NHS
Derby and Derbyshire
Clinical Commissioning Group

NHS DERBY AND DERBYSHIRE CCG

GOVERNING BODY – MEETING IN PUBLIC

Date & Time: **Thursday 5th March 2020 – 9.15am to 11.00am**

Venue: **Charnos Hall, Heanor Road, Ilkeston, Derbyshire DE7 8LN**

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

Item	Subject	Paper	Presenter	Time
GBP/1920/232	**Welcome, Apologies & Quoracy** Dr Bruce Braithwaite, Ian Gibbard, Gill Orwin, Robyn Dewis	**Verbal**	**Dr Avi Bhatia**	**9.15**
GBP/1920/233	**Questions from members of the public**	**Verbal**	**Dr Avi Bhatia**	
GBP/1920/234	**Declarations of Interest** • Register of Interests • Summary register for recording any conflicts of interests during meetings • Glossary	**Papers**	**Dr Avi Bhatia**	
CHAIR AND CHIEF OFFICER REPORTS				
GBP/1920/235	**Chair's Report**	**Paper**	**Dr Avi Bhatia**	**9.20**
GBP/1920/236	**Chief Executive Officer's Report**	**Verbal**	**Dr Chris Clayton**	
FOR DECISION				
GBP/1920/237	**Relocation of inpatient services for older people with functional mental health conditions at London Road Community Hospital (LRCH) to Kingsway Hospital, Derby**	**Paper**	**Zara Jones**	**9.30**

FOR DISCUSSION				
GBP/1920/ 238	**Update on the re-design of Clinical Pathways to support hospital discharge in Erewash**	**Paper**	**Zara Jones**	**9.55**
CORPORATE ASSURANCE				
GBP/1920/ 239	**Finance and Savings Report – Month 10**	**Paper**	**Sandy Hogg / Richard Chapman**	**10.05**
GBP/1920/ 240	**2020/21 Financial Outlook and efficiency savings**	**Paper**	**Sandy Hogg / Richard Chapman**	
GBP/1920/ 241	**Finance Committee Assurance Report – February 2020** • **Governing Body support of a verbal update from the Finance Committee**	**Verbal**	**Andrew Middleton**	
GBP/1920/ 242	**Quality and Performance Committee Assurance Report – February 2020**	**Paper**	**Dr Buk Dhadda**	
GBP/1920/ 243	**Primary Care Commissioning Committee Assurance Report – February 2020**	**Paper**	**Prof Ian Shaw**	
GBP/1920/ 244	**Risk Register Report – February 2020**	**Paper**	**Helen Dillistone**	
FOR INFORMATION				
GBP/1920/ 245	**Ratified Minutes of Corporate Committees:** • Engagement Committee – 8 January 2020 • Primary Care Commissioning Committee – 22January 2020 • Quality and Performance Committee – 30 January 2020	**Papers**	**Committee Chairs**	**10.30**
GBP/1920/ 246	**Minutes of the Joined Up Care Derbyshire Board Meeting – January 2020**	**Paper**	**Dr Avi Bhatia**	
GBP/1920/ 247	**South Yorkshire & Bassetlaw Joint CCGs Committee / Integrated Care System Health Executive Group CEO report**	**Paper**	**Dr Avi Bhatia**	

GBP/1920/ 248	**Minutes of the Governing Body Meeting in Public held on 6th February 2020**	**Paper**	**Dr Avi Bhatia**	**10.45**
GBP/1920/ 249	**Matters arising from the minutes not elsewhere on agenda:** • Action Log	**Paper**	**Dr Avi Bhatia**	
GBP/1920/ 250	**Forward Planner**	**Paper**	**Dr Avi Bhatia**	
GBP/1920/ 251	**Any Other Business**	**Verbal**	**All**	

Date and time of next meeting:

Thursday 2nd April 2020 at 9.15am – Cardinal Square, Nottingham Road, Derby DE1 3QT

