

NHS DERBY AND DERBYSHIRE CCG

GOVERNING BODY – MEETING IN PUBLIC

Date & Time: Thursday 3rd September 2020 – 9.30am to 11.15 am

Via Microsoft Teams

Members of the public may dial in to the meeting on 020 3321 5208
Conference ID: 779 436 015#

Please notify us in advance of your intention to join the meeting by emailing DDCCG.Enquiries@nhs.net by close of play 2nd September

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/2021/041	Welcome, Apologies & Quoracy Apologies: Dr Steve Lloyd, Dr Robyn Dewis	Verbal	Dr Avi Bhatia	9.30
GBP/2021/042	Questions from members of the public	Paper	Dr Avi Bhatia	
GBP/2021/043	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/2021/044	Chair's Report	Paper	Dr Avi Bhatia	9.35
GBP/2021/045	Chief Executive Officer's Report	Paper	Dr Chris Clayton	
GBP/2021/046	NHS Derby and Derbyshire CCG Annual Report and Accounts for 2019/20 Link to Annual Report/Accounts: https://www.derbyandderbyshireccg.nhs.uk/publications/annual-report-accounts/	Link	Dr Chris Clayton / Richard Chapman	

FOR DECISION				
GBP/2021/047	Constitution Changes	Papers	Helen Dillistone	10.10
FOR DISCUSSION				
GBP/2021/048	NHS People Plan	Presentation /Paper	Helen Dillistone	10.20
GBP/2021/049	Feedback from Our Big Conversation – Inclusivity and Diversity Report	Paper	Helen Dillistone	
CORPORATE ASSURANCE				
GBP/2021/050	Finance Report – Month 4	Paper	Richard Chapman	10.45
GBP/2021/051	Finance Committee Assurance Report – August 2020	Verbal	Andrew Middleton	
GBP/2021/052	Engagement Committee Assurance Report – July 2020	Paper	Martin Whittle	
GBP/2021/053	Primary Care Commissioning Committee Assurance Report – August 2020	Paper	Professor Ian Shaw	
GBP/2021/054	Quality and Performance Committee Assurance Report – August 2020	Paper	Andrew Middleton	
GBP/2021/055	Governing Body Assurance Framework – Quarter 1 – 2020/21	Paper	Helen Dillistone	
GBP/2021/056	Draft Integrated CCG Corporate and COVID-19 Risk Register - August 2020	Paper	Helen Dillistone	
FOR INFORMATION				
GBP/2021/057	Ratified Minutes of Corporate Committees: <ul style="list-style-type: none"> • Primary Care Commissioning Committee <ul style="list-style-type: none"> ○ 22nd July 2020 • Quality and Performance Committee <ul style="list-style-type: none"> ○ 30th July 2020 	Papers	Committee Chairs	11.05
GBP/2021/058	South Yorkshire and Bassetlaw Integrated Care System JCCCG minutes and meeting papers	Papers	Dr Chris Clayton	
MINUTES AND MATTERS ARISING FROM PREVIOUS MEETING				
GBP/2021/059	Minutes of the Governing Body Meeting in Public held on 6th August 2020	Paper	Dr Avi Bhatia	11.10

GBP/2021 060	Matters arising from the minutes not elsewhere on agenda: <ul style="list-style-type: none"> • Action Log – August 2020 	Paper	Dr Avi Bhatia	
GBP/2021/ 061	Forward Planner	Paper	Dr Avi Bhatia	
GBP/2021/ 062	Any Other Business	Verbal	All	

Date and time of next meeting: Thursday 1st October 2020 at 9.30am to 11.15am – via Microsoft Teams

NHS DERBY AND DERBYSHIRE CCG GOVERNING BODY MEMBERS' REGISTER OF INTERESTS 2020/21



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

Name	Job Title	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 (also a member of Erewash Place Alliance Group; Derbyshire Primary Care Leadership Group; and Derbyshire Place Board)	GP Partner at Moir Medical Centre	✓				2000	Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
		GP Partner at Erewash Health Partnership	✓				April 2018	Ongoing	
		Spouse works for Nottingham University Hospitals in Gynaecology				✓	Ongoing	Ongoing	
		Part landlord/owner of premises at College Street Medical Practice, Long Eaton, Nottingham	✓				Ongoing	Ongoing	
Blackwell, Dr Penny	Governing Body GP (also a member of Derbyshire Primary Care Leadership Group; Gastro Delivery Group; Derbyshire Place Board; Dales Health & Wellbeing Partnership; and Dales Place Alliance Group)	Director of Flourish Derbyshire Dales CIC, which aims to provide creative arts and activity projects and to support others in this activity for the Derbyshire Dales		✓			Feb 2019	Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
		GP partner at Hannage Brook Medical Centre, Wirksworth. Interests in Drug misuse	✓				Oct 2010	Ongoing	
		GP lead for Shared Care Pathology, Derbyshire Pathology		✓			2011	Ongoing	
Braithwaite, Bruce	Secondary Care Specialist (also a member of Audit Committee; and Clinical & Lay Commissioning Committee)	Shareholder in BD Braithwaite Ltd and Vascular Ultrasound Ltd, which provide clinical services in the East Midlands (including NHS funded patients and those who are not eligible for NHS funded treatment according to CCG guidelines)	✓				Aug 2014	Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
		Employed by Nottingham University Hospital NHS Trust which is commissioned by the CCG to provide services to NHS patients.	✓				Aug 2000	Ongoing	
		Founder Member, Shareholder and Director of Clinical Services for Alliance Surgical plc which is a company that bids for NHS contracts.	✓				July 2007	Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
		Fellow of the Royal College Of Surgeons of England and Member of the Vascular Society of Great Britain and Ireland. Advisor to NICE on an occasional basis.		✓			Aug 1992	Ongoing	No action required
		Honorary Associate Professor, University of Nottingham, involved in clinical research activity in the East Midlands.			✓		Aug 2009	Ongoing	No action required

Chapman, Richard	Chief Finance Officer (also a member of Clinical & Lay Commissioning Committee; Finance Committee; Financial Recovery Group; and Primary Care Commissioning Committee)	Nil							No action required
Clayton, Dr Chris	Chief Executive Officer (also a member of Clinical & Lay Commissioning Committee; Financial Recovery Group; and Primary Care Commissioning Committee)	Spouse is a Director at PWC					2001	Ongoing	Declare interest at relevant meetings
Cooper, Dr Ruth	Governing Body GP (also a member of Clinical & Lay Commissioning Committee; Finance Committee; North East Derbyshire & Bolsover Place Alliance Group; Derbyshire Primary Care Leadership Group; CRHFT CQRG; GP Workforce Steering Group; and Conditions Specific Delivery Board)	GP Partner at Staffa Health, Tibshelf Shareholder in North Eastern Derbyshire Healthcare Ltd	✓				Sep 1992 2015	Ongoing Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Dewis, Dr Robyn	Public Health Representative (also a member of 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; and Respiratory Delivery Group)	Nil							No action required
Dentith, Jill	Lay Member for Governance (also a member of Audit Committee; Governance Committee; Primary Care Commissioning Committee; and Remuneration Committee)	Self-employed through own management consultancy business trading as Jill Dentith Consulting	✓				2012	Ongoing	Declare interests at relevant meetings
Dhadda, Dr Bukhtawar S	Governing Body GP (also a member of Clinical & Lay Commissioning Committee; Finance Committee; Quality & Performance Committee; UHDB Clinical Quality Review Group; and Clinical Policy Advisory Group)	GP Partner at Swadlincote Surgery	✓				2015	Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Dillistone, Helen	Executive Director of Corporate Strategy & Delivery (also a member of Engagement Committee; Financial Recovery Group; and Governance Committee)	Nil							No action required

Gibbard, Ian	Lay Member for Audit (also a member of Audit Committee; Clinical & Lay Commissioning Committee; Finance Committee; Governance Committee; Remuneration Committee; and Individual Funding Requests Panel)	Nil							No action required
Hogg, Sandy*	Executive Turnaround Director (also a member of Clinical & Lay Commissioning Committee; Finance Committee; Financial Recovery Group; and Primary Care Commissioning Committee)	Nil							No action required
Jones, Zara	Executive Director of Commissioning & Operations (also a member of Clinical & Lay Commissioning Committee; Financial Recovery Group; Quality & Performance Committee; and CRHFT Contract Management Board)	Nil							No action required
Lloyd, Dr Steven	Medical Director (also a member of CVD Delivery Group; Clinical & Lay Commissioning Committee; Conditions Specific Delivery Board; CRHFT Contract Management Board; EMAS Quality Assurance Group; Finance Committee; Financial Recovery Group; Primary Care Commissioning Committee; and 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
Middleton, Andrew	Lay Member for Finance (also a member of Audit Committee; Finance Committee; Quality & Performance Committee; and Remuneration Committee)	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 - charring 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
McCandlish, Simon	Lay Member for Patient and Public Involvement (also a member of Clinical & Lay Commissioning Committee; Engagement Committee; Primary Care Commissioning Committee; and Quality & Performance Committee)	Nil							No action required
Orwin, Gillian*	Lay Member for Patient and Public Involvement (also a member of Clinical & Lay Commissioning Committee; Engagement Committee; Primary Care Commissioning Committee; and Quality & Performance Committee)	Patient at Wingerworth Surgery			✓		Mar 2017	Ongoing	Will not take part in any decisions relating to Wingerworth Surgery
Pizzey, Dr Emma	Governing Body GP (also a member of Clinical & Lay Commissioning Committee; Governance Committee; Quality & Performance Committee; Erewash Place Alliance Group; and DCHS Clinical Quality Review Group)	Partner at Littlewick Medical Centre, with an interest in diabetes (but not clinical lead) Executive director Erewash Health Partnership	✓ ✓				2002 Apr 2018	Ongoing	Declare interest at relevant meetings

Shaw, Professor Ian	Lay Member for Primary Care Commissioning (also a member of Clinical & Lay Commissioning Committee; Engagement Committee; Primary Care Commissioning Committee; and 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 (also a member of Clinical & Lay Commissioning Committee; Finance Committee; Financial Recovery Group; 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; and 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 (also a member of Clinical & Lay Commissioning Committee; Governance Committee; Quality & Performance Committee; and 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	✓ ✓ ✓				2009 2016 2009 18.03.20 2015	Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Wallace, Dean	Director of Public Health, Derbyshire County Council (also a member of Derbyshire Place Board)	Panel Member for Active Derbyshire part of a local charitable organisation			✓		April 2019	Ongoing	Declare interest at relevant meetings
Watkins, Dr Merryl	Governing Body GP (also a member of Clinical & Lay Commissioning Committee; and 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 (also a member of Engagement Committee; Finance Committee; Governance Committee; Quality & Performance Committee; and 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

<u>Glossary</u>	
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 September 2020

Item No: 044

Report Title	Chair's monthly report
Author(s)	Dr Avi Bhatia – Clinical Chair
Sponsor (Director)	Dr Avi Bhatia – 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 asked to **NOTE** the contents of the report.

Report Summary

On behalf of Governing Body colleagues and myself I would like to extend another warm welcome to our third virtual Governing Body meeting in public. For the immediate future we will continue to hold our Governing Body meetings virtually pending further guidance on when we are able to hold them face to face. In the meantime we will continue to offer members of the public the opportunity to ask questions of Governing Body colleagues and we will respond directly and publish them on the website.

Welcome also to the additional agenda item for today in the form of a summary of our annual report and accounts which my colleagues will take us through shortly. This is in place of a traditional Annual General meeting in recognition of the significant shift in our priorities as we have responded to the pandemic. However we are very keen to share the headline outputs from our first year as NHS Derby and Derbyshire Clinical Commissioning Group.

From a Governing Body perspective we continue to be proactive in supporting our system partners and CCG colleagues as we continue with our response to the pandemic. We have been closely involved throughout from the initial emergency response phase and more recently through to the restoration and recovery phase. Chris, our Chief Executive Officer will cover some of the key operational areas in his report and I will focus on examples of work that Governing Body colleagues are involved in, including some of our most immediate challenges.

From a primary care perspective, and speaking as a working GP, one of our most pressing priorities is to ensure that our patients are seeking support for health needs that concern them at the earliest opportunity. All GP practices are open and dealing

with patients both remotely and face to face when needed, however a concern shared by GP colleagues and clinicians across the system is that people, some with potential cancer symptoms, are not seeking advice early enough. Equally concerning is that some people believe that practices are closed or that GPs are mainly focussed on the response to COVID-19 issues and they don't want to "get in the way." We have been working throughout the pandemic to reverse these perceptions and Chris explains this in more detail including the support we have received from the media with their regular coverage. However, it remains a challenge that we are continuing to work on as a system.

Involving our patients and public in the restoration and recovery of services continues to be one of our highest priorities. Many services are returning to near pre COVID-19 levels of activity but the pandemic has provided our health and care system with invaluable insights into how services could be delivered differently in the future.

We want to involve people wherever opportunities to do things differently present themselves and we have already collated a wealth of patient experience and feedback. However we want to extend the opportunities for involvement further and we are in the process of launching Derbyshire Dialogue which will start as a virtual opportunity for anyone with an interest in health and care to join these sessions covering a range of health and care services. Governing Body colleagues share the passion with colleagues across the CCG to involve our public and patients at every opportunity and we will be well represented at these sessions.

Our Governing Body also has a pivotal role to play over the coming months as we start to enact winter plans. These have been developed together with system colleagues and at an earlier stage than usual in readiness for a range of scenarios that we may face. Alongside this we must also resume our journey towards becoming an Integrated Care System (ICS) in 2021. Whilst we recognise that responding to the next challenges that COVID-19 will inevitably bring is of paramount importance and our first priority, we must ensure that our system is able to benefit from the improvements that becoming an ICS will provide. We are one of the earlier health and care systems nationally to reach this point and we need to continue to deliver against our ambition.

In the meantime I want to assure you that we will continue to do everything we can as a CCG and as a health and care system to protect the people of Derbyshire from the pandemic. We will also ensure that we deliver the programme of work around restoration and recovery of services and will keep you informed, and wherever possible involved as we work to improve health and care services for Derbyshire.

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 September 2020

Item No: 045

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

As we continue on our journey through this unprecedented year we must continually take stock and evaluate our response to the COVID-19 pandemic. This is both as a health and care system working together and also in our individual roles as partner organisations. Reflecting on our performance and lessons learned is a vital part of informing our planning as we move forward.

In Derbyshire to date we have seen 675 deaths from COVID-19 which includes colleagues from our NHS family. Each one represents a personal tragedy for the loved ones they left behind. Although the rate of infections and deaths from COVID-19 has slowed down significantly in recent weeks, it is so important that we keep the real and present danger of the virus at the front of our minds as we move towards the challenges of winter. We are continuing to promote the "stay alert" messages to our local population as we work together to keep people across Derbyshire informed and aware.

Whilst it is positive to note that the R number or infection rate for Derbyshire remains below 1.0 and stable, the recent and well publicised local outbreaks in High Peak and Glossop and more recently in Ilkeston are a clear reminder that we must remain in a high state of vigilance and preparedness at all times. In terms of learning from our experiences I would like to acknowledge the local authority led response to both local outbreaks in the form of the local outbreak plan. Supported by the wider system it was reassuring to see how quickly the plan was implemented including the provision of Mobile Testing Units in both areas.

The local outbreak response is a good example of the collaborative working of the local health and care system. I have described previously how system partners worked together from the earliest days of the pandemic and I cited the example of how partners shared their PPE allocations to ensure that it reached the organisation with the greatest need. This spirit of collaboration continues as we work together to restore and recover health and care services for our patients and public.

Getting services back up to speed quickly and effectively is one of our most urgent priorities. A&E figures are nearly back to pre COVID levels and non-elective activity is recovering at a similar rate to A&E. We still face challenges with cancer performance and although it continues to recover in some areas including a reduction in long waits, referral rates continue to be an area of concern as described by our Chair in his report and we are working hard to remind people that seeking advice early is extremely important.

Over the coming weeks we will be enacting the winter and flu plans which especially significant this year as we must prepare the system for a number of scenarios including a second wave of COVID-19 in the middle of winter and the flu season which would be very challenging for the system. Another scenario could be more localised outbreaks in different communities as we have seen in recent weeks but we must be ready to deal with these and other possible scenarios. We must also plan for a COVID-19 vaccination programme which could potentially run in conjunction with a flu vaccination programme. This is all subject to developments with the national and international research on vaccinations but it is a scenario we must be ready for should it arise.

In my reports I always mention my passion for patient and public involvement and our Chair has described the new opportunities for direct involvement in potential changes. Engaging with staff is also very important and in my July report I referred to the programme of internal engagement which we have described as “Our Big Conversation.” We launched in July with Inclusion and Diversity as our first topic and I continue to be delighted by the response of CCG colleagues in the form of challenges, discussions, thoughts and ideas. The richness of the conversation has been inspiring and as a result we now have a short, medium and long term action plan which will help us to develop our organisational culture.

Many of our discussions have also focussed on how we can use our learning to enhance our commissioning role on behalf of our patients and work is already underway in that regard. Our second, recently launched topic is on new ways of working and will incorporate our experiences over recent months to help us become more productive, more efficient and also support our green responsibilities and ambitions.

Finally, I am again adopting a slightly different approach with regard to sharing my meetings schedule for this report. I hope that the table below illustrates the examples of the key meetings I attend but also their purpose and wider context. You will see that some of the frequencies have changed as we have moved forward, for example the System Escalation meeting was daily but has now moved to twice weekly whilst other meetings have been introduced to align with new priorities around restoration and recovery.

Chief Executive Officer Meeting Programme

Meeting and purpose	Attended by	Frequency
NHS England and Improvement (NHSE/I) meetings – to receive strategic direction and share local intelligence and information including system performance and escalation issues	Senior regional NHSE/I colleagues and CCG executive colleagues	Weekly
System Escalation Meetings - to agree system responses to escalation issues and mutual support. The agenda changes to reflect changing priorities, for example, the emergency response aspect is reduced but restoration and recovery of services and system performance is a core agenda item for each meeting.	Health and care system CEOs or their nominees including NHSE/I	Wednesday & Friday
Local Resilience Forum Strategic Coordinating Group meetings (Police led) - to share intelligence and responses to health and care, public service provision (including emergency services) and all other key service providers regarding issues which impact upon our communities	All system partner CEOs or their nominees	Weekly
System CEO meetings – to discuss and agree short, medium and longer term strategic direction	NHS system CEOs	Fortnightly
Joined Up Care Derbyshire Board meetings	NHS system CEOs	Monthly
System Review Meeting Derbyshire	NHSE/System/ CCG	Monthly
Executive Team Meetings – to determine the CCG’s strategic approach and response to escalation issues	CCG Executive Directors	Weekly
Senior Leadership Team Meeting to highlight escalation issues and agree actions by function for each day	Executive Team and Functional Directors	Monday, Wednesday & Friday
Governing Body Meetings – meetings in Public and Confidential to develop our strategic response in support of the system and make decisions at pace	Governing Body	Monthly
Derbyshire Local Resilience Forum meetings	Derbyshire MPs, Derbyshire County Council	Monthly
Team Talk – to provide staff with current information, priorities and direction and to ensure visibility of CCG leadership and support	All staff	Weekly

3.0 National developments, research and reports

3.1 Celebrities with cancer have joined NHS doctors to encourage the public to come forward for vital, life-saving checks

Famous faces backing the move to increase take-up of NHS checks include the Nolan sisters, who have recently opened about their cancer diagnosis and former BBC Breakfast presenter. Read more [here](#)

3.2 Doorstep delivery of chemotherapy to keep patients safe

Thousands of patients with cancer have had chemotherapy delivered to their doors so that they can more safely receive treatment during the coronavirus pandemic. Up to 10,000 chemo home deliveries were made over three months at the peak of the outbreak, avoiding the need for patients to venture out and risk infection. Read more [here](#)

3.3 Coronavirus and the social impacts on Great Britain

Indicators from the Opinions and Lifestyle Survey covering the period 5 August to 9 August 2020 to understand the impact of the coronavirus (COVID-19) pandemic on people, households and communities in Great Britain. Read more [here](#)

3.4 What parents and carers need to know about early years providers, schools and colleges during the coronavirus (COVID-19) outbreak

The return to school and the questions and concerns that this raises has been well documented in the media. You can find detailed information and sources of support [here](#)

3.5 Study finds very low numbers of COVID-19 outbreaks in schools

Coronavirus (COVID-19) outbreaks and infections in schools are rare, a new study by Public Health England (PHE). Read more [here](#)

3.6 Coronavirus (COVID-19) Infection Survey pilot: England and Wales

Results include infections estimates for England and initial results for Wales. This survey is carried out in partnership with IQVIA, Oxford University and UK Biocentre. Read more [here](#)

3.7 “Transformative” treatment announced for Cystic Fibrosis

From 21 August 2020 thousands of NHS cystic fibrosis patients in England can benefit from a ‘transformative’ treatment for cystic fibrosis. NHS patients will be among the first in Europe to be prescribed Kaftrio, which significantly improves lung function, helping people with cystic fibrosis to breathe more easily and enhancing their overall quality of life. Find out more [here](#)

4.0 Local news updates for Derbyshire

4.1 Reducing the risk of cancers not being diagnosed and treated as quickly as they would have been prior to Covid-19

The CCG is working with NHS health care providers and partners across the health and care system to:

- Make sure patients are aware they should contact their GP if they have any concerns or symptoms so they can be referred and screened.
- Give patients rapid access to diagnosis by working with the county’s hospitals to support them with their plans to manage cases while Covid-19 measures continue.

Also, Dr Louise Merriman, Clinical Lead for Cancer for NHS Derby and Derbyshire Clinical Commissioning Group (CCG) has spoken on local TV and radio news and she said;

- “We really appreciate the support of the public in protecting the NHS while we all fight Covid-19, but the NHS is – and always has been – open for business.

- “Nobody should risk their health because they feel like they don’t want to take up valuable appointment time.
- “And if you’re worried about visiting your practice because of the risks of contracting Covid-19 you should know that stringent infection and prevention control measures are in place to keep patients and staff safe and well.”

The NHS website has more information about cancer symptoms [here](#)

We are asking everyone who reads this to share the key messages above and particularly where someone may have potential cancer symptoms as described in the link - so please support us wherever you can.

4.2 Videos and information to help patients and visitors know what to expect in hospital

Colleagues at the University Hospitals of Derby and Burton NHS Foundation Trust have produced a short film so patients and visitors at their sites know what to do and expect as COVID measures remain in place and you can see it [here](#)

Colleagues at Chesterfield Royal Hospital NHS Foundation Trust have a dedicated information section on their website explaining all the work they have been doing on COVID measures which you can see more information [here](#)

4.3 Local People Asked For Their Views on Virtual Appointments

Healthwatch Derbyshire is asking local people the reasons behind why they have not accessed virtual appointments with a doctor, nurse or carer during lockdown as part of a new research project. The aim is to understand the knock-on effects of COVID-19 on Derbyshire residents who have either been unable to access virtual appointments by telephone or video or who have chosen not to. Read more [here](#)

4.4 NHS People Plan for 2020/21

We are now working on our local version of the People Plan. As a reminder from a previous item on this, the NHS is made up of 1.3 million people who care for the people of this country with skill, compassion and dedication. [This plan](#) sets out what the people of the NHS can expect – from their leaders and from each other – for the rest of 2020 and into 2021. It sets out actions to support transformation across the whole NHS. It focuses on how we must all continue to look after each other and foster a culture of inclusion and belonging, as well as action to grow our workforce, train our people, and work together differently to deliver patient care [here](#)

4.5 Mental health support for children, young people, parents and carers

You can find information on a whole range of support services [here](#) including Information about the new Derby and Derbyshire Emotional Health and Wellbeing website, which has been set up to support the mental health and wellbeing of children, young people, parents and carers and professionals in Derby and Derbyshire. On the website you can find a range of information including local and national support, training and resources.

4.6 Service changes updates

To help people to keep up-to-date with any service changes we are continually providing updates via the Joined Up Care [website](#) regarding all the latest health service information and what to expect when they arrive.

4.7 Stakeholder Bulletins

Throughout the pandemic we have provided our stakeholders (including MPs and local politicians) with the latest developments both nationally and locally. These continue to be well received and you can see find the current and previous versions [here](#).

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

Governing Body Meeting in Public

3rd September 2020

Item No: 046

Report Title	NHS Derby and Derbyshire CCG Annual Report and Accounts 2019/20
Author(s)	Suzanne Pickering, Head of Governance
Sponsor (Director)	Dr Chris Clayton, Chief Executive Officer Richard Chapman, Chief Finance Officer Helen Dillistone, Executive Director of Corporate Strategy and Delivery

Paper for:	Decision	Assurance	X	Discussion	Information	X
Assurance Report Signed off by Chair			N/A			
Which committee has the subject matter been through?			The Derby and Derbyshire CCG Annual Report and Accounts 2019/20 were approved by the Audit Committee on the 26 th May 2020			
Recommendations						
The Governing Body is asked to RECEIVE NHS Derby and Derbyshire CCG's Annual Report and Accounts 2019/20 for information and assurance.						
Report Summary						
<u>Context and Introduction</u>						
<p>Clinical Commissioning Groups are required to prepare an Annual Report and Accounts in accordance with NHS England and Improvement directions, as outlined in the National Health Service Act (2006, as amended). The Annual Report and Accounts presented covers the financial year 2019/20.</p> <p>NHS Derby and Derbyshire CCG's Annual Report and Accounts for the 2019/20 financial year describes our activities during that time, our achievements and our challenges. It also describes our financial performance and how we are meeting our governance requirements. This year's report is our first as a new CCG following the merger of NHS Erewash, Hardwick, North Derbyshire and Southern Derbyshire CCGs.</p> <p>Our Financial Statements are subject to a rigorous audit process and we are delighted that for 2019/20 the CCG's external auditors, KPMG, provided an unqualified audit opinion without issuing any recommendations.</p> <p>On behalf of the entire CCG Governing Body we would like to extend our sincere thanks to our CCG staff, GP Practice membership, our public and voluntary sector partners and NHS staff across Derbyshire for their ongoing contribution towards</p>						

continuously improving the health and wellbeing of the people of Derbyshire. In accordance with the Audit Committee Terms of Reference, the Audit Committee has delegated authority from the Governing Body to review and approve the Annual Report and Accounts on behalf of the Governing Body. The Audit Committee approved the Annual Reports and Accounts on the 26th May 2020.

The Accountable Officer must sign the Annual Report and Accounts to confirm adherence to the reporting framework and these were signed by Dr Chris Clayton on the 26th May 2020.

Due to the implications of the COVID-19 pandemic, NHS England nationally extended the submission date and the signed Annual Report and Accounts were submitted to NHS England and the External Auditors on the 25th June 2020.

NHS Derby and Derbyshire CCG published the Annual Report and Accounts in full on their public website on the 8th July 2020. They can be accessed via the following link:

<https://www.derbyandderbyshireccg.nhs.uk/publications/annual-report-accounts/>

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

Summary of the Annual Report and Accounts

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

- The Performance Report;
- The Accountability Report; and
- The Financial Statements

1. The Performance Report

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

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

The key developments of the CCG during 2019/20 were in relation to the following areas:

- Quality Innovation Prevention and Productivity Programme (QIPP);
- Urgent Care;
- Primary Care;
- Community Services;

- Planned Care;
- Mental Health;
- Ambulance and NHS 111 Commissioning;
- Medicines Management;
- System Working and Collaboration;
- Place Development and Delivery;
- Digital Services; and
- Addressing our Financial Challenge.

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

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

2. The Accountability Report

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

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

- The Members Report.
The report contains the details of the Member Practices, the composition of the Governing Body, Audit Committee membership, Register of Interests, Personal Data Related Incidents and the Statement of Disclosure to the Auditors.
- The Statement of Accountable Officer's Responsibilities.
The Accountable Officer must explain their responsibility for preparing the financial statements and confirm that the ARA as a whole is fair, balanced and understandable and that he takes personal responsibility for the ARA.
- The Governance Statement.
The Governance Statement reflects on the circumstances in which the CCG has operated during 2019/20, particularly;
 - The Governing Body and its Committees and Governing Body Performance during the year;
 - Risk management arrangements and effectiveness;
 - Other sources of assurance;
 - Control Issues;
 - Head of Internal Audit Opinion; and
 - Review of effective governance, risk management and internal control.

The Remuneration and Staff Report sets out the CCG's remuneration policy for its directors and senior managers, reports on how the policy has been implemented and sets out the amounts awarded to directors and senior managers which are detailed in the Remuneration Report tables.

The Staff Report provides an analysis of staff numbers and costs, staff composition and sickness absence data.

The Parliamentary Accountability and Audit Report. The CCG is not required to produce a Parliamentary Accountability and Audit report. Disclosures on remote contingent liabilities and losses and special payments are included where applicable in the Financial Statements and an Audit Certification is included after the Financial Statements.

3. The Financial Statements

The annual accounts include a set of primary financial statements and the format of the statement must be followed precisely as per the Department of Health and Social Care Group Accounting Manual 2019/20. The CCG Auditors have reviewed the Accountability Report for consistency with other information in the financial statements and provided an unqualified opinion on the disclosures detailed in the Accountability Report.

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

Resource implications have been identified and managed through the merger process.

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

Not required for this paper. Notwithstanding this, where any issues/risks are identified from Data Protection Impact Assessment (DPIA) then appropriate actions will be taken to manage the associated risks.

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

Not required for this paper. Notwithstanding this, where any issues/risks are identified from Quality Impact Assessment then appropriate actions will be taken to manage the associated risks.

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

Not required for this paper. Notwithstanding this, where any issues/risks are identified from Equality Impact Assessment then appropriate actions will be taken to manage the associated risks.

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

Not required for this paper

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

The public will be involved in any service changes or developments proposed through the delivery of the Commissioning Strategy.

Have any Conflicts of Interest been identified/ actions taken?

None identified.

Governing Body Assurance Framework

Any corporate risks relating to this agenda and recorded in the Risk Register are aligned to the Governing Body Assurance Framework.

Identification of Key Risks

Any corporate risks relating to this agenda and recorded in the Risk Register are aligned to the Governing Body Assurance Framework.

Governing Body Meeting in Public

3rd September 2020

Item No: 047

Report Title	Constitution Changes
Author(s)	Suzanne Pickering, Head of Governance
Sponsor (Director)	Suzanne Pickering, Head of Governance

Paper for:	Decision	X	Assurance	Discussion	Information
Assurance Report Signed off by Chair	N/A				
Which committee has the subject matter been through?	N/A				
Recommendations					
<p>The Governing Body is asked to:</p> <ul style="list-style-type: none"> • AGREE the inclusion of the Executive Director of Commissioning and Executive Director of Corporate Strategy as voting members of Governing Body; and • AGREE for the Governing Body quoracy to remain as Option1. 					
Report Summary					
<p>With effect from the 1st August 2020, the Turnaround Director role is no longer included in the composition of Governing Body (GB).</p> <p>This was a Fixed Term post which ended on 31st July 2020, and is therefore not part of the organisation's permanent establishment.</p> <p>Section 5.5 Composition of the Governing Body, section 5.5.3 (l) Turnaround Director has been removed from the composition. Governing Body approved this change to the Constitution on the 6th August 2020.</p> <p>As a result of this change the Governing Body recommended that the membership and quoracy should be reviewed whilst continuing to maintain a balance of Lay Member and Clinical for quoracy and a similar clinical majority for decision making.</p> <p>A Lay Member and Clinical majority means that the total number of Lay Members and Clinicians together are greater than the total number of CCG Officers/ Executive in making a decision.</p>					
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
Any corporate risks relating to this agenda and recorded in the Risk Register are aligned to the Governing Body Assurance Framework.
Identification of Key Risks
Any corporate risks relating to this agenda and recorded in the Risk Register are aligned to the Governing Body Assurance Framework.

CONSTITUTION CHANGES

Introduction

With effect from the 1st August 2020, the Turnaround Director role is no longer included in the composition of Governing Body (GB). This was a Fixed Term post which ended on 31st July 2020, and is therefore not part of the organisation's permanent establishment. Section 5.5 Composition of the Governing Body, section 5.5.3 (l) Turnaround Director has been removed from the composition. Governing Body approved this change to the Constitution on the 6th August 2020.

As a result of this change the Governing Body recommended that the membership and quoracy should be reviewed whilst continuing to maintain a balance of Lay Member and Clinical for quoracy and a similar clinical majority for decision making.

A Lay Member and Clinical majority means that the total number of Lay Members and Clinicians together are greater than the total number of CCG Officers/ Executive in making a decision.

The Membership of Governing Body

Currently all those who are members of the Governing Body are voting members. The Governing Body membership (see the table 1 below) has been reviewed to consider the balance of voting rights and a proposal to extend the GB voting members to include the Executive Director of Commissioning and Executive Director of Corporate Strategy and Delivery as additional voting members.

This proposal will mean that all Governing Body members have voting rights. The two Public Health Consultants will continue to be in attendance at the meetings.

Generally, it is expected that the Governing Body's meeting decisions will be reached by a consensus. Should this not be possible then a vote of members will be required. A majority is required to confirm a decision. With the proposed inclusion of the two Executive Directors, the ratio of Lay Members and Clinicians to CCG Officers and Executive Directors is 14:6 where there is full attendance.

Governing Body Role	Current Member / Attendee	Proposed Member / Attendee
Clinical / Lay Members		
1 x Clinical Chair	Clinical Member	Clinical Member
6 x GP Members (in addition to the Clinical Chair)	Clinical Members	Clinical Members
6 x Lay Members	Lay Members	Lay Members
1 x Secondary Care Specialist	Clinical Member	Clinical Member
Executives		
1 x Accountable Officer	Executive Member	Executive Member
1 x Chief Finance Officer	Executive Member	Executive Member
1 x Chief Nursing Officer	Executive Member	Executive Member

Governing Body Role	Current Member / Attendee	Proposed Member / Attendee
1 x Medical Director	Executive Member	Executive Member
1 x Executive Director of Commissioning	Attendee	Executive Member
1 x Executive Director of Corporate Strategy and Delivery	Attendee	Executive Member
Others		
1 x Public Health Consultant Derby City Council	Attendee	Attendee
1 x Public Health Consultant Derbyshire County Council	Attendee	Attendee
Total Members	Clinical Members = 8 Lay Members = 6 Executive members = 4	Clinical Members = 8 Lay Members = 6 Executive Members = 6
Total Attendees	Executive Attendees = 2 Other Attendees = 2	Other Attendees = 2

Table 1 – detailing current and proposed governing body members and those in attendance

Governing Body Quoracy

The CCG Constitution Appendix 3, Standing Orders section 3.6 set out the required quorum necessary for the transaction of Governing Body business.

Table 2 below sets out the original GB quoracy as defined in the constitution, the current quoracy as approved in April 2020 as a result of the GB working in emergency Covid 19 arrangements and the proposed GB quoracy following the addition of the two additional Executive Directors as voting GB members.

Governing Body Role	Option 1 – Retain the original GB quoracy	Option 2 - Current revised Covid 19 GB quoracy	Option 3 - Proposed GB quoracy to include other Executives
CCG Clinical Chair, Vice Chair (PPI Lay Member)	1	1	1
Lay Members	2	2	2
Voting Clinicians (Including GP Members, Secondary Care Doctor)	4	2	4
CCG Officer (CEO/CFO/CNO)	1	1	1
CCG Executive Director	0		
Total number of members	8	6	8

Table 2 – quoracy options

All three options would give a Clinical / Lay Member majority.

Deputy Officers

As per section 3.6.1 of the Standing Orders, Voting Executive Officers may nominate a deputy to attend on their behalf. The nomination must be approved by the Chair. Where a nominated deputy attends, the nominated individual will have delegated responsibility for representation at meetings including voting, actions as required and any decisions made.

Recommendation

The Governing Body is asked to:

- **AGREE** the inclusion of the Executive Director of Commissioning and Executive Director of Corporate Strategy as voting members of Governing Body.
- **AGREE** for the Governing Body quoracy to remain as Option1.

Governing Body Meeting in Public

3rd September 2020

Item No: 048

Report Title	NHS People Plan
Author(s)	Beverley Smith, Director of Corporate Strategy and Development
Sponsor (Director)	Helen Dillistone, Executive Director of Corporate Strategy and Delivery

Paper for:	Decision	Assurance	X	Discussion	Information	X
Assurance Report Signed off by Chair			N/A			
Which committee has the subject matter been through?			Future reports regarding the CCG implementation of actions within the NHS People Plan will be provided to the Governance Committee.			

Recommendations

This is a nationally mandated programme for all NHS employers, therefore it is **RECOMMENDED** that the Governing Body receive details and understand the employer responsibilities and workforce implications for the CCG.

That the Governing Body **RECEIVES ASSURANCE** that the programme of actions as identified in this report fulfils the requirements of employers contained in The NHS People Plan.

That the Governing Body **RECEIVES ASSURANCE** that the CCG is a committed partner to the JUCD (Joined Up Care Derbyshire) system response to The NHS People Plan.

Report Summary

Introduction

This report and presentation (Appendix 1) introduces the NHS People Plan.

[We Are The NHS – People Plan 2020-21](#)

[We Are The NHS – People Plan 2020-21\(Easy Read\)](#)

All NHS employers are obligated to have their own People Plan in response to the national plan. DDCCG has previously had an annual HR Plan; this will now be known as DDCCG People Plan and will encompass the requirements from the national plan. Furthermore, each system is required to have its own People Plan. The JUCD People Plan (draft) was submitted to NHSEI end of August as required in direct response to the national plan and will be shared at the inaugural People and Culture Board in early September, Helen Dillistone is the DDCCG representative on the Board. Final

date of submission for the Derbyshire system plan is 30 September 2020. This will be presented to the Governing Body at the October meeting.

Please see below the requirements for NHS employers:

NHS People Plan – Detailed Actions

In each area of the [We Are The NHS – People Plan 2020-21](#) the document sets out actions for employers, national bodies and systems.

Please find below a summary of these actions (101 in total). All employer actions have been RAG rated to show current progress status for the CCG as of 12th August 2020.

Red = Not commenced (13/101)

Amber = Commenced (22/101)

Green = Complete (6/101)

Grey = Not relevant for CCG/ or action not required from CCG (60/101)

HEALTH AND WELLBEING

	Action
1	Put in place effective infection prevention and control procedures.
2	Ensure all staff have access to appropriate personal protective equipment (PPE) and are trained to use it.
3	All frontline healthcare workers should have a vaccine provided by their employer.
4	Complete risk assessments for vulnerable staff, including BAME colleagues and anyone who needs additional support, and take action where needed.
5	Ensure people working from home can do safely and have support to do so, including having the equipment they need.
6	Ensure people have sufficient rests and breaks from work and encourage them to take their annual leave allowance in a managed way.
7	Prevent and tackle bullying, harassment and abuse against staff, and create a culture of civility and respect.
8	Prevent and control violence in the workplace – in line with existing legislation.
9	NHS violence reduction standard to be launched.
10	Appoint a wellbeing guardian.
11	Continue to give staff free car parking at their place of work.
12	Support staff to use other modes of transport and identify a cycle-to-work lead.

13	Ensure staff have safe rest spaces to manage and process the physical and psychological demands of the work.
14	Ensure that all staff have access to psychological support.
15	Continue to provide and evaluate the national health and wellbeing programme.
16	Identify and proactively support staff when they go off sick and support their return to work.
17	Ensure that workplaces offer opportunities to be physically active and that staff are able to access physical activity throughout their working day.
18	Make sure line managers and teams actively encourage wellbeing to decrease work-related stress and burnout.
19	Every member of NHS staff should have a health and wellbeing conversation.
20	All new starters should have a health and wellbeing induction.
21	Provide a toolkit on civility and respect for all employers.
22	Pilot an approach to improving staff mental health by establishing resilience hubs.
23	Pilot improved occupational health support in line with the SEQOHS standard.

FLEXIBLE WORKING

	Action
1	Be open to all clinical and non-clinical permanent roles being flexible.
2	All job roles across NHS England and NHS Improvement and HEE will be advertised as being available for flexible working patterns.
3	Develop guidance to support employers.
4	Cover flexible working in standard induction conversations for new starters and in annual appraisals.
5	Requesting flexibility – whether in hours or location, should (as far as possible) be offered regardless of role, team, organisation or grade.
6	Board members must give flexible working their focus and support.

7	Add a key performance indicator on the percentage of roles advertised as flexible at the point of advertising to the oversight and performance frameworks.
8	Support organisations to continue the implementation and effective use of e-rostering systems.
9	Roll out the new working carers passport to support people with caring responsibilities.
10	Work with professional bodies to apply the same principles for flexible working in primary care.
11	Continue to increase the flexibility of training for junior doctors.

EQUALITY AND DIVERSITY

	Action
1	Overhaul recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets.
2	Discuss equality, diversity and inclusion as part of the health and wellbeing conversations described in the health and wellbeing table.
3	Publish progress against the Model Employer goals to ensure that the workforce leadership is representative of the overall BAME workforce.
4	51 per cent of organisations to have eliminated the ethnicity gap when entering into formal disciplinary processes.
5	Support organisations to achieve the above goal, including establishing robust decision-tree checklists for managers, post-action audits on disciplinary decisions, and pre-formal action checks.
6	Refresh the evidence base for action, to ensure senior leadership represents the diversity of the NHS, spanning all protected characteristics.

CULTURE AND LEADERSHIP

	Action
1	Work with the National Guardians office to support leaders and managers to foster a listening, speaking up culture.
2	Promote and encourage employers to complete the free online just and learning culture training and accredited learning packages, and take demonstrable action to model these leadership behaviours.
3	Provide refreshed support for leaders in response to the current operating environment.

4	Work with the Faculty of Medical Leadership and Management to expand the number of placements available for talented clinical leaders each year.
5	Update the talent management process to make sure there is greater prioritisation and consistency of diversity in talent being considered for director, executive senior manager, chair and board roles.
6	Launch an updated and expanded free online training material for all NHS line managers, and a management apprenticeship pathway for those who want to progress.
7	All central NHS leadership programmes to be available in digital format and accessible to all.
8	Review governance arrangements to ensure that staff networks are able to contribute to and inform decision-making processes.
9	Publish resources, guides and tools to help leaders and individuals have productive conversations about race, and to support each other to make tangible progress on equality, diversity and inclusion for all staff.
10	Publish competency frameworks for every board-level position in NHS provider and commissioning organisations.
11	Place increasing emphasis on whether organisations have made real and measurable progress on equality, diversity and inclusion, as part of the well-led assessment.
12	Launch a joint training programme for Freedom to Speak Up Guardians and WRES Experts, and recruit more BAME staff to Freedom to Speak Up Guardian roles.
13	Publish a consultation on a set of competency frameworks for board positions in NHS provider and commissioning organisations.
14	Finalise a response to the Kark review.
15	Launch a new NHS leadership observatory highlighting areas of best practice globally, commissioning research, and translating learning into practical advice and support for NHS leaders.

NEW WAYS OF DELIVERING CARE

	Action
1	Use guidance on safely redeploying existing staff and deploying returning staff, developed in response to COVID-19 by NHSEI and key partners, alongside the existing tool to support a structured approach to ongoing workforce transformation.
2	Continued focus on developing skills and expanding capabilities to create more flexibility, boost morale and support career progression.

3	Use HEE's e-Learning for Healthcare programme and a new online Learning Hub, which was launched to support learning during COVID-19.
4	Work with the medical Royal Colleges and regulators to ensure that competencies gained by medical trainees while working in other roles during COVID-19 can count towards training.
5	Develop the educational offer for generalist training and work with local systems to develop the leadership and infrastructure required to deliver it.
6	Support the expansion of multidisciplinary teams in primary care.

