commissioning Committee NOTED and RECEIVED the update on the DDCCGs financial position for Month 2.**	
PCCC/2122/116	**RISK REGISTER EXCEPTION REPORT** Hannah Belcher (HB) presented an update from the shared paper. The paper was taken as read and the following points of note were made. The Committee noted that there has been no change to the level of risks from previous months. HB reported that General Practice remain to be under a considerable amount of pressure with increased demand and increasing numbers of contacts. Practices are talking about potentially merger options, boundary changes and closing the lists. HB stressed that the risk for general practice remains the same and the team are doing all they can to help support practices through a challenging time for all providers. **Risk 04A**: ***Contracting***: *Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on*	

	*patient care – **Risk Score 16*** Jill Dentith (JeD) enquired if Risk 04A should be increased from a risk score of 16. HB explained that this risk could be increased to a 20 stating the current risk is quite prudent in the current circumstances, however, would be happy to take a view to increase. CN stated the rating of 16 is fair and whether 04A is rated at 16 or 20 the mitigations remain the same. CN stressed that this is a pressured time for General Practice and with winter pressures approaching it would be advisable to hold off increasing risk 04A to a score of 20 until September 21. Kath Bagshaw (KB) informed the Committee that come September there may be a clearer view reporting that Practices are seeing significant challenges around isolation and COVID contacts which is beginning to take effect on top of the summer holidays. The Committee noted that across Derbyshire there are around 30 GP vacancies which is concerning. Practices advertise for staff six months before required however there is concern around these posts being filled therefore there is a need for the risk to be reviewed in September 2021. **Risk 04B:** ***Quality:*** *Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care.* ***Risk Score 20*** IS stated that there will also be a surge of COVID-19 booster vaccines in October which also needs to be taken in to account. **The Primary Care Commissioning Committee NOTED and RECEIVED the update on the two outstanding risks and AGREED that the scores remain unchanged and continue to be reviewed monthly.**	
	FOR INFORMATION	
PCCC/2122/117	**ANNUAL FLU REPORT** Hannah Belcher (HB) presented an update from the shared paper. The paper was taken as read and the following points of note were made. Jill Dentith (JeD) referred to lessons learned within the report stating that it should be clearly noted that the organisation has gone through a comprehensive process with the flu campaign in 2020 with the benefits of that process playing into this year's programme. Simon McCandlish (SMc) referred to a trial that has been undertaken in Bristol and Western regarding combining the Flu and COVID-19 booster vaccines stating hat from a participation point of view this could have a significantly positive impact on the uptake of the flu vaccine querying how the trial is going. CN responded and reported that the GDCI vaccine committee have stated that vaccines can be combined for people in care and residential homes and housebound citizens. This has been agreed on the basis that evidence is still been worked through around effectiveness of the combined vaccines. A report is due in August 2021 therefore at this moment in time this cannot be confirmed until the clinical position has been confirmed. JeD referred to Appendix 1 of the report where there is an Asterix against people's names suggesting that a note be included that states *denotes that a Deputy was in attendance to ensure quoracy of the meeting **The Primary Care Commissioning Committee NOTED and RECEIVED the Annual Flu Report**	

MINUTES AND MATTERS ARISING		
PCCC/2122/118	**Minutes of the Primary Care Commissioning Committee meeting held on 23rd June 2021** The minutes from the meeting held on 23rd June 2021 were agreed to be an accurate record of the meeting.	
PCCC/2122/119	**MATTERS ARISING MATRIX** There are no outstanding actions on the Action Matrix.	
PCCC/2122/120	**ANY OTHER BUSINESS** There were no items of any other business	
PCCC/2122/121	**ASSURANCE QUESTIONS** Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? **Yes** Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? **Yes** Were papers that have already been reported on at another committee presented to you in a summary form? **Yes** Was the content of the papers suitable and appropriate for the public domain? **Yes** Were the papers sent to Committee members at least five 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** Is the Committee assured on progress regarding actions assigned to it within the Recovery & Restoration plan? **N/A** 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 25th August 2021, 10:00-10:30am via Microsoft Teams Meeting		

MINUTES OF QUALITY AND PERFORMANCE COMMITTEE
HELD ON 29th July 2021, 9AM TO 10.00AM
MS TEAMS

Present:		
Andrew Middleton	AM	Lay Member, Finance (Chair)
Niki Bridge	NB	Deputy Director of Finance
Alison Cargill	AC	Asst Director of Quality, DDCCG
Simon McCalandish	SMcC	Lay Member, Patient Experience
Dan Merrison	DM	Senior Performance & Assurance Manager, DDCCG
Hannah Morton	HM	Healthwatch
Brigid Stacey	BS	Chief Nurse Officer, DDCCG
Dr Greg Strachan	GS	Governing Body GP, 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
Dr Steve Lloyd	SL	Medical Director - DDCCG
Craig Cook	CC	Deputy Director of Commissioning
Dr Emma Pizzey	EP	GP South
Philip Sugden	PS	Assistant Director of Quality - DDCCG
Stephanie Harris (Deep Dive Only)	SH	Performance and Assurance Manager, DDCCG
Jo Rhodes (Deep Dive Only)	JR	Senior Commissioning Manager Urgent Care, DDCCG
Mike Goodwin (Deep Dive Only)	MG	Divisional Director of Cancer, Diagnostics and Clinical Support, UHDB
Berenice Groves (Deep Dive Only)	BG	Deputy CEO and Chief Operating Officer, CRH
Krishna Kallianpur (Deep Dive Only)	KK	Executive Chief Nurse
Sharon Martin (Deep Dive Only)	SM	Chief Operating Officer, UHDB
Kerry Pape (Deep Dive Only)	KP	Lead Cancer Nurse Manager, UHDB
Anna Fletcher (Deep Dive Only)	AF	Cancer Audit Officer, UHDB
In Attendance:		
Maria Muttick (Minutes)	MM	Corporate Development Officer, DDCCG
Apologies:		
Dr Buk Dhadda (Chair)	BD	Chair, Governing Body GP, DDCCG
Laura Moore	LM	Deputy Chief Nurse, DDCCG
Helen Hipkiss	HH	Deputy Director of Quality - DDCCG

APPROVED

Jackie Carlile – Present at the Cancer Deep Dive, apologies for Public	JC	Head of Performance and Assurance, DDCCG
Zara Jones	ZJ	Executive Director of Commissioning Operations, DDCCG

Item No.	Item	Action
QP2122 /059	**WELCOME, APOLOGIES & QUORACY** Apologies were received as above. AM declared the meeting quorate.	
QP2122 /060	**DECLARATIONS OF INTEREST** AM reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG. Declarations declared by members of the Quality and Performance Committee are listed in the CCG's Register of Interests and included with the meeting papers. The Register is also available either via the corporate secretary to the Governing Body or the CCG website at the following link: www.derbyandderbyshireccg.nhs.uk Declarations of interest from sub-committees No declarations of interest were made. Declarations of interest from today's meeting No declarations of interest were made.	
QP2122 /061	**CANCER DEEP DIVE** AM introduced the presentation noting that it was a very comprehensive and informative paper. SM presented the paper from University Hospitals of Derby and Burton (UHDB) and BG presented for Chesterfield Royal Hospital (CRH). The Cancer Deep Dive consisted of four parts: • Audit of two week referrals by the CCG Cancer Commissioning Team to highlight differences from Pre Pandemic to the current time. • Update from Chesterfield Royal Hospital on the effects of the pandemic (also a copy of their latest breach) • Update from UHDB on the effects of the pandemic	