NHS DERBY AND DERBYSHIRE CCG GOVERNING BODY & COMMITTEE MEMBERS' REGISTER OF INTERESTS 2019/20

NHS Derby and Derbyshire Clinical Commissioning Group

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

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 Parter at Erewash Health Partnership	✓				April 2018	Ongoing	
		Spouse works for Nottingham University Hospitals in Gynaecology				✓	Ongoing	Ongoing	
		Part landlord/owner of premises at College Street Medical Practice, Long Eaton, Nottingham	✓				Ongoing	Ongoing	
Blackwell, Dr Penny	Governing Body GP (also a member of Clinical & Lay Commissioning Committee; Finance Committee; 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	✓				Ongoing	Ongoing	
		GP lead for Shared Care Pathology, Derbyshire Pathology		✓			2011	Ongoing	
Braithwaite, Bruce	Secondary Care Specialist (also a member of Audit Committee; Clinical & Lay Commissioning Committee; and Remuneration Committee)	Shareholder in BD Braithwaite Ltd, which provides clinical services to Ilkeston Community Hospital and provides private medical services in the East Midlands (including patients who are not eligible for NHS funded treatment according to CCG guidelines)	✓				Aug 2014	Ongoing	Withdraw from all discussion and voting if organisation Is potential provider unless otherwise agreed by the meeting chair
		Employed by Nottingham University Hospital NHS Trust which is commissioned by the CCG to provide services to NHS patients.	✓				Aug 2000	Ongoing	Declare interest in relevant meetings
		Founder Member, Shareholder and Director of Clinical Services for Alliance Surgical plc which is a company that bids for NHS contracts.	✓				July 2007	Ongoing	Withdraw from all discussion and voting if organisation Is potential provider unless otherwise agreed by the meeting chair
		Fellow of the Royal College Of Surgeons of England and Member of the Vascular Society of Great Britain and Ireland. Advisor to NICE on an occasional basis.		✓			Aug 1992	Ongoing	No action required
		Honorary Associate Professor, University of Nottingham, involved in clinical research activity in the East Midlands.		✓			Aug 2009	Ongoing	No action required

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. Roles in the practice: Senior partner; Prescribing Lead; Adult Safeguarding Lead; Lead for Frailty and integrated care; PCN practice lead; interest in Dermatology and contraception including fitting of IUDs and Implants Shareholder in North East Derbyshire Health Ltd Sessional GP for DHU	✓ ✓ ✓				1992 2016 1995	Ongoing Ongoing Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Dentith, Jill	Lay Member for Governance (also a member of Audit Committee; Finance Committee; Governance Committee; Primary Care Commissionig Committee; and Remuneration Committee)	Self-employed through own management consultancy business trading as Jill Dentith Consulting Providing part time consultancy service to Conexus (a GP Federation in Wakefield) Providing part-time management consultancy support to Sheffield Health and Social Care NHS FT	✓ ✓ ✓				2012 16 Jan 19 28 Oct 19	Ongoing 31 Aug 19 31 Mar 20	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
Edwynn, Dr Cate	Director of Public Health, Derby City Council (also a member of Derbyshire Place Board)	Member of Health and Wellbeing Board, Derby City Council Member of Stronger Communities Board, Derby City Council Employee of Derby City Council	 ✓	✓ ✓			Ongoing	Ongoing	Declare interests at relevant meetings
Gibbard, Ian	Lay Member for Audit (also a member of Audit Committee; Clinical & Lay Commissioning Committee; Governance Committee; and Remuneration Committee)	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; Derbyshire Primary Care Quality & Performance Sub-Committee; and Quality & Performance Committee)	GP Partner and sessions x2 per week at St. Lawrence Road Surgery Shareholder in premises of Emmett Carr Surgery, Renishaw; and St. Lawrence Road Surgery, North Wingfield	✓ ✓				2012 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 Member for Governance at South West Lincolnshire CCG Lay Chair of Performers List Decision Panels for NHS England Central Midlands Lay Chair of Appointment Advisory Committees at United Hospitals Leicester - chairing panels for appointing hospital consultants	✓ ✓ ✓ ✓				Jan 2017 June 2017 May 2013 Mar 2020	Mar 2020 Mar 2020 Ongoing Mar 2023	Declare interests at relevant meetings There is no overlap of direct commissioning responsibilities but as with most East Midlands CCGs there may be services commissioned for the region through a lead CCG. In such cases this interest will be declared. Will not sit on any case which has knowledge of the GP or their practice.
Orwin, Gillian	Lay Member for Patient and Public Involvement (also a member of Clinical & Lay Commissioning Committee; Engagement Committee; Primary Care Commissioning Committee; Quality & Performance Committee; and Remuneration 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)	✓				2002	Ongoing	Declare interest at relevant meetings

