NHS
Derby and Derbyshire
Clinical Commissioning Group

NHS DERBY AND DERBYSHIRE CCG

GOVERNING BODY – MEETING IN PUBLIC

Date & Time: Thursday 3rd February 2022 – 9.30am to 11.00am
Via Microsoft Teams

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

Item	Subject	Paper	Presenter	Time
GBP/2122/234	**Welcome, Apologies & Quoracy** Apologies: Dean Wallace	**Verbal**	**Dr Avi Bhatia**	**9.30**
GBP/2122/235	**Questions from members of the public**	**Verbal**	**Dr Avi Bhatia**	
GBP/2122/236	**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/2122/237	**Chair's Report – January 2022**	**Paper**	**Dr Avi Bhatia**	**9.35**
GBP/2122/238	**Chief Executive Officer's Report – January 2022**	**Paper**	**Dr Chris Clayton**	
FOR DECISION				
GBP/2122/239	**JCCCG Transitional Arrangements**	**Paper**	**Dr Chris Clayton**	**9.50**
FOR DISCUSSION				
GBP/2122/240	**Update on the Joined Up Care Derbyshire Vaccination Programme**	**Paper**	**Dr Steve Lloyd**	**10.05**
CORPORATE ASSURANCE				
GBP/2122/241	**Finance Report – Month 9**	**Paper**	**Richard Chapman**	**10.20**
GBP/2122/242	**System Finance and Estates Committee Assurance Report – January 2022**	**Verbal**	**Andrew Middleton**	

GBP/2122/ 243	**Audit Committee Assurance Report – January 2022**	**Paper**	**Ian Gibbard**	
GBP/2122/ 244	**Clinical and Lay Commissioning Committee Assurance Report – January 2022**	**Paper**	**Dr Ruth Cooper**	
GBP/2122/ 245	**Derbyshire Engagement Committee Assurance Report – January 2022**	**Paper**	**Martin Whittle**	
GBP/2122/ 246	**Primary Care Commissioning Committee Assurance Report – January 2022**	**Verbal**	**Simon McCandlish**	
GBP/2122/ 247	**Quality and Performance Committee Assurance Report – January 2022**	**Paper**	**Dr Buk Dhadda**	
GBP/2122/ 248	**CCG Risk Register – January 2022**	**Paper**	**Helen Dillistone**	
FOR INFORMATION				
GBP/2122/ 249	**Ratified Minutes of Corporate Committees:** • Audit Committee – 18.11.2021 / 17.12.2021 • Derbyshire Engagement Committee – 16.11.2021 • Primary Care Commissioning Committee – 22.12.2021 • Quality and Performance Committee – 23.12.2021	**Papers**	**Committee Chairs**	**10.45**
GBP/2122/ 250	**South Yorkshire and Bassetlaw – ICS Development Update – January 2022**	**Paper**	**Dr Chris Clayton**	
MINUTES AND MATTERS ARISING FROM PREVIOUS MEETING				
GBP/2122/ 251	**Minutes of the Governing Body Meeting in Public held on 13th January 2022**	**Paper**	**Dr Avi Bhatia**	**10.50**
GBP/2122/ 252	**Matters arising from the minutes not elsewhere on agenda:** • Action Log – January 2022	**Paper**	**Dr Avi Bhatia**	
GBP/2122/ 253	**Forward Planner**	**Paper**	**Dr Avi Bhatia**	
GBP/2122/ 254	**Any Other Business**	**Verbal**	**All**	

Date and time of next meeting: Thursday 3rd March 2022 from 9.30am to 11am – via Microsoft Teams

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

NHS
Derby and Derbyshire
Clinical Commissioning Group

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

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

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

SUMMARY REGISTER FOR RECORDING ANY INTERESTS DURING MEETINGS

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

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

Abbreviations & Glossary of Terms

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

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

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

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

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

Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

3rd February 2022

Item No: 237

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

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

Recommendations

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

Report Summary

There has been a relatively short period since the last Governing Body meeting. Last month I updated on the good progress being made to ensure the safe transfer of responsibilities from CCG to ICB, and the shadow working that will take place to ensure there is a handover of knowledge and decision-making.

The revised establishment date clearly gives us additional time to form the new committees for Integrated Care Board (ICB), further develop the membership and have greater clarity on the roles and responsibilities of each. The only statutory committees required of the ICB are the Audit Committee and Remunerations Committee, but we will be establishing committees to cover other areas, including quality and performance, our workforce, finance and our public partnerships. These are al in the formative stage although we are already seeing increased collaboration across the current CCG and system committees to prepare for this change.

Operationally the system remains under significant pressure and this month's Chief Executive's Report describes that in more detail. As a GP, the last two months have seen a mixture of reasons why general practice has needed to focus on urgent-only work to try to manage demand. In December, NHS England sanctioned this approach to free up general practice capacity to deliver the booster programme, which was hugely successful in Derbyshire. In January, general practice has needed to continue that approach due to the significant absence of practice staff due to covid-19 infections or isolations. Absence may hopefully have peaked and is starting to reduce, but we did see absence rates of nearly 12% in general practice during mid-January.

Clearly general practice will get back to more usual business as soon as possible, but there is a conversation we need to have with the public about what this means. General practice was in a challenged position prior to the pandemic, with increased demand and an ongoing workforce and recruitment challenge. The role of general

practice has been evolving for many years and there are many new roles within our surgeries that we wouldn't have seen in the past, including social prescribers, care coordinators and others. Our practice nurses are also frequently able to provide advice and care that would historically have come straight to the GP.

Practices have seen criticism during the pandemic for the telephone-first approach and for 'not being open for business'. November 2021 saw more appointments in general practice that ever before and two thirds of those appointments were face to face, so there are first some myths we must tackle to ensure general practice is getting a fair representation, followed closely by far reaching messages that fully explains the operating model of general practice in 2022, and the roles within the practices which are able to provide high quality care and support.

What is of concern is the build-up of the care that has occurred during the last two or three months. This will see the need to catch up on routine health checks and other work that is important but hasn't been urgent, whilst at the same time trying to deliver the urgent service and continue to support the Covid-19 vaccination programme. There is additional funding available to general practice to support winter pressures, and many practices will use this to help to tackle the backlogs, but this will likely take time and may see a short-term increase in waiting times before we are able to see some normality return.

The CCG, NHS England and the Royal College of General Practitioners are supporting practices with advice, guidance, and real help, including guarantee on income. This support is also including communications to the public on the challenge facing general practice, and this will be further developed with the campaign described above. General practice remains an important part of our health and care system, so there is an ongoing onus on practice teams to work with other local community health and care professionals to understand workload and pressures and to agree how best to prioritise and share work, including the temporary reduction of routine asks and working together to cover home visits for bloods, dressings, wound care and other matters. Practices are already providing mutual aid for practices who are struggling to cope, as well as continuing to support staff to work for the out of hours GP services.

Dr Avi Bhatia
Clinical Chair and CPRG Co-Chair

Are there any Resource Implications (including Financial, Staffing etc)?
None
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?
N/A
Has a Quality Impact Assessment (QIA) been completed? What were the findings?
N/A

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

NHS
Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

3rd February 2022

Item No: 238

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

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

Recommendations

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

Report Summary

Due to the way our Governing Body meetings have fallen, there has been only three weeks since the January meeting, but there is much to report from that relatively short period.

The health and care system remains under pressure, with the priority at present being around creating flow of hospital capacity. This is so that we can continue to treat our patients who are most in need of urgent care whilst also keeping our flow of urgent elective and cancer cases going. One of the biggest challenges we face as a system is the flow of patients out of the hospital when they are medically fit to be discharged. We are working on all fronts here and with our colleagues in Local Authorities, where we have seen increasing challenges to accessing social care-related packages of care and admissions into care homes due to staffing availability and local Covid-19 outbreaks.

Within this challenge, there are glimmers of hope as we start to see infection rates in the community and the absence levels of staff reducing. All of this will contribute to us being able to increase the capacity of our services and care for more patients or residents, but this will take time. One positive we can take at present is the feedback we have received from NHS England following their detailed review of our systems and processes for maintaining flow and caring for patients.

A series of facilitated Multi-Agency Discharge Events (MADE) have run across all Midlands systems during the last few weeks, including in Derbyshire. In short, these events bring together the local health system to support improved patient flow across the system by recognise and unblocking delays and challenging, improving and simplifying complex discharge processes. We've had events running in Burton, Derby and Chesterfield involving colleagues from across the health and social care community and it is testament to the teams delivering care and seeking solutions to

the 'flow' challenge that we have received some very complimentary feedback from our regulators on the approach we have been taking.

We are not complacent, and we will continue to learn as a system where there are opportunities to improve, but external validation that we are doing everything in our power to serve our patients is welcome assurance. Each MADE has seen a thorough review of patients' pathways to seek to find any further improvements to our process, and NHS England have complimented on our system relationships, our processes, governance and shared accountability. Regulators have also commented on our care for our patients and residents, acknowledging softer but vitally important features within our services, such as how well our staff know our patients. Despite the pressure, quality care remains at the heart of our work, and receiving such feedback during such difficult times is very welcome.

The work of the system in other areas of care is just as important. Our Accident and Emergency Delivery Board heard on Thursday that our GPs provided almost 613,000 appointments to patients during November, compared to just over 531,000 appointments in January 2019 and almost 540,000 appointments in January 2020. Of these appointments in November, 65% were face to face. We have read a lot of analysis and commentary about the performance of practices during the pandemic, but these figures help to dispel the myths and show that general practice is open for business. During December practices were enabled to stand down routine work to meet the Prime Minister's accelerated challenge to deliver the Covid-19 vaccination booster programme by the end of 2021. Due to significant staff absences due to covid-19 infections or isolation, this focus on urgent work has continued into January, so while we expect December and January's appointment totals to be lower, in fact practices have supported many hundreds of thousands of people in December when giving them their booster jab.

Our vaccination programme has celebrated the milestone of delivering 2.25 million vaccinations. This is the total of first, second, third and booster doses, and is an astonishing number. Within this figure was the 300 or so vaccinations delivered so far by our new mobile vaccination service. Basing themselves in community locations and operating out of pop-up centres, the team is offering walk-in vaccinations for local people in venues potentially more convenient than some of the vaccination centres and as people go about their daily lives. Removing barriers to access for the vaccination and supporting members of the public who may have been hesitant in having the vaccine so far, perhaps through a lack of convenience, is going to play a big part in the next phase of the vaccination programme. To date the mobile service has held sessions in Chesterfield Town Centre, Creswell and Bolsover, with emerging plans for other areas.

We have achieved some big numbers of vaccinations per day or week at our large vaccination centres during the programme, but the strategy must now be to work on smaller gains. Whilst the system remains under pressure, these vaccinations are an important line of defence in preventing further illness and admissions, and while the vaccination totals may now creep up more slowly week by week, every jab is crucial in the aim to keep everyone healthy.

Our progress towards the establishment of the Integrated Care Board (ICB) continues. NHS England has released an updated timeline for the establishment

process, with many milestones now seeing longer lead times as we work towards the revised date of 1 July 2022. As previously stated, we will continue with our progress and work in shadow form where that is practical and within our constitution. We are also preparing to announce details of four recently-appointed Non-Executive members for the ICB Board, and our interview for the ICB's Executive Director positions are now underway.

Chris Clayton - Accountable Officer and Chief Executive

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

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

3.0 National developments, research and reports

3.1 NHS National Medical Director Professor Stephen Powis, says: NHS staff will have many tough months ahead
Pressures remain high in hospitals, with more than 93.2% adult general and acute beds occupied in the week ending 16 January 2022 – equivalent to nearly 500 more adult patients per day than the week before.

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

3.3 NHS cancer checks at record high with quarter of a million in one month
Record numbers of people are coming forward for cancer tests, with almost a quarter of a million referrals in one month according to the latest data. The figures show that 246,000 people were checked for cancer in November – three times as many compared to the beginning of the pandemic in April 2020.

3.4 NHS launches landmark mental health campaign with 'Help!' from The Beatles
The NHS has launched a new campaign using the iconic Beatles song 'Help!" to get the nation taking better care of their mental health. Backed by some of the UK's biggest artists, the campaign will encourage people struggling with their mental health to seek support.

3.5 New weight loss support on the high street
People struggling to lose weight will now be offered help from their local high street pharmacy as part of the NHS's radical action to tackle rising obesity levels and type 2 diabetes. Community pharmacy teams can now refer adults living with obesity, and other conditions, to the twelve-week online NHS weight management programme.

3.6 New Chief Pharmacist appointed for England
The NHS in England has confirmed David Webb as the next Chief Pharmaceutical Officer for England.

3.7 NHS staff in England boost four in five eligible adults
More than four in five eligible adults aged 18 or over have now had their life-saving COVID-19 booster vaccine.

3.8 COVID-19 boosters offered to most at risk 12 to 15 year-olds
The NHS is now offering booster vaccines to clinically at-risk 12 to 15 year-olds or those who live with someone who is immunosuppressed.

3.9 Hundreds of thousands of teens to get boosted on NHS
Every eligible 16 and 17-year-old is now able to book their vital COVID-19 booster jab using the national booking service.

4.0 Local developments

4.1 Public invited to share thoughts on new Urgent and Emergency Care Development
Chesterfield Royal Hospital NHS Foundation Trust is inviting the public for their thoughts on the look and feel of the brand new £24m Urgent and Emergency Care Development. Further to this, the Trust has also started construction of the purpose-built Paediatric Assessment Unit (PAU) on the hospital site.

4.2 Mobile COVID-19 vaccination service begins operation
The mobile service will be rolling into communities across Derby and Derbyshire over the next couple of months in an effort to reach those who either keep meaning to get their life-saving first, second or booster dose, but haven't got round to it or those who still have some questions about the vaccine which they would like to talk through.

4.3 Chesterfield Royal Hospital Chief Executive to retire in spring
Chesterfield Royal Hospital NHS Foundation Trust's Chief Executive, Angie Smithson, will retire in April. Dr Hal Spencer, the Trust's current Medical Director, will take the role in the interim before recruitment is expected to begin later in the year.

4.4 New treatment offered to vulnerable Covid patients in Derbyshire
Vulnerable patients in Derbyshire are being offered a new treatment by DHU Health Care to reduce the risk of complications for people with COVID-19. Sotrovimab, a neutralising monoclonal antibody (nMAB), can be given to reduce the risk of serious illness that can arise amongst vulnerable people testing positive for Covid-19.

4.5 Urgent Treatment Centre review
Derby and Derbyshire, like many other areas across the country, is in the process of reviewing its Urgent Treatment Centres to determine if any changes are needed to the way urgent care is currently provided.

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

4.7 New support for NHS and health and social care colleagues experiencing long COVID
On behalf of Joined Up Care Derbyshire, University Hospitals of Derby and Burton (UHDB) Occupational Health Physician Dr Fauzia Begum and team have set up the Long Covid Staff Support Service. The service aims to help support and guide NHS and health and social care colleagues across Derbyshire with managing symptoms of Long COVID.

4.8 Joined Up Care Derbyshire – January newsletter now available
The latest edition of the Joined Up Care Derbyshire newsletter is now available. In this edition you can find out more about the ongoing development of the Integrated Care System for Derby and Derbyshire.

4.9 Key health messages and positive health behaviours
Colleagues in Derbyshire have rounded up some of the best resources produced by Public Health England and the NHS to make it easier for partners to support important winter health messages and promote positive health behaviours.

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

4.11 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

NHS
Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

3rd February 2022

	Item No: 239

Report Title	South Yorkshire and Bassetlaw Joint Committee of CCGs Transitional Arrangements
Author(s)	Hill Dickinsen LLP
Sponsor (Director)	Dr Chris Clayton, Chief Executive Officer

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

Recommendations

The Governing Body is requested to **APPROVE** the proposed changes to the Joint Committee of CCG for its operation until the end of June 2022.

Report Summary

EXECUTIVE SUMMARY

a) The NHS 2022/23 Priorities and Operational Planning Guidance released on 24 December 2021, included confirmation that the earliest date on which the Health and Care Bill will be implemented is now 1 July 2022. Until that date, at the earliest, CCGs will continue in existence and not be dissolved on 1 April 2022, as had been expected. Current arrangements in relation to CCGs' statutory functions will continue in place until at least 1 July 2022.

b) Given this change of date, the planning period for the transition to the South Yorkshire Integrated Care System ("ICS") is also extended. It is then proposed that, the Joint Committee of the CCGs ("the Joint Committee") will continue in place to plan for and manage transition across the longer period from April to July. However, in view of the extended period of operation, there are further considerations in relation to steps which can / should be taken between now and 1 July 2022. This document describes those considerations and steps.

c) Additional guidance is expected with extended deadlines for preparatory steps including the February 2022 submission for ICB Readiness to Operate / System Development Plan. However, the Guidance does note that designate ICB leaders, CCG AOs, and NHSE/I regional teams should agree ways of working for 2022/23 by the end of March 2022.

d) It is proposed that the Joint Committee of the CCGs ("the Joint Committee") will continue to prepare for the transition to the South Yorkshire Integrated Care System during the extended period (as was previously approved in meetings in November/December 2021) by:

   i. Maintaining the scope of its delegation to include transition work such as preparing the constitution for the new Integrated Care Board ("ICB");

   ii. Maintaining its sub-committees (excluding Bassetlaw) to carry out preparatory work for the ICB (where appropriate);

   iii. Meeting in common with the designate senior leadership team of the ICB (as appointed);

   iv. To support the ICB to begin operating in shadow form, to prepare for operation from July 2022;

   v. Having a clear working arrangement with Bassetlaw CCG that the CCG will not participate in parts of the meeting that are not directly relevant to Bassetlaw, following the move of Bassetlaw from South Yorkshire ICS to Nottinghamshire & Nottingham ICS; and

   vi. Work on strategy and operational planning matters for 2022/23.

e) We would not at this stage propose any further changes to the Joint Committee's constitutional documents beyond those recommended previously. This is because:

   i. There remains a need to move quickly as the system prepares for July 2022. Any changes to the Terms of Reference would require approval by NHS England, which will introduce delay and uncertainty; and

   ii. There remain many details to be provided in legislation and guidance about how the ICS will operate from July 2022. The governance arrangements for the Joint Committee will need to adapt and be flexible as those details become clear.

f) This proposal seeks agreement from the Joint Committee members to the approach and a recommendation to take to the Governing Bodies for approval during February.

g) It should be noted, that the ICB operating in shadow form constitutes a separate entity from the Joint Committee, with a separate purpose, and that the ICB shadow form meetings will take place separately from those of the Joint Committee. Work will continue to develop the shadow form ICB which will in turn work with the Joint Committee during the transitional period as appropriate.

NEXT STEPS FOR IMPLEMENTING THE PROPOSED APPROACH

1 The steps of the proposed process for developing the Joint Committee would then be as follows:

a) Agreeing the approach: Stakeholders (including the ICB) agree they are happy in principle with the proposed changes to the Joint Committee for its operation until the end of June 2022. If there is any disagreement, it will be for the Member CCGs to make the final decision. All stakeholders (including the ICB) agree in principle how the governance of the new transitional arrangements will operate including the integrated operation of the Joint Committee and ICB shadow group during the transition to the statutory ICS. In particular, stakeholders will need to confirm:

- The sub-committees of the Joint Committee, what each covers and who attends (see further below)
- Desired membership of the Joint Committee – Note that any change to voting members will require a change to the Terms of Reference. Given current timescales, we do not propose that any such changes are made at this stage.

b) Updating the documentation:

- Proposed changes to the Manual and Delegation will be drafted for approval by Member CCGs. This will include drafting a Joint Committee Transition Paper that will be appended to the Manual. Changes to the Terms of Reference have therefore been avoided.
- Terms of reference for the sub-committees of the Joint Committee are drafted for approval to the extent that they are not already in place.

c) The Governing Body of each CCG then adopts the updated documents. Organisations who are represented by non-voting attendees (such as the ICB and NHS England) will also need to ensure that their officers understand the commitment to attend meetings and their role.

d) The ICB acting in shadow form adopts the Joint Committee Transition Paper.

BACKGROUND

1 NHS Operational Planning Guidance for 2021/22 originally required 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 planning involves the establishment of a statutory Integrated Care Board (ICB) and an Integrated Care Partnership (ICP) which together make up the Integrated Care System (ICS). 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.

2 The five CCGs and ICS wished to put in place arrangements to ensure a smooth transition to the ICB and chose to bring together the work of the Joint Committee of CCGs ("the Joint Committee") with aspects of the ICS non-statutory arrangements. The intention was to enable the CCGs to begin to take joint decisions on matters that would be likely to be decided/ adopted at ICS level (once the anticipated NHS reforms have been passed), in a way that is linked to the current (non-statutory) ICS operating arrangements. Subsequent changes were approved to the boundaries of the ICS which mean that NHS Bassetlaw will be moving from the ICS into Nottinghamshire and a neighbouring integrated care system.

3 In December 2021, the NHS 2022/23 Priorities and Operational Planning Guidance ("the Guidance") confirmed a delay to the implementation of the Health and Care Bill until 1 July 2022, and consequently a new target date of 1 July 2022 for statutory arrangements to take effect and ICBs to be legally and operationally established.

4 The Guidance notes that this additional three month period between April and July 2022 is to serve as a 'continued preparatory period' with the designated ICB leadership to continue preparations in line with previous NHSE/I guidance, including recruitment, and CCGs to continue transition preparations. The CCG leadership is to work closely with the designate ICB leaders on key decisions which affect the future.

5 Additional guidance is expected with extended deadlines for preparatory steps including the February 2022 submission for ICB Readiness to Operate / System Development Plan. However, the Guidance does note that designate ICB leaders, CCG AOs, and NHSE/I regional teams should agree ways of working for 2022/23 by end of March 2022.

PROPOSED APPROACH IN LIGHT OF THE EXTENDED IMPLEMENTATION DATE

6 Bearing in mind the extended implementation date, in summary, the proposed approach is:

6.1 For the Joint Committee to continue to be tasked by the Member CCGs to carry out work which is required to prepare for the introduction of the South Yorkshire ICS, in particular:

- The development of draft plans for consideration/ adoption by the ICB once it is formally established e.g. the Forward Plan and the Capital Plan
- 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.
- Producing the constitution for the ICB and liaising as appropriate with NHS England in order to gain approval for the constitution.
- Producing/ providing input into the transition schemes that will manage the move from CCGs to the ICB and liaising as appropriate with NHS England

6.2 In addition, the extended implementation date now also provides the opportunity for additional steps to be taken towards the effective introduction of the South Yorkshire ICS:

- Further recruitment of senior ICS personnel – we understand that recruitment will continue as planned through Jan / Feb 2022.
- Processes to be undertaken to nominate and appoint ICB partner members.
- As these additional personnel are recruited, there will be the opportunity for the ICB to be constituted in 'shadow' form and begin working together to prepare for its formal establishment in July 2022. While any formal decision-making will still need to be transacted via the Joint Committee, with more designate ICB members in situ, realistic forward-looking plans and decisions can be progressed and members can commence working together effectively, with potential issues starting to be identified.
- ICP membership – we understand that work is already underway between the designate senior leadership of the ICB and the local authorities to consider the membership structure of the ICP. With additional time before implementation, there is now the opportunity to constitute the body informally and begin meetings between its members, such that it can be formally established shortly after the implementation date and move forward with its planning role.
- Particularly once the ICB's place directors are appointed, developing the role of place-based partnerships including questions of how delegation to these bodies will be effected, and the agreements required to put these into place.
- As the ICS' provider collaboratives are formalised, further work can be carried out to understand where these will feed into the work of the ICS and how arrangements with them will move forward following implementation.

6.3 As previously, some preparatory work can be done by one or more sub-committees of the Joint Committee, made up of representatives from the SY CCGs. Members of the shadow ICB Group can also be invited to attend. That work will need to be approved by all the Member CCGs (including NHS Bassetlaw) at the Joint Committee. This is because the quorum rules are that all Member CCGs must be present in order for a decision to be taken at the Joint Committee (see paragraph 8.1 of the Terms of Reference). This will include NHS Bassetlaw as, unlike Derby & Derbyshire, technically NHS Bassetlaw is a Member CCG for all matters. Furthermore, in most matters NHS Bassetlaw will need to agree to the decision as there needs to be more than 80% agreement for a decision to be adopted (see paragraph 7.2 of the Terms of Reference). Conducting the preparatory work though sub-committees where appropriate will minimise the time that NHS Bassetlaw spends on it at full Joint Committee.

Currently the intention is that sub-committees may be used if considered appropriate but that the Joint Committee will look to manage its own business with NHS Bassetlaw in attendance wherever possible.

6.4 For the Joint Committee to meet in common with a defined shadow ICB Group (potentially representing the proposed constituency of the Integrated Care Board and informed by the Health and Care Bill), with each group's business being transacted in parallel and in full sight of the other. So far as the governance of the Joint Committee is concerned, this is achieved by the Joint Committee inviting the members of the shadow ICB group to attend the Joint Committee meeting as non-voting members under paragraph 5.4 of the existing terms of reference. It is initially intended that the ICB will be represented on the Joint Committee through the membership of the designate Chair, Chief Executive and Director of Finance.

7 Where it would aid the work of the Joint Committee and the shadow ICB Group, it may invite other ICB officers and/or provider collaborative representatives to meetings for input as non-voting members (paragraph 5.4 of the terms of reference) or on an ad hoc basis as experts (paragraph 10.4 of the terms of reference). We understand that the initial ICB appointments consist of the interim Chair, Chief Executive and two non-executive directors. Given the extended implementation date, there is now time for other senior ICB personnel to be appointed to post (we understand that recruitment is continuing through Jan/Feb 2022) such that it may become appropriate for them to join the meetings. For this to happen, the ICB Chief Executive will notify the Chair of the Joint Committee. The Joint Committee can then formally decide to invite the new non-voting member if appropriate.

8 The appendices below review the existing governance arrangements (Appendix 1), the suggested process for the Joint Committee to implement the new approach (Appendix 2) and also how the ICB can also conduct its own business as a shadow group in common with the Joint Committee as part of the same meeting (Appendix 3).

Hill Dickinson LLP – 20th January 2022

APPENDIX 1 - EXISTING GOVERNANCE ARRANGEMENTS

1 By way of reminder, the Joint Committee is governed by:

- the *Manual/ Agreement for JC CCGs* (**"the Manual"**)
- the delegation to the Joint Committee that has been adopted by each of the CCGs that is Appendix 1 to the Manual (**"the Delegation"**)
- the terms reference of reference for the Joint Committee, which are at Appendix 2 to the Manual ("**Terms of Reference"**)

We will refer to the CCGs who are voting members of the Joint Committee as **"Member CCGs"**. This includes the Associate CCG (NHS Derby & Derbyshire) on issues where they have a vote and also Bassetlaw CCG, which has moved to the Nottinghamshire and Nottingham ICS. We will refer to the CCGs within the South Yorkshire ICS as the SY Member CCGs.

The ICS is currently governed by:

- A **Health and Care Compact** (setting out the commitment of the health and care system to work together on the core purpose of an ICS)
- A number of strategic partnership arrangements to support collaboration between health organisations and between health and care and other organisations (exercising mutual accountability and non-statutory decision-making)
- An **Integrated Assurance Committee** of non-executives from statutory organisations giving challenge and assurance
- A number of other committees and programme boards

APPENDIX 2 - CHANGES TO OPERATION OF THE JOINT COMMITTEE

1 We have previously proposed a table of the potential options for the development of the Joint Committee and the processes which will be required to implement them.

We have refreshed this below in respect of matters capable of being taken forward via approvals of the CCG Governing Bodies.

As previously, the table assumes that the Manual, Delegation and ToRs were passed in accordance with the constitutions of the different CCGs and therefore that all the powers/ functions of the Joint Committee set out in them have been properly delegated.

Ref.	Change		Comment
Core actions to implement the proposed shadow approach			
1	Add non-voting members (ICB officers to the group to sit with the Joint Committee)		The Terms of Reference of the Joint Committee allow it to invite non-voting members to join the Joint Committee (5.4) and invite additional experts on an ad hoc basis (10.4).
2	Expand scope of the Joint Committee to cover the proposed approach set out above		This can be done by amending the Delegation and updating the Manual – there is no need to update the Terms of Reference.

3	Create sub-committees of the Joint Committee for specific elements of the proposed approach		Permitted by the Manual at 16.1. The terms of reference of any sub-committee will however need approving by the Rotherham Chief Officer or Governing Body.
4	Remove non-voting members from the Joint Committee (where required)		Ideally the Terms of Reference would be amended to reflect this but as an interim measure a non-voting member could simply stop attending as they do not count to the quorum.

APPENDIX 3 - FIT WITH ICS GOVERNANCE (SHADOW APPROACH)

1 As previously, the intention is for the ICB to take its decisions (as a shadow body) informed by but separate to decisions that are being made by CCG Members in the Joint Committee. For example, there might be a discussion about a particular care pathway involving CCG Members and non-voting attendees. This would be followed by a joint decision made by the CCG Members for the Joint Committee, and a later decision made on behalf of the shadow ICB by the ICB designate appointees (though this would not have statutory force until the implementation of the ICB as a statutory body in July).

2 There would be a similar approach within the sub-committees of the Joint Committee set up to deliver the transition work. For example, a sub-committee might be discussing the drafting of the proposed constitution for the ICB for approval by the Joint Committee. ICB officers might join the sub-committee so that the ICB and sub-committee can understand one another's thinking and take an aligned approach.

3 In this model, it will be important to be clear which grouping is making which decision at each stage. Practical steps to facilitate this process are:

- A flag in the agenda where a Joint Committee/ sub-committee decision is needed and if/ when it is expected that the decision should be one for the ICB.
- When the minutes are drafted, to clearly separate the Joint Committee/ sub-committee decisions and votes from ICB matters. We would suggest colour coding decision(s) for the Joint Committee/ sub-committee and matters passed to the ICB.
- Confirmation from the non-voting attendees of the scope of their authority to make decisions on behalf of their organisations (to the extent required).

Under this approach none of the ICB representatives can vote on the Joint Committee business.

4 The Manual will be updated to reflect this new mode of operation by adding a new Joint Committee Transition Paper appendix that covers these transitional arrangements for the conduct of meetings.

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

N/A

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

N/A

Has a Quality Impact Assessment (QIA) been completed? What were the findings?
N/A
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
N/A
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
N/A
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
N/A
Have any Conflicts of Interest been identified / actions taken?
N/A
Governing Body Assurance Framework
N/A
Identification of Key Risks
N/A

NHS
Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

3rd February 2022

Item No: 240

Report Title	Update on the Joined Up Care Derbyshire (JUCD) Vaccination Programme
Author(s)	Mandy Simpson, JUCD Vaccination Programme Director
Sponsor (Director)	Dr Steve Lloyd, Executive SRO Vaccination Programme

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

Recommendations

The Governing Body is requested to **NOTE** the update on the progress of JUCD Vaccination Programme.

Report Summary

COVID

- 2.25m COVID-19 vaccinations delivered to date
- 83.5% of eligible patients have had their booster
- Universal offer to all to access the vaccine with a proportionate focus
- Positive response on flexible mobile teams with 400 vaccines delivered to date
- Finalising plans to vaccinate 5–11-year-olds that are clinically vulnerable week commencing 31/1/2022

Flu

- Ambitious targets set by NHS England to achieve in 2021/22
- 2nd highest performing system in the Midlands for flu uptake

nMAB and Antivirals

- Pathways established within acute and community settings for access and treatment, and working well

Communications

- Supporting services and system to achieve challenging targets
- Treading new ground in our community approach to campaigns
- Developing new relationships that can be utilised for other tasks

Are there any Resource Implications (including Financial, Staffing etc)?
All implications are worked through with People Resource Team to ensure the programme is sufficiently staffed.
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
An QEIA exists for the programme. Individual QEIAs will be carried out as applicable.
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
The vaccination programme involves all stakeholders and there is good engagement through vaccine inequalities.
Have any Conflicts of Interest been identified / actions taken?
Conflicts of interest are identified as part of standard governance processes.
Governing Body Assurance Framework
This paper supports **Strategic Objective: 3** Continue with the roll out of the Covid-19 vaccination programme and ensure a sustainable planning and operational model is in place
Identification of Key Risks
GBAF Risk 6

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Clinical Commissioning Group

Governing Body Meeting in Public

3rd February 2022

Item No: 241

Report Title	Finance Report – Month 9
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 – 27.1.2022				

Recommendations

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

- Allocations have been received for the full year at £2.090bn
- The YTD reported underspend at month 8 is £3.146m
- Retrospective allocations received for half 1 Covid spend on the Hospital Discharge Programme were £5.498m further funding is expected of £1.358m relating to quarter 3.
- Additional anticipated funding include:
  - Elective Recovery Fund reimbursed £0.761m for April to December with an additional £0.306m forecast.
  - Winter Access fund forecast to spend and reimbursed £3.472m
  - Additional Roles Reimbursement Scheme forecast to spend and receive £5.759m
- The year-end position is forecast at £6.403m underspent.

Report Summary

The report describes the month 9 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 9, December 2021

NHS
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Statutory Duty/ Performance	Target	Result	Achieved	Key	Comments/Trends
Achievement of expenditure to plan	£1566.445m	£1565.57m		Green <1%, Amber 1-5% Red >5%	Expected reimbursements of £2.270m for Covid resulting in a YTD favourable variance of £3.146m.
Remain within the Delegated Primary Care Co-Commissioning Allocation	£119.078m	£119.078m		Green <1%, Amber 1-5% Red >5%	Breakeven position for YTD. Co-Commissioning is on plan with minor variances offsetting each other across the service.
Remain within the Running Cost Allowance	£13.995m	£12.939m		Green <1%, Amber 1-5% Red >5%	Running costs are £1.055m underspent against plan. This is attributed to pay underspends due to staff vacancies and uncommitted running cost allocations.
Remain within cash limit	Greatest of 1.25% of drawdown or £0.25m	0.20%		Green <1.25%, Amber 1.25-5% Red >5%	Closing cash balance of £0.320m against drawdown of £161.5m.
Achieve BPPC (Better Payment Practice Code)	>95% across 8 areas	Pass 8/8		Green 8/8 Amber 7/8 Red <6/8	In month and YTD payments of over 95% for invoices categorised as NHS and non NHS assessed on value and volume.

Operating Cost Statement For the Period Ending: December 2021

	Year to Date				Budget and Forecast			
	YTD Budget	YTD Actual	YTD Variance	YTD Variance as a % of YTD Budget	Annual Budget	Annual Forecast Outturn	Forecast Variance	FOT Variance as a % of Annual Budget
	£'000's	£'000's	£'000's	%	£'000's	£'000's	£'000's	%
Acute Services	823,775	820,438	3,337	0.41	1,096,521	1,092,374	4,146	0.38
Mental Health Services	178,033	177,508	525	0.29	239,862	239,318	544	0.23
Community Health Services	119,236	120,042	(806)	(0.68)	158,382	159,973	(1,591)	(1.00)
Continuing Health Care	82,212	86,971	(4,759)	(5.79)	108,630	117,313	(8,684)	(7.99)
Primary Care Services	159,644	160,346	(702)	(0.44)	211,527	212,925	(1,398)	(0.66)
Primary Care Co-Commissioning	119,078	119,078	0	0.00	159,630	168,861	(9,231)	(5.78)
Other Programme Services	63,640	65,593	(1,953)	(3.07)	81,091	82,559	(1,468)	(1.81)
Total Programme Resources	**1,545,618**	**1,549,975**	**(4,358)**	**(0.28)**	**2,055,642**	**2,073,324**	**(17,682)**	**(0.86)**
Running Costs	13,995	12,939	1,055	7.54	18,851	18,028	824	4.37
Total before Planned Deficit	**1,559,612**	**1,562,915**	**(3,302)**	(0.21)	**2,074,494**	**2,091,352**	**(16,858)**	(0.81)
In-Year Allocations	2,937	695	2,242	76.34	12,372	8,251	4,121	33.31
In-Year 0.5% Risk Contingency	4,244	1,960	2,284	53.82	4,244	0	4,244	100.00
In year Planned Deficit (Control Total)	(348)	0	(348)	100.00	(696)	0	(696)	100.00
Total Incl Covid Costs	**1,566,445**	**1,565,570**	**876**	(0.21)	**2,090,414**	**2,099,603**	**(9,189)**	(0.44)
Expected Covid Reimbursement in Future Months	**5,498**	**7,768**	**(2,270)**		**5,498**	**11,553**	**(6,055)**	
Expected Elective Recovery Fund Allocation	**761**	**761**	**0**		**761**	**1,067**	**(306)**	
WAF Reimbursement	**0**	**0**	**0**		**0**	**3,472**	**(3,472)**	
ARRS Funding Above Baseline	**0**	**0**	**0**		**0**	**5,759**	**(5,759)**	
Total Reduced for Reclaimable Covid Costs, ERF and ARRS	**1,560,186**	**1,557,040**	**3,146**	0.20	**2,084,155**	**2,077,752**	**6,403**	0.31

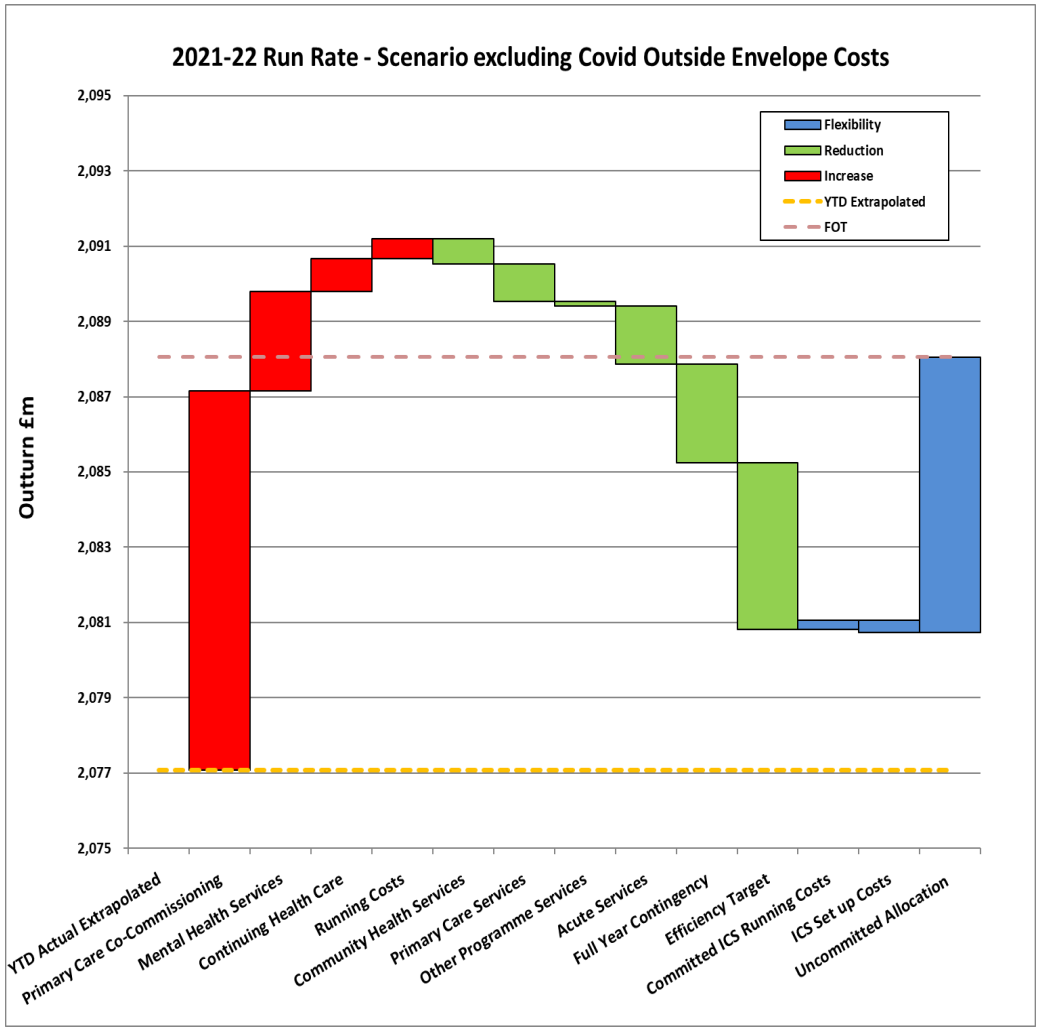
The reported position at month 9 is an underspend of £3.146m and favourable FOT underspend of £6.403m. The movement in the position is due to the late receipt of allocations of £5.37m for the Community Diagnostic Centre and £2.33m discharge funding which unlikely to be spent before the year end.

This position includes an expected reimbursement of £2.270m YTD and £6.055m FOT relating to Covid expenditure for the Hospital Discharge, Asylum Seekers and Vaccine Inequalities Programmes. Allocations totalling £5.498m for out of envelope covid expenditure have been received relating to quarters 1 and 2. Quarter 3 funding is anticipated to be received in month 11.

Primary Care Co-Commissioning has a £9.231m forecast overspend. This includes expenditure of £5.759m relating to Additional Roles Reimbursement Scheme (ARRS) and £3.472m for Winter Access Funding (WAF). Costs are above the baseline allocations and both amounts are expected to be funded.

The CCG has released £2.284m of the H1 £4.244m contingency into the month 9 position.

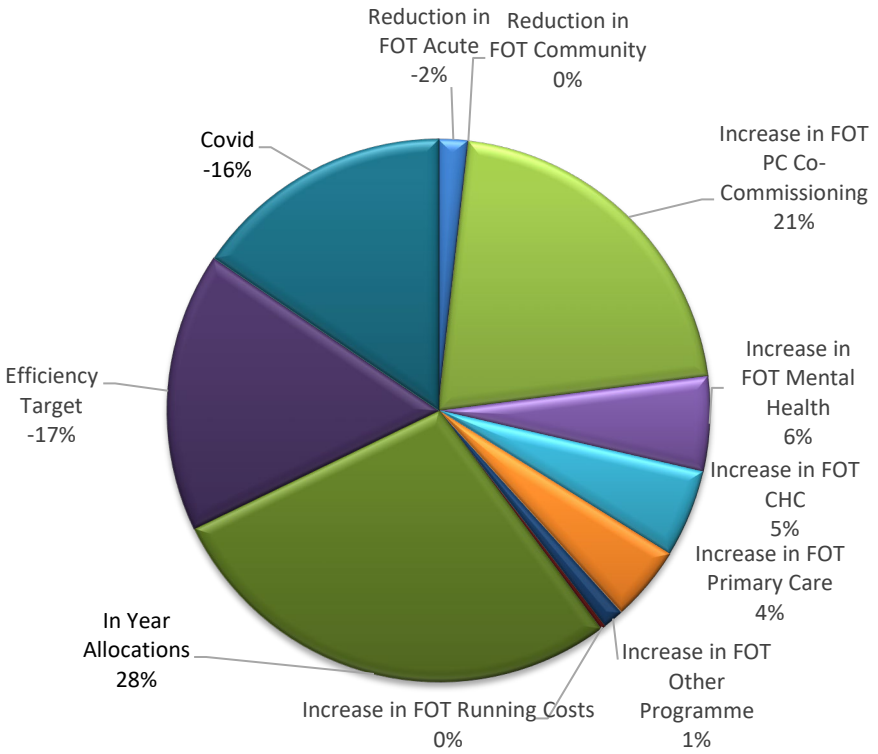
Run Rate based on Year to Date Expenditure



£10.982m variation between the position to date continuing at its current rate and the forecast outturn for the full financial year.

- **PC Co-Commissioning** – Costs relating to ARRS and Winter Access Funds allocations expected to be spent later in the year and reimbursed in full.
- **Mental Health Services** –MHIS Investments growth due to increased allocations in H2. Other increases include complex care costs in CAMHS and Learning Disabilities, growth in Section 117 and increased activity for Improving Access to Psychology Therapies.
- **Continuing Health Care** –Differences relating to caseload phasing, additional Personal Health Budget costs expected later in the year and an estimation for discharge to access costs for patients discharged at the end of March.
- **Running Costs** – Vacancies expected to be filled reducing underspends on pay costs.
- **Community Health Services** – Reduction in costs with transfer of ophthalmology providers to acute services.
- **Primary Care Services** – Changes to Enhanced Services during the year, prescribing costs based on historic trends and Covid costs incurred in H1 only.
- **Other Programme Services** – Lower 111 first costs in H2 offset by Better Care Fund timing of payments and savings achieved in H1.
- **Acute Services** – ERF allocations received in H1 and paid to NHS providers off set by an increases for independent sector ophthalmology providers and for NHS payments due to inflation, pay award and non-recurrent support.
- **Full Year Contingency –** Balance of H1 contingency funding to be utilised in H2.
- **Efficiency Target –** Efficiencies expected to be achieved in H2.
- **ICS Set up Costs –** One off expected expenditure identified in H1.
- **Uncommitted Allocations –** Allocations received still awaiting distribution to areas forecast to be spent.

Main Changes in Forecast Outturn – Month 8 to Month 9



		£m	£m
Month 8 Annual Forecast Outturn			2,094.20
Reduction in FOT	Acute	(0.28)	
	Community	(0.02)	
Increase in FOT	PC Co-Commissioning	3.56	
	Mental Health	0.95	
	CHC	0.88	
	Primary Care	0.75	
	Other Programme	0.21	
	Running Costs	0.05	
In Year Allocations		4.71	
Efficiency Target		(2.80)	
Covid		(2.61)	
Total Movement			5.40
Month 9 Annual Forecast Outturn			2,099.60

- **Acute –** Reduction in UHDB payment relating to CDC offset by a EMAS payment where the funding is to be moved from central allocations. A reduction in independent sector payments partly offset by expenditure relating to non-recurrent allocations received.
- **Co-commissioning –** Increase in the forecast to include expected Winter Access expenditure, offset by a small reduction in each of GMS, PMS and APMS contract expenditure, rents and rates.
- **Mental Health –** Higher costs for Learning Disabilities and CAMHS relating to complex cases partly offset by reduction in High Cost Patients due to discharges and IAPT reduction in activity.
- **CHC –** Increase in caseload costs partly offset by reduction in estimated growth.
- **Primary Care–** Expenditure relating to Primary Care Transformation allocations received in month 9 offset by small reductions in other areas.
- **Other Programme –** Non-recurrent allocations received for Maternity Transformation and Tobacco Dependency Treatment.
- **In Year Allocations –** Non-recurrent allocations received in month 9 awaiting distribution to areas.
- **Efficiency Target** – Efficiency savings expected to be made by end of financial year.