GROWING THE WORKFORCE

	Action
1	Enabling up to 300 peer-support workers to join the mental health workforce and expanding education and training posts for the future workforce.
2	Increasing the number of training places for clinical psychology and child and adolescent psychotherapy by 25 per cent (with 734 starting training in 2020/21).
3	Investing in measures to expand psychiatry, starting with an additional 17 core psychiatry training programmes in 2020/21 in areas where it is hard to recruit, and the development of bespoke return to practice and preceptorship programmes for mental health nursing.
4	Prioritise the training of 400 clinical endoscopists and 450 reporting radiographers.
5	Training grants are being offered for 350 nurses to become cancer nurse specialists and chemotherapy nurses.
6	Training 58 biomedical scientists, developing an advanced clinical practice qualification in oncology, and extending cancer support-worker training.
7	HEE is funding a further 400 entrants to advanced clinical practice training.
8	Investing in an extra 250 foundation year 2 posts, to enable the doctors filling them to grow the pipeline into psychiatry, general practice and other priority areas, notably cancer, including clinical radiology, oncology and histopathology.
9	Increase of over 5,000 undergraduate places from September 2020 in nursing, midwifery, allied health professions, and dental therapy and hygienist courses.
10	Employers should fully integrate education and training into their plans to rebuild and restart clinical services, releasing the time of educators and supervisors; supporting expansion of clinical placement capacity during the remainder of 2020/21; and providing an increased focus on support for students and trainees, particularly those deployed during the pandemic response.

11	For medical trainees, employers should ensure that training in procedure-based competencies is restored as services resume and are redesigned to sustain the pipeline of new consultants in hospital specialties.
12	Ensure people have access to continuing professional development, supportive supervision and protected time for training.
13	Establish a £10m fund for nurses, midwives and allied health professionals to drive increased placement capacity and the development of technology-enhanced clinical placements.
14	HEE to further develop its e-learning materials, including simulation, building on the offer provided in response to COVID-19.
15	Start delivering a pre-registration blended learning nursing degree programme. The programme aims to increase the appeal of a nursing career by widening access and providing a more flexible approach to learning, using current and emerging innovative and immersive technologies.
16	HEE to pursue this blended learning model for entry to other professions.

RECRUITMENT

	Action
1	Increase recruitment to roles such as clinical support workers, highlighting the importance of these roles for patients and other healthcare workers as well as potential career pathways to other registered roles.
2	Offer more apprenticeships, ranging from entry-level jobs through to senior clinical, scientific and managerial roles.
3	Develop lead-recruiter and system-level models of international recruitment, which will improve support to new starters as well as being more efficient and better value for money.
4	Primary care networks to recruit additional roles, funded by the additional roles reimbursement scheme, which will fund 26,000 additional staff until 2023/24.
5	Increase ethical international recruitment and build partnerships with new countries, making sure this brings benefit for the person and their country, as well as the NHS.
6	HEE will pilot English language programmes – including computer-based tests, across different regions as well as offering English language training.
7	Establish a new international marketing campaign to promote the NHS as an employer of choice for international health workers.
8	Encourage our former people to return to practice as a key part of recruitment drives during 2020/21, building on the interest of clinical staff who returned to the NHS to support the COVID-19 response.

9	Continue to work with professional regulators to support returners who wish to continue working in the NHS to move off the temporary professional register and onto the permanent register.
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RETAINING STAFF

	Action
1	Design roles which make the greatest use of each person's skills and experiences and fit with their needs and preferences.
2	Ensure that staff who are mid-career have a career conversation with their line manager, HR and occupational health.
3	Ensure staff are aware of the increase in the annual allowance pensions tax threshold.
4	Make sure future potential returners, or those who plan to retire and return this financial year, are aware of the ongoing pension flexibilities.
5	Explore the development of a return to practice scheme for other doctors in the remainder of 2020/21, creating a route from temporary professional registration back to full registration.
6	Develop an online package to train systems in using the HEE star model for workforce transformation.
7	Improve workforce data collection at employer, system and national level.
8	Support the GP workforce through full use of the GP retention initiatives outlined in the GP contract, which will be launched in summer 2020.
9	Strengthen the approach to workforce planning to use the skills of our people and teams more effectively and efficiently.
10	Work with HEE and NHSEI regional teams to further develop competency-based workforce modelling and planning for the remainder of 2020/21, including assessing any existing skill gap and agreeing system-wide actions to address it.

RECRUITMENT AND DEPLOYMENT ACROSS SYSTEMS

	Action
1	Actively work alongside schools, colleges, universities and local communities to attract a more diverse range of people into health and care careers.
2	Make better use of routes into NHS careers (including volunteering, apprenticeships and direct-entry clinical roles) as well as supporting recruitment into non-clinical roles.
3	Develop workforce sharing agreements locally, to enable rapid deployment of our people across localities.

4	When recruiting temporary staff, prioritise the use of bank staff before more expensive agency and locum options and reducing the use of 'off framework' agency shifts during 2020/21.
5	Work with employers and systems to improve existing staff banks' performance on fill rates and staff experience.

There are a number of actions that the CCG recognise are priority and will therefore be implementing. These are:

- Complete risk assessments for vulnerable staff, including BAME colleagues and anyone who needs additional support, and take action where needed.
Status: Complete - A risk assessment has been undertaken for each member of staff, including vulnerable and BAME colleagues. Risk assessments will be subject to review should any circumstances change.
- Every member of NHS staff should have a health and wellbeing conversation. Discuss equality, diversity and inclusion as part of the health and wellbeing conversations.
Status: Complete and ongoing - Health and wellbeing conversations have been mandated for each member of staff. HR developed a wellbeing checklist and delivered briefings to support line managers with these conversations. Questions to support a conversation on equality, diversity and inclusion are being added to the wellbeing checklist.
- Ensure line managers and teams actively encourage wellbeing to decrease work-related stress and burnout.
Status: In progress – forms part of the conversations on health and wellbeing.
- Promote flexible working and cover flexible working in standard induction conversations for new starters and in annual appraisals.
Status: Not yet commenced –organisational pledge on equality, diversity and inclusion drafted to incorporate and promote flexible working. Review of induction and appraisal to be incorporated into HR work plan.
- Ensure Board members give flexible working their focus and support.
Status: Not yet commenced.
- Overhaul recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets.
Status: In progress – review commenced.
- Review governance arrangements to ensure that staff networks are able to contribute to and inform decision-making processes.
Status: In progress.
- Continued focus on developing skills and expanding capabilities to create more flexibility, boost morale and support career progression (staff retention).
Status: In progress.

Are there any Resource Implications (including Financial, Staffing etc)?
No, the requirements of the CCG as set out in The NHS People Plan will be contained within existing resources.
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?
No, however the NHS people plan sets out actions to support transformation across the whole NHS. It specifically focuses on fostering a culture of inclusion and belonging with an emphasis on valuing people and promoting a more inclusive service and workplace so that people will want to stay. The People Plan promotes equality, diversity and inclusion. It emphasises that discrimination, violence and bullying have no place in the NHS and we need to understand, encourage and celebrate diversity in all its forms.
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
There will be full involvement and engagement with the CCG staff through Our Big Conversations, our staff forum (OEIG) and utilising the experience and expertise of our staff within our Diversity and Inclusion Network.
Have any Conflicts of Interest been identified/ actions taken?
None identified.
Governing Body Assurance Framework
This report has been developed to provide information and assurance to the Executive Team and the Governing Body.
Identification of Key Risks
The NHS People Plan sets out a range of actions for the CCG to undertake to support transformation across the whole NHS. It focuses on how we must continue to look after each other and foster a culture of inclusion and belonging, as well as take action to grow our workforce, train our people and work together differently to deliver patient care. The CCG is required to report progress in relation to the actions.

WE ARE THE NHS:

People Plan for 2020/21 - action for us all



The NHS People Plan



Introduction

- We are the NHS: action for us all from (NHSEI) and Health Education England (HEE) sets out what our NHS people can expect from their leaders and each other.
- It focuses on how we must look after each other and foster a culture of **inclusion and belonging**, as well as action to grow and train our workforce, and work together differently to deliver patient care.
- The plan is focused primarily on the immediate term (2020-21) with an intention for the principles to create longer lasting change.
- There are funding commitments made within the plan, however some of the workforce growth aspirations outlined in the interim plan and the government's manifesto, require further discussion and are therefore outside of the scope of this plan.



A practical and ambitious plan that ...

- responds to new **challenges and opportunities**
- focuses on the action **NHS people tell us** they need right now
- sets out what NHS people **can expect** from their leaders and each other



...with specific commitments around:

- **Looking after our people**
- **Belonging in the NHS**
- **New ways of working**
- **Growing for the future**



Looking after our people

Sets out our People Promise to everyone who works in the NHS.

This will help make the NHS a better place to work by ensuring staff are:

- **Safe and healthy**
- **Physically and mentally well**
- **Able to work flexibly**

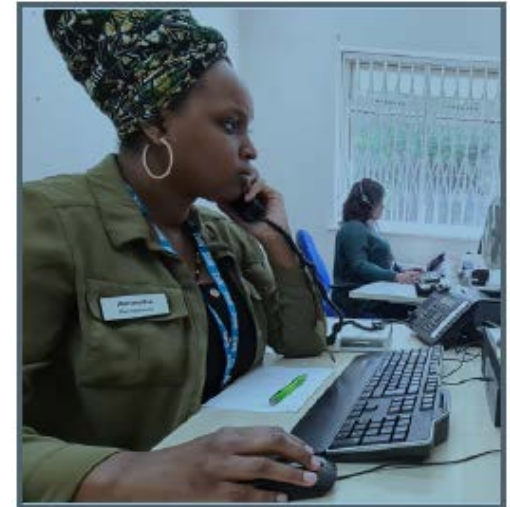


OUR NHS PEOPLE PROMISE



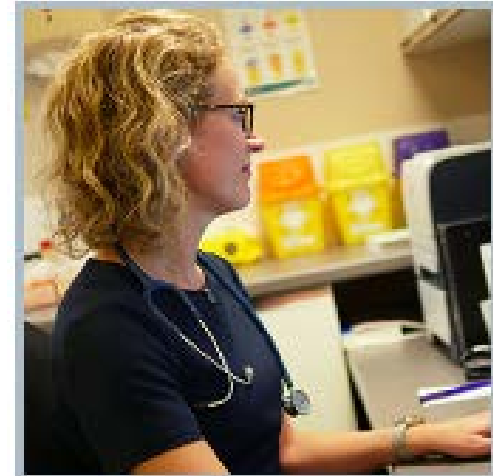
Belonging in the NHS

- Action to ensure the NHS is
 - **inclusive and diverse**
 - a place where discrimination, violence and bullying do not occur
- Includes
 - Overhauling **recruitment practices** to improve representation
 - **Health and wellbeing conversations**
 - Confidence to **speak up** and empowering staff to **use their voice** to inform learning and improvement
 - **Inclusive, compassionate leadership**



New ways of working and delivering care

- COVID-19 compels us to
 - be **flexible**
 - make **best use** of skills and experience
- We will continue to enable working differently
 - **Upskilling** staff
 - Expanding **multi-disciplinary teams**
 - Supporting **volunteers** in the NHS and expanding routes into health and care careers
 - Supporting staff **learning and development**
 - access to CPD
 - greater access to online learning



Growing for the future

- We want to capitalise on
 - **unprecedented interest** in NHS careers
 - higher **numbers of applications** to education and training.
- We will do this through
 - **Recruiting** into entry-level clinical and non-clinical roles
 - **Return to practice**
 - **Training places** in shortage professions
 - **International recruitment**
 - **Retaining more people** in the service



Asks to Local Employers and Systems

- There are a list of detailed asks of employers and systems within each of the four categories to be delivered during 2020-21. These are captured in a separate table for ease.
- Each local system is asked to develop a local People Plan in response to the national plan, to be reviewed by regional and system level People Boards. **Joined Up Care Derbyshire have developed a System People Plan to capture and monitor progress against the system wide actions. We will work with our partner organisations to deliver the System People Plan.**
- Employers are encouraged to devise their own local People Plan. **Local actions required from the CCG have been captured and will be monitored with progress reported to the Governance Committee on a quarterly basis.**
- Metrics will be developed by September 2020 with the intention to track progress using the NHS Oversight Framework.

Governing Body Meeting in Public

3rd September 2020

Item No: 049

Report Title	Outcome of the CCG Big Conversation 1 (Inclusion and Diversity)
Author(s)	Beverley Smith Director of Corporate Strategy and Development
Sponsor (Director)	Helen Dillistone Executive Director of Corporate Strategy and Delivery

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

The Governing Body is requested to receive the outcome of our first Big Conversation and confirm agreement to the actions as set out in the action plan.



The Governing Body is asked to note the inter relationship between the action plan and The NHS People Plan (covered under a separate agenda item at this meeting).

Report Summary

Background

NHS Derby and Derbyshire CCG is committed to ensuring that it is an inclusive organisation and an inclusive health service commissioner. We identified the need to discuss both things openly to understand what this means, for our staff and our population.

The COVID-19 pandemic and its disproportionate impact on Black and Minority Ethnic (BAME) citizens, coupled with the death of George Floyd in America have rightly brought the conversations about equality into sharp focus. Reports from Public Health England and others on the impact of COVID-19 on BAME citizens pose questions for us as a commissioner and for all of us as citizens.

Therefore our first conversation topic was launched on 7 July and was paused on Tuesday 4 August to allow for a review of information to date. This report identifies key findings from The Big Conversation 1 and includes the organisational action plan that supports the findings.

How we engaged

There were a number of ways in which staff could offer feedback:

- Dedicated email address
- Staff Facebook Group
- Intranet discussion
- 4 discussion groups
- Manager briefings

114 Managers took part in the four July briefing sessions.

23 Colleagues took part in polls on Facebook and the Intranet.

41 Colleagues have been involved or expressed interest in the inclusion discussion groups via Microsoft Teams.

23 Colleagues have used the "survey" link as a way of providing us with valuable insight.

Feedback

The feedback below has been themed to maintain anonymity of those responding and is directly from colleagues via Our Big Conversation Facebook group, dedicated inbox, intranet discussion forums, anonymous survey link and Team Talk notes since the launch of the first conversation on 7 July 2020.

***Please note:** Due to identifying factors not all comments provided will appear here and have been dealt with on an individual basis. Comments are provided mostly verbatim to ensure the essence of the staff feedback isn't lost.*

Changing the DNA of the organisation

- We have a long way to go with changing attitude and recognising unconscious bias.
- 'Bandism' or 'Gradeist' language seems so pervasive within the organisation and our partners and providers. It has such a strong potential to reduce motivation/de-skill and disempower staff - ultimately impacting on their performance and reducing their chance to progress to higher positions.
- Promoting colleagues due to factors like age and length of time in role has been mentioned as a negative, rather than promotion due to their performance, experience, qualifications and skillset to be brought to the role, ageism is an issue both ways.
- **"Courage in putting a mirror in front of the organisation face."**
- Organisation needs to agree **"what good looks like."**
- Ensuring that all staff even from non-minority groups feel empowered to speak up and have a voice.
- Anxiety and depression aren't illnesses that can be cured, we need to take a better more accepting approach for people living with it rather than trying to imply they should get better at dealing with stress.
- Colleagues have felt judged for flexible working – work/life balance is so important especially now, we need to learn from the way we have adapted.

Awareness around Protected Characteristics

- There is no legal requirement to inform your employer you are transgender, and there should not be any requirement to even ask this on any 'diversity and inclusion' form, so no real need to have a definitive statement. There should always be the choice of whether to inform your organisation of anything you feel is relevant, or have the choice not to, which covers the Miss, Mr or Mrs question.
- Faith and religion, acknowledge all holidays and festivals, also the similarities and shared beliefs we hold.
- Encouragement for BAME staff and understanding/breaking down barriers between and within all races and ethnic backgrounds.
- We need to consider the disparity between BAME groups within themselves. The racism between Caucasian and BAME exists but some feel the racism between BAME groups themselves is on the rise.
- Consider different socioeconomic backgrounds that may not feel included, particularly those from poorer areas, not necessarily just minority groups.
- Also staff from different socioeconomic backgrounds could be offended by certain conversations - be conscious of those around you and those you talk to, we can't all relate and have everything in common with each other but we can be respectful with our language.
- We need to celebrate the differences in families and be mindful of the assumptions we make both with our colleagues and our communities – family means different things to different people and who a family includes can also be very different.
- For colleagues who don't have children we need to be sensitive to reasons for this, for example, some may be childless by choice whereas for others this might not be the case. It is also important to recognise that some colleagues may be childless but that does not mean they can't also opt to have school holidays off.
- Colleagues have reported some judgement around "invisible illness" or disabilities others may not recognise – it's hard coming back after being off with mental health issues or circumstances they feel are hard to explain.

Staff training and education

- Stop the 'tick box exercises' on ESR when it comes to equality and Inclusion this isn't powerful enough.
- PowerPoints and ESR based on multiple choice don't "stick" or move people.
- We need it to be powerful, by **real people with lived experiences**.
- We should tap into Derby LGBT+ community for training and visit existing ethnic groups, religious places, Care Voluntary Sector and the deaf community.
- More awareness around mental health especially depression and anxiety, outside support and training would be good, MHFA are colleagues and some may find it hard to approach them.
- This link has been suggested more than once:
<http://salmapatel.co.uk/healthy-teams/white-senior-leaders-practical-things-to-create-supportive-culture-for-black-bame-colleagues/>
- Unconscious bias video could be built into our training or team meeting agenda, numerous colleagues have fed back how powerful it was and that every member of staff should be given time to watch it.
- "Reverse" mentoring - sharing lived experiences with more senior members of

staff works very well, more of this, but some have fed back the term “reverse” is incorrect, as the mentor is the subject matter expert.

- In PCT days there was a great two day equality masterclass. A tour around local faith centres, then time to reflect on what impact it had on individuals.
- EMLA courses all aimed at more senior levels. Not enough for lower levels to aid development.
- Do we have an equality lead for the organisation and if not why not?
- More training for management who sit on interview panels, with a special focus on recognising unconscious bias also, colleagues have raised personality traits as being a potential issue and interview panels needs to be made up of varied personality and leadership “types” there are tests you can do for this that some teams recommend.

Ideas, initiatives and ways in which we address some of the issues

- Could we establish a BAME youth apprenticeship programme within the CCG?
- Can we set up diversity and inclusion book groups, where there may be set material (at least to start) and then suggestions within a book group or from one group to another, up to five people perhaps, to allow for meaningful discussion?
- Inclusion and diversity network events with guest speakers: We could have a session around how to safely and effectively challenge racism and prejudice? Not everyone feels comfortable doing so. A session about language use would be useful too.
- CCG aims and objectives (mission statement if you like) including a clearly articulated diversity and inclusion strategy.
- CCG recruitment, selection and staff retention training - this should be at all levels including the Executive Team.
- Development of staff and access to opportunity, executive level lead for inclusion and diversity.
- Develop clear behavioural standards and hold people accountable for these.
- Develop a visible scorecard to measure progress including metrics for recruiting, promotion rates, retention/turnover.
- Personality tests; these are a good way for a manager to learn more about their team, also when the recruitment process is carried out that all personality traits e.g. red, blue, green, yellow (or as many as possible) are included on the recruitment panel and also during the shortlisting process (if the majority of a recruitment panel represents one particular colour then they are more likely consciously or subconsciously to recruit the same personality trait).
- Recruitment process good to shortlisting. When the ‘mask’ comes off how unbiased are we? Suggestions made that we should do more debriefing afterwards to understand how we came to the decision and if we didn’t let any personal views come into it. Also what feedback do we give to people who we have not recruited? Do they understand the reasons why to empower them to succeed next time around.

Positive feedback, what we are getting right

- Staff gender representation – females at all levels including female executives is refreshing compared to some organisations.
- We tend to be a social organisation.

- The fact we are having these conversations is such a positive start.
- We encourage conversations regarding mental health and have the mental health first aiders.
- Colleagues have reported their teams and managers being supportive of them through the pandemic and some staff say management are sensitive to home life and carer responsibilities.
- Executives are more present and visible since MS Teams meetings etc this is really positive to get to know those who lead us.
- Having anonymous routes to feedback gives staff confidence and security to say what they really think and no fear of repercussions or judgement, keep up the survey links.

The recommendations for this report were as follows:

- The **report** to be presented to OEIG and the Inclusion and Diversity Forum for discussion on feedback to date – **complete**.
- For OEIG and the Inclusion and Diversity Forum to note feedback and agree actions to be developed into a short, medium and long term action plan for review - **complete**.
- For OEIG and the Inclusion and Diversity Forum to support the allocation of actions and delivery of the action plan – **in progress**.
- OEIG and the Inclusion and Diversity Forum to present their feedback and action plan to the Senior Leadership Team – **complete**.
- Senior Leadership Team to review and accept the action plan – **Friday, 14 August - complete**.
- OEIG and the Inclusion and Diversity Forum to work with the communications team to publish the action plan and support feedback to staff through preferred channels and mechanisms – **complete**
- Report to be presented to Governing Body in September in conjunction with the NHS People Plan – **Thursday, 3 September**.
- OEIG and the Inclusion and Diversity Forum to support ongoing conversation and feedback recognising that this topic will remain open indefinitely – **ongoing**.

What Next?

- The Action Plan is attached as **Appendix 1**.
- It is intended that ownership of the Action Plan is with the whole organisation, but will be driven by the Senior Leadership Team. Dr Steven Lloyd as the executive lead and diversity and inclusion champion, will provide overall leadership of the programme.
- The Staff Survey 2020 will be launched in September and will provide a benchmark for the 2021 results. It will be helpful to see whether the new staff engagement strategy (Our Big Conversation) helps to improve our staff survey results. The Staff Survey in 2019 identified that a higher proportion of BAME staff were considering leaving the CCG, less satisfied with opportunities to use their skills, and less satisfied with opportunities to access flexible working and learning and development. In addition, when asked if the organisation acts fairly in relation

to career progression, 81% of White employees responded positively compared with 56% BAME. A similar disparity was recorded for non-disabled staff with 81% responding positively compared to 66% for people with disabilities.

- The senior leadership team have embraced the Reverse Mentoring programme, and it is now underway.
- In line with the NHS People Plan, the HR team will overhaul recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets. This will include:
 - Implementing diverse recruitment panels
 - Adding an organisational pledge/statement around diversity and inclusion to attract a diverse workforce
 - A positive statement on all roles open for flexible working patterns
 - Introducing values based recruitment within the CCG
- The one-to-one wellbeing conversations will be extended to include a conversation relating to equality, diversity and inclusion.

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

No, The Big Conversation is an essential component of the CCG's employee engagement strategy and as such is delivered within existing staff resources. There are no costs associated within the Action Plan that have not been accounted for outside of existing budgets.

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, however the CCG recognises the Action Plan as set out will make improvements within the organisation to enable it to become a more diverse and inclusive organisation.

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

As above.

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

Yes, all staff have been involved in our Big Conversation, using surveys, focus groups, Team Talk briefings, Facebook group, Inclusion and Diversity staff network and through discussion in the Organisation Effectiveness and Improvement Group

(OEIG), which is our staff network forum.

Have any Conflicts of Interest been identified/ actions taken?

None identified.

Governing Body Assurance Framework

This report has been developed to provide information and assurance to the Executive Team and the Governing Body.

Identification of Key Risks

Inequalities within the workplace can impact adversely on staff satisfaction, health and wellbeing, morale and motivation and lead to higher sickness absence, higher staff turnover, increased complaints and risk of litigation for unfair treatment. A diverse and engaged workforce ensures a variety of different perspectives are heard leading to better decision making, increased creativity and innovation.

Activity	Potential further action	Action owner	Review	Status	Comments
Short term - in the next month					
Identify all the holidays and festivals we would wish to celebrate/mark in relation to faith and religion. What events/festivals/holidays celebrate our similarities and the shared beliefs we hold?	Volunteers to research	Diversity & Inclusion Network	30-Sep-20	Commenced	
Something about socio-economic backgrounds? Book club as a tool to help conversations about life experiences / different perspectives.	Check whether the colleague who promoted the book club idea is known or anonymous	OEIG	30-Sep-20	Not Commenced	
Recirculate link for unconscious bias video and research other opportunities to share video material - potential to create vox pops or mini clips to share on a rolling basis	To share via channels including Team Talk, links in staff bulletin	Human Resources	30-Sep-20	Not Commenced	
Identify "real" people who can talk about their lived experiences relating to inclusion and diversity (mental health included in this). Could be like when members of the public presented their 'patient story' to Governing Body. Or could be professional trainers. Explore the suggestion - We should tap into Derby LGBT+ community for training and visit existing ethnic groups, religious places, Care Voluntary Sector and the deaf community	Potential to share lived experiences with the Governing Body to promote the importance of diversity and inclusion and our commitment	Diversity & Inclusion Network/ Human Resources	30-Sep-20	Not Commenced	
We need to fully understand the demographic of our organisation	Request to HR to share any available analysis	Human resources	30-Sep-20	Commenced	Quarterly HR Monitoring report, WRES & WDES
Medium term - 2 -6 months					
Something to raise awareness of 'invisible' illnesses - training or using 'real' people as above?	Identify champion/s to share their lived experiences	Diversity & Inclusion Network/ Human Resources	Nov-20	Not Commenced	
Implement 'reverse' mentoring scheme in the organisation. Lots of people don't like the term 'reverse' mentoring so perhaps just call it 'peer mentoring' or simply 'mentoring'? Steve suggested co-mentoring as his preferred.	To define at which levels	Human Resources	Oct-20	Commenced	Initially available to members of SLT
Set up a programme of inclusion and diversity network events with guest speakers. Session ideas: how to safely and effectively challenge racism and prejudice, language use.	Potential to deliver short sessions via Team Talk?	Diversity & Inclusion Network	Oct-20	Not Commenced	
Promote the importance of having an equality/diversity lead for the organisation		Senior Leadership Team	Oct-20	Not Commenced	
Check to see if EMLA courses (or other suitable courses) could be made accessible to all staff to aid development and progress opportunities		Human Resources	Nov-20	Not Commenced	
Identify suitable 'unconscious bias' training for recruiters (those that sit on interview panels)		Human Resources		Commenced	
Long term - 6 months+					
Ensure CCG has a diversity and inclusion strategy. Establish metrics such as recruitment, promotion rates, retention / turnover		Human Resources	Mar-21	Not Commenced	
Carry out personality insights across the organisation to support mutual understanding and better communications with one another		Human Resources	Mar-21	Not Commenced	
Revisit the potential for BAME apprenticeship subject to position re working from sites	Needs further research to establish potential	Human Resources	Jan-21	Not Commenced	
To promote the CCG as an employer of choice with a diverse group of staff to encourage more people from diverse backgrounds to apply to join us. Suggestions included a video of existing diverse range of staff (discussing role and working for the CCG) and/or blogs on social media		Human Resources	Jan-21	Not Commenced	Develop statement/pledge by Oct-20

Governing Body Meeting in Public

3rd September 2020

Item No: 050

Report Title	Finance Report – Month 4
Author(s)	Carl Twibey, Senior Finance Manager
Sponsor (Director)	Richard Chapman, Chief Finance Officer

Paper for:	Decision	Assurance	X	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 asked to NOTE the following:							
<ul style="list-style-type: none"> there is a temporary financial regime in place for the period 1st April to 31st July 2020; at month 4 the year to date overspend is £6.418m; amendments are expected to the allocations that have been received; and scenario models have been produced for the full year position. 							
Report Summary							
The report describes the month 4 position. The key points are listed in the recommendations section above.							
Are there any Resource Implications (including Financial, Staffing etc)?							
N/A							
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?							
N/A							
Has a Quality Impact Assessment (QIA) been completed? What were the findings?							
N/A							
Has an Equality Impact Assessment (EIA) been completed? What were the findings?							
None identified							
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below							
No							

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

No

Have any Conflicts of Interest been identified/ actions taken?

None identified

Governing Body Assurance Framework

Any risks highlighted and assigned to the Finance Committee will be linked to the Derby and Derbyshire CCG Board Assurance Framework.

Identification of Key Risks

Potential risks are included in section 5 of the report

NHS Derby and Derbyshire CCG

2020-21 Finance & Risk Report – Month 4

1st April 2020 – 31st July 2020

1. Introduction

The purpose of this report is to:

- Inform members of the performance of NHS Derby and Derbyshire CCG against a number of key financial criteria and targets for the period ending 31st July 2020, focusing on the statutory and administrative financial duties of the CCG.
- Update members on the temporary financial regime which has been put in place for the period of the current emergency, and the CCG's compliance with the requirements of that regime.
- Describe to members the scenario modelling which the CCG has undertaken for the full financial year, and the outcome of that modelling.

The Covid situation and associated guidance is developing. The 4 month **temporary financial regime** for the period 1st April – 31st July 2020 replaced the suspended extant operational and planning guidance and with it existing budgetary plans. The key elements of the temporary regime are detailed below:

- All CCGs are expected to break even for the period 1st April to 31st July 2020. Allocations will be adjusted non-recurrently to reflect “expected expenditure” during this period.
- All NHS provider contracts are now “fixed block” arrangements. Although national teams originally informed the CCG that this would continue until at least October 31st 2020, latest guidance indicates that the situation may change at the end of September. Independent sector healthcare providers are currently contracted for nationally. There is as yet no indication that this is likely to change in the near future.
- CCGs are monitored against the adjusted allocation position. Actual expenditure incurred is reviewed on a monthly basis, and a retrospective non-recurrent adjustment, “... will be actioned for reasonable variances between actual expenditure and the expected monthly expenditure”.
- CCGs have been required to set budgets for the four month period.

The CCG is now in receipt of correspondence from NHSE/I nationally and regionally regarding the remainder of the year. The temporary regime will continue for months 5 and 6. The national letter, dated July 31st, states that, “*The month 5 and month 6 block contract and top-up payments will be the same as for month 4.*”

A subsequent letter from the NHSE/I Midlands Region, dated August 12th, outlines the ‘NHS’s Third Phase Response to Covid-19’. The CCG and system partners are working through all aspects of the letter and subsequent technical guidance to develop a plan for the remainder of the year. Both sets of correspondence indicate that there are as yet no decisions on resource availability for the remainder of the year.

2. Four Month Accounting Period

The CCGs financial performance against the Revenue Resource Limit of £582.8m for the four month period of April to July 2020 is shown in the Summarised Operating Cost Statement (OCS) below.

Table 2.1 - Summarised Operating Cost Statement

Area	April to July 2020 Budget and Actual (as at Month 4)						
	April 2020 - July 2020	Actual	Variance	Covid Budget	Covid Actual	Actual excl Covid	Variance excl Covid
	£'000's	£'000's	£'000's	£'000's	£'000's	£'000's	£'000's
Acute Services	276,205	273,540	2,666	755	996	272,544	2,907
Mental Health Services	64,958	65,567	(609)	692	1,481	64,086	181
Community Health Services	48,391	47,485	905	657	881	46,604	1,130
Continuing Health Care	40,560	43,573	(3,013)	6,925	10,817	32,757	878
Primary Care Services	69,990	75,688	(5,699)	2,215	2,867	72,822	(5,047)
Primary Care Co-Commissioning	46,871	49,073	(2,201)	85	128	48,945	(2,158)
Other Programme Services	30,909	28,374	2,535	2,140	2,518	25,856	2,914
Total Programme Resources	577,885	583,300	(5,415)	13,468	19,688	563,612	805
Running Costs	4,904	5,907	(1,003)	0	39	5,868	(964)
Total In-Year Resources	582,789	589,208	(6,418)	13,468	19,728	569,480	(159)

The month 4 financial position is £6.418m overspent year to date for the four month period April to July 2020. £6.260m of this overspend relates to July's covid expenditure and the balance of £0.159m relates to cost pressures on non Covid areas. Under the temporary financial regime Covid and top-up allocations are received a month in arrears. Therefore July's costs and other cost pressures would be funded in August subject to NHSE/I approval.

Non-recurrent allocations of £9.046m and £4.422m were received in months 3 and 4. In month 4 another non-recurrent allocation of £8.009m was received to fund the YTD variance reported as at month 3. Table 2.2 below summarises the allocations received to date. Although the £9.046m received in M3 was equal to the value of the CCG's claim for costs incurred in servicing the Covid emergency, it is not clear that this allocation is considered by NHSE/I to be a direct reimbursement for those costs. The accompanying narrative stated that the allocation value was, "... the lower of the Covid claim submitted and the sum required to enable the organisation to break even at Month 2". The CCG was instructed to allocate the budget to Covid analysis codes, and so for internal purposes it is being considered as though it were direct reimbursement as per the table below.

Table 2.2 – Summary of Allocations Received to Date

Category	Received in Month 3	Received in Month 4	Total Received as at Month 4
	£'000	£'000	£'000
Covid Allocation	9,046	4,422	13,468
Top Up Allocation	0	8,009	8,009
Total	9,046	12,431	21,477

Due to the uncertainty surrounding the current temporary financial regime and what will happen during the remainder of the financial year it is unclear what impact this will have on anticipated allocations.

The top up allocations aim to help the CCG achieve a break even position each month and are applied retrospectively. There is therefore no direct correlation between the allocations received to date and the full year allocations the CCG would normally expect to receive.

Anticipated Allocations

It is anticipated that further allocations will be received by the CCG in recognition of material expenditure contained within the month 4 position which is not yet funded. These allocations include:

- £6.260m of further costs identified in July as having been incurred necessarily and exclusively for the purpose of servicing the current emergency
- £0.515m of costs relating month 4 of the new GP contract, which is nationally negotiated and a pressure to all CCGs. It is assumed that costs for months 1 to 3 were included in the top up allocation
- £0.058m for CAMHs, where expenditure is being incurred before the allocation is received.

Allocation Corrections

- NHSE/I recognised that the current four month allocations were calculated hurriedly and may be incomplete. The CCG identified two areas in which it believes errors were made, and has notified NHSE/I accordingly. Specifically, these were:
 - Running cost allocations were based on an 11.8% reduction in the previous year's outturn where they should have been based on the previous year's allocation. The CCG had already prepared for the anticipated reduction in allocation and its 2019-20 outturn was lower than the previous year's allocation. This error has reduced 2020-21 allocation by some 11.8% from where it should be.
 - The calculation appears not to have adjusted for the fact that £7.7m of QIPP delivered in the last financial year was identified as non-recurrent.
- These allocation shortfalls will have a contributory part year impact in the top up allocations received but it remains unclear how NHSE/I will manage the allocation shortfalls and top up allocations.

3. Financial Position Scenarios for the Full Year

The CCG has modelled expenditure for the full financial year to 31st March 2021. This is based on the scenario that block contract arrangements will remain in place until 30th September 2020.

There remains as yet no robust intelligence as to the likely final revenue resource limit for the full financial year, which will undoubtedly be impacted by ongoing system work on the impact on existing capacity of enhanced Infection Prevention and Control (IPC) measures, the requirement for "restoration and recovery", and the uncertainty as to the level of success which will be achieved in suppressing Covid.

The scenario takes the reported month 4 expenditure outturn as a starting point, applies normalisation adjustments for material non-recurrent expenditure in the first four months, and extrapolates this expenditure to a full year on a straight line basis. The impacts of modelled assumptions are then applied to derive a full year expenditure forecast.

In the absence of robust intelligence as to the likely level of revenue resource which will be made available, the CCG's focus is on a full understanding of the expenditure trajectory which results from its assumptions. It is anticipated that this modelling will form the basis of an in-year financial risk management programme as the level of available resource becomes clearer.

The forecast outturn values of the scenarios are shown in Section 5, Table 5.1

4. Detailed Financial Position by Area

4.1 Acute Position

Table 4.1a – Acute Position YTD

	4 Month Budget and Actual			
	April 2020- July 2020 Budget	April 2020- July 2020 Actual	April 2020- July 2020 Variance	Variance as a % of April 2020 -July 2020 Budget
	£'000's	£'000's	£'000's	%
Acute Services				
Chesterfield Royal Hospital NHSFT	65,291	65,282	9	0.01
Derbyshire Community Health Services NHSFT - Acute	3,231	3,231	0	0.00
East Midlands Ambulance Service NHST	12,848	12,848	0	0.00
Nottingham University Hospitals NHST	13,236	14,175	(939)	(7.09)
Sheffield Teaching Hospitals NHSFT	9,050	9,050	0	0.00
Sherwood Forest Hospitals NHSFT	9,498	9,498	0	0.00
Stockport Hospital NHSFT	8,403	8,404	(2)	(0.02)
University Hospitals of Derby and Burton NHSFT	139,958	139,958	0	0.00
Other NHS Acute Contracts	9,193	9,249	(55)	(0.60)
Non-NHS Acute Contracts	6,838	126	6,712	98.16
Acute Additional Efficiency Requirement with NHS	(577)	0	(577)	100.00
Acute Additional Efficiency Requirement with non-NHS	(5,485)	0	(5,485)	100.00
Acute Covid	755	996	(242)	(32.05)
Acute NCAs	3,259	0	3,259	100.00
Acute Savings	0	0	0	0.00
Acute Savings Investments	0	15	(15)	0.00
Acute Other	708	707	1	0.12
	276,205	273,540	2,666	0.97

Budgets

The Acute budget of £276.2m represents 4 months budget aligned to the 4 months financial allocation plus an increase of £0.75m on the opening budget relating to Covid funding allocations covering months 1 to 3. The budget has been set for NHS Providers in line with the predetermined block monthly payments being made, and for Non-NHS Providers based on the CCG's latest financial plan.

Efficiency Requirement

An Efficiency requirement negative budget of (£6.06m) has been identified as a result of recognising an adverse difference between the 4 months financial allocation received compared to the 4 months NHS block payments, and 4 months budget for Independent Sector Providers not included in the allocation.

The value of the block payments being made were based on the Provider's Notified value in the 2019-20 Month 9 Agreement of Balances submission, whilst the allocation was based on the 2019-20 Month 11 Non-ISFE reported position (except for Independent Sector providers covered by the national contract).

Year to Date (YTD) Position

The month 4 YTD position represents the 4 months block arrangement with NHS providers with the exception of Birmingham Women's and Children's (BWCH) and Nottingham University Hospitals Treatment Centre, and nil cost for Independent Sector Providers except

for One Health Group, DHU (for ED Streaming), Consultant Connect costs and the new Orthotics contract.

BWCH monthly block payments of £0.015m and NUH Treatment Centre monthly block payments of £0.235m have now ceased. These were paid for months 1 to 4 due to not being included in the initial NHSE/I block payment schedule. NHSE/I have since confirmed that these will not be funded through Covid, the CCG has instead been reimbursed as part of the allocation to break even.

One Health Group has been paid a fixed monthly SLA amount of £0.26m for months 1 to 4 as agreed by the Executive Team to aid with their business continuity. The intention was for this to be reconciled against activity later in the year at months 9 and 12. This has also now ceased following notification that NHSE/I have purchased independent sector capacity for the full 12 months meaning the provider can no longer catch the activity up in the latter part of the year. A credit is being sought from One Health for payments made to them over and above the actual activity carried out and they will revert to a PbR contract for the remainder of the year.

The DHU GP Streaming service is included in the Acute Other YTD spend of £0.707m. There is an agreed monthly block payment of £0.082m being made, in line with current arrangements for NHS Providers, covering the period 1st March to 31st July 2020. This line also includes the new Orthotics contract which started in June 2020.

4.2 Mental Health Position

Table 4.2a – Mental Health Position YTD

	4 Month Budget and Actual			
	April 2020- July 2020 Budget	April 2020- July 2020 Actual	April 2020- July 2020 Variance	Variance as a % of April 2020 -July 2020 Budget
	£'000's	£'000's	£'000's	%
Mental Health Services				
Derbyshire Community Health Services NHSFT - MH	5,819	5,819	0	0.00
Derbyshire Healthcare NHS FT - CORE Contract	34,337	34,337	0	0.00
Other NHS Mental Health Contracts	1,654	1,554	100	44.49
CAMHS	3,743	4,022	(280)	(7.48)
Learning Disabilities	3,581	3,614	(33)	(0.92)
IAPT	3,105	3,166	(61)	(1.97)
High Cost Patients	3,777	4,303	(526)	(13.92)
Section 117 MH clients	6,180	6,111	69	1.11
Mental Health Services Additional Efficiency Requirement with NHS	71	0	71	100.00
Mental Health Services Additional Efficiency Requirement with non-NHS	678	0	678	100.00
Mental Health Covid	692	1,481	(790)	(114.19)
Mental Health Savings	0	0	0	0.00
Mental Health Savings Investments	0	0	0	0.00
Mental Health Other	1,323	1,160	162	12.27
	64,958	65,567	(609)	(0.94)

Budgets

As with Acute Services the budgets for NHS providers have been set in line with the NHS block payment schedule. The overall budget per area has to balance to the 4 month allocation received. Surplus budgets have been set within mental health services and these are shown on the additional efficiency lines.

Year to Date Position (YTD) – Mental Health

For DCCHS, DHcFT and Other NHS Mental Health Contracts (including Leicester Partnership Trust and UHDB), YTD expenditure remains in line with the agreed NHSE/I block contract payments.

PICU activity levels have increased throughout May to July. There was an expectation of 12 patients but providers are seeing a peak of 25. The situation has been discussed at the Mental Health Recovery Cell and with DHcFT. A clinical review/route cause analysis has been undertaken by the Trust and they have found that there are changes in people's presentations on to their wards, with more psychosis being seen, which is due to the impact of Covid/lockdown as there is less freedom to see family and friends, changes to "normal" life, financial and employment concerns, etc. In addition to that, 40 of their staff were shielding from Covid and there has been a reduction in the level of crisis services being delivered within the community. This means that there is less support for individuals when their condition worsens and the overarching issues are combining to such an extent that more people are being admitted to PICU.

This is not an isolated situation, the increase in PICU is being seen across the region. On the basis of all of the above intelligence, it has been agreed that the stepped change in activity in PICU from the middle of May will be claimed under the Covid funding arrangements (£0.4m). As a result of the removal of Covid related PICU costs, an underspend position is now being reported because additional observations costs are lower than expected at around 6% of total costs compared to 15% in 2019-20. This is partly due to the focus being placed on this by the Commissioning and Contracting teams and a change in provider.

DHcFT are undertaking further work to assess the impact of the continued surge in psychosis presentations against the original trajectory of reducing OoA placements that was agreed prior to Covid. The work aims to establish the real impact of Covid on planned OoA bed usage for the remainder of 2020-21 against the planned trajectories and most importantly what the evidence is telling us to the reasons and causal factors so that plans can be developed to address the OoA and PICU situation. As part of the restoration and recovery process it is planned that the joint partnership OoA programme will be re-instated in September to oversee plans to manage OoA placements. It will consider currently available alternative services, use of more local PICU services until the Derbyshire PICU unit is built, trajectory of expected activity reductions.

High Cost Patients are seeing YTD overspends across Crisis, Locked Rehab and Brain Injury due to activity being higher than expected.

IAPT activity is now seeing an overspend YTD which is a deterioration from last month. Originally there was an underspend due to lower levels of activity than expected; however, more recently there has been an increase in patient numbers being seen and this is expected to continue increasing during the remainder of the year.

Covid spend of £1.481m has been incurred in respect of PICU, Section 117 and Brain Injury caseload and CAMHS additional support to children and young people during Covid.

4.3 Community Health Services Position

Table 4.3a – Community Health Services Position YTD

	4 Month Budget and Actual			
	April 2020- July 2020 Budget	April 2020- July 2020 Actual	April 2020- July 2020 Variance	Variance as a % of April 2020 -July 2020 Budget
	£'000's	£'000's	£'000's	%
Derbyshire Community Health Service NHS FT - Community	38,256	38,260	(5)	● (0.01)
Derbyshire Healthcare NHS FT - Childrens Community	1,826	1,826	0	● 0.00
Other NHS Community Health Contracts	381	378	3	● 0.81
Non- NHS Independent Care Providers	3,174	1,846	1,328	● 41.84
Other Non-NHS Community Care Providers	4,699	4,293	406	● 8.63
Community Health Services Additional Efficiency Requirement with NHS	(590)	0	(590)	● 100.00
Community Health Services Additional Efficiency Requirement with non-NHS	(12)	0	(12)	● 100.00
Community Health Services Covid	657	881	(225)	● (34.20)
	48,391	47,485	905	● 1.87

Budgets

As with Acute and Mental Health Services, the budgets for NHS providers have been set in line with the NHS block payment schedule. The overall budget per area has to balance to the 4 month allocation received; deficit budgets have been set within Community Health Services in order to achieve this balance. These are shown on the additional efficiency lines.