Shaw, 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	✓				1992	Ongoing	Declare interest 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	✓ ✓	 ✓			2009 2016 2009	Ongoing Ongoing 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; Joint Area Prescribing Committee; and Quality & Performance Committee)	GP Partner at Vernon Street Medical Centre Husband is Anaesthetic and Chronic Pain Consultant at Royal Derby Hospital	✓			✓	Ongoing 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

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

DoH	Department of Health
DOI	Declaration of Interests
DoLS	Deprivation of Liberty Safeguards
DRRT	Dementia Rapid Response Service
DSN	Diabetic Specialist Nurse
DTOC	Delayed Transfers of Care – the number of days a patient deemed medically fit is still occupying a bed.
ED	Emergency Department
EDEN	Effective Diabetes Education Now
EDS2	Equality Delivery System 2
EIHR	Equality, Inclusion and Human Rights
EIP	Early Intervention in Psychosis
EMAS	East Midlands Ambulance Service NHS Trust
EMAS Red 1	The number of Red 1 Incidents (conditions that may be immediately life threatening and the most time critical) which resulted in an emergency response arriving at the scene of the incident within 8 minutes of the call being presented to the control room telephone switch.
EMAS Red 2	The number of Red 2 Incidents (conditions which may be life threatening but less time critical than Red 1) which resulted in an emergency response arriving at the scene of the incident within 8 minutes from the earliest of; the chief complaint information being obtained; a vehicle being assigned; or 60 seconds after the call is presented to the control room telephone switch.
EMAS A19	The number of Category A incidents (conditions which may be immediately life threatening) which resulted in a fully equipped ambulance vehicle able to transport the patient in a clinically safe manner, arriving at the scene within 19 minutes of the request being made.
EMLA	East Midlands Leadership Academy
ENT	Ear Nose and Throat
EOL	End of Life
EPRR	Emergency Preparedness Resilience and Response
FCP	First Contact Practitioner
FFT	Friends and Family Test
FGM	Female Genital Mutilation
FIRST	Falls Immediate Response Support Team
FRG	Financial Recovery Group
FRP	Financial Recovery Plan
GAP	Growth Abnormalities Protocol
GBAF	Governing Body Assurance Framework
GDPR	General Data Protection Regulation
GNBSI	Gram Negative Bloodstream Infection
GP	General Practitioner
GPFV	General Practice Forward View
GPSI	GP with Specialist Interest
GPSOC	GP System of Choice
HCAI	Healthcare Associated Infection
HDU	High Dependency Unit
HEE	Health Education England
HLE	Healthy Life Expectancy
HSJ	Health Service Journal
HWB	Health & Wellbeing Board
IAF	Improvement and Assessment Framework
IAPT	Improving Access to Psychological Therapies

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

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

SPA	Single Point of Access
SQI	Supporting Quality Improvement
SRG	Systems Resilience Group
SIRO	Senior Information Risk Owner
SRT	Self-Assessment Review Toolkit
STAR PU	Specific Therapeutic Group Age-Sec Prescribing Unit
STEIS	Strategic Executive Information System
STHFT	Sheffield Teaching Hospital Foundation Trust
STOMPLD	Stop Over Medicating of Patients with Learning Disabilities
STP	Sustainability and Transformation Partnership
TCP	Transforming Care Partnership
TDA	Trust Development Authority
T&O	Trauma and Orthopaedics
UTC	Urgent Treatment Centre
UEC	Urgent and Emergency Care
UHDBFT	University Hospitals of Derby and Burton Foundation Trust
YTD	Year to Date
111	The out of hours service delivered by Derbyshire Health United: a call centre where patients, their relatives or carers can speak to trained staff, doctors and nurses who will assess their needs and either provide advice over the telephone, or make an appointment to attend one of our local clinics. For patients who are house-bound or so unwell that they are unable to travel, staff will arrange for a doctor or nurse to visit them at home.
52WW	52 week wait

Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

5 March 2020

Item No: 235

Report Title	Chair's monthly report
Author(s)	Dr Avi Bhatia
Sponsor (Director)	Dr Avi Bhatia

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

Recommendations

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

Report Summary

Our health and care system in Derbyshire continues to work collaboratively and at pace as we move ever closer to becoming an Integrated Care System (ICS). This is reflected across the system partnership and at every level throughout partner organisations.