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3rd February 2022

Item No: 243

Report Title	Audit Committee Assurance Report – January 2022
Author(s)	Frances Palmer, Corporate Governance Manager
Sponsor (Director)	Ian Gibbard, Audit Lay Member and Audit Committee Chair

Paper for:	**Decision**		**Assurance**	x	**Discussion**		**Information**	
Assurance Report Signed off by Chair				Ian Gibbard, Audit Committee Chair				
Which committee has the subject matter been through?				Audit Committee – 20.1.2022				

Recommendations

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

Report Summary

This report provides the Governing Body with highlights from the 20th January 2022 meeting of the Audit Committee. This report provides a brief summary of the items transacted for assurance.

External Audit Plan 2021/22

The Audit Committee RECEIVED and NOTED the KPMG External Audit Plan 2021/22. The report summarised the main risks that the auditors will focus on in 2021/22.

Internal Audit

360 Assurance Progress Report

The Committee:

- NOTED the key messages and progress made against the Internal Audit Plan since the last meeting, of which there were no concerns;
- APPROVED the proposed adjustments to the 2021/22 Internal Audit Plan; and
- RECEIVED the information and guidance papers produced by 360 Assurance and were ASSURED that the issues raised are being addressed by the CCG within the required timescales.

Integrity of the General Ledger & Financial Reporting – Final Report

The Committee NOTED the outcome of 'significant assurance' for the Integrity of the General Ledger & Financial Reporting – Final Report. The CCG's controls in relation to the general ledger and financial reporting were generally operating effectively based on (sample) testing of the specified expected controls. One low risk was raised, in respect of retaining evidence of retrospective journal posting centrally and an advisory action was issued.

Head of Internal Audit Opinion State 2 Report

The Committee NOTED the Head of Internal Audit Opinion Stage 2 Report, of which there were no concerns raised.

Finance

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

Direct Award NHS Standard Contracts for existing spot purchase
The Committee retrospectively APPROVED the direct awards for retrospective NHS Standard Contract Particulars being issued, to support Individual Placement Agreements.

Single Tender Waivers
The Committee NOTED the Single Tender Waivers approved by the Chief Finance Officer from December 2021.

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

Accruals Report
The Committee NOTED the accruals in the ledger in December 2020/21, March 2020/21 and December 2021/22.

Governance

Freedom to Speak Up Report
The Committee NOTED the update on the role of the CCG's Freedom to Speak Up Ambassadors within the CCG.

Annual Report and Annual Governance Statement Update
The Committee NOTED the updated provided for the 2021/22 Annual Report and Annual Governance Statement.

Governing Body Assurance Framework 2021/22 Quarter 3
The Committee NOTED and GAINED ASSURANCE of the Quarter 3 Governing Body Assurance Framework (GBAF).

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

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

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

- Conflicts of Interest Forward Planner 2021/22
- Decision Makers' Register of Interests

- Governing Body & Committee Members' Register of Interests
- Confidential Register of Interests – no further updates since last meeting
- Summary Register for Recording Any Interests During Meetings
- Gifts & Hospitality Register
- Procurement Register
- Breach Register – the committee discussed one breach which has been identified since the last meeting. The breach was reported to NHS England and is detailed within the CCG's Breach Register.

Forward Plan

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

Any Other Business

The Committee discussed the future committee meeting dates in respect of the key documentation and deadlines for year-end accounts and reporting.

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

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3rd February 2022

Item No: 244

Report Title	Clinical and Lay Commissioning Committee Assurance Report – January 2022
Author(s)	Zara Jones, Executive Director of Commissioning Operations
Sponsor (Director)	Zara Jones, Executive Director of Commissioning Operations

Paper for:	**Decision**	x	**Assurance**	x	**Discussion**		**Information**	
Assurance Report Signed off by Chair				Dr Ruth Cooper, CLCC Chair				
Which committee has the subject matter been through?				CLCC – 13.1.2022				

Recommendations

The Governing Body is requested to **RATIFY** the decisions made by the Clinical and Lay Commissioning Committee (CLCC) on the 13th January 2022.

Report Summary

CLC/2122/166 Employment advisors in IAPT contract award

The Committee were informed that the CCG has undertaken a due process to commission an EA in IAPT (Employment Advisors in Improving Access to Psychological Therapies) Service subject to external funding, for 12 months beyond 1.4.2022 with an option to extend for a further 12 months. One provider submitted a response – the incumbent provider of this service, Ingeus UK Ltd.

CLCC were asked to approve the following recommendations:

- **To award a six-month contract** (up until 30.09.2022) to the bidder, who successfully demonstrated that they exceeded the minimum quality threshold. This contract duration is in line with the current confirmed DWP (Department of Work and Pensions) funding for this service.
- **To pre-approve a further 6-month contract extension** up until 31.03.2023 should DWP funds be confirmed for this purpose (confirmation expected February 2022).

CLCC SUPPORTED the decision to extend the contract for six months with a view to further extension of six months should DWP funds be confirmed.

The following items had been received virtually by the Committee:

CLC/2122/171 Clinical Policies

CLCC RATIFIED the following policies:

1.a Arthroscopic Shoulder Decompression for Subacromial Pain Policy
1.b Laser Treatment for Skin Conditions Policy
1.c Circumcision Policy
1.d Non-Standard MRI Scan Policy
1.e Photodynamic Therapy for Management of Central Serous Chorioretinopathy (CSCR)
1.f Trigger Finger Policy
1.g Removal of Benign Skin Lesions Policy
1.h Epidermoid and Pilar Cyst Policy
1.i Congenital Pigmented Lesion Policy

Areas for Servicer Development

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

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

Clinical Policy Advisory Group - updates for ratification and information

CLCC NOTED and RATIFIED the following:

Update to Glossop Transition for Clinical Policies

- To update CLCC with the current position on the Glossop transition process for Clinical Policies.

It was noted that there was a potential clinical risk with the Glossop transfer as certain policies will be different and where there are out of area providers working to different criteria. CLCC were assured that this risk sits with the Glossop Board.

gInterim and Full CPAG Terms of Reference (ToR)

- CLCC RATIFIED the Interim and Full CPAG TOR for one year:
  - Paper 3bi – Full CPAG ToR
  - Paper 3bii – Interim CPAG ToR

It was noted that CPAG meetings had currently been stepped down due to the CCG operating at Level 4. During this time the interim ToR were being used.

EMACC update

CLCC NOTED the update provided by EMACC.

CLC/2122/173 GBAF Risk 3

CLCC were asked to:

- DISCUSS and REVIEW the Quarter 4 (January to March) Governing Body Assurance Framework Strategic Risk 3 owned by CLCC.
- REVIEW and UPDATE any further mitigating actions and assurances;
- REVIEW and UPDATE the current risk score.

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

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

Derby and Derbyshire
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3rd February 2022

Item No: 245

Report Title	Derbyshire Engagement Committee Assurance Report – January 2022
Author(s)	Sean Thornton, Deputy Director, Communications and Engagement
Sponsor (Director)	Martin Whittle, Vice Chair/Lay Member for PPI

Paper for:	**Decision**		**Assurance**	x	**Discussion**		**Information**	
Assurance Report Signed off by Chair					Martin Whittle, Vice Chair/Lay Member for PPI			
Which Committee has the subject matter been through?					Engagement Committee – 18.1.2022			

Recommendations

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

Report Summary

This report provides the Governing Body with highlights from the meeting of the Engagement Committee, held on 18th January 2022. This report provides a summary of the items transacted for assurance.

Integrated Care System Update

The Committee received an update on the current progress towards creating a statutory Integrated Care System and Integrated Care Board (ICB). This included the notification of a change to the timeline for establishment of the ICB, moving from 1 April 2022 to 1 July 2022. Members were also briefed on the proposed current position regarding formal Committees of the ICB including a Public Partnership Committee. Progress was to be made during January and February on the draft functions of the Committee, with further discussion to take place during March's Engagement Committee.

Integrated Care System Communications and Engagement Plan (Standing Item)

A significant amount of work has continued during the last two years in creating a solid foundation on which to build continuous community engagement across the Derbyshire system. The Committee received a detailed progress update on all aspects on this work, ahead of the submission of a revised engagement strategy being produced as part of the establishment process for ICBs later in the year. This updated included work on:

- System Insight Group and Library
- Online Engagement Platform
- Citizen's Panel

- Patient and Public Partners Programme
- Our engagement model and governance guide
- Place Partnerships involvement pilot

The draft engagement strategy, building on the existing strategy for JUCD, will be available in draft form during March.

Communications and Engagement Response to the Vaccination Programme and System Pressures
The Committee received a presentation on the work undertaken to date on the Covid-19 vaccination programme (including the approach to tackling vaccine inequalities) and the activities in support of ongoing system pressures. These two issues have been a significant focus for the CCG/JUCD communications and engagement team during 2021, working in partnership with colleagues in NHS provider organisations and local authorities. The work has reflected the prioritisation given to both issues by the JUCD system, and the subsequent reduction in 'business as usual' engagement matters coming through to the engagement Committee.

Urgent Treatment Centres
The Committee received an update on the surveying work now underway to seek views of local people on their use and perception of Derbyshire's urgent treatment centres. Having already received a large response, the survey remains open into February and will help inform a review of urgent treatment centres taking place later in 2022.

Accessible Services for Deaf People
The Committee agreed to support a review of issues faced by citizens who are deaf, deafened and hard of hearing in accessing healthcare. A proposal was made to work with the British Deaf Association and local Deaf people to set up a discussion session highlight experience in accessing health services. This will be facilitated by one of the Involvement Managers currently based in the CCG. The session will provide issues, experience and areas for development. A report will be presented back to the Engagement Committee along with an action plan for developments to ensure that the voice of Deaf people is heard and that reasonable adjustments are agreed and made.

Exception Risk Report and Governing Body Board Assurance Framework
The Committee agreed to reduce the score 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. Given the work to date on the engagement model and governance guide, in addition to the ongoing examples of engagement and communications taking place across the vaccination programme, the Committee felt able to agree a reduction of the score to 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.

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3rd February 2022

Item No: 247

Report Title	Quality and Performance Committee Assurance Report – January 2022
Author(s)	Jackie Carlile, Head of Performance and Assurance Ali 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**	
Assurance Report Signed off by Chair				Dr Buk Dhadda, Q&PC Chair				
Which committee has the subject matter been through?				Quality and Performance Committee – 27.1.2022				

Recommendations

The Governing Body is requested to **NOTE** the paper and agree its contents for assurance purposes.

Report Summary

Performance:

Urgent and Emergency Care:

- The A&E standard was not met at a Derbyshire level at 72.1% (YTD 77.8%). CRH did not achieve the standard achieving 85.7% (YTD 91.2%). UHDB achieved 63.6% during December (YTD 69.8%).
- UHDB had 124 x 12-hour trolley breaches during December – 122 were due the availability of medical beds and 2 were due to the unavailability of a suitable mental health bed.
- EMAS were non-compliant for all 6 of their standards for Derbyshire during December 2021, reflecting the continuing significant pressures being experienced by the trust.

Planned Care:

- 18 Week Referral to Treatment (RTT) for incomplete pathways continues to be non-compliant at a CCG level at 66.5% (YTD 66.3%) – a marginal improvement on last month's figure of 66.3%.
- CRHFT performance was 68.3% (YTD 68.6%) and UHDB 62.2% (YTD 61.7%).
- Derbyshire had 5,399 breaches of the 52-week standard across all trusts – 306 less than last month.
- Diagnostics – The CCG performance was 35.02%, a similar figure to last month. Neither CRH (20.96%) or UHDB (38.57%) have achieved the standard, but both have shown improvement.

Cancer:

During November 2021, Derbyshire was compliant in 1 of the 9 Cancer standards:

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

During November 2021, Derbyshire was non-compliant in 8 of the 9 Cancer standards:

- **2-week Urgent GP Referral – 72.4%** (93% standard) – Compliant for Stockport.
- **2 week Exhibited Breast Symptoms – 12.5%** (93% standard) – Compliant at Stockport and Sherwood Forest.
- **28-day Faster Diagnosis – 71.2%** (75% standard) – Compliant for Chesterfield, NUH and Sherwood Forest.
- **31 days from Diagnosis – 87.6%** (96% standard) – Compliant for Stockport.
- **31-day Subsequent Surgery – 72.0%** (94% standard) – Compliant at East Cheshire, Stockport, and Sherwood Forest.
- **31-day Subsequent Radiotherapy – 93.9%** (94% standard) – Compliant at Sheffield.
- **62-day Urgent GP Referral – 59.0%** (85% standard) – Noncompliant for all trusts.
- **62-day Screening Referral – 66.7%** (90% standard) – Noncompliant for all trusts.

104 day wait – Data unavailable at a CCG level.

Quality

Chesterfield Royal Hospital FT
Staff absence is on an improving trajectory however remains high at 11.6%. Steps have been taken to reduce footfall in the hospital including pausing of visiting (apart from compassionate visiting) and closing of the trust café/restaurant to visitors. All this information has gone out on Trust Comms. Trust pressures continue, there is a significant number of patients fit for discharge but due to Covid outbreaks, staffing issues and outstanding risk assessments there is a delay in discharging to Care Homes. DDCCG are working with CRH in addressing these issues. There is significant service pressure in gastroenterology The service is subsequently under significant pressure with 1 part-time nurse covering the service due to staff absence and consideration is taking place around re-deploying medical cover to the service into other areas. The service is continuing but expecting to see significant waiting lists. This will be monitored in line with existing pressures at CQRG.

University Hospitals of Derby and Burton FT
With the current demand, UHDB are redeploying corporate and clinical staff. As such internal meetings are being cancelled unless critical to operations or staffing. DDCCG have accepted the request for normal reports/audits due during January are postponed until February and then be reviewed with regards to re implementation.

Derbyshire Community Health Services FT
The Trust's sickness absence rate has shown a month on month increase since June and is currently 6.35%. This is 1.76% higher than the average sickness rate for September over the last 9 years (4.59%). CQC leads attended private and public Board on the 7th October 2021. This is the first time the new inspectors have attended Board. The Head of Inspection/Hospitals (Mental Health and Community Health Services) visited services in the Trust on the 18th October. Feedback following the visit has been positive.

Derbyshire Healthcare Foundation Trust
There are ongoing work streams to support the continuing need to reduce restrictive practice, including the introduction of body worn cameras and monitoring of restrictive practice within the “reducing restrictive practice forum”. Data analysis and review has shown that even where restraint and seclusion has increased, the use of prone restraint has continued to reduce. April to July 2021 remained below the mean line and demonstrated the ongoing falls reduction work being developed and implemented within

Older adult services. However, August and September saw an increase in falls. A further review is ongoing to understand this pattern and will be monitored through CQRG.

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

Update from the Committee

Integrated Report
Integrated Report approved by the Chair. It was noted that there are concerns in relation to the backlog in breast services. A system-wide breast service review is being undertaken to support the system approach. Progress will be reviewed at the next Quality and Performance Committee.

CEDOP Reports
The Committee received the CEDOP Quarterly and Annual Reports and were assured that there are robust systems and processes in place to manage CEDOP.

DCC Care Home Consultation
Committee noted that CCG response to consultation is to be formulated and approved next steps.

CHC Policy Refresh
The report highlighted that the CCG had wanted to refresh the CHC policy prior to the pandemic, however this had been delayed, therefore it was presented to the Committee and the proposed amendments were approved.

Are there any Resource Implications (including Financial, Staffing etc)?
No
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?
N/A
Has a Quality Impact Assessment (QIA) been completed? What were the findings?
N/A
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
N/A
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
N/A

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
N/A
Have any Conflicts of Interest been identified/ actions taken?
None
Governing Body Assurance Framework
The report covers all of the CCG objectives
Identification of Key Risks
The report covers GBAFs 1, 2 and 6.

NHS
Derby and Derbyshire
Clinical Commissioning Group

Month 08
Quality & Performance Report
2021/22

January 2022

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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 72.1% (YTD 77.8%). CRH did not achieve the standard achieving 85.7% (YTD 91.2%). UHDB achieved 63.6% during December (YTD 69.8%). • UHDB had 124 x 12 hour trolley breaches during December – 122 were due the availability of medical beds and 2 were due to the unavailability of a suitable mental health bed. • EMAS were non-compliant for all 6 of their standards for Derbyshire during December 2021, reflecting the continuing significant pressures being experienced by the trust.
Planned Care	• 18 Week Referral to Treatment (RTT) for incomplete pathways continues to be non-compliant at a CCG level at 66.5% (YTD 66.3%) – a marginal improvement on last months figure of 66.3%. • CRHFT performance was 68.3% (YTD 68.6%) and UHDB 62.2% (YTD 61.7%). • Derbyshire had 5,399 breaches of the 52 week standard across all trusts – 306 less than last month. • Diagnostics – The CCG performance was 35.02%, a similar figure to last month. Neither CRH (20.96%) or UHDB (38.57%) have achieved the standard but both have shown improvement.
Cancer	During November 2021, Derbyshire was compliant in 1 of the 9 Cancer standards: • **31 day Subsequent Drugs – 98.8%** (98% standard) – Compliant for all Trusts except Sherwood Forest. During November 2021, Derbyshire was non-compliant in 8 of the 9 Cancer standards: • **2 week Urgent GP Referral – 72.4%** (93% standard) – Compliant for Stockport. • **2 week Exhibited Breast Symptoms – 12.5%** (93% standard) – Compliant at Stockport and Sherwood Forest. • **28 day Faster Diagnosis – 71.2%** (75% standard) – Compliant for Chesterfield, NUH and Sherwood Forest • **31 day from Diagnosis – 87.6%** (96% standard) – Compliant for Stockport. • **31 day Subsequent Surgery – 72.0%** (94% standard) – Compliant at East Cheshire, Stockport and Sherwood Forest. • **31 day Subsequent Radiotherapy – 93.9%** (94% standard) – Compliant at Sheffield. • **62 day Urgent GP Referral – 59.0%**(85% standard) – Non compliant for all trusts. • **62 day Screening Referral – 66.7%** (90% standard) – Non compliant for all trusts. • **104 day wait –** Data unavailable at a CCG level.

Executive Summary

Trust	
Chesterfield Royal Hospital FT	Staff absence is on an improving trajectory however remains high at 11.6%. Steps have been taken to reduce footfall in the hospital including pausing of visiting (apart from compassionate visiting) and closing of the trust café/restaurant to visitors. All this information has gone out on Trust Comms. Trust pressures continue, there is a significant number of patients fit for discharge but due to Covid outbreaks, staffing issues and outstanding risk assessments there is a delay in discharging to Care Homes. DDCCG are working with CRH in addressing these issues. There is significant service pressure in gastroenterology The service is subsequently under significant pressure with 1 part-time nurse covering the service due to staff absence and consideration is taking place around re-deploying medical cover to the service into other areas. The service is continuing but expecting to see significant waiting lists. This will be monitored in line with existing pressures at CQRG.
University Hospitals of Derby and Burton NHS FT	With the current demand, UHDB are redeploying corporate and clinical staff. As such internal meetings are being cancelled unless critical to operations or staffing. DDCCG have accepted the request for normal reports/audits due during January are postponed until February and then be reviewed with regards to re implementation.
Derbyshire Community Health Services FT	The Trust's sickness absence rate has shown a month on month increase since June and is currently 6.35%. This is 1.76% higher than the average sickness rate for September over the last 9 years (4.59%). CQC leads attended private and public Board on the 7th October 2021. This is the first time the new inspectors have attended Board. The Head of Inspection/Hospitals (Mental Health and Community Health Services), visited services in the Trust on the 18th October. Feedback following the visit has been positive.
Derbyshire Healthcare Foundation Trust	There are ongoing work streams to support the continuing need to reduce restrictive practice; including the introduction of body worn cameras and monitoring of restrictive practice within the “reducing restrictive practice forum”. Data analysis and review has shown that even where restraint and seclusion has increased, the use of prone restraint has continued to reduce. April to July 2021 remained below the mean line and demonstrated the ongoing falls reduction work being developed and implemented within Older adult services. However, August and September saw an increase in falls. A further review is ongoing to understand this pattern and will be monitored through CQRG.
East Midlands Ambulance Trust	There continues to be challenges with demand with EMAS being in Clinical Safety Plan 4 (CSP4) Clinical Safety Plan 4 Avoidance (CSP4A) for a significant amount of time Delays in response was now the most prevalent type of serious incident reported by EMAS. Harm reviews were conducted between October and November to provide further assurance regarding if patients were coming to harm due to delays in care. The Harm reviews did not identify any harm as a result of delays in care. The Delayed Hospital Handovers impact assessment of patient harm was also published on the 15th of November 2021. The CQRG will reviewed the findings of the report and the increase in serious incidents at its extraordinary meeting in December 2021.

PERFORMANCE OVERVIEW MONTH 9 – 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%	Dec-21	↑	72.1%	77.8%	75	85.7%	91.2%	4	63.6%	69.8%	75	75.6%	79.9%	75
		A&E 12 Hour Trolley Waits	0	Dec-21					0	14	0	124	377	17	12986	43231	75

NHS Derby & Derbyshire CCG Assurance Dashboard

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

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

EMAS Dashboard for Ambulance Performance Indicators

	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	Dec-21	→	00:08:56	00:08:39	18	00:08:59	00:08:44	17	00:07:54	00:09:05			00:09:13	00:08:27	8
		Ambulance - Category 1 - 90th Percentile Respose Time	00:15:00	Dec-21	→	00:15:28	00:14:54	4	00:16:17	00:15:40	6	00:14:06	00:16:29			00:16:12	00:14:57	6
		Ambulance - Category 2 - Average Response Time	00:18:00	Dec-21	↓	00:49:45	00:39:28	17	00:55:34	00:46:30	18	00:33:40	00:49:29			00:53:21	00:39:24	17
		Ambulance - Category 2 - 90th Percentile Respose Time	00:40:00	Dec-21	↓	01:49:32	01:22:06	17	02:03:31	01:39:23	17	01:10:09	01:46:26			01:59:12	01:24:29	9
		Ambulance - Category 3 - 90th Percentile Respose Time	02:00:00	Dec-21	→	06:42:06	05:55:27	17	07:27:27	06:46:37	17	04:30:11	07:17:52			07:11:44	05:32:02	9
		Ambulance - Category 4 - 90th Percentile Respose Time	03:00:00	Dec-21	→	05:47:42	05:27:52	9	07:01:10	06:08:16	9	04:43:53	06:45:03			08:05:16	06:30:13	1

PERFORMANCE OVERVIEW MONTH 8 – PLANNED CARE

NHS Derby & Derbyshire CCG Assurance Dashboard

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

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

Part A - National and Local Requirements

CCG Dashboard for NHS Constitution Indicators

						Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance
Planned Care	Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Nov-21	↑		66.5%	66.3%	46	68.3%	68.6%	31	62.2%	61.7%	47	65.5%	66.8%	69
		Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Nov-21	↑		5399	48957	22	1084	9114	20	5469	52797	21	306996	2532493	175
	Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Nov-21	↓		35.02%	31.38%	42	20.96%	16.27%	20	38.57%	35.46%	21	25.02%	24.45%	99
	2 Week Cancer Waits	All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	Nov-21	↓		72.4%	83.8%	15	Cancer 2 Week Wait Pilot Site - not currently reporting			65.6%	77.7%	15	77.4%	83.7%	18
		Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	Nov-21	↓		12.5%	59.0%	3				0.6%	57.3%	2	52.2%	68.8%	18
	28 Day Faster Diagnosis	Diagnosis or Decision to Treat within 28 days of Urgent GP, Breast Symptom or Screening Referral	75%	Nov-21	↓		71.2%	74.4%	3	76.1%	76.9%	0	68.0%	72.8%	4	71.3%	72.9%	8
	31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	96%	Nov-21	↓		87.6%	91.8%	11	88.0%	93.9%	3	86.8%	91.6%	16	93.0%	93.9%	11
		Subsequent Surgery Within 31 Days Of Decision To Treat	94%	Nov-21	↓		72.0%	79.5%	24	81.3%	94.8%	1	79.6%	83.6%	6	82.0%	85.4%	40
		Subsequent Drug Treatment Within 31 Days Of Decision To Treat	98%	Nov-21	↓		98.8%	99.1%	0	100.0%	100.0%	0	98.9%	98.9%	0	98.9%	99.0%	0
		Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	Nov-21	↓		93.9%	95.3%	1				89.5%	92.1%	2	94.3%	96.0%	0
	62 Days Cancer Waits	First Treatment Administered Within 62 Days Of Urgent GP Referral	85%	Nov-21	↓		59.0%	65.3%	33	71.9%	72.9%	28	46.7%	60.9%	43	67.5%	70.9%	71
		First Treatment Administered - 104+ Day Waits	0	Nov-21	↔		N/A	110	68	4	39	43	37	196	68	1319	8094	71
		First Treatment Administered Within 62 Days Of Screening Referral	90%	Nov-21	↑		66.7%	68.0%	31	53.3%	54.5%	31	79.1%	80.9%	12	72.8%	73.7%	44
		First Treatment Administered Within 62 Days Of Consultant Upgrade	N/A	Nov-21	↑		87.0%	81.0%		87.5%	88.6%		90.4%	89.3%		78.9%	80.6%	

PERFORMANCE OVERVIEW MONTH 8 – PATIENT SAFETY

NHS Derby & Derbyshire CCG Assurance Dashboard

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

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

Part A - National and Local Requirements

CCG Dashboard for NHS Constitution Indicators

					Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance
Patient Safety	Incidence of healthcare associated Infection	Healthcare Acquired Infection (HCAI) Measure: MRSA Infections	0	Nov-21	↓	1	1	1	Cancer 2 Week Wait Pilot Site - not currently reporting			0	1	0	52	410	32
		Healthcare Acquired Infection (HCAI) Measure: C-Diff Infections	Plan	Nov-21	↑		159						80				
			Actual				171	0		11	0		46	0		9861	
		Healthcare Acquired Infection (HCAI) Measure: E-Coli	-	Nov-21	↑	54	575		20	176		46	407		54	575	
		Healthcare Acquired Infection (HCAI) Measure: MSSA	-	Nov-21	↑	16	95		5	33		14	62		1060	4933	

PERFORMANCE OVERVIEW MONTH 8 – MENTAL HEALTH

CCG Dashboard for NHS Constitution Indicators

Mental Health

Area	Indicator Name	Standard	Latest Period	Direction of Travel	NHS Derby & Derbyshire CCG Current Month	NHS Derby & Derbyshire CCG YTD	NHS Derby & Derbyshire CCG consecutive months of failure	Cancer 2 Week Wait Pilot Site - not currently reporting Current Month	Cancer 2 Week Wait Pilot Site - not currently reporting YTD	Cancer 2 Week Wait Pilot Site - not currently reporting consecutive months of failure	Current Month	YTD	consecutive months of failure	NHS England Current Month	NHS England YTD	NHS England consecutive months of failure	Current Month	YTD	consecutive months of failure
Early Intervention In Psychosis	Early Intervention In Psychosis - Admitted Patients Seen Within 2 Weeks Of Referral	60.0%	Sep-21	↑	47.8%	52.9%	3	45.8%	51.7%	3				69.4%	67.6%	0			
	Early Intervention In Psychosis - Patients on an Incomplete Pathway waiting less than 2 Weeks from Referral	60.0%	Sep-21	↑	50.0%	50.0%	3	33.3%	56.3%	3				35.8%	29.3%	29			
Mental Health	Dementia Diagnosis Rate	67.0%	Nov-21	↓	64.2%	64.8%	17							62.0%	62.8%	20			
	CYPMH - Eating Disorder Waiting Time % urgent cases seen within 1 week		2021/22 Q2	↓	87.6%	74.6%													
	CYPMH - Eating Disorder Waiting Time % routine cases seen within 4 weeks		2021/22 Q2	↓	82.1%	83.9%													
	Perinatal - Increase access to community specialist perinatal MH services in secondary care	4.5%	2021/22 Q1	↑	3.1%	3.9%	6												
	Mental Health - Out Of Area Placements		Sep-21	↑	475	3420													
	Physical Health Checks for Patients with Severe Mental Illness	25%	2021/22 Q2	↑	23.9%	29.6%	6												
Area	**Indicator Name**	**Standard**	**Latest Period**		**NHS Derby & Derbyshire CCG**			**Talking Mental Health Derbyshire (D&DCCG only)**			**Trent PTS (D&DCCG only)**			**Insight Healthcare (D&DCCG only)**			**Vita Health (D&DCCG only)**		
Improving Access to Psychological Therapies	IAPT - Number Entering Treatment As Proportion Of Estimated Need In The Population	Plan	Nov-21	↑	2.10%	16.80%													
		Actual			2.74%	21.26%	0												
	IAPT - Proportion Completing Treatment That Are Moving To Recovery	50%	Nov-21	↑	53.3%	52.9%	0	57.9%	54.6%	0	51.5%	52.6%	0	48.9%	48.0%	2	56.6%	56.9%	0
	IAPT Waiting Times - The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment	75%	Nov-21	↓	89.3%	93.5%	0	86.8%	89.0%	0	88.5%	94.5%	0	97.2%	97.9%	0	100.0%	98.2%	0
	IAPT Waiting Times - The proportion of people that wait 18 Weeks or less from referral to entering a course of IAPT treatment	95%	Nov-21	↓	99.9%	100.0%	0	99.8%	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%	Nov-21	↓	59.3%	79.0%	6												
	Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Nov-21	↓	0	1	0												

Quality Overview

QUALITY OVERVIEW M09

Trust	Key Issues
Chesterfield Royal Hospital FT	**Summary** Staff absence is on an improving trajectory however remains high at 11.6% Steps have been taken to reduce footfall in the hospital including pausing of visiting (apart from compassionate visiting) and closing of the trust café/restaurant to visitors. All this information has gone out on Trust Comms There has been a significant decrease in ED attendance, the trial of the electronic streaming is ongoing. **Pressures** **Discharge:** There is a significant number of patients fit for discharge but due to Covid outbreaks, staffing issues and outstanding risk assessments there is a delay in discharging to Care Homes. DDCCG are working with CRH in addressing these issues with regards to IPC assessment and supporting risk assessments and communication with Care Homes. **Gastroenterology:** There is significant service pressure in gastroenterology The service is subsequently under significant pressure with 1 part-time nurse covering the service due to staff absence and consideration is taking place around re-deploying medical cover to the service into other areas. The service is continuing but expecting to see significant waiting lists.
University Hospitals of Derby and Burton NHS FT	**Pressures** **Discharge**: There is a significant number of patients fit for discharge but due to Covid outbreaks, staffing issues and outstanding risk assessments there is a delay in discharging to Care Homes. DDCCG are working with UHDB in addressing these issues with regards to IPC assessment and supporting risk assessments and communication with Care Homes. **Redeployment:** With the current demand, UHDB are redeploying corporate and clinical staff. As such internal meetings are being cancelled unless critical to operations or staffing. DDCCG have accepted the request for normal reports/audits due during January are postponed until February and then be reviewed with regards to re implementation.

QUALITY OVERVIEW M8 continued

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

QUALITY OVERVIEW M8

Derbyshire Wide Integrated Report

Part B: Provider Local Quality Indicators

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

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

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

QUALITY OVERVIEW M8

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

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

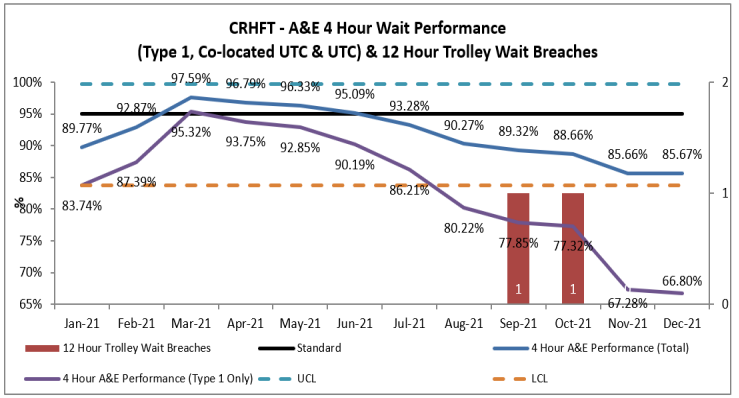
Urgent & Emergency Care

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

Performance Analysis

During December 2021 the trust did not meet the 95% standard, achieving 85.7% and the Type 1 element achieving 66.8%, Similar to the previous month..

There were no 12 hour trolley breaches during December.



What are the next steps?

- The official Winter Plan will see increased bed capacity over the pressured season.
- The acute frailty service will continue to operate over the winter – with a geriatrician led team located in ED.
- Creating a discharge lounge to improve flow through acute and elective care beds and ED/assessment units
- Broadening the Same Day Emergency Care (SDEC) pathway offer following a Perfect Week exercise, especially for surgical and Gynaecological conditions.
- Implementing further actions recommended by the Missed Opportunities Audit, including other pathway alterations, increased access to diagnostics and alternative streaming options

What are the issues?

- Staff sickness levels (due to the Omicron wave and other winter illnesses) across the trust have had a major impact on the performance in A&E. Towards the end of the month the staff sickness levels were at 11.3% with over half of these due to Covid19.
- There continued to be severely delayed discharges for patients requiring Packages Of Care, due to capacity for these in the county. This has led to the medical bed base being full (at times there have been enough Medically Fit For Discharge patients to fill whole inpatient wards), therefore reducing the beds available for those in A&E who need them.
- The combined Type 1 & streamed attendances are close to pre-pandemic levels, with an average of 246 attendances per day.
- There were surges of Covid19 admissions & outbreaks in the middle and end of the month, with as many as 47 positive inpatients at one point, including 7 in ICU. This added more pressure to a trust with an escalated critical care position.
- 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?

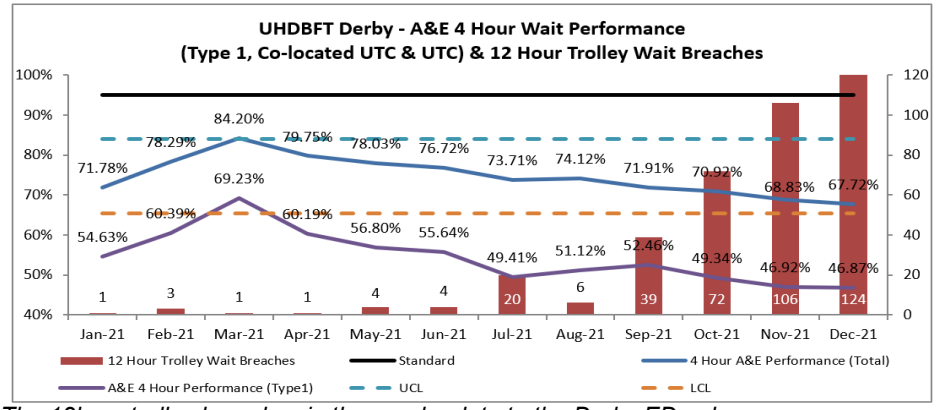
- System level meetings have been stood up to take place every day (including weekends) as either a System Escalation Call (SEC) or System Organisational Resilience Group (SORG). The membership includes acute trusts, community trusts and councils, solving problems collaboratively in addition to focussed meetings & communications to secure more capacity.
- The Same Day Emergency Care (SDEC) area has been moved closer to the front door to more easily divert patients there, avoiding A&E.
- Increased capacity to clinically stream patient, avoiding the need for patients with more minor needs to need A&E.
- Implemented a recurrent increase to the level of P1 capacity with the County increasing its new start capability by 20%, ensuring speedier discharges and freeing capacity.
- Expanded the physical footprint of the Majors area in order to accommodate more of these patients and to asses and/or treat them more quickly.
- The cancellation of the least urgent elective procedures to free up critical care capacity and inpatient beds.

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

Performance Analysis

During December 2021, performance overall did not meet the 95% standard, achieving 67.7% (Network figure) and 46.9% for Type 1 attendances. These continue the deterioration since March 2021.

There were 124 x 12 hour breaches during December 2021 due to the availability of suitable Mental Health beds (2) and medical capacity issues (122).



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

What are the next steps?

- Opening Ward 5 and expanding Ward 2 at Florence Nightingale Community Hospital to treat Nursing Home and End Of Life patients in a more appropriate setting.
- Longer-term commissioning of the UTC to enable consistency in opening times and staffing.
- Developing workforce plans to increase the numbers working 'on the floor'.
- Improved back-up rotas have been devised to ensure unexpected absence, in anticipation of further staff sickness/isolation due to the Omicron wave.
- Developing an action plan following the MADE event of early December which focussed on flow of P1 patients.
- A further constructive peer review by Chris Morrow-Frost (NHSEI) to gain advice about further improvements now that the UTC has been established at his suggestion. Long-term contractual work to ensure consistent staffing is also taking place.

What are the issues?

- Staff sickness levels (due to the Omicron wave and other winter illnesses) across the site have had a major impact on the performance in A&E. Towards the end of the month the staff sickness levels were at 12.2% across the trust with 39% of these due to Covid19.
- The volume of attendances were very high, with an average of 428 attendances per day at Derby. These comprise both Type 1 and co-located Urgent Treatment Centre (UTC) numbers, as the UTC sees patients who would otherwise have been classed as minors.
- The acuity of the attendances was high, seeing an average of 13 Resuscitation patients & 172 Major patients per day.
- Attendances at Children's ED continue to be high, with concerns about RSV and Bronchiolitis being major factors. Children's Type 1 attendances at Derby have averaged at 109 per day during December 2021.

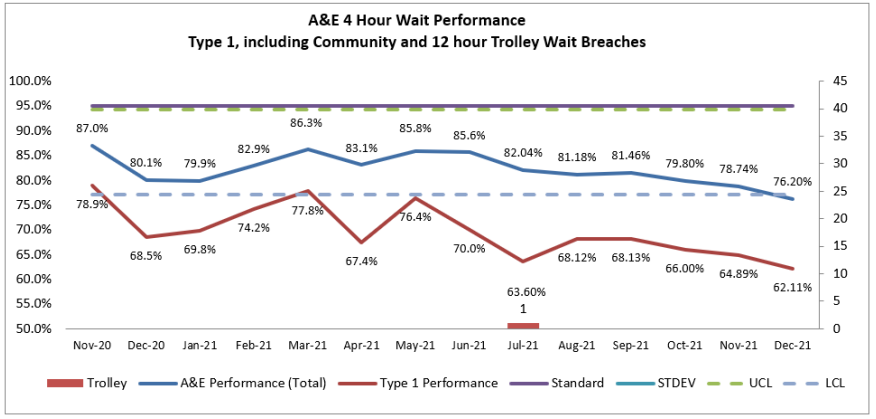
What actions have been taken?

- System level meetings have been stood up to take place every day (including weekends) as either a System Escalation Call (SEC) or System Organisational Resilience Group (SORG). The membership includes acute trusts, community trusts and councils, solving problems collaboratively in addition to focussed meetings & communications to secure more capacity.
- The Same Day Emergency Care (SDEC) area now opens at weekends, treating 30% of non-electives and bypassing the Early implementation of the Winter Plan, with an Orthopaedic ward given over to non-elective emergency care. Some of the elective Orthopaedic patients are now being seen in the Burton Treatment Centre, to free up emergency capacity.
- The Frail Elderly team have opened 4 cubicles away from A&E to see & treat unheralded patients in a more appropriate setting and reducing their time in A&E.
- Reinstatement of a Frailty Geriatrician Of The Day, enabling speedier and more specialised care for patents attending due to frailty related conditions.
- Continued use of the co-located UTC (with 24/7 opening) meaning that more minor cases can be seen, reducing unnecessary Type 1 ED attendances.
- The UTC has been developed to improve communications, escalation procedures, flow processes and referrals straight to inpatient wards or assessment areas.
- Pre-emptive escalation of potential 12hour trolley breaches to trigger immediate actions to admit the patients sooner.

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

Performance Analysis

During December 2021, performance overall did not meet the 95% standard, achieving 62.1% for the Burton A&E and 76.2% including community hospitals. Performance has been deteriorating since Autumn. There were no 12 hour breaches during December 2021.



What were the issues?

- Staff sickness levels (due to the Omicron wave and other winter illnesses) across the site have had a major impact on the performance in A&E. Towards the end of the month the staff sickness levels were at 12.2% across the trust with 39% of these due to Covid19.
- The department have experienced a high volume of activity with an average of 199 Type 1 attendances per day.
- The acuity of the attendances is high, with an average of 125 Resuscitation/Major patients per day (68% of Type 1s).

What actions have been taken?

- Further recruitment of clinical staff including 1 middle-grade and 2 JCFs.
- Development of a revised Clinical Navigation Model with DHU.
- Opening an Acute Medical Unit Triage (AMUT) to assess patients away from ED as GPs refer directly into the unit or patients are 'pulled' there from the ED waiting room. An escalation plan has also been developed for this area.
- Every walk-in patient is now streamed by Clinical Navigators to ascertain whether ED is the most appropriate setting for their assessment or care.
- The Surgical Assessment Unit (SAU) now operates for 12 hours a day (9am-9pm) with 9 trolleys available for specialised assessment away from ED.
- Increased use of the Burton Treatment Centre to see elective patients and therefore release beds for emergency activity.
- The Discharge Team now have weekend cover, enabling speedier discharges for medically appropriate patients over the weekend and improving flow over the whole hospital.
- Further improvements to the discharge process to include earlier input to the discharge process and increased in-reach.
- Increased 'Every Day Counts' accreditation for wards to increase their focus on discharge planning to improve patient flow.
- Development of the 'In-Department Pathway' project to include alternative navigation/streaming process and the 'pulling' of patients into Same Day Emergency Care (SDEC) pathways.
- The addition of a modular building to house GP Streaming services.
- The opening of a 2nd Ultrasound Room has increased availability of scanning capacity and increasing patient flow.

What are the next steps?

- Developing workforce plans to increase the numbers working 'on the floor' in the department, to include the utilisation of more Allied Healthcare Professionals (AHPs).
- Improved back-up rotas have been devised to ensure unexpected absence, in anticipation of further staff sickness/isolation due to the Omicron wave.
- Relaunching the Acute Medicine Lead role, with a focus on escalation during times of pressure.
- Work with the surgical division to launch nurse-led A&E and Same Day Emergency Care (SDEC) pathways.
- Launch of a Professional Standards campaign to influence medical practice across the Trust and therefore improve patient flow.
- The acute frailty service will continue to operate over the winter – with a geriatrician led team located in ED.

DHU111 Performance Month 8 (November 2021)

Performance Summary

- DHU111 achieved three of the five contractual Key Performance Indicators (KPIs) during November 2021. The following two KPIs were not achieved:

    1. Abandonment rate which was 3.1% higher than the contractual KPI, at 8.1%.
    2. The Average speed of answer which was 2 minutes and 46 seconds above the contractual KPI, at 3 minutes and 13 seconds.

- It is worth noting that 111 providers across the country continue to experience high levels of demand and although there has been a deterioration in DHU111's performance, it remains good comparative to the national position which shows an abandonment rate of 21.5% and an average speed of answer of 8 minutes and 19 seconds.

Regional Performance Year Six - Key Performance Indicators (KPI's)							
		Year Five - Quarter Four (July- September)			Quarter One (October – December)		
Contractual KPI's	Standard	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21
Abandonment rate (%)	≤5%	1.1%	3.1%	5.4%	7.0%	8.1%	
Average speed of answer (seconds)	≤27s	00:00:26	00:01:00	00:01:47	00:02:23	00:03:13	
Call Transfer to a Clinician	≥50%	64.5%	66.0%	65.2%	69.2%	66.7%	
Self Care	≥17%	19.0%	17.2%	17.4%	19.0%	18.8%	
Patient Experience	≥85%	84.0%			This data is updated on a six monthly basis		
C3 Validation	≥50%	98.2%	98.0%	98.0%	98.2%	97.9%	

Activity Summary

- During November, calls offered were 20.2% above the newly negotiated indicative activity plan (IAP) for Year 6 and clinical calls were 29.7% below the IAP. Please note that, as per the agreements made as part of the Year 6 contract, COVID activity is now included within the core activity lines. The coordinating commissioning team will work with DHU111 to understand why the variance to plan between the two activity lines is so different.
- A total of 9,213 Category 3 validations were carried out during November, this was a slight decrease compared to the previous month where 10,382 validations took place.

DHU111 Performance Month 8 (November 2021)

What are the issues?

- DHU111 continue to experience high levels of activity, which is having a significant impact throughout the service. DHU111 have reported a further increase in COVID related activity with an average of 500 calls per day.
- Dental related activity continues to increase and the pressure has further intensified due to lack of dental services for DHU111 to refer in to.
- DHU111 have seen an increase in short term sickness levels for the month of November 2021 for both Health Advisors and Clinical Advisors which is causing pressure.
- DHU111 continue to experience challenges in relation to recruitment, however the retention of call takers has seen an improvement for the month of November 2021.

What actions have been taken?

- Commissioners have worked through the H2 Funding available to Integrated Urgent Care (IUC) systems to support short term increases in capacity to cope with increased demand over winter. The amounts being allocated to DHU111 were confirmed by Leicestershire, Lincolnshire and Nottinghamshire at the December Contract Management Board (CMB) meeting. Northamptonshire and Derbyshire are currently going through their internal formal governance processes before providing final formal confirmation.
- DHU111 continue to do everything they can to recruit staff which includes mass recruitment and financial incentives such as an entrance bonus to recruit clinicians.

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

What are the next steps?

- With regards to Year 7, the Coordinating Commissioning Team will write to DHU111 formally setting out the proposal for Year 7 and this has been included as an agenda item at the January 2022 Contract Management Board meeting.
- To increase staffing levels further DHU111 are planning to link in with a national recruitment campaign that is supplemented by NHS England and to utilise the H2 funding to support short term increases in staffing once the final values have been confirmed by commissioners.

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 M8 (November 2021)

What are the issues?