Year to Date Position (YTD)

DCHS, DHcFT and Other NHS Community Health Contracts YTD expenditure is in line with the agreed NHSE/I block contract payments.

Non-NHS Independent Care Providers – some activity has continued during lockdown, but significantly less than anticipated.

Other Non-NHS Community Care Providers – activity is less than expected based on last year's activity levels for Care Home Beds and Non-Weight Bearing Beds.

Expenditure on Covid of £0.881m has been incurred mainly in respect of additional community beds commissioned via Derby City Council in support of the Hospital Discharge Programme.

4.4 Continuing Health Care (CHC) Position

Table 4.4a – Continuing Health Care Position YTD

	4 Month Budget and Actual			
	April 2020- July 2020 Budget	April 2020- July 2020 Actual	April 2020- July 2020 Variance	Variance as a % of April 2020 -July 2020 Budget
	£'000's	£'000's	£'000's	%
Continuing Health Care				
Continuing Health Care Services	19,940	17,825	2,115	10.61
Local Authority / Joint Services	5,713	7,638	(1,925)	(33.69)
Children's Continuing Health Care	2,210	2,182	28	1.27
Funded Nursing Care	6,721	5,112	1,609	23.94
Continuing Health Care Services Covid	6,925	10,817	(3,891)	(56.19)
Continuing Health Care Additional Efficiency Requirement NHS	(22)	0	(22)	100.00
Continuing Health Care Additional Efficiency Requirement Non-NHS	(927)	0	(927)	100.00
	40,560	43,573	(3,013)	(7.43)

Year to Date (YTD) Position

The YTD position shows actual spend of £43.573m against YTD budget of £40.560m. This position is made up of actual costs calculated at patient and package level and an estimated 4.8% price growth in line with the rise in the national living wage.

Covid costs for the Hospital Discharge Programme (HDP) significantly impact on the YTD positions, with 24.8% of the total actual costs made up of spend on Covid care at £10.817m. All care costs of patients discharged from hospital or for admission avoidance under the HDP are currently funded through CHC regardless of whether the patient has a healthcare or social care need.

The costs for joint funded adult packages include estimates for potential differences between CCG and Local Authority caseloads whilst the CCG completes in year reconciliations.

Lower than anticipated costs have been seen across other areas of CHC, Children's and FNC due to caseload reductions because cases are not being replaced when they end following deaths or changes in need. New cases are Covid related due to the HDP and the suspension of the national CHC framework until 1st September. The backdated 2019-20 FNC uplift has now been funded, and is reflected in the YTD budget

4.5 Primary Care & Co-Commissioning

Table 4.5a – Primary Care Position YTD

	4 Month Budget and Actual			
	April 2020- July 2020 Budget	April 2020- July 2020 Actual	April 2020- July 2020 Variance	Variance as a % of April 2020 -July 2020 Budget
	£'000's	£'000's	£'000's	%
Primary Care				
Practice Prescribing	48,565	54,331	(5,766)	● (11.87)
Prescribing Other	3,140	2,998	141	● 4.50
Out of Hours	4,291	4,401	(110)	● (2.57)
GP IT	1,337	1,908	(571)	● (42.74)
Primary Care Other	7,389	6,854	535	● 7.24
GP Forward View	2,304	2,329	(24)	● (1.06)
Primary Care Services Covid	2,215	2,867	(652)	● (29.41)
Primary Care Additional Efficiency Requirement NHS	122	0	122	● 100.00
Primary Care Additional Efficiency Requirement Non-NHS	628	0	628	● 100.00
	69,990	75,688	(5,699)	● (8.14)
Primary Care Co-Commissioning				
Co-Commissioning Payments	50,316	48,945	1,371	● 2.72
Primary Care Co-Commissioning Covid	85	128	(43)	● (50.78)
PC Co-Commissioning Additional Efficiency Requirement NHS	(2,073)	0	(2,073)	● 100.00
PC Co-Commissioning Additional Efficiency Requirement Non-NHS	(1,456)	0	(1,456)	● 100.00
	46,871	49,073	(2,201)	● (4.70)
Sub Total	116,861	124,761	(7,900)	● (6.76)

Year to Date (YTD) Position

The current YTD position is showing an actual spend of £124.761m against YTD budget of £116.861m giving a YTD overspend of £7.9m.

The variance includes a prescribing overspend of £5.6m, which reflects April and May's actuals with estimated costs for June to July. The main reasons for this continues to be as follows:

- Category M drug tariff has increased by around 10% from 1st June 2020; a 5% increase had been expected.
- NCSO price concessions were high in March and are set to continuing through to June (actual data for June is received in August). Sertraline is the main drug causing increasing costs.
- The savings programme developed prior to Covid is under-achieving due to schemes not being fully operational throughout the pandemic.
- £1.3m of additional prescribing costs were incurred in March 2020 due to an increase in the number of drugs prescribed, particularly in respiratory and cardiovascular. This is suspected to be caused by changed prescribing behaviours and patient stockpiling as a result of Covid.
- It has been assumed that actual costs will increase from June back to pre-Covid levels, due to the expectation that suspected stockpiling behaviours through the high spend in March and the low spend in April and May, will not reoccur.

The Primary Care Other areas are reporting an underspend of £0.535m against the four months budgets allocated. This is mainly due to the following reasons:

- Various areas are underspending due to Covid, and the lack of activity seen during months 1 to 3. Activity has started to rise again in month 4, however, it is still low compared to levels expected in normal circumstances. These areas include Optometry, IUCD's, Insulin Initiation, wound care, minor injuries and cancer reviews.
- The Immigration Assessment Centre (IAC) has higher than anticipated costs due to the increase of asylum seekers at the IAC and local hotels. This pressure is expected to increase due to a further anticipated influx of asylum seekers and the lack of repatriation for those who have been declined asylum due to Covid restrictions.

Primary care co-commissioning is £2.201m overspent at month 4 and this is explained as follows:

- NHSE/I set 4 month budget allocations based on 2019-20 expenditure at month 11 plus growth and this does not fully reflect the actual allocation required as it fails to take account of the revised GP contract, which significantly increases costs for 2020-21. This accounts for £3.529m.
- The prior year QOF has been finalised, and a benefit of £0.62m has now been released into the co-commissioning position.
- Costs are lower than anticipated in other areas including: dispensing and prescribing and locum sickness. The dispensing and prescribing reduction reflects the behaviours seen on the practice prescribing budget. Locums costs are being incurred for shielding and self-isolating staff but these are being recognised through the practice reimbursement Covid spend rather than the delegated budget.

Out of hours shows an overspend of £0.110m YTD to take account of the cost implications of an option appraisal that may lead to increased contract costs. These costs have been prudently built into the position but are not committed until the finance committee makes an investment decision on this issue.

GPIT is overspent YTD by £0.571m. This is prudent as anticipated NHSE/I funding has not yet been agreed.

4.6 Other Programme

Table 4.6a – Other Programme Position

	4 Month Budget and Actual			
	April 2020- July 2020 Budget	April 2020- July 2020 Actual	April 2020- July 2020 Variance	Variance as a % of April 2020 -July 2020 Budget
	£'000's	£'000's	£'000's	%
Other Programme				
Better Care Fund	16,984	16,984	0	0.00
111 Call Services	1,674	1,646	28	1.68
Patient Transport	3,160	3,160	0	0.00
Medical - Pay	2,675	2,620	55	2.05
Nursing & Quality - Pay	850	802	48	5.62
Turnaround - Pay	95	98	(4)	(3.74)
Programme Non-Pay	555	552	4	0.63
Other Programme Services Covid	2,140	2,518	(379)	(17.70)
Other Programme Services	5,560	(8)	5,568	100.14
Other Programme Additional Efficiency Requirement Non-NHS	(2,784)	0	(2,784)	100.00
	30,909	28,373	2,536	8.20

National guidance is still outstanding in relation to the Better Care Fund; expenditure is shown at the expected plan levels based on the previously confirmed nationally-mandated uplift.

The variances to budget at month 4 relate to Covid expenditure and the budget setting issue for 2019-20 non-recurrent QIPP described in Section 2.

The budget of £5.560m on the Other Programme Services line is the balance of the top-up allocation received in month 4 and offsets overspends recognised in other areas.

4.7 Running Costs

Table 4.7a – Running Costs Position

	4 Month Budget and Actual			
	April 2020- July 2020 Budget	April 2020- July 2020 Actual	April 2020- July 2020 Variance	Variance as a % of April 2020 -July 2020 Budget
	£'000	£'000	£'000	%
Operational Costs (Running Costs)				
Board & Management Team	522	542	(20)	(3.81)
Finance	686	694	(7)	(1.07)
Commissioning	2,023	1,911	111	5.50
Corporate Strategy and Delivery - Pay	765	753	13	1.64
Corporate Strategy and Delivery - Non Pay	1,781	1,806	(25)	(1.40)
IT & Digital	178	162	17	9.26
Running Costs Covid	0	39	(39)	0.00
Running Costs Additional Efficiency Requirement NHS	(268)	0	(268)	100.00
Running Costs Additional Efficiency Requirement Non-NHS	(784)	0	(784)	100.00
Total Admin Resources	4,904	5,907	(1,003)	(20.45)

The overspend at month 4 is due to issues on the Running Cost allocation received from NHSE/I for the four month period as described in Section 2.

The month 4 position is showing YTD costs of £5.907m which against a budget of £4.904m gives an overspend of £0.716m. The equivalent recurrent costs in 2019-20 at month 4 were £5.955m.

5. Risk and Mitigations

Owing to the current exceptional circumstances the CCG has not been able to actively plan and implement new QIPP schemes in the current financial year. However, it remains imperative for the CCG to actively to consider and mitigate risk in the short (in year) and longer terms.

In-Year Risk

The uncertainty on the level of allocations presents a key risk. The allocation received for the 4 month period to 31 July 2020 is lower than the CCG would expect for the 4 month period and discussions with NHSE/I are ongoing.

The CCG has, throughout the emergency period, maintained a detailed and comprehensive log of costs incurred necessarily and exclusively as a result of the Covid emergency.

The forecast scenario for the full year provide a forecast of £1,730.7m which is £26.2m higher than the normalised extrapolated YTD position.

Area	M4 Normalised YTD Position Extrapolated	M12 Forecast Outturn Normalised Excl Covid	Run Rate Movement
	£'000's	£'000's	£'000's
Acute Services	817,631	816,411	(1,219)
Mental Health Services	192,258	199,667	7,410
Community Health Services	139,814	142,512	2,697
Continuing Health Care	94,269	107,885	13,616
Primary Care Services	218,466	218,675	210
Primary Care Co-Commissioning	146,835	149,486	2,652
Other Programme Services	77,565	78,403	838
Total Programme Resources	1,686,837	1,713,040	26,203
Running Costs	17,604	17,650	46
Total In-Year Resources	1,704,441	1,730,690	26,249

Within the forecast scenario there is considerable risk owing to a range of factors. These include:

- Uncertainty on what activity will be delivered as part of the Third Phase of NHS Response to Covid-19 planning, and therefore what the associated cost will be.
- Uncertainty on what the financial regime will be within the modelled scenario.

The scenario is therefore a reflection of best estimates of the likely outturn positions given a set of assumptions which can be tested, and which have been tested with operational colleagues in each area.

Mitigations

Draft System plans will need to be submitted by 1st September 2020 with final plans due 21st September. The plans will further inform risk and mitigations.

Under the 4 month temporary financial regime the intention is for NHSE/I to support CCGs to achieve a break even position and this is expected to continue until month 6.

The CCG is well sighted on the fact that the most material risk which is potentially controllable, and for whose control it is likely to be held to account is, by a considerable margin, the expenditure commitment on CHC. The CCG has established an operational working group with system partners to develop a response to the new 6 week HDP and the requirement to review all current HDP patients. The working group's aim is to establish a robust review process by 1st September that ensures patients continue to receive an appropriate level of care in the correct place with the right funding and to find a pragmatic solution, which is fair to all parties. The Committee will be updated on these plans as they develop.

Longer Term Risk

The Governing Body has previously and separately been updated on the likely direction of the future financial framework for the NHS and its move to a system basis. Alongside this, work is ongoing within the system to provide a single system I&E and development work to provide a version of this which sights the system on its underlying position is also progressing.

This work will form the basis of a system financial strategy which will facilitate a system efficiency programme.

6. Better Payments Practice Code

CCGs have a responsibility to meet the Better Payments Practice Code (BPPC), which requires 95% of invoices (both in value and in volume) to be paid within 30 days of receipt.

Table 5.1 - Better Payment Practice Code

Volume / Value invoices paid within 30 days	Non NHS		NHS	
	July 2020	Cumulative to July 2020	July 2020	Cumulative to July 2020
	%	%	%	%
Volume	99.35%	99.55%	100.00%	99.85%
Value	99.59%	99.74%	100.00%	99.99%

- All 4 monthly targets were met in July.
- All 4 of the cumulative targets have been met.

7. Recommendations

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

- there is a temporary financial regime in place for the period 1st April to 31st July 2020;
- at month 4 the year to date overspend is £6.418m;
- amendments are expected to the allocations that have been received; and
- scenario models have been produced for the full year position.

Governing Body Meeting in Public

3rd September 2020

Item No: 152

Report Title	Engagement Committee Assurance Report – July 2020
Author(s)	Sean Thornton, Assistant Director Communications and Engagement
Sponsor (Director)	Martin Whittle, Vice Chair and Lay Member for PPI

Paper for:	Decision	Assurance	X	Discussion	Information
Assurance Report Signed off by Chair				Martin Whittle, Vice Chair and Lay Member for PPI	
Which committee has the subject matter been through?				Engagement Committee	
Recommendations					
<p>The Governing Body is asked to NOTE the contents of this report for assurance, including the assurances given on progress with the Restoration and Recovery activity.</p>					
Report Summary					
<p>This report provides the Governing Body with highlights from the meeting of the Engagement Committee, held on 29th July 2020. This report provides a brief summary of the items transacted for assurance.</p> <p><u>COVID-19 Service Recovery</u></p> <p>The Committee was updated on the processes being followed in assuring service changes occurring during the pandemic and providing assurance to NHSE England/Improvement in line with their directives and requirements. This has involved a review panel of all system partners from a wide range of disciplines assessing service changes against three initial questions to inform their potential ability to be retained or the need to restore services to their previous state:</p> <ul style="list-style-type: none"> • Does the service change improve or maintain safety compared to the pre-COVID 19 model? • Does the service change improve or maintain clinical effectiveness compared to the pre-COVID 19 model? • Does the service change improve or maintain patient experience compared to the pre-COVID 19 model? <p>For each of the 100+ service changes in question, any negative answers to the above questions meant that the particular service would need to be restored to its pre-COVID 19 state. All remaining service changes are now the subject of ongoing review by the Joined Up Care Derbyshire programme boards to assess their suitability to be retained.</p> <p>The Engagement Committee also heard that the systems Quality & Equality Impact</p>					

Assessment (QEIA) process was being reinstated to ensure that assessments being made by programme boards are fully assured using the existing impact assessment tools. This involves an assessment against the legal duties on patient and public involvement.

Conducting Consultations During a Pandemic

The Committee heard that advice had been sought with regards to the ability of the CCG and system to undertake engagement and consultation activities during a pandemic. This was prompted by the consideration of potentially commencing the consultation on the proposed transfer of older people's mental health care from London Road Community Hospital to Kingsway.

Evidently, being able to use the traditional face to face routes to engagement are hampered during this period of social distancing and isolation, although digital methods of engagement are now more widely adopted as a result. The advice provided assurance that it was possible to successfully engage and consult during this period, with due regard for any adaptations that might be required.

Presentation on latest COVID-19 information

The Committee received a presentation on the latest data and status of the health and care system's response to the pandemic. This utilised the presentation given to the Derbyshire Health Improvement and Scrutiny Committee a few days prior and discussed the changes we have seen in activity, the ongoing recovery of care and the assurance around the service change process described above.

The presentation also described the insight work being undertaken to provide greater understanding of the:

- impact of pandemic on population health;
- impact (positive and negative) of service changes;
- way in which people have used particular services during the pandemic; and
- themes to aid recovery planning and guide pre-engagement for any proposed permanent change.

CCG Restoration & Recovery

The committee received a report for assurance on the progress that is being made in Communications and Engagement to aid recovery. In addition to items already covered above, the committee were informed about the:

- alignment of service changes identified for recovery against existing Joined Up Care Derbyshire Programme Boards, to ensure they are factored into programme restoration and recovery work;
- tendering for behavioural insight research support, with research to commence shortly;
- ongoing delivery of messaging to support the NHS Help Us To Help You campaign, with particular focus in mid-July on cancer symptom promotion to encourage presentations into primary care; and
- mapping of community contacts and assets to support outbreak management in conjunction with local authorities.

Risk Report

It was noted that the two risks that the Committee had responsibility for had

increased in score.

- **Risk 031: Development of engagement methods.** This risk has increased from a moderate score of 6 (probability 2 x impact 3), to a high score of 12 (probability 4 x impact 3); and
- **Risk 032: Standardised process in the CCG Commissioning Arrangements.** This risk has increased from a high score of 8 (probability 2 x impact 4), to a very high score of 16 (probability 4 x impact 4).

Both risk scores had increased due to COVID-19 and the relaxation of Project Management Office processes, which had meant that the required engagement assessment forms were no longer subjected to completion and scrutiny. This has since been resolved as described above and the risk scores will be reduced at the September meeting of 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?

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

Identified risks are progressing for inclusion in the GBAF. Any further risks highlighted and assigned to the Engagement Committee will be linked to the Derbyshire Board Assurance Framework.

Identification of Key Risks
Noted as above.

Governing Body Meeting in Public

3rd September 2020

Item No: 053

Report Title	Primary Care Commissioning Committee Assurance Report
Author(s)	Hannah Belcher, Assistant Director GP Commissioning and Development
Sponsor (Director)	Clive Newman, Director of GP Development

Paper for:	Decision	Assurance	X	Discussion	Information	
Assurance Report Signed off by Chair				Professor Ian Shaw, Chair		
Which committee has the subject matter been through?				Primary Care Commissioning Committee		
Recommendations						
<p>The Governing Body is requested to RECEIVE the Primary Care Commissioning Committee (PCCC) report from the Public meeting held on Wednesday 26th August 2020 for information and assurance; and NOTE that the PCCC Terms of Reference have been updated. There were no decisions required at the public meeting in August.</p>						
Report Summary						
<p>The committee also received the following key reports for assurance:</p> <ul style="list-style-type: none"> • Finance report – Month 3 report • Primary Care Quality and Performance Assurance Quarter 1 <p>The ratified minutes of the PCCC is included on the agenda for the Governing Body on a monthly basis. The minutes include the detail and decisions relating to the discussion on each agenda item considered by this Committee. The minutes from the July meeting of the PCCC meeting is included within the Governing Body papers. The ratified minutes of the Primary Care Commissioning Committee meeting held on Wednesday 26th August 2020 will therefore be received at the August Governing Body meeting.</p> <p>The Governing Body is requested to note that the Terms of Reference have been updated to include that the Primary Care Commissioning Committee Public meetings will be held at least quarterly (change from monthly). The updated Terms of Reference will be presented at October’s Governing Body meeting.</p>						
Are there any Resource Implications (including Financial, Staffing etc)?						
Outlined specifically in each report considered by the Primary Care Commissioning Committee.						
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?						
Included as part of each report as required.						

Has a Quality Impact Assessment (QIA) been completed? What were the findings?
Included as part of each report as required.
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
Included as part of each report as required.
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
Included as part of each report as required.
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Included as part of each report as required.
Have any Conflicts of Interest been identified/ actions taken?
Declaration provided at the beginning of the meeting and raised for any specific agenda items.
Governing Body Assurance Framework
Considered for each agenda item.
Identification of Key Risks
Considered for each agenda item.

Governing Body Meeting in Public

3rd September 2020

					Item No: 054
Report Title		Quality and Performance Assurance Report			
Author(s)		Jackie Carlile, Head of Performance and Assurance Helen Hipkiss, Director of Quality			
Sponsor (Director)		Zara Jones, Executive Director of Commissioning Operations Brigid Stacey, Chief Nurse Officer			
Paper for:	Decision	Assurance	X	Discussion	Information
Recommendations					
The Governing Body is asked to REVIEW this report from the Quality and Performance Committee meeting on 27 th August 2020, and seek further assurance as required.					
Report Summary					
<u>Performance:</u>					
Urgent and Emergency Care:					
<ul style="list-style-type: none"> • The Accident & Emergency (A&E) standard was not met at a Derbyshire level (89.2%, Year To Date (YTD) 90.1%), with University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) failing to achieve the 95% target in July 2020 but Chesterfield Royal Hospital NHS Foundation Trust (CRHFT) managing to achieve it. CRHFT achieved 95.3% (YTD 94.7%) which is a significant improvement. UHDB performance was 85.1% (YTD 86.8%) which is similar to previous months. Of our associate providers only Sherwood Forest Hospitals NHS Foundation Trust achieved the target, although others have shown an improvement. • There were no 12 hour breaches for Derbyshire or at our associate providers in July. • East Midlands Ambulance Service NHS Trust (EMAS) were compliant in 5 out of 6 national standards for Derbyshire during July. 					
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 57.1%. The full year figure was 63.0%. There has been deterioration across all providers. • CRHFT performance was 63.8% and UHDB 43.1%. The year-to-date figures were 72.1% and 57.0% respectively. • Derbyshire had 527 breaches of the 52 week standard across all trusts - there were 242 the previous month so these have more than doubled. 425 of these were at our main two acute providers with the remaining 102 on waiting lists at many different providers. • Diagnostics – The CCG performance was 48.9%, an improvement on the previous month. Neither CRH nor UHDB have achieved the target due to the cancellations of investigations due to the COVID pandemic. 					

Cancer:

During June 2020 Derbyshire was non-compliant in 7 of the 8 Cancer standards:

- **62 day Urgent GP Referral** – 73.3% (85% standard) – Non compliant for all trusts.
- **31 day from Diagnosis to treatment** – 90.2% (96% standard) – Non compliant for all trusts except East Cheshire.
- **2 week Urgent GP Referral** - 92.8% (93% standard) - Non compliant for all trusts except Sheffield, Sherwood Forest and Stockport.
- **31 day Subsequent Surgery** – 62.1% (94% standard) – Non compliant for all trusts except East Cheshire. This is deterioration from May 2020 where 4 trusts were compliant and the Derbyshire total was 82.5% compliance.
- **31 day Subsequent Radiotherapy** – 87.2% (94% standard) – Non compliant for all trusts.
- **31 day Subsequent Drugs** – 97.9% (98% standard) – Non compliant for UHDB and Sheffield.
- **62 day Screening Referral** – 0% (90% standard) – Non compliant for all trusts and the standard that has deteriorated the most.
- There were 45 Derbyshire patients treated during June who had been waiting more than 104 days.

Quality:

UHDB:

Trust Mortality The proposed process to be followed to review deaths during the Covid-19 crisis was outlined to the Trust Board. It was agreed that this was a sound proposal with a widespread membership including external input. It was agreed that this should enable the Trust to identify any changes in process that might be required should a second wave of the pandemic arise. Benchmark data around mortality in the period leading up to the pandemic indicated that the Trust's overall mortality was at or below the expected level.

CQC In July 2020 CQC contacted the Trust to assess them against the Infection prevention & Control Board Assurance Framework. The outcome of the meeting was positive, and the report discussed at CQRG on 13/08/20. Oversight in relation to the Board Assurance Framework continues to be via the IPC system assurance group.

CRHFT :

CQC In July CQC contacted the Trust to assess them against the Infection, Prevention & Control Board Assurance Framework. The outcome of the meeting was positive and CQC were assured. Once agreed the final assessment document will be discussed to the Trust Clinical, Quality Reference Group (CQRG).

Patient Safety Incident Response Framework (PSIRF) As early adopters CRHFT was initially scheduled to launch this in April 2020. In March 2020 NHS England placed the PSIRF programme on-hold nationally until September 2020 in order to allow the NHS to focus on responding to the COVID outbreak. Development of a Patient Safety Incident Response Plan (PSIRP) is a key aspect of PSIRF implementation.

The PSIRP defines the Trust's patient safety priorities based on a local situational analysis. These incident categories, along with the national priorities will be the focus for full system-based patient safety investigations over the coming year. The patient safety team have developed the PSIRP and identified the priority incident categories. The plan will go to the Trust Board in September 2020 for approval and will be in place by Early October 2020.

Derbyshire Community Health Services Foundation Trust:

2020/21 CQUIN: The 2020/21 CQUIN scheme remains suspended for all providers for the remainder of the year; an allowance for CQUIN will continue to be included in the block payments made to Trusts. A letter has been received confirming that whilst the CQUIN is suspended the 90% target remains an expectation for staff vaccination.

Derbyshire Healthcare Foundation Trust:

IAPT 6 week referral to treatment: Talking Mental Health Derbyshire (TMHD) continues to exceed the national standard for referral to treatment, however the rate achieved in the last 3 months has been lower than normal. This is a result of referrals to the Trust being on hold owing to the pandemic, the Trust IAPT clinicians are currently staffing the mental health helpline. The Trust's sub-contractors are maintaining the IAPT service during this time.

East Midlands Ambulance Service:

Performance Targets: 12 Serious Incidents (SIs) were reported during June 2020 with no delayed responses. So far no trends have been identified; however Lincolnshire is noted to be an outlier with seven of the SIs occurring within the division. The Co-ordinating Commissioning Team is continuing to closely monitor for further emerging trends and themes. Fortnightly learning from events sessions, delivered through Microsoft Teams, have been introduced. These sessions are open to all staff (including third party providers and volunteers) and include learning from both adverse events and when things have gone well.

Committee Update 27th August 2020

Performance at A&E has continued to reflect pre-covid figures. Urgent Care activity in August has worsened. The waiting lists for treatment are deteriorating, there is a group proposed of GPs and consultants to review all patients waiting; neurology and cardiology will be the pilot areas. All relevant CCGs are being contacted to understand the reasons for the delays. Early data indicates this mainly comprises patients who are not in the priority groups.

Diagnostics are improving. Demand and capacity is being reviewed to maintain this. The Planned Care group is challenging the Trusts on the elective activity plans. The Committee recognised how complex delivery of normal activity is in the current requirements such as IPC. Staff wellbeing is a key concern in both secondary and primary care providers as the pressure continues. All Trusts and the CCG are aware of this and have staff support programmes in place.

Cancer remains a significant concern. Patients are still reluctant to attend the Trust. Face to face appointments have increased and all patients have an appointment.

Infection Prevent and Control CQC assessments have gone well in the two Trusts. The Chair noted that staff are working at high standards and with understanding of the challenges revealed by the data. The risk stratification group is meeting weekly. There is good representation of all Trusts. There is also collaboration with the Cancer networks.

The CCG patient experience team is working with patients to understand the impact of the Covid response on what happened to them. There is a project to specifically look at urgent care experience. Trusts are contacting patients directly, particularly with cancer. For example specialist nurses are calling patients. A suggestion of direct survey contacts with all GP practices to gather patient experiences was thought to have merit.

The Committee was assured on the progress of preparing for the return to Continuing Healthcare on the 1st September 2020. The support package for specialist nursing homes to be a re-ablement service are being considered.

The new Infection, Prevention Control was noted. The assurance group is in place.

The winter plan is in development and will be presented at the September 2020 Committee. There is likely to be a significant non-elective demand over the winter. There are initiatives to reduce the numbers of people attending A&E. For example the red home support for care homes. Support to GPs with the increased capacity is taking place, included improvements in telephony and coding.

There are concerns that the workload for Primary Care will increase with children returning to schools, in particular the differentiation of normal child ailments from potential Covid indicators. There will be an ability to step up the red hubs. Maintaining the Infection, Prevention Control will be essential.

The Covid-19 risk register has been merged with the operational risk register. The revised risks have been reviewed by the Directors and the Senior Leadership Team. There were no challenges to the proposed new risks ratings. The GBAFs were reviewed. The pressing action is to understand the impact of Covid on inequalities. The relevant board has been reinstated, under Steve Lloyd's leadership.

The Committee asked that the restoration impact on patient experience is reviewed. The change of General Practice during Covid was also noted as area to be investigated by the Patient Experience Team. Reports from the PPG would be welcomed. Patient Experience of communication to those on waiting lists would help to inform approached going forward. An independent review of this rather than the Trust responses would be helpful, possibly through the citizen panel.

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?
None
Governing Body Assurance Framework
The report covers all of the CCG objectives
Identification of Key Risks
The report covers GBAFs 1-3.

Month 3 Quality & Performance Report 2020/21

August 2020

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EXECUTIVE SUMMARY

Key Messages	<ul style="list-style-type: none"> The tables on slides 6-9 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 (89.2%, YTD 90.1%), with UHDB failing to achieve the 95% target in July 2020 but CRH achieving it. CRH achieved 95.3% (YTD 94.7%) which is a significant improvement. UHDB performance was 85.1% (YTD 86.8%) which is similar to previous months. Of our associate providers only Sherwood Forest achieved the target, although others have shown an improvement. There were no 12 hour breaches for Derbyshire or at our associate providers in July. EMAS were compliant in 5 out of 6 national standards for Derbyshire during July.
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 57.1%. The full year figure was 63.0%. There has been a deterioration across all providers due to the COVID pandemic. CRHFT performance was 63.8% and UHDB 43.1%. The year-to-date figures were 72.1% and 57.0% respectively. Derbyshire had 527 breaches of the 52 week standard across all trusts - there were 242 the previous month so these have more than doubled. 425 of these were at our main two acute providers with the remaining 102 on waiting lists at many different providers. Diagnostics – The CCG performance was 48.9%, an improvement on the previous month. Neither CRH or UHDB have achieved the target due to the cancellations of investigations due to the COVID pandemic.
Cancer	<p>During June 2020, Derbyshire was non-compliant in 7 of the 8 Cancer standards:</p> <ul style="list-style-type: none"> 62 day Urgent GP Referral – 73.3% (85% standard) – Non compliant for all trusts. 31 day from Diagnosis – 90.2% (96% standard) – Non compliant for all trusts except East Cheshire. 2 week Urgent GP Referral - 92.8% (93% standard) - Non compliant for all trusts except Sheffield, Sherwood Forest and Stockport. 31 day Subsequent Surgery – 62.1% (94% standard) – Non compliant for all trusts except East Cheshire. This is a deterioration on June 2020 where 4 trusts were compliant and the Derbyshire total was 82.5% compliance. 31 day Subsequent Radiotherapy – 87.2% (94% standard) – Non compliant for all trusts. 31 day Subsequent Drugs – 97.9% (98% standard) – Non compliant for UHDB and Sheffield. 62 day Screening Referral – 0% (90% standard) – Non compliant for all trusts and the standard that has deteriorated the most. There were 45 Derbyshire patients treated during June who had been waiting more than 104 days.

Executive Summary

Trust	Key Issues - Quality
University Hospitals of Derby and Burton NHS FT	<p><u>Trust Mortality</u> The proposed process to be followed to review deaths during the Covid-19 crisis was outlined to the Trust Board. It was agreed that this was a sound proposal with a widespread membership including external input. It was agreed that this should enable the Trust to identify any changes in process that might be required should a second wave of the pandemic arise. Benchmark data around mortality in the period leading up to the pandemic indicated that the Trust's overall mortality was at or below the expected level.</p> <p><u>CQC</u> In July 2020 CQC contacted the Trust to assess them against the Infection prevention & Control Board Assurance Framework. The outcome of the meeting was positive, and the report discussed at CQRG on 13/08/20. Oversight in relation to the Board Assurance Framework continues to be via the IPC system assurance group.</p>
Chesterfield Royal Hospital FT	<p><u>CQC</u> In July CQC contacted the Trust to assess them against the Infection, Prevention & Control Board Assurance Framework. The outcome of the meeting was positive and CQC were assured. Once agreed the final assessment document will be discussed to the Trust Clinical, Quality Reference Group (CQRG).</p> <p><u>Patient Safety Incident Response Framework (PSIRF)</u> As early adopters CRHFT was initially scheduled to launch this in April 2020. In March 2020 NHS England placed the PSIRF programme on-hold nationally until September 2020 in order to allow the NHS to focus on responding to the COVID outbreak. Development of a Patient Safety Incident Response Plan (PSIRP) is a key aspect of PSIRF implementation. The PSIRP defines the Trust's patient safety priorities based on a local situational analysis. These incident categories, along with the national priorities will be the focus for full system-based patient safety investigations over the coming year. The patient safety team have developed the PSIRP and identified the priority incident categories. The plan will go to the Trust Board in September 2020 for approval and will be in place by Early October 2020.</p>
Derbyshire Community Health Services FT	<p><u>2020/21 CQUIN:</u> The 2020/21 CQUIN scheme will remain suspended for all providers for the remainder of the year; an allowance for CQUIN will continue to be included in the block payments made to Trusts. A letter has been received confirming that whilst the CQUIN is suspended the 90% target remains an expectation for staff vaccination.</p>
Derbyshire Healthcare Foundation Trust	<p><u>IAPT 6 week referral to treatment:</u> Talking Mental Health Derbyshire (TMHD) continues to exceed the national standard for referral to treatment, however the rate achieved in the last 3 months has been lower than normal. This is a result of referrals to the Trust being on hold owing to the pandemic, the Trust IAPT clinicians are currently staffing the mental health helpline. The Trust's sub-contractors are maintaining the IAPT service during this time.</p>
East Midlands Ambulance Trust	<p><u>Performance Targets:</u> 12 Serious Incidents (SIs) were reported during June 2020 with no delayed responses. So far no trends have been identified; however Lincolnshire is noted to be an outlier with seven of the SIs occurring within the division. The Co-ordinating Commissioning Team is continuing to closely monitor for further emerging trends and themes. Fortnightly learning from events sessions, delivered through Microsoft Teams, have been introduced. These sessions are open to all staff (including third party providers and volunteers) and include learning from both adverse events and when things have gone well.</p>

PERFORMANCE OVERVIEW MONTH 4 (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		Performance Deteriorated From Previous Period						
										Indicator not applicable to organisation										
EMAS Dashboard for Ambulance Performance Indicators					Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Q1 2019/20	Q2 2019/20	Q3 2019/20	Q4 2019/20	Current Month	YTD	consecutive months non-compliance		
Urgent Care	Area	Indicator Name	Standard	Latest Period	East Midlands Ambulance Service Performance (NHSD&DCCG only - National Performance Measure)				EMAS Performance (Whole Organisation)				EMAS Completed Quarterly Performance 2020/21				NHS England			
	Ambulance System Indicators	Ambulance - Category 1 - Average Response Time	00:07:00	Jul-20	↓	00:07:02	00:06:46	1	00:06:47	00:06:35	0					00:06:47	00:07:18	0		
		Ambulance - Category 1 - 90th Percentile Respose Time	00:15:00	Jul-20	↓	00:11:58	00:12:04	0	00:11:53	00:12:15	0					00:12:02	00:12:50	0		
		Ambulance - Category 2 - Average Response Time	00:18:00	Jul-20	↓	00:17:15	00:15:31	0	00:18:10	00:16:14	1					00:16:39	00:23:46	0		
		Ambulance - Category 2 - 90th Percentile Respose Time	00:40:00	Jul-20	↓	00:33:29	00:31:58	0	00:36:27	00:34:15	0					00:32:33	00:49:03	0		
		Ambulance - Category 3 - 90th Percentile Respose Time	02:00:00	Jul-20	↓	01:35:06	01:22:25	0	01:44:11	01:30:38	0					01:38:58	02:51:15	0		
		Ambulance - Category 4 - 90th Percentile Respose Time	03:00:00	Jul-20	→	02:38:44	02:23:07	0	02:44:22	02:07:17	0					02:27:08	03:23:41	0		
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	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			Derbyshire Community Health Services FT			NHS England		
	Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	Jul-20	↑	89.2%	90.1%	58	95.3%	94.7%	0	85.1%	86.8%	58	100.0%	100.0%	0	93.0%	93.2%	58
		A&E 12 Hour Trolley Waits	0	Jul-20					0	0	0	0	1	0	0	0	0	271	776	58
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	5.00%	4.60%	2	4.68%	4.22%	11

PERFORMANCE OVERVIEW MONTH 3 – PLANNED CARE

NHS Derby & Derbyshire CCG Assurance Dashboard

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

Part A - National and Local Requirements

CCG Dashboard for NHS Constitution Indicators

				Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance
Area	Indicator Name	Standard	Latest Period	NHS Derby & Derbyshire CCG				Chesterfield Royal Hospital FT			University Hospitals of Derby & Burton FT			Derbyshire Community Health Services FT			NHS England		
Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Jun-20	↓	51.7%	63.0%	29	63.8%	72.1%	14	43.1%	57.0%	30				52.0%	61.9%	52
	Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Jun-20	↓	527	872	5	53	74	3	580	1016	4				50536	87607	158
Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Jun-20	↓	48.87%	50.45%	25	40.09%	37.53%	3	52.59%	56.40%	4				47.82%	53.61%	82
2 Week Cancer Waits	All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	Jun-20	↓	92.8%	93.4%	1	Cancer 2 Week Wait Pilot Site - not currently reporting			90.2%	91.8%	2				92.5%	92.0%	1
	Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	Jun-20	↓	98.3%	94.7%	0				98.6%	96.2%	0				90.6%	89.5%	1
31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	96%	Jun-20	↓	90.2%	92.7%	2	90.4%	91.3%	2	88.8%	90.6%	2				93.7%	94.7%	2
	Subsequent Surgery Within 31 Days Of Decision To Treat	94%	Jun-20	↓	62.1%	73.9%	7	61.3%	76.7%	1	50.0%	68.2%	2				86.8%	88.6%	23
	Subsequent Drug Treatment Within 31 Days Of Decision To Treat	98%	Jun-20	↓	97.9%	97.3%	1	100.0%	100.0%	0	97.9%	97.3%	1				98.7%	98.9%	0
	Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	Jun-20	↓	87.3%	90.7%	2				91.0%	92.3%	4				94.9%	95.5%	0
62 Days Cancer Waits	First Treatment Administered Within 62 Days Of Urgent GP Referral	85%	Jun-20	↑	73.3%	70.2%	16	81.6%	78.7%	11	69.3%	69.1%	26				75.2%	73.3%	54
	First Treatment Administered - 104+ Day Waits	0	Jun-20	↑	45	77	51	9	18	26	27	49	51				1062	2328	54
	First Treatment Administered Within 62 Days Of Screening Referral	90%	Jun-20	↓	0.0%	40.5%	14	0.0%	50.8%	14	0.0%	11.8%	2				12.9%	62.0%	27
	First Treatment Administered Within 62 Days Of Consultant Upgrade	N/A	Jun-20	↑	95.0%	89.2%		N/A	80.0%		87.9%	75.0%					82.3%	80.6%	
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 3 – PATIENT SAFETY

NHS Derby & Derbyshire CCG Assurance Dashboard

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

Part A - National and Local Requirements

CCG Dashboard for NHS Constitution Indicators

				Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance		
Area	Indicator Name	Standard	Latest Period	NHS Derby & Derbyshire CCG			Chesterfield Royal Hospital FT			University Hospitals of Derby & Burton FT			Derbyshire Community Health Services FT			NHS England					
Patient Safety	Mixed Sex Accommodation	Mixed Sex Accommodation Breaches	0	Feb-20	↓	4	89	11	0	5	0	10	128	11				4929	21179	11	
	Incidence of healthcare associated Infection	Healthcare Acquired Infection (HCAI) Measure: MRSA Infections	0	Jun-20	↔	1	2	2	0	0	0	0	0	0				60	180	15	
		Healthcare Acquired Infection (HCAI) Measure: C-Diff Infections	Plan	Jun-20	↓		60			9			30								
			Actual				63	1		3	0		14	0							
		Healthcare Acquired Infection (HCAI) Measure: E-Coli	-	Jun-20	↑	64	196		16	46		43	138						64	196	
Healthcare Acquired Infection (HCAI) Measure: MSSA	-	Jun-20	↓	20	57		4	12		9	28						937	2717			

PERFORMANCE OVERVIEW MONTH 3 – MENTAL HEALTH

CCG Dashboard for NHS Constitution Indicators				Direction of Travel	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure	
Mental Health	Area	Indicator Name	Standard	Latest Period	NHS Derby & Derbyshire CCG			Derbyshire Healthcare FT						NHS England						
	Early Intervention In Psychosis	Early Intervention In Psychosis - Admitted Patients Seen Within 2 Weeks Of Referral	50.0%	May-20	↑	90.9%	85.4%	0	90.0%	86.9%	0				70.0%	74.3%	0			
		Early Intervention In Psychosis - Patients on an Incomplete Pathway waiting less than 2 Weeks from Referral	50.0%	May-20	↓	66.7%	83.2%	0	100.0%	85.6%	0				24.2%	30.5%	13			
	Mental Health	Dementia Diagnosis Rate	67.0%	Jul-20	↓	67.0%	67.8%	0							63.2%	64.0%	0			
		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 Q1	↑	83.1%	74.6%													
		CYPMH - Eating Disorder Waiting Time % routine cases seen within 4 weeks		2020/21 Q1	↑	94.3%	83.9%													
		Perinatal - Increase access to community specialist perinatal MH services in secondary care	4.5%	Mar-19	↑	3.0%	3.1%	2												
		Mental Health - Out Of Area Placements		May-20	↓	455	7540													
	Physical Health Checks for Patients with Severe Mental Illness	25%	2019/20 Q4	↓	29.2%	29.6%	0													
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	Jun-20	↑	2.10%	6.30%													
			Actual			1.28%	4.52%	3												
		IAPT - Proportion Completing Treatment That Are Moving To Recovery	50%	Jun-20	↓	56.7%	56.5%	0	52.7%	54.9%	0	59.4%	58.0%	0	57.1%	54.2%	0	50.0%	50.0%	0
		IAPT Waiting Times - The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment	75%	Jun-20	↓	86.0%	88.3%	0	72.8%	80.0%	1	93.7%	93.4%	0	92.7%	91.0%	0	100.0%	100.0%	0
IAPT Waiting Times - The proportion of people that wait 18 Weeks or less from referral to entering a course of IAPT treatment	95%	Jun-20	↑	99.9%	99.9%	0	100.0%	100.0%	0	100.0%	100.0%	0	99.4%	99.6%	0	100.0%	100.0%	0		
Referral to Treatment for planned consultant led treatment	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												
	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Jun-20	↓	85.7%	88.8%	3												
Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways		0	Jun-20	↔	0	0	0													

Quality Overview

QUALITY OVERVIEW M3

Trust	Key Issues
Chesterfield Royal Hospital FT	<p><u>CQC</u> In July CQC contacted the Trust to assess them against the Infection, Prevention & Control Board Assurance Framework. The outcome of the meeting was positive and CQC were assured. Once agreed the final assessment document will be discussed to the Trust Clinical, Quality Reference Group (CQRG).</p> <p><u>Patient Safety Incident Response Framework (PSIRF)</u> As early adopters CRHFT was initially scheduled to launch this in April 2020. In March 2020 NHS England placed the PSIRF programme on-hold nationally until September 2020 in order to allow the NHS to focus on responding to the COVID outbreak. Development of a Patient Safety Incident Response Plan (PSIRP) is a key aspect of PSIRF implementation. The PSIRP defines the Trust's patient safety priorities based on a local situational analysis. These incident categories, along with the national priorities will be the focus for full system-based patient safety investigations over the coming year. The patient safety team have developed the PSIRP and identified the priority incident categories. The plan will go to the Trust Board in September 2020 for approval and will be in place by Early October 2020.</p> <p><u>Stroke services</u> Following agreement of a business case presented in April 2020 to the Trust Board, hyper acute stroke beds have now been introduced and recruitment of a second Stroke nurse specialist is in progress. An update will be provided in terms of progress at the CQRG meeting on the 24th August 2020.</p>
University Hospitals of Derby and Burton NHS FT	<p><u>Update on Dermatology wrong site surgery never events</u> The standard operating procedure (SOP) for skin surgery has been re-written and approved at divisional level. The process is supported by a patient pathway booklet, to be used for each procedure. Two departmental training afternoons have taken place, with each member of the department been signed off as competent in the new SOP. The department has completed an audit of the SOP that showed excellent results.</p> <p><u>Trust Mortality</u> The proposed process to be followed to review deaths during the Covid-19 crisis was outlined to the Trust Board. It was agreed that this was a sound proposal with a widespread membership including external input. It was agreed that this should enable the Trust to identify any changes in process that might be required should a second wave of the pandemic arise. Benchmark data around mortality in the period leading up to the pandemic indicated that the Trust's overall mortality was at or below the expected level.</p> <p><u>CQC</u> In July 2020 CQC contacted the Trust to assess them against the Infection prevention & Control Board Assurance Framework. The outcome of the meeting was positive, and the report discussed at CQRG on 13/08/20. Oversight in relation to the Board Assurance Framework continues to be via the IPC system assurance group.</p>

QUALITY OVERVIEW M3 continued

Trust	Key Issues
Derbyshire Community Health Services FT	<u>2020/21 CQUIN:</u> The 2020/21 CQUIN scheme will remain suspended for all providers for the remainder of the year; an allowance for CQUIN will continue to be included in the block payments made to Trusts. A letter has been received confirming that whilst the CQUIN is suspended the 90% target remains an expectation for staff vaccination.
Derbyshire Healthcare Foundation Trust	<u>IAPT 6 week referral to treatment:</u> Talking Mental Health Derbyshire (TMHD) continues to exceed the national standard for referral to treatment, however the rate achieved in the last 3 months has been lower than normal. This is a result of referrals to the Trust being on hold owing to the pandemic, the Trust IAPT clinicians are currently staffing the mental health helpline. The Trust's sub-contractors are maintaining the IAPT service during this time. The people completing treatment who move to recovery target has been achieved for this month and throughout the previous financial year. This is a result of the Area Service Manager tightly monitoring the position on a daily basis and reacting to address any deterioration. Performance has also been monitored at regular contractual and operational meetings. The third phase of NHS response to COVID19 stipulates that IAPT services should fully resume and normal contractual meetings have been resumed to monitor performance and to ensure this restoration is achieved..
East Midlands Ambulance Trust	<u>Performance Targets:</u> For the month of June 2020 the Trust delivered all of the operational performance metrics, for the first time since the new Ambulance Response Programme (ARP) standards were introduced in August 2017. The Trust also delivered all the new Ambulance Response Programme standards for quarter one. All divisions except for Lincolnshire delivered all national standards in quarter one, Lincolnshire division delivered four of the six standards. 12 Serious Incidents (SIs) were reported during June 2020 with no delayed responses. So far no trends have been identified; however Lincolnshire is noted to be an outlier with seven of the SIs occurring within the division. The Co-ordinating Commissioning Team is continuing to closely monitor for further emerging trends and themes. Fortnightly learning from events sessions, delivered through Microsoft Teams, have been introduced. These sessions are open to all staff (including third party providers and volunteers) and include learning from both adverse events and when things have gone well. <u>Handover Delays:</u> A regional Handover Collaborative has been established to support a reduction in hospital handover delays for which EMAS have signed up to. The collaborative will be known as "Right Care, Right Time, First Time". The regional team will be contacting those Trusts in the East Midlands who have been identified to join the collaborative. Additionally, the development of a regional Managing Conveyance policy by NHS England/Improvement, which incorporates a rapid hospital handover protocol, will support reducing delays.