The Chairs of each partner organisation have a clear role to play in this and I have recently met with fellow Chairs across the partnership. Our meeting was constructive and included discussions on how we can best support our respective organisations to work more effectively together on behalf of our patients and also how we can work more efficiently through reducing duplication. From a Chair's perspective we also want to create stronger links between our Governing Bodies and Boards and we will continue to meet regularly to take this forward.

Clinical leadership has a vital role to play as we move our system forward and the Clinical and Professional Reference Group (CPRG) is the Joined Up Care Derbyshire (JUCD) vehicle for the coordinating and representing our professional and clinical voice. The terms of reference for CPRG have recently been reviewed to strengthen its positioning within our STP and this is important as we move towards becoming an ICS.

I am pleased to report some real progress with our Integrated Care Partnerships (ICPs) which will form a cornerstone of the ICS for Derbyshire and we are moving quickly towards these being launched in shadow form from April 2020. Our system has made tremendous progress since September 2019 when we started planning in earnest and one of the main developments has been the agreement of the four ICP areas which are recognised by our local authorities. This is important in ensuring they are relevant to their local populations in terms of delivering population health and prevention. The four areas are:

i) Chesterfield, North East Derbyshire and Bolsover
ii) Derby City
iii) South Derbyshire, Amber Valley and Erewash
iv) Derbyshire Dales and High Peak

We will see a lot more in terms of ICP developments including the leadership arrangements for each one but more importantly we will soon start to see their outputs. I will be sharing more information about our ICPs in conjunction with Chris through our respective updates to Governing Body meetings over the coming months.

I provided an update on Coronavirus in my last report and I would like to offer the same note of reassurance regarding the system response. As a GP I can confirm that practices across the county are receiving a constant stream of information and are responding immediately to every new instruction. This helps to ensure that we fulfil our role alongside system partners as we jointly work to manage this situation on behalf of our Derbyshire population.

Finally, on behalf of Governing Body colleagues and colleagues across the CCG I would like to formally register our thanks and best wishes to Gill Orwin further to her announcement that she will be stepping down from her role as Lay Member for Public and Patient Involvement (PPI). Gill has been tremendously active in her PPI role having joined Hardwick CCG from the start she was then successful in her application to the Governing Body PPI Lay Member role for Derby and Derbyshire CCG. A passionate advocate of public and patient involvement and the patient voice, Gill has also chaired PPG Networks in the north of the county throughout her period of tenure. Gill is unable to join us today but she will continue to deliver her role in our various committees including the Engagement Committee until she leaves on 31 March 2020.

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

Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

5th March 2020

Item No: 237

Report Title	Relocation of inpatient services for older people with functional mental health conditions at London Road Community Hospital (LRCH) to Kingsway Hospital, Derby
Author(s)	Tracy Lee, Head of Mental Health Commissioning
Sponsor (Director)	Zara Jones, Executive Director of Commissioning Operations

Paper for:	**Decision**	X	**Assurance**		**Discussion**		**Information**	
Assurance Report Signed off by Chair				N/A				
Which committee has the subject matter been through?				Derby City Improvement & Scrutiny Committee – February 4th 2020 Clinical and Lay Commissioning Committee - February 13th 2020 Engagement Committee -February 17th 2020				

Recommendations

The Governing Body is requested to:

- **NOTE** the update provided for functionally mentally ill older adults who are currently receiving inpatient provision at London Road Community Hospital

- **APPROVE** the commencement of a public consultation process with regard to the relocation of this inpatient function (currently met at LRCH) over to the Kingsway Hospital site.

Report Summary

The inpatient services for older people with functional mental health conditions, such as depression, anxiety and psychosis, are currently provided in adapted mental health facilities at the London Road Community Hospital (LRCH), in Derby City Centre.

The inpatient service for older people (65+) for organic mental illness (such as dementia) are provided in purpose-built mental health facilities on the Kingsway Hospital site in Derby.

There are a number of people who will have both an organic and functional mental health diagnosis. These people could be supported through either service or a combination, depending on the nature of each individual's clinical needs.

Historically, 2 wards at LRCH, Wards 1 and 2, provided the inpatient care for this

patient group. However, the level of capacity was higher than the average demand for inpatient care; evidence suggested that a shift in the clinical model could change into a more progressive form.

During 2016, using the same staff working differently, a community outreach offer was developed to support more people in their own familiar home environments which progressively allowed the larger bed base to be reliably reduced at the same time the community offer was further developed.