- The contractual standard is for the Derbyshire division to achieve national performance on a quarterly basis. For Quarter three to date, Derbyshire are not meeting any of the six national standards. The variation to the national standard for the quarter three to date position is as follows:
  - C1 mean +2 minute and 12 seconds
  - C1 90th Centile +1 minute
  - C2 mean +26 minutes and 10 seconds
  - C2 90th Centile +53 minutes and 35 seconds
  - C3 90th Centile +5 hours, 21 minutes and 59 seconds
  - C4 90th Centile +3 hours, 49 minutes and 22 seconds
- There is a regional level trajectory for performance which is linked to the receipt of additional national funding. During November, EMAS did not achieve any of the performance trajectories, however performance against all trajectories has seen an improvement when compared to October 2021.
- Within Derbyshire demand from NHS111 is the highest in the region at 27%, with variation in the region being between 18%-27%.
- There continues to be challenges with demand, with EMAS being in CSP4/CSP4A for 54.58% of the month, this is a total of 393 hours out of a potential 720 hours within November, and is an equivalent to 16.38 days out of 30.
- Average Pre hospital handover times during November 2021 continued to be above the 15 minute National Standard across Derbyshire at 23 minutes and 19 seconds which was and improvement when compared to October 2021 performance (24 minutes and 28 seconds).
- Average Post handover times during November 2021 remained above the 15 minute national standard across Derbyshire with the exception of Macclesfield District (13 minutes and 23 seconds). Overall the post handover time in November 2021 was 19 minutes and 56 seconds which was similar to October 2021 performance at 19 minutes and 26 seconds.
- Incidents in Derbyshire in November 2021 saw an decrease when compared to October 2021 (13,181 compared to 13,505) and remained above the indicative activity plan. Although when looking at the average per day, this is only a very slight increase.
- For Derbyshire the percentage of calls being classed as a duplicate calls during November 2021 was lower (20.7%) when compared to October (21.9%), but these remain above the contractual threshold of 17.9%.

Performance	Category 1		Category 2		Category 3	Category 4
	Average	90th centile	Average	90th centile	90th centile	90th centile
National standard	**00:07:00**	**00:15:00**	**00:18:00**	**00:40:00**	**02:00:00**	**03:00:00**
EMAS Actual – November	00:09:18	00:16:21	00:55:02	01:59:24	07:59:56	07:15:18
Derbyshire Actual - November	00:09:12	00:15:43	00:42:05	01:28:20	06:51:32	07:21:54
Derbyshire Actual – Quarter Three to date	00:09:12	00:16:00	00:44:10	01:33:35	07:21:59	06:49:22

November 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	00:35:49	130:18:31	00:16:00	28:57:57	00:51:49	142:10:45
Chesterfield Royal	00:20:55	266:40:36	00:20:29	292:46:11	00:41:24	481:41:38
Macclesfield District General Hospital	00:46:36	23:52:15	00:13:23	3:04:59	00:59:59	22:55:14
Royal Derby	00:22:57	597:47:16	00:20:31	527:48:25	00:43:28	991:47:47
Sheffield Northern General Hospital	00:32:56	41:35:06	00:18:43	15:24:06	00:51:40	50:18:50
Stepping Hill	00:23:18	59:52:19	00:15:12	23:36:20	00:38:30	70:29:07
Derbyshire TOTAL	00:23:19	1120:06:03	00:19:56	891:37:58	00:43:15	1759:23:21

AMBULANCE – EMAS PERFORMANCE M8 (November 2021)

What actions have been taken?

- An extraordinary CQRG was held on the 16th December 2021 focused on gaining assurance regarding the increase in delayed response serious incidents. The CQRG acknowledged that system measures were required to address all the contributory factors.
- To reduce duplicate calls, EMAS have implemented the National initiative with British Telecom which screens callers wanting an update on arrival time but the patients condition has not changed. It was reported at the November Strategic Delivery Board meeting that this service stopped 52 duplicate calls, within the week commencing 22nd November 2021.
- EMAS have continued to successfully recruit additional staff within the emergency operations centres in order to cope with the anticipated surge in demand over the winter period.
- EMAS were part of a national pilot to expand the number of C3/4 codes that are eligible for validation by the ambulance service. The pilot evidence demonstrated that clinical validation was an effective way to manage a select range of less urgent cases and the pilot is to be extended to all trusts as business as usual.
- From 1st September 2021, DHU111 extended their C3 validation timeframe from 30 minutes to 60 minutes allowing more time for a DHU111 clinician to clinically validate C3 dispositions. The aim of the pilot was to reduce the number of calls being passed through to EMAS for dispatch. Unfortunately the pilot sites have not experienced the anticipated benefits and therefore the pilot has stopped and all 111 services have reverted back to a 30 minute timeframe for C3/4 validation.

What are the next steps

- Since the December extraordinary CQRG meeting, commissioners were tasked with providing a response to the Coordinating Commissioning Team the week commencing 20th December 2021 regarding actions being taken at county level to address the system wide contributory factors including, EMAS's harm prevention tool, sharing good practice that can be cascaded throughout the region to improve delayed responses, action on falls and respiratory pathways. An update will be presented as a paper at the next Strategic delivery board meeting in January 2022.
- On the 13th December 2021, NHSE/I sent a letter out in relation to preparing the NHS for the potential of the Omicron variant and other winter pressures, which also declared a Level 4 National Incident. Within the letter was guidance for systems to reduce ambulance response times and eliminating ambulance delays.

EMAS Activity - 2021 to 2022				
Derbyshire	Quarter Two 2021 -2022	October	November	Quarter Three to date
Calls (Total)	66,076	22,150	20,588	42,738
Total Incidents	40,260	13,505	13,181	26,686
Total Responses	35,986	12,251	11,963	24,214
Duplicate Calls	14,530	4,842	4,262	9,104
Hear & Treat (Total)	15,560	5,057	4,363	9,420
See & Treat	13,038	4,405	4,343	8,748
See & Convey	22,948	7,846	7,620	15,466
Duplicates as % Calls	22.0%	21.9%	*20.7%*	*21.3%*
H&T ASI as % Incidents	10.6%	9.3%	*9.2%*	9.3%
S&T as % Incidents	32.4%	32.6%	*32.9%*	*32.8%*
S&C as % Incidents	57.0%	58.1%	*57.8%*	*58.0%*
S&C to ED as % of incidents	52.7%	54.0%	*53.5%*	53.7%

Planned Care

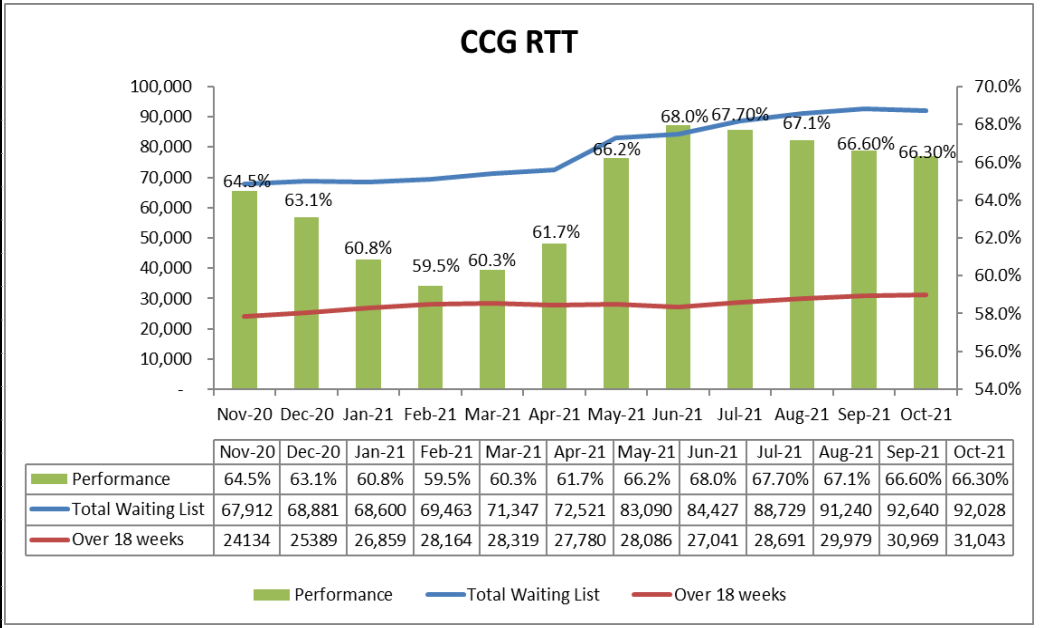
DERBYSHIRE COMMISSIONER – INCOMPLETE PATHWAYS (92%)

Performance Analysis

Performance for November 2021 was 66.5% a very slight increase on the October figure.

The total incomplete waiting list for DDCCG was 92,607 an increase of 559 on the previous month. .
The number of referrals across Derbyshire during November showed that there was an increase of 14% on the weekly referrals and a reduction of 27% of routine referrals when compared to the 51 weeks to March 2020. (Urgent referrals were 13% above and routine referrals 24% fewer than the same month during 2019.

Treatment Function	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Total 52 plus weeks
General Surgery Service	5,013	2,618	52.2%	811
Urology Service	4,095	2,959	72.3%	232
Trauma and Orthopaedic Service	13,602	7,390	54.3%	1,621
Ear Nose and Throat Service	6,289	4,266	67.8%	375
Ophthalmology Service	12,738	7,505	58.9%	815
Oral Surgery Service	20	15	75.0%	0
Neurosurgical Service	612	398	65.0%	20
Plastic Surgery Service	642	440	68.5%	51
Cardiothoracic Surgery Service	184	108	58.7%	20
General Internal Medicine Service	234	194	82.9%	2
Gastroenterology Service	4,566	3,561	78.0%	85
Cardiology Service	2,500	1,971	78.8%	42
Dermatology Service	6,857	4,745	69.2%	69
Respiratory Medicine Service	1,478	1,187	80.3%	1
Neurology Service	2,342	1,888	80.6%	6
Rheumatology Service	1,771	1,387	78.3%	6
Elderly Medicine Service	300	254	84.7%	2
Gynaecology Service	6,688	4,426	66.2%	328
Other - Medical Services	6,318	5,151	81.5%	66
Other - Mental Health Services	305	260	85.2%	0
Other - Paediatric Services	7,068	4,667	66.0%	255
Other - Surgical Services	7,969	5,315	66.7%	561
Other - Other Services	1,016	838	82.5%	31
Total	**92,607**	**61,543**	**66.5%**	**5,399**



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

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

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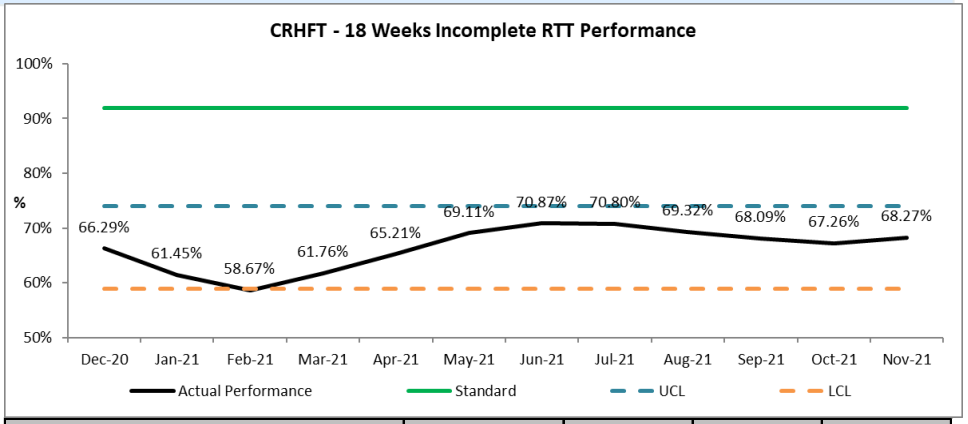
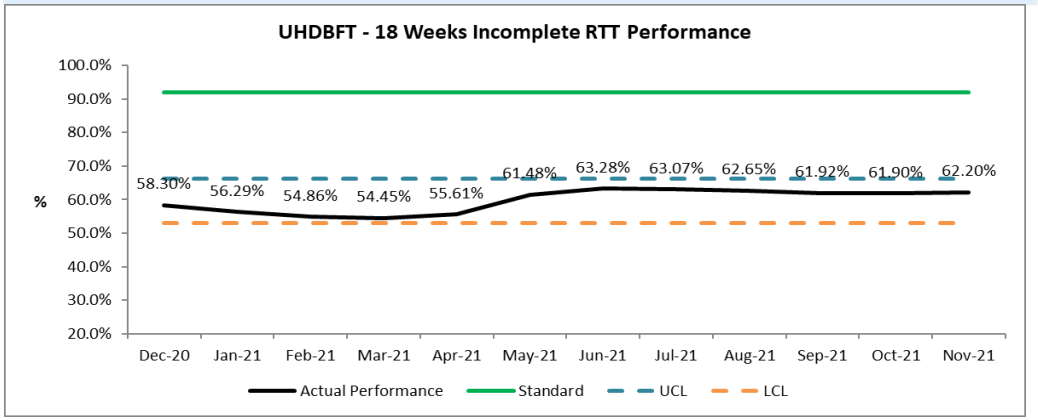
Referral to Treatment – Incomplete Pathways (92%).

CRH – During November the trust achieved 68.3%, a slight increase on the October figure of 67.3%. The incomplete waiting list at the end of November was 19,937 (October - 19,921).



Treatment Function	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Total 52 plus weeks
General Surgery Service	1,354	630	46.5%	264
Urology Service	1,109	889	80.2%	14
Trauma and Orthopaedic Service	1,985	1,036	52.2%	194
Ear Nose and Throat Service	1,624	1,188	73.2%	89
Ophthalmology Service	2,276	1,355	59.5%	162
Oral Surgery Service	1,350	756	56.0%	88
General Internal Medicine Service	199	167	83.9%	0
Gastroenterology Service	1,275	990	77.6%	7
Cardiology Service	527	414	78.6%	4
Dermatology Service	1,968	1,499	76.2%	0
Respiratory Medicine Service	531	379	71.4%	0
Rheumatology Service	328	278	84.8%	1
Gynaecology Service	1,464	986	67.3%	159
Other - Medical Services	854	686	80.3%	10
Other - Paediatric Services	1,154	937	81.2%	14
Other - Surgical Services	1,939	1,421	73.3%	78
Total	19,937	13,611	68.3%	1,084

UHDB - During November the trust achieved a standard of 61.8%, the same figure as October. The incomplete waiting list at the end of November was 84,869 (October - 85,487)



Treatment Function	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Total 52 plus weeks
General Surgery Service	4,527	2,562	56.6%	509
Urology Service	3,572	2,354	65.9%	264
Trauma and Orthopaedic Service	13,859	7,291	52.6%	1,778
Ear Nose and Throat Service	6,770	4,103	60.6%	270
Ophthalmology Service	11,528	5,731	49.7%	957
Oral Surgery Service	2,848	1,386	48.7%	266
Neurosurgical Service	103	63	61.2%	0
Plastic Surgery Service	348	260	74.7%	18
Cardiothoracic Surgery Service	12	11	91.7%	0
General Internal Medicine Service	22	19	86.4%	0
Gastroenterology Service	3,352	2,757	82.2%	9
Cardiology Service	1,942	1,568	80.7%	9
Dermatology Service	6,210	3,664	59.0%	174
Respiratory Medicine Service	727	660	90.8%	2
Neurology Service	2,013	1,588	78.9%	4
Rheumatology Service	1,695	1,294	76.3%	7
Elderly Medicine Service	335	267	79.7%	5
Gynaecology Service	6,792	4,241	62.4%	291
Other - Medical Services	6,115	4,863	79.5%	48
Other - Mental Health Services	1	1	100.0%	0
Other - Paediatric Services	4,343	2,660	61.2%	203
Other - Surgical Services	6,660	4,284	64.3%	609
Other - Other Services	1,095	859	78.4%	46
Total	84,869	52,486	61.8%	5,469

DERBYSHIRE COMMISSIONER – OVER 52 WEEK WAITS

52 Week Waits

At the end of November there were 5,399 Derbyshire patients waiting over 52 weeks for treatment in Derbyshire. Of these 4,204 were waiting for treatment at our two main providers UHDB and CRH, the remaining 1,191 were waiting at various trusts around the country as outlined in the table on the following slide.

The number is again a decrease on the previous month's figure – a reduction of 406.

CCG Patients – Trend – 52 weeks														
	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sept-21	Oct-21	**Nov-21**
DDCCG	2,658	3,388	4,245	5,903	7,554	8,261	7,490	6,859	6,199	5,897	5,627	5,781	5,705	**5,399**

Main Providers:

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

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sept-21	Oct-21	**Nov-21**
UHDB	2,968	3,751	4,706	6,629	8,767	9,728	8,605	7,573	6,806	6,206	5,755	5,692	5,659	**5,469**
CRH	438	594	797	1,202	1,475	1,471	1,278	1,179	1,095	1098	1,118	1,129	1,133	**1,084**

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

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

Actions:

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

DERBYSHIRE COMMISSIONER – OVER 52 WEEK WAITERS

Associate Providers – Derbyshire Patients waiting over 52 weeks in October 2021 at associate providers were 1195.

Provider	Total	Provider	Total
ASPEN - CLAREMONT HOSPITAL	11	SPIRE REGENCY HOSPITAL	7
BARTS HEALTH NHS TRUST	3	STOCKPORT NHS FOUNDATION TRUST	375
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	4	TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	4
BMI - THE ALEXANDRA HOSPITAL	5	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	1
BMI - THE PARK HOSPITAL	1	THE ONE HEALTH GROUP LTD	2
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	5	THE PRINCESS ALEXANDRA HOSPITAL NHS TRUST	1
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	8	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	1
EAST CHESHIRE NHS TRUST	26	THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	4
GEORGE ELIOT HOSPITAL NHS TRUST	1	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	2
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	1	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	32
HARROGATE AND DISTRICT NHS FOUNDATION TRUST	1	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	3
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	2	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	58
LEEDS TEACHING HOSPITALS NHS TRUST	6	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	9
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	2	WEST SUFFOLK NHS FOUNDATION TRUST	1
MID YORKSHIRE HOSPITALS NHS TRUST	1	WOODTHORPE HOSPITAL	4
NEWMEDICA COMMUNITY OPHTHALMOLOGY - BARLBOROUGH TREATMENT CENTRE	2	WORCESTERSHIRE ACUTE HOSPITALS NHS TRUST	1
NORTH BRISTOL NHS TRUST	1	HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST	2
NORTH WEST ANGLIA NHS FOUNDATION TRUST	1	LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	6
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	277	BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	1
NUFFIELD HEALTH, DERBY HOSPITAL	33	SPAMEDICA DERBY	25
NUFFIELD HEALTH, LEICESTER HOSPITAL	1	PRACTICE PLUS GROUP HOSPITAL - BARLBOROUGH	15
ROYAL FREE LONDON NHS FOUNDATION TRUST	6	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	1
SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	43	SPAMEDICA MANCHESTER	1
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	74	UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST	1
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	93	CIRCLE READING HOSPITAL	1
SPIRE NOTTINGHAM HOSPITAL	3	NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	22
		Total	1195

Actions:

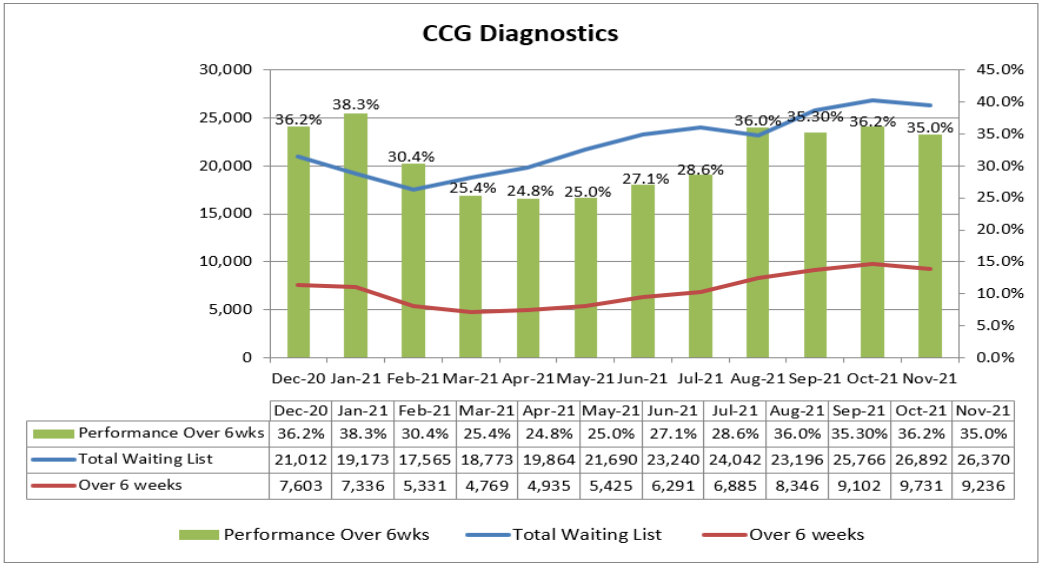
- The performance team make enquiries of the relevant CCGs and responses received back are that these patients are not clinically urgent but are being reviewed. We have not been informed of any TCI dates.

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

Performance Analysis

Derbyshire CCG Diagnostic performance at the end of November was 35.0% waiting over six weeks, an improvement on the 36.2% waiting at the end of October.

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



	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21
Performance Over 6wks	36.2%	38.3%	30.4%	25.4%	24.8%	25.0%	27.1%	28.6%	36.0%	35.30%	36.2%	35.0%
Total Waiting List	21,012	19,173	17,565	18,773	19,864	21,690	23,240	24,042	23,196	25,766	26,892	26,370
Over 6 weeks	7,603	7,336	5,331	4,769	4,935	5,425	6,291	6,885	8,346	9,102	9,731	9,236

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	40.8%	1.2%	3.6%	3.9%	3.6%	70.0%	0.0%
Computed Tomography	32.5%	2.3%	1.6%	16.0%	31.8%	7.5%	0.0%
Non-obstetric Ultrasound	47.6%	1.3%	0.2%	12.2%	20.4%	12.0%	0.0%
DEXA Scan	9.4%	4.0%	21.1%	15.3%	13.9%	55.7%	
Audiology - Audiology Assessments	30.9%	35.4%	12.3%	5.2%	2.4%	22.0%	11.9%
Cardiology - Echocardiography	38.4%	68.8%	29.9%	11.9%	31.0%	36.7%	73.3%
Peripheral Neurophysiology	0.7%		0.0%	32.8%		0.0%	
Respiratory physiology - Sleep Studies	6.5%		7.1%	8.0%	35.7%	25.2%	50.0%
Urodynamics - Pressures & Flows	55.3%	42.4%	27.3%	55.4%	12.5%	34.1%	
Colonoscopy	12.5%	4.9%	81.6%	32.6%	13.9%	48.8%	30.3%
Flexi Sigmoidoscopy	21.6%	12.1%	87.0%	54.7%	12.6%	54.1%	14.3%
Cystoscopy	20.2%	8.2%	0.0%	22.0%	33.9%	8.7%	50.0%
Gastroscopy	16.5%	6.8%	71.9%	46.3%	15.1%	50.5%	13.0%
Total	**38.6%**	**21.0%**	**32.0%**	**16.5%**	**20.0%**	**43.6%**	**24.7%**

Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Percentage waiting 6+ Weeks
Magnetic Resonance Imaging	5,540	1,960	669	35.4%
Computed Tomography	2,601	522	207	20.1%
Non-obstetric Ultrasound	9,311	3,396	922	36.5%
DEXA Scan	763	103	21	13.5%
Audiology - Audiology Assessments	1,176	355	56	30.2%
Cardiology - Echocardiography	3,700	1,982	287	53.6%
Peripheral Neurophysiology	373	12	2	3.2%
Respiratory physiology - Sleep Studies	200	48	11	24.0%
Urodynamics - Pressures & Flows	137	72	24	52.6%
Colonoscopy	954	302	189	31.7%
Flexi Sigmoidoscopy	392	144	56	36.7%
Cystoscopy	262	53	21	20.2%
Gastroscopy	961	287	149	29.9%
Total	**26,370**	**9,236**	**2,614**	**35.0%**

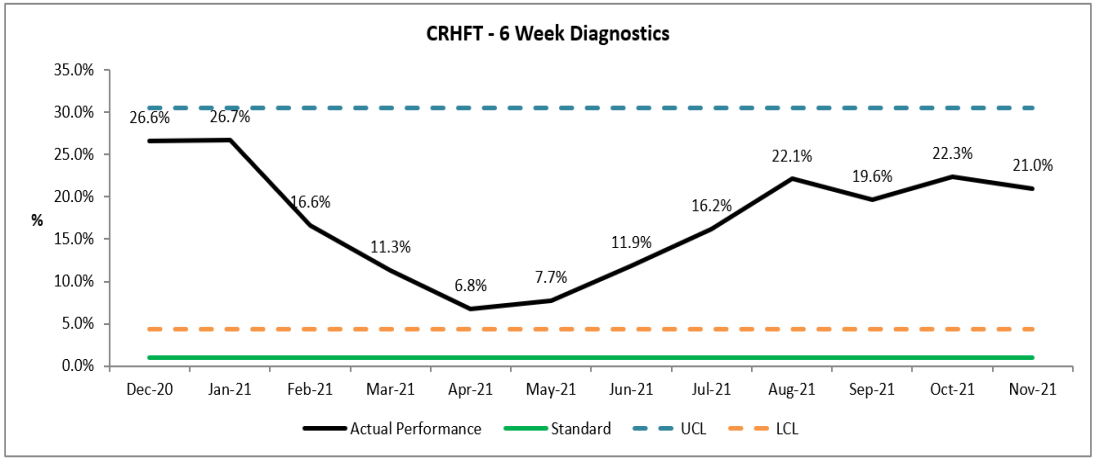
CRHFT DIAGNOSTICS - 6 WEEK DIAGNOSTIC WAITING TIMES (Less than 1% of pts should wait more than six weeks)

Performance Analysis

Performance during November was 21.0%, an improvement on the September figure of 22.3%.

The numbers on the waiting list have increased overall.

The number waiting over 6 weeks have also increased but the number waiting over 13 weeks have decreased.



Issues

- Staff sickness levels (due to the Omicron wave and other winter illnesses) across the trust have affected diagnostic capacity.
- The high demand due to higher outpatient referrals and increased non-elective activity continues.

Actions

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

Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Percentage waiting 6+ Weeks
Magnetic Resonance Imaging	746	9	0	1.2%
Computed Tomography	611	14	0	2.3%
Non-obstetric Ultrasound	1,950	25	0	1.3%
DEXA Scan	252	10	0	4.0%
Audiology - Audiology Assessments	537	190	0	35.4%
Cardiology - Echocardiography	1,394	959	241	68.8%
Urodynamics - Pressures & Flows	33	14	1	42.4%
Colonoscopy	185	9	3	4.9%
Flexi Sigmoidoscopy	58	7	2	12.1%
Cystoscopy	61	5	0	8.2%
Gastroscopy	146	10	5	6.8%
Total	**5,973**	**1,252**	**252**	**21.0%**

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

Performance Analysis

Performance during November was 38.6%, an improvement on the October position of 40.9%.

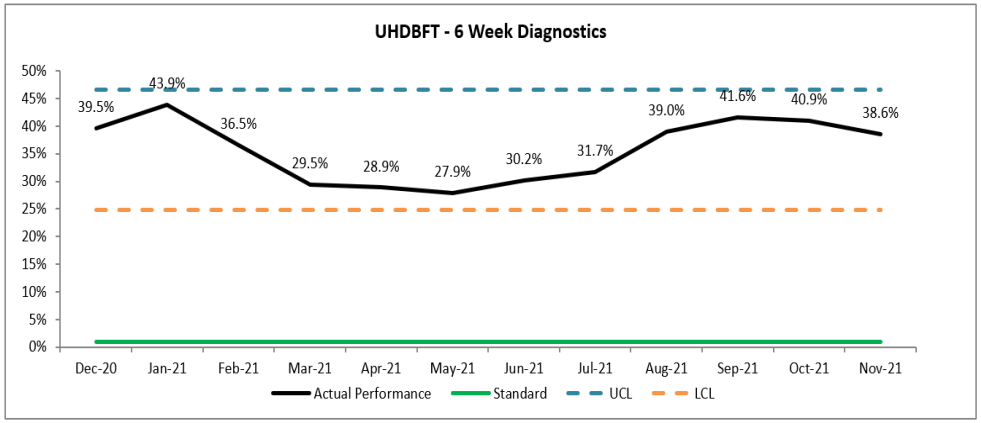
The overall numbers on the waiting list have decreased during November, with the numbers waiting over 6 weeks and over 13 weeks decreasing proportionally.

Issues

- Staff sickness levels (due to the Omicron wave and other winter illnesses) across the trust have affected diagnostics, especially in Radiology.
- There has been limited ability to accommodate General Anaesthetic patients in Endoscopy, leading to higher waits for these patients.
- The high demand due to higher outpatient referrals and increased non-elective activity continues. The high emergency demand is particularly impacting Imaging service including Non Obstetric ultrasounds.

Actions

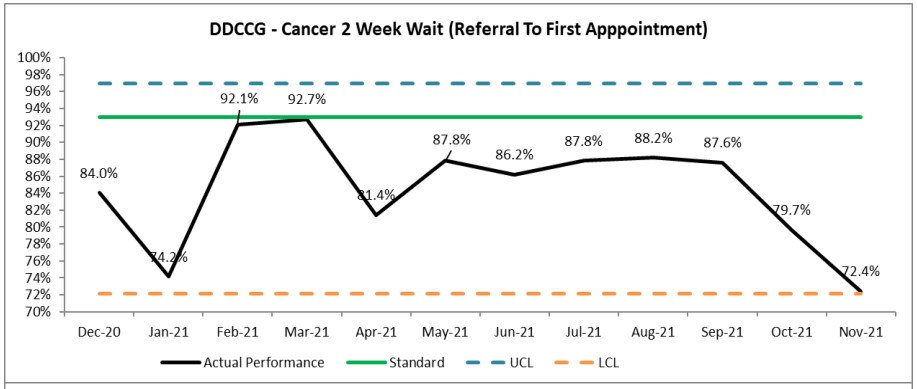
- Imaging have recruited 12 additional CT & MRI Radiographers from abroad, therefore not drawing away from other local labour pools.
- Agreement for the Alliance CT & MRI vans to remain operational at the RDH site for a further 6 months.
- Increased outsourcing of Echocardiography and Non-Obstetric Ultrasound activity.
- Infection Control have allowed turnaround times between patients have been relaxed by 5 minutes in some areas.
- The bid for a Rapid Diagnostics Site at the Trust was successful, which will enhance patient flow.
- Validation of the DM01 records identified approximately 800 patients who were incorrectly counted as exceeding the target.

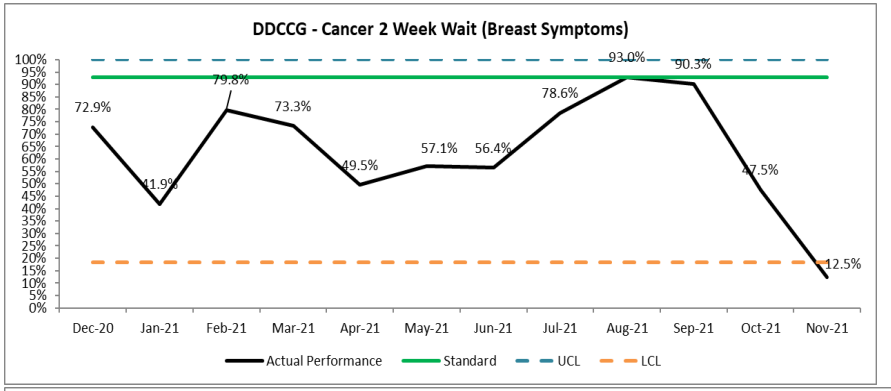


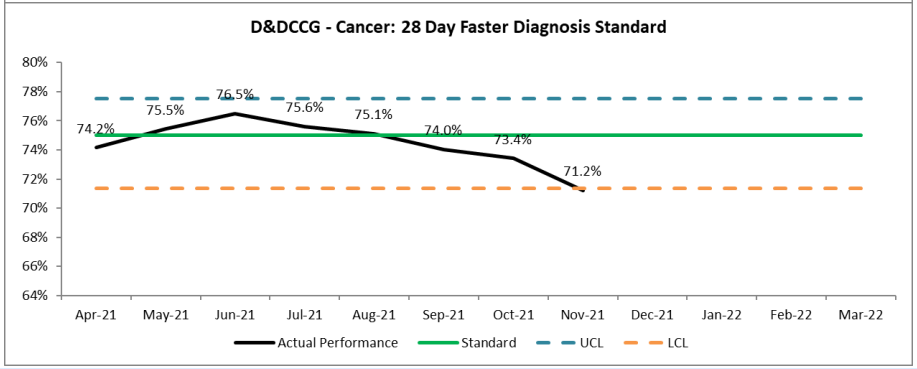
Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Percentage waiting 6+ Weeks
Magnetic Resonance Imaging	5,326	2,171	535	40.8%
Computed Tomography	2,609	849	258	32.5%
Non-obstetric Ultrasound	9,426	4,487	1,246	47.6%
DEXA Scan	502	47	6	9.4%
Audiology - Audiology Assessments	1,009	312	68	30.9%
Cardiology - Echocardiography	2,389	917	31	38.4%
Peripheral Neurophysiology	424	3	1	0.7%
Respiratory physiology - Sleep Studies	168	11	0	6.5%
Urodynamics - Pressures & Flows	123	68	28	55.3%
Colonoscopy	639	80	8	12.5%
Flexi Sigmoidoscopy	305	66	2	21.6%
Cystoscopy	168	34	20	20.2%
Gastroscopy	632	104	21	16.5%
Total	**23,720**	**9,149**	**2,224**	**38.6%**

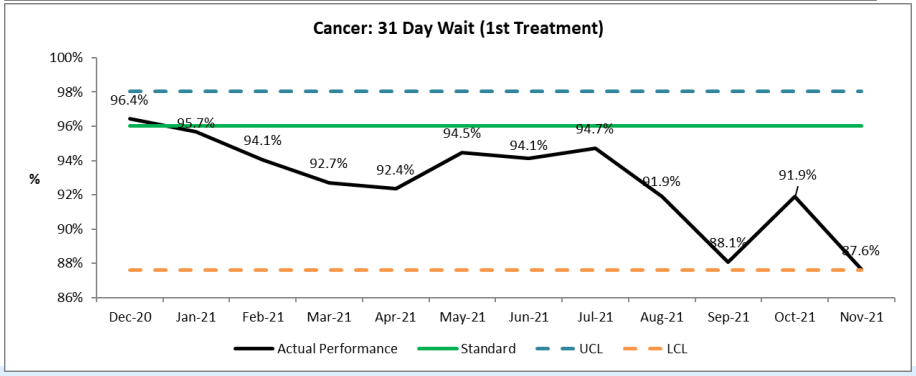
DERBYSHIRE COMMISSIONER – CANCER WAITING TIMES

During November 2021, Derbyshire was compliant in 1 of the 9 Cancer standards:
31 day Subsequent Drugs – 98.8% (98% standard) – Compliant for all Trusts except Sherwood Forest.
During November 2021, Derbyshire was non-compliant in 8 of the 9 Cancer standards:
2 week Urgent GP Referral – 72.4% (93% standard) – Compliant for Stockport.
2 week Exhibited Breast Symptoms – 12.5% (93% standard) – Compliant at Stockport and Sherwood Forest.
28 day Faster Diagnosis – 71.2% (75% standard) – Compliant for Chesterfield, NUH and Sherwood Forest
31 day from Diagnosis – 87.6% (96% standard) – Compliant for Stockport.
31 day Subsequent Surgery – 72.0% (94% standard) – Compliant at East Cheshire, Stockport and Sherwood Forest.
31 day Subsequent Radiotherapy – 93.9% (94% standard) – Compliant at Sheffield.
62 day Urgent GP Referral – 59.0%(85% standard) – Non compliant for all trusts.
62 day Screening Referral – 66.7% (90% standard) – Non compliant for all trusts.
104 day wait – Data unavailable at a CCG level.



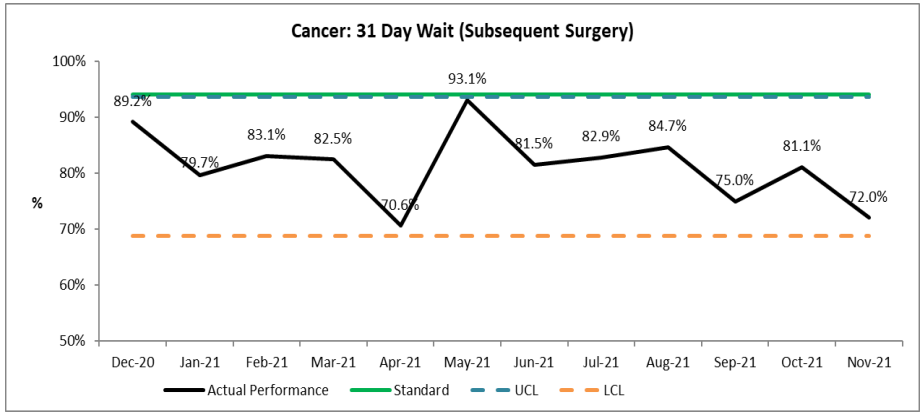


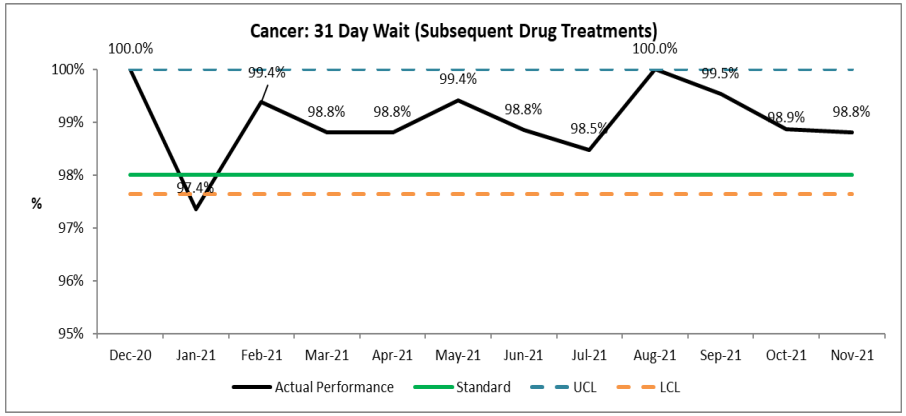


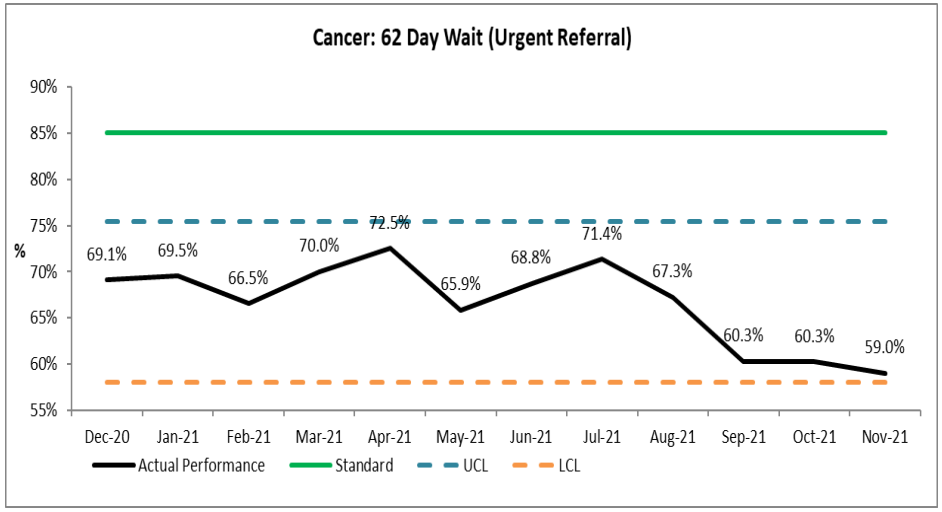


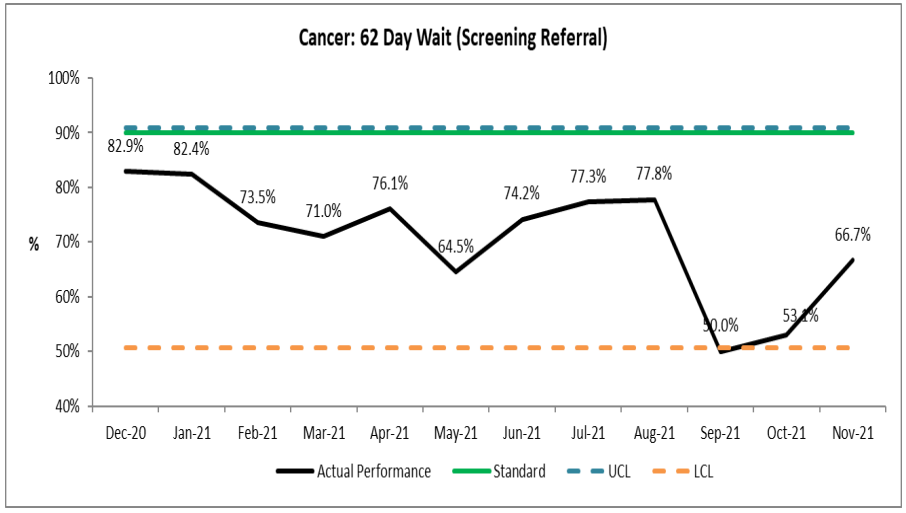
CCG performance data reflects the complete cancer pathway which for many Derbyshire patients will be completed in Sheffield and Nottingham.

DERBYSHIRE COMMISSIONER – CANCER WAITING TIMES









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)

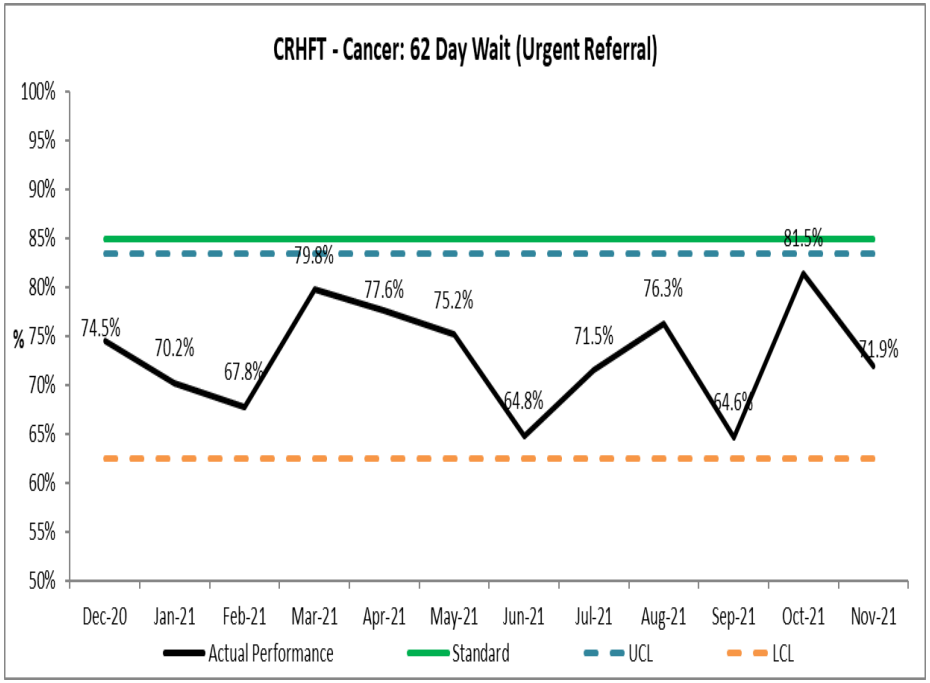
Performance Analysis

CRH performance during November for first treatment within 62 days of urgent referral reduced slightly to 71.9% against the standard of 85%.

There were 92.5 accountable treatments with 66.5 of these within 62 days, with 26 breaches of the standard.

Of the 26 breaches 12 were treated by day 76, with 10 between day 77 and 104, with 4 patients being treated after day 104.

The tumour sites reporting the breaches include Breast (10.5), Lower GI (5), Lung (2), Skin (1), Urology (4.5) and Other (3).



Current Issues

- Issues currently going through tracking.
- Imaging reporting turnaround times.
- US reporting delays due to number of breast patients going through the pathway.
- Workforce issues – impacted upon by Covid and Isolation, particularly affecting Lower and Upper GI.
- PTL numbers over 62 day stabilising. ASI in Lower GI

Actions Being Taken

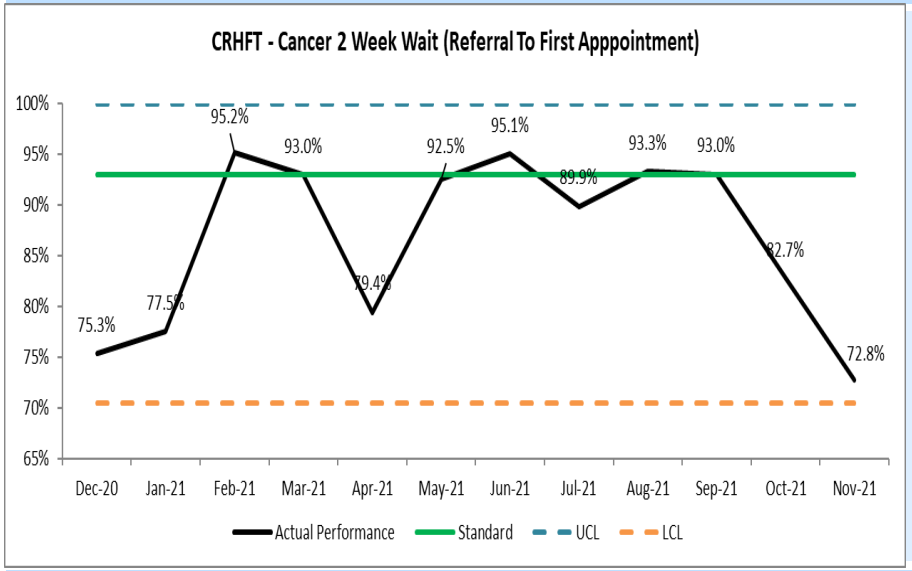
- Additional Breast Clinics, creating extra capacity.
- Monthly Tumour site Improvement meetings.
- Focus on reducing longest waits.