APPROVED

	• Screening Update from NHSE for JUCD SM confirmed that that the cancel referrals have dropped significantly during the COVID pandemic with most cancers being found incidentally i.e. though elective procedures. However, the tumour site two week referrals are now on the increase. UHDB reported a significant backlog in breast screening as many of the programmes were paused, the backlog is not expected to clear until March 2022. There are more patients waiting on the 62 day target and 104 day pathway than there was pre-COVID. However, a percentage of those patients do not have a cancer diagnosis. New treatments have been introduced for prostate and lung cancer. There is unfortunately general reluctance from patients to attend appointments on the cancer pathway. The urologist audit shows that those patients which have presented later have had optimum treatments minimised due to their cancer progressing. Radiotherapy, chemotherapy, and surgical treatments are within the 31 day target. **ACTION: GPs to reflect on the reluctance of patients to attend appointments on the cancer pathway and look at possible solutions to rectify this.** BG confirmed that SM's updates around the pathways is the same for CRH, as well as nationally. CRH have also seen an increase in referrals. In 2019/20 there were 7 stage 4 cancer patients, in 2020/21 this has risen to 28. However, in 2019/20 there were 80 palliative care patients, compared to 73 in 2020/21. A recent inpatient experience survey has been carried out which gave positive feedback. Breast screening has been an area of concern and therefore many actions have taken place which has resulted in a reduction in waiting times. Bowel screening's backlog of 27 weeks has reduced to 6 weeks. The 104 days have all received a Harm review (2 at low harm, 2 at severe harm, 1 near miss) and a Peer review by will take place shortly. AM asked for it to be noted that cancer performance was sustained well during this time. MW asked how many Serious Incidents had been raised. KP advised there were 2 patients that had harm. The first patient was admitted to hospital with COVID and found to be at a later stage of cancer than initially diagnosed. The second patient was reluctant to attend her appointment as her husband had COVID and then she was found to be at a later stage. A root cause analysis was carried out and both were found to be unavoidable. MW advised he had been following the algorithm in Urology and had seen that there was a 20% drop in referrals in 2021 compared to 2002 and a drop of 27% in diagnosis, but the conversion rate was higher and asked if this could be explained further. BG confirmed with the referrals and diagnosis being the	 **GPs**

APPROVED

	same the conversion looks higher. MW asked is this was due to patients presenting later and BG confirmed it was. MW commented that the report mentioned a Clinical Lead Meeting and asked if there had been any feedback. BG confirmed she would check on this and let MW know. **ACTION: BG to check the outcome/feedback from the Clinical Lead Meeting and share with MW.** EP commented that this was an interesting paper and asked if the figures per practice could be shared with the GPs. **ACTION: BG/SM to share Cancer Deep Dive practice figures with GPs.** EP commented that the figures prove there is a pool of patients with undiagnosed cancers and asked what can be done to target these individuals and overcome reluctance in patients to attend appointments. BG advised that both the Cancer Alliances (South Yorkshire and East Midlands) are looking at this issue. MW also commented that it isn't just the hospital attendances but the original check up at the GP that needs addressing. Patients must be encouraged to come forward. JR confirmed the 2ww audit data is being shared with PCNs and support is being given in identifying area of focus for PCNs and practices. SM asked MW if this could be raised at the next Engagement Committee Meeting. MW agreed that it would be good to discuss this in September so that conversations can go ahead with the Council Delivery Board and the Communication Team first. GS asked if videos should be filmed and shared encouraging patients to visit there GPs, these could then be put on practice websites. SL agreed with the suggestions on the immediate ask and confirmed that the Strategic Intent Committee is a good place to take this forward in the longer term i.e. 5/10/15yrs from now ensuring patients are rapidly transferred through Primary Care into Secondary Care. MW agreed with GS on the videos confirming that this was used to great effect in a campaign about the effects of drinking alcohol. The success in the video was canvassing first to find out what would stop people from drinking, the same could be done around patient reluctance in visiting the GP or attending hospital appointments.	 **BG** **BG/SM**

APPROVED

	BS asked if JC and AC were assured by this report. Both confirmed they were. JC also confirmed that a Healthwatch report regarding patient experiences would also be shared with the Quality and Performance Committee after it has been presented at the steering groups and an action plan (if necessary) developed. AC advised that the Risk Stratification could extend to wider quality and safety issues around waits. **ACTION: BS to discuss with the communication team how we can communicate with patients to encourage them to attend appointments on the cancer pathways and to contact a GP if they have any worrying symptoms.** **ACTION: MW to request the Derbyshire Engagement Committee include an item on engaging with patients/reluctance to attend appointments.** **ACTION: SL to attend the Strategic Intent Committee (when stood back up) and raise the issue around engaging with patients/reluctance to attend appointments.** The Committee reviewed and were **assured** by the contents of this paper.	**BS** **MW** **SL**
QP2122 /062	**INTEGRATED REPORT** **Performance** The paper was taken as read and the Committee were asked for any further questions. DM presented the paper. CC added that over the past 2 to 3 weeks the system has moved from Opel Level 2 to Opel Level 3 with some operations working at Opel Level 4. The drivers for this are self-isolation and absence. The absence rate is at least double of what it was pre-pandemic. AM asked if the younger aged infection rate is going to translate into a further compromise of hospital capacity? CC confirmed the original projections were approximately 3.5% of beds would be occupied with COVID patients, this stands at 2% however the expectation is for it rise to 5%. This is being monitored every day. EP asked why the A&E figures between Derby and Chesterfield were so different. CC confirmed that Chesterfield has a more developed triage service working with DHU for several years whilst this service is relatively new in Derby. SL confirmed that weekly STAC and Planning Group Meetings are taking place to address this problem. SL shared a slide which showed the prediction of ambient COVID activity in the community and confirmed that hospitals admissions are being tracked against this. SL said it is difficult to predict with the delta variants,	

APPROVED

	however this chart not only includes the COVID notification rates both in City and County but also the impact of the vaccination programme as it pertains to Derbyshire. AM confirmed this provided assurance. **Activity** The paper was taken as read. HW advised the COVID occupancy position has improved, unfortunately Derbyshire is not seeing the same drops as those seen nationally or in other parts of the Midlands, however the conclusion is that Derbyshire is feeling the benefit of its high double vaccination rate. AM confirmed this is additional assurance. **Quality** The paper was taken as read. The Committee reviewed and **agreed** the contents of the Integrated Report.	
QP2122 /063	**GBAF Q2** The paper was taken as read. MW referred to his pre-meeting question: *Is a 95% target for double vaccination something that is achievable; what would a herd immunity figure look like; how does this compare to other vaccination targets?* MW explained that his concerns were around the psychology of such a high target. SL advised that herd immunity is a very nebulous concept and was pushed to one side because it is so variable and dependent on so many factors. In the most vulnerable cohorts of the vaccination programme, namely cohorts 1 to 9 a sense of assurance can be taken if this reaches 90%. The whole adult population is at 89% for the first dose and 82% for the second. Cohort 6 (150000 people) is at 84% for the second dose and therefore a deep dive is taking place as part of the focus to achieve over 90%. The Committee discussed and **approved** the contents of the GBAF.	
QP2122 /064	**RISK REGISTER** The paper was taken as read. The Committee supported and **approved** both recommendations.	