Currently a much greater number of older people with functional illness are having their needs met within their home environment than would have been the case. This is known to provide a better patient experience and reduce any confusion or disorientation that can be created when older people have a short stay in hospital.

The community support service is called the Older Adults In-Reach and Home Treatment Team (IRHTT). The new service also prevents admissions to hospital, through the offer of intensive support at times of crisis or changes in circumstances, linking in with other services in the community.

The IRHTT service also links in to the inpatient ward capacity at LRCH to enable smoother transition from in-patient care back into the community. The service has continued to operate from Ward 1 and this arrangement has proven to be able to more than meet subsequent demand for inpatient beds throughout.

Proposed service delivery

The proposal for the consultation is to relocate the remaining required clinical capacity of the inpatient function to Tissington House, which is an 18 bedded modern facility based at Kingsway Hospital in Derby. Tissington House was previously used as an inpatient unit for older people with organic mental illness and it is currently vacant.

The way that services are offered will not change, offering inpatient beds when needed and improved community support, but being based on the Kingsway site. The opportunity will enable greater link working with other wards such as Cubley Court which is a dementia ward. This is helpful in those cases where patients may have functional illness and early stage dementia. There are a number of other benefits from basing these services close to each other, including joint training for staff, greater staffing resilience across the new units and the sharing of expertise and best practice across a small site.

Consultation

A report was taken through the CCG's Clinical and Lay Commissioning Committee (CLCC) on February 13th, the Engagement Committee on February 17th and the Derby City Improvement and Scrutiny Committee on February 4th to provide assurance and gain support for a formal consultation process. This was supported by all committees. The 60 day public consultation which the CCG Governing Body is asked to support is proposed to take place between March 2020 and May 2020.

The option to remain at the LRCH site has been considered and is deemed to be the least desirable option since the sister ward which was not required has been repurposed and this leaves the ward and the staffing isolated. The option to relocate is the preferred option, as it will mean patients moving to a purpose-built ward in a mental health setting where there is greater availability of a wider skill set and larger staffing resource locally available.

It is important to note that the proposed change is about the relocation of the service to an enhanced environment and not the closure of the service.

A small and specific number of ambulant service receivers who would be occupying a bed at the time, will be affected directly by the move. Each individual's circumstances, in terms of how the move may impact on their care pathway, will be taken into consideration as part of the consultation.

Transport and parking for family and carers will also be reviewed as part of the consultation.

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

It is anticipated that the relocation will be cost neutral, since the staffing resource will move to the new site.

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

Yes – Stage 1 completed

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

January 7th 2020 – Approved and found to be moderate risk. The panel submitted follow-up questions around negative impact on the move. These have been responded to in terms of this being considered as part of the consultation for each individual and will be considered again by the panel – date to be confirmed. This will be reviewed again following consultation.

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

January 7th – Approved. The proposed move will not impact on any individual with protected characteristics accessing the service

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

Panel on January 7th – panel approved plan and remains at moderate risk. The panel have asked for a review should the move go ahead following consultation.

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

Formal Public Consultation to commence March 2020.

Have any Conflicts of Interest been identified/ actions taken?
None
Governing Body Assurance Framework
Improved patient access and experience – Kingsway site offers a purpose built environment. There are green spaces that patients can use and there is greater access to mental health resources, e.g. for patients who may have functional and organic presentations.
Identification of Key Risks
Insufficient workforce capacity in our providers may prevent the delivery of our strategic priorities and NHS Constitutional standards. DHcFT are proposing to maximise their workforce by proposing the relocation to a purpose built site where there is greater opportunity to move staff around where the need is required.

Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

5th March 2020

Item No: 238

Report Title	Update on the re-design of Clinical Pathways to support hospital discharge in Erewash
Author(s)	Louise Swain - Assistant Director of Joint & Community Commissioning and Jo Warburton Head of Joint and Community Commissioning
Sponsor (Director)	Zara Jones – Executive Director of Commissioning Operations

Paper for:	**Decision**		**Assurance**	X	**Discussion**		**Information**	X
Assurance Report Signed off by Chair				N/A				

Recommendations

The Governing Body (GB) supported the proposed changes to the re-design of clinical pathways to support hospital discharge in Erewash on 5th September 2019 and asked that an update report be brought back to GB in March 2020. The GB are now asked to:

1. **REVIEW** the enclosed report which provides a summary of the impact of the changes and a review of patient experience. These demonstrate that:

    a. more Erewash patients are now seen in a pathway 2 facility than before the changes;
    b. it can be concluded that the patient experience at Ladycross House has overall been very positive; and
    c. the number of beds available in Ilkeston Community Hospital has met patient demand.