What are the next steps

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

Tumour Type	Total patients seen	Seen Within 62 Days	Breaches	% seen within 62 days
Breast	14.5	4	10.5	27.59%
Lower Gastrointestinal	13.5	8.5	5	62.96%
Lung	6	4	2	66.67%
Other	18.5	15.5	3	83.78%
Skin	26	25	1	96.15%
Urological	14	9.5	4.5	67.86%
Grand Total	**92.5**	**66.5**	**26**	**71.89%**

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



Performance Analysis

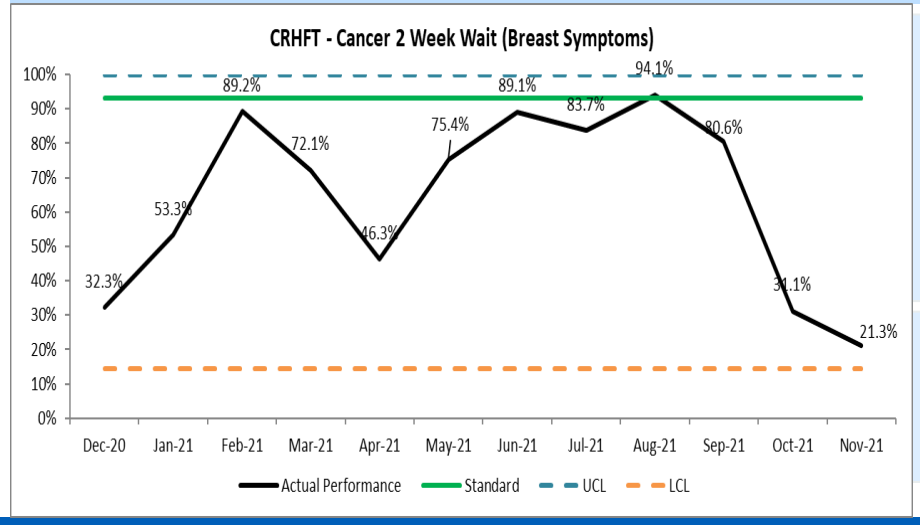
November performance at CRH was 72.77%. The main challenges for 2ww performance this month has been associated with Breast which has continued to receive a high number of referrals and first appointments have been taking place outside the 14 day target.

All other tumour sites were above 90% compliance with only skin, Upper GI and Urology not meeting the standard as well as breast.

There were a total of 1054 patients seen this month, a similar number to October and is above the trajectory submitted to NHSE as part of the H2 recovery plan.

Of the 1054 patients seen 767 were seen within the 14 days resulting in 287 breaches with the large majority of these being breast appointments.

CRHFT - CANCER WAITING TIMES – Breast Symptomatic



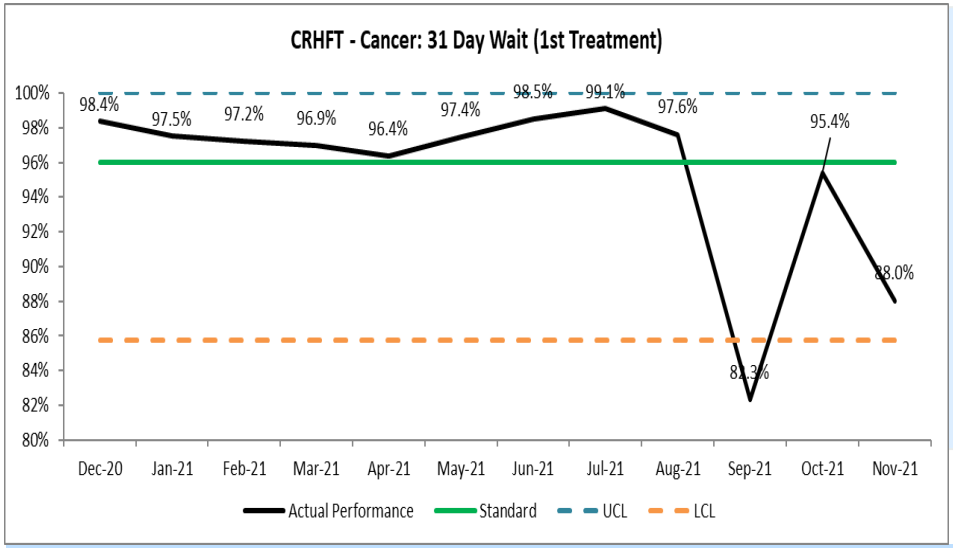
Performance Analysis

Performance in November at CRH for the Breast Symptomatic standard has reduced to 21.3%

There were 47 patients seen which is again a high number and there were 37 breaches. 23 of these patients were seen between 15 and 21 days with 9 being seen after day 28, reflecting the outpatient availability.

It is to be noted that CRH are not required to report 2WW and Breast performance nationally as they are a pilot site for the new 28 day to diagnosis standard.

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



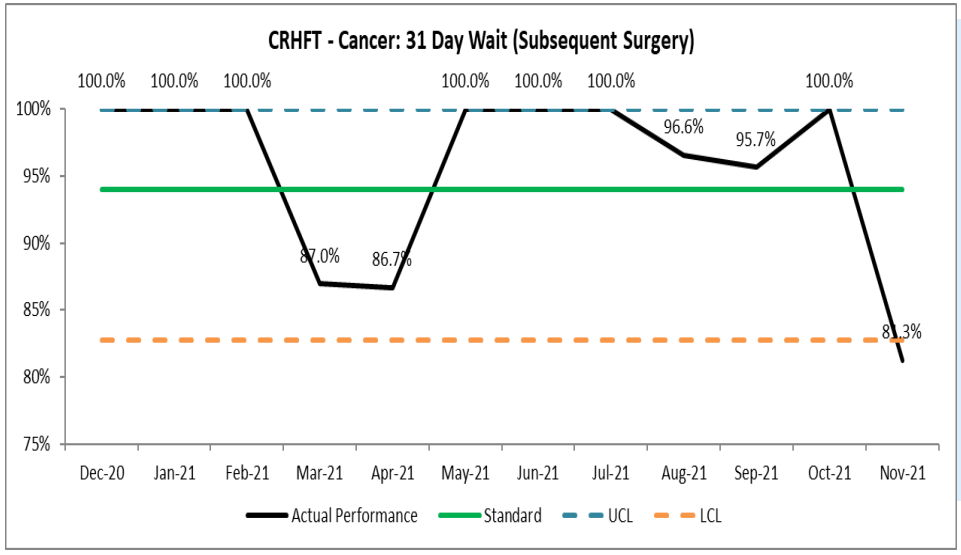
Performance Analysis

Performance in November at CRH for 31 day from diagnosis to first treatment was 88.0% against the standard of 96%.

There were a total number of 167 patients go through this part of the pathway, with 147 of them treated within 31 days resulting in 20 breaches. The tumour sites reporting the breaches are breast (16) and Lower GI (3).

Out of the 20 breaches 16 were treated by day 48 with 2 patients treated by day 62 and two after day 62 days.

CRHFT - CANCER WAITING TIMES – 31 days to Subsequent Surgery



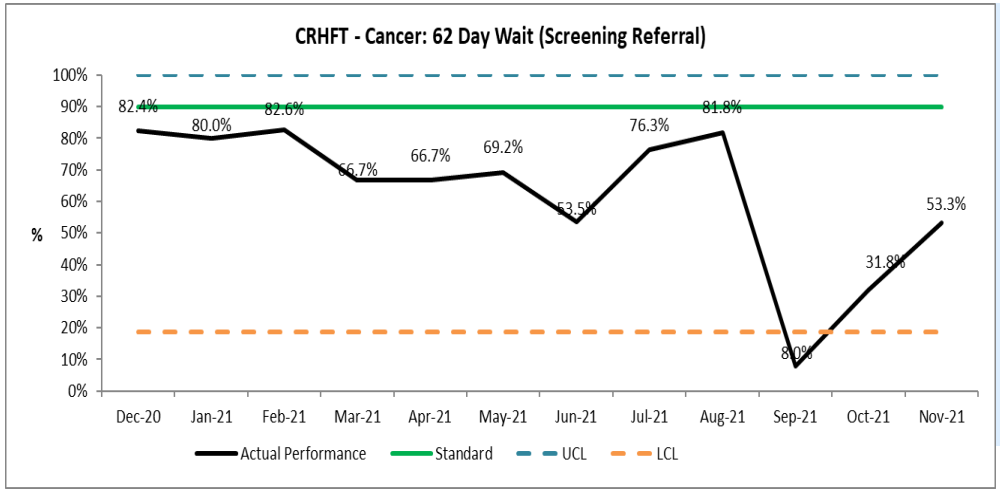
Performance Analysis

Performance in November was 81.25% for 31 day to subsequent surgery standard.

As can be seen from the chart this is the first time this standard has not been achieved since April 2021.

There were a total of 16 patients of which 13 were treated within 31 days resulting in 3 breaches. 2 of these were treated within 62 days with one after 31 days.

CRHFT - CANCER WAITING TIMES – 62 day Screening Referral



Performance Analysis

Performance in November for the 62 day screening standard has improved to 53.3% an increase from the 31.8% for October, however, it continues to remain non-complaint against the standard of 90%.

The number of patients treated via screening referral was 15 with 8 of these within 62 days, resulting in 7 breaches.

Of the 7 breaches 2 were treated between day 63 and 76, 3 between day 77 and 104 days with 2 treated after day 104.

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

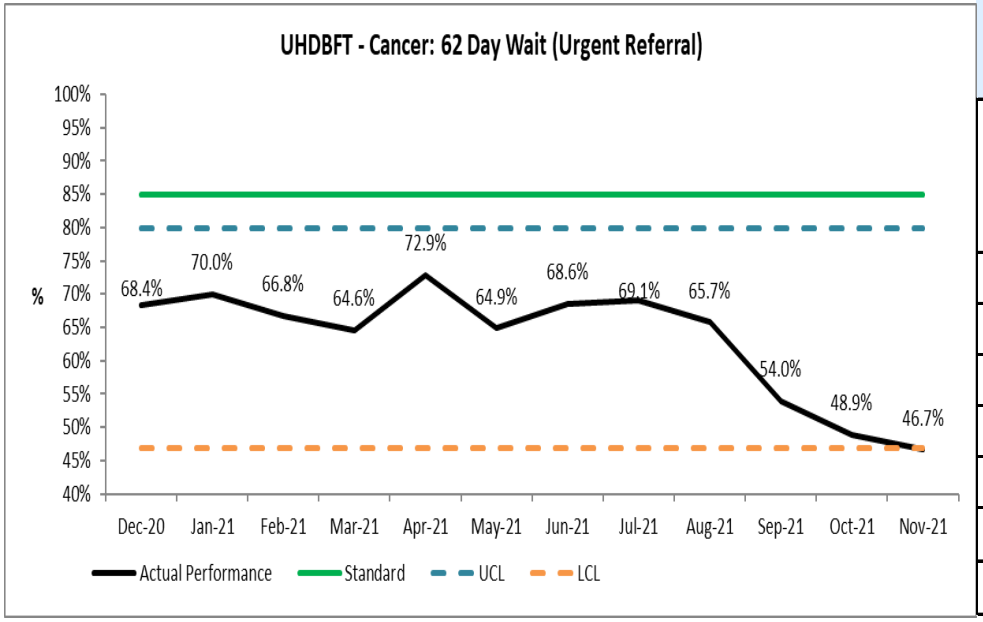
Performance Analysis

UHDB performance during November was 46.67%, a similar performance to October against the standard of 85%.

This is reflecting those patients who are receiving their first treatment after day 62.

There were a total of 210 patients treated along this pathway in November with 98 of those patients being treated within the 62 day standard resulting in 112 breaches.

Out of the 112 breaches there were 34.5 accountable treatments by day 76, 40.5 by day 104 with 37 patients being treated after day 104, with 20.5 of these within urology.



Current Issues

- Continued increase in referrals – Derbyshire currently receiving 130-135% more referrals than the same period in 2019 against a national average of 1155.
- Workforce issues – impacted upon by Covid and Isolation
- Limited workforce to schedule additional capacity.
- Capacity issues are particular high in lower GI

Actions Being Taken

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

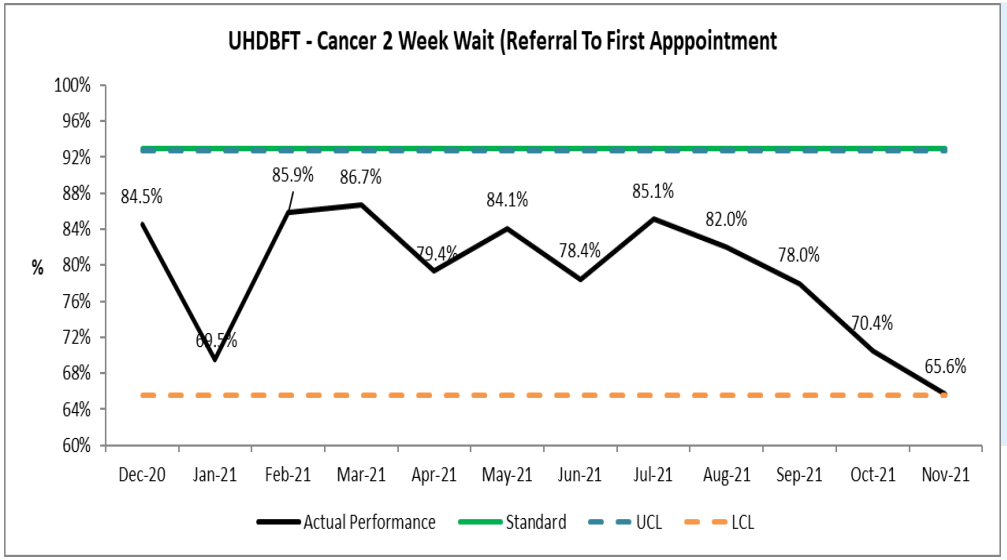
What are the next steps

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

Tumour Type	Total patients seen	Seen Within 62 Days	Breaches	% seen within 62 days
Breast	21.5	14	7.5	65.12%
Lower Gastrointestinal	26	6	20	23.08%
Lung	14	7	7	50.00%
Other	58	28	30	48.28%
Skin	40	30	10	75.00%
Urological	50.5	13	37.5	25.74%
Grand Total	210	98	**112**	**46.67%**

85

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

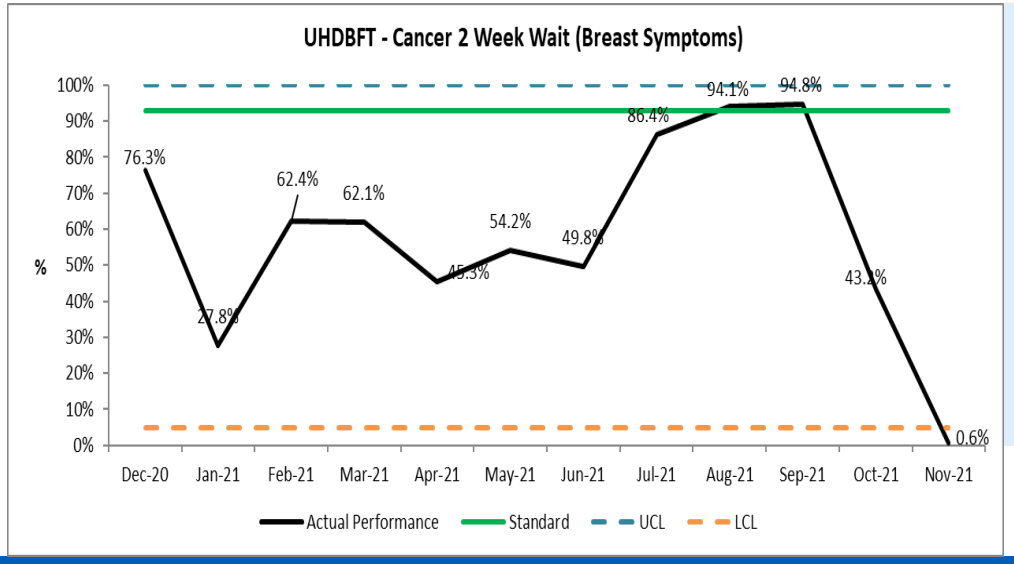


Performance Analysis

November performance at UHDB for 2 week wait has reduced to 65.62% and continues to remain non-compliant against the standard of 93%. The main challenges for 2ww performance has been associated with Breast and Gynaecology performance as a result of and referrals which have continued at a higher number.

There were a total of 3,383 patients seen in November which is 550 more patients than the number submitted as part of the H2 recovery trajectory and is 189 more than the previous month. For the same period in 2019 there were 2704 patients so the trust saw a 21% increase.

UHDB - CANCER WAITING TIMES – Breast Symptomatic



Performance Analysis

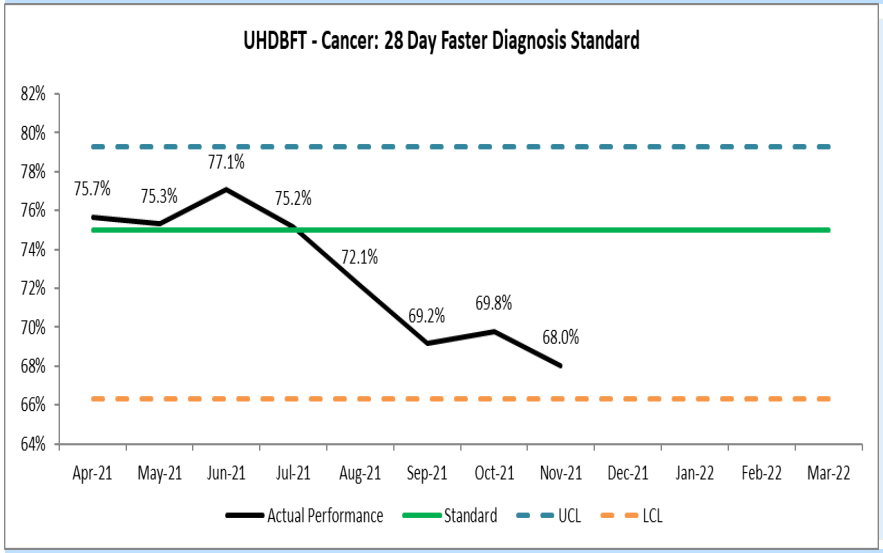
Performance in November at UHDB for the Breast Symptomatic standard has reduced to 0.57% resulting in the Trust being non-complaint against the standard of 93%.

There were 174 patients seen via the Breast Symptomatic pathway in November, again an increase in activity.

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

86

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



Performance Analysis

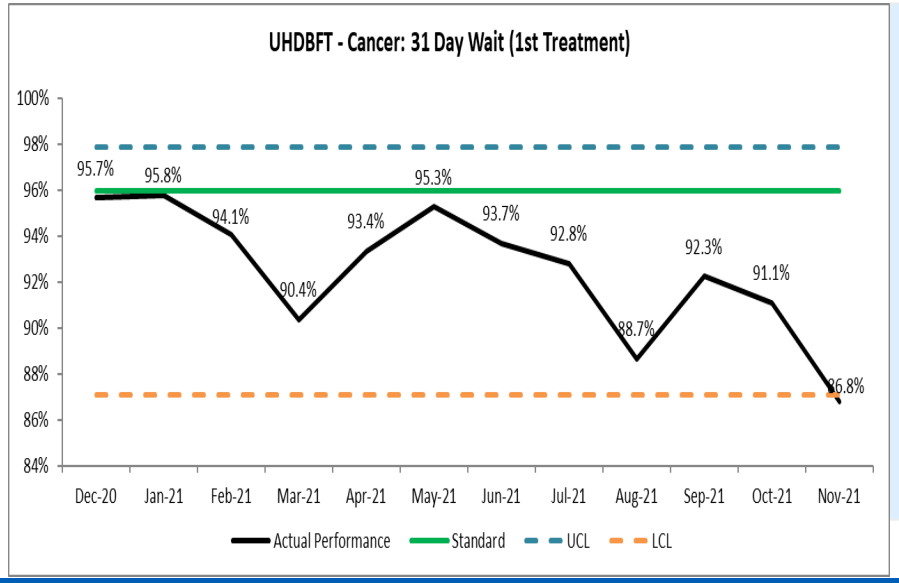
Performance in November at UHDB for the 28 day Faster Diagnostic Standard was 68.05% remaining non-Compliant against the 75% standard.

There were a total of 3521 patients through this part of the pathway in November 2021, an increase on the 3200 patients during October.

Of these 2396 patients were informed of a cancer diagnosis or told that they didn't have cancer during November resulting in 1125 breaches.

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

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



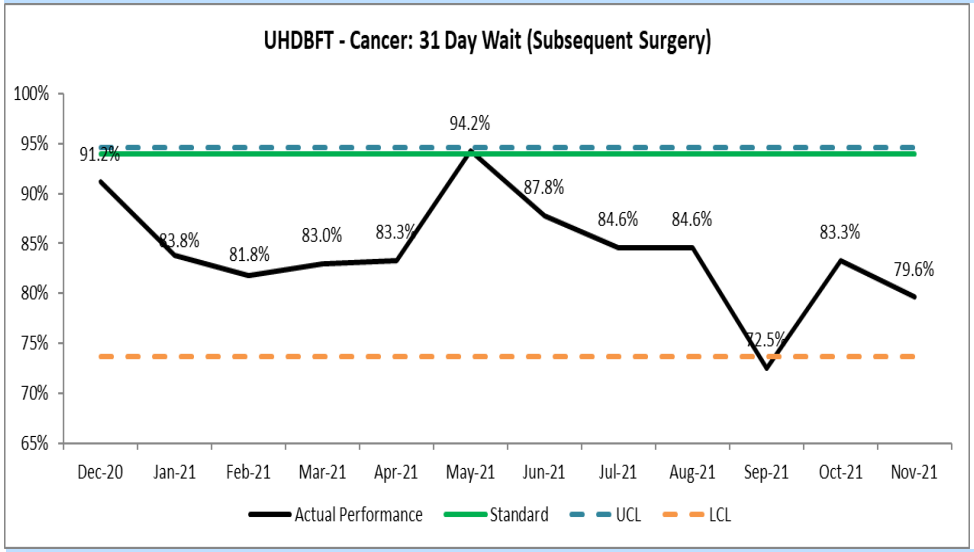
Performance Analysis

Performance in October at UHDB for 31 day from diagnosis to first treatment has reduced to 86.8%, resulting in the Trust remaining non-compliant against the standard of 96%.

There were a total number of 402 patients treated in November along this pathway (371 during October) with 349 patients within the 31 day standard. The tumour sites reporting the breaches include Lower GI (13), Other (6), Skin(17) and Ur9ology (16).

The numbers seen during the month exceeds the trajectory submitted to NHSE as part of the H2 recovery plan.

UHDB - CANCER WAITING TIMES – 31day to Subsequent Surgery



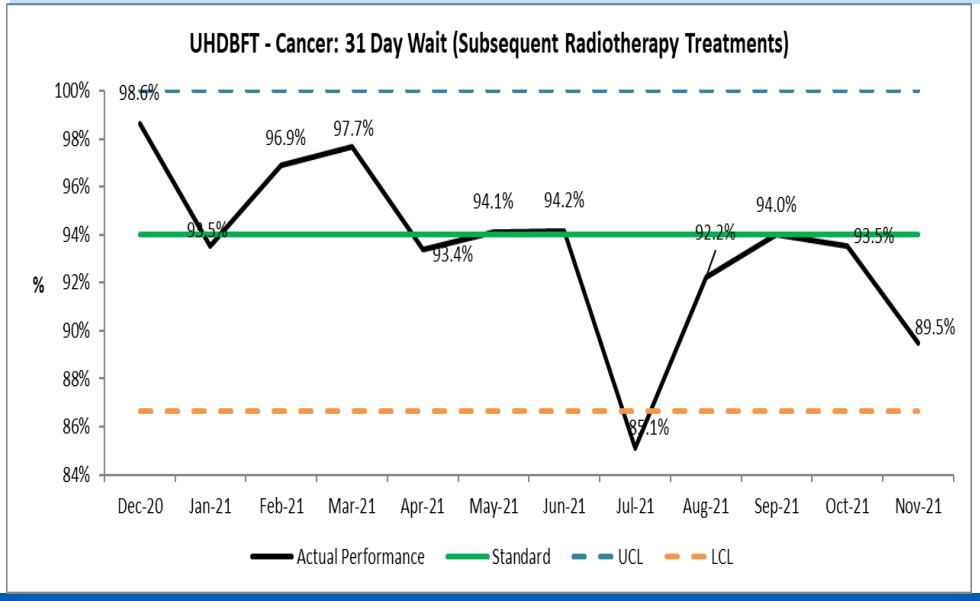
Performance Analysis

November performance at UHDB for 31 day to subsequent surgery has reduced to 79.63%, continuing to be non-compliant against the standard of 94%.

There were a total number of 54 patients treated along the subsequent surgery pathway in November with 43 of those patients being treated within the 31 day standard, resulting in 11 breaches.

Of the 11 breaches, 4 of those patients were treated by day 38, 5 by day 62, and 2 over 62 days.

UHDB - CANCER WAITING TIMES – 31day Subsequent Radiotherapy Treatment



Performance Analysis

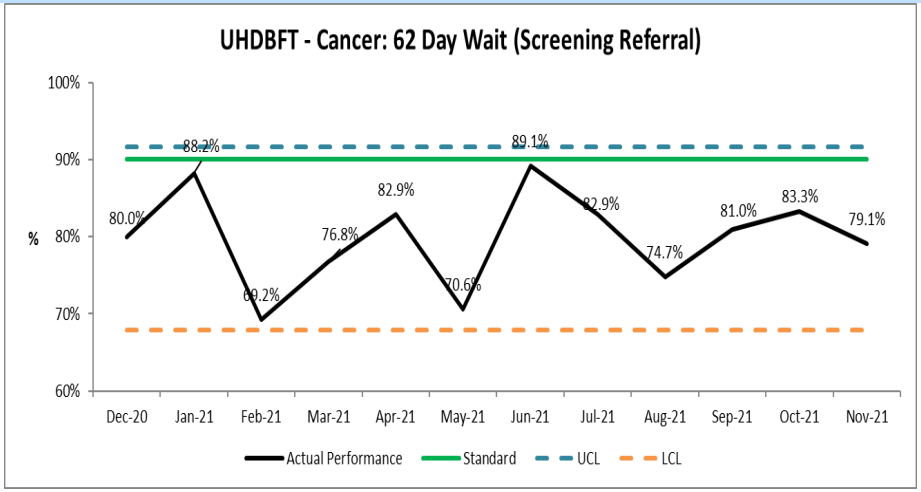
November performance for subsequent radiotherapy was 89.47%, a slight decrease on the 93.5% achieved during October, against the standard of 94%.

There were a total of 95 patients treated during November with 85 f these receiving treatment before day 31.

Of the 10 breaches 4 received their radiotherapy treatment by day 38 with the remainder between 39 and 62 days.

88

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



Performance Analysis

Performance in November was 79.07% a reduction on the 83.3% achieved in October.

There were a total of 43 patients treated in November who were referred through via a screening referrals with 34 of those patients treated within 62 days.

Of the 9 breaches, 4 were treated after day 104.

Appendix

PERFORMANCE OVERVIEW M8 – ASSOCIATE PROVIDER CONTRACTS

Provider Dashboard for NHS Constitution Indicators						East Cheshire Hospitals				Nottingham University Hospitals				Sheffield Teaching Hospitals FT				Sherwood Forest Hospitals FT				Stockport FT			
	Area	Indicator Name	Standard	Latest Period	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance
Urgent Care	Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	Dec-21	↑	60.6%	62.0%	42	A&E pilot site - not currently reporting 4 hour breaches				↑	70.5%	73.5%	68	↑	82.5%	86.4%	14	↑	59.4%	69.1%	19
		A&E 12 Hour Trolley Waits	0	Dec-21	↑	24	228	9	↑	362	1248	6	↓	11	49	10	↓	56	97	5	↓	13	28	5
Planned Care	Referral to Treatment for non-urgent consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Nov-21	↓	67.0%	56.4%	51	↑	66.3%	67.6%	26	↓	76.6%	79.7%	22	↑	72.6%	69.4%	51	↓	53.7%	56.7%	46
		Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Nov-21	↑	451	3770	23	↓	3552	27599	20	↑	1002	6944	20	↓	745	8924	20	↑	3803	30950	43
	Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Nov-21	↑	24.70%	53.82%	21	↓	43.63%	42.37%	21	↑	16.53%	15.80%	21	↑	20.02%	21.87%	23	↓	32.02%	42.64%	29
	2 Week Cancer Waits	All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	Nov-21	↓	58.9%	90.1%	3	↓	73.6%	86.5%	8	↓	77.7%	83.0%	8	↓	90.4%	91.6%	6	↓	98.6%	97.7%	0
		Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	Nov-21	↑	60.6%	76.4%	9	↓	10.5%	76.3%	1	↓	2.3%	30.9%	8	↑	94.4%	94.3%	0	↔	N/A	N/A	0
	28 Day Faster Diagnosis	Diagnosis or Decision to Treat within 28 days of Urgent GP, Breast Symptom or Screening Referral	75%	Nov-21	↓	46.0%	63.8%	8	↓	80.4%	80.5%	0	↓	69.4%	66.9%	8	↓	75.5%	77.1%	0	↓	59.8%	58.7%	8
	31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	96%	Nov-21	↓	94.4%	92.1%	1	↓	88.4%	89.3%	32	↑	91.2%	91.0%	8	↓	91.5%	93.6%	6	↑	100.0%	97.7%	0
		Subsequent Surgery Within 31 Days Of Decision To Treat	94%	Nov-21	↔	100.0%	92.3%	0	↓	66.7%	69.2%	43	↓	61.8%	75.0%	12	↑	100.0%	93.0%	0	↔	100.0%	94.4%	0
		Subsequent Drug Treatment Within 31 Days Of Decision To Treat	98%	Nov-21	↔	N/A	100.0%	0	↑	98.6%	98.5%	0	↓	99.5%	99.4%	0	↓	66.7%	89.7%	1	↔	100.0%	100.0%	0
		Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	Nov-21					↓	92.8%	94.0%	1	↓	95.4%	96.6%	0								
	62 Days Cancer Waits	First Treatment Administered Within 62 Days Of Urgent GP Referral	85%	Nov-21	↓	61.1%	63.0%	26	↓	62.9%	68.1%	20	↑	63.8%	61.4%	75	↑	62.6%	67.2%	23	↑	75.6%	75.1%	31
		First Treatment Administered - 104+ Day Waits	0	Nov-21	↑	1.0	32.0	15	↑	27.5	167.5	68	↓	12.5	154.0	68	↓	7.5	54.5	43	↓	2.0	18.0	31
		First Treatment Administered Within 62 Days Of Screening Referral	90%	Nov-21	↑	86.7%	75.8%	12	↑	83.8%	73.6%	12	↓	53.5%	68.3%	12	↑	73.3%	76.6%	6	↑	N/A	40.0%	0
		First Treatment Administered Within 62 Days Of Consultant Upgrade	N/A	Nov-21	↑	90.9%	86.9%		↑	75.8%	75.3%		↓	62.8%	74.7%		↑	82.7%	76.4%		↓	70.4%	80.2%	
Patient Safety	Incidence of healthcare associated Infection	Healthcare Acquired Infection (HCAI) Measure: MRSA Infections	0	Nov-21	↔	0	2	0	↔	0	0	0	↔	0	0	0	↔	0	0	0	↔	0	1	0
		Healthcare Acquired Infection (HCAI) Measure: C-Diff Infections	Plan	Nov-21	↔		19		↓		80		↑		112		↑		55		↓		35	
			Actual				4	0			54	0			79	0			35	0			22	0
		Healthcare Acquired Infection (HCAI) Measure: E-Coli	-	Nov-21	↑	8	129		↑	52	465		↓	48	361		↔	25	229		↑	14	150	
		Healthcare Acquired Infection (HCAI) Measure: MSSA	-	Nov-21	↓	9	27		↑	16	107		↑	16	76		↔	6	33		↑	2	16	

Governing Body Meeting in Public

3rd February 2022

ITEM NO: 248

Report Title	CCG Risk Register Report at 31st January 2022
Author(s)	Rosalie Whitehead, Risk Management & Legal Assurance Manager
Sponsor (Director)	Helen Dillistone, Executive Director of Corporate Strategy and Delivery

Paper for:	**Decision**	x	**Assurance**	x	**Discussion**		**Information**	
Assurance Report Signed off by Chair	N/A							
Which committee has the subject matter been through?	Engagement Committee – 18.1.2022 Governance Committee *(by virtual approval)* – 21.1.2022 Primary Care Commissioning Committee – 26.1.2022 Quality and Performance Committee – 27.1.2022 Finance Committee – 27.1.2022							

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 January 2022;
- Appendix 2 which summarises the movement of all risks in January 2022;
- The decrease in risk score for:
    - Risk 16 relating to lack of standardised process in CCG commissioning arrangements.

APPROVE:

- **Closure** of risk 32 relating to the risk of exploitation by malevolent third parties if vulnerability is identified within any of the Microsoft Office 2010 applications after 14th October 2020.

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 January 2022.

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 January 2022 detailed in Appendix 1.

NHS DERBY AND DERBYSHIRE CCG GOVERNING BODY MEETING

RISK REPORT AS AT 31ST JANUARY 2022

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 purple within the Risk Register in Appendix 1.

2. RISK PROFILE – JANUARY 2022

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

Risk Register as at 31st January 2022

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 January 2022	7	12	5	0	24
New Risks	0	0	0	0	0
Increased Risks	0	0	0	0	0
Decreased Risks	0	1	0	0	1
Closed Risks	0	0	1	0	1

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

3. COMMITTEES – DECEMBER VERY HIGH RISKS OVERVIEW

3.1 Quality & Performance Committee

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

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

   The current risk score is 20.

   December performance:

   - CRH reported 85.7% (YTD 91.2%) and UHDB reported 63.6% (YTD 69.8%).
   - CRH: The combined Type 1 & streamed attendances were high, with an average of 94 Type 1 attendances and 152 streamed attendances per day.
   - There were further surges of Covid19 admissions and outbreaks towards the end of the month, with 47 positive inpatients , including 7 in ICU. This added more pressure to the Trust with an escalated critical care position.
   - UHDB: The volume of attendances is high, with an average of 428 attendances per day at Derby (Type 1 and co-located UTC) and 199 at Burton (Type 1 & Primary Care Streaming). As a network the numbers of attendances were at 83% of pre-pandemic levels (December 2021 compared to December 2019).
   - The acuity of the attendances was high, with Derby seeing an average of 13 Resuscitation patients and 172 Major patients per day and Burton seeing 125 Major/Resus patients per day.
   - Attendances at Children's ED continue to be high, with concerns about Respiratory Syncytial Virus (RSV) and Bronchiolitis being major factors. Children's Type 1 attendances at Derby have averaged at 109 per day during December 2021 (compared to 104 per day in December 2019).

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

   The current risk score is 20.

January update

Current bed position:

- CCG beds = 32 (Q4 2021/22 target 19).
- Adult Specialised Commissioning = 16 (Q4 2021/22 target 14).
- Children and Young People (CYP) specialised commissioning = 6 (Q4 2021/22 target 3).
- In response to the Operational Planning Guidance, 2022/23 trajectories will need to be refreshed to mirror the changed Integrated Care Board (ICB) footprint. It is important to note that although the number of inpatients remain over trajectory there have been 15 patients discharged during Quarter 3, one of which was a Specialised Commissioning patient and one CCG inpatient had been in hospital since 2009.
- A time limited Task and Finish Group has been established to focus on ensuring the Dynamic Support Register (DSR) is evidence based and clinically led and that it focusses on enhanced wrap around provision in the community when appropriate, rather than admission avoidance.
- We are identifying ways in which to better utilise pre-commissioned community services such as the Intensive Support Team (IST) and Statutory Autism Team (SAT). This workstream will align itself with ASD Leads in NHSE/I.
- The provider Trust has funded the substantive appointment of an additional 1.0 wte Band 7 Commissioning Manager post to provide additional capacity to the TCP Team, this post holder will commence with the TCP team in March 2022.
- There continues to be no administrative support within the team, block booking of a Band 4 agency admin continues to be a priority to enable coordination of Care (Education) Treatment Reviews (C(E)TRs) and support with admin within the team.
- Colleagues in the CCG nursing and quality team have been redeployed to support the enhanced Covid 19 vaccine programme, the TCP team have been asked to undertake the 8 week out of area commissioner oversight visits. There is currently no additional capacity within the TCP team to undertake this additional role and function. This may potentially impact on the timeliness of community CTRs and Local Area Emergency Protocols (LAEPs).
- In order to ensure timely and concise reporting to NHSE/I, mapping of required reporting and associated timeframes has been undertaken. Clinical audit platform submissions continue to

be completed in a timely manner on a monthly basis. A robust system is now in place to maintain compliance.

- Safe and wellbeing reviews (previously five eyes), Derby and Derbyshire have 31 of the regional 91 red RAG rated reviews, however as a system we have demonstrated most progress regionally in achieving completion of red RAG rated reviews. This requirement was paused from mid-December to mid-January though has now been resumed: There are 7 green CCG reviews, 3 red, 4 amber and 2 green Specialised Commissioning reviews to be completed before the end of February.

- ICS scrutiny panels are now being facilitated to identify themes and trends for local action, service delivery and/or improvement. We are focusing on the reviews that have identified concerns as our priority.

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.

   January update:

   - Focus on 104 day cancer waits with planned work to explore harm in more depth.

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.

January update:

- NHSE/I issued guidance to practices to focus and prioritise urgent care to support the Covid-19 vaccination booster programme until end of December 2021.
- A programme of national support for practices was set out including partial protection of QOF, protection of majority of PCN Investment and Impact Fund, protection of minor surgery DES payments.
- In January 2022, there continues to be increasing demand and pressure that General Practice are facing as a result of restoration and recovery, continued support to the Covid-19 vaccination programme, increasing in practices having Covid-19 outbreaks and/or increasing numbers of practice staff being off work.
- As a result, the need has now switched from an urgent-only service due to the need to vaccinate, to an urgent-only service because that is all there is the capacity to provide. The delivery of urgent appointments is expected to continue until at least the end of January.
- Winter Access funding additional capacity to support urgent appointments is agreed and has commenced from the end of December / early January.
- This risk remains under regular review and in view of the pressures there is no change recommended to the existing high risk level this month.

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

and unexpected are key influencing dynamics that can affect quality and care outcomes.

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

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

The current risk score is 20.

January update:

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

3.3 Finance Committee – Very High Risks

One Finance Committee risk is rated as very high.

1. Risk 11: *Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the CCG to move to a sustainable financial position.*

   The current risk score is 16.

   January update

   December 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 a long term financial position and deliver a balanced in-Year position.

   - As at Month 9 the CCG are not seeing any major financial pressures against planned expenditure with the exception of CHC and we continue to work with Midland &Lancashire Commissioning Support Unit and providers to rectify this.

- The CCG are reporting a year to date underspend of £3.146m against total anticipated resources available of £1,560.186m for the period covering April to December 2021.

- Against total anticipated resources available in 2021/22 of £2,084.155m the CCG is forecasting a surplus of £6.403m. The increase in the forecast surplus is due to the impact of receipt £2.4m winter discharge funding, £4.365m Community Diagnostic Hub funding and £2m Cancer funding received late in the year and not all of which can be committed.

- While the in-year position now shows a surplus the underlying recurrent position for both the CCG and the wider system remains very challenging and we are some way from achieving a sustainable system financial position.

4. JANUARY OVERVIEW

4.1 Decreased risks since last month

One risk has decreased in score.

1. Risk 16: *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.

   This risk has decreased in score from a high score of 8 (probability 2 x impact 4) to a moderate score of 6 (probability 2 x impact 3).

   This decrease was approved at the Engagement Committee on 18th January 2022.

   - Engagement Committee has reviewed the risk and ongoing work and determined that the score can be reduced to the target score of 6. This reflects the breadth of engagement governance, infrastructure and delivery during 2021/22 that supports greater mitigation of this risk.

   - The risk remains on the register for review for a further two months and if the position is the same, the risk will be recommended for closure.

4.2 Closed risks since last month

One risk is proposed to be closed.

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

updates and patches for vulnerabilities found within this suite of applications.

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

This risk is now recommended to be closed as NECS have affirmed the upgrade or removal of all unsupported devices from the NECS managed network.

The closure of this risk has been approved virtually by Governance Committee on 21st January 2022.

5. RECOMMENDATION

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

- The Risk Register Report;
- Appendix 1 as a reflection of the risks facing the organisation as at 31st January 2022;
- Appendix 2 which summarises the movement of all risks in January 2022;
- The decrease in risk score for:
    - Risk 16 relating to lack of standardised process in CCG commissioning arrangements.

APPROVE:

- **Closure** of risk 32 relating to the risk of exploitation by malevolent third parties if vulnerability is identified within any of the Microsoft Office 2010 applications after 14th October 2020.

