

NHS DERBY AND DERBYSHIRE CCG
GOVERNING BODY – MEETING IN PUBLIC

Date & Time: Thursday 3rd June 2021 – 9.30am to 11.15am

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/2122/049	Welcome, Apologies & Quoracy Apologies: Zara Jones, Dr Chris Clayton, Dr Merryl Watkins, Richard Chapman, Dean Wallace, Dr Robyn Dewis, Dr Penny Blackwell, Dr Greg Strachan	Verbal	Dr Avi Bhatia	9.30
GBP/2122/050	Questions from members of the public	Verbal	Dr Avi Bhatia	
GBP/2122/051	Declarations of Interest <ul style="list-style-type: none"> • Register of Interests • Summary register for recording any conflicts of interests during meetings • Glossary 	Papers	Dr Avi Bhatia	
CHAIR AND CHIEF OFFICER REPORTS				
GBP/2122/052	Chair's Report	Paper	Dr Avi Bhatia	9.35
GBP/2122/053	Chief Executive Officer's Report	Paper	Helen Dillistone	
GBP/2122/054	Joined Up Care Derbyshire Board Update	Paper	Dr Avi Bhatia	
FOR DECISION				
GBP/2122/055	Primary Care Commissioning Committee Terms of Reference	Paper	Helen Dillistone	9.50

FOR DISCUSSION				
GBP/2122/056	2021/22 Operational Plan	Paper	Mick Burrows	9.55
CORPORATE ASSURANCE				
GBP/2122/057	Finance Report – Month 1	Paper	Niki Bridge	10.15
GBP/2122/058	Finance Committee Assurance Report – May 2021	Verbal	Andrew Middleton	
GBP/2122/059	Audit Committee Assurance Report – May 2021	Paper	Ian Gibbard	
GBP/2122/060	Clinical and Lay Commissioning Committee Assurance Report – May 2021	Paper	Dr Ruth Cooper	
GBP/2122/061	Derbyshire Engagement Committee Assurance – May 2021	Paper	Martin Whittle	
GBP/2122/062	Governance Committee Assurance Report – May 2021	Paper	Jill Dentith	
GBP/2122/063	Primary Care Commissioning Committee Assurance Report – May 2021	Verbal	Professor Ian Shaw	
GBP/2122/064	Quality and Performance Committee Assurance Report – May 2021	Paper	Andrew Middleton	
GBP/2122/065	CCG Risk Register – May 2021	Paper	Helen Dillistone	
FOR INFORMATION				
GBP/2122/066	LeDeR Annual Report 2020/21	Paper	Brigid Stacey	10.40
GBP/2122/067	Derbyshire Transforming Care Partnership Annual Report 2020/21	Paper	Brigid Stacey	
GBP/2122/068	Joined Up Care Derbyshire Board meeting minutes – April 2021	Paper	Dr Avi Bhatia	
GBP/2122/069	Health and Wellbeing Board meeting minutes – Derbyshire County Council – April 2021	Papers	Dr Avi Bhatia	
GBP/2122/070	Ratified Minutes of Corporate Committees: <ul style="list-style-type: none"> • Audit Committee – 22.4.2021 • Derbyshire Engagement Committee – 16.3.2021 • Governance Committee – 11.3.2021 	Papers	Committee Chairs	

	<ul style="list-style-type: none"> • Primary Care Commissioning Committee – 28.4.2021 • Quality and Performance Committee – 29.4.2021 			
GBP/2122/071	South Yorkshire and Bassetlaw Integrated Care System CEO Report – May 2021	Paper	Dr Avi Bhatia	
MINUTES AND MATTERS ARISING FROM THE PREVIOUS MEETING				
GBP/2122/072	Minutes of the Governing Body Meeting in Public held on 6th May 2021	Paper	Dr Avi Bhatia	11am
GBP/2122/073	Matters arising from the minutes not elsewhere on agenda: <ul style="list-style-type: none"> • Action Log – May 2021 	Paper	Dr Avi Bhatia	
GBP/2122/074	Forward Planner	Paper	Dr Avi Bhatia	
GBP/2122/075	Any Other Business	Verbal	All	

Date and time of next meeting: Thursday 1st July 2021 from 9.30am to 11.15am – via Microsoft Teams

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

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

Name	Job Title	Committee Member	Also a member of	Declared Interest (Including direct/ indirect Interest)	Type of Interest				Date of Interest		Action taken to mitigate risk	
					Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From	To		
Bhatia, Dr Avi	Clinical Chair	Governing Body	Erewash Place Alliance Group Derbyshire Primary Care Leadership Group Derbyshire Place Board Joined Up Care Derbyshire Long Term Conditions Workstream	GP Partner at Moir Medical Centre GP Parter at Erewash Health Partnership Spouse works for Nottingham University Hospitals in Gynaecology Part landlord/owner of premises at College Street Medical Practice, Long Eaton, Nottingham	✓	✓		✓	2000 April 2018 Ongoing Ongoing	Ongoing Ongoing Ongoing Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair	
Blackwell, Dr Penny	Governing Body GP	Governing Body	Derbyshire Primary Care Leadership Group Gastro Delivery Group Derbyshire Place Board Dales Health & Wellbeing Partnership Dales Place Alliance Group Joined Up Care Derbyshire Long Term Conditions Workstream	Director of Flourish Derbyshire Dales CIC, which aims to provide creative arts and activity projects and to support others in this activity for the Derbyshire Dales GP partner at Hannage Brook Medical Centre, Wirksworth. Interests in Drug misuse GP lead for Shared Care Pathology, Derbyshire Pathology Clinical advisor to the board of Sinfonia Viva, a professional orchestra		✓			Feb 2019 Oct 2010 2011 01/04/21	Ongoing Ongoing Ongoing Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair	
Braithwaite, Bruce	Secondary Care Specialist	Governing Body	Audit Committee Clinical & Lay Commissioning Committee	Shareholder in BD Braithwaite Ltd, which provides clinical services to Independent Healthcare Group and provides private medical services in the East Midlands (including patients who are not eligible for NHS funded treatment according to CCG guidelines) Employed by Nottingham University Hospital NHS Trust which is commissioned by the CCG to provide services to NHS patients. Founder Member, Shareholder and Director of Clinical Services for Alliance Surgical plc which is a company that bids for NHS contracts. Fellow of the Royal College Of Surgeons of England and Member of the Vascular Society of Great Britain and Ireland. Advisor to NICE on an occasional basis. Honorary Associate Professor, University of Nottingham, involved in clinical research activity in the East Midlands. Medical Director of Independent Healthcare Group which provides local anaesthetic services to NHS patients in Leicestershire, Gloucestershire, Wiltshire and Somerset. Chief Medical Officer for Circle Harmony Health Limited which is part owned by Circle Health Group who run BMI and Circle Hospitals	✓				Aug 2014 Aug 2000 July 2007 Aug 1992 Aug 2009 Oct 2020 Aug 2020	Ongoing Ongoing Ongoing Ongoing Ongoing Ongoing Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair Declare interest in relevant meetings Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair No action required No action required Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair	
Chapman, Richard	Chief Finance Officer	Governing Body	Clinical & Lay Commissioning Committee Finance Committee Primary Care Commissioning Committee	Nil								No action required
Clayton, Dr Chris	Chief Executive Officer	Governing Body	Clinical & Lay Commissioning Committee Primary Care Commissioning Committee	Spouse is a partner in PWC				✓	2019	Ongoing		Declare interest at relevant meetings

Cooper, Dr Ruth	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Finance Committee North East Derbyshire & Bolsover Place Alliance Group Derbyshire Primary Care Leadership Group CRHFT Clinical Quality Review Group GP Workforce Steering Group Conditions Specific Delivery Board	Locum GP at Staffa Health, Tibshelf Shareholder in North Eastern Derbyshire Healthcare Ltd Director of IS and RC Limited, providing medical services to Staffa Health and South Hardwick PCN, which includes the role of clinical lead for the Enhanced Health in Care Homes project Fundraising Activities through Staffa Health to support Ashgate Hospice and Blythe House	✓ ✓ ✓	✓	✓	Dec 2020 2015 03/02/2021 Ongoing	Ongoing Ongoing Ongoing Ongoing	Declare interests at relevant meetings and Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Dentith, Jill	Lay Member for Governance	Governing Body	Audit Committee Governance Committee Primary Care Commissioning Committee Remuneration Committee System Transition Committee System People and Culture Group	Self-employed through own management consultancy business trading as Jill Dentith Consulting Providing part-time, short term corporate governance support to Rotherham NHS Foundation Trust Director of Jon Carr Structural Design Ltd	✓ ✓ ✓			2012 6 Oct 2020 6 Apr 2021	Ongoing 8 April 2021 Ongoing	Declare interests at relevant meetings
Dewis, Dr Robyn	Director of Public Health, Derby City Council	Governing Body	Clinical & Lay Commissioning Committee Clinical Policy Advisory Group Joint Area Prescribing Committee Conditions Specific Delivery Board CVD Delivery Group Derbyshire Place Board Derby City Place Alliance Group Respiratory Delivery Group	Nil						No action required
Dhadda, Dr Bukhtawar S	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Finance Committee Quality & Performance Committee UHDB Clinical Quality Review Group Clinical Policy Advisory Group	GP Partner at Swadlincote Surgery	✓			2015	Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Dillstone, Helen	Executive Director of Corporate Strategy & Delivery	Governing Body	Engagement Committee Governance Committee	Nil						No action required
Gibbard, Ian	Lay Member for Audit	Governing Body	Audit Committee Clinical & Lay Commissioning Committee Finance Committee Governance Committee Remuneration Committee Individual Funding Requests Panel	Nil						No action required
Jones, Zara	Executive Director of Commissioning & Operations	Governing Body	Clinical & Lay Commissioning Committee Quality & Performance Committee CRHFT Contract Management Board	Nil						No action required
Lloyd, Dr Steven	Medical Director	Governing Body	CVD Delivery Group Clinical & Lay Commissioning Committee Conditions Specific Delivery Board CRHFT Contract Management Board 999 Quality Assurance Group Derbyshire Prescribing Group Derbyshire System Flu Planning Cell Finance Committee Primary Care Commissioning Committee Quality & Performance Committee	GP Partner at St. Lawrence Road Surgery Clinical sessions at St. Lawrence Road Surgery Shareholder in premises of Emmett Carr Surgery, Renishaw; and St. Lawrence Road Surgery, North Wingfield	✓ ✓ ✓			2012 2012 Ongoing	Ongoing Ongoing Ongoing	Declare interests at relevant meetings
McCandlish, Simon	Lay Member for Patient and Public Involvement	Governing Body	Clinical & Lay Commissioning Committee Engagement Committee Primary Care Commissioning Committee Quality & Performance Committee Commissioning for Individuals Panel (Shared Chair)	Nil						No action required
Middleton, Andrew	Lay Member for Finance	Governing Body	Audit Committee Finance Committee Quality & Performance Committee Remuneration Committee Commissioning for Individuals Panel (Shared Chair) Derbyshire System Finance Oversight Group	Lay Vice Chair of East Riding of Yorkshire Clinical Commissioning Group Lay Chair of Performers List Decision Panels for NHS England Central Midlands Lay Chair of Appointment Advisory Committees at United Hospitals Leicester - chairing panels for appointing hospital consultants	✓ ✓ ✓			Jan 2017 May 2013 Mar 2020	Mar 2023 Ongoing Mar 2023	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 DCHS Clinical Quality Review Group	Partner at Littlewick Medical Centre Executive director Erewash Health Partnership Involvement with INR service	✓ ✓ ✓			Mar 2002 Apr 2018 1 Apr 2021	Ongoing Ongoing Ongoing	Declare interests at relevant meetings. The INR service interest is to be noted at Governance Committee due to the procurement highlight report, which refers to, for information only, the INR service re-procurement. No further action is necessary as no decisions will be made at this meeting and the information provided does not cause a conflict.
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 18.03.20 2015 1 April 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 Meryl	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Quality & Performance Committee	GP Partner at Vernon Street Medical Centre Husband is Anaesthetic and Chronic Pain Consultant at Royal Derby Hospital	✓		✓	2008 1992	Ongoing Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair	
Whittle, Martin	Lay Member for Patient and Public Involvement	Governing Body	Engagement Committee Finance Committee Governance Committee Quality & Performance Committee Remuneration Committee	Nil							No action required

SUMMARY REGISTER FOR RECORDING ANY INTERESTS DURING MEETINGS

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

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

Glossary	
A&E	Accident and Emergency
AfC	Agenda for Change
AGM	Annual General Meeting
AHP	Allied Health Professional
AQP	Any Qualified Provider
Arden & GEM CSU	Arden & Greater East Midlands Commissioning Support Unit
ARP	Ambulance Response Programme
ASD	Autistic Spectrum Disorder
ASTRO PU	Age, Sex and Temporary Resident Originated Prescribing Unit
BCCTH	Better Care Closer to Home
BCF	Better Care Fund
BME	Black Minority Ethnic
BMI	Body Mass Index
bn	Billion
BPPC	Better Payment Practice Code
BSL	British Sign Language
CBT	Cognitive Behaviour Therapy
CAMHS	Child and Adolescent Mental Health Services
CATS	Clinical Assessment and Treatment Service
CCE	Community Concern Erewash
CCG	Clinical Commissioning Group
CDI	Clostridium Difficile
CETV	Cash Equivalent Transfer Value
Cfv	Commissioning for Value
CHC	Continuing Health Care
CHP	Community Health Partnership
CMP	Capacity Management Plan
CNO	Chief Nursing Officer
COP	Court of Protection
COPD	Chronic Obstructive Pulmonary Disorder
CPD	Continuing Professional Development
CPN	Contract Performance Notice
CPRG	Clinical & Professional Reference Group
CQC	Care Quality Commission
CQN	Contract Query Notice
CQIN	Commissioning for Quality and Innovation
CRG	Clinical Reference Group
CSE	Child Sexual Exploitation
CSU	Commissioning Support Unit
CRHFT	Chesterfield Royal Hospital NHS Foundation Trust
CSF	Commissioner Sustainability Funding
CTR	Care and Treatment Reviews
CVD	Chronic Vascular Disorder
CYP	Children and Young People
D2AM	Discharge to Assess and Manage
DAAT	Drug and Alcohol Action Teams
DCCPC	Derbyshire Affiliated Clinical Commissioning Policies
DCHSFT	Derbyshire Community Healthcare Services NHS Foundation Trust
DCO	Designated Clinical Officer
DHcFT	Derbyshire Healthcare NHS Foundation Trust
DHU	Derbyshire Health United
DNA	Did not attend

DoH	Department of Health
DOI	Declaration of Interests
DoLS	Deprivation of Liberty Safeguards
DRRT	Dementia Rapid Response Service
DSN	Diabetic Specialist Nurse
DTOC	Delayed Transfers of Care – the number of days a patient deemed medically fit is still occupying a bed.
ED	Emergency Department
EDEN	Effective Diabetes Education Now
EDS2	Equality Delivery System 2
EIHR	Equality, Inclusion and Human Rights
EIP	Early Intervention in Psychosis
EMAS	East Midlands Ambulance Service NHS Trust
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.
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.
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.
EMLA	East Midlands Leadership Academy
ENT	Ear Nose and Throat
EOL	End of Life
EPRR	Emergency Preparedness Resilience and Response
FCP	First Contact Practitioner
FFT	Friends and Family Test
FGM	Female Genital Mutilation
FIRST	Falls Immediate Response Support Team
FRG	Financial Recovery Group
FRP	Financial Recovery Plan
GAP	Growth Abnormalities Protocol
GBAF	Governing Body Assurance Framework
GDPR	General Data Protection Regulation
GNBSI	Gram Negative Bloodstream Infection
GP	General Practitioner
GPFV	General Practice Forward View
GPSI	GP with Specialist Interest
GPSOC	GP System of Choice
HCAI	Healthcare Associated Infection
HDU	High Dependency Unit
HEE	Health Education England
HLE	Healthy Life Expectancy
HSJ	Health Service Journal
HWB	Health & Wellbeing Board
IAF	Improvement and Assessment Framework
IAPT	Improving Access to Psychological Therapies

ICM	Institute of Credit Management
ICO	Information Commissioner's Office
ICP	Integrated Care Provider
ICS	Integrated Care System
ICU	Intensive Care Unit
IGAF	Information Governance Assurance Forum
IGT	Information Governance Toolkit
IP&C	Infection Prevention & Control
IT	Information Technology
IWL	Improving Working Lives
JAPC	Joint Area Prescribing Committee
JSAF	Joint Safeguarding Assurance Framework
JSNA	Joint Strategic Needs Assessment
k	Thousand
KPI	Key Performance Indicator
LA	Local Authority
LAC	Looked after Children
LCFS	Local Counter Fraud Specialist
LD	Learning Disabilities
LGB&T	Lesbian, Gay, Bi-sexual and Trans-gender
LHRP	Local Health Resilience Partnership
LMC	Local Medical Council
LMS	Local Maternity Service
LOC	Local Optical Committee
LPC	Local Pharmaceutical Council
LPF	Lead Provider Framework
m	Million
MAPPA	Multi Agency Public Protection arrangements
MASH	Multi Agency Safeguarding Hub
MCA	Mental Capacity Act
MDT	Multi-disciplinary Team
MH	Mental Health
MHMIS	Mental Health Minimum Investment Standard
MIG	Medical Interoperability Gateway
MIUs	Minor Injury Units
MMT	Medicines Management Team
MOL	Medicines Order Line
MoM	Map of Medicine
MoMO	Mind of My Own
MRSA	Methicillin-resistant Staphylococcus aureus
MSK	Musculoskeletal
MTD	Month to Date
NECS	North of England Commissioning Services
NEPTS	Non-emergency Patient Transport Services
NHAIS	National Health Application and Infrastructure Services
NHSE	NHS England
NHS e-RS	NHS e-Referral Service
NICE	National Institute for Health and Care Excellence
NOAC	New oral anticoagulants
NUH	Nottingham University Hospitals NHS Trust
OJEU	Official Journal of the European Union
OOH	Out of Hours
ORG	Operational Resilience Group
PAD	Personally Administered Drug

PALS	Patient Advice and Liaison Service
PAS	Patient Administration System
PCCC	Primary Care Co-Commissioning Committee
PCD	Patient Confidential Information
PCDG	Primary Care Development Group
PCNs	Primary Care Networks
PEARS	Primary Eye care Assessment Referral Service
PEC	Patient Experience Committee
PHB's	Personal Health Budgets
PHSO	Parliamentary and Health Service Ombudsman
PICU	Psychiatric Intensive Care Unit
PIR	Post-Infection Review
PLCV	Procedures of Limited Clinical Value
POA	Power of Attorney
POD	Point of Delivery
PPG	Patient Participation Groups
PPP	Prescription Prescribing Division
PRIDE	Personal Responsibility in Delivering Excellence
PSED	Public Sector Equality Duty
PSO	Paper Switch Off
PwC	Price, Waterhouse, Cooper
QA	Quality Assurance
QAG	Quality Assurance Group
Q1	Quarter One reporting period: April – June
Q2	Quarter Two reporting period: July – September
Q3	Quarter Three reporting period: October – December
Q4	Quarter Four reporting period: January – March
QIA	Quality Impact Assessment
QIPP	Quality, Innovation, Productivity and Prevention
QUEST	Quality Uninterrupted Education and Study Time
QOF	Quality Outcome Framework
QP	Quality Premium
Q&PC	Quality and Performance Committee
RAP	Recovery Action Plan
RCA	Root Cause Analysis
REMCOM	Remuneration Committee
RTT	Referral to Treatment
RTT Admitted	The percentage of patients waiting 18 weeks or less for treatment of the patients on admitted pathways
RTT Non admitted	- The percentage if patients waiting 18 weeks or less for the treatment of patients on non-admitted pathways
RTT Incomplete	- The percentage of patients waiting 18 weeks or less of the patients on incomplete pathways at the end of the period
ROI	Register of Interests
SAAF	Safeguarding Adults Assurance Framework
SAR	Service Auditor Reports
SAT	Safeguarding Assurance Tool
SBS	Shared Business Services
SDMP	Sustainable Development Management Plan
SEND	Special Educational Needs and Disabilities
SHFT	Stockport NHS Foundation Trust
SFT	Stockport Foundation Trust
SNF	Strictly no Falling
SOC	Strategic Outline Case

SPA	Single Point of Access
SQI	Supporting Quality Improvement
SRG	Systems Resilience Group
SIRO	Senior Information Risk Owner
SRT	Self-Assessment Review Toolkit
STAR PU	Specific Therapeutic Group Age-Sec Prescribing Unit
STEIS	Strategic Executive Information System
STHFT	Sheffield Teaching Hospital Foundation Trust
STOMPLD	Stop Over Medicating of Patients with Learning Disabilities
STP	Sustainability and Transformation Partnership
TCP	Transforming Care Partnership
TDA	Trust Development Authority
T&O	Trauma and Orthopaedics
UTC	Urgent Treatment Centre
UEC	Urgent and Emergency Care
UHDBFT	University Hospitals of Derby and Burton Foundation Trust
YTD	Year to Date
111	The out of hours service 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.
52WW	52 week wait

Governing Body Meeting in Public

3rd June 2021

Item No: 052

Report Title	Chair's Report - May 2021
Author(s)	Dr Avi Bhatia, CCG Clinical Chair
Sponsor (Director)	Dr Avi Bhatia, CCG Clinical Chair

Paper for:	Decision	Assurance	Discussion	Information	x
Assurance Report Signed off by Chair			N/A		
Which committee has the subject matter been through?			N/A		
Recommendations					
The Governing Body is requested to NOTE the contents of the report					
Report Summary					
<p>Our system continues to respond to multiple challenges as we tackle the pandemic whilst simultaneously working to restore services as quickly as possible. In my last report I mentioned primary care and this month I want to highlight the increasing demand for GP services and our system response to support the management of this increased demand.</p> <p>March 2021 saw an average 9% increase or 40,000 more GP appointments than the same month in 2020 and 2019. We know that access to your GP is very important for our patients and following the pandemic, we are seeing an increasing expectation for more face to face appointments. We are also seeing some quite challenging narrative at both a national and local level from various sources and we must support our primary care colleagues. This is particularly important at a time when competing priorities include working to restore services as quickly as possible whilst maintaining routine services for our patients and also playing a key role in the delivery of the vaccination programme.</p> <p>Throughout the pandemic, GP consultations were nearly all delivered virtually but we are quickly restoring a level of balance whilst applying the learning from delivering services in more innovative ways. Although we know that concerns regarding this continue, I am pleased to report that Derbyshire is the highest performing system nationally on NHS 111 direct booking appointments. Also, in March, 53% of appointments were offered on the same day and 56% were face to face. As we move forward, our plan is to reach a balance of face to face and other channels for delivering consultations which works for both our patients and our practices but we know this will require a process of adjustment for us all.</p> <p>In the meantime, we are delivering a campaign to raise awareness on how we can all help to support our practices as we work through this readjustment to new ways of working. As part of this we are preparing a patient insight campaign to help us understand what patients want and also expect from their GP practice. This will also help us to understand some anecdotal changes in patient behaviour recently which is seeing more people seeking help for conditions which they may have accessed through different services in the past. Responding</p>					

with appropriate advice, treatment and care for patient needs is our top priority and understanding their expectations is vitally important if we are to achieve our ambition.

The core purpose of the campaign is to inform our patients and the overriding message is that “your GP is open for business and we are here when you need us.” Our plea is that if any of our patients have symptoms that worry them, or could indicate something serious, they should call us without delay and we will respond. However our further message is to request that patients please choose the most appropriate service for their condition and these include self-care, pharmacy, NHS 111 plus other services rather than phoning your GP as an automatic first option. Other messages include why your GP may recommend a virtual consultation, why you may have to wait longer for a consultation, the importance of respecting practice staff and being a “patient patient.” The campaign will cover a broad range of channels and we are asking system colleagues and our public and patients to help us share these messages.

Over the coming months we will be seeing some exciting developments that will help us to embed new arrangements and ways of working. These will include a ‘mixed method’ of delivering appointments with over a third delivered in a non-face to face setting. Additional funding will see an increase in the number of GPs which will also facilitate continued support for the delivery of the Covid-19 vaccination programme and our aim to reduce the number of patients needing or awaiting treatment for chronic disease. Expanding our digital capability and capacity is a further objective.

To conclude, the coming weeks and months are particularly important for primary care and we will be working hard to support colleagues in every way we can. We will no doubt face additional challenges along the way but we will succeed given the tremendous commitment and collaborative approaches that help us to perform so well as a system.

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

None

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

N/A

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

N/A

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

N/A

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

N/A

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

N/A

Have any Conflicts of Interest been identified/ actions taken?
None
Governing Body Assurance Framework
N/A
Identification of Key Risks
N/A

Governing Body Meeting in Public

3rd June 2021

Item No: 053

Report Title	Chief Executive Officer's Report
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

May has seen us achieve some significant milestones and I would particularly like to formally acknowledge the monumental efforts of our Derbyshire health and care system which saw us reach one million vaccinations delivered since 8 December last year. I would again like to thank system colleagues and all our volunteers who have together enabled us to become one of the best performing systems nationally.

The next phase of the lifting of lockdown roadmap on 17 May came as a welcome change for all. Although it is still too early to ascertain any impact, anecdotally we are seeing good levels of compliance with the government guidance on staying safe which remains incredibly important. This is a message we continue to promote as part of our regular communications.

Unfortunately we have seen incidences of Covid variants including the so called Indian variant in parts of the county. We are working in close collaboration with system partners and other health and care systems to ensure that our response is rapid and effective. I want to assure people that we are well prepared and our response includes a surge plan which would enable us to mobilise an enhanced vaccination programme at very short notice should this be required.

In other developments with the vaccination programme, further to a recent government announcement, we have enacted our plan to deliver second doses for cohorts one to nine at eight weeks rather than the initial 12 weeks. We also continue to move rapidly through the younger age cohorts and we expect to have vaccinated everyone who wants a Covid vaccination by the end of summer. However this only means that we conclude delivery of the first two phases of the programme and we will then move to the third phase of the longer term programme of booster vaccinations to maximise protection.

May has also seen us continue to make progress with our Integrated Care System development. This includes the commencement of discussions on establishing our

strategic health improvement priorities for the future and a discussion on the border of our ICS. A system partner has formally requested that the boundary in Derbyshire be considered as part of the ICS development, specifically relating to the potential inclusion of Glossop. The decision on any boundary changes will be made by the Secretary of State in June. The CCG is acting as the conduit for feedback on behalf of the Joined Up Care Derbyshire system and will coordinate the process on behalf of NHSEI, and pass feedback to NHS England for review and to then make a recommendation to the Secretary of State. The recovery of services remains an immediate priority for us and we are working on a number of key areas as part of our recovery plan. Planned care is one of these areas and we remain on track for the surgical backlogs of priority 2 patients (those requiring surgery within one month) to be restored to normal levels by the end of June 2021. We also have a plan to recover surgical backlogs for priority 3 patients (those requiring surgery within three months) to be restored to normal levels by the end of September 2021.

In addition to this we are maintaining ongoing clinical review of all patients who have been on the waiting list for over three months to monitor priority status and to identify any deterioration. Working collaboratively is helping to equalise waiting lists and maximise use of available capacity across the system and we continue to focus on the management of referrals which will support us in recovering the backlog. An example of this is the extensive use of “Advice & Guidance” as a referral route.

In other service areas, the effect of our cancer restoration activity will see the number of people waiting for longer than 62 days reduce to the level that we saw pre-pandemic (February 2020) and meet the increased level of referrals and treatment required to address the shortfall in number of first treatments by March 2022. With regard to urgent and emergency care, our system has worked collaboratively to introduce a number of initiatives including “Team Up Derbyshire” and Derby City ‘Home First’ plus the Derbyshire County Council Rapid Response prototype. For mental health, learning disabilities and autism we are seeing additional funding and a raft of new initiatives which will significantly enhance provision for our patients and service users. Primary care will also see additional funding and new initiatives to improve services.

I am pleased to be able to report good progress in critical areas and our mission is to continue to drive our agenda and plans forward in all key areas. Derbyshire continues to receive positive attention at national level and we have seen the Secretary Of State For Health and the Chair Of NHS England and Improvement visit the area in recent weeks, further to visits by the Prime Minister and Chief Executive for NHS England earlier in the year.

I will continue to use my monthly reports to update on our challenges and our performance and hopefully continue to report on positive news and developments from both Covid and non-Covid perspectives over the coming weeks and months.

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
Accelerating our System Transformation	CCG/System/KPMG	Ad Hoc
2021/22 Planning – Derbyshire System	CCG/System/NHSE	Monthly
LRF/Derbyshire MPs	Members and MPs	Monthly
Derbyshire Quarterly System Review Meeting	NHSE/System/CCG	Quarterly
Derbyshire Chief Executives	System/CCG	Bi Monthly
EMAS Strategic Delivery Board	EMAS/CCGs	Bi-Monthly
Joint Health and Wellbeing Board	DCC/System/CCG	Bi-Monthly
NHS Midlands Leadership Team Meeting	NHSE/System/CCG	Monthly
Joint Committee of CCG	CCGs	Monthly
Derbyshire Covid-19 SCG Meetings	CEOs or nominees	Weekly
Outbreak Engagement Board	CEOs or nominees	Fortnightly
Partnership Board	CEOs or nominees	Monthly
Clinical Services and Strategies workstream	System Partners	Ad Hoc
Collaborative Commissioning Forum	CCG/NHSE	Monthly
Urgent and emergency care programme	UDB & CCG	Ad Hoc
System Operational Pressures	CCG/System	Ad Hoc
Clinical & Professional Reference Group	CCG/System	Ad Hoc
Derbyshire MP Covid-19 Vaccination briefings	CCG/MPs	Two per week
Regional Covid Vaccination Update	CCG/System/NHSE	Three per week
Gold Command Vaccine Update	CG/DCHS	Three per week

Integrated Commissioning Operating Model	CCG/System/NHSE	Ad Hoc
Team Talk	All staff	Weekly

3.0 National developments, research and reports

3.1 Supporting people to access the care they need

Blog addressing general practice from Dr Nikki Kanani, Medical Director of Primary Care for NHS England and NHS Improvement [here](#)

3.2 Ambulance iPads improve patient care under NHS Long Term Plan

Tens of thousands of iPads will be issued to ambulance crews across England so that patients get the right care faster, NHS Chief Executive Sir Simon Stevens announced today. The 30,000 devices will allow ambulance crews to send photographs from the scene of an accident so stroke specialists and other clinicians on standby in emergency [here](#)

3.3 NHS sees record number of people in March following urgent cancer referrals

Hard working NHS staff saw a record number of people, who were referred for urgent cancer checks, in March, new figures have revealed today. Almost quarter of a million people with suspected cancer were seen as NHS services began to bounce back after the peak of the winter COVID-19 wave [here](#)

3.4 NHS £160 million accelerator sites to tackle waiting lists

The NHS has today announced a £160 million initiative to tackle waiting lists and develop a blueprint for elective recovery as early reports show the health service is recovering faster after the second wave of the coronavirus pandemic. Indicators suggest operations and other elective activity were already at four fifths of pre-pandemic levels [here](#)

3.5 Latest Coronavirus rules and guidance

Coronavirus restrictions remain in place across the country, including for people who have been vaccinated. For more information on the latest changes go [here](#)

3.6 Stopping the spread of Coronavirus

This guidance is for everyone to help reduce the risk of catching coronavirus (COVID-19) and passing it on to others. By following these steps, you will help to protect yourself, your loved ones and those in your community. This helpful document is available in Arabic, Bengali, Simplified Chinese, Traditional Chinese, French, Gujarati, Polish, Portugese, Punjabi and Urdu. Find out more [here](#)

4.0 Local developments

4.1 Primary care support campaign

Our campaign to support primary care is utilising a range of channels and our CCG Twitter account provides a good overview and examples of the messages we are sharing [here](#)

4.2 100 days of the Derbyshire vaccination programme

Derbyshire began the vaccination programme in December and on 17 March it celebrated 100 days. In recognition and to see some of the milestones you can see our [video](#) here and also read more [here](#). We have now passed another major milestone with one million vaccinations delivered in Derbyshire.

4.3 Video on what to expect when you go for your vaccination

Dr Komal Raj, GP at Wilson Street Surgery and one of the lead GPs at the Derby Arena Vaccination centre talks through the [NHS COVID-19 Vaccination Patient Journey](#) and explains what to expect when getting your vaccine. This video is available in multiple languages and we have also developed a patient flyer that explains the journey.

4.4 Latest vaccination statistics

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

4.5 Find out more about the vaccination programme and regular bulletins

As we move through different cohorts for the vaccination programme it is important that people are clear about the eligibility criteria and to help with this we continually update the information on the Joined Up Care Derbyshire website. For the latest information about Covid-19 and the vaccination programme go to website [here](#).

4.6 Media update

We continue to see extensive media coverage of the vaccination programme. You can see examples of recent news releases on the vaccination programme and other issue. Recent media releases include an update on vaccination status, vaccinating homeless people and support for getting to vaccinations [here](#)

4.7 Information on “when will I get my vaccine?”

For more information about when and how you are likely to receive your COVID-19 vaccination if you have not already one. You will also find more information about the vaccination sites in operation across Derby and Derbyshire. Find out more [here](#)

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

Not Applicable

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

Not Applicable

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

Not Applicable

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

Not Applicable

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

Not Applicable

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

Not Applicable

Have any Conflicts of Interest been identified/ actions taken?

None Identified

Governing Body Assurance Framework

Not Applicable

Identification of Key Risks

Not Applicable

Governing Body Meeting in Public

3rd June 2021

Item No: 054

Report Title	Joined Up Care Derbyshire Board Update
Author(s)	Sean Thornton, Assistant Director Communications and Engagement
Sponsor (Director)	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 NOTE the update provided from the Joined Up Care Derbyshire Board meeting held on 20 th May 2021.					
Report Summary					
Patient Story					
<p>The Board meeting opened with a patient story relating to the success of social prescribing in the Erewash area. The story talked about the journey of Sue, who had been referred to a social prescriber by her care co-ordinator. Social prescribing can work for a wide range of people, including those with one or more health condition, who need support with their mental health, who are lonely or isolated or who have complex social needs. Sue had been a frequent caller to 999 and to her GP practice, partly due to her anxiety about being isolated from her usual life and routine and had several admissions to hospital.</p> <p>Intensive support had been provided for Sue and the interventions, which included helplines to call 24/7 when feeling lonely, a referral for a pendant alarm to provide reassurance that she could contact someone if there was a problem, being referred to a phone befriender and to a local peer support group, have made a real difference. The Board reflected on what was a fabulous and heart-warming story, recognising that while there was on-going support required, it had reduced the number of calls to the practice, 999 and admissions quite substantially and also Sue's anxiety. The Place Board is currently overseeing the progress of social prescribing, and how we evaluate initiatives.</p>					
Derbyshire System Update					
Covid-19 cases continue to decline across Derby and Derbyshire with GP Covid-19 activity having decreased by 23% in the week prior to Board, compared to the previous week. There has also been a significant decrease in Covid-19 hospitalisation and a reduction in community and hospital incidence. The Derbyshire					

system continues to make good progress in delivering the rollout of the Covid-19 Vaccination and is the 3rd highest performing system nationally (NHS data 6 May 2021). Further national direction on rolling out cohort 11 for 35 to 39-year olds is expected imminently, with Derbyshire continuing to deliver within JCVI guidelines. Responding to supply challenges and avoiding wastage continues to be an absolute priority for those involved in the Vaccination programme.

Strategic Commissioning and Strategic Intent

A significant proportion of the JUCD Board meeting was allocated to a discussion around the 'strategic intent' of the Integrated Care System. Recognising again that Joined Up Care Derbyshire is 'the health and social care partnership for adults and children', making improvements to the Derby & Derbyshire populations' life expectancy AND healthy life expectancy in comparison to other parts of the country AND reduce the health inequalities that are driving these differences. The existing commissioning functions of the Clinical Commissioning Group will be disseminated in April 2022 to one of either regional, ICS or Place/PCN level. For those responsibilities at ICS level, there will be a requirement for a strategic commissioning function under new statutory powers in April 2022. Strategic commissioning priorities will be informed and guided by the ICS' strategic intent, which will outline the destination for healthcare in Derbyshire based on a detailed assessment of health evidence and the agreement of clinical models and priorities. Ongoing discussions on this complex and crucial agenda will take place through May and June.

Health Inequalities Focus Visit

NHS England Chair Lord David Prior and Amanda Pritchard, Chief Operating Officer at NHS England toured Derbyshire on Thursday 13 May to hear about the range of schemes taking place to tackle health inequalities across the County. Hosted by Dr Bola Owolabi, a GP at Creswell Primary Care Centre, former Deputy Medical Director at Derbyshire Community Health Services, and now Director of Health Inequalities at NHS England, the visit took in stops at two GP practices in north Derbyshire, Creswell Primary Care Centre and Rectory Road Medical Centre in Staveley, who have taken steps to understand the inequalities affecting their patients and to use different ways to work with patients to address them.

Royal Derby Hospital then hosted three discussions, with Directors of Public Health Robyn Dewis and Dean Wallace joining Dr Chris Clayton to outline the overall strategic approach to tackling health inequalities in the city, doctors from RDH discussing their work in addressing health inequalities from an acute trust perspective, and a briefing on the work of the Strategic Discharge Group, which has been successful in streamlining the way in which patients are cared for on their journey through the local health system. This was brought to life through a visit to the Discharge Assessment Unit at the hospital, where staff were able to describe the fully joined-up approach to discharge planning and care pathways which has seen such success in recent years.

The visitors were impressed with the approaches being taken across the different settings and were grateful to the partners across the system for delivering a comprehensive visit programme

Quarterly System Review Meeting

The Quarterly System review meeting with regional NHS E/I on 12 May 2021 and focused on Covid-19, Planning and ICS system development. The following highlights the feedback received during the meeting:

- Significant praise on our progress and presentation as a system
- Delivery against key challenges is the main concern
- Financial risk management in H1, creation of the financial recovery plan for H2 and negotiating a medium-term financial plan is a key concern
- Delivery against the elective recovery plan and the Transforming Care/Out of Area (OoA) placements in Mental Health and Learning Disabilities
- Cancer outcomes a divergence from a regional position on our current pathway use
- Keeping sighted and prepared for the UEC agenda
- MH Dorms £80million spend as this is a massive priority for Region and National team

Transition Assurance Sub-Committee

The role of the Transition Assurance sub-committee is to ensure coherence and integrity of the system comprising the various building blocks (Place Partnerships, Collaboration at Scale, Strategic Intent, Corporate ICS etc.) as JUCD transitions to become a statutory ICS. The sub-committee will therefore oversee the alignment across the various developments through a single transition plan. Transitioning to a statutory ICS is a significant programme of change and the work required should not be underestimated.

Transition lead arrangements are in place:

ICS Transition SRO: Vikki Ashton Taylor

CCG Transition SRO: Helen Dillistone

Internal Audit 360 report

360 Assurance were commissioned by JUCD ICS to undertake a consultancy review to examine current arrangements for decision making and identify relevant key areas for development during 2021/22 and beyond. This is the third system wide audit undertaken to support JUCD ICS development, using resources made available in the 2020/21 Internal Audit Plans of several of the constituent partners of JUCD ICS. The draft report was reviewed by the System Transition Assurance sub-committee who noted the findings that JUCD ICS has made good progress in several areas that ultimately support effective system wide decision making. In particular, relationships between partners have improved, there are demonstrable examples of service change that have been initiated by collective decision making, and the governance structure has, iteratively, developed to a point where there is increasing involvement of board/governing body members of partners.

Looking forward, the draft report noted that systems, structures and relationships need to continue to be developed in a wide range of areas to ensure that decision making can be delegated to the right officers who have been empowered to make service change. Critical to the successful delivery of necessary service redesign and tackling of health inequalities is the implementation of a structure which facilitates decision making at Place level. As part of the review, auditors undertook a series of interviews with partner organisation leaders, as a result the report suggests a

number of questions (30 in total), grouped into the themes noted below, that JUCD ICS may wish to consider and use as a basis to seek assurance that appropriate actions are being taken to implement arrangements to facilitate effective decision making as part of the transition to become a statutory ICS.

The view of the Transition Assurance sub-committee is that the questions posed offer a helpful reference point for the development work underway to establish the building blocks of the statutory ICS. The sub-committee agreed that the report and questions should inform, rather than drive JUCD ICS thinking and assurance through the respective sub committees, and that the report be shared with relevant sub committees to consider as part of their development and assurance roles during the coming year as follows:

Theme	Responsible Governance Group
What has worked well within JUCD	System Leadership Team
Current arrangements for making System-wide decisions within both statutory body and JUCD governing documentation	System Leadership Team
Developing arrangements at Place and Provider Collaboratives	Place Partnerships sub committee Provider collaboratives at scale sub committee
Relationship between Health and Social Care	JUCD ICS Board
Organisation cultures	JUCD ICS Board
Risk Management	Finance and Estates Assurance sub committee System Oversight and Delivery Board
Information needs	Digital Delivery Board Strategic Intent

2021/22 Planning

The JUCD ICS draft plan was submitted to NHS E/I on 6 May 2021. The following sets out the headline messages from the submission:

1. A strong draft plan overall, which tells a good story across the 6 core themes.
2. JUCD ICS is cognisant of the plan gaps and challenges (including those areas the planning guidance hasn't asked about).
3. Risks remain very real, including the potential impact of a further COVID-19 spike, however comprehensive modelling has been undertaken in conjunction with dialogue with the regional team to ensure we are compliant with the national modelling whilst having robust local monitoring in place to understand trends and emerging risks.
4. JUCD ICS are demonstrating a compliant plan in terms of metric requirements across many of the areas, including those where we have significant recovery challenges as a system e.g. elective care.
5. There is more to do on some of the wider requirements e.g. gateway criteria to access Elective Recovery Fund and progressing our Health Inequalities work more broadly.
6. A strong position from a People Plan perspective and supporting our staff recovery and wellbeing, but more to do on the workforce planning elements and links to our capacity and financial planning e.g. temporary workforce position.
7. Our financial plans – 12 months for Mental Health and H1 (April – September 2021) for the rest – JUCD ICS are meeting the key requirements of the planning guidance. However, we are clear on further work required and our delivery risks.

Communications & Engagement

The Board approved a revised communications and engagement strategy for Joined Up Care Derbyshire. In a period of transition, the strategy outlines the principles by which we will communicate and engage with our staff, citizens and other stakeholders, including the primary aims to foster a culture of transparency through our early engagement with local people. The strategy also highlights our ambitions for communications and engagement across major disciplines including public involvement, health campaigning and the use of digital communications.

People and Culture

The JUCD People and Culture Board is tasked in part with devising plans for four areas outlined in NHS England workforce guidance. These are: looking after our people; new ways of working and delivering care; belonging in the NHS; and growing for the future. Derbyshire already has a detailed workforce development programme and the P&C Board is overseeing progress. Wherever possible the Derbyshire system is looking to do things once, to benefit from those partners leading in certain areas, and to avoid duplication where that is possible and desirable. The JUCD Board endorsed the local approach and noted the progress to date.

Finance

Joined Up Care Derbyshire ended the 2020/21 financial year with a surplus of £600,000, which was a tremendous achievement given the tumultuous year that has faced the NHS. The JUCD system also has a balanced financial plan for the first half of the 2021/22 financial year, as the Covid-19 funding regime continues, but further work is required on the underlying financial position of the system, which is a deficit position of £74million. JUCD is waiting for confirmation of the financial approach for the second half of the financial year and we are aiming for a three-year financial recovery programme. The Board noted that the financial challenge is being tackled in partnership, with one savings figure and without moving any of the financial challenges to a different part of the system.

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

None as a result of this report.

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

Not applicable to this report.

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

Not applicable to this report.

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

Not applicable to this report.

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

Not applicable to this report.

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

Not applicable to this report.

Have any Conflicts of Interest been identified/ actions taken?

Not applicable to this report.

Governing Body Assurance Framework

To support the development of a sustainable health and care economy that operates within available resources, achieves statutory financial duties and meets NHS Constitutional standards.

Identification of Key Risks

Not applicable to this report.

Governing Body Meeting in Public

3rd June 2021

		Item No: 055
Report Title	Primary Care Commissioning Committee Terms of Reference	
Author(s)	Suzanne Pickering, Head of Governance	
Sponsor (Director)	Helen Dillistone, Executive Director of Corporate Strategy and Delivery	

Paper for:	Decision	X	Assurance	Discussion	Information
Assurance Report Signed off by Chair				N/A	
Which committee has the subject matter been through?				Primary Care Commissioning Committee – 26.5.2021	
Recommendations					
The Governing Body is requested to APPROVE the Primary Care Commissioning Committee Terms of Reference.					
Report Summary					
As part of the Governing Body's six month review of all Committee Terms of Reference, the Primary Care Commissioning Committee Terms of Reference have been reviewed and agreed. No amendments were made by the committee.					
Are there any Resource Implications (including Financial, Staffing etc)?					
None identified					
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?					
Not applicable					
Has a Quality Impact Assessment (QIA) been completed? What were the findings?					
Not applicable					
Has an Equality Impact Assessment (EIA) been completed? What were the findings?					
Not applicable					
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below					
Not applicable					

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Not applicable
Have any Conflicts of Interest been identified / actions taken?
None identified
Governing Body Assurance Framework
Not applicable
Identification of Key Risks
Not applicable

Primary Care Commissioning Committee

Terms of Reference

1. INTRODUCTION

- 1.1 In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended); NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to NHS Derby and Derbyshire CCG. Schedule 1 and 2 are specified in the NHS Derby and Derbyshire CCG Delegated Agreement.
- 1.2 The CCG has established the Primary Care Commissioning Committee (the “Committee”). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.
- 1.3 It is a committee comprising representatives of the following organisations:
 - NHS Derby and Derbyshire Clinical Commissioning Group (the “CCG”).

2. STATUTORY FRAMEWORK

- 2.1 NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the National Health Service Act 2006 (as amended).
- 2.2 Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.
- 2.3 Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:
 - 2.3.1 management of conflicts of interest (section 14O);
 - 2.3.2 duty to promote the NHS Constitution (section 14P);
 - 2.3.3 duty to exercise its functions effectively, efficiently and economically (section 14Q);
 - 2.3.4 duty as to improvement in quality of services (section 14R);
 - 2.3.5 duty in relation to quality of primary medical services (section 14S);
 - 2.3.6 duties as to reducing inequalities (section 14T);
 - 2.3.7 duty to promote the involvement of each patient (section 14U);

- 2.3.8 duty as to patient choice (section 14V);
- 2.3.9 duty as to promoting integration (section 14Z1);
- 2.3.10 public involvement and consultation (section 14Z2).
- 2.4 The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those set out below:
 - duty to have regard to impact on services in certain areas (section 13O);
 - duty as respects variation in provision of health services (section 13P).
- 2.5 The Committee is established as a committee of the Governing Body in accordance with Schedule 1A of the National Health Service Act 2006 (NHS Act).
- 2.6 The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

3. ROLE OF THE COMMITTEE

- 3.1 The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in the CCG, under delegated authority from NHS England.
- 3.2 In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and the CCG, which will sit alongside the delegation and terms of reference.
- 3.3 The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.
- 3.4 The Committee have oversight of the CCG Recovery and Restoration work related to the Health and Care Pillar and will receive assurance regarding progress.
- 3.5 The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act. This includes the following decisions in relation to the commissioning, procurement and management of Primary Medical Services Contracts, including but not limited to the following activities:
 - 3.5.1 decisions in relation to Enhanced Services;
 - 3.5.2 decisions in relation to Local Incentive Schemes (including the design of such schemes);
 - 3.5.3 decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices;
 - 3.5.4 decisions about 'discretionary' payments;

- 3.5.5 decisions about commissioning urgent care (including home visits as required) for out of area registered patients;
 - 3.5.6 the approval of practice mergers;
 - 3.5.7 planning primary medical care services in the Area, including carrying out needs assessments;
 - 3.5.8 undertaking reviews of primary medical care services in the Area;
 - 3.5.9 decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list);
 - 3.5.10 management of the Delegated Funds in the Area;
 - 3.5.11 Premises Costs Directions Functions;
 - 3.5.12 co-ordinating a common approach to the commissioning of primary care services with other commissioners in the Area where appropriate; and
 - 3.5.13 such other ancillary activities that are necessary in order to exercise the Delegated Functions.
- 3.6 The CCG will also carry out the following activities to:
- 3.6.1 plan, including needs assessment, primary medical care services in the CCG's geographical area;
 - 3.6.2 undertake reviews of primary medical care services in the CCG's geographical area;
 - 3.6.3 co-ordinate a common approach to the commissioning of primary care services generally;
 - 3.6.4 manage the budget for commissioning of primary medical care services in the CCG's geographical area.

4. GEOGRAPHICAL COVERAGE

The Committee will comprise NHS Derby and Derbyshire CCG's geographical area.

5. MEMBERSHIP

- 5.1 The membership of the Committee is as follows:
- 3 x Governing Body Lay Members;
 - Chief Finance Officer or nominated Deputy;
 - Chief Nurse Officer or nominated Deputy;
 - Medical Director or nominated Deputy.

- 5.2 Representatives shall attend the Committee as regular attendees as follows:
- NHS England Primary Care Representative;
 - Local Medical Committee Representative;
 - Health and Wellbeing Board (County);
 - Health and Wellbeing Board (City);
 - Senior Healthwatch Representatives.
- 5.3 Officers of the CCG shall attend or nominate deputies appropriate to the items for discussion on the agenda. The Committee may also request attendance by appropriate individuals to present relevant reports and/ or advise the Committee.
- 5.4 The Chair of the Committee shall be the Governing Body Primary Care Commissioning Lay Member.
- 5.5 The Deputy Chair of the Committee shall be a Patient and Public Involvement Lay Member.
- 5.6 GP members of the Governing Body shall be invited to attend meetings to participate in strategic discussions on primary care issues, subject to adherence with the CCG's conflicts of interest requirements and the appropriate management of conflicts of interest. They will be required, for example, to withdraw from the meeting during the deliberations leading up to decisions and from the decision where there is an actual or potential conflict of interest.

6. MEETINGS AND VOTING

- 6.1 The Committee will operate in accordance with the CCG's Standing Orders. The Secretary to the Committee will be responsible for giving notice of the meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than five working days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.
- 6.2 Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.
- 6.3 If a decision is needed which cannot wait for the next scheduled meeting or it is not considered necessary to call a full meeting, the Committee may choose to convene a telephone conference or conduct its business on a 'virtual' basis through the use of email/online communication platform. Minutes will be recorded for telephone conference and virtual meetings in accordance with the Derby and Derbyshire Corporate Governance Framework at Section 5.4.
- 6.4 Members are required to declare any interest relating to any matter to be considered at each meeting, in accordance with the CCG's constitution and the CCG Standards for Business Conduct and Managing Conflicts of Interest Policy. Members who have declared an interest will be required to leave the meeting at the

point at which a decision on such matter is being made. At the discretion of the Chair, they may be allowed to participate in the preceding discussion.

7. QUORUM

- 7.1 A quorum shall be four voting members, at least two of whom shall be Lay Members, to include the Chair or Deputy Chair. Deputies are invited to attend in the place of the regular members as required.
- 7.2 A duly convened meeting of the Committee at which quorum is present at the meeting, or are contactable by telephone conference call, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.
- 7.3 If a decision is needed which cannot wait for the next scheduled meeting or it is not considered necessary to call a full meeting, the Committee may choose to convene a telephone conference or conduct its business on a 'virtual' basis through the use of email/online communication platform. Minutes will be recorded for telephone conference and virtual meetings in accordance with relevant sections of the Derby and Derbyshire CCG Governance Handbook.

8. FREQUENCY AND NOTICE OF MEETINGS

- 8.1 The meetings to discuss items of a confidential nature will be held monthly and cancelled if necessary.
- 8.2 The meetings held in public session will take place at least quarterly with the option to be held more frequently. On the dates of the meetings held in public session the meetings will be divided into two sections; Public and Confidential. The Public session will commence at the start of the meeting and shall be held in public.
- 8.3 The Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.
- 8.4 Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.
- 8.5 The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.

- 8.6 The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.
- 8.7 Members of the Committee shall respect confidentiality requirements as set out in the CCG's Standing Orders.
- 8.8 The Committee will present its public minutes to NHS England Midlands and the Governing Body of the CCG each quarter for information. Confidential minutes will be presented on a monthly basis.
- 8.9 The CCG will also comply with any reporting requirements set out in its constitution.
- 8.10 It is envisaged that these Terms of Reference will be reviewed from time to time, reflecting experience of the Committee in fulfilling its functions.

9. ACCOUNTABILITY OF COMMITTEE

The Committee will operate within the delegation detailed within the CCG Standing Orders, Schemes of Reservation and Delegation and Prime Financial Policies.

10. PROCUREMENT OF AGREED SERVICES

The detailed arrangements regarding procurement are set out in the delegation agreement¹.

11. SUB-COMMITTEES

- 11.1 The Committee delegates responsibility for specific aspects of its duties to the following sub-committees:
- Primary Care Quality and Performance Review Sub Committee
 - Estates Steering Group Sub Committee
 - GP Digital Sub Committee
 - Primary Care Workforce Steering Group Sub Committee
 - Primary Care Leadership Sub Committee
- 11.2 Each sub-committee will be required to submit a summary of key actions and minutes from each meeting to the subsequent meeting of the Committee.
- 11.3 Terms of Reference of the sub-committees will be reviewed annually by the Committee.

¹ *NHS England Next Steps in primary care co-commissioning guidance*
<https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/nxt-steps-pc-cocomms.pdf>

12. DECISIONS

12.1 Scheme of Delegation

- 12.1.1 The Committee will make decisions within the bounds of its remit.
- 12.1.2 The decisions of the Committee shall be binding on NHS England and the CCG.
- 12.1.3 The Committee will produce an executive summary report which will be presented to the Governing Body of the CCG each month for information.

12.2 CCG Allocations

- 12.2.1 The Committee shall make recommendations for CCG funding decisions to the Executive Team for additional and new allocations received in-year (please refer to section 2.10 within Annexure 1 of Appendix 4 – Standing Financial Instructions – Financial Limits for Delegated Authority).
- 12.2.2 The Committee are empowered to prioritise service investments and disinvestments within available resources. The Committee can review and recommend investment decisions based on which services should be commissioned or decommissioned, but cannot commit additional CCG financial resources, unless approved by the Executive Team.
- 12.2.3 Subject to 12.2.2, the Clinical and Lay Commissioning Committee shall make recommendations to the Primary Care Commissioning Committee on any changes in relation to the investment or disinvestment of Primary Care commissioned services.

13. REVIEW OF TERMS OF REFERENCE

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

Reviewed by Primary Care Commissioning Committee: 26th May 2021

Approved by Governing Body: 3rd June 2021

Review Date: November 2021

Governing Body Meeting in Public

3rd June 2021

Item No: 056

Report Title	2021/22 Operational Plan
Author(s)	Craig Cook, Director of Acute Commissioning, Contracting & Performance
Sponsor (Director)	Zara Jones, Executive Director of Commissioning Operations

Paper for:	Decision	Assurance	Discussion	X	Information
Assurance Report Signed off by Chair	N/A				
Which committee has the subject matter been through?	Draft submission submitted to CLCC for review/consideration – 13.5.2021 JUUCD Board – 27.5.2021				
Recommendations					
The Governing Body is requested to NOTE and DISCUSS the Derby and Derbyshire Integrated Care System's Operational plan for the period April 21-September 21.					
Report Summary					
<p>On the 24th March 2021, NHS England issued the terms of the 2021/22 Operational Planning Guidance, which described a range of priorities for which ICS's should plan to deliver over the next 6 month period – all relating to six core themes:</p> <ul style="list-style-type: none"> • Supporting the health and wellbeing of staff and taking action on recruitment and retention; • Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with Covid-19; • Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services; • Expanding primary care capacity to improve access, local health outcomes and address health inequalities; • Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay; and • Working collaboratively across systems to deliver on these priorities. <p>The attached presentation gives an overview of the final submission that the ICS made on the 3rd June 2021.</p>					

Key headline – overall summary:

1. We are demonstrating a compliant plan in terms of metric requirements across many of the areas, including those where we have significant recovery challenges as a system e.g. elective care.
2. Risks remain very real, including the potential impact of a further Covid-19 spike, however comprehensive modelling has been undertaken in conjunction with dialogue with the regional team to ensure we are compliant with the national modelling whilst having robust local monitoring in place to understand trends and emerging risks.
3. We will continue to enhance the sharpness of action and specificity of impact, to many areas of this plan as we operationalise delivery – particularly in terms of prevention and reducing health inequalities.
4. A strong position from a People Plan perspective and supporting our staff recovery and wellbeing, but more to do on the workforce planning elements and links to our capacity and financial planning for the second half of the year.
5. Our financial plans – 12 months for Mental Health and H1 for the rest – will see us meet the key requirements of the planning guidance. However, we are clear on further work required and our delivery risks.

Key headlines – service line specifics:

Area	Focus
Planned care and cancer	<ul style="list-style-type: none">• Over the next 6 months, we will see elective services restored to at least 85% of what the ICS was delivering before the pandemic. Our plan trajectory is in line with the NHSE ask.• The effect of our cancer restoration activity will see the number of people waiting for longer than 62 days reduce to the level that we saw pre-pandemic (February 20) and meet the increased level of referrals and treatment required to address the shortfall in number of first treatments by March 2022.
Urgent and emergency care	<ul style="list-style-type: none">• We will be making it easier for patients to access the urgent and emergency care services by building on the new direct booking from NHS 111 into Primary Care, Urgent Treatment Centres and Same Day Emergency Care Services at the Hospital.• The delivery of a consistent 2 hr crisis community health response service is a critical element of our plan so that proactive support can be given to those most in need.
Mental Health, Learning Disabilities and Autism	<ul style="list-style-type: none">• We will spend an additional ~£20m on mental health services in 2021/22.• We will also see a major boost to our capacity with 160+ additional staff.• Our plan is fully compliant with the requirement to enhance children and young people's services – with a particular focus on increasing

	<p>access to NHS-funded community mental health services and introducing a new digital offer.</p> <ul style="list-style-type: none"> • Our performance to reduce the number of adult and children with LD&A in an inpatient setting is not on target.
Primary Care	<ul style="list-style-type: none"> • We will see appointment volumes restored to pre-Covid-19 levels over the period – with a 'mixed method' of meeting this demand – using face-to-face and virtual means. • Our priorities over the next 6-12 month period will be to: <ul style="list-style-type: none"> - deliver the C-19 vaccination programme; - make inroads into appointment backlog for chronic disease; - continue with digital capacity expansion.
Rolling out the COVID vaccination programme and meeting the needs of patients with COVID-19	<ul style="list-style-type: none"> • We will have vaccinated the adult population against COVID by the end of July 2021 – in line with the NHS England ask, all other things being equal. • The post-Covid-19 service offering remains and we will increase capacity as demand dictates over the next 12 months.
Health Inequalities	<ul style="list-style-type: none"> • This plan will see the ICS delivering work against 5 core priorities over the next 6-12 months: <ul style="list-style-type: none"> - restoring services inclusively; - mitigating against digital exclusion; - improving the quality of our data; - connecting prevention work with the health inequalities agenda; - strengthening leadership and accountability across the H&SC system.
Delivering for our people	<ul style="list-style-type: none"> • This plan will see the ICS looking after its people by focussing on: <ul style="list-style-type: none"> - scaling the health and wellbeing offering to staff; - addressing inequality across the workforce; - maintaining the positive aspects of 'working differently' during the pandemic; - creating extra capacity so that we provide greater resilience.

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

Finance

- JUCD is planning to submit a first half-year plan with a **breakeven position.**
- Delivering this position requires the ICS to bring about 1.1% or **~15.5m** of efficiency improvement.
- From a mental health perspective, we will spend an extra £19.5m on services over the next 12 months – **in line with our MHIS obligations.**

Workforce

- The number of **General Practitioners and Nurses** will remain stable. The number of other health professionals (e.g. paramedics, mental health

<p>workers) will increase by 95 WTE by March 2022 through the additional roles reimbursement scheme.</p> <ul style="list-style-type: none"> This plan will see the number of substantive clinical staff working across acute, community and ambulance services increase by 2.2% by the end of September 2021.
<p>Has a Privacy Impact Assessment (PIA) been completed? What were the findings?</p>
<p>Not applicable.</p>
<p>Has a Quality Impact Assessment (QIA) been completed? What were the findings?</p>
<p>Not applicable.</p>
<p>Has an Equality Impact Assessment (EIA) been completed? What were the findings?</p>
<p>Not applicable.</p>
<p>Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below</p>
<p>Not applicable.</p>
<p>Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below</p>
<p>Not applicable.</p>
<p>Have any Conflicts of Interest been identified / actions taken?</p>
<p>No conflicts of interest were identified.</p>
<p>Governing Body Assurance Framework</p>
<ol style="list-style-type: none"> To reduce our health inequalities and improve the physical health, mental health and wellbeing of our population. To reduce unwarranted variation in the quality of healthcare delivered across Derbyshire. To plan and commission quality healthcare that meets the needs of our population and improves its outcomes. To support the development of a sustainable health and care economy that operates within available resources, achieves statutory financial duties and meets NHS Constitutional standards. Work in partnership with stakeholders and with our population

2021/22 Operational Plan

Briefing to the JUCD Board
27 May 2021

Section	Slide number
1. Key Messages & Background	3-9
2. What does the plan deliver for our patients and local population?	10-15
3. What does the plan deliver for our people?	16-17
4. How does this mean for our financial position during the period?	18-20
5. Systemic Risk Appraisal	21-22
6. Beyond the planning submission	23-28

Key messages

- **A strong plan** overall in terms of planning compliance, which tells a good story across the 6 core themes.
- We know our **gaps and challenges** (including those areas the planning guidance hasn't asked us about).
- **Risks remain very real**, including the potential impact of a further COVID-19 spike, however comprehensive modelling has been undertaken in conjunction with dialogue with the regional team to ensure we are compliant with the national modelling whilst having robust local monitoring in place to understand trends and emerging risks.
- We are demonstrating a **compliant plan** in terms of metric requirements across many of the areas, including those where we have significant recovery challenges as a system e.g. elective care.
- We will continue to enhance the sharpness of action and specificity of impact, to many areas of this plan as we operationalise delivery – particularly in terms of **prevention and reducing health inequalities**.
- A strong position from a **People Plan** perspective and supporting our staff recovery and wellbeing, but more to do on the **workforce planning** elements and links to our capacity and financial planning for the second half of the year.
- **Our financial plans** – 12 months for MH and H1 for the rest – we are meeting the key requirements of the planning guidance. However we are clear on further work required and our delivery risks.