2. **SUPPORT** the recommended next steps to continue to improve discharge arrangements by;
    - Continuing to monitor discharges to ensure patients are being discharged to the correct pathways and have all that is needed for their effective transfer from acute hospital to alternative pathways.
    - Ensuring that Standard Operating Procedures (SOP) which are being revised through system wide 'Improving Flow' work, are adopted across Derby and Derbyshire to support safe and efficient utilisation Community Hospital beds (P3), Community Support Beds (P2) and support at home (P1).
    - Continuing to collect patient experience feedback across all 3 pathways.
    - Regularly report progress through system wide Quality and Performance processes.

3. **NOTE** that Derbyshire County Council is currently out to consult on the future of a number of care homes including Ladycross (see risk below).

4. **RECEIVE** an update in a further 6 months.

Report Summary

Overview of Paper

The attached report provides an update on the flow of patients into each of the three pathways of care in the Erewash area showing:

- The utilisation of beds for Erewash patients
- Information on achievement against KPIs and outcome measures
- An update of the patient experience project illustrating patients experience of the changes
- An overview of the impact of the change and suggests recommendations of how to further improve.

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

The model remains affordable and the financial savings suggested in the previous papers (June and September 2019) remain on track

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

The Data Protection Impact Assessment screening proforma has been completed reviewed and signed off (Ref 066). No stage 2 process was required.

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

A Quality Impact Assessment was completed in May 2019 and assessed as Moderate Risk. On implementation the QIA has been revisited and the findings are as follows:

- Completed, patient experience has been regularly sought over the implementation period (see appendix 1)

- There have been very few reported problems with recruitment/training of new/existing staff. DCHS have highlighted that they have had some difficulties in recruiting into band 5 therapy posts, however DCHS anticipate that 95% of recruitment will be completed by the end of March 2020.

- Impact of changes on staff at ICH: All nursing, therapy and clinical support staff have either maintained their roles, obtained other roles within the organisation or have voluntarily moved to other posts (before the management of change). Upskilling / training has been put in place for staff transferring from the ward into the community. Staff moving to the community have had tailored on the job training depending on the role they have moved

to –this has included shadowing, clinical supervision and support from therapy professional leads, wound clinic lead or care coordinator lead. A positive measure of the upskilling and training support staff have received is evidenced in the retention of all ward therapy staff who have transferred to working across community support beds, which is a significant change in their practice.

- It has not been possible to fully recruit to the therapy roles. Staff have been used flexibly but this has impacted on planned therapy patient wait times (Occupational and Physiotherapy). However, referral to treatment is still within the required timeframes.

- No complaints or concerns have been raised by patient/carers on issues of travel but some patients commented on the location of the P2 beds.

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

Yes, completed in September 2019 – no changes identified

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

During the implementation of changes there has been fortnightly meetings with all stakeholders (primary care, acute, Social care, DCHS, UHDB, CCG) and also engagement with patients using the beds at Ladycross. This group captured any issues with discharges into the Ladycross beds and also captured data and patient stories to show the impact of the changes in activity and flow. This group have been instrumental in developing trusted relationships between stakeholders, and resolving issues as they occur.

Have any Conflicts of Interest been identified/ actions taken?

It is identified that one practice in Erewash is contracted to provide clinical support to the Ilkeston Hospital wards and another provides support to the Ladycross beds and therefore have a direct financial benefit to be taken into account. Other Erewash GPs may indicate that they have an indirect benefit. The appropriate action in line with the CCG policy for managing conflicts of interest has been applied.

Governing Body Assurance Framework

- Reduce Health Inequalities by improving the physical and mental health of the people of Derby & Derbyshire
- Take the Strategic lead in planning and Commissioning care for the population of Derby & Derbyshire
- Make best use of available resources

Identification of Key Risks
The following are key risks that may affect ongoing delivery: • Derbyshire County Council is currently undertaking a consultation – 'Revised Vision and future strategy for direct care homes for older people 2020–2025 (the consultation is due to close on 24th April 2020)'. Under the proposal Ladycross Care Home will no longer be available. The CCG will work with Derbyshire County Council to understand the implications and potential alternative options should the consultation recommendations be agreed.