NHS
Derby & Derbyshire
Clinical Commissioning Group

Appendix 1 - Derby and Derbyshire CCG Risk Register - as at January 2022

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						
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. January - SEC has been stood up to take place Monday's, Wednesday's and Thursday's in response to the current pressures. SORG has been stood up over weekends.	December 2021 performance CRH reported 85.7% (YTD 91.2%) and UHDB reported 63.6% (YTD 69.8%). CRH: The combined Type 1 & streamed attendances were high, with an average of 94x Type 1 attendances and 152 streamed attendances per day. There were further surges of Covid19 admissions & outbreaks towards the end of the month, with 47 positive inpatientst, including 7 in ICU. This added more pressure to a trust with an escalated critical care position. UHDB: The volume of attendances is high, with an average of 428 attendances per day at Derby (Type 1 & co-located UTC) and 199 at Burton (Type 1 & Primary Care Streaming). As a Network the numbers of attendances were at 83% of pre-pandemic levels (December 2021 compared to December 2019). The acuity of the attendances was high, with Derby seeing an average of 13 Resuscitation patients & 172 Major patients per day and Burton seeing 125 Major/Resus patients per day. Attendances at Children's ED continue to be high, with concerns about RSV and Bronchiolitis being major factors. Children's Type 1 attendances at Derby have averaged at 109 per day during December 2021 (compared to 104 per day in December 2019).	5	4	20	5	4	20	3	3	9	On going	Linked to Strategic Aims 1, 2, 3, 4, 5	Jan-22	Feb-22	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.	September: The CSU will take over the ReX applications to the COP on behalf of the CCG once the SOP has been approved. This should ensure that the CCG has no outstanding ReX applications by the time LPS replaces the current DoL legislation. October 21 - Re X applications are slowly being processed. The risk remains the same as the numbers of Re X applications the CSU are making are not significant enough at the moment to reduce the risk. November 21: The CSU have been asked if they can transfer a worker to assist in the Re X applications for the CHC cohort because these numbers are far higher than the TCP cohort, yet have the same number of staff allocated to process. December: An LPS implementation group will be established in the New Year to take this work forward across health providers who will become responsible bodies under the new framework. January: No change this month.	3	4	12	3	4	12	3	3	9	March 2022	Linked to Strategic Aims 1, 2, 3, 4, 5	Jan-22	Feb-22	Brigid Stacey - Chief Nursing Officer	Bill Nicol, Head of Adult Safeguarding Michelle Grant, Designated Nurse Safeguarding Adults/MCA Lead
03	21/22	TCP unable to maintain and sustain performance, pace and change required to meet national TCP requirements. The Adult TCP is on a recovery trajectory and rated amber with confidence, whilst CYP TCP is rated green. The main risks to delivery are within market resource and development with workforce provision as the most significant risk for delivery.	Quality and Performance	Quality/ Reputational	3	4	12	• System leadership group meets bi-monthly to review performance and address system issues, chaired by DHcFT SRO. • System wide plan developed identifying priorities for joint action and delivery • Additional funding and capacity in place for crisis response and forensic • Quality standards in place within contracts for NHS providers monitored quarterly at CQRG • Investment in Speech and Language Therapist for mental health wards to improve formulation in mental health care. • System Recovery & Restoration Plan implemented and ongoing • Weekly Discharge Review meeting to seek assurance against agreed trajectories • LD,MH,Autism delivery group have established a Provider development task and finish group to oversee the work to improve the capacity and resilience of local providers. - LD-A (Learning Disability and Autism) Delivery Group Meeting meet bi-weekly to monitor implementation of the seven 'lanes' on the improvement plan, with leads identified for the each workstream. - Weekly reconciliation meetings with DHcFT to ensure that admissions are appropriate with regards to confirmed diagnosis. - Mental health in-reach secondment: Funding agreed to establish a temporary in-reach post to acute mental health wards from Dec 2020 – May 2021. - Proposal to enhance the Derbyshire Autism offer: The System Delivery Board (via TCP SRO and Director of Quality) has requested a costed options proposal. This will go to the December meeting - Interim services to support Autistic people scoped and provided. The temporary secondment post and Case Managers will enhance oversight for people admitted with an ASD diagnosis. - Monthly NHSE/I regional Escalation assurance meetings - Weekly DDCCG TCP meeting • Derby and Derbyshire all-age Dynamic Support Register (DSR) for people with a formally diagnosed Learning Disability and/or Autistic Spectrum Disorder implemented • Weekly 1:1 – TCP Programme manager and NHSE TCP Lead Nurse • Covid-19 – impacting on transitions from Locked Rehab hospitals into community placements causing delays in discharges. Alternative transition planning being explored, • Case Managers redeployed to support DHcFT services – each Case Manager redeployed for 2 days per week to ensure they are able to continue to support case load.	TCP Recovery Action plan developed and monitored weekly: - Revised assurance systems and processes led by new TCP Programme Manager (Discharge Review Meeting (DRM), weekly NHS Provider meetings, appointment of two CCG Case Managers) - Mental health in-reach role: establish a temporary in-reach post to acute mental health wards from November 2020 – May 2021. - Weekly procurement updates: Multi agency weekly meetings with providers developing new services in Derbyshire led by Local Authority. - NHSE training sessions and case reviews for Ministry of Justice (MoJ) cases with Christine Hutchinson. - 1:1 support for TCP Programme Manager Admission avoidance - Proposal to enhance the Derbyshire Autism offer: The System Delivery Board (via TCP SRO and Director of Quality) has requested a costed options proposal is submitted to the group in December 2020. - Local Area Emergency Protocol (LAEP) notifications: It is an expectation that LAEPS are requested as part of meeting national and contractual expectations to notify about potential admissions. - Strengthen management of people in distress: These will focus on detailed review of care plans and provision for people with previous high levels of admissions & development of the Dynamic Support Register - Review of short breaks provision. - New Strategic Commissioner posts	Current bed position: CCG beds = 32 (Q4 2021/22 target 19) Adult Specialised Commissioning = 16 (Q4 2021/22 target 14) Children and Young People (CYP) specialised commissioning = 6 (Q4 2021/22 target 3). In response to the Operational Planning Guidance 2022/'23 trajectories will need to be refreshed to mirror the changed ICB footprint. It is important to note that although the number of inpatients remain over trajectory there have been 15 patients discharged during Q3 one of which was a Spec Comm patient and one CCG inpatient had been in hospital since 2009. A time limited Task and Finish Group has been established to focus on ensuring the DSR is evidence based and clinically led and that it focusses on enhanced wrap around provision in the community when appropriate, rather than admission avoidance. We are identifying ways in which to better utilise pre-commissioned community services such as IST and SAT: This workstream will align itself with ASD Leads in NHSE/I. One of the substantive 1.0 wte Band 7 Commissioning Managers that will primarily lead on the delivery of CTRs commenced in post January 10 2022 and is now undertaking 4 week's induction. The provider Trust has funded the substantive appointment of an additional 1.0 wte Band 7 Commissioning Manager post to provide additional capacity to the TCP Team, this post holder will commence with the TCP team on March 16 2022. There continues to be no admin support within the team, block booking of a Band 4 agency admin continues to be a priority to enable coordination of C(E)TRs and support with admin within the team. Colleagues in the CCG nursing and quality team have been redeployed to support the enhanced Covid 19 vaccine programme, the TCP team have been asked to undertake the 8 week out of area commissioner oversight visits. There is currently no additional capacity within the TCP team to undertake this additional role and function. This may potentially impact on the timeliness of community CTRs and Local Area Emergency Protocols (LAEPs). In order to ensure timely and concise reporting to NHSE/I mapping of required reporting and associated timeframes has been undertaken. Clinical audit platform submissions continue to be completed in a timely manner on a monthly basis: A robust system is now in place to maintain compliance. Safe and wellbeing reviews (previously five eyes), Derby and Derbyshire have 31 of the regional 91 red RAG rated reviews, however as a system we have demonstrated most progress regionally in achieving completion of red RAG rated reviews. This requirement was paused from mid-December to mid-January though has now been resumed: There are 7 green CCG reviews, 3 red, 4 amber and 2 green Spec Comm reviews to be completed before the end of February. ICS scrutiny panels are now being facilitated to identify themes and trends for local action, service delivery and/or improvement. We are focusing on the reviews that have identified concerns as our priority.	5	4	20	5	4	20	2	3	6	tbc	Linked to Strategic Aims 1, 2, 3, 4, 5	Jan-22	Feb-22	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: C**CG 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.	September no change to risk score. There continues to be increasing demand and pressure General Practice are facing. Appointment levels are already at least 10% higher than pre pandemic levels (additional 50,000 per month appointments across Derbyshire) as well as Primary Care continuing to deliver 75% of the COVID vaccination programme to date largely through the existing workforce. The regular sitrep report is providing an accurate picture of the situation in General Practice that can be reported into the wider system meetings so partners have a clear understanding of what is happening in general practice and how it can be supported. Planning for support for General Practice for the winter period is in progress to support requests for additional funding and resources in Primary Care to increase capacity in Primary Care to support the system. In addition, Primary care will also be starting the flu programme in September and therefore there are no changes recommended to the existing levels of risk this month. October - No change this month. November - There continues to be increasing demand and pressure that General Practice are facing. The regular sitrep report is providing an accurate picture of the situation in General Practice that can be reported into the wider system meetings so partners have a clear understanding of what is happening in general practice and how it can be supported. Winter Access plans were submitted to NHSE/I for consideration to provide additional support and capacity for increased number of GP appointments until 31 March 2022 and feedback is awaited. There are no changes recommended to the existing levels of risk this month. December - No changes this month. January - NHS E/I issued guidance to practices to focus and priories urgent care to support the Covid-19 vaccination booster programme until end of December 2021. A programme of national support for practices was set out including partial protection of QOF, protection of majority of PCN Investment and Impact Fund, protection of minor surgery Direct Enhanced Services (DES) payments. In January 2022, there continues to be increasing demand and pressure that general practice are facing as a result of restoration and recovery, continued support to the Covid-19 vaccination programme, increasing in practices having Covid-19 outbreaks and/or increasing numbers of practice staff being off work. As a result, the need has now switched from an urgent-only service due to the need to vaccinate, to an urgent-only service because that is all there is the capacity to provide. The delivery of urgent appointments is expected to continue until at least the end of January. Winter Access funding additional capacity to support urgent appointments is agreed and has commenced end of December / early January. This risk remains under regular review and in view of the pressures there is no change recommended to the existing high risk level this month.	4	4	16	4	4	16	4	3	12	On going	Linked to Strategic Aims 1, 2, 3, 4, 5	Jan-22	Feb-22	Dr Steve Lloyd - Medical Director	Hannah Belcher, Head of GP Commissioning and Development (Primary Care)
04B	21/22	Quality: Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care. There are 112 GP practices in Derbyshire all with individual Independent Contracts GMS, PMS, APMS to provide Primary Medical Services to the population of Derbyshire. Six practices are managed by NHS Foundation Trusts and one by an Independent Health Care Provider. The majority of Derbyshire GP practices are small independent businesses which by nature can easily become destabilised if one or more core components of the business become critical or fails. Whilst it is possible to predict and mitigate some factors that may impact on the delivery of care the elements of the unknown and unexpected are key influencing dynamics that can affect quality and care outcomes. Nationally General Practice is experiencing increased pressures which are multi faceted and include the following areas: *Workforce - recruitment and retention of all staff groups *COVID-19 potential practice closure due to outbreaks *Recruitment of GP Partners *Capacity and Demand *Access *Premises *New contractual arrangements *New Models of Care *Delivery of COVID vaccination programme *Restoration and Recovery *2021/22 FLU Programme *Becton Dickinson Blood Tube shortage	Primary Care Commissioning	Primary Care	4	5	20	**Primary Care Quality Team**: team providing monitoring of and support to practices county wide, proactive and reactive, direct contact available to practices to clinical team members, via telephone and email, for advice and support of any clinical queries and patient safety issues. Communication pathways established including membership bulletin, Information Handbook, web site development and direct generic inbox **Primary Care Quality and Performance Committe**e: 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) proces**s - 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 August - JUCD moving into Phase 3 of the Covid Vaccination Programme/ FLU programme whilst General Practice also working as BAU. Demand on general practice is above pre pandemic levels September - Flu Programme - Delays in delivery of flu vaccine to GP practices. Where flu clinics have already been organised, this is adding additional pressures. Shortage of Becton Dickinson blood tubes is being managed as a system - updates and associated information is being issued to GP practices and there are only four instances where phlebotomy can be undertaken currently, due to the shortage. Therefore, phlebotomy undertaken within GP practices is severely restricted which will have a future impact on QOF prevention. It is expected that the situation will improve from 20.09.21 but pressures will still be felt. From 31.08.21 to 17.09.21 blood tests carried out in GP practices will be only in the four instances. Phase 3 COVID delayed until 22.09.21, planning taking place. October - The risk score remains the same this month but this may increase over the coming months due to the fragility in the system. This is due to the COVID pandemic and as we move into the winter months additional pressures will be experienced. November - The blood tube shortage has stabilised. Issue around the impact of the recent government announcement on the mandatory COVID vaccination of NHS staff. The mitigation in place for this is that the CCG is working with the GP taskforce to understand the impact on Primary Care. The GP taskforce are organising practice feedback to ascertain the numbers affected and the possible impact. December: Improving Access in General Practice has begun, this will support an increase in appointment capacity. January - No update.	4	5	20	4	5	20	4	4	16	On going	Links to Strategic Aims 1, 2, 3, 4, 5	Jan-22	Feb-22	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 .	October update. Waiting lists for ND pathway all have come down as a consequence of mitigating actions taking effect. However there is now a surge of demand doubling for Psychology CYP 30% up for CAHMS and 40% up for targeted interventions. Eating disorder cases up 70% all pandemic related. Further waiting list initiatives utilising slippage from transformation schemes being taken forwards. November update: Slippage identified and schemes to support waiting times agreed by MH,LDA,CYP Board and being initiated. (CAMHS core, ND pathway, targeted intervention, sexual violence). December update: System MH,LDA,CYP Board approved outline plan to reduce ND wait list for cyp to get to 18 weeks by 2024/5 . work underway across east midlands to support choice agenda and wait times for ADHD adults .Recommended to review and subdivide this risk from April as system risk update with impact of Covid -19 escalation. DHCFT CAMHS ASIST (assessment) team have reported on their targeted waiting list initiative in Oct to reduce the external wait for CAMHS Initial assessment. This has reduced their waiting list to 266 young people on the CAMHS external wait list (down from 444 in August 2021) with the longest wait reducing from 52 weeks to approximately 25 weeks at this time. CAMHS have maintained all critical/essential services and continue to prioritise these. Further waiting list initiatives with Action for Children, DHCFT and CRH underway. January update - Emergence of Omicron and impact on workforce capacity has resulted in reduced access to services.	4	3	12	4	3	12	3	3	9	Mar 22	Links to Strategic Aims 1, 2, 3, 4, 5	Jan-22	Feb-22	Zara Jones Executive Director of Commissioning Operations	Dave Gardner Assistant Director, Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning
06	21/22	Demand for Psychiatric intensive Care Unit beds (PICU) has grown substantially over the last five years. This has a significant impact financially with budget forecast overspend, in terms of poor patient experience , Quality and Governance arrangements for uncommissioned independent sector beds. The CCG cannot currently meet the KPI from the Five year forward view which require no out of area beds to be used from 2021.	Quality and Performance	Commissioning	5	3	15	Beds commissioned on block and to be extended for a further year. STP developing a plan for Derbyshire PICU. Use has escalated during COVID19 and funding recoverable from COVID funding this therefore has resulted in no change to the financial risk despite numbers doubling to 24 from 12. However plans will need to be in place to ensure numbers return to agreed baseline. 07.08.20 Length of stay rising is a factor in increased use mitigated by reduced use of additional observations. DHCFT have submitted 250M capital funding Bid to national capital scheme. this includes a new build PICU for men. Options for Women will need to be considered within the estate changes made possible if the bid is successful.	Continue to Explore regional options for bed optimisation being taken forward with clinical network DHcFT to take a lead provider role . OOA bed reduction plan to include PICU and manages through STP. Report on Options for Derbyshire PICU and controls to be brought back to DDCCG in September, Ensure plan in place to reduce PICU usage post COVID. Ensure that DHCFT returns patients back to Derby as soon as possible. Maintain reduced additional observation costs with continued provider challenge. 07.08.20 Issue raised in MH recovery Cell . short life group formed to address . Report on Options for future dependent on outcome of 250Mcapital bid. Subgroup of recovery cell to produce plan to reduce numbers . Finance teams to discuss how COVID funding arrangements can be taken forward with DHcFT as "top up funding" announced in phase 3 arrangements may be linked to provider costs not CCG costs. This is being investigated further.	August update Papers on procurement outcome and proposals for next steps to come to CLCC. Concerns remain as for July depending on outcome of search for provider who can meet quality requirements . September Update use remains stable ,searches underway for suitable providers .Risk level remains unchanged until suitable providers identified. October Update. Providers who can meet quality requirements identified but at a distance from Derby. Direct award for providers being considered in papers to CLCC. November update: Outline Business Cases for the development of 14 bedded Derbyshire Male PICU service have been reviewed by the CCG and JUCD governance and are supported to progress to full business case. Negotiated procedures have been conducted with current contracted providers of PICU services to agree contract terms for the provision of block funded beds until the proposed Derbyshire unit is in place, this will provide an increased level of block funded access and will support the JUCD system in the achievement of no OOAP through the provision of continuity of care arrangements with the contracted providers. Contracts will be agreed by the end of November with full implementation of CoC arrangements to be in place Q4 2021/22. December update: Contracts agreed with providers for block funded beds. Mobilisation period commenced and actions agreed. Risk score amended to reflect actions taken. January Update - On track to agree new contracts. Impact of Covid on staff capacity will delay implementation of system links by +4 weeks.	2	3	6	2	3	6	2	3	6	Dec 21	Links to Strategic Aims 1, 2, 3, 4, 5	Jan-22	Feb-22	Zara Jones Executive Director of Commissioning Operations	Dave Gardner Assistant Director, Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning

Risk Reference	Year	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk Rating			Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating			Residual/ Current Risk			Target Risk			Target Date	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						
09	21/22	Sustainable digital performance for CCG and General Practice due to threat of cyber attack, network outages and the impact of migration of NHS Mail onto the national shared tenancy. The CCG is not receiving the required metrics to provide assurance regarding compliance with the national Cyber Security Agenda, and is not able to challenge any actual or perceived gaps in assurance as a result of this.	Governance	Corporate	3	4	12	• NECS receive and acts on CareCERT alerts, received in response to NHS Digital monitoring of threats to the external system. Actions taken are reported via the NECS contract management meetings, and escalated to the Digital Lead where required. • The network infrastructure is proactively monitored and anti-virus signatures are maintained adequately. • NECS actively provide compliance evidence for the DSPT and provides assurance to the CCG regarding network security. • The Governance Committee has responsibility to oversee the arrangements for ensuring that technology is secure and up-to-date and IT systems are protected from cyber threats. • The NECS contract management board receives routine assurance reports regarding cyber security preparedness and resilience. • Hygiene reports (progress against technical security measures) are provided to the NECS contract management board The CCG has agreed a local policy for the shared tenancy and Microsoft Office 365 that seeks to prevent the introduction of new functionality into Microsoft Teams and other associated software until the business case has been proven that this functionality would be beneficial and until such time as the Governance is in place. Where changes are known in advance, these are communicated to staff appropriately including the effect of the change. The CCG are also working with NECS to develop system policies at the local level to allow as much local control over changes as is feasible while feeding back to the national teams. Our CCG is also two/three weeks behind the rollout in other NECS Customers to enable us to learn lessons from their experiences and adjust accordingly. The CCG receives regular automated updates from NHS Digital to enable them to identify any new risks or variations or escalation in existing risks. These are also automatically published into a Microsoft Teams environment which is shared with Primary Care to allow further propagation of the information. NECS has also agreed to provide named contacts within the CCG with regular updates around critical and high priority changes such that the CCG can actively participate in any risk management decisions and remains information of progress. Following discussion and approval at PCCC, the CCG is procuring dedicated connections into currently shared sites to remove the dependency upon AGEM and their supplier chain. This will ensure that NECS own the connection from the desktop to the data centre and out to the Internet.	CCG proposes to work closely with cyber awareness training provider / Cyber Resilience Support team which may include identification and recommendations of cyber issues that may impact on cyber security, for example developing and implementing further strategies and policies - and identification of practical opportunities where necessary to support operational awareness. Development of local policies and working with the national team to devolve as much responsibility as possible to the local level thereby allowing us to have more control over the deployment, removal and changes to functionality within the Microsoft Teams and other environments linked to the NHS shared tenancy and Microsoft Office 365. Additionally, the migration of the CCG and colleagues within General Practice away from the previous NHS Mail system and onto the NHS' national shared tenancy brings both benefits and risks. While there are economies of scale and additional functionality available, there is a lack of control over the launch of new functionality and removal of existing functionality. There are also configuration issues between settings at the national and local level, leading to a temporary pause in the deployment of Microsoft Office 365 within Derby & Derbyshire until these are remedied. Visibility of the NECS responses and strategies to dealing with critical and high priority risks.	12.07.21 - No evidence of the recent (and ongoing) distributed denial of service attack penetrating any of our networks or devices and NECS has confirmed that geo-blocking is in place to prevent connections from countries and areas known to be active in attacks such as these. We are continuing to work with NECS on the 'PrintNightmare' vulnerability and we have tracked this from initially being of low significance to requiring action. NECS has mitigated the risk by removing the printing function from all unnecessary devices, but to fully secure the network we would need to suspend all printing from all devices which is impractical. We therefore continue to scan all devices connected to the network for any signs of the vulnerability being utilised - if found, the device will automatically be isolated from the network and the security team informed. To date, there have been no exploitations identified within the CCG or Primary Care. Risk remains the same, as there is the risk of exploitation, but no evidence of this being exploited - similar to the scenario with Microsoft Office 2010. 17.08.21 - We have agreed an initial reporting procedure with NECS for the communication of any high level or escalating CareCERT alerts accompanied by appropriate assurances and mitigations; this allows the CCG to be aware of all potential threats and to manage those risks in tandem with NECS and assurances that alerts are being appropriately responded to. We have also subscribed to the NHS Digital CareCERT data feed to ensure that we also receive any low level or for information alerts so that these can be assessed and raised with NECS and/or through appropriate internal routes as appropriate. The risk continues to be low. 13.09.21 - Recommend reduction of the impact of the risk, as previously risk mitigation and responses to critical and high-level alerts were provided directly to NHS Digital for assurance with subsequent reporting to the CCG through operational contractual meetings. The revised approach means the CCG are both aware of all risks (not just critical and high-level) and receive more timely reports from NECS on how these are being actively managed. It also allows for the CCG to challenge responses where appropriate and to receive assurance that the risk has been addressed or where risks remain. Reviewing the available information would indicate risks are being appropriately managed and actioned and with the additional investment made in our off-site storage and improvements to the firewall, we feel the impact of the risk should be reduced given these additional mitigating actions. 26.10.21 - Recommendation that the risk remains the same until the additional 12 dedicated and NECS managed connections are installed, as this will then remove the risks to service delivery through the shared sites. 17.11.21 - The risk score remains the same, as we are awaiting a funding decision from NHSX to upgrade existing slower connections and the intention would be to commission both pieces of work together - the additional sites and the upgrades to any sites with lower than 30MB/sec connectivity speeds. 14.12.21 - At the time of writing the update there is currently a high severity CareCert in place for a vulnerability within the Log4j component which is to be found in a number of different systems including Apple's iCloud and a number of systems in use across Derbyshire. This vulnerability can lead to remote agents taking control of a host system and as a result NECS has already identified Internet facing systems which cause a potential threat and has taken steps to suspend these pending further investigation. There is currently no evidence to suggest any breaches of any NHS organisations within Derbyshire including the CCG or Primary Care. Mitigations also include local business recovery plans. However, given the severity of the vulnerability, the current status of not knowing all affected systems and the duration that this situation is likely to be ongoing, it seems prudent to raise the probability significantly to identify this increased risk 12.01.2022 - With regard to the Log4Shell vulnerability above, the CCG and cyber colleagues from NECS are engaged with the national response programme, delivered by NHSEI, and are in receipt of the national validations and patch requirements. We are assured at this point that as much as is possible to be delivered is in train, and the national team are advising where attempts may have been made to exploit this. We have had no reported instances of impact from this across Derby and Derbyshire, and we remain vigilant.	4	4	16	4	4	16	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	Jan-22	Feb-22	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	January Update • Local Health Resilience Partnership (LHRP) meetings re-established • Local Resilience Forum (LRF) Sub-Groups meeting regularly • ICS Hours increased to meet increased demand • System Wide On Call Rota created to provide additional resilience at times of increased pressure The score has been reviewed and remains the s+K5ame as there are additional demands on the system due to winter pressures and the effects of COVID	2	4	8	2	4	8	2	2	4	On going	Links to Strategic Aims 3, 4	Jan-22	Feb-22	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 M9 the CCG are not seeing any major financial pressures against planned expenditure with the exception of CHC and we continue to work with M&LCSU and providers to rectify this. The CCG are reporting a year to date underspend of £3.146m against total anticipated resources available of £1,560.186m for the period covering April to December 2021. Against total anticipated resources available in 2021/22 of £2,084.155m the CCG is forecasting an surplus of £6.403m. The increase in the forecast surplus is due to the impact of receipt £2.4m winter discharge funding, £4.365m Community Diagnostic Hub funding and £2m Cancer funding received late in the year and not all of which can be committed. However, while the in-year position now shows a surplus the underlying recurrent position for both the CCG and the wider system remains very challenging and we are some way from achieving a sustainable system financial position. The score remains the same as while the in-year position now shows a surplus, the underlying recurrent position for both the CCG and the wider system remains very challenging and we are some way from achieving a sustainable system financial position.	4	4	16	4	4	16	2	3	6	On going	Links to Strategic Aims 1, 2, 3, 4, 5	Jan-22	Feb-22	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 January Update: · Proposal being taken to MH, LD&ASD and CYP System Delivery Board Finance Sub Committee for use of monies to support delivery of the programme. · Programme infrastructure being established.	3	3	9	3	3	9	2	3	6	December 21	Links to Strategic Aims 1, 2, 3, 4, 5	Jan-22	Feb-22	Brigid Stacey - Chief Nursing Officer	Mick Burrows Director for Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning, Helen Hipkiss, Deputy Director of Quality /Phil Sugden, Assistant Director Quality, Community & Mental Health, DCHS
16	21/22	Lack of standardised process in CCG commissioning arrangements. CCG and system may fail to meet statutory duties in S14Z2 of Health and Care Act 2012 and not sufficiently engage patients and the public in service planning and development, including restoration and recovery work arising from the COVID-19 pandemic.	Engagement	Communications/ Engagement/ Statutory	3	4	12	Systematic completion of S14Z2 forms will provide standardised assurance against compliant decision making and recording of decisions at project level. Engagement Committee established to strengthen assurance and risk identification.	PMO processes are not being applied to restoration and recovery projects, therefore there are no checks and balances as projects proceed to ensure that they have completed either the S14Z2 or EIA forms. An equality and engagement policy is being developed to address this gap in part, for proposed adoption by all JUCD partners. EIA/QIA process adopted by JUCD. Not all projects follow a systematic project management/commissioning/transformation process to ensure standardisation of process and application of legal duties. June update: Engagement Governance Guide and training being developed to support consistency of approach for officers involved with transformational change. Meeting with new ICS Director of Transformation to be arranged to ensure processes embedded in future project management approaches. September: Completion of Engagement Governance Guide in October and alignment with transformation/PMO processes.	Engagement Committee re-established in June 2020 following pause during peak of COVID-19 pandemic. Training for Engagement committee members on consultation law completed. Replacement lay members recruited to ensure sufficient lay voice on Engagement Committee following recent resignations. S14Z2 log reviewed regularly by Engagement Committee. CCG planning approach under review to identify potential annual commissioning business cycle, thus enabling rolling engagement programme in commissioning development and activity. July: Consultation Law refresher training undertaken for engagement team to support governance process review and strengthen our approach to planning and delivery of engagement, including additional context of engagement requirements in a virtual world. Will feed Governance Guide production this month, to be reviewed by Engagement Committee in August 2021. August: Meeting with ICS Director of Transformation taken place 17.8.21; meeting with QEIA panel leads on 18.8.21. Governance Guide remains in development, aligned to revision of Engagement Model. Will also align with emerging JUCD transformation processes, with agreement that that S14Z2 check will be included in documentation and digital tool. Further strengthening of S14Z2 process also agreed with QEIA Panel process, to improve quality and timeliness of submissions of S14Z2 forms. These actions combined will serve to achieve the target score this risk during Q3. September/October: Engagement Model refresh to September Engagement Committee, governance guide sits behind this as a resource for teams undertaking service change. Planning for guide to be completed in October 2021, with parallel alignment into Transformation/PMO processes. Target risk score achievable by October/November 2021. November:The Governance Guide is progressed and submitted for approval at November Engagement Committee. December: Governance Guide verbal update given at November Committee - final amendments required prior to approval that could not be completed in time for the meeting due to team capacity challenge. To be reviewed at January 2022 Engagement Committee. January: Engagement Committee has reviewed the risk and ongoing work and determined that the score can be reduced to target 2x3=6. This reflects the breadth of engagement governance, infrastructure and delivery during 2021/22 that supports greater mitigation of this risk. The risk remains on the register for review for a further two months and if the position is the same, the risk will be recommend for closure.	2	4	8	2	3	6	2	3	6	Feb 22	Links to Strategic Aims 1, 2, 3, 4, 5	Jan-22	Feb-22	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Sean Thornton Assistant Director Communications and Engagement
17	21/22	S117 package costs continue to be a source of high expenditure which could be positively influenced with resourced oversight, this growth across the system, if unchecked, will continue to outstrip available budget	Quality & Performance	Corporate	3	4	12	Although not overspent to budget at this time the rising cost of care under s117 is around 38m to the system. The CCG is investing in additional case managers, re-introducing S117 work stream under MHSDB when this is possible. It is anticipated that both of these measures will positively affect outturn at system level. 17.09.20 The CCG have agreed to employ a number of case ,managers, which will cover s117 packages of Care. This is being negotiated with the CSU to start in October. The Commissioning for Individuals panel is now in place. This includes s117 cases. Although not overspent to budget at this time the rising cost of care under s117 is around 38m to the system. The CCG is investing in additional case managers, re-introducing S117 work stream under MHSDB when this is possible. It is anticipated that both of these measures will positively affect outturn at system level.	There is slippage in the introduction of case managers, so the savings have slipped from October 2020 to January 2021. Further re-design of specification now means delivery start date now Q1 21-22	Recruitment challenges 17.08.21 Risk remains unchanged pending case load review, CSU have not yet confirmed timeline. 12.10.21 Discussed with MLCSU today, she confirms that reviews are now ongoing and that potential savings will be quantified over the next quarter. The risk remains high due to the ongoing issues that need resolving with systems partners. 17.11.21 Reviews remain on track as per previous report, potential savings quantified over next quarter still. December 21 & January 22: Reviews continuing as per previous updates, potential savings to be quantified in Q4	3	3	9	3	3	9	2	2	4	tbc	Links to Strategic Aims 1, 2, 3, 4, 5	Jan-22	Feb-22	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.	December - No further update due to continued home working. January - No change due to continued home working. February - No change due to continued home working, paused. 14.09.21 - Trial of flexible/hybrid model of working commences on 20.9.21 with staff able to book desks at CCG sites. Project group to recommence review of HR files with a view to scanning into an electronic filing system. Files to be reviewed ahead of transition to ICS on 1 April 2022. 13.10.21 - New operating model in place from 20.9.21. Project group to recommence review of HR files with a view to scanning into an electronic filing system. Files to be reviewed ahead of transition to ICS on 1 April 2022.. 15.11.21 - Project group to recommence review of HR files with a view to scanning into an electronic filing system. Meeting to be held on 17.11.2021 - Files to be reviewed ahead of transition to ICS on 1 April 2022. 10.12.21 - Project group met on17.11.2021 - agreed that work can commence on current personal files as all the paperwork was agreed previously, with a front sheet added to everyone's HR folder. At this stage any that are required to be archived will remain in a separate filing cabinet clearly marked with meta data. Files to be reviewed ahead of transition to ICS on 1 April 2022.Update 13.12.2021 - Government advice to work from home wherever possible will temporarily pause project. 17.01.22 - Government advice to work from home wherever possible has temporarily paused project.	3	3	9	3	3	9	1	2	2	On going tbc	Links to Strategic Aim 4	Jan-22	Feb-22	Beverley Smith, Director of Corporate Strategy & Development	Sam Robinson, Service Development Manager
22	21/22	The mental health of CCG staff and delivery of CCG priorities could be affected by remote working and physical staff isolation from colleagues.	Governance 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, health advice and support for health, social care and community staff in relation to the Covid-19 virus. For confidential support and counselling the CCG employee assistance programme provider (EAP) can be accessed by all CCG colleagues and family members in the same household and is available 365 days a year, 24 hours a day. They have also launched a 25 minute web based "Working from Home and Resilience" seminar details of which have been included in the CCG Staff update email. 1 to 1 wellbeing checklist introduced for line managers to facilitate support for members of their team. Virtual tea breaks and initiatives to promote social connectivity introduced and ongoing.	08.04.20 A range of ideas to support the wellbeing of staff working from home will be launched shortly, with a toolkit to help staff all maintain a positive outlook and ensure interaction with colleagues 'off topic' to maintain spirits during the working week. Staff are encouraged that they should all take time to remember that they are not "working from home", but "at home, during a crisis, trying to work". 17.04.20 continue to monitor and assess sickness returns for trends and patterns and review good practice for staff H&WB e.g. NHS Employer, Social Partnership Forum etc. 12.05.20 The CCG will develop and run briefings for line managers to support them in undertaking 1 to 1 wellbeing checks with their team (to include wellness action plan, display screen equipment review and risk assessments for vulnerable staff).	14.09.21 - Majority of staff have reviewed and submitted an updated risk assessment pro-forma and individual preferences. 90% of CCG staff are fully vaccinated with a further 3.4% who have received the first does only. Continuation of wellbeing communication and initiatives for staff, including flexible working, social connectivity, relaxation sessions. Anticipate that the probability of health risks from remote working will reduce (probability of 1) when the CCG introduces the flexible model/hyriid working with effect from 20 .9.21 whereby staff will be able to choose to attend and work at a CCG base. Briefing for all staff at Team Talk on 14.9.21 regarding the flexible model linked to virus transmission rates (red/amber/green) and an overview of the standard operating procedure (e.g. amber - 80 desks bookable, social distancing, requirement to wear mask and max 2 people in a meeting). 13.10.21 - Continuation of wellbeing communication and initiatives for staff, including flexible working, social connectivity, relaxation sessions. CCG has introduced the new operating model (hybrid working) and staff are able to choose to attend and work at a CCG base. Mid-year review conversation to focus on health & wellbeing & support required by staff. 15.11.21 - Mid-year review conversations focussing on health & wellbeing & support required by staff taking place during October & November .Continuation of wellbeing communication and initiatives for staff, including flexible working, social connectivity, relaxation sessions. Also promoting access to virtual exercise classes and MSK exercises. Staff remain able to book a desk and work from a CCG base. 10.12.21 - Majority of mid-year review conversations focussing on health & wellbeing & support required by staff have now taken place. All staff webinar held on personal resilience and change by Thrive psychologists Promotion of virtual exercise classes and exercises to undertake whilst working to maintain good MSK health. Continuation of wellbeing communication and initiatives for staff, including flexible working, social connectivity, relaxation sessions. From 13.12.2021 staff will no longer be able to book a desk to work from a CCG location, however, exceptions will be looked at for health and wellbeing grounds as previously. 17.01.22 - Continuation of wellbeing communication and initiatives for staff, including flexible working, social connectivity, exercise classes and maintaining good MSK. Staff working from home with exception of a few CCG staff for health & wellbeing reasons.	2	3	6	2	3	6	1	3	3	On going	Links to Strategic Aims 1, 2, 3, 4, 5	Jan-22	Feb-22	Beverley Smith, Director of Corporate Strategy & Development	Beverley Smith, Director of Corporate Strategy & Development James Lunn, Head of People and Organisational Development

Risk Reference	Year	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk Rating: Probability	Initial Risk Rating: Impact	Initial Risk Rating: Rating	Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating: Probability	Previous Rating: Impact	Previous Rating: Rating	Residual/ Current Risk: Probability	Residual/ Current Risk: Impact	Residual/ Current Risk: Rating	Target Risk: Probability	Target Risk: Impact	Target Risk: Rating	Target Date	Link to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
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	12.08.21 - Ongoing review of existing redeployments and consideration of alternative solutions. 14.09.21 - CCG staff continue to provide support in the vaccine operational cell (VOC) and at the vaccination centres. The number of CCG staff/ time commitment has reduced from 1 September 2021 with the move away from the mass vaccination centre. There is an ongoing review of existing redeployments and consideration of alternative solutions. 13.10.21 - Ongoing review of existing redeployments and consideration of alternative solutions. The Vaccine Operational Cell (VOC) currently has vacancies and SLT discussions around how these can be filled are being carried out. Sickness absence rates continue to be below pre-covid levels (3.16%) but have increased in the last 6 months from (2.16% in April to 2.34%). 15.11.21 - Number of redeployments has significantly reduced. CCG has agreed to fund additional external resource to boost capacity in the short-term (until 31 March 2021) from underspend on both running and programme costs. 20.12.21 - Increasing number of redeployments away from the CCG, due to requirements to support the system with the COVID booster and vaccination programme. Risk probability score increased accordingly from 1 to 3. Permanent structure developed for VOC to support continuity & deployment and submitted to Executive Team for consideration. Additional interim resource being brought in to boost capacity in the short-term (until 31 March 2021) from underspend on both running and programme costs. 17.01.22 - Increasing number of redeployments away from the CCG, due to need to increase surge capacity (clinical) and open wards plus ongoing requirements to support the system with the COVID booster and vaccination programme. Permanent structure developed for VOC to support continuity & deployment to be further reviewed in 1 month.	3	4	12	3	4	12	1	3	3	On going	Links to Strategic Aims 1, 2, 3, 4, 5	Jan-22	Feb-22	Beverley Smith, Director of Corporate Strategy & Development James Lunn, Head of People and Organisational 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.	13/8/21- Vaccinations rolled out to 16-18 age group. Booster jabs for over 50's+, adults aged 16-49 who are in a flu or Covid-19 at-risk group and those living in the same house as people who are immunosuppressed. 13/08/21- Our system is currently under significant pressure. Not only are our Emergency Departments filling up, but our ambulance service, general practice, urgent treatment centres, mental health units and our discharge support teams are all experiencing unprecedented demand. This 'perfect storm' is now also being exacerbated by increasing numbers of staff needing to self-isolate having either had a positive test for Covid-19, having to self-isolate because of an alert from the NHS Covid-19 app or having to take time off work to look after their children. 10/09/21- The pressures on our health and social care system continue to intensify and urgent talks took place to see what measures were needed to support and bolster our local NHS network against unprecedented demand. System leaders are monitoring the live situation and will make changes to relieve capacity where possible and we're also asking the public to work with us by accessing the right NHS service. 13/10/21- No progress update. Advise to keep the risk on the tracker due to forthcoming winter pressures and the spread of COVID variants. 13/11/21- No progress update. Advise to keep the risk on the tracker due to forthcoming winter pressures and the spread of COVID variants. 10/12/21- Concern over Omicron variant and national measures have been introduced to tackle the spread. Booster jab roll out for all 40+ commenced. Advise to keep the risk on the tracker due to forthcoming winter pressures and the spread of COVID variants. January - The spread of the Omicron COVID-19 variant across our communities has not yet resulted in the increased use of our Intensive Care Services but general admissions to our hospitals with COVID-19 are increasing, together with an increase in care activity and requirements in our community-based services. With circa 200,000 confirmed cases each day nationally (7/1/22) , it is inevitable that our staff will pick up the virus themselves. At present, this is the main challenge to service delivery; in both health and social care we have the estate and the facilities to meet much of the demand, but we are challenged in sustaining the staffing levels required to use it fully.	2	3	6	2	3	6	2	3	6	On going	Links to Strategic Aims 1, 2, 3, 4, 5	Jan-22	Feb-22	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.	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. 10/09/21- Held a stakeholder workshop to commence development of the Post COVID Rehab Centres. Currently working closely with multi-agency providers to develop the workforce model. Funding agreed to appoint a Long COVID Project Manager to lead the programme. Interviews scheduled for w/c 20/09. 15/10/21- Project Manager appointed, with a phased start date agreed as the 18th October. The system is working on developing two initial Post COVID Rehab centres. 12/11/21- Agreed to develop two rehab centres at CRH and Florence Nightingale. Recruitment to the workforce has commenced and system wide partners are dialogue to develop the patient pathway. 12/11/21- Concern over waiting lists and recruitment at the Assessment Clinic. Funding being utilised to recruit additional clinician time to eradicate backlog by Dec 21. 10/12/21- Ongoing development of the rehab service, and DCHS are implementing a revised plan to reduce the assessment clinic waiting list. January- The North and South Long COVID rehab centres have appointed case managers and assistant practitioners. Aiming for a March launch of both centres. To support the Post COVID Syndrome backlog, DCHS are triaging referrals and have recruited bank staff to eradicate the 230 patient backlog by March 22.	3	3	9	3	3	9	3	3	9	On going	Links to Strategic Aims 1, 2, 3, 4, 5	Jan-22	Feb-22	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	August update - increased programme / commissioning capacity agreed to deliver the LTP priorities at Pace. The impact of RSV a particular concern for bed capacity at paediatric acutes which has potential to impact when also an increase in CYP with MH / challenging behaviours - mtgs held with agreed escalation routes ,data flow ,and system response. September update - progressing recruitment to increase programme capacity, bronze, silver, gold escalation routes for CYP with MH / challenging behaviours insitu to facilitate flow. October 21. Improvement in numbers of CYP admitted to paediatric wards. Severe pressure in community. System identification of opportunities for short term accommodation being sought. Use of slippage in CYP to support increased demand and manage wait times . Winter pressure plan developed. November 21 - Additional CYP crisis staff starting to come in to post i.e. in CAMHS Eating Disorder urgent care team . Continued pressures on paediatric units and in community. Working up / reviewing opportunities for CYP short term accommodation. December update - Continuing to recruit to Crisis, Liaison and Intensive Home treatment team. Ongoing pressures affecting flow across in tier 4, paediatric units and community January update - Emergence of Omicron and impact on workforce capacity has resulted in reduced access to services. Continued focus on planning for additional investment in crisis response offers.	4	3	12	4	3	12	2	2	4	Oct-21	Links to Strategic Aims 1, 2, 3, 4, 5	Jan-22	Feb-22	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 Rastell TCP Programme Manager Jenn Stothard Head of Mental Health
27	21/22	Increase in the number of safeguarding referrals linked to self neglect related to those who are not in touch with services. These initially increased immediately following COVID lockdown. The adult safeguarding processes and policy are able to respond to this type of enquiry once an adult at risk has been identified. Numbers are difficult to predict but are predicted to increase as COVID restrictions ease.	Quality & Performance	Clinical	5	4	20	Key statutory partners such as Health , Local Authority, Police and Voluntary Sector are working closely together to ascertain who are at enhanced risk. Safeguarding meetings and assessments are continuing to take place via virtual arrangements. Families and individuals are being signposted to relevant support services.	Domestic Abuse is likely to increase as family groups are forced to be together for extended periods of time, children are at home on a full time basis, there are financial pressures due to restrictions upon employment, and adults at risk from abusive partners become socially isolated. It remains at an early stage. Referrals are expected to increase with another sharp spike in activity predicted when COVID restrictions are eased and victims feel safer in making disclosures Self Neglect. Individuals are finding it problematic to obtain aids to daily living and basic essentials. They do not have the motivation or ability to access sources to access or replenish essential items. Scamming. Individuals are targeted due to their physical or cognitive vulnerability and persuaded and cajoled to trust unscrupulous individuals During the COVID19 pandemic the number of referrals to adult social care services has increased but not as yet at the rates envisaged and predicted at the outset of lockdown and enforced isolation. Ongoing close partnership working is required. The Derby and Derbyshire Safeguarding Adult Boards are continuing to work collaboratively to gather information / intelligence and data regarding domestic abuse and adult abuse prevalence during the COVID 19 pandemic to formulate relevant action / contingency plans. Police are undertaking safe and well checks as appropriate and will use powers of entry if deemed necessary and proportionate.	September: The Safeguarding Adult Boards and their Quality and Performance Committees have taken a view that the risk of escalating adult safeguarding activity remains an unknown quantity. Referrals have continued to rise every quarter as more adults at risk are in contact with families and service providers. Self-Neglect and Domestic Abuse, particularly within those aged 65 plus have increased. It would be fair to say that systems are under increasing pressure and it would be optimistic and naïve to amend the risk factors and threats at this time. As stated previously we are only likely to begin to understand the impact of Covid upon adults at risk when we have had a sustained and consistent period of normality. This has been exacerbated by a heightened alert around Prevent and anti-terrorist activity particularly within extreme right wing groups. This is in itself linked to the Black Lives Matter strategy and the recent Afghan migration to the UK No further update to add for October. November - Safeguarding Adult referrals have increased by 16% over the last Quarter. This was anticipated due to an easing of lockdown restrictions began to take effect. These referral rates and types are monitored through the Safeguarding Adult Boards and also via case file audit. There should be little doubt that systems and resource ex are stretched and challenged but at the time of writing there are no particular areas of concern requiring escalation. Suggest that we continue with the risk levels as they currently stand until completing a root and branch review during March 2022. December - No changes this month. January - This is currently under review. Update February/March. No change this month.	4	3	12	4	3	12	3	3	9	On going	Links to Strategic Aims 1, 2, 3, 4, 5	Jan-22	Feb-22	Brigid Stacey, Chief Nursing Officer	Bill Nicol, Head of Adult Safeguarding
32	21/22	Risk of exploitation by malevolent third parties if vulnerability is identified within any of the Microsoft Office 2010 applications after October 14th 2020 and not patched, due to support for Microsoft Office 2010 officially ending, after which point Microsoft will cease to issue updates and patches for vulnerabilities found within this suite of applications	Governance	Corporate	4	4	16	Replace all instances of Microsoft Office 2010 with Microsoft Office 365; Additional Cyber Security communications to all CCG and Primary Care staff to raise awareness of the potential for increased phishing emails, suspicious attachments and downloading documents from unfamiliar web sites; Reinforce the message that devices should be connected to the network every two weeks to ensure that anti-virus and other system management software updates accordingly; Identify other mitigation which NECS have put in place to prevent the execution and spread of any malicious code or exploitation of any vulnerability;	Task and finish group has been established with NECS to develop the programme of work which removes the risk, but also ensure continuity of service across commissioning and Primary Care; Already under development as part of the response to the CORS report; information will be cascaded through the CCG Comms team for CCG and Primary Care colleagues and also shared with the LMC;	12.07.21 - All unsupported versions of Microsoft Windows 10 have now been removed from all devices currently connected to the network. There are three devices outstanding, but these are with colleagues not currently at work and the device will be required to be upgraded prior to re-connecting to the network. The installation of Microsoft Office 365 has been mandated across all CCGs as of 4pm on July 9th with personal follow-up from NECS for any outstanding. There are around 700 devices yet to be upgraded onto Microsoft Office 365 across Primary Care - NECS continue to work with Practice Managers to resolve and Engineer visits will be arranged where more convenient. Risk remains the same. 17.08.21 - All remaining CCG devices yet to upgrade to Microsoft Office 365 are having the installation forced when the device first starts up. A communication has been sent to GP Practices informing them that the forced upgrade will be introduced in Primary Care on August 17th; any devices not upgraded by September 8th will have their network accounts disabled and will require all outstanding upgrades and updates to be carried out prior to being allowed back onto the network. This allows a three week period for any engineer visits or remedial actions to take place prior to the deadline of October 2021. 13.09.21 - There remain around 300 devices yet to be migrated onto the latest version of Microsoft Office with around 4 of these still on older versions of Microsoft Windows 10 - these are primarily within the GP estate including a specific GP Practice which has been undergoing a number of operational issues. Communications have been issued to Practice Managers reminding them of the need to engage with the project which re-enforces messages sent directly to the devices. The decision was taken on Friday Sept 10th to instigate the action to disable the computer accounts of all devices not updated by cop Wednesday Sept 15th. This will also be picked up by engineers routinely visiting sites. Risk score remains the same until all devices are disabled or updated. 26.10.21 - There are currently 2 devices in the CCG (99.6% complete) and 43 devices in Primary Care (99.1% complete) outstanding. Further comms have been distributed to reduce this number, but the majority of these devices appear to be dormant. NECS Engineers have been asked to uncover all dormant devices and return to the CCG if not in active use. All older versions of Windows 10 have now been removed and there are no examples of exploitation of any unpatched vulnerabilities within older versions of Microsoft Office. Suggestion is the risk remains the same until all devices upgraded or blocked. 17.11.21 - The risk score remains the same. The project will be reviewed again in the operational meeting which takes place on 19.11.21 at which time assurance can be given that the risk has been eliminated from CCG and Primary Care estates. 14.12.2021 - NECS have affirmed the upgrade or removal of all unsupported devices from the NECS managed network. The proposal is to reduce the risk score with this assurance in place, to a probability 1, reducing the overall risk to 4. 12.01.2022 - Given the update in December, **the recommendation is for this risk to be closed, and removed from the risk register.**	1	4	4	1	4	4	2	1	2	Dec-21	Links to Strategy Aims 4	Jan-22	Feb-22	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Ged Connolly-Thompson - Head of Digital Development, Chrissy Tucker - Director of Corporate Delivery
33	21/22	There is a risk to patients on waiting lists as a result of their delays to treatment as a direct result of the COVID 19 pandemic. Provider waiting lists have increased in size and it is likely that it will take significant time to fully recover the position against these.	Quality & Performance	Clinical	4	4	16	• Risk stratification of waiting lists as per national guidance • Work is underway to attempt to control the growth of the waiting lists – via MSK pathways, consultant connect, ophthalmology, reviews of the waiting lists with primary care etc. • Providers are providing clinical reviews and risk stratification for long waiters and prioritising treatment accordingly.	• An assurance group is in place to monitor actions being undertaken to support these patients which reports to PCDB and SQP • Providers are capturing and reporting any clinical harm identified as a result of waits as per their quality assurance processes • An assurance framework has been developed and completed by all providers the results of which will be reported to PCDB • A minimum standard in relation to these patients is being considered by PCDB • Work to control the addition of patients to the waiting lists is ongoing	• Monthly groups are in place with all 4 providers represented • Completion of assurance framework quarterly is undertaken by all providers and reports to PCDB quarterly, and to SQG • Identified harm is reported on STEIS and all providers are monitoring this • A risk stratification tool is being piloted by providers November: Nothing further to add this month. December: Provider Governance processes have been reviewed and strengthened regarding oversight. January: Focus on 104 day cancer waits with planned work to explore harm in more depth.	4	4	16	4	4	16	3	2	6	Feb-22	Links to Strategy Aims 1, 2, 3, 4	Jan-22	Feb-22	Brigid Stacey, Chief Nursing Officer	Alison Cargill Assistant Director of Quality
37	21/22	The Royal College of Physicians identified that there is a risk to the sustainability of the Hyper Acute Stroke Unit at CRHFT and therefore to service provision for the population of North Derbyshire.	Quality & Performance	Clinical	4	5	20	Short term work has been undertaken and assurance re the safety of services has been provided by the Medical and Nursing Director at CRHFT, however the long term sustainability of the service now needs to be addressed. March update: CRH Stroke Service Contingency Plan has been implemented, with sign-off from impacted surrounding trusts (Kings Mill, Hallamshire, UHDB, and Stepping Hill). Short-term mitigations in place to support service continuity, reducing the risk of service suspension and patient divert.	• Locum Consultant cover is in place • Clinical Leadership support is being provided by Liverpool Consultant • Trust to go out for advert to recruit new Stroke Lead consultant & work being done to make advert attractive • CCG , NHSE & System working with Trust Medical Director to contact other organisations and the Stroke Network for support. • Trust reviewing staff daily and escalating as per safer staffing policy as required, including red flag acuity reporting • CRHFT and Integrated Stroke Delivery Network (ISDN) leads to develop service contingency plan to understand internal measures, mutual aid options, and patient divert impact. • SOP to operationalise the contingency plan. • A task and finish group to commence a service review of the HASU, including options appraisal. All options to be reviewed with the aim of providing a sustainable service.	June-21- HASU service review is on-going. The T&F group have agreed to review 4 options that includes: Continuation of HASU with consultant workforce, conveyance and repatriation model, alternative workforce models or closure and conveyance to surrounding trust. Jo Keogh (CRH Divisional Director) is leading the review with support from CCG colleagues. July 21- HASU service review update- 5 options have been identified by the group that include;- 1.HASU provision continues as is delivered by the existing substantive Consultant, locum support and telemedicine. 2.The current HASU service is strengthened by redesign. 3.The Trust introduces a review and convey (drip and ship) model. 4.Decommission the CRH HASU element of the Stroke Service pathway, if workforce sustainability issues cannot be resolved, with either a single HASU provider or multiple providers.5.Review of the CRH HASU as part of a wider East Midlands review to rationalise sites; continuing to provide the service 'as is' at CRH. To support the identification of the preferred option and to provide transparency on decision making, the task and finish group have requested that an outcome matrix and criteria is developed and is to be presented at the August meeting for review. August 21- Workshop to be delivered in Sept 21, to allow all stakeholders to review the options and gain consensus on the preferred service delivery option. CRH are in discussion with Sheffield Teaching Hospitals to develop a joint staffing model for consultants to work across both sites. If agreed the proposal will be added to the consultation options. Sept 21- Workshop has been rescheduled for Oct 21. The workshop will be utilised to enable stakeholders to work-up the options only. The decision on the future service option will be made by an Independent Panel appointed by the CCG. Oct 21- HASU options appraisal workshop to take place on 25th November. CRH are in the process of developing information packs for the workshop and independent panel. CCG are reviewing the independent panel process to be assured by the Governance Committee. It is expected that the independent panel will take place w/c 6th December to review the options and provide recommendations. Expected one month slippage to the programme of work caused by workshop delays. 12/11/21- Independent Panel is now due to meet virtually 13th December. The recommendations identified by the independent panel will be required to be presented to CCG, CRH and wider governance committees throughout Jan 2022. 10/12/21 HASU workshop was delivered on 25/11/21 and all outcomes/ information has been written up in preparation for the Independent Panel on 13th December. For each service option the panel is required to provide recommendations as to whether the option will be shortlisted, discounted, or could proceed for further review subject to caveats. The Clinical Senate has also been approached to undertake a desk top review of the process and outputs. 14/1/21- Independent panel recommend exploring the options of strengthening the HASU service by redesign. The working group will focus on the workforce challenges and consider all possible workforce models and good practice, taking learning from independent panel members. Support will also be sought from the East Midlands and South Yorkshire and Bassetlaw Integrated Stroke Delivery Networks. The working group will be required to develop a plan and provide detail of the service redesign for option 2. The independent panel will then be requested to reconvene and assess the fully worked-up option before the commencement of the implementation phase in March 2022.	3	4	12	3	4	12	3	3	9	Jan-22		Jan-22	Feb-22	Dr Steve Lloyd, Medical Director	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster Head of Strategic Clinical Conditions and Pathways