QUALITY OVERVIEW M3

Derbyshire Wide Integrated Report

Part B: Provider Local Quality Indicators

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

Part B: Acute & Non-Acute Provider Dashboard for Local Quality Indicators				Latest Period	Direction of travel	See Section D for Commentary	Current Period	YTD	Latest Period	Direction of travel	See Section D for Commentary	Current Period	YTD	Latest Period	Direction of travel	See Section D for Commentary	Current Period	YTD	Latest Period	Direction of travel	See Section D for Commentary	Current Period	YTD	
Section	Area	Indicator Name	Standard	Chesterfield Royal Hospital FT					University Hospitals of Derby & Burton FT					Derbyshire Community Health Services					Derbyshire Healthcare FT					
Ratings	CQC Ratings	Inspection Date	N/A	Aug-19					Mar-19					May-19					Jul-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%	Mar-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%	Mar-20	↑		98.6%	99.3%						
	Complaints	Number of formal complaints received	N/A	Jun-20	↓		11	30	Sep-19	↑		63	420	May-20	↓		4	4	Jun-20	↑		7	24	
		% of formal complaints responded to within agreed timescale	N/A	Jun-20	↓		87.0%	95.7%	Sep-19	↓		65.2%	59.0%	May-20	↑		100.0%	91.5%	Jun-20	↓		83%	88.14%	
		Number of complaints partially or fully upheld by ombudsman	N/A	Jun-20	↔		0	1	19-20 Q2	↔		1	2	May-20	↔		0	0	Jun-20	↔		0	0	
	Pressure Ulcers	Category 2 - Number of pressure ulcers developed or deteriorated	N/A	Jun-20	↓		4	16	Sep-19	↑		48	302	May-20	↓		112	182	Jun-20	↑		0	1	
		Category 3 - Number of pressure ulcers developed or deteriorated	N/A	Jun-20	↓		1	4	Sep-19	↓		20	106	May-20	↑		45	99	Jun-20	↔		0	2	
		Category 4 - Number of pressure ulcers developed or deteriorated	N/A	Jun-20	↔		0	0	Sep-19	↑		0	1	May-20	↓		6	9	Jun-20	↔		0	0	
		Deep Tissue Injuries(DTI) - numbers developed or deteriorated		Jun-20	↑		0	5	Sep-19	↑		16	94	May-20	↓		87	207	Jun-20	↔		0	0	
		Medical Device pressure ulcers - numbers developed or deteriorated							Sep-19	↓		4	20	May-20	↓		12	18	Jun-20	↔		0	0	
		Number of pressure ulcers which meet SI criteria	N/A	Jun-20	↓		1	2	Sep-19	↔		0	4	May-20	↑		1	4	Jun-20	↔		0	0	
	Falls	Number of falls	N/A	Jun-20	↑		74	222	Sep-18	Data Not Provided in Required Format			May-20	↑		41	85	Jun-20	↓		34	75		
		Number of falls resulting in SI criteria	N/A	Jun-20	↑		0	1	Sep-19	↑		0	19	May-20	↓		1	1	Jun-20	↔		0	0	
	Medication	Total number of medication incidents	?	Jun-20	↔		55	162	Sep-19	↑		180	1314	May-20	↔		0	0	Jun-20	↓		61	163	
	Serious Incidents	Never Events	0	Jun-20	↔		0	0	Sep-19	↑		0	6	May-19	↔		0	0	Jun-20	↔		0	0	
		Number of SI's reported	0	Jun-20	↓		5	7	Sep-19	↑		7	115	May-20	↓		7	13	Jun-20	↓		6	19	
		Number of SI reports overdue	0	Jun-20	↔		0	0	May-19	↓		19	28	May-19	↔		0	0						
		Number of duty of candour breaches which meet threshold for regulation 20	0	Jun-20	↔		0	0	May-19	↔		0	0	May-20	↔		0	0						

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Part B: Acute & Non-Acute Provider Dashboard for Local Quality Indicators cont.				Latest Period	Direction of travel	See Section D for Commentary	Current Period	YTD	Latest Period	Direction of travel	See Section D for Commentary	Current Period	YTD	Latest Period	Direction of travel	See Section D for Commentary	Current Period	YTD	Latest Period	Direction of travel	See Section D for Commentary	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	18 - 19 Q1	↔		2	2						Jun-20	↔		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	Jun-20	↓		105.7		Jun-19	↔		92.7	92.7											
Summary Hospital-level Mortality Indicator (SHMI): Ratio of Observed vs. Expected			Feb-20	↓		0.986		Feb-20	↓		0.890													
Crude Mortality			May-20	↑		1.75%	2.89%	Sep-19	↔		1.20	1.28												
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																Jun-20	↔		0	0		
Workforce	Staff	Staff turnover (%)		Jun-20	↑		8.0%	8.6%	Sep-19	↔		9.7%	9.95%	May-20	↔		9.0%	9.0%	Jun-20	↑		10.3%	10.5%	
		Staff sickness - % WTE lost through staff sickness		Jun-20	↔		6.0%	6.0%	Sep-19	↓		4.4%	4.3%	May-20	↑		5.2%	5.8%	Jun-20	↔		5.7%	6.2%	
		Vacancy rate by Trust (%)		Sep-17	↓		1.9%	1.3%	Dec-18	↓		8.3%	7.3%	May-20	↓		4.2%	4.1%	Jun-20	↑		9.4%	10.0%	
		Agency usage	Target Actual																	Jun-20	↓		1.45%	0.96%
		Agency nursing spend vs plan (000's)		May-20	↑		£462	£1,117	Oct-18	↑		£723	£4,355	May-20	↑		£73	£182						
		Agency spend locum medical vs plan (000's)		May-20	↓		£272	£566																
	Training	% of Completed Appraisals	90%	Jun-20	↑		53.0%	35.1%	Sep-19	↓		86.3%	89.1%	May-20	↓		83.5%	84.6%	Jun-20	↑		79.6%	80.5%	
Mandatory Training - % attendance at mandatory training		90%	Jun-20	↓		83.0%	83.3%	Aug-19	↓		85.4%	89.1%	May-20	↓		96.4%	96.7%	Jun-20	↓		84.4%	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 July 2020, the Trust met the 95% standard again (as they had done in May 2020, achieving 95.3%). The Type 1 element of these were 92.5% for July, following the same pattern of improvement through the year and now levelling off.

There were no 12 hour breaches during July 2020.

What are the issues?

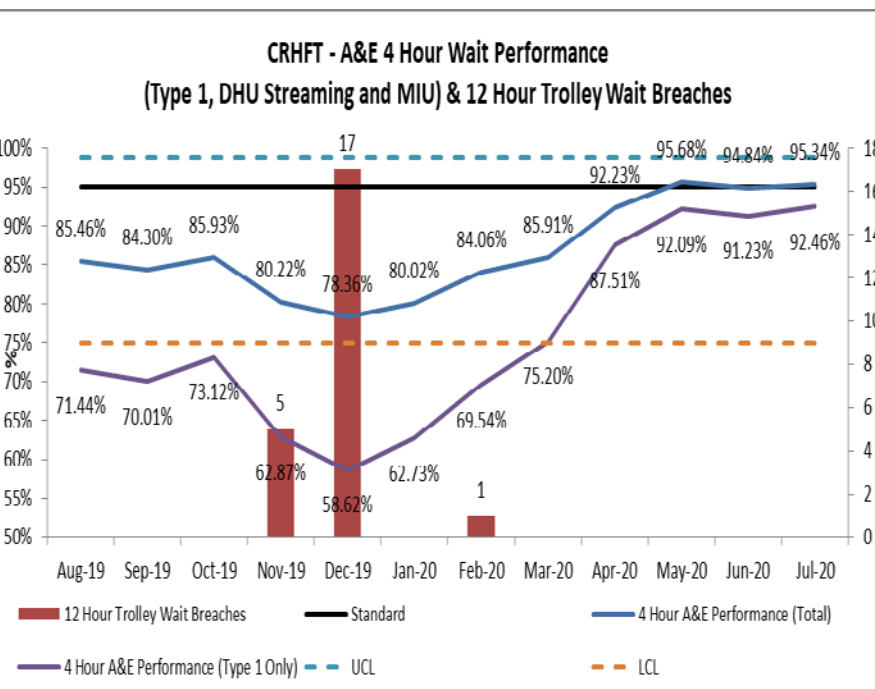
- The Trust has experienced a significant decrease in attendances, with 763 less Type 1 attendances during July 2020 than for the same time last year (a reduction by 11.5%). This goes some way to explaining the improvement in performance, however there are still an average of 189 attendances per day (there were 157 per day in June 2020 so this is a 20% increase on last month).

During the COVID-19 pandemic many A&E departments experienced lower numbers of attendances but were still highly pressured due to:

- The physical footprint of ED has been 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.
- The acuity of the attendances was high, with 29.2% of A&E attendances resulting in admission to either an assessment unit or a ward during July 2020 (the average admission rate for 2019/20 was 26.4%).

What actions have been taken?

- The ORG (Organisational Resilience Group) have postponed their weekly meetings in favour of the daily communication needed during this situation. The group is still represented by all relevant Urgent Care providers in the Derbyshire System.
- Staff aim to have assessment units cleared by 6pm to maintain capacity levels.
- Increased availability of GP Streaming services (through various ongoing initiatives) to support patient flow and same day discharge.
- PTS communications were improved in order to facilitate speedier discharge.
- Additional beds were opened over winter and have remained open since, with additional capacity opened ahead of schedule to cope with demand.



The following operational changes have been made during the COVID19 pandemic:

- ED Departments have implemented streaming systems at the physical front doors, whereby patients are designated to either Red (COVID symptomatic) or Green (not COVID symptomatic but presenting for other reasons) in Pods situated outside. They are in place to ensure that patients are treated in the most appropriate areas with the correct infection control precautions being applied.
- ED Waiting Rooms have blocked chairs to ensure safe distances between waiting patients.
- Relatives are not allowed to accompany patients.
- Once triaged patients are being sent directly for assessments (e.g. X-Rays) where possible, freeing up space within the ED.
- At MIUs patients are waiting in their cars (instead of waiting rooms) where possible.

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

Performance Analysis

During July 2020 performance overall did not meet the 95% standard, achieving 86.9% (Network figure) and 78.6% for Type 1 attendances. Prior to this there had been a gradual improvement in performance since the winter (peaking at 90.9% for May 2020) but deteriorating since then.

There were no 12 hour breaches during July 2020.

What were the issues?

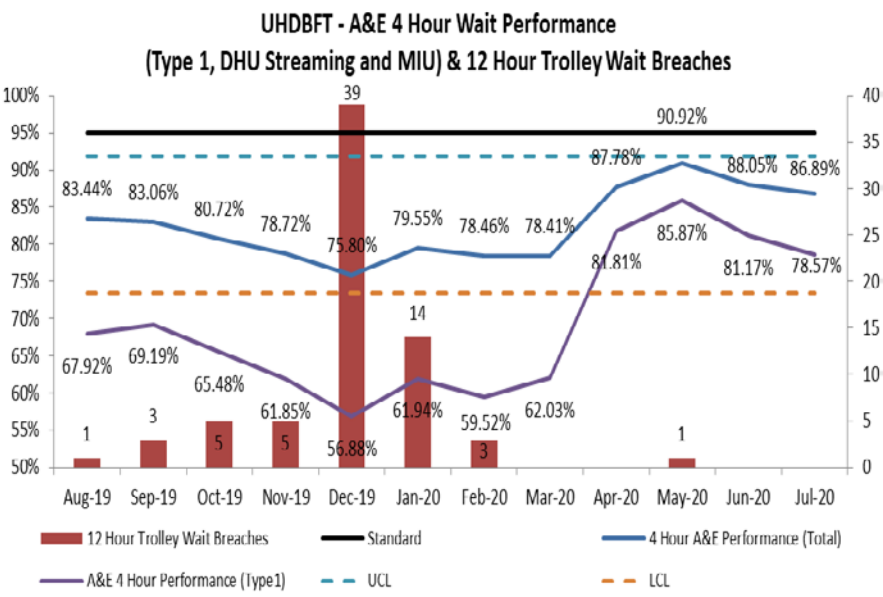
- The trust has experienced a significant decrease in attendances, with 1,986 less Type 1 attendances during July 2020 than for the same time last year (a reduction by 16%). This goes some way to explaining the improved performance for some months, however there are still an average of 338 attendances per day putting pressure on the system.
- The Medical Assessment Unit has declared OPEL 2/3 at times due to staffing issues and beds being available but not appropriate for the patient's needs.

During the COVID-19 pandemic many A&E departments experienced lower numbers of attendances but were still highly pressured due to:

- 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.
- The acuity of the attendances was high, with an average of 21 Resuscitation patients and 198 Major patients per day (5.7% and 53.4% of the total attendances respectively).

What actions have been taken?

- The ORG (Organisational Resilience Group) have postponed their weekly meetings in favour of the daily communication needed during this situation. The group is still represented by all relevant Urgent Care providers in the Derbyshire System.
- Increased availability of GP Streaming services (through various ongoing initiatives) to support patient flow and same day discharge.
- Establishment of an Orthopaedic Assessment Unit and a Renal Assessment Unit to ensure that these patients are treated more quickly and appropriately, without the need to attend ED.
- Physical capacity has been increased by converting unused bathrooms to clinical space, although this has been restricted during the current situation.



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

The following operational changes have been made during the COVID19 pandemic:

- ED Departments have implemented streaming systems at the physical front doors, whereby patients are designated to either Red (COVID symptomatic) or Green (not COVID symptomatic but presenting for other reasons) in Pods situated outside. They are in place to ensure that patients are treated in the most appropriate areas with the correct infection control precautions being applied. The mix of Red/Green patients has now changed, with less space needed for Red and more space needed for Green patients.
- Derby are only allowing ambulance arrivals into the Pitstop area when there is a bay available, preventing any queueing in this area.
- ED Waiting Rooms have blocked chairs to ensure safe distances between waiting patients.
- Relatives are not allowed to accompany patients.
- Paediatric patients at UHDB are no longer being streamed by GPs, but GP Streaming is still taking place for adults at UHDB.
- Once triaged patients are being sent directly for assessments (e.g. X-Rays) where possible, freeing up space within the ED.
- At MIUs patients are waiting in their cars (instead of waiting rooms) where possible.

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

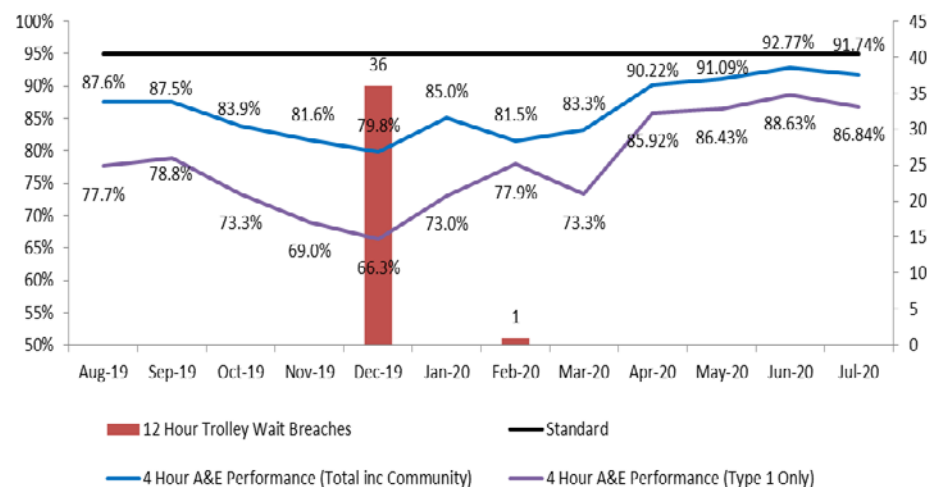
Performance Analysis

During July 2020, performance overall did not meet the 95% standard, achieving 86.8% for the Burton A&E and 91.7% including community hospitals. These reflect the increasing improvement in performance since the winter, although they have dipped for July 2020. There were no 12 hour breaches during July 2020.

What were the issues?

- The trust has experienced a significant decrease in attendances, with 2,205 less Type 1 attendances during July 2020 than for the same time last year (a reduction by 33.6%). This goes some way to explaining the improvement in performance, however there are still an average of 141 attendances per day putting pressure on the system..
- The acuity of the attendances was high, with an average of 100 Resuscitation/Major patients per day (63.2% of total attendances).

A&E 4 Hour Wait Performance
Type 1, including Community and 12 hour Trolley Wait Breaches



What actions have been taken?

- Ambulatory Emergency Care provision was expanded from 5 to 7 days.
- Implementation of a Medical Triage Model whereby patients referred by GPs are triaged in situ rather than in a fixed place in ED.
- Increased WMAS HALO (WMAS onsite manager) from 1wte to 2.4wte to cover 7 days per week. This has improved communications, consistency and escalation procedures in addition to reduced handover delays.
- All extra escalation ward beds were opened in line with the Bed Escalation Plan.
- Introducing an on-site Pharmacist on a Saturday to increase weekend discharges.
- Single Point of Access (SPA) process and initial phone assessment process continues.

The following operational changes have been made during the COVID19 pandemic:

- ED Departments have implemented streaming systems at the physical front doors, whereby patients are designated to either Red (COVID symptomatic) or Green (not COVID symptomatic but presenting for other reasons) in Pods situated outside. They are in place to ensure that patients are treated in the most appropriate areas with the correct infection control precautions being applied.
- ED Waiting Rooms have blocked chairs to ensure safe distances between waiting patients.
- Relatives are not allowed to accompany patients.
- Once triaged patients are being sent directly for assessments (e.g. X-Rays) where possible, freeing up space within the ED.
- At MIUs patients are waiting in their cars (instead of waiting rooms) where possible.

Performance Summary

- Actual Calls offered were 10,492 below plan in June 2020 and Clinical Activity was 21,548 above plan.
- Performance against the contractual Key Performance Indicators for abandonment rate and average speed of answer continued to see an improvement for the month of June 2020.
- The 95% of all calls answered in 60 seconds national standard was achieved in June 2020. DHU111 are not contracted to deliver the calls answered in 60 seconds national standard, as this standard was not nationally mandated at the time of contract award. Performance against this standard is reported on a daily basis and monitored by the Coordinating Commissioning Team, this is also compared with national performance.

Regional Performance Year Four										
		Q1			Q2			Q3		
Key performance indicator	Standard	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Abandonment rate (%)	≤5%	1.20%	1.90%	1.90%	0.70%	2.00%	29.20%	10.00%	0.90%	0.60%
Average speed of answer (seconds)	≤27 s	00:00:11	00:00:26	00:00:26	00:00:06	00:00:28	00:10:32	00:03:04	00:00:15	00:00:08
Calls answered in 60 seconds DHU111 (%)	≥95%	94.00%	87.20%	87.30%	97.70%	86.10%	49.80%	63.50%	93.40%	96.60%
Calls answered in 60s England Ave. (%)	≥95%	82.00%	77.80%	75.70%	85.20%	69.80%	30.20%	65.10%	86.00%	91.60%

Regional Activity Year Four Contracted Calls Offered and Clinical Activity				
June-2020				
	Actual	Plan	Variance (%)	Year to Date (Cumulative %)
Contracted Calls Offered	133,728	144,220	-7.3%	12.2%
Contracted Clinical Activity	45,518	23,970	39.5%	30.2%

What are the issues?

- Calls offered continued to be over plan in June 2020, with the cumulative position now 12.2% over plan (166,777 calls) this is a slightly improved position compared to May 2020 when it was 14.5% over plan across all commissioners. As activity is above the 5% threshold, but lower than Quarter Two a credit is due to Commissioners for Quarter Three of £44k.
- Clinical Calls continue to be significantly over plan at 30.2% (66,663 calls) this is an increase from May 2020, 30.0% (59,803 calls). As activity is over the 5% threshold, there is an additional payment due to DHU111 of £359k.
- In June 2020 DHU111 achieved the national standard for calls answered in 60 seconds, when compared to other NHS 111 Providers nationally DHU111 rank fourth in the Country.

What actions have been taken?

- Activity continues to be monitored and regular updates are being provided to associate commissioners via the Coordinating Commissioning Team.
- The NHS Pathways License easements that were introduced in March 2020 continue to enable Health Advisors to work from home, which supports rota planning.
- DHU111 have been working with EMAS in relation to a reduction in Category Two and Category Three calls.

What are the next steps

- The Coordinating Commissioning Team will continue to closely monitor performance against contractual standards.
- Learning from COVID-19 will be applied when undertaking preparations for Winter Planning, with robust recruitment plans and the possibility of increased home working for Clinical and Health Advisors.
- DHU111 plan to explore the differences in planned and actual call volumes and the results will be reported at a future Contract Management Board Meeting.

AMBULANCE – EMAS PERFORMANCE

June 2020	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	00:06:32	00:11:19	00:16:37	00:32:31	01:27:22	01:59:39
Derbyshire Actual	00:06:39	00:11:20	00:15:39	00:29:31	01:25:00	03:38:43
Derbyshire - Quarter One	00:06:41	00:11:27	00:14:56	00:27:59	01:06:59	01:52:38

June 2020	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	00:18:20	26:31:23	00:19:36	40:26:32	00:37:56	58:26:36
Chesterfield Royal	00:22:07	295:09:18	00:18:03	213:30:59	00:40:10	429:38:16
Macclesfield District General Hospital	00:23:27	05:53:34	00:12:46	01:02:33	00:36:13	05:30:59
Royal Derby	00:20:14	415:47:43	00:19:05	428:21:45	00:39:20	727:07:02
Sheffield Northern General Hospital	00:25:49	19:25:31	00:18:41	11:29:33	00:44:30	25:07:39
Stepping Hill	00:21:11	20:02:12	00:13:41	12:26:01	00:34:51	44:48:24

Derbyshire	April	May	June	Quarter one
Calls (Total)	15,219	14,050	14,733	44002
Total Incidents	12,994	12,339	12,351	37684
Total Responses	11,462	11,598	11,508	34568
Duplicate Calls	1,609	1,226	1,772	4607
Hear & Treat (Total)	2,157	1,230	1,449	4836
See & Treat	4,969	4,107	3,913	12989
See & Convey	6,493	7,491	7,595	21579
<i>Duplicates as % Calls</i>	10.60%	8.70%	12.00%	10.5%
<i>H&T ASI as % Incidents</i>	11.80%	6.00%	6.80%	8.3%
<i>S&T as % Incidents</i>	38.20%	33.30%	31.70%	34.5%
<i>S&C as % Incidents</i>	50.00%	60.70%	61.50%	57.3%

What are the issues?

- The contractual standard is for the division to achieve national performance on a quarterly basis. In Quarter One, Derbyshire met all six national standards, however June 2020 saw a slight deterioration for all standards within C1, C2, and C3 compared to May 2020. In June 2020 C4 90th centile saw a significant deterioration (3 hours and 38 minutes) when compared to May 2020 (1 hour and 35 minutes).
- Average Pre hospital handover times during June 2020 remained above the 15 minute national standard across Derbyshire (20 minutes and 27 seconds), this was comparable to May 2020 (20 minutes and 31 seconds).
- Average Post handover times during June 2020 remained above the 15 minute national standard across Derbyshire with the exception of Macclesfield Hospital (12 minutes and 46 seconds) and Stepping Hill (13 minutes and 41 seconds). Overall the post handover time in June 2020 (18 minutes and 36 seconds) was comparable to May 2020 (18 minutes and 57 seconds).
- The average total turnaround time in June 2020 (39 minutes and 3 seconds) remains above the 30 minute standard in all hospitals across the county this was comparable to May 2020 (39 minutes and 28 seconds).
- During April the activity mix in EMAS saw a considerable shift, with an increase in Hear and Treat (H&T) and See and Treat (S&T) and a reduction in See and Convey (S&C). In June 2020 S&C activity numbers increased, and S&T numbers decreased. This resulted in an increase in S&C as a % of incidents increasing to 61.5% compared to 50% in April, and S&T as a % of incidents reducing from 38.2% in April to 31.7% in June 2020.

What actions have been taken?

- Monthly regional Recovery and Restoration meetings are taking place with Commissioners and EMAS with local service development and transformation meetings being held to embed these at local system level.
- Work is taking place to understand the risks of non-delivery of performance and quality, and how these can be mitigated so that EMAS continue to deliver national performance standards.
- A regional Handover Collaborative known as “Right Care, Right Time, First Time” has been established to support a reduction in hospital handover delays for which EMAS are signed up to. In addition NHS England/Improvement are developing a regional Managing Conveyance policy which incorporates a rapid hospital handover protocol, and an escalation process for delays. This will support reducing delays.
- Across the region EMAS have implemented a number of measures to improve H&T, S&T and S&C rates such as:
 - Implementation of System1 to the EMAS Clinical Assessment Team
 - Review of Clinical Team profiles to meet patient acuity and demand
 - Recruitment of a Mental Health clinician in Emergency Operations Centre (EOC) to provide clinical advice and support and continued access to clinical advice from the EOC either from a General Practitioner or a medical practitioner with experience of pre-hospital medicine

What are the next steps

- With regards to performance from analysis undertaken to date, as a region there are four areas that have been identified as having the greatest impact; Demand, Handover delays, Resource hours and Reducing Conveyance to emergency departments. Derbyshire are currently working with EMAS on reducing avoidable conveyance, along with understanding the source of demand so work can commence on identifying and accessing alternative pathways.

Planned Care

DERBYSHIRE COMMISSIONER – INCOMPLETE PATHWAYS (92%)

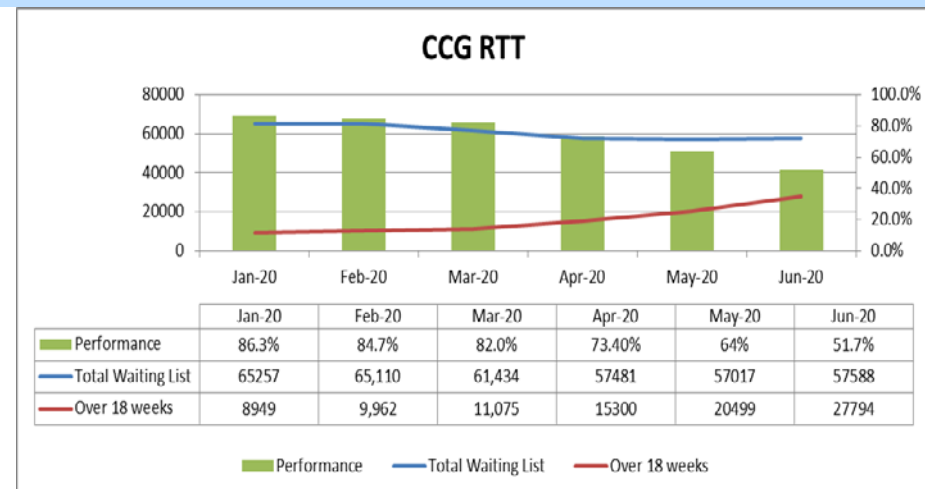
Performance Analysis

Performance for June 2020 is shown as 51.07%. A further decrease on the May performance of 64.05% and is significantly lower than the national standard of 92%.

Non Urgent elective surgery was cancelled from 17th March as a directive from NHSE to free up capacity to be available as a result of the COVID 19 pandemic. This has caused a delay for a large amount of non-urgent elective surgery.

The total incomplete waiting list for DDCCG increased slightly but is still lower than the waiting list at the end of March 2020. The number of referrals across Derbyshire during June showed a decrease of 36% urgent referrals and 61% decrease in routine referrals compared to the same month last year.

Treatment Function Name	Total Incomplete Waiting List	Number < 18 Weeks	Backlog (+18 Weeks)	% <18 Weeks	March 2020 Waiting List	Movement from March 20
General Surgery	4,609	2,560	2049	55.54%	4387	222
Urology	2,786	1,713	1073	61.49%	3110	-324
Trauma & Orthopaedics	10,414	3,738	6676	35.89%	9881	533
ENT	3,842	1,707	2135	44.43%	4117	-275
Ophthalmology	8,025	3,294	4731	41.05%	8468	-443
Oral Surgery	8	3	5	37.50%	2	6
Neurosurgery	355	228	127	64.23%	383	-28
Plastic Surgery	421	211	210	50.12%	395	26
Cardiothoracic Surgery	107	79	28	73.83%	113	-6
General Medicine	1,103	667	436	60.47%	1156	-53
Gastroenterology	2,641	1,857	784	70.31%	2920	-279
Cardiology	1,873	1,156	717	61.72%	2598	-725
Dermatology	3,405	1,816	1589	53.33%	3690	-285
Thoracic Medicine	798	518	280	64.91%	1215	-417
Neurology	1,127	680	447	60.34%	1476	-349
Rheumatology	1,196	775	421	64.80%	1606	-410
Geriatric Medicine	205	143	62	69.76%	207	-2
Gynaecology	3,511	1,871	1640	53.29%	3426	85
Other	11,162	6,778	4384	60.72%	12284	-1122
All specialties	57,588	29,794	27794	51.74%	61434	-3846



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 June.

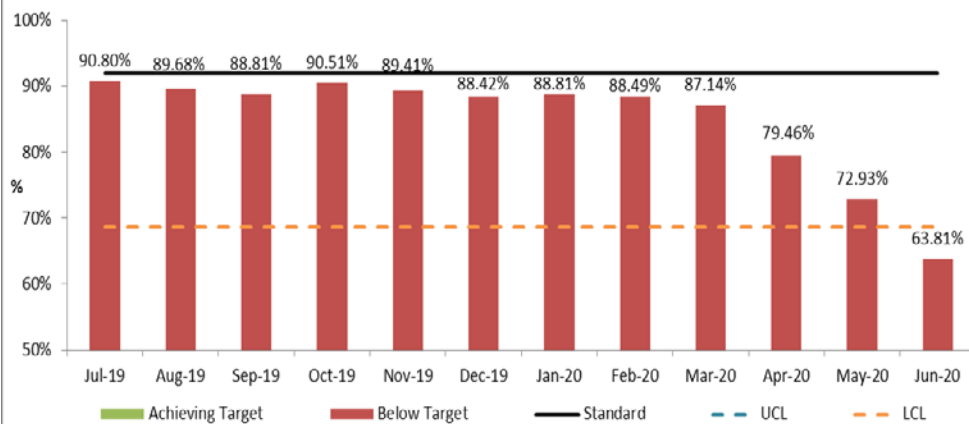
Referral to Treatment – Incomplete Pathways (92%).

CRH

During June the trust performance was 63.81% performance a further deterioration on the May performance.

The number of incomplete pathways at the end of June 2020 has increased although still lower than the March 2020 figure.

18 Weeks Incomplete RTT Performance - CRHFT

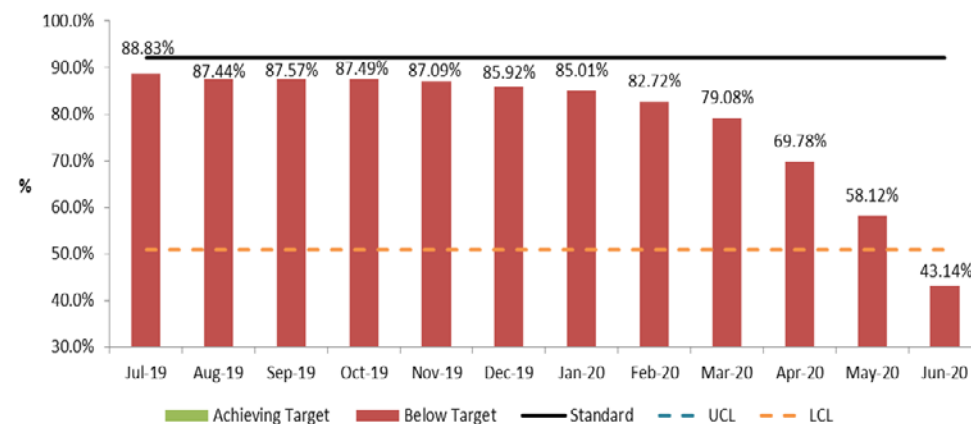


UHDB

During May the trust achieved a standard of 43.81%. This is a reflection of the delays due to the cancellation of elective surgery during March.

The waiting list at the end of June had increased slightly at 53,885 but this does not take into account a large number of patients on the trust ASI list who have not yet received appointments.

18 Weeks Incomplete RTT Performance - UHDBFT



Treatment Function Name	Total Incomplete Waiting List	Number < 18 Weeks	Backlog (+18 Weeks)	% <18 Weeks	March 2020 Waiting List	Movement from March 20
General Surgery	1824	1238	586	67.87%	1917	-93
Urology	1015	680	335	67.00%	1183	-168
Trauma & Orthopaedics	1398	821	577	58.73%	1157	241
ENT	948	569	379	60.02%	1204	-256
Ophthalmology	1392	652	740	46.84%	1605	-213
Oral Surgery	592	272	320	45.95%	780	-188
General Medicine	389	305	84	78.41%	476	-87
Gastroenterology	728	532	196	73.08%	873	-145
Cardiology	341	238	103	69.79%	554	-213
Dermatology	1053	736	317	69.90%	1076	-23
Thoracic Medicine	212	150	62	70.75%	392	-180
Rheumatology	288	202	86	70.14%	408	-120
Gynaecology	1057	743	314	70.29%	944	113
Other	1054	705	349	66.89%	1447	-393
All specialties	12291	7843	4448	63.81%	14016	-1725

Treatment Function Name	Total Incomplete Waiting List	Number < 18 Weeks	Backlog (+18 Weeks)	% <18 Weeks	March 2020 Waiting List	Movement from March 20
General Surgery	2904	1181	1723	40.67%	3202	-298
Urology	2196	1089	1107	49.59%	2309	-113
Trauma & Orthopaedics	10385	2948	7437	28.39%	10622	-237
Ear, Nose & Throat (ENT)	4247	1665	2582	39.20%	4171	76
Ophthalmology	7902	2579	5323	32.64%	8623	-721
Oral Surgery	347	12	335	3.46%	401	-54
Neurosurgery	69	21	48	30.43%	74	-5
Plastic Surgery	264	109	155	41.29%	257	7
Cardiothoracic Surgery	5	4	1	80.00%	2	3
General Medicine	247	179	68	72.47%	118	129
Gastroenterology	2409	1641	768	68.12%	2585	-176
Cardiology	1853	1214	639	65.52%	2500	-647
Dermatology	3327	1507	1820	45.30%	3323	4
Thoracic Medicine	403	217	186	53.85%	628	-225
Neurology	858	426	432	49.65%	876	-18
Rheumatology	1215	670	545	55.14%	1693	-478
Geriatric Medicine	236	137	99	58.05%	280	-44
Gynaecology	3095	1381	1714	44.62%	2995	100
Other	11923	6268	5655	52.57%	12504	-581
Total	53885	23248	30637	43.14%	57163	-3278

DERBYSHIRE COMMISSIONER – OVER 52 WEEK WAITERS

52 Week Waits

June performance data reflects the impact of COVID with 527 patients reporting as waiting over 52 week waits for treatment in Derbyshire. Of these 425 are waiting at our two main providers UHDB and CRH, the remaining 102 are waiting at various trusts around the country as outlined in the table to the right.

It is expected the number of patients waiting over 52 weeks will continue to increase during the next few months of 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
DDCCG	0	1	27	103	242	527

Main Providers:

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

Provider Patients – Trend – 52 weeks

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
UHDB	0	0	45	138	298	493
CRH	0	0	0	4	17	40

NB: UHDB/CRH figures for all patients to include Derbyshire, Specialised Commissioning and Out of Area at Associate Providers.

Main Provider Actions:

The Surgery Division are following national Royal College of Surgeon guidance on prioritisation of surgical patients. This will identify 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 us to tackle the growing backlog of long waiters.

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

Provider	Specialty	Total
BARTS HEALTH NHS TRUST	General Surgery	1
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	Other	1
EAST CHESHIRE NHS TRUST	Plastic Surgery	1
	Trauma & Orthopaedics	5
LEWISHAM AND GREENWICH NHS TRUST	General Surgery	1
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	General Surgery	1
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	ENT	2
	General Surgery	4
	Ophthalmology	1
	Other	1
	Plastic Surgery	1
	Trauma & Orthopaedics	1
NORTH BRISTOL NHS TRUST	Neurosurgery	1
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	ENT	3
	Gastroenterology	2
	Other	4
	Plastic Surgery	1
	Trauma & Orthopaedics	1
	Urology	4
NUFFIELD HEALTH, DERBY HOSPITAL	General Surgery	2
SALFORD ROYAL NHS FOUNDATION TRUST	Dermatology	2
	General Surgery	1
SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	Other	10
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	Other	1
	Trauma & Orthopaedics	3
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	Cardiology	2
	ENT	1
	General Surgery	2
	Trauma & Orthopaedics	4
	Urology	1
SPAMEDICA (SHEFFIELD)	Ophthalmology	1
STOCKPORT NHS FOUNDATION TRUST	ENT	2
	General Medicine	11
	General Surgery	4
	Rheumatology	1
	Trauma & Orthopaedics	2
	Urology	6
UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	Ophthalmology	1
	Urology	1
UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	Other	4
	Urology	1
WOODTHORPE HOSPITAL	Urology	1
WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	Trauma & Orthopaedics	1
HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST	Other	1
Grand Total		102

Next steps

- System Planned Care Group are leading on the plans for restoration and recovery across the system.
- NHSEI engagement is in place to include fortnightly calls.

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

Performance Analysis

Derbyshire CCG Diagnostic performance year to date position at the end of June was 48.9% which although non compliant is showing an improvement on the May figure of 59.8%. The total number of Derbyshire patients waiting for a diagnostic procedure has increased by nearly 3,000 but the number waiting over six weeks has decreased since May.

The Covid-19 response has dramatically impacted upon the CCGs performance of Diagnostics with both the two main acute providers and associate providers all having an affect. It is anticipated this will continue and part of the phase 3 planning is to increase the activity, particularly in Endoscopy.