APPROVED

QP2122 /065	**CQC REPORT – INFECTION CONTROL** The paper was taken as read. AM congratulated the CCG and IPC Teams on a positive CQC report, and a job well done. The Committee **noted** the contents of the paper.	
QP2122 /066	**CQC – PROVIDER COLLABORATIVE REVIEW LEARNING DISABILITY & AUTISM** The paper was taken as read. BS highlighted that the CQC inspection was not carried out because Derbyshire had any issues, they must cover the whole spectrum of services and they chose Learning Disability and Autism for Derbyshire. AM asked that as provider collaboratives are going to be a feature in the future, were there any generic messages for acute provider collaboratives or primary care collaboratives. BS advised that it was good that the CQC chose the Mental Health, Learning Disability and Autism provider collaborative, as the CCG is established as a provider collaborative in that delivery board, and it was an opportunity to show how established they are in the provider collaborative process. The review assured the System Quality Group that they have quality services. The Committee **noted** the contents of the paper.	
QP2122 /067	**CONTINUING HEALTH CARE (CHC)** The paper was taken as read. The Committee **noted** the contents of the report and there were no questions raised.	
QP2122 /068	**INFECTION PREVENTION & CONTROL (IPC)** The paper was taken as read. The Committee **noted** the contents of the report and there were no questions raised.	

APPROVED

QP2122 /069	**CARE HOMES** The paper was taken as read. The Committee **reviewed** the contents of the report and there were no questions raised.	
QP2122 /70	**PATIENT SAFETY** The paper was taken as read. The Committee **received** the report and there were no questions raised.	
QP2122 /71	**DDCCG ANNUAL REPORT** The paper was taken as read. The Committee **noted** the contents of the report and agreed this was a true and fair statement.	
QP2122 /72	**LeDeR 2020 ANNUAL REPORT** The paper was taken as read. PS confirmed this report is from the University of Bristol who have been supporting LeDeR for 5 years. There involvement ended on 31/5/21 and this is their final report. AM asked if there is any important take away from the CCG Annual Report presented 29/4/21 and the LeDeR Annual Report today. PS confirmed in line with national findings, representation of the BAME community was recommended at the steering groups and 111 are receiving training around LD and Autism. The recommendations are being incorporated in the LD and Autism Board as the local area co-ordinators develop the 3 year strategy for LeDeR. This will be sent to all steering groups as it is for the ICS not CCG. AM advised that he has attended the Mental Health Delivery Board and provided assurance that they do take ownership very seriously on all their areas of responsibility. The Committee **noted** the findings and recommendations for Commissioners from the national 2020 LeDeR Annual Report from the University of Bristol.	
QP2122 /073	**MINUTES FROM SUB COMMITTEES** The Committee noted the minutes from the following sub-Committees. • DPG 3rd June 21 • Update reports from DCHS CQRG UHDBFT CQRG	

APPROVED

	CRHFT CQRG DHCFT CQRG	
QP2122 /074	**MINUTES FROM THE MEETING HELD ON 24th JUNE 2021.** The minutes were **approved** as a true and accurate record.	
QP2122 /075	**MATTERS ARISING AND ACTION LOG** There is one action on the action log. Update below: **Action Q&P 1920/230:** *BD suggested a piece of work looking at the development of the MH pathway. The Committee agreed that it would be useful to invite colleagues from the MH Trust to a future Committee to present a deep dive on the pathway from a performance and quality point of view.* PS confirmed that the Trust will be asked to attend the September Quality and Performance Meeting to present their deep dive on the MH pathway from a performance and quality perspective. **ACTION: MM to add MH Pathway Deep Dive presentation to the forward planner for the September 2021 meeting.**	**MM**
QP2122 /076	**AOB** AM asked what does it mean by way of challenge for this committee and BS that Glossop is now joining the Derby and Derbyshire CCG. BS confirmed that a meeting is being arranged for BS to meet the Chief Nurse at Glossop to understand the quality issues and the logistics of staff transferring. The Committee should note that the patient flows will not change. Stepping Hill Hospital will be a new provider for the CCG and will need the same links as CRH and UHDB.	
QP2122 /077	**FORWARD PLANNER** The Forward Planner was reviewed. No updates were made. MH Pathway Deep Dive presentation is to be added, captured QP2122/055.	
QP2122 /078	**ANY SIGNIFICANT SAFETY CONCERNS TO NOTE** None raised.	
	ASSURANCE QUESTIONS • Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? Yes	

APPROVED

	• Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? Yes • Were papers that have already been reported on at another committee presented to you in a summary form? Yes • Was the content of the papers suitable and appropriate for the public domain? Yes • Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? Yes • Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? Yes, MH Pathway Deep Dive • What recommendations do the Committee want to make to Governing Body following the assurance process at today's Committee meeting? Cancer Deep Dive, Provider Collaborative, CHC Fast Track and Glossop.	

DATE AND TIME OF NEXT MEETING
Date: 26th August 2021
Time: 9am to 10.30am
Venue: MS Teams

APPROVED

South Yorkshire and Bassetlaw Integrated Care System

Chief Executive Report

Health Executive Group

10th August 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

- ☑ Understanding health in SYB including prevention, health inequalities and population health management
- ☑ Getting the best start in life
- ☑ Better care for major health conditions
- ☑ Reshaping and rethinking how we flex resources

Building a sustainable health and care system

- ☑ Delivering a new service model
- ☑ Transforming care
- ☑ Making the best use of resources

Strengthening our foundations

- ☑ Working with patients and the public
- ☑ Empowering our workforce
- ☑ Digitally enabling our system
- ☑ Innovation and improvement

Broadening and strengthening our partnerships to increase our opportunity

- ☑ Partnership with the Sheffield City Region
- ☑ Anchor institutions and wider contributions
- ☑ Partnership with the voluntary sector
- ☑ Committment to work together

Where has the paper already been discussed?	
Sub groups reporting to the HEG:	**System governance groups:**
☐ **Quality Group**	☐ **Joint Committee CCGs**
☐ **Strategic Workforce Group**	☐ **Acute Federation**
☐ **Performance Group**	☐ **Mental Health Alliance**
☐ **Finance and Activity Group**	☐ **Place Partnership**
☐ **Transformation and Delivery Group**	

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 July 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

10th August 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 July 2021.