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

Appendix 2 - Movement during January 2022

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 acuity of attendances is high.	Zara Jones Executive Director of Commissioning Operations	Quality & Performance	Craig Cook Director of Contracting and Performance / Deputy Director of Commissioning Operations Jackie Carlile Catherine Bainbridge, Head of Urgent Care Dan Merrison Senior Performance & Assurance Manager
02	21/22	Changes to the interpretation of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) safeguards, results in greater likelihood of challenge from third parties, which will have an effect on clinical, financial and reputational risks of the CCG	3	4	12	3	4	12	⟺	An LPS implementation group will be established in the New Year to take this work forward across health providers who will become responsible bodies under the new framework.	Brigid Stacey - Chief Nursing Officer	Quality & Performance	Bill Nicol, Head of Adult Safeguarding
03	21/22	TCP unable to maintain and sustain performance, Pace and change required to meet national TCP requirements. The Adult TCP is on recovery trajectory and rated amber with confidence whilst CYP TCP is rated green, main risks to delivery are within market resource and development with workforce provision as the most significant risk for delivery.	5	4	20	5	4	20	⟺	As a system we have demonstrated most progress regionally in achieving completion of red RAG rated reviews	Brigid Stacey - Chief Nursing Officer	Quality & Performance	Helen Hipkiss, Deputy Director of Quality / Phil Sugden, Assistant Director Quality, Community & Mental Health, DCHS
04A	21/22	Contracting: Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care. There are 112 GP practices in Derbyshire all with individual Independent Contracts GMS, PMS, APMS to provide Primary Medical Services to the population of Derbyshire. Six practices are managed by NHS Foundation Trusts and one by an Independent Health Care Provider. The majority of Derbyshire GP practices are small independent businesses which by nature can easily become destabilised if one or more core components of the business become critical or fails. Whilst it is possible to predict and mitigate some factors that may impact on the delivery of care the elements of the unknown and unexpected are key influencing dynamics that can affect quality and care outcomes. Nationally General Practice is experiencing increased pressures which are multi-faceted and include the following areas: *Workforce - recruitment and retention of all staff groups *COVID-19 potential practice closure due to outbreaks *Recruitment of GP Partners *Capacity and Demand *Access *Premises *New contractual arrangements *New Models of Care *Delivery of COVID vaccination programme	4	4	16	4	4	16	⟺	Winter Access funding additional capacity to support urgent appointments is agreed and has commenced end of December / early January.	Dr Steve Lloyd - Medical Director	Primary Care Commissioning	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 +C30	4	5	**20**	4	5	**20**	⟷	Improving Access in General Practice has begun, this will support an increase in appointment capacity.	Dr Steve Lloyd - Medical Director	Primary Care Commissioning	Judy Derricott, Head of Primary Care Quality
05	**21/22**	Wait times for psychological therapies for adults and for children are excessive. For children there are growing waits from assessment to psychological treatment. All services in third sector and in NHS are experiencing significantly higher demand in the context of 75% unmet need (right Care). COVID 19 restrictions in face to face treatment has worsened the position.	4	3	**12**	4	3	**12**	⟷	Emergence of Omicron and impact on workforce capacity has resulted in reduced access to services.	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.	2	3	**6**	2	3	**6**	⟷	On track to agree new contracts.	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.	4	4	**16**	4	4	**16**	⟷	Regarding the Log4Shell vulnerability, the CCG and cyber colleagues from NECS are engaged with the national response programme, delivered by NHSEI, and are in receipt of the national validations and patch requirements.	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 has been reviewed and remains the same as there are additional demands on the system due to winter pressures and the effects of COVID.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Chrissy Tucker - Director of Corporate Delivery / Richard Heaton, Business Resilience Manager

11	**21/22**	Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the CCG to move to a sustainable financial position.	4	4	**16**	4	4	**16**		The score remains the same as while the in-year position now shows a surplus, the underlying recurrent position for both the CCG and the wider system remains very challenging and we are some way from achieving a sustainable system financial 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**		Proposal being taken to MH, LD&ASD and CYP System Delivery Board Finance Sub Committee for use of monies to support delivery of the programme.	Brigid Stacey - Chief Nursing Officer	Quality & Performance	Mick Burrows Director for Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning, Helen Hipkiss, Deputy Director of Quality /Phil Sugden, Assistant Director Quality, Community & Mental Health, DCHS
16	**21/22**	Lack of standardised process in CCG commissioning arrangements. CCG and system may fail to meet statutory duties in S14Z2 of Health and Care Act 2012 and not sufficiently engage patients and the public in service planning and development, including restoration and recovery work arising from the COVID-19 pandemic.	2	4	**8**	2	3	**6**		Engagement Committee has reviewed the risk and ongoing work and determined that the score can be reduced. This reflects the breadth of engagement governance, infrastructure and delivery during 2021/22 that supports greater mitigation of this risk.	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**		Potential savings to be quantified in Q4	Zara Jones, Executive Director of Commissioning Operations	Quality & Performance	Helen Hipkiss, Director of Quality / Dave Stevens, Head of Finance
20	**21/22**	Failure to hold accurate staff files securely may result in Information Governance breaches and inaccurate personal details. Following the merger to Derby and Derbyshire CCG this data is not held consistently across the sites.	3	3	**9**	3	3	**9**		Government advice to work from home wherever possible will temporarily pause project.	Beverley Smith, Director of Corporate Strategy & Development	Governance	Sam Robinson, Service Development Manager
22	**21/22**	The mental health of CCG staff and delivery of CCG priorities could be affected by remote working and physical staff isolation from colleagues.	2	3	**6**	2	3	**6**		Continuation of wellbeing communication and initiatives for staff, including flexible working, social connectivity, exercise classes and maintaining good MSK.	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.	3	4	**12**	3	4	**12**	⟷	Increasing number of redeployments away from the CCG, due to need to increase surge capacity (clinical) and open wards plus ongoing requirements to support the system with the COVID booster and vaccination programme.	Beverley Smith, Director of Corporate Strategy & Development	Governance	Beverley Smith, Director of Corporate Strategy & Development James Lunn, Head of People and Organisational Development
24	**21/22**	Patients deferring seeking medical advice for non COVID issues due to the belief that COVID takes precedence. This may impact on health issues outside of COVID 19, long term conditions, cancer patients etc.	2	3	**6**	2	3	**6**	⟷	The spread of the Omicron COVID-19 variant across our communities has not yet resulted in the increased use of our Intensive Care Services but general admissions to our hospitals with COVID-19 are increasing.	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**	⟷	The North and South Long COVID rehab centres have appointed case managers and assistant practitioners.	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**	⟷	Emergence of Omicron and impact on workforce capacity has resulted in reduced access to services.	Zara Jones, Executive Director of Commissioning Operations	Quality & Performance	Mick Burrows, Director of Commissioning for MH, LD, ASD, and CYP Helen O'Higgins, Head of All Age Mental Health Tracy Lee, Head of Mental Health Clinical Lead
27	**21/22**	Increase in the number of safeguarding referrals linked to self neglect related to those who are not in touch with services. These initially increased immediately following COVID lockdown. The adult safeguarding processes and policy are able to respond to this type of enquiry once an adult at risk has been identified. Numbers are difficult to predict but numbers are predicted to increase as COVID restrictions ease.	4	3	**12**	4	3	**12**	⟷	Safeguarding Adult referrals have increased by 16% over the last Quarter. This was anticipated due to an easing of lockdown restrictions began to take effect.	Brigid Stacey, Chief Nursing Officer	Quality & Performance	Bill Nicol, Head of Adult Safeguarding
32	**21/22**	Risk of exploitation by malevolent third parties If vulnerability is identified within any of the Microsoft Office 2010 applications after October 14th 2020 and not patched, due to support for Microsoft Office 2010 officially ending, after which point Microsoft will cease to issue updates and patches for vulnerabilities found within this suite of applications	1	4	**4**	1	4	**4**	**Risk recommended to be closed.**	NECS have affirmed the upgrade or removal of all unsupported devices from the NECS managed network.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Ged Connolly-Thompson - Head of Digital Development, Chrissy Tucker - Director of Corporate Delivery

33	**21/22**	There is a risk to patients on waiting lists as a result of their delays to treatment as a direct result of the COVID 19 pandemic. Provider waiting lists have increased in size and it is likely that it will take significant time to fully recover the position against these.	4	4	**16**	4	4	**16**		Focus on 104 day cancer waits with planned work to explore harm in more depth.	Brigid Stacey, Chief Nursing Officer	Quality & Performance	Laura Moore, Deputy Chief Nurse
37	**21/22**	The Royal College of Physicians identified that there is a risk to the sustainability of the Hyper Acute Stroke Unit at CRHFT and therefore to service provision for the population of North Derbyshire.	3	4	**12**	3	4	**12**		Independent panel recommend exploring the options of strengthening the HASU service by redesign.	Dr Steve Lloyd, Medical Director	Quality & Performance	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster Head of Strategic Clinical Conditions and Pathways
38	**21/22**	The quality of care could be impacted by patients not receiving a care needs review in a timely way as a result of the COVID pandemic and the requirement for some of the Midland and Lancashire Commissioning Support Unit (MLCSU) Individual Patient Activity /Continuing Health Care (CHC) services to redirect service delivery to support system wide pressures. This has had an impact on core CHC and Funded Nursing Care (FNC) service delivery in relation to care needs reviews.	3	2	**6**	3	2	**6**	**Risk recommended to be closed.**	Risk recommended to be closed.	Brigid Stacey Chief Nursing Officer	Quality & Performance	Nicola MacPhail Assistant Director of Quality
40	**21/22**	In the period of transition from CCG to ICS, it is likely that a larger proportion of contracts will be extended on expiry rather than reprocured. The CCG is advised by Arden & GEM CSU on best practice for our procurement activity, but in some circumstances, the CCG may decide to proceed against best practice in order to give sufficient time for review of services within the framework of movement to an ICS. Proceeding against advice, carries a small risk of challenge from any providers who may have felt excluded from the process.	2	3	**6**	2	3	**6**		The new provider selection regime has not yet come into force.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Chrissy Tucker - Director of Corporate Delivery
42	**21/22**	If the CCG does not prioritise the importance of climate change it will have a negative impact on its requirement to meet the NHS's Net Carbon Zero targets and improve health and patient care and reducing health inequalities and build a more resilient healthcare system that understands and responds to the direct and indirect threats posed by climate change.	4	3	**12**	4	3	**12**		Derbyshire ICS Green Plan in development.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Suzanne Pickering - Head of Governance

Derby and Derbyshire
Clinical Commissioning Group

MINUTES OF DERBY AND DERBYSHIRE CCG AUDIT COMMITTEE
HELD ON 18 NOVEMBER 2021

VIA MS TEAMS AT 9.30AM

Present:

Ian Gibbard	Lay Member (Audit) Chair
Andrew Middleton	Lay Member (Finance)
Jill Dentith	Lay Member (Governance)

In Attendance:

Richard Chapman	Chief Finance Officer (part)
Andrew Cardoza	Director, KPMG
Liam Daley	Finance Graduate Placement, DDCCG (Observer)
Christopher Dean	Audit Manager, KPMG
Debbie Donaldson	EA to Chief Finance Officer (minute taker)
Darran Green	Associate Chief Finance Officer
Sean McGrath	Trainee, KPMG (Observer)
Frances Palmer	Corporate Governance Manager
Suzanne Pickering	Head of Governance
Kevin Watkins	Business Associate, 360 Assurance

Apologies:

Helen Dillistone	Executive Director of Corporate Strategy and Delivery
Chrissy Tucker	Director of Corporate Delivery

Item No	Item	Action
AC/2021/423	**Welcome and Apologies** The Chair welcomed members to the Derby and Derbyshire Audit Committee. Apologies were received from Helen Dillistone and Chrissy Tucker.	
AC/2021/424	**Declarations of Interest** The Chair reminded Committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG.	

	Declarations made by members of the Derby and Derbyshire Audit Committee were listed in the CCG's Register of Interests and included with the meeting papers. The Register was also available either via the Corporate Secretary to the Governing Body or the CCG's website at the following link: www.derbyandderbyshireccg.nhs.uk Declarations of interest from today's meeting There were no declarations of interest made. The Chair declared that the meeting was quorate.	
AC/2021/425	**Minutes of the Derby and Derbyshire Audit Committee held on 16 September 2021** The Minutes of the Derby and Derbyshire Audit Committee held on 16 September 2021 were presented. **The Minutes from the Derby and Derbyshire Audit Committee held on 16 September 2021 were agreed and signed by the Chair.**	
AC/2021/426	**Matters Arising Matrix** The Matters Arising Matrix was reviewed and updated. There were no further matters arising.	
AC/2021/427	**External Audit Health Sector Update – November 2021** Andrew Cardoza introduced Chris Dean, Audit Manager, and Sean McGrath, trainee, from KPMG. It was noted that Chris Dean had taken over from Richard Walton and Sean McGrath would be observing this Committee. Andrew Cardoza presented the Health Sector update for November 2021 and highlighted the following: • Page 2 of the report concentrated on the main technical issues currently having an impact on the health sector. • Better Care Fund (BCF) planning requirements 2021-22 – the need to become familiar with the policy framework to ensure compliance with the BCF plans. • BCF plans had to be submitted by 16 November 2021; Darran Green confirmed that the BCF plan had been submitted on time. The Chair reported that the plan had not been submitted to Finance Committee. Darran Green agreed to check the governance process for this plan and report back to Committee. • NHSI had released detail on the finance and contracting arrangements for 1 October 2021 – 31 March 2022 (H2 2021/22). The document outlined additional information or	DG

	changes from the H1 regime and should be read alongside the previously published H1 2021/22 guidance. • NHS/I had released detail on updated planning guidance for H2 2020/21, as well as an accompanying submission guidance, to provide further detailed policy and technical information to enable ICSs and their constituent organisations to develop and agree operational plans for the second half of 2021/22. • The government had agreed an overall financial settlement for the NHS for the second half of the year which provided £5.4bn bn funding (which included £1bn revenue and £500m capital) to support the continued recovery for elective services. • System and Providers to work with their regional NHSE/I to rapidly develop and submit by 14 October elective recovery and capacity plans for H2. A proposed shortlist of investments for the TIF that could be delivered in year and submit a final set of plans covering H2 by 16 November 2021 using the templates issued and covering key actions set out in the document. • Provider financial planning templates were due by 25 November 2021. • Fair pay disclosures had changed from previous years to bring the disclosures in line with changes to the HM Treasury 2021-22 Financial Reporting Manual. • Andrew Cardoza had met with Richard Chapman and Darran Green to discuss the things that would be reviewed in the accounts audit/VFM work this year. Work would also include Integrated Care Partnership and how it was being progressed. • Page 14 Healthcare CEO Future Pulse Report link was included for information. • Andrew Middleton asked whether there was flexibility and time in the Audit Plan for BCF governance, accountability, and expenditure to be reviewed. • Kevin Watkins reported that BCF had been reviewed in the past when they were launched, but it had been many years ago, back in PCT days. • Andrew Middleton requested that Darran Green and Richard Chapman give some thought for a deep dive on BCF by Finance Committee, and whether it should be included within the Audit Plan for Audit Committee. • The Chair asked Darran Green to include BCF on the Finance Committee forward planner in order that members could review the submission, even if it was retrospectively. • Jill Dentith referred to 2022-23 and the impact of Glossop being amalgamated within Derbyshire. She requested assurance from Darran Green that work was being undertaken to ensure the smooth transition of Glossop into the Derby and Derbyshire ICB. • Darran Green reported that work was being undertaken to look at all aspects of the transfer of Glossop into the ICB and we were also working with NHSE/I around some of the technical issues. Glossop had a population of around 35k across 6 general practices but had no fixed assets. It was noted that working groups were meeting on a regular basis to work through the details.	DG/RC

	• It was noted that KPMG were also picking this up as part of this year's audit in preparation for the External Auditors, whomever they may be, going forwards. **The Audit Committee NOTED the External Audit Health Sector Update – November 2021 from KPMG.**	
AC/2021/428	**Internal Audit Progress Report** Kevin Watkins reported that 360 Assurance provided Internal Audit services to many NHS organisations, and he was responsible for providing those services to Derbyshire and Nottinghamshire CCGs. Kevin Watkins reported that since the last Audit Committee meeting 360 Assurance had: • Issued the final report for Primary Medical Care Services – Finance Arrangements. • Joined the CCG's Transition Project Group in an assurance and advisory role. • Commenced fieldwork on the General Ledger and Key Financial Systems, Benchmarking s117, CHC and Prescribing Spend and ICS Transformation and Efficiency reviews. • Drafted Terms of Reference for a review of arrangements for developing the ICS People Management function. • Kevin Watkins had met with the Audit Committee Chair, the Chief Finance Officer and the Associate Chief Finance Officer to discuss the impact of the ongoing pandemic and the CCG's transition to the ICB, and on the content and delivery of the Internal Audit Plan. Following the outcome of this meeting several adjustments to the Plan were being proposed for the Audit Committee's approval. • 360 Assurance had undertaken follow-up work in response to updates provided by Management in respect of the implementation of actions. • Everything that 360 Assurance had done so far in terms of the follow up work and the reports that had been issued, and the first stage of the head of internal opinion work was showing a positive outcome for the CCG. If that continued that would support the overall Head of Internal Audit Opinion. • It was noted that it had been a very challenging time for the CCG and its staff, as it dealt not only with the ongoing situation with Covid but preparing to shut down one organisation and open another. This had had an impact on the Internal Audit Plan as had been anticipated at the beginning of the year. A level of flexibility had been maintained and in recent discussions, one or two proposals had been suggested. • Primary Care Networks Review – Given the ongoing pressures within primary care, it was proposed that this audit be removed from the Plan. 360 Assurance had been involved in ongoing discussions with the CCG agreeing a secondment of its PPV officer to the CCG to support one of the vaccination teams and	

	it was proposed that time in the Plan for this audit be utilised to partly fund the secondment. Depending on how long the secondment lasted for, the role may be further funded from available resource in the Contingency/Emerging Risks line in the Plan. • Investments/Disinvestments – 360 Assurance were undertaking a review of Transformation & Efficiency Planning within JUCD which would be examining similar areas to the original proposal for this audit. It was proposed that this allocation would now be used to undertake an assurance review of the CCG's compliance with adjustments it made to its financial decision-making arrangements. • Data Quality & Performance Management Framework – The potential for using this allocation to undertake a review of waiting list coding was currently being explored. • ICS Transition Programme Assurance – 360 Assurance were attending the CCG's Transition Project Group and would use their presence on this Group to support delivery of the requirements in the CCG Transition to ICB Due Diligence checklist relating to Internal Audit. The CCG had also requested their involvement in the Project Board being set up with SBS to create a new ledger, using data from the legacy ledgers by the go-live data of 1st April 2022, and carry out a controlled closure of the legacy CCG ledger. • 360 Assurance would also be using this role to monitor the CCG's progress in completing the tasks contained within the CCG Closedown and Establishment of ICB Due Diligence checklist issued by NHSE. • 360 Assurance were continuing to liaise with the JUCD Workforce and OD Lead with the objective of agreeing a Terms of Reference for an exercise that could support ongoing work to develop the ICS People Management function. • Jill Dentith felt this would be helpful to ensure that the CCG had this kind of input from 360 Assurance; it was a significant piece of work. • Jill Dentith referred to page 51 of the pack and the item on Liberty Protection Safeguard and asked whether this was in the pipeline or had it been confirmed, and if so, what were the timescales. • Kevin Watkins reported that this was still in the pipeline but was expected to come into force on 1 April 2022. A lot of preparatory work was being undertaken, and there was a link to the website on that page which explained a bit more about what was being done. • Jill Dentith asked what the impact would be on the ICB. Kevin Watkins reported that he would have to come back to her on that when he had spoken to their expert Elaine Dower. • The Chair reported that Audit Committee had been invited to discuss and approve the changes to the Internal Audit Plan. The Chair had already had an opportunity to consider that with Richard Chapman and Darren Green. The Chair highlighted the pressure that had come onto our primary care colleagues due	KW

	to Covid, and we had to respect that we could not possibly begin to start adding to their current workload, and therefore we needed to stand back from some of this Audit work. • In terms of how that resource was used, initially there was some work that we could do, around the way that we had managed some of the change financial arrangements that had to be put in place this year. It was noted that the Chair was very keen to see that and so he very much supported these changes. • These changes had been set out in Appendix B in the Terms of Reference for the General Ledger and Key Financial Systems. • The Chair asked whether KPMG wanted any additional assurance work to be undertaken by 360 Assurance in the Internal Audit Plan. Andrew Cardoza thanked the Chair but reported that sadly it would not reduce their workload, as from KPMG's risk point of view it had to be their work that they relied upon. • 360 Assurance had been tasked with looking at some of these new areas including waiting list coding, and the Chair asked whether 360 Assurance could, by January Audit Committee, give us a better understanding of how this work could be finished in Q4? • Kevin Watkins felt sure that he would have identified whether this could be completed but hoped at least to have a TOR developed by then. • Andrew Middleton referred to the new Data Intelligence Unit, headed by Craig Cooke, and asked whether the data intelligence unit would fall under the remit of 360 Assurance's ICB scoping work? He felt that this may need guidance and assurance from 360 Assurance or others. • Kevin Watkins felt it would be a good idea to get some assurance around it and confirmed that indirectly it was within 360 Assurance's work; they were currently doing a piece of work on Maria Riley's transition and efficiency programme and this may then interface with the Data Intelligence Unit. • It was noted that the Chair, Jill Dentith and Andrew Middleton supported the changes as proposed to the Internal Audit Plan. **Audit Committee NOTED the 360 Assurance Progress Report and APPROVED the changes set out to the Internal Audit Plan.** **Primary Medical Care Arrangements** Kevin Watkins presented the Primary Medical Care Arrangements report and highlighted that: • 2021/22 Internal Audit Plan included an allocation of time to undertake a review of primary medical care commissioning and contracting in accordance with an Internal Audit Framework issued by NHS England (NHSE). • This framework sets out the requirement for independent assessments to be undertaken across four domains, on a cyclical basis, by March 2022, the four domains being as follows:	

	• Commissioning and Procurement of Services • Contract Oversight and Management Functions • Primary Care Finance • Governance (common to each of the above areas). • It was agreed with the CCG that the Internal Audit focus for 2021/22 would be on primary care finance. 360 Assurance also completed tests deferred from 2020/21 on contract management and oversight arrangements. • The CCG achieved Significant Assurance that we had appropriate arrangements in place for setting budgets and forecasts for delegated co-commissioning. Financial reports were presented to PCCC each month and there had been evidence of scrutiny and challenge. It was noted that finance staff meet regularly with the Assistant Director of GP Commissioning and Development and the budget report was signed off by the Medical Director. • It was also confirmed that appropriate arrangements were in place within the Primary Care Contracts Team reflecting that many of the duties previously undertaken by NHSE through the General Medical Advisory Support Team (GMAST) had now transitioned to the CCG. No recommendations had been made. • Jill Dentith was pleased that we had got full assurance and wanted to thank the team who had done the work. • In terms of moving forward Jill Dentith felt that it gave us a firm foundation on which to build. **The Audit Committee NOTED the Significant Assurance achieved for the Primary Medical Care Arrangements report.**	
AC/2021/429	**Finance Report** Darran Green gave a verbal finance report and highlighted the following: • M7 position had been finalised, but not yet reported to Finance Committee. • In line with NHSE/I guidance, planning for H2 had not been completed for M7 reporting. • There was no variance analysis in terms of YTD position. • The FOT was in line with plan. • The CCG and System were submitting their H2 plans today. They had gone through Extraordinary Governing Body meeting and were approved on Monday. • There was risk within the plan, it did require efficiencies to be delivered both within the CCG and our System partners. • We were confident of delivering both the System and CCG plan for H2 and for the overall financial year 2021-22. This would be covered through some non-recurrent mitigations which were being worked through now. • Due to the timing of the H2 plan, detailed delegated budgets that would normally be signed off by Executive Directors around the time of that submission, had not been completed. A paper would	

	be going to Finance Committee next week explaining that in more detail. • But signed off budgets would hopefully go to Finance Committee in December for approval. • Richard Chapman was currently attending the JUCD meeting as we speak, and he would be challenging the Board members in terms of now we had submitted that plan, what would that now mean for the System. What were those risks and mitigations, and what were the next steps? • The Chair reported that he would revert those questions to Finance Committee next week. **The Audit Committee NOTED the verbal Finance Report.**	
AC/2021/430	**IFRS16 Report** Darran Green presented the IFRS16 report and highlighted the following: • The deferred IFRS16 would come into force on 1 April 2022. • The CCG had done some good preparatory work and had been ready for IFRS16 for the last couple of years; it had been national guidance that had delayed its implementation. • Operating leases would now be accounted for on the balance sheet. • Any new operating leases would have to be approved through some kind of capital business planning and this would probably be at a System and ICB level. • Financial Control Team had been working with, and training CCG Managers, and working with the Contracts Oversight Group. • New processes had been put in place together with a new asset review form and we had updated the Capital Accounting Policy. • We were working with KPMG to gain their assurance over our readiness to transition to IFRS16. • Jill Dentith reported that this had been an excellent paper and asked for an update with regard to the Glossop amalgamation and IFRS16. • Darran Green reported that the CCG had spoken to Glossop about what work they had been doing with regard to IFRS16. It was noted that they were quite a small CCG who outsourced a lot of their activities, and their initial answer was that they would not be transferring anything to us that would impact on IFRS16. But the CCG would be doing a piece of work with them after Christmas to confirm that. • The Chair asked Darran Green to expand on the capital business plan, what were the timescales that we would have to work to in order to get approval of those leases that were now going to form part of our capital spend? • Darran Green reported a lot of work was being done with Senior Managers within the CCG to ensure that when they were contracting a service or doing something that would fall within the remit of IFRS16 that we had early sight of that and then we put that through a system capital programme. It was not	

	something that the CCG particularly gets involved in now, the vast majority of assets were held by providers and the CCG had very little assets other than assets held for IT equipment. We were working closely with Aaron Gillott, Finance Lead for the System (UHDB) to keep him informed of any new assets that may come on board. • The Chair asked Andrew Cardoza's view as to whether there were any estimating uncertainties facing the CCG. • Andrew Cardoza reported that IFRS16 was something that KPMG and the CCG had been working on for several years. He reported that he did not see any particular issues in terms of how this was going to be accounted for; he confirmed that there was nothing that worried him at this moment in time. It was noted that there was a lot of checking that had to be done in terms of making sure that every single lease was covered, etc. We needed to ensure that Glossop had done the same and that would be part of the Audit work that KPMG would do. • Andrew Cardoza reported that Darran Green's paper presented today had been one of the better reports he had seen regarding IFRS16. • Andrew Middleton reported that SFEC had not had a discussion regarding IFRS16/leased premises. He asked Darran Green to put it on a check list for Richard Chapman as lead for System Finance, as SFEC had not turned its lens on this yet and would need to before April 2022. • The Chair felt that there had been some excellent material contained within this report and the CCG should be congratulated for the quality of work they had put into it. • The Chair understood that the next steps would be an IFRS16 2022-23 impact forecast due in January 2022, and asked what the route was for that? Was any oversight required from Audit Committee? Was that something which we were on schedule to produce? • Darran Green reported that the intention was to take it through CCG Finance (or SFEC as it would be then) but would be happy to bring it back to Audit Committee as well. By taking it to SFEC, this may prompt the wider conversation that Andrew Middleton was looking for as to how IFRS 16 would affect the wider System and not just the CCG. **Audit Committee NOTED the IFRS16 Update.**	DG
AC/2021/431	**Aged Debt Report** Darran Green presented the aged debt report and highlighted the following: • Darran Green apologised for the error spotted in last months report in terms of the zeros after the £ sign, which had crept into this report again. He agreed to remind colleagues to remove/amend that. • The report was a similar profile to the previous report presented to the last Audit Committee.	

	• It was noted that the debt with Astra Zeneca was quite old and Darran Green was personally keeping an eye on how we were dealing with that. This invoice was not related to Covid activity. • There had been a concentrated effort from January to clear as many of the debts and credit note balances in anticipation of transitioning into the ICB next year. • In terms of some of the old debts, they were generally salary overpayments where people had got agreement to pay those over a considerable period. • The Chair reported that in terms of an aged debt report, this had been something of an improvement from those previously presented. It was noted that the Chair, as a result, did not have any major concerns to voice. **Audit Committee NOTED the Aged Debt position.**	
AC/2021/432	**Single Tender Waivers** Darran Green presented the Single Tender Waiver (STW) report and highlighted the following: • There was still a significant number of single tender waiver's going through. But he felt this was as a result of the increased surveillance from the Financial Control Team. • In the past some of these STWs could possibly have previously been unreported. • There were several STWs on the list for individual packages of care. These were things that we had been doing for many, many years now, but perhaps had not previously been reported as such. • All had been approved by the Richard Chapman, and several have gone through a confirm and challenge process by the CCG's senior leadership team. • The Chair reported that he had always had a concern about the STW process for individual packages of care; there were some quite sizable sums involved. • The Chair reported that there was always concern that these should be seen as STWs, where we were simply anointing an external provider for quite expensive individual care packages; but he felt that it was helpful to have these presented to the Audit Committee. He went on to add that he did not have a particular concern about them, as in many of these cases it would not be appropriate to put them out to tender either, in terms of the needs of the patient, or in terms of the value for money for the taxpayers. • Andrew Middleton expressed his concerns regarding these very expensive complex packages of care, but we needed to focus on safe and effective packages of care for patients; it was not uncommon to be faced with packages of £10k/week, or recently a case of £35k/week. Unfortunately, Derbyshire did not always have capacity through its Mental Health Provider to accommodate these patients. This would be an urgent issue for the ICB going forwards; the cohort of demand was rising, getting more complex and more expensive.	

	• The Chair asked whether the STW spreadsheet could include an indication of the governance decision route taken, eg CLCC, CFI Panel or Executive Officers in order to understand the oversight process. Darran Green agreed to ensure that this information was included. **Audit Committee NOTED the report on Single Tender Waivers approved by the Chief Finance Officer.**	DG
AC/2021/433	**Freedom to Speak Up Report** Jill Denith presented the verbal Freedom to Speak Up Report and highlighted the following: • In August there had been an item on Team Talk about Freedom to Speak Up guardian role. • At that meeting it was announced that we needed 3 volunteers to fill the posts of freedom to speak up ambassador roles to act as a bridge between staff and the guardian role. • It was noted that the 3 volunteers across a range of disciplines had commenced in their roles in September and had been working well with the support of Rachel Brentnall in HR. • It was noted that during the period August to October the guardian and ambassadors had been contacted by six members of staff with issues around bullying, and inappropriate use of language in a racial context. • Concerns had also been raised with regards to, managing long term sickness and how that impacted on the team, feedback on work completed which was felt to be inappropriate, and or offensive, and a perceived lack of not upholding the organisations values. • The people who had been accessing the service had been really appreciative of the time and support given by their colleagues. • Jill Dentith had reported to Governance Committee that when we looked at the role of the ambassadors, these were not people who are going to solve the problems for individuals. They were about signposting and providing support; it was really important that we made that clear, because we did not want to burden these volunteers with issues that they were not formally trained to handle. They were trained to manage a process, but not to manage individual cases, • There was learning from the feedback received, and some of the issues seemed to have been magnified because of remote working. • Remote working had been fantastic in some respects and we would not have been able to function for the past 12-18 months without it. But unfortunately, it had impacted adversely on some individuals and the conversation had been a bit more stilted. • It was much harder to have that sort of corridor conversation or a conversation over a cup of coffee when you were doing it online or over emails. It was felt that this perhaps had compounded some the specifics.	

	• Jill Dentith reported that we were obviously doing some learning from this and providing additional support to the ambassadors, and we were going to meet up monthly and touch base. • We were looking at providing some training for staff on reflective practice and looking at how positive feedback could be given, and also improving signposting for staff. • Jill Dentith reported that this had been the first time we have had staff contacting us and wanting some help and support. • The Chair expressed his concern at some of the quite serious issues coming through. Jill Dentith assured the Chair that the concerns raised would be pursued through formal routes where necessary. • Andrew Middleton highlighted two training modules on the NHS mandatory training list which the ambassadors may find useful, each one only 30 minutes long; he had found them to be very informative. Jill Dentith confirmed that the ambassadors had completed these packages. **Audit Committee NOTED the update from the Freedom to Speak Up Guardian and was reassured by the appointment of the three ambassadors. The Committee looked forward to getting further updates in terms of the process and the extent to which these were being managed.**	
AC/2021/434	**National Audit Office Guide on Climate Change Risk Assessment** Suzanne Pickering presented the National Audit Office Guide on Climate Change Risk Assessment and highlighted the following: • The guidance was attached for information to the agenda papers. • The National Audit Office had produced a good practice guide for climate change risk for Audit and Risk Committees as attached at Appendix 1. • Audit and Risk Assurance Committees (ARACs) play a key role in supporting and advising the Board and Accounting Officers in their responsibilities over risk management. • The guide included a checklist for Audit Committees to complete a risk assessment of questions to ask on their readiness for climate change and the management of climate change risks. • Appendix 2 detailed the checklist and risk RAG rating for the organisation. • We had arrangements in place in terms of governance through the NHSE Midlands Greener Board, which Helen Dillistone was the senior responsible officer/net zero lead. • We had a Derbyshire ICS Greener Delivery Group which meets bimonthly, and members of that group were the sustainable leads across the Derbyshire providers. • Everything was in progress, and in terms of the nature of the work, it was starting to gain pace. • Individual Trusts were finalising their Green plans. • Andrew Middleton felt that progress had been good, but a component of this would be a flexible smarter staff working	

	policy. He asked how developed the CCG's hybrid working policy was? • It was noted that the Red Rag Rating in the report indicated things were already in place, not that they were outstanding. • Suzanne Pickering reported that the CCG had a flexible working/hybrid policy standard operating procedure in place (SOP). In terms of a smarter policy this would be developed with HR colleagues over the coming months. • This would also need completing for a System workforce going forwards. • It was noted that we had appointed some consultants to work closely with the CCG and Derbyshire providers to develop the Derbyshire ICB Green Plan. It was hoped that this would be ready go through individual governance arrangements by January, in time to be put forward to shadow Committees in February, and through for approval to ICS Shadow Board in March. This would be implemented once the reorganisation was settled from 1 April 2022. • It was noted that a full risk assessment would be taken through the CCG's Governing Body and we would be identifying a risk through the CCG's Risk Register and the ICS Risk Register. • The Chair reported that we were required to put something into the financial impact statement at the end of the year, did we have a process for this? • Andrew Cardoza reported that it was just a narrative to begin with, but it would get more complicated when you started to have to prove and evidence the way you were reducing your carbon footprint, etc. • The Chair thanked Suzanne Pickering for this very comprehensive report. **The Audit Committee NOTED the NAO Good Practice Guide and completed risk assessment checklist for assurance.**	
AC/2021/435	**National Audit Office Guide on Cyber Security - October 2021** Suzanne Pickering presented the update from the National Audit Office on Cyber Security for October 2021 and highlighted the following: • The guidance was attached to the agenda papers for information. • The guidance had included several key lines of enquiry, and a number of recommended areas for review. These had been considered by the Head of Governance and the Head of Digital Development, supported by the Information Standards Lead, and an initial view report provided for assurance for Audit Committee, pending a formal report to go to Information Governance Assurance Forum in January 2022. • The check list started on page 235 of the pack. Most of the 39 questions had either been marked green or in progress. Question 31 on engagement and training had been referred to the NECs CSU, as we had commissioned this from them, in order to obtain more clarity.	

	• The Chair was happy that NECs CSU were providing a cyber security service but highlighted that at year end they did not provide a SAR for their practice. There was an action outstanding from the finance team/Chrissy Tucker to request a Service Auditor Report (SAR) from them. • It was noted that Governance Committee had also picked this issue up. • Going forwards we were not sure what this model would look like; currently we could choose our IT/cyber security provider, but this may not be the case going forwards, we may have to go to our local CSU for this service. There was an element of uncertainty in the not-too-distant future; this was a potential risk but hopefully not a significant one. • Suzanne Pickering reported that the Cyber Security report would go through the CCG Information Governance Assurance Forum in terms of the ongoing work, and she would then report any progress back to the Audit Committee. **The Audit Committee NOTED the NAO Good practice guide for Cyber and information security, with a completed risk assessment checklist for assurance.**	
AC/2021/436	**GBAF 2021/22 Quarter 2** Suzanne Pickering presented the Governing Body Assurance Framework (GBAF) and reported that the following strategic risks had decreased in risk score during Q2, July to September 2021: **Strategic Risk 7:** CCG staff retention and morale during the transition will be adversely impacted due to uncertainty of process and implications of the transfer to the ICS, despite the NHSEI continuity of employment promise. The responsible Committee was the Governance Committee. The risk score has decreased from a high 8 to a moderate 6. The reduction in score is due to the HR Framework being published by NHSEI and the various HR Briefings and Health and Wellbeing sessions offered to all staff in the transition to the Integrated Care Board. **Strategic Risk 8:** If the CCG is not ready to transfer its functions or has failed to comprehensively and legally close the organisation, or if the system is not ready to receive the functions of the CCG, the ICS operating model cannot be fully established. The responsible Committee was the Governance Committee. The risk score had reduced from a very high 20 to a very high 16. The reduction in score was due to the various documents being published to support the close of the CCG and due diligence and readiness to operate as an Integrated Care Board. The corporate committees responsible for their assigned strategic risks had scrutinised and approved their GBAF Strategic Risks at their committee meetings held during July to September 2021.	

	The GBAF Q2 could be found at Appendix 1 to this report and updates to the strategic risk extract documents were detailed in red text. The GBAF was presented and agreed by the Governing Body on the 7th October 2021. It was noted that Q3 GBAF would be presented to Governing Body in January 2022. The following questions were raised: • Andrew Middleton referred to Risk 7 staff retention, and asked whether the CCG had seen an increase in staff leaving the CCG now that we were going into a transition stage? • Suzanne Pickering reported that the CCG had experienced some leavers over recent months, but mostly for promotions. The staff survey closes on 26 November and further feedback on morale and long-term sickness etc would be gained from this and compared to last year's results. • Jill Dentith reported that Governance Committee had received the Q2 GBAF but had also received a verbal update regarding staff retention, and it appeared that we were starting to move in an adverse direction, but this would be monitored over the next couple of months. • The Chair reported that with regard to the GBAF, there had always been a recognition of the pressure on the System arising from Covid, which was making it impossible for us to achieve our normal constitutional targets. He asked whether we had the right profile in terms of our strategic risks? In terms of our patients there was a huge issue around our ability going forward over the winter as to whether we could maintain a sustainable health system; he felt this was something that Governing Body should be looking at. We were in unprecedented times and he was concerned that the risk profile did not entirely reflect how far the CCG was under stretch over the last few months. • Suzanne Pickering responded that as we moved into the final quarter of the CCG, and into the shadow committees and shadow ICB board, the transfer of these strategic risks and into an ICB GBAF would all need to be in place by January (Q4). The Chair and Chief Executive Officer for the ICB were now in place and things were gaining pace. • Strategic Objectives were being set for the ICB. • Jill Dentith reported from a PCCC perspective, in relation to the GBAF and the risk register and the capacity within primary care to deliver on some of these targets. We were keeping a watchful eye over this and there had been conversations about whether we needed to increase that score. They were at the higher end anyway, but it was felt, at this point in time, it was not appropriate to do that, so as assurance for this committee, those conversations were taking place in the relevant forums. • Andrew Middleton agreed that this Committee had received assurance on CCG staffing, retention, and morale and that it was being monitored very closely. We also got very detailed reports on financial wellbeing and soundness every month at Finance Committee, but the reason we were not delivering on so many constitutional targets was not because we did not	

	have the money, it was because we had not got the staff. He asked why we were not getting monthly people reports? We were struggling to get staff at all grades and levels; the Board would need to focus on workforce as vigorously as it did finance. • Richard Chapman responded to this comment, he felt the logical process was that finance was a function of capacity and workforce was a constituent part of capacity. But from a business perspective, if we did not train and retain, then we would not have the capacity to meet the demand that was coming through. He added that as we started to incorporate proper capacity planning into the future financial plans, the risk to the delivery of that capacity was our workforce plan and that was how we needed to incorporate it systematically going forward. **The Audit Committee RECEIVED and NOTED the 2021/22 Quarter 2 (July to September 2021) Governing Body Assurance Framework.**	
AC/2021/437	**Risk Report** Suzanne Pickering presented the Risk Report and highlighted the following: • There were 6 very high risks on the Risk Register and detailed within the report. • Risk 9 was decreased in September to a moderate 6. • Risks 38 and 40 were decreased in October. • Risk 30 had been closed and transferred to the ICB Risk Register. • Risk 14 had been closed in October by Quality and Performance Committee and reported through Governing Body. • It was noted that the Transition Assurance Committee had its own Risk Register and was fully integrated with Audit Committee's view here. • The Chair reported that there were some outstanding issues on that Risk Register but were gradually being cleared. There was a very clear process for appointing the Board, and it would be in place in due course, 360 Assurance were overseeing that process. **The Audit Committee RECEIVED and NOTED:** • **The Risk Register Report** • **Appendix 1 as a reflection of the risks facing the organisation as at 31st October 2021; and** • **Appendix 2 which summarised the movement of all risks during October 2021.**	

AC/2021/438	**Committee Meeting Business Log** Frances Palmer presented the Committee Meeting Log which summarised discussions and approved items at the following NHS Derby and Derbyshire CCG's committees, that have been formally ratified and not yet presented to the Audit Committee: • Clinical & Lay Commissioning Committee • Engagement Committee • Finance Committee • Governance Committee (Confidential & Public) • Primary Care Commissioning Committee (Confidential & Public) • Quality and Performance Committee **Audit Committee NOTED the NHS Derby and Derbyshire CCG's Committee Meeting Log.** The Chair asked whether it would be possible for the Committee Logs to have a more standardised presentation. Frances Palmer agreed to arrange this.	FP
AC/2021/439	**Conflicts of Interest Update** Frances Palmer presented the Conflicts of Interest (COI) Update and highlighted the following: • We had distributed COI forms for this financial year to all CCG employees and the response rate had continued to be positive. At the last meeting it was reported that we had received 74% of forms back, we were now up to 99%. There were only 6 forms outstanding. • Line Managers of those 6 were to be contacted in order to make staff aware that the forms were required back by end of November 2021. • As at 17th of November, the COI training was still at 93%. Line managers were being emailed where outstanding training for employees had gone past the three months mark. • An update had been prepared for the CCG membership bulletin for GPs who undertake work on behalf of the CCG or attend CCG meetings to ensure that their COI was still up to date. • Frances Palmer asked Committee whether they would find it beneficial to receive a register of interests for CCG employees who were not classed as decision makers. • The Chair felt that we had some very rigorous procedures within the CCG, and he was very keen to make sure that those did transfer across to the ICB. But for the purpose of this Committee, it was felt that this was not required. • Frances Palmer reported that the managing conflicts of interest policies were integrated with the standards of business conduct currently, and these were having to be separated and it was hoped that they would be approved prior to the ICB establishment. No guidance had yet been received from NHSEI about managing conflicts of interest in the ICS.	