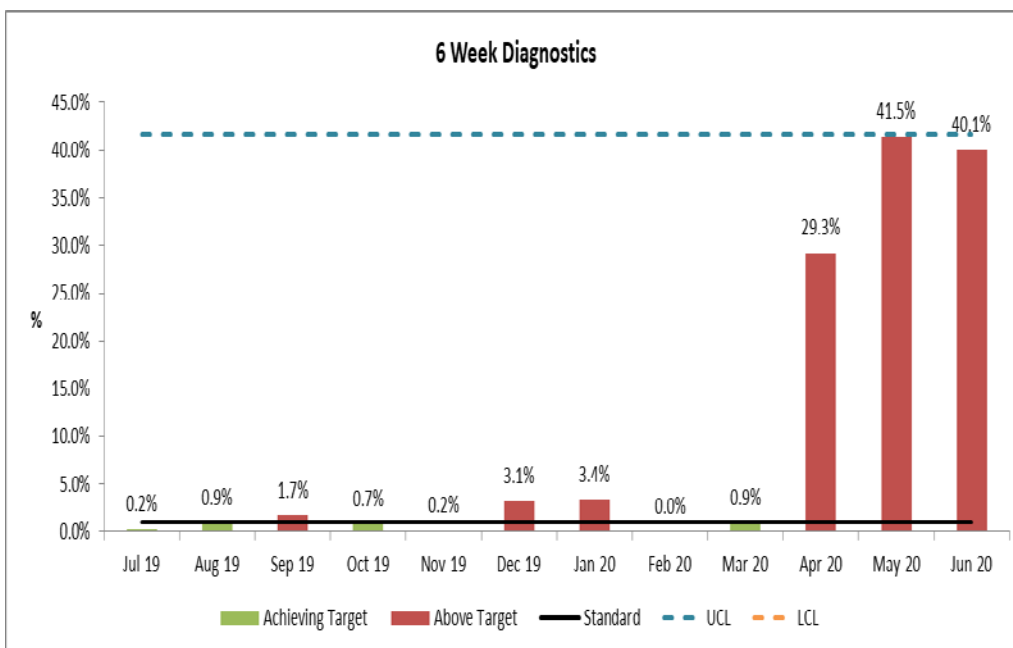
Diagnostic Test Name	Total Waiting List	Number waiting 6+	Number waiting 13+ Weeks	May 6+ Weeks	Movement May to June 6+	Percentage waiting 6+ Weeks
Magnetic Resonance Imaging	2,309	722	494	1,096	-374	31.3%
Computed Tomography	2,026	508	324	667	-159	25.1%
Non-obstetric Ultrasound	6,818	3,011	2,192	3,052	-41	44.2%
Barium Enema	1	0	0	0	0	0.0%
DEXA Scan	642	383	139	355	28	59.7%
Audiology - Audiology Assessments	1,774	1,282	414	1,138	144	72.3%
Cardiology - Echocardiography	2,710	1,536	823	1,653	-117	56.7%
Neurophysiology - Peripheral Neurophysiology	582	431	351	440	-9	74.1%
Respiratory physiology - Sleep Studies	144	89	63	128	-39	61.8%
Urodynamics - Pressures & Flows	116	78	65	83	-5	67.2%
Colonoscopy	985	623	397	622	1	63.2%
Flexi Sigmoidoscopy	495	288	189	282	6	58.2%
Cystoscopy	441	198	96	214	-16	44.9%
Gastroscopy	1,116	702	461	685	17	62.9%
Total	20,159	9,851	6,008	10,415	-564	48.9%

Diagnostic Test	University Hospitals of Derby & Burton	Chesterfield Royal Hospital	Stockport Hospital	Sheffield Teaching Hospital	Sherwood Forest Hospitals	Nottingham University Hospitals	East Cheshire Hospitals
Magnetic Resonance Imaging	28.13%	2.87%	23.70%	41.78%	52.63%	65.21%	53.63%
Computed Tomography	26.11%	2.65%	44.70%	26.75%	54.77%	46.99%	41.56%
Non-obstetric Ultrasound	58.66%	20.71%	48.09%	44.56%	36.15%	45.57%	40.20%
Barium Enema	42.86%						0.00%
DEXA Scan	78.00%	33.21%	69.59%	87.65%	62.27%	78.36%	
Audiology - Audiology Assessments	73.39%	74.87%	100.00%	79.35%	63.72%	76.43%	86.86%
Cardiology - Echocardiography	50.00%	49.01%	54.49%	43.70%	56.09%	47.88%	64.17%
Neurophysiology - Peripheral Neurophysiology	75.53%			47.88%		71.56%	
Respiratory physiology - Sleep Studies	48.98%		87.50%	76.44%	71.20%	88.74%	50.00%
Urodynamics - Pressures & Flows	63.54%	85.00%	0.00%		65.33%	100.00%	
Colonoscopy	61.31%	62.00%	71.78%	65.64%	51.49%	60.72%	63.00%
Flexi Sigmoidoscopy	56.00%	55.56%	84.07%	70.57%	59.14%	56.23%	54.11%
Cystoscopy	52.09%	14.15%	100.00%	43.24%	61.83%	7.98%	83.33%
Gastroscopy	55.39%	60.71%	74.85%	68.28%	57.03%	59.53%	59.96%
Total	52.59%	40.09%	58.56%	48.20%	50.01%	57.74%	55.80%

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

Performance Analysis

Performance during June improved slightly compared to May although the number of patients on the waiting list has increased by nearly 1,000. The number of patients waiting over 6 and 13 weeks has also increased.



Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Percentage waiting 6+ weeks
Magnetic Resonance Imaging	349	10	4	2.87%
Computed Tomography	415	11	3	2.65%
Non-obstetric Ultrasound	1671	346	109	20.71%
DEXA Scan	262	87	13	33.21%
Audiology - Audiology Assessments	1174	879	154	74.87%
Cardiology - Echocardiography	706	346	168	49.01%
Urodynamics - Pressures & Flows	40	34	30	85.00%
Colonoscopy	350	217	126	62.00%
Flexi Sigmoidoscopy	126	70	39	55.56%
Cystoscopy	106	15	2	14.15%
Gastroscopy	336	204	121	60.71%
Total	5535	2219	769	40.09%

What are the issues?

Reduced capacity in endoscopy during June has resulted in the backlog increasing.

The number of sessions is reduced as a result of social distancing measures and unable to do undertake as many tests per session pre-COVID. For e.g. Pre Covid there would be 10 patients in one session, this has now reduced to 5.

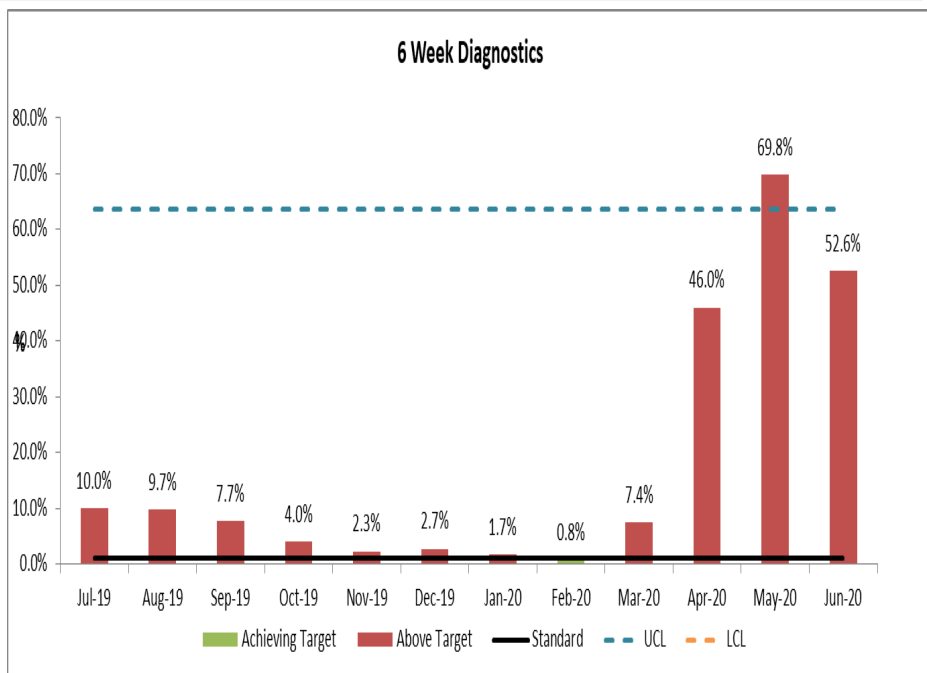
The number of endoscopy lists increased during the month, to include clinics on Saturdays,

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

Performance Analysis

The performance during June improved to a figure of 52.6% compared to the May performance of 69.8%, although well above the expected standard of 1%.

The number of patients on the waiting list has increased by over 800 but the numbers waiting over six weeks has reduced, which is reflected in the improved performance. All diagnostic tests are showing an improved position particularly the imaging tests, MRI, CT and Ultrasound.



Issues

All service areas have been impacted upon and are a concern, resulting in a dramatic increase of patients waiting over 6 weeks but this number is now starting to reduce.

Actions

- Nuffield capacity for MRI, CT and X ray is being utilised.
- Community venues – Ilkeston and Tamworth are being used.
- Replacement programme for MRI scanners at LRCH has been brought forward and a mobile MRI has been ordered.

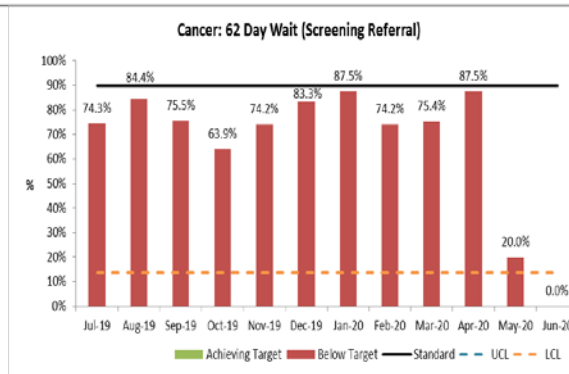
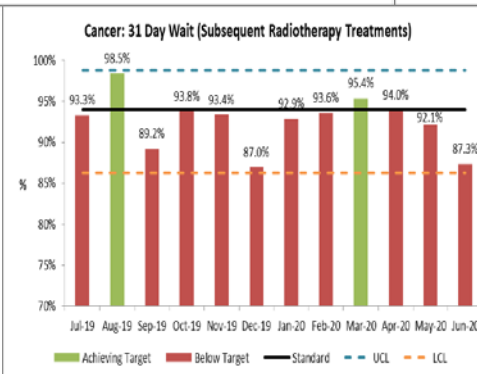
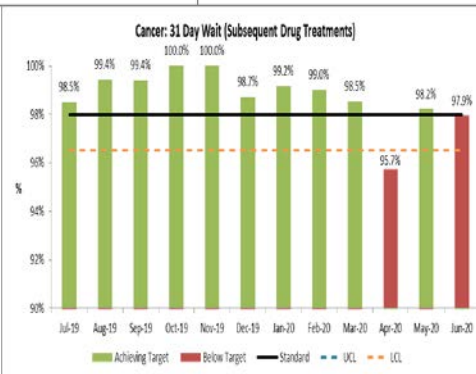
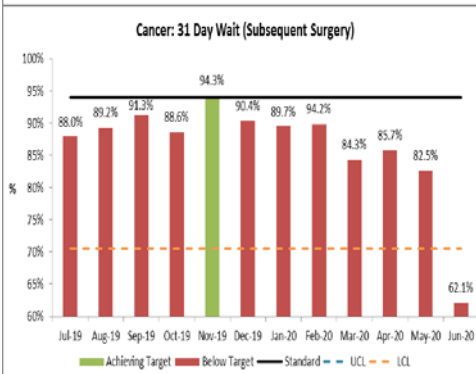
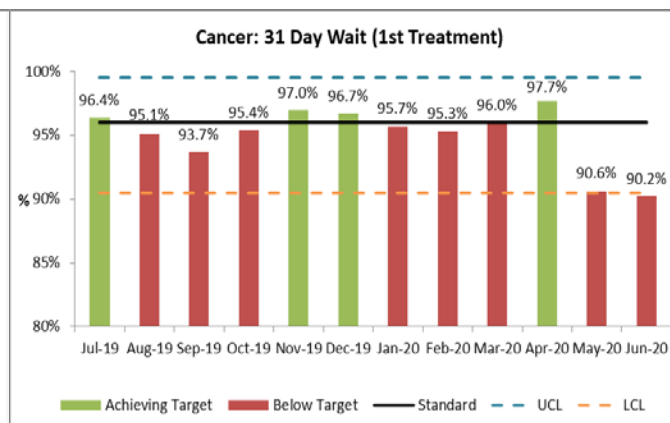
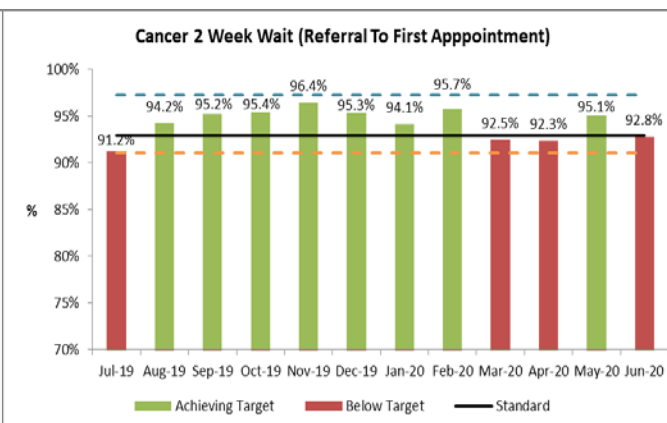
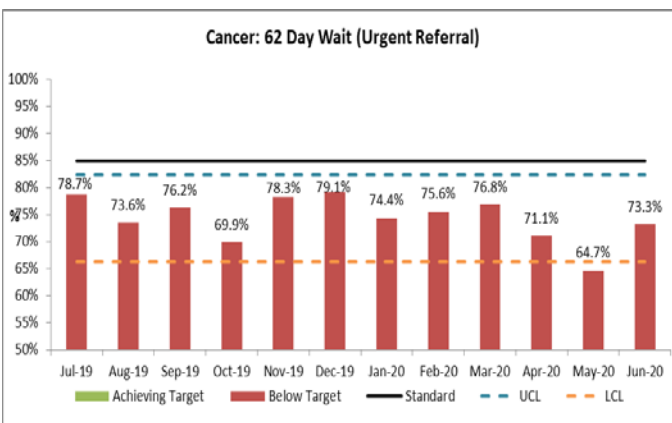
Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Percentage waiting 6+ weeks
Magnetic Resonance Imaging	1575	443	377	28.13%
Computed Tomography	1593	416	361	26.11%
Non-obstetric Ultrasound	6030	3537	2980	58.66%
Barium Enema	7	3	2	42.86%
DEXA Scan	400	312	180	78.00%
Audiology - Audiology Assessments	714	524	416	73.39%
Cardiology - Echocardiography	2366	1183	612	50.00%
Neurophysiology - Peripheral Neurophysiology	711	537	447	75.53%
Respiratory physiology - Sleep Studies	196	96	60	48.98%
Urodynamics - Pressures & Flows	96	61	49	63.54%
Colonoscopy	597	366	225	61.31%
Flexi Sigmoidoscopy	450	252	182	56.00%
Cystoscopy	382	199	107	52.09%
Gastroscopy	751	416	260	55.39%
Total	15868	8345	6258	52.59%

DERBYSHIRE COMMISSIONER – CANCER WAITING TIMES

Performance Analysis

During June 2020 Derbyshire was non-compliant in 7 of the 8 Cancer standards:

- **62 day Urgent GP Referral** – 73.3% (85% standard) – Non compliant for all trusts.
- **Cancer 2 Week Wait** - 92.8% (93% standard) – Compliant at Sheffield, Sherwood forest and Stockport.
- **31 day from Diagnosis** – 90.2% (96% standard) – Non compliant for all trusts except East Cheshire.
- **31 day Subsequent Surgery** – 62.1% (94% standard) – Non compliant for all trusts except East Cheshire.
- **31 day Subsequent Drug** – 97.9% (98% standard) – Non compliant at UHDB and Sheffield.
- **31 day Subsequent Radiotherapy** – 87.3% (94% standard) – Non compliant for all trusts.
- **62 day Screening Referral** – 00.0% (90% standard) – Non compliant for all trusts.



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

Trust performance during June improved to 81.65% compared to 71.3% achieved in May. There were 79 patients treated during the month compared with 47 during May.

There were 14.5 breaches during June relating to 20 patients as some of the breaches were shared with Sheffield Teaching Hospital

A number of the breaches were due to COVID delays but there were a number with a complex pathway.

12 of the patients had waited longer than 104 days for treatment.

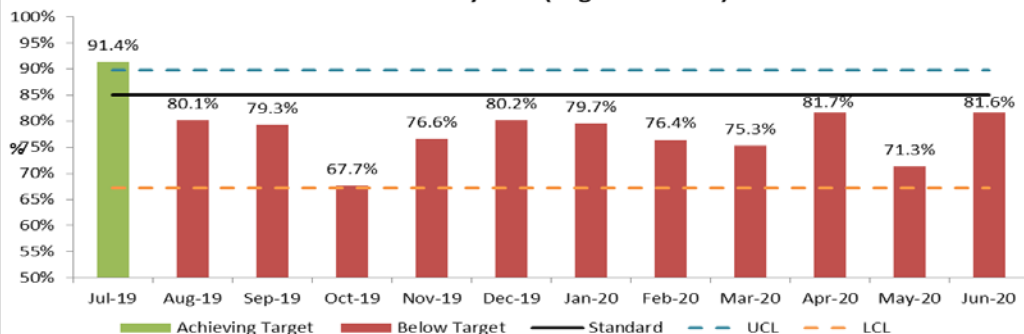
What are the issues?

- A number of the patients had a clinical pathway pause for treatment or diagnostics. Diagnostic capacity is limited by the guidance issued for e.g. Gastroscopies, there can only be 5 procedures per session when it used to be 10.
- A number of patients had a change of treatment due to guidance and risk stratification.
- A number of patients still reluctant to attend the hospital for their diagnostic procedures or treatment.

What actions have been taken?

- A system Restoration and recovery plan was submitted to NHSE during June and recovery of cancer performance is overseen through the System Planned Care Steering group which meets monthly.
- Increased Colonoscopy CT Capacity will be available during August. Scoping the use of capsule endoscopy. Currently used for a small number of patients for small bowel but further scoping being done for additional patients.
- Some surgery being undertaken at Barlborough and Thornbury (Breast and Skin).
- Increased focus on those patients waiting over 62 days.
- Discussions taking place with patients to reassure them that it is safe to attend their appointments.

Cancer: 62 Day Wait (Urgent Referral)

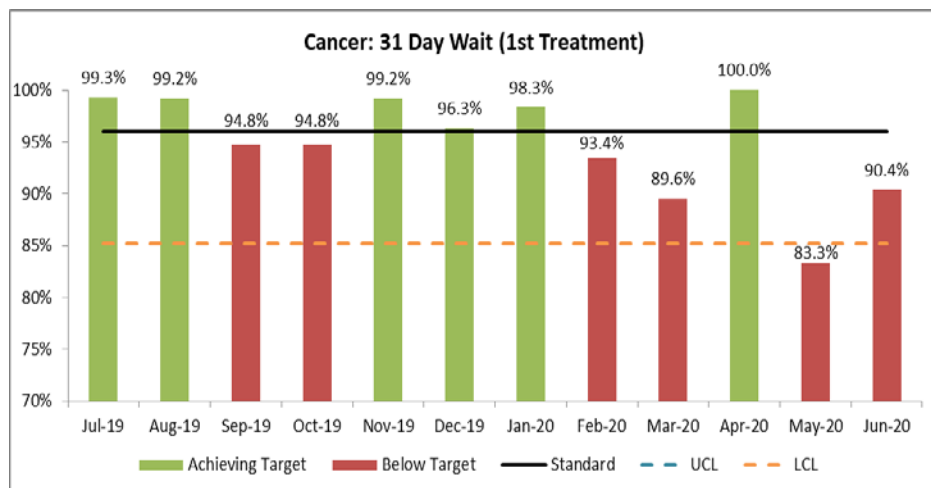


Tumour Type	Total Patients treated	Treated <62 days	% Performance
Breast	12.5	7.5	60.00%
Gynaecological	0.5	0.5	100.00%
Haematology	9	9	100.00%
Head and Neck	2.5	2	80.00%
Lower GI	6	2.5	41.67%
Lung	4	2.5	62.50%
Other	1	1	100.00%
Sarcoma	1	1	100.00%
Skin	32	31	96.88%
Upper GI	4.5	3	66.67%
Urology	6	4.5	75.00%
Totals	79.0	64.5	81.65%

What are the next steps

- Restoration and recovery plans are currently being developed focussing on increasing endoscopy activity, reducing 104 and 62 day patients.

CRHFT - CANCER WAITING TIMES (31 days from Diagnosis to First Treatment)



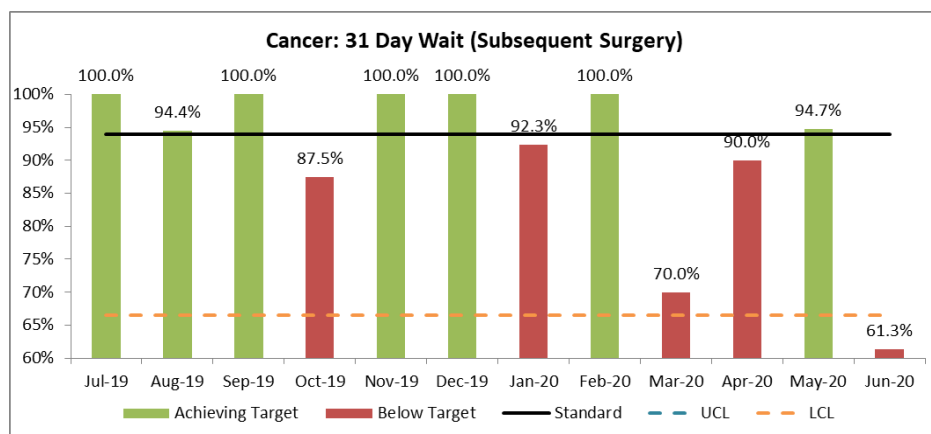
Performance Analysis

June's performance from Cancer Diagnosis to first treatment has improved slightly since the previous month.

The number of patients seen in this part of the pathway in June has increased to 125 compared to 72 reported in May. Of the 125 patients the number of breaches was 12. Breast (7), Lower GI (3) and Urology (2).

This standard was impacted upon by the clinical risk stratification plan where all patients are reviewed to identify the most clinically urgent cases who are then allocated in accordance with theatre capacity. This approach is part of the Trusts Cancer COVID-19 response plan which is in line with national guidance. It is anticipated performance may continue to be affected in the short term.

CRHFT - CANCER WAITING TIMES (31 days to Subsequent Treatment Surgery)



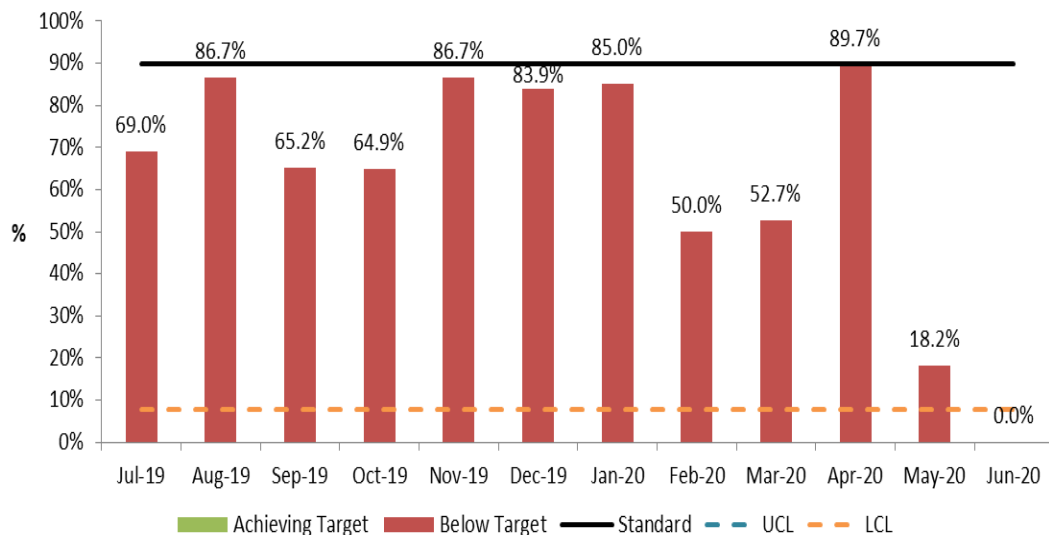
Performance Analysis

Performance of 31 day for subsequent surgery treatment in June was 61.3% - there were 31 patients treated during this time with 19 of them receiving treatment within the 31 day standard. This is an increase on the May figure of 19 treated.

All 12 breaches were due to delays in elective capacity.

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

Cancer: 62 Day Wait (Screening Referral)



Performance Analysis – Screening Referral

62 day screening performance was 0%.

There were 16 patients treated during June who were referred through screening. None of these patients were treated within the 62 days.

Out of the 16 patients 5 of these were breast, 2 Gynaecology and 9 Lower GI.

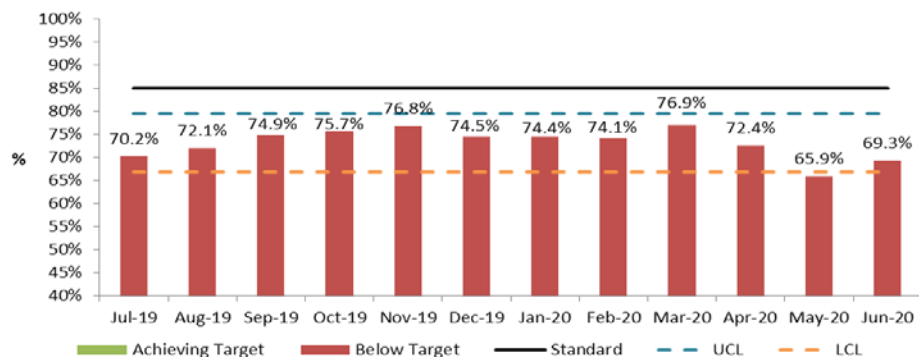
June performance was affected by risk stratification of patients, elective capacity and delays in diagnostic.

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

Performance Analysis

62 day performance during June 2020 was non compliant at 69.3%. The number of treatments taking place each month are continuing to increase with June activity 166 as opposed to 133 reported in May. Out of the 166 patients 27 of these had been waiting over 104 days for treatment.

Cancer: 62 Day Wait (Urgent Referral)



Tumour Type	Total Patients treated	Treated <62 days	% Performance
Breast	37	35	94.59%
Gynaecological	12	4	33.33%
Haematology	7.5	3.5	46.67%
Head and Neck	13	10	76.92%
Lower GI	19	6	31.58%
Lung	13.5	10.5	77.78%
Sarcoma	2	0	0.00%
Skin	32	30	93.75%
Testicular	1	1	100.00%
Upper GI	12	6	50.00%
Urology	17	9	52.94%
Totals	166.0	115	69.28%

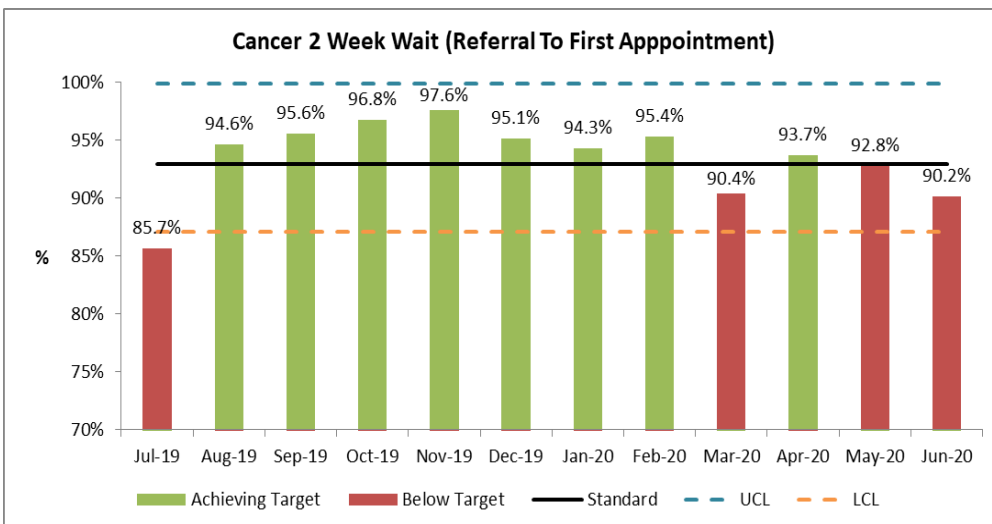
What are the issues?

- Services were impacted by Clinical Risk stratification due to the COVID 19 response and also delays for diagnostics in a number of cases.
- During this month there were still a number of patients who were reluctant to attend for their appointments due to COVID and also due to shielding.
- Of the 27 patients treated over 104 day 19 of these were treated by the Lower and Upper GI teams, which is reflected in the lower performance of these tumour sites. The main reasons for these reporting as a breach include elective capacity or diagnostic delay.

What are the next steps?

- Breast, Gynae and Head and Neck surgery continues to be undertaken at the Nuffield Hospital.
- Although Cancer recovery is overseen currently by the system wide planned care steering group, it has been agreed that Cancer will have a separate work stream and will focus on reduction of 104 days patients to Zero, a reduction of the number of patients over 62 days and an intention to increase the endoscopy activity as this is impacting speed of diagnosis, particularly for lower and upper GI.

UHDB - CANCER WAITING TIMES – 2 Week Wait (Referral to First appointment)



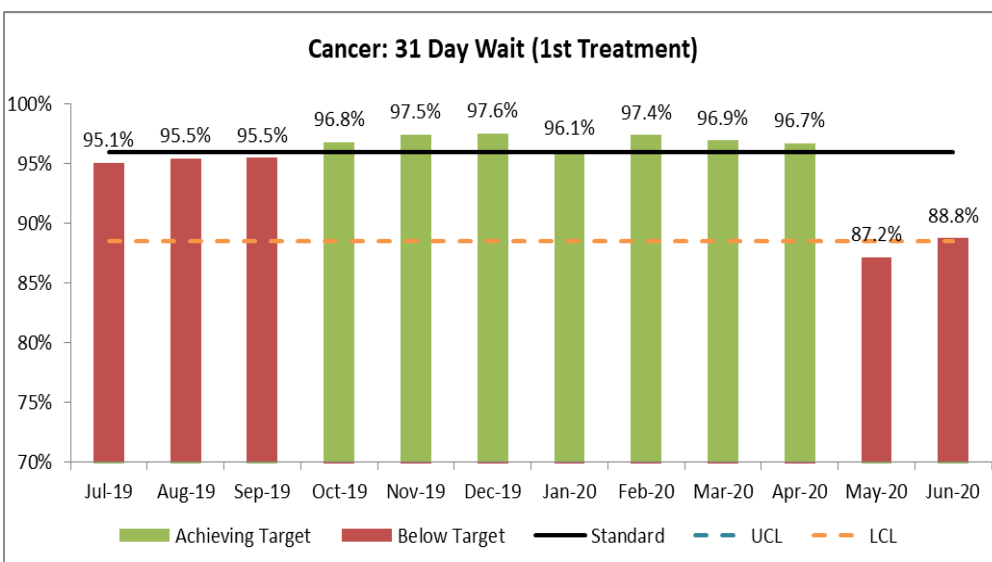
Performance Analysis

The trust did not achieve this standard with a performance of 90.20%, compared to 92.8% during May.

In June the number of patients seen had increased by 67% compared to May with 2203 patients being seen. There were 216 breaches mainly with over 50% of the breaches (126) occurring in Lower GI due to inadequate outpatient capacity. These patients would go “Straight to Test” and would be seen in Endoscopy for their first appointment, which is being operated with lower activity currently.

47 of the delays were due to patient choice to delay their first outpatient appointment.

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



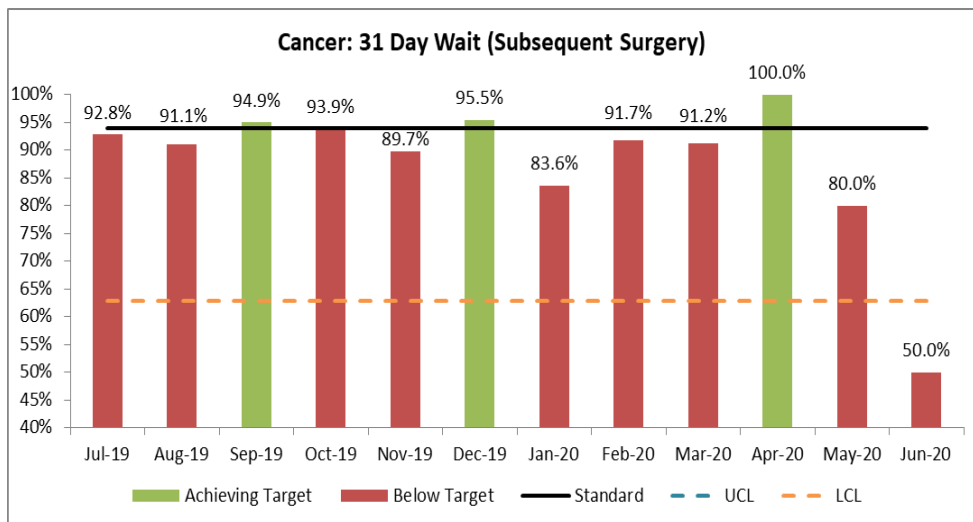
Performance Analysis

Performance for 31 day wait to first treatment during June was 88.77%, a slight increase on the May figure of 87.2%.

The number of patients going through this part of the pathway increased by compared to the previous month, 285 compared to 226.

There were 30 breaches of the 31 day standard with the main delays in Lower GI (15) and Urology (8). The majority of the breaches were due to inadequate elective capacity to enable the patients to be treated on time.

UHDB –CANCER WAITING TIMES – Subsequent Surgery within 31 days of decision to Treat



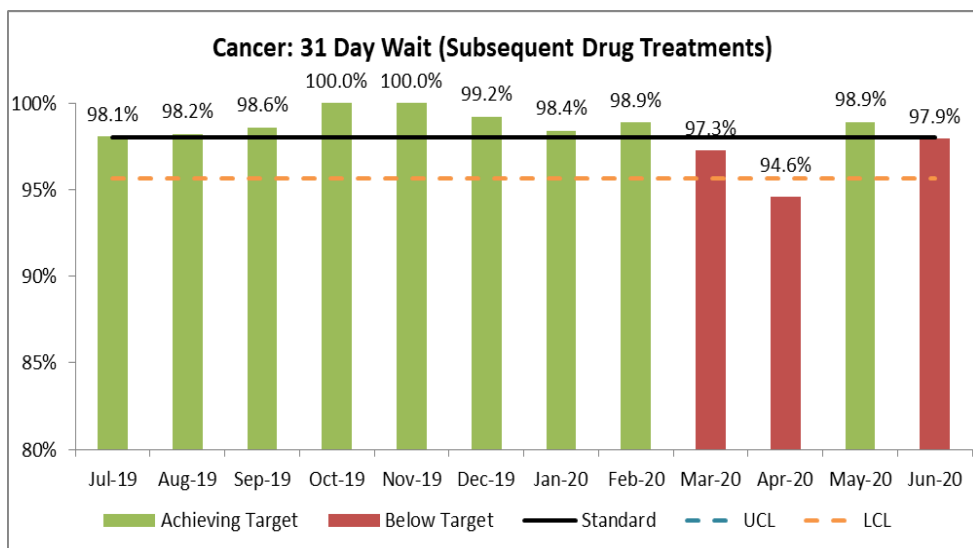
Performance Analysis

Performance of 31 day for subsequent surgery treatment was 50% - there were 46 patients treated during this time with 23 of them receiving treatment after day 31.

The number of patients treated was over 100% more than the previous month. (46 as opposed to 20 in May).

All delays were due to elective capacity issues and or health care provider delays.

UHDB –CANCER WAITING TIMES – Subsequent Drug Treatment within 31 days of decision to Treat

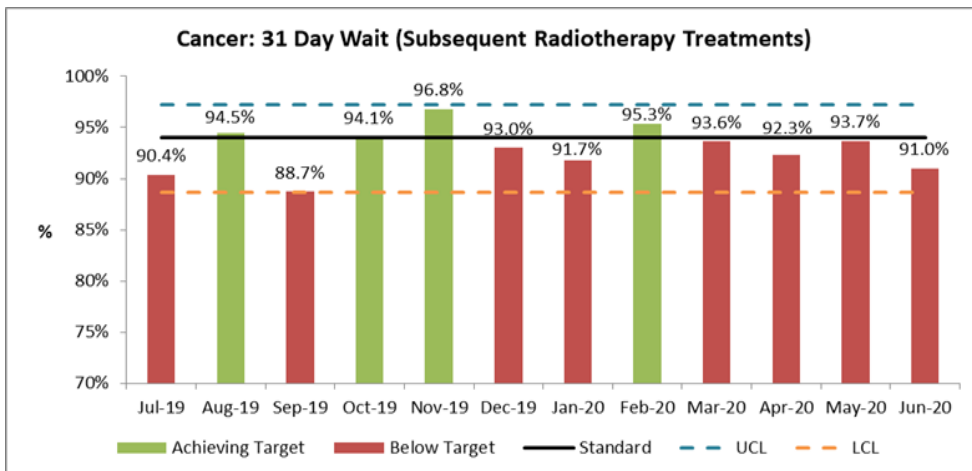


Performance Analysis

Performance of 31 day for subsequent drug treatment during June 2020 was marginally non compliant at 97.95%. Of the 146 patients treated there were just 3 that were not treated within 31 days.

One due to capacity, one due to a hospital delay and one delayed for medical reasons.

UHDB –CANCER WAITING TIMES – Subsequent Radiotherapy within 31 days of decision to Treat

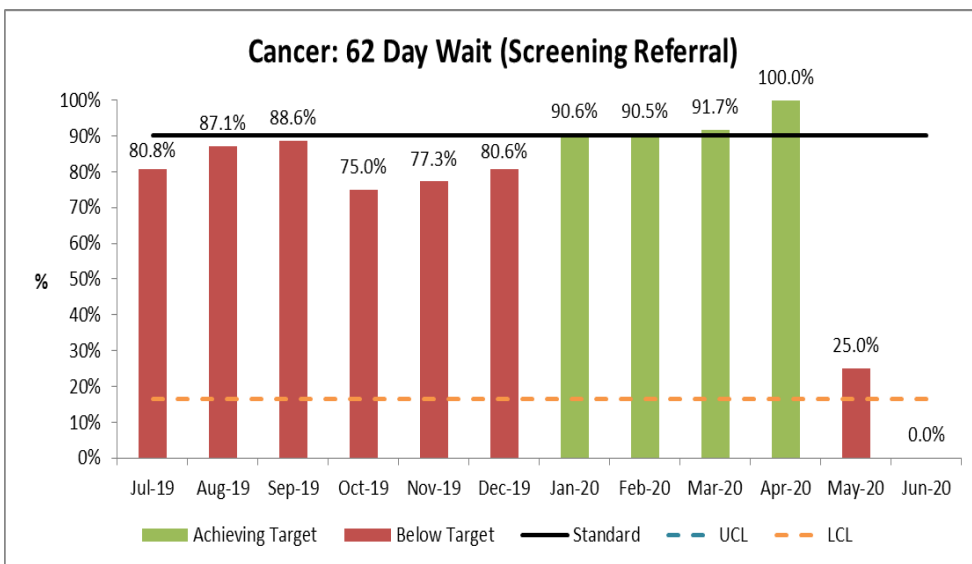


Performance Analysis

Performance of 31 day for subsequent radiotherapy during June 2020 was non compliant at 91.03%. Of the 78 patients treated there were 7 who were not treated within the 31 days.

Delay reasons were elective capacity inadequate, outpatient capacity and a health care provider initiated delay.

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



Performance Analysis

During June no patients referred through screening were treated within 62 days. Although the number of patients treated during this month had increased compared to the previous month (12 to 4), this was still around 66% less than the normal amount of patients treated through this referral route, reflecting the pause in the screening services during the pandemic.

8 of the breaches were within Lower GI, with one delay through medical reasons but the remainder due to elective capacity. The remaining four breaches were Breast (2), delays during the pathway and Gynaecology (2), both through delays through medical reasons.

Appendix

APPENDIX 1: PERFORMANCE OVERVIEW M3 – 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							
Urgent Care	Area	Indicator Name	Standard	Latest Period	East Cheshire Hospitals			Nottingham University Hospitals			Sheffield Teaching Hospitals FT			Sherwood Forest Hospitals FT			Stockport FT										
					↓	90.0%	89.9%	25	A&E pilot site - not currently reporting 4 hour breaches			↑	90.0%	92.3%	51	↓	96.7%	96.6%	0	↑	82.3%	88.5%	2				
	Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	Jul-20	↔	0	0	0	↔	0	0	0	↔	0	0	0	↔	0	0	0	↓	1	1	1			
Planned 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%	Jun-20	↓	51.0%	62.9%	34	↓	58.6%	69.1%	9	↓	65.8%	75.4%	5	↓	70.8%	76.7%	34	↓	48.7%	58.2%
	2 Week Cancer Waits	All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	Jun-20	↓	91.2%	90.6%	1	↑	91.9%	89.0%	3	↓	95.8%	96.5%	0	↓	97.7%	97.5%	0	↑	95.9%	93.6%	0			
					Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	Jun-20	↓	83.7%	86.7%	1	↑	97.9%	91.4%	0	↑	99.1%	97.4%	0	↔	100.0%	100.0%	0	↔	N/A	N/A	0
	31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	96%	Jun-20	↔	100.0%	100.0%	0	↓	93.1%	93.9%	15	↑	94.9%	93.6%	3	↑	92.1%	92.3%	2	↓	71.7%	85.4%	2			
					Subsequent Surgery Within 31 Days Of Decision To Treat	94%	Jun-20	↔	100.0%	100.0%	0	↓	74.8%	80.8%	26	↓	89.1%	89.3%	4	↓	50.0%	70.0%	1	↓	50.0%	83.3%	1
					Subsequent Drug Treatment Within 31 Days Of Decision To Treat	98%	Jun-20	↑	N/A	100.0%	0	↑	99.4%	98.5%	0	↑	96.8%	96.4%	2	↑	100.0%	88.9%	0	↔	100.0%	100.0%	0
					Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	Jun-20	↓	88.0%	93.6%	1	↓	84.3%	89.1%	2	↓	80.0%	80.6%		↑	90.0%	79.4%					
	62 Days Cancer Waits	First Treatment Administered Within 62 Days Of Urgent GP Referral	85%	Jun-20	↑	67.3%	63.3%	9	↑	77.4%	73.8%	3	↑	71.5%	67.6%	58	↓	64.7%	70.3%	6	↑	55.0%	56.7%	14			
					First Treatment Administered - 104+ Day Waits	0	Jun-20	↑	1.5	4.5	16	↑	10.5	27.5	51	↑	12.0	31.0	51	↑	6.0	10.5	26	↑	11.5	15.5	14
					First Treatment Administered Within 62 Days Of Screening Referral	90%	Jun-20	↑	N/A	64.3%	0	↔	0.0%	29.0%	3	↑	66.7%	58.1%	10	↓	0.0%	16.7%	3	↔	N/A	N/A	0
					First Treatment Administered Within 62 Days Of Consultant Upgrade	N/A	Jun-20	↑	88.9%	89.9%		↓	79.3%	82.7%		↑	78.0%	60.6%		↑	80.0%	80.6%		↑	90.0%	79.4%	
	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			
					Incidence of healthcare associated Infection	Healthcare Acquired Infection (HCAI) Measure: MRSA Infections	0	Jun-20	↔	0	1	0	↑	0	2	0	↑	0	1	0	↔	0	0	0	↔	0	1
	Plan	Jun-20	↑						9		↓		30		↑		42		↑		21		↑		15		
	Actual		↑			2	0	↓		19	0	↑		24	0	↑		3	0	↑		8	0				
	Healthcare Acquired Infection (HCAI) Measure: E-Coli	-	Jun-20	↑		7	28		↑	58	166		↓	49	120		↓	24	64		↓	13	40				
Healthcare Acquired Infection (HCAI) Measure: MSSA	-	Jun-20	↓	4	10		↓	20	52		↑	15	45		↓	9	22		↓	5	13						

Governing Body Meeting in Public

3rd September 2020

Item No: 055

Report Title	Governing Body Assurance Framework - Quarter 1 – 2020-21
Author(s)	Rosalie Whitehead, Risk Management & Legal Assurance Manager Suzanne Pickering, Head of Governance
Sponsor (Director)	Helen Dillistone, Executive Director of Corporate Strategy and Delivery

Paper for:	Decision	X	Assurance	X	Discussion		Information
Recommendations							
The Governing Body is asked to AGREE the 2020/21 Quarter 1 (April to June) Governing Body Assurance Framework.							
Report Summary							
<p>The Governing Body Assurance Framework (GBAF) provides a structure and process that enables the organisation to focus on the strategic and principal risks that might compromise the CCG in achieving its corporate objectives. It also maps out both the key controls that should be in place to manage those objectives and associated strategic risks, and confirms that the Governing Body has sufficient assurance about the effectiveness of the controls.</p> <p>During 2019/20 the Governing Body has strengthened the GBAF to incorporate the implementation and embedding of the measurement of progress in the achievement of the CCG strategic aims, including the mapping of performance targets. This has supported the achievement of our aims and performance targets through the Organisational Effectiveness and Improvement Programme Board (OEIPB) work streams and the Clinical Commissioning Strategy outcomes.</p> <p>The Governing Body reviewed and agreed the CCG's Strategic Aims at their public meeting on the 2nd July. A draft opening 2020/21 GBAF defining the strategic risks was presented and agreed at the public meeting on the 6th August.</p> <p>The Corporate Committees responsible for their assigned strategic risks have scrutinised and approved their GBAF Strategic Risk at their Committee meetings during August 2020.</p> <p>Updates to the strategic risk extract documents are detailed in red text in appendix 1. The initial scores on each strategic risk are the opening risk scores for 2020/21; these are the closing risk scores from the 2019/20 quarter 4 GBAF.</p>							

The quarter 1 GBAF will be also presented to the Audit Committee on the 17 th September for assurance and challenge.
Are there any Resource Implications (including Financial, Staffing etc)?
The Derby and Derbyshire CCG attaches great importance to the effective management of risks that may be faced by patients, members of the public, member practices and their partners and staff, CCG managers and staff, partners and other stakeholders, and by the CCG itself.
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?
Not required for this paper. Notwithstanding this, where any issues/risks that have been identified from Data Protection Impact Assessment (DPIA) appropriate actions will be taken to managed the associated risks.
Has a Quality Impact Assessment (QIA) been completed? What were the findings?
Not required for this paper. Notwithstanding this, where any issues/risks that have been identified from a Quality Impact Assessment) appropriate actions will be taken to manage the associated risks.
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
An EIA is not found applicable to this update on the basis that the GBAF is not a decision making tool; however, addressing risks will impact positively across the organisation as a whole.
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
Due Regard is not found applicable to this update on the basis that the GBAF is not a decision making tool; however, addressing risks will impact positively across the organisation as a whole.
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Not applicable to this update.
Have any Conflicts of Interest been identified/ actions taken?
Not applicable to this update.
Governing Body Assurance Framework
The paper provides the Committee the updated Quarter 1 GBAF.
Identification of Key Risks
The GBAF identifies the strategic/ principal risks which are linked to the corporate/ operational risks identified in the Corporate Risk Register.