2021/22 Operating Plan: 6 Core Themes

Staff

COVID and
Vaccinations

Electives,
Cancer &
Mental
Health

Primary Care
Capacity &
Outcomes

Community
& UEC

Working collaboratively across systems to deliver

Compliant and Non-Compliant Areas At a Glance

Key Requirements	National Target	Status
A1 Looking after our people and helping them to recover	n/a	
A2 Belonging in the NHS and addressing inequalities	n/a	
A3 Embed new ways of working and delivering care	n/a	
A4 Grow for the future	Numeric targets in plan	
B Continuing to meet the needs of patients with COVID-19	Home oximetry, virtual wards, long COVID service and vaccine programmes	
C1 Maximise elective activity and transform delivery	Elective recovery trajectory A 70, M 75, J 80, Ju-S 85	
C2 Restore full operation of all cancer services	63 day restored to pre-COVID, treatment volumes restored to pre-COVID	
C3b Expand and improve services for people with Learning Disability and/or Autism	AHC numerical target, reduce inpatient care, implement LeDeR	Inpatient care reduction not met for adults
C4 Deliver improvements in maternity care	Pandemic recovery, plan in place re Ockenden, LMS governance improvement	

Key Requirements	National Target	Status
D1 Restoring and increasing access to primary care services	Fully restore including dental	
D2 Implementing PHM and personalised care approaches	Smoking cessation, diabetes prevention, digital weight management	
E1 Transforming community services and improving discharge	Increase capacity, maintain LoS reductions	
E2 Ensuring the use of NHS111 as the primary route to access urgent care and the timely admission of patients from ED	NHS111 to SDEC, roll out ECDS	ECDS roll out not currently possible at CRH
Elective Recovery Framework: Gateway Criteria	Significant programme of work to access ERF	
Health Inequalities: 5 priority areas <ul style="list-style-type: none"> - Restore NHS Services inclusively - Mitigate against digital exclusion - Ensure datasets are complete and timely - Accelerate preventative programmes - Strengthen leadership and accountability 		

Background

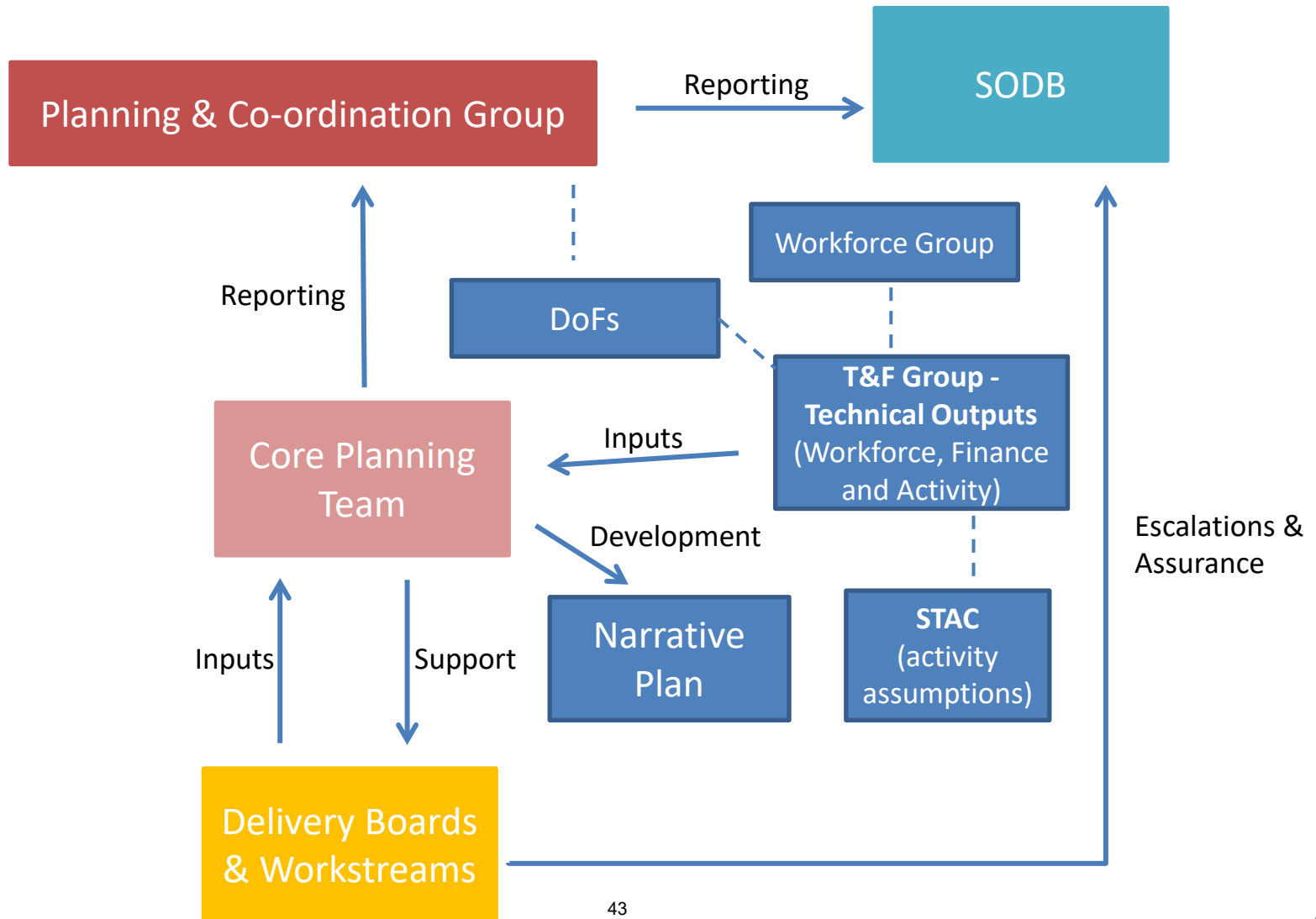
Submission elements split as follows:

- Narrative Plan – focuses on explaining the key actions required to secure delivery of the targets set and the ‘key ingredients’ of the operating environment which will facilitate delivery.
- Workforce Plan – provides a plan for workforce resourcing plan across all providers in the ICS for H1 and the full year for MH.
- Mental Health Plan – finance and workforce submissions only, no narrative plan.
- Finance plan – separately submitted summary of full system finance.
- Activity and metric submission – sets out our trajectory against the numerical targets set for H1.
 - The majority of the planning ‘ask’ focusses on the first 6 months of this financial year with the exception being : Ambulance metrics (full year) and the 2 hr Community response (full year).

Our Timeline for Draft & Final Plans

Item	Deadline
JUCD Senior Leadership Team Sign-off of Draft Plan and Final MH Plan	4 th May
MH Workforce submission	6 th May
MH Finance submission	
Finance draft plan submission	
Workforce draft plan submission	
Draft operational plan submission	
Narrative plan submission	
Revisions in response to NHSEI feedback on draft submission	
Delivery Board sign-offs of final submission	24 th May
SODB confirm and challenge session	24 th May
Non-mandatory provider finance submission	w/c 24th May
Extraordinary JUCD Board sign-off of final plan	27 th May
Final plan submissions – all as above for draft plan (except MH no further submission)	3 rd June

Co-ordination of Process



**What does this plan deliver for
our patients and local
population?**

Planned Care and Cancer

- Over the next 6 months we will see **elective services restored to at least 85% of what the ICS was delivering before the pandemic**. Our plan trajectory is in line with the NHSE ask.
- Within this, we will be **prioritising care for those patients who require time critical surgery** – referred to as ‘Priority 2 and 3’ care. For these cohorts, both Acute Trusts remain on track to restore numbers back to pre-COVID levels for Priority 2 patients by the end of quarter 1 21/22 and Priority 3 patients by the end of Q2 21/22.
- The ICS will **sustain and where necessary enhance transformation works for outpatient provision** - with further expansion of referral advisory services and targets for extending virtual appointments and piloting patient-initiated follow-ups across 3 high volume specialties.
- The ICS will also start to implement the changes necessary to bring about the productivity improvements identified by the **GIRFT Programme** – within T&O, ENT and Ophthalmology - supported by the NHSE Midlands Elective Recovery Team.
- The effect of our cancer restoration activity will see the **number of people waiting 63 days of more after an urgent suspected cancer referral** reduce to the level that we saw pre-pandemic (February 20) and meet the increased level of referrals and treatment required to address the shortfall in number of first treatments by March 2022.

Community and Urgent and Emergency Care

- From a demand perspective, we are expecting **A&E volumes and emergency admissions to be restored to pre-pandemic levels over the next 6 months**. All other things being equal, if presentations and admissions do reach these levels we can still deliver our elective restoration target.
- Within this trajectory, we have assumed a **relatively low level of COVID-19 bed occupancy** throughout the period: June 1.5%; July 3.0%; August: 4.0% September: 4.9% - in line with NHSE guidance. Again, if this level of presentation materialises we could still deliver our elective restoration targets, all other things being equal.
- We will be making it easier for patients to access the urgent and emergency care services they need with **direct booking from NHS 111** into Primary Care, Urgent Treatment Centres and Same Day Emergency Care Services at the Hospital.
- Improving **ambulance turnaround times** is a specific performance focus for the ICS over the next 6 months.
- The delivery of a consistent **2 hr crisis community health response service** is a critical element of our plan so that proactive support can be given to those most in need.
- **The key signature moves** for the ICS will be to see the “Team Up Derbyshire” offering implemented and the Derby City ‘Home First’ plus DCC Rapid Response prototype operationalised.

Mental Health, Learning Disabilities and Autism

- We will spend an **additional ~£20m on mental health services in 2021/22** coming from 4 main sources MHIS uplift, SDF, SR and LD/ASD.
- A number of pre-commitments (mainly recurrent pick-up of costs for services previously funded through NHSEI non-recurrent monies) have been factored into the plan, with focus on **Crisis (children and adults), community services and Case Managers**.
- In addition, uplifts have been applied to **Section 117 and Prescribing** (in line with national guidance) and **growth in IAPT**. The anticipated savings arising from the Case Managers investment have provided a benefit to the plan.
- We will also see a **major boost to our capacity** with 160+ additional staff.
- Our plan is fully compliant with the requirement to enhance **children and young people's services** – with a particular focus on increasing access to NHS-funded community mental health services.
- The ICS will **maintain the transformative change** that was enacted during the pandemic - including 24/7 open access, Freephone all age crisis lines and staff wellbeing hubs.
- The ICS plans to deliver the **Health Check target** for adults with Learning Difficulties and Autism – with delivery close to 100%.
- Our performance to reduce the number of adult and children with **LD&A in an inpatient setting is not on target** and a 3 yr improvement road map will be submitted to achieve it– with an initial focus on improving crisis support.
- Additional resource will be committed to **LeDeR reviews** which are currently on target.

Primary Care – General Practice

- We will see appointment volumes **restored to pre-COVID levels over the period** – with March 2021 recording the second highest level of activity delivered by General Practice over the last 17 months and 8% more appointments (44,365) than March 2019 pre-pandemic
- A **‘mixed method’ of delivering appointments** will continue with over a third delivered in a non-face to face setting.
- The number of General Practitioners and Nurses **will remain stable**. The number of other health professionals (e.g. paramedics, mental health workers) **will increase by 95 WTE** by March 2022 through the additional roles reimbursement scheme
- Our priorities over the next 6-12 month period will be to:
 - Deliver the C-19 vaccination programme
 - Make inroads into appointment backlog for chronic disease;
 - Continue with digital capacity expansion.

All facilitated with the extra funds that have been made available.

Health Inequalities

1. Restoring NHS services inclusively

- Covers restoration plans for primary care, community, planned and urgent care which reference consideration of health inequalities.
- Update on MH Delivery Board review of pandemic impact.

2. Mitigating against digital exclusion

- Covers plans for expansion of digital usage and intention to ensure no new inequalities are created for protected groups.
- Remote monitoring plans for care homes and at home health monitoring
- Evaluation of patient experience of digital channels.

3. Ensuring datasets are complete and timely

- Details progress on improving primary care ethnicity data to achieve 100% - current achievement 86.7%.
- Includes plans to work on secondary care ethnicity, especially IS providers.
- Details implementation of Derbyshire Shared Care Record following recent procurement.

4. Accelerating preventative programmes which proactively engage those at greatest risk of poor health outcomes

- Specific programmes include Maternity Continuity of Carer, Place Team Up approach and Anticipatory Care for Ageing Well.
- East Midlands Cancer Alliance leading on ensuring cancer prevention has equal impact via Wellbeing for All.

5. Strengthening leadership and accountability

- Sets out system plans for managing health inequalities through shared leadership and networked responsibilities.
- Health Inequalities support to Delivery Boards.

**What does this plan deliver for
our people?**

Looking after our people and helping them to recover – we have:

- Developed a health and wellbeing programme for staff across all sectors to access to deal with physical and mental health issues.
- Made provision for the process of annual leave and the offer of flexibility for staff to take or buyback unused leave.
- All our staff have been risk assessed and we are now undertaking wellbeing conversations – completion by end July.

Belonging in the NHS and addressing inequalities - we have:

- Established a System Equality Diversity Inclusion Collaborative with all Partners across Health and Social Care which will...
- Construct specific EDI targets for the ICS to achieve through 2021.

Embed new ways of working and delivering care – we have:

- Adopted innovative ways of working to make the best use of the skills of our workforce and both benefit them and the patients they care for.
- committed to maximising the use and benefits of e-rostering and all use the Allocate Health Roster System.

Grow for the future – we will:

- Increase the number of substantive clinical staff working across acute, community and ambulance services of 2.2% by the end of September 2021.
- Increase the number of staff delivering direct patient care in Primary Care by March 2022.

**What does this mean for our
financial position
during the period?**

Headlines – System Finance

H1 JUCD System Plan	2021/22 Plan		
	H1 Gross Plan £m's	H1 Efficiencies £m's	H1 Net Plan £m's
CCG Allocations	1,013.7	0.0	1,013.7
Provider Income Not From CCG	365.4	0.0	365.4
Total System Income	1,379.1	0.0	1,379.1
Provider Core Expenditure	(973.4)	11.2	(962.2)
CCG Expenditure Non With JUCD	(421.2)	4.3	(416.9)
Total System Expenditure	(1,394.6)	15.5	(1,379.1)
Core Business Surplus / (Deficit)	(15.5)	15.5	0.0

Key aspects of the Mental Health planning return – finance

We will spend an extra £19.5m on mental health services over the next 12 months – in line with our MHIS obligations

Source of Funding		MHIS £'000	SDF £'000	SR £'000	LD/ASD £'000	TOTAL £'000
MHIS		7,176				7,176
SDF			7,015			7,015
SR				5,021		5,021
LD/ASD					524	524
Total Sources of Funding		7,176	7,015	5,021	524	19,737

Systemic risk appraisal

JUCD Operational Plan Delivery - Risk Profile

Theme	There is a risk that....	Key indicators to be tracked	How likely is it that the risk will materialise?	What will be the impact if it does?
Capacity and workforce	Our Acute hospitals will not have sufficient general and acute medical bed capacity to meet expected levels of emergency demand and deliver to the terms of the elective recovery framework	1) Actual Bed occupancy (ITU and G&A) vs. plan 2) % of surgical bed base occupied with medical outliers 3) Elective Cancellation rates 4) Actual elective volumes (activity & cost) vs. Planned		
	There will be insufficient capacity in Primary Care to manage restoration activities, increase access to primary care services and deliver the Phase II and III vaccination programme	1) Staff sickness rates 2) OPEL report		
	There will be insufficient capacity within the community service offering to deliver a consistent 2-hour crisis community health response for patients at home	1) Actual volume of avoidable admissions vs. plan		
	There will be insufficient capacity within the discharge to assess pathways to consistently deliver timely discharge	1) Actual Delayed Transfers of Care vs. plan 2) P1, 2 and 3 Length of Stay		
Finance	JUCD's financial deficit will hinder our ability to deliver and sustain the restoration and recovery of NHS services and deliver the LTP.	1) Monthly surplus/deficit position (actual and underlying)		
COVID-19 Vaccination	The ICS will not deliver the terms of the Phase III vaccination programme.	1) Actual vaccination rates (by cohort) vs. planning trajectory		
Health inequalities	Patients who require NHS services will not access them in a timely fashion due to fears about contracting COVID and/or 'over-burdening' the health care system	1) GP Consultation volumes: Observed age and ethnicity presentations vs. expected 2) A&E attendance volumes: Observed Age and Ethnicity presentations vs. expected 3) Hospital referral volumes: Observed Age and Ethnicity presentations vs. expected 4) Cancer screening volumes: Observed Age and Ethnicity presentations vs. expected		

Beyond the Planning Submission

Future Function in the ICS

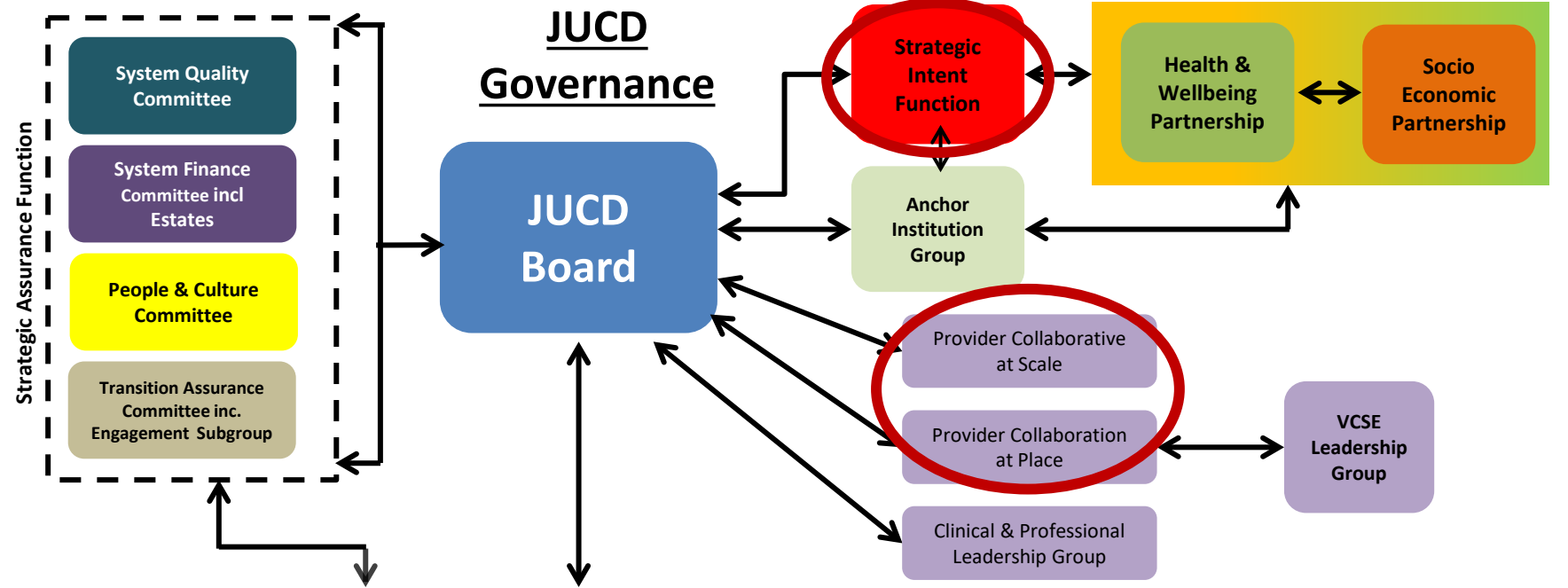
Overall question:

*What does our **strategic planning function** need to look like within the ICS compared to what we have now?*

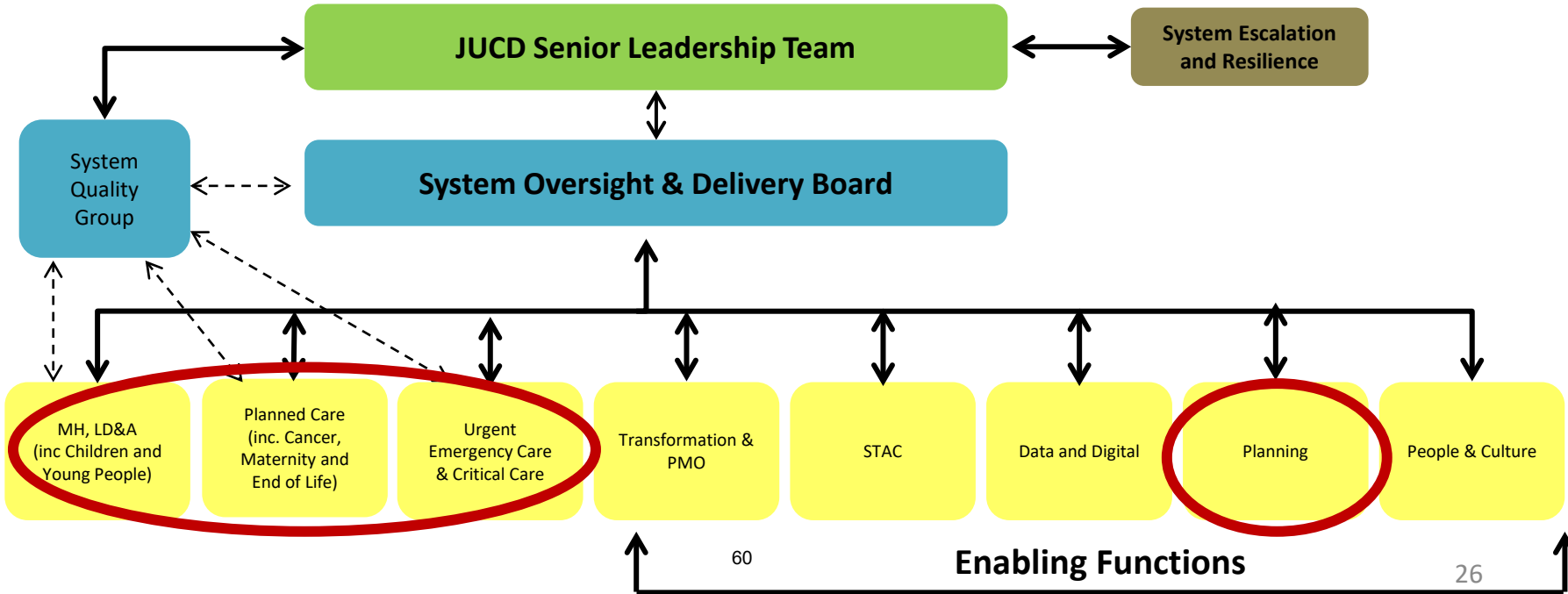
- What do we need to consider?
- What actions do we need to take?
- What are some of our next steps including the role and function of the System Planning & Co-ordination Group?

What	Focus
<p>System Oversight and Delivery Board</p> <p>(and supported through activities of Planning & Co-ordination Group)</p>	<p>Oversight of Delivery Board action to deliver the fundamental aspects of this Plan.</p> <p>Consider the streamlined and public facing summary of ‘our plan’ – interlinked with JUCD Comms & Engagement Strategy and ensuring clarity of our ‘top priorities’ and what this means for patients and the local population.</p>
<p>Second half year preparedness</p>	<p>Overseeing the production of a H2 plan which ensures that we can:</p> <ul style="list-style-type: none"> • Roll out the COVID-19 Vaccination Programme • 2021 Influenza Vaccination Programme • Enhance Winter Preparedness: Deploying sufficient capacity to manage unscheduled COVID and non-COVID demand. • Finance: H1 plan completed, further work required for H2 planning around underlying cost base, ongoing Covid19 costs, and the approach to efficiency, and triangulation of the available financial improvement headroom with the Model System/Hospital.
<p>Efficiency and service improvement</p>	<p>Co-ordinate the production of the ICS’ Efficiency and Service Improvement Plan, so that:</p> <ul style="list-style-type: none"> • Further work is being undertaken on the benefits of specific funded allocations for mental health and primary care, and the benefits of specific potential investments in the underlying position. • The overall improvement approach, and its conversion to efficiency, is being reviewed and quantified via the four main System Programme Boards alongside efficiency within organisations.

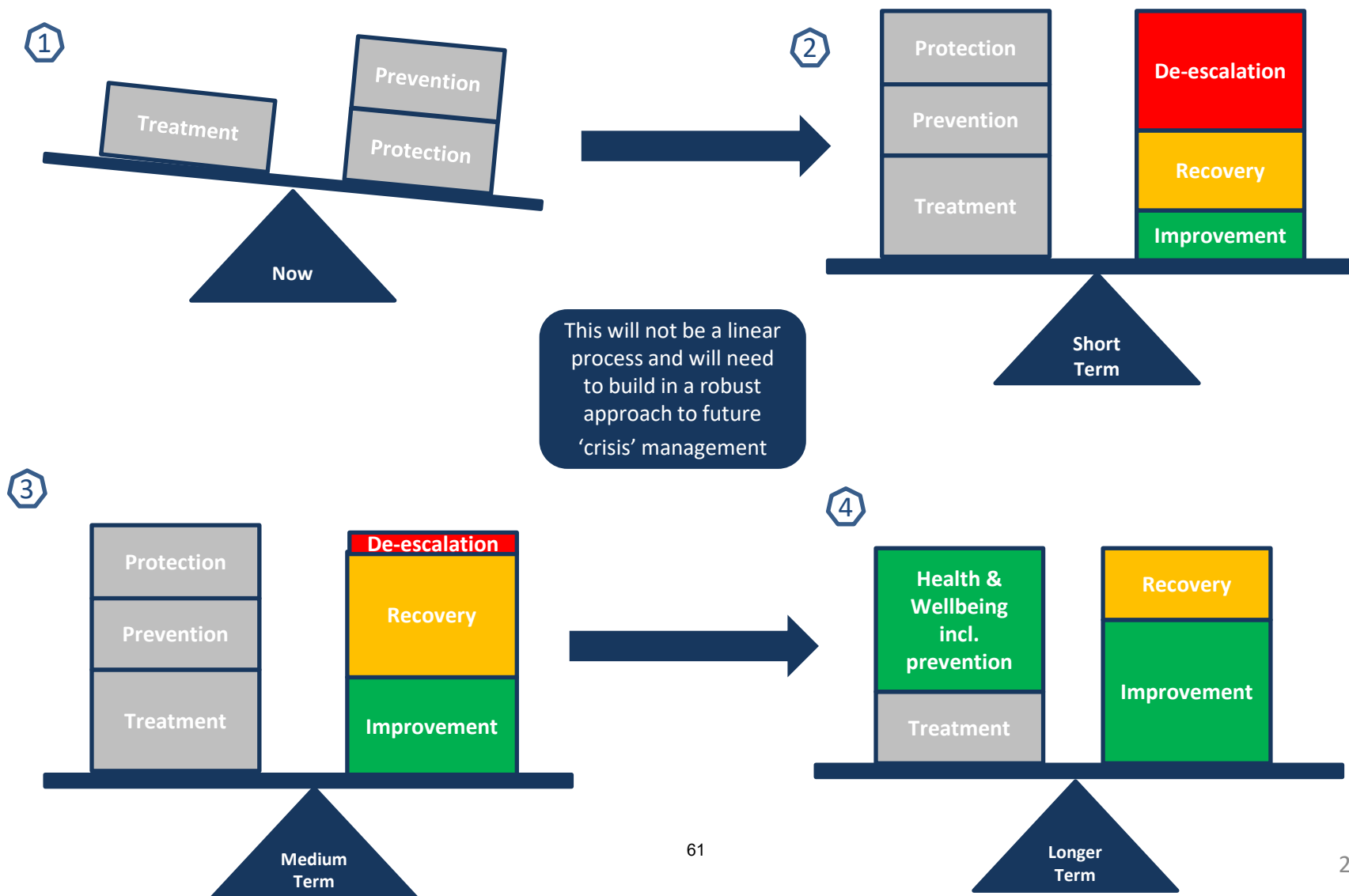
Strategy & Assurance



Implementation & Delivery



The Balancing Act of our Planning



SODB Planning Session 24th May

Our collective planning priorities

We can't afford not to focus on.....

Now

Covid
Vaccinations/response

Wellbeing and
welfare of our staff

Elective recovery
(long waits)

Start winter
planning/ capacity

Community capacity,
avoiding ED admissions
(linked to GP capacity)

Cancer care

Immediate dedicated
services for staff/fast
access (HWB)

Monitor and
support GP access

Mental Health
Crisis

Secondary prevention activities could
be implemented now (invitations to
screenings etc.)

What can we do to support
same day appointments,
urgent home visits etc.

Later this year

Expanded flu
vaccination
programme

Staff HWB

LTC catch up

Admission
avoidance

Winter planning

Phase 3 covid
vaccinations

Elective care
backlogs

Urgent and cancer
care

Shared Care Record across all
system partners (minimal viable
solution by Sept this year)

Next year

LTC catch up

Improved
personalisation

Longer term- Shared responsibility,
improved integration between
partners, prevention and upstream
interventions etc⁶²

Governing Body Meeting in Public

3rd June 2021

Item No: 057

Report Title	Finance Report – Month 1
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 – 27.5.2021	
Recommendations					
The Governing Body is requested to NOTE the following: <ul style="list-style-type: none"> The reported YTD overspend is £0.162m. The position includes Covid costs of £0.323m which are expected to be reimbursed. The YTD budget is based on the H1 plan submitted in May 2021. 					
Report Summary					
The report describes the month 1 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 1, April 2021

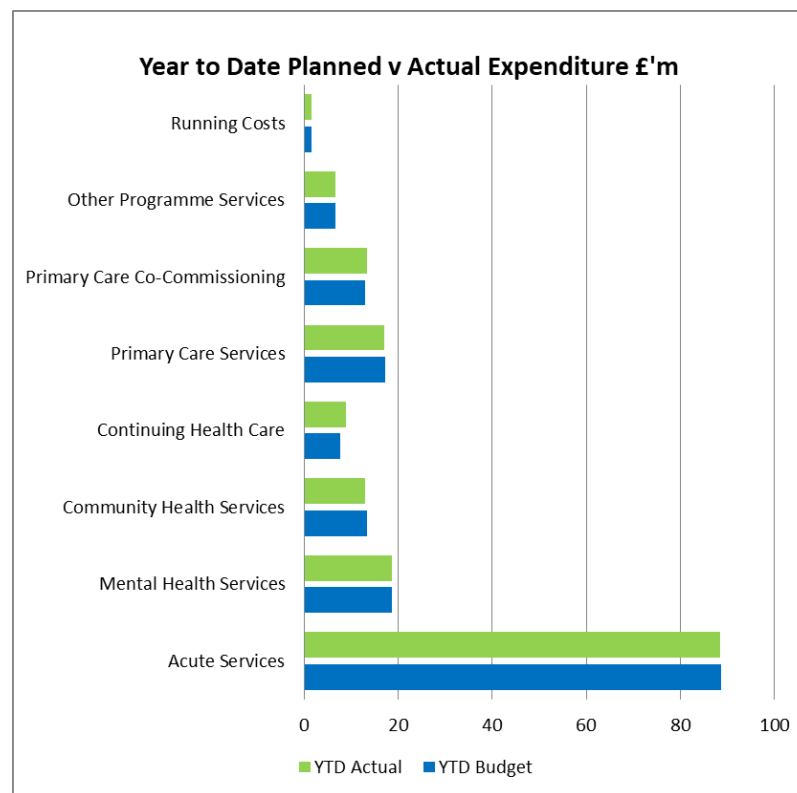
Statutory Duty/ Performance	Target	Result	Achieved	Key	Comments/Trends
Achievement of expenditure to plan	£166.829m	£167.313m		Green <1%, Amber 1-5% Red >5%	There is a small unfavourable variance of £0.485m which is offset by an expected reimbursement of £0.323m for CHC HDP
Remain within the delegated Primary Care Co-Commissioning Allocation	£13.028m	£13.282m		Green <1%, Amber 1-5% Red >5%	Adverse variance of £0.254m, however additional allocations are expected to cover the expenditure
Remain within the Running Cost Allowance	£1.652m	£1.524m		Green <1%, Amber 1-5% Red >5%	Target achieved with a favourable variance of £0.128m.
Remain within cash limit	Greatest of 1.25% of drawdown or £0.25m	0.58%		Green <1.25%, Amber 1.25-5% Red >5%	Closing cash balance of £0.892m against drawdown of £153.0m.
Achieve BPPC (Better Payment Practice Code)	>95% across 8 areas	Pass 8/8		Green 8/8 Amber 7/8 Red <6/8	In month and YTD payments of over 95% for invoices categorised as NHS and non NHS assessed on value and volume.

Operating Cost Statement For the H2 Period Ending: April 2021



Derby and Derbyshire Clinical Commissioning Group

	Year to Date			
	YTD Budget	YTD Actual	YTD Variance	Variance as a % of Planned Expenditure
	£'000's	£'000's	£'000's	%
Acute Services	88,604	88,472	131	0.15
Mental Health Services	18,748	18,614	134	0.71
Community Health Services	13,266	12,863	403	3.04
Continuing Health Care	7,624	8,806	(1,181)	(15.49)
Primary Care Services	17,296	17,119	178	1.03
Primary Care Co-Commissioning	13,028	13,282	(254)	(1.95)
Other Programme Services	6,610	6,634	(23)	(0.35)
Total Programme Resources	165,177	165,790	(613)	(0.37)
Running Costs	1,652	1,524	128	7.78
Total before Planned Deficit	166,829	167,313	(485)	(0.29)
In-Year Allocations	0	0	0	0.00
In-Year 0.5% Risk Contingency	0	0	0	0.00
Total Incl Covid Costs	166,829	167,313	(485)	(0.29)
Covid Costs Expected in Future Months	0	323	(323)	
Total Including Reclaimable Covid Costs	166,829	166,991	(162)	(0.10)



The reported variance for month 1 is an overspend of £0.162m.

This position includes an amount of £0.323m relating to expected reclaimable Covid expenditure for Hospital Discharge Programme.

Governing Body Meeting in Public

3rd June 2021

Item No: 059

Report Title	Audit Committee Assurance Report – 25 th May 2021
Author(s)	Frances Palmer, Corporate Governance Manager Suzanne Pickering, Head of Governance
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 – 25.5.2021	

Recommendations

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

Report Summary

This report provides the Governing Body with highlights from the 25th May 2021 meeting of the Audit Committee. This report provides a brief summary of the items transacted for assurance.

Finance

Losses and Special Payments

The Audit Committee APPROVED the outcome and treatment of a CCG Information Commissioner’s Office reportable incident.

Aged Debt Report

The Audit Committee NOTED that a long term aged debt issue has now been resolved.

2020/21 Annual Report, Accounts and Governance Statement

Annual Accounts

The Audit Committee were made aware of adjustments since the last meeting and APPROVED the 2020/21 Annual Accounts for the CCG.

Final Annual Report, Accounts and Governance Statement

The Audit Committee RECEIVED the final version of the 2020/21 Annual Report and Accounts. Updates were given on significant changes, which have been made to the report since the draft Annual Report was received by the committee in April.

The Audit Committee APPROVED the 2020/21 Annual Report and Accounts under the delegated authority of Governing Body.

Service Auditor Reports 2020/21

The Audit Committee NOTED the service auditor reports for 2020/21.

External Audit

KPMG Year End Report 2020/21 – ISA 260

The Audit Committee RECEIVED the KPMG Year End Report 2020/21 – ISA 260.

External Audit Opinion

The Audit Committee NOTED the External Audit Opinion and GAINED ASSURANCE of the unqualified opinion of the Financial Statements and a no significant weaknesses conclusion on the use of resources.

Letter of Representation

Audit Committee NOTED the update provided on the Letter of Representation.

Internal Audit

2020/21 Head of Internal Audit Opinion

The Audit Committee RECEIVED and GAINED ASSURANCE of the ‘Significant Assurance’ rating received from 360 Assurance within the 2020/21 Head of Internal Audit Opinion.

The Committee NOTED and GAINED ASSURANCE on the ‘Substantial Assurance’ of the Data Security and Protection Toolkit audit, which has recently been finalised.

360 Assurance 2020/21 Annual Report

The Audit Committee NOTED the 360 Assurance 2020/21 Annual Report.

Governance

Freedom to Speak Up Report

The Audit Committee NOTED the nil return of the report.

Governing Body Assurance Framework Q4

The Committee NOTED and GAINED ASSURANCE of the Quarter 4 Governing Body Assurance Framework

Risk Register

The Audit Committee RECEIVED and NOTED the CCG Risk Register Report.

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 Register of Interests;
- Confidential Register of Interests;
- Summary Register for Recording Any Interests During Meetings;

- Gifts & Hospitality Register – no further updates since the last meeting;
- Procurement Register; and
- Breach Register – no further updates since the last meeting.

Forward Plan

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

Any Other Business

There was no items of any other business:

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

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

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

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

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

An EIA is not found applicable to this update. This report is for assurance and information.

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

Not applicable to this update. This report is for assurance and information.

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

Not applicable to this update. This report is for assurance and information.

Have any Conflicts of Interest been identified/ actions taken?

None identified.

Governing Body Assurance Framework

Any risks highlighted and assigned to the Audit Committee will be linked to the Derby and Derbyshire CCG GBAF and risk register.

Identification of Key Risks

Noted as above.

Governing Body Meeting in Public

3rd June 2021

Item No: 060

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

Paper for:	Decision	Assurance	X	Discussion	Information
Assurance Report Signed off by Chair				Dr Ruth Cooper, CLCC Chair	
Which committee has the subject matter been through?				CLCC - 13.5.2021	

Recommendations

The Governing Body is requested to **RATIFY** the decisions made by the Clinical and Lay Commissioning Committee (CLCC) on 13th May 2021.

Report Summary

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

CLC/2122/23 Clinical Policies to be ratified

CLCC were asked to approve a minor policy amendment:

- Male breast reduction surgery for gynaecomastia

CLCC RATIFIED the policy

Areas for Service Development

CLCC NOTED that CPAG have reviewed Individual Funding Request (IFR) cases submitted and Interventional Procedures Guidance (IPGs), Medtech Innovation Briefings (MIBs), Medical Technology Guidance (MTGs) and Diagnostic Technologies (DGs) for March 2021.

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

CLCC NOTED the CPAG Bulletin for March 2021

CLC/2122/25 CLCC Risk Tracker Emerging Risks

CLCC RECEIVED AND NOTED the updated Emerging Risk Tracker. There were no additional risks added.

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

Governing Body Meeting in Public

3rd June 2021

Item No: 061

Report Title	Derbyshire Engagement Committee Assurance Report – May 2021
Author(s)	Sean Thornton, Assistant Director Communications and Engagement
Sponsor (Director)	Martin Whittle, Vice Chair/Lay Member for Patient & Public Involvement

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 – 20.5.2021	

Recommendations

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

Report Summary

This report provides the Governing Body with highlights from the meeting of the Engagement Committee, held on 20th May 2021. This report provides a brief summary of the items transacted for assurance.

Joined Up Care Derbyshire (JUCD) Communications and Engagement Strategy 2021-23

The Committee signed off the final draft of the JUCD Communications and Engagement Strategy ahead of it being reviewed at the JUCD Board later that same week. Developed iteratively with the committee, the purpose of the strategy is to identify how the Derbyshire Integrated Care System (ICS) will communicate, engage, consult and co-produce the solutions to our transformation, recovery and other agendas in partnership with the citizens of Derbyshire. The strategy sets out our approach to six priority areas, along with our ambition and initial actions for each topic. These priorities, and the associated ambitions are:

Priority	Ambition
Patient and Public Involvement	<p>Embed our engagement model at the heart of planning, priority setting and decision-making across system transformation work, ensuring the voices of patients, service users, communities and staff are involved and that their insights are sought and utilised.</p> <p>To recognise that relationship building is important to increase trust and improve participation and needs to be considered on a planned, systematic, and continuous basis, with the required</p>

	<p>investment of time.</p> <p>To see continuous engagement that reflects a new relationship with the public, capitalises on emotional connections with our partnership and brings citizens into the discussion rather than talks to them about the decision.</p>
Internal Engagement and Communication	<p>To engage partnership staff more deeply in the partnership, where they can understand their role within the JUCD system and how their views can help shape and transform care.</p> <p>To embed our engagement model at the heart of planning, priority setting and decision-making across system transformation work, ensuring the voices of patients, service users, communities and staff are involved and that their insights are sought and utilised.</p>
Stakeholder Relationship Management	<p>To establish JUCD and the ICS as a recognised brand. Local citizens and stakeholders should be supported to understand what JUCD is, what it is doing, how they can shape it or benefit from it and (if they wish) understand how it works.</p> <p>To recognise that relationship building is important to increase trust and improve participation and needs to be considered on a planned, systematic, and continuous basis, with the required investment of time.</p> <p>To be recognised as an open and transparent health and care system that belongs to the communities and people we serve.</p> <p>To establish transparent governance and co-production processes so that everyone can see clearly how decisions are made and inform the process that leads to them.</p>
Health Campaigning and Behavioural Change	<p>To deliver a systematic approach to reaching into, understanding and supporting the needs of groups that are seldom heard, including young people.</p> <p>To devise funded programmes that talk to citizens and communities where we see lower life expectancy and higher inequalities, guided by data and evidence, deriving insight that informs interventions and enables a segmented and evaluated approach.</p> <p>To support a movement that empowers local citizens to see themselves as the primary source of their own health.</p>
Supporting Collaboration at Place and Scale	<p>To develop a compelling vision and narrative that all system partners can buy into, which is well understood and supported by the public and staff, and which is traceable through all of the work undertaken by the system as a 'golden thread'.</p>

	<p>To recognise that relationship building is important to increase trust and improve participation and needs to be considered on a planned, systematic, and continuous basis, with the required investment of time.</p> <p>To be recognised as an open and transparent health and care system that belongs to the communities and people we serve.</p>
Digital Communications and Engagement	<p>To embrace modern application of digital media and tools that bring the JUCD strategy to life, with engaging online content derived through excellence in production, driven by a clear communication and engagement programme.</p> <p>To deliver a systematic approach to reaching into, understanding and supporting the needs of groups that are seldom heard, including young people.</p>

A detailed action plan will now follow, to be overseen by the Engagement Committee. It should be noted that the strategy received approval at the JUCD Board on 22nd May.

System Insight Group

The Committee received a verbal update on the System Insight Group, which was established as part of the pandemic response to coordinate the gathering of insight across the system. An important development is the imminent launch of an insight database which will be available to all system partners and will enable teams to search for existing knowledge on specific subjects prior to commencing their own patient research.

Dormitories

There is a national mandate that acute mental health units provide single en-suite bedrooms, to support patients' privacy and dignity. Both the Hartington Unit and the Radbourne Unit currently offer dormitory style accommodation that does not meet this expectation. Significant national funding has been allocated to make these improvements across Derbyshire, through the creation of two new units – one in Derby, one in Chesterfield. There are time restrictions related to this funding and the units need to be fully operational by Spring 2024.

The committee was briefed on the emerging engagement planning, including constructive discussions held so far with Derby City and Derbyshire County scrutiny committees. Initially there has been a focus on those with lived experience on supporting the design and development of plans. Once plans are in final draft wider engagement with the population of Derby and Derbyshire will be done through the usual planning processes.

London Road Ward 1&2

The Engagement Committee reviewed plans for a consultation on the relocation of London Road Community Hospital Wards 1 and 2 to Kingsway Hospital in early 2020. These wards provide functional mental health support to predominantly older people.

This consultation was due to commence in March 2020 and local health scrutiny committees had agreed to a 60-day consultation due to the streamlined stakeholder group affected by this changed. The consultation process unfortunately was paused due to the restrictions that came into effect with COVID-19 later that month.

We have been waiting for an opportunity to resume this consultation, with the intention to continue with a 60-day formal consultation. However, we have recently been notified that there is an urgent clinical need for University Hospitals of Derby and Burton NHS Foundation Trust, to use Ward 1 as part of their growing restoration and recovery work, as we move through the national roadmap.

Derbyshire Healthcare NHS Foundation Trust continue to have a vacant facility at Kingsway Hospital, where the older people's mental health service can be relocated to at relatively short notice. This move would be to Tissington House, which is the unit that had been identified for the service in the previous planned consultation. There would be some remedial work to ensure the building was fit for purpose, but otherwise, the service could transfer in a matter of weeks.

Health scrutiny committees have been approached and the initial response is supportive of this temporary change. We will develop communications materials to help inform patients of the change. At the same time, we are also making plans to progress again the 60-day consultation to permanently transfer the Ward 1 patients to Tissington House, in line with our previous plans. These plans will be brought back to the Engagement Committee in due course once the approach has been refreshed.

Section 14Z2 (S14Z2)

The committee received the latest log of completed engagement assessment form (known as S14Z2 forms after the sub-section of the health and Social Care Act relating to patient and public involvement. The log was received in part for assurance that programmes are now recommencing the assessment process following the intervening pandemic period, and also enabled the committee to understand the breadth of programmes being assessed and to highlight where a deep dive might be required or desired. The log will be reviewed by to the committee monthly.

Risk Report

There were no updates made to ratings of risks currently managed by the engagement committee.

Meeting Frequency

The Committee agreed to revert to monthly meetings, given the increase in activity requiring members' attention.

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

None identified.

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

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

Has a Quality Impact Assessment (QIA) been completed? What were the findings?
A QIA is not found applicable to this update. This report is for assurance and information.
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
An EIA is not found applicable to this update. This report is for assurance and information.
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
Not applicable to this update. This report is for assurance and information.
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Not applicable to this update. This report is for assurance and information but describes a range of patient, public communications and engagement activity across the breadth of CCG work.
Have any Conflicts of Interest been identified/ actions taken?
None identified.
Governing Body Assurance Framework
Risks assigned to the Engagement Committee are reviewed monthly and changes noted within this assurance report.
Identification of Key Risks
Noted as above.

Governing Body Meeting in Public

3rd June 2021

Item No: 062

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

Paper for:	Decision	Assurance	X	Discussion	Information
Assurance Report Signed off by Chair			Jill Dentith, Governance Lay Member and Chair of Governance Committee		
Which committee has the subject matter been through?			Governance Committee - 20.5.2021		
Recommendations					
The Governing Body is requested to NOTE the contents of this report for information and assurance.					
Report Summary					
<p>This report provides the Governing Body with highlights from the 20th May 2021 meeting of the Governance Committee. This report provides a brief summary of the items transacted for assurance.</p> <p><u>Derby and Derbyshire CCG Procurement Highlight Report</u> The Governance Committee RECEIVED and NOTED the Highlight report for Derby and Derbyshire CCG.</p> <p><u>Corporate Governance Policies & Procedures for Approval</u> New Government Functional Standards for Counter Fraud were released on the 1st April 2021. In order to comply with the new standard the Fraud, Bribery & Corruption Policy has been reviewed by the CCG's Counter Fraud Specialist and updated accordingly.</p> <p>The Governance Committee APPROVED the following polices:</p> <ul style="list-style-type: none"> • Fraud, Bribery and Corruption Policy. • Policy Management Framework. <p><u>Business Continuity, Emergency Planning Resilience and Response 2020/21</u> The Governance Committee NOTED the contents of the report for information and assurance.</p> <p><u>CCG Recovery and Restoration Plan</u> The Committee reviewed the status of the Recovery and Restoration Plan. The majority of actions are now completed, with many of the remaining actions relating to continuing staff health and wellbeing, or actions relating to preparations for return to</p>					

office accommodation when permitted. It was proposed to the Committee that a final review will be completed across all open actions to identify their closure or the future ownership of continuing actions will be embedded as business as usual.

It was proposed for the Plan to be formally closed down. It was agreed that the plan will be brought back to the Governance Committee in July for final review and the Terms of Reference amended to remove this responsibility.

The Governance Committee NOTED the contents of the report and APPROVED the closure of the Recovery and Restoration Plan with any outstanding items being embedded as business as usual.

Quarter 4 Complaints Report

The Governance Committee NOTED and received ASSURANCE on the content of the quarter 4 Complaints Report.

Quarter 4 Freedom of Information Report

The Governance Committee NOTED and received ASSURANCE on the content of the quarter 4 Freedom of Information Report.

Mandatory Training Report

The Governance Committee NOTED the current compliance of the report as at the end of April 2021.

Contract Oversight Report

The Committee NOTED that the Contracts Oversight Group has been reinstated from April 2021 after being paused due to working at level 4 escalation. The Committee NOTED that the contract requirements for the Data Security and Protection Toolkit have been met.

Next steps include:

- Agreement of how the database will be maintained and kept current, including review of any new contract information emerging;
- Understanding the future offer of the Atamis tool and how long it will be free of charge; and
- Incorporating the project into the CCG Transition Plan, the database will be needed as part of asset transfer work into the ICS.

Staff Survey Results and Action Plan

On the 1st April 2021, the Governing Body received a report detailing the results of the 2020 NHS Staff Survey. The Governing Body requested that a Staff Survey Action Plan be developed and reported to the Governance Committee for discussion and approval. Agreed actions will be incorporated into the CCG People Plan, and the Workforce Race Equality Standard (WRES)/ Workforce Disability Equality Standard (WDES) action plans as appropriate; and progress will be reported to the Governance Committee.

The Governance Committee NOTED the contents of the report and NOTED the outcome of the joint Organisational Effectiveness and Improvement Group (OEIG) and Diversity and Inclusion Network workshop. The Committee APPROVED the

recommended staff survey action plan and propose that this action delegated to it from Governing Body be closed.

Apprenticeship Scheme

The Committee RECEIVED and GAINED ASSURANCE from the verbal update on the current position of the scheme. It was felt that this was a really positive initiative that the CCG had embraced and was using to support the scheme and individuals within it.

Information Governance Compliance Report

The Information Governance Compliance Report detailed a summary of the activities of the Information Governance Assurance Forum held on the 23rd April 2021.

An overview of the activity of the IG team including: Data Protection Impact Assessments (DPIAs) undertaken; IG Incidents reported; Data Security and Protection Toolkit activities and compliance with Data Security Level One Training.

There were no incidents reportable to the Information Commissioners Office during the period.

The Governance Committee APPROVED the revised Terms of Reference for the IG Assurance Forum and RECEIVED the update regarding actions and compliance activities.

The Committee GAINED ASSURANCE of the Substantial Assurance received on the Data Security and Protection Toolkit Audit.

Digital Development Update

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

Risk Register Report April 2021

The Governance Committee RECEIVED the Governance risks assigned to the committee as at 30th April 2021. The Committee NOTED no changes to the risk scores during April.

Governing Body Assurance Framework Q4 2020/21

The committee RECEIVED the Governing Body Assurance Framework Quarter 4 for INFORMATION and ASSURANCE.

Health and Safety Update

The Governance Committee RECEIVED ASSURANCE that Derby and Derbyshire CCG is coordinating work to meet its health and safety obligations to remain compliant with health and safety legislation and RECEIVED ASSURANCE that Derby and Derbyshire CCG is responding effectively and appropriately to the changes in working practices as a consequence of the COVID-19 pandemic.

Non-Clinical Adverse Incidents

There were no non-clinical adverse incidents to reports to the Committee.

Local Security – Violence Reduction Standards

On the 2nd January 2021, NHSEI published the Violence Prevention and Reduction Standards which are applicable to all NHS organisations including Clinical Commissioning Groups (CCG's). A draft action plan has been developed which details the standard indicator, responsible lead, action and timescale.

The Governance Committee:

- NOTED the contents of this report for information and assurance;
- AGREED to include the Violence Prevention and Reduction Standards as a standing agenda item for this Committee to monitor progress and supporting the future work in achieving compliance and transfer to the ICS; and
- AGREED that the Executive Director of Strategy and Corporate Delivery will act as the Executive Lead for Violence Prevention and Reduction including acting as conduit to the Integrated Care System (ICS).

Any Other Business

One item was raised in relation to the proposed identification of a new risk with regard to the Derbyshire Shared Care Record project. The Committee will APPROVE the new risk virtually at the end of May and will be reported to Governing Body in July.

Minutes of the Governance Committee 11th March 2021

The minutes of the 11th March 2021 were APPROVED as an accurate, true record.

Governance Committee's forward planner

The forward plan was REVIEWED and AGREED the further additions to the planner.

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

None identified.

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

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

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

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

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

An EIA is not found applicable to this update. This report is for assurance and information.

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

Not applicable to this update. This report is for assurance and information.

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

Not applicable to this update. This report is for assurance and information.

Have any Conflicts of Interest been identified/ actions taken?

None identified.

Governing Body Assurance Framework

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

Noted as above.

Governing Body Meeting in Public

3rd June 2021

Item No: 064

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

Paper for:	Decision	Assurance	X	Discussion	Information
Assurance Report Signed off by Chair	Andrew Middleton				
Which committee has the subject matter been through?	Quality and Performance Committee – 27.5.2021				

Recommendations

The Governing Body is requested to **RECEIVE** the Quality and Performance Committee Assurance Report for assurance purposes.

Report Summary

Performance:

Urgent and Emergency Care:

- The A&E standard was not met at a Derbyshire level at 84.1% (YTD 84.1%). CRH exceeded the 95% target for the 2nd consecutive month in April 2021, achieving 96.8% (YTD 96.8%) and UHDB achieved 77.1% (YTD 77.1%), which is a deterioration.
- UHDB had 1x 12hour breach due to the availability of a paediatric bed.
- EMAS were compliant in 1 of the 6 national standards for Derbyshire during April 2021.
- Improving in CRH and levelling at UHDB

Planned Care

- 18 Week Referral to Treatment (RTT) for incomplete pathways continues to be non-compliant at a CCG level at 60.3% (YTD 59.5%) CRHFT performance was 61.8% (YTD 64.7%) and UHDB 54.5% (YTD 53.3%).
- Derbyshire had 8,261 breaches of the 52 week standard across all trusts - there were 7,562 the previous month so these have increased by a further 9%.
- Diagnostics – The CCG performance was 25.4%, an improvement from the previous month. Neither CRH or UHDB have achieved the standard.
- UHDB are bidding for a rapid diagnostic site.

Cancer

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

- **31 day Subsequent Drugs** – 98.8% (98% standard) – Compliant all Trusts except Sherwood Forest.
- **31 day Subsequent Radiotherapy** – 96.5% (94% standard) – Compliant for all relevant Trusts.

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

- **2 week Urgent GP Referral** – 92.7% (93% standard) – Compliant for East Cheshire, Nottingham, Sheffield and Sherwood Forest.
- **2 week Exhibited Breast Symptoms** – 73.3% (93% standard) - Compliant for East Cheshire, Nottingham and Sherwood Forest.

- **31 day from Diagnosis** – 92.7% (96% standard) – Compliant for Chesterfield and Sherwood Forest.
- **31 day Subsequent Surgery** – 82.5% (94% standard) - Compliant for Sherwood Forest.
- **62 day Urgent GP Referral** – 70.0% (85% standard) – Non compliant for all trusts.
- **62 day Screening Referral** – 71.0% (90% standard) – Non compliant for all trusts.
- **104 day wait** – 34 CCG patients waited over 104 days for treatment.

Update from Committee 27th May 2021

The Integrated Quality and Performance (Q&P) Report was approved by the chair.

Safeguarding Adult and Children Reports

The Committee received reports from both Adult and Childrens Safeguarding teams. They recognised the significant pressures that both teams had faced during the pandemic and the increase in activity for both areas. The Committee considered that there was significant grip and effective responses in both teams to the challenges and thanked the staff for their hard work.

EMAS

Positive feedback in relation to 'hear and treat' and 'see and treat', and evidence of a clear way forward.

Medicines Management

Positive assurance in relation to the System Antimicrobial Resistance and Infection Prevention and Control Group, and it's readiness ion terms of the new ICS structure.

JUCD Quality Architecture

The presentation relating to the JUCD Operating Framework / Quality Architecture was received by the Committee and they were assured that the local architecture will deliver the national requirements for quality and safety. They were also assured regarding the smooth transition of Quality into the System space.

Stroke

It was reported that there had been a reduction on the SSNAP Audit rating in Stroke Services at UHDB. The Committee were assured that the CCG are sighted and that is being followed up via CQRG, with a plan to report back to Q&P.

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

No

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

N/A

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

N/A

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

N/A

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

N/A

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

N/A

Have any Conflicts of Interest been identified/ actions taken?

None

Governing Body Assurance Framework

The report covers all of the CCG objectives

Identification of Key Risks

The report covers GBAFs 1-3.

Month 12 Quality & Performance Report 2020/21

May 2021

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EXECUTIVE SUMMARY

Key Messages	<ul style="list-style-type: none"> The tables on slides 5-8 show the latest validated CCG data against the constitutional targets. A more detailed overview of performance against the specific targets and the associated actions to manage performance is included in the body of this report.
Urgent & Emergency Care	<ul style="list-style-type: none"> The A&E standard was not met at a Derbyshire level at 84.1% (YTD 84.1%). CRH exceeded the 95% target for the 2nd consecutive month in April 2021, achieving 96.8% (YTD 96.8%) and UHDB achieved 77.1% (YTD 77.1%), which is a deterioration. UHDB had 1x 12hour breach due to the availability of a paediatric bed. EMAS were compliant in 1 of the 6 national standards for Derbyshire during April 2021.
Planned Care	<ul style="list-style-type: none"> 18 Week Referral to Treatment (RTT) for incomplete pathways continues to be non-compliant at a CCG level at 60.3% (YTD 59.5%) CRHFT performance was 61.8% (YTD 64.7%) and UHDB 54.5% (YTD 53.3%). Derbyshire had 8,261 breaches of the 52 week standard across all trusts - there were 7,562 the previous month so these have increased by a further 9%. Diagnostics – The CCG performance was 25.4%, an improvement from the previous month. Neither CRH or UHDB have achieved the standard.
Cancer	<p>During March 2021, Derbyshire was compliant in 2 of the 8 Cancer standards:</p> <ul style="list-style-type: none"> 31 day Subsequent Drugs – 98.8% (98% standard) – Compliant all Trusts except Sherwood Forest. 31 day Subsequent Radiotherapy – 96.5% (94% standard) – Compliant for all relevant Trusts. <p>During March 2021, Derbyshire was non-compliant in 6 of the 8 Cancer standards:</p> <ul style="list-style-type: none"> 2 week Urgent GP Referral – 92.7% (93% standard) – Compliant for East Cheshire, Nottingham, Sheffield and Sherwood Forest. 2 week Exhibited Breast Symptoms – 73.3% (93% standard) - Compliant for East Cheshire, Nottingham and Sherwood Forest. 31 day from Diagnosis – 92.7% (96% standard) – Compliant for Chesterfield and Sherwood Forest. 31 day Subsequent Surgery – 82.5% (94% standard) - Compliant for Sherwood Forest. 62 day Urgent GP Referral – 70.0% (85% standard) – Non compliant for all trusts. 62 day Screening Referral – 71.0% (90% standard) – Non compliant for all trusts. <p>104 day wait – 34 CCG patients waited over 104 days for treatment.</p>

Executive Summary

Trust	
Chesterfield Royal Hospital FT and University Hospitals of Derby and Burton NHS FT	<p>Re-instatement of CQRG</p> <p>These have now been rearranged as per the usual quarterly cycle process. It is acknowledged that all contractual reporting requirements remain paused against the Quality Schedule and the agenda will be informed by known and emerging themes. First meeting for CRH is planned for Monday 24th May, and 10TH June for UHDB.</p>
University Hospitals of Derby and Burton NHS FT	<p>Stroke</p> <p>It has been reported that there has been a deterioration of the Sentinel Stroke National Audit Programme (SSNAP) rating, moving from a C to D (scores rate from A to E). A paper has been requested from the Trust in relation to action being taken, and governance processes.</p>
Derbyshire Community Health Services FT	<p>COVID-19 Activity</p> <p>Activity is declining and services are beginning to stabilise. Heanor ward is no longer designated as a Covid-19 ward. Whilst Video consultations has improved for some, video consultations digital poverty / access has been identified as an issue for some patients. This will be discussed at CQRG.</p>
Derbyshire Healthcare Foundation Trust	<p>Patients placed out of area</p> <p>18 beds remain closed on the acute wards for adults of working age and utilisation continues to be monitored weekly. From April 2021 placements at Mill Lodge will not be reported to NHSE/I as out of area placements because continuity arrangements are in place.</p>
East Midlands Ambulance Trust	<p>Handover Delays</p> <p>Average post handover delays have deteriorated slightly in March at 19 minutes and 14 seconds compared to 19 minutes and 4 seconds in February. Post handover delays above 60+ minutes remain consistent at 1% Hours lost to post handovers were higher than modelled in March, Q4 and 2020/21 overall. These will be monitored through contractual mechanisms.</p>

PERFORMANCE OVERVIEW MONTH 12 (20/21) – URGENT CARE

NHS Derby & Derbyshire CCG Assurance Dashboard

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

EMAS Dashboard for Ambulance Performance Indicators

EMAS Dashboard for Ambulance Performance Indicators				Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Current Month	YTD	consecutive months non-compliance		
Urgent Care	Area	Indicator Name	Standard	Latest Period	East Midlands Ambulance Service Performance (NHSD&CCG only - National Performance Measure)				EMAS Performance (Whole Organisation)				EMAS Completed Quarterly Performance 2020/21				NHS England		
	Ambulance System Indicators		Ambulance - Category 1 - Average Response Time	00:07:00	Apr-21	→	00:07:24	00:07:24	10	00:07:25	00:07:25	9	00:06:32	00:07:18	00:07:35	00:07:22	00:07:00	00:07:00	0
		Ambulance - Category 1 - 90th Percentile Respose Time	00:15:00	Apr-21	→	00:12:28	00:12:28	0	00:13:14	00:13:14	0	00:11:28	00:12:57	00:13:30	00:12:58	00:12:26	00:12:26	0	
		Ambulance - Category 2 - Average Response Time	00:18:00	Apr-21	→	00:22:32	00:22:32	9	00:26:12	00:26:12	10	00:15:36	00:23:12	00:28:19	00:25:56	00:20:16	00:20:16	9	
		Ambulance - Category 2 - 90th Percentile Respose Time	00:40:00	Apr-21	→	00:44:59	00:44:59	9	00:53:42	00:53:42	9	00:30:19	00:47:36	00:58:38	00:53:12	00:40:29	00:40:29	1	
		Ambulance - Category 3 - 90th Percentile Respose Time	02:00:00	Apr-21	↓	02:46:41	02:46:41	9	03:15:26	03:15:26	9	01:40:16	02:38:30	03:31:37	03:06:38	02:18:23	02:18:23	1	
		Ambulance - Category 4 - 90th Percentile Respose Time	03:00:00	Apr-21	↓	03:46:01	03:46:01	1	04:12:29	04:12:29	1	01:40:16	03:27:52	03:33:06	02:59:42	03:48:46	03:48:46	1	

NHS Derby & Derbyshire CCG Assurance Dashboard

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

Part A - National and Local Requirements

CCG Dashboard for NHS Constitution Indicators

CCG Dashboard for NHS Constitution Indicators				Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	
Urgent Care	Area	Indicator Name	Standard	Latest Period	NHS Derby & Derbyshire CCG				Chesterfield Royal Hospital FT			University Hospitals of Derby & Burton FT			NHS England		
	Accident & Emergency		A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	Apr-21	↑	84.1%	84.1%	67	96.8%	96.8%	0	77.1%	77.1%	67	86.6%	86.6%
		A&E 12 Hour Trolley Waits	0	Apr-21					0	0	0	1	1	9	523	523	67
DToC		Delayed Transfers Of Care - % of Total Bed days Delayed	3.5%	Feb-20	↓	Reporting on this indictor has been suspended due to COVID-19			5.05%	1.95%	1	4.13%	3.61%	2	4.68%	4.22%	11

PERFORMANCE OVERVIEW MONTH 12 – PLANNED CARE

NHS Derby & Derbyshire CCG Assurance Dashboard

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

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

Part A - National and Local Requirements

CCG Dashboard for NHS Constitution Indicators

Area	Indicator Name	Standard	Latest Period	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Chesterfield Royal Hospital FT			University Hospitals of Derby & Burton FT			NHS England				
								Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance		
Planned Care	Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Mar-21	↑	60.3%	59.5%	38	61.8%	64.7%	23	54.5%	53.3%	39	64.4%	62.1%	61	
		Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Mar-21	↑	8261	37449	14	1471	6688	12	9728	42610	13	436127	2128699	167	
	Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Mar-21	↓	25.40%	38.57%	34	11.34%	30.34%	12	29.45%	40.71%	13	24.29%	36.15%	91	
	2 Week Cancer Waits	All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	Mar-21	↑	92.7%	89.1%	7	Cancer 2 Week Wait Pilot Site - not currently reporting				86.7%	88.3%	7	91.2%	88.7%	10
		Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	Mar-21	↓	73.3%	80.2%	5		62.1%	80.0%	4	76.9%	75.9%	10			
	31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	96%	Mar-21	↓	92.7%	94.1%	3	96.9%	96.2%	0	90.4%	93.4%	8	94.7%	94.9%	3	
		Subsequent Surgery Within 31 Days Of Decision To Treat	94%	Mar-21	↓	82.5%	81.4%	16	87.0%	87.9%	1	83.0%	78.2%	11	86.4%	87.9%	32	
		Subsequent Drug Treatment Within 31 Days Of Decision To Treat	98%	Mar-21	↓	98.8%	98.5%	0	100.0%	100.0%	0	98.6%	98.2%	0	99.0%	99.1%	0	
		Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	Mar-21	↓	96.5%	95.3%	0				97.7%	94.7%	0	97.9%	96.6%	0	
	62 Days Cancer Waits	First Treatment Administered Within 62 Days Of Urgent GP Referral	85%	Mar-21	↑	70.0%	71.6%	25	79.8%	77.4%	20	64.6%	70.8%	35	73.9%	74.3%	63	
		First Treatment Administered - 104+ Day Waits	0	Mar-21	↑	34	273	60	5	62	35	33	207	60	1162	10105	63	
		First Treatment Administered Within 62 Days Of Screening Referral	90%	Mar-21	↓	71.0%	69.7%	23	66.7%	69.5%	23	76.8%	70.4%	4	75.1%	75.0%	36	
		First Treatment Administered Within 62 Days Of Consultant Upgrade	N/A	Mar-21	↓	83.7%	87.4%		100.0%	88.5%		87.8%	86.5%		82.3%	82.5%		
	28 Day Faster Diagnosis	Diagnosis or Decision to Treat within 28 days of Urgent GP, Breast Symptom or Screening Referral	75%	Mar-21	↑	81.8%	76.5%	0										
	Cancelled Operations	% Of Cancelled Operations Rebooked Over 28 Days	N/A	2019/20 Q3	↑	Reporting on this indicator has been suspended due to COVID-19			6.5%	12.1%		6.1%	5.2%		9.1%	8.4%		
Number of Urgent Operations cancelled for the 2nd time		0	Feb-20	↔	Reporting on this indicator has been suspended due to COVID-19			0	0	0	0	0	0	20	163	1		

PERFORMANCE OVERVIEW MONTH 12 – 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	Mixed Sex Accommodation	Mixed Sex Accommodation Breaches	0	Feb-20	↓	4	89	11	Cancer 2 Week Wait Pilot Site - not currently reporting			10	128	11	4929	21179	11	
	Incidence of healthcare associated Infection	Healthcare Acquired Infection (HCAI) Measure: MRSA Infections	0	Mar-21	↑	0	6	0	0	1	0	55	694	24				
		Healthcare Acquired Infection (HCAI) Measure: C-Diff Infections	Plan		Mar-21	↓		235			34			117				
			Actual				252	3		15	0		69	0		12496		
		Healthcare Acquired Infection (HCAI) Measure: E-Coli	-	Mar-21	↓	70	856		14	221		52	585		70	856		
		Healthcare Acquired Infection (HCAI) Measure: MSSA	-	Mar-21	↑	20	232		7	63		10	143		1055	11689		