1. Introduction

On 5th September 2019 Derby & Derbyshire CCG (DDCCG) Governing Body supported the recommendation to implement changes in the provision of community rehabilitation for the Erewash area. The Governing Body requested that an implementation update report be presented back to them in March 2020 to review the success of the changes implemented.

This paper gives an overview of the changes and provides a summary of the impact, highlighting feedback from patients through the patient experience report and shares information about the metrics and outcome measures for the pathway changes.

2. Context and background

The overall ambition remains to ensure that we have the right services available in the right place to meet the needs of people discharged from acute hospital care, who are not able to go straight home without additional rehabilitation or support. By ensuring care is delivered according to people's needs and in the right settings, people will have the best health outcomes, be kept safe and independent and wherever possible, at home.

To do this we have described care using 3 pathways:

Pathway 1 (P1) is care and rehabilitation provided **at home** by an integrated community team.

Pathway 2 (P2) is managed by social care with medical oversight from an Advanced Care Practitioner with GP supervision, in **a less medicalised setting** where patients are able to demonstrate greater independence and mobility, with input from therapist and community nursing teams to meet any ongoing health needs.

Pathway 3 (P3) is nurse-led, as patients have **24 hour nursing needs** as well as requiring rehabilitation input.

2.1 The modelling

The modelling, which the changes in Erewash were based on, is provided in the table below:

Table 1: Modelled requirement of capacity for Erewash demand

Type	Modelled Requirement	Proposed capacity	Occupancy	Length of stay (LOS)
P1 (Home)	29 to 40 patients per month	37	Not specified	Not Specified
P2 (Community Support bed)	10 beds	11	85%	14 days
P3 (Community hospital bed)	12 beds	16-18	85%	18 days

(Governing body paper, June 19).

2.2 What we delivered?

From 9th September 2019 after the Governing Body approved the proposed recommendations, the following care capacity was made available:

Table 2: Actual capacity delivered

Type	What we delivered
P1 (Home)	An increase in capacity to support people at home (Increased from 27 to 40 care packages available per month)
P2 (Community Support bed)	An increase in Pathway 2 beds or community support bed provision (From 3 at Florence Shipley to 8 beds at Ladycross care home and 3 beds at Florence Shipley)
P3 (Community hospital bed)	A reduction in the number of Pathway 3 beds at Ilkeston Community Hospital (ICH) (From 24 to 16 beds with 'flex' to 18 available at times of increased demand)

The proposed level of capacity across each type of pathway was implemented incrementally; beds were phased in at 2 beds per week and full availability was reached at the beginning of October. The additional rehabilitation support was in place from 14th October apart from band 5 therapy posts but DCHS anticipate recruitment will be nearing completion by the end of March 2020.

3. Methodology used to monitor the process of change

Operational changes in Erewash community provision were overseen by the Erewash Pathways and Patients Flow Operational Oversight Group (EPPFOOG) This group met fortnightly at Ladycross care home with a range of stakeholders including Derbyshire Community Health Services (DCHS), GP representation, Derbyshire County Council (DCC), the discharge team from Derby Royal Hospital, DDCCG, Nottingham University Hospital, and the care home manager. Together they participated in 'solution focused' meetings to ensure patient flow in Erewash was managed effectively.

This group captured any issues with discharges and also captured data and patient stories to show the impact of the changes in activity and flow. This group have been instrumental in developing trusted relationships between stakeholders and resolving issues as they occurred. They have been responsible for collating data and monitoring the output of the changes.

4. Impact Summary

4.1 Positive impact

Workforce:

- DCHS undertook an internal review of implementation from their perspective and concluded that the transition for staff from working in a hospital setting to working in the community had been well managed and that staff felt supported and have adapted well to the change.
- From the detailed discussions at the EPPFOOG group the medical oversight of both the Pathway 3 and pathway 2 beds is considered to be working well. The Advanced Nurse Practitioner and GP oversight partnership supports the pathway 2 beds and GP oversight of the ICH ward continues.