Introduction

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

The Strategic Objectives of Derby and Derbyshire CCG are:

1. To reduce measurably our health inequalities and improve the physical health, mental health and wellbeing of our population.
2. To reduce measurably unwarranted variation in the quality of healthcare delivered across Derbyshire.
3. To plan and commission quality healthcare that meets the needs of our population and improves its outcomes, and accounts for the long-term sequelae of Covid-19 .
4. 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.
5. Work in partnership with stakeholders and with our population to achieve the above four objectives.

	Strategic Risk(s)	Current Rating	Executive Lead
1	Lack of timely data, insufficient system ownership and ineffective commissioning may prevent the ability of the CCG to improve health and reduce health inequalities.	9	Steve Lloyd
2	The CCG is unable to harness the skills and capacity in the organisation and across the system to identify priorities for variation reduction and reduce or eliminate them.	12	Steve Lloyd
3	Ineffective system working may hinder the creation of a sustainable health and care system by failing to deliver the scale of transformational change needed at the pace required.	12	Zara Jones
4A	The Derbyshire health system is unable to manage demand, reduce costs and deliver sufficient savings to enable the CCG to move to a sustainable financial position.	16	Richard Chapman
4B	The Derbyshire health system is unable to manage demand, reduce costs and deliver sufficient savings to enable the system to move to a sustainable financial position.	25	Richard Chapman
5	The Derbyshire population is not sufficiently engaged to identify and jointly deliver the services that patients need.	12	Helen Dillistone

Strategic Aim: 1 To reduce measurably our health inequalities and improve the physical health, mental health and wellbeing of our population.				GBAF RISK 1				Executive Lead: Steve Lloyd Assigned to Committee: Quality and Performance					
What would success look like and how would we measure it? <i>Agreement of and commitment to agenda at JUCD Board. Strategic Long Term Conditions Programme Board to be established or system to collate and triangulate data and agree actions. Focussing on particular patient cohorts, measures around services to be put in place to support reduction of inequalities. LTC Board identify group(s) for focus.</i>				Risk Description Lack of timely data, insufficient system ownership and ineffective commissioning may prevent the ability of the CCG to improve health and reduce health inequalities.									
Risk rating		Likelihood	Consequence	Total				Date reviewed		July 2020			
Initial		4	3	9				GBAF Risk 1 				Rationale for risk rating (and any change in score): <ul style="list-style-type: none"> Capacity in commissioning has improved. PLACE areas are now supported by a CCG Functional Director. QIA/EIA process in place. OEIPB process in place. 	
Current		3	3	9									
Risk Appetite		Level	Category	Target Score				Link to Derby and Derbyshire Risk Register 1,2,3,4,5,6,7,9,12,14,17,19,21,22,24,25,26,27,28					
		Moderate	Commissioning and Contracting	8									
KEY CONTROLS TO MITIGATE RISK						SOURCES OF ASSURANCE							
Internal <ul style="list-style-type: none"> QIPP and Service Benefit Reviews challenge process. Prioritisation tool. Clinical & Lay Commissioning Committee providing clinical oversight of commissioning and decommissioning decisions. Robust QIA process for commissioning/ decommissioning schemes and System QIA now in place Clinical Quality Review Group (CQRG) measures built into all contracts OEIPB Board and Action Plan OEIPB progress and assurance reported monthly to Governing Body through the Quality & Performance Assurance report 2020/2021 Commissioning Intentions published and on website 2020/2021 Contracting approach and objectives developed 			External <ul style="list-style-type: none"> NHSE and NHSI assurance arrangements CQC inspections and associated commissioner and provider action plans Programme Boards STP Oversight Meetings with Local Authority to identify joint funding opportunities. System wide efficiency planning has commenced for 2020/2021 showing commitment to joint system working System Quality and Performance Group has been established and monthly meetings in place. System ownership of the health inequalities agenda. Daily System Escalation Cell (SEC) meetings established to support the management of COVID 19 across the Derbyshire System. 			Internal <ul style="list-style-type: none"> Quality & Performance Committee Risk management controls and exception reports on clinical risks to Quality & Performance Committee Performance reporting framework in place Lay representation within Governing Bodies and committee in common structures. NHSE assurance meetings to provide assurance. OEIPB Action Plan and Highlight Report owned by Quality & Performance Committee Draft Joined Up Care 5 Year Strategy Delivery Plan 19/20 - 23/24 STP Refresh Summary OEIPB progress and assurance reported monthly to Governing Body through the Quality & Performance Assurance report Measurement of performance targets System Quality and Performance Group 			External <ul style="list-style-type: none"> Quality Surveillance Group Recovery Action Plans Commissioning Boards Health and Well-being Boards Legal advice where appropriate NHSE Assurance Letters System Quality and Performance Group minutes. Agreement and commitment to the Health Inequalities agenda at JUCD Board. SEC Agendas and Papers. SEC Action Logs. 				

<ul style="list-style-type: none"> • Brigid Stacey Chief Nurse of DDCCG is the Chair of the System Quality and Performance Group • Quality and Performance Committee meetings reinsated from June 20. as a result of the COVID 19 pandemic 		minutes	
GAPS IN CONTROL		GAPS IN ASSURANCE	
<u>Internal</u>	<u>External</u>	<u>Internal</u>	<u>External</u>
	<ul style="list-style-type: none"> • Develop and agree an evidence-based strategy to address inequalities. • Agree a programme of work for appropriate interventions, informed by public health data and incorporating the wider determinants of health. 		<ul style="list-style-type: none"> • Understanding health data and implications of Covid including disparities of outcomes. • Understanding direct impacts and long-term implications of Covid.Triangulating through system.
ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)			
<u>Internal</u>	<u>Timeframe</u>	<u>External</u>	<u>Timeframe</u>
		<ul style="list-style-type: none"> • Long Term Conditions Strategy. • Strategic Long Term Conditions Programme Board to be established or system to collate and triangulate data and agree actions. • Long Term Conditions Board to identify groups for focus 	<ul style="list-style-type: none"> • Sept/ October 2020 • Sept/ October 2020 • September 2020

Strategic Aim: 2 To reduce measurably unwarranted variation in the quality of healthcare delivered across Derbyshire.				GBAF RISK 2				Executive Lead: Steve Lloyd Assigned to Committee: Quality and Performance					
What would success look like and how would we measure it? Links to Strategic Long Term Conditions programme board to address variation. Set timescales and what will reduce by when for variation. Agree and implement the at-scale activity.				Risk Description The CCG is unable to harness the skills and capacity in the organisation and across the system to identify priorities for variation reduction and reduce or eliminate them.									
Risk rating		Likelihood	Consequence					Date reviewed		July 2020			
Initial		3	4					Total		Rationale for risk rating (and any change in score):			
Current		3	4					12		<ul style="list-style-type: none"> The STP Clinical leadership group is becoming established. The Systems saving group is bringing key partners together to deliver the financial priorities and has increased joint ownership of priorities PLACE commissioning is developing. 			
Risk Appetite		Level	Category	Target Score		<p style="text-align: center;">Link to Derby and Derbyshire Risk Register 1,2,3,4,5,6,7,9,12,14,17,21,22,23,24,25,26,27,28,29</p>							
		Moderate	National Quality and Direction	8									
KEY CONTROLS TO MITIGATE RISK						SOURCES OF ASSURANCE							
<u>Internal</u> <ul style="list-style-type: none"> Clinical & Lay Commissioning Committee providing clinical oversight of commissioning and decommissioning decisions Robust QIA process for commissioning/ decommissioning schemes and new System QIA panel in place Clinical Quality Review Group (CQRG) measures built into all contracts Financial Recovery Group (FRG) oversight. Contract Management Board (CMB) oversight Quality & Performance Committee OEIPB Board and Action Plan OEIPB progress and assurance reported monthly to Governing Body through the Quality & Performance Assurance report Brigid Stacey, Chief Nurse of Derby and Derbyshire CCG is the Chair of the System Quality & Performance Group Internal resource planning work led by HR Quality and Performance Committee meetings 			<u>External</u> <ul style="list-style-type: none"> NHSE assurance arrangements Provider Governance arrangements are clear and include any subcontracting responsibilities. CQC inspections and associated commissioner and provider action plans NHSI assurance arrangements STP Oversight System Quality & Performance Group established and meets on a monthly basis 			<u>Internal</u> <ul style="list-style-type: none"> Quality & Performance Committee Risk management controls and exception reports on clinical risk to Quality & Performance Performance reporting framework Lay and Council representation within Governing Bodies and committees in common structure. Clinical committee established at Place, Quality assurance visits NHSE assurance meetings to provide assurance. OEIPB Action Plan and Highlight Report owned by Quality & Performance Committee Draft Joined Up Care 5 Year Strategy Delivery Plan 19/20 - 23/24 STP Refresh Summary OEIPB progress and assurance reported monthly to Governing Body through the Quality & Performance Assurance report 			<u>External</u> <ul style="list-style-type: none"> Collaboration with Healthwatch Health and Well-being Boards 360 Assurance audits NHSE/I assurance meetings CQC Inspections and action plans Quality Surveillance Group Minutes of System Quality & Performance Group 				

reinsated from June 20. as a result of the COVID 19 pandemic		<ul style="list-style-type: none"> • Brigid Stacey, Chief Nurse of Derby and Derbyshire CCG is the Chair of the System Quality & Performance Group. • Daily System Escalation Cell meetings established to support the management of COVID 19 across the Derbyshire System. 	
GAPS IN CONTROL		GAPS IN ASSURANCE	
<u>Internal</u>	<u>External</u> <ul style="list-style-type: none"> • System Quality and Performance Group meetings stood down from March 2020 to July 2020 due to COVID 19 pandemic. • Identify variation caused through system processes and work with system partners to eliminate or reduce. • Agree the priorities which carry the most significant at-scale benefits for early action. 	<u>Internal</u> <ul style="list-style-type: none"> • STP planning in development and refresh in progress 	<u>External</u> <ul style="list-style-type: none"> • System Quality and Performance Group minutes not currently available. • Differentiate which variation is appropriate for elimination and which is not; develop a prioritised plan for the former. • Agree dataset to measure improvement in outcomes and patient experience.
ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)			
<u>Internal</u>	<u>Timeframe</u>	<u>External</u> <ul style="list-style-type: none"> • Increased system working with system partners to deliver transformation change. • Refer issues to System Quality and Performance Group. • Strategic Long Term Conditions Programme Board to address variation. • Right Care Evidence and Data • Agree Priorities at System Event. • Strategic Long Term Conditions Programme Board to agree dataset measurement 	<u>Timeframe</u> <ul style="list-style-type: none"> • Ongoing • Monthly System Quality & Performance Group • November 2020 • November 2020 • TBC • November 2020

<p>Strategic Aim: 3 To plan and commission quality healthcare that meets the needs of our population and improves its outcomes, and accounts for the long-term sequelae of Covid-19 .</p>				<p>GBAF RISK 3</p>				<p>Executive Lead: Zara Jones Assigned to Committee: Clinical & Lay Commissioning</p>				
<p>What would success look like and how would we measure it? Delivery of system transformation schemes – improved outcomes and reduced cost. Improved / sustained relationships with system partners – increased collaboration and strengthened planning and delivery, less duplication and more shared accountability for delivery. Improved and streamlined contracting approach for 20/21 with contracts agreed earlier and aligned to system requirements.</p>				<p>Risk Description Ineffective system working may hinder the creation of a sustainable health and care system by failing to deliver the scale of transformational change needed at the pace required.</p>								
<p>Risk rating</p>		<p>Likelihood</p>	<p>Consequence</p>	<p>Total</p>					<p>Date reviewed</p>	<p>July 2020</p>		
<p>Initial</p>		<p>3</p>	<p>4</p>	<p>12</p>					<p>Rationale for risk rating (and any change in score):</p> <ul style="list-style-type: none"> System working is still developing, however scale of transformation required is clear and principles of collaborative system working are agreed. measures are easily measurable making the score more subjective. 			
<p>Current</p>		<p>3</p>	<p>4</p>	<p>12</p>								
<p>Risk Appetite</p>		<p>Level</p>	<p>Category</p>	<p>Target Score</p>	<p>Link to Derby and Derbyshire Risk Register 1,2,3,4,5,6,9,10,12,14,17,19,22,23,24,25,26,27,28,29</p>							
		<p>Moderate</p>	<p>Collaborative working</p>	<p>8</p>								
					<p>KEY CONTROLS TO MITIGATE RISK</p>				<p>SOURCES OF ASSURANCE</p>			
<p>Internal</p> <ul style="list-style-type: none"> Senior members of staff are fully involved in STP workstreams Link with STP Strong CEO lead and influence on STP Good clinical engagement i.e. Medical Director a key player in CPRG CPAG and new Clinical Pathways Forum Commissioning Intentions 19/20 finalised and agreed with Providers and published on website Clinical Leadership Framework in place Deep Dives on areas of poor performance involving provider partners e.g. Q&P deep dives Lessons learned application to 20/21 planning and delivery through Finance Committee and shared with GB and system Clinical and Lay Commissioning Committee meetings reinstated June 2020 a result of the COVID 19 pandemic. Clinical Cell established to manage COVID 19 		<p>External</p> <ul style="list-style-type: none"> Governance structure becoming embedded Good CEO/DoF system engagement JUCD Board now fully functioning as a group of system leaders Systems Savings Group Future in Mind Plan agreed by the CCG, Derby City Council and Derbyshire County Council System Quality and Performance Group established to support in-year delivery strategically, linked to the transformation agenda System Planning leads oversight of contracting and planning for 20/21, linked to DoFs group to ensure we set the right framework for delivery of our transformation as a system. System Clinical and Professional Reference Group established and meets monthly. System intelligence – one version of the truth 		<p>Internal</p> <ul style="list-style-type: none"> Clinical & Lay Commissioning Committee meetings Governing Body PMO Executive Team OEIPB Board and Action Plan OEIPB Highlight Report owned by Clinical & Lay Commissioning Committee Clinical & Lay Commissioning Assurance Report provided to Governing Body. STP System Refresh Draft Joined Up Care 5 Year Delivery Plan 19/20 – 23/24 Commissioning Intentions published and available on the CCGs website 		<p>External</p> <ul style="list-style-type: none"> JUCD Board System Forums incl.delivery boards, planning leads CEO/DoF meetings CPRG meetings NHSE/I reviews Derby City Council Derbyshire County Council Future in Mind Plan published on Derby City Council website Future in Mind Plan published on Derbyshire County Council website STP refresh System Clinical and Professional Reference Group Minutes 						

<p>issues, Steve Lloyd Medical Director is the lead for the cell.</p> <ul style="list-style-type: none"> • Zara Jones, Executive Director of Commissioning and Operations is the lead for the System Planning Cell. • Daily System Escalation Cell meetings established to support the management of COVID 19 across the Derbyshire System • System Planning and Operations Cell established to manage and determine recovery plans and future planning. • Established intelligence and baseline data on finance, activity and workforce to enable scenario modelling to inform decision making 			
GAPS IN CONTROL		GAPS IN ASSURANCE	
<p style="text-align: center;"><u>Internal</u></p> <ul style="list-style-type: none"> • Not able to influence decisions • Limited CCG capacity to contribute to all meetings Clinical and Lay Commissioning Committee meetings stood down from March 2020 to June 2020 due to CCG operating at level 4 Business Continuity Escalation as a result of the COVID 19 pandemic. • Withdrawal of Turnaround approach 	<p style="text-align: center;"><u>External</u></p> <ul style="list-style-type: none"> • National directives • 'Club v's country' i.e. organisational sovereignty over system • System Clinical and Professional Reference Group meetings stood down due to COVID 19 pandemic. • Workforce plans to be established across the system to provide the necessary competency and capacity to deliver healthcare, including contingency plans for staff reductions due to Covid-19. • Suspension of operational planning • Suspension of Systems Savings Group and PMO • Necessary delays in some transformation work 	<p style="text-align: center;"><u>Internal</u></p> <ul style="list-style-type: none"> • None. Mitigating actions in place • 	<p style="text-align: center;"><u>External</u></p> <ul style="list-style-type: none"> • None. Mitigating actions in place • System Clinical and Professional Reference Group Minutes not available due to current Position. • Quantify residual health need resulting from Covid infection and factor into capacity and demand planning.
ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)			
<p style="text-align: center;"><u>Internal</u></p> <ul style="list-style-type: none"> • System savings work in place and ongoing • Joined Up Care Derbyshire Workstream Delivery Boards / Assurance • Strategic commissioner and ICS / ICP development • Virtual urgent decisions can be made by CLCC as per the Terms of Reference as required. • Weekly 30 minute Confidential GB Virtual Meetings established, with focused agenda have been established for urgent decision making and any urgent committee business. • Clinical Cell established to manage COVID 19 issues, Steve Lloyd Medical Director is the lead for the cell. • Zara Jones, Executive Director of Commissioning and Operations is the lead for the System Planning Cell. 	<p style="text-align: center;"><u>Timeframe</u></p> <ul style="list-style-type: none"> • Monthly review • March to June 2020 • April to June 2020 • April to June 2020 • Since March 2020. Ongoing 	<p style="text-align: center;"><u>External</u></p> <ul style="list-style-type: none"> • Continued work with system partners to develop and deliver transformation plans • Development of Direct Enhanced Services during 2020/21 through PCCC. • Daily System Escalation Cell meetings established to support the management of COVID 19 across the Derbyshire System. • System Planning and Operations Cell established to manage and determine recovery plans and future planning. 	<p style="text-align: center;"><u>Timeframe</u></p> <ul style="list-style-type: none"> • Monthly review • March 2020 Ongoing • April to June 2020 • March 2020. Ongoing.

Strategic Aim: 4 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				GBAF RISK 4A				Executive Lead: Richard Chapman Assigned to Committee: Finance Committee				
What would success look like and how would we measure it? <ul style="list-style-type: none"> Delivery of agreed 2020/21 financial position. 				Risk Description The Derbyshire health system is unable to manage demand, reduce costs and deliver sufficient savings to enable the CCG to move to a sustainable financial position.								
Risk rating		Likelihood	Consequence	Total					Date reviewed	July 2020		
Initial		5	5	25					Rationale for risk rating (and any change in score): <ul style="list-style-type: none"> Identify underlying system position, current and forward-looking 			
Current		4	4	16								
Risk Appetite		Level	Category	Target Score	Link to Derby and Derbyshire Risk Register .11,30							
		Low	Financial Statutory Duties	10								
		2	5									
KEY CONTROLS TO MITIGATE RISK					SOURCES OF ASSURANCE							
Internal <ul style="list-style-type: none"> Contract management incl. validation of contract information, coding and counting challenges etc. Internal management processes – monthly confirm and challenge by FRG & FinCom OEIPB Board and Action Plan. OEIPB progress and assurance reported monthly to Governing Body through the Finance Committee Assurance report. Finance Committee meetings reinstated from June 2020 			External <ul style="list-style-type: none"> Standardised contract governance in line with national best practice. System Finance Oversight Group (SFOG) established. Daily System Escalation Cell meetings established to support the management of COVID 19 across the Derbyshire System System Savings Group established and in place System Finance Oversight Group in place 		Internal <ul style="list-style-type: none"> Monthly reporting to NHSE/NHSI, Finance Recovery Group and Finance Committee. Internal Audit Financial Management review giving significant assurance OEIPB Board and Action Plan. OEIPB progress and assurance reported monthly to Governing Body through the Finance Committee Assurance report Finance Committee Minutes 			External <ul style="list-style-type: none"> Internal audit review of Finance and Contract Management processes. Regulator review and oversight of monthly financial submissions System Finance Oversight Group Minutes 				

GAPS IN CONTROL		GAPS IN ASSURANCE	
<u>Internal</u>	<u>External</u>	<u>Internal</u>	<u>External</u>
<ul style="list-style-type: none"> Consistent and regular reporting of timely, accurate and complete activity data with associated financial impact. 	<ul style="list-style-type: none"> Absence of integrated system reporting of the health financial position. System Finance Oversight Group meetings to be reinstated September 2020. Establish common system objective to deliver financial sustainability on a system-wide basis. Identify underlying system position, current and forward-looking. Establish system-wide monitoring, efficiency and transformational delivery process. 	<ul style="list-style-type: none"> Regularisation of integrated activity, finance and savings reporting incorporating activity trajectory matched to provider capacity to deliver and associated commissioner financial impact 	<ul style="list-style-type: none"> Absence of commitment to open-book reporting with clear risk identification. System Finance Oversight Group Minutes
ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)			
<u>Internal</u>	<u>Timeframe</u>	<u>External</u>	<u>Timeframe</u>
<ul style="list-style-type: none"> Strengthening of activity data reporting to ensure improved business intelligence to support decision making. Development of an integrated Activity Finance & Savings report in place 	<ul style="list-style-type: none"> Ongoing April 2020 	<ul style="list-style-type: none"> Transparency of open book reporting through System Savings Group Output from Demand & Capacity Workstream on waiting list growth (reduction) and consider in financial sustainability terms. 	<ul style="list-style-type: none"> Ongoing October 2020

Strategic Aim: 4 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				GBAF RISK 4B				Executive Lead: Richard Chapman Assigned to Committee: Finance Committee				
What would success look like and how would we measure it? <ul style="list-style-type: none"> Delivery of agreed 2020/21 financial position on a system basis. 				Risk Description The Derbyshire health system is unable to manage demand, reduce costs and deliver sufficient savings to enable the <u>system</u> to move to a sustainable financial position.								
Risk rating		Likelihood	Consequence	Total					Date reviewed	July 2020		
Initial		5	4	20					Rationale for risk rating (and any change in score): <ul style="list-style-type: none"> Identify underlying system position, current and forward-looking It is not yet clear what resources will be made available to the Derbyshire health economy. It is not yet clear whether the Derbyshire health economy will be required to operate to organisational or system control totals. The system does not currently have a functional efficiency programme or agreed structures to implement such a programme. 			
Current		5	5	25								
Risk Appetite		Level	Category	Target Score	Link to Derby and Derbyshire Risk Register 11,30							
		Low	Financial Statutory Duties	10								
		2	5									
KEY CONTROLS TO MITIGATE RISK					SOURCES OF ASSURANCE							
Internal <ul style="list-style-type: none"> Internal management processes – monthly confirm and challenge by FRG & Finance Committee Integrated financial reporting incorporating I&E and savings positions and risk OEIPB Board and Action Plan. Clinical Leadership Framework in place across the system to support governance and clinical workstreams. OEIPB progress and assurance reported monthly to Governing Body through the Finance Committee Assurance report Finance Committee meetings reinstated from June 2020 			External <ul style="list-style-type: none"> Standardised contract governance in line with national best practice. System Finance Oversight Group (SFOG) established Requirement to agree a multi-year system recovery plan with regulator in order to mitigate impact score 		Internal <ul style="list-style-type: none"> Monthly reporting to NHSE/NHSI, Finance Recovery Group and Finance Committee. OEIPB Board and Action Plan. Clinical Leadership Framework in place across the system to support governance and clinical workstreams. OEIPB progress and assurance reported monthly to Governing Body through the Finance Committee Assurance report Finance Committee Minutes 			External <ul style="list-style-type: none"> Internal audit review of Finance and Contract Management processes. Regulator review and oversight of monthly financial submissions System Finance Oversight Group Minutes 				

GAPS IN CONTROL		GAPS IN ASSURANCE	
<u>Internal</u>	<u>External</u>	<u>Internal</u>	<u>External</u>
<ul style="list-style-type: none"> Consistent and regular reporting of timely, accurate and complete activity data with associated financial impact. 	<ul style="list-style-type: none"> Absence of a single system view of activity data which is timely, accurate and complete. Absence of a system planning function on which partners place reliance. Absence of integrated system reporting of the health financial position. Regulatory and statutory financial duties mitigate against system collaboration and cooperation to reduce health cost. System Activity Finance & Savings report System Savings Group established and in place System Finance Oversight Group in place System Finance Oversight Group to be reinstated September 20. Establish common system objective to deliver financial sustainability on a system-wide basis. Identify underlying system position, current and forward-looking. Establish system-wide monitoring, efficiency and transformational delivery process. 	<ul style="list-style-type: none"> Regularisation of integrated activity, finance and savings reporting incorporating activity trajectory matched to provider capacity to deliver and associated commissioner financial impact 	<ul style="list-style-type: none"> Absence of commitment to open-book reporting with clear risk identification. Provider rules only allow reforecasting on a quarterly basis, unable to influence this Provider Sustainability Fund rules incentivise delay in risk recognition meaning forecasting may not be fully objective, unable to influence this System Finance Oversight Group minutes not available due to current position
ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)			
<u>Internal</u>	<u>Timeframe</u>	<u>External</u>	<u>Timeframe</u>
<ul style="list-style-type: none"> Development of new System Activity Finance & Savings report 	<ul style="list-style-type: none"> Ongoing 	<ul style="list-style-type: none"> Establish greater system working across finance teams Transparency of open book reporting through System Savings Group Daily System Escalation Cell meetings established to support the management of COVID 19 across the Derbyshire System Output from Demand & Capacity Workstream on waiting list growth (reduction) and consider in financial sustainability terms. 	<ul style="list-style-type: none"> Ongoing Ongoing April to June 2020 October 2020

Strategic Aim: 5 Work in partnership with stakeholders and with our population to achieve the above four objectives.				GBAF RISK 5				Executive Lead: Helen Dillistone Assigned to Committee: Engagement Committee								
What would success look like and how would we measure it? Output and delivery of comprehensive engagement programme, with % increase to Citizen's Panel membership and agreed % population engaged in planning in Yr1. Fully populated and network engagement structure, with permanent membership of Engagement Committee confirmed.				Risk Description The Derbyshire population is not sufficiently engaged to identify and jointly deliver the services that patients need.												
Risk rating		Likelihood	Consequence	Total							Date reviewed		July 2020			
Initial		4	3	12							Rationale for risk rating (and any change in score):		<ul style="list-style-type: none"> The CCG recognises the risk of operating in a complex and financially challenged environment and the need to balance decision making with appropriate engagement and involvement. 			
Current		4	3	12							Link to Derby and Derbyshire Risk Register 4,5,6,7,9,12,14,16,24,25,26,27,28					
Risk Appetite		Level	Category	Target Score												
		Low	Commissioning	6												
		2	3													
KEY CONTROLS TO MITIGATE RISK					SOURCES OF ASSURANCE											
Internal <ul style="list-style-type: none"> Clearly defined system strategy which identifies key health priorities and forward planning to ensure public engagement can be embedded. Engagement function with clearly defined roles and agreed priorities. Engagement Committee to provide challenge and internal scrutiny; the Committee has broad representation from provider Governors, members of the public, Local Government, Healthwatch and the Voluntary Sector. Alignment of CCG and JUCD communications and engagement agendas where necessary to provide streamlined and coherent approach. Identified involvement of communications and engagement lead involvement in all projects. Clearly defined offer and ownership of 					External <ul style="list-style-type: none"> Engagement Committee has dual responsibility for the alignment of JUCD and CCG communications and engagement agendas where necessary to provide streamlined and coherent approach. Relationship development with local parliamentary and council politicians. Structured approach to broader stakeholder engagement. Proactive formal and informal Engagement with Overview & Scrutiny Committees, with clear business plan. Co-production approach to planning utilising existing local experts by experience (Lay Reference Groups) Joined Up Care Derbyshire Comms and Engagement collaboration and planning. Legal/Consultation Institute advice on challenging issues. 					Internal <ul style="list-style-type: none"> Confirm and challenge and outputs for Engagement Committee providing assurance to GBs. Governing Body assurance of Engagement Committee evidence from training and development. Commissioning cycle to involve patient engagement. EIA and QIA process. QIA/EIA panel. Communications & Engagement work plan and links to QIPP tracker which aims to maintain understanding of emerging work and implications Systematic completion of S14Z2 forms at PID stage will provide standardised assurance against compliant decision making and recording of decisions at project level. 			External <ul style="list-style-type: none"> Membership (and other stakeholder) feedback via annual 360 survey. Approval of commissioning strategy and associated decisions by the Clinical Lay Commissioning Committee. Approval of engagement and consultation processes from Overview and Scrutiny Committees. NHS England CCG Assurance – Outstanding Rating assessment Internal Audit Report. 			

<p>communications channels to support consistency of approach and clarity of message.</p> <ul style="list-style-type: none"> • Improved coordination of membership engagement mechanisms, linked to planning. • Links to QIA/EIA Panel, work streams and planning processes to keep sighted on emerging work. • Simple engagement model now approved to support project flow through consistent process. • Strengthening of CCG committee cover sheets to ensure committees making implementation decisions have full assurance that duties have been met. • 2020/21 Commissioning Intentions finalised and agreed with Providers. • Population Health Management in development • OEIPB • Governing Body • Commissioning Intentions published and on website. • Engagement Committee meetings reinstated from June 2020. • Zara Jones, Executive Director of Commissioning and Operations is the lead for the System Planning Cell. • Daily System Escalation Cell meetings established to support the management of COVID 19 across the Derbyshire System • System Planning and Operations Cell established to manage and determine recovery plans and future planning 		<ul style="list-style-type: none"> • Training for Engagement Committee membership to ensure robust understanding and application of guidance and statutory responsibility. • 2020/21 Commissioning Intentions finalised and agreed with Providers. • Population Health Management supported by Public Health Directors and Governing Body. • Establishment of Strategic Advisory Group. • Governing Body developing CCG Strategy. • Commissioning Intentions published and on website 	
GAPS IN CONTROL		GAPS IN ASSURANCE	

<p>Internal</p> <ul style="list-style-type: none"> EIA/QIA process to be adopted by JUCD . PMO process currently scaled back, with risk to placement of S14Z2 in decision making. A robust engagement programme that supports the health inequalities and commissioning agendas at the planning stage, with full population analysis to support reaching seldom heard groups. Finalise construct of engagement mechanisms from PPG level, through PCN, Place, ICP to Engagement Committee level, subject to system structure agreement. Embed clear and robust statements and processes relating to the desire to engage in CCG strategic policies. 	<p>External</p> <ul style="list-style-type: none"> Potential lack of provider engagement in JUCD communications and engagement work. Lack of clarity in place development. PMO process currently scaled back, with risk to placement of S14Z2 in decision making. 	<p>Internal</p> <ul style="list-style-type: none"> Embed insight gathering processes into BAU for health service commissioning, with programme support identification of behaviours and issues that affect service commissioning and health inequalities S14Z2 process to be amalgamated with QEIA processes to ensure scrutiny 	<p>External</p> <ul style="list-style-type: none"> S14Z2 process to be amalgamated with QEIA processes to ensure scrutiny
ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)			
<p>Internal</p> <ul style="list-style-type: none"> Training support for project managers in development on commissioning cycle to standardise processes, building on recent project management training. Fully populated and network engagement structure, with permanent membership of Engagement Committee confirmed. S14Z2 process to be amalgamated with QEIA processes to ensure scrutiny 	<p>Timeframe</p> <ul style="list-style-type: none"> Q2 2020/21 Q3 2020/21 Q2 2020/21 	<p>External</p> <ul style="list-style-type: none"> Engagement Committee re-established Insight programme in progress but requires longer-term funding model S14Z2 process to be amalgamated with QEIA processes to ensure scrutiny 	<p>Timeframe</p> <ul style="list-style-type: none"> June 2020 Q3 2020/21 Q2 2020/21

Governing Body Meeting in Public

3rd September 2020

Item: 056

Report Title	Draft Integrated CCG Corporate and COVID-19 Risk Register
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?	Primary Care Commissioning Committee 26 th August 2020. Quality and Performance Committee 27 th August 2020. Finance Committee 27 th August 2020.					
Recommendations						
The Governing Body is asked to: <ul style="list-style-type: none"> • RECEIVE the draft integrated CCG operational and COVID-19 risk register. • APPROVE the closed risks 8,13,15,18,24,36,38,41,43,45,COVID 03, COVID13. • APPROVE the new risk 29. 						
Report Summary						
The CCG operational risk register was suspended as a result of the COVID 19 pandemic during March 2020.						
A specific CCG COVID 19 risk register was compiled in early April 2020 and this has been reviewed and updated on a fortnightly basis and presented at both the CCG Governing Body and the Senior Leadership Team meeting. The risks have been identified as the CCG continues to manage and coordinate the COVID 19 response and its impact on future planning.						
Work has been carried out to integrate the COVID-19 risk register with the previous operational risk register. The operational risk register was reviewed from the COVID-19 perspective which slightly changed the risk descriptions and required mitigations. COVID-19 risks which are unrelated to the existing operational risks are also included. This work was undertaken with the Functional Director's and risk owners. The draft integrated CCG risk register was reviewed and discussed by the Senior Leadership Team on the 17 th August and subsequently has been reviewed and agreed at the CCG's Corporate Committees at their August meetings.						

The former COVID-19 risks devolved to Committee ownership will review the initial risk score, target score and links to board assurance framework objectives at their next monthly committee meeting.

This reports details the risks where the risk score or description has changed, along with new and closed risks. The attached risk register details all risks, including those that continue to be a risk from 2019/20 into 2020/21.

For noting, working with partners across Joined Up Care Derbyshire, a system wide COVID Risk register has also been produced. This register is reviewed updated on a monthly basis in collaboration with the Derbyshire system wide providers and presented at the System Escalation Call.

Quality & Performance Committee

The following risks detailed are the closed or revised risks from the 2019/2020 Quality & Performance Committee and COVID related CCG risks, along with any new risks identified.

Three risks have revised risk descriptions:

1. Risk 05: The original risk description was: *Wait times for psychological therapies for adults and for children are excessive. This risk has been reset from a general concern at availability of psychology and Mental health staff - concerns for which actions have been taken in 2017-19. DHcFT have made significant efforts to address recruitment and retention for nursing staff and their workforce planning is good despite a context of a nationally poor picture in available workforce) The difficulty appears to be a combination of varied productivity, poor data to make analysis of the problem outdated specifications and activity requirements coupled with significant and rising demand and national work force training issue. 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).*

The new risk description is: *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.*

2. Risk 17: The original risk description was: *The CCG and the System is facing significant pressure in relation to S117 aftercare costs. At M9, the CCG reported a forecast overspend of £3.5m (24%) against budget (there was some significant budget setting error at the beginning of the year and cost shift from CHC in year but real growth remains a concern). Derbyshire CC are O/S £1.5m to budget and Derby City circa £0.5m O/S to budget. (Generally S117 costs are split 50-50).*

S117 will also become a right to have as a Personal Health Budget from December 2019.

The new risk description is: 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.

The score for Risk 17 was a high 8 at the close of 2019/20 (probability 2 x impact 4). The new risk score for 2020/21 is a high 9 (probability 3 x impact 3).

3. Risk 27: The original risk description was: *Incidence of Domestic Abuse, Scamming and Self Neglect may increase during lockdown.*

The new risk description is: 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.

Five risks are recommended to be closed:

1. Risk 13: *The Derbyshire CCGs incurred a significant recurrent underlying deficit in 2018/19. The CHC financial position continues to be challenging in 2019/20 and there is a risk that the underlying position could deteriorate, putting pressure on the achievement of the financial targets and increasing the gap on the 2020/21 financial plan.*

This risk is recommended to be closed as it is no longer relevant to the current environment as the CHC framework has been suspended in response to COVID. However, the framework will be reintroduced with effect from September 1st and work is ongoing within the system to restore this and convert current COVID CHC patients to appropriate funding streams or to become self-funders by March 31st 2021. If a specific risk becomes apparent through this process then a new risk will be identified for the risk register. Currently, the general risk is covered by 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.

2. Risk 18: *Data Quality issue with University Hospitals Derby Burton (UHDB) with incorrect data being provided for several consecutive months during the current financial year.*

This risk is jointly owned by both the Quality & Performance Committee and Finance Committee.

Under COVID emergency arrangements, the Trust is being paid in block and the data does not present a financial risk. The risk is recommended to be

closed as it is not applicable for the current contract year. Data is still being reviewed by the Contracting team and data quality issues addressed with the provider as they arise.

3. Risk 41: *Lack of peer support for nursing home bedside manufacture of syringe drivers after 31.01.20.*

Risks reported at the time have been mitigated and the management of the project has now been handed over to the End Of Life Operational Group. Should any new risks be identified, these will be added to the register.

4. Risk 43: *Loss of Service / QIPP delivery and reputational damage due to notice given on Toll Bar House prior to securement of alternative premises with adequate IT infrastructure in place for South Medicines Order Line.*

The service has now moved in to Ilkeston Health Centre and functionality has been tested with several MOL operatives working on site.

5. Risk COVID-03: *Patient health could be compromised through the inability to reorder repeat medication supplies through the Medicine Order Lines - IT failure and loss of business continuity could lead to patients being without the ability to reorder repeat medication supplies.*

This risk is recommended to be closed as IT performance as a whole is now integrated into a separate risk 9.

Primary Care Commissioning Committee

The following risks detailed are the closed or revised risks from the 2019/2020 Primary Care Commissioning Committee and COVID related CCG risks, along with any new risks identified.

Two risks have revised risk descriptions. The red text highlights the additional narrative to the risk description:

1. Risk 04: *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*

2. Risk 07: 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*

Two risks are recommended to be closed:

1. Risk 36: There is a risk of reputational damage and damage to GP relationships with the CCG where effective provision is not in place, leading to risks of non-compliance with UK data protection law. This is because the CCG has not yet made a decision regarding the provision of a Data Protection Officer (DPO) for General Practice as required by NHS England.

Practices have commissioned their own DPO support (or provided it themselves) and the CCG has funded it. This has been agreed and signed off by the Primary Care Commissioning Committee. The Director of GP Development is assured and this risk can now be closed.

2. Risk COVID 13: Cross infection and subsequent reduction in clinical capacity in the system with patients, staff, visitors and volunteers being exposed to the virus, resulting in varying levels of physical harm, due to issues relating to supply and guidance regarding Personal Protective Equipment (PPE).

A push system is now in operation for ordering the supply of PPE. PPE supply and guidance is also in operation. The PPE Cell ceased operating on 30th June. Any issues relating to PPE are now directed to the Primary Care Quality Team and links remain with the LRF. If it is determined that PPE

becomes an issue in the future, PPE cell will be re-instated.

Governance Committee

The following risks detailed are the closed or revised risks from the 2019/2020 Governance Committee and COVID related CCG risks, along with any new risks identified.

One risk has a revised risk description:

1. Risk 09: The original risk description was: *There is a risk of a successful cyber-attack, causing widespread disruption to systems and therefore the provision of services.*

The new description is: *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.*

This risk has been amended to incorporate the wider risk around NECS support to the way the organisation wishes to work as discussed at the Governance Committee meeting on 09.07.20.

Seven risks are recommended to be closed:

1. Risk 08: *The CCG may not remain compliant with the 10 National Data Guardian principles, the Data Protection Act (2018) and General Data Protection Regulations where IG standards are not a priority by CCG staffs, managers and leaders.*

This risk can now be closed as the CCG has received a substantial assurance audit report along with ongoing engagement of staff who remain engaged with the IG agenda.

2. Risk 24: *If the CCG fails to engage with the membership and does not put in place succession planning relating to recruitment to clinical support roles, this will lead to gaps in the organisation and decrease in performance.*

This risk can now be closed as the clinical leadership model is now in place.

3. Risk 38: *Because of a lack of formal committee oversight of NECS performance reporting, the CCG is not receiving assurance regarding compliance with the national Cyber Security Agenda, and is not able to challenge any actual or perceived gaps in assurance as a result of this.*

This risk has been integrated into risk 09.

4. Risk 45: *If the COVID-19 virus is not mitigated in Derby and Derbyshire, cases could rise to unmanageable levels. This would result in high levels of*

infection and staff absence. DDCCG would be unable to perform its statutory duties. This would negatively impact System work and transformation, patient care and the CCG and System financial positions.

This risk is no longer live, there are no current concerns regarding staff availability for work as evidenced by the regular Staff Sitreps presented to the Senior Leadership Team.

5. Risk COVID-01: *Possibility of delays to work deadlines and potential key work priorities due to failure of IT and remote working (VPN connection).*

This can be closed as the risk wraps into general IT performance which is detailed in risk 09.

6. Risk COVID-06: *Lack of compliance in priority areas due to a reduction in performance/activity resulting from loss of CCG resources to the system from staff redeployment.*

CCG staff have now returned to their substantive roles. If there were to be a second wave of COVID-19, the CCG has demonstrated that the potential staffing issue can be managed.

7. Risk COVID-07: *The CCG does not comply with its statutory duties due to ungoverned movement between Business Continuity levels of escalation if there is not sufficient control.*

This risk can now be closed as the CCG is now reverting back to the previous governance arrangements and CCG Committee meetings are now also taking place.

One new risk is proposed:

1. Risk 29: *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.*

This risk has been scored at a very high 20 (probability 5 x impact 4).

Finance Committee

The following risks detailed are the closed or revised risks from the 2019/2020 Finance Committee and COVID related CCG risks, along with any new risks identified:

One risk has a revised risk description:

1. Risk 11: *The original risk description was: DDCCG has a £61m underlying deficit at the start of 2019/20, an in year deficit control total of £29m and £69.5m of approved savings plan. There is a significant risk that the CCG will*

fail to meet its statutory financial duties in 2019/20.

The new description is: *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 risk score was a very high 15 at the close of 2019/20 (probability 3 x impact 5). The new risk score for 2020/21 is a high 12 (probability 3 x impact 4).