PERFORMANCE OVERVIEW MONTH 12 – MENTAL HEALTH

CCG Dashboard for NHS Constitution Indicators

CCG Dashboard for NHS Constitution Indicators				Direction of Travel	Current Month	YTD	consecutive months of failure	Cancer 2 Week Wait Pilot Site - not currently reporting			Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure		
Mental Health	Area	Indicator Name	Standard	Latest Period	NHS Derby & Derbyshire CCG							NHS England									
	Early Intervention In Psychosis	Early Intervention In Psychosis - Admitted Patients Seen Within 2 Weeks Of Referral	60.0%	Feb-21	↑	88.9%	85.4%	0	88.9%	86.9%	0				71.5%	74.3%	0				
		Early Intervention In Psychosis - Patients on an Incomplete Pathway waiting less than 2 Weeks from Referral	60.0%	Feb-21	↓	66.7%	83.2%	0	100.0%	85.6%	0				33.7%	30.5%	22				
	Mental Health	Dementia Diagnosis Rate	67.0%	Apr-21	↑	65.0%	66.4%	10							61.7%	62.8%	13				
		Care Program Approach 7 Day Follow-Up	95.0%	2019/20 Q3	↑	96.1%	96.1%	0	96.1%	96.7%	0				95.5%	95.0%	0				
		CYPMH - Eating Disorder Waiting Time % urgent cases seen within 1 week		2020/21 Q4	↑	96.2%	74.6%														
		CYPMH - Eating Disorder Waiting Time % routine cases seen within 4 weeks		2020/21 Q4	↑	95.1%	83.9%														
		Perinatal - Increase access to community specialist perinatal MH services in secondary care	4.5%	2020/21 Q2	↓	3.4%	3.9%	3													
		Mental Health - Out Of Area Placements		Feb-21	↑	690	7540														
	Physical Health Checks for Patients with Severe Mental Illness	25%	2020/21 Q4	↓	17.9%	29.6%	4														
Mental Health	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	Mar-21	↑	2.10%	25.20%														
			Actual			3.56%	26.34%	0													
	Improving Access to Psychological Therapies	IAPT - Proportion Completing Treatment That Are Moving To Recovery	50%	Mar-21	↑	57.6%	56.6%	0	55.9%	54.6%	0	58.4%	58.0%	0	56.2%	54.9%	0	60.5%	54.8%	0	
		IAPT Waiting Times - The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment	75%	Mar-21	↑	98.9%	92.7%	0	97.5%	85.6%	0	99.5%	98.0%	0	98.0%	94.9%	0	100.0%	99.4%	0	
		IAPT Waiting Times - The proportion of people that wait 18 Weeks or less from referral to entering a course of IAPT treatment	95%	Mar-21	↑	100.0%	98.6%	0	100.0%	99.9%	0	100.0%	100.0%	0	100.0%	99.6%	0	100.0%	100.0%	0	
Mental Health	Area	Indicator Name	Standard	Latest Period	Derbyshire Healthcare FT																
	DToC	Delayed Transfers Of Care - % of Total Bed days Delayed	3.5%	Feb-20	↑	1.34%	0.90%	0													
	Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Mar-21	↓	96.6%	90.6%	0													
Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways		0	Mar-21	↔	0	4	0														

Quality Overview

QUALITY OVERVIEW M12

Trust	Key Issues
Chesterfield Royal Hospital FT	<p>CQRG These have now been rearranged as per the usual quarterly cycle process. It is acknowledged that all contractual reporting requirements remain paused against the Quality Schedule and the agenda will be informed by known and emerging themes. First meeting is planned for Monday 24th May.</p> <p>CQC The well-led discussions with the CQC have not generated any further concerns. The Trust continue to work with the CQC in regards their new approach to regulation monitoring.</p>
University Hospitals of Derby and Burton NHS FT	<p>CQRG These have now been rearranged as per the usual quarterly cycle process. It is acknowledged that all contractual reporting requirements remain paused against the Quality Schedule and the agenda will be informed by known and emerging themes. First meeting is planned for Thursday 10th June.</p> <p>CQC The CQC visits with key focus on Community, Children and Young People, and Well-led are now arranged. They will start at the end of April and progress into June. The Trust feel they are very well-prepared and that the CQC are happy so far with all the information provided in readiness for this process.</p> <p>Stroke It has been reported that there has been a deterioration of the Sentinel Stroke National Audit Programme (SSNAP) rating, moving from a C to D (scores rate from A to E). A paper has been requested from the Trust in relation to action being taken, and governance processes.</p>

QUALITY OVERVIEW M12 continued

Trust	Key Issues
Derbyshire Community Health Services FT	<p>IPC (Derby Mass Vaccination Centre): In April DCHS IP&C team commended assurance visits to the site. The feedback was positive and the report will be reviewed and monitored at CQRG.</p> <p>COVID-19 Vaccination: 92.5% of eligible staff have received at least one vaccination. (92.5% are frontline staff and 90.4% are non-frontline). This will be monitored through CQRG.</p> <p>Staff Survey Results: Within their benchmarking group the Trust ranked highest with 87% of staff recommending its services to friends or family. An improvement was noticed on 19/20 in 5 out of 10 themes with 4 remaining the same.</p> <p>COVID-19 Activity: Is declining and services are beginning to stabilise. Heanor ward is no longer designated as a Covid-19 ward. Whilst Video consultations has improved for some, video consultations digital poverty / access has been identified as an issue for some patients. This will be discussed at CQRG.</p>
Derbyshire Healthcare Foundation Trust	<p>COVID-19 Test and Trace: Since November 2020 over 2,100 lateral flow testing (LFT) kits have been registered with 38,000 test results submitted. This resulting information has enhanced the identification of potential COVID-19 breakouts and minimised potential spread. Staff complete LFT every 3 days even if vaccinated.</p> <p>Patients placed out of area: 18 beds remain closed on the acute wards for adults of working age and utilisation continues to be monitored weekly. From April 2021 placements at Mill Lodge will not be reported to NHSE/I as out of area placements because continuity arrangements are in place.</p> <p>Waiting list for Autistic Spectrum Disorder (ASD) assessment: A recovery plan to resume face to face assessments is in place with 60 individuals prioritised who have declined video/telephone assessment previously. Recruitment has commenced to develop phase 1 of the Specialist Autism Team.</p>
East Midlands Ambulance Trust	<p>Performance: EMAS achieved C1 90th centile and C4 90th centile during March 2021, this is an improvement on February 2021, when only C4 90th centile was achieved. Derbyshire achieved two of the six national standards. For Derbyshire the standards achieved were C1 90th centile and C4 90th centile. When compared to February, Derbyshire have met the same standards. This will be monitored through contractual mechanisms.</p> <p>Handover Delays: Average post handover delays have deteriorated slightly in March at 19 minutes and 14 seconds compared to 19 minutes and 4 seconds in February. Post handover delays above 60+ minutes remain consistent at 1% Hours lost to post handovers were higher than modelled in March, Q4 and 2020/21 overall. These will be monitored through contractual mechanisms.</p>

QUALITY OVERVIEW M11

Derbyshire Wide Integrated Report

Part B: Provider Local Quality Indicators

Dashboard Key:

CCG assured by the evidence

CCG not assured by the evidence

Performance Improved From Previous Period

Performance Maintained From Previous Period

Performance Deteriorated From Previous Period

↑

↔

↓

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

Section	Area	Indicator Name	Standard	Chesterfield Royal Hospital FT				University Hospitals of Derby & Burton FT				Derbyshire Community Health Services				Derbyshire Healthcare FT			
				Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD
Ratings	CQC Ratings	Inspection Date	N/A	Aug-19				Mar-19				May-19				May-18			
		Outcome	N/A	Good				Good				Outstanding				Requires Improvement			
Adult	FFT	Staff 'Response' rates	15%	2019/20 Q2	↑	7.6%	8.6%	2019/20 Q2	↑	10.1%	10.1%	2019/20 Q2	↑	2.7%	21.7%	2019/20 Q2	↑	3.2%	18.1%
		Staff results - % of staff who would recommend the organisation to friends and family as a place to work		2019/20 Q2	↑	56.0%	64.1%	2019/20 Q2	↑	70.2%	70.2%	2019/20 Q2	↑	50.4%	70.5%	2019/20 Q2	↑	57.3%	66.7%
		Inpatient results - % of patients who would recommend the organisation to friends and family as a place to receive care	90%	Feb-20	↑	96.6%	97.7%	Feb-20	↓	97.1%	96.4%	Jul-20	↔	100.0%	98.6%				
		A&E results - % of patients who would recommend the organisation to friends and family as a place to receive care	90%	Feb-20	↓	83.5%	77.8%	Feb-20	↓	85.6%	80.3%	Jul-20	↓	N/A	99.3%				
	Complaints	Number of formal complaints received	N/A	Feb-21	↓	19	168	Jan-21	↓	31	TBC	Feb-21	↑	2	45	Feb-21	↓	18	149
		% of formal complaints responded to within agreed timescale	N/A	Feb-21	↔	100.0%	89.7%	Feb-21	↓		69.9%	Feb-21	↑	75.0%	84.8%	Feb-21	↓	92%	94.6%
		Number of complaints partially or fully upheld by ombudsman	N/A	Feb-21	↔	0	1	19-20 Q2	↔	1	2	Feb-21	↔	0	0	Feb-21	↔	0	0
	Pressure Ulcers	Category 2 - Number of pressure ulcers developed or deteriorated	N/A	Feb-21	↓	10	94	Feb-21	↓	47	TBC	Feb-21	↓	91	1054	Feb-21	↔	0	1
		Category 3 - Number of pressure ulcers developed or deteriorated	N/A	Feb-21	↑	1	31	Feb-21	↑	4	TBC	Feb-21	↑	27	417	Feb-21	↔	0	2
		Category 4 - Number of pressure ulcers developed or deteriorated	N/A	Feb-21	↔	0	1	Feb-21	↔	0	TBC	Feb-21	↑	3	41	Feb-21	↔	0	0
		Deep Tissue Injuries(DTI) - numbers developed or deteriorated		Feb-21	↓	5	28	Sep-19	↑	16	94	Feb-21	↓	79	767	Feb-21	↔	0	0
		Medical Device pressure ulcers - numbers developed or deteriorated						Sep-19	↓	4	20	Feb-21	↓	13	121	Feb-21	↔	0	0
	Falls	Number of pressure ulcers which meet SI criteria	N/A	Sep-20	↑	0	3	Sep-19	↔	0	4	Feb-21	↑	1	19	Feb-21	↔	0	0
		Number of falls	N/A	Feb-21	↑	92	931	Data Not Provided in Required Format				Feb-21	↓	37	345	Feb-21	↑	20	317
	Medication	Number of falls resulting in SI criteria	N/A	Sep-20	↑	0	8	Sep-19	↑	0	19	Feb-21	↔	0	1	Feb-21	↔	0	0
		Total number of medication incidents	?	Feb-21	↑	59	714	Data Not Provided in Required Format				Feb-21	↔	0	0	Feb-21	↓	64	689
	Serious Incidents	Never Events	0	Feb-21	↔	0	1	Feb-21	↔	0	TBC	May-19	↔	0	0	Feb-21	↔	0	0
		Number of SI's reported	0	Sep-20	↑	4	26	Sep-19	↑	7	115	Dec-20	↔	1	34	Feb-21	↔	0	49
		Number of SI reports overdue	0	Feb-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 M11

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

				Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD	
Section	Area	Indicator Name	Standard	Chesterfield Royal Hospital NHS Foundation Trust				University Hospitals of Derby & Burton FT				Derbyshire Community Health Services				Derbyshire Healthcare FT				
Adult	VTE	Number of avoidable cases of hospital acquired VTE		Mar-20	↓	0	15	Feb-21	↔	0	TBC					Feb-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	Feb-21	↓	105.9		Nov-20	↔	107.4										
		Summary Hospital-level Mortality Indicator (SHMI): Ratio of Observed vs. Expected		Oct-20	↑	0.964		Oct-20	↓	0.898										
		Crude Mortality		Feb-21	↓	3.21%	2.29%	Feb-21	↑	3.00%	TBC									
Maternity	FFT	Antenatal service: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Feb-20	↑	95.5%	98.5%	Feb-20	↓	97.6%	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?		Feb-20	↑	97.8%	98.9%	Feb-20	↓	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?		Feb-20	↓	100.0%	98.4%	Feb-20	↓	99.2%	98.0%									
		Postnatal community service: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Feb-20	↔	N/A	98.8%	Feb-20	↔	100.0%	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													Feb-21	↔	0	0	
Workforce	Staff	Staff turnover (%)		Feb-21	↔	8.0%	8.2%	Feb-21	↓	10.1%	TBC	Feb-21	↔	8.8%	8.8%	Feb-21	↔	10.3%	10.4%	
		Staff sickness - % WTE lost through staff sickness		Feb-21	↓	5.1%	5.2%	Feb-21	↑	5.4%	TBC	Feb-21	↑	5.2%	5.1%	Feb-21	↑	5.1%	5.5%	
		Vacancy rate by Trust (%)		Sep-17	↓	1.9%	1.3%	Data Not Provided in Required Format				Feb-21	↔	4.2%	3.7%	Feb-21	↑	6.7%	8.7%	
		Agency usage	Target Actual														Feb-21	↓	2.44%	1.29%
		Agency nursing spend vs plan (000's)		Feb-21	↑	£252	£3,251	Oct-18	↑	£723	£4,355	Feb-21	↑	£109	£1,063					
		Agency spend locum medical vs plan (000's)		Feb-21	↑	£856	£7,516													
	Training	% of Completed Appraisals	90%	Feb-21	↔	92.9%	73.9%	Feb-21	↑		79.8%	Feb-21	↑	84.6%	83.7%	Feb-21	↑	75.5%	76.5%	
		Mandatory Training - % attendance at mandatory training	90%	Feb-21	↓	83.2%	84.2%	Feb-21	↓		83.9%	Feb-21	↓	96.1%	96.8%	Feb-21	↓	82.9%	85.3%	
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																		

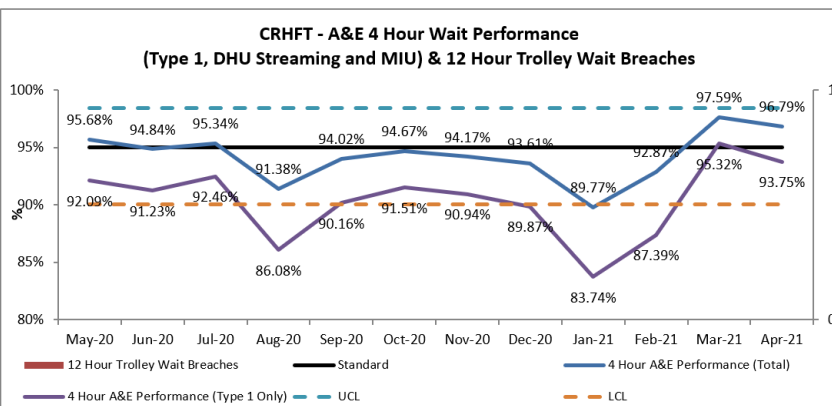
Urgent & Emergency Care

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

Performance Analysis

During April 2021 the trust met the 95% standard, achieving 96.8% and the Type 1 element achieving 93.8%. This is a slight decline but still above target.

There were no 12 hour breaches during April.



What are the next steps?

- The adoption of more Same Day Emergency Care (SDEC) pathways, especially those who can be directed through Assessment Units.
- Continue to implement actions recommended by the Missed Opportunities Audit. These could include other pathway alterations, increased access to diagnostics and alternative streaming options.
- Increased public communications regarding 111First and Urgent Treatment Centres as alternatives to automatic A&E attendances.
- More designated COVID nursing home beds are due to come on line, subject to CQC qualification.
- EMAS are undertaking monthly audits on patients that did not need to be conveyed to ED. Data is being collated and a system action plan has been developed to focus on reducing unnecessary conveyances.

What are the issues?

- At the start of the pandemic the volume of Type 1 attendances were much lower but are now approaching pre-pandemic levels, with an average of 172 attendances per day. However, April 2021 volumes were still 18% lower than April 2019 levels.
 - Patient flow had been affected by high numbers of confirmed Covid cases, however during April 2021 these were significantly lower with zero confirmed cases on some days.
- During the COVID-19 pandemic many A&E departments are highly pressured due to:
- The physical footprint of ED was increased to ensure social distancing but this can make it more difficult for the clinical lead to take a 'helicopter' view of the situation.
 - Streaming of patients at the physical front door to ensure that patients with COVID19 symptoms were treated in the most appropriate setting.
 - The redeployment of some staff to dedicated COVID19 wards.
 - Staff absence due to sickness or self-isolation.
 - Additional time required between seeing patients to turnaround the physical space ensuring increased strict infection control.

What actions have been taken?

- An Urgent Treatment Centre (UTC) pilot model started on 16th February, with initial data indicating that 28% of attendances were seen in the UTC.
- Development of Same Day Emergency Care (SDEC) pathways and speciality improvements, with initial figures showing an increase of direct streaming by 15 per week.
- Established 24 hour access to the Assessment Units for relevant Medical, Surgical and Gynaecological patients.
- The implementation of the 111First project, whereby patients only access ED via 999 calls or booked appointments – to reduce unnecessary attendances.
- The implementation of new urgent care pathways including improved High Peak rapid response access, Dementia, Palliative Care, early pregnancy assessment, Urology, TIA and an additional route into the Mental health Safe Haven.
- Procedures embedded to safely treat Medical patients in the Surgical Assessment Unit (if clinically appropriate) at times of tight capacity.
- Mental Health Liaison Team in place to ensure that all appropriate patients are given an assessment within 24 hours.
- Increased Clinician to Clinician contact availability to assist EMAS clinical decision making and avoid unnecessary conveyances.

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

Performance Analysis

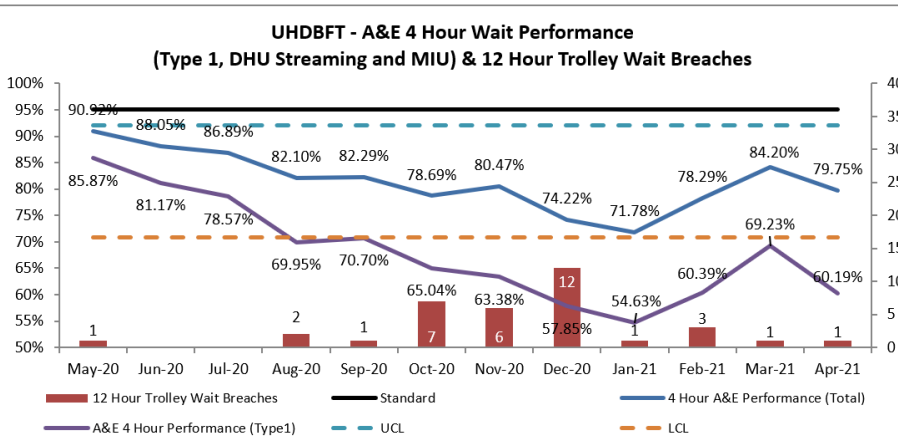
During April 2021, performance overall did not meet the 95% standard, achieving 79.5% (Network figure) and 60.2% for Type 1 attendances. These show significant improvement since January. There was 1x12 hour breach during April 2021 due to the availability of a suitable Paediatric bed.

What are the issues?

- At the start of the pandemic the volume of Type 1 attendances were much lower but are now approaching pre-pandemic levels, with an average of 324 attendances per day. However, April 2021 volumes were still 18% lower than April 2019 levels.
- The acuity of the attendances was high, with an average of 24 Resuscitation patients and 206 Major patients per day (11% and 89% of the total attendances respectively). The proportions have increased due to the UTC treating most of the Minor patients.
- Patient flow was affected by the high numbers of confirmed Covid cases during winter, but are now significantly lower.
- ED and Assessment areas are separated in red/green areas according to Covid19 symptoms to ensure infection control. This limits physical space and therefore flexibility of patient flow. In addition, delayed Covid19 results have led to delays in transfers to the appropriate red/green assessment areas.

What actions have been taken?

- The opening of a co-located Urgent Treatment Centre (UTC), in collaboration with DHU. As an enhanced form of streaming this has been significant in reducing the number of patients attending the ED department unnecessarily.
- 24/7 opening of the UTC over Easter Bank Holiday eased pressures in A&E.
- Establishing a front-door Geriatrician rota to enable appropriate treatment for frail patients.
- The advanced booking of slots by 111-referred patients has made capacity much more manageable, with 70% of these patients arriving at expected times.
- The UTC has established direct access for requesting diagnostic pathology testing which can be done through Lorenzo.
- A major capital programme expanded physical ED capacity into an adjoining area to provide more physical capacity and to improve patient flow while ensuring infection control.
- The use of Ready Rooms to create Covid-safe treatment areas and utilise the space more effectively, improving patient flow.
- The implementation of the 111First project, whereby patients only access ED via 999 calls or booked appointments – to reduce unnecessary attendances and improve capacity management for those who do attend.
- Sign up to undertake the NHS Elect SDEC Accelerator programme to help identify opportunities for expanding Same Day Emergency Care (SDEC) provision and help to pull together an action plan to establish/redesign pathways.
- Internal Professional Standards were altered in regard to escalation plans and disputes procedures. In addition a Critical Friend Review (peer review) identified longer 'working up' times at the front door rather than further along the patient pathway.



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

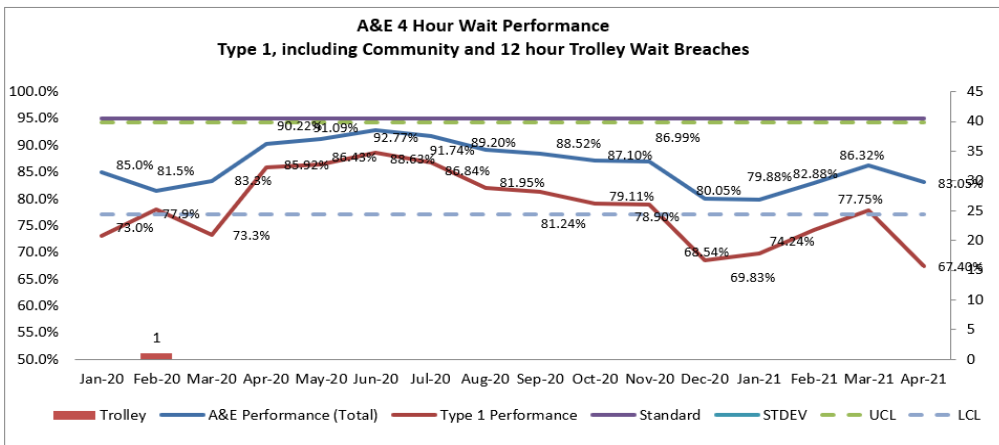
What are the next steps?

- Further development of the Urgent Treatment Centre, with an aspiration to operate 24/7.
- Creating forums to share good practice for the Every Day Counts project, to improve discharges.
- Improving the shared Pitstop area for patients arriving by ambulance.
- Increased public communications regarding 111First and Urgent Treatment Centres as alternatives to automatic A&E attendances.
- Identifying pathways where patients could be transferred to the Derby Urgent Treatment Centre instead of being seen in ED as Minors..

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

Performance Analysis

During April 2021, performance overall did not meet the 95% standard, achieving 83.1% for the Burton A&E and 67.4% including community hospitals. Performance had been improving since winter. There were no 12 hour breaches during April 2021.



What were the issues?

- The trust had been experiencing a decrease in attendances but now the attendances exceed the previous year by 40%, with an average of 162 Type 1 attendances per day.
- The acuity of the attendances is high, with an average of 110 Resuscitation/Major patients per day (67.9% of total attendances).
- Patient flow was affected by surges in numbers of confirmed Covid cases, sometimes occupying a third of beds during the winter.
- The isolation of wards due to Covid outbreaks has limited capacity and therefore flow for those needing admission as an inpatient.

What actions have been taken?

- Bi-weekly improvement cycle meetings have been established to maintain the momentum of developments.
- A peer review by Chris Morrow-Frost which should include suggestions for transformation.
- The implementation of the Staffordshire 111First project, whereby patients only access ED via 999 calls or booked appointments – to reduce unnecessary attendances and improve capacity management for those who do attend.
- Improved data analysis support inform transformation.
- The implementation of revised Same Day Emergency Care (SDEC) pathways for Thunderclap Headaches, Dementia and Palliative Care.
- The GP Connect service now includes Frailty as a condition, whereby GPs can connect with UHDB Geriatricians before deciding whether a patient needs hospital support.
- The Meditech can now flag Medically Fit For Discharge patients, to speed their discharge and improve patient flow.
- The standardisation of discharge processes in inpatient wards.
- Twice-weekly multi-disciplinary team meetings in community hospitals with a focus on patients medically fit for discharge.
- The Every Day Counts project has begun, promoting advanced discharge planning and inpatient ward accreditation to improve flow.

What are the next steps?

- Reviewing the peer review findings and taking forward potential transformations.
- A major capital programme is increasing the number of Assessment Unit beds, increasing Majors bed capacity and establishing a Pitstop area for patients arriving by ambulance.
- The addition of a modular building to house GP Streaming services.
- Continued development of the Every Day Counts programme, focussing on engagement and working behaviours.
- Extending the use of the Meditech IT system to community hospitals to enable improved patient flow processes.
- The Non-Elective Improvement Group (NELIG) continue to work on improvements, currently focussing on overall bed capacity at the Queens Hospital site.

DHU111 Performance Month 12 (March)

Performance Summary

- DHU achieved all five contractual Key Performance Indicators in March 2021.
- The national standard for 95% of calls answered within 60 seconds was not achieved in March 2021, however performance was much higher than the national position and DHU remained the highest performing provider across the Country. DHU111 are not contracted to deliver the calls answered in 60 seconds national standard, as this was not a nationally mandated standard at the time of contract award, performance against this standard is monitored.

Activity Summary

- Calls offered are 21.7% below plan year to date (October – March). This is outside of the +/- 5% threshold, it is therefore likely that a credit will be due to commissioners at the end of Q3. The credit due to commissioners based on October 2020 – March 2021 data is £1,197,984*.
- Clinical Calls are also below plan the year to date to March at - 8.7%. This again is outside of the +/- 5% threshold, which means a credit to commissioners is likely at the end of Q3. The credit due to commissioners based on October 2020 – March 2021 data is £134,449*.
- There were 12,742 Category 3 Ambulance Validations in March, with an associated cost of £229,738.
- The regional cost of COVID-19 activity for March was £38,335, taking the cumulative cost since October 2020 to £538,603. There were much fewer COVID-19 calls in March 2021, than has been seen in previous months.

* The credit due is subject to change once actual data for Q3 becomes available.

Regional Performance Year Five - Key Performance Indicators (KPI's)								
			Quarter One (October – December)			Quarter Two (January – March)		
KPI's		Standard	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Contract	Abandonment rate (%)	≤5%	0.5%	0.1%	0.2%	0.2%	0.2%	1.0%
Contract	Average speed of answer (seconds)	≤27s	00:00:09	00:00:06	00:00:06	00:00:10	00:00:09	00:00:18
Contract	Call Transfer to a Clinician	≥50%	66.0%	66.7%	69.6%	71.6%	70.4%	68.7%
Contract	Self Care	≥17%	26.2%	23.6%	20.9%	20.6%	20.1%	20.4%
Contract	Patient Experience	≥85%	88.0%	This data is updated on a six monthly basis				
Contract	C3 Validation	≥50%	98.0%	98.9%	92.0%	98.9%	98.8%	98.4%
National Standard	Calls answered in 60 seconds DHU111 (%)	≥95%	96.7%	99.4%	99.9%	98.4%	98.5%	92.2%
National Standard	Calls answered in 60 seconds England Ave. (%)	≥95%	79.1%	80.7%	79.5%	72.3%	86.0%	78.2%

DHU111 Performance Month 12 (March)

What are the issues?

- It is unclear what is driving the high levels of underactivity as it cannot be distinguished explicitly from the data, however it is suspected that this is due to a combination of 111 First activity not materialising and the usual winter illness not coming through. This position is not unique to DHU and this level of underactivity is being seen across the country.
- In the month of March there was significant demand nationally into NHS 111, including DHU, which then impacted on performance. The increase in demand was mostly related to concerns regarding the Astra Zeneca Vaccination. Despite the increase in month, activity still did not meet IAP levels.
- There was a planned server migration in March which took longer to complete than initially anticipated. This resulted in delays in reporting and the absence of some daily reporting. DHU have been given assurance that all data is safe; the issues have either been server performance, server access, or data flow from Advanced to DHU. The issues do not affect data recording or storage.

What actions have been taken?

- DHU have formally written to commissioners outlining the financial pressure the underactivity position and associated credit is causing. Commissioners have responded proposing to postponed the financial reconciliation to the end of Q3, rather than the end of Q2.
- Data is now flowing from AdastrA, however a number of minor issues remain and there is currently a fix in place.

What are the next steps?

- Commissioners are awaiting a formal reply from DHU in relation to the underactivity position regarding the proposal to postpone reconciliation.
- Daily tests are being run by DHU and AdastrA in order to get data flows set back up and running effectively.
- The monthly Contract Management Board and quarterly Clinical Quality Review Group meetings have been reinstated from April 2021 to gain assurance on all aspects relating to the contract and quality.

Activity		Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar -21	Year to date (Contract Year Oct 2020-Sep 2021)
Calls Offered	Actual	148,098	146,417	146,590	135,746	119,595	145,732	842,178
	Plan	152,299	153,848	203,460	199,210	177,571	188,612	1,075,000
	Variance	-2.8%	-4.8%	-28.0%	-31.9%	-32.6%	-22.7%	-21.7%
Clinical Calls	Actual	30,215	30,687	32,894	31,929	27,493	32,072	185,290
	Plan	29,898	30,333	39,528	36,350	31,639	35,140	202,890
	Variance	1.1%	1.2%	-16.8%	-12.2%	-13.1%	-8.7%	-8.7%

Covid-19 Activity – Actual	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
Non-Clinical	9,371	9,142	7,413	9,122	5,652	2,943
Clinical (total)	2,208	2,435	2,392	3,259	1,809	995

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 M12 (March)

What are the issues?

- The contractual standard is for the division to achieve national performance on a quarterly basis. In Quarter Four, Derbyshire achieved two of the six national standards, C1 90th Centile and C4 90th Centile. C1 mean was not achieved by 43 seconds, C2 mean was not achieved by 9 minutes and 4 seconds, C2 90th Centile was not achieved by 15 minutes and 51 seconds and C3 90th was not being achieved by 1 hour 14 minutes and 32 seconds.
- Average Pre hospital handover times during March 2021 remained above the 15 minute national standard across Derbyshire (20 minutes and 6 seconds), this is comparable to February (20 minutes and 33 seconds).
- Average Post handover times during March 2021 remained above the 15 minute national standard across Derbyshire with the exception of Stepping Hill (14 minutes and 33 seconds) and Macclesfield District General Hospital (10 minutes and 41 seconds). Overall the post handover time in March 2021 (19 minutes and 14 seconds) was comparable to February 2021 (19 minutes and 4 seconds).
- Derbyshire saw an overall increase in incidents in March 2021 when compared to February 2021. The activity mix during March 2021 saw a reduction in H&T and S&T and an increase in S&C when compared to February. There has also been an increase in duplicate calls, 16.4% in March compared to 14.6% in February 2021.
- In Derbyshire, the % of on scene demand passed through from 111 is the joint highest across the East Midlands at 30% of total calls (joint with Leicestershire).
- S&C to ED saw an increase in March 2021, with S&C incidents to ED being 55.9% compared to 53.5% in February 2021. Although S&C to ED is reducing, it remains “middle of the pack” at 56% when compared to other ICS within the East Midlands footprint, with the lowest ICS area being Leicestershire at 45% and the highest area being North and North East Lincolnshire at 66%.

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 - March	00:07:09	00:12:39	00:23:57	00:48:58	02:37:00	02:42:57
Derbyshire Actual - March	00:07:33	00:12:38	00:22:34	00:46:19	02:28:23	01:35:06
Derbyshire Actual - Quarter Four	00:07:43	00:13:14	00:27:04	00:55:51	03:14:32	02:04:57

March	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	00:23:54	71:19:22	00:16:51	35:07:23	00:40:45	91:41:58
Chesterfield Royal	00:20:03	255:09:51	00:18:23	238:32:46	00:38:26	408:16:41
Macclesfield District General Hospital	00:24:01	9:16:48	00:10:41	0:56:10	00:34:42	6:57:39
Royal Derby	00:19:30	390:13:43	00:20:31	542:40:34	00:40:01	815:21:37
Sheffield Northern General Hospital	00:28:46	29:47:13	00:15:56	10:17:39	00:44:42	33:09:38
Stepping Hill	00:19:05	32:42:52	00:14:33	16:39:39	00:33:38	38:55:33
Derbyshire TOTAL	00:20:06	788:29:49	00:19:14	844:14:11	00:39:19	1394:23:06

AMBULANCE – EMAS PERFORMANCE M12 (March)

What actions have been taken?

- C3/C4 clinical triage pilot – EMAS have completed phase two and work continues with an unofficial phase three. Phase three of the C3/4 pilot is exploring the use of video conferencing within the clinical assessment process to explore whether this helps to reduce the number of ambulances dispatched.
- EMAS has recently acquired a version of the ambulance simulation modelling software used by ORH (who undertook the demand and capacity review). Use of this tool will enable EMAS to model the expected impact on performance of changes to variables.
- A piece of work is taking place between EMAS and commissioners to focus on identifying outliers across the East Midlands in order to reduce variation – with regards Derbyshire a couple of areas have been RAG rated as red when compared to other ICS footprints; On scene demand and post hospital handover times. One area has been identified as amber for Derbyshire; S&C to ED percentage (54%).
- Derbyshire has a reducing avoidable conveyance lead who will continue to review failed pathways to identify how S&C to ED can be reduced when safe and appropriate.
- Derbyshire continues to roll out SDEC pathways and two hour community response teams and are developing the use of the JRCalc App which will allow crews to access alternative pathways when on scene. Work continues nationally to ensure the most commonly referred into pathways by Ambulance services are profiled on the DoS so that ambulance crews can access available alternatives consistently across the Country.
- EMAS continues to work closely with the Urgent Treatment centres across Derbyshire to reduce conveyancing to the acutes; including undertaking observation shifts to identify areas of improvement and build on relationships with UTC staff. There has been an increase to 12 conveyances week from around 3, with an aim to reach 25 per week.

What are the next steps

- A national piece of work is due to commence in April 2021 to review the level of C2 activity within AMPDS Trusts. The % of C2 activity is much lower in those services who use NHS Pathways. Discussions are taking place nationally as to the most appropriate triage tool to support a reduction in variation across codes and acuity.
- The final C3/C4 clinical triage pilot report into phase two is due in May 2021. The updated UTC guidance, which is yet to be published, will include information to support increased conveyance to a UTC by the ambulance service.
- EMAS continues to work closely with both acute trusts on post handover delays – Royal Derby Hospital held a ‘Perfect week’ w/c 19th April.
- EMAS are in the process of giving UTCs access to their electronic patient record (EPR system) to enable the sharing of patient information and support the handover process.
- Discussions continue with DHU and the Acute Trusts regarding the scale of opportunity of co-locating UTCs at the front door following on from the missed opportunity audit led by NHE/I regional team.
- Work to roll out SDEC pathways continues across both acute trusts sites, with there being focus on Surgical, Gynae and frailty.

Derbyshire	Quarter Three	January	February	March	Quarter Four
Calls (Total)	55,053	19,880	15,932	17,478	53,290
Total Incidents	41,009	14,396	12,687	13,539	40,622
Total Responses	37,019	12,953	11,544	12,408	36,905
Duplicate Calls	10,493	3,832	2,330	2,856	9,018
Hear & Treat (Total)	7,541	3,095	2,058	2,214	7,367
See & Treat	12,831	4,869	4,242	4,195	13,306
See & Convey	24,188	8,084	7,302	8,213	23,599
Duplicates as % Calls	19.1%	19.3%	14.6%	16.4%	16.9%
H&T ASI as % Incidents	9.7%	10.0%	9.0%	8.4%	9.2%
S&T as % Incidents	31.3%	33.8%	33.4%	31.0%	32.8%
S&C as % Incidents	59.0%	56.2%	57.6%	60.7%	58.1%
S&C to ED as % of incidents	54.8%	52.4%	53.5%	55.9%	53.9%

Planned Care

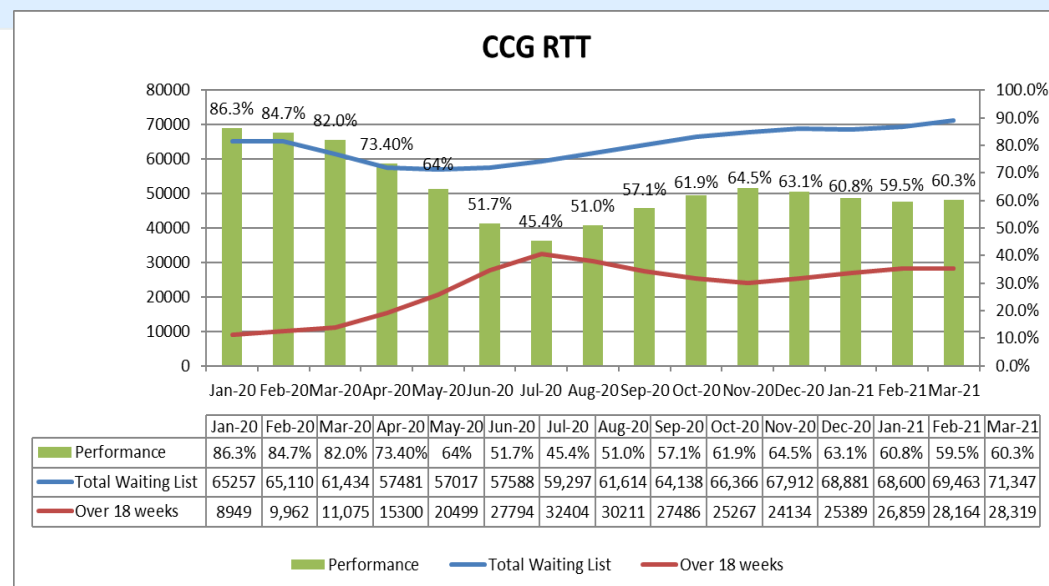
DERBYSHIRE COMMISSIONER – INCOMPLETE PATHWAYS (92%)

Performance Analysis

Performance for March 2021 was 60.3%, a slight improvement on the February figure of 59.5%. The number of patients waiting over 18 weeks has increased slightly and the overall number of patients on the waiting list has increased.

The total incomplete waiting list for DDCCG was 71,347 at the end of March. The number of referrals across Derbyshire during March showed an increase of 10% for Urgent referrals and the routine referrals showed a reduction of 23% when compared with the average weekly referral of the previous 51 weeks.

Treatment Function	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Average (median) waiting time (in weeks)	92nd percentile waiting time (in weeks)
General Surgery	6,197	3,100	50.0%	18.0	52+
Urology	3,466	2,409	69.5%	9.9	52+
Trauma & Orthopaedics	12,047	4,906	40.7%	22.7	52+
Ear, Nose & Throat (ENT)	4,663	2,272	48.7%	18.7	52+
Ophthalmology	10,542	5,630	53.4%	15.9	52+
Oral Surgery	1	1	100.0%	-	-
Neurosurgery	436	267	61.2%	13.6	51.0
Plastic Surgery	518	278	53.7%	15.8	52+
Cardiothoracic Surgery	129	92	71.3%	10.8	45.7
General Medicine	1,459	1,047	71.8%	10.3	45.1
Gastroenterology	4,473	3,469	77.6%	8.3	29.8
Cardiology	2,141	1,609	75.2%	7.7	31.5
Dermatology	3,261	2,362	72.4%	6.3	49.7
Thoracic Medicine	1,209	873	72.2%	10.0	27.4
Neurology	1,120	798	71.3%	8.5	31.2
Rheumatology	1,345	967	71.9%	9.6	29.2
Geriatric Medicine	234	193	82.5%	5.9	29.6
Gynaecology	4,552	2,860	62.8%	12.2	52+
Other	13,554	9,895	73.0%	8.4	52+
Total	71,347	43,028	60.3%	12.8	52+

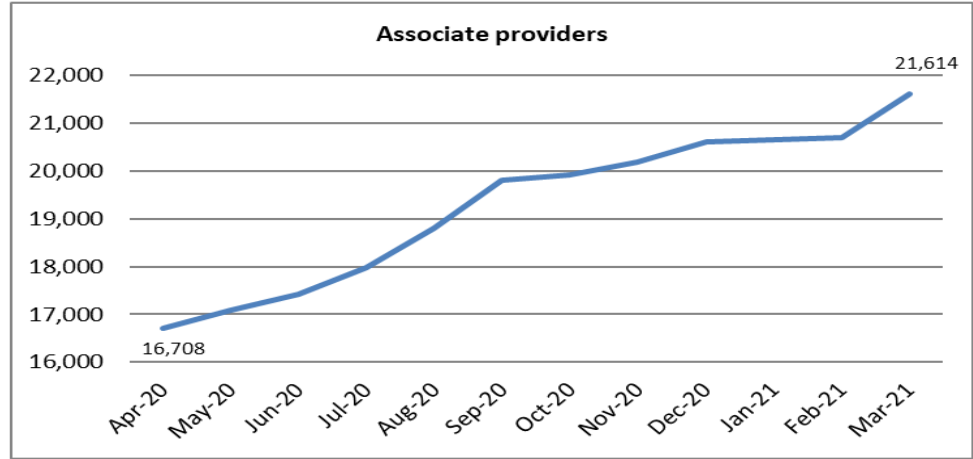
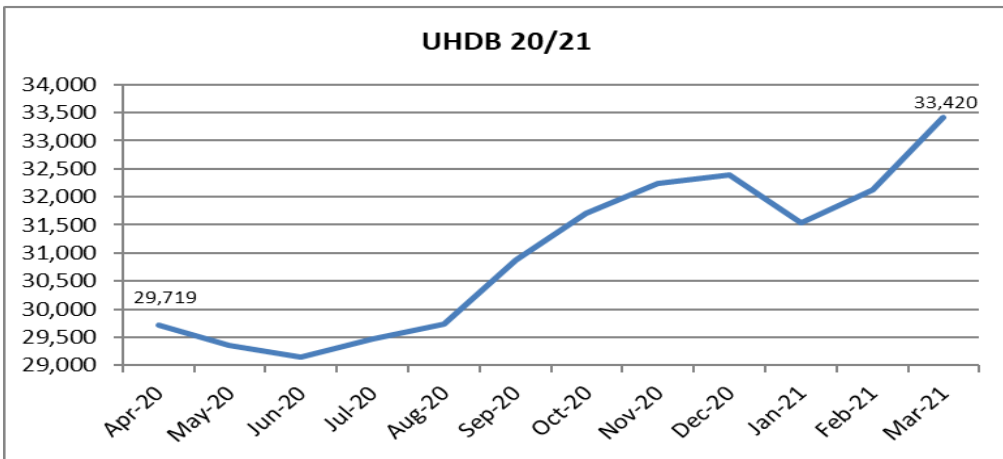
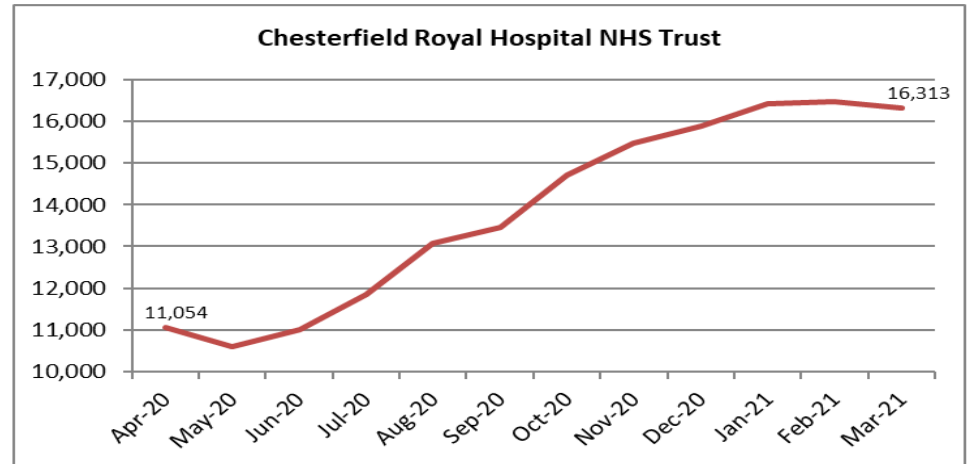
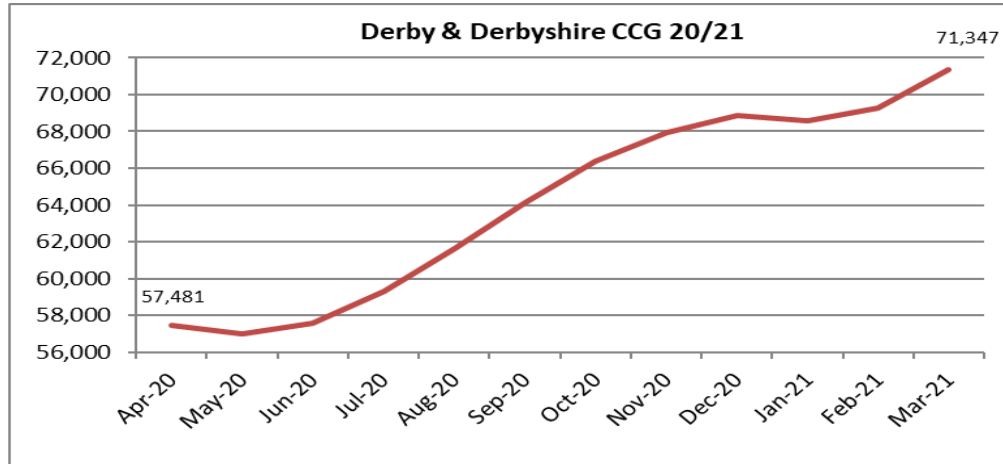


- The Derbyshire CCG position is representative of all of the patients registered within the CCG area attending any provider nationally.
- 70% of Derbyshire patients attend either CRHFT (25%) or UHDB (45%). The RTT position is measured at both CCG and provider level.
- The RTT standard of 92% was not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

ELECTIVE CARE – DDCCG Incomplete Pathways

Derbyshire CCG incomplete waiting list at the end of March 2021 is 71,347.

Of this number 48,602 patients are currently awaiting care at our two main acute providers CRH (16,313) and UHDB (33,420). The remaining 21,614 Derbyshire residents are on an incomplete pathways at other trusts out of Derbyshire. The graphs below show the current position and how this has changed over the last few months.

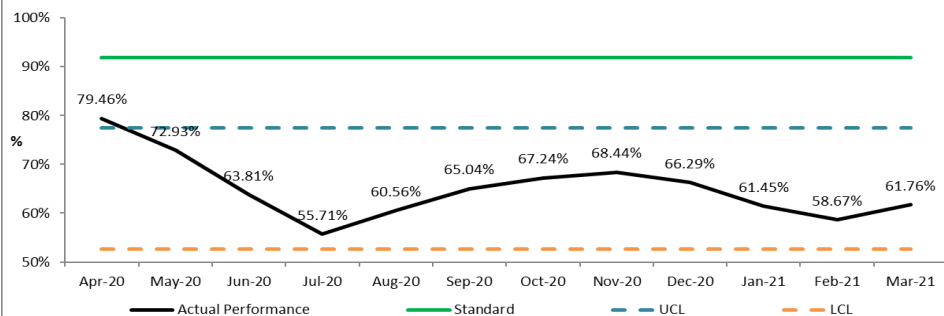


Referral to Treatment – Incomplete Pathways (92%).

CRH

During March the trust achieved performance of 61.8%, an improvement on the February performance of 58.7%. The waiting list at the end of March stands at 17,860, a slight increase on the February figure.

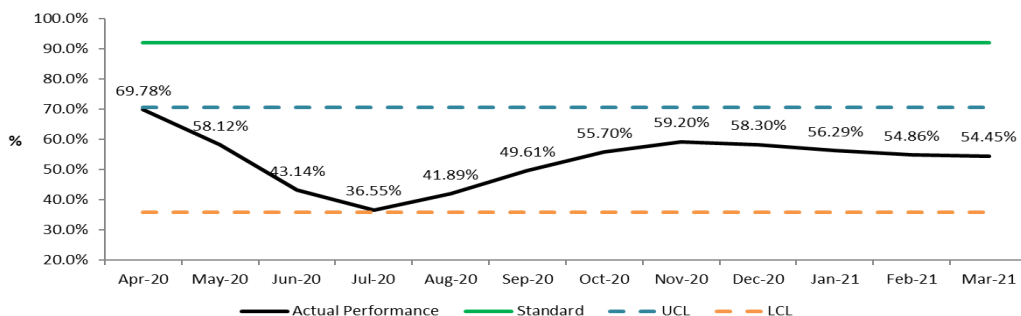
18 Weeks Incomplete RTT Performance - CRHFT



UHDB

During March the trust achieved a standard of 54.5%, similar to the February figure of 54.9%. The waiting list at the end of March is 63,064, an increase on the February 2021 figure.

18 Weeks Incomplete RTT Performance - UHDBFT



Treatment Function	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Average (median) waiting time (in weeks)	92nd percentile waiting time (in weeks)
General Surgery	3,160	1,638	51.8%	16.7	44.8
Urology	1,089	887	81.5%	7.6	33.4
Trauma & Orthopaedics	1,582	775	49.0%	18.9	52+
Ear, Nose & Throat (ENT)	1,470	930	63.3%	11.0	52+
Ophthalmology	2,114	974	46.1%	19.7	52+
Oral Surgery	1,016	615	60.5%	12.2	52+
General Medicine	603	477	79.1%	8.6	25.3
Gastroenterology	1,672	1,014	60.6%	14.0	36.0
Cardiology	530	397	74.9%	9.0	28.7
Dermatology	919	823	89.6%	4.0	20.7
Thoracic Medicine	504	365	72.4%	9.8	26.4
Rheumatology	403	269	66.7%	10.9	27.9
Gynaecology	1,441	876	60.8%	11.9	52+
Other	1,357	991	73.0%	7.9	52+
Total	17,860	11,031	61.8%	11.7	52+

Treatment Function	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Average (median) waiting time (in weeks)	92nd percentile waiting time (in weeks)
General Surgery	3,495	1,750	50.1%	18.0	52+
Urology	2,851	1,573	55.2%	15.8	52+
Trauma & Orthopaedics	12,559	4,472	35.6%	25.0	52+
Ear, Nose & Throat (ENT)	4,897	2,033	41.5%	22.1	52+
Ophthalmology	8,828	4,218	47.8%	19.0	52+
Oral Surgery	93	26	28.0%	52+	52+
Neurosurgery	63	29	46.0%	19.0	30.5
Plastic Surgery	316	137	43.4%	23.5	52+
Cardiothoracic Surgery	11	9	81.8%	-	-
General Medicine	340	309	90.9%	5.8	19.9
Gastroenterology	3,003	2,755	91.7%	6.3	18.2
Cardiology	1,711	1,448	84.6%	6.0	24.7
Dermatology	3,173	1,762	55.5%	14.7	52+
Thoracic Medicine	427	304	71.2%	12.0	27.7
Neurology	917	552	60.2%	13.6	34.3
Rheumatology	1,099	824	75.0%	8.8	28.2
Geriatric Medicine	268	202	75.4%	8.2	34.5
Gynaecology	4,251	2,416	56.8%	15.7	52+
Other	14,762	9,522	64.5%	11.2	52+
Total	63,064	34,341	54.5%	15.9	52+

DERBYSHIRE COMMISSIONER – OVER 52 WEEK WAITERS

52 Week Waits

March performance data reflects the impact of COVID with 8,261 patients reporting as waiting over 52 week waits for treatment in Derbyshire. Of these 6,684 are waiting at our two main providers UHDB and CRH, the remaining 1,577 are waiting at various trusts around the country as outlined in the table on the following slide.

It is expected the number of patients waiting over 52 weeks will continue to increase further during 20/21 until elective surgery is fully re-instated and the back log has been addressed.

CCG Patients – Trend – 52 weeks

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
DDCCG	0	1	27	103	242	527	934	1,519	2,107	2,658	3,388	4,245	5,903	7,554	8,261

Main Providers:

In terms of Derbyshire's the two main acute providers the 52ww position for March at UHDB and CRH is as follows:

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21
UHDB	0	0	45	138	298	580	1,011	1,667	2,367	2,968	3,751	4,706	6,629	8,767	9,728
CRH	0	0	0	4	17	53	117	212	308	438	594	797	1,202	1,475	1,471

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

Main Provider Actions:

The Surgery Division are following national Royal College of Surgeon guidance on prioritisation of surgical patients which was issued in October 2020. This identifies patients who are clinically appropriate to delay for periods and those who will need to be prioritised. This will aid the teams to use the limited elective capacity on the patients who are most at risk of harm, allowing trusts to tackle the growing backlog of long waiters. As well as priority levels 1-4 there are a further two - 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.

DERBYSHIRE COMMISSIONER – OVER 52 WEEK WAITERS

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

Provider	Total	Provider	Total
AIREDALE NHS FOUNDATION TRUST	1	ROYAL FREE LONDON NHS FOUNDATION TRUST	4
ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	1	SALFORD ROYAL NHS FOUNDATION TRUST	19
ASPEN - CLAREMONT HOSPITAL	44	SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	62
BARTS HEALTH NHS TRUST	3	SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	64
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	6	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	169
BMI - THE ALEXANDRA HOSPITAL	4	SPIRE BRISTOL HOSPITAL	1
BMI - THE PARK HOSPITAL	1	SPIRE NOTTINGHAM HOSPITAL	5
BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	1	SPIRE REGENCY HOSPITAL	19
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	3	STOCKPORT NHS FOUNDATION TRUST	425
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	1	TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	2
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FT	19	THE ONE HEALTH GROUP LTD	15
EAST CHESHIRE NHS TRUST	46	THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FT	4
FRIMLEY HEALTH NHS FOUNDATION TRUST	1	THE ROTHERHAM NHS FOUNDATION TRUST	1
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	1	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	1
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	2	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	1
LEEDS TEACHING HOSPITALS NHS TRUST	8	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	17
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	3	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	2
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	19	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	54
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	1	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	9
NEWMEDICA COMMUNITY OPHTHALMOLOGY - BARLBOROUGH	5	WOODTHORPE HOSPITAL	11
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FT	1	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	4
NORTH BRISTOL NHS TRUST	2	HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST	11
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	332	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	1
NUFFIELD HEALTH, DERBY HOSPITAL	107	LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	6
NUFFIELD HEALTH, NORTH STAFFORDSHIRE HOSPITAL	1	BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	1
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	2	PRACTICE PLUS GROUP HOSPITAL - BARLBOROUGH	51
PENNINE ACUTE HOSPITALS NHS TRUST	1	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	1
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	1	Total	1577

Actions:

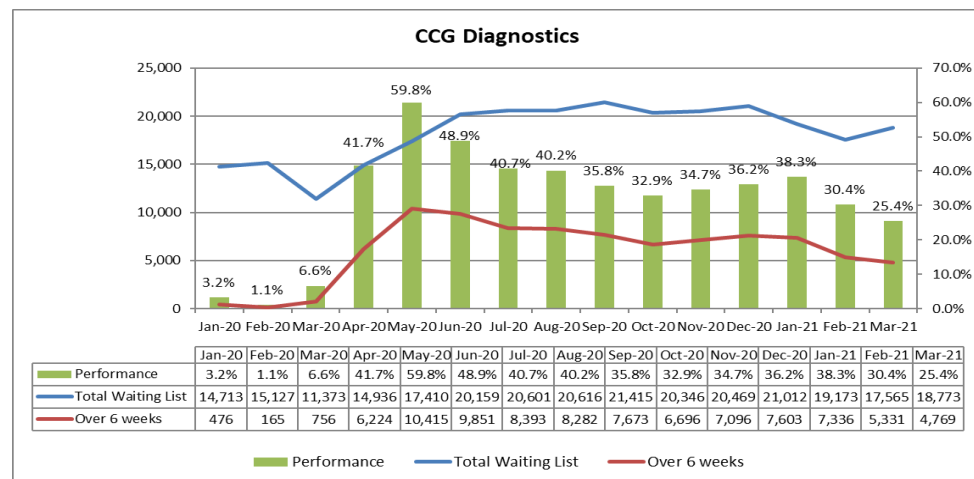
- The performance team make enquiries of the relevant CCGs and responses received back are that these patients are not clinically urgent but are being reviewed. We have not been informed of any TCI dates.

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

Performance Analysis

Derbyshire CCG Diagnostic performance at the end of March was 25.4% waiting over six weeks, an improvement on the February position of 30.4%.

The total number of Derbyshire patients waiting for diagnostic procedures has increased during March. The number of patients waiting over six weeks has also increased but the number waiting over 13 weeks has decreased. All of our associates are showing non compliance for the diagnostic standard.



Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Percentage waiting 6+ Weeks
Magnetic Resonance Imaging	2,590	490	279	18.9%
Computed Tomography	1,981	278	117	14.0%
Non-obstetric Ultrasound	7,824	2,256	419	28.8%
DEXA Scan	484	78	13	16.1%
Audiology - Audiology Assessments	784	136	37	17.3%
Cardiology - Echocardiography	1,771	296	129	16.7%
Neurophysiology - Peripheral Neurophysiology	249	4	0	1.6%
Respiratory physiology - Sleep Studies	68	8	4	11.8%
Urodynamics - Pressures & Flows	123	73	39	59.3%
Colonoscopy	970	422	308	43.5%
Flexi Sigmoidoscopy	375	123	71	32.8%
Cystoscopy	244	73	40	29.9%
Gastroscopy	1,310	532	371	40.6%
Total	18,773	4,769	1,827	25.4%

Diagnostic Test	University Hospitals of Derby and Burton	Chesterfield Royal Hospital	Stockport	Sheffield Teaching Hospital	Sherwood Forest Hospitals	Nottingham University Hospitals	East Cheshire
Magnetic Resonance Imaging	13.7%	0.9%	2.3%	1.6%	3.9%	63.8%	13.4%
Computed Tomography	21.0%	1.8%	49.7%	3.7%	32.8%	8.3%	1.8%
Non-obstetric Ultrasound	51.3%	1.0%	28.5%	1.0%	1.8%	61.1%	4.9%
Barium Enema	11.1%						
DEXA Scan	37.0%	2.7%	43.3%	59.1%	9.8%	53.0%	
Audiology - Audiology Assessments	19.6%	22.2%	60.0%	48.8%	1.1%	23.6%	51.2%
Cardiology - Echocardiography	2.4%	7.5%	10.9%	5.6%	59.1%	1.9%	71.7%
Neurophysiology - Peripheral Neurophysiology	3.3%		0.0%	0.0%		0.0%	
Respiratory physiology - Sleep Studies	5.3%		3.2%	0.0%	33.5%	7.7%	13.3%
Urodynamics - Pressures & Flows	68.5%	72.0%	33.3%	0.0%	2.5%	21.7%	
Colonoscopy	10.4%	46.3%	83.0%	50.4%	57.9%	3.4%	68.3%
Flexi Sigmoidoscopy	16.8%	60.9%	80.6%	66.2%	23.5%	5.9%	63.2%
Cystoscopy	25.6%	8.6%	0.0%	20.0%	52.0%	4.2%	0.0%
Gastroscopy	13.9%	62.5%	83.5%	55.2%	45.9%	8.2%	64.6%
Total	36.5%	16.6%	50.8%	14.6%	29.7%	47.6%	51.8%

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

Performance Analysis

Performance during March was 11.3%, an improvement on the February figure of 16.6%.

The numbers on the waiting list have decreased again during February, and the number of patients waiting over 6 and 13 weeks has also reduced.

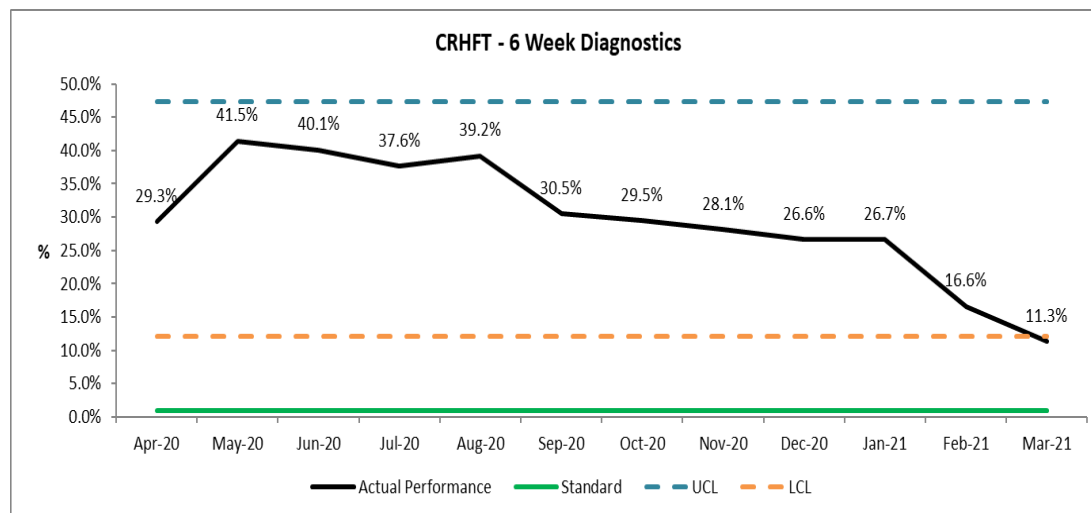
What are the issues?

Issues

- Endoscopy capacity is still proving to be difficult although all procedures going through endoscopy has improved on their performance.
- Some patients who were reluctant to attend their appointments during the early part of the year due to COVID concerns are now attending.

Actions

- Imaging and Endoscopy activity for those patients on a cancer pathway is prioritised.
- The Colorectal straight to test process has resumed.
- Further development of the clinical triage set and CAB.
- Roll out of the Attend Anywhere scheme, utilising phone and video. This approach also included patients being allowed the choice of how they receive diagnostic results.
- Cardio-Respiratory diagnostic areas have validated waiting lists to ensure data quality.



Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Percentage waiting 6+ Weeks
Magnetic Resonance Imaging	529	3	0	0.6%
Computed Tomography	502	9	1	1.8%
Non-obstetric Ultrasound	1,554	0	0	0.0%
DEXA Scan	150	2	1	1.3%
Audiology - Audiology Assessments	339	71	29	20.9%
Cardiology - Echocardiography	408	57	9	14.0%
Urodynamics - Pressures & Flows	25	17	11	68.0%
Colonoscopy	257	87	57	33.9%
Flexi Sigmoidoscopy	91	39	28	42.9%
Cystoscopy	62	4	0	6.5%
Gastroscopy	379	198	128	52.2%
Total	4,296	487	264	11.3%

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

Performance Analysis

Performance during March was 29.5% an improvement on the February figure of 36.57%.

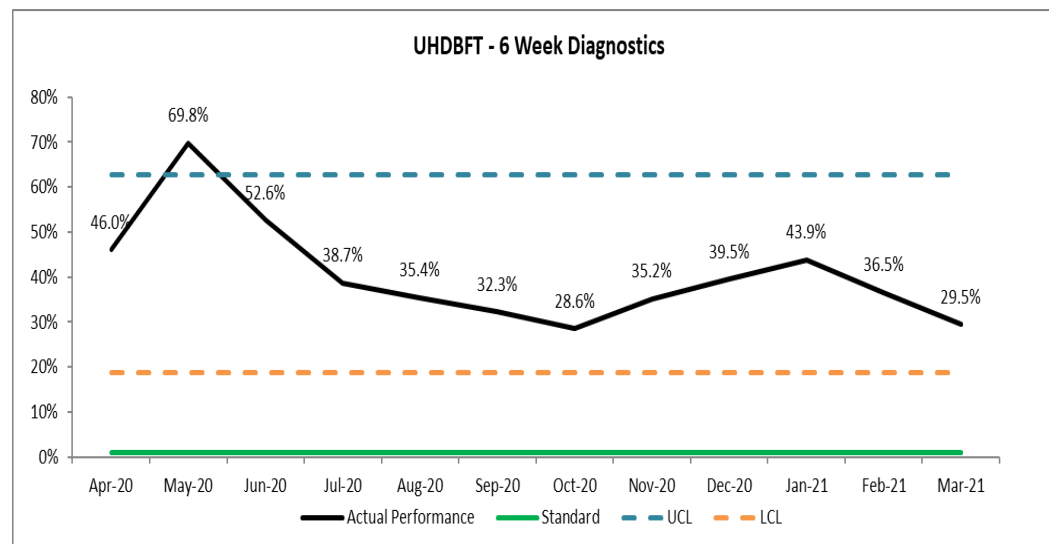
The numbers on the waiting list have increased during March, although the number waiting over six weeks has decreased, but those waiting over 13 weeks has increased.