2. Summary update for activity during July

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

Our overall vaccination numbers remain very high. Over 85.7 per-cent have been vaccinated across cohorts 1-12 of the Joint Committee on Vaccination and Immunisation (JCVI) recommended priority list with 71.6 per-cent having also received second doses. Much of our efforts are now focused on reaching our unvaccinated populations, in which an estimated 173,000 have not yet had their Covid vaccinations, and planning for a possible 'booster' campaign in the autumn.

Rates of Covid across SYB rose dramatically during July rise but are now falling. The region was impacted by Euro 2021, with cases rising towards the end of the tournament as people mixed and while each of our places are seeing a fall in rates, they all remain relatively high.

On average, SYB hospitals have 25/30 per cent occupancy with Covid patients. The number of deaths is rising and are at levels similar to those in September 2020.

Demand for primary care services continues to be high, alongside increases in hospital bed occupancy and rising admissions to accident and emergency (A&E) departments across SYB. There is an increase in respiratory viruses which is adding increased pressures on our system.

At the same time, there has been an increase in staff absences relating to Covid, both in terms of being infected but also from the NHS Test and Trace app. New national guidance was issued in July to support frontline NHS and social care staff to attend work rather than self-isolate (in exceptional circumstances), helping to safely reintroduce staff who are able to effectively demonstrate they are Covid-negative.

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 July, discussions focused on the ongoing Covid response and vaccination programme, urgent and emergency care and winter resilience, planning and recovery and ICS development (including feedback from the NEY transition oversight group).

2.3 National update

2.3.1 New Chief Executive Officer (CEO) of NHS England.

Amanda Pritchard has been appointed as the new Chief Executive Officer of NHS England. Amanda is the first woman in the health service's history to hold the post, which she took up on Sunday August 1, replacing Sir Simon Stevens.

As NHS chief executive, she will be responsible for an annual budget of more than £130 billion while ensuring that everyone in the country receives high quality care. She takes up the role after serving as the NHS' Chief Operating Officer (COO) for two years.

Her appointment follows an open and competitive recruitment process by the Board of NHS England and NHS Improvement.

2.3.2 NHS staff awarded The George Cross

More than 1.1 million NHS staff were awarded The George Cross by Her Majesty The Queen to mark the NHS' 73rd anniversary.

The award serves as a poignant reminder of the courage, resilience and sacrifices made since the beginning of the Covid Pandemic to protect our most vulnerable communities. The award also acknowledges colleagues who sadly lost their lives to Covid and receive this award posthumously.

2.4 Integrated Care System update

2.4.1 System Development Plans

All 42 ICSs across England have developed System Development Plans setting out how they will establish statutory ICSs.

SYB discussed its draft plan at the July Health Executive Group meeting and subsequently shared the plan with NHS England. The focus is now on the key steps which will need to be taken to establish the new organisation ready for April 1st 2022 and the required work to transition people and functions. This work is being overseen by the ICS Development Steering Group, established at the beginning of this year by partners and CCGs respectively. Further national guidance is expected to support local systems.

2.4.2 Boundary decision

Earlier this year, Ministers asked NHS England to set out options for boundary alignment in integrated care systems in specific geographies where upper-tier local authorities currently work across more than one ICS footprint. The working principle was that coterminous boundaries deliver clear benefits in integration between local authorities and NHS organisations.

Following an assessment of the impact of changes for Bassetlaw, the Secretary of State announced (July 22) that the district of Bassetlaw would align with the Nottingham and Nottinghamshire Integrated Care System. The change will take effect from 1st April 2022.

Until then, Bassetlaw remains a part of South Yorkshire and Bassetlaw Integrated Care System (SYB ICS). As the transition towards and development of statutory ICS bodies progresses, Bassetlaw CCG and its staff will increasingly work with Nottingham and Nottinghamshire ICS to design the future.

In the meantime, the change and transition work that is taking place in SYB will continue to include Bassetlaw CCG and its staff will continue to be supported by SYB.

2.4.3 National designate appointments

- Appointment of Independent Chair/Chair Designate

Pearse Butler has been appointed the South Yorkshire and Bassetlaw Integrated Care System Independent Chair and Chair Designate of the future organisation, the South Yorkshire Integrated Care Board (SY ICB). The announcement is part of the transformation of the ICS to become a statutory body by April 2022.

Following a recruitment process, Pearse, who recently moved to the area and was previously chair at Blackpool Teaching Hospitals NHS Foundation Trust, has been approved by the Secretary of State. He joins the ICS on 1st September 2021

He is very keen to join the SY ICS and continuing the great work of the ICS and I am sure partners will join me in welcoming Pearse into the SY Partnership and we look forward to working with him.

- Appointment of Chief Executive designates

The appointments process for the chief executive appointments are due to begin in mid-August and expected to conclude by end October.

2.5 Yorkshire & Humber Academic Health Science Network – Impact Report 2021

The Yorkshire & Humber Academic Health Science Network (Yorkshire & Humber AHSN) has celebrate a successful year for health innovation across the region.

Their newly published Impact Report (2020 – 2021), showcases some of the developments initiated across SYB during the Covid pandemic including the Agile Workforce Project and Fit Fans. These projects were led by SYB's Innovation Hub which has also helped to secure research and innovation bids worth £240k for our region.

We have also worked closely with the AHSN to deliver our Digital Care Homes project and supporting our Clinical Commissioning Groups (CCGs) to adopt pulse oximeter devices to enable high-risk Covid patients to accurately monitor and manage their symptoms at home.

2.6 Tackling obesity report – The King's Fund

The 'Tackling Obesity' report by The King's Fund sets out a clear agenda for change to support health and care systems to take greater preventative action in reducing harm from excess weight gain.

SYB is featured as a case study in the report (page 25) highlighting our multifaceted approach to tackle obesity; our collaborative work with local authority partners, our improved referral pathways into weight management services and our work to encourage greater physical activity among staff through green initiatives/wellbeing programmes.

2.7 Sheffield Olympic Legacy Park sustainable vision

Sheffield Olympic Legacy Park set out its vision to create a lasting environmental legacy for Sheffield in July.

Project Lead Richard Caborn outlined plans for the next stage of investment and development at the world's only Olympic legacy park outside a host city during a recent visit (July 22nd) with Councillor Douglas Johnson, Sheffield City Council's Executive Member for Climate Change and Environment, and other councillors.

The environment is one of the four legacy themes of the Park which is reflected in the second phase of development which includes plans for improvements to public transport and cycling links to the unique site as well as opening up access to Sheffield and Tinsley Canal. Through the four themes of sport, community, environment and economy, the Park is uniquely delivering a long-lasting legacy from the London 2012 Olympic and Paralympic Games that was at the heart of the UK's bid.

SYB ICS is part of a region-wide partnership (Legacy Park Ltd) which also comprises Sheffield City Council, Sheffield Teaching Hospitals NHS Foundation Trust, Sheffield Hallam University, Sheffield City Trust, Sheffield Children's NHS Foundation Trust, and Yorkshire & Humber Academic Health Sciences Network and Darnall Well Being.