One risk is recommended to be closed:

1. **Risk 18:** *Data Quality issue with University Hospitals Derby Burton (UHDB) with incorrect data being provided for several consecutive months during the current financial year.*

This risk is jointly owned by both the Quality & Performance Committee and Finance Committee.

Under COVID emergency arrangements, the Trusts are being paid in block and the data does not present a financial risk. The risk is recommended to be closed as it is not applicable for the current contract year. Data is still being reviewed by the Contracting team and data quality issues addressed with the provider as they arise.

One new risk is proposed:

1. **Risk 30:** *There is an ever present risk of fraud and cybercrime; the likelihood of which may increase during the COVID emergency response period.*

This risk has been scored at a high 8 (probability 2 x impact 8).

Engagement Committee

The following risks detailed are the closed or revised risks from the 2019/2020 Engagement Committee and COVID related CCG risks, along with any new risks identified:

One risk has a revised risk descriptions:

The red text highlights the additional narrative to the risk description.

1. **Risk 16:** *Lack of standardised process in CCG commissioning arrangements. CCG and system may fail to meet statutory duties in S14Z2 of Health and Care Act 2012 and not sufficiently engage patients and the public in service planning and development, including restoration and recovery work arising from the COVID-19 pandemic.*

Risk 16 has also increased in score from a high 8 (probability 2 x impact 4) to a very high 16 (probability 4 x impact 4).

One risk is recommended to be closed.

1. **Risk 15:** *Failure to develop engagement methods and processes to support the emerging service developments of the Derbyshire system may mean the Derbyshire system would fail to meet statutory duties in S14Z2 of the Health and Care Act 2012 and not sufficiently engage local people in service planning and development, including residual service changes resulting from the COVID-19 pandemic.*

This risk can be closed as the risk lies with the system and is not assigned to the Engagement Committee.

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

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

All members of staff are accountable for their own working practice, and have a responsibility to co-operate with managers in order to achieve the objectives of the CCG.

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

Not applicable to this update.

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

Not applicable to this update.

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

Not applicable to this update; however, addressing risks will impact positively across the organisation as a whole.

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

Not applicable to this update.

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

Not applicable to this update.

Have any Conflicts of Interest been identified/ actions taken?

Not applicable to this update.

Governing Body Assurance Framework

The risks highlighted in this report are linked to the Derby and Derbyshire CCG Board Assurance Framework.

Identification of Key Risks

The paper identifies the process of amalgamating the COVID 19 risk register and operational risk register for the Derby and Derbyshire CCG and presents the final CCG operational risk register.

Risk Reference	RFA	Risk Description	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			Revised/Current Risk			Target Risk			Last Board Assurance	Date Reviewed	Review Due Date	Executive Lead	Action Owner
							Probability	Impact	Overall	Probability	Impact	Overall	Probability	Impact	Overall					
07	2021	There are 112 GP practices in Derbyshire, all with different independent contracts. DASH (DASH) is managed by NHS Foundation Trusts and one by Independent Health Care providers. The majority of Derbyshire GP practices are small independent businesses which rely on one or two core components of the business (contractual or staff). While it is possible to predict and mitigate some factors that may impact on the delivery of care the elements of the unknown and unpredictable are the unknown and unpredictable. The COVID-19 potential practice closure due to financial difficulties. Resilience of GP Partners. Capacity and Demand. Access. Franchise. New contractual arrangements. New Models of Care.	4	5	20	4	5	20	4	4	16	no	no	no	July 20	Aug 20	Dr Steve Lloyd Medical Director	Judy Denton, Head of Primary Care Quality		
08	2021	There is a risk of failure to implement and embed compliance activities required in UK Data Protection Legislation. The CCG may not remain compliant with the 10 National Data Guardian principles, the Data Protection Act (2018) and General Data Protection Regulations where IG standards are not a priority by CCG staff, managers and leaders. Close - CCG received substantial assurance audit report, ongoing engagement of staff who are engaged with the IG agenda.	4	4	16	no	no	no	no	no	no	no	no	no	July 20	Aug 20	Helen Dillstone Executive Director of Corporate Delivery / Ruth Lloyd, Information Governance Manager	Christy Tucker, Head of Digital Delivery / Ruth Lloyd, Information Governance Manager		
09	2021	There is a risk of a successful cyber-attack causing widespread disruption to systems and therefore the provision of services. Sustainable digital performance for CCG and General Practice to invest in cyber attack and network outages. The CCG is not receiving the required external assurance regarding compliance with the National Cyber Security Agency, and is not able to challenge any actual or projected gaps in assurance as a result of this.	4	4	12	no	no	no	no	no	no	no	no	no	July 20	Aug 20	Helen Dillstone Executive Director of Corporate Strategy and Delivery	Ged Conolly-Thompson - Head of Digital Development, Christy Tucker - Director of Corporate Delivery		
10	1920	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 current and future ability to deliver Derbyshire CCG, which may lead to an ineffective response to local and national pressures.	4	4	16	no	no	no	no	no	no	no	no	no	Mar-20	Apr-20	Helen Dillstone Executive Director of Corporate Strategy and Delivery	Christy Tucker - Director of Corporate Delivery / Richard Heston, Business Resilience Manager		
1920 24	1920	If the CCG fails to engage with the membership and does not put in place succession planning relating to recruitment to clinical support roles, this will lead to gaps in the organisation and decrease in performance. Risk can now be closed as the clinical leadership model is now in place.	3	3	9	no	no	no	no	no	no	no	no	no	Mar-20	Apr-20	Helen Dillstone, Executive Director of Corporate Strategy and Delivery	Beverley Smith, Director of Corporate Strategy & Development / Sarah Reister, HR Business Partner		
11	2021	DOCCO has a £81m underlying deficit at the start of 2019/20, an in year deficit control total of £28m and £89.5m of approved savings plan. There is a significant risk that the CCG will fail to meet its statutory financial duties in 2019/20. 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	no	no	no	no	no	no	no	no	no	July 20	Aug 20	Richard Chapman, Chief Finance Officer	Darran Green, Assistant Chief Finance Officer		
12	2021	Inability to deliver current service provision due to impact of service review. The CCG has initiated a review of NHS provided Short Breaks respite service for people with learning disabilities in the north of the county without recourse to eligibility criteria laid down in the Care Act. Depending on the subsequent actions taken by the CCG fewer people may have access to the same hours of respite, delivered in the same way as previously. There is a risk of significant distress that may be caused to individuals including carers, both during the process of engagement and afterwards depending on the subsequent commissioning decisions made in relation to this issue. There is a risk of organisational reputation damage and the process needs to be as thorough as possible. There is a risk of reduced service provision due to provider inability to retain and recruit staff. There is an associated but yet unquantified risk of increased admissions - this picture will be informed by the review.	4	4	14	no	no	no	no	no	no	no	no	no	July 20	Aug 20	Biggid Stacey - Chief Nursing Officer	Mick Burrows Director for Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning, Helen Hymas, Deputy Director of Quality Phil Sugden, Assistant Director Quality, Community & Mental Health, DCHS		

Risk Reference	Risk #	Risk Description	Responsible Committee	Type of Risk	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				Revised/Current Rating				Target Risk Rating	LA Data Report Reference	Date Reviewed	Review Due Date	Executive Lead	Action Owner				
									High	Medium	Low	Very Low	High	Medium	Low	Very Low										
13	1920	The Derbyshire CCGs incurred a significant reputational risk in 2019/20. The CHC financial position continues to be challenging in 2020/21 and there is a risk that the underlying position could deteriorate, putting pressure on the achievement of the financial targets and increasing the gap on the 2020/21 financial plan. Close - This risk should be closed as it is no longer relevant to the current environment as the CHC framework has been suspended in response to COVID. However the framework will be reintroduced with effect from September 1st and work is ongoing within the system to restore this and current current COVID CCGs submit to appropriate funding streams or to become self-funders by March 31st 2021. If a specific risk becomes apparent through this process then a new risk will be identified for the risk register. Currently, the general risk is covered by 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.	Quality and Performance	4	Mitigations implemented include: Strengthened care package approval processes; Tighter contract management;	Detailed analysis of all areas of spending, reviews and referrals to focus the work of the Quality team.	Robust contract management in place - new Contract Lead appointed and now in post. Financial position reviewed a fortnightly CCG CHC internal meeting. Complex care panels operating each week to review and challenge the complex care provided to individuals and the associated costs. Uplift panels operating on a bi-monthly basis to challenge provider uplift requests.	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3				
14	2021	On-going non-compliance of completion of health assessments (HAs) within statutory timescales for Children in Care due to the increasing numbers of children requiring the care system. This may have an impact on the health assessment as statutory health assessment as statutory health assessment. Close - This risk should be closed as it is no longer relevant to the current environment as the CHC framework has been suspended in response to COVID. However the framework will be reintroduced with effect from September 1st and work is ongoing within the system to restore this and current current COVID CCGs submit to appropriate funding streams or to become self-funders by March 31st 2021. If a specific risk becomes apparent through this process then a new risk will be identified for the risk register. Currently, the general risk is covered by 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.	Quality and Performance	5	Development of a new CCG Collaborative Operational Meeting in Derbyshire - the first meeting took place on 09/03/2020 and this will meet on a bi-monthly basis - which will review the statutory HA pathway and will work from a multi-agency perspective (Health - CCG Designated Nurse & Doctor for CCG, CRH FT, DCHS FT and the LA - DCC) in order to address the compliance issues and improve compliance (the reasons for non-compliance are multi-faceted and complex because of the nature and complexity of children and young people who are placed in care and this is why there has not been a speedy resolution to this risk. "Back Stoppers" of all CCG who are not bought for their HA within the 20 day statutory period are held by health and social care). The CCG Collaborative Operational Meeting has a RAG Rated Work plan in place and HA Compliance is included within said workplan and will be reviewed at every meeting for progress. Close - This risk should be closed as it is no longer relevant to the current environment as the CHC framework has been suspended in response to COVID. However the framework will be reintroduced with effect from September 1st and work is ongoing within the system to restore this and current current COVID CCGs submit to appropriate funding streams or to become self-funders by March 31st 2021. If a specific risk becomes apparent through this process then a new risk will be identified for the risk register. Currently, the general risk is covered by 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.	Completion of Multi-agency HA Action Plan. Increasing numbers of children requiring people entering care. Multi-agency compliance with timescale pathway. Monthly and quarterly analysis of HA performance continues at this time. Review and Monitoring of the whole pathway/process via RAG Rated Action Plan (via new multi-agency meeting - CCG Collaborative Operational Meeting - which meets on a bi-monthly basis - next meeting is due on 20/07/2020). Review by Derbyshire Corporate Planning Board on the 09/09/2020. Monthly review of figures from CRH FT & Quarterly Reporting of HA progress by the Designated Nurse CCG (Derbyshire). Designated Doctor CCG (Derbyshire) remains responsible for HA Quality Assurance and for liaison with external health providers who are identified to be providing late HA's consistently. Close - This risk should be closed as it is no longer relevant to the current environment as the CHC framework has been suspended in response to COVID. However the framework will be reintroduced with effect from September 1st and work is ongoing within the system to restore this and current current COVID CCGs submit to appropriate funding streams or to become self-funders by March 31st 2021. If a specific risk becomes apparent through this process then a new risk will be identified for the risk register. Currently, the general risk is covered by 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.	July 2020 Update - Q4 2019/2020 HA reporting highlighted some slow sustained improvements within the HA pathway for CCG placed within Derbyshire; however it highlighted a significant decline in improvement in the external HA pathway (where Derbyshire Children are placed externally outside of Derbyshire). In June an Extraordinary Improvement Board Meeting was called by DCC to try to address the ongoing concerns. The Designated Nurse and CCG Action identified an external health provider (one in the previous 6 month period) who had not returned HA's in a timely manner (The Designated Doctor for CCG in Derbyshire continues at this time to work with that provider to address the timescale issues that have been impacted upon by the redeployment of external CCG Health Provider Medical Staff). 44% of late cases from the external health provider notified that the LA (DCC) were late in sending appropriate HA paperwork/consents to the external provider. The CCG Collaborative Operational Meeting - meet on a bi-monthly basis - which will review the statutory HA pathway and will work from a multi-agency perspective (Health - CCG Designated Nurse & Doctor for CCG, CRH FT, DCHS FT and the LA - DCC) in order to address the HA compliance issues and improve compliance (the reasons for non-compliance are multi-faceted and complex because of the nature and complexity of children and young people who are placed in care and this is why there has not been a speedy resolution to this risk. "Back Stoppers" of all CCG who are not bought for their HA within the 20 day statutory period are held by health and social care). Collaborative Operational Meeting has a RAG Rated Work plan in place and HA Compliance is included within said workplan and will be reviewed at every meeting for progress. The Designated Nurse CCG also has regular meetings with the Designated Doctor CCG and also with the Lead LA DCC Manager for CCG, in order to review and monitor progress. As part of the ongoing HA work stream - data collection differences have been identified between health and social care have been identified; however provider health data is widening sustained improvement and if this continues into Q1 & Q2 of 2020/21 then consideration can be taken to removing HA's from the CCG & Provider Risk Registers because we cannot share the LA Data Risk of External Provider Risks (NHS) have confirmed that they are responsible for any risks around HA's not being completed by them for Derbyshire Children placed in their area). Monthly and quarterly analysis of performance continues at this time. Designated Doctor CCG (Derbyshire) remains responsible for HA Quality Assurance and for liaison with external health providers who are identified to be providing late HA's consistently. Designated Doctor CCG (Derbyshire) remains responsible for HA Quality Assurance and for liaison with external health providers who are identified to be providing late HA's consistently. Close - This risk should be closed as it is no longer relevant to the current environment as the CHC framework has been suspended in response to COVID. However the framework will be reintroduced with effect from September 1st and work is ongoing within the system to restore this and current current COVID CCGs submit to appropriate funding streams or to become self-funders by March 31st 2021. If a specific risk becomes apparent through this process then a new risk will be identified for the risk register. Currently, the general risk is covered by 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.	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
15	2021	Failure to develop engagement methods and processes to support the emerging service developments of the Derbyshire system may mean the Derbyshire system would fail to meet statutory duties in S142Z of the Health and Care Act 2012 and not sufficiently engage patients and the public in service planning and development, including regular review changes resulting from the COVID-19 pandemic. Close - This risk can be closed as it is a system risk	Communication/Engagement Strategy	3	Simple engagement model now approved to support project flow through consistent process, including place. S142Z form now part of PFD development process and embedded into CCG PFD documentation. Strengthening of CCG committee cover sheets to ensure committees making implementation decisions have full assurance that duties have been met. Systematic completion of S142Z forms at PFD stage will provide standardised assurance against compliant decision making and recording of decisions at project level. Engagement Committee established to strengthen assurance and risk identification. Training for Engagement Committee members to ensure robust understanding and application of guidance and statutory responsibilities. Process for identifying and ensuring COVID-19 service change in place, aligned with Quality Assurance processes and being with JUCD Delivery Boards.	CCG Communications and Engagement Strategy delayed due to COVID-19 pandemic, but system COVID-19 engagement strategy agreed by SEC, June 2020. Engagement processes now agreed in principle for development of community engagement to feed local planning and also populate Engagement Committee. Actions required to support implementation of recovery plans not yet visible or tangible at 107. With reduced PFD oversight, visibility of projects status and assurance against key stages not available in uniform manner and will require a different approach to ensure engagement is undertaken where service change is desired.	Engagement process from PFD through to Engagement Committee developed with Lay Reference Group and Engagement Committee and now in implementation phase being revised to reflect advent of CDPs. Engagement Model refreshed in January 2020 and revisions approved by Engagement Committee. Engagement Committee Terms of Reference reviewed and refreshed in Q4 2019/20, taking into account changes to the structure of the Derbyshire system and learning from first year of operation. Advice received to confirm option of consultation is available during pandemic, subject to caveats on process. COVID-19 Engagement Strategy agreed through SEC, June 2020. Links being established to Delivery Boards to cross reference service change list and devise appropriate engagement plans.	2	3	4	4	3	2	2	3	3	3	3	3	3	3	3	3	3	3	
16	2021	Lack of standardised process in CCG commissioning arrangements. CCG and system may fail to meet statutory duties in S142Z of Health and Care Act 2012 and not sufficiently engage patients and the public in service planning and development, including regular review changes resulting from the COVID-19 pandemic. Close - This risk can be closed as it is a system risk	Communication/Engagement Strategy	4	Systematic completion of S142Z forms will provide standardised assurance against compliant decision making and recording of decisions at project level. Engagement Committee established to strengthen assurance and risk identification.	PFD processes are not being applied to resolution and recovery projects, therefore there are no checks and balances as projects proceed ensuring that they have completed either the S142Z or EA forms. An equality and engagement policy is being developed to address this gap in part, for proposed adoption by all JUCD partners. EIA/DA process adopted by JUCD. Not all projects follow a systematic project management/commissioning/transformation process to ensure standardisation of process and application of legal duties. CCG Communications and Engagement Strategy to be written Q3 2019/20 has been delayed. The strategy will set out engagement elements of commissioning and transformation processes.	Engagement Committee re-established in June 2020 following pause during peak of COVID-19 pandemic. Training for Engagement committee members on consultation law completed. Replacement lay members recruited to ensure sufficient lay voice on Engagement Committee following recent resignations. S142Z log reviewed regularly by Engagement Committee.	2	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4			
1920 36	1920	There is a risk of reputational damage and damage to GP relationships with the CCG where effective provision is not in place, leading to risks of non-compliance with UK data protection law. This is because the CCG has not yet made a decision regarding the provision of a Data Protection Officer (DPO) for General Practice as required by NHS England. Close - This risk has been mitigated through the provision of a DPO support (or provided it themselves) and the CCG has limited it. This has been agreed and signed off by the Primary Care Commissioning Committee. The Director of GP Development is assured and this risk can now be closed.	Primary Care Commissioning	4	For 1920 the requirement that a DPO function is to be provided / commissioned via the CCG. For 2021 the requirement that the DPO function is in entirety for each practice is either funded or provided direct from the CCG. It was expected that a revision of the guidance document would be available in May 2019, and explicitly confirm that the provision of DPO services would be the responsibility of the CCG on behalf of practices, for either direct provision where DPO services are provided via an employee of the CCG, or commissioned via the CCG for all practices. An options appraisal will be considered whether the CCG provide the function in house, or whether they seek to reimburse practices for their DPO reasonable costs. This decision has not yet been taken.	The CCG has not yet formally considered this provision requirement, and does not have a position which can be affirmed to GP practices. A decision is required as to how this responsibility will be provided An options appraisal will be considered whether the CCG provide the function in house, or whether they seek to reimburse practices for their DPO reasonable costs. This decision has not yet been taken.	Currently the requirement to have in place a DPO function is part of the responsibilities of each practice. These arrangements remain in place for each practice. October Update: - Agreed in principle to reimburse practices for expenditure that they incur. Consultation taking place with LMC. Lowest quote to date is £200/practice. Additional support on specific items could be made available to individual practices in the event a significant issue was to emerge. Progress discussions with colleagues in finance, regarding the provision of budget for this provision. No decision has yet been taken. November Update: Budget identified, Option appraisal paper to be submitted to November's PCCC meeting No further change for December January / February Update: PCCC have agreed to accept the option of reimbursing practices on the basis of costs actually incurred. Communications are being issued to practices to inform them of the process for submitting invoices. A budgetary value of £48k has been identified for planning purposes. It is noted that planning for 2020/21 will be starting in February 2020. Governance Committee agreed to the transfer of this risk to PCCC. February Update: 2020/21 planning is underway, with an update being prepared for PCCC February meeting.	2	3	4	4	3	4	3	4	3	4	3	4	3	4	3	4	3	4	3
1920 38	2021	Because of a lack of formal committee oversight of NECS performance reporting, the CCG is not receiving assurance regarding compliance with national Cyber Security Agenda, and is not able to challenge any actual or perceived gaps in assurance as a result of this. Close - This risk has been mitigated through the provision of a DPO support (or provided it themselves) and the CCG has limited it. This has been agreed and signed off by the Primary Care Commissioning Committee. The Director of GP Development is assured and this risk can now be closed.	Governance	4	There is a risk that the CCG is non-compliant with national expectations of Cyber security and the NIS initiative, because the reporting of activity on these areas is not visible to CCG leaders. Should any gaps be in place, the organisation does not have sufficient oversight of these issues to be able to direct resources to support. The control and organisational oversight of ICT projects and GP ICT support activities is not visible within the committee structures. 150819 PH confirmed that the CORG review will identify the gaps in Cyber Compliance within NECS. Monthly contract monitoring board meetings are in place with NECS and the lead for digital strategy.	Currently the CCG IG Assurance Forum has no oversight of the Service Level Agreement performance data from NECS, which will include cyber compliance. NECS have affirmed that within the Data Security and Protection Toolkit they will assess only mandated standards.	Monthly NECS contract management board meetings in place. October Update: The CCG was subject to regulation on this, which would be described in NECS contract management board papers In place a regular meeting between the CCG IG Lead and the NECS ICT Compliance Manager, Alison Emble, to deliver the requirements of the Data Security and Protection Toolkit November Update: No further change No further change for December January Update: Membership of the CMB is being reviewed as a consequence of ADDO leaving the organisation, and the general reorganisation of digital services. Fortnightly DSPTK meetings in place. February Update: The 2019/20 DSPTK is in preparation for submission at the 31/03/20. Chair of the CMB is being handed over from the ADDO to the Director of Corporate Delivery	2	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4		
17	2021	The LMS and the system is being significant pressure in relation to S117 offshore costs. At M9, the CCG reported a forecast overspend of £3.5m (24%) against budget (there was some significant budget setting error at the beginning of the year and cost shift from CHC in year total growth remains a concern). Derbyshire CC are £15.5m to budget and Derby City circa £5.5m Q1's to budget. (Generality S117 costs are split 50-50). S117 will also become a right to have a Personal Health Budget from December 2019. New description: S117 package costs continue to be a source of high expenditure which could be positively influenced with resource oversight, this growth across the system, if unchecked, will continue to eat into available budget	Quality & Performance	4	Although not overspent to budget at this time the rising cost of care under S117 is around 20m to the system. The CCG is investing in additional case managers, re-introducing S117 workstream under M10CB when this is possible. It is anticipated that both of these measures will positively affect outcome at system level.	There is a gap in the introduction of case managers, so the savings have slipped from October 2020 to January 2021. Recruitment challenges Investment is being made in additional case managers via CSU, re-introducing the S117 workstream under the M10CB enhance the oversight will also help.	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3				
18	CLOSE	Data Quality Issue with University Hospitals Derby Burton (UHB) with incorrect data being provided for several consecutive months during the current financial year. Close - Under COVID emergency arrangements, the Trust are being paid in black and the data does not present a financial risk. The risk is recommended to be closed as it is not applicable to the current contract year. Data is still being reviewed by the Contracting team and data quality issues addressed with the provider as they arise.	Primary Care Commissioning	4	From the start of the year, the Contracting team have been carefully reviewing data each month when submitted by the Trust and highlighting data quality issues and engaging the Trust to dialogue around how to resolve them. Contractual action has been, and will be, taken where appropriate to hold the Trust to account for the failures.	Contractually, 2 information breach notices have been issued to date. There are also monthly meetings (CMG and MCG) addressing the issues and ongoing dialogue with the Trust around their resolution. If support has been offered to UHB by the CCG. Regular updates are obtained from the Trust at the Contract Management meeting - CMCG.	First Information Breach Notice closed due to correction of identified data quality issues. Further Information Breach Notice served due to further data quality issues identified. The 2 additional issues identified continue to be unresolved at M10 date. Unfortunately, a number of additional issues have been identified in M10 which are now being investigated with the Trust. There is no financial risk associated with these changes as a year end settlement has already been reached with the Trust but data accuracy is still important for completion of system and organisational planning for 2021. No update required for month 11.	3	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4			

**MINUTES OF PRIMARY CARE COMMISSIONING COMMITTEE
PUBLIC MEETING**

HELD ON

Wednesday 22nd July 2020

Microsoft Teams Meeting 11:30 – 12 Noon

PRESENT

Ian Shaw (Chair)
Niki Bridge
Jill Dentith
Marie Scouse
Sam Taylor

IS Lay Member Derby & Derbyshire CCG
NB Deputy Chief Finance Officer
JeD Lay Member Derby & Derbyshire CCG
MS AD of Nursing & Quality Derby & Derbyshire CCG
ST Deputy Medical Director DDCCG

IN ATTENDANCE

Hannah Belcher
Judy Derricott
Lisa Wain

HB AD GP Commissioning & Development Derby
JDe Head of Primary Care Quality Derby & Derbyshire CCG
LW Senior GP Commissioning & Development Manager DDCCG

Kathryn Markus
Pauline Innes

KM Chief Executive Derby & Derbyshire LMC
PI Executive Assistant to Dr Steven Lloyd

APOLOGIES

Steve Lloyd
Simon McCandlish
Clive Newman
Richard Chapman
Brigid Stacey

SL Executive Medical Director Derby & Derbyshire CCG
SMc Deputy Chair, Lay Member, Derby & Derbyshire CCG
CN Director of GP Development Derby & Derbyshire CCG
RC Chief Finance Officer Derby & Derbyshire CCG
BS Chief Nurse Derby & Derbyshire CCG

ITEM NO.	ITEM	ACTION
PCCC/2021/11	<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/2021/12	<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. Declarations declared by members of the Primary Care Commissioning Committee are listed in the CCG's Register of Interests and included within the meeting papers. The Register is also available either via the corporate secretary to the Governing Body or the CCG website at the following link:</p>	

	<p style="text-align: center;">www.derbyandderbyshireccg.nhs.uk</p> <p>There were no Declarations of Interest made.</p> <p>The Chair declared that the meeting was quorate.</p>	
FOR DECISION		
	<p>There were no items for decision.</p>	
FOR DISCUSSION		
	<p>There were no items for discussion.</p>	
FOR ASSURANCE		
PCCC/2021/13	<p>FINANCE UPDATE</p> <p>Niki Bridge provided a verbal financial position update.</p> <p>There is a temporary financial regime in place for the period 1st April to 31st July 2020</p> <ul style="list-style-type: none"> • At month 3 the year to date overspend for the CCG is £12.431m • The forecast position for the four months of April to July 2020 is an overspend of £20.477m • Amendments are expected to the allocations that have been received • Scenario models have been produced for the full year position based on a 7 months block scenario and a 12 months block scenario. <p>The M4 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 September 2020 meeting.</p> <p>The Primary Care Commissioning Committee RECEIVED and NOTED the verbal update on the CCGs Finance position at Month 2.</p>	
PCCC/2021/14	<p>PILSLEY BRANCH SURGERY - QUARTERLY PROGRESS REPORT</p> <p>Hannah Belcher (HB) provided an update from the quarterly progress report.</p> <p>The Committee approved the closure of the Pilsley Branch Surgery at the February 2020 meeting and requested that a regular update be provided on progress relating to the mitigating actions prior to the closure date of 1st April 2021. This is the first report that the practice has prepared regarding progress made and taking in to consideration COVID-19 response which significantly changed the way services have been provided..</p> <p>The report provided by the practice is a comprehensive report and is available on their website and has also been shared with the parish council. The Practice Manager reported that positive feedback has been received from the parish council where the report was discussed on the 6th July 2020.</p>	

	<p>The residents remain to have concerns around public transport issues however the practice is not able to influence this concern. Kerrie Woods, NHS England agreed to follow up the transport concerns raised by patients and the CCG will ensure that there is no further work required from the organisation.</p> <p>The Committee noted that appointments are due to resume at the practice during July and August 20 particularly around restoring phlebotomy services a couple of times a week.</p> <p>Jill Dentith (JeD) thanked HB for the helpful report which provides the Committee with the assurance actions are being taken referring to the COVID-19 pandemic querying if the practice over the next 9 months had any plans to consult and support patients in a positive way in terms of different ways of working longer term.</p> <p>HB thanked JeD for her comments and agreed to discuss with the Practice Manager. It has been recognised that due to the COVID-19 pandemic patients have needed to access services in a different way and therefore the practice could take this as an opportunity to embrace changes in a positive way with patients over the next 9 months.</p> <p>The Primary Care Commissioning Committee RECEIVED and NOTED the contents of the report.</p>	HB
MINUTES AND MATTERS ARISING		
<p>PCCC/2021/15</p>	<p>Minutes of the Primary Care Commissioning Committee meeting held on 24th June 2020</p> <p>The minutes from the meeting held on 24th June 2020 were agreed to be an accurate record of the meeting.</p>	
<p>PCCC/2021/16</p>	<p>MATTERS ARISING MATRIX</p> <p>The Action Matrix was reviewed.</p>	
<p>PCCC/2021/17</p>	<p>ANY OTHER BUSINESS</p> <p>There was no other business transacted.</p>	
<p>PCCC/2021/18</p>	<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?</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>What recommendations does the Committee want to make to Governing Body following the assurance process at today's Committee meeting? None</p> <p>Is the Committee assured on progress regarding actions assigned to it within the Organisational Effectiveness and Improvement action plan? Yes</p>	
DATE AND TIME OF NEXT MEETING		
Wednesday 26th August 11:30-12:30 via Microsoft Teams Meeting		

**MINUTES OF QUALITY AND PERFORMANCE COMMITTEE
HELD ON 30TH JULY 2020, 9AM TO 11AM
MS TEAMS**

Present:		
Dr Buk Dhadda (Chair)	BD	Chair, Governing Body GP, DDCCG
Andrew Middleton	AM	Lay Member, Finance
Dr Emma Pizzey	EP	GP South
Brigid Stacey	BS	Chief Nurse Officer, DDCCG
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
Simon Macallandish	SM	Lay Member, Patient Experience
Laura Moore	LM	Deputy Chief Nurse, DDCCG
Jackie Carlile	JC	Head of Performance and Assurance -DDCCG
Helen Wilson	HW	Deputy Director Contracting and Performance - DDCCG
James Barker	JB	Patient Safety Lead, DDCCG
Helen Hipkiss		Deputy Director of Quality - DDCCG
Steve Lloyd	SL	Medical Director, DDCCG
Nicola McPhail	NMcP	Assistant Director of Quality - DDCCG
Michelina Racioppi	MR	Assist Director Safeguarding Children/Lead Designated Nurse
Bill Nicol	BN	Assistant Director - Safeguarding Adults
Temi Omorinoye	TO	Head of Medicines Management Safety & Quality, DDCCG
Zara Jones	ZJ	Executive Director of Commissioning Operations, DDCCG
In Attendance:		
Jo Pearce (Minutes)	JP	Executive Assistant to Chief Nurse, DDCCG
Apologies:		
Suzanne Pickering	SP	Head of Governance- DDCCG
Craig Cook	CC	Deputy Director of Commissioning
Helen Henderson Spoons	HHS	Healthwatch

Item No.	Item	Action
QP 2021/016	<p>WELCOME, APOLOGIES & QUORACY</p> <p>Apologies were received as above. BD declared the meeting quorate.</p>	
QP 2021/017	<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>	
Section One – End of Year Report		
QP 2021/018	<p>INTEGRATED REPORT</p> <p>BD noted that Quality and Performance committee will follow a three step process in the restoration and recovery journey.</p> <ul style="list-style-type: none"> • Step 1 - June – Planning going forward and the sign off of events leading up to covid. • Step 2 – July – looks at events and activity during the covid period and how the Quality and Performance Committee move forward. • Step 3 – August - How the Quality and Performance Committee will function in a consistent way over the next few months. <p>JC presented the integrated report to the Committee.</p>	

Urgent and Emergency Care:

- A&E standard was not met at a Derbyshire level (89.9%, YTD 90.5%), with both main providers failing to achieve the 95% target in June 2020 and the 2020/21 year to date. CRH achieved 94.8% (YTD 94.5%) which is an improvement and close to target. UHDB performance was 86.6% (YTD 87.6%) which is also an improvement on previous months. Of our associate providers only Sherwood Forest achieved the target, although others have shown an improvement.
- There were no 12 hour breaches for Derbyshire or at our associate providers in June.
- EMAS were compliant in 5 out of 6 national standards for Derbyshire during June.

Unvalidated data for both sites at UHDBFT is at pre covid levels. For CRHFT this is over 90%. Trusts are analysing attendances for acuity.

Planned Care:

- 18 Week Referral to Treatment (RTT) for incomplete pathways continues to be non-compliant at a CCG level at 64.0%. The full year figure was 68.7%. There has been deterioration across all providers.
- CRHFT performance was 72.9% and UHDB 58.1%. The year-to-date figures were 76.3% and 64.0% respectively.
- Derbyshire had 242 breaches of the 52 week standard across all trusts. 204 of these were at our main two acute providers with the remaining 38 on waiting lists at many different providers.
- Diagnostics – The CCG performance was 59.8%. Neither CRH nor UHDB have achieved the target due to the cancellations of investigations due to the COVID pandemic. This was mainly endoscopy and due to social distancing, NICE Guidance has since been received and procedures are being reviewed.

Cancer

During May 2020 Derbyshire was non-compliant in 5 of the 8 Cancer standards:

- 62 day Urgent GP Referral – 64.7% (85% standard) – Non compliant for all trusts.
- 31 day from Diagnosis – 90.6% (96% standard) – Non

	<p>compliant for all trusts except East Cheshire.</p> <ul style="list-style-type: none"> • 31 day Subsequent Surgery – 82.5% (94% standard) – Non compliant overall but compliant at CRH, East Cheshire, Stockport and Sherwood Forest. • 31 day Subsequent Radiotherapy – 92.1% (94% standard) – Non compliant for all relevant trusts except Nottingham. • 62 day Screening Referral – 20.0% (90% standard) – Non compliant for all trusts. • There were 26 Derbyshire patients treated during May who had been waiting more than 104 days. <ul style="list-style-type: none"> • There is currently a big national focus around cancer and the CCG are working with both Trusts to put a system plan together to reduce the number of patients who have been waiting over 62 and 104 days. The plan is to be submitted to the regional team by 21st August. <p>AM asked if anything can be done in terms of patients adopting pre covid behaviours when attending A&E. JC responded to say that the acuity of patients is currently being reviewed and the CCG is working with UHDBFT. Attendances are being tracked on a weekly basis and it is type 1 attendances where the increases are being reported.</p> <p>AM asked about the responsiveness from acute colleagues around the challenges during covid. JC responded to say that the Trusts are doing all they can however they have to work within the guidelines. There is a lot of scrutiny from NHSE/I and the CCG are supporting as much as possible.</p> <p>The Committee NOTED and APPROVED the contents of the paper.</p>	
<p>QP 2021/019</p>	<p>EMAS OVERVIEW</p> <p>JJ presented the report to the Committee.</p> <p>JJ was pleased to report EMAS has delivered all national performance standards in Q1.</p> <p>The opportunity is being taken to focus on Recovery & Restoration and take the learning over the recent months as well as looking at the key factors to maintaining performance and quality.</p>	

A significant reduction in prolonged waits has been reported. EMAS is looking at how it can affect demand into the ambulance service from areas such as care homes, mental health and 111. Work is being done around reducing the amount of handover delays. A regional handover collaborative has been put together to work with organisations to improve handover delays and details of this work will go to the A&E Delivery Board.

A new policy will focus on delays over 60 minutes and any patient waiting in excess of 60 minutes will be treated in the same way as an A&E 12 hour trolley breach. These breaches will have to be reported and investigated.

EMAS greatest focus is in reducing conveyance to A&E, work is being carried out with community Primary Care around alternative pathways that EMAS can access and direct access to acute Trusts. EMAS are also ensuring that they provide the correct level of resource to match the demand. Increases in activity is being seen however this has been expected. The effects of the night time economy is not yet being seen, this will be a significant factor.

An update on the coding error was received recently and the full report is available for information. JJ confirmed EMAS have appointed a Head of IPC which was one of the identified gaps, with the successful applicant commencing in post at end August. A new Head of Quality post is also being advertised.

MW asked if there was any analysis on the turnaround times. JJ replied to say a reduction in handover delays has been seen with the greatest impact being seen in Leicester Royal Infirmary, Lincoln County and Boston Pilgrim who have all significantly reduced their lost hours in turnaround. Derbyshire however have not reduced their handover times and there is work taking place over handover delays to address this. JJ is working with the Medical Director of EMAS on the role of the Advanced paramedic and how they can support the emergency operational centre in clinical decision making.

GS referred to p26 noting that EMAS are working with national teams to identify how seen and treated levels can be maintained. GS asked if there was evidence on GPs behaviour that is good and could be learned from. JJ replied to say one of the comments made was around the support EMAS crews got from GPs across the county which has been an enabling factor for crews to treat patients at home. That access to Primary Care and GP advice has been invaluable.

	<p>EP commented that it will be easier for EMAS crews to keep patients at home if they have access to shared patient notes and asked how close EMAS are to facilitating this. JJ confirmed that almost all GP practices in Derbyshire have signed up to GP Connect which allows crews to see the last three GP interventions and this has been an enabler in supporting see and treat.</p> <p>The Committee NOTED and APPROVED the contents of the paper.</p>	
<p>QP 2021/020</p>	<p>PATIENT SAFETY</p> <p>JB presented the report to the Committee.</p> <p>The Patient Safety Incident Response Framework (PSIRK) early adopters will start in September and October and will run for one year before being rolled out nationally. A 'learning from incidents' event took place in February which was very successful. The focus was on wrong site surgery and was attended by neighbouring providers and CCGs who shared their learning.</p> <p>The Committee NOTED and APPROVED the contents of the paper.</p>	
<p>QP 2021/021</p>	<p>SYRINGE DRIVER END OF PROJECT REPORT</p> <p>TO presented the report to the Committee.</p> <p>The Syringe Driver project has now successfully concluded and the syringe driver service has moved to a bedside service delivered by DCHS for patients in care homes in non-nursing beds and by nursing staff for patients in nursing homes. Feedback been positive from GPs and nurses. The next stage for the End of Life Operational Group to work with the nursing homes to access their own syringe driver pumps. The long terms plan is for homes to purchase their own pumps and be responsible for their maintenance.</p> <p>BD queried why there are differing sizes of pumps and noted the potential risk in changing volumes, TO will investigate this.</p>	

	<p>AM asked what made the project a success. TO replied, the key elements to the success were the system working together with a common vision and deadline. Leadership was key with and included a task and finish group where all decisions were made. There were also clear reporting lines.</p> <p>MW referred to p108 in terms of the long term finance solution and asked if there was any work outstanding. TO confirmed that further work needs to be done around the suitability and availability of pumps.</p> <p>MWa referred to p112 and noted the list of consumables that are to be prescribed and raised the issue around the length of time this would take. TO replied that the long term plan is that Nursing Homes would keep their own stocks of consumables and Care Homes would be supplied by DCHS.</p> <p>The Committee NOTED and APPROVED the contents of the paper.</p>	
<p>QP 2021/022</p>	<p>SAFEGUARDING CHILDREN</p> <p>MR took the paper as read and noted that the minutes of the Joint Safeguarding Childrens and Adults Committee are included in the paper giving an overview of key points discussed and policies and strategies that have been approved.</p> <p>AM asked if there is local concern around the potential increase in referrals that could be seen once the school return in September. MR confirmed that there is local concern and work is being done with schools to support with this potential issue.</p> <p>GS referred to p129 which states the challenges on professionals around the threshold document. GS asked if there is feedback on possible changes to this document. MR replied to say that there is an awareness that numerous referrals are being made to City and County Social Care that do not meet the threshold. There is an aim to deliver training around the completion of the threshold document as well as feeding back to the referrer the reasons why the criteria has not been met.</p> <p>The Committee NOTED and APPROVED the contents of the paper.</p>	

<p>QP 2021/023</p>	<p>SAFEGUARDING ADULTS</p> <p>BN gave a verbal update to the Committee.</p> <p>Regular contact has been maintained with a wide variety of provider Trusts to ensure they are coping with changes due to the COVID-19 pandemic. There have been no significant changes reported however it is thought that these may be seen once the country starts to emerge from lockdown and people are able to talk to others and disclosures can be made. The referral rate is currently the same as it was this time last year. A small increase in domestic abuse (3%) has been seen compared to last year and this is replicated across the country.</p> <p>Local Authority is producing reports on referral trends and types on a more regular basis. There is a concern about referrals that are not Safeguarding and this is being monitored. The Safeguarding Boards have been operating as usual and this will continue. A new strategy around PREVENT is due to be launched. Training has been difficult to deliver however MS TEAMS is now being explored as an option as this is something that cannot be delayed any further.</p> <p>The Committee NOTED and APPROVED the contents of the paper.</p>	
<p>QP 2021/024</p>	<p>CONTINUING HEALTH CARE</p> <p>NMcP presented the paper to the Committee.</p> <p>NMcP explained that the CHC framework has been suspended and it is thought that there will be some communication around the return to working to the framework due imminently. In preparation the CCG have started CHC recovery and restoration planning with weekly meetings being held with actions taken being reported into this Committee. It is likely there will be a new discharge pathway which will mean the COVID emergency funding will only be in place for 6 weeks. There will also be the expectation for the backlog of assessments to be cleared.</p>	

	<p>AM raised concerns from the Finance Committee as this could have a significant impact on the overall CCG budget. AM requested that information on what the projected net impact is and what percentage of that impact can be charged against COVID-19 to be submitted to the Finance Committee when possible. ACTION NMcP to report the financial risks of CHC Restoration to the Finance Committee.</p> <p>NMcP confirmed data has been recorded on any patient funded through COVID and the CCG are working closely with discharge hubs and LA colleagues to see how many patients will be CHC eligible once Covid funding has ceased.</p> <p>BD requested that a CHC update is brought back to the Quality and Performance Committee on a monthly basis.</p> <p>The Committee NOTED and APPROVED the contents of the paper.</p>	<p>NMcP</p>
<p>QP 2021/025</p>	<p>IPC</p> <p>LM took the paper as read.</p> <p>A system wide IPC group has been established for which the Terms of Reference (TOR) is included in this paper. The TOR will be submitted to System Quality and Performance Committee next week for discussion and approval. Work is progressing with pace.</p> <p>The Committee NOTED and APPROVED the contents of the paper.</p>	
<p>QP 2021/026</p>	<p>ECHO WAIT LISTS</p> <p>LM presented the paper to the Committee.</p> <p>The paper confirms that there were very few patients experiencing delays for ECHO pre COVID however there is now a backlog. UHDBFT have commenced the procurement process to procure diagnostic service to help with the backlog. Work is being carried out in terms of risk stratification to ensure the correct patients are prioritised.</p>	

	<p>GS asked if any harm has been identified. LM confirmed that no harm has been identified however the risk stratification and mitigation work is in place to try to prevent this and any relevant Serious Incidents can be flagged to this Committee.</p> <p>The Committee NOTED and APPROVED the contents of the paper.</p>	
<p>QP 2021/027</p>	<p>CLINICAL QUALITY REFERENCE GROUPs</p> <p>LM confirmed that this was discussed at the meeting in July and the meetings are being reinstated..</p> <p>The Committee NOTED and APPROVED the contents of the paper.</p>	
<p>QP 2021/028</p>	<p>DRAFT AGENDA FOR QUALITY AND PERFORMANCE COMMITTEE</p> <p>HH explained that a sub-group of the Quality and Performance Committee recently met to look at the Committee priorities for the next 3-6 months. A proposed agenda for the Quality and Performance Committee was brought for consideration however this may be amended in the event of a second Covid-19 spike.</p> <p>The Committee agreed that this would be the standing agenda for the following three months and will be reviewed before the meeting in November. ACTION – JP to add a review of the standing agenda to the forward planner for October.</p> <p>The Committee NOTED and APPROVED the contents of the paper.</p>	<p>JP</p>
<p>QP 2021/029</p>	<p>AMENDED TOR FOR QUALITY AND PERFORMANCE COMMITTEE.</p> <p>BS noted the TOR have been amended due to the Recovery and Restoration work the is being undertaken.</p> <p>AM asked if the wording relating to Vice Chair could state “<i>The Vice Chair will be a Lay Member</i>” ACTION – JP will request for the amendment to be made.</p>	<p>JP</p>

	With the amendments noted the Committee approved the updated TOR.	
QP 2021/030	QUALITY ACCOUNTS - DCHS The Committee NOTED and APPROVED the contents of the paper.	
QP 2021/031	QUALITY ACCOUNTS - EMAS The Committee NOTED and APPROVED the contents of the paper.	
Minutes, Matters Arising, Action Log, Assurance Questions		
QP 2021/032	MINUTES OF THE MEETING HELD ON 25th June 2020 FOR ACCURACY. The minutes of the meeting on 25th June 2020 were approved as a true and accurate record.	
QP 2021/033	MATTERS ARISING / ACTION LOG NOT ELSEWHERE ON AGENDA. The action log was reviewed and updated where necessary.	
QP 2021/034	ANY OTHER BUSINESS <u>Risk Stratification</u> LM explained that a paper around Risk Stratification is being discussed at the System Quality and Performance Committee on 5th August 2020 however due to deadline the paper was not available for discussion at today's meeting. ACTION: LM will circulate the risk stratification paper to members for information. <u>Integrating First Level Mental Health Into GP Practices</u> AM referred to his recent reading on this subject and asked if this is something that the CCG endorse. SL commented that it is the ambition of the PCN Network that going forward there will be the ability to employ MH workers across a PCN footprint.	LM

	<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? Yes 	
DATE AND TIME OF NEXT MEETING		
Date: Thursday 27th August 2020		
Time: 9.00am to 10.30am		
Venue: MS Teams		



Addressing Equality, Diversity and Inclusion

Health Executive Group

14 July 2020

Author(s)	Richard Stubbs, Kevan Taylor
Sponsor	Kevan Taylor. Workforce Lead
Is your report for Approval / Consideration / Noting	
Consideration and debate	
Links to the STP (please tick)	
<input type="checkbox"/> Join up health and care <input checked="" type="checkbox"/> X <input type="checkbox"/> Standardise acute hospital care <input type="checkbox"/> Create financial sustainability <input type="checkbox"/> Invest and grow primary and community care <input type="checkbox"/> Simplify urgent and emergency care <input type="checkbox"/> Work with patients and the public to do <input type="checkbox"/> Treat the whole person, mental and physical <input type="checkbox"/> Develop our workforce <input type="checkbox"/> Use the best technology	
Are there any resource implications (including Financial, Staffing etc)?	
No specific resource implications at present.	
Summary of key issues	
<p>The purpose of the debate at HEG is to consider, take stock, and develop the ICS response to BAME issues.</p> <p>The presentation will be led by Richard Stubbs and Fatima Khan-Shah based on the experience of developing EDI work in West Yorkshire.</p>	
Recommendations	
To agree next steps in the ICS EDI response.	