Issues

- Non Obstetric ultrasounds and cystoscopy are problem areas currently.
- Although NOUS is an issue the trust are performing well for the volume of tests that they are currently undertaking.
- Most areas are continuing to improve each month.

Actions

- Cystoscopy – Urology day case to reopen at the beginning of April to help with the backlog and hope to be almost back to compliance by the end of April.
- Pressure in MRI with scanners breaking down and staffing issues. Trying to recruit as many locum as possible.
- Ultrasounds – Reviewing additional weekend capacity. Proposals received from two companies to do 3m months work at tariff based in the UHDB facilities.
- Community diagnostic hubs proposal – Plan to have three hubs across Derbyshire which will increase capacity over the next five years.
- Have developed a bid for additional capacity to include CMD and endoscopy at Tamworth.



Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Percentage waiting 6+ Weeks
Magnetic Resonance Imaging	1,877	182	68	9.7%
Computed Tomography	1,363	249	115	18.3%
Non-obstetric Ultrasound	8,922	3,949	894	44.3%
Barium Enema	6	0	0	0.0%
DEXA Scan	304	21	10	6.9%
Audiology - Audiology Assessments	490	79	12	16.1%
Cardiology - Echocardiography	1,206	5	1	0.4%
Neurophysiology - Peripheral Neurophysiology	300	3	1	1.0%
Respiratory physiology - Sleep Studies	87	0	0	0.0%
Urodynamics - Pressures & Flows	130	74	32	56.9%
Colonoscopy	430	44	10	10.2%
Flexi Sigmoidoscopy	262	29	1	11.1%
Cystoscopy	196	67	28	34.2%
Gastroscopy	605	63	28	10.4%
Total	16,178	4,765	1,200	29.5%

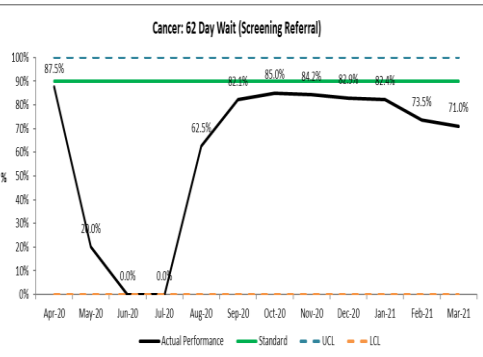
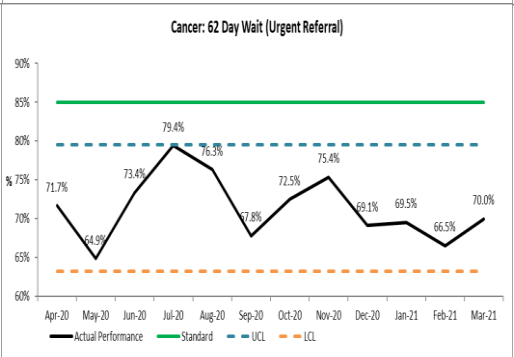
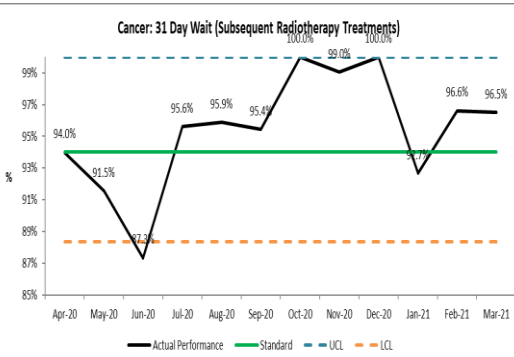
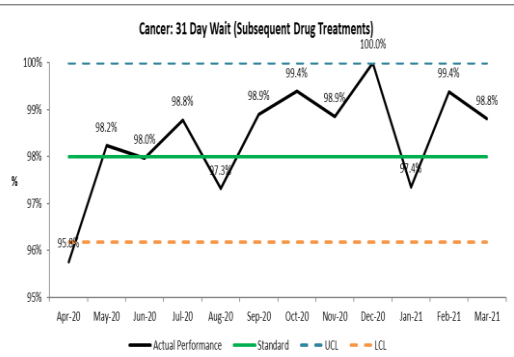
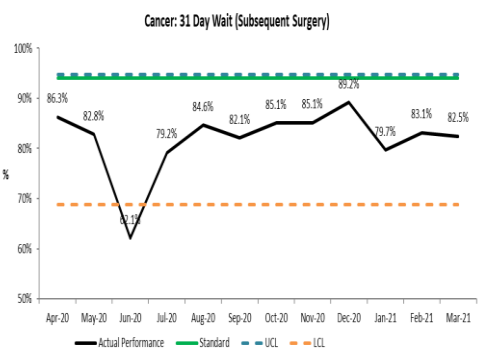
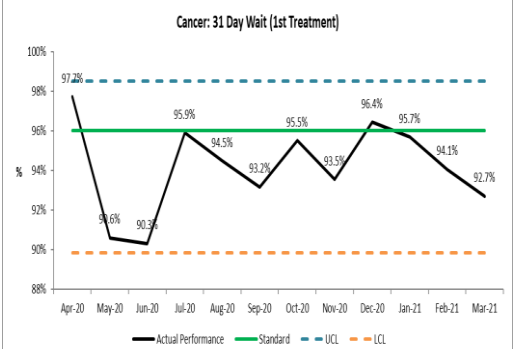
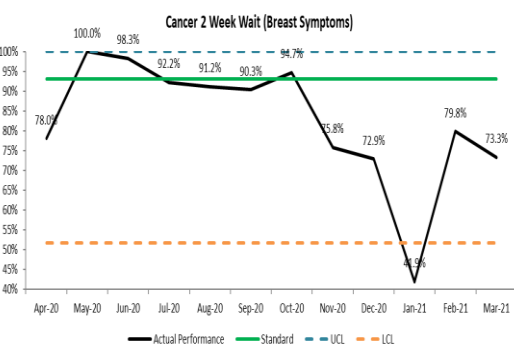
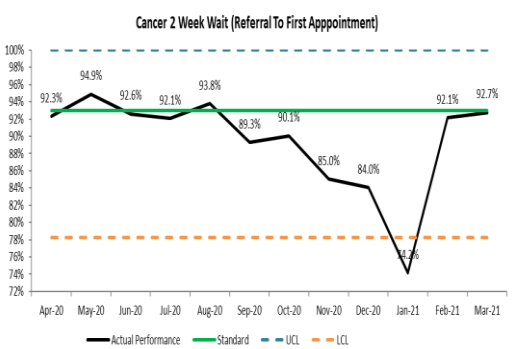
DERBYSHIRE COMMISSIONER – CANCER WAITING TIMES

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

- **31 day Subsequent Drugs** – 98.8% (98% standard) – Compliant all Trusts except Sherwood Forest.
- **31 day Subsequent Radiotherapy** – 96.5% (94% standard) – Compliant for all relevant Trusts.

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

- **2 week Urgent GP Referral** – 92.7% (93% standard) – Compliant for East Cheshire, Nottingham, Sheffield and Sherwood Forest.
 - **2 week Exhibited Breast Symptoms** – 73.3% (93% standard) - Compliant for East Cheshire, Nottingham and Sherwood Forest.
 - **31 day from Diagnosis** – 92.7% (96% standard) – Compliant for Chesterfield and Sherwood Forest.
 - **31 day Subsequent Surgery** – 82.5% (94% standard) - Compliant for Sherwood Forest.
 - **62 day Urgent GP Referral** – 70.0% (85% standard) – Non compliant for all trusts.
 - **62 day Screening Referral** – 71.0% (90% standard) – Non compliant for all trusts.
- 104 day wait** – 34 CCG patients waited over 104 days for treatment.



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)

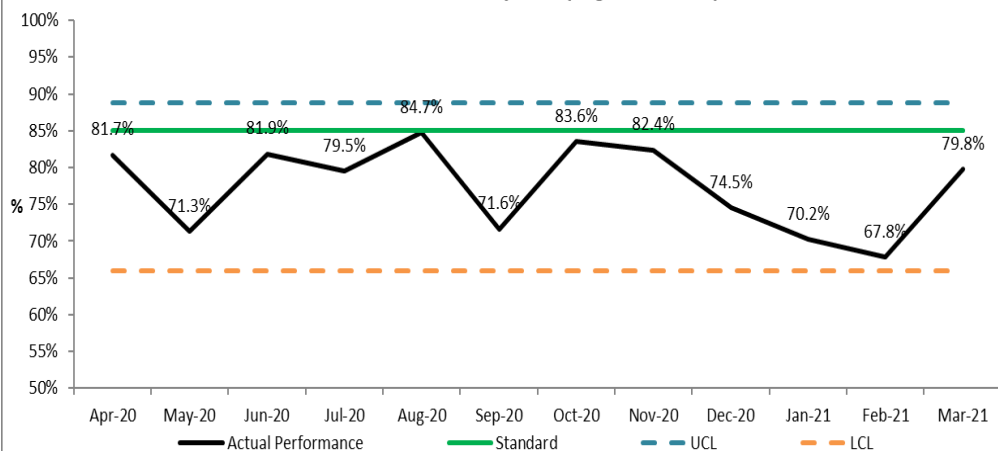
Performance Analysis

CRH performance during March for first treatment within 62 days of urgent referral has improved to 79.8%, remaining non-compliant against the standard of 85%.

Breaches related to hospital delays and patient choice and complex pathways.

Out of the 16.5 breaches 5 were reported as waiting over 104 days for treatment (equating to 6 patients).

CRHFT - Cancer: 62 Day Wait (Urgent Referral)



Current Issues

- Breast Outpatient Capacity.
- Theatre Capacity to accommodate demand.
- Lower GI Backlog.
- Long appointment waits for Template Biopsies.
- Recent increase of referrals in Head and Neck.
- Inappropriate Dental referrals.
- Now that a number of patients have had both vaccinations there is not such an issue with patients reluctant to come into the trust.

Actions Being Taken

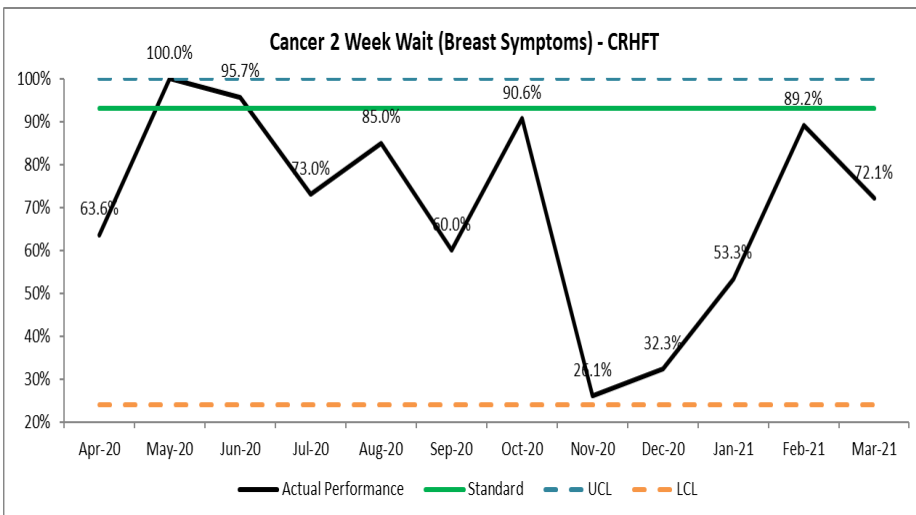
- Derbyshire Breast Pain Clinic going live in June which is expected to help alleviate demand on the breast cancer pathway.
- Increasing theatre capacity to help reduce theatre waiting times.
- Additional clinics in place to support the bladder pathway and alleviate the backlog to support lower GI.
- Improvement underway on the Urology pathway.
- Consultant undertaking Template Biopsy training and once complete will help with capacity issues.
- Inappropriate dental referrals is under review with the Dental Practices concerned.

What are the next steps

- Continued focus on those patients over 62 day and 104 day on the PTL. The H1 Operational Plan for 21/22 requires trust to reduce their PTL of patients over 63 days who have not yet been treated to the February 2020 figure or lower.

Tumour Type	Total referrals seen during the period	Seen Within 62 Days	Breaches of 62 Day Standard	% Performance
Breast	17	11.5	5.5	67.6%
Gynaecological	0.5	0.5	0	100.0%
Haematological (Excl. Acute Leukaemia)	9	9	0	100.0%
Head and Neck	3	2.5	0.5	83.3%
Lower Gastrointestinal	4.5	3	1.5	66.7%
Lung	4	4	0	100.0%
Other	1	0.5	0.5	50.0%
Skin	18	18	0	100.0%
Testicular	3	3	0	100.0%
Upper Gastrointestinal	6	5	1	83.3%
Urological (Excluding Testicular)	15.5	8	7.5	51.6%
Totals	81.5	65	16.5	79.8%

CRHFT - CANCER WAITING TIMES – 2 Week Wait Breast Symptomatic



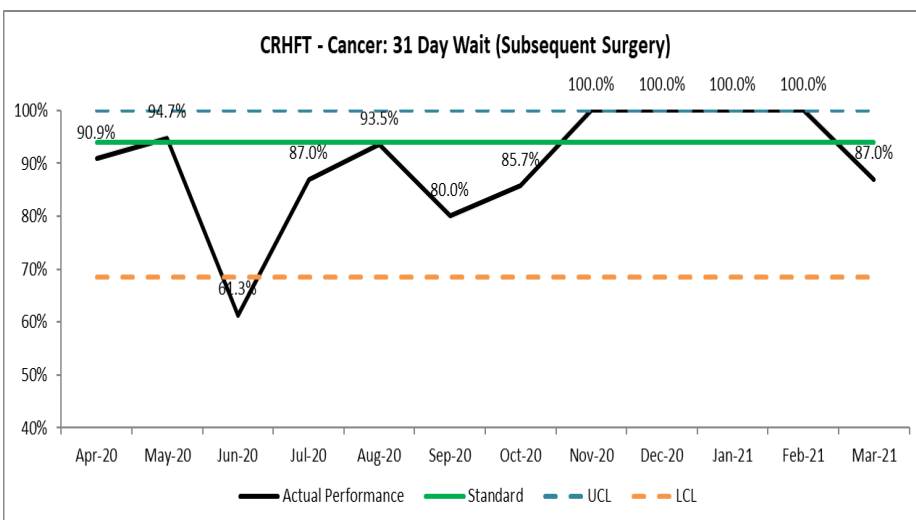
Performance Analysis

March performance at CRH for 2 Week Wait Breast Symptomatic has decreased since the month prior to 72.1%, remaining non-compliant against the standard of 93%. The main challenges for being non-compliant is due to outpatient capacity and a high increase in demand. An increase in Breast referrals is a national issue and has been evident across the region since October.

The total number of patients seen this month by way of referral to Breast Symptomatic was 43 with 31 of those patients being seen within the 2 week wait standard, resulting in 12 breaches. The reasons for the breaches include Outpatient Capacity(7), Patient Choice(3) and Administrative(2).

Out of the 12 breaches 10 of the patients were seen within 21 days, with the remaining 2 being seen at 22 and 25 days.

CRHFT - CANCER WAITING TIMES – 31 Day Wait – Subsequent Surgery



Performance Analysis

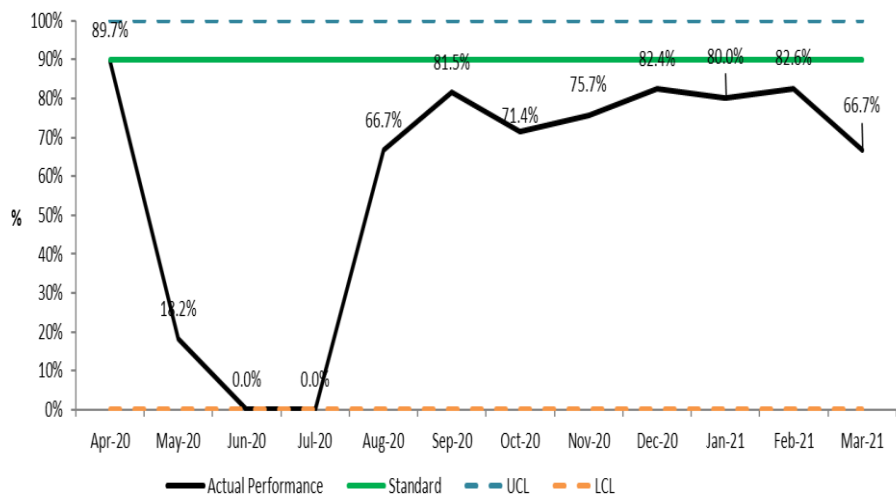
March Performance at CRH for 31 day for Subsequent Surgery Treatment has decreased slightly to 87%, non-compliant against the standard of 94%.

There were 23 patients who received subsequent surgery this month with 20 of those patients having surgery within the 31 day standard, resulting in 3 breaches. The activity during March has over doubled when compared to February where there were 9 patients who received subsequent surgery and all within 31 days.

The number of days the patients breached were 36, 44 and 51 days.

CRHFT - CANCER WAITING TIMES – 62day Screening Referral

CRHFT - Cancer: 62 Day Wait (Screening Referral)



Performance Analysis

Performance in March has reduced to 66.7%, remaining non-compliant against the standard of 90%.

There were a total of 12 patients treated this month who were initially referred through the screening service with 8 of those patients being treated within the 62 day standard, resulting in 4 breaches.

All 4 breaches related to Lower GI and breached as a result of Complex Diagnostics.

The number of days the patients breached at were 104, 106, 125 and 140 days.

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

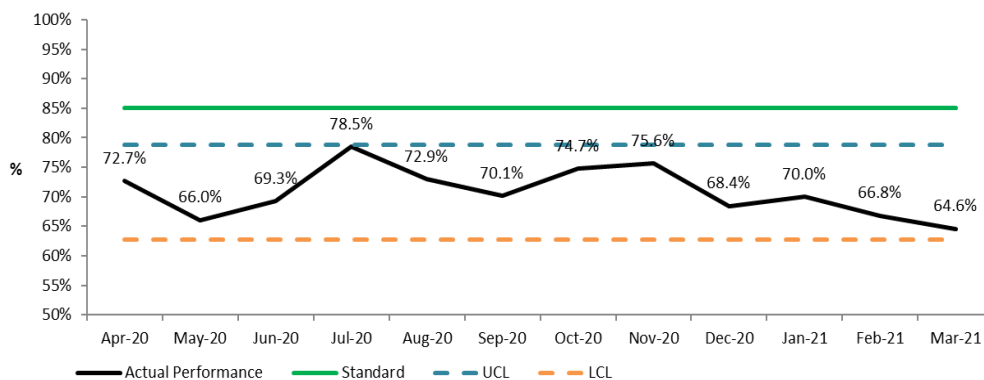
Performance Analysis

March Performance for first treatment within 62 days has reduced slightly to 64.6%, remaining non-compliant against the standard of 85%.

There was a total of 206 patients treated on this pathway which is an increase from the 155 patients treated in February. Out of the 206 patients treated in March there were 133 treated within the 62 day standard, resulting in 73 breaches (75 patients).

The main reasons for the breaches were outpatient capacity (37) which is expected to show an improvement during April and 12 due to elective capacity.

UHDBFT - Cancer: 62 Day Wait (Urgent Referral)



Current Issues

- High increase in Gynaecology referrals, particularly from Staffordshire.
- Theatre Capacity.
- Template Biopsies capacity.
- Recent increase of referrals in Head and Neck.
- Increase in Endoscopy waiting lists.
- Lower GI backlog.
- Inappropriate Dental referrals.
- Patient Choice with a proportion of patients being reluctant to attend the hospital due to Covid and choosing to wait until being vaccinated. Although this was reported as an issue in March, it has since improved.

Actions Being Taken

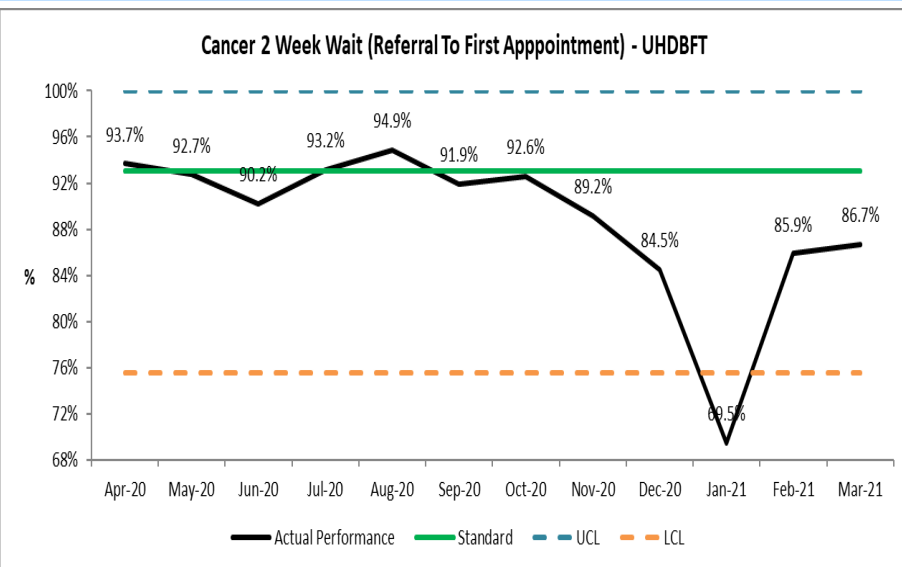
- Gynaecology pathway under review to ensure consistency across both sites.
- Increasing theatre capacity to help reduce theatre waiting times.
- Extra clinics being arranged in Urology to aid capacity.
- Weekend appointment lists implemented to support Trust Biopsies.
- Inappropriate dental referrals is under review with the Dental Practices concerned.

What are the next steps

- Continued focus on those patients over 62 day and 104 day on the PTL. The H1 Operational Plan are requiring Trusts to reduce their PTL to the February 2020 figure or lower.

Tumour Type	Total referrals seen during the period	Seen Within 62 Days	Breaches of 62 Day Standard	% Performance
Breast	35	28	7	80.0%
Gynaecological	9	4	5	44.4%
Haematological (Excl. Acute Leukaemia)	8	3	5	37.5%
Head and Neck	14	12	2	85.7%
Lower Gastrointestinal	33	14	19	42.4%
Lung	12	9	3	75.0%
Other	2	0	2	0.0%
Sarcoma	6.5	6	0.5	92.3%
Skin	36.5	32	4.5	87.7%
Testicular	3	2	1	66.7%
Upper Gastrointestinal	18	9	9	50.0%
Urological (Excluding Testicular)	29	14	15	48.3%
Totals	206.0	133	73	64.6%

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



Performance Analysis

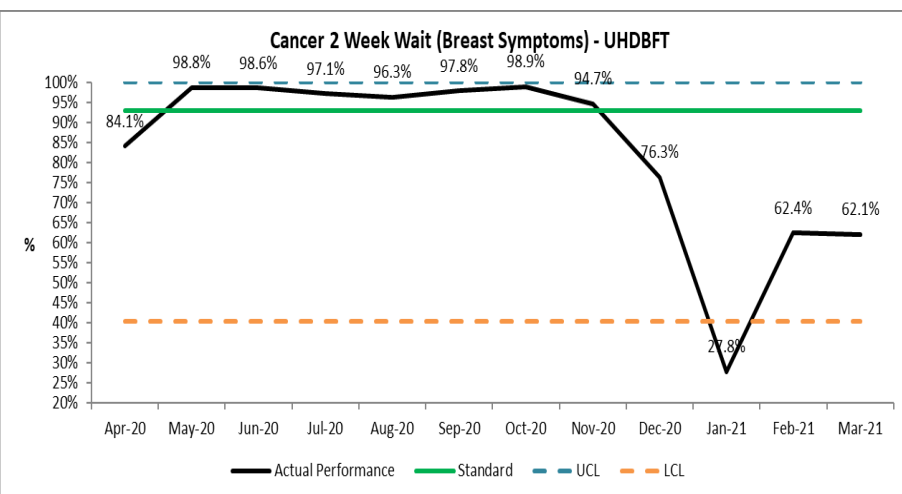
March performance at UHDB for 2 week wait has improved slightly to 86.7%, however, it continues to be non-compliant against the standard of 93%. The main challenges for 2ww performance have been associated with Breast, Lower GI and Upper GI.

There were a total number of 3407 patients seen this month by way of GP Urgent referral to first appointment which is an increase from the 2541 reported in February and is the first time it has exceeded 3000 since July 2019. There were 200 more patients seen by the Breast team and Lower GI team than the previous month.

Out of the 3407 patients referred in March, 2954 of these patients were seen within the 2 week wait standard. Performance against this standard is expecting to improve in April.

The 453 breaches occurred in Brain(1) Breast(245), Children(1), Gynaecology(54), Haematology(3), Head and Neck(4), Lower GI (63), Lung(3), Skin(27), Upper GI(43) and Urology(10). The majority of the breach reasons were due to Outpatient Capacity with the remaining reasons being as a result of Patient Choice.

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



Performance Analysis

March performance at UHDB for 2 week wait Breast Symptomatic has reduced very slightly since last month to 62.1%, remaining non-compliant against the standard of 96%.

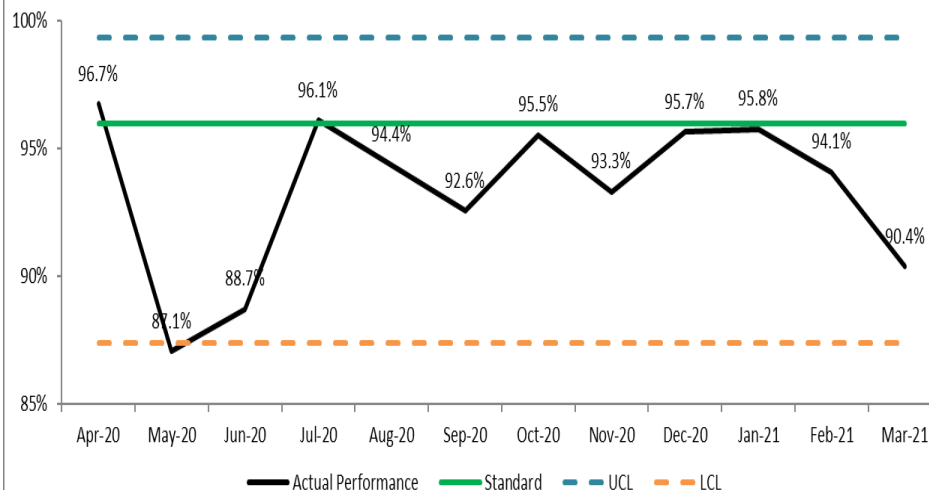
The total number of patients seen this month by way of referral to Breast Symptomatic was 253 with 157 of those patients being seen within 2 weeks, resulting in 96 breaches.

Out of the 96 breaches 66 of the patients were seen within 21 days, 17 waiting up to 28 days and 13 waiting over 28 days. The majority of the breach reasons were due to outpatient capacity, with the remaining being as a result of Patient Choice.

Breast Referrals during January and February increased overall by 23% compared to the same period last year which has resulted in the delays.

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

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



Performance Analysis

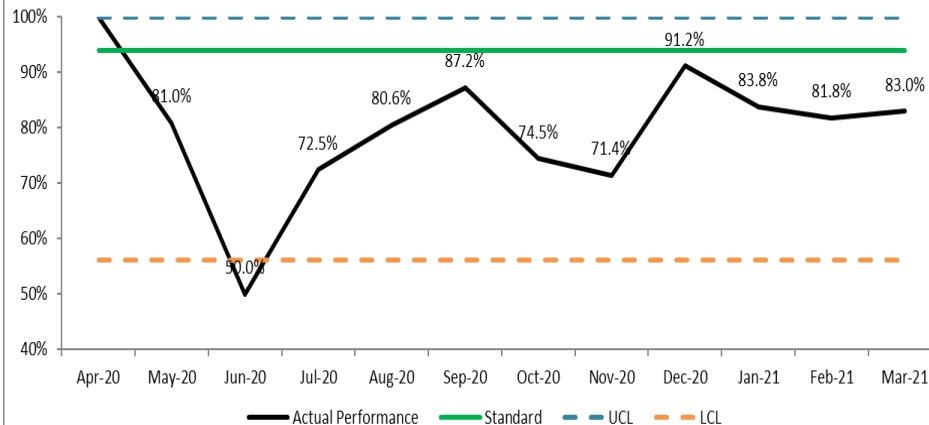
March performance at UHDB for 31 day from diagnosis to first treatment has reduced since the month prior to 90.4%, continuing to be non-compliant against the standard of 96%.

There were a total number of 395 patients treated along this pathway which is a significant increase to the 288 patients treated in February. During March there were 357 out of the 395 patients who were treated within 31 days resulting in 36 breaches, compared to the 271 patients treated in target and 16 breaches reported last month.

The 36 breaches occurred in Breast(2), Gynaecology(6), Lower GI (11), Skin(8), Upper GI(1), and Urology(8). The majority of the breach reasons were due to Elective Capacity with the remaining being due to Medical Reasons and Patient Choice.

UHDB - CANCER WAITING TIMES – 31 Day Wait – Subsequent Surgery

UHDBFT - Cancer: 31 Day Wait (Subsequent Surgery)



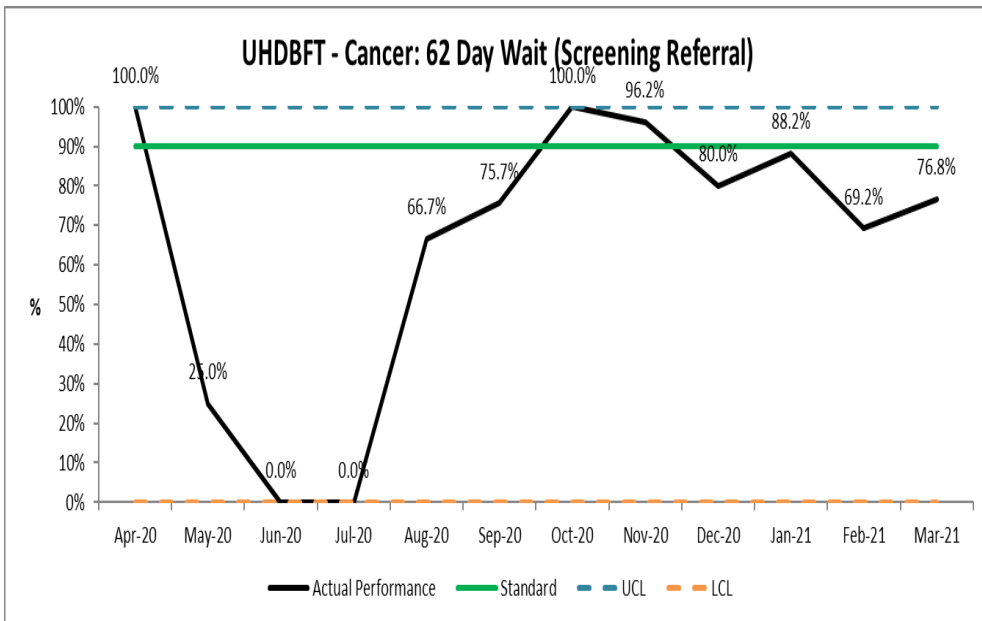
Performance Analysis

Performance of 31 day for Subsequent Surgery Treatment at UHDB in March has improved slightly to 83%, remaining non-compliant against the standard of 94%.

There were 47 patients who received subsequent surgery this month with 39 of those patients having surgery within the 31 day standard, resulting in 8 breaches.

The reasons for these breaches were mainly due to Elective Capacity with just 1 out of the 8 being due to complex diagnostics. The number of days the patients breached ranged between 40 to 76 days.

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



Performance Analysis – Screening Referral

Performance in March at UHDB has improved since last month to 76.8%, remaining non-compliant against the standard of 90%.

There were a total of 28 patients treated this month who were referred from a screening service with 21.5 of those patients being treated within 62 days, resulting in 6.5 breaches.

Out of the 6.5 breaches, 5.5 related to Lower GI – equating to 6 patients, with just 1 relating to Breast. The breaches occurred as a result of Elective Capacity(3), Outpatient Capacity(1), Complex Diagnostics(1.5) and Patient Choice(1).

The number of days the patients breached ranged between 67 and 127 days.

Mental Health - IAPT

MENTAL HEALTH – Improving Access to Psychological Therapies

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)			
				↑	2.10%	25.20%													
Improving Access to Psychological Therapies	IAPT - Number Entering Treatment As Proportion Of Estimated Need In The Population	Plan	Mar-21	↑	2.10%	25.20%													
		Actual			3.56%	26.34%	0												
	IAPT - Proportion Completing Treatment That Are Moving To Recovery	50%	Mar-21	↑	57.6%	56.6%	0	55.9%	54.6%	0	58.4%	58.0%	0	56.2%	54.9%	0	60.5%	54.8%	0
	IAPT Waiting Times - The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment	75%	Mar-21	↑	98.9%	92.7%	0	97.5%	85.6%	0	99.5%	98.0%	0	98.0%	94.9%	0	100.0%	99.4%	0
	IAPT Waiting Times - The proportion of people that wait 18 Weeks or less from referral to entering a course of IAPT treatment	95%	Mar-21	↑	100.0%	98.6%	0	100.0%	99.9%	0	100.0%	100.0%	0	100.0%	99.6%	0	100.0%	100.0%	0

- The number of people in Derbyshire entering treatment as a proportion of estimated need is consistently above the trajectory needed to meet LTP increased access rates by 2024
- Access rates were affected negatively by the COVID-19 restrictions at the start of wave 1, as per the national picture, but have continued to improve since and are now at approx. 95% of pre-COVID-19 levels.
- Providers are seeing an increase in referrals which are related to the direct and indirect impact of COVID-19, in particular from healthcare professionals and other keyworkers. Providers have collaborated to create a system-wide IAPT response to Long-COVID as part of the newly established Long-COVID clinic.
- Treatment offered is effective, and wait times in Derbyshire are within the national target.
- The proportion of people who are moving into recovery is above the national target and other data shows that improvement is reliable.

Appendix

APPENDIX 1: PERFORMANCE OVERVIEW M11 – ASSOCIATE PROVIDER CONTRACTS

Provider Dashboard for NHS Constitution Indicators					Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance
Urgent Care	Area	Indicator Name	Standard	Latest Period	East Cheshire Hospitals				Nottingham University Hospitals				Sheffield Teaching Hospitals FT				Sherwood Forest Hospitals FT				Stockport FT			
	Urgent Care	Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	Mar-21	↓	78.0%	82.1%	33	A&E pilot site - not currently reporting 4 hour breaches				↑	78.1%	85.5%	59	↓	94.0%	94.0%	5	↓	76.9%	75.8%
A&E 12 Hour Trolley Waits			0	Mar-21	↑	0	53	0	↑	8	44	3	↓	4	7	1	↔	2	12	4	↔	0	72	0
Urgent Care	DToc	Delayed Transfers Of Care - % of Total Bed days Delayed	3.5%	Feb-20	↓	7.15%	5.91%	10	↑	4.13%	3.61%	2	↑	4.37%	3.18%	3	↑	5.29%	4.75%	9	↑	7.18%	4.49%	6
	Referral to Treatment for non-urgent consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Feb-21	↓	54.4%	56.6%	42	↓	68.2%	65.8%	17	↓	79.9%	75.5%	13	↓	62.1%	69.2%	42	↓	55.6%	55.2%	37
Urgent Care	Diagnostics	Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Feb-21	↑	760	2979	14	↑	3479	11178	11	↑	958	2920	11	↑	1385	4992	11	↑	4524	18289	34
		Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Feb-21	↓	51.79%	54.69%	12	↓	47.60%	51.20%	12	↓	14.57%	31.42%	12	↓	29.75%	39.47%	14	↓	48.07%	52.73%	20
Urgent Care	2 Week Cancer Waits	All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	Feb-21	↑	94.4%	89.9%	0	↑	95.4%	92.4%	0	↑	96.2%	95.9%	0	↑	96.8%	95.9%	0	↑	90.4%	90.1%	7
		Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	Feb-21	↑	94.2%	76.3%	0	↑	98.6%	95.6%	0	↑	90.5%	91.5%	2	↓	97.5%	99.7%	0	↔	N/A	N/A	0
Urgent Care	31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	96%	Feb-21	↓	82.4%	94.1%	2	↑	91.4%	92.4%	23	↓	94.8%	94.7%	1	↑	99.0%	93.0%	0	↓	84.3%	90.6%	3
		Subsequent Surgery Within 31 Days Of Decision To Treat	94%	Feb-21	↓	66.7%	93.0%	1	↑	71.4%	77.2%	34	↑	90.7%	87.4%	3	↑	100.0%	82.0%	0	↑	81.8%	84.3%	2
Urgent Care	62 Days Cancer Waits	Subsequent Drug Treatment Within 31 Days Of Decision To Treat	98%	Feb-21	↑	N/A	100.0%	0	↑	99.3%	99.1%	0	↑	99.2%	98.3%	0	↑	80.0%	91.3%	2	↓	99.2%	99.4%	0
		Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	Feb-21	↑	99.1%	95.0%	0	↑	97.8%	93.8%	0	↑	97.8%	93.8%	0	↑	97.8%	93.8%	0	↑	97.8%	93.8%	0
Urgent Care	Cancelled Operations	First Treatment Administered Within 62 Days Of Urgent GP Referral	85%	Feb-21	↓	50.7%	63.7%	17	↓	67.3%	74.3%	11	↑	62.5%	61.9%	66	↑	71.6%	67.9%	14	↓	56.3%	60.7%	22
		First Treatment Administered - 104+ Day Waits	0	Feb-21	↑	5.5	27.5	6	↓	13.0	125.0	59	↓	6.0	191.5	59	↑	5.0	55.0	34	↑	8.0	55.0	22
Urgent Care	Cancelled Operations	First Treatment Administered Within 62 Days Of Screening Referral	90%	Feb-21	↓	77.8%	76.6%	3	↑	81.4%	67.2%	3	↑	65.9%	57.5%	3	↓	77.3%	69.8%	1	↔	0%	60.0%	2
		First Treatment Administered Within 62 Days Of Consultant Upgrade	N/A	Feb-21	↓	65.4%	84.0%		↓	79.9%	86.6%		↓	67.8%	74.3%		↓	81.1%	88.5%		↓	70.5%	81.1%	
Urgent Care	Cancelled Operations	% Of Cancelled Operations Rebooked Over 28 Days	N/A	2019/20 Q3	↔	0.0%	0.0%		↓	9.5%	7.5%		↓	2.3%	2.0%		↑	2.3%	3.2%		↓	2.9%	2.3%	
		Number of Urgent Operations cancelled for the 2nd time	0	Feb-20	↔	0	0		↔	0	0		↔	0	2		↔	0	0		↔	0	0	
Patient Safety	Mixed Sex Accommodation	Mixed Sex Accommodation Breaches	0	Feb-20	↑	13	393	11	↔	0	0	0	↔	0	0	0	↔	0	0	0	↔	0	6	0
		Healthcare Acquired Infection (HCAI) Measure: MRSA Infections	0	Feb-21	↔	0	2	0	↔	0	2	0	↓	1	3	1	↔	0	0	0	↔	0	2	0
Patient Safety	Incidence of healthcare associated Infection	Healthcare Acquired Infection (HCAI) Measure: C-Diff Infections	Plan	Feb-21	↔		25		↑		110		↑		153		↓		73		↓		47	
			Actual	Feb-21	↔		6	0	↑		77	0	↑		98	0	↓		35	0	↓		18	0
Patient Safety	Incidence of healthcare associated Infection	Healthcare Acquired Infection (HCAI) Measure: E-Coli	-	Feb-21	↑	3	106		↑	52	631		↑	45	506		↓	28	281		↓	19	171	
		Healthcare Acquired Infection (HCAI) Measure: MSSA	-	Feb-21	↑	2	41		↑	19	215		↓	20	180		↓	9	80		↓	7	38	

Governing Body Meeting in Public

3rd June 2021

Item No: 065

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

Paper for:	Decision	X	Assurance	X	Discussion	Information
Assurance Report Signed off by Chair	N/A					
Which committee has the subject matter been through?	Clinical and Lay Commissioning Committee – 13.05.21 Primary Care Commissioning Committee – 18.05.2021 Engagement Committee – 18.05.21 Governance Committee – 20.05.21 Quality and Performance Committee – 27.05.2021 Finance Committee – 27.05.2021					

Recommendations

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

- The Risk Register Report
- Appendix 1 as a reflection of the risks facing the organisation as at 31st May 2021
- Appendix 2 which summarises the movement of all risks in May 2021
- The decrease in score for one risk:
 - Risk 28 relating to the increase in safeguarding referrals.

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 May 2021.

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

Are there any Resource Implications (including Financial, Staffing etc.)?
<p>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.</p> <p>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.</p>
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 31 st May 2021 detailed in Appendix 1.

NHS DERBY AND DERBYSHIRE CCG GOVERNING BODY MEETING

RISK REPORT AS AT 31ST MAY 2021

1. INTRODUCTION

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

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

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

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

2. RISK PROFILE – MAY 2021

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

Risk Register as at 31st May 2021

Risk Profile	Very High (15-25)	High (8-12)	Moderate (4-6)	Low (1-3)	Total
Total number on Risk Register reported to GB for May	6	18	3	0	27
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	0	0	0

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

3. **COMMITTEES – MAY VERY HIGH RISKS OVERVIEW**

3.1 **Quality & Performance Committee**

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

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

The current risk score is 20.

April performance:

- CRH reported 96.8% (YTD 96.8%) and UHDB reported 77.1% (YTD 77.1%).
- CRH - At the start of the pandemic the volume of Type 1 attendances were much lower but are now approaching pre-pandemic levels, with an average of 172 attendances per day. However, April 2021 volumes were still 18% lower than April 2019 levels.
- UHDB - At the start of the pandemic the volume of Type 1 attendances were much lower but are now approaching pre-pandemic levels, with an average of 324 attendances per day. However, April 2021 volumes were still 18% lower than April 2019 levels. Since the start of the pandemic the numbers had been significantly lower but now the numbers surpass the previous years. In addition the infection control measures required result in a longer turnaround time needed for patients. Measures include Red/Green streaming of patients, non-streaming of Paediatric patients or 111 patients and increased infection control procedures.
- At Derby the acuity of the attendances was high, with an average of 24 Resuscitation patients and 206 Major patients per day (11% and 89% of the total attendances respectively). The proportions have increased due to the Urgent Treatment Centre (UTC) treating most of the Minor patients. The acuity at Burton is also high, with an average of 110 Resuscitation/Major patients per day (67.9% of total attendances).
- COVID-19 preparations had an effect on the system with increased pressure on 111 services and ED departments devoting physical capacity to isolation areas.
- SORG manages operational escalations and issues if required.

2. Risk 003: *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.*

The current risk score is 20.

May update:

Current bed position:

- CCG beds = 33 (target 17).
 - Adult Specialised Commissioning = 17 (target 14).
 - Children and Young People (CYP) specialised commissioning = 3 (target 3).
 - A system wide root cause analysis is taking place to understand the reasons for admissions without Local Area Emergency Protocols (LAEPs).
 - Recommendations and an action plan have been developed and presented at the Mental Health, Learning Disability and Autism Board held on 13th May 2021. Ongoing monthly meetings planned to monitor the implementation of recommendations.
 - A TCP Summit meeting was held on 7th April 2021 which reviewed Partners commitment to delivery and the changes and resources required. A follow up summit is scheduled for 22nd June 2021.
 - A three year Learning Disability and Autism road map has been submitted to NHSE/I. Task & Finish Group Lanes have been refreshed and aligned to the road map.
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.

May update:

- Providers are currently in the process of completing the assurance framework again to monitor progress.
- The Terms of Reference (ToR) is now agreed and the next three meetings will focus on individual aspects of the minimum standard

requirements to facilitate sharing and learning as all providers work to achieve this.

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.

May update:

- There are no changes to the existing levels of risk for this month.
 - NHSE/I have advised that the COVID-19 capacity expansion fund will continue until the end of September 2021.
 - QOF income protection is withdrawn with effect from April 2021.
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*

The current risk score is 20.

May update:

- Primary Care Performance and Quality Committee and monthly Primary Care Hub meetings reinstated from June 2021.
- Practice Quality Visits re-commencing from July 2021.
- Clinical Governance Leads Meetings reinstated from July/August 2021.
- CQC inspections commenced from April 2021.

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.

May update:

April 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 M1 the CCG are not seeing any major financial pressures against planned expenditure with the exception of CHC fast track packages and a review is underway to understand the cause of this pressure.
- The CCG is also working with system partners to understand the recurrent underlying position and early work suggests there is a £150m recurrent deficit.

4. **MAY OVERVIEW**

4.1 **Decreased risk since last month**

One risk has decreased in score.

1. *Risk 28: Increase in safeguarding referrals once the lockdown is lifted and children and parents are seen and disclosures/injuries/evidence of abuse are seen/disclosed.*

This risk has been decreased in score from a high 12 (probability 3 x impact 4) to a high score of 9 (probability 3 x impact 3). This was approved at the Quality & Performance Committee meeting held on 27th May 2021.

- The Derby and Derbyshire Safeguarding Children Partnership (DDSCP) – Quality Assurance subgroup and Predicting Demand group are closely monitoring performance and activity for safeguarding children.
- The CCG risk rating has been reduced because currently we have not seen the significant rise in referrals to children social care and the figures are currently at pre-lockdown level. Clearly this will be closely reviewed by the Quality Assurance subgroup and the Predicting Demand group and the CCG risk will be reviewed if we see an increase or change in activity.

5. **RECOMMENDATION**

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

- the Risk Register Report;
- Appendix 1 as a reflection of the risks facing the organisation as at 31st May 2021;
- Appendix 2 which summarises the movement of all risks in May 2021;
- the decrease in score for one risk:
 - Risk 28 relating to the increase in safeguarding referrals.

Risk Reference	Year	Risk Description	Type of Control or Measure	Initial Risk Rating	Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating			Residual/Current Risk			Target Risk			Link to Risk Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
								Previous Rating	Previous Rating	Previous Rating	Residual/Current Risk	Residual/Current Risk	Residual/Current Risk	Target Risk	Target Risk	Target Risk					
								4	3	2	4	3	2	4	3	2					
32	2021	Risk of exploitation by malware 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	Software	4	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 CORES report. Information will be cascaded through the CCG Commits team to CCG and Primary Care colleagues and also shared with the LMC. 15.02.21 - Policies have been agreed with NECS over the GP and CCG estates to manage the deployment of cloud based apps and services from the Microsoft Office 365 suite of applications. A process will be developed for colleagues to request access to apps not included in the initial agreement along with a process of evaluating the risk of implementation against business benefits. The ability for colleagues to also install third party apps through the Microsoft Office products is also being removed, as this would create variability in the estate and subsequent issues with troubleshooting any issues or updating of third party apps. There remain some issues around licences and temporary members of staff specifically within our GP Practices and we are awaiting a national decision on this; in the meantime, a local solution has been developed to allow GP Practices to keep a number of devices on Microsoft Office 2010 until the full project has deployed. After which time, the remaining machines will be upgraded and additional licences purchased if necessary to maintain flexibility within GP Practices. 11.03.21 - The pilot projects have completed and Microsoft Office 365 will be made available to all CCG staff through the self-service portal - allowing them to download the application in line with their workload. However, there will be a cut-off point of July 2021 when the application will be forced onto all remaining devices. In line with the planned Cyber Essentials Plus audit. The suggestion is to keep the risk rating at the current level, as although the process has begun, there remain potential vulnerabilities while there is still Microsoft Office 2010 and unpatched instances of Microsoft Windows 7 on the network. 21.04.21 - Agreement has been reached with Accutone for the management of locum accounts, working with the LMC to understand the local context. Work is progressing with CCG colleagues and GP Practices to validate user lists to support validation of user lists, rationalise NHS Mail accounts and audit leavers/joiners processes. It is intended that the user audit within GP Practices will be undertaken on a monthly basis to ensure that access is appropriately managed, that accounts are closed/moved and that licences are managed effectively to reduce the risk of overusers on Office 365 deployment. Awaiting confirmation from NECS regarding removal of the last Windows 7 device from the network which was located within a GP Practice. Scores remain the same, as work is ongoing and progressing, but the risk has not yet been fully mitigated. 18.05.21 - CCG has begun migration onto Microsoft Office 365. GP Practices have begun to back in for their upgrades. Both programmes will be completed by the end of July, three months before the mandated deadline to allow for any unforeseen anomalies. Concerns have been raised with NHS Digital regarding the suitability of their policy based security systems, with users able to access functionality which is turned off locally and nationally. Therefore, while the Office 365 project is progressing, there are a number of concerns with the way in which NHS Digital has chosen to implement Microsoft Office 365 within the NHS Shared Terernity, the amount of local control that we have and the tools that are being provided nationally to allow us to manage local variation. Scores will be reduced when the rollout programme is complete and again further when NHS Digital can evidence the issues identified have been addressed.	3	4	12	3	4	12	2	1	2	31/03/21	May-21	Jun-21	Helen O'Halloran Executive Director of Corporate Strategy and Delivery	Ged Connolly- Thompson - Head of Digital Development, Christy Tucker - Director of Corporate Delivery	
33	2021	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 of Care	4	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.	Monthly reporting of progress against all work to control growth of waiting lists Two weekly task and finish groups with all 4 providers represented Completion of assurance framework has been undertaken by all providers and is being collated to go to PCDB for discussion Identified harm has been reported on STEG and all providers are monitoring this All providers have completed the assurance framework and this is being collated to go back to PCDB for discussion re further risk mitigations Work is ongoing around Consultant Connect, MSK and Ophthalmology 12.03.21 Update - PCDB on 25.02.21 agreed the Minimum standard document and regular use of the associated assurance framework to monitor progress against the delivery of this for providers. Task and finish group to be stood down and Programme group to be established with wider membership to continue to progress this work TOR are in progress 12.04.21 Update - PCDB on 25.02.21 agreed the Minimum standard document and regular use of the associated assurance framework to monitor progress against the delivery of this for providers. Task and finish group has been stood down and Programme group has been established with wider membership to continue to progress this work TOR are in draft and plan to be agreed at next meeting on 21.04.21 The size of the waiting lists and the length of time people are waiting is increasing, as a direct result of COVID. The risk score has not been increased as we are working to put mitigations in place across the system and then plans in relation to performance and reducing the lists are being worked up. 14.05.2021 update - Providers are all in the process of completing the assurance framework again to monitor progress. TOR now agreed and the next 3 meetings will focus on individual aspects of the minimum standard requirements to facilitate sharing and learning as all providers work to achieve this. Risk scores to remain.	4	4	16	4	16	3	2	6	16/03/21	May-21	Jun-21	Brigid Stacey, Chief Nursing Officer	Laura Moore, Deputy Chief Nurse		
37	2021	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 of Care	4	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. Match update. CRH Stroke Service Contingency Plan has been implemented, with sign-off from impacted surrounding trusts (Kings Mill, Hallamshire, LHDB, and Sheppings 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, A 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 (SDN) leads to develop service contingency plan to understand internal measures, protect ad options, and patient divert impact. SOP to operationalise the contingency plan. A task and finish group to commence a service review of the HASU, including options appraisal. All options to be reviewed with the aim of providing a sustainable service.	Feb 21 - Stroke admission data has been analysed to support development of CRH Contingency Plan, this includes full, partial and mimic divert data. Feb 21 - The CRH Contingency Plan is in its final draft form and conversations have commenced with surrounding impacted trusts to understand CRH's internal measures and mitigations. Medical Director sign off to take place w/c 22/2/21 Mar 21 - The Stroke Delivery Group have appointed a task and finish group to commence a service review of the HASU, including options appraisal. All options to be reviewed with the aim of providing a sustainable service. Risk score reduced to 12 due to implementation of contingency plan and hour cover in place. The reduction in risk was agreed by the Stroke Delivery Group 8/3/21. Apr 21 - SDN to operationalise the contingency plan in collaboration with surrounding Trusts. Apr 21 - CRH HASU options appraisal commenced in May 21 and is to be chaired by the NHSE/National Stroke Clinical Lead Deb Lowe. Membership includes all key stakeholders including surrounding Trusts (Sheffield Teaching Hospitals, Sherwood Forest Hospitals and LHDB). May 21 - CRH's SSNAP rating has improved from an overall rating (July-Sep 20) to B rating (Oct-Dec 20). An 'A' or 'B' SSNAP rating is indicative of this class quality of care and a good or excellent service in many aspects respectively.	3	4	12	3	4	12	3	3	9	May-21	May-21	Jun-21	Dr Steve Lloyd, Medical Director	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Sue Webster, Head of Strategic Clinical Conditions and Pathways

Appendix 2 - Movement during May 2021

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
01	20/21	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	↔	At the start of the pandemic the volume of Type 1 attendances were much lower but are now approaching pre-pandemic levels.	Zara Jones Executive Director of Commissioning Operations	Quality & Performance	Craig Cook Director of Contracting and Performance / Deputy Director of Commissioning Operations Jackie Carlile Claire Hinchley Dan Merrison Senior Performance & Assurance Manager
02	20/21	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	↔	Posts recruited to. Backlog of re: X applications	Brigid Stacey - Chief Nursing Officer	Quality & Performance	Bill Nicol, Head of Adult Safeguarding
03	20/21	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	↔	Whilst we have but a number of measures in place to reduce the risk it is still high. This will not probably change until the autism service is commissioned.	Brigid Stacey - Chief Nursing Officer	Quality & Performance	Helen Hipkiss, Deputy Director of Quality / Phil Sugden, Assistant Director Quality, Community & Mental Health, DCHS
04A	20/21	<u>Contracting:</u> Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care. There are 112 GP practices in Derbyshire all with individual Independent Contracts GMS, PMS, APMS to provide Primary Medical Services to the population of Derbyshire. Six practices are managed by NHS Foundation Trusts and one by an Independent Health Care Provider. The majority of Derbyshire GP practices are small independent businesses which by nature can easily become destabilised if one or more core components of the business become critical or fails. Whilst it is possible to predict and mitigate some factors that may impact on the delivery of care the elements of the unknown and unexpected are key influencing dynamics that can affect quality and care outcomes. Nationally General Practice is experiencing increased pressures which are multi-faceted and include the following areas: *Workforce - recruitment and retention of all staff groups *COVID-19 potential practice closure due to outbreaks *Recruitment of GP Partners *Capacity and Demand *Access *Premises *New contractual arrangements *New Models of Care *Delivery of COVID vaccination programme	4	4	16	4	4	16	↔	NHSE/I advised that Covid capacity expansion fund to continue until end of September 2021. QOF income protection is withdrawn from April 2021. No changes to the existing levels of risk for this month.	Dr Steve Lloyd - Medical Director	Primary Care Commissioning	Hannah Belcher, Head of GP Commissioning and Development (Primary Care)

Risk Reference	Year	Risk Description	Previous Rating		Residual/ Current Risk		Movement	Reason	Executive Lead	Responsible Committee	Action Owner		
			Probability	Impact	Probability	Impact							
04B	20/21	<p><u>Quality:</u> Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care. There are 112 GP practices in Derbyshire all with individual Independent Contracts GMS, PMS, APMS to provide Primary Medical Services to the population of Derbyshire. Six practices are managed by NHS Foundation Trusts and one by an Independent Health Care Provider. The majority of Derbyshire GP practices are small independent businesses which by nature can easily become destabilised if one or more core components of the business become critical or fails. Whilst it is possible to predict and mitigate some factors that may impact on the delivery of care the elements of the unknown and unexpected are key influencing dynamics that can affect quality and care outcomes.</p> <p>Nationally General Practice is experiencing increased pressures which are multi faceted and include the following areas: *Workforce - recruitment and retention of all staff groups *COVID-19 potential practice closure due to outbreaks *Recruitment of GP Partners *Capacity and Demand *Access *Premises *New contractual arrangements *New Models of Care *Delivery of COVID vaccination programme</p>	4	5	20	4	5	20	↔	Primary Care Performance and Quality Committee and monthly PC Hub meetings re starting June. Practice Quality Visits re commencing July. Clinical Governance Leads Meetings re starting July / August. CQC Inspections commenced April.	Dr Steve Lloyd - Medical Director	Primary Care Commissioning	Judy Derricott, Head of Primary Care Quality
05	20/21	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	↔	The pathway to Helios is being finalised and CBT pathway incorporated.	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	20/21	Demand for Psychiatric intensive Care Unit beds (PICU) has grown substantially over the last five years. This has a significant impact financially with budget forecast overspend, in terms of poor patient experience, Quality and Governance arrangements for uncommissioned independent sector beds. The CCG cannot currently meet the KPI from the Five year forward view which require no out of area beds to be used from 2021.	3	2	6	3	2	6	↔	Procurement window closed for PICU block beds and framework.	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	20/21	Sustainable digital performance for CCG and General Practice due to threat of cyber attack and network outages. The CCG is not receiving the required metrics to provide assurance regarding compliance with the national Cyber Security Agenda, and is not able to challenge any actual or perceived gaps in assurance as a result of this.	2	4	8	2	4	8	↔	CheckPoint VPN upgrade is underway and over 50% complete; the Cisco ISE endpoint protection has also been procured and deployment is starting.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Ged Connolly-Thompson - Head of Digital Development, Chrissy Tucker - Director of Corporate Delivery
10	20/21	If the CCG does not review and update existing business continuity contingency plans and processes, strengthen its emergency preparedness and engage with the wider health economy and other key stakeholders then this will impact on the known and unknown risks to the Derby and Derbyshire CCG, which may lead to an ineffective response to local and national pressures.	2	4	8	2	4	8	↔	The score is proposed to remain as it is due to how the risk is described. To reduce it any further would weaken the case for continued development internally and with wider stakeholders.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Chrissy Tucker - Director of Corporate Delivery / Richard Heaton, Business Resilience Manager

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
11	20/21	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	↔	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.	Richard Chapman, Chief Finance Officer	Finance	Darran Green- Assistant Chief Finance Officer
12	20/21	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	↔	Ownership of 'Crisis' Lane as part of the Three Year LD/A Road Plan changed to DCCG Strategic Commissioner.	Brigid Stacey - Chief Nursing Officer	Quality & Performance	Mick Burrows Director for Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning, Helen Hipkiss, Deputy Director of Quality /Phil Sugden, Assistant Director Quality, Community & Mental Health, DCHS
14	20/21	On-going non-compliance of completion of initial health assessments (IHA's) within statutory timescales for Children in Care due to the increasing numbers of children/young people entering the care system. This may have an impact on Children in Care not receiving their initial health assessment as per statutory framework.	4	3	12	4	3	12	↔	The score remains the same as the percentage of compliance has not improved overall due to the added pressures of sickness within CRHFT, the complexities surrounding CIC, impact of Covid (particularly on external Health Providers) and timely notifications from LA (SW workload capacity).	Brigid Stacey - Chief Nursing Officer	Quality & Performance	Alison Robinson, Designated Nurse for Looked After Children
16	20/21	Lack of standardised process in CCG commissioning arrangements. CCG and system may fail to meet statutory duties in S14Z2 of Health and Care Act 2012 and not sufficiently engage patients and the public in service planning and development, including restoration and recovery work arising from the COVID-19 pandemic.	2	4	8	2	4	8	↔	S14Z2 forms log to be presented to Engagement Committee for assurance. Business Continuity Level 4 is not preventing other projects from being commenced; this will need to be reviewed in context of capacity to deliver.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Engagement	Sean Thornton Assistant Director Communications and Engagement

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
17	20/21	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	↔	Service now live, risk score unchanged until caseload review has been completed.	Zara Jones, Executive Director of Commissioning Operations	Quality & Performance	Helen Hipkiss, Director of Quality / Dave Stevens, Head of Finance
20	20/21	Failure to hold accurate staff files securely may result in Information Governance breaches and inaccurate personal details. Following the merger to Derby and Derbyshire CCG this data is not held consistently across the sites.	3	3	9	3	3	9	↔	No further update due to continued home working.	Beverley Smith, Director of Corporate Strategy & Development	Governance	Sam Robinson, Service Development Manager
22	20/21	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	↔	The mitigations do not entirely remove the risk of mental health problems for our staff and the probability remains at 2 as we are in the main continuing to work from home.	Beverley Smith, Director of Corporate Strategy & Development	Governance	Beverley Smith, Director of Corporate Strategy & Development James Lunn, Head of People and Organisational Development
23	20/21	CCG Staff capacity compromised due to illness or other reasons. Increased numbers of CCG staff potentially unable to work due to COVID 19 symptoms / Self isolation.	1	4	4	1	4	4	↔	The staff sickness has reduced and hence the probability reduced to 1 previously. The impact of reduced resources is still a 4 as would have a significant impact due to supporting vaccination programme, system in response to pandemic and core CCG business.	Beverley Smith, Director of Corporate Strategy & Development	Governance	Beverley Smith, Director of Corporate Strategy & Development James Lunn, Head of People and Organisational Development
24	20/21	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.	3	3	9	3	3	9	↔	The A&E activity has been lower in 2020 throughout the Covid19 pandemic. However, this changed in March 2021 and activity now exceeds last year but not pre-pandemic levels. Elective Care-Weekly GP Referral activity during March appear to be at pre-COVID levels. March GP appointments is 10% above pre pandemic levels.	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	20/21	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	↔	CG and DCHS continue to develop new PCS workforce model.	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

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
26	20/21	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	↔	IAPT continues to increase capacity and access including training for long COVID.	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	20/21	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	↔	As Covid restrictions are eased organisations are preparing for an increase in operational referrals and enquiries.	Brigid Stacey, Chief Nursing Officer	Quality & Performance	Bill Nicol, Head of Adult Safeguarding
28	20/21	Increase in safeguarding referrals once the lockdown is lifted and children and parents are seen and disclosures / injuries / evidence of abuse are seen / disclosed.	3	4	12	3	3	9	↓	The CCG risk rating has been reduced because currently we have not seen the significant rise in referrals to children social care and the figures are currently at pre-lockdown level. Clearly this will be closely reviewed by the QA subgroup and the predicting demand group and the CCG risk will be reviewed if we see an increase/ change in activity.	Brigid Stacey, Chief Nursing Officer	Quality & Performance	Michalina Racioppi, Assistant Director for Safeguarding Children / Lead Designated Nurse for Safeguarding Children
29	20/21	There is a risk of significant reputational damage to the CCG where contracts have been in place and the current contract management arrangements do not provide assurance that providers are compliant with the Data Security and Protection Toolkit.	3	3	9	3	3	9	↔	The Contracts Oversight Group have reconvened and during May focussing on completing any outstanding DSPT assurances with an aim to complete these by June.	Zara Jones Executive Director of Commissioning Operations	Governance	Helen Wilson, Deputy Director of Contracting & Performance Chrissy Tucker, Director of Corporate Delivery
30	20/21	There is an ever present risk of fraud and cybercrime; the likelihood of which may increase during the COVID emergency response period.	2	4	8	2	4	8	↔	Will consider reducing the risk when the NHS Digital tools are in place to allow us to monitor vulnerabilities through a third party tool.	Richard Chapman, Chief Finance Officer	Finance	Darran Green- Assistant Chief Finance Officer / Ged Connolly-Thompson, Head of Digital Development

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
32	20/21	Risk of exploitation by malevolent third parties If vulnerability is identified within any of the Microsoft Office 2010 applications after October 14th 2020 and not patched, due to support for Microsoft Office 2010 officially ending, after which point Microsoft will cease to issue updates and patches for vulnerabilities found within this suite of applications	3	4	12	3	4	12	↔	Scores will be reduced when the rollout programme is complete and again further when NHSD can evidence the issues identified have been addressed.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Ged Connolly-Thompson - Head of Digital Development, Chrissy Tucker - Director of Corporate Delivery
33	20/21	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	↔	Providers are all in the process of completing the assurance framework again to monitor progress.	Brigid Stacey, Chief Nursing Officer	Quality & Performance	Laura Moore, Deputy Chief Nurse
37	20/21	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	↔	CRH's Sentinel Stroke National Audit Programme (SSNAP) rating has improved from an overall C rating (July-Sept 20) to B rating (Oct-Dec 20).	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

Governing Body Meeting in Public

3rd June 2021

Item No: 066

Report Title	LeDeR Annual Report – 2020/21
Author(s)	Lisa Coppinger, Commissioning Manager – Learning Disabilities & Autism
Sponsor (Director)	Phil Sugden, Assistant Director of Quality - Community

Paper for:	Decision	Assurance	Discussion	Information	X
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Recommendations

The Governing Body is requested to **NOTE** the Derbyshire LeDeR Annual Report 2020/21 for information. This will then be shared with the Joint Mental Health, Learning Disability/Autism Spectrum Disorder Board before being shared publicly and included on the Joined Up Care Derbyshire and CCG websites.