2.8 Sheffield Hallam University pledges 'civic' action

As part of a new Civic University Agreement launched in July, Sheffield Hallam University (SHU) has pledged to provide more opportunities to become an apprentice, double the annual intake of students studying to become healthcare professionals (by 2025) and to develop their newly opened Early Years Community Research Centre (EYCRC).

South Yorkshire Mayor, Dan Jarvis MP has also allocated £100,000 funding to help expand the successful GROW school mentoring programme, founded in the summer of 2020 with the Northern Powerhouse Partnership, to help regional schools address the disproportionate impact of Covid on young people and their education

The agreement is fully supported by SYB ICS, local authorities, other educational providers, the South Yorkshire Combined Authority and the Local Enterprise Partnership.

3. Finance

At month 3 the system has a surplus of £19.8m which is £16.4m favourable to plan. The forecast is a £2.7m surplus which compares to a break even plan. The Elective Recovery Fund threshold has been raised from 85% to 95% in the second quarter in the year. This will impact on planned income by circa £22m. An exercise will be undertaken as part of month 4 reporting to assess the impact of this on the forecast position.

Capital spend at month 3 is £17.7m which is £1.5m higher than plan. Forecast spend is £121.4m which is £12.6m greater than plan. Further work will be required to mitigate against the forecast deficit which is due to the temporary work in relation to the critical incident in the Women & Children's block at Doncaster Royal Infirmary.

Further bids are being sought for the next phase of hospital developments to bring the total to forty. Expressions of interest are sought by 9 September with final decisions expected in Spring 2022.

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

Date: 4th August 2021

Derby and Derbyshire CCG Governing Body Meeting in Public Held on 5th August 2021 via Microsoft Teams

UNCONFIRMED

Present:

Dr Avi Bhatia	AB	Clinical Chair
Dr Bruce Braithwaite	BB	Secondary Care Consultant
Richard Chapman	RCp	Chief Finance Officer
Dr Chris Clayton	CC	Chief Executive Officer
Dr Ruth Cooper	RC	Governing Body GP
Jill Dentith	JD	Lay Member for Governance
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
Dr Merryl Watkins	MW	Governing Body GP
Martin Whittle	MWh	Lay Member for Patient and Public Involvement

Apologies:

Dr Penny Blackwell	PB	Governing Body GP
Dr Robyn Dewis	RD	Director of Public Health - Derby City Council
Dr Buk Dhadda	BD	Governing Body GP
Professor Ian Shaw	IS	Lay Member for Primary Care Commissioning
Dean Wallace	DW	Director of Public Health - Derbyshire County Council

In attendance:

Dawn Litchfield	DL	Executive Assistant to the Governing Body/Minute Taker
Suzanne Pickering	SP	Head of Governance
Linda Garnett	LG	Workforce and OD Lead, Joined Up Care Derbyshire (part meeting)

Item No.	Item	Action
GBP/2122/ 096	**Welcome, Apologies & Quoracy** Dr Avi Bhatia (AB) welcomed members to the meeting. Apologies were received as above. It was confirmed that the meeting was quorate.	
GBP/2122/ 097	**Questions received from members of the public** One question was received from Keith Venables as follows:	

	• What is the position with regard to GP data being sold off to private companies? There have been many contradictory statements and I am unsure of the current situation. Response: It has been confirmed by our Governance Team that this is not a subject where the CCG has a decision-making role. A link was provided to the national position, which advises that the data collection is paused until further engagement has been undertaken. GP Data for Planning and Research: Letter from Parliamentary Under Secretary of State for Health and Social Care to general practices in England - 19 July 2021 - NHS Digital	
GBP/2122/ 098	**Declarations of Interest** AB reminded Committee members and visiting delegates of their obligation to declare any interests that they may have on any issues arising at Committee meetings which might conflict with the business of the CCG. Declarations declared by members of the Governing Body are listed in the CCG's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Governing Body or the CCG website at the following link: www.derbyandderbyshireCCG.NHS.uk No further declarations of interest were made and no changes were requested to the Register of Interests.	
GBP/2122/ 099	**Presentation – NHS People and Culture Development** Linda Garnett (LG) attended the meeting for this item only in order to provide an update on the work being undertaken by the people and culture programme across Joined Up Care Derbyshire (JUCD); a copy of the presentation provided was circulated in advance of the meeting. A request was made by the Governing Body for an update on this matter as concerns had been raised in relation to the People and Culture Oversight Group's ability to deliver in a System wide setting. LG advised that there are clear lines of accountability for the People and Culture work, which is being driven System wide, with HR Director representation from each partner organisation, in order to ensure that the key issues are acted upon collaboratively and in a timely manner. The following questions were raised in relation to the presentation: • Although 'one NHS workforce' is the ultimate desirable goal, there are currently greater, more essential immediate challenges to be faced i.e., finding locum doctors, the high turnover of staff in adult social care and recruiting NHS staff in general. A reality check on Organisational Developmental type of issues is required; although they are beneficial and essential in the long-term strategy, doctors and nurses to treat patients need to take priority, as notwithstanding COVID-19, there is not enough supply to meet demand. It was enquired how the new ways of working have improved services for patients. LG responded that the biggest differences in terms of staff and patient experience have been where person centred care and approaches have been delivered. 'Quality Conversations' is an initiative which equips staff at all levels to have person centred conversations with people on 'what matters to	

	them' rather than 'what is the matter with them'. This has had an impact on staff delivering high quality services, by focusing on the right areas and freeing them up from non-essential tasks. • It was enquired how many additional nurses and doctors have been put in place in Derbyshire over the last 2 years, nett of retirement. LG agreed to provide feedback on actual numbers. The workforce has grown significantly; according to the latest System Dashboard; the growth between pre-COVID-19 and now is significant. • It was queried how a local recruitment focus will be maintained by JUCD to grow for the future in Derbyshire over the next few years. LG responded that workforce planning is one of the areas that has been a struggle, as the different elements needed to achieve it are held in different parts of the System. The test has been finding a clear sense of what the training pipeline is, what the short, medium and long term service requirements are and what the options are for supply. The challenge now is about bringing a collaborative and strategic lens to the task. The workforce is growing well, and Derbyshire is comparable to other areas. • As the Primary Care Workforce Steering Group has now been dissolved, it was asked if another group will be focusing on Primary Care staffing. LG is involved in the production of the Terms of Reference for a new group. There is a need to strike a balance between engaging with Primary Care Networks (PCN) and not over burdening them. • It was asked how having a single workforce is going to work practically across 112 practices, all of which are small businesses, and all doing different things. LG has fed this issue up to national team. There is currently good primary care representation on the People and Culture Board. Although the 'one workforce' label is a good ambition, there needs to be more thought as to what this means, and not to assume that all parts of the System want to be 'one workforce'. Further exploration to understand what Derby and Derbyshire would like it to mean is needed. The Steering Group was originally stood down as the money moved over to PCNs; it was asked whose responsibility it is to lead on this, whether it should be the CCG or the providers as a collective, facilitated by the CCG. The GP Taskforce has done incredible work to support junior doctors; this should not be underestimated. Health Education Derbyshire needs to start working as part of the System and raise its profile. This will need to be part of the transition into the ICS. • The broader contrast of what makes a happy, productive workforce seems to be within the NHS as a whole, whereas the things that affect NHS workers are what the patients and press are doing. Some doctors are working 12 to 13 hour days and yet the press reports that General Practices and hospitals are not doing enough, which is negative publicity. There is a need to present a positive picture of the fantastic work being done in the NHS. There must be a cultural change to get the public and press to value the NHS more. LG advised that the Communications Team work hard to get positive messages out. The Joined Up Careers website and social media put forward positive stories. The Trusts focus on recognition and try to show staff in many different ways that they are appreciated. The System needs to constantly build resilience, be supportive, show recognition and thanks for what staff do whilst managing outwards to publicise good news stories.	**LG**