	• Frances Palmer reported she was doing some work for System Delivery Boards around how they were being documented and managed; she hoped to be able to meet with the PA's who facilitated those meetings to understand how COIs were managed at meetings. **Audit Committee NOTED the Conflicts of Interest Update Report.**	
AC/2021/440	**Any Other Business** Suzanne Pickering reported that we needed to call an Extraordinary Audit Committee meeting on 17 December to review a due diligence report. NHSE had requested that the CCG submit some draft evidence in line with the readiness to operate statement and Helen Dillistone wanted to ensure that Audit Committee members were fully sighted on the information that was going to be submitted. Suzanne Pickering agreed to email Audit Committee members further details prior to the meeting to ensure that members were fully sighted on what was required. There was no further business.	SP
AC/2021/441	**Forward Planner** The Chair requested a review of accruals be added to the forward planner for January 2022. Darran Green reminded members that at the last Audit Committee meeting a report was presented explaining some of the work the Finance Team were doing on accruals: • It was explained that the finance team had put this process in place previously at Months 4, 8 and 12 where we adjust the journal limits so that journals of significant values over £100k could only be authorised by Richard Chapman, Niki Bridge or Darran Green; this provided an additional confirm and challenge to those. • This had been brought about because of a comment made by KPMG around the fluctuating levels of accruals made throughout the year. • Every month, because of the suggestions made by KPMG, a process was undertaken where Georgina Mills and Darran Green reviewed all the accruals that had been done, and compared them to the previous month, the previous quarter, and that particular month the previous year. This was analysed and recorded as an audit trail. As a result, we would then be able to fully understand why we had accrued for a different amount from one month to the next. Darran Green agreed to bring an Accruals update paper to January Audit Committee, and report on the learning received from the process described above.	DG

	Audit Committee NOTED the Forward Plan.	
AC/2021/442	**Assurance Questions** 1. Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance processes? Yes. 2. Were the papers presented to the Committee of an appropriate professional standard, did they incorporate a detailed report with sufficient factual information and clear recommendations? Yes. 3. Were papers that have already been reported on at another committee presented to you in a summary form? Some were. 4. Was the content of the papers suitable and appropriate for the public domain? Not entirely. 5. Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow Committee members to review the papers for assurance purposes? Yes. 6. Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? Yes, a deep dive on the Better Care Fund (BCF) for Finance Committee – Darran Green/Richard Chapman to arrange. 7. What recommendations does the Committee want to make to the Governing Body following the assurance process at today's Committee meeting? Governing Body would be supplied with a standard Assurance Report from the meeting today.	DG/RC IG

AC/2021/443	**Date of Next Meeting: Extraordinary Audit Committee Meeting to be held Friday 17 December 2021 at 9.30am via MS Teams.** **Dates for future meetings:** Thursday 20 January 2022, 9.30-12.30	

Signed: ……... Dated: …….
(Chair)

Derby and Derbyshire
Clinical Commissioning Group

MINUTES OF DERBY AND DERBYSHIRE CCG
EXTRAORDINARY AUDIT COMMITTEE
HELD ON 17 DECEMBER 2021

VIA MS TEAMS AT 9.30AM

Present:

Ian Gibbard	Lay Member (Audit) Chair
Andrew Middleton	Lay Member (Finance)
Jill Dentith	Lay Member (Governance)

In Attendance:

Richard Chapman	Chief Finance Officer
Andrew Cardoza	Director, KPMG
Debbie Donaldson	EA to Chief Finance Officer (minute taker)
Darran Green	Associate Chief Finance Officer
Frances Palmer	Corporate Governance Manager
Chrissy Tucker	Director of Corporate Delivery
Kevin Watkins	Business Associate, 360 Assurance

Apologies:

Helen Dillistone	Executive Director of Corporate Strategy and Delivery
Suzanne Pickering	Head of Governance

Item No	Item	Action
AC/2021/444	**Welcome and Apologies** The Chair welcomed members to the Derby and Derbyshire CCG Extraordinary Audit Committee. Apologies were received from Helen Dillistone and Suzanne Pickering.	
AC/2021/445	**Declarations of Interest** The Chair reminded Committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG.	

	Declarations made by members of the Derby and Derbyshire Audit Committee were listed in the CCG's Register of Interests and included with the meeting papers. The Register was also available either via the Corporate Secretary to the Governing Body or the CCG's website at the following link: www.derbyandderbyshireccg.nhs.uk Jill Dentith reported that she had made an amendment to her Register of Interests, which would be incorporated by Frances Palmer into the Register going forwards. Declarations of interest from today's meeting There were no declarations of interest made. The Chair declared that the meeting was quorate.	
AC/2021/446	**CCG Closedown – Draft Due Diligence Checklist** Chrissy Tucker presented a paper regarding the CCG Closedown, which included a draft due diligence checklist. The following was highlighted: • The due diligence checklist had been provided by NHSE/I as a guide for the CCG to ensure that we had done everything that we needed to safely and legally close down the CCG in readiness for the establishment of the ICB within the ICS. • It was not a document that we would be assessed on at a national level, however, the regional team had asked to see a draft of our current position, hence this Extraordinary Audit Committee meeting had been called. • The CCG was to upload evidence in support of close down and establishment next week. • We had a deadline of 31st of December for this and for the readiness to operate statement, which was the checklist that establishes the ICB itself. • It was a helpful template, which was divided into several sections; we had received a few updates on it and more had been added. • The version presented today was version three; we were expecting further versions. • Parts of it were incomplete, such as the ODS checklist and the DSPT toolkit. This was being managed by a CCG Project Group and Internal Transition Group; functional members within those groups were responsible for picking up each element of the due diligence plan. • We had not yet started collecting the evidence required; this would be done towards the end of January or early February and the intention was to then to bring it to Audit Committee for a final review before it was taken to NHSE/I regionally for them to review, and for us to satisfy ourselves that we had closed down the CCG safely.	

	• The Chair had made an offer to go through the document with the team ahead of that February meeting to understand exactly what Audit Committee would like to see and to make sure we meet the requirements. • We now had Glossop's due diligence draft template which we would be working through in the next few weeks and aligning it with our own. We had contacts there to ensure that any material that needed to be transferred could be. • We had also had an initial conversation with Capsticks to get some advice on any sticking points there might be. With a further meeting booked with them in the New Year to review progress. • It was noted that Audit Committee's role, on behalf of the Governing Body, would be to provide assurance on the reported progress set out in the due diligence checklist, and through that provide assurance to NHSE/I that there had been a review of it, and that it was currently considered to be a reasonable statement of position. The following questions were asked: • Andrew Middleton was confident that the Governance Team had got all bases covered and this paper confirmed that, and he felt confident in assuring Governing Body that that was the case. National checklists from NHSE/I were typically comprehensive, but he asked whether any omissions been found from the due diligence template? • Andrew Middleton asked whether any lessons had been learned when the four Derbyshire CCGs merged into one? • Andrew Middleton reported that the transfer was different this time as it was a transfer into an ICS, was there any mention of the system requiring a different or additional approach? • Chrissy Tucker responded that she was not aware of any omissions from the due diligence template. The project group had gone through all the functions of the CCG, and they were holding monthly meetings with function leads looking at what things needed to be done in each department to close down the CCG. We had the due diligence checklist and then we had the more detailed project plan. The project plan also contained the sub actions that lead to the outcome required in the due diligence checklist. Chrissy Tucker felt that nothing had been missed because we were running both those processes well. • In terms of lessons from the previous merger, she reported that we did not have a choose and book representative on the project group. We did have primary care, but that link was missed and therefore when we changed our organisational code, a lot of rapid work had to be done on choose and book to set up all the right codes. We had learned that lesson and that member of staff was in fact one of the first people invited into this round of work. • Regarding the consolidation into an ICS, we were going from one statutory organisation into another statutory organisation. It might have been different if the ICS had devolved some of its statutory powers elsewhere within the system, but at the moment we're going from one into another.	

	• Richard Chapman reported that in terms of the CCG's responsibilities, it was less complex than the PCT close down because it was a one-to-one transfer. However, in terms of the establishment of the ICB, it was potentially a many to one transfer because we had got Derby and Derbyshire CCG, the Glossop element of Tameside and Glossop, and potentially NHSE/I functions coming into the new organisation. But from a CCG Audit Committee perspective, it was a one-to-one transfer, and less complex than former PCTs were. • Andrew Middleton was assured by the responses to his questions. • Jill Dentith felt that it was a helpful document and she too felt assured. However, following discussions regarding staff redeployment due to the pandemic over the next three weeks, she asked whether the timescales for this work were likely to slip, and if so, would we be able to catch up? • Jill Dentith asked about the HR due diligence referenced in the paper, this talked about staff transferring automatically, but what about the staff who were not automatically transferring, she presumed this would be picked up along the line; she did have some concerns there. • Jill Dentith requested further assurance regarding the section on finances 3.3.18 and the issue around Glossop. • Chrissy Tucker responded regarding the staff capacity issue, SLT had discussed how the CCG could support the booster programme across the next 3-4 weeks and the need to keep business continuity/transition moving forward. We were looking at which staff could be released for the booster programme and which staff would need to remain for business continuity; we were not taking a blanket approach to redeployment of CCG staff. • Regarding HR due diligence, Chrissy Tucker needed to speak to James Lunn before answering the question re staff not automatically transferring into the ICB – she hoped to be able to give assurance to Audit Committee by February on this. We also had colleagues in the STP that would need to transfer from that organisation into the ICB. The Glossop element added a level of complexity, but we had close relationships with Glossop, and they were part of the steering group, which boded well for getting the right outcomes. • The Chair reported that clearly there was a requirement within the process for Auditors to provide a level of assurance over this process and he asked Kevin Watkins if he could confirm to Audit Committee that he felt that the CCG had got an effective oversight arrangement there and that any third-party assurances required were going to be provided. • Kevin Watkins reported that the answer to that question was yes. 360 Assurance would be providing written progress reports to Audit Committee; they would provide a formal update on the work that they had been doing with the CCG, to make sure that the transition process was going smoothly. • Kevin Watkins provided Audit Committee with a verbal update on work that 360 Assurance had been doing. He felt the CCG was well placed, it had got experience, it had started the project	

	group in May, of which 360 Assurance had been members from October; this was good and positive. It was noted that a lot of work had been assigned to finance eg the set-up of the new ledger. 360 Assurance would be doing some work regarding the general ledger and looking at the CCGs process to ensure that it responded to all these various elements in the due diligence checklist on finance. 360 Assurance would be attending the first meeting of the project board next week. • Kevin Watkins reported that within 360 Assurance they members of four different transition groups covering four different health communities and they were also linking in with TIAN (The Internal Audit Network), and other NHS internal audit consortia doing the same, and trying to pick up on themes which would be described in the paper coming to this Committee in January. • Kevin Watkins reported that where a CCG was bringing in another organisation, such as Glossop for Derbyshire, there would be challenges around the difference of clinical policies for example IVF treatment. • It was noted that in overall terms, Kevin Watkins had no concerns with regards to the CCG processes that he had seen so far since attending the meetings from October. • Andrew Cardoza reported that KPMG would be looking to gain assurance from the processes that the CCG had as a demising organisation; this would be key for the external audit for this year to ensure that the close down was accurate and to provide and extra layers of comfort to Audit Committee. KPMG would not be joining the project boards as they were required to remain independent. • Chrissy Tucker reported that regarding clinical policies, there had been concerns in relation to Glossop. The Medicines Management and Contracting Teams had worked together to draw up a statement of principles; IVF was one of the areas where Glossop patients currently enjoyed three rounds of IVF, whereas Derbyshire were entitled to one. The statement of principles had been shared with Tameside and Glossop colleagues, and would be shared with our legal advisors to gain some double assurance on it. It would then be brought through to the Transition Working Group for review. • Andrew Middleton asked whether there would be a requirement for each of the CCGs Committee to do a handover report highlighting key issues, and he asked whether there would be a template for this? • Chrissy Tucker reported that she hoped to focus on this over the next few weeks. She felt it would be an important requirement, not only in terms of the business needing to be handed over, but also for learning purposes. • The Chair reported that Audit Committee were invited to note the contents of the due diligence checklist. Note the fact that we would be seeing it again in February, and to approve this draft submission to NHSE/I to be completed no later than the end of this month. • It was noted that Audit Committee members were content with the recommendations in the report.	

	Audit Committee NOTED the contents of the Due Diligence Checklist and APPROVED the submission to NHSE/I by 31st December 2021.	
AC/2021/447	**Financial Transition Project** Darran Green reported that Derby and Derbyshire CCG (DDCCG) would be changing its boundaries to incorporate Glossop from Tameside and Glossop CCG (TGCCG) and would transition to an Integrated Care Board (ICB) from the 1st April 2022. This would require the ICB to have a single financial system and bank account. To ensure the transition was effective, a financial systems project group would be set up and would report into the CCG Transition Project Group on a regular basis. The CCG Transition Project Group had been meeting monthly for some time to monitor and report on progress of the transition and they would oversee the financial systems project and report into Executive Management Team and NHSE/I. This report sets out the governance arrangements and work involved, along with timelines to meet the deadline for implementation 1st April 2022. It was proposed that monthly updates would be provided to Audit Committee. Darran Green highlighted the following: • We would be able to keep our existing bank account – it would just involve a name change as at the 1st of April 2022. • In terms of the financial system, this would be a bit more of a challenge as the paper sets out. Donna Johnson would be leading on this, as she did with the merger. A project group had been set up and members included Darran Green, Donna Johnson, Kevin Watkins, SBS and Arden and Gem CSU to give further support. It was noted that Arden and Gem CSU had provided a package to lots of CCGs to support this process. • Arden and Gem CSU would be able to bring in lots of people at appropriate levels to do the range of work required. • Risks had been identified in the paper around payments to the providers and getting information from Glossop. • The paper had also highlighted one of the problems that the CCG had last time was getting the confirmation letter from NHSE/I. Darran Green reported that this was not the case this time, as we had already received it. • Darran Green pointed out the key milestones were set out at the end of the paper and asked members how often they required an update on progress made. The following questions were asked:	

	• Jill Dentith reported that this was a very comprehensive paper with very detailed attachments, and she felt assured that the CCG were on track. • Jill Dentith highlighted the issue regarding provider payments, the CCG had an excellent record around BPPC, and asked whether the CCG was confident in maintaining that during the transfer? There had been conversations in other Committees regarding the services provided by SBS, and whether there was a possibility of looking at alternative suppliers. Would we be able to choose which CSU provided those services in future? • Regarding update reports, Jill Dentith would be happy receiving updates at Audit Committee, but would be guided by others if interim reports were needed. • Darran Green reported that he had no concerns regarding the services provided by SBS; SBS had given assurance that they were appropriately staffed to deal with the coming mergers. • It was noted that CSUs had started to specialise a bit more; the package obtained from Arden and Gem CSU represented good value for money and would bring in a range of skills required for the merger. • Andrew Middleton reported that in respect of Finance Committee he felt it would be useful to bring assurance/exception reports detailing progress made. From January 2022 Finance Committee would be merging with SFEC with an enlarged membership, and he felt that it would be a good educational experience for the merged committee to have a regular transition report. • Darran Green reported that he would be happy to do that. • The Chair reported that Audit Committee did normally meet in January to have a view on the year end timetable. He felt it would be helpful to have a transition update in January together with timescales for close down of the accounts; it would be useful to have a consolidated picture. • The Chair reported that the activity in January was about getting into more detail on the chart of accounts. He was not clear what sign offs were being expected by NHSE/I or for that matter by our own finance team in terms of the proposed chart of accounts going forward next year. He felt that Audit Committee needed to review this in order to be able to give assurance to the System Transition Assurance Committee that it had been looked at by this Committee. • The Chair referred to the statement regarding Glossop that it was unclear whether open transactions made by Tameside and Glossop would wholly transfer to Manchester – what were we expecting at year end in terms of picking up any of their opening balances, leases (particularly with IFRS16) and comparative data that we may need for future years. • Darran Green reported that in terms of the chart of accounts, when ISFE was brought in when CCGs were first established, it had been a very rigid approach by NHSE/I and there was no flexibility. This time there had been a lot of discussions between NHSE/I (a central team in NHSE/I) and CCGs, so we had been able to input into that process much more. We had been asked	

	how we wanted our ICB chart of accounts setting up, so they had responded much better than they did with CCGs. It was noted that the Derby and Derbyshire ICB chart of accounts was still being built, but we were having much more input into it. • The Chair asked to what extent were we integrating this with the rest of the project and saying, well, there's going to be a sign off either by the ICB or by the shadow ICB. This would determine to a certain extent the accountabilities that we were setting within our new structure. Would sign off be something that would be delegated to a working level discussion? • Darran Green reported that sign off was still some way off, but it could certainly be taken to Finance or Audit Committee when we get there. The Chair felt, in his view, it should go to SFEC. • Richard Chapman agreed that it should go to SFEC. He went on to add that one of the key points here was that we had flexibility. We currently regularly have conversations where we were not able to match the chart of accounts and the scheme of delegation that necessarily comes with the chart of accounts to the way in which the organisation manages its business. We have to work around that, eg Zara Jones might need to assure areas which technically she did not have authority for, simply because they fall within her remit on the chart of accounts. The flexibility that the future ledger and structure gives us would enable us to avoid some of those issues as we move forward. That said, the important thing was that the chart of accounts that we end up with reflects, as best as we can, the operating model that the system would work to in the future and that clearly was dependent on the operating model. Richard Chapman was not sure that we would have an operating model on 1st of April which might not be our final operating model. He was unsure what flexibilities would there to adjust that to give the best match of financial reporting to the operating model and alignment of responsibility to accountability and authority within that. • The Chair reported that he looked forward to that in January, even if it was still a work in progress. • The Chair referred to end of year in terms of Glossop, he asked whether we were saying that we were not going to require any capture of data in terms of either comparators or any assets or liabilities that needed to come in. What were we expecting to have to transfer at that point, or was it all going to Manchester ICB? • Darran Green reported that we would need to bring some information that was currently in their non ISFE into ours, but it would be minimal, and it would be around the suppliers that they pay, but a lot of their suppliers we already dealt with. Their local suppliers would need to be set up, but we were working with Glossop to identify those; this was all built into the project plan. • Darran Green reported that we had been told by NHSE/I yesterday that we could do a local agreement in terms of the assets and liabilities of Tameside and Glossop. We had reviewed the assets and liabilities, and there were no huge assets coming our way so there was no infrastructure. There	

	were no physical assets, and nothing that would impact on IFRS16. It was just basically current assets, and current liabilities that would be relevant to us. The Northwest region and the Midlands region had both agreed with the respective CCG's that we could come up with a local agreement, and that local agreement would be in principle, that all those current assets and liabilities transfer to the Greater Manchester ICB. He reported that we were going to put some kind of cap and collar on that, so that we were not necessarily lumbering them with any potential large value risks, or if there were any large value benefits then we would actually get our share of those. • Jill Dentith understood that there were still conversations ongoing about the scheme of reservation and delegation and the committee structure, which was mapped out provisionally, but there might be some alterations; we needed to make sure that we had got that flexibility. If we do need to tweak later, we could do with as little disruption to the chart of accounts. • The Chair reported that Audit Committee would be meeting again in January, and that another meeting would need to be scheduled in February to have a final look at the due diligence work. He recommended that a further statement and update on the work going on in the transition project be presented. • The Chair reported that Audit Committee were invited to note the actions taken to date and the assurance given, in terms of the amount of work that had gone into this, and the detail that had gone into the design. • The Chair noted the approach to ensuring the ICB's financial systems and banking arrangements were in place and tested. • In terms of frequency of the updates, as stated above, the Chair felt it appropriate to take an update in January and a further one in February. However, if anything appeared to be changing our risk assessment, this would also feature in the current arrangements through the Transition Working Group/ Transition Assurance Committee structures. • Andrew Cardoza reported that KPMG were completely assured in terms of the preparation and progress that Richard Chapman, Darran Green and Chrissy Tucker had highlighted. From an External Auditors point of view, he felt that everything was on track. **Audit Committee:** • **NOTED the actions taken to date, and the size and scope of the proposed project to ensure the smooth transition of financial systems and banking arrangements.** • **NOTED the proposed approach to ensuring the ICB's financial systems and banking arrangements were in place and tested by 31st March 2022.** • **CONFIRMED the frequency of updates to this committee to ensure the committee was satisfied with progress.**	

AC/2021/448	**Any Other Business:** There was a short confidential meeting to discuss the procurement of an External Auditor for the ICB. There was no further business.	
AC/2021/449	**Date of Next Meeting:** Thursday 20 January 2022, 9.30-12.30 via MS Teams.	

Signed: ……... Dated: …….
(Chair)

MINUTES OF DERBYSHIRE ENGAGEMENT COMMITTEE MEETING HELD ON 16 November 2021 VIA MICROSOFT TEAMS 11:15 TO 13:15

Present:		
Martin Whittle – Chair	MW	Governing Body Lay Member, DDCCG
Helen Dillistone	HD	Executive Director Corporate Strategy and Delivery, DDCCG
Maura Teager	MT	Lead Governor, University Hospitals of Derby and Burton NHS Foundation Trust
Margaret Rotchell	MR	Public Governor, CRH
Rebecca Johnson	RJ	Health Watch Derby
Simon McCandlish	SMc	Governing Body Lay Member, DDCCG (Deputy Chair)
Chris Mitchell	CM	Governing Body Member, Derbyshire Healthcare NHS Foundation Trust
Lynn Walshaw	LW	Deputy Lead Governor, Derbyshire Community Health Service
Steven Bramley	SB	Lay Representative
Tim Peacock	TP	Lay Representative
Ian Shaw	IS	Lay Member for Primary Care Commissioning
Jocelyn Street	JS	Lay Representative
Vikki Taylor	VT	ICS Director Lead, Joined Up Care Derbyshire
Sean Thornton	ST	Assistant Director Communications and Engagement DDCCG and Joined Up Care Derbyshire
Karen Lloyd	KL	Head of Engagement, Joined Up Care Derbyshire
In Attendance:		
Lucinda Frearson	LF	Executive Assistant, DDCCG (Administration)
Claire Haynes	CH	Engagement Manager, DDCCG
Hannah Morton	HM	Engagement Specialist, NHS Derby and Derbyshire Clinical Commissioning Group/ Joined Up Care Derbyshire
Apologies:		
Helen Henderson-Spoors	HHS	Chief Executive Officer, Healthwatch Derbyshire
Beverley Smith	BSm	Director Corporate Strategy & Development, DDCCG
Kim Harper	KM	Community Action Derby

Item No.	Item	Action
EC/21/22-87	**WELCOME APOLOGIES AND QUORACY** MW welcomed all to the meeting. Chris Mitchell, Derbyshire Healthcare Trust Governing Body member and representative on behalf of Derbyshire Dales and High Peak and Hannah Morton, Engagement Specialist with the Clinical Commissioning Group (CCG) were both attending for the first time. Apologies were noted as above and the meeting was declared quorate.	
EC/21/22-88	**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 (GB) or the CCG website at the following link: www.derbyandderbyshireccg.nhs.uk	

	Declarations of Interest from today's meeting No declarations were made for this meeting.	
EC/21/22-89	**OLDER PEOPLE'S MENTAL HEALTH CONSULTATION** CH presented the paper on a topic which had been to Committee previously when London Road Wards 1 and 2 were discussed and the moving of services from the Florence Nightingale Community Hospital to Kingsway to ensure correct services were in place. There was now a look at the north as well as south with a similar move around beds. CH emphasised that this was a reduction in beds especially towards the north. Proposal for City was Wards 1 and 2 beds to be moved to the Kingsway site and go to Tissington House, which will be a permanent move. Proposal for the north was a reduction from 30 beds down to 15 beds. The Dementia Rapid Response Team (DRRT) had been developed over the last few years and now intervened at an earlier stage which had had a very significant impact in reducing the number of beds required. A consultation document was circulated to members of the Committee and both scrutiny committees had approved a period of 60 days to enable adequate time for feedback. Plan was to launch consultation on 1st December to the beginning of February and produce a report. Teams are working quite quickly but if the feedback received is to the contrary to what is expected then they will look to mitigate or change plans. There may be issues due to winter pressures and the expectation of negative feedback, but these are specialist beds not winter pressure beds. Engagement Committee offered the following comments and questions: • JS was in favour of the plans but felt an explanation to why was required within the documentation. • JS queried who would be approving the CCG or Integrated Care System (ICS). CH advised they were working on both at the moment. MW explained that the CCG was still accountable. • SB fully supported the paper to improve services and reduce resources highlighting other work ongoing around mental health and due to the reduction in elderly beds will there be an increase in availability for younger people and working age people for mental health beds. If going to improve the balance is it not important to mention in the consultation. CH agreed it was important to mention the increase of mental health beds and explain in totality being more specific about the specialist elements and the whole picture not just the older people. • MR asked as the Lead Governor for CRH if the information could be shared with other Governors, so they are fully appraised in readiness of public questions. **Action: CH to prepare a briefing prior to launch for CRH Governors.**	**CH**

	• LW believed this was a great paper that made perfect sense but there was more to go in the consultation paper around Walton and being a more bespoke service, more patient friendly and improving services by another provision. It was great to hear about the work of DRRT but all people will hear will be the reduction in beds. • MT supported LW's comments. • CM gave sympathies as he felt the paper will come out at a difficult time in terms of public understanding and believe the public will only see the bed reduction. **The Engagement Committee COMMENTED and APPROVED the Consultation Document.**	
EC/21/22-90	**PROPOSED SINFIN HEALTH CENTRE DEVELOPMENT – UPDATE** KL gave a verbal update advising that a comprehensive comms and engagement plan had not been written as still waiting to see if the land can be leased if not then it is unsure where the development will be sited, defining whether consultation or a development exercise. Focus groups for stakeholders had taken place around what was known about the development so far and the hope for the development to get people's thoughts. Engagement Committee offered the following comments and questions: • MW asked about the timings. KL was hoping to get the decision of the lease imminently and the outline business case together by the end of November. If the lease on the land is not agreed this will delay as a new place for the development of the centre would be required. **Action: Update to be brought to the December meeting.** **The Engagement Committee NOTED the verbal update**	**KL**
EC/21/22-91	**LONDON ROAD WARDS 4,5,6 (FLORENCE NIGHTINGALE) – UPDATE** KL gave an update explaining that these wards had already been closed during the pandemic as a response to the pandemic and updates had been given at previous meetings. An engagement exercise was due to take place and to assess the impact of the closures. Although the wards were closed other services were funded and put in place. An engagement exercise was required to give people the opportunity to input on the impact of the changes. An evaluation of the current services is underway. Once evaluation results are gathered work can begin on the contents of the engagement documents and it is hoped the exercise would last 3 months. It is unlikely to take place prior to Christmas and hopefully start in January 2022 with 2 parts, a general engagement put out as wide as possible and a more targeted engagement with groups of people that have a say. KL was looking to bring a document to Committee next month but may have to send prior to the meeting for comment. SB and JS indicated they would be happy to be part of a small group and assist with this project. **The Engagement Committee NOTED progress to gather feedback, APPROVED the engagement approach and was ASSURED of progress.**	

EC/21/22-92	**NEWHOLME HOSPITAL- SERVICE MOVE – UPDATE** CH presented the paper and reported they were now at the stage where the development discussed by the BCCTH consultation was happening. Not everything in the old Newholme build would be transferred but had come to the stage were some services required moving. There was an assumption this particular service move had been covered in the consultation, but it had not. Some services are to be transferred nearby into a business park. The services being a community mental health team for working age and older adults, some office based but some outpatient appointments and nurse consultations and improving access to psychological therapies with consulting rooms, plus other offices that do not have a direct impact on patients. Around 293 patients will be affected, and each will be written to directly with an explanation and directions. Patient Participation Groups (PPGs) with links to the patients will also be contacted and by analysis see how many patients are coming from the GP practices writing to all with a briefing and the same information the patients will receive. If any negative feedback is received, plans will stop and be reviewed, establishing if more engagement is required. Engagement Committee provided the following comments and questions: • JS commented on the parking at Newholme and also advised that PGGs were different so more emphasis must be made to practice managers. CH would be contacting each practice manger to ensure they understand the change that may impact their patients. **Action: Update to be brought to the December or January meeting.** **The Engagement Committee NOTED the update received.**	**CH**
EC/21/22-93	**S14Z2 LOG** HD explained the following 3 papers form part of the corporate assurance section of the agenda. The paper is an important governance document to provide assurance to Committee around areas of service development. The log was ongoing, indicating the different activities being undertaken across the CCG and the system and the approach the team are taking to provide that assurance under the law, Section 14. The log allows committee members to raise queries or request deep dives on particular areas. There were currently 4 main areas to the plan, some covered already: • Medicines Order Line (MOL) • Audrey House and the development of the Radbourne unit • Newholme • Older people's mental health Engagement Committee provided the following comments and questions: • JS had concerns around the MOL and a lot of practices still not having access to the MOL and was looking for assurance that it was being rolled out. HD offered to follow up with the medical team lead. **Action: HD to discuss with SHu and provide status update.**	**HD**

	• TP highlighted how useful the document was and asked if he wished to raise or make enquires about individual projects there were no contact details provided would this be done through Committee. ST advised TP to contact any member of the comms and engagement team with questions. • TP felt that the general public would have the same interest in the document and asked if they had access. HD advised there are web pages on the CCG website as there is nothing secretive about consultations already underway. • MW emphasised the timing of when it goes on the website which was very important and only when there is something substantial to provide. • KL emphasised this was the whole point of the new online engagement platform and would expect any future page on the website to link to the online engagement platform, being a one-stop shop for everyone. **The Engagement Committee REVIEWED the report and were ASSURED they were being completed appropriately.**	
EC/2122-94	**DDCCG EXCEPTION RISK REPORT** HD explained this was a risk assigned to, overseen and managed by the Committee. Other Committees have a similar process which helps inform the wider risk register reported to GB every month. The risk is No16, the description is there could be or there is a risk of lack of standardised processes in the CCG's commissioning arrangements which could lead to a failure in meeting statutory duties under Section 14. The risk had not changed from last month with no reason to move the score from a medium risk score of 8. Engagement Committee offered the following comments and questions: • TP believed the risk was scored correctly and was reassured that forms were being completed and presentations made to Committee, but we all know that the NHS is in crisis and admitting there have been no consultations through covid, asked who was managing the resource risk. MW explained that there were other risks around workforce capacity and money that were assigned to other committees which come together in one major public document at the public GB meeting. HD advised workforce capacity risk is monitored through Governance Committee and all gets reported through GB assurance network. When the pandemic broke some of that business-as-usual tasks were stood down and paused. The exec team have agreed additional resource to priority areas to help some areas of work with engagement and comms one of those areas. • JS asked should there not be a note on the risk explaining why we are not achieving and what is being done to mitigate. ST felt comfortable and satisfied that once the governance guide was in place that the risk level would reduce to level 5 or 6 and close the risk. **The Engagement Committee RECEIVED and DISCUSSED the report, NOTING no changes to risk scores.**	

EC/2122-95	**GBAF** HD explained the GBAF (Governing Body Assurance Framework) sets out for each Committee the strategic risk against the various objectives the GB sets itself at the beginning of the financial year and forms part of the framework. It is a record of the internal and external mitigations and levels of assurance seen throughout the year. A fairly continuous level of risk has been seen across the year at a level 9, the target is level 6. Work is required in Quarter 4 around how we get assurance across the risk to enable an update in the new year to reduce down to a level 6 and these are the key steps taken across the organisation to do that. As we start to formally close down the CCG and move into the Integrated Care Board (ICB) a formal process across the organisation through all the committees will be undertaken around how we can formally close risks, that can be closed, and more importantly any outstanding risks that can be transferred into the ICB. Challenge is how to put the steps in place now and into the new year to get this score down to a 6 and how to transfer into the new arrangements from April. **The Engagement Committee RECEIVED the report, after reviewing the log the Committee were ASSURED it had been updated appropriately.**	
EC/2122-96	**MINUTES OF THE MEETING HELD ON: 21 SEPTEMBER 2021** **The Engagement Committee ACCEPTED the Minutes of the previous meeting as a true and accurate record.**	
EC/2122-97	**MATTERS ARISING** No additional matters were raised.	
EC/2122-98	**ACTION LOG FROM THE MEETING HELD ON: 21 SEPTEMBER 2021** <u>EC/21/22-74 – Engagement Model and Governance Guide</u>: The action was around the need to get public engagement in quality agenda moving forward in the ICS. MW had now met with Brigid Stacey (BS) and BS had assured MW that she understood the importance and was looking to bring engagement into the quality committee moving into ICS. **Item closed.** <u>EC/21/22-71 - Winter Communications and Engagement Plan</u>: ST provided a verbal update and was happy to circulate the plan submitted. There was now a plan that sits behind also. The plan whilst called winter is more around the ongoing pressures in the service and has 2 elements a campaign element and an operational element. **Item closed.** <u>EC/21/22-70 – GP and Urgent Care Access Insight – Update</u>: ST had been working with Britain Thinks with the research work progressing. There are 3 elements with work underway with Primary Care development team around: • Giving more information about roles and therefore the access people can have as there seemed a lack of knowledge in General Practice. • Broader work around additional investment regarding additional access to GP during winter. General statistics released show a significant increase in appointments at practices with over 66% being face to face.	**ST**

	Also, access groups to work with practices that are deemed to be struggling through access. • Working with Medical Committee around trust campaign around violence and aggression which is being adopted within the acutes. SB reiterated the displeasure around people being abusive to staff and made comment on GP access at his surgery had improved and there are now patients in the waiting room which was good to see. **Item closed.** EC/2122-64 – AOB, ICS's Future Committees: HD had been required this week to submit indicative plans, what the ICS and Committees may start to look like and proposal around this agenda. These proposals may change but engagement is key to the ICB and Integrated Care Partnership (ICP), concern is the time scales as have to get feedback from NHSEI before working through some of the detail. **Paper to be presented at the January Committee.** EC/2122/29a – Presentation by Dean Wallace: It was suggested to close, at the time it was thought it would be an interesting discussion around a presentation but there is a lot happening at the moment and time can be better spent elsewhere. **Committee AGREED to close this item.** **The Engagement Committee reviewed the action log and updated accordingly**.	
EC/2122-99	**ENGAGEMENT COMMITTEE FORWARD PLANNER 2021/22 FOR REVIEW AND AGREEMENT.** **The Engagement Committee REVIEWED and AGREED the Forward Planner.**	
EC/2122-100	**ANY OTHER BUSINESS** Pregnancy and Covid: IS raised a question around patients engagement and the fact that figures were particularly high around covid and pregnant women were not seeking vaccines, and asked for information around the comms for this patient group regarding vaccinations. ST provided a verbal update advising of specific work linked in with case studies from the hospital trusts including a midwife who had gone through pregnancy through covid with messages about the journey and about having or not having a vaccination. MT highlighted this had also been covered by Derby Evening Telegraph. Social media had been used to highlight the importance of being vaccinated whilst pregnant and information shared with Neonatal and Voice groups also. Hereford and Worcester are carrying out work around pregnant women not being vaccinated which ST will be discussing with them.	
EC/2122-101	**FUTURE MEETINGS IN 2021/22** **Time: 11:15 – 13:15** **Meetings will be held as virtual meetings until further notice** Tuesday 21 December 2021 Tuesday 18 January 2022 Tuesday 15 February 2022	

	Tuesday 15 March 2022	
EC/2122-102	**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. Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? **No** **7.** What recommendations do the Committee want to make to Governing Body following the assurance process at today's Committee meeting? ***None, there was felt to be no specific recommendation at this stage.***	
DATE AND TIME OF NEXT MEETING		
Date: Tuesday 21 December 2021		
Time: 11:15 – 13:15		

NHS
Derby and Derbyshire
Clinical Commissioning Group

MINUTES OF PRIMARY CARE COMMISSIONING COMMITTEE

PUBLIC MEETING

HELD ON

Wednesday 22nd December 2021

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

PRESENT		
Ian Shaw (Chair)	**IS**	Lay Member Derby & Derbyshire CCG
Richard Chapman	**RC**	Chief Finance Officer
Jill Dentith	**JeD**	Lay Member Derby & Derbyshire CCG
Steve Lloyd	**SL**	Executive Medical Director Derby & Derbyshire CCG
Simon McCandlish	**SMc**	Deputy Chair, Lay Member, Derby & Derbyshire CCG
Marie Scouse	**MS**	AD of Nursing & Quality Derby & Derbyshire CCG (for CNO)
IN ATTENDANCE		
Hannah Belcher	**HB**	AD GP Commissioning & Development Derby DDCCG
Judy Derricott	**JDe**	Head of Primary Care Quality Derby & Derbyshire CCG
Clive Newman	**CN**	Director of GP Development Derby & Derbyshire CCG
Dr Peter Williams	**PW**	Derby & Derbyshire LMC
Jean Richards	**JR**	Senior GP Commissioning Manager DDCCG
Pauline Innes	**PI**	Executive Assistant to Dr Steven Lloyd DDCCG
APOLOGIES		
Niki Bridge	**NB**	Deputy Chief Finance Officer, DDCCG (for CFO)
Ged Connolly-Thompson	**GCT**	Head of Digital Development
Abid Mumtaz	**AM**	Service Commissioning Manager Public Health, Derbyshire County Council
Brigid Stacey	**BS**	Chief Nurse Derby & Derbyshire CCG

ITEM NO.	ITEM	ACTION
PCCC/2122/159	**WELCOME AND APOLOGIES** The Chair (IS) welcomed Committee Members to the meeting, there were no members of the Public present at today's meeting. Apologies were received and noted as above. The Chair confirmed that the meeting was quorate.	
PCCC/2122/160	**DECLARATIONS OF INTEREST** The Chair informed members of the public of the committee members' obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG.	

	Declarations declared by members of the Primary Care Commissioning Committee are listed in the CCG's Register of Interests and included within the meeting papers. The Register is also available either via the corporate secretary to the Governing Body or the CCG website at the following link: www.derbyandderbyshireccg.nhs.uk **Declarations of interest from today's meeting** There were no declarations of interest made The Chair declared that the meeting was quorate.	
FOR DECISION		
	No items for decision	
	FOR DISCUSSION	
	No Items for discussion	
FOR ASSURANCE		
PCCC/2122/161	**FINANCE UPDATE** Richard Chapman (RC) presented an update from the shared paper. The paper was taken as read and the following points of note were made. The Month 7 finance position has been received at the Finance Committee and Governing Body. Key points of interest: • Allocations have been received for the full year at £2.074bn • In line with NHSE/I guidance planning for H2 had not been completed for month 7 reporting. As a result, the finance report has been compiled comparing actual monthly expenditure in month 7 with month 6 and overall expenditure against the H2 allocation allowance. • Retrospective allocations received for half 1 Covid spend on the Hospital Discharge Programme were £5.498m further funding is expected of £0.625m relating to month 7. • The Elective Recovery Fund has been reimbursed £0.702m for April to September. The M8 financial position has not yet been reported to the Governing Body and so will be reported to the public session of the PCCC at the next 2022 meeting. **The Primary Care Commissioning Committee NOTED and RECEIVED the update on the DDCCGs financial position for Month 7.**	
PCCC/2122/162	**RISK REGISTER EXCEPTION REPORT** Hannah Belcher (HB) presented an update from the shared paper. The paper was taken as read and the following points of note were made. **Risk 04A**: ***Contracting***: *Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care –* ***Risk Score 16*** Hannah Belcher (HB) HB reported to the Committee that there is no recommendation to change the level of risk at this moment in time due to	

	ongoing pressures for general practice. **Risk 04B:** ***Quality:*** *Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care.* ***Risk Score 20*** Marie Scouse (MS) reported that the risk remains the same due to the current pressures within Primary Care particularly in relation to workforce. It was noted that there may be a need to increase this risk as the organisation move forwards and not decrease which will be reported back through the Committee. **The Primary Care Commissioning Committee NOTED and RECEIVED the update on the two outstanding risks and:** • **AGREED that the scores remain unchanged** • **Were ASSURED that the risk scores are reviewed on a regular basis.**	
FOR INFORMATION		
	There were no items for Information	
MINUTES AND MATTERS ARISING		
PCCC/2122/163	**Minutes of the Primary Care Commissioning Committee meeting held on 24th November 2021** The minutes from the meeting held on 24th November 2021 were agreed to be an accurate record of the meeting.	
PCCC/2122/164	**MATTERS ARISING MATRIX** There are no outstanding actions on the Action Matrix.	
PCCC/2122/165	**ANY OTHER BUSINESS** There were no items of any other business	
PCCC/2122/166	**ASSURANCE QUESTIONS** **1.** Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? **Yes** **2.** Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? **Yes** **3.** Were papers that have already been reported on at another committee presented to you in a summary form? **Yes** **4.** Was the content of the papers suitable and appropriate for the public domain? **Yes** **5.** Were the papers sent to Committee members at least five working days in advance of the meeting to allow for the review of papers for assurance purposes? **Yes** **6.** Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? **No**	

	7. What recommendations does the Committee want to make to Governing Body following the assurance process at today's Committee meeting? **None**	
	DATE AND TIME OF NEXT MEETING	
Wednesday 26th January 2022, 10:00-10:30am via Microsoft Teams Meeting		

NHS
Derby and Derbyshire
Clinical Commissioning Group

MINUTES OF QUALITY AND PERFORMANCE COMMITTEE
HELD ON 23rd DECEMBER 2021
9AM TO 10.30AM
MS TEAMS

Present:		
Dr Buk Dhadda (Chair)	BD	Chair, Governing Body GP, DDCCG
Tracy Burton	TB	Deputy Chief Nurse, DDCCG
Jackie Carlile	JC	Head of Performance and Assurance -DDCCG
Helen Hipkiss	HH	Director of Quality, DDCCG
Sarah MacGillivray	SMacG	Head of Patient Experience, DDCCG
Dan Merrison	DM	Senior Performance & Assurance Manager, DDCCG
Andrew Middleton	AM	Lay Member, Finance
Grace Mhora	GM	Senior Quality Assurance Manager
Hannah Morton	HM	Healthwatch
Dr Emma Pizzey	EP	GP South
Dr Greg Strachan	GS	Governing Body GP, DDCCG
Brigid Stacey	BS	Chief Nurse Officer, DDCCG
Phil Sugden	PS	Asst Director of Quality & Named Patient Safety Specialist
Dr Merryl Watkins	MWa	Governing Body GP, DDCCG
Rosalie Whitehead	RW	Risk Management & Legal Assurance Manager
In Attendance:		
Jo Pearce (Minutes)	JP	Executive Assistant to Chief Nurse, DDCCG
Apologies:		
Martin Whittle	MW	Vice Chair and Governing Body Lay Member, Patient and Public Involvement, DDCCG
Dr. Katherine Bagshaw	KB	Deputy Medical Director
Alison Cargill	AC	Asst Director of Quality, DDCCG
Simon McCalandish	SMcC	Lay Member, Patient Experience
Suzanne Pickering	SP	Head of Governance- DDCCG
Dr Steve Lloyd	SL	Medical Director - DDCCG
Helen Henderson-Spoors	HHS	Healthwatch Derbyshire
Zara Jones	ZJ	Executive Director of Commissioning Operations, DDCCG

Item No.	Item	Action
QP2122 /163	**WELCOME, APOLOGIES & QUORACY** Apologies were received as above. BD declared the meeting quorate.	
QP2122 /164	**DECLARATIONS OF INTEREST** BD reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG. Declarations declared by members of the Quality and Performance Committee are listed in the CCG's Register of Interests and included with the meeting papers. The Register is also available either via the corporate secretary to the Governing Body or the CCG website at the following link: www.derbyandderbyshireccg.nhs.uk <u>Declarations of interest from sub-committees</u> No declarations of interest were made. <u>Declarations of interest from today's meeting</u> No declarations of interest were made.	
	BD confirmed that the meeting will be conducted in a more abbreviated form. Some of the papers have been listed on the agenda for information only and Committee members were asked to submit questions relating to the papers before the meeting. Responses to the questions were circulated to the Committee members prior to the meeting and are included within these minutes. The questions are being collated for future reference if needed.	
QP2122 /165	**Integrated Report** The report was taken as read. JC noted that she attended the UHDBFT Operational Performance Improvement Group meeting yesterday which spoke about ongoing workforce issues. The effects of Omicron are still to be confirmed however in the meantime UHDBFT are trying to carry out as much elective activity as possible.	

	Activity Report There were no questions raised on the activity report. BD **APPROVED** the Integrated Report.	
QP2122 /166	**GBAF Q3** The paper was taken as read. GS referred to risk 6 and the low vaccination uptake for the school age immunisation service and asked about any costs incurred as a result. RW agreed to take this query back to the author of the report and feedback to GS. **ACTION** The Committee noted the contents and approved the paper.	**RW**
QP212 /167	**RISK REGISTER** The paper was taken as read. The report makes the following recommendations. • Decrease risk 06 relating to the demand for Psychiatric Intensive Care Unit beds (PICU) • Close risk 38 relating to the quality of care potentially being impacted by patients not receiving a care needs review in a timely way as a result of the COVID pandemic and the requirement for some of the Midland and Lancashire Commissioning Support Unit (MLCSU) Individual Patient Activity /Continuing Health Care (CHC) services to redirect service delivery to support system wide pressures. The Committee noted the contents and the approved the recommendations in the paper.	
QP2122 /168	**Follow Up report on Cancer Waits** JC gave the Committee a high-level update on cancer waiting times. Both trusts are seeing increased levels of referrals. At UHDBFT patients referred in to see gynae consultants are not being seen until days 30-35 and are therefore exceeding the 14 day and 28-day targets. This leaves just 27 days in which to diagnose and treat before the 62-day target is impacted. JC confirmed that once the patient has received a diagnosis then treatment occurs very quickly. Both trusts are trying to offer extra clinics however staffing is an ongoing problem.	