Report Summary

Executive Summary from the report:

This report is the second annual report for Derbyshire on the learning from deaths of those with learning disabilities. The report uses data collated from 1st April 2020 up until 31st March 2021 except for the table below whereas a comparison for data purposes, data is also shown for the 1/4/2019 to 31/3/2020 year.

The purpose of the report is to share the findings and the learning with those involved in the LeDeR programme and those working with individuals with learning disabilities, sharing the work that has been done in the previous year to address these findings to work on service improvement.

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
Yes – case studies are included as part of the report
Have any Conflicts of Interest been identified/ actions taken?
N/A
Governing Body Assurance Framework
N/A
Identification of Key Risks
N/A

Derbyshire Learning from Deaths of
those with a Learning Disability

The LeDeR Programme

Annual Report

1st April 2020 to 31st March 2021

Derbyshire LeDeR Mortality Review

Annual Report 2020-2021

Responsible Committee	Derby and Derbyshire Clinical Commissioning Group Quality and Performance Committee
Target Audience:	Internal report for those agencies involved in the programme. LeDeR Mortality Review Steering Group LeDeR Clinical Quality Review Group Derby and Derbyshire Clinical Commissioning Group National LeDeR Programme NHS England
Date of Approval:	29 th April 2021 at DDCCG Quality & Performance Committee
Review date:	
Version:	
Document Type	Annual Report (Quality)

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20/4/21	3.0	Final ready for review and discussion at DDCCG Quality & Performance Committee

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List of Abbreviations

Abbreviation	Explanation
ACPLD	Association of Chartered Physiotherapists for People with a Learning Disability
AHC	Annual Health Check
A&E	Accident and Emergency
BAME	Black Asian Minority Ethnicity
CAG	Confidential Advisory Group
CDOP	Child Death Overview Panel
CHC	Continuing Health Care
CIPOLD	Confidential Inquiry into premature deaths of people with learning disabilities
CLDT	Community Learning Disability Team
CQRG	Clinical Quality Review Group
CT scan	A computerised tomography (CT) scan uses X-rays and a computer to create detailed images of the inside of the body
CYP	Children and Young People
DDCCG	Derby & Derbyshire Clinical Commissioning Group
DCHS	Derbyshire Community Health Services
DHcFT	Derbyshire Healthcare NHS Foundation Trust
DSAB	Derbyshire Safeguarding Adults Board
DcSAB	Derby City Safeguarding Adults Board
GP	General Practitioner
HQIP	Healthcare Quality Improvement Partnership
LAC	Local Area Contact
LD	Learning Disability
LeDeR	Learning Disabilities Mortality Review
MCA	Mental Capacity Act
MDT	Multidisciplinary Team
NHSE/I	NHS England and NHS Improvement
OPMH	Older Peoples Mental Health
OT	Occupational Therapist
SALT	Speech and Language Therapy
SEND	Special Educational Needs and Disability
SJR	Structured Judgement Review

Executive Summary

This report is the second annual report for Derbyshire on the learning from deaths of those with learning disabilities. The report uses data collated from 1st April 2020 up until 31st March 2021 except for the table below where as a comparison for data purposes, data is also shown for the 1/4/19 to 31/3/20 year.

The purpose of the report is to share the findings and the learning with those involved in the LeDeR programme and those working with individuals with learning disabilities, sharing the work that has been done in the previous year to address these findings to work on service improvement.

LeDeR Summary of Data for Derbyshire

Data for year 01/04/2019 to 31/03/2020	Data for year 01/04/2020 to 31/03/2021
64 notifications received	74 notifications received
35 of those received 1/4/19 to 31/3/20 were completed at 31/3/20 55%	55 of those received since 1/4/20 are completed at 31/3/21 74%
Of all reviews received since start of programme 92 completed in year 19/20 61%	Of all reviews received since start of programme 83 completed in year 20/21 203 reviews have been completed since the start of the programme 41% of total completed have been completed this year
29 were allocated at year end	15 reviews were allocated at year end (there are no reviews unallocated) (4 are on On Hold due to coroner or police investigations)
44% died in their usual place of residence	41% died in their usual place of residence
41% died in hospital 15% died elsewhere	58% died in hospital 1% died elsewhere
58% of the deaths were males 42% were females	39% of the deaths were males 61% were females
3 of the notifications were from BAME communities	4 of the notifications were from BAME communities

Introduction to the LeDeR Programme

LeDeR (the Learning from Deaths Review Programme) started in April 2017 and is a national programme funded by NHSE/I and commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. It grew out of the Confidential Inquiry into Premature Deaths of People with a Learning Disability (CIPOLD) and was piloted in parts of the country in 2016. A commitment to continuing the LeDeR programme was made in the NHS Long Term Plan 2019. The Programme is currently being delivered by the Norah Fry Research Centre at the University of Bristol although this will end on 31st May 2021 and a new LeDeR platform and policy will then be in place.

A short summary of the development of the LeDeR programme is included in Appendix 1.

Nationally, annual reports have been produced for the past 4 years. The fourth LeDeR annual report was published on 16 July 2020. From 1st July 2016 – 31st December 2019, 7,145 deaths were notified to the LeDeR programme with 3,060 deaths notified in 2019.

All deaths of people with learning disabilities are notified to the National LeDeR programme at the University of Bristol. Notification of the death is then allocated to the Local Area Co-ordinator (the area is based on the area of the GP practice of the individual). For Derbyshire, the Local Area Contact (LAC) and Assistant LAC are employed by Derby and Derbyshire Clinical Commissioning Group (DDCCG). It is then their responsibility to allocate the review to a reviewer in order that the initial review can be undertaken for all deaths notified to the LeDeR Programme of people with learning disabilities aged 18 years and above. There is a separate process followed for children and young people from 4 to 17 years of age managed by the Child Death Overview Panel process (mentioned later in this report).

In Derbyshire, throughout the last year there has been a lot of work and effort to complete reviews in a timely manner and balance this with working on embedding the learning as well as build relationships with partner organisations and agree pathways where there is an overlap with the LeDeR programme.

We are very keen to use the learning found and improve services for individuals with learning disabilities. Through the development of end of life pathways, promoting awareness of conditions amongst people with a learning disability and working closely with providers of health and social care we are working locally in Derbyshire to improve services and make changes. It is important that we recognise the good services that are provided in many areas and which have been identified in reviews too and a large area of our work is about promoting the good work that is already done, but there is clearly more to do to improve in some areas as identified in this report.

Definition of a Learning Disability in use by the programme

The LeDeR Programme uses the definition included in the 'Valuing People', the 2001 White Paperⁱ on the health and social care of people with learning disabilities which states:

'Learning disability includes the presence of:

- significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with
- reduced ability to cope independently (impaired social functioning)
- which started before adulthood, with a lasting effect on development

How does the LeDeR process work?

Anyone can notify the national programme of a death including people with learning disabilities themselves, family members, friends and paid staff.

Notifications were made by telephone number or by completing an [online form](#).ⁱⁱ

All deaths reported to the LeDeR Programme had an initial review to establish if there were any specific concerns about the death, and if any further learning could be gained from a [multiagency review](#)ⁱⁱⁱ of the death that would contribute to improving services and practice.

It is the job of the local reviewer to conduct the initial review of each death and where indicated a full multiagency review was held. All information is accessed, edited and completed via the web based portal/ LeDeR Review System.

The LeDeR Process is described in Figure one below. However, the initial review includes:

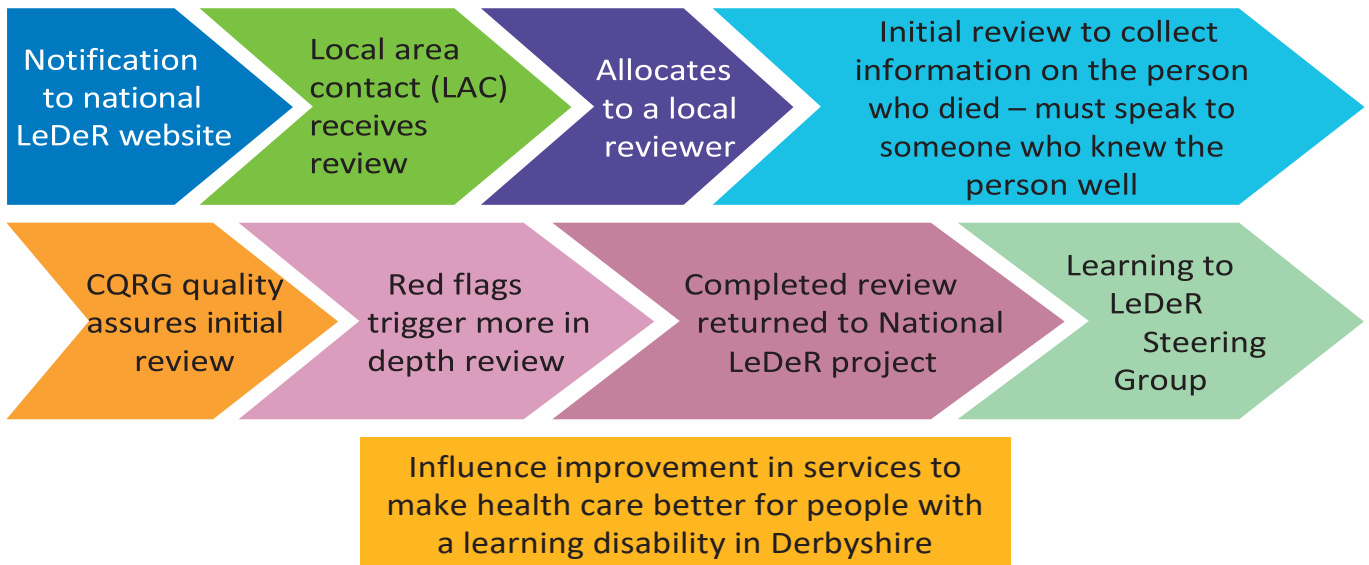
- Checking and completing the information received at the notification stage.
- Contacting a family member or another person who knew the deceased person well and discussing with them the circumstances leading up to the death.
- Scrutinising at least one set of relevant case notes and extracting core information about the circumstances leading up to the person's death: for example summary records from GP, social care, Community Learning Disability Team (CLDT), or hospital records.
- Developing a pen portrait of the person who has died and a timeline of the circumstances leading to their death.
- Making a recommendation to the Local Area Contact whether a multiagency review is required.
- Completing the online documentation and an action plan which will be reviewed by the Clinical Quality Review Group and reviewed as part of the national LeDeR process.
- However, this process ceased at March 2021 and a new LeDeR process was set in place from June 2021. This is described in the LeDeR Futures section below.

ⁱ [Department of Health. \(2001\). Valuing People: A New Strategy for Learning Disability for the 21st Century. A White Paper.](#)

ⁱⁱ http://www.bristol.ac.uk/sps/leder/notify-a-death/?_ga=2.426591.1531124673-1987643447.1528363357

ⁱⁱⁱ <http://www.bristol.ac.uk/sps/leder/about/detailed-review-process/multiagency-review/>

Figure one – LeDeR process in Derbyshire



LeDeR Futures


A new LeDeR web-based platform for completing LeDeR reviews will be in place by 1st June 2021. The NHSE contract with Bristol University comes to an end at 31st May 2021 and they will no longer support the platform. At the time of writing this report NHSE/I had just announced a new policy for the LeDeR programme. This policy aims to set out for the first time for the NHS the core aims and values of the LeDeR programme and the expectations placed on different parts of the health and social care system in delivering the programme from June 2021.

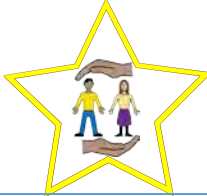

The detailed policy is available at <https://www.england.nhs.uk/publication/learning-from-lives-and-deaths-people-with-a-learning-disability-and-autistic-people-ledeR-policy-2021/>

What are reviewers looking for?

Within the LeDeR Programme reviewers are asked to consider potentially avoidable contributory factors, this refers to anything that has been identified as being a factor in a person’s death, and which, could have possibly been avoidable with the provision of good quality health or social care.

CIPOLD and numerous serious reviews of deaths nationally have highlighted many examples of potentially avoidable contributory factors, and it would not be possible to list them all here, however areas reviewers are asked to consider include:

<p>The person and /or their environment</p> <p>care at home</p> 	<p>People who live in unsuitable placements for their needs including the availability of appropriate communications facilities/channels to ensure the person has access to information/support appropriate for their foreseeable needs.</p>
	<p>Inadequate housing that places the person at risk of falls, accidental injury or isolation in their home.</p>
	<p>Key information provided by family members or other carers being ignored or concerns not taken seriously or low expectations of family members.</p>
	<p>Families not wanting or feeling able to challenge medical professionals’ authority and opinion.</p>

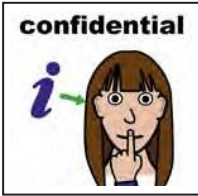
<p>The person's care and its provision:</p> <p>quality care</p> 	The lack of provision of reasonable adjustments for a person to access services.
	Lack of routine monitoring of a person's health and individual specific risk factors.
	Lack of understanding of the health needs of people from minority ethnic groups.
	Inadequate care.
<p>The way services are organised and accessed:</p> <p>my care</p> 	No designated care coordinator to take responsibility for sharing information across multi-agency teams, particularly important at times of change and transition.
	Lack of understanding and/or recording of the Mental Capacity Act when making essential decisions about health care provision.
	Inadequate provision of trained workers in supported living units.
	Inadequate coverage of specialist advice and services, such as Speech and Language Therapy (SALT) or hospital learning disability liaison nurses.

Data sharing and confidentiality

The LeDeR programme aims to ensure that, as far as possible, personal information relating to individuals who have died, and their families, **remains confidential** to the services that supported them.

The national LeDeR team collect the minimal amount of personal identifying data possible, and this will be pseudo-anonymised as soon as possible. Additionally, all information will be anonymised in any presentation, publication or report, and no opportunity will be provided for readers to infer identities.

In order to learn from the deaths of people with learning disabilities so that service improvements can be made, we need to ensure that timely, necessary and proportionate mortality reviews are undertaken, involving the full range of agencies that support people with learning disabilities. Each of these organisations will hold a piece of the jigsaw that together creates a full picture of the circumstances leading to the death of the individual. Information viewed alone or in silos is unlikely to give the full picture, identify where further learning could take place, or contribute to cross-agency service improvement initiatives.



The National LeDeR Programme applied to the national Confidential Advisory Group (CAG) for Section 251 (of the NHS Act 2006) approval for the use of patient identifiable information in order that reviews can be undertaken of the deaths of people with learning disabilities. The programme has been given full approval to process patient identifiable information without consent.

Specifically, this provides assurance for health and social care staff that the work of the Learning Disabilities Mortality Review Programme has been scrutinized by the national CAG.

The CAG is appointed by the Health Research Authority to provide expert advice on uses of data as set out in the legislation, and advises the Secretary of State for Health whether applications to process confidential patient information without consent should or should not be approved. The key purpose of the CAG is to protect and promote the interests of patients and the public whilst at the same time facilitating appropriate use of confidential patient information for purposes beyond direct patient care. More information about Section 251 approval is available using the link below.

<http://www.hra.nhs.uk/about-the-hra/our-committees/section-251/what-is-section-251/>

The LeDeR Programme in Derbyshire

Throughout 2020/21 in Derbyshire we have worked to balance the completion of reviews alongside embedding learning as it was felt extremely important that the learning that had been gathered was used to start to make a difference to individuals. There has also been a lot of important work done to work closely with other agencies who are involved in the LeDeR programme and agree pathways/processes where applicable. One area of work is in relation to work with the coroner, police or safeguarding where, if applicable, the LeDeR review is placed on 'Hold' while the investigation takes place.

One particular area that came out of last year's Derbyshire annual report was around promoting the awareness of learning disability annual health checks. Although this work is very much still ongoing this has been a priority area this year and we are very proud to say that at the end of March 2021 Derbyshire has achieved 78% completion of annual health checks from 1st April 2020 to 31st March 2021 of those individuals who are on the GP Learning Disability register. This figure was 58% at the end of 2019/20 and shows a great achievement by our GP practices and others involved in the promotion of and work in relation to annual health checks such as the LD Health Facilitation team, particularly at a time when they were all also dealing with the challenges of Covid-19 including redeployment and vaccinations. Due to Covid-19 it was agreed nationally that some annual health checks would have to be completed virtually where an individualised approach was made.

Below are case studies of local Derbyshire people and their experiences of their recent health checks. They have both given permission to use their real names and photos.

Denise of Ilkeston



"I had my annual health check in November 2020. I usually see the doctor at the surgery but it was done over the telephone because of the pandemic. It felt a bit strange doing this over the telephone but it was still worth doing and went well. Because it was done over the telephone, the doctor was not able to take my blood pressure or weigh me. I have now bought some scales so have been able to check my weight.

The doctor asked me lots of questions about my health, asked if there had been any changes and asked how I had been during Covid. The health check was very useful. I was able to explain to the doctor that I had been feeling tired. He said he thought that I was not getting enough iron (anaemia) and he prescribed me some iron tablets. He explained what these were for and some changes that I might notice when taking these. The tablets worked well and I did not feel so tired.

At my last health check in 2019, I was weighed and said that I would try to lose some weight. Even though we have been in lockdown, I have found out that I have lost half-a-stone in weight in the last year which I am proud about. I try to eat well and have not been drinking alcohol. I like going for a walk when I am able to go."

Asked whether she would recommend health checks to others, Denise said: "I would tell people to go and get yourselves checked out. It is not a scary thing to do. It is easy. Your doctor will listen to you and your worries and is there to help you. If you do not go, they may miss something."

James of Tibshelf

“I had my health check in September 2020. It was a video call due to being deaf and was held at home. I was asked for weight, blood pressure (which I was able to measure at home), how I was doing (particularly during lockdown), whether I have any problems and how were my worries/anxiety.



It means I can check that my body is ok, that I'm keeping myself healthy and it gives me the chance to ask what else I could do to keep myself healthy. I have a treadmill machine at home which helps me with my exercise and it keeps my anxieties lower. I also spend a lot of time with animals which calms me down. I try to eat healthily and I am learning how to cook healthy meals.”

Asked whether he would recommend health checks to others, James said: “Definitely. I feel happy talking to my doctor. I talk to the same one each time so he understands me and my medical conditions and I don't have to repeat things all the time to someone new. I trust my doctor and know that he will help me to stay healthy.”

Another area of importance to us in Derbyshire is to ensure we are providing families with the opportunity to be involved in the LeDeR review should they wish to be and this is something we have worked on this year to ensure contact is being made with family members and reviews shared with them.



Conversations with family can be difficult and upsetting conversations for our reviewers as well as the family member/s, and we therefore also aim to provide support for reviewers to discuss and share experiences with each other and other members of the LeDeR team. This was further evidenced through the survey we produced as a result of the national Oliver McGowan report where we asked reviewers specific questions about the support they received. Please see Appendix 2 for detail of the report produced and shared through the Derbyshire Governance process.




Learning from Themes:

In Derbyshire themes are collected as part of the review process:-

- On completion of each review the reviewer completes a theme form to identify any themes relevant to the review.
- The theme form is reviewed alongside the review as part of the quality review process. Our reviewers have been collecting themes in 2020/21 that also identifies the relevant type of care provider. This means when the themes are shared with organisations they can see themed areas of work that are relevant to them for potential review.
- The themes are collated and reviewed to identify areas where commissioning concerns may need to be identified. These themes are collected through the strategic action plan which is fed through the LeDeR Steering Group.

Below are some of the top themes across Derbyshire that have been identified as part of the LeDeR Programme in Derbyshire in 2020/21.

<p>Service needs not provided</p> 	<p>Areas where service needs are evidenced through themes as not provided:-</p> <p>For Local Authority - lack of learning disability specialist residential or Nursing Homes. Commissioning or contracting issues (no LD specialist care providers for care in someone's own home), lack of LD training for staff.</p> <p>For GP practices - lack of; reasonable adjustments such as home visits; offering different type of health screening to achieve the same outcome; signposting referrals to other agencies.</p> <p>For Acute services - lack of referral to Acute liaison nurse, lack of appropriate health care assistant or 1:1 support offered to someone on the ward who needs help with anxiety, feeding etc.</p> <p>For CTLD - service not being offered as referrer told that person with LD can access mainstream services.</p> <p>Non-LD care home not monitoring baselines such as bowels/pain and not knowing about the need for Annual Health Checks or hospital passport.</p> <p>Care home not using monitoring tools due to person being independent with toileting so were not able to recognise when bowels became problematic.</p>
<p>No or poor reasonable adjustments</p> 	<p>A lack of or poor reasonable adjustments being made is shown in themes, particularly captured across GP and acute services. Some examples seen include:-</p> <p>no offer of home visits</p> <p>blood tests not attempted due to resistance by individuals without any evidence of attempting reasonable adjustments</p> <p>screening not attended, no reasonable adjustments made or documented to address this</p> <p>lack of accessible information on health care needs.</p>

<p>Poor sharing of information</p> 	<p>This is seen across a number of different care providers, particularly GP and acute services and care homes. Sharing of the individual's information is important to ensure care is being given based on the up to date presentation of the individual. Examples seen:-</p> <p>District Nurse not discussing with family what services could be accessed.</p> <p>Coding for conditions not being used by GP so this could be easily picked up when transferred to another practice.</p> <p>Condition info/advice/education could have been shared by GP with family/care home.</p>
<p>Lack of or poor use of best interest or consent</p> 	<p>Although the phrases 'mental capacity' and 'best interest decisions' are recorded in medical notes, in many cases there is no written evidence of the decision making process including weighing up of alternative options.</p>
<p>No GP Health Action Plan</p> 	<p>Although we have seen some evidence of no LD annual health check taking place, there are many cases where the individual has had the annual health check but no GP health action plan is evidenced.</p>

The themes above are only a few of those identified. Appendix 4 contains all of the themes in Derbyshire identified between 1st April 2020 and 31st March 2021.

Identifying actions and good practice

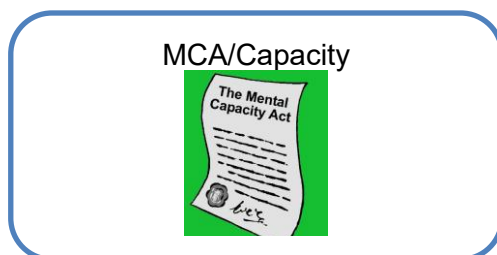
As part of the Initial Review, the reviewer identifies issues and makes recommendations based on these. The reviewer also collates details in relation to good practice. The completed review is then quality assured and part of this process is to look at the issues and recommendations and agree actions from these. All of the actions are collated and monitored using the Derbyshire Action Tracker. Good practice is shared and celebrated.

The following is a “good practice” story which has been adapted from one of our Derbyshire reviews and shows evidence of some of the good work that is being done in Derbyshire to support individuals with learning disabilities. Some of the work we have been doing in this past year is to promote areas of work such as that being done by the Dementia Palliative Care Team and this is great evidence of teams working together to make a difference to individuals and make their end of life experience as good as possible.

Derbyshire Case Study – Case Study 1

This 56yr old lady lived with her family until they died many years previously. She moved out briefly and her home was converted to supported living accommodation. She lived there with her 3 house mates until she passed away this year supported by the same staff group. She had a moderate learning disability and Down syndrome. She was an anxious lady at times so her activities, routines and familiar staff were very important to her as was her familiar home and community.

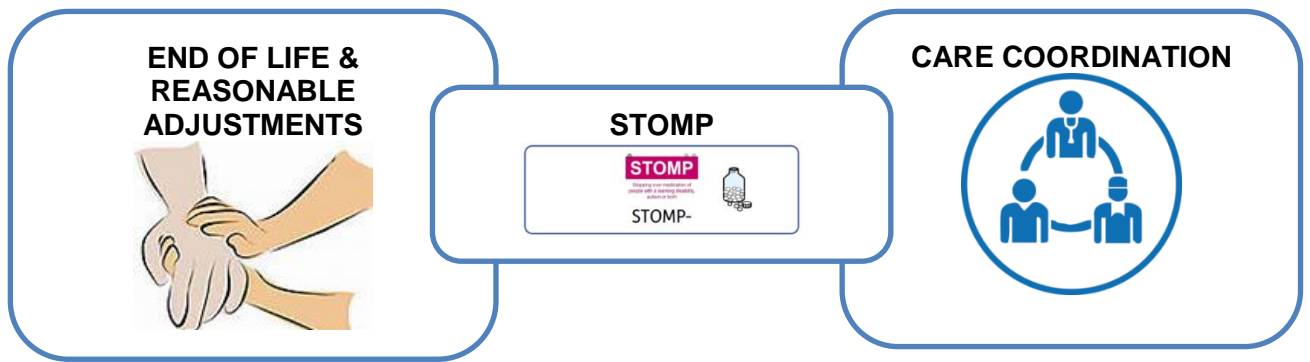
She was screened annually by the Community Learning Disability Team (CLDT) for dementia as people with Down syndrome are more likely to experience dementia. Staff from her home contacted the CLDT to report that her behaviours were changing which included her becoming fearful and hesitant with her mobility particularly using the stairs. The CLDT reassessed her and referred to Older Peoples Mental Health (OPMH) for consideration of a diagnosis.



An assessment was coordinated and completed by adult care. The decision was made to swap bedrooms with her housemate and move her downstairs so her mobility needs could be supported in her environment using equipment.



The CLDT referred her to the Dementia Palliative Care Team prior to a diagnosis so work could start to support her ongoing needs. This was acted on quickly and benefitted her as she began to deteriorate quickly. Future planning began immediately involving all of the multi disciplinary team (MDT).



The Learning Disability End of Life Care Guidelines were followed and coordinated by the Dementia Palliative Care Team. The nurse liaised with the GP and was able to prescribe medication following the Derbyshire symptom management guidance. All MDT members remained involved and regular meetings, preferred priorities for care, RESPECT and person centred plans reviewed; care staff were supported and educated throughout.

Continuing Care fast track was completed and anticipatory medication prescribed, and non-essential medications stopped. She died at home peacefully supported by her familiar staff and her house mates. The Dementia Palliative Care Team continues to support care staff and house mates with bereavement support.

Leadership and Governance

In Derbyshire, for governance and/or assurance reports are shared across the Derbyshire system through the Derby & Derbyshire CCG Quality and Performance Committee and the Joint Mental Health, Learning Disability & Autism System Delivery Board Meeting.

Derbyshire LeDeR Steering Group

The local LeDeR Steering Group is attended by the Assistant Director of Quality for DDCCG and is currently chaired by a Senior Clinical Quality Manager. The Local Area Contact (LAC) is also in attendance and membership includes colleagues from across health and social care who represent various agencies such as Derbyshire Healthcare Foundation Trust (DHcFT), Derbyshire Community Health Services (DCHS) and Local Authority as well as carers.

The purpose of our Local Steering Group is to:

- To receive regular updates from the Local Area Contact and Clinical Quality Review Group about the progress and findings of reviews.
- To ensure that any learning, recommendations and actions arising from reviews of deaths are considered and taken forward, as appropriate, using locally agreed governance structures.
- To work in partnership with the Local Area Contact and Clinical Quality Review Group.



Derbyshire LeDeR Clinical Quality Review Group

The purpose of our local Clinical Quality Review Group is to:

- To receive regular updates from and work in partnership with the Local Area Contact and Local LeDeR Steering Group.
- To monitor progress and completion of reviews to ensure that they are of a consistent standard, to the required quality and completed in a timely way.
- To quality assure every completed review for:
 - Comprehensiveness
 - Scrutiny of sufficient and appropriate evidence
 - Focused on recommendations and actions.
 - Dissemination of lessons learnt.

Derbyshire Safeguarding Adults Board (DSAB) and Derby City Safeguarding Adults Board (DcSAB)



There are obvious and strong linkages between detecting and reducing premature mortality for individuals with a learning disability and safeguarding – particularly in relation to the preventative element of the role of DSAB and DcSAB. The Care Act clearly lays out responsibilities in relation to **safeguarding adults** as not only about abuse or neglect but also **the risk** of abuse or neglect. The emphasis is on behaviours rather than the consequence of the behaviours.

The LeDeR programme and approach offers a process of learning from a death which can enable both DSAB and DcSAB and local structures to **focus on how to protect people** with care and support needs from the behaviours and systems that pose a risk of abuse or neglect.

Such learning may usefully inform where such boundaries (or tipping points) are, and should be, **between poor quality, neglect/abuse and organisational neglect/abuse.**

Whilst the LeDeR Steering group is not a direct subgroup of either DSAB or DcSAB there is a close working relationship with key personnel involved. Members of both Derbyshire County and Derby City safeguarding boards are members of the LeDeR Steering Group in Derbyshire and trained as LeDeR reviewers. Safeguarding Boards are included on the list of members who receive 6 monthly reports in relation to LeDeR and presentations are made to DSAB and DcSAB on a regular basis to update on the LeDeR position in relation to safeguarding. Processes are in place for working alongside safeguarding teams where there are open safeguarding referrals for any LeDeR reviews.

Child Death Overview Panel (CDOP)

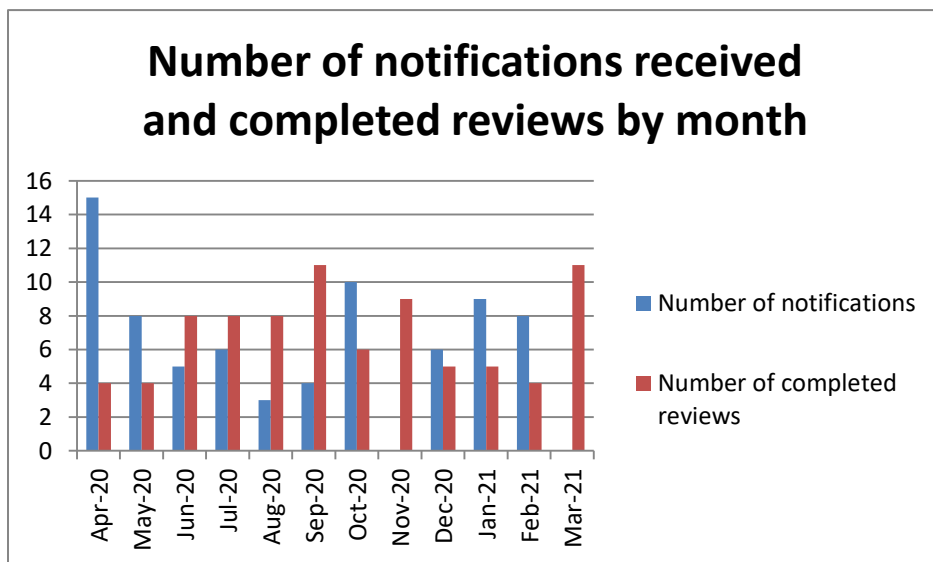
It is a statutory requirement to review all deaths of children and this process is completed by CDOP. In Derbyshire we work closely with our CCG CDOP colleagues and have developed a pathway to work together (see Appendix 3 for agreed pathway). This involves a LeDeR reviewer being part of the CDOP panel for deaths of children with learning disabilities in order to offer expertise about learning disabilities as appropriate. Any learning identified as part of the CDOP process is shared with LeDeR and uploaded onto the LeDeR system. Where any learning is identified this is included as part of the LeDeR process.

There are currently five CDOP cases that are not completed in the LeDeR system as due to Covid-19 and/or investigations these reviews have not gone through the CDOP process and therefore no learning is currently available. CDOP cases are kept separately from LeDeR reviews and are not included in any numbers shown throughout the rest of this report.

Derbyshire – what’s been happening locally in the past 12 months

Deaths in Derbyshire

Since the programme began there have been 223 deaths reported to LeDeR in Derbyshire covering the period April 2017 to end March 2021 of which 203 of these deaths have had a review undertaken and completed.



For the year 1st April 2020 to 31st March 2021 there were 74 notifications and 55 of those have had a review completed.

83 reviews in total have been completed in the year.

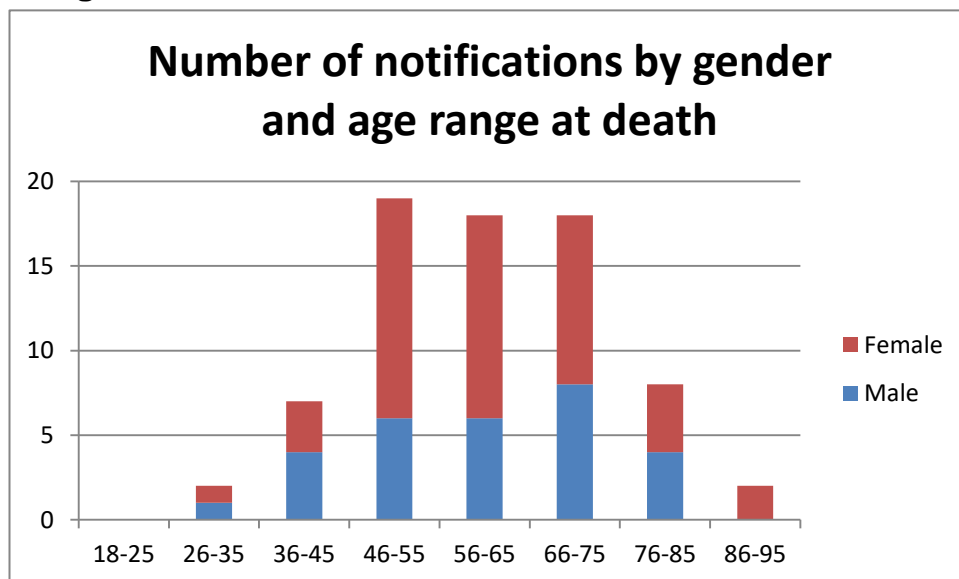
During March 2021 there have been no notifications received due to the national move to a new LeDeR platform and all notifications have therefore been put on hold and will be available for allocation when the new platform is available, expected 1st June 2021.

Deaths by gender and age range

Of the 74 notifications received there were 45 female deaths and 29 male deaths.

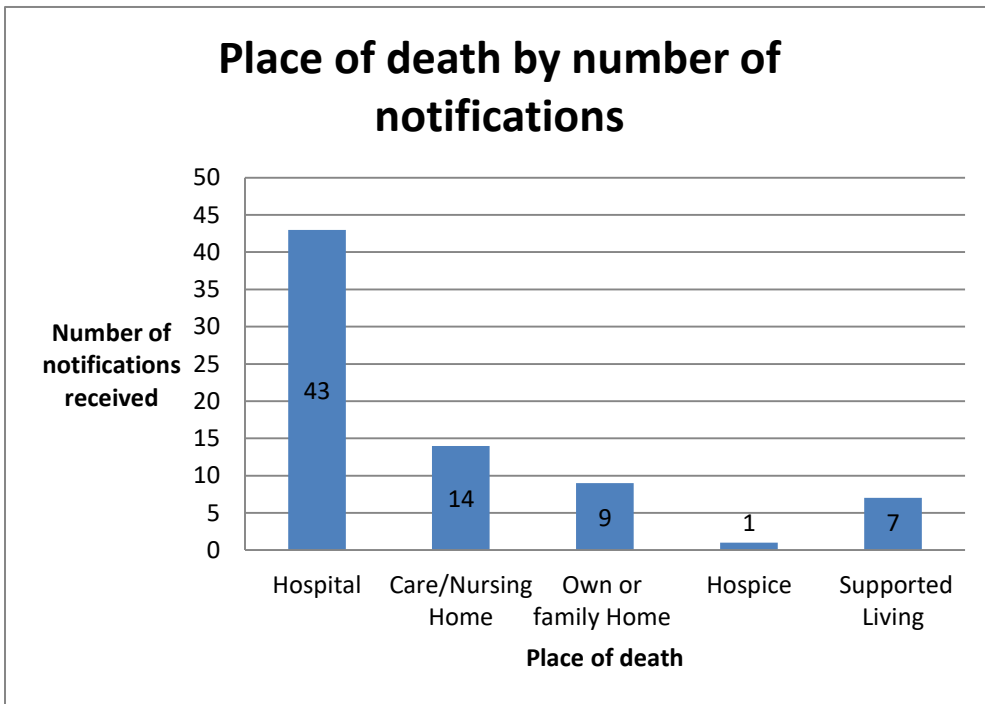
The average age at death was 62 for female and 60 for male.

If we compare this to the [2019/20 NHS England national Action from Learning Report](#), the average age of death was 59 for female and 61 for male.



The 2019/20 NHS England national Action from Learning Report stated that only 37% of people with a learning disability live beyond the age of 65. For the rest of the population 85% die over 65. Based on the notifications received, for 2020/21 in Derbyshire, 38% lived beyond the age of 65.

Places of death

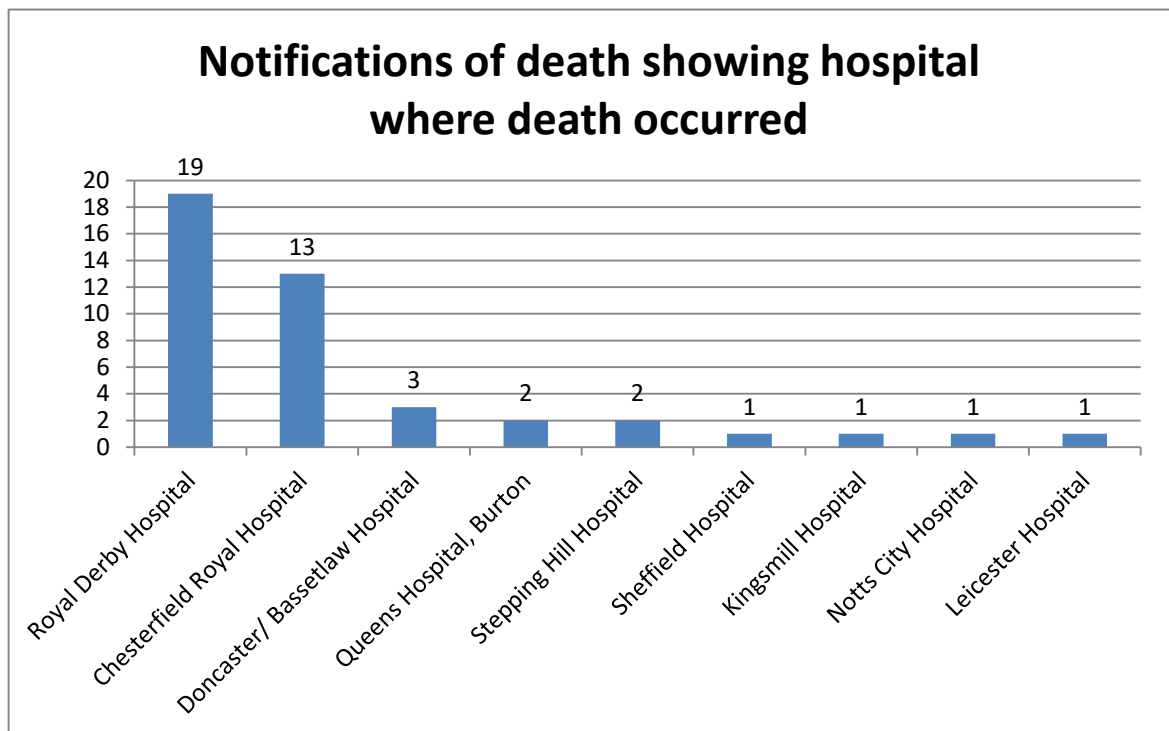


The graph shows that of the 74 notifications in the year, the majority of individuals died in hospital.

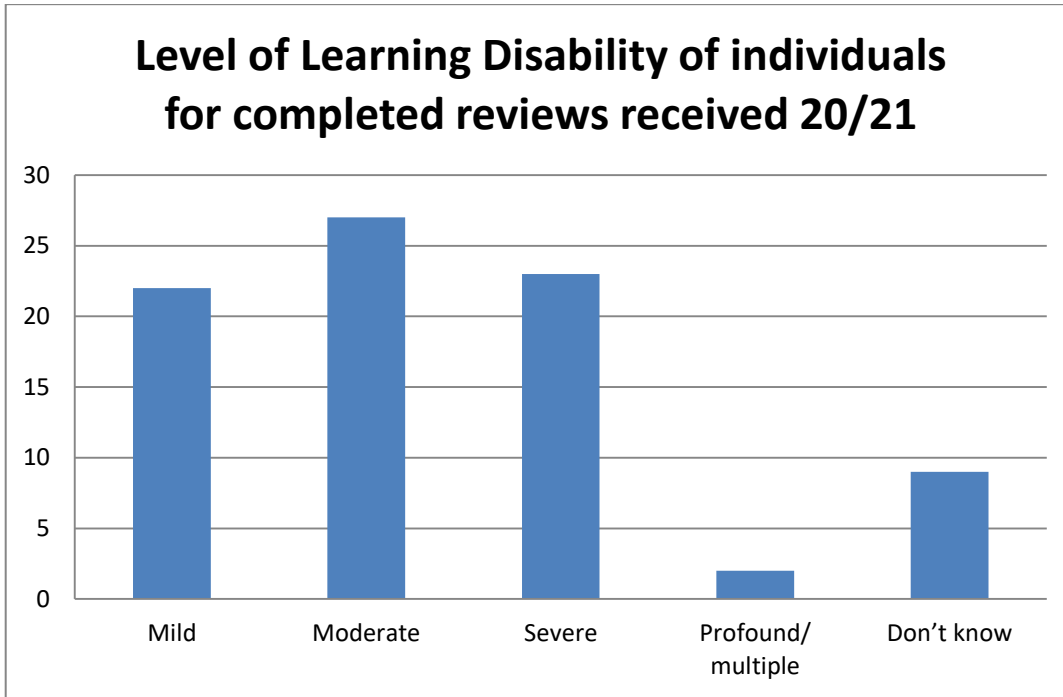
30 individuals died in their normal place of residence, split between care/residential home, supported living and their own or family home.

One individual died in a local hospice.

As expected, the two acute hospitals in Derbyshire had the majority of the hospital deaths, although due to the geography of Derbyshire there were a few deaths in out of area hospitals. We have worked to ensure we have contacts at all hospitals in order to request any information needed to complete the reviews and learning is shared where appropriate with all areas. We have particular involvement from Royal Derby and Chesterfield Royal hospitals and individuals from their organisations work as part of the LeDeR programme and are members of our LeDeR Steering Group and CQRG meetings.



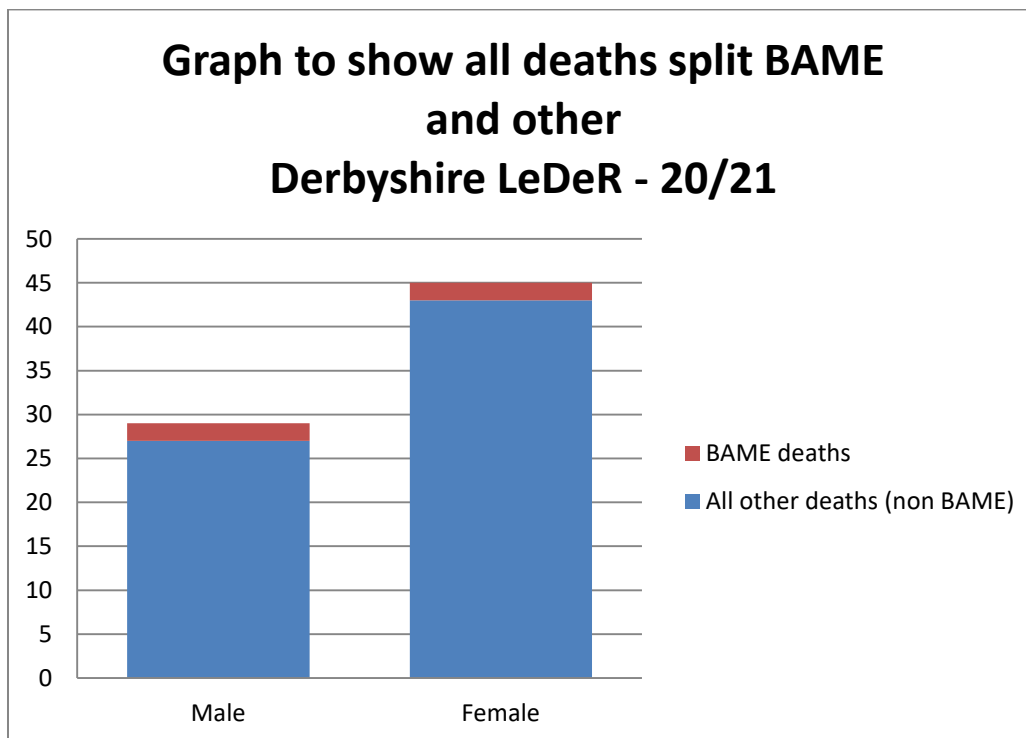
Level of Learning Disability



The majority, 33%, of the completed reviews were for individuals with a moderate learning disability.

Less than 2% were for individuals with a profound and multiple learning disabilities

Black Asian Minority (BAME) deaths



Only four of the completed reviews were for individuals of Black Asian ethnicity.

This is 5.4% of the total 74 notifications received.

Two of the individuals were male (7% of the total male notifications) and two were female (4% of the total female notifications).

The average age at death across the four notifications was 44, significantly lower than the overall average of all deaths in Derbyshire which was 61.

One of the individuals lived in the County and 3 lived in the City.

Public Health figures from the 2011 census stated that BAME deaths account for 4.2% in Derbyshire County and 24.7% in Derby City.

In Derbyshire:

- We have received a total of 17 death notifications in the City. BAME notifications therefore account for 18%
- We have received a total of 57 death notifications in the County. BAME notifications therefore account for 1.75%

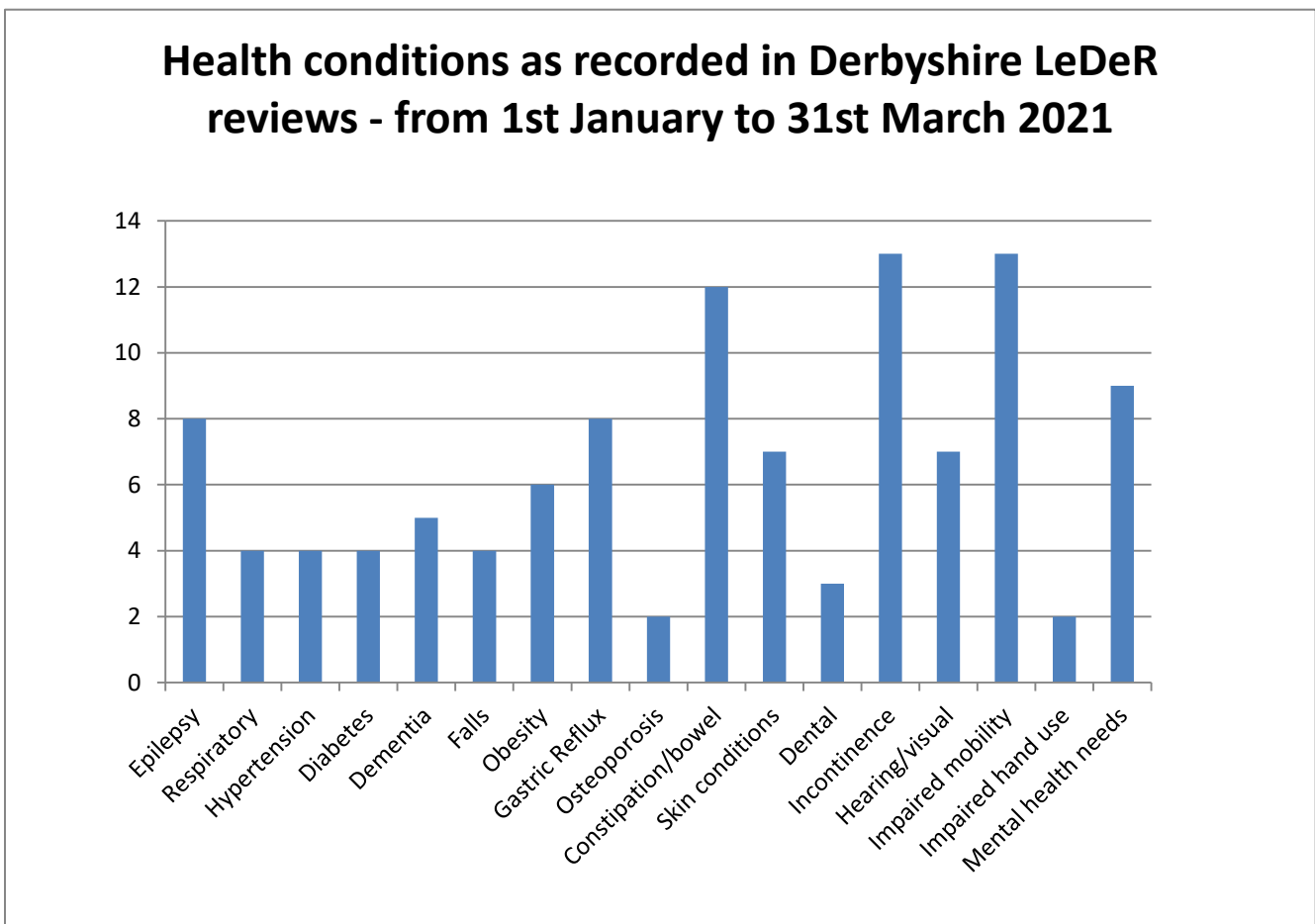
We have recently nominated a BAME lead for the Derbyshire Steering Group. We are actively looking at reasons why notifications are low and are working more closely with our BAME network to look at promotion of the LeDeR programme in BAME communities with an aim to increase the number of BAME notifications.

Multi Agency Reviews

During the year there have been four reviews that went to multiagency review. Although one only took 3 months to complete, unfortunately, due to Covid-19 the remaining 3 reviews took longer to complete than would normally be acceptable, two took 8 months and the third took 18 months.

Health Conditions

Part way through 2020/21, as part of the embedded learning work we were keen to work on, it was decided that it would be useful to start to capture the health conditions that were recorded in completed reviews. Twenty reviews were completed in the period 1st January 2021 to 31st March 2021 and the graph below shows the health conditions and the number of times each condition was identified.



This identified that in 60% of cases the individuals had some kind of bowel/constipation issue. In

addition, work that has been done in one of our local hospital showed results that presenting conditions for people with learning disabilities were often such things as increased seizures, swollen abdomen, off food & drink and vomiting. On investigation at the hospital although the reason for death was not constipation it was often seen as a common issue in the decline of the individuals' health.

As a result of this a task and finish group has been set up to include Community Learning Disability Teams (CLDT) Managers, Nurses, Physiotherapists, Occupational Therapists, members of Continence services and the LD Health Facilitation Team to discuss and share best practice. Further details of the work they are doing are included in the "Learning into Action" section later in this report.

Working with partners across Derbyshire

The importance of working with our health and social care partners is crucial to the success of the LeDeR programme. Their involvement is key as reviewers, Steering Group members and CQRG members, using their wide range of knowledge and expertise to review the care and then using the learning gained to share good practice and improve care. The experience of staff who work directly in the system is so important to the programme and our reviewers are members of Community Learning Disability teams, the Learning Disability Health Facilitation team, social care staff, local hospice staff and staff members from Derby and Derbyshire CCG.

Here are some areas where our partners have worked with us and been involved in the LeDeR programme and initiatives they are working on to improve care for individuals with a learning disability :-

Training/raising awareness – the reviewer attended our team meeting to provide training and raise awareness in relation to LeDeR. Our team works with clients with complex support needs, including behaviours which challenges, many of who are in specialist residential or supported living placements. Orientation to the LeDeR programme will assist workers when undertaking their care co-ordination role.

The LeDeR programme has made a difference as it has enabled me and our organisation to share information wider and work closer with the LD teams

We have amended our reporting system to ensure we are capturing deaths of people with Learning Disabilities and set up a monthly data report of these deaths to ensure that they are reported promptly to LeDeR.

We have also strengthened our Learning from Deaths process by screening all LD deaths received and carry out case note reviews on deaths alongside the LeDeR review.

We also have a close working partnership with the CCG and LD teams to share information and improve processes. A quarterly paper is produced to the Mortality Review Group on LD deaths and updates to cascade and share actions.

We attend the LeDeR Steering Group and Quality Governance Group for DCHS. We report deaths to LeDeR and share themes/quality improvement opportunities within DCHS.

The 'easy read' information sent out by the Derbyshire LeDeR team is distributed to our team, who in turn cascade to the residential / supported living providers we work with.

The trust has completed SJRs which are fed into the CCG led LeDeR process. We have included this in the Trust review of mortality and disseminated learning from this. Representatives from the Safeguarding team attend the LeDeR meetings and report back to the Trust. In refining the process of completing and learning from this process we have met with the Safeguarding Team to develop and agree a pathway for the SJRs and thematic feedback is being produced and reported within the Trust.

*The LD liaison nurse is invaluable in supporting our patients to access services. Patient stories are regularly reported through the Patient Experience Group and Trust Board. In terms of developing the skills of our staff, improving understanding and raising the profile of our patients who live with neuro-diversity issues; We are embarking on developing a neuro-diversity framework / strategy; our Emergency Departments are pursuing accreditation from the National Autistic Society and we are participants in the Oliver McGowan (Health Education England/Mencap) training pilot
The Trust is undertaking a significant programme of learning from deaths to include deaths of those patients from Covid-19*

Covid-19 and the LeDeR Programme

Throughout the Covid-19 pandemic the LeDeR programme in Derbyshire has continued to be a priority area. During short periods of the year, particularly when staff were redeployed to support Covid-19 clinically, LeDeR reviews were only quality assured virtually with relevant members of the group. Any actions and queries were dealt with and collated as per the normal process. LeDeR Steering Group meetings were cancelled but updates continued to be shared with the group via email. When the LeDeR Clinical Quality Review Group (CQRG) meeting and LeDeR Steering Group have taken place the meetings have been held through Microsoft Teams.

During the whole of the pandemic LeDeR reviews have continued to be completed, ensuring reviews where families are already engaged remained a priority. There were some added complications to obtaining information for reviews as many health and social care providers were redeployed as part of Covid-19 and/or are extremely busy providing care to individuals, which has led to some carers being unable to provide information to support the LeDeR review process. This meant that some reviews were taking longer than normal to complete, although the 6 month target to complete reviews as requested by NHSE/I continued to be met.

During the early stages of Covid-19, NHSE/I requested that an additional “rapid response” review was completed by the reviewer (this was in addition to the normal full review). This was in order to collate and identify any early learning (for any deaths between March and June) and this was pulled together and shared nationally. The national report is available at <https://www.england.nhs.uk/learning-disabilities/improving-health/mortality-review/action-from-learning/people-with-a-learning-disability-and-coronavirus/>.






In Derbyshire we have had a total of 21 cases notified through the LeDeR programme where the reason for death has been recorded as Covid-19.

Derbyshire LeDeR Programme			Covid deaths - as at 31st March 2021		
Number of reported LD deaths with Covid-19 shown as cause of death			21		
Number died in hospital	Chesterfield Royal Hospital = 7 4 of 7 admitted with Covid symptoms	Royal Derby Hospital = 6 5 of 6 admitted with Covid symptoms	Doncaster & Bassetlaw Hospital = 1 Admitted with Covid symptoms	Queens Hospital, Burton = 1 Admitted with Covid	Stepping Hill Hospital = 2 One of 2 admitted with Covid symptoms
Number died in care/residential home			4		
Normal accommodation type in the community	Residential/nursing home = 12	Family home = 3	Supported living = 5	Specialised low secure unit = 1	

As in other LeDeR reviews, we have seen both issues and some areas of really good practice in the death from Covid-19 reviews. These are captured in the table below. We have also seen other

reviews where Covid-19 is not the reason for death but has affected the care of the individual in some way and this is therefore also captured in the information below.

Identified Issues and Learning from Covid-19 cases

Identified Issue	Detail	Learning
<p>Alone in hospital with no one who knows them</p> 	<p>Earlier cases found that due to hospital Covid rules individuals with LD were alone in hospital without people who understood them or who they knew</p>	<p>Use of hospital passport. Link with Acute LD Liaison Nurse Correct PPE provided to support visiting to allow people who know the individual to be with them</p>
<p>Use of Covid-19 testing</p> 	<p>Earlier cases showed a delay in Covid testing in hospital due to the ward staff not identifying that this was a different health problem and assumptions made this was their normal presentation</p>	<p>Earlier Covid-19 testing needed</p>
<p>Do not attend A&E</p> 	<p>Earlier case where admission to hospital delayed as individual told not to go to A&E due to Covid - individual then later died of community acquired pneumonia (not Covid)</p>	<p>Earlier issues over understanding of when important to still use hospitals</p>
<p>Lack of tests for care homes</p> 	<p>If testing had been available in care homes the cases would have been identified sooner and measures taken to contain the cases</p>	<p>More Covid-19 tests to be available for care homes</p>
<p>Cancelled planned care due to Covid-19</p> 	<p>No CT scan as planned by neurology due to Covid - reduction in planned care due to Covid</p>	<p>This has obviously been identified as a problem for all individuals Introduction of routine planned care needed as soon as possible</p>

The issues found were in the majority in the early days of Covid-19 and were common issues found nationally. However, later cases in particular identified some areas of good practice.

Areas of good practice identified through Covid cases

<p>Hospital Passport</p>	<p>Good use of hospital passport ensuring that staff understood the individual's needs</p>
<p>Hospital allowed care staff to be with individual</p>	<p>Members of care staff allowed to stay with individual to offer reassurance and help doctors to diagnose and treat as they knew the individual's normal presentation</p>
<p>Use of technology</p>	<p>Video calls made between the care home and individual's family when visiting not allowed due to Covid-19</p> <p>In one case family paid for video to be available so that care staff from home could watch the funeral that they were unable to attend due to Covid-19 rules</p>

Grading of care

83 reviews were completed in total between 1/4/2020 and 31/3/2021. Grading of care shows the LeDeR Reviewers' overall assessment of the care received (where this has been recorded on completed reviews).






75 of the reviews completed received satisfactory or above levels of care, this equates to 90% or a ratio of 9 people out of 10 in Derbyshire receiving satisfactory care or above.

The Derbyshire report for 2019/20 showed 85% (or 8.5 out of 10 people) receiving satisfactory care or above.

Grading of care	Count of Grading of care	Percentage of overall
1 = Excellent Care	8	10%
2 = Good care	41	49%
3 = Satisfactory care	26	31%
4 = Care fell short of expected good practice and this did impact on the person's wellbeing but did not contribute to the cause of death	4	5%
5 = Care fell short of expected good practice and this significantly impacted on the person's wellbeing and/or had the potential to contribute to the cause of death	3	4%
6 = Care fell far short of expected good practice and this contributed to the cause of death	1	1%
Grand Total	83 reviews	100%

Reasons for Death in Derbyshire

Of the completed reviews that were notified during the period 1st April 2020 to 31st March 2021 the top 5 reasons for death are categorised and separated out below.

Death category	Percentage across deaths where reviews completed 1 st April 2020 to 31 st March 2021
<p>Covid-19</p> 	<p>25%</p>
<p>Respiratory</p> 	<p>22%</p>
<p>Heart failure/cardiac arrest</p> 	<p>13%</p>
<p>Cancers</p> 	<p>11%</p>
<p>Dementia/Alzheimer</p> 	<p>9%</p>
<p>Others (including Sepsis, hypoxia, Bowel obstruction, Epilepsy)</p>	<p>20%</p>

In the 2019/20 NHS England national Action from Learning Report pneumonia was shown as the highest cause of death for people with a learning disability at 41%. However, there was obviously no awareness of Covid-19 at this time which has been identified as the main reason for death in 2020/21.

Areas of Improvement and Best Practice

Derbyshire Case Studies

Case Study 2 – 75 year old White man with a moderate learning disability living in Supported Living

Conditions: Anxiety; claustrophobia; Apert Syndrome (a congenital disorder characterized by malformations of the skull, face, hands and feet); gastric reflux; constipation; consideration of dementia at time of cancer diagnosis.


He had previously lived with his parents and had no contact with Social Services at all until his 93 year old mother died when he was 63. He moved into a supported living bungalow with 2 other men and continued to live there until he died 11 years later.



He was a private, quietly spoken man. He was considered able to make choices about everyday decisions such as where he chose to spend his time when in the bungalow; whether he wanted pain medication and what he wanted to eat. The GP was not sure why he was prescribed Lorazepam, Mirtazapine, Risperidone and Prochlorperazine but wrote they were for “anxiety generally but may have been for early symptoms of dementia”.

By the time he was diagnosed with cancer it was stage 4 in his bladder with metastases in his spine, lungs, kidneys and urethra. He was immediately put on end of life care and lived for another 9 months (longer than expected). He had involvement from District Nurses and specialist Palliative care nurses. An Occupational Therapist was involved 4 months after diagnosis regarding equipment as he found it hard to sleep and by that time spent a lot of time in bed. He was so weak that he needed the support of 2 staff and a hoist to get out of bed. His cousin who was his only family said that the care he received at the end of his life was excellent.

Cause of death – Bladder cancer


Identified Issues and Learning from this case

Identified Issue	Detail	Learning
<p>Lack of referral to Community Learning Disability Team</p> 	<p>He was diagnosed with cancer and exhibited anxiety about the changes that were happening with his physical health. Due to a childhood experience he was frightened of doctors and white coats. There was no referral to a Speech and Language Therapist (SALT) and/ or Clinical Psychologist at any point before or after the cancer diagnosis. Support staff and health professionals were not sure about his level</p>	<p>A referral to the CLDT would have enabled him to receive information in an accessible format to help him understand his diagnosis to some extent. Communication guidelines for health professionals could have helped people communicate with him in a consistent way thus reducing the possibility of mixed messages and increased anxiety levels.</p>

	<p>of learning disability. He did not have an assessment of his receptive and expressive communication. There was no guidance for staff on how to best communicate with him about his diagnosis or advice on how staff could try to mitigate his significant anxiety. He was on antipsychotic and anti-depressant medication because of his anxiety levels. He also refused all vaccinations. Again he could have had support regarding this (desensitization or appropriate augmented communication). This may have led to a reduction in his psychotropic and anti-depressant medication as well as significant reductions in his anxiety about his failing health.</p>	
<p>Lack of understanding of or poor evidence of consent or best interest</p> 	<p>There was a lack of evidence of records of mental capacity assessments and subsequent MDT best interest meeting/ decisions about the pros and cons of possible treatment or what to tell him about his cancer diagnosis and symptoms.</p>	<p>A discussion considering all options should have looked at how to support him to understand his diagnosis. If an MDT discussion had occurred it should have been discussed what could help him understand (referral to SALT for communication guidelines). He had significant anxiety. Not knowing what was happening to him could have increased that anxiety (as he knew he was not well) rather than the assumption that being told very little would keep his anxiety levels low.</p>
<p>Lack of routine health screening</p> 	<p>Bowel screening was offered over a number of years - GP notes recorded "No response to bowel screening programme invitation". GP records stated that he also "refused" all vaccinations. This links to the issue of lack of a SALT communication and comprehension assessment with lack of mental capacity assessments and best interest records. Again assumptions might have been made about his</p>	<p>The Supported Living manager was not aware that this person had missed out on routine health screening appointments. Staff were not aware what health checks he was entitled to and why they were important. The Manager was not aware that the GP or other health professionals had a legal duty to consider what reasonable adjustments they should make to enable the man to access their services (including accessible information, home</p>

	<p>fear of doctors and hospitals. Again there was no mental capacity assessment and best interest decision around these significant health decisions. There was no record of any other health screening.</p>	<p>visits etc.)</p>
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Area of good practice identified

<p>Reasonable adjustments made</p> 	<p>This man’s carers were employed by a supported living provider so did not have training in monitoring health stats or end of life care. However they and their manager did not want him to have to move care providers either after the initial diagnosis or at end of life (he was offered a hospice bed at the end) as the bungalow was his ‘home’. He also regularly said “stay home”.</p> <p>In the last 6 months CHC provided funding for additional carers when he needed 2 staff to support him. Health provided the appropriate equipment for him to remain in his home (eg profile bed and rails, hoist, sleep system).</p> <p>The District nurses were aware that staff took him to A & E at times due to their reasonable concerns about their own lack of experience and knowledge so the DN’s supported the staff as well as directly supporting him. The carers stayed in hospital with him so that they could communicate with doctors on his behalf.</p> <p>Family member said that carers were “brilliant. I couldn’t praise them highly enough”.</p>
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Case Study 3 – 75yr old gentleman with a mild LD who had lived with his brother and sister in law before moving into an older persons’ residential home in Aug 2020

This gentleman had lived with his brother and sister-in-law before moving into an older persons’ residential home in August 2020. As a result of the move he had a change of GP.




He experienced high blood pressure, borderline diabetes and constipation and received medication for these conditions. He was not invited for an Annual Health check within the last year. He had not received any age or gender related health screening.