	• The presentation has provided some reassurance on the work being undertaken by the People and Culture programme across the System. It was queried if there is a dotted or solid line from the Strategic Oversight Group into the JUCD Board. LG confirmed that there is a solid line between the two Groups. • There are a number of parts of the System now feeding into the People and Culture agenda; the Governing Body requested assurance that there will be a smooth transition for CCG staff into the ICS and how this will operate. • The issue of primary care recruitment and retention was raised at the last PCCC meeting and will be picked up as a risk by that Committee to oversee. • Concern was expressed as to whether there is engagement from the Royal College of Nursing, the Royal College of Surgeons, the Royal College of Physicians, Health Education England (HEE) and the people who set the tone for the education and training of doctors, as this is where a lot of the issues come from. LG confirmed that there is good engagement with HEE, with representation on the People and Culture Board; however, there is not as much representation from the other professional bodies at System level; this is an area that could be built upon. • It was enquired if there are any plans to think differently. There are people in their 40s and 50s who want to the join the NHS but are only able to come in at Healthcare Assistant level and are blocked from moving into higher roles because they do not have the required registration, even though they are quite capable of undertaking more responsibility. They subsequently leave as they cannot move forward any further. LG responded that the main emphasis is on the apprenticeship route however this is not always suitable for everyone; this is an area which could be done better. A better approach to talent management is being worked upon which provides staff with opportunities for career progression. The Chair thanked LG for providing the very informative update. **The Governing Body NOTED the presentation provided**	
GBP/2122/ 100	**Chair's Report – July 2021** AB provided a written report, a copy of which was circulated with the meeting papers; the report was taken as read and no questions raised. **The Governing Body NOTED the contents of the report provided**	
GBP/2122/ 101	**Chief Executive Officer's Report – July 2021** Dr Chris Clayton (CC) provided a written 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: • The Health and Social Care Bill has now progressed through parliament, and after the summer will go through the committee stages. • A decision has been made by the Secretary of State on the Glossop boundary; in due course the transition arrangements will be set out for DDCCG and the Derbyshire Integrated Care System (ICS).	

	• There has been a change in the national leadership of the NHS with Lord Simon Stevens leaving his role and Amanda Pritchard being appointed as his replacement of what will become the Head of NHS England (NHSE), following the merger of NHS England and NHS Improvement once the Bill is approved. • Section two provided examples of the meetings attended by Dr Clayton during the past month on behalf of the Governing Body and ICS. • Section three described national developments, research and reports. • Section four described local news and developments **The Governing Body NOTED the contents of the report provided**	
GBP/2122/ 102	**Joined Up Care Derbyshire Board Update – July 2021** Dr Chris Clayton (CC) provided a written 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: • Details of the discussions held at the JUCD Board were provided for information. • A patient story was presented to the Board; CC emphasised how important these stories are to Board members to highlight the things that are happening on the ground. • A reflection on System operations and performance was provided to the Board for information. The rising COVID-19 position has, in the last few days, started to stabilise, particularly in the hospital setting however the General Practice and community setting remains busy. There has been a non-COVID increase in terms of demand in health and care, with notable increases in 111 and 999 service requests over recent weeks. • An update was provided on statutory changes and developments with an explanation provided as to how the issues will be worked through. • Updates were received from the sub-committees reporting into the JUCD Board. The people and culture presentation, as discussed at the start of today's meeting, was received by the Board in to explain how it fits into the governance approach. • The context of an Anchor Institution approach is being progressed; this is a way in which JUCD can make a difference by operating collectively to tackle the wider determinants of health. • There are ongoing developments in terms of data and digital, which is an important area. Progress is being made on the Shared Care Records and in the development of a decision support unit for the System of a shared business intelligence function which will be significant. The following questions were raised: • It was asked if the Anchor Charter is available for circulation as yet. CC advised that this is not as yet complete. The Governing Body will be requested to provide agreement to this Charter in due course. • The Governing Body requires assurance around the smooth transition of the Glossop boundary situation; an overview of the issues and how they are being tackled was requested. CC agreed to provide a formal report in September. • A question was raised around the COVID-19 situation and the shifting focus on the younger demographic. Government policy has shifted regarding how the messaging and vaccination programme for students will be handled. One of our Anchor Institutions is the University of Derby.	**CC**

	Assurance was requested that work is being undertaken to shift messaging towards the younger demographic and that any issues are being picked up in partnership. Brigid Stacey (BS) responded that the colleges and university are part of the Health Protection Board. Throughout the pandemic there have been constant communications on how to support them in testing and targeting. They are active members of the Board in both the County and the City; reassurance was provided that there is good engagement. **The Governing Body NOTED the contents of the report provided**	
GBP/2122/ 103	**Remuneration Committee – Updated Terms of Reference** Helen Dillistone (HD) presented the updated Terms of Reference (TOR) of the Remuneration Committee for consideration and approval. On a 6 monthly rolling cycle, all Corporate Committees' TOR are reviewed to ensure that their work remains in line with requirements and any changes required are reflected. Two amendments have been proposed for the purposes of transparency: Section 1.3 – Clarifies that the Remuneration Committee is accountable to the Governing Body. Section 5.7 – An addition was made to clarify that the Lay Members' remuneration is discussed and agreed by the Governing Body. **The Governing Body APPROVED the amendments to the Remuneration Committee's Terms of Reference**	
GBP/2021/ 104	**Finance Report – Month 3** Richard Chapman (RCp) provided an update on the financial position as at Month 3. The following points of note were made: • There is a Year To Date (YTD) favourable variance of £113k after accounting for expected reimbursement for the hospital discharge programme of £2.7m and the elective recovery fund of £448k. • A forecast outturn of breakeven is expected after receipt of £2.6m of the H1 contingency reserve of £4.2m; 60% of the reserve is now committed. The position includes reimbursement of incurred and assumed expenditure relating to the hospital discharge programme of £4.6m and assumed elective recovery funding of £1.6m, which offsets an expenditure overspend on Community Health Services for ophthalmology activity in excess of the Elective Recovery Fund threshold by the independent sector. This expenditure is expected to be incurred in months 4 to 6. • There are planned investments relating to the Mental Health Investment Standard (MHIS) on top of the existing expenditure run rate. • There is expected to be a seasonal variation in prescribing to the Quarter 1 run rates; the rates are usually lower in July to September than they are in April to June. Up to £5.1m additional expenditure could be absorbed and still allow the forecast position to be delivered. • Three key risks were described in the report:	