Pathway 3 – Ilkeston Community Hospital

- Erewash patients that have needed to be cared for in a P3 bed have been consistently able to access a bed at Ilkeston Community Hospital (Pathway 3) although in October 2019 the hospital was full. Any patients that were unable to be discharged to Ilkeston Hospital were cared for in another community hospital within Derbyshire in line with the need to use resources flexibly. This was a month when the whole of the NHS system experienced unprecedented levels of urgent and emergency care demand, impacting provider facilities across Derbyshire.
- Ilkeston Community Hospital (P3) is achieving against the KPI for length of stay set in the modelling with an average length of stay of 17.9 days. (KPI = 18 days)

Table 3 below shows the KPIs for ICH

Table 3	No. bed days used in month	No. patients discharged in month	Average LOS*	No of Beds used by patients	ICH Occupancy (against 18 beds)
Sep-19	504	27	18.7	17	93%
Oct-19	558	27	20.7	18	100%
Nov-19	291	17	17.1	10	54%
Dec-19	411	27	15.2	13	74%

This is data is based on unplanned admissions only into the beds.
* LOS - Length of Stay.

Pathway 2 – Ladycross Care Home

- More Erewash patients are now supported in a community support bed (Pathway 2) than before the changes.
- Ladycross (P2) is over achieving on the KPI set for average length of stay. The target is an average LOS of 14 days and Ladycross from Sept 19 – Dec 19 had an average stay of 10.9 days, with the majority of patients being discharged home after their stay at Ladycross.
- DCHS completed evidence based outcome assessments for patients receiving Pathway 2 care. This shows 82% of patients (31) had a good outcome against the goals set during their stay.
- The survey of patients concluded that overall the patient experience at Ladycross was very positive. (See appendix 1)

Table 4 shows the KPIs for Ladycross care home

	No bed days used	Occupancy	No. patients admitted in month	Average LOS (days)
Sep-19	44	37%	6	12.7
Oct-19	78	31%	10	7.8
Nov-19	108	45%	14	11
Dec-19	120	48%	15	12

Pathway 1 – Rehabilitation in people's own homes

- Pathway 1 therapy (DCHS) capacity has continued to adequately manage demand, although pathway 1 social care has at times struggled to fully meet demand due to a reconfiguration of the internal home care workforce. This is being addressed by a temporary increase in Health Support Workers (HCAs) to assist in times of higher demand during the period of social care change.
- DCHS have had some difficulties recruiting into band 5 therapy posts although DCHS anticipate recruitment will be close to completion by the end of March 2020. This has not prevented discharge to pathway 1 but has contributed to increased therapy waiting times.

4.2 Areas for improvement

- We have seen historically across the whole of Derbyshire, including the City that patients are not always discharged to the correct pathway and Erewash is not an exception. Through transformation work in the north of the county, we have seen improvements and a closer match between numbers of patients clinically assessed as requiring care in a particular setting post-acute stay and the destination they ended up being transferred into. There is more work to do, particularly in the South and City.

- The discharge decision making process across Derby and Derbyshire is currently undergoing further work in the form of audits and demand analysis overseen by the Improving Flow work programme as part of Joined Up Care Derbyshire. The programme will share the recommendations in April 2020.
- The utilisation of community support beds (P2) is below the expected target although occupancy over the last 2 months has continued to rise. Work is underway to develop a revised standard operating procedure for all pathway 2 beds through the Improving Flow work programme. Erewash people will benefit from these changes by ensuring that all P2 beds operate to the same operating standards as other P2 facilities.
- Other delays, including timely access to medication for patients post-acute discharge are being addressed through the Improving Flow work programme.

5. Patient Experience Feedback

The CCG Patient Experience Team used previous work on the issues that patients and carers report as problematic around discharge to examine the experiences for a sample of people discharged to Ladycross. The detailed findings are included as appendix 1.

Eight patients shared their "story" of what had been happening from admission to acute hospital care to the present day. They also completed rating scales and questions about the experience and how they felt at each stage of their care. A further 20 patients completed friends and family feedback forms. From the stories and the questions the following key themes emerged:

- People understood why they needed hospital care and all, except one patient, understood why they had a stay at Ladycross Care Home (LCH).
- Everyone surveyed agreed that they needed extra help after leaving acute hospital care and agreed that a time in another care facility, in this case LCH, was right for them. Some patients felt they would have preferred a different location in closer proximity to their own home and so did not always agree that their thoughts on admission to LCH had been considered.
- Everyone surveyed talked about feeling safe and well supported in the care facilities.
- There is evidence of lots of activities taking place to support people and people talked about being much more mobile and safe since being in LCH.
- Not everyone said that