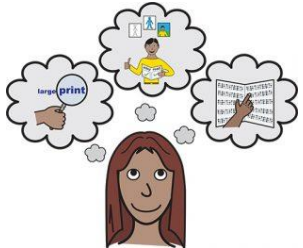

He had experienced several episodes of constipation in the last year of his life with several GP consultations and an admission to hospital with impacted bowels and secondary urine retention resulting in the need for a urinary catheter.

There was a further problem 5 months later with faecal vomiting and abdominal pain which resulted in an out of hours call. Extra bowel medication was prescribed on this occasion. Five weeks later he was admitted to hospital with coffee ground vomiting and upper GI bleed and tested positive for Covid-19 5 days later.

**Cause of Death –
Died in hospital 1 week later from Covid-19 pneumonia**

Identified Issues and Learning from this case

Identified Issue	Detail	Learning
<p>No recent Annual Health Check</p> 	<p>No invite to a Learning Disability annual health check in last year of life</p>	<p>All individuals on the GP LD register over the age of 14 should be invited to an annual health check</p>
<p>Poor sharing of information</p> 	<p>Poor sharing of information between GP practice and Residential Home</p>	<p>Training and awareness needed to understand the importance of sharing information</p>
<p>Constipation</p> 	<p>Constipation not managed effectively, baseline bowel habits not known, holistic approach not considered (including diet, fluids, and exercise), lack of examination and lack of</p>	<p>Better awareness needed of constipation and bowel management</p>

	discussion with individual, not signposted to continence service.	
<p>No signposting</p> 	Lack of signposting and support offered to family	Importance of involving and supporting family
<p>Lack of reasonable adjustments</p> 	Lack of reasonable adjustments, monitoring charts, discussions and accessible information shared with individual	Awareness of need to use reasonable adjustments and what reasonable adjustments are available to ensure the individual understands what is happening
<p>Workforce training issues</p> 	Nursing home not aware of needs for LD clients or constipation management	Training needed to ensure residential homes understand the individual needs of people living in their homes

Case Study 4 – 53 year old female with moderate learning disability living in a Nursing Home

Conditions: Down syndrome; moderately obese; Alzheimer's; 'reactive depression'; severe osteoporosis (hips and knees); glaucoma and further eye infections


This lady had lived at her previous Care Home for 20 years. Her MDT (including GP) wanted to support her to remain there for as long as possible after her diagnosis of Alzheimer's three years previously.

Her Community Care Worker secured some health funding for 21 hours a week of 1:1 support around her symptoms of anxiety and to encourage her to leave her bedroom and mix with other residents.

She eventually had to move from the Home due to her reduced mobility and need for hoist, worsening short term memory and symptoms of Alzheimer's. This happened during the Covid -19 lockdown restrictions. The 1:1 hours did not transfer with her as she was partially funded by Health in her Nursing Placement. She died 3 months after moving Home.

Cause of Death Ischemic small bowel and small bowel obstruction

Learning from this case

Identified Issue	Detail	Learning
<p>Lack of referral to CLDT</p> 	<p>This lady was moved from a specialist Residential Home for people with learning disabilities to a generic Nursing Home (without a dementia specialism) at a time when her mobility was decreasing; she had a variety of health issues; was experiencing anxiety and distress as symptoms of Alzheimer's.</p> <p>It would have been extremely useful if the new Home had made a referral for support and advice from the CTLD team and specifically the Community Nurse around the particular health issues that people with Down Syndrome experience. This would have assisted the nursing and care staff to ensure that they were monitoring her physical health appropriately and reduced the chance of diagnostic overshadowing (where physical</p>	<p>The Home had a number of new managers in the 3 months after she moved in and then after she passed away. It was difficult to find out whether they were aware of the local CTLD team.</p> <p>The move and the death occurred during the Covid Pandemic restrictions.</p> <p>Had a referral been made to the CTLD, staff at the Home may have been more aware of physical health symptoms to be concerned about (such as constipation) and had a care plan for when to escalate concerns to GP or hospital for further investigation.</p>

	<p>health symptoms are not spotted as they are mistaken as symptoms of her Alzheimer's or her 'learning disability').</p>	
<p>Service needs indicated but not provided</p> 	<p>This lady would have benefited from a Nursing Home that had specialist knowledge of supporting people with learning disabilities with physical health needs and dementia. This was not available in the area near her family.</p> <p>The Senior Social Worker stated that it is hard to find Nursing Home placements for people with learning disabilities and dementia (that are aged under or over 65) close to or in Derby. Workers often have to ask mainstream Older Person's Homes (where residents are usually in their 70's, 80's and beyond) to agree to one off contracts.</p>	<p>It is important for Integrated Care Services to take account of the facts that people with Down Syndrome (and other diagnosis) are tending to live longer, with symptoms of dementia and other significant physical health comorbidities.</p> <p>This should be reflected in future service commissioning, Care Home registration and Integrated Health Budget development.</p>
<p>Not recognised that person was deteriorating/ no person centred support plan describing care and support needs</p> 	<p>This lady experienced a number of painful physical health conditions. There was no apparent detailed person centred support plan which described each condition and what 'not good' looked like.</p> <p>It is possible that carers who knew her better would have understood that her presentation was not 'normal' for her, that her apparent constipation was more than that (as she did not have a record of suffering from this) and needed further investigations.</p>	<p>Constipation was recorded in care home notes for 4 days before she was sick which led to GP being called and then hospital admission.</p> <p>During transition from one care setting to another it is extremely important that the details of care and support are transferred even if the care plans cannot be. Assumptions should not be made about constipation being 'normal' for anyone.</p>
<p>Lack of understanding of or poor evidence of consent or best interest</p>	<p>When this lady was diagnosed in hospital as having an ischemic bowel it was recorded that after a discussion with her brother (who did not want her to be have any further stressful interventions) that she was not for surgical intervention and was to have ward based ceiling of care. The hospital notes described that "given her comorbidities surgical intervention would not be in her best</p>	<p>There was no suggestion of a short term surgical action to be taken on the day of admission (a Saturday) to deal with the immediate health emergency to then enable a best interest decision meeting involving her full MDT to be convened virtually on the Monday to look at both the harm and benefit of alternative courses of action.</p>



interests” and that she would not tolerate a stoma as she was already pulling out her cannulas and catheter.

There was no record of a discussion of the harms and benefits of 2 possible courses of action. The alternative to not operating appears to have been pain medication to support her as she died.

The Mental Capacity Act provisions question the right of clinicians to make unilateral decisions to deny lifesaving emergency treatment without full best interest decisions and records of such analysis. A best interest meeting may have resulted in the same conclusion as occurred.



Area of good practice identified

Person Centred Support

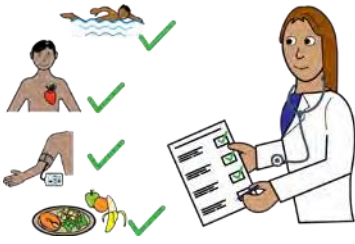


This lady appears to have experienced very person centred support during her time at the previous Care Home. Her GP advocated for her rights to remain at the Home and to have increased support based on her developing needs. She also had thorough support from the CTLD team for a number of years around her physical health and her dementia diagnosis. They worked jointly with the Mental Health team at time of diagnosis.

Learning into Action – How learning from LeDeR Reviews is being used to drive quality improvement in Derbyshire

<p>Training & awareness of the LeDeR programme and sharing the themes/learning</p> 	<p>‘Sharing The Learning, Improving Health Outcomes of people with Learning Disabilities and/ or Autism’ development sessions are being provided to a variety of Health and Social care teams and care providers.</p> <p>This has included all of Derby City Council Adult Social Services Teams, many locality and LD specialist teams in Derbyshire, student nurses and major care and support providers in Derbyshire.</p> <p>During Covid restrictions these sessions were initially put on hold but we then provided them as virtual sessions which have in fact enabled larger number of attendees from agencies.</p> <p>Sessions planned for this year include delivery to specialist and community advocates, Shared Lives carers and unpaid carers. As lockdown restrictions are reduced we hope to provide development sessions to families, people with learning disabilities and anyone else in a supporting role.</p> <p>Session content includes:</p> <ul style="list-style-type: none"> • sharing information on the LeDeR process and why it is needed • identifying the causes of the health inequalities • information and guidance on what we can all do to improve health outcomes by, for example, advocating for reasonable adjustments • promoting annual health checks • and being clear about the legal framework for ‘best interest’ decision making.
<p>Working more closely with providers of care</p> 	<p>As well as their involvement in the LeDeR Steering Group and LeDeR CQRG we are working closely with care providers:-</p> <ul style="list-style-type: none"> • sharing learning from LeDeR through themes and reporting • regular update reports • attending GP practice sessions • attending LD care home information sharing sessions • delivering training sessions

Annual Health Checks



Communications and support to access primary care Learning Disability Annual Health Checks (AHC) in some reviews could have been improved.

Quality of the check could have been improved in some cases and the need for a good quality Health Action Plan.

Actions completed to date:

1. Survey of Parent Carer forum members
2. Promotion of AHCs through parent carer forums
3. Promotion of AHCs using Joined Up Care website
4. Collating patient experiences
5. Recruitment of Project Coordinator in LD Health Facilitation team. Main work area to raise awareness of LD AHCs and develop processes to ensure future/ongoing attendance at AHCs, including share good practice, developing good health action plans

In progress:

1. AHC promotional video – particular emphasis on 14+ and health action plans. The video is being produced with input from parent carer forums and their members and Healthwatch volunteers who have a learning disability, as well as the LD health facilitation team.
2. Working with CYP SEND colleagues to promote AHCs in 14-25 year old
3. Working with Project Coordinator to develop workplan of action to promote AHCs

Mental Capacity



Utilisation and documentation of the Mental Capacity Act by mainstream health services was shown to be inconsistent in some of the reviews completed. Best interest decision making information is offered through the training and awareness sessions.


Bowel Awareness and Constipation





We often see constipation or other bowel related issues as something a person with learning disabilities has to deal with during their lifetime – see conditions graph on page 23.

Actions in progress:

1. Production of constipation video – to promote awareness of bowel issues and constipation
2. A regular meeting has been set up with Community Learning

	<p>Disability Teams (CLDT) managers, nurses, physios, OT's, continence services and the LD Health Facilitation Team to discuss and share best practice</p> <ol style="list-style-type: none"> 3. Continence team have been sharing their work with the group – review of training offered and who this is delivered to with the offer of additional training to teams. 4. South CLDT physios offer abdominal massage and training to carers - work now in progress on sharing best practice and skills to assist in developing this service with the North CLDT team. The Learning Disability Health Facilitation Team have delivered bowel management training to the North team - to continue to roll out across county – including LD homes & smaller supported living providers. A training flyer has been produced that will be shared with the acknowledgement letter for referrals into the CLDT for people to contact and arrange training. 5. Existing documentation and leaflets have been reviewed and bowel information leaflets are being sent out by the North CLDT when referrals are received to care teams and families to increase bowel awareness. 6. The north and south physio teams have reviewed the national training and available research into abdominal massage as part of bowel management. Training has now been identified through the ACPPLD (Association of Chartered Physiotherapists for People with a Learning Disability) 7. The North CLDT have reviewed their initial assessment and nursing assessment paperwork to ensure the right questions are asked with regard to bowel management. An additional prompt sheet that supports depth of questioning in the initial information gathering has been shared within the county for agreed consistency. Additionally existing constipation risk assessment screening tools are being reviewed and work is underway to develop a tool that will trigger where extra support or signposting is required. 8. The health facilitation team will share and update this through their work with GP's. 9. Links with medicine management have been made and plans to discuss with LD psychiatry.
<p>End of Life Care</p> 	<p>We are in the process of working with care providers to promote the “Improving end of life care for people with learning disabilities” resource pack which has been developed with an aim to take steps to reduce the barriers faced by the patient group and support all involved in providing high quality and equitable care at end of an individual’s life. The resource pack ensures:</p> <ul style="list-style-type: none"> • Delivery of high quality care for all people in all locations

	<p>ensuring that those with learning disabilities are not disadvantaged.</p> <ul style="list-style-type: none"> • The early identification of all individuals approaching end of life. • Initiation of discussions about preferences and wishes for end of life care. • Inclusive Advance Care Planning that includes: assessing needs and preferences. • Agreement of a care plan and ensuring regular review. • Knowledge and awareness of resources and tools available to support care delivered.
<p>Quality Care in Care and Nursing Homes</p> 	<p>One of our recurring themes is in relation to workforce training for care homes.</p> <p>Actions completed and in progress:</p> <ol style="list-style-type: none"> 1. Offering training to care homes 2. Working with CCG care home quality members 3. Attending local LD care home meetings – sharing information
<p>Epilepsy</p> 	<p>The CLDT in the North are exploring what epilepsy training is available both for nursing staff and across the wider team. Epilepsy guidance is being reviewed particularly “Step Together Integrating Care for People with Epilepsy and a Learning Disability” 2020.</p>

Conclusion and Recommendations

1. Acknowledgement of all the work and effort that has gone into continuing to complete reviews in a timely manner as well as working on embedding learning relevant to care provided to people with learning disabilities in Derbyshire.
2. The ongoing commitment from Derbyshire to ensure all reviews are completed within 6 months of notification.
3. Continue to ensure that reviews are completed and quality assured to an acceptable standard that ensures the programme can share and use learning to make meaningful changes to the lives of individuals with learning disabilities.
4. Continue to build relationships and work with health and social care partners in relation to the LeDeR programme and acknowledging the importance of making service improvements across the whole system as we develop into an Integrated Care System (ICS).
5. To follow the new guidance of the LeDeR policy and ensure there is clear and effective governance in place.
6. Use learning from the LeDeR programme and work with the BAME lead to reduce the health inequalities faced by people from Black, Asian and Minority Ethnic communities who live locally and who have a learning disability.
7. To ensure we have meaningful involvement of people with learning disabilities and their families in the LeDeR programme.
8. This report will be shared across Derbyshire learning disability forums and shared with learning disability services and care providers. It will also be produced in an easy read format and shared across Derbyshire learning disability forums and care providers. Both versions will be made available on public areas of the DDCCG and Joined Up Care Derbyshire websites.

References

Links to relevant pages on the Bristol University website are shared below:-

Department of Health. (2001). Valuing People: A New Strategy for Learning Disability for the 21st Century. A White Paper.

Bristol – CIPOLD enquiry - <http://www.bris.ac.uk/cipold/>

Bristol – about LeDeR - <http://www.bristol.ac.uk/sps/leder/>

Multiagency review details - <http://www.bristol.ac.uk/sps/leder/about/detailed-review-process/multiagency-review/>

Section 251 approval - <http://www.hra.nhs.uk/about-the-hra/our-committees/section-251/what-is-section-251/>

Bristol notification of a death –

http://www.bristol.ac.uk/sps/leder/notify-a-death/?_ga=2.4265911.589001362.1531124673-1987643447.1528363357

<http://www.bristol.ac.uk/sps/leder/about/detailed-review-process/notification-of-a-death/>

Bristol review process - <http://www.bristol.ac.uk/sps/leder/about/detailed-review-process/people-involved-review/>

NHSE Action from Learning report 2019/20 - <https://www.england.nhs.uk/publication/leder-action-from-learning-report/>

National LeDeR annual report 2019 - <https://www.hqip.org.uk/resource/the-learning-disabilities-mortality-review-programme-annual-report-2019/#.YEjalP1FDIU>

LeDeR Futures Policy 2021 - <https://www.england.nhs.uk/publication/learning-from-lives-and-deaths-people-with-a-learning-disability-and-autistic-people-leder-policy-2021/>

Covid National report - <https://www.england.nhs.uk/learning-disabilities/improving-health/mortality-review/action-from-learning/people-with-a-learning-disability-and-coronavirus/>

Appendix 1 – Development of the LeDeR Programme

2015	<p>1ST June – The LeDeR Programme (Learning from Deaths review of people with a learning disability) is established by NHS England and led by the University of Bristol. This follows on from the Confidential Enquiry into Premature Deaths of people with LD (CIPOLD), the findings of which demonstrated that on average someone with a Learning Disability lives 20 years less than someone without.</p> <p>The LeDeR acronym stands for Learning Disabilities Death Review and LeDeR is pronounced as ‘leader’</p> <p>The team based at the University of Bristol are responsible for developing and rolling out a review process for deaths of people with learning disabilities</p>
2016	<p>Pilot sites are established across England with a trial review process (Derbyshire is <u>not</u> one of the pilot sites)</p> <p>The NHSE National Operational Steering Group is established.</p> <p>Each NHS region is appointed an NHS England Regional Coordinator to guide the roll out of the LeDeR programme across their geographical region.</p> <p>October 2016 – the first LeDeR annual report is published describing the ‘set up activities for the programme.</p>
2017	<p>February & March 2017 – first Derbyshire reviewers attend face to face training sessions</p> <p>February 2017 – First LeDeR Steering Group in Derbyshire</p> <p>April 2017 – Derbyshire starts to receive first notifications</p>
2018	<p>May 2018 – second annual national report published</p> <p>September 2018 – handover of quality assurance of completed reviews from University of Bristol to local areas</p> <p>Train the trainer model, and e-learning introduced for training reviewers and local area contacts.</p>
2019	<p>May 2019 – third annual national report published</p> <p>May 2019 – NHSE start “backlog project” project to ensure more timely completion of reviews. NHSE set performance targets for local areas to meet.</p>
2020	<p>Publication of Action from Learning report by NHS England.</p> <p>NHS Long Term Plan supports the continuation of the LeDeR programme.</p> <p>Department of Health and Social Care publish response to third LeDeR annual report.</p> <p>March 2020 – work starts to discuss the future of LeDeR including a new LeDeR system</p> <p>The LeDeR Programme and the work done locally continues throughout the Covid-19 pandemic and is still classed as a priority area of work within Derbyshire CCG</p> <p>July 2020 – first Derbyshire LeDeR annual report published</p> <p>July 2020 – fourth annual national report published</p> <p>NHSE commissioned IPSOS Mori to undertake independent research into views of stakeholders about how to improve the LeDeR programme</p>
2021	<p>23rd March 2021 – the new LeDeR policy is shared</p>

Appendix 2 - Independent Review into Thomas Oliver McGowan's LeDeR Process – Derbyshire LeDeR Process Assurance

Assurance was asked of the Derbyshire Quality and Performance Committee following the publication of the Independent Review into Thomas Oliver McGowan's LeDeR Process (<https://www.england.nhs.uk/publication/independent-review-into-thomas-oliver-mcgowans-leder-process-phase-two/>) with local and regional recommendations for CCGs & NHSE.

Report Summary

In October 2020 NHS England shared a recently published report by Fiona Ritchie OBE, Chair on behalf of an Independent Panel for NHS England and NHS Improvement. It was suggested that this was essential reading for all Systems to gain valuable insight into the findings of the Review and particularly the governance arrangements surrounding local LeDeR Programmes.

Summary and Action Plan

The delays and difficulties in completing the LeDeR process for Oliver was found to be characterised by poor governance contributed to by poor leadership, reorganisation, changes in personnel and lack of oversight by the CCG executive team.

Recommendations from the Independent Panel

The independent panel has made a number of recommendations to ensure that:

- the CCG takes its leadership responsibilities seriously
- the national LeDeR processes are more robust
- Learning is taken forward nationally and not continually repeated.

The Derbyshire LeDeR Local Area Co-ordinator reviewed the CCG recommendations to ensure compliance or to identify any gaps in the current processes.

RECOMMENDATIONS & ACTIONS FROM THE INDEPENDENT REVIEW AND THE DERBYSHIRE POSITION

As part of the Derbyshire LeDeR programme we have reviewed the report and recommendations found as part of this independent review against our Derbyshire processes. This has included running a Survey Monkey to see responses/opinions from our Derbyshire reviewers. The table at the end of this report includes all the recommendations from the independent review and which organisation holds responsibility for the recommendation. A rag rating is included to show the Derbyshire position for all those that are CCG or LAC responsibility.

Survey Monkey

The survey was shared with any LeDeR reviewer who had completed a review in the last year or is currently working on a review. This was a total of 12 individuals. Responses were received from 7 individuals and full details are below. The responses received were used to complete the table of recommendations at the end of this report.

Questions & responses

1) Were you allocated a 'buddy' who was experienced in the LeDeR process when you were new to the role of lead reviewer? Yes = 2 (29%) No = 5 (71%)

Additional Comments:

- *I wasn't allocated a 'buddy' but was supported by a colleague who is an experienced reviewer*
- *I did have the support of staff at the CCG (not Derbys) but this was not an official "buddy"*

2) Do you feel as though dedicated time and administrative support is given to reviewers and LACs to undertake complex LeDeRs: Yes = 5 (100%) Skipped = 2 (see last 2 comments below for reason why skipped)

Additional Comments:

- *Administrative support is very good*
- *admin support yes; dedicated time - no*
- *I can't comment as I have not yet completed a complicated review*
- *I work independent of the NHS so this is not as appropriate. I have always had the support I need from the LACs though*

3) Do you feel that the LeDeR process in Derbyshire is transparent, with robust governance and appropriate resources to ensure that each review is properly monitored in terms of procedure and outcomes: Yes = 7 (100%)

Additional Comments:

- *Robust procedures in place*

4) At the onset of a review do you feel as though you have enough support? Yes = 7 (100%)

Additional Comments:

- *Support received and any queries are promptly addressed*

5) Do you have regular, appropriately documented supervision? Yes = 4 (67%) No = 2 (33%) Skipped = 1

Additional Comments:

- *Supervision received through our organisation*
- *This is through our own organisation*
- *I can speak to my LAC any time I want and she always has time for my questions or concerns. She actively tries to help or signposts me. The admin support is brilliant.*

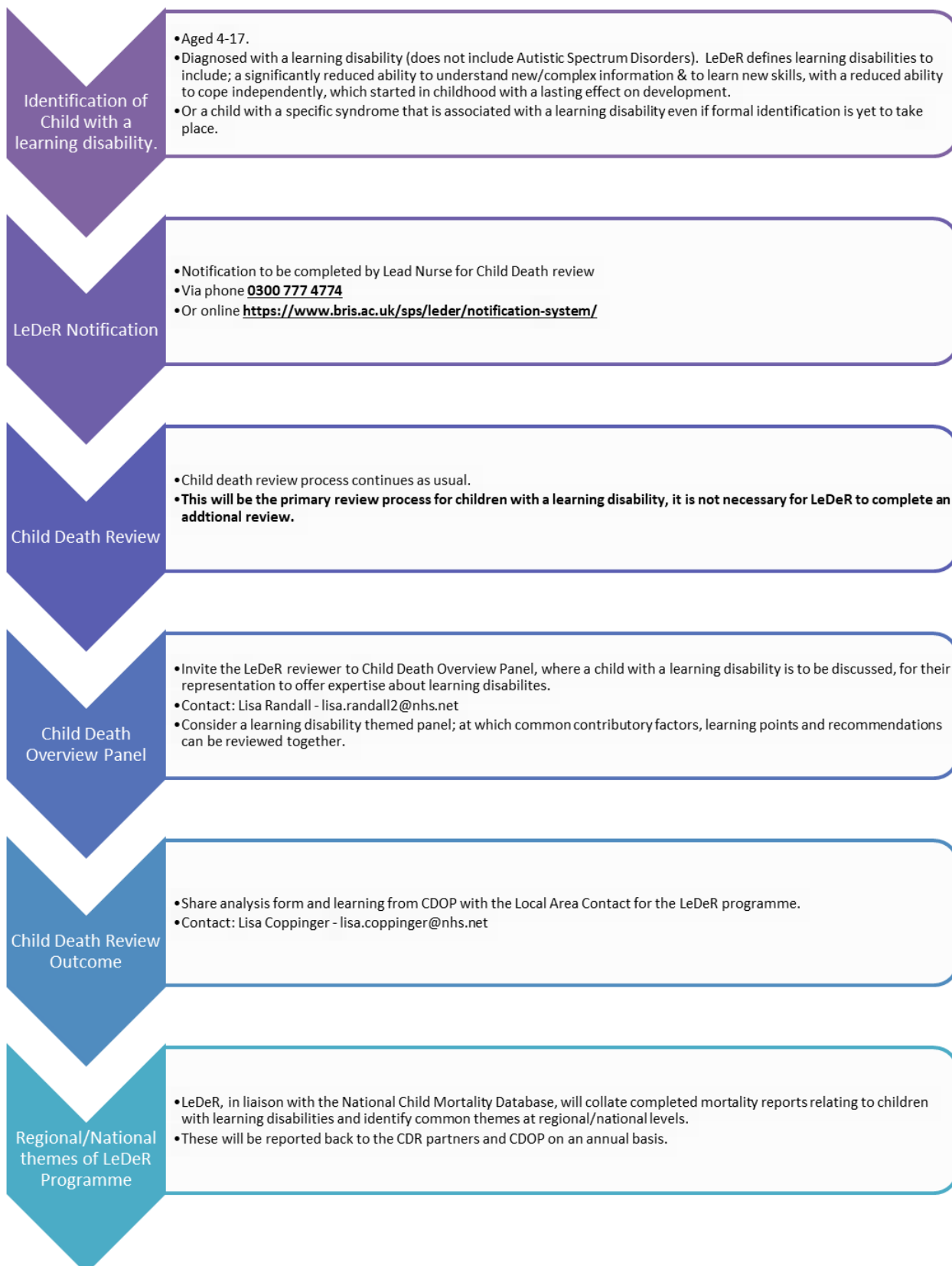
Compliance against the recommendations are as follows:

RECOMMENDATIONS & ACTIONS FROM THE INDEPENDENT REVIEW AND THE DERBYSHIRE CCG POSITION (RAG rated)			
	Recommendations	Action/Responsibility of	RAG
3	All those who are new to the role of lead reviewer, or local area contact (LAC), must be allocated a 'buddy' who is experienced in the LeDeR process.	CCGs	
	Derbyshire LeDeR response to 3 above: At the start of the LeDeR programme we did allocate a main reviewer and buddy to each review. This process was reviewed and discussed at a Derbyshire reviewer training session and a group decision was made, supported by the LeDeR Steering Group, that the buddy process would no longer be a requirement, although available as an option for anyone that wanted to still work in this way. Most reviewers found that it was difficult to complete reviews – arranging meetings with health and social care providers being a particular problem – to agree a suitable date that was acceptable to all, and having a buddy and reviewer just provided an additional person to agree dates with. It was therefore agreed that any new reviewers could have the option to have a buddy if they wanted one. As we now have CCG employed reviewers we now also ask that any new reviewer meets with our CCG reviewers before their first review for training, information sharing and to give the new reviewer an opportunity to ask any questions and/or raise any concerns. Our CCG employed reviewers are available at any time to work with the reviewer and offer any advice, second opinion etc.		

5	Dedicated time and administrative support must be given to reviewers and LACs to undertake complex LeDeRs.	CCGs	
Derbyshire LeDeR response to 5 above: There is a full time administrator currently in post to support the LAC and reviewers. However, this post is on a secondment basis and is currently funded through NHSE monies. Although NHSE have agreed to funding being used to secure this secondment until 31 st March 2022 there is still concern about the future funding of this post.			
9	<p>The LAC and the lead reviewer should confirm at the onset of the LeDeR process how much support is needed and what it should look like.</p> <p>Guidance for reviewers should emphasise that when undertaking a LeDeR, there is an onus on a team responsibility to complete the process to the required standards, rather than it falling to an individual (the lead reviewer, in this case).</p>	LACs and lead reviewers	
Derbyshire LeDeR response to 9 above: Reviewers are supported with a support pack and provided with details of our CCG reviewers who will offer support. Our 2 CCG employed reviewers have regular contact and we run weekly LeDeR meetings to offer support. Once a review is completed it goes through our quality review process where the review is quality assured and actions/next steps are agreed as a team responsibility.			
12	The CCG executive lead for LeDeR will ensure that LeDeRs are completed in a timely and correct manner and will intervene where problems are escalated, such as the inability to obtain critical information from the relevant agencies.	CCGs	
Derbyshire LeDeR response to 12 above: A process is in place to escalate any concerns from the LAC through to the CCG executive lead			
13	<p>When a multi-agency review (MAR) is indicated, it is important that the correct process and outcomes are achieved.</p> <p>It is therefore expected that where the reviewer and the LAC have no previous experience of a MAR, they will seek support from a 'buddy' who does.</p>	LeDeR reviewers and LACs	
Derbyshire LeDeR response to 13 above: The MAR process is seen as a group responsibility and decision to take a review to MAR although originally highlighted in the review by the main reviewer is then agreed at LeDeR CQRG by the group.			

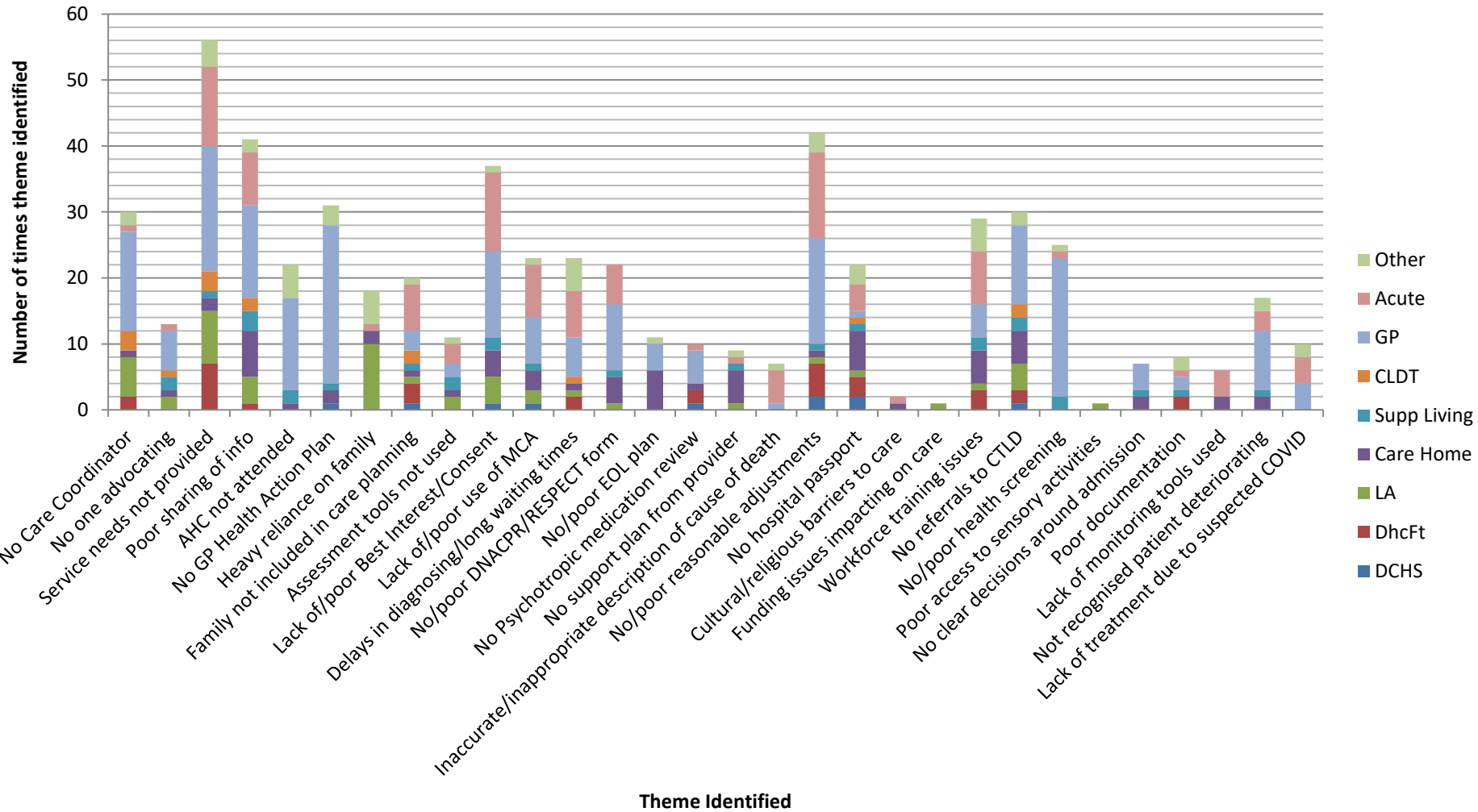
	The MAR process is agreed by the LeDeR team and the reviewer works with the LAC and LeDeR Administrator to agree the steps for the MAR along objectives and required outcomes of the MAR		
15	In regard to the MAR meeting itself, it is recommended that there is action taken to:		
	ensure that families are central to the process, are offered full sight of all documents, and are invited to attend all or part of the meeting as they wish	CCGs	
18	There should be an assurance process with regard to providing regular, appropriately documented supervision for individual LeDeR reviewers.	CCGs	
	Derbyshire LeDeR response to 18 above: CCG employed reviewers have supervision as part of their 1:1s at the CCG. Non CCG employed reviewers who continue have been asked previously about supervision and confirmed this is provided as part of their clinical roles. However, they stated at the time they were happy to use this clinical supervision if needed. Action: This will be re-visited and taken for discussion to the next LeDeR Steering Group		
20	Appropriate support should be available to reviewers, along with strong governance, to ensure that all LeDeR recommendations are robust and actioned in a timely manner, and that lessons learnt are shared nationally.	CCGs	
	Derbyshire LeDeR response to 20 above: All LeDeR reviews and recommendations are taken through our quality process. Actions are agreed and monitored through our Derbyshire LeDeR Action Tracker. The Derbyshire Annual report is shared with NHSE and is available to view by all on the CCG website. Learning is taken from the Bristol LeDeR system and local annual reports and pulled into the LeDeR annual national report by Bristol University/NHSE.		
21	Each CCG must formally undertake and document and review its own systems and processes against the learnings and recommendations arising from Oliver's re-review.	CCGs and ICSS	

Appendix 3 – LeDeR & CDOP Pathway



Appendix 4 – Derbyshire LeDeR Themes Graph

Derbyshire LeDeR Themes - taken from completed reviews 1/4/2020 to 31/3/21



Governing Body Meeting in Public

3rd June 2021

Item No: 067

Report Title	Derbyshire Transforming Care Partnership Annual Report 2020/2021
Author(s)	Helen Van Ristell, Transforming Care Partnership Programme Manager
Sponsor (Director)	Helen Hipkiss, Director of Quality

Paper for:	Decision	Assurance	Discussion	Information	X
Recommendations					
The Governing Body is requested to NOTE the Derbyshire Transforming Care Partnership Annual Report 2020/2021 for information.					
Report Summary					
This is the Annual Report for the Transforming Care Partnership, which summarises the key achievements and challenges of the Transforming Care Partnership in 2020/21, including performance against NHSE&I trajectories and outcomes of funding streams.					
Are there any Resource Implications (including Financial, Staffing etc)?					
No					
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?					
No					
Has a Quality Impact Assessment (QIA) been completed? What were the findings?					
No					
Has an Equality Impact Assessment (EIA) been completed? What were the findings?					
No					
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?					
No					
Governing Body Assurance Framework					
N/A					
Identification of Key Risks					
N/A					

Derbyshire
Transforming Care Partnership
Annual Report 1st April 2020 to 31st March
2021

Derbyshire Transforming Care Partnership

Responsible Committee	
Target Audience:	
Date of Approval:	
Review date:	
Version:	
Document Type	Annual Report (Quality)

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Introduction

The review which followed the Winterbourne View scandal in 2011 identified that too many people with learning disabilities and /or autism were inappropriately admitted to, or stay too long in hospital settings.

In 2015 NHS England published Building the Right Support¹. This plan described how community and inpatient services can support people with mental health conditions, learning disabilities and autism. It stated that children, young people and adults with a learning disability and/or autism have the right to the same opportunities as anyone else to live satisfying and valued lives, and to be treated with dignity and respect. They should have a home within their community, be able to develop and maintain relationships, and get the support they need to live healthy, safe and rewarding lives.

Transforming Care Partnerships (TCP) were developed to lead a programme to improve health and care services so that more people with a learning disability and/or autism can live in the community, with the right support, and close to home. Each TCP identified ways that their local services could be improved so that people with mental health conditions, learning disabilities and autism can be supported to live close to their families and that they are cared for and supported by staff with the right skills.

However, although many people with Learning Disabilities and / or autism have been discharged from hospital to live in the community, others have been admitted in their place so the programme continues.

Derby and Derbyshire Transforming Care Partnership

The Transforming Care Partnership (TCP) across Derby and Derbyshire comprises

of

- Derby and Derbyshire Clinical Commissioning Group (CCG),
- Derbyshire County Council
- Derby City Council
- Derbyshire Community Health Services (DCHS)
- Derbyshire Healthcare NHS Foundation Trust (DHcFT).

Representatives from all of these organisations form the Building the Right Support Delivery Group which reports into the Joined Up Care Derbyshire Mental Health, Learning Disability and Autism Board.

¹NHSE, LGA, ADASS (2015) Building the right support. Available from <https://www.england.nhs.uk/wp-content/uploads/2015/10/ld-nat-imp-plan-oct15.pdf>

Derbyshire TCP Performance Indicators

In-patient trajectory 2020/2021:

	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21
CCG	17	14	14	17
Spec Com – adults	14	14	14	14
CYP	6	6	8	7
Total	37	34	36	38

Actual in-patient numbers:

	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21
CCG	23	32	29	30
Spec Com – adults	14	12	17	18
CYP	8	6	6	3
Total	45	50	52	41

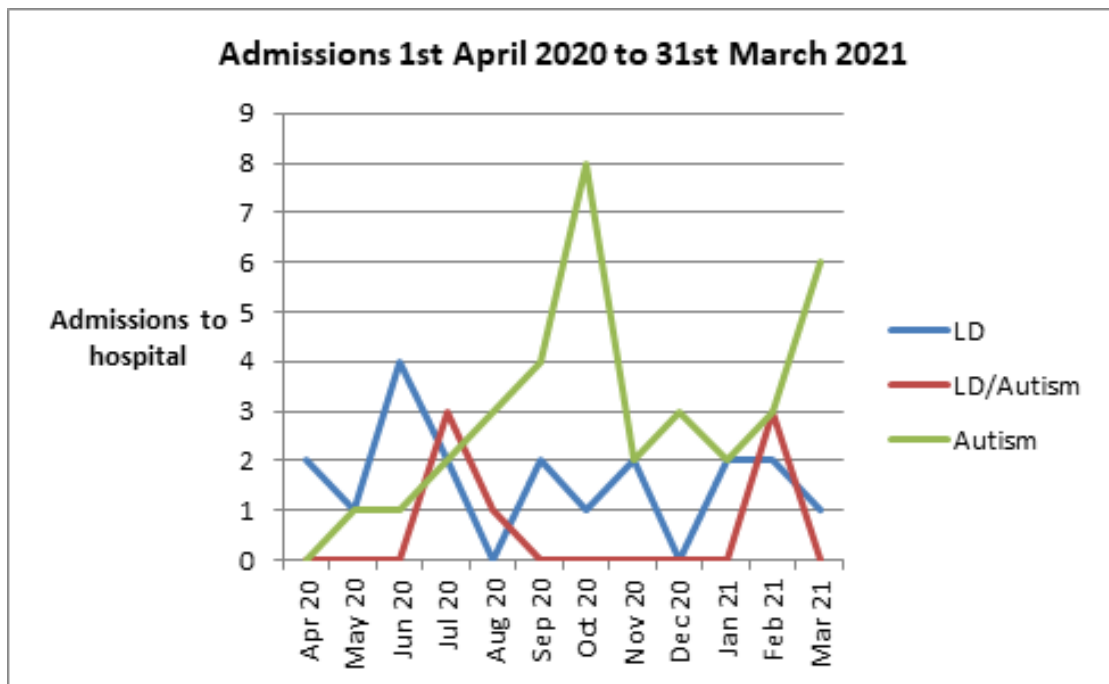
Children and Young People's (CYP) in-patient numbers have decreased during 20/21 and are below trajectory. There has been significant investment in crisis services for CYP this year (see Logic Model diagram) which has had a positive impact on the ability of community services to support children and young people in crisis and a reduction in the level of admissions.

Specialised Commissioning (adults) includes High, Medium and Low secure services and Eating Disorder services. In-patient numbers for these services have increased slightly during 20/21; this was due to Covid restrictions impacting on the transition pathways for discharges for patients and the availability of suitable accommodation and support services in the community. Market development work led by the Local Authorities is increasing the availability of specialist services with three new developments due to open in 2021 and two further projects opening in 2022.

CCG bed numbers include Acute Mental Health hospitals, Assessment and Treatment Units, Psychiatric Intensive Care Units and Locked Rehabilitation Hospitals. There has been an increase in the number of people in CCG beds during 2020/21. This has been the result of different challenges faced by the system. Following a review by the new TCP Programme Manager in September 2020, it was identified that there were five service users in Locked Rehabilitation beds who required inclusion in the TCP cohort. The availability of suitable accommodation was also an additional factor which delayed discharge for some people in CCG beds. Covid restrictions have impacted on both admissions and discharges with delays to people’s transition pathways for discharges and a spike in admissions of people with Autism following both national lockdowns. It has been recognised that a lack of community services for people with Autism has contributed to the increase in acute mental health admissions. Admission Avoidance funds have been utilised to provide interim psychological support for people with Autism. The development of a new community autism offer has been agreed by JUCD MH, LD and A Board and is planned to commence in August 2021.

Admissions

Adult CCG admissions



Review of the admissions data shows that:

- There was a spike in admissions during September (9 cases) and October (16

cases) 2020

- Of these 25 patients, 16 had a diagnosis of autism only (64%)
- At the end of the February 2021 the cohort was at 44 but in one day (3rd March 2021) there were 5 admissions reported. Another 3 patients were added in the same week
- Of these 8, 7 were people with autism only (87.5%)
- The average admission rate for TCP is 5 per month. Without the spikes the rate is 3.3

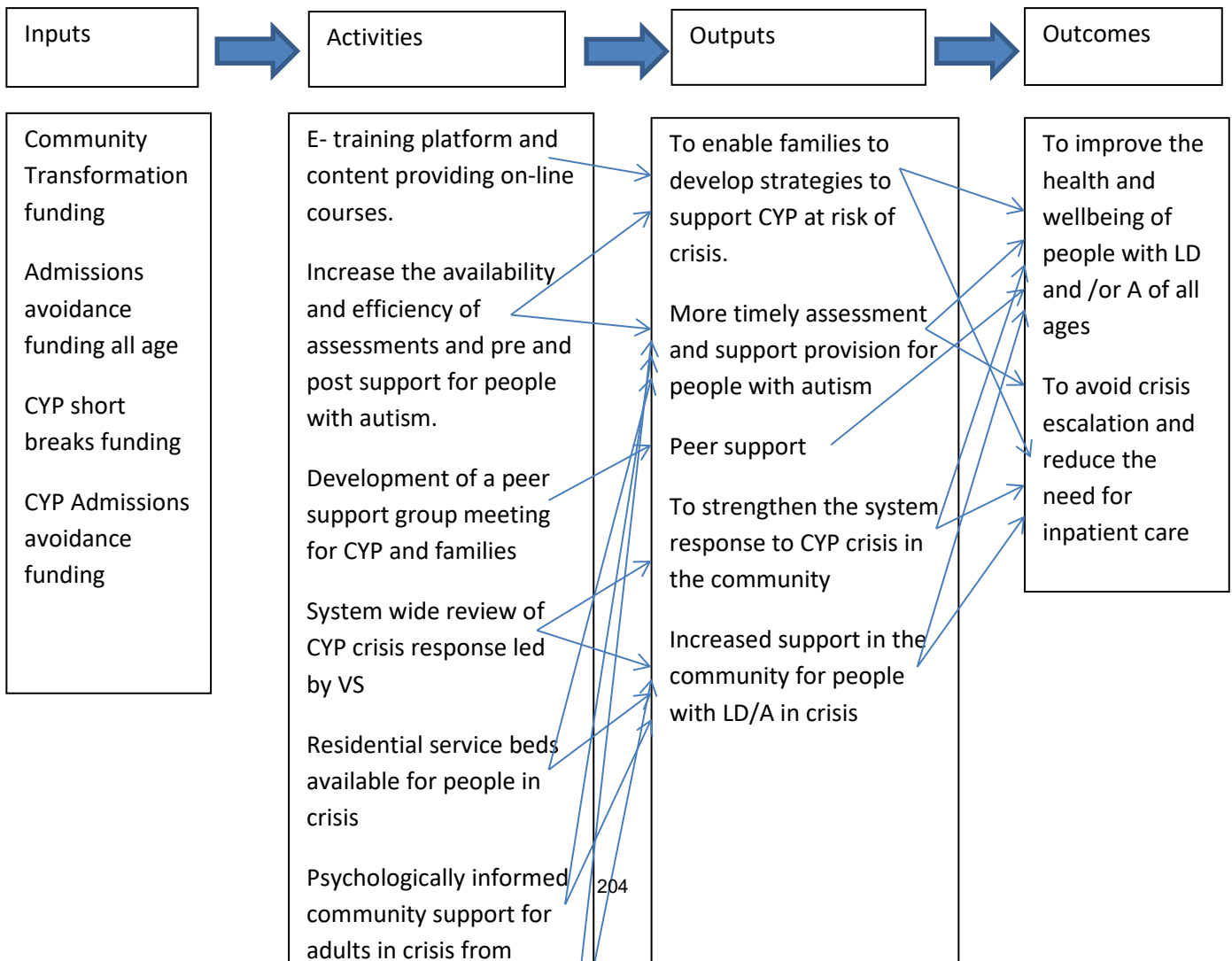
Admission challenges

Admissions for patients with LD has remained low throughout the year, however admissions for people with autism in crisis has spiked twice (October 2020 & February 2021). This is due to limited community crisis services for people with autism, which leads to admission to acute mental health services when people present in crisis.

Admission Avoidance

A number of new systems and processes have been developed and implemented in 2020/2021 to strengthen admission avoidance.

Admission avoidance logic model



The Dynamic Support Register

Working in partnership with locality partners, DDCCG led the development of a Dynamic Support Register which was implemented in December 2020. This is a register of people with learning disabilities and/or A who are deemed at risk of admission to a specialist learning disability or mental health inpatient setting. The DSR aims to reduce admissions of people, with LD and/or A, by providing a forum which encourages partners to work openly and jointly in order to seek alternatives for those people identified as at risk of being admitted to a specialist learning disability and/or autism or mental health inpatient setting.

The DSR has enabled health and social care partners to monitor people who are at risk of admission and to utilise Enhanced Multi-disciplinary meetings (EMDTs), Community Care and Treatment Reviews (CCTRs) and Local Area Emergency Protocols (LAEPs) to provide additional support as an alternative to admission.

CSU Case Managers

Two case managers have been recruited to work with TCP clients, starting in February 2021. The case managers provide additional support for admission avoidance working alongside partner agencies to source additional support and alternative placements as required. This has been particularly valuable supporting social care colleagues working with people with autism in crisis where there is currently no health offer.

Patient story

D is 20 year old young man with learning disability and autism who lives at home with his mum, step dad and siblings. He visits his dad who lives close-by on a regular basis.

D was referred to the Dynamic Support Register as he was demonstrating challenging behaviour, which included being aggressive towards his mum, this was caused by increased anxiety. D was having suicidal thoughts and attempted to jump out of his bedroom window. D's mum was finding it extremely difficult and was struggling to cope with the situation and the constant attention that D needed, she had been off work with long term sickness and was completely burnt out. D relied on

mum for everything and he would just either be in bed or sat on the sofa. He did not engage in helping with household duties, especially at times of anxiety.

D's home environment is extremely busy with lots of people in the household and his community teams were finding it difficult to engage D to carry out all necessary assessments. D had a community CTR, but as his behaviours escalated he became at imminent risk of being admitted to hospital and two Mental Health Act assessments were carried out, both recommended not detainable under the Mental Health Act as he did not need hospital treatment.

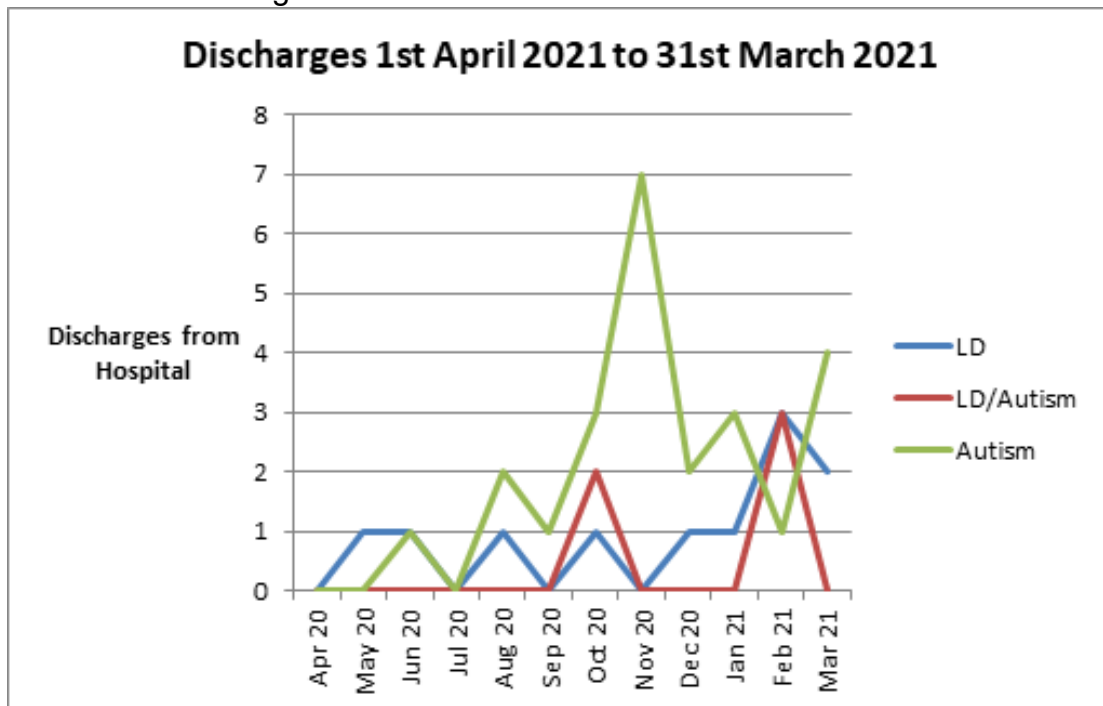
D continued to present with challenging behaviour, aggression, hearing voices and become paranoid. At this time the TCP Senior Commissioner and TCP Case Manager were involved in a number of Enhanced MDTs (EMDTs) to see if any additional support and/or short term 'crisis' placements could help D and his family.

The MDT agreed with D and his family that he would move to a supported living placement to allow his community teams to do necessary assessments. In addition, as D had a history of trauma, a referral to a Third Sector provider of psychologically informed therapy was made, that would work not only with D but with his circle of support i.e. his family and care team.

D has now successfully moved into his own room in a supported living placement. He has settled in extremely well and to date not shown any signs of anxiety, challenging behaviour or aggression since being there. He has started to be involved in household tasks such as doing his own washing and helping his support team to cook meals.

Discharges

Adult CCG discharges:



Review of the discharge data shows that:

- The run rate has improved from 1.5 discharges per month in the first 6 months of

the TCP year to 4.8 for the last 6 months

- Although discharges continued these were people who had been admitted to acute Mental Health beds, the long stay patients remained static
- The discharge rate for all patients has improved and the data shows that people with autism and acute mental illness were discharged rapidly to the community
- However, the re-admission rate for people with autism is high. People with autism settle in hospital are then discharged with limited support and go back into crisis, with subsequent re-admission

Discharge challenges

Covid-19 has impacted directly and indirectly on the discharge plans for six of our cohort.

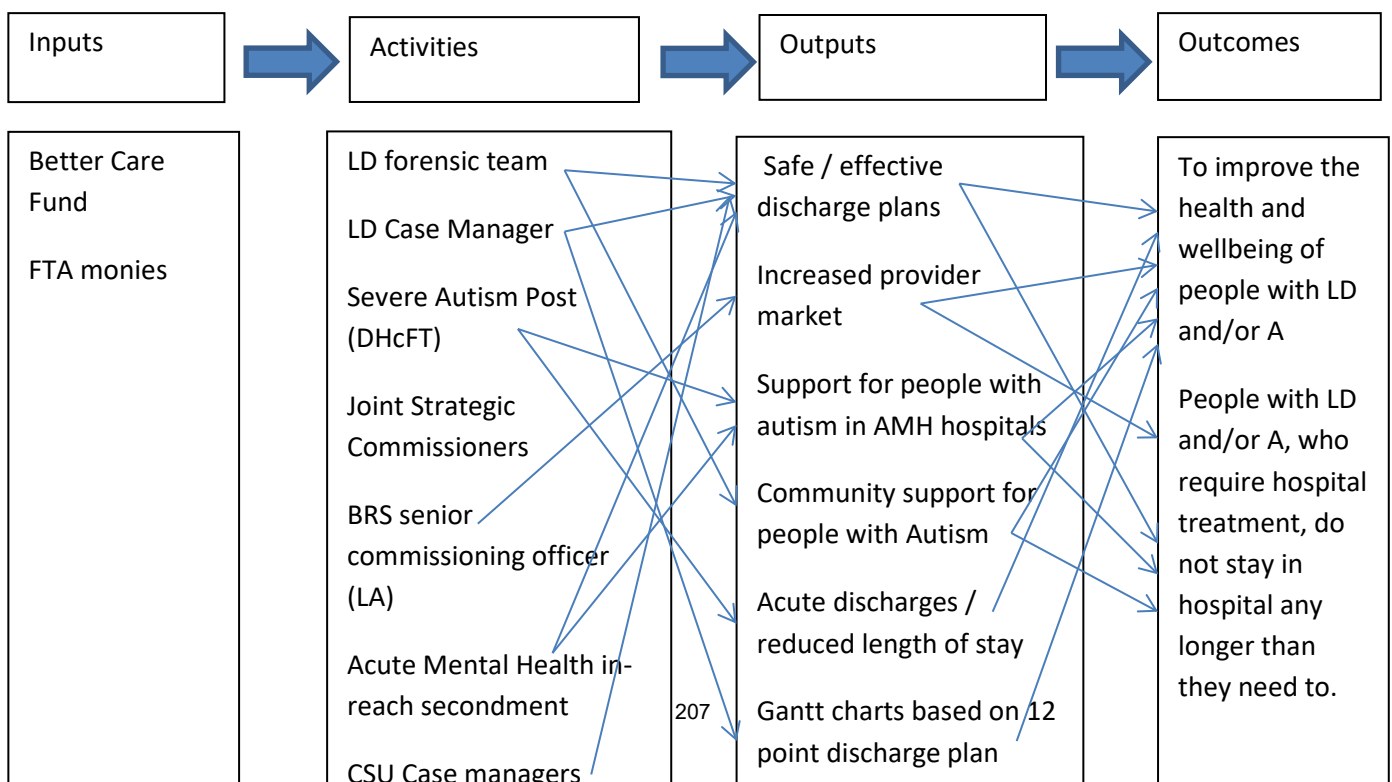
Three patients were due to move into a new supported living bespoke bungalow development in Derby between February and May 2021. However, a number of challenges, including a covid outbreak in the building team and covid restrictions preventing transition visits caused the expected discharge dates to be delayed.

Subsequent planning issues have delayed the opening of the service further and two of these patients are now expected to move in May and June 2021. The third patient has deteriorated in hospital and is not currently ready for discharge.

Two patients, who are detained under the Mental Health Act on Ministry of Justice sections and will require discharge via a Mental Health Review Tribunal, have been delayed due to the covid restrictions impacting on their transition plans.

One patient, who was ready for discharge February 2020, had a provider identified who had agreed they would provide support and accommodation in the community. However, the provider furloughed their accommodation staff from March 2020. This meant that accommodation was not found and the patient remained in hospital. An alternative provider was sourced and this patient has commenced transition and is expected to be discharged to their new home in May 2021.

Discharge Logic Model





Discharge planning

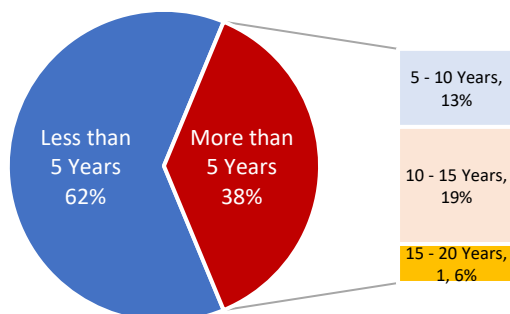
A number of systems and processes have been reviewed, developed and implemented in 2020/2021 to strengthen discharge planning.

The discharge review meeting has been reviewed to provide additional assurance, confirm and challenge with senior management oversight and the introduction of Gantt charts based on the 12 point discharge plans to provide robust estimated discharge dates.

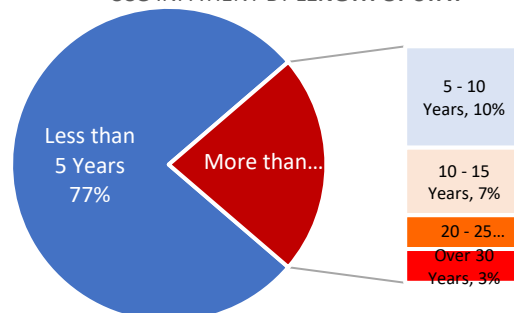
Market development, a work stream led by the BRS senior commissioning officer has mapped current provision and identified gaps. This has led to three new developments, increasing the availability of specialist services, due to open in 2021 and two further projects opening in 2022. Further work is continuing to identify future need and to attract providers into Derby and Derbyshire.

The TCP team have been working with NHSE/I and five other systems in the Midlands region on the long stay patients' network. This network is working to understand the data, to review discharge plans and local ambitions for patients who have been in hospital for five years or more. Currently of the in-patients in Derby and Derbyshire, 23% of patients in CCG beds and 38% of patients have been in hospital for over 5 years.

NHSE INPATIENT BY LENGTH OF STAY



CCG INPATIENT BY LENGTH OF STAY



Patient story

A is a young man with LD and A who was detained on s3 of the Mental Health Act to a locked rehabilitation hospital in June 2020 following a deterioration in his mental health. A was admitted to hospital from an out of area residential service, where he had been living, that was a long distance from his family.

The hospital team worked closely with his community team, including his Case Manager to plan his discharge. The Case manager identified a residential home which is much nearer to family, although out of area for the CCG. A and his mum were able to take a “virtual tour” of the home as Covid restrictions meant they were not able to facilitate visits.

The TCP team and Case manager met with the local TCP commissioners to discuss and agree contingency and crisis plans.

A virtual transition took place, with staff from the new service meeting A via video links and receiving hand over and training from the hospital MDT via Teams meetings.

A was successfully discharged to his new home in January. He has settled in very well and is enjoying visits from family especially his Mum.

Leadership and Governance

During 2020/21 the TCP team within the CCG has undergone a reorganisation, moving from the Commissioning Directorate to the Nursing and Quality Directorate.

The team has also changed with the recruitment of new

- TCP Programme Manager
- Senior Commissioning for Individuals Manager
- Commissioning for Individuals Manager

In addition the team has been supported by the recruitment of a Mental Health in-reach secondment role; this was an interim role to work into the Acute Mental Health Wards to support discharges.

More recently, two CCG Case Managers have been recruited to work within Commissioning Support Unit who will support with admission avoidance work with referrals from the Dynamic Support Register and also to support discharges from the Acute Mental Health wards.

Two Joint Strategic Commissioners for LD and A have been recruited and commenced in role in March 2021. They will be working across health and social care and will strengthen the capacity to commission services for people with LD and/or A. They are currently developing the community autism offer.

NHSE/I support

NHSE/I have provided support for the Derby and Derbyshire TCP programme which has included

- Two half day sessions with an Approved Clinician who is an expert in the

implementation of the Mental Health Act and Mental Capacity Act. These were used for case reviews of legal frameworks to support discharges of people on Ministry of Justice restricted sections.

- 1:1 support for TCP Programme Manager from NHSE/I TCP Lead Nurse
- Deep dives of complex cases without clear discharge plans with NHSE/I TCP Lead Nurse

Covid Vaccinations

5,740 people with Learning Disabilities are eligible for the vaccine in Derbyshire.

	22-Mar-21	29-Mar-21	06-Apr-21	12-Apr-21
% Uptake	82%	87%	90%	91%
Cohort Remaining	1,017	746	567	525

Annual Health Checks

At the end of 2019/2020, Annual Health checks had been completed for 58% of individuals on the GP LD Register. By the end of 2020/21 the aim was for this to be 75% across Derbyshire PCNs. This has been updated following the publication of the Covid Capacity Expansion fund for all practices in Derbyshire to achieve a minimum of 67% as per the national requirement.

	Q1	Q2	Q3	Q4	Total for year	Current %

Phased delivery (Planned)	0	427	1811	1811		
Actual figures*	482	644	1181	2194	4501	78% of total register

*Figures shown are face to face and remote consultations with individualised approach agreed.

LeDeR

100% of notifications received were allocated within 3 months of notification as requested by NHSE/I and 88% of reviews have been completed within 6 months of notification.

The LeDeR Annual Report contains full details of the programme.

As at 17 th March 2021	
Total notifications received	224
Current reviews in progress	16
Current reviews not yet assigned to reviewer	0
Total reviews completed	202
Reviews on hold	6
Reviews going to Multi Agency Review (MAR)	0

Conclusion

2020/21 has been a difficult year for all everyone. The Covid-19 pandemic has affected all areas of society and this has also been true for the TCP cohort. There have been delays in people moving out of hospital and an increase in people with Autism being admitted to acute mental health services in crisis, many of these caused by the Covid restrictions.

There are too many adults with Learning Disability and/or Autism in Derby and Derbyshire being admitted to hospital and staying too long.

However, it is important to acknowledge all of the work the system partners have done to develop resilience in the system following the rise in numbers of CCG in-patients.

This has already led to a reduction in the number of children and young people requiring hospital admission and the system is confident that there will be a significant reduction in adult in-patients in 2021/22. The forecast for March 2022 will be 26 adults in hospital, a reduction of 23 from March 2021.