	• The increasing fast track activity for Continuing Health Care (CHC); however, cases are now starting to reduce as a result of the actions taken starting to take effect. • Emerging cost pressures for Section 117 – The national mental health planning guidance stated that Section 117 activity should not be above 2020/21 outturn; consequently, the CCG was only allowed to apply an uplift of 1.71%. This is contradictory with local trends. The System has invested in additional case management capacity; although this will provide additional knowledge, it is not expected to bring it in line with budget. When signing up to the System Operational Plan, the Mental Health, Autism and Learning Disability Delivery Board recognised this risk and accepted that it was their responsibility to manage. • Spa Medica is an independent ophthalmology provider in Derby, at present the activity is within the scope of the Elective Recovery Fund. This is an issue that would previously have seen an offset in acute provider activity, however as block contracts are now in situ this will not occur. This is a financial pressure on the System. The financial controls and access criteria are being considered; however, the additional expenditure will be covered by the Elective Recovery Fund. • All financial control targets have been met. • The System deficit has now improved from a £600k deficit to a £200k deficit. There is no major cause for concern that the System will not deliver a breakeven position. **The Governing Body NOTED the following:** • **Allocations have been received for H1 at £1.017bn** • **The YTD reported underspend at month 3 is £0.113m** • **Retrospective allocations expected for COVID-19 spend on the Hospital Discharge Programme is £2.697m** • **The Elective Recovery Fund has a YTD estimated £0.448m and H1 forecast of £1.579m which is expected to be reimbursed** • **H1 is forecast to conclude at a breakeven position**	
GBP/2122/ 105	**Finance Committee Assurance Report – July 2021 / Annual Report** Andrew Middleton (AM) provided a verbal update following the Finance Committee meeting held on 29th July 2021. The following points of note were made: • AM corroborated RCp's report as correct in terms of the balance and forecast outturn position however, at the System Finance and Estates Committee (SFEC) meeting this week it was confirmed that the underlying System challenge is in the region of £180m, as estimated before the pandemic. The System is in dialogue with NHSEI to achieve a breakeven run rate over a period of years. Although this is a huge challenge, the SFEC is working on a partnership principle and philosophy and there is joint ownership of and solutions to the challenge. • It is comforting that the System Efficiencies Team has now been reformed. Between the collective goodwill of the System, there is a good chance of achieving this challenge through the use of pathway redesign and more efficient and effective ways of working. Hope was provided that with the right people on the case this will be possible.	

	• It was confirmed that the CCG is discharging all of its statutory duties. • The Annual Report was noted for information. **The Governing Body NOTED the verbal update provided for assurance purposes and NOTED the Annual Report provided**	

GBP/2122/ 106	**Clinical and Lay Commissioning Committee (CLCC) Assurance Report – July 2021 / Annual Report**
	
	Dr Ruth Cooper (RC) provided an update following the CLCC meeting held on 8th July 2021. The report was taken as read and the following points of note were made:
	
	• The CLCC approved the updated Position Statement on Epidurals for all forms of Sciatica (Lumbar Radiculopathy). The CCG does not commission this procedure.
	• The CLCC noted the progress to date regarding the EBI2 Interventions and ratified the following policies/position statements which have been updated to reflect the EBI2 proposals:
	    • Lumbar Discectomy
	    • Fusion Surgery for Mechanical axial low back pain
	    • Injections for Non-specific Back Pain
	• The CLCC noted the following EBI2 interventions that are covered by existing policies/position statements to remain unchanged:
	    • Removal of adenoids for glue ear
	    • Low Back Pain Imaging
	    • Cholecystectomy
	    • Repair of minimally symptomatic Inguinal Hernia
	• The Annual Report was noted for information
	
	The Governing Body NOTED the contents of the report provided for assurance purposes and NOTED the Annual Report provided	

GBP/2122/ 107	**Derbyshire Engagement Committee Assurance Report – July 2021 / Annual Report** Martin Whittle (MWh) provided an update following the Derbyshire Engagement Committee meeting held on 20th July 2021. The report was taken as read and the following points of note were made: • The Sinfin Health Centre development is in the early stages – a briefing will be received by the Committee on the engagement next month. • A briefing was received on the St Thomas Road surgery engagement plan which was well thought through; the Committee was assured that it is meeting the expected standards. • The Committee wanted to be more systematic and mythological in measuring how the engagement function is being carried out to support the Engagement Strategy, which was approved in May. The Committee reviewed the first draft of a range of metrics that could be used and measurements that could provide a more objective view of what is being undertaken in wider engagement. Monthly reports will be received by the Committee to measure how well it is doing. • The Committee received the log of completed engagement assessment forms (S14Z2 forms) for assurance that programmes are now re-commencing following the pandemic; this enabled the Committee to	

	understand the breadth of programmes being assessed and to highlight where a deep dive might be required. • The Annual Report was noted for information. **The Governing Body NOTED the contents of the report provided for assurance purposes and NOTED the Annual Report provided**	

GBP/2122/ 108	**Governance Committee Assurance Report – July 2021 / Annual Report**
	
	Jill Dentith (JD) provided an update following the Governance Committee meeting held on 15th July 2021. The report was taken as read and the following points of note were made:
	
	• The Governance Committee approved the following polices:
	  ◦ Freedom of Information
	  ◦ Standards of Business Conduct and Managing Conflicts of Interest
	  ◦ Gifts and Hospitality
	  ◦ Procurement
	• The Recovery and Restoration closure report was discussed, and it was agreed that any outstanding actions would form part of business-as-usual arrangements.
	• A report was received on HR performance which overall was positive.
	• A report was received on the CCG's Gender Pay Gap. The actions being taken to reduce the gap were highlighted, including strengthening work around equality, and promoting flexible working options.
	• Procurement decisions in the ICS transitional arrangements were discussed and it was agreed that the Governance Committee would be the overseeing Committee for procurement decision-making processes and ensuring that Conflicts of Interest are managed appropriately.
	• The Annual Report was noted for information. JD thanked Fran Palmer, the CCG's Governance Manager, for drafting the Annual Reports on behalf of the Committee Chairs.
	
	The Governing Body NOTED the contents of the report provided for assurance purposes and NOTED the Annual Report provided	

GBP/2122/ 109	**Primary Care Commissioning Committee (PCCC) Annual Report** The Annual Report was noted for information. **The Governing Body NOTED the Annual Report provided**	
GBP/2122/ 110	**Quality and Performance Committee (Q&PC) Assurance Report – July 2021 / Annual Report** Andrew Middleton (AM) provided an update following the Q&PC meeting held on 30th July 2021. The report was taken as read and the following points of note were made: • The breadth of expertise and passion with which the Quality and Performance teams address most issues successfully is phenomenal. • A deep dive and challenge session was held with the cancer leads from the two Derbyshire Acute Trusts; this was positively received. • AM was pleased to hear that BS is involved with the Tameside and Glossop matter, helping to ensure a smooth transfer.	