	BS agreed that a specific piece of work around cancer waits be undertaken and a paper on the long waits and risk stratification work brought back to the Quality and Performance Committee in February 22. **ACTION – Add to the forward planner**. The Committee noted the contents and approved the paper.	**JP**
QP2122 /169	**Breast Pain Pathway** The paper is to give the Quality and Performance Committee an update on the Derbyshire breast pain clinics, particularly covering activity and patient experience. JC noted the number of patients in the pathway is starting to increase. Feedback from the patient experience questionnaire is positive. BD referred to the importance of ongoing education around breast pain for both GP Registrars and established GP's. AM asked if there is scope for nurse practitioners to carry out breast pain assessments. BS responded to say that whilst nurse practitioners are capable or undertaking the assessments and are working to the top of their licence there is not the workforce available. During the pandemic there has been an increase in the number of students enrolling to train in nursing however the benefits of this will not be seen for another 3 years. Another risk around workforce is the number of nurses who will be eligible and will take the option to take retirement in the next 5 years. MWa referred to specific tasks that nurse practitioners are not allowed to carry out due to current legislation, for example, signing a death certificate or signing a sick note and noted the impact it could have on easing workload pressures on GPs if this was changed. The Committee noted the contents and approved the paper.	
QP2122 /170	**Outcome of the WSOA from Ofsted and CQC** As a result of a WSOA for improvements in the SEND structure, work has been ongoing for the last 2 years between the CCG, Derby City Local Authority and Education. A reinspection was carried out in October 2021 and significant progress was awarded. DG highlighted that not all the improvements which have been made have been seen, this relates, to the Neurodevelopment wait pathway. The impact of children returning into schools has seen a surge in demand and there are currently 2,200 children on the waiting list. DG spoke about the challenges around shortages of psychologists and nurses with the right training and confirmed that the MH System Delivery Board has agreed to an investment	

	programme of £1.7m over the next 3 years to manage the waiting list. DG assured the Committee that the work is ongoing, and the necessary actions are in place to take the work forward. Part of the work includes improving the pathway for Foetal Alcohol Syndrome using the same processes and teams. DG informed the Committee that there will be an inspection in 2022 for Derbyshire County. This will be under new arrangements which have yet to be published. It is not known what the focus of the inspection will be, but it is believed there will be increased focus on inequality and inclusivity in schools. There is also a piece of assurance work between the CCG and Local Authority colleagues to ensure the ICB have the correct focus on SEND within its structures. This work has received regional recognition as an example of good practice. AM asked if there might be obstacles that can be removed due to the collaborative working that is taking place in the transition to the ICS. DG responded to say that conversations are taking place on how staff throughout the county can be utilised as a whole and there is a commitment from DHCFT and CRHFT to work together as a collaborative on this issue. There is also a move towards a single pathway to utilise staff rather than having separate children and adults' pathways. The Committee noted the contents and approved the paper.	
QP2122 /171	**URGENT TREATMENT CENTRE (UTC) PATIENT INSIGHT** HM shared the presentation on UTC – System Insight which was undertaken as part of the UTC review. GS asked if the full GP record can be viewed when a patient attends a UTC as this would be useful if a patient states they cannot get a GP appointment. HM could not confirm if the full GP record was available at the UTC but explained that as part of the engagement work, she is trying to understand patient flow and looking at whether the patient has tried to use another service prior to attending the UTC. The Committee noted the contents of the presentation.	
QP2122 /172	**SYSTEM QUALITY ARCHITECTURE** BS shared the presentation called "Derby and Derbyshire Journey to an ICS" which explains the history of the System Quality Group and its current position in the ICS transition.	

	AM asked for an example of where working in partnership has improved system efficiencies. BS referred to the conversations that have taken place at System Quality Group around the 136 Suite and explained that although robust conversations around this issue had taken place the other organisations did not feel threatened by them, and this is due to the relationships that have been built over the last two years. The Committee noted the contents and approved the paper.	
QP2122 /173	**CLIVE TREACY INDEPENDENT REVIEW** The paper was taken as read. PS explained that the service user, who was from Staffordshire, died at Cedarvale which at the time was a Danshell Group Independent hospital and has been owned by Cygnet Healthcare since 2017. The report lists 59 recommendations, and 22 organisations were involved in the writing of the report. The recommendations for commissioners are focused on commissioning and maintaining oversight to ensure individuals are placed in the correct location. There was focus on the cardiac condition of the individual and the voice of the individual's family. MWa asked if Primary Care was involved in the individual's care. PS explained that as the placement was in Nottinghamshire, and occurred in 2017, the model was quite different to what is currently in place. GP practices tend to have more input when an individual is planned to be discharged. BS clarified that should an independent hospital require Primary Care involvement the links are in place and a GP would attend the setting. GS noted the report states that during the last months of Mr Treacy's life his CPAP machine was unavailable and asked if there is a failsafe way for the CCG to ensure this does not happen. PS confirmed that the CCG have very good host commissioner arrangements in place and regular meetings take place with all independent providers and CQC. The CCG link in with case managers and 8-week checks take place to identify any clinical concerns. As part of the national program, enhanced safe and well checks have been carried out for all CCG service users in independent hospitals. The Committee noted the contents and approved the paper.	

QP2122 /174	**CONTINUING HEALTH CARE (CHC)** The paper was taken as read. There were no questions raised by the Committee members. The Committee noted the contents and approved the paper.	
QP2122 /175	**IPC** The paper was taken as read. There were no questions raised by the Committee members. The Committee noted the contents and approved the paper.	
QP2122 /176	**CARE HOMES** The paper was taken as read. There were no questions raised by the Committee members. The Committee noted the contents and approved the paper.	
QP2122 /177	**JUCD QEIA** The paper was taken as read. There were no questions raised by the Committee members. The Committee noted the contents and approved the paper.	
QP2122 /178	**MINUTES FROM SUB COMMITTEES** The Committee noted the minutes from the following sub-Committees: Updates from Trust CQRG meetings. UHDBFT CRHFT DCHS	
QP2122 /179	**MINUTES FROM THE MEETING HELD ON 25th NOVEMBER 2021.** The minutes were approved as a true and accurate record.	

QP2122 /180	**MATTERS ARISING AND ACTION LOG** The action log was reviewed and updated.	
QP2122 /181	**AOB** There were no matters raised under AOB.	
QP2122 /182	**FORWARD PLANNER** The Forward Planner was reviewed. No updates were made.	
QP2122 /183	**ANY SIGNIFICANT SAFETY CONCERNS TO NOTE** None raised.	
	ASSURANCE QUESTIONS • Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? Yes • Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? Yes • Were papers that have already been reported on at another committee presented to you in a summary form? Yes • Was the content of the papers suitable and appropriate for the public domain? Yes • Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? Yes • Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? No • What recommendations do the Committee want to make to Governing Body following the assurance process at today's Committee meeting? None	

DATE AND TIME OF NEXT MEETING
Date: 27th January 2022
Time: 9am to 10.30am
Venue: MS Teams

South Yorkshire and Bassetlaw Health Executive Group

Date: 11 January 2022

Subject: Progress update on ICS development

Report of: Will Cleary-Gray, Chief Operating Officer, SYB ICS

Sponsor: Pearse Butler, Chair SYB Health and Care Partnership, Chair Designate South Yorkshire Integrated Care Board

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SUMMARY OF THE REPORT

This report provides an update on transition progress made over November and December. It builds on previous updates to the SYB Health Executive Group and sets out a number of key next steps.

KEY MESSAGES

- The naming convention for Integrated Care Boards (ICBs) was confirmed in December 2021.
- The approach to transition presented at the September HEG, including transition of functions, people, liabilities and assets and the associated due diligence of CCG and NHSEI functions, has been progressing well. It presented an approach for a landing position for April 2022. Aspects of this work has been slowed as a result of the level 4 incident and an interim due diligence report is scheduled for January 2022.
- Organisation development work on functional design of the ICB has been progressing well. The work began in October / November. The work has been slowed or rescheduled in some areas given the level 4 incident.
- A revised establishment date has been confirmed in the 2022/23 Planning guidance for ICBs. A summary of the impact is attached in A1 and the progress made to-date meets that the impact will be limited for South Yorkshire.
- Between September and November Partners engaged in both considering and giving feedback on national guidance and local proposals to support the establishment of the South Yorkshire Integrated Care Board (ICB) and its draft Constitution.
- The ICB draft Constitution, setting out board size, make-up and approach to eligibility, nomination and selection was proposed to NHS England on 3 December with feedback given on 23 December 2021. The draft constitution was approved by NHS England for South Yorkshire.
- Consultation with staff affected by establishing the ICB began in early December and closed week ending 9 January. Recruitment to wider non-executives and executive members is underway.
- A key next step is discussions with partners on the co-production work to inform wider governance and how the ICB can best support the ambitions and priorities of our Places, Collaboratives and Alliances.

PURPOSE OF THE REPORT

This report summarises progress to ensure system partners, their boards and organisations are supported with keeping up to date on key issues and progress.

Progress update on ICS development

Purpose

1. This report provides an update on transition progress made over the last month to establish statutory Integrated Care Systems (ICSs). It builds on previous updates to the SYB Health Executive Group and sets out a number of key next steps.

2. It summarises progress over November and December to ensure system partners, their boards and organisations are supported with keeping up to date on key issues and progress.

Summary

3. NHS England confirmed the naming convention for ICBs in December. For South Yorkshire the public name is **NHS South Yorkshire** and legal naming NHS South Yorkshire Integrated Care Board. Both will be adopted when ICBs are legally established. On the wider naming of ICSs and Integrated Care Partnerships (ICPs) systems were to share any further changes by 21 December 2021 – no further changes have been made to the proposals which formed part of the engagement with partners in November and **are at Appendix, A.**

4. The previous update to HEG summarised key guidance in context of the ICB and the steps required to ensure this was in place, including engaging on the draft constitution for NHS South Yorkshire (ICB) a **reminder of the engagement approach and timetable is at Appendix, B.** The draft constitution was shared with NHS England and Improvement and has been approved.

5. Work to progress actions as set out in our transition approach including recruitment of wider NHS South Yorkshire board members continues. Our designate chief executive Gavin Boyle formally takes up the role on 1st February 2022.

6. The NHS Planning Guidance set out a new target date for implementation of statutory ICSs of 1st July which is an additional full quarter. CCGs will remain in place until 30 June 2022 and CCGs and ICB designate leaders should agree the best way of working together to manage this. SYB has made significant progress to-date which puts us in a good position to manage the implications and complexities which will arise as a result. In light of the level 4 incident a number of adaptations and changes have already been made to the development work to account for the requirement to focus on the immediate operational priorities. We are also still working through the potential implications of the new target date and will update HEG partners as this develops.

7. Development work in our places and collaboratives continues to progress on ambition and priorities and the arrangements needed to continue to work well together and consider the relationship and arrangements needed between these and the future ICB / ICP to continue to support thriving places and strong and vibrate collaborates and alliances. The addition preparation time afforded now by the new target date will help deepen these preparations.

Development of the South Yorkshire Health and Care Partnership (ICP)

8. We previously updated HEG on the ICS development Steering Groups keenness to progress the work we had done involving all partners to advance a refreshed South Yorkshire Health and Care Partnership. NHS South Yorkshire designate chair and

Chief executive met in January 2021 with Local Authority Chief executive to agree steps to establish South Yorkshire revised Health and Care Partnership (ICP). The new target date has given more time to engage with partners including Health and Well-being Boards as part of these steps.

Establishing NHS South Yorkshire

9 We previously clarified CCGs legal responsibility for proposing the ICB Constitution to NHS England and Improvement and engaging with relevant partners and how they have agreed a collective approach through the JCCCG and led by the designate chair and designate chief executive.

10. Engagement with partners on the draft constitution took place over October and November, including the Board size and makeup and approach to eligibility, nomination and section. Both formal and informal approaches were employed to seek insights and experiences of our partners to shape thinking as we've developed the new NHS South Yorkshire (ICB) Board and its draft constitution. This was led by the ICB designate chair and designate chief executive and engaged with Healthwatch's VCSE's, NHS Trusts and Foundations Trusts, Local Authorities and CCGs.

11. Final comments on the draft constitution were received on the 26 November 2021 and the constitution was proposed to NHS England and Improvement on 3 December 2021 with feedback received. The draft constitution was approved by NHS England and Improvement.

12. Steps are now being taken led by the ICB chair and chief executive to recruit to NHS South Yorkshire board (ICB). The consultation with staff affected commenced in early December 2021 and closed week ending 9 January 2022.

13. A key next step is to establish discussions with partners on the co- production work to inform wider governance and how NHS South Yorkshire (ICB) can best support the ambitions and priorities of our places, collaboratives and alliances. This will also involve revisiting our current ICS governance in advance of the new statutory arrangements and the new target date gives more time to progress this.

14. It is anticipated that the additional preparation time with give time for shadow running NHS South Yorkshire's Board during the first quarter of 2022

A summary schematic of current ICS governance is at Appendix, C.

Organisational Development work on functional design

15. The organisational development work on functional design is now well underway. It began with the staff most affected by the changes who will become employees of NHS South Yorkshire (ICB) and has now started to widen to involve the wider one workforce of the ICS and partners. A key objective of the work is to ensure there is a rich understanding of the transferring functions, good practice already supporting integration and opportunities. Christine Joy our interim director of OD and HR is leading this work. **A summary of the key functions is at appendix, D.** This work was slowed in December as a result of the level 4 incident and current pressure and key work considered for reschedule in February /March.

Due diligence

16. The arrangements to support CCG close-down and safe transition of people and

functions was previously set out to HEG. These arrangements continue to provide a robust framework and give assurance to those transferring organisations.

17. We previously updated on the ICS designate chairs and leadership meeting with the regional director and wider team in Q3 to share and discuss progress in relation to transition. This covered all aspects including CCG and NHSE transition and system development. Formal feedback has now been received and is part of this agenda for noting. A revised transition progress position (RoS) was shared with NHS England in December prior to publication of the new target date with no serious concerns identified.

18. Discussions are currently underway with CCGs and ICS leadership to consider what steps might be taken given the new target date for statutory ICS and how CCGs and the ICS can best work together. Current considerations include how our CCGs might use existing legal collaborative forums of the Joint Committee to support decision-making on issues which are forward looking and require ICB designate leadership. This include action on the 2022/23 planning guidance which will set the strategic planning, priorities, financial and contracting context for year 1 of the ICB.

Recommendations:

The Health Executive Group is asked to:

- Note the progress and summary of the position.
- Note the public and legal naming for the South Yorkshire Integrated Care Board
- Note the new target implementation date for statutory ICSs of 1st July and the initial assessment of impact.
- Note action being taken by the chair designate and LA Chief executives to consider steps to establish the new South Yorkshire Health and Care Partnership (ICP)
- Note formal approval of the draft constitution of NHS South Yorkshire (ICB)
- Note the next steps to recruit to NHS South Yorkshire Board (ICB)
- Note the functional design work and continue to support colleagues to engage in this work where appropriate.
- Note the Due Diligence work and assurance feedback from NHS England and Improvements
- Not discussions underway with CCGs to support and manage the requirement for CCGs to remain in place until 30 June 2022.

Appendix, A. ICS naming g convention 7/12/21

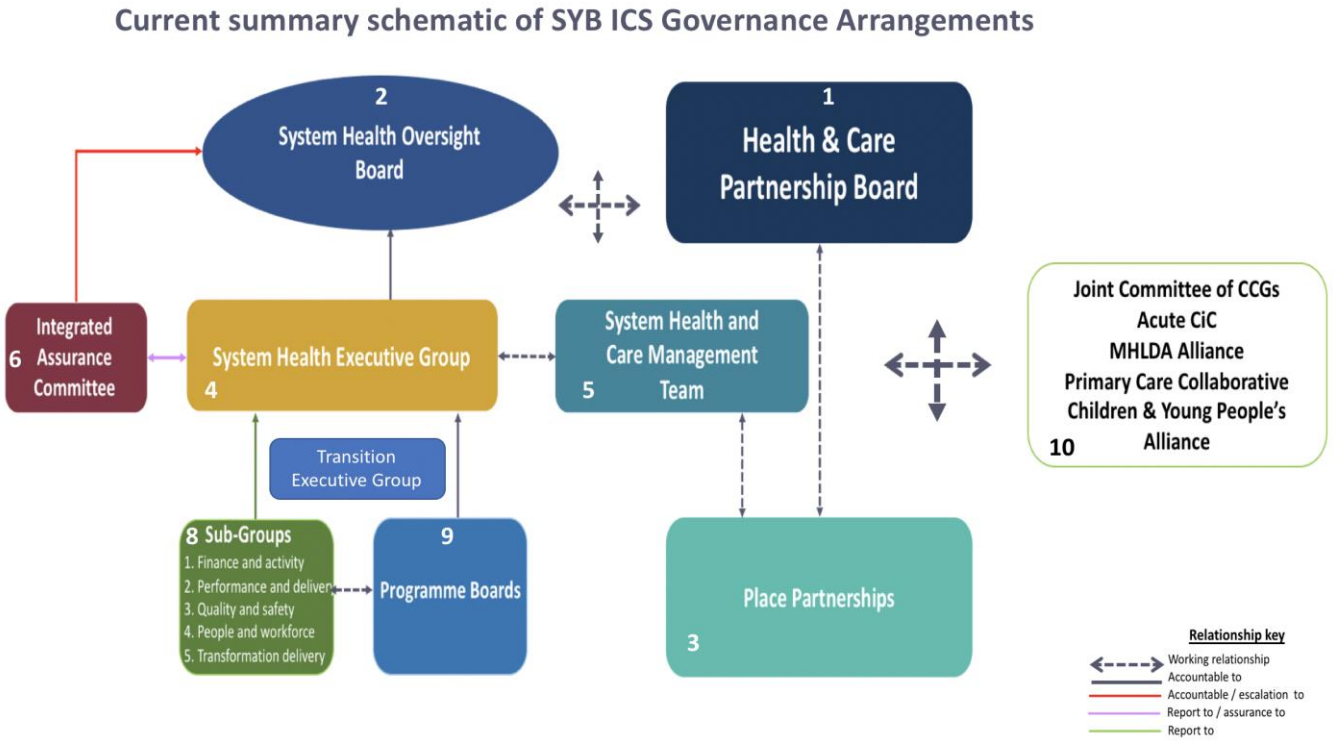
ICS Names as at 07.12.21

	Current ICS geographical descriptor	Integrated Care Board (ICB) legal name (applying naming convention and based on current geographical descriptor of ICS)	Public name of ICB	Proposed name of integrated care System (ICS)	Proposed description/name of Integrated Care Partnership (ICP)	NHS Region
4	South Yorkshire	NHS South Yorkshire Integrated Care Board	NHS South Yorkshire	South Yorkshire Integrated Care System	South Yorkshire Health and Care Partnership	North East and Yorkshire

Appendix, B. Previously shared partners engagement timetable on draft constitution now proposed to NHS England and Improvement

	Action for SY partners, led by ICB Designate Chair	To be completed by
Step 1	Early discussions with partners on the make-up of the board and the process for appointing partners	Friday 22nd October 2021
Step 2	Follow up letters to partners with a small number of key questions for consideration and feedback.	Monday 25th October 2021
Step 3	Deadline for SY partners to send in comments to the letter.	Monday 1st November 2010
Step 4	Share proposals based on discussions and the feedback received from partners	Friday 12th November 2021
Step 5	Second deadline for SY partners to send in comments	Friday 26th November 2021
Step 6	Shared draft Constitution with NHS England and Improvement	Friday 3rd December 2021

Appendix, C



Appendix, D. Summary of functional design themes.

People, Culture and OD and Workforce Development
Population Health, Strategy, planning and commissioning
Finance and Capital Planning
Oversight and Assurance
EPRR
Quality, Safety and Improvement Support
Digital, Data and Business Intelligence
Clinical and Care Professional
Corporate
Partnerships, Involvement and Engagement

NHS
Derby and Derbyshire
Clinical Commissioning Group

Derby and Derbyshire CCG Governing Body Meeting in Public
Held on
13th January 2022 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 (part meeting)
Dr Ruth Cooper	RC	Governing Body GP
Jill Dentith	JD	Lay Member for Governance
Dr Buk Dhadda	BD	Governing Body GP
Helen Dillistone	HD	Executive Director of Corporate Strategy and Delivery
Ian Gibbard	IG	Lay Member for Audit
Zara Jones	ZJ	Executive Director of Commissioning Operations
Dr Steven Lloyd	SL	Medical Director
Simon McCandlish	SM	Lay Member for Patient and Public Involvement
Andrew Middleton	AM	Lay Member for Finance
Dr Emma Pizzey	EP	Governing Body GP
Professor Ian Shaw	IS	Lay Member for Primary Care Commissioning (part meeting)
Dr Greg Strachan	GS	Governing Body GP
Dr Merryl Watkins	MW	Governing Body GP
Martin Whittle	MWh	Lay Member for Patient and Public Involvement / Vice Chair

Apologies:

Dr Penny Blackwell	PB	Governing Body GP
Dr Robyn Dewis	RD	Director of Public Health - Derby City Council
Suzanne Pickering	SP	Head of Governance
Brigid Stacey	BS	Chief Nursing Officer
Dean Wallace	DW	Director of Public Health - Derbyshire County Council

In attendance:

Helen Hipkiss	HH	Director of Quality
Dawn Litchfield	DL	Executive Assistant to the Governing Body / Minute Taker
Maria Muttick	MM	Executive Assistant
Fran Palmer	FP	Corporate Governance Manager
Sean Thornton	ST	Deputy Director Communications and Engagement

Item No.	Item	Action
GBP/2122/214	**Welcome, Apologies & Quoracy** Dr Avi Bhatia (AB) welcomed members to the meeting. Apologies were received and noted as above. It was confirmed that the meeting was quorate.	
GBP/2122/215	**Questions received from members of the public** No questions were received from members of the public.	

GBP/2122/216	**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/2122/217	**Chair's Report – December 2021** AB presented a 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: • It was announced in December that there will be a delay in the setting up of Integrated Care Boards (ICBs), from April 2022 to July 2022, mainly due to the operational pressures currently being experienced across the health and social care system. • An update was provided on the work of the Clinical Professional and Leadership Group (CPLG); the CPLG aims to ensure that a full range of clinicians and care professionals are embedded in the decision-making process in order to ensure that balanced decisions are taken to manage the risks to the delivery of safe care, within the finite resources available. The following questions were raised in relation to the report: • One interpretation of the delay to the ICB was that it presents an opportunity for system-focused development work for the new members of the Board. Moving from CCGs to a System will be a significant cultural change and there is a need for long term emersion to achieve osmosis on the differences; it was enquired if any thought had been given to acceleration of joint development work with a System focus. AB agreed that the delay provides opportunities, as well as issues. Discussions have been held on how the ICB Board will shadow the CCG's Governing Body; the work already undertaken with the Corporate Committees will be built upon and used to benefit the incoming individuals. Helen Dillistone (HD) added that there are pros and cons and risks and benefits to the delay. As already stated, one of the main benefits is that it provides more time for the development work and for the ICB to engage with and learn from the CCG. It will also enable further testing and formalisation of governance. • The opportunity was taken to pay tribute to all NHS and care staff who have worked so hard over the past few months during a very challenging time; it has been difficult for all concerned. Nationally data is captured in terms of COVID-19 infections, hospital admissions and deaths however the numbers of staff available to look after patients is rarely captured. The NHS was already stretched prior to the pandemic however over the last few months it has become more challenging due to staff contracting COVID-19 and self-isolating. The fact that a good	

	quality health service has been maintained despite this is testament to the hard work of its staff. AB concurred with this; it is important that staff are looked after, and their goodwill maintained. Many staff are working beyond their contracted hours on a continual basis to help care for patients. • Patients and their relatives were also commended for stepping up due to the staff shortages. The lower paid staff that are working above and beyond their normal hours and covering extra clinics are also very much appreciated. The CCG's teams have been helpful in finding solutions for the vaccination clinics and this was much appreciated. • It was noted that the focus is on undertaking the most urgent levels of surgery during this period; it was enquired whether the delay to the ICS will change the coherent picture for patients, as most people know someone who has had their surgery delayed. AB suspected that the concerns on the delay at a strategic level are very different to the concerns on the front line where the care is delivered. There are measures in place operationally to deal with the movement of resources to keep the NHS running and cope with the most important matters going forward. AB does not anticipate that the delay will affect operational issues, the hope is that integrated working will improve things moving towards and the lessons learnt from the first wave of the pandemic will be remembered and built upon; there is a lot of work going on behind the scenes to manage all of this. • Dr Bruce Braithwaite (BB) added that hospitals are fairly autonomous in dealing with their patients; staff are doing their best to treat the patients that need to be treated first. He also advised that the independent sector has been contracted to take extra patients. AB considers that the Governing Body has a good understanding of what is happening on the ground. **The Governing Body NOTED the content of the report provided**	
GBP/2122/218	**Chief Executive Officer's Report – December 2021** HD presented Dr Chris Clayton's (CC) report, a copy of which was circulated with the meeting papers. The report was taken as read and the following points of note were made: • The importance of System resilience was reiterated. The Christmas and new year periods are always challenging times of the year, but even more so this year. The report outlines the escalation processes implemented across the broader System partnership; it is helpful to know that the processes are tested and work, building upon the history of working together to overcome the many challenges experienced over the last few years. • The important work on the vaccination and booster programme continues. • There is ongoing communications work to encourage people to access services should they have urgent health requirements or are experiencing worrying symptoms. • Many CCG staff are also currently supporting operational services. The work of the CCG is being reprioritised over the following four areas: - Support to the vaccination programme - Support to System operational resilience	

	- Maintaining CCG business continuity, operating at level 4 activities only - Transition – statutory activities only • All staff were thanked and their hard work over the current difficult time was recognised. The following question was raised: • It was enquired whether the staff survey results are yet available. HD confirmed that the results are imminent, and the headlines will be available for either the February or March Governing Body meetings. It was noted that the response rate had improved by 1% on last year. **The Governing Body NOTED the content of the report provided**	
GBP/2122/219	**2022-23 NHS Priorities and Operational Planning Guidance** Zara Jones (ZJ) introduced the planning guidance for 2022/23, received on 24th December 2021. Guidance is expectedly shortly on the requirements for the Annual Plan for the next financial year; further detailed technical guidance on specific requirements is also expected; however, an overview has been provided on the key areas upon which to focus the efforts with System partners, over the next few weeks, in order to pull together a plan for what will be a challenging 12-month period, with a number of priority areas to be focused upon. The following key points were made: • A timetable has been set for the submission of the final plan by the end of April 2022 to address the key areas of the guidance. • The plan includes ambition around managing the elective programme, particularly the concerns around the effects of the pandemic on non-COVID routine care. There is a clear, strong emphasis on recovering the position as far as possible over the next 12 months. • It is not known how the pandemic will continue to progress and what further impacts may be seen. The System is stressed and strained operationally at the present time which could continue into the next financial year; this is recognised in the guidance however an assumption of stability has been made if the plans set out are to be achieved. • There is a welcome focus on staff health and wellbeing; the strain on capacity as a result of front-line absences was noted. • A significant focus is made on the vaccination programme, which Derbyshire has performed well against, and the longer-term effects of COVID, prioritising long COVID and its associated work. • Elective care - the ambition is to reach 110% of pre-pandemic elective activity, which is a very tall order; it will take a lot, particularly around the workforce and capacity issues, to be able to address this target. Other targets have been set relating to patients waiting long periods of time and improving the backlog. • Cancer – The System has, in terms of recovery, done exceptionally well in terms of cancer waiting times despite increased referrals being made; it is encouraging that people are coming forward for diagnosis. The guidance requests a focus on cancer alliances to ensure improvement and reiterates the importance of screening restoration. • Diagnostics – There is a level of ambition to increase community diagnostics; funding has been made available to support and develop this further.	

	• Maternity care – The forthcoming second Ockendon report and resultant actions will receive funding to invest in the workforce requirements. • Urgent and emergency care – There are challenging targets to achieve, both around length of waits in Emergency Departments for admission, and ambulance delays; targets have been set to ensure that patients are treated and moved through the System in a timely manner to receive the care they need. The provision of rapid response community crisis care to proactively support urgent care provision is welcomed. • Primary Care – The guidance builds on the access plans already developed, looking at supporting practices through their PCNs. There is a focus on digital as an enabler for the System. • Mental health – Traditionally a separate return has been made for the mental health planning process, however this has now been aligned with the operating plan. Clear ambitions are reiterated around the mental health implementation plan, supporting people with learning disabilities and/or autism, and aligning funding flows to maintain continued mental health investment to transform and expand community health services and improve access. The children's mental health programme is also being worked through. • Population health management – Health inequalities have been highlighted due to the widening gaps seen during the pandemic. A focus needs to be maintained on prevention and providing help upstream. The final plan will be submitted towards the end of April, with a draft plan submitted in March. Governing Body members will be kept appraised of the situation accordingly. The following questions were raised: • Building on the work already being undertaken in the organisation and across the System, it is pleasing to see that workforce is a key priority area, as the workforce position underpins all activity; should staff not be available, it will become an area of concern. • Although the establishment of the ICB has moved to 1st July, the planning guidance indicated the need to continue to work collaboratively; it was enquired how Glossop will continue to be included in the conversations to ensure that a System response is provided. ZJ responded that working groups have been established to go through the detail, and assurance was provided that Glossop is being linked into discussions considering the contracting and commissioning side of the transition; this work is being included in the overall planning position. The delay may now allow more time for broader engagement to be undertaken with stakeholders. • Although the plan includes expected and reasonable aspirations, none of them will be achieved without the available workforce. The delay presents a 5 ½ month opportunity to address the staffing issue however the ability to influence the core clinical workforce is out with the CCG's control. Retaining the staff already in place is important. It is pleasing to note that the ICB is appointing an independent member and executive lead for workforce. It was enquired how this essential aspiration will be used to accelerate and grow a substantive workforce in a local context using different types on entrants and apprenticeships; this may require further consideration of the remuneration of low paid staff. It is hoped that the ICB and CCG will give the workforce agenda the prominence it deserves. ZJ agreed that, when the updates on the development of the plan are presented to the Governing Body, a key spotlight will be given to workforce developments; this issue needs to be worked through with the workforce Leads. HD added that the delivery of the plan is dependent	

	upon having a skilled and available workforce in situ. The ICB has a different role, remit, and scope to the CCG, particularly in relation to workforce; it will have an opportunity to drive the workforce through System leadership. Conversations are required around the demand being delivered by the workforce and whether clinicians are being enabled to deliver the right care. A broader strategic conversation is also required with the public on what realistically the NHS will be able to deliver in future. • The guidance assumes that COVID levels will return to a low level; however, the last couple of years has taught us that this cannot be foreseen. It was enquired whether wording will be included in the response to the plan that, although planning is being undertaken for a favourable context regarding COVID, measures will have to be implemented should something happen. ZJ responded that scenario planning will continue to be undertaken in conjunction with the System's research and analytical group to develop modelling and examine trends and variables against national data. It is helpful that the planning guidance recognises that any further waves may impact on the delivery of some of the initiatives included in the plan. • Communication with the public is required, primarily around primary care but also on a different skill mix going forward. There is now a mix of competent professionals in primary care, however there is a misconception that people must see a doctor; 38% of GPs are over 50 and approaching retirement, GPs are not coming in at the same rate as they are leaving therefore a different skill mix will be required going forward. The message that a doctor is not necessarily the best person to solve a problem needs to be communicated widely and it was requested that this be included in the plan. AB added that the message around the different model of General Practice is a positive one, in that patients are able to see the best person to help them. ZJ agreed and will work with the communications team to accelerate this. • A 110% proposed turnover was disheartening when the hospital is not currently achieving 100%. The public may assume that more routine operations will be undertaken however, cancer and emergency work will be prioritised. Concern was expressed for staff morale when they are already working so hard. ZJ agreed with the need for clear communications to support this, although there is an ambition to recover the backlog if the situation allows. • The ambitions included in the paper were saluted and although some new money is to be made available, there is talk of a return to a normal financial regime and an affordability gap, with reference to efficiency targets and convergence adjustments that could mean a reduction in the money available. Pre-pandemic, the overall strategy was to shift towards prevention and primary care to address health inequalities. It is hoped that this ambition will be retained, as if there is an ambition to increase hospital turnover, the money may need to go to the Acute Hospitals; it was enquired how this will be reconciled. Richard Chapman (RCp) advised that every System will be required to make an efficiency saving next year. The change in the external financial environment for Systems is that all support monies previously directed at organisations within CCGs will now be put into a single financial envelope to be distributed according to a fair shares formula on a System basis, including the Commissioner Support Funding and Provider Support Funding received. As the CCG was in receipt of such large amounts it is above target; the contractual value was based on what was received in the last financial year, based on the costs of running a system rather than a fair shares formula. A national efficiency saving is required, and convergent	

	adjustments will have to be contended with to bring us closer to a fair shares formula. Derbyshire will receive less in 2022/23 than in 2021/22, the greatest reduction being COVID funding; if the COVID funding was removed, the CCG would have received more in 2022/23. The guidance references £2.3m of elective recovery funding to be earned by Acute Trusts for going above 110%; this would be additional money into the System if it is delivered. Preventing avoidable admissions will help to free up avoidable acute bed occupation and drive efficiencies. • Currently 20% of beds are taken up by patients that cannot be discharged due to unavailability of care packages, and 20% of beds are taken up by avoidable respiratory admissions; if these problems were solved, 40%. Capacity would be gained. • The focus on primary care must shift away from patients' dissatisfaction should they not be able to get an appointment with a doctor; the primary issue is having a concern addressed and resolved in a timely manner. If the focus were to be shifted to this measurement of primary care, it would prevent unnecessary criticism of GPs who are only trying to guide patients in the right direction. A national campaign may be needed to achieve this, however with only 42 ICBs, there will be a better chance of reaching a coherent agreement. • Helen Hipkiss (HH) confirmed that there is a significant programme of work underway to review all discharges; the issue is not only around social care, but also a lack of NHS staffing with significant numbers of staff off with COVID or self-isolating. A three-week programme of work commenced yesterday which will focus on how to move things forward. AB concluded that General Practice is a complex and emotive subject and a very difficult issue to fix; all points made were very valid and will be taken on board for transfer into the ICB. **The Governing Body NOTED the content of the guidance and will be updated further as the planning work proceeds over coming weeks**	
GBP/2122/220	**Update to Transition Timeline and implications for consideration** HD outlined the implications of the change in the timeline for the ICS transition which were included in the planning guidance received in December 2021. There will be a slippage in the closedown of the CCG and creation of the ICB, from 1st April to 1st July 2022. Consequently, the implications of the revision need to be understood. The revised establishment timeline is still awaited. The CCG's Transition Working Group (TWG) and System's Transition Assurance Committee (TAC) have overseen the key areas of development over the last 7 months and will consider the implications of the delay. It is not expected that there will be a significant amount of slippage in the key milestone dates therefore the work will continue as planned. There is a need to ensure that an effective operational ICB is in situ until 1st July 2022 and that the Governing Body is able to function appropriately. Areas for consideration included: • Preparation for the establishment of the ICB • Continuation of corporate governance processes • Clarity on the timetabling of Annual Reports and the logistics as to whether it could be undertaken as a 15-month report • The implications and impact of the delay on financial planning • Audit planning	

	• HR matters including continued staff support for the protracted period of uncertainty • The impact on operational and technical matters, including contracting • The boundary change relating to Glossop and the associated activities to support it. It is unclear whether this will be April or July; further national advice is being taken on this. **The Governing Body NOTED the contents of the paper and letter, and considered the issues outlined that highlight some of the implications which need to be worked through as a consequence of the delay**	
GBP/2122/221	**Finance Report – Month 8** RCp provided an update on the financial position as at Month 8 (H2). The following points of note were made: • It was confirmed that all targets will be met assuming receipt of COVID reimbursement and Elective Recovery Funding. • Forecast outturn as at month 8 remains at breakeven, with additional reimbursement expected of £7.759m for the Additional Roles' Reimbursement Scheme (ARRS) for Primary Care Co-Commissioning. • £1.631m of the H2 contingency has been released into the year-to-date position. • A straight-line extrapolation of the Year-To-Date (YTD) expenditure to forecast outturn was presented. • There is circa £2.5m retained flexibility for the current financial year. • Continuing Health Care (CHC) pressures continue with increased discharge pressures across the System; controls remain in place. • Prescribing pressures, driven by volumes as opposed to prices of prescriptions, continue in primary care services. **The Governing Body NOTED the following:** • **Allocations have been received for the full year at £2.079bn** • **The YTD reported underspend at month 8 is £0.730m** • **Retrospective allocations received for H1 Covid spend on the Hospital Discharge Programme were £5.498m, further funding is expected of £1.358m relating to month 7 and 8** • **The Elective Recovery Fund has been reimbursed £0.756m for April to November with an additional £5k anticipated** • **The year-end position is forecast at £0.03m underspent**	
GBP/2122/222	**Finance Committee Assurance Report – December 2021** Andrew Middleton (AM) provided a verbal update following the Finance Committee meeting held on 23rd December 2021. The following points of note were made: • These are exceptional times and there are risks attached to this budget, one being CHC, which receives constant attention. • The Finance Committee, in its deep dive agenda, continues to focus on matters that will not come to fruition before the demise of the CCG; nevertheless, the System needs to understand them. These include the Better Care Fund and Personal Health Budgets. • Double running costs relating to the setup of the ICB are now being incurred; for financial governance purposes, RCp has been requested to identify the components of the ICS preparation costs, the costs of	

	which will be absorbed by the CCG as there is no national fund for this purpose. RCp advised that, at the start of the financial year, it was anticipated that there were likely to be transitional double running costs and a reserve was set aside to cover them. RCp is not aware of a national requirement to keep a record of the transition costs incurred, however the CCG will be able to collate the local costs. **The Governing Body NOTED the verbal update provided for assurance purposes**	
GBP/2122/223	**Audit Committee Assurance Report – December 2021** Ian Gibbard (IG) provided an update following the Extraordinary Audit Committee meeting held on 17th December 2021. The report was taken as read and the following point of note was made: • The Committee signed off the due diligence checklist and finance transition plan; although both good reports, this is clearly still a work in progress on which the change of ICB implementation date will have an impact. The Committee will receive updates at its February meeting. **The Governing Body NOTED the update provided for assurance purposes**	
GBP/2122/224	**Clinical and Lay Commissioning Committee (CLCC) Assurance Report – December 2021** Dr Ruth Cooper (RC) provided an update following the CLCC meeting held on 9th December 2021. The report was taken as read and no questions were raised. **The Governing Body NOTED the paper for assurance purposes and RATIFIED the decisions made by the CLCC**	
GBP/2122/225	**Primary Care Commissioning Committee (PCCC) Assurance Report – December 2021** Simon McCandlish (SM) provided a verbal update following the PCCC meeting held on 22nd December 2021. The following points of note were made: • There were no items for discussion at the meeting. • The financial position was noted. • Assurance was provided on the improving position at the Brailsford and Hulland practice. • No changes were made to the to Risk Register. **The Governing Body NOTED the verbal update provided for assurance purposes**	

GBP/2122/226	**Quality and Performance Committee (Q&PC) Assurance Report – December 2021** Dr Buk Dhadda (BD) provided an update following the Q&PC meeting held on 23rd December 2021. The report was taken as read and the following points of note were made: • SEND re-inspection in Derby City – Prior to the pandemic, significant areas requiring urgent action were identified. A reinspection took place in October 2021 by Ofsted and the CQC, the outcome of which was that significant progress has been made in addressing the previous weaknesses. The quarterly support and challenge visits from NHSEI will now cease. This is an ongoing piece of work, with some improvements still to be made. Thanks were recorded to the Local Authority and CCG teams for their hard work in pulling this together. • Workforce – The Q&PC is aware of the workforce challenges which are affecting performance and have invited Linda Garnett, the System's workforce lead, to a Q&PC meeting to provide an oversight of the work being undertaken at a System level. The sickness rates at Derbyshire Community Health Service are concerning and underline the importance of having a good staff base from which to call upon. Through the System work, it is hoped that such issues can be addressed, and resolved. It was disappointing to note that the System's People and Culture Committee meeting was cancelled yesterday. BD added that the Q&PC has been addressing this over the last few months and saw the challenge ahead. The operational planning guidance was welcomed, and the Committee is keen to understand what is happening with the workforce at a System level; a close eye is being kept on this and the Governing Body will be updated accordingly. **The Governing Body NOTED the paper for assurance purposes**	
GBP/2122/227	**Governing Body Assurance Framework Quarter 3** HD presented the Governing Body Assurance Framework (GBAF) for Quarter 3 detailing the organisation's strategic risks and the processes that underpin their ongoing monitoring, support, and delivery. The following changes were noted: • Risk 7 relates to CCG staff retention and morale. It is overseen by the Governance Committee. It was requested that this risk be increased from 6 to 12, due to concern around losing staff, particularly with the change and uncertainly of the ICB timeframe. The scoring of this risk will be aligned with the overarching Transition Plan. • Risk 8 relates to the transfer of functions and the work to close down the CCG and transition it into the ICB. It was requested that this risk be reduced as a result of the systems and processes now implemented and the signing off of the due diligence by the Audit Committee. The following questions were raised: • It was enquired whether Risk 7 relates to a general reading of the uncertainties of the transition or whether it is based on hard evidence from resignations to date. HD confirmed that some turnover has been	

	seen across the organisation however it is not necessarily related to the transition and the uncertainty; many people have moved into System wide roles. It was recognised that as people move on, during a period of transition, it is harder to recruit staff therefore the organisation is having to rely on agency staff or use its teams differently. There could potentially be an increase in this risk. Given that the ICB will embrace the concept of one workforce, it was asked if there will be any opportunity to trial this when CCG vacancies arise. HD advised that all vacancies are advertised in the most appropriate way. Of the people moving on, there is a cohort of individuals moving to providers, some moving to the Regulator and some leaving the NHS altogether. Good interest is being received for the substantive roles advertised; however, as some roles need to be filled on a fixed term or secondment basis, they are not all being appointed to; the need to support staff to develop must be balanced with business continuity. It was enquired what changes have been seen to warrant an increase in Risk 7. HD responded that additional support has been implemented for staff and teams, with regular communications held to balance business continuity with staff being able to progress and apply for secondments. Conversations are being held to prevent the creation of a bigger problem for the organisation as roles are lifted and shifted into the ICB. The redeployment of some teams due to the pandemic was also recognised. The Senior Leadership Team meets twice weekly, and these types of issues are discussed and escalated appropriately. **The Governing Body AGREED the 2021/22 Quarter 3 (October to December 2021) Governing Body Assurance Framework**	

GBP/2122/228	**CCG Risk Register – December 2021**
	
	HD advised that this report highlights areas of organisational risk recorded in DDCCG's Corporate Risk Register as at 31st December 2021. All risks in the Register are allocated to one of the CCG's Corporate Committees which reviews them on a monthly basis to ascertain if any amendments in risk score are required. The paper was taken as read and no questions were raised.
	
	The Governing Body RECEIVED and NOTED:
	
	• **The Risk Register Report**
	• **Appendix 1 as a reflection of the risks facing the organisation as at 31st December 2021**
	• **Appendix 2 which summarises the movement of all risks in December 2021**
	• **The decrease in risk score for:**
	  • **Risk 06 relating to the demand for Psychiatric intensive Care Unit beds**
	  • **Risk 32 relating to the risk of exploitation by malevolent third parties if vulnerability is identified within any of the Microsoft Office 2010 applications after 14th October 2020 and not patched**
	• **The increase in risk score for:**
	  • **Risk 09 relating to sustainable digital performance**	

	• **Risk 23 relating to CCG staff capacity compromised** • **New risk 42 relating to climate change** **And APPROVED the closure of risk 38 relating to the quality of care potentially being impacted by patients not receiving a care needs review in a timely way as a result of the COVID pandemic and the requirement for some of the Midland and Lancashire Commissioning Support Unit Individual Patient Activity/Continuing Health Care**	
GBP/2122/229	**Ratified Minutes of DDCCG's Corporate Committees:** • Primary Care Commissioning Committee – 24.11.2021 • Quality and Performance Committee – 25.11.2021 **The Governing Body RECEIVED and NOTED these minutes**	
GBP/2122/230	**Minutes of the Governing Body meeting in public held on 2nd December 2021** **The minutes of the above meeting were agreed as a true and accurate reflection of the discussions held**	
GBP/2122/231	**Matters Arising / Action Log** Action Log – December 2021 – No outstanding items	
GBP/2122/232	**Forward Planner** **The Governing Body NOTED the Planner for information**	
GBP/2122/233	**Any Other Business** None raised	
DATE AND TIME OF NEXT MEETING – Thursday 3rd February 2022 at 9.30am via MST		

Signed by: ……. Dated: ……
(Chair)

Derby and Derbyshire
Clinical Commissioning Group

GOVERNING BODY MEETING IN PUBLIC
ACTION SHEET – January 2022

Item No.	Item title	Lead	Action Required	Action Implemented	Due Date
2021/22 Actions					
GBP/2122/054	Joined Up Care Derbyshire Board Update – May 2021	Helen Dillistone	It was requested that a Governing Body Development / Transition Session be planned to ensure that Governing Body members are sufficiently sighted on the measures being taken to address the health inequalities in Derbyshire; Dr Robyn Dewis and Dean Wallace will be requested to provide input into this session on the inequalities' strategy.	To be picked up as part of the integrated working arrangements going forward	**Item complete**
GBP/2122/174	Winter Plan Update	Helen Dillistone	It was requested that the Governing Body holds a deep dive on the workforce challenges.	To be picked up as part of the integrated working arrangements going forward	**Item complete**

NHS
Derby and Derbyshire
Clinical Commissioning Group

Derby and Derbyshire CCG Governing Body Forward Planner 2021/22

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

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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		
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			
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	
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

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AGENDA ITEM / ISSUE												
Minutes of Health and Wellbeing Board Derby City	X		X		X				X			
Minutes of Health and Wellbeing Board Derbyshire County	X		X		X				X			
Minutes of Joined Up Care Derbyshire Board	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												