Next steps

A 3 year road map is being developed by the TCP system partners and will include

- Endorsement of a new 'autism support model' from MH, LD & ASD System Delivery Board.
- Co-design and co-production of a Derby & Derbyshire Learning Disability & Autism Strategy
- 'Phase 1' expansion of the Intensive Support Team to include those people who are autistic but do not have a learning disability.
- 16 units being brought online for TCP, Transitions, those who cannot remain in their current accommodation (Eden Futures, Moorview Care)
- Begin integration of autism into the new Community Mental Health Framework
- Commissioning of 'crisis accommodation' and 'inreach crisis support' to help avoid admission for those people who need urgent care and treatment.
- Commissioning of a community partner to oversee expansion of the third and community sector.
- Engagement across the ICS, including people with a learning disability &/or who are autistic, regarding the 3 Year Road Map
- Strategic Commissioning review of short breaks/respite
- Implementation of a new, improved approach to Children & Young People's Crisis support
- Development and launch of new Neurodiversity Pathway
- Commencement of enhanced 0-25 diagnostic service
- Parental and carer e-learning comes online for those awaiting ASD assessment
- Commencement of CYP crisis inreach service
- Strategic alignment of adults and CYP crisis services

Appendix 1

Acronyms

ASD	Autism Spectrum Disorder
BRS	Building the Right Support
CCG	Clinical Commissioning Group
CCTR	Community Care and Treatment Review
CSU	Commissioning Support Unit
CYP	Children and Young People
DCHS	Derbyshire Community Health Service
DDCCG	Derby and Derbyshire Clinical Commissioning Group
DHcFT	Derbyshire Healthcare NHS Foundation Trust
DSR	Dynamic Support Register
EMDT	Enhanced Multi-Disciplinary Team
GP	General Practitioner
LA	Local Authority
LAEP	Local Area Emergency Protocol
LD	Learning Disability
LD and /or A	Learning Disability and / or Autism
LeDeR	Learning Disabilities Mortality Review

MDT	Multi-Disciplinary Team
NHSE/I	National Health Service England / Improvement
TCP	Transforming Care Partnership
VS	Voluntary Sector

Joined Up Care Derbyshire Board
Minutes of the Meeting held in PUBLIC on
Thursday 15 April 2021 (0900-0955 hours)
Via Microsoft Teams

CONFIRMED

Present:		Designation:	Organisation:	
Lee Outhwaite	LO	JUCD Finance Lead & Director of Finance	Chesterfield Royal Hospital NHSFT	
Helen Phillips	HP	Chair	Chesterfield Royal Hospital NHSFT	
Angie Smithson	ASm	Chief Executive	Chesterfield Royal Hospital NHSFT	
Avi Bhatia	AB	GP & Clinical Chair	Derby & Derbyshire CCG	
Chris Clayton	CC	Chief Executive & ICS Executive Lead	Derby & Derbyshire CCG	
Brigid Stacey	BS	Chief Nurse	Derby & Derbyshire CCG	
Sean Thornton	ST	Assistant Director Communications & Engagement	Derby & Derbyshire CCG JUCD	
Martin Whittle	MW	Chair of the System Engagement Committee	Derby & Derbyshire CCG	
Kath Markus	KM	Chief Executive	Derby & Derbyshire LMC	
Webb, Roy	RW	Councillor	Derby City Council	
Carol Hart	CH	Councillor & Cabinet Member for Health & Communities	Derbyshire County Council	
Helen Jones	HJ	Executive Director of Adult Social Care & Health	Derbyshire County Council	
Tracy Allen	TA	Chief Executive	Derbyshire Community Health Services NHSFT	
Prem Singh	PS	Chair	Derbyshire Community Health Services NHSFT	
Paddy Kinsella	PK	Exec of GP Alliance	Derbyshire GP Alliance	
Ifti Majid	IM	Chief Executive	Derbyshire Healthcare NHSFT	
Phil Cox	PC	Non-Executive Director	DHU Health Care	
John MacDonald (Chair)	JM	ICS Chair	Joined Up Care Derbyshire	
Sukhi Mahil	SKM	ICS Assistant Director	Joined Up Care Derbyshire	
Vikki Ashton Taylor	VT	ICS Director	Joined Up Care Derbyshire	
Gavin Boyle	GB	Chief Executive	University Hospitals Derby & Burton NHSFT	
Kathy Mclean	KMc	Chair	University Hospitals Derby & Burton NHSFT	
In Attendance:		Designation:	Organisation:	Deputy on behalf of/Item No:
Clive Stevens	CS	Bank Porter	Chesterfield Royal Hospital FT	Observing
Parveez Sadiq	PSa	Director Adult Social Care Services	Derby City Council	Deputy for Andy Smith
Ellie Houlston	EH	Assistant Director Adult Social Care & Health (ASCH) & Public Health	Derbyshire County Council	Deputy for Dean Wallace
Richard Wright	RWr	Non-Executive Director	Derbyshire Healthcare NHSFT	Deputy for Caroline Maley
Paul Tilson	PT	Managing Director	DHU Healthcare	Deputy for Stephen Bateman

Jackie Counsell	JC	ICS Executive Assistant	Joined Up Care Derbyshire	Note taking
Linda Garnett	LG	ICS Workforce & OD Lead	Joined Up Care Derbyshire	Item 8
Diane Gamble	DG	Deputy Director of Strategic Transformation, North Midlands	NHS E/I – Midlands	Deputy for Fran Steele
Members of the Public in Attendance:				
Ian Frankcom	IF	Attending as Member of the Public		
Marc Goddard (Part meeting)	MG	Attending as Member of the Public		
Trevor Illsley	TI	Attending as Member of the Public		
Apologies:		Designation:	Organisation:	
Penny Blackwell	PB	Place Board Chair & Governing Body GP	Derby & Derbyshire CCG	
Robyn Dewis	RD	Director of Public Health	Derby City Council	
Andy Smith	AS	Strategic Director of People Services	Derby City Council	
Dean Wallace	DW	Director of Public Health	Derbyshire County Council	
Riten Ruparelia	RR	GP Alliance Provider Representative	Derbyshire GP Alliance	
Caroline Maley	CM	Chair	Derbyshire Healthcare NHSFT	
Stephen Bateman	SB	Chief Executive	DHU Health Care	
Rachel Gallyot	RG	Clinical Chair	East Staffordshire CCG	
William Legge	WL	Director of Strategy & Transformation	EMAS NHSFT	
Pauline Tagg	PT	Chair	EMAS NHSFT	
Fran Steele	FS	Director of Strategic Transformation, North Midlands	NHS E/I – Midlands	

150421/1	Welcome, Apologies and Minutes of Previous Meeting	Action
	<p><i>As per the Agenda, members were reminded that the meeting was being recorded purely for the purpose of minute accuracy.</i></p> <p>The Chair welcomed Board members to the meeting and apologies for absence were noted as reflected above; the meeting was confirmed as being quorate.</p> <p>The Chair welcomed Councillors Carol Hart and Roy Webb who had joined the Board, which was an important adjustment for the JUCD Board membership to help further alignment and reinforce partnership working and to work through the changes required by the White Paper.</p> <p>The minutes of the last meeting held in public on 18 March 2021 were noted to be an accurate record. Today's meeting was confirmed as being held in public.</p>	
150421/2	Action Log	
	VT advised that the 4 live actions on the action log were all future agenda items.	
150421/3	Declarations of Interest	
	<p>The Chair asked for any changes to the Declarations of Interest to be identified in the meeting. The purpose was to record any conflicts of interest and note any other conflicts in relation to the meeting agenda. The Chair asked for his entry to be amended to reflect that with effect from 17th April 2021 he would be stepping down as Chair of Sherwood Forest Hospitals NHSFT and taking up the position of Interim Chair of University Hospitals of Leicester NHSFT for the next year on a secondment basis. ACTION: JC to update DoI.</p>	JC
150421/4	Chair and ICS Executive Lead Update (JM, CC)	
	The Chair noted that in addition to the Chair and Executive Lead Report (<i>previously circulated</i>), the programme of work to the end of the year in order to establish the statutory ICS and build the Health & Care Partnership was going to require a lot of careful	

thought and discussion, with a huge amount of work needed over the next year. There would be some immediate things i.e., appointment to key positions; guidance on the ICS NHS Board; building the Health & Care Partnership MoU; building the system and enhancing all the good work already done on Provider Collaboration at Place/Scale and the Anchor work. He placed on record thanks to all concerned for the excellent work progressed to date on these areas.

It was important moving forward to maintain the good working relationships/partnerships Derbyshire currently had in place. He recognised that there would be some difficult issues and challenging discussions but having good and productive relationships was vital to addressing these. For example continuing to strengthen the bridge between individual organisations and the system; build governance as agile as possible; shape the guidance to how we want to work in Derbyshire; ceasing duplication/looking at different ways of working; and working through challenges together as a system. Having Chairs of three ICSs puts JUCD in a good position learn from others and to share our experiences.

CC highlighted some salient points from the report, around the **Covid position**, i.e., it was important to note that although there had been a decrease in the disease activity, including admissions to hospitals, we should not be complacent. Working within the national parameters and the continuation of the testing programme with local authority partners and the vaccination programme means we are in a targeted/positive position. We now need to consider how to improve non covid disease/activity. In terms of the **Publication of 2021/22 Planning Guidance** it was suggested a mutually convenient extraordinary JUCD Board meeting be arranged in May to review/agree our submission ahead of final submission of the plan. JUCD Board **SUPPORTED** this approach during the meeting. **ACTION: Date/invite to be confirmed.** *Post meeting note: invite issued for 27 May 2021 (1130-1300).*

JC

The Report also highlighted the establishment of the national UK Health Security Agency (UKHSA); progress around planned care, noting there were challenges to work through; the development/progression of the Mary Seacole Local Programme and the local proposals around the Sinfin Cavell Pioneer Centre.

VT gave a brief update on the future role of organisational Governors and discussions held earlier this year with several Governor representatives to explore how they can influence, be involved and engaged in the ICS going forward whilst not forgetting their day jobs. There had been great enthusiasm to be involved and a strong message/opportunity regarding engagement in the emerging Place partnerships, as many were ideally situated to engage most effectively and use their skills/knowledge to support/influence the system in this key area. It was felt that as further national guidance emerges there would be benefit in holding a broad Governors development session, however in the interim further ongoing engagement would continue with VT/JM meeting the group of Governor representatives, plus VT would continue to attend organisation's governors meetings as requested. MW pointed out that the Engagement Committee was fully supportive of this approach and he would be happy to join VT at any organisational Governors meetings. It was noted that the Governors paper (*appendix to Chair's report*) had been written prior to making the decision that we would have 2 Places.

The following key summary discussion points were highlighted:

- DG advised that the current understanding is that the finance plan submission on 6 May is expected to be final not draft.
- It would be helpful to have an aide memoir around Place/definitions (KM)
- Support for the Place based engagement with Governors, would be picked up as the partnership structures develop (TA).

	<ul style="list-style-type: none"> • Chairs to be involved in the next stage discussions regarding the future role of Governors in the ICS, to assist with managing council in organisations (KMc) • It will be important to clarify expectations of Governors and what authority they have in the system, as cannot undertake a statutory role without fully understanding the system (JM) • Consideration should be given on how best to have a multifaceted approach as Governors also have a role around strategy consultation/engagement, i.e., provider collaboration at Place/Scale and patient experience (IM). • A mindset shift was required to ensure we all consider everything going forward (including the role of Governors), as a collective as we are all part of JUCD to help shape the future direction of travel (CC). <p>The Chair thanked the Board for the helpful feedback/observations and gave assurance that discussions with the Governors would continue mindful of the above key discussion points.</p>	
150421/5	Derbyshire System Financial Delivery (LO, RWr)	
	<p>LO gave an update on the 2020/21 out-turn, 2021/22 projections and forward approach, including understanding the legacy covid-19 leaves us with financially. He highlighted that there was a lot going on in the finance agenda with 4 complementary pieces of work ongoing:</p> <p>Workstream 1 – looking at year end/cost pressures/cost based changes underlying efficiency requirements, which results in an underlying system financial pressure challenge of c. £145m, which has taken a considerable amount of time, but we now have a much better common understanding of system finance rather than organisational finance.</p> <p>Workstream 2 - not yet complete, plays into the planning space and impact of H1 (first half of the financial year) funding, which is a different funding regime to H2 (second half of the financial year) and the need to mobilise around the efficiency programme/agree how to deal with risks. Currently working through how the system deals with funding for elective recovery fund, mental health investment standards and primary care developments. In addition, JUCD must be mindful of restoring services with H1 funding, while dealing with the tensions of a tired/exhausted workforce.</p> <p>Workstream 3 - looking at how we work differently in an ICS space which is developmental, considering what the roles will be for: strategic commissioner and Provider Collaboration (PC) at Place/Scale.</p> <p>Workstream 4 - looking at capital and estates planning and core capital affordability and what that means for the system running alongside some of the STP capital.</p> <p>The Board considered the following points:</p> <ul style="list-style-type: none"> • How we define a process to collectively review and challenge cost pressures affordability • Clarify our ambition on efficiency for H2 and ascertain if 3% is deliverable. • If we have “one pot of money” how do organisations, make standalone decisions on committing resources? • Do we have a view on the organisational imperative to “consume own cost pressure smoke”, or regard all savings as a collective challenge once cost pressures are peer reviewed? <p>The following key summary discussion points were highlighted:</p> <ul style="list-style-type: none"> • We are inevitably in a position looking at trade-offs, with a £1m deficit for the ICS in H2 and the long-term strategic objectives. Although we have additional funding for extra services, there is not enough core funding for everyday activities and as such we need c. 6% efficiency savings, creating the need to take some hard decisions (RWr). 	

	<ul style="list-style-type: none"> • The first challenge as a system is for all Board members to fully understand the underlying position. There is a serious financial technical piece of work to undertake to manage the funding and the real challenge will be to think about the demands of the care we need to provide and the resource (including people/estate) needed to enable that delivery, which will be considered further as part of the planning process in May, from this we can then understand the gaps and establish how/what action needs taking (CC). • Need to ensure consistency across all organisations mindful of different systems/ accounting processes and what our shared risk appetite is across the system (JM). • Clarify/develop a methodology for achieving our big organisational/transformational challenges so organisations can sign up to it. We need to be brave and radical and look at how we commit to patient service transformation, prioritisation including tackling health inequalities and balance the money (KMc). • It is unlikely that the elective recovery fund will meet the needs of elective recovery. The need to understand our cost base as a system is an important exercise to undertake collectively to enable an informed conversation with regulators around what a realistic recovery plan looks like (GB). • The importance of speaking with one voice as a system to regulators is paramount (JM). • Equally important to have one voice and clarity for staff, so we are all on the same journey and to look at multi-year/the long-term picture not purely 1 year (ASm). • There is a big 'elective' recovery challenge sitting outside of acute service scope covered by the Elective Recovery Fund and we need to maintain a focus on this (TA). • It was noted that transformation/efficiencies would not happen in 1 year, nor without appropriate investment. There was a need to concentrate on the strategic view and options for a reduction in cost base or different ways of working to mitigate efficiencies (RWr). • The long-term view was important in order to genuinely tackle Health Inequalities and prevention otherwise there was a danger we continue to be reactive (SKM). • There was a suggestion to have 3 or 4 big ticket issues to focus on, which would give a better message/help get public support by engaging with them whilst setting priorities (MW). • The need to find a mechanism and clearly define as a system on cost base, risk appetite and trade-offs, recognising it was a much broader challenge and would be a multi-year financial recovery (LO). <p>ACTION: The Chair asked CC to consider what this means for the Board, the ICS programme of work; to ensure we all own it and not just see it as 'Finance'.</p> <p>The Chair thanked the Finance Committee for all the hard work to date, it was NOTED that it was a very live issue, which would be progressed taking on board the above discussion points through Finance Committee/SLT before coming back to Board.</p>	CC
150421/6	<p>JUCD ICS Board Forward Plan (CC)</p> <p>CC went through the paper (<i>previously circulated</i>), highlighting that the forward plan was an iterative document and there were many things to work through, i.e., PC at Place/Scale; infrastructure; governance of the ICS NHS Board, reporting timelines for Finance/Quality coming back to the Board and what does 'business as usual' look like aligned with developmental sessions.</p> <p>The JUCD Board was asked to:</p> <ul style="list-style-type: none"> • To approve the proposed JUCD Board forward plan. • To note the potential need to modify the agenda, as appropriate based on emerging guidance. <p>The following key summary discussion points were highlighted:</p>	

	<ul style="list-style-type: none"> Although the forward plan nicely laid out activities coming to the Board, consideration should be given to how clinical risk/hot spots can be factored in, for example, Transforming Care Partnerships (TCPs) - IM/CC were carrying the risk on behalf of JUCD, but the whole Board still needed to be aware of it (IM). It was noted that some of the risk would be managed via the system Assurance Subcommittees, i.e., via the Quality Committee, however further consideration will be given to IM's point and total system risk (CC). ACTION: VT to schedule within the JUCD Board forward plan a discussion on the expected Oversight Framework and risk management. Need to ensure as we make big saving efficiencies, that we keep a close eye on quality as well as looking at current risks. In the key milestones we need to review the system risk policy/approach (broader issues) as well as the Quality Committee picking up quality issues/keeping the Board informed (JM). The Oversight Framework was an important document that would confirm what is expected from ICSs/system oversight (PS). <p>The JUCD Board SUPPORTED the forward plan as a live iterative document on the basis that a wider risk management process was built in and quality issues were picked up via the Quality Committee. If Board members had any further comments/observations these should be fed back to VT.</p>	VT
150421/7	For Information	
	No Items.	
150421/8	Any Other Business	
	<p>No items were raised as requiring urgent consideration under AOB. The Chaired thanked the Board for the quality of the papers and meaningful discussion at today's meeting.</p> <p>Key messages to be drafted following the meeting would cover:</p> <ul style="list-style-type: none"> Linking with Health and Wellbeing Boards, towards a statutory Integrated Care System (ICS) Current System Position Understanding our priorities and finances Broadening the input of Governors 	
150421/13	Questions from members of the public	
	No questions had been received from members of the public.	
150421/14	Date of Next Meeting	
	The next formal JUCD Board meeting was scheduled to take place on Thursday 20 May 2021; to be held via MS Teams.	All to Note

MINUTES of a meeting of the **DERBYSHIRE HEALTH AND WELLBEING BOARD** held as a Microsoft Teams Live Event on 01 April 2021.

PRESENT

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

A Appleton	Derbyshire County Council
H Bowen	Chesterfield Borough Council
H Henderson-Spoors	Healthwatch Derbyshire
L Hickin	Bolsover District Council
H Jones	Derbyshire County Council
P Manning	Derbyshire County Council
C Prowse	Tameside & Glossop CCG
J Parfremment	Derbyshire County Council
S Scott	Erewash CVS
A Smithson	Chesterfield Royal Hospital
V Taylor	Derbyshire STP
J Vollar	Derbyshire County Council
D Wallace	Derbyshire County Council
J Wharmby	Derbyshire County Council

Also in attendance – N Richmond (Derbyshire County Council), R Farrand (Derbyshire County Council), K Iles (Derbyshire County Council), and Councillor G Wharmby (Derbyshire County Council).

Apologies for absence were submitted on behalf of C Clayton (DD CCGs), T Slater (EMAs)

01/21 **MINUTES RESOLVED** that the minutes of the meeting of the Board held on 06 February 2020 be confirmed as a correct record.

02/21 **IMPACT OF COVID-19** A presentation had been given from D Wallace to outline the direct and indirect negative impacts Covid-19 had across Derbyshire and to anticipate the future.

HWB Members had been asked to submit questions, comments and insights on the information shared within the presentation, this information would be used as a survey to analyse how data intelligence was used to influence local decision making and review population health and wellbeing in a broader sense.

The original scope was to discover what the anticipated negative effects of COVID-19 measures would be on accumulating unmet need and build-up of morbidity in relation to:

- Healthcare and wider universal and public health service resource restrictions
- Changes in healthcare seeking and lifestyle behaviours
- Broader material, psychosocial and socioeconomic impacts

Data from national datasets had been updated to provide a more recent overview of inequalities, recovery, vulnerable populations and NHS activity. It had been noted that due to the time lag in some data being made available, reporting during the 2020/21 period covering the COVID-19 pandemic had not always been available. Whilst in some instances data was only available at a national level, a number of datasets provided a more local overview.

Due to the wealth of national publications since March 2020, the original studies and reports included in the first version of the presentation remained and had not been updated. Discussions following the latest presentation were anticipated to direct and focus a review of the latest and most relevant reports and studies to best inform future activity at a local level.

The next steps were to assess data and intelligence available across Derbyshire on both negative and positive impacts of COVID-19, with a view to setting the priorities for the local Derbyshire response to restoration and recovery. Review available data and bodies of work conducted during the pandemic by partners, to allow for information and intelligence gaps to be identified and addressed. This would assist in ensuring a robust approach was taken in the coming months and years in the local response to the pandemic. Extend how Derbyshire worked with academic partners. As well as to ensure robust evaluation of local response and continual engagement with local population.

RESOLVED to note the presentation.

03/20 **REFRESH OF THE DERBYSHIRE HEALTH AND WELLBEING STRATEGY** The Derbyshire 'Our Lives, Our Health' Health and Wellbeing Strategy currently shaped the work and actions of the Health and Wellbeing Board and wider system actions. The strategy was scheduled to be reviewed in 2023. The strategy outlined five priority areas of action for improving health and wellbeing across Derbyshire and focused on action to address the wider determinants of health.

A range of factors had come together which suggested that it was appropriate to undertake a review and refresh of the strategy over the next six

months with a view that an updated document was in place by Autumn 2021. In summary these were:

- a) Impact of COVID-19 on the health and wellbeing of the population, both directly and indirectly, which would result in local priorities having to be reshaped to effectively support recovery and the ongoing impact of COVID-19 in communities across Derbyshire.
- b) The launch of the Derbyshire Integrated Care System, which would result in new structures and governance arrangements being introduced which would influence how the health and wellbeing strategy was implemented countywide, at place and via the effective engagement of local Primary Care Networks.
- c) Changes to the Public Health landscape, which included new and emerging structures associated with the creation of the National Institute of Health Protection and disbandment of Public Health England by September 2021.
- d) The opportunity to work with Derby City Council to align or join up the approach to health and wellbeing across both the city and council reflecting the shared health footprint in place for the integrated care system and learning from partnership working via Local Resilience Forum structures throughout the past 12 months.
- e) Opportunities to incorporate emerging themes in the Health White Paper and other strategic documents that were anticipated from the Government in relation to Public Health and Social Care in the local strategy document.

Qualitative insight from engagement with the population of Derbyshire would be drawn from across the system to inform the refresh.

The Board had been asked to agree that further scoping work would take place to consider the strategic developments highlighted above and engagement would take place with Board members to inform the strategy review.

RESOLVED to agree that work should take place over the next six months to revise and refresh the Health and Wellbeing Strategy to consider the impact of and recovery from COVID-19 and reflect other system changes.

04/20 JOINED UP CARE DERBYSHIRE ICS – UPDATE FOR HWB

A presentation had been given by Vikki Taylor to update the HWB on Joined Up Care Derbyshire.

Joined up Care Derbyshire had reaffirmed their purpose for the citizens of Derby and Derbyshire to have the Best Start in Life, Live Well, Age Well and Die Well.

The priorities were for strategic partnership working with a common purpose and single set of outcomes agreed between JUCD STP and broader system partners. As well as, strategic leadership through good governance and ways of working that empowered clinical, professional and managerial teams to transform services for the benefit of the people of Derbyshire whilst ensuring financial sustainability. Strong and vibrant communities and *Places* benefitting from reduced health inequalities informed by the strategic use of intelligence and innovation. As well as the strategic understanding and use of assets; the greatest asset being, Our People, strengthened by the diverse nature of their heritage, culture and experience including Covid-19 recovery: staff welfare and wellbeing.

The aim had been to improve Derby and Derbyshire citizens life expectancy and healthy life expectancy. With the next steps to enable a different ways of working. The revised operating model agreed had been agreed in December 2020, and the implementation was underway.

It had been agreed to replace the previously agreed Risk and Governance Assurance sub-committee by a transition Assurance subcommittee. The function of Transition Assurance subcommittee would be:

- i. Not to second guess work of groups developing proposals but provide assurance and advice to Board that the system as a whole was coherent.
- ii. Provide oversight of move of functions between statutory organisations and assure Board these influence and were consistent with the way the system would operate.
- iii. Advise Board on challenges and risks of White Paper and legislation.

RESOLVED to note the presentation.

05/20 **HEALTH PROTECTION BOARD UPDATE** DW had provided HWB members with an update on the Health Protection Board and Covid-19 Health Protection Board as required under the HWB terms of reference, and the governance structures.

The Health Protection Board met quarterly and then a specific Covid-19 Health Protection Board had been required to meet weekly. Both Boards covered both the city and county jointly and were both co-owned by DW as Director of Public Health at Derbyshire County and RD as Director of Public Health at Derby City.

The original Health Protection Board had one meeting on 07 July 2020 and picked up problems relating to how providers of health services were delivering these safely in a Covid-19 environment. Air quality and how this agenda would be moved across the Joined up Care Derbyshire Board and HWB Board. They had reviewed the outbreaks not relating to Covid-19 across the

County and City to give assurances against infection prevention control and health protection.

The Covid-19 Health Protection Board had been set up to seek assurance that the Covid-19 response across the City and County was providing appropriate specialist technical scientific advice. To support the local outbreak engagement boards, links to the LRF structures, and oversee the outbreak management plan for Covid-19 across the County and City.

RESOLVED to note the information provided.

06/20 **CARE HOME REPORT: SHARING GOOD PRACTICE AND SUGGESTIONS** H Henderson-Spoors presented the report on behalf of Healthwatch Derbyshire with the purpose to share good practice and suggestions within care homes.

HWD decided to gather information to try to understand how the Covid-19 pandemic had affected the wellbeing of care home residents and their relatives and to examine what measures had been introduced to combat these issues. The pandemic had been a particularly difficult time for residents, their friends and family and care home staff. At the same time, HWD were aware of some amazing examples of care and innovation by care homes. The aim of the project was to allow HWD to identify and share these good practice initiatives and helpful ideas across the care home community in Derbyshire.

Between 26th October and 16th November 2020, an online survey was shared with residents of Derbyshire. The survey asked about how the mental and physical wellbeing of care home residents had been affected during the pandemic and about any steps the homes had taken to address these challenges. The survey also asked about contact between relatives and their loved ones and communication between the relatives and the care homes themselves. Respondents were encouraged to share ideas and best practice.

HWD had received 90 responses. Those responses received shared the experiences of spouses, children, extended family and friends of care home residents thus offering a diverse perspective.

The report would be shared with The Strategic Care Home Group which provided guidance and support for the COVID Care Homes Cell on matters such as infection control, agreeing on local interventions needed and to ensure a good quality, safe and effective care home sector in Derbyshire that meets the needs of the local population. Copies would also be provided to the Directors of Public Health for Derbyshire and Derby City, and to the Association of Directors of Public Health nationally. The report would also be shared with Healthwatch England and used to inform national policy.

The findings of the survey had been outlined within the report.

RESOLVED to note the report.

07/20 **NOTE TERMS OF REFERENCE FOR HEALTH AND WELLBEING BOARD** The HWB members had been provided with a written report containing the terms of reference for the Health and Wellbeing Board.

RESOLVED to note the information contained in this report.

08/20 **DERBYSHIRE BETTER CARE FUND 2020-21 PLAN** On 03 December 2020 the Department of Health and Social Care, Ministry of Housing, Communities and Local Government, and NHS England published the Better Care Fund (BCF) planning guidance for 2020-21. The details of allocations of funding for the BCF 2020-21 were made available in February 2020 as per the guidance the planning template was not submitted nationally but agreed locally to ensure the national conditions were met.

A national review of the BCF was due to be undertaken, and therefore any substantial changes to the overall policy and subsequent planning requirements would not be made until this had been completed – likely during 2021, with changes to take effect 2021-2024, however this may be further delayed.

NHS England had published individual Health and Wellbeing Board (HWB) level allocations of the BCF for 2020-21. This included an uplift in contributions in line with CCG revenue growth. The minimum contributions required for Derbyshire from partners for 2020- 21 had been outlined in the report.

The 2020-21 plan had been agreed locally at the BCF Programme Board as per the guidance. The guidance had excluded any requirement to complete a narrative plan for 2021. The Derbyshire 2020-20 BCF Plan was, in effect, a continuation of the 2019-20 plan. The overarching vision and aims of the plan remained the same as established in 2015-16.

The Plan had been developed in conjunction with key partners through the Joint BCF Programme Board and its Monitoring and Finance Group. The final plan had been approved by the Joint BCF Programme Board, a delegated subgroup of the Derbyshire Health and Wellbeing Board (HWB), at its meeting on January 18th 2021, the section 75 was updated in March 2021.

RESOLVED to note (1) the summary of the 2020-21 Better Care Fund Planning Requirements; and (2) the 2020-21 Better Care Fund Plan for Derbyshire.

09/20 **HWB ROUND UP** DW had provided HWB members with a written report containing a round-up of key progress in relation to Health and Wellbeing issues and projects not covered elsewhere on the agenda.

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

10/21 **TERMS OF REFERENCE FOR DERBYSHIRE CHILDREN'S PARTNERSHIP** The HWB members had been provided with a written report containing the terms of reference for Derbyshire Children's Partnership.

RESOLVED to note the information contained in this report.

**MINUTES OF DERBY AND DERBYSHIRE AUDIT COMMITTEE
HELD ON 28 APRIL 2021**

VIA MS TEAMS AT 1.30AM

Present:

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

In Attendance:

Niki Bridge	Deputy Chief Finance Officer
Andrew Cardoza	Director, KPMG
Richard Chapman	Chief Finance Officer
Helen Dillistone	Executive Director of Corporate Strategy and Delivery
Debbie Donaldson	EA to Chief Finance Officer (minute taker)
Darran Green	Associate Chief Finance Officer
Donna Johnson	Head of Finance
Suzanne Pickering	Head of Governance
Kevin Watkins	Business Associate, 360 Assurance

Apologies:

Frances Palmer	Corporate Governance Manager
Tim Thomas	Director, 360 Assurance
Chrissy Tucker	Director of Corporate Delivery

Item No	Item	Action
AC/2021/371	Welcome and Apologies The Chair welcomed members to the Derby and Derbyshire Audit Committee. Apologies were received from Tim Thomas, Chrissy Tucker and Frances Palmer.	
AC/2021/372	Declarations of Interest The Chair reminded Committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG.	

	<p>Declarations made by members of the Derby and Derbyshire Audit Committee were listed in the CCG's Register of Interests and included with the meeting papers. The Register was also available either via the Corporate Secretary to the Governing Body or the CCG's website at the following link:</p> <p>www.derbyandderbyshireccg.nhs.uk</p> <p><u>Declarations of interest from today's meeting</u></p> <p>There were no declarations of interest made.</p> <p>The Chair declared that the meeting was quorate.</p>	
AC/2021/373	<p>Minutes of the Derby and Derbyshire Audit Committee held on 18 March 2021</p> <p>The Minutes of the Derby and Derbyshire Audit Committee held on 18 March 2021 were presented.</p> <p>The Minutes from the Derby and Derbyshire Audit Committee held on 18 March 2021 were agreed and signed by the Chair.</p>	
AC/2021/374	<p>Matters Arising – not elsewhere on agenda</p> <p>There were no further matters arising.</p>	
AC/2021/375	<p>Derby and Derbyshire Audit Committee Action Log</p> <p>The Audit Committee Action Log was reviewed and updated.</p> <p>There were no further actions.</p>	
AC/2021/376	<p>Internal Audit Verbal Update</p> <p>Kevin Watkins reported that there were two pieces of work outstanding from the 2020-21 Plan:</p> <p>DSPT Audit – It was noted that the testing 360 Assurance had done had not identified any concerns, and no major issues were expected to emerge at this time.</p> <p>JUCD decision making piece of work – an early draft had been issued to Lee Outhwaite, Lead Officer, within JUCD. A post audit meeting had been booked with Lee Outhwaite on Friday 30 April 2021 to go through the draft. It was noted that there was a plan for the draft to be more widely considered at the next JUCD Board on 20 May 2021.</p> <p>Kevin Watkins reported that in terms of 2021-22 Plan, meetings had already been arranged with the Executive Team. It was noted that there would be no carry over of work into next year due the demise of the CCG into an ICS. 360 Assurance were focused on timings of audits and getting TORs agreed with the Executive</p>	

	<p>Team. It was hoped that any relevant actions/generic messages/lessons for the future would be taken through to the ICS.</p> <p>The Chair thanked Kevin Watkins for his verbal update.</p>	
<p>AC/2021/377</p>	<p>CCG Draft Annual Accounts 2020-21</p> <p>Richard Chapman introduced Donna Johnson who would be presenting the CCG's Draft Annual Accounts 2020-21.</p> <p>Donna Johnson gave a detailed description of the Annual Accounts through her presentation (attached to these minutes as Appendix A for information).</p> <p>Donna Johnson highlighted the following:</p> <ul style="list-style-type: none"> • The draft Annual Accounts had been reviewed by the CFO, Deputy CFO and Associate CFO. • This year had been extraordinary due to Covid-19 and there had been some large movements. • The accounts had been submitted, along with other documents, to NHSE and KPMG ahead of the national deadline. • No adjustments had been made to the accounting policies since they had been presented to Audit Committee on 18 March 2021. <p>It was noted that the Chair had emailed several questions to Donna Johnson regarding the draft Annual Accounts prior to this Committee, and the answers to these questions had been incorporated into the presentation today.</p> <p><u>Note 6 - BPPC:</u></p> <p>It was noted that the CCG had achieved its 95% BPPC target for non NHS and NHS invoices paid in year. Andrew Middleton was extremely pleased to hear this, but reported that he had recently been informed, to his dismay, that the Sector (Providers) were somewhat adrift of this target. He went on to add that he felt it important that non NHS suppliers should not be waiting for money from the NHS. Andrew Middleton thanked Donna Johnson and her colleagues in the Finance Team for ensuring that this target had been met.</p> <p><u>Note 2 – Operating Revenue</u></p> <p>Jill Dentith referred to the apprenticeship training grants revenue, and asked if the CCG had taken on additional apprentices. Niki Bridge reported that we had not taken on additional apprentices, and explained that this revenue gave the ability for the CCG to apply it to courses to support professional and non-professional training to improve the skills and knowledge of CCG staff.</p>	

Andrew Middleton believed the NHS had a social value duty to use our strength and mass to create work opportunities through apprenticeships, and therefore he would like to see an apprenticeship scheme be firmly established. Helen Dillistone agreed with Andrew Middleton and reported that it was part of the CCG's People Plan to ensure we did support young people from local communities.

Note 4 Employee Benefits:

Andrew Middleton asked whether the CCG recorded and reported gender pay difference anywhere. Helen Dillistone confirmed that this was recorded and reported in the Annual Report.

Donna Johnson reported that a query had been raised in advance of this meeting, to question whether there was a balance in note 4.1.2 for recoveries in 2019/20; whilst note 4.1.1 shows a nil balance. The extract was included here and showed that the two Notes do correspond. The Total column to the right related to 2020/21.

Note 5 – Operating Expenses:

The Chair reported that he had not seen anywhere in the Accounts or in the report a separate single figure for the net incremental cost of Covid; he asked whether anything had come down from NHSE that required us to declare that as part of the report and Accounts? Donna Johnson reported that we had not received any guidance about this from NHSE, and she had specifically looked for it as she felt that we should be disclosing something around Covid in the Accounts. Darran Green confirmed that there was something in the Annual Report that identified that figure which currently stood at £104.5m.

Jill Dentith requested further clarification to the prior year adjustment on premises and NHS Property Services. Donna Johnson reported that this item mainly related to subsidies for non-head quarter properties (eg dentists in a property that when NHS Property Services took over they couldn't afford market value rents and the CCG had, as a consequence, had to subsidise those). It was noted that we had done this for several properties.

Andrew Middleton requested confirmation that the CCG was not responsible for dentistry at the moment, but was required to pay the premises cost of it. Darran Green reported that the CCG had challenged this with NHSE/I; there was a generic rule that if there was vacant NHS premises within the CCG boundaries then it was the CCG's responsibility to pick it up for that limited period of time.

Note 9 – Operating Leases:

Donna Johnson reported that Minimum Lease Payments (MLP) had reduced this year. This related to Property Services revisions in charges for both Scarsdale and Cardinal Square, particularly around the sessional space. This was offset by the increase in

	<p>cost for the new Cardinal Square area compared with the charges for Toll Bar House.</p> <p>Future MLP: only the new wing at Cardinal Square had an agreed lease with a private non-NHS organisation and this ended March 2023, and so only this had been identified.</p> <p>New reprographic equipment contracts had been agreed and these made up the 'Other' category.</p> <p>The footnote to the operating leases explained that whilst we had treated arrangements with NHS Property Services as lease agreements, no formal contract was in place to commit the CCG to future payments and hence these were excluded from the future MLP.</p> <p><u>Note 11.2 Receivables past their due date:</u></p> <p>Donna Johnson reported there had almost been no balances over 6 months, which reflected the key work being carried out to recover debts. 2019/20 balances over 6 months included the £158k invoice with NHS Birmingham and Solihull, which had now been addressed and will be reported to Audit Committee at its next meeting.</p> <p>Andrew Middleton reported that this was a very good position and the Finance Team deserved praise for this.</p> <p><u>Note 14 Provisions:</u></p> <p>Donna Johnson highlighted the obligation to provide Minor surgery to patients who would usually been treated in 2020/21, but were delayed due to Covid. Activity taken for 2018/19 and 2019/20 and compared to 2020/21 had been used to identify the shortfall.</p> <p>The Chair highlighted a typing error in the accounts which referred to 'minor injuries backlog' – this should have read minor surgery backlog. Donna Johnson agreed to take this as an action to amend.</p> <p>Jill Denith referred to Note 14 Provisions, she was keen to ensure that these were activated and not lost for next year, and asked for clarification as to how this would be picked up at the relevant committees. The Chair invited relevant Finance and Governance colleagues to ensure that these provisions were in the correct work plans, and that they would report through to make sure we understood how they would be delivered.</p> <p>Donna Johnson went onto highlight the next steps:</p> <ul style="list-style-type: none"> • The external Audit had commenced on 28 April 2021. • KPMG were hoping to issue the final draft ISA260 report by 21 May 2021. • Audited Accounts – Audit Committee approval 25 May 2021. 	<p>DG</p> <p>DJ</p> <p>DG/HD</p>
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	<ul style="list-style-type: none"> • The General Ledger would re-open after the Audit Committee sometime between 4-9 June 2021. • Confirmation that General Ledger agrees to approved Accounts. • Issue of signed audit opinions • The Audited Accounts and Annual Report would be submitted to NHSE on 15 June 2021. <p>The Chair referred to accruals for staff annual leave due to the pandemic, this had not been featured in the notes for the Annual Accounts. Donna Johnson confirmed that it had not featured in the Notes within the statutory accounts, but the position was in there; there was an increase of £150k this year, the figure was around £330k last year and had gone up to approx. £460k this year as more staff were carrying annual leave.</p> <p>Andrew Cardoza referred to Related Party Transactions, usually KPMG do not see names on other organisations Accounts, they only see titles and organisations; he felt that this was too much disclosure and agreed to speak to Donna Johnson after the meeting about this. Andrew went onto add that a lot of questions that KPMG had about the Annual Accounts had been answered today by Donna's presentation. It was noted that the Audit would be remote as had been last year. Andrew confirmed that it would be a robust Audit and set of Accounts in preparation for the CCG to transfer into a new organisation next year.</p> <p>The Chair thanked Donna Johnson and the Finance Team for their help and assistance in the preparation of the draft 2020-21 Annual Accounts.</p> <p>Audit Committee thanked Donna Johnson for her detailed presentation and for her help in the preparation of the CCG's 2020-21 Draft Annual Accounts, with the assistance of the Finance Team. It was NOTED that the draft 2020-21 Draft Annual Accounts had been submitted to both NHSE and KPMG by the required due date.</p>	
AC/2021/378	<p>Any Other Business</p> <p>There was no further business.</p>	
AC/2021/379	<p>Forward Plan</p> <p>The Chair requested that Accrual Review be added to the Forward Planner for January 2022.</p> <p>Audit Committee NOTED the Forward Plan.</p>	DD

<p>AC/2021/380</p>	<p>Assurance Questions</p> <ol style="list-style-type: none"> 1. Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance 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? Not relevant. 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? No. 7. Is the Committee assured on progress regarding actions assigned to it within the Recovery & Restoration plan? The Audit Chair assured members that each of the responsible corporate committees were issued with the Recovery & Restoration Plan as part of a standard item on their agendas and received regular updates. 8. 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. 	<p>IG</p>
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AC/2021/381	<p>Date of Next Meeting: Thursday 25 May 2021 at 9.30am-12.30pm.</p> <p>Dates for future meetings:</p> <p>Thursday 16 September 2021, 9.30-12.30 Thursday 18 November 2021, 9.30-12.30 Thursday 20 January 2022, 9.30-12.30</p>	
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Signed: Dated:
(Chair)

**MINUTES OF ENGAGEMENT COMMITTEE MEETING HELD ON
16 MARCH 2021 AS A VIRTUAL MEETING VIA MICROSOFT TEAMS
AT 11:15 TO 13:15**

Present:		
Martin Whittle – Chair	MW	Governing Body Lay Member, DDCCG
Beverley Smith	BSm	Director of Corporate Strategy & Development, DDCCG
Helen Dillistone	HD	Executive Director of Corporate Strategy and Delivery DDCCG
Ian Shaw	IS	Governing Body Lay Member, DDCCG
Jocelyn Street	JS	Lay Representative
Karen Lloyd	KL	Head of Engagement, Joined Up Care Derbyshire
Kevin Richards	KR	Public Governor, Derbyshire Healthcare NHS Foundation Trust
Lynn Walshaw	LW	Deputy Lead Governor, DCHS
Margaret Rotchell	MR	Public Governor, CRH
Maura Teager	MT	Lead Governor at University Hospitals of Derby and Burton NHS Foundation Trust
Roger Cann	RC	Lay Representative
Sean Thornton	ST	Assistant Director Communications and Engagement DDCCG and JUCD
Simon McCandlish	SMc	Governing Body Lay Member, DDCCG (Deputy Chair)
Steven Bramley	SB	Lay Representative
Tim Peacock	TP	Lay Representative
Vikki Taylor	VT	ICS Director Lead, Joined Up Care Derbyshire
In Attendance:		
Ilona Davies – Minutes	ID	Executive Assistant to the Executive Director of Corporate Strategy and Delivery, DDCCG
Apologies:		
Ruth Grice	RG	Lay Representative

Item No.	Item	Action
EC/2021/100	<p>WELCOME APOLOGIES AND QUORACY</p> <p>MW welcomed all to the meeting. Apologies were noted as above.</p> <p>MW declared the meeting quorate.</p> <p>MW explained the protocol of virtual meetings.</p> <p>It was noted the meeting was being recorded for the purpose of the minutes and the recording would be deleted once the minutes were approved at the next meeting. This was agreed.</p>	
EC/2021/101	<p>Standing Item: DECLARATIONS OF INTEREST</p> <p>MW reminded Committee members of their obligation to declare any interest they may have on any issues arising at Committee meetings which might conflict with the business of the CCG.</p> <p>Declarations declared by members of the Engagement Committee are listed in the CCG’s Register of Interests and included with the meeting papers. The Register is also available either via the corporate secretary to the Governing Body or the CCG website at the following link: www.derbyandderbyshireccg.nhs.uk</p>	

	<p><u>Declarations of interest from today's meeting</u> No declarations of interest were made.</p>	
EC/2021/102	<p>ENGAGEMENT COMMITTEE TERMS OF REFERENCE REVIEW</p> <p>The Committee reviewed and discussed the Terms of Reference. Following the discussion MW summarised the key points for action.</p> <p>MW summarised the key points discussed.</p> <ol style="list-style-type: none"> 1) Format of Committee's terms of reference to reflect that the Committee is a Derbyshire ICS Committee – to include both logos DDCCG and JUCD and to be called the Derbyshire Engagement Committee. 2) Ensure that the wording within the terms of reference safeguards the CCG's statutory role should there be a need over the next twelve months to refer things to the Governing body; 3) KPIs to be formalised around engagement with a view of creating a routine performance report on communications and engagement that would be reported to the Committee on a regular basis; ACTION: ST 4) Reflect wording that the Committee seeks assurance that all commissioners and providers 'Design health and care services to meet the needs and wants of the people who use them, not the organisations who provide them' as to the Joined Up Care Derbyshire 5 Year Strategy Delivery Plan: 2019/20 to 2023/24. <p>The Engagement Committee AGREED the Engagement Committee Terms of Reference subject to the comments above.</p>	ST
EC/2021/103	<p>REVIEW OF PATIENT AND COMMUNITY ENGAGEMENT IMPROVEMENT AND ASSESSMENT FRAMEWORK (IAF) INDICATOR 2019/20 AND PROPOSALS FOR 2020/21</p> <p>HD presented the paper. The CCG received its results for the NHS Oversight Framework Patient and Community Engagement Indicator on 25 November 2020. The CCG's rating has reduced to Amber – Requires Improvement based on the electronic evidence uploaded; however, the CCG has also produced an annual engagement report which contained detail around engagement and engagement development activities across the CCG but for some reason was not pulled through in the actual system for submitting evidence. This was a learning point for the organisation given the CCG felt they have more evidence to support the areas marked for improvement albeit it accepts there are some gaps and more development.</p> <p>One the gaps that the CCG is committed to work on is around the development of the communications and engagement strategy to ensure that it links with the ambitions of the system and key programmes of work.</p> <p>Another area is around greater focus on health inequalities and the way in which the CCG engages with diverse communities. There have already been some good examples of the work undertaken to date, such as the vaccinations programme.</p> <p>Overall, it was felt that the report provided valuable feedback and it will be taken forward.</p> <p>SMc queried the score the organisation would have achieved had they been</p>	

	<p>able to submit all the evidence available. HD responded that had the CCG submitted the full breadth of evidence, they would expect the regulators' assessment to be higher albeit noting some gaps.</p> <p>SMc suggested seeking benchmarking opportunities and sharing of best practice that NHS England/Improvement may be able to support. HD agreed with this suggestion. ST added that they had already spoken with other systems which have received green* this year such as Leeds CCG and Birmingham and Solihull CCG.</p> <p>IS commented that inequalities can be across the board but can also vary depending on treatment/illness area.</p> <p>MT requested there was more focus on health inequalities in children and young people.</p> <p>The Engagement Committee NOTED AND SUPPORTED the paper and APPROVED the proposed measures to improve the rating for the 2020/2021 submission and move the position from Amber – Requires Improvement in the 2019/20 assessment to Green – Good in 2020/21 and to Green* Outstanding in 2021/22.</p>	
<p>EC/2021/104</p>	<p>DRAFT JUCD COMMUNICATIONS AND ENGAGEMENT STRATEGY – UPDATE</p> <p>ST explained that the work on strategy has been impacted by the pressures of vaccination programme rollout and suggested the next meeting was focused on review of the draft communications and engagement strategy. The Committee agreed with this proposal. ACTION: ST / April's agenda</p> <p>The Engagement Committee NOTED the verbal update.</p>	<p>ST</p>
<p>EC/2021/105</p>	<p>STANDING ITEM: CCG RECOVERY AND RESTORATION</p> <p>BSm brought to the Committee's attention the following key points.</p> <ul style="list-style-type: none"> • The CCG & JUCD communications and engagement teams have had considerable focus on the Covid-19 vaccination programme. This has in effect meant the team has reverted to working in Phase 1 conditions, reactive to the emerging demands of the vaccination programme. • Restoration and recovery activity has therefore been minimal due to capacity constraints • Remaining tasks from the original review will be progressed when capacity allows. <p>The Committee discussed the frequency of this report and suggested pausing it for two months. Should there be anything by exception, this will be brought before the Committee as a separate paper. ACTION: May's agenda (next formal meeting)</p> <p>Further discussion took place on the restoration of services from 23 June 2021 and the impact on how patients use or access the services. HD noted that Quality and Performance Committee and Clinical Care Commissioning Committee would oversee the actions in relation to this in more detail. In the meantime, this will be raised through the Governing Body.</p> <p>ST suggested he would share a recent public briefing with the Committee on that very subject. ACTION: ST</p>	<p>ID</p> <p>ST</p>

	<p>The Engagement Committee</p> <ul style="list-style-type: none"> • NOTED the contents of the report and the actions for Recovery and Restoration described; • PROVIDED comments as noted above. <p><i>Meeting adjourned for a 10 minutes' break.</i></p>	
EC/2021/106	<p>ICS DEVELOPMENT AND WHITE PAPER</p> <p>VT referred to the White Paper released in February 2021, which set out the direction of travel for future NHS and social care reform. VT said that the proposals fit very well with the local plans for Derbyshire.</p> <p>The key points noted were as follows:</p> <ul style="list-style-type: none"> • ICSs are to become statutory entities with effect from April 2022; • CCG statutory functions will transfer into the ICS; • The CCGs will cease to exist. <p>Within Derbyshire there will be an ICS NHS Board established, responsible for overseeing statutory functions currently managed by the CCG. There will be also a requirement for a health and care partnership to support development of plans to address wider health issues. In addition, there is a strong emphasis for collaboration at Place and Scale. It is likely that there will be a Derby City Place and a Derbyshire County Place. Furthermore, there is a strong focus on provider collaboration at Scale, which is looking more broadly than Places e.g. at clinical pathways.</p> <p>VT concluded that it was a significant change for commissioning functions.</p> <p>MW relayed IS's question around organograms and if there was a final structure. VT said she would share the organogram for the agreed interim operational model to oversee transition. ACTION: VT Work is ongoing on the governance structure and the operating model expected from 1st April.</p> <p>HD added that internally within the CCG the working was being undertaken on the statutory functions, which would transfer into the ICS. One of the statutory duties is to engage with patients and public, and a relationship with overview and scrutiny. HD assured the Committee that this function will transfer and the Committee will continue to play an integral role through the transition and once the ICS becomes an NHS body.</p> <p>SMc asked if there was the right level of focus and resources to transition within 1 year in terms of IT continuity, people planning, finance, etc. HD responded that the CCG had had an experience of the merger and prior to that the transfer of PCTs into CCGs. HD confirmed there was a detailed plan of what we expect to transfer to the assigned timescale recognising as the ICS develops there will be more work to do.</p> <p>TP asked for clarification if the citizens of Derbyshire had been given an opportunity to be involved in ICS to present their views. MW said that ICS, the way it has been set up, was encouraging collaboration. VT felt that it was a phenomenal opportunity for the public to be involved, and take a different approach through working with partners collaboratively. VT confirmed the definite date for ICS was from 1 April 2022 however, there is an opportunity to work and get public engagement from now.</p>	VT

	<p>SB felt the proposed two place model might limit how ICS might be able to filter specific needs of specific populations locally. VT confirmed that within the proposal the current eight Derbyshire places would remain but would be renamed as Local Place Alliances to better reflect their local role. The two places will take on the role of coordinating bodies.</p> <p>HD added that ICS is likely to take on other commissioning responsibilities for the whole population and currently CCGs do not commission on that basis.</p> <p>The Committee requested future updates to be provided as the transition goes through from the ICS Board or the CCG.</p> <p>The Engagement Committee NOTED the verbal update.</p>	
EC/2021/107	<p>EVOLVING ROLE OF GOVERNORS IN THE ICS</p> <p>VT introduced the paper, which explores potential opportunities for governors to engage more with the evolving ICS. The paper is intended to start a discussion and seek views from the Committee.</p> <p>The Engagement Committee CONSIDERED the paper and recognised that further work was taking place and feedback will be reviewed as it comes back.</p>	
EC/2021/108	<p>JUCD BOARD – KEY MESSAGES (FOR INFORMATION)</p> <p>The Engagement Committee NOTED the key messages from the JUCD Board.</p>	
EC/2021/109	<p>OUTLINING RISKS FOR 2021/22</p> <p>ST presented the paper for discussion.</p> <p>The current risk was accepted and agreed to keep through the transition process.</p> <p>Further risks presented for Committee's consideration were:</p> <ul style="list-style-type: none"> • The blurring of governance and accountability boundaries as the system makes changes towards possible statutory ICS status from April 2022. • The role of local authority scrutiny becomes blurred during 2021/22 as proposed legislation removes the function, leaving the CCG at exposed risk. <p>The Committee AGREED to keep the current risk through the transition process and REVIEWED and ACCEPTED the proposed risks and rationale for 2021/22 to enable onward development of risk summary forms for review at a future meeting.</p>	
EC/2021/110	<p>Standing item: DDCCG EXCEPTION RISK REPORT</p> <p>It was noted the risk rating remained unchanged due to the CCG being currently at level 4 business continuity escalation, which means that tasks are</p>	

	<p>currently suspended that would affect this risk.</p> <p>The Engagement Committee RECEIVED the Engagement Committee risk assigned to the committee as at March 2021 noting no change.</p>	
EC/2021/111	<p>GOVERNING BODY ASSURANCE FRAMEWORK (GBAF) – STRATEGIC RISK 5</p> <p>ST brought to the Committee's attention the changes in the last quarter highlighted in red. ST proposed no change to the score however, addition of a couple of points in respect of:</p> <ul style="list-style-type: none"> • External controls – Release of ICS White Paper affirms direction for the future; • Internal controls – Significant community engagement to support vaccination programme. <p>The Engagement Committee DISCUSSED and REVIEWED the Quarter 4 (January to March) Governing Body Assurance Framework Strategic Risk owned by the Engagement Committee. The Committee ACCEPTED additional comments and concurred with no change to the score.</p>	
EC/2021/112	<p>MINUTES OF THE MEETING HELD ON 20 JANUARY 2021</p> <p>The Committee accepted the minutes as a true and accurate record of the meeting.</p>	
EC/2021/113	<p>ACTION LOG FROM THE MEETING HELD ON 20 JANUARY 2021</p> <p>The Committee reviewed the action log. Actions were updated and recorded.</p>	
EC/2021/114	<p>ENGAGEMENT COMMITTEE'S FORWARD PLANNER FOR REVIEW AND AGREEMENT</p> <p>The Engagement Committee REVIEWED and AGREED the Forward Planner.</p>	
EC/2021/115	<p>ANY OTHER BUSINESS</p> <p>There was no other business.</p> <p>The Committee discussed future meetings. It was agreed that the next meeting will be held as planned in April focused on Communications and Engagement Strategy.</p> <p>Next formal meeting of the Engagement Committee will be held on 18 May 2021.</p>	
EC/2021/116	<p>FUTURE MEETINGS IN 2021/22 Time: 11:15 – 13:15 NB. The meetings will be held as virtual meetings until further notice. Tuesday 20 April 2021 Tuesday 18 May 2021 Tuesday 15 June 2021 Tuesday 20 July 2021 Tuesday 17 August 2021 Tuesday 21 September 2021</p>	

	<p>Tuesday 19 October 2021 Tuesday 16 November 2021 Tuesday 21 December 2021 Tuesday 18 January 2022 Tuesday 15 February 2022 Tuesday 15 March 2022</p>	
EC/2021/117	<p>ASSURANCE QUESTIONS</p> <ol style="list-style-type: none"> 1. Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? Yes 2. Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? Yes 3. Were papers that have already been reported on at another committee presented to you in a summary form? Yes 4. Was the content of the papers suitable and appropriate for the public domain? Yes 5. Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? Yes 6. Is the Committee assured on progress regarding actions assigned to it within the Recovery & Restoration plan? Yes 7. Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? No 8. What recommendations do the Committee want to make to Governing Body following the assurance process at today's Committee meeting? The Committee gives assurances on the way they engage noting however, that today's meeting was about receiving updates rather than doing the assurance job which is the key role of the Committee. 	
DATE AND TIME OF NEXT MEETING		
Date: Tuesday 20 April 2021		
Time: 11:15 – 13:15		

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

Present:		
Jill Dentith (Chair)	JED	Governing Body Lay Member – Governance, DDCCG
Dr Emma Pizzey	EP	Governing Body GP, DDCCG
Dr Greg Strachan	GS	Governing Body GP, DDCCG
Helen Dillistone	HD	Executive Director of Corporate Strategy and Delivery, DDCCG
Ian Gibbard	ICG	Governing Body Lay Member – Audit, DDCCG
Martin Whittle	MW	Governing Body Lay Member – Patient and Public Involvement, DDCCG
In Attendance:		
Chrissy Tucker	CT	Director of Corporate Delivery, DDCCG
Ged Connolly-Thompson	GCT	Head of Digital Development, DDCCG
Ilona Davies (Minutes)	ID	Executive Assistant to the Executive Director of Corporate Strategy and Delivery, DDCCG
James Lunn	JL	Head of Human Resources and Organisational Development, DDCCG
Lisa Butler	LB	Complaints and PALS Manager, DDCCG (part meeting)
Lisa Farier	LF	Head of Business Intelligence, DDCCG
Lisa Innes	LI	Head of Procurement, NHS Arden and GEM CSU (part meeting)
Ruth Lloyd	RL	Information Governance Manager, DDCCG
Suzanne Pickering	SP	Head of Governance, DDCCG
Apologies:		
Richard Heaton	RH	Business Resilience Manager, DDCCG
Rosalie Whitehead	RW	Risk Management and Legal Assurance Manager, DDCCG

Item	Subject	Action
GC/2021/95	<p>WELCOME, APOLOGIES & QUORACY</p> <p>JED welcomed the members of the Committee to the meeting and confirmed that the meeting was quorate.</p> <p>Apologies were noted and recorded as above.</p> <p>It was noted the meeting was being recorded for the purpose of the minutes and the recording would be deleted once the minutes were approved at the next meeting.</p>	
GC/2021/96	<p>DECLARATIONS OF INTEREST</p> <p>JED reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG.</p> <p>Declarations made by members of the Governance Committee are listed in the CCG's Register of Interests and included with the meeting papers. The Register is also available either via the corporate secretary to the Governing Body or the CCG website at the following link: www.derbyandderbyshireccg.nhs.uk</p>	

	<p><u>Declarations of interest from today's meeting</u> EP and GS declared an interest in respect of item GC/2021/97 Procurement Highlight Report given their involvement in the INR service. The Committee noted that the item was for information rather than decision and therefore agreed that no action was required. The interests will be recorded on the register of interests. ACTION: SP</p> <p>There were no other declarations of interest made.</p>	SP
GC/2021/97	<p>DERBY AND DERBYSHIRE CCG PROCUREMENT HIGHLIGHT REPORT</p> <p>LI presented the report.</p> <p>It was noted that the pandemic impacted commissioned services and contract renewals with potential for further delays. Non-essential commissioning procurement processes have been temporarily suspended including ongoing service reviews and development opportunities however, some business as usual activity has resumed.</p> <p>The following key points were noted.</p> <ul style="list-style-type: none"> • Ophthalmology Review – In progress and progressing as planned. Mini competitions for Cataract, Glaucoma and Wet AMD services will be undertaken by 1 July 2021. Whilst completion date states 31 March 2021, there is a programme in place to support progress in this area. • MSK Triage and Physio Services – Further extension option is planned for these services, currently awaiting Executive approval. • Derby IAPT Service – Twelve months extension has been agreed until March 2022. • Cataracts and Minor Eye Condition Services – Extended until March 2022. • GP Streaming Services – Due to move into the acute contract from 1 April 2021. • Step Down Beds – Temporary extension until 30 April 2021. • High Intensity Users Service – Decommissioned. • Non-emergency Patient Transport Services (NEPTS) – Awaiting confirmation that the Governing Body has approved extension. <p>JED asked for an update on the issues listed in the risk section regarding the impact of Brexit and White Paper discussion, and what needs to be done to manage them. LI responded that a couple of papers were out for consultation at the moment – The Green Paper and Provider Regime for Commissioners. The Arden and Gem Corporate Lead has completed a high level summary of the intentions and proposals. LI will share the papers with the Committee post meeting. ACTION: LI</p> <p>JED queried the services with the completion date of 31 March 2021 and what would happen with those. LI said that three were awaiting commissioner's response with regard to contract extensions and assured the Committee that the progress was being continuously monitored.</p> <p>GS asked if there are any foreseeable challenges for procurement in view of the ICS forming. LI responded that they expected there would be more front end engagement with more market engagement and analysis in determining routes to market. The intention is that the onus is put more on the</p>	LI

	<p>commissioner in terms of how they make their decisions.</p> <p>EP asked if the contracts ending 31 March 2021 would be rolled on or if they needed approval. LI confirmed that some of the services had extensions granted, others are awaiting decisions from Executive team and Governing Body. EP was reassured the procurement rules were being followed.</p> <p>ICG queried if the risks discussed had or needed to be captured on the risk register. CT responded they were not on risk register but will review whether they should be and action accordingly. CT will advise Rosalie Whitehead, Risk Manager to link in with LI with a view of updating the risk register.</p> <p>ACTION: CT</p> <p>The Governance Committee</p> <ul style="list-style-type: none"> • REVIEWED the Highlight report for Derby and Derbyshire CCG; • NOTED status of projects - Pipeline, In progress and Completed; • NOTED the priority status of service; • REVIEWED key issues and activities over the current period. <p><i>LI left the meeting.</i></p>	CT
GC/2021/98	<p>GOVERNANCE COMMITTEE TERMS OF REFERENCE</p> <p>The Governance Committee AGREED the Governance Committee Terms of Reference and NOTED no further changes were required by the Committee. The Committee RECOMMENDED approval of the Terms of Reference to the Governing Body.</p>	
GC/2021/99	<p>POLICIES AND PROCEDURES</p> <p><u>HR POLICIES</u></p> <p>1. FLEXIBLE WORKING POLICY</p> <p>JL informed the Committee that the policy has been updated in line with NHS People Plan requirements.</p> <p>GS queried whether there was a process for checking if the flexible working was working. JL responded that the flexibility reflected agreed working patterns. In addition, the CCG has a process of one to one wellbeing conversations built in for working remotely and as part of that staff have been encouraged to work flexibly around their commitments in order to support wellbeing. There is no formal review process, however, it is now part of the annual review appraisal process, which includes a checking mechanism for work life balance.</p> <p>JED was asked for assurance that when an application is made that consideration is given to the impact on colleagues applying for flexible working patters, others within the team and the impact on the organisation itself. JL confirmed that this formed part of the application process for requesting flexible hours.</p> <p>ICG asked whether the granting of that flexibility was pertinent to the individual's role. JL said that flexibility applied to an individual rather than the</p>	

	<p>post however, it applied to a specific set of circumstances. Therefore, if an individual changed role, they would need to reapply.</p> <p>The Governance Committee were ASSURED re questions asked and assurances provided. The Committee APPROVED the updated Flexible Working Policy.</p> <p>2. LEARNING DEVELOPMENT POLICY</p> <p>It was noted that the policy provides a framework for learning and development and consistent methodology for courses that incur significant costs to ensure equity and fairness in terms of access to career progression and development within the organisation.</p> <p>MW asked whether transition to the ICS should be reflected in this policy in some way. JL felt that at present there was insufficient clarity to amend the policy but noted that discussions about learning and development will be part of the ICS conversation.</p> <p>JED suggested covering transition to ICS as part of supporting conversations when the policy was being launched. JL noted.</p> <p>EP expressed her support of this policy and felt having a unified approach to funding of education rather than it being down to the individual line manager.</p> <p>HD also expressed her support of the policy and agreed with MW that whilst an ICS is unknown quantity at this stage, it was known that the CCG functions would be transferring. MW felt that it was an opportunity to reassure people.</p> <p>CT added that as part of policy implementation there would be training and communication to staff as well as lunch and learn events.</p> <p>GS said that forward thinking comments on transition to ICS should now be standard now for any policy. JED agreed and noted it was a very good point.</p> <p>ACTION: JL</p> <p>The Governance Committee APPROVED the aligned new Learning and Development Policy.</p>	<p>JL</p>
<p>GC/2021/100</p>	<p>BUSINESS CONTINUITY, EMERGENCY PLANNING RESILIENCE AND RESPONSE AND EU EXIT TRANSITION UPDATE</p> <p>SP presented the report on behalf of RH. The CCG is still working at Business Continuity Escalation Level 4.</p> <p>The following key points were noted.</p> <ul style="list-style-type: none"> • The revised Business Continuity Plan and Policy has been posted on the staff intranet and signposted in the staff bulletin. The Policy Implementation Plan has been completed accordingly. • EPRR – Planning for potential flooding had taken place with special attention given to the sites administering COVID 19 vaccine to ensure there was no disruption. 	

	<ul style="list-style-type: none"> • EU Exit – Daily weekday return continues to be submitted to NHS England/Improvement until further instruction, noting that reporting at weekends has been stood down as of last weekend. <p>The Governance Committee NOTED the contents of this report for information and assurance.</p>	
GC/2021/101	<p>CCG RECOVERY AND RESTORATION UPDATE</p> <p>CT informed the Committee that the CCG continued to manage the actions in the report. Until staff are able to move back into the offices, some actions remain outstanding.</p> <p>EP was concerned about managing staff wellbeing. CT confirmed that wellbeing activities were in place across the organisation and line managers were encouraged to have wellbeing conversations with staff. The CCG is flexible and tries to take into account staff needs. In addition, staff have been recently encouraged to take annual leave.</p> <p>HD added that a paper had been taken to the Executive Team looking at annual leave. Whilst the organisation has low levels of sickness, the use of annual leave also remains low. A cohort of staff with 10 days of annual leave remaining was encouraged to take annual leave to ensure they have a break.</p> <p>The Governance Committee NOTED the contents of the report and the actions for Recovery and Restoration described.</p>	
GC/2021/102	<p>COMPLAINTS REPORT QUARTER 3 2020/21</p> <p><i>LB joined the meeting.</i></p> <p>It was noted that there was a rise in complaints in the third quarter, however, 92% of those complaints had been resolved within initial agreed timescales.</p> <p>The main themes are: CHC, concerns about ADHD assessment, process for authorisation of patient transport for out of area, orthotic provider and orthotic service provision, and one about timely access to MOL prior to Christmas.</p> <p>The report details action and learning from those. There were no new referrals to the Ombudsman.</p> <p>MW asked for clarification of the last paragraph on page 99 and if the complaints were the same or the same topics. LB confirmed it was the same themes. MW asked what was being done to address it. LB noted that at the last meeting there was an action on HD to raise with the CHC service. HD confirmed that she had spoken with Brigid Stacey, Chief Nursing Officer, who had picked up the action and feedback to the Governing Body.</p> <p>EP asked if the waiting lists due to COVID resulted in complaints. LB said there had been none, however, queries had been received from patients seeking help or asking for clarification.</p> <p>The Governance Committee NOTED the content of the report and</p>	

	<p>GAINED ASSURANCE from the processes in place.</p> <p><i>LB left the meeting.</i></p>	
GC/2021/103	<p>INFORMATION GOVERNANCE & GDPR UPDATE REPORT</p> <p>RL gave a brief overview of the paper. The following key points were noted.</p> <ul style="list-style-type: none"> • The Control of Patient Information (COPI) notice, which enabled information sharing in response to Covid-19, has been extended to 30 September 2021. • Data Security and Protection Toolkit (DSPT) – NECS provided evidence for the audit and the auditors indicated that the CCG is in a strong position with only a couple of areas of evidence outstanding. Final submission is required by the end of June 2021. • IG Assurance Forum – At their meeting on 23 February 2021 the Forum received the final report of Information Flow Mapping. The forum also reviewed key areas of risk identified to enable a letter of assurance from the SIRO to the Chief Executive Officer. • Move to N365 – National guidance on standards DPIAs has now been received. • Data Security level 1 training is currently at 84% compliance. <p>JED commended RL and the team on the good work in encouraging training and compliance, particularly whilst working remotely.</p> <p>The Governance Committee RECEIVED the update regarding actions and compliance activities and NOTED the letter from the CCG SIRO to Chief Officer regarding the information flow mapping exercise completion.</p>	
GC/2021/104	<p>DIGITAL DEVELOPMENT UPDATE</p> <p>GCT presented the report. The Committee noted the following key points:</p> <ul style="list-style-type: none"> • The CCG is actively involved and is being supported by West Midlands Ambulance Service for the Cyber Essentials and Cyber Essentials Plus work. • The deadline for Cyber Essentials accreditation has now been extended to June 2021. The CCG continues to be accredited up to that point. • Vulnerabilities through unsupported software are being actively managed. The CCG is working with GP practices to remove Windows 7 on old machines. • To support the COVID vaccination programme and other additional work being undertaken by GP Practices, devices from the CCG are being reallocated into Primary Care. • A Cisco ISE system has now been procured and will assist the CCG in managing the physical connectivity of third-party devices onto the clinical network, thereby allowing the CCG to discharge their responsibilities under the current GP IT Operating Model. • Cyber security continues to be monitored and improve. • Mobile device management solution has started to be deployed across all mobile phones within the CCG. • The risk register remains unchanged at this point in time in relation to digital development issues. 	