	• Quality and Performance is working more and more in a whole System manner; BS was requested to explain how it will be ensured that nothing gets lost in translation from CCG to System working. BS confirmed that there is now a robust quality architecture in place; the Regional Team is assured by the progress made and the plans going forward. BS chairs the System Quality Group, which reports into the System Quality Assurance Committee (SQAG). Certain elements which the CCG would normally gain assurance from within its own Q&P, i.e., complex children in the Emergency Department, are a System issue rather than a CCG one. The CCG is gaining assurance from the SQAG which prevents duplication and also ensures that nothing gets lost. • CC advised that there is a statutory being in place now (the CCG) and a new one coming in (the ICS) and a transition between the two. One of the suggestions is to use the joint mechanism of the SFEC or SQAG to provide mutual assurance to both the CCG and ICS. Something similar was utilised when the Derbyshire CCGs merged. This is an important principle, and it was suggested that it be brought back for further discussion in mid to late Autumn before the last quarter of the financial year. AB advised that this will be worked through by the Transition Working Group and Transition Assurance Sub-Committee, however the CCG has statutory responsibility until the end of March 2022; there is a need to remain cognisant of this and the Governing Body needs to be assured that things are happening. **The Governing Body NOTED the key performance and quality highlights and the actions taken to mitigate the risks and NOTED the Annual Report provided**	**Agenda item**
GBP/2122/ 111	**CCG Risk Register – July 2021** HD advised that this report highlights areas of organisational risk recorded in DDCCG's Corporate Risk Register as at 31st July 2021. All risks in the Risk Register are allocated to one of the CCG's Corporate Committees which reviews them monthly. Approval was requested for the closure of risk 28 on the increase in safeguarding referrals following the lifting of lockdown. This is being monitored through the appropriate committees. Due to close working partnerships and processes, the predicted increase in referrals has not materialised therefore it is proposed that this risk be closed. AM attended the modular training on domestic abuse and considered it be excellent. Although designed for front line staff, it was a good experience for Governing Body members who do not have front line experience to see what the staff on the front line are doing. BS was asked if there is any evidence to suggest that there will be more domestic abuse concerns and cases after the pandemic than there were before. BS confirmed that the number of safeguarding referrals has not increased, therefore the Committee was assured that the risk could be closed. In terms of domestic abuse, it is one of those things that is hidden and does not always come to the fore as people are embarrassed to raise it. The training was provided to raise awareness of domestic abuse. 160 people attended the training sessions, following which a small number of members of staff came forward for confidential support; mechanisms have now been implemented for those individuals. Domestic abuse is one the most under-reported areas of safeguarding; the CCG continues to work with stakeholders to raise awareness of it.	

	The Governing Body RECEIVED and NOTED: • **The Risk Register Report** • **Appendix 1 as a reflection of the risks facing the organisation as at 31st July 2021** • **Appendix 2 which summarises the movement of all risks in July 2021** • **One new risk has been added - Risk 40 relating to the extension of contracts** • **Risk 06 relating to the demand for psychiatric intensive Care Unit beds (PICU)has been increased** **The Governing Body APPROVED:** • **The closure of Risk 28 relating to an increase in safeguarding referrals once lockdown was lifted**	
GBP/2122/ 112	**Joined Up Care Derbyshire Board – ratified minutes – May 2021** **The Governing Body RECEIVED and NOTED these minutes**	
GBP/2122/ 113	**Derby City Health and Wellbeing Board meeting – ratified minutes – March 2021** **The Governing Body RECEIVED and NOTED these minutes**	
GBP/2122/ 114	**Ratified Minutes of DDCCG's Corporate Committees:** • Derbyshire Engagement Committee – 15.6.2021 • Governance Committee – 20.5.2021 • Primary Care Commissioning Committee – 23.6.2021 • Quality and Performance Committee – 24.6.2021 **The Governing Body RECEIVED and NOTED these minutes**	
GBP/2122/ 115	**South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) CEO Report – July 2021** CC advised that this is a routine report which will cease at the end of March from which point a new way of interacting with SYB will be found. AM advised that Bassetlaw will in future be part of greater Nottinghamshire ICS and not included the South Yorkshire ICS; he asked if this would make a difference in terms of the collaborative relationship. CC considered that this question links to the paper which will be presented in September on the boundary changes for Derbyshire, as there will be similarities for Bassetlaw and Glossop. The Secretary of State decided to move the boundary for Bassetlaw into the Nottinghamshire System. Patient flows into secondary care services are unlikely to change immediately. There will be a transition to understand the requirements. One of the key objectives operationally is the concept of Place and thinking about the interactions between Place and the Glossop area, and that of the PCN infrastructure, in order to understand the relationships and partnerships that will need to be created. **The Governing Body RECEIVED and NOTED the report**	

GBP/2122/ 116	**Minutes of the Governing Body meeting in public held on 1st July 2021** **The minutes of the above meeting were agreed as a true and accurate reflection of the discussions held**	
GBP/2122/ 117	**Matters Arising / Action Log** Action Log – July 2021 – There are no outstanding action items	
GBP/2122/ 118	**Forward Planner** • An update on the Derbyshire ICS boundary to include Glossop will be provided at the next meeting. • The Annual Report and Financial Accounts will be presented at the September meeting. **The Governing Body NOTED the Planner for information purposes**	
GBP/2122/ 119	**Any Other Business** None raised	
DATE AND TIME OF NEXT MEETING – Thursday 2nd September 2021 – 9.30am to 11.15am via Microsoft Teams		

Signed by: …………………………………………………. Dated: …………………
(Chair)

GOVERNING BODY MEETING IN PUBLIC
ACTION SHEET – August 2021

Item No.	Item title	Lead	Action Required	Action Implemented	Due Date
2021/22 Actions					
GBP/2122/ 054	Joined Up Care Derbyshire Board Update – May 2021	Helen Dillistone	It was requested that a Governing Body Development / Transition Session be planned to ensure that Governing Body members are sufficiently sighted on the measures being taken to address the health inequalities in Derbyshire; Dr Robyn Dewis and Dean Wallace will be requested to provide input into this session.	To be scheduled in for the October Session	October 2021
GBP/2122/ 099	Presentation – NHS People and Culture Development	Linda Garnett	It was enquired how many additional nurses and doctors have been put in place in Derbyshire over the last 2 years, nett of retirement.	LG agreed to provide feedback on actual numbers.	September 2021
GBP/2122/ 102	Joined Up Care Derbyshire Board Update – July 2021	Dr Chris Clayton	The Governing Body requires assurance around the smooth transition of the Glossop boundary situation; an overview of the issues and how they are being tackled was requested.	CC agreed to provide a formal report Agenda item for September.	**Item complete**

Derby and Derbyshire CCG Governing Body Forward Planner 2021/22

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

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

	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
AGENDA ITEM / ISSUE												
City												
Minutes of Health and Wellbeing Board Derbyshire County	X		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												