Addressing Equality, Diversity and Inclusion

SOUTH YORKSHIRE AND BASSETLAW INTEGRATED CARE SYSTEM

Health Executive Group – 14 July 2020

Context

Black, Asian and Minority Ethnic people face multiple inequalities in many areas including health, health care and outcomes, education, employment, income and a range of other social issues. As a public sector leadership community, we have been presented continuously with a wide range of data and evidence.

There has also been a range of actions and initiatives that the NHS and Local Authorities have taken. There are many examples of excellent practice across the whole of South Yorkshire and Bassetlaw. While progress can be shown in a number of areas, inequalities persist.

As a leadership community we share both a commitment and a responsibility to support change.

We have clear direct responsibility in terms of health care and outcomes and, as employers, for access to employment, experience of employment, training, development and leadership. Additionally, as Anchor Institutions, we have a major role to play in reducing inequalities within the wider economy and community.

Reflecting on ourselves, we are not a particularly diverse group of Leaders, our engagement could be better and EDI issues have not featured as highly as they need to. The nationally led NHS drive is “to bring EDI into all Boardrooms”.

At an organisational level, and within place, we will all be undertaking actions that seek to improve the experiences of our BAME staff and citizens. However, it is also important that we come together as health and care leaders across the region to have honest, appreciative discussions about these issues, consider what commitments we should make as a group, and how we can support each other as we strive to understand more about the BAME experience of living and working in South Yorkshire and Bassetlaw.

Covid 19 has greatly exposed existing inequalities and the Black Lives Matter movement has led to an international outpouring of anger and commitment, given even greater emphasis following the killing of George Floyd. It feels like a very significant point in history and we have to both reflect that and make best use of the energy and commitment shown by so many.

As a Leadership community we need to address action on a wide range of issues. But perhaps firstly we need to reflect on our own leadership roles and behaviours and why, despite the commitment and actions, we have not been as successful as we would have wished in eliminating inequalities.

Session Description

Following our AOB discussion at the June HEG, Richard Stubbs and Kevan Taylor have worked with Fatima Khan Shah and Dean Royles to develop an hour-long working session on 14th July. The session aims to focus on our individual understanding and empathy with the lived experience of BAME communities, including experiencing ‘othering’ (ie treating someone as intrinsically

different or alien to oneself) or micro-aggressions (defined as 'brief, everyday exchanges that send denigrating messages to people of colour because they belong to a minority group').

Fatima and Richard will present an overview of the journey undertaken by the West Yorkshire and Harrogate Health and Care Partnership CEOs and the joint commitments that have been developed as a result of many uncomfortable conversations. We will then break into smaller, facilitated groups for personal reflections and questions, before returning to a plenary session to produce our next steps, including a commitment to issue a combined ICS statement.

We do not see this session as being a standalone discussion, but it will be for the group discussion to determine the appetite and commitment for us to own this agenda and take it forward together as a group of leaders.

Additional Reading

There are no additional papers to be read in advance of the session on 14th July. Instead we would encourage attendees to read at least one of the following books:

Why I'm No Longer Talking to White People About Race - Reni Eddo-Lodge

White Fragility: Why It's So Hard for White People to Talk About Racism - Robin DiAngelo

Paper prepared by Richard Stubbs & Kevan Taylor
On behalf of Kevan Taylor
Date 14 July 2020



CHIEF EXECUTIVE REPORT

July 2020

Author(s)	Andrew Cash, Chief Executive Officer		
Sponsor	Andrew Cash, Chief Executive Officer		
Is your report for Approval / Consideration / Noting			
For noting and discussion			
Links to the STP (please tick)			
<input checked="" type="checkbox"/> Reduce inequalities	<input checked="" type="checkbox"/> Join up health and care	<input type="checkbox"/> Invest and grow primary and community care	<input checked="" type="checkbox"/> Treat the whole person, mental and physical
<input checked="" type="checkbox"/> Standardise acute hospital care	<input checked="" type="checkbox"/> Simplify urgent and emergency care	<input checked="" type="checkbox"/> Develop our workforce	<input checked="" type="checkbox"/> Use the best technology
<input checked="" type="checkbox"/> Create financial sustainability	<input checked="" type="checkbox"/> Work with patients and the public to do		
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 (SYB ICS) provides a summary update on the work of the SYB ICS for the month of June 2020.			
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.			

South Yorkshire and Bassetlaw Integrated Care System

CHIEF EXECUTIVE REPORT

July 2020

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 Integrated Care System for the month of June 2020.

2. Summary update for activity during June 2020

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

There continues to be an ongoing decline in new cases, including the number of Covid-19 cases in South Yorkshire and Bassetlaw. This sustained reduction in new cases allows the system to firmly look ahead towards Phase Three from August 2020 to April 2021 - resetting the NHS.

There are a number of key concerns for health leaders as the NHS recovery process looks to restore services. Issues raised include restoring the NHS amidst workforce challenges, potential lengthening of waiting lists, and strict infection control measures – all of which will significantly impede capacity.

Supplies of Personal Protective Equipment (PPE) have improved significantly, particularly sterile gowns and sterile gloves and alternative suppliers through the support of Heads of Procurement have been sourced. General PPE continues to improve though there remain some concerns about the supply of PPE in Primary Care, and this remains a high priority.

PCR testing (testing of swabs to see if people have the virus) continues to be in a strong position. SYB labs have capacity to undertake testing of NHS and social care patients and staff. In addition, members of the public with symptoms have access to swabbing via the regional testing sites at Doncaster Airport and Meadowhall as well as via the mobile testing units (MTUs) that are sited most days at Barnsley County Way, Rotherham AESSEAL stadium and Dearne Valley Leisure Centre. The MTU at Meadowhall continues to be one of the five busiest in England, typically undertaking more than 400 swabs per day.

For antibody testing, approximately 50% of all NHS staff in SYB have now been tested (up to 22nd June) although this varies between each of SYB's five Places; Doncaster and Bassetlaw were first to have the analytical capacity in the lab and most staff there have been tested.

With regards to the NHS reset, there is now a very strong case being considered for returning to fewer hospital Covid treatment sites in SYB. This would see the scale-down of the Covid surge capacity response, mirroring the original scaling up in March. At the same time, partners are now resuming some services, focusing on clinical priorities for those who most urgently require treatment. Cancer care continues to be one of the main priorities in SYB's system recovery plans and partners are working to review and reprioritise patients.

The System also has a role in supporting reset in the community. Working with partners in primary care and the community there is a need to ensure that population health and the needs of our communities post-Covid are understood and supported. This includes the plans that are underway for how to manage the follow-up and rehabilitation needs of patients who have had Covid.

Each of SYB's Local Authorities has a robust Local Outbreak Plan which is supported by a regular flow of data and led by Directors of Public Health. With the recent further easing of lockdown

measures at the beginning of July, partners' Plans took into account the potential for increase in demand, particularly in relation to urgent and emergency services.

2.2 National update

On June 9th, there was a joint session between ICS and STP Independent Chairs and Executive leaders with senior colleagues at NHSE where the future of system working was discussed. The event was one of a broader conversation on the future of systems, alongside further opportunities to be involved in the coming months.

2.3 Regional Update

The North East and Humber Regional ICS Leaders continue to meet weekly with the NHS England and Improvement Regional Director to discuss where support during Covid-19 should be focused. Discussions during June focused on improving BAME inclusion, outbreak management arrangements, support for care homes, supporting urgent and emergency care as public confidence returns and planning for Phase Three.

2.4 Planning for Phase 3 and Phase 4

Further NHS planning guidance and a financial framework are expected in mid-July. A first draft SYB System Plan, which is an amalgamation of all five Place Plans, is currently in development. It takes into account constraints such as workforce, estates management, infection control and PPE while also incorporating examples of best practice in SYB and nationally. There will be a final submission at the end of July.

To support the planning process, a workshop to stress test the restoration of broader health and sustainment of care services in a COVID environment with partners took place on June 1st. This valuable exercise explored four possible scenarios across Places, offering opportunities for colleagues across health and care to analyse local plans in order to make improvements. Feedback from the session was very positive, with the learning now being built into local plans.

2.5 Identifying and embedding transformational change across SYB and capturing learning from the Covid-19 crisis

The ICS Programme Management Office is working with the Yorkshire and Humber Academic Health Science Network to capture views of senior leaders and colleagues from across SYB's health and social care organisations to feed into the joint project: 'Identifying and embedding transformational change across SYB and capturing learning from the Covid-19 crisis'. To accurately capture and understand the innovation that is emerging, views are being gathered from those directly involved in the implementation of the rapid changes through an extensive consultation exercise.

2.6 Cancer update

Cancer care continues to be one of the main priorities in SYB's system recovery plans. Partners are working to review and reprioritise patients who have previously been on waiting lists. Those patients who have waited for a long time already and are a priority clinically are very much at the forefront of efforts to receive fast-track diagnostic and treatment services.

The results of the recently published NHS England and Improvement commissioned National Cancer Patient Experience Survey saw SYB 2% above the national average in the areas of patients thinking they were seen 'as soon as necessary' (86%) and the length of time 'waiting for tests to be done being about right' (90%). The survey monitors national progress on the patient's experience of cancer care and acts as a driver to improve quality at local level. This is strong evidence of the excellent work taking place across SYB.

2.7 Planning for Flu

Modelling for influenza infections in the UK is now starting to take place as preparations for winter get underway, with a recognition that this could occur alongside a further Covid-19 peak. This is firmly on the radar of SYB's testing cell which has started to devise a winter testing strategy to support the system level planning. Supporting this work will be a system level flu strategy, which will be made up of five Place plans and a SYB Flu Board.

2.8 Accelerating NHS progress on health inequalities during the next stage of COVID recovery

The disproportionate impact on people from Black, Asian and minority ethnic communities, people living in areas of high deprivation and inclusion health groups shows starkly the health inequalities which persist in England today. The NHS Long-Term Plan commits the NHS to addressing health inequalities and much excellent work is underway already, particularly focused on medium and long-term action. But progress needs to be accelerated; responding to and recovering from COVID calls for more focused, additional and immediate actions.

To address this, NHS England and Improvement have established a Task and Finish Group, composed of a range of system leaders and voluntary sector partners, to focus on what specific, measurable actions should be taken by the NHS in the next few months. The Group will take account of feedback and ideas already received from BAME organisations, the VCSE sector, local systems and others.

This work is distinct from but complementary to the dedicated work on the NHS as an employer being led by the Chief People Officer on supporting our BAME NHS staff and implementing the NHS Workforce Race Equality Standard.

In SYB, the response to health inequalities is being taken forward by Workforce Leads, Kevan Taylor and Dean Royles.

2.9 Support for the Centre for Child Health Technology (CCHT)

The Sheffield MPs wrote to the Government to outline their support for a new world class research and innovation facility in Sheffield. The Sheffield Children's Hospital sponsored Centre for Child Health Technology (CCHT) at the Sheffield Olympic Legacy Park would be a multi-million transformational project supported by regional partners and international businesses including IBM Watson Health, Cannon Medical, Phillips and the South Yorkshire and Bassetlaw Integrated Care System. The site would span over 51,000 square metres, delivering world-class clinical and technical innovations to support children's health and wellbeing in SYB and beyond.

2.10 Sheffield City Region devolution deal agreed

South Yorkshire's devolution deal has finally been agreed and brought to the House of Commons. This is a significant step forward for South Yorkshire's economy and our congratulations go to Dan Jarvis, Mayor of the Sheffield City Region, and his team on this fantastic achievement. Once passed into law, an additional £30million pounds will be allocated to Sheffield City Region for regeneration projects supporting local growth and transformation. This is a great example of partnership working and its long-term impact is likely to shape the lives of the population for years to come.

2.11 Volunteers and Carers

Partners recognised the thousands of carers in SYB during Carers Week (8-14 June). Many of the patients who visit GP surgeries or go into hospital are cared for by a relative or have caring responsibilities themselves. Carers Week was a timely opportunity to thank them for all they do and particularly for their vital role in helping vulnerable people manage their health and care needs during the coronavirus outbreak.

It was also National Volunteers Week 1-7 June. Likewise, volunteers bring significant added value to health and care organisations with their experience and talent and the week was a great opportunity to thank the many thousands of volunteers in South Yorkshire and Bassetlaw for all they do.

3. Finance update

A new national financial framework is being developed to cover the period from August 2020 to March 2021 which is built upon the financial framework adopted for the period from April 2020 to July 2020. This will form part of the planning guidance is due to be released shortly.

The system has submitted capital plans to the region which total £47.1m which cover both the 'base case' and 'stepped up case' planning assumptions provided for this exercise. Further work is being undertaken to prioritise these schemes if the system is provided with a cash limited financial envelope to cover such expenditure.

From March to July 2020, commissioners and providers have been funded at actual cost to enable a break even position each month. From August 2020 to March 2021 this will be replaced with a cash limited sum which will replace the retrospective top-ups to commissioners and providers to allow them to break even and to reimburse costs associated with COVID 19. The intention is to provide systems rather than organisations with a financial envelope.

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

Date: 6 July 2020

Derby and Derbyshire CCG Governing Body Meeting in Public
Held on
6th August 2020 via Microsoft Teams

UNCONFIRMED

Present:

Dr Avi Bhatia	AB	Clinical Chair
Dr Bruce Braithwaite	BB	Secondary Care Consultant
Dr Chris Clayton	CC	Chief Executive Officer
Dr Ruth Cooper	RC	Governing Body GP
Jill Dentith	JD	Lay Member for Governance
Dr Robyn Dewis	RD	Acting Director of Public Health - Derby City Council
Helen Dillistone	HD	Executive Director of Corporate Strategy and Delivery
Ian Gibbard	IG	Lay Member for Audit
Zara Jones	ZJ	Executive Director of Commissioning Operations
Dr Steven Lloyd	SL	Medical Director
Simon McCandlish	SM	Lay Member for Patient and Public Involvement
Andrew Middleton	AM	Lay Member for Finance
Dr Emma Pizzey	EP	Governing Body GP
Brigid Stacey	BS	Chief Nursing Officer
Dr Greg Strachan	GS	Governing Body GP
Dean Wallace	DW	Director of Public Health - Derbyshire County Council
Dr Merryl Watkins	MW	Governing Body GP
Martin Whittle	MWh	Lay Member for Patient and Public Involvement

Apologies:

Dr Penny Blackwell	PB	Governing Body GP
Richard Chapman	RCp	Chief Finance Officer
Dr Buk Dhadha	BD	Governing Body GP
Professor Ian Shaw	IS	Lay Member for Primary Care Commissioning

In attendance:

Niki Bridge	NB	Deputy Chief Finance Officer
Dawn Litchfield	DL	Executive Assistant to the Governing Body / Minute Taker
Suzanne Pickering	SP	Head of Governance
Sean Thornton	ST	Assistant Director of Communications and Engagement

Item No.	Item	Action
GBP/2021/021	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/2021/022	Questions from members of the public AB advised that the following question has been received from a member of the public and confirmed that the response will be included in the minutes and provided directly to the individual concerned.	

	<p><u>Question 1</u> - I would like to ask the board to comment on the state of the Medicines Management budget and the risk of over spend to the CCG.</p> <p><u>Response</u> - The CCG is operating in a very different financial regime than previous financial years as a result of the COVID-19 pandemic, and prescribing is just one aspect of the overall budget and expenditure. Budget allocations have been set nationally by NHSEI and are currently only known to the end of July 2020. The CCG actively monitors prescribing expenditure and any risks are identified, managed and reported to the Governing Body and NHSEI.</p> <p>The Governing Body NOTED the question raised</p>	
<p>GBP/2021/023</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><u>GBP/2021/032 - Primary Care Commissioning Committee Assurance Report</u> - Dr Ruth Cooper (RC) declared an interest in this item which included an update on the impact on patients following the closure of the Pilsley Branch Surgery. As no decisions were to be made it was agreed that RC would remain in the room for this item.</p> <p>No further declarations of interest were made and no changes were requested to the Register of Interests.</p>	
<p>GBP/2021/024</p>	<p>Chair's Report</p> <p>AB provided a written report, a copy of which was circulated with the papers; the report was taken as read and the following points of note were made:</p> <ul style="list-style-type: none"> • The CCG is now in the Restoration and Recovery phase, progressing towards a 'new normal'. • The Governing Body is returning to a more formal pattern, with Development Sessions being reinstated following Governing Body meetings from September onwards. • The health and care system in Derbyshire is working jointly to review the impact and learning from the COVID-19 pandemic in its journey towards becoming an Integrated Care System (ICS). • Dr Chris Clayton (CC) continues to undertake membership briefings, with General Practices and will continue to do so in a way which best helps and informs members, modifying the agenda from COVID specific to include a wider spectrum of general practice related items. <p>The Governing Body NOTED the contents of the report</p>	

<p>GBP/2021/025</p>	<p>Chief Executive Officer's Report</p> <p>CC provided a written report, a copy of which was circulated with the papers. The following points of note were made:</p> <ul style="list-style-type: none"> • This would normally be the month when a verbal report was provided however given the current position it was felt necessary for a written report to be presented in order to demonstrate the amount of work being undertaken throughout the Restoration and Recovery phase. • CC wrote to the GP membership to request the stepping down of the weekly membership briefings and implementing monthly ones in their place; feedback was received that this would be a reasonable position. CC will request the input of Governing Body GPs as to how these meetings continue to be relevant to all General Practices. • A letter was received this week from Sir Simon Stevens and Amanda Pritchard on the Phase 3 Recovery Response to COVID-19; a copy of this letter will be circulated to Governing Body members. • The health care system is working through Phase 2 of the recovery and restoration work to restore services, and continues to make good progress, particularly in cancer services. • CC is pleased by the support received from the whole health and social care system in response to the pandemic. He gave particular thanks to Public Health for their input into the System Executive Call. <p>The Governing Body NOTED the contents of the report</p>	<p>DL</p>
<p>GBP/2021/026</p>	<p>Constitution Changes</p> <p>Helen Dillistone (HD) presented a paper detailing 5 amendments to the CCG's Constitution for consideration / approval by the Governing Body.</p> <ol style="list-style-type: none"> 1. <u>Removal of the Turnaround Director (TD) post from the composition of Governing Body</u> - The TD was a member of the Governing Body and a key part of the Senior Leadership Team for the CCG. It was recognised that this post was fixed term and that it was terminated at the end of July. It is now necessary to amend the Constitution to reflect this – Agreed. 2. <u>To return to formal Governing Body quoracy as per section 3.6, Appendix 3 of the Constitution to include:</u> <ul style="list-style-type: none"> • Clinical Chair or Vice Chair (PPI Lay Member); • 1 x CCG Officer (Accountable Officer, or Chief Finance Officer or Chief Nurse Officer); • 2 x Lay Members; • 4 x Voting Clinicians (to include GP Members and or Secondary Care Clinician). <p>Jill Dentith (JD) requested confirmation that it was previously agreed that quoracy would be 8 Governing Body members in attendance at meetings, with Dr Bhatia not being included in the 4 voting clinicians; HD confirmed that this was the case.</p> <p>JD also enquired whether, if there became a need for the CCG to return to increased escalation levels, a proviso should be added to allow the CCG to do so without obtaining further Governing Body</p> 	

approval. HD considered that if this scenario were to arise, Governing Body oversight would be required; however there is provision within the CCG's Constitution, under extraordinary powers for escalation through the different Business Continuity Levels, if it is not possible to obtain Governing Body approval within the required timescales; this may be implemented by the CEO and Lay Members, and presented to the Governing Body retrospectively for decision making.

CC requested that further thought be given to consideration of the Executive Director (ED) element of the voting membership now that the TD post has been removed from the permanent CCG establishment. There are currently 2 ED's that are not Governing Body voting members (Helen Dillistone (HD) and Zara Jones (ZJ)) and CC would like to ask the Governing Body to consider making them both voting members in line with new quoracy arrangements. It was requested that a paper be brought back to the next meeting on this matter for further consideration, bearing in mind the professional portfolio conflicts of interest that will arise for each of these EDs; it is important to note that these are not personal conflicts of interest.

Dr Greg Strachan (GS) enquired what regimes other CCGs have implemented regarding voting EDs on Governing Bodies. HD confirmed that there is a mixture of Executive and Non-Executive members having voting rights for all CCGs. GS also stated that careful consideration would be required of any professional portfolio conflicts of interest as and when they arise on the agenda.

3. To return to the formal Audit Committee membership of 3 Lay Members – Agreed.
4. From 1st August 2020, the permanent governance arrangements in respect of invoice approval will be reinstated – Agreed.
5. From 1st August 2020, all temporary approval limits for members of the finance team that were agreed by the Finance Committee will be removed and the original approval limits will be restored – Agreed.

The Governing Body APPROVED the following changes to the CCG's Constitution:

- **Removal of the Turnaround Director post from the composition of Governing Body.**
- **To return to the formal Audit Committee membership of 3 Lay Members.**
- **From 1st August 2020, the permanent governance arrangements in respect of invoice approval will be reinstated.**
- **From 1st August 2020, all temporary approval limits for members of the finance team that were agreed by the Finance Committee will be removed and the original approval limits will be restored.**

Further consideration is to be given to returning to the formal Governing Body quoracy in the Constitution. Thought to be given to

	<p>providing the Executive Director of Commissioning and the Executive Director of Corporate Strategy and Delivery with voting membership of the Governing Body; however there is a need to ensure that the Executive voting membership does not exceed clinical and Non-Executive voting membership. It was agreed that a paper would be presented to the September meeting for further consideration.</p>	<p>HD</p>
<p>GBP/2021/027</p>	<p>COVID-19 Outbreak – Management and Lessons Learnt</p> <p>Dr Robyn Dewis (RD) and Dean Wallace (DW) gave a presentation on COVID-19 outbreak management and the lessons learnt, a copy of which will be circulated post meeting for information. The following points of note were made:</p> <ul style="list-style-type: none"> • Concern was expressed that some people are not able to read in their own language and are therefore not receiving the COVID-19 stay safe messages. It was enquired how messages are being communicated to this cohort of people. RD confirmed that various methods are being used including the close relationship with the Iman at the local mosque. The Friday before Eid the Iman read out relevant information in order to catch a large cohort of people. Social media has been used to reach the Eastern European element of the local population who actively use online applications. A conscious effort has also been made to contact the deaf signing community to include them in all communications. DW confirmed that the CCG’s communications team has been involved in covering all cultural and language aspects, both written and verbal. • Work has been undertaken with employers across the county in order to be proactive and create links. • It was asked if the messages being given are being believed. The experience with the Muslim community in particular was that, in the early stage of the pandemic, they were incredibly impacted and suffered a significant number of deaths; they are therefore very open to hearing the messages being given and take action. • Andrew Middleton (AM) enquired if the learning from the previous few months will help with any sudden surges or increase in cases. It was confirmed that the system is in a better position now, having better, more timely data available. One-off funding has been built in to Public Health budgets this year; Public Health are still in response mode and this funding will be used to continue to build systems and networks going forward. • Dr Merryl Watkins (MW) asked what the CCG could change to improve the health and wellbeing of those families living together in close proximity, some of whom are key workers, some are on zero hours contracts and do not receive sick pay and do not feel they can be absent from work as they will not be paid. Although these problems are well identified there is little information on what action is being taken to tackle them. RD agreed that the health inequalities have been made stark; DW and RD plan to keep on with this message nationally. They both link into weekly Public Health England meetings where issues are shared and pushed forward nationally, as there is only so much that can be done locally. • Dr Emma Pizzey (EP) asked if there is a reluctance to engage with the Test and Trace programme due to the knock on effects of not being able to work and shop if self-isolating, or if the issue of not hitting the 	

	<p>targets relates to the system itself. RD considered the issues to be due to the Test and Trace system itself, which ideally should have been established locally in order to develop local responses.</p> <p>CC noted that, as a system, real learning has been achieved from this pandemic on how to approach a public health emergency. A lot has been learnt about connectivity into multiple communities via Public Health inroads. The connectivity between health and social care systems is important and helpful in terms of relationships and working with data out with the formal route. The health and housing issues have been known for some time; the Governing Body have previously held sessions on health inequalities, however these inequalities have been further exposed by COVID-19. Further thought is to be given to understanding the issues by working together as a system in order to influence the wider determinants of health.</p> <p>Dr Ruth Cooper (RC) considered that, in relation to the health and housing aspect, the situation has worsened with the increase in private rental; this has created many individuals having no powers to change their situations.</p> <p>Learning from other regions has helped identify high risk employers in Derbyshire; closer working has been established with these organisations by Environmental Health Teams across both the City and County. RC requested that this information be shared with General Practices.</p> <p>Ian Gibbard (IG) requested sight of the plans implemented to deal with local outbreaks, particularly in view of the imminent opening of schools in September. RD advised that every new area opening up increases the number of potential contacts and transmissions; schools have done a lot of work to minimise any potential transmission risks. Many schools are now academies, of which the Local Authorities has no oversight. Parents congregating outside of schools, car sharing, children playing together outside schools and people going back to work will also increase transmission. There is evidence that younger children transmit to each other but not to adults in the school setting.</p> <p>The Governing Body RECEIVED and NOTED this presentation.</p>	RD
<p>GBP/2021/028</p>	<p>Finance Report – Month 3</p> <p>Niki Bridge (NB) presented the Month 3 Finance Report. The following points of note were made:</p> <ul style="list-style-type: none"> • The CCG has been working under a temporary financial regime from 1st April to 31st July 2020. • The year to date overspend is £12.432m, as at Month 3. The forecast year-end overspend as at the end of July 2020 is £20.477m. • Some requested amendments have been received to help bring to the CCG to a breakeven position. • Scenario modelling has been undertaken for the full financial year based on 7 and 12 months respectively, details of which were provided for information. Scenario 1 is for block contract arrangements to remain in place until 31st October 2020 and Scenario 2 is for block contract arrangements to remain in place until 31st March 2021. • Not all contracts are covered by block arrangements and therefore 	

there are still some risks to the CCG of overspends in certain areas. Work is being undertaken to mitigate any risks to the CCG – further guidance is expected shortly.

- There remains, as yet, no robust intelligence as to the likely final revenue resource limit for the full financial year.
- Some expected allocations are still outstanding, including co-commissioning GP contract monies, the Free Nursing Care money uplift and money for investment into the mental health services; if received, these would bring the forecast outturn deficit to £3.7m year to date and £4.8m as at Month 4.
- Post-anticipated allocation corrections have been flagged up around running costs and non-recurrent programme QIPP in the baseline. If refunded, this would bring the deficit to £0.497m at Month 3 and a forecast year-end overspend of £0.559m.
- An allocation of £9.046m was received in Month 3 to cover the identified COVID-19 costs which were incurred necessarily and exclusively for the purpose of servicing the emergency.
- Under the current financial regime it will be ensured that the CCG will receive support to breakeven.

Dr Bruce Brathwaite (BB) queried why the overspend for care services is so high when activity has reduced during the pandemic; he asked why expenditure has exceeded budget. Dr Steve Lloyd (SL) confirmed that the Primary Care budget contains a prescribing overspend of £5m, £1.5m of which relates to March 2020, for which the CCG has now been reimbursed. A 5% growth in prescribing for Category M drugs was expected however a 10% growth has actually materialised. COVID-19 has also had an impact on the delivery of savings programmes which are currently under-achieving. There is a block contract in place for prescribing within the Acute hospital setting therefore no overspend has been demonstrated in that area. An overspend has however been seen for Sertraline.

GS enquired if the costs relating to the increased prescribing of Sertraline could be moderated through the use of an alternative first line antidepressant. SL advised that part of the problem is that prescribing data is only available up to May 2020. It is therefore difficult to implement rapid changes; however the situation is being continually monitored.

IG raised a concern in relation to the CCG's governance structure in that the CCG is currently operating with no budget beyond Month 4. He requested that the Governing Body provides some direction for the Executives to follow in terms of operating within budget for this financial year based on forecast outturn, pending clarification. NB confirmed that guidance was provided in the Phase 3 letter received this week. Confirmation was given for Months 5 and 6, and a high level outline for Months 6 to 12 is being developed. There is a move towards a system control total, with the CCG managing budget allocations, and block contracts implemented to provide certainty for the NHS. There are expectations that activity will start to resume, with top ups given to Providers, and a non-recurrent COVID budget implemented which will not be retrospective. NB advised that discussions were held at the Senior Leadership Team meeting yesterday and weekly strategy meetings are also being held on how to achieve a system control total.

MWh raised a concern that, although block contracts improve position, the

	<p>problems do not go away – they are just moved to other parts of the system; there is a need to reflect on this. NB advised that there is work to be done underneath the block contracts, linked to recovery, in order to better understand demand and capacity. The block contracts were flexed on anticipation of restoring activity and building upon them for the next financial year. There is no information as yet available for March 2021 onwards. If the situation continues there will be a need to know how to set the blocks and also to understand where non-recurrent monies sit within Trusts.</p> <p>The Governing Body NOTED the following:</p> <ul style="list-style-type: none"> • There is a temporary financial regime in place for the period 1st April to 31st July 2020 • At Month 3 the year to date overspend is £12.431m • The forecast position for the 4 months of April to July 2020 is an overspend of £20.477m • Some expected amendments to the allocations have now been received • Scenario models have been produced for the full year position based on a 7 month and 12 month block scenarios 	
<p>GBP/2021/029</p>	<p>Engagement Committee Assurance Report</p> <p>Martin Whittle (MWh) presented the Engagement Committee Assurance Report. The following points of note were made:</p> <ul style="list-style-type: none"> • The Engagement Committee is now a joint Joined Up Care Derbyshire / DDCCG Committee with a combined agenda. • A University Hospital of Derby and Burton Foundation Trust Governor is now included within the Committee's membership to match representation from other local Trusts. • The COVID-19 Communications and Engagement Strategy sets out a proposal for a 'system' approach to consultation and engagement during the restoration and recovery period. An audit of all changes to services will be undertaken with a view to establishing where engagement is required; this will include ensuring equitable access to engagement opportunities. • A system-wide Insight Group has been convened to collect, collate and share insight activity across partner organisations, and to agree priorities for additional work to support decision making. The strategy had been agreed by the System Escalation Call and investment has been secured to commence a broad piece of research to understand population health behaviours and preferences during the pandemic; the survey will commence during July 2020. <p>The Governing Body NOTED the contents of this report for assurance purposes, including the assurances given on progress made with the Restoration and Recovery activity</p>	
<p>GBP/2021/030</p>	<p>Finance Committee Assurance Report</p> <p>Andrew Middleton (AM) provided a verbal update following the Finance Committee meeting held on 30th July 2020. The following points of note were made:</p>	

	<ul style="list-style-type: none"> • AM thanked NB for the comprehensive financial report provided. • What will be will be this year. Even though the Governing Body has been provided with high level assurances, this year is still an abnormal scenario. The key is to undertake the ground work in preparation for next year. • Assurance was provided that the Quality and Performance Committee and the Finance Committee are both capturing the beneficial gains made during the pandemic in order to ensure that they are not lost. • Notwithstanding the breakeven position promised, the system went into this year with an underlying efficiency challenge of >£100m. • The System Finance Oversight Group will reconvene on 4th September. • 100% of suppliers continue to be paid within the required timescale. <p>The Governing Body NOTED the contents of this update for assurance purposes</p>	
<p>GBP/2021/031</p>	<p>Governance Committee Assurance Report</p> <p>Jill Dentith (JD) provided an update on the discussions undertaken at the Governance Committee meeting held on 9th July 2020. The following policies and reports were noted and approved:</p> <ul style="list-style-type: none"> • The Policy Management Framework • The Managing Conflicts of Interest Policy • The Gifts and Hospitality Policy • The Procurement Policy <ul style="list-style-type: none"> • The Cyber Operational Readiness Support (CORS) Audit and Action Plan was noted. • It was good to note that Freedom Of information requests were compliant with the response deadlines and met during the pandemic. • An Information Governance Control of Patient Information (COPI) notice was issued to support health and care organisations in sharing data where this would benefit system management, and a combined response. The COPI notice is authorised until the end of September 2020, however this may be rescinded prior to this time, or extended beyond this time, dependent upon the continuation of the COVID-19 response. • The Committee received assurances on the CCG's health and safety regarding working arrangements during the pandemic at home, in the office and within clinical settings. <p>The Governing Body NOTED the contents of this report for assurance purposes</p>	
<p>GBP/2021/032</p>	<p>Primary Care Commissioning Committee Assurance Report</p> <p>RC raised a conflict of interest in relation to the update on the Pilsley Branch Surgery closure update.</p> <p>Dr Steve Lloyd (SL) provided an update on the discussions held at the Primary Care Commissioning Committee meeting held on 22nd July 2020. The following points of note were made:</p> <ul style="list-style-type: none"> • No decisions were made at the July meeting. 	

	<ul style="list-style-type: none"> • A quarterly assurance report was received relating to the closure of the Pilsley branch surgery of Staffa Health, which was approved by the Committee in February. One of the mitigating actions was for the Committee to be assured of patient access to primary care services. A request was made for the next report to include details of how the practice plans to feedback and engage with patients on the changes made to access primary care services as part of the COVID-19 response and whether video conferencing/telephone triage has mitigated some of the original concerns made by patients. <p>JD was impressed with the information provided by Staffa Health; it has undertaken a lot of work which will be helpful to both the practice and patients in the longer term.</p> <p>The Governing Body NOTED the contents of this report for assurance purposes</p>	
<p>GBP/2021/033</p>	<p>Quality and Performance Committee Assurance Report</p> <p>Brigid Stacey (BS) provided an update on the discussions held at the Quality and Performance Committee meeting held on 30th July 2020. The following points of note were made:</p> <p><u>Cancer / 2 Week Waits</u> – A system plan has been produced to help reduce delays across pathways; this is due out in mid-August and will be presented to the Committee in September.</p> <p><u>Safeguarding adults and children</u> – The Committee considered that it has received significant assurance in relation to all safeguarding issues throughout the pandemic, with business as usual being maintained throughout</p> <p><u>Continuing Health Care</u> – An update on the restoration was received and welcomed, as was the proactive approach taken.</p> <p><u>EMAS</u> – All performance targets were achieved for the first time in a long period.</p> <p><u>Terms of Reference</u> – These were amended, agreed and adopted by the Committee. The agenda has been signed off for 3 months in order to ensure consideration of the priorities identified by the Task and Finish Group for Restoration and Recovery. The updated Terms of Reference will be presented to the Governing Body in due course.</p> <p>AM stated that activity levels in A&E are now nearly normal pre-COVID and asked if patients are still not aware of alternative places for treatment. BS advised that there is more activity now that different parts of the economy are opening up and getting back to normal. Work is ongoing to publicise the right places to access emergency health care.</p> <p>JD raised a question in relation to the achievement of the cancer 62 day screening standard which appears to have reduced. ZJ confirmed that the national screening programmes have now restarted. The targets were at a low point due to a pause in screening during COVID. This mirrors all aspects of cancer performance and referrals, and the diagnostics position is also reduced, although an upturn in performance is now being seen.</p>	

	<p>This is being closely monitored, as are recovery plans.</p> <p>The Governing Body NOTED the key performance and quality highlights and the actions taken to mitigate the risks</p>	
GBP/2021/034	<p>Draft Governing Body Assurance Framework – Quarter 1 – 2020/21</p> <p>HD advised that the Governing Body Assurance Framework (GBAF) provides a structure and process that enables the organisation to focus on any strategic/principal risks that might compromise the CCG in achieving its strategic objectives. It also maps out both the key controls in place to manage the objectives and associated strategic risks, and helps to provide the Governing Body with sufficient assurance on the effectiveness of the controls.</p> <p>HD presented the first draft of the 2020/21 GBAF which identifies seven strategic risks to the achievement of the CCG’s strategic objectives. Further to the discussions held at the last Governing Body meeting, additional work has been undertaken to identify the opening position for 2020/21; this will be further developed through the CCG’s Corporate Committees in order to finalise the Quarter 1 GBAF for presentation at the September meeting.</p> <p>JD enquired if the initial ratings for the 2020/21 GBAF had been rolled over from 2019/20; HD confirmed that the ratings used were based on last year’s closing position however this position will be subject to review by the Corporate Committees.</p> <p>The Governing Body DISCUSSED the draft GBAF for 2020/21. It AGREED that the Corporate Risks will be assessed by the Corporate Committees during August and a final version of the GBAF presented to the Governing Body in September for approval</p>	
GBP/2021/035	<p>Corporate and COVID-19 Risk Register Integration Update Report</p> <p>HD presented this paper which describes the process used to develop and amalgamate the Corporate and COVID-19 Risk Registers in order to provide an Integrated Risk Report to be worked through by the CCG’s Corporate Committees. Work is being undertaken by the CCG’s Functional Directors, overseen by the Executive Directors, in preparation for presentation to the Governing Body in September.</p> <p>The Governing Body NOTED this report on the amalgamation process of the COVID-19 and CCG operational Risk Register</p>	
GBP/2021/036	<p>Ratified Minutes of DDCCG’s Corporate Committees:</p> <ul style="list-style-type: none"> • Engagement Committee – 17th June 2020 • Governance Committee – 12th March 2020 • Primary Care Commissioning Committee – 24th June 2020 • Quality and Performance Committee – 25th June 2020 <p>The Governing Body RECEIVED and NOTED these minutes</p>	

GBP/2021/037	Minutes of the Governing Body meeting held on 2nd July 2020 The minutes of the above meeting were agreed as a true and accurate record.	
GBP/2021/038	Matters Arising / Action Log The action log will be updated and amended accordingly.	
GBP/2021/039	Forward Planner <ul style="list-style-type: none"> • Governing Body Development sessions are to be re-implemented from September onwards. • Winter Planning discussions to be scheduled into the agenda. 	
GBP/2021/040	Any Other Business <ul style="list-style-type: none"> • <u>NHS Rehabilitation Centre – Public Consultation Launch</u> – Nottingham and Nottinghamshire CCG are leading on a consultation, on behalf of all East Midlands CCGs, for the development of a new rehabilitation centre for NHS patients in the East Midlands. It is consulting on whether or not to take forward this opportunity, including the proposed transfer of existing services to the new facility. The funding and land is only available to develop an NHS Rehabilitation Centre (NHSRC) at the Stanford Hall Rehabilitation Estate, therefore this is a single option consultation. The Centre will be purpose built for rehabilitation and will provide an enhanced service for patients, with access to state-of-the-art facilities, enabling a centre of excellence to be created. <p>The intention is to develop a CCG response to the consultation, which runs from 27th July to 18th September 2020, at the Clinical and Lay Commissioning Group (CLCC); the CLCC will feedback to the Governing Body accordingly. AM enquired if an analysis will be undertaken to ascertain the impact on existing facilities as a result of this new facility. ZJ confirmed that an impact analysis would be undertaken.</p>	ZJ
DATE AND TIME OF NEXT MEETING Thursday 3 rd September 2020 – 9.30am to 11.15am via Microsoft Teams		

Signed by:
(Chair)

Dated:

**GOVERNING BODY MEETING IN PUBLIC
ACTION SHEET – August 2020**

Item / Minute No.	Action Proposed	Lead	Action Required	Action still to be taken	Due Date
2019/20 Actions					
GBP/1920/215	Audit Committee Assurance Report – January 2020	Helen Dillistone	It was agreed that it could be useful for the Governing Body to look at its own views of its effectiveness and also to explore learning and the system position.	To be included as part of a Governing Body Development Session – included on the development session forward plan	October 2020
2020/21 Actions					
GBP/2021/025	Chief Executive Officer's Report	Dawn Litchfield	A letter was received this week from Sir Simon Stevens and Amanda Pritchard on the Phase 3 Recovery Response to COVID-19.	A copy of this letter will be circulated to Governing Body members.	Complete
GBP/2021/026	Constitution Changes	Helen Dillistone	Further consideration is to be given to returning to the formal Governing Body quoracy in the Constitution. Thought to be given to providing the Executive Director of Commissioning and the Executive Director of Corporate Strategy and Delivery with voting membership of the Governing Body; however there is	It was agreed that a paper would be presented to the September meeting for further consideration – Agenda item.	September 2020

			a need to ensure that the Executive voting membership does not exceed clinical and Non-Executive voting membership.		
GBP/2021/027	COVID-19 Outbreak – Management and Lessons Learnt	Dr Robyn Dewis	Learning from other regions has helped identify areas of high risk employs in Derbyshire; closer working has been established with these organisations by Environmental Health Teams across both the City and County.	It was requested that this information be shared with General Practices.	September 2020
GBP/2021/040	Any Other Business – NHS Rehabilitation Centre – Public Consultation Launch	Zara Jones	The intention is to develop a CCG response to the consultation, which runs from 27th July to 18th September 2020, at the Clinical and Lay Commissioning Group (CLCC).	The CLCC will feedback to the Governing Body accordingly.	October 2020

Derby and Derbyshire CCG Governing Body Forward Planner 2020/21

	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												
Affirmation of Corporate Governance Responsibilities								X				
Review of Committee Terms of References						X						
FOR DISCUSSION												
360 Stakeholder Survey												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 		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"> • Complaints • 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								
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		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	
Minutes of STP Joined Up Care Board	X	X	X	X	X	X	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												