	<ul style="list-style-type: none"> Internal conversations and discussions with system partners around NECS transition year 4 and year 5 have commenced with a view to moving to shared working and shared understanding. <p>MW queried the difference between video and online consultations. GCT clarified that online consultation was a submission of a form whilst video consultations were via a secure link to have a one to one discussion.</p> <p>MW also asked if any work in terms of web hosting considered future transition to ICS to avoid repeating the work and costs in 12 months' time. GCT assured the Committee that the contract allowed the PCN and GP practice websites to be novated into the ICS system.</p> <p>ICG asked if there were foreseeable issues regarding funding of IT. GCT said that there was dedicated PCN IT funding however, if there was to be a requirement for large amounts equipment there could be issues with the supply chain. Traditionally, the CCG has received most of the IT funding as capital to allow us to purchase equipment, perpetual software licences, etc. However, starting with Microsoft Office 365 we are now seeing more costs start to appear as revenue as we move more towards different ways of providing access to software and services, but the capital/revenue split for funding has not changed. This will hopefully be addressed in the next round of BAU and Digital First Primary Care funding, but we have yet to receive information on those allocations for the current financial year.</p> <p>GS felt assured about hardware, however, asked if discussions had commenced about interacting between systems. GCT confirmed that interoperability was on the agenda at Derbyshire Informatics Delivery Board and Heads of IT meeting, and that system partners were starting to look at how the tools they have can be best used to interact across systems and bridge any gaps.</p> <p>The Governance Committee RECEIVED the comprehensive IT update report for the Corporate and GP estates and NOTED assurances given in the paper.</p>	
GC/2021/105	<p>RISK REGISTER REPORT</p> <p>SP presented the updated risk report for RW. Risk 10 has been reduced in risk score following virtual approval on 28 January 2021.</p> <p>The Governance Committee RECEIVED the Governance risks assigned to the committee as at 28 February 2021; and NOTED the decrease in score for risk 10, relating to business continuity, approved virtually on 28 January 2021.</p>	
GC/2021/106	<p>HEALTH AND SAFETY REPORT</p> <p>SP presented the report for RH. The key points in respect of health and safety activity were noted as follows:</p> <ul style="list-style-type: none"> The Government's roadmap out of lockdown has been assessed and the implications for the CCG have been relayed to staff via regular, weekly Team Talk discussions. Work has been ongoing on the new ways of working and continuity of 	

	<p>home working.</p> <p>EP asked how health and safety was being managed by the CCG in an uncontrolled environment whilst staff are working from home. EP was concerned that some people might experience issues as a result of poor working conditions whilst working from home. SP replied that all employees are encouraged to do DSE assessments and the module has now been added to mandatory training on ESR. Risk assessments have been undertaken and if necessary staff had collected chairs and additional equipment from work.</p> <p>The Governance Committee</p> <ul style="list-style-type: none"> • RECEIVED ASSURANCE that NHS Derby and Derbyshire CCG is coordinating work to meet its health and safety obligations to remain compliant with health and safety legislation; • RECEIVED ASSURANCE that Derby and Derbyshire CCG is responding effectively and appropriately to the changes in working practices as a consequence of the COVID-19 pandemic. 	
GC/2021/107	<p>NON-CLINICAL ADVERSE INCIDENTS</p> <p>There were no non-clinical adverse incidents.</p>	
GC/2021/108	<p>MINUTES OF THE MEETING HELD ON 21 JANUARY 2021</p> <p>The Governance Committee APPROVED the minutes of the meeting on 21 January 2021 as a true and accurate record of the meeting.</p>	
GC/2021/109	<p>MATTERS ARISING</p> <p>None.</p>	
GC/2021/110	<p>ACTION LOG FROM THE MEETING HELD ON 21 JANUARY 2021</p> <p>The Governance Committee REVIEWED the action log. Actions were updated and recorded.</p>	
GC/2021/111	<p>GOVERNANCE COMMITTEE FORWARD PLANNER 2021/22 (FOR DISCUSSION/AGREEMENT)</p> <p>The Governance Committee REVIEWED and AGREED the Forward Planner.</p>	
GC/2021/112	<p>ANY OTHER BUSINESS</p> <p>HD informed the Committee that a proposal was being considered by the CCG to support one of the system partners by allowing them to utilise premises at Cardinal Square on a short term basis. Committee members thought that some that staff might feel threatened by the reduction in space and might need further assurance.</p> <p>HD provided assurance that this space is not currently being used by the CCG. The formal proposal will be shared with the Committee to seek</p>	

	<p>approval in due course. There were no further items of any other business.</p>	
GC/2021/113	<p>FUTURE MEETINGS DATES Time: 13:00 – 15:00 <i><u>NB. The meetings will be held as virtual meetings until further notice.</u></i> FUTURE MEETING DATES</p> <p>Thursday 20 May 2021 Papers due: Tuesday 11 May 2021</p> <p>Thursday 22 July 2021 Papers due: Tuesday 13 July 2021</p> <p>Thursday 23 September 2021 Papers due: Tuesday 14 September 2021</p> <p>Thursday 11 November 2021 Papers due: Tuesday 2 November 2021</p> <p>Thursday 10 February 22 Papers due: Tuesday 2 February 2022</p> <p>Thursday 24 March 2022 Papers due: Tuesday 15 March 2022</p>	
GC/2021/114	<p>ASSURANCE QUESTIONS</p> <ol style="list-style-type: none"> 1. Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? Yes 2. Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? Yes 3. Were papers that have already been reported on at another committee presented to you in a summary form? Yes 4. Was the content of the papers suitable and appropriate for the public domain? Yes, being mindful of procurement report content. 5. Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? Yes 6. Is the Committee assured on progress regarding actions assigned to it within the Recovery & Restoration plan? Yes 7. Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? No 8. What recommendations do the Committee want to make to the Governing Body following the assurance process at today's committee meeting? Yes – two HR policies approved and general update. <p>JED closed the public session of the meeting.</p>	

MINUTES OF PRIMARY CARE COMMISSIONING COMMITTEE

PUBLIC MEETING

HELD ON

Wednesday 28th April 2021

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

PRESENT

Ian Shaw (Chair)	IS	Lay Member Derby & Derbyshire CCG
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
Jill Savoury	JS	Assistant Chief Finance Officer DDCCG
Marie Scouse (part of Meeting)	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
Kath Markus	KM	Chief Executive Derby & Derbyshire LMC
Jean Richards	JR	Senior GP Commissioning Manager DDCCG
Pauline Innes	PI	Executive Assistant to Dr Steven Lloyd

APOLOGIES

Niki Bridge	NB	Deputy Chief Finance Officer, DDCCG (for CFO)
Richard Chapman	RC	Chief Finance Officer Derby & Derbyshire CCG
Clive Newman	CN	Director of GP Development Derby & Derbyshire CCG
Adam Norris	AN	Service Commissioning Manager Public Health, Derbyshire County Council
Brigid Stacey	BS	Chief Nurse Derby & Derbyshire CCG

ITEM NO.	ITEM	ACTION
PCCC/2021/86	<p>WELCOME AND APOLOGIES</p> <p>The Chair (IS) welcomed Committee Members to the meeting and introductions took place. Apologies were received and noted as above.</p> <p>The Chair confirmed that the meeting was quorate.</p>	
PCCC/2021/87	<p>DECLARATIONS OF INTEREST</p> <p>The Chair informed members of the public of the committee members' obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG.</p> <p>Declarations declared by members of the Primary Care Commissioning Committee are listed in the CCG's Register of Interests and included within the meeting papers. The Register is also available either via the corporate</p>	

	<p>secretary to the Governing Body or the CCG website at the following link:</p> <p style="text-align: center;">www.derbyandderbyshireccg.nhs.uk</p> <p>There were no Declarations of Interest made.</p> <p>The Chair declared that the meeting was quorate.</p>	
FOR DECISION		
	No items for Decision	
FOR DISCUSSION		
	No Items for Discussion	
FOR ASSURANCE		
PCCC/2021/88	<p>FINANCE UPDATE</p> <p>Jill Savoury (JS) presented an update from the shared paper.</p> <p>This Finance Report for M11 was presented at the April 2021 Governing Body meeting.</p> <p>The Primary Care Commissioning Committee is asked to NOTE the following key points in the Governing Body report:</p> <ul style="list-style-type: none"> • The month 11 year to date position • The temporary financial regime in place • The scenario model showing ongoing work in respect of full year outturn positions • The highlighted risks and mitigations <p>The M12 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 May 2021 meeting.</p> <p>The Primary Care Commissioning Committee RECEIVED and NOTED the update on the CCGs financial position for month 11.</p>	
PCCC/2021/89	<p>RISK REGISTER EXCEPTION REPORT</p> <p>Hannah Belcher (HB) presented an update from the shared paper.</p> <p>As at April 2021, Primary Care Commissioning Committee are responsible for 2 Primary Care Commissioning risks, with both of these risks rated very high (red).</p> <p>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.</p> <p>April update:</p> <ul style="list-style-type: none"> • There are no changes to the existing levels of risk for this month. • NHSE/I have advised that the COVID capacity expansion fund will continue until the end of September 2021. 	

	<ul style="list-style-type: none"> • QOF income protection is withdrawn with effect from April 2021. <p>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.</p> <p>April update:</p> <ul style="list-style-type: none"> • GP services are moving towards recovery and restoration including the reinstatement of CQC inspections. • The risk will continue to be reviewed and amended as required. <p>The Primary Care Commissioning Committee RECEIVED and NOTED the update on the two outstanding risks.</p>	
FOR INFORMATION		
	No items for information	
MINUTES AND MATTERS ARISING		
PCCC/2021/90	<p>Minutes of the Primary Care Commissioning Committee meeting held on 24th March 2021</p> <p>The minutes from the meeting held on 24th March 2021 were agreed to be an accurate record of the meeting.</p>	
PCCC/2021/91	<p>MATTERS ARISING MATRIX</p> <p>There are no outstanding actions on the Action Matrix.</p>	
PCCC/2021/92	<p>ANY OTHER BUSINESS</p> <p>There were no items of any other business</p>	
PCCC/2021/93	<p>ASSURANCE QUESTIONS</p> <p>Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? Yes</p> <p>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</p> <p>Were papers that have already been reported on at another committee presented to you in a summary form? Yes</p> <p>Was the content of the papers suitable and appropriate for the public domain? Yes</p> <p>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</p> <p>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</p> <p>Is the Committee assured on progress regarding actions assigned to it within the Recovery & Restoration plan? N/A</p> <p>What recommendations does the Committee want to make to Governing Body following the assurance process at today's Committee meeting? None</p>	

	DATE AND TIME OF NEXT MEETING	
	Wednesday 26th May 2021, 10:00-10:30am via Microsoft Teams Meeting	

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

Present:		
Dr Buk Dhadda (Chair)	BD	Chair, Governing Body GP, DDCCG
Kath Bagshaw	KB	Deputy Medical Director
Niki Bridge	NB	Deputy Director of Finance
Jackie Carlile	JC	Head of Performance and Assurance -DDCCG
Craig Cook	CC	Deputy Director of Commissioning
Alison Cargill	AC	Asst Director of Quality, DDCCG
Simon McCalandish	SMcC	Lay Member, Patient Experience
Sarah MacGillivray	SMacG	Head of Patient Experience, DDCCG
Dan Merrison	DM	Senior Performance & Assurance Manager, DDCCG
Andrew Middleton	AM	Lay Member, Finance
Hannah Morton	HM	Healthwatch
Suzanne Pickering	SP	Head of Governance-DDCCG
Dr Emma Pizzey	EP	GP South
Dr Greg Strachan	GS	Governing Body GP, DDCCG
Dr Merryl Watkins	MWa	Governing Body GP, DDCCG
Martin Whittle	MW	Vice Chair and Governing Body Lay Member, Patient and Public Involvement, DDCCG
Helen Hipkiss	HH	Deputy Director of Quality - DDCCG
In Attendance:		
Jo Pearce (Minutes)	JP	Executive Assistant to Chief Nurse, DDCCG
Apologies:		
Brigid Stacey	BS	Chief Nurse Officer, DDCCG
Laura Moore	LM	Deputy Chief Nurse, DDCCG
Helen Wilson	HW	Deputy Director Contracting and Performance - DDCCG
Steve Lloyd	SL	Medical Director - DDCCG
Zara Jones	ZJ	Executive Director of Commissioning Operations, DDCCG
Dr Bruce Braithwaite	BB	Secondary Care GP

Item No.	Item	Action
QP2122 /001	<p>WELCOME, APOLOGIES & QUORACY</p> <p>Apologies were received as above. BD declared the meeting quorate.</p>	
QP2122 /002	<p>DECLARATIONS OF INTEREST</p> <p>BD reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG.</p> <p>Declarations declared by members of the Quality and Performance Committee are listed in the CCG's Register of Interests and included with the meeting papers. The Register is also available either via the corporate secretary to the Governing Body or the CCG website at the following link: www.derbyandderbyshireccg.nhs.uk</p> <p><u>Declarations of interest from sub-committees</u> No declarations of interest were made.</p> <p><u>Declarations of interest from today's meeting</u> No declarations of interest were made.</p>	
	<p>BD confirmed that the meeting will be conducted in a more abbreviated form. Some of the papers have been listed on the agenda for information only and Committee members were asked to submit questions relating to the papers before the meeting. Responses to the questions were circulated to the Committee members prior to the meeting and are included within these minutes.</p>	
QP2122 /003	<p>Integrated Report</p> <p>Performance</p> <p>The paper was taken as read and the Committee were asked for any further questions.</p> <p>BD referred to the question raised prior to the Committee for which responses had been provided.</p> <p>Q. There are four times as many 52WWs at UHDB as compared with CRH. Is the difference pro-rata to patient populations, or are there issues of staffing, leadership and management, accommodation, etc.?</p>	

A. UHDB is a much larger hospital than CRH with a much larger bed base. Before the pandemic there were 74% more patients on an incomplete pathway at UHDB which gives an idea of the difference in size (currently 71% more). There are also several different specialities that are treated at UHDB but not at CRH e.g., Hand Surgery (T&O), Bariatrics (East Midlands centre), Plastic surgery, cardiothoracic surgery, neurology, and geriatric medicine. Some of these specialities, e.g., Bariatrics, hold a large number of lower priority patients who would be expected to be delayed for longer while cancer and higher priority patients are prioritised.

Q. The report highlights the concern of potentially un-diagnosed cancer patients, in respect of secondary care. Could this also be an issue of patients not presenting to GPs?

A. It has been estimated by the regional team that there are around 5,000 less cancer referrals across Derbyshire over the last year, and as there has been a 3% year on year increase previously on cancer referrals there are a lot of patients who have yet to be seen. Not all these referrals would result in a cancer diagnosis but there are still a number that may not have been picked up, whether through patients' reluctance to go and see their GP or other reasons.

There is to be a complete clinical audit of 2Ww referrals to understand the reduction by tumour site and geographic area and to address the issues linked to the pandemic.

In addition, 7% of patients referred through the "urgent" route, although not initially thought to be cancer have been found to have cancer. There is also a large backlog of screening patients who have yet to be seen. It is estimated that around 10% of those patients seen as a screening referral would result in a cancer diagnosis.

The issue is not only in relation to cancer referrals – it is also linked to "routine" referrals. Although the 2Ww and urgent are now starting to be back to pre-COVID levels, routine referrals are still not showing the same referral rate as before the pandemic. A percentage of patients referred as routine may also be found to have cancer once diagnostics are completed. These issues are affecting all areas of the UK and Derbyshire is working within the East Midlands Cancer Alliance to fully size the problem and identify remedial actions to address this.

JC confirmed that a paper is due to be presented to UHDBFT Trust Board around the difficulties in performance during the last year.

Action - JC has permission to share the paper with Quality and Performance Committee members once it has gone through UHDBFT Trust Board.

	<p>EP raised a point around EMAS performance, noting the report states the figures are close to targets however this is different to what is being experienced in reality.</p> <p>EP also commented on the fact that Consultant Connect is not available for general surgery and asked if there were any plans to put this service in place. CC responded to say that there is a piece of work being undertaken to look at better coverage in the use of consultant connect and to expand the scope of the consultant.</p> <p>Activity</p> <p>CC presented the Activity report and noted the areas of focus.</p> <p>In terms of elective activity, over the next 6 months the system is prioritizing P2 and P3 patients on the waiting list. This equates to approx. 4,000 patients across both acute trusts. The current planning ambition is to reduce this cohort to pre-Covid levels by the end of September 2021.</p> <p>Referring to urgent care, CC highlighted the importance of perspective, and explained that whilst there are reports of record numbers of attenders the figures are considered to be of normal volume. The admission rates at CRHFT are approx. 51% in comparison to the previous year when they were approx. 30% which indicates an impact on streaming and the complexity of the patients entering A&E.</p> <p>Reports are showing reduction in cancer long waits due to both trusts having more capacity to undertake cancer surgery and diagnostics. As a whole Derbyshire has done well in comparison to other areas in terms of cancer performance.</p> <p>MW asked how the waiting lists are being prioritised. CC replied to say both acutes are working to a consistent set of rules where urgent surgery is being prioritised over routine or long wait surgery. BS further reiterated the waiting lists are being reviewed and prioritised by clinical need on a regular basis, this work is being led by Laura Moore, Deputy Chief Nurse for the CCG as a subgroup of the Planned Care Delivery Board. The work is reported through the Quality and Performance Committee and the CCG are assured.</p> <p>BD APPROVED the Integrated Report.</p>	
	<p>GBAF Q4</p> <p>The paper was taken as read and there were no further questions raised.</p> <p>BD referred to the question raised prior to the Committee for which responses had been provided.</p>	

	<p>AM submitted the following question.</p> <p>Q. Page 62, GBAF, strategic objective one - It is acknowledged that we lack an evidence-based strategy to mitigate this risk, and by implication agreed measures of inequality, with priorities for addressing these. Who is owning this element of our strategy and how and when will a roadmap for progress be agreed? Will the JUCD Vaccination Inequalities Group transform into a broader, inequalities ownership group?</p> <p>A. Steve Lloyd is the Executive Lead for health inequalities. Work on ICS Strategic Intent will start to shape how inequalities are prioritised and managed across the system for the future, and this will need a strong alignment to existing public health structures and processes. This is being discussed by the JUCD Board in May and June, and therefore we will be able understand this further. It will also be discussed at our GB confidential session on the 6th May where we are reviewing the CCG strategic objectives.</p> <p>There is already a Health Inequalities Cell which has formed as part of the Local Resilience Forum (LRF) structures and is chaired by Dr Robyn Dewis. This has membership including people on the Vaccine Inequalities Group. The Vaccine Inequalities Group is an offshoot of that broader approach.</p>	
	<p>RISK REGISTER</p> <p>The paper was taken as read.</p> <p>BD noted the recommendation to reduce risk number 6 and the associated reasons for the reduction.</p>	
	<p>SECOND WAVE RESPONSE TO COVID-19</p> <p>The paper was taken as read and there were no questions raised by the Committee.</p> <p>CC asked Committee members for their thoughts around changing the contents of the paper to focus on the broader aspects of restoration and recovery. BS added that there is a clear message from the national team that the pausing of elective surgeries will not be an option during the predicted third wave. CC and BS will further discuss the focus of the paper.</p>	
	<p>CRHFT STROKE UPDATE</p> <p>The paper was taken as read and there were no questions raised by the Committee.</p>	

	<p>AC highlighted that the frequency of reporting to the regional team has now been stepped down and in light of this is a monthly report still required to Quality and Performance. BD and BS were both supportive of this and confirmed the assurance process would be handed back to the CRHFT Clinical Quality Reference Group and escalate to Quality and Performance should any issues arise.</p> <p>BS continued to say that the SNAP data is being monitored. Recent scoring shows that CRHFT have recently scored a B, however UHDBFT has fallen to a D. Ratings range from a high A to a low E. SL confirmed that Magnus Harrison, Medical Director at UHDBFT will report more information into the System Quality Group meeting. Once the issues and actions taken have been identified a paper will be brought to a future Quality and Performance Committee meeting. This will be delegated through the UHDBFT CQRG meetings.</p>	
	<p>CHILDREN AND YOUNG PEOPLE UPDATE</p> <p>The paper was taken as read and there were no further questions raised.</p> <p>BD referred to the question raised prior to the Committee for which responses had been provided.</p> <p>AM submitted the following question.</p> <p>Q. An excellent paper on CYP, which is a sound framework against which to measure progress. Very sound and self-critical analysis and evaluation. How confident are DG and others that we can galvanise the system to commit the required resource and ensure an effective and timely people plan? Could more collaborative traction be achieved with education providers - schools, colleges, and work-based trainers, all of whom have major contact time with CYP?</p> <p>DG replied to say at the time of writing the paper there is approx. £1.9m of resource being put into the CYP in crisis service in addition to £700k recurrent funding from NHSE/I. there is also £600k for work in localities which will link to the Community mental health framework for children in transition that 18- to 26-year-old groups. The CCG is assured that the financial resources are in place however sourcing clinical staff is a national issue. It will take some years until trainees are ready for employment. The mitigation is the utilisation of qualified, non-clinical staff. Youth workers have been employed and there are plans to employ graduate Psychologists who have the right training and mindset and are more plentiful source of recruitment. The colleges are an important</p>	

	<p>are in assisting 18–26-year-olds who have neurodiversity issues in the transition into adulthood and finding employment.</p> <p>The hope is to have this in operation during the first quarter of 2021 financial year however it is very unlikely due to delays in recruitment.</p> <p>EP acknowledged the staffing issues and the solutions in place to mitigate this risk. EP noted the omission of Primary Care within the paper and asked that this area is given consideration. There is not enough resource in place for patients when they initially present to help stop them reaching crisis point. DG agreed and confirmed that this is the feedback that is being received through Futures in Mind and therefore improvements need to be place on a local level. Mental Health Teams are being set up in some of the schools to help with early intervention, however this is a slow process.</p> <p>MWa queried the section in the paper that referred to the Pharmacist liaising with the GP when prescribing to under 18's. BD added, and asked DG to note, that the majority of GPs will not go outside of this remit due to clinical risk.</p> <p>AM asked if this has been discussed at a system level. BS confirmed that the issues of children being placed in Emergency Departments for long periods of time with no suitable onward placement has been discussed at a system level for some time through the Childrens Board and is due to be discussed at the System Quality Group in June.</p>	
	<p>LeDeR ANNUAL REPORT</p> <p>The paper was taken as read. The Committee noted the contents of the report and there were no questions raised.</p>	
	<p>TRANSFORMING CARE PROGRAMME ANNUAL REPORT</p> <p>The paper was taken as read. The Committee noted the contents of the report and there were no questions raised.</p>	
	<p>CONTINUING HEALTH CARE (CHC)</p> <p>The paper was taken as read. The Committee noted the contents of the report and there were no questions raised.</p>	
	<p>INFECTION PREVENTION & CONTROL</p> <p>The paper was taken as read. The Committee noted the contents of the report and there were no questions raised.</p>	

	<p>CARE HOMES</p> <p>The paper was taken as read. The Committee noted the contents of the report and there were no questions raised.</p>	
	<p>MINUTES FROM SUB COMMITTEES</p> <p>The Committee noted the minutes from the following sub-Committees.</p> <ul style="list-style-type: none"> • UHDBFT CQRG • CRHFT CQRG • DCHS CQRG • DHCFT CQRG • DHU • DPG 	
	<p>MINUTES FROM THE MEETING HELD ON 25TH MARCH 2021.</p> <p>The minutes were approved as a true and accurate record.</p>	
	<p>MATTERS ARISING AND ACTION LOG</p> <p>The action log was reviewed and updated.</p>	
	<p>AOB</p> <p>National Quality Board BS noted the National Quality Board have published a refreshed commitment to quality position statement which BS will circulate to Committee members for information. At the meeting in June BS will talk about the new quality architecture for JUCD in order to determine the future role of the Quality and Performance Committee in transition.</p> <p>Current Format of Quality and Performance Committee BS reflected on the current format of the Quality and Performance Committee. The submission of questions prior to the meeting is working well and gives teams the time to formulate a full response. BS asked for agreement from BD as Chair to continue in this way. BD supported the approach.</p>	
	<p>FORWARD PLANNER</p> <p>The Forward Planner was reviewed. No updates were made.</p>	

	<p>ANY SIGNIFICANT SAFETY CONCERNS TO NOTE</p> <p>None raised.</p>	
	<p>ASSURANCE QUESTIONS</p> <ul style="list-style-type: none"> • Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? Yes • Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? Yes • Were papers that have already been reported on at another committee presented to you in a summary form? Yes • 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 	
<p>DATE AND TIME OF NEXT MEETING</p>		
<p>Date: 27th May 2021</p>		
<p>Time: 9am to 10.30am</p>		
<p>Venue: MS Teams</p>		



Chief Executive Report

Health Executive Group

11th May 2021

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

System provides a summary update on the work of the South Yorkshire and Bassetlaw health and care partners for the month of April 2021.

Recommendations

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

Chief Executive Report

SOUTH YORKSHIRE AND BASSETLAW INTEGRATED CARE SYSTEM

Health Executive Group

11th May 2021

1. Purpose

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

2. Summary update for activity during April

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

More than 50 million COVID-19 (Covid) vaccine doses have now been administered across the UK providing all regions, including South Yorkshire and Bassetlaw (SYB), with a real sense of optimism as we look ahead to the next phase of lockdown easing which is on track for the 17th May.

The SYB vaccination programme continues to go from strength to strength and is playing an important role in reducing new hospitalisations and community transmissions. Covid infections are not spreading or 'stacking' into older or more vulnerable age groups and the over-65s population is experiencing low numbers of positive cases with very few patients being admitted to hospital due to Covid-related illness.

In terms of variants of concern, the data shows that we are not currently seeing any new or additional pressure on health and care services within SYB. The so-called 'Kent variant' remains the most prevalent strain in our region, and although other variants are emerging, it is still responsible for the majority of positive cases without being any more or less severe - despite being more infectious.

National and regional public health teams continue to analyse vaccine effectiveness against the most dominant variants of concern, but so far, the data indicates that vaccines remain highly effective against all of these in general circulation.

Overall, there continues to be ongoing, sustained progress in our ability to manage Covid in SYB but we remain cautious about the impact on community infection rates and further lockdown easing as time moves on.

2.2 Regional update

The North East and Humber Regional ICS Leaders meet weekly with the NHS England and Improvement Regional Director. During April, discussions focused on the ongoing Covid response and vaccination programme, planning and recovery, a memorandum of understanding for the region on a greener NHS and ICS development and People Framework.

2.3 National update

2.3.1 Simon Stevens departure

I am sure colleagues will join me in paying tribute to Simon Stevens who is stepping down as NHS England and Improvement Chief Executive at the end of July 2021. Simon's achievements during his seven-year tenure are outstanding and he leaves a significant legacy which will have a profound impact on the direction of health and healthcare in the future. He has been a hugely inspiring leader with vast experience and knowledge of the NHS. I know you will join me in wishing him every success for the future.

2.3.2 ICS' operating across England

As of 1st April, every area of England is now operating as an Integrated Care System (ICS), achieving a major milestone in the NHS Long Term Plan. A total number of 42 ICSs have been set up across England to provide joined up health and care through integrating hospital, community and mental health trusts, GPs and other primary care services.

The transitional roadmap (April 2021 - April 2022) for ICS', including SYB, will see closer working arrangements between the NHS and Local Authorities and the voluntary, community and social enterprise sector (VCSE).

2.3.3 New Office for Health Promotion

A new Office for Health Promotion, which will sit within the Department of Health and Social Care (DHSC), is being set up. It will lead national efforts to improve and level up the health of the nation by tackling obesity, improving mental health and promoting physical activity. The new office will bring together a range of skills to lead a new era of public health polices, leveraging modern digital tools, data and actuarial science and delivery experts. It plans to promote good health and prevent illness, building on the work of Public Health England.

2.4 ICS development update

SYB ICS continues to make in-roads in our ICS development transition, with new timelines emerging for more immediate areas of work:

- By the end of May, health and care leaders will provide feedback and comments on the initial key outputs from the first phase of the ICS development work
- By the end the June, we will have put together a system development plan in time for the national submission deadline

The next phase requires us to develop a System Development Plan, which will outline the key actions for partners over the coming months as our ICS evolves into a new organisation – reflecting its new statutory framework (as an NHS body) and its wider obligations as a Health and Care Partnership.

The next ICS Development Steering Group meeting in May will focus on the work of our provider collaboratives and the main transition commitments for 2021, in recognition of the development phases and guidance expected in June/July.

2.5 The Macmillan Living With and Beyond Cancer (LWABC) Programme in South Yorkshire, Bassetlaw and North Derbyshire

The Living With and Beyond programme, which launched five years ago, came to an end in March. The programme was a partnership with Macmillan Cancer Support to help improve the experience of people living with and beyond cancer in our region. It specifically focused on breast, bowel and prostate cancer services with the aim of ensuring everyone diagnosed with these cancers can live well after a diagnosis.

The programme evaluation and executive summary report are now available and you can view them from the link below. The evaluation highlights the benefits to people diagnosed with cancer and the region's cancer care workforce from the £5 million investment.

The developments in improving personalised cancer care have been far reaching and will support regional cancer services in meeting the challenges brought about by the pandemic. The improvements include the recruitment of 43 Macmillan Cancer Support Worker roles, better IT coordination, establishing patient support groups and providing the cancer workforce with learning and development opportunities.

The link to the reports is:

<https://canceralliancesyb.co.uk/what-we-do/living-and-beyond-cancer/macmillan-living-and-beyond-cancer-programme>

You can learn more about personalised care in the video here:

<https://vimeo.com/showcase/8239370/video/510707639>

2.6 New SYB ICS website

The South Yorkshire and Bassetlaw ICS website has been refreshed and is now live. The revamped site has new content layout, greater emphasis on more visual formats and it aims to appeal to a broad audience. It incorporates the views and feedback from our Citizen's Panel, online membership and SpeakUp (an autism and learning disability advocacy charity). Its main objectives are to clearly explain what the ICS is, our key priorities and act as an easy-to-use information repository for key documents and reports.

Alongside the main ICS site, a subsidiary site for the QUIT Programme, sponsored by Yorkshire Cancer Research, has also been built and includes an overview of the Programme, clinical and patient resources and e-platform training modules.

Both sites aim to be accessibility compliant (ISO regulated), easy to use, functional and interesting to encourage repeat visits in order to find out more and be more involved in the work of the ICS.

Link to the new SYB ICS site: www.sybics.co.uk

Link to the QUIT website: www.sybics-quit.co.uk

2.7 Partner appointments

Two new Board appointments have been confirmed at Rotherham, Doncaster and South Humber NHS Foundation Trust (RDaSH). Pauline Vickers will join as Non-Executive Director and Ian Currell will join as the Director of Finance and Performance.

Pauline has extensive business and leadership experience at board level in a variety of executive roles, most recently as a Director of Royal Mail where she was also a member of Royal Mail Groups Diversity Council and Gender Steering Group. She has previous experience in the NHS, having been a Non-Executive Director at Bradford Teaching Hospitals NHS Foundation Trust.

Ian, who is currently the Chief Finance and Deputy Chief Officer at NHS Kirklees Clinical Commissioning Group (CCG), will join the Trust in August. He started out in the NHS as a graduate finance trainee and went on to work in a range of provider and commissioner organisations including as Director of Finance at NHS England area teams and Deputy and Acting Director of Finance at Calderdale and Huddersfield NHS Foundation Trust.

Ian replaces Steve Hackett, who leaves the Trust at the end of June to work at The Rotherham NHS Foundation Trust.

2.8 NICE Strategy 2021-2026

A five-year strategy has been released by the National Institute for Health and Care Excellence (NICE) setting out how it aims to drive change following the health challenges posed by COVID-19. It sets out a need to:

- Embrace innovation by speeding up access to new and effective treatments, practices and technologies.
- Integrate real-world data into our evaluation processes to inform rapid but robust decisions.
- Provide information in dynamic, useable formats that support busy health and care practitioners in their work and encourage shared decision.
- To work collaboratively and seamlessly with others, particularly to reduce health inequalities.

There are a number of parallels with the work we have undertaken in SYB in which our partnership with the Yorkshire and Humber Academic Health Science Network (YH AHSN) around Rapid Insights has been instrumental in our future planning discussions.

The link to the report is: <https://www.nice.org.uk/about/who-we-are/corporate-publications/the-nice-strategy-2021-to-2026>

2.9 King's Fund Report: Place-based Partnerships

The King's Fund has published a report that explores the importance of developing successful place-based partnerships. In *Developing place-based partnerships: The foundation of effective integrated care systems*, the report authors set out a series of principles to help guide local health and care leaders in these efforts. They also explore how each principle can be applied and examples of how they are being put into practice.

The report also looks at the implications of these ways of working for the development of ICSs and for national bodies and regional teams as they approach the next stages of policy development and support for integrated care.

<https://www.kingsfund.org.uk/publications/place-based-partnerships-integrated-care-systems>

3. Finance update

I am pleased to report that the system has met its two key system financial targets to operate within its revenue and capital financial envelopes. The pre audit draft accounts show a revenue underspend of £36.8m and an underspend against total capital of £15.9m of which £14.3m of the under-spend relates to the system capital envelope of £84.7m.

The system has submitted a balanced financial plan for the period April to September 2021 (H1) which includes efficiencies of £37.3m or 1.3% of allocation/expenditure. Risks of £36.6m have been identified (1.3%) which require to be managed and of which over 50% relates to risks around efficiency schemes.

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

Date: 6th May 2021

Derby and Derbyshire CCG Governing Body Meeting in Public
Held on
6th May 2021 via Microsoft Teams

UNCONFIRMED

Present:

Dr Avi Bhatia	AB	Clinical Chair
Dr Bruce Braithwaite	BB	Secondary Care Consultant
Richard Chapman	RCp	Chief Finance Officer
Dr Chris Clayton	CC	Chief Executive Officer
Dr Ruth Cooper	RC	Governing Body GP
Jill Dentith	JD	Lay Member for Governance
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
Dr Greg Strachan	GS	Governing Body GP
Dean Wallace	DW	Director of Public Health - Derbyshire County Council
Dr Merryl Watkins	MW	Governing Body GP
Martin Whittle	MWh	Lay Member for Patient and Public Involvement

Apologies:

Dr Penny Blackwell	PB	Governing Body GP
Brigid Stacey	BS	Chief Nursing Officer
Dr Robyn Dewis	RD	Director of Public Health - Derby City Council

In attendance:

Helen Hipkiss	HH	Director of Quality
Dawn Litchfield	DL	Executive Assistant to the Governing Body/Minute Taker
Suzanne Pickering	SP	Head of Governance

Item No.	Item	Action
GBP/2122/026	Welcome, Apologies & Quoracy Dr Avi Bhatia (AB) welcomed members to the meeting. Apologies were received as above. It was confirmed that the meeting was quorate.	
GBP/2122/027	Questions received from members of the public The following questions were received from members of the public:	

Questions from Markus James

1. You refer to “system financial pressures” and “system financial position” on page 23 of the board papers in the Joined up Care Derbyshire board update. Can you clarify exactly what constitutes the “system”? The JUCD website speaks of 12 partners but seems to list only 11.

Response: The partners are listed below and do total 11 as you reference in your question. Thank you for raising this issue and we will ensure that the way they are presented on websites and in any documentation is addressed.

Partners in Joined Up Care Derbyshire are:

Organisations that commission health services:

NHS Derby and Derbyshire Clinical Commissioning Group

Organisations that provide healthcare services:

Chesterfield Royal Hospital

Derbyshire Community Health Services

Derbyshire GP Alliance

Derbyshire GP Alliance & GP Task Force

Derbyshire Healthcare

DHU Health Care

University Hospitals of Derby and Burton

East Midlands Ambulance Service

Organisations that provide public services and social care:

Derby City Council

Derbyshire County Council

2. Page 69 of the board papers summarises the financial gap of £53.3m. Where will the axe fall to meet this shortfall?

Response: The paper on planning and budget setting is really to inform GB of the latest guidance and approach that the CCG and other system partners are taking as a collaborative to manage the system finances. The paper outlines the progress made so far in bridging the recurrent financial gap for the system but there is still further work to do in understanding the cost drivers behind this and any potential slippage in investments to reduce this further. The plan already contains a 3% efficiency requirement for the system to manage and deliver which will be done through productivity efficiencies and transformation schemes. In addition, discussions are already taking place with regional colleagues to agree a multi-year recovery plan to manage any residual gap.

3. Page 66 speaks of a 0.28% efficiency and Page 69 of a 3% additional efficiency. Please explain the difference between the two.

Response: The 0.28% efficiency has already been applied to the system allocation for H1 and will be managed through the budgets of each organisation to ensure delivery. The system is planning for a break-even delivery for H1

The 3% efficiency target is a national expectation and has been applied to the overall expenditure plan with delivery expected from Q2 onwards. Schemes have not yet been identified but they will be delivered through productivity efficiencies and transformation schemes on both a recurrent and non-recurrent basis.

Questions from Liz James

4. Page 263 of the board papers has a summary of the discussion of the results of the 2020 staff survey. The discussion at the meeting and the summary in the minutes seem to seek to minimise the feedback given by Black, Asian Minority Ethnic (BAME) staff and explain their reporting of a worsened situation as resulting from outside factors (the pandemic and Black Lives Matter).

You speak of trying to understand what is “driving this”. The reasons for people reporting now may be interesting but what is more important is what the CCG will do to address the inequalities and discrimination that have now been brought to its attention. What steps will you be taking?

Response: The CCG has shared the results of the 2020 staff survey with both the staff Diversity and Inclusion Network and the members of the Organisational Effectiveness and Improvement Group (staff forum). Following feedback from these groups and an analysis of the NHS Workforce Race Equality Standard (WRES) data, the CCG has committed to the following actions to address inequalities and discrimination and foster a culture of inclusion and belonging:

- The CCG to be a [model employer](#)
- CCG to become a 'culturally intelligent' organisation. To support this we will participate in an expert-led system-wide cultural intelligence (CQ) programme.
- Executive Directors to own the representation Agenda, as part of the culture changes in the CCG/ICS, with improvement in BAME representation (and other under- represented groups) as part of objectives and appraisal.
- Staff networks prominent in contributing to and informing decision-making processes.
- Training for managers on Equality, Diversity & Inclusion (including good practice to ensure fair and inclusive practices are used) - *review of existing training in the Joined Up Care Derbyshire system.*
- Overhaul the recruitment and selection procedures, including implementing diverse recruitment panels (gender & ethnicity) – *complete.*
- Via the annual review conversations and 1 to 1's, support and encourage BME staff to access the NHS Leadership academy (e.g. Stepping Up, Ready Now, Nye Bevan, Elizabeth Garrett Anderson).
- Advertise acting up and development opportunities internally to all staff.
- Roll out the reverse mentoring programme to all line managers within the CCG.
- Add an organisational pledge/statement around diversity & inclusion to attract a diverse workforce – *complete*

- CCG to promote a culture of civility & respect in line with the NHS People Plan, including a refresh of the Dignity at Work Policy. This will include briefings for managers and staff.

5. Page 155 (Quality and Performance Committee Assurance Report) refers to the Learning Disabilities Mortality Review report. How many people with a learning disability have died from Covid-19 in Derbyshire? Are people with a learning disability statistically over-represented in the number of deaths?

Response: Through the LeDeR (mortality review) programme in Derbyshire we have received 21 notifications where the reason for death (as per the death certificate) was Covid-19. Please note that notifications to the LeDeR programme are not mandatory so we cannot guarantee that the number received are all LD deaths for Derbyshire.

The following is not included in the LeDeR Annual report, however:

- According to Public Health Derbyshire there were 2222 deaths in Derbyshire up to 16th April 2021 where Covid-19 was reported on the death certificate.
- Therefore, based on the LeDeR notifications the LD deaths were 0.95% of this figure.
- Based on a Derbyshire population of 802,700 ([Derbyshire Observatory – Population and Households](#)) and we have around 5750 people on LD registers, LD population in Derbyshire is therefore approx. 0.72% of the Derbyshire population.
- This therefore shows that LD deaths were slightly higher in the LD population

Questions not related to 6.5.2021 Agenda

Questions from Keith Venables

6. 56 London GP practices are now owned by a USA Insurance company. Can you tell me which are the next 3 Primary Care Practices whose contracts are up for renewal at this CCG and who chairs the relevant committee that will make the decision?
7. Can you promise that no new contracts will be given to non-NHS companies?

Response: There are no APMS contracts this year and there is one APMS practice in 22/23 whose contract will expire in October 2022. Primary Care Commissioning Committee is the delegated committee from NHS England and Improvement with responsibility for the GP contracts.

The CCG will follow the national guidance and procurement advice so we are unable to guarantee that no new contracts will be given to non-NHS companies. In addition, GP practices are independent businesses and therefore whilst they provide NHS services they are not NHS organisations.

Responses to these questions will be provided within 7 working days and included in the minutes for completeness.

<p>GBP/2122/028</p>	<p>Declarations of Interest</p> <p>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.</p> <p>Declarations declared by members of the Governing Body are listed in the CCG's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Governing Body or the CCG website at the following link: www.derbyandderbyshireCCG.NHS.uk</p> <p>Dr Ruth Cooper (RC), Governing Body GP, has made an addition to the register since the last meeting as she has set up a Limited Company 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. This interest was duly noted and will be declared as appropriate going forward when the agenda relates to either of these areas.</p> <p>No further declarations of interest were made and no changes were requested to the Register of Interests.</p>	
<p>GBP/2122/029</p>	<p>Chair's Report</p> <p>AB provided a written report, a copy of which was circulated with the meeting papers; the report was taken as read.</p> <p>The Governing Body NOTED the contents of the report provided</p>	
<p>GBP/2122/030</p>	<p>Chief Executive Officer's Report</p> <p>Dr Chris Clayton (CC) provided a written report, a copy of which was circulated with the meeting papers. The report was taken as read and the following points of note were made:</p> <ul style="list-style-type: none"> • Progress continues to be made on the vaccination programme, with Derbyshire performing extremely well. • A visit was made in April to the Derby Arena Local Vaccination Service site by Sir Simon Stevens, Chief Executive of the NHS. Sir Simon was keen to see the Derbyshire model, which is a good example of collaborative working, and the busiest site of that scale in the country during early April. • Last month saw progression to the next stage of the journey towards becoming a Derbyshire Integrated Care System (ICS), with clear priorities and actions emerging for the CCG and the System over the coming weeks and months. • An increasing range of System communication channels have been developed over recent months; the pandemic has helped the System think differently and innovatively in terms of reaching its audiences. • There continues to be an increased uptake for the expanding programme of virtual sessions covering a wide range of current issues; a recent Derbyshire Dialogue session on the vaccination programme was well attended. • Section 2 provided an overview of the activities engaged in by CC, in his dual role as CCG CEO and Executive Lead for Joined Up Care 	

	<p>Derbyshire (JUCD), bringing the organisations together and supporting the System partnership model.</p> <ul style="list-style-type: none"> • Whilst there is still a lot to do on the COVID response, the System is working hard on the recovery and restoration of non-COVID services in order to reduce waiting lists. • Section 3 highlighted national developments, research and reports. Of note is the Joint Committee on Vaccination and Immunisation advice for pregnant women to obtain COVID vaccinations, and the appointment of 10,000 Healthcare Support Workers in the first 3 months of this year which will provide much needed assistance to both staff and patients. Advice on how to stop the spread of the pandemic was also highlighted, requesting that people continue to remain vigilant at all times. • Section 4 contained details of local developments including the use of the 111 service for worsening vaccine side-effects in order to ease pressure on GPs. Pop up clinics have been extremely successful in helping to vaccinate hard to reach groups. <p>The following questions were raised:</p> <ul style="list-style-type: none"> • Governing Body members were keen to thank the volunteers and staff working at the vaccination centres; everyone is tired, but they keep going, as there is lots more still to do. • The stress felt by the medical workforce, and the effect on their mental health, is causing some staff to seek alternative employment; as there is still a lot to deal with including the vaccination programme, the recovery and meeting the backlog of demand, it was enquired if there is anything practical the CCG could do to help with staff retention. CC responded that there will be multiple different challenges ahead; a balance is needed between available resources and the human element. Demands will be coming from new health needs caused by the pandemic and the System's backlog, which the Governing Body and the System are well sighted on; this will continue be the context of much discussion over the next few months. <p>Helen Dillistone (HD) added that staff support and wellbeing around resilience is essential to the Operating Plan set out for this year and beyond; the Plan includes a section on staff wellbeing. HD was pleased to announce that £600k support has been provided to the System for the development of its staff; this will be worked through with HR Directors on how it could be best used to support staff. Zara Jones (ZJ) confirmed that a Hub has been established to support staff, to receive the funding and take it forward.</p> <ul style="list-style-type: none"> • With the social care reforms shelved and Sir Simon Stevens standing down, it was asked what the likely impact will be on the ICS and the timeline. CC advised that this reform has been discussed previously but was not taken forward. Both Local Authorities remain important contributors to and a valuable part of the Derbyshire ICS. Derbyshire is well placed from a health and social care perspective in terms of how it operates and continues to do so through the health and social care partnerships. The challenge to social care itself remains the same in terms of increasing demand and available resources; the System will come together to support this, however the long-term questions on the social care reform remain unanswered. 	
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	<ul style="list-style-type: none"> It was queried when information on the waiting lists for operations would be made available. CC confirmed that information on the 52 week wait position and the overall waiting list figures is already available. Work is ongoing on the recovery trajectories and is included in the Quality and Performance Report and Operating Plan for visibility. <p>The Governing Body NOTED the contents of the report provided</p>	
<p>GBP/2122/031</p>	<p>Joined Up Care Derbyshire Board Update – April 2021</p> <p>CC provided a written report, a copy of which was circulated with the meeting papers. The report was taken as read and the following points of note were made:</p> <ul style="list-style-type: none"> The Derbyshire System continues in its development to become an ICS, moving through the transition towards becoming a statutory organisation in April 2022. The Board welcomed Cllr Carol Hart and Cllr Roy Webb as representatives of the aligned Derby and Derbyshire Health and Wellbeing Boards, to reflect the further collaboration on agendas between those Boards and the ICS. Work continues in earnest on the pillars of development: the outline of strategic intent, Provider collaboration at scale and Place, and the JUCD role as an anchor institution. The Foundation Trust Governors have a very important role in holding Boards to account. The Derbyshire System recognises that the skills and knowledge of Governors could support the development of the transformation programme, especially at Place level. Discussions will continue with Governors to ensure that their assurance role is not compromised, and that they are supported appropriately to become involved in future discussions. <p>The following questions were raised:</p> <ul style="list-style-type: none"> It was queried if the statutory obligation of the ICS to engage with both the public and its members through appropriate mechanisms will be a similar model to that used by the CCG with its member practices; it was asked how the Trusts' Governors would fit into this. Martin Whittle (MWh) confirmed that there will be similarities in the way that engagement is done, but the end point will be different as to why we are engaging and what we are engaging for. Trust Governors are the representatives of members of the public using the Trusts, whilst the CCG's membership is formed of General Practices. MWh recently attended a Derbyshire Healthcare Foundation Trust Governors' meeting to gauge thoughts; this was a helpful meeting, which highlighted the different ways in which governors could be utilised to benefit the local population. Although the methodology will be the same, there are different audiences and drivers as the statutory responsibilities will be different. This is work in progress. It was considered to be a good move to consult with the Trusts' Governors and would be prudent for JUCD to also engage with the CCG's Lay Members, who have a similar purpose as advocate champions for the population. CC argued that Lay Members are more akin to Non-Executive Directors than Governors, which differ in purpose. Consideration will be given to the engagement of all Lay 	

	<p>Members / Non-executive Directors across the system. CC agreed to pick this up.</p> <p>The Governing Body NOTED the contents of the report provided</p>	CC
GBP/2122/032	<p>DDCCG Corporate Committees' Updated Terms of Reference</p> <p>Helen Dillistone (HD) presented the updated Terms of Reference of the CCG's Corporate Committees, which are considered on a six-month basis to ensure their continued relevance in terms of function and membership.</p> <p>Each Committee has reviewed its respective Terms of Reference and will do so again in the autumn of 2021, which will be timely in the ICS transition process. No material changes were made, only points of clarity addressed.</p> <p>It was noted that the Terms of Reference for the Remuneration Committee were updated and approved by the Governing Body in January 2021 therefore were not included in the papers today.</p> <p>The Governing Body APPROVED the Terms of References of all the Corporate Committees, with the exception of the Primary Care Commissioning Committee which will be presented at the next meeting</p>	
GBP/2122/033	<p>Financial Plan 2021/22</p> <p>Richard Chapman (RCp) provided an update on the changes to the financial planning assumptions made to date by the CCG and Joined Up Care Derbyshire partners in preparation for the final System Financial Plan being submitted to NHSEI today. The paper explained to the Governing Body how the CCG and JUCD System partners have identified an efficiency gap, and outlined the proposed management of the risks with suggested mitigations; it also demonstrated how the CCG is progressing the planning and budget setting for the overall System position. A presentation was given by RCp summarising the latest planning information and figures.</p> <p>The following points of note were made:</p> <ul style="list-style-type: none"> • Expenditure for the CCG's own staff is less than 1% of total resource budget. • The 0.5% contact uplift included in contracts is the growth built into the NHS planning guidance for this year. <p>The Governing Body NOTED the progress to date on producing a Joined Up Care Derbyshire Financial Plan for 2021/22</p>	
GBP/2122/034	<p>South Yorkshire and Bassetlaw (SYB) ICS Development Update</p> <p>A copy of a letter from Sir Andrew Cash was provided for discussion in relation to the health and care developments in SYB and the work currently being undertaken to address the requirements of the ICS transition.</p> <p>CC advised that DDCCG inherited formal membership of the SYB Joint CCGs Committee from North Derbyshire and Hardwick CCGs. CC has attended these meetings regularly due to DDCCG's connectivity with CRHFT patient flows and to learn from other Systems. His view is that when</p>	

	<p>DDCCG moves into an ICS, its membership of the Joint Committee will come to a natural end. DDCCG is not a formal member of SYB ICS. A dialogue will be entered into between the 2 ICS's in relation to future requirements for alignment and governance arrangements.</p> <p>The following points of note were made:</p> <ul style="list-style-type: none"> • Due to the population flow it is pertinent to have a continuing dialogue into Sheffield regarding acute specialisms. Erewash also needs to maintain links with the Nottingham System. The information provided by SYB ICS's design group was commended; a lot of development work has been undertaken and it was asked if learning could be taken from their experiences and governance structures in relation of Places. CC concurred with the Place concept, and although the 2 ICSs have different operating models, and cross multiple Local Authority boundaries, there is mutual learning to be had. DDCCG also has much to offer to SYB ICS. In his response CC will suggest that the 2 ICSs continue to work together for developmental purposes. • Derbyshire's Cancer Alliance Network was originally part of the South Yorkshire Cancer Alliance Network however, concern was raised that it now operates within the East Midlands region; it needs to be ensured that both interfaces, and that of the Continuing Care Network, are managed appropriately. The CCG has now formally moved into the East Midlands Cancer Alliance Network. It was confirmed that there continues to be links into other groups given the patient flows and geography of Derbyshire. • It was enquired if Teaching Trusts could share the benefit of their knowledge with the Derbyshire Trusts. CC advised that this is the foundation on which the provider collaborative programme was formed within the East Midlands; it will see collaboratives develop around acute hospital services to broaden the conversations and give further thought to specialised commissioning. The East Midlands ICS Commissioning Board met for the first time last month. • When responding to the Greater Manchester reconfiguration, it was helpful for North Derbyshire CCG to have a formal understanding of patient flows through its associate membership status. It was queried whether something of this nature is needed to provide an understanding should any formal changes be made to the configuration of health services which may affect the Derbyshire population. CC will highlight in his response that continuing cooperation will be required. • It was requested that patient flows be kept in mind and that the good working relationship with Kingsmill Hospital maintained in order to prevent the patients on the boundaries from becoming disadvantaged. It was suggested that this may become a Place responsibility. The links with Nottingham are also important and need to be given thought. <p>CC agreed to take this to the next JUCD Board on 20th May for further consideration and respond on behalf of both organisations. A copy of the response will be shared with Governing Body members.</p> <p>The Governing Body:</p> <ol style="list-style-type: none"> 1. NOTED the progress made on the SYB ICS development work across all of the work streams 2. COMMENTED on the outputs of the SYB ICS design group by, specifically the: 	<p style="text-align: center;">CC</p>
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	<p>a. Health and Care Compact b. Health and Care Partnership Terms of Reference c. Place Development Matrix</p> <p>3. PROVIDED COMMENTS for the SYB ICS on the above</p>	
<p>GBP/2021/035</p>	<p>Finance Report – Month 12</p> <p>RCp provided an update on the Month 12 financial position. The following points of note were made:</p> <ul style="list-style-type: none"> • The CCG has underspent against its running cost allocation by 4%; the running costs were delivered well within the allocation. • The Better Payment Practice Code is designed to ensure that there are no delays in payments made by the CCG to their suppliers, thus helping to support the economy. The target is to ensure that 95% of valid invoices are paid by the due date; DDCCG has exceeded this target this year, by paying over 99% of invoices by the due date. • The CCG has delivered a year end surplus of £298k which forms part of the Derbyshire System surplus of £359k. • This has been an unusual year in that movement was seen between the Month 11 predicted year end position and final year end outturn. This was due to payments made to Providers to cover in year service pressures. <p>The Governing Body NOTED:</p> <ul style="list-style-type: none"> • The financial arrangements for H2, October 2020 to March 2021 • A full year underspend of £0.298m has been delivered • Cumulative allocations of £51.930m have been reimbursed for Covid-19 costs and Acute Independent Sector (IS), this includes a late NHSEI reduction of a net £0.077m relating to a reduction in costs in month 12 in comparison to the month 11 forecast • The top-up allocation stands at £6.865m 	
<p>GBP/2122/036</p>	<p>Finance Committee Assurance Report – April 2021</p> <p>Andrew Middleton (AM) provided a verbal update following the Finance Committee meeting held on 29th April 2021. The following points of note were made:</p> <ul style="list-style-type: none"> • The achievement of the Better Payment Practice Code target is a tribute to the Finance Team which owns this as important part of its duty, taking pride in it. • Assurance was provided that the Team submitted the accounts in accordance with the required deadlines. • The Finance Officers declared an unprecedented level of collaboration on System finance matters, which bodes well for the ICS. • The 2021/22 financial year will present another highly dynamic situation; the Team will continue to provide assurance to the Governing Body at the most pertinent times. • Despite financial balance not being anticipated in 2021/22, organisations will have to be cognisant as there remains a sizeable System gap to address through transformation. • Relationship building is the pre cursor to transformation programmes; in that respect, the System Finance and Estates Committee is 	

	<p>broadening the role of the future financial management regime. Assurance was provided that the Deputy CFOs and specialist estates' officers are advantaged by clearly understanding the position.</p> <ul style="list-style-type: none"> • A copy of the notes on the 360 Assurance webinar were circulated to the Governing Body for information in advance of the meeting. <p>The Governing Body NOTED the verbal update provided for assurance purposes</p>	
GBP/2122/037	<p>Audit Committee Assurance Report – April 2021</p> <p>Ian Gibbard (IG) provided an update following the Audit Committee meeting held on 28th April 2021. The report was taken as read and the following points of note were made:</p> <ul style="list-style-type: none"> • The April meeting was held to review the draft submission of the CCG's Annual Report and Accounts to NHSEI; they were recognised by the Auditors as being well prepared and presented. • The May meeting will receive the Report and Account's findings and subsequently sign them off on behalf of the Governing Body. All Governing Body members are welcome to attend the meeting on 25th May. <p>The Governing Body NOTED the contents of the report provided for assurance purposes</p>	
GBP/2122/038	<p>Clinical and Lay Commissioning Committee (CLCC) Assurance Report – April 2021</p> <p>Dr Ruth Cooper (RC) provided an update following the CLCC meeting held on 8th April 2021. The report was taken as read and the following points of note were made:</p> <ul style="list-style-type: none"> • The CLCC reviewed and agreed its Terms of Reference. • The CLCC virtually ratified the Non-Standard MRD Scan Policy. • The CLCC virtually noted that CPAG have reviewed the Individual Funding Request (IFR) cases submitted and Interventional Procedures Guidance (IPGs), Medtech Innovation Briefings (MIBs), Medical Technology Guidance (MTGs) and Diagnostic Technologies Guidance (DGs) for February 2021 and were assured that no areas for service developments were identified. • The CLCC virtually noted the following for information purposes: <ul style="list-style-type: none"> • Medtech Funding Mandate Policy 2021/22 • Evidence-based Interventions List 2 Guidance • Clinical Policies Specification • Orthotics Mobilisation Position Statement • Clinical Policies Specification • CPAG Policy Specification • CPAG Bulletin – February • The CLCC received and noted the updated Emerging Risk Tracker. <p>The Governing Body NOTED the contents of the report provided for assurance purposes</p>	

<p>GBP/2122/039</p>	<p>Primary Care Commissioning Committee (PCCC) Assurance Report – April 2021</p> <p>Professor Ian Shaw (IS) provided a verbal update following the PCCC meeting in public held on 28th April 2021. The meeting mainly consisted of discussion of the standing agenda items.</p> <p>The Governing Body NOTED the verbal update provided for assurance purposes</p>	
<p>GBP/2122/040</p>	<p>Quality and Performance Committee (Q&PC) Assurance Report – April 2021</p> <p>Dr Buk Dhadda (BD) provided an update following the Q&PC meeting held on 29th April 2021. The report was taken as read and the following points of note were made:</p> <ul style="list-style-type: none"> • The Committee noted the good performance in relation to cancer targets and reassured the Governing Body that the CCG compared favourably with national performance data during the second wave of the pandemic. • A deep dive is underway on patient referrals and waiting times; there are a high number of patients still waiting to receive initial appointments. The Committee is fully sighted on all aspects of the waiting lists. <p>The Governing Body NOTED the key performance and quality highlights and the actions taken to mitigate the risks</p>	
<p>GBP/2122/041</p>	<p>CCG Risk Register – April 2021</p> <p>This report highlights areas of organisational risk recorded in DDCCG's Corporate Risk Register as at 30th April 2021. All risks in the Risk Register are allocated to one of the CCG's Corporate Committees which reviews them on a monthly basis. No material changes have been made to the risk scores since the last meeting however one risk has been decreased, as detailed below.</p> <p>The Governing Body RECEIVED and NOTED:</p> <ul style="list-style-type: none"> • The Risk Register Report • Appendix 1 as a reflection of the risks facing the organisation as at 30th April 2021 • Appendix 2 which summarises the movement of all risks in April 2021; and • The decrease in score for one risk: <ul style="list-style-type: none"> • Risk 6 relating to the demand for Psychiatric Intensive Care Unit beds (PICU) 	
<p>GBP/2122/042</p>	<p>Joined Up Care Derbyshire Board – Ratified Minutes – March 2021</p> <p>The Governing Body RECEIVED and NOTED the minutes</p>	

GBP/2122/ 043	Ratified Minutes of DDCCG's Corporate Committees: <ul style="list-style-type: none"> • Audit Committee – 18.3.2021 • Primary Care Commissioning Committee – 24.3.2021 • Quality and Performance Committee – 25.3.2021 The Governing Body RECEIVED and NOTED these minutes	
GBP/2122/ 044	South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) CEO Report – April 2021 <p>The Governing Body RECEIVED and NOTED the report</p>	
GBP/2122/ 045	Minutes of the Governing Body meeting in public held on 1st April 2021 <p>The minutes of the above meeting were agreed as a true and accurate record</p>	
GBP/2122/ 046	Matters Arising / Action Log <p>There were no outstanding action items for consideration at this meeting.</p>	
GBP/2122/ 047	Forward Planner <p>The Governing Body NOTED the Planner for information</p>	
GBP/2122/ 048	Any Other Business <p>None raised.</p>	
DATE AND TIME OF NEXT MEETING - Thursday 3rd June 2021 – 9.30am to 11.15am via Microsoft Teams		

Signed by:
(Chair)

Dated:

**GOVERNING BODY MEETING IN PUBLIC
ACTION SHEET – May 2021**

Item No.	Item title	Lead	Action Required	Action Implemented	Due Date
2021/22 Actions					
GBP/2122/031	<u>JUCD Board Update – April 2021</u>	Dr Chris Clayton	It was considered that it would be prudent for JUCD to also engage with the CCG's Lay Members, Consideration will be given to the engagement of all Lay Members / Non-executive Directors across the system. CC agreed to pick this up.	In progress	June 2021
GBP/2122/034	<u>South Yorkshire and Bassetlaw (SYB) ICS Development Update</u>	Dr Chris Clayton	CC will take this discussion to the next JUCD Board on 20 th May for further comment and respond on behalf of both organisations. A copy of the response will be shared with Governing Body members.	In progress	June 2021

Derby and Derbyshire CCG Governing Body Forward Planner 2021/22

	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
AGENDA ITEM / ISSUE												
WELCOME/ APOLOGIES												
Welcome/ Apologies and Quoracy	X	X	X	X	X	X	X	X	X	X	X	X
Questions from the Public	X	X	X	X	X	X	X	X	X	X	X	X
Declarations of Interest <ul style="list-style-type: none"> • Register of Interest • Summary register of interest declared during the meeting • Glossary 	X	X	X	X	X	X	X	X	X	X	X	X
CHAIR AND CHIEF OFFICERS REPORT												
Chair's Report	X	X	X	X	X	X	X	X	X	X	X	X
Chief Executive Officer's Report	X	X	X	X	X	X	X	X	X	X	X	X
FOR DECISION												
Review of Committee Terms of References		X					X					
FOR DISCUSSION												
360 Stakeholder Survey												X
Mental Health Update								X				
CORPORATE ASSURANCE												
Finance and Savings Report	X	X	X	X	X	X	X	X	X	X	X	X
Finance Committee Assurance report	X	X	X	X	X	X	X	X	X	X	X	X
Quality and Performance Committee Assurance Report <ul style="list-style-type: none"> • Quality & Performance Report • Serious Incidents • Never Events 	X	X	X	X	X	X	X	X	X	X	X	X
Governance Committee Assurance Report <ul style="list-style-type: none"> • Business Continuity and EPRR core standards • Complaints 	X		X		X		X		X		X	

	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
AGENDA ITEM / ISSUE												
<ul style="list-style-type: none"> • Conflicts of Interest • Freedom of Information • Health & Safety • Human Resources • Information Governance • Procurement 												
Audit Committee Assurance Report	X	X	X	X			X		X		X	
Engagement Committee Assurance Report	X	X	X	X	X	X	X	X	X	X	X	X
Clinical and Lay Commissioning Committee Assurance Report	X	X	X	X	X	X	X	X	X	X	X	X
Primary Care Commissioning Committee Assurance Report	X	X	X	X	X	X	X	X	X	X	X	X
Risk Register Exception Report	X	X	X	X	X	X	X	X	X	X	X	X
Governing Body Assurance Framework	X	X		X		X		X			X	
Strategic Risks and Strategic Objectives		X		X	X							
Annual Report and Accounts			X			X						
AGM						X						
Audit Committee Annual Report				X								
Joined Up Care Derbyshire Board Update	X		X		X		X		X		X	
FOR INFORMATION												
Director of Public Health Annual Report						X						
Minutes of Corporate Committees												
Audit Committee	X	X	X				X		X		X	
Clinical & Lay Commissioning Committee	X	X	X	X	X	X	X	X	X	X	X	X
Engagement Committee	X	X	X	X	X	X	X	X		X	X	X
Finance Committee	X	X	X	X	X	X	X	X	X	X	X	X
Governance Committee			X		X		X		X		X	
Primary Care Commissioning Committee	X	X	X	X	X	X	X	X	X	X	X	X
Quality and Performance Committee	X	X	X	X	X	X	X	X	X	X	X	X
Minutes of Health and Wellbeing Board Derby	X		X		X		X		X		X	

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

H&WB meetings –

Derby City dates – 18th March 2021, 13th May 2021

Derbyshire County dates – 20th January 2021, 1st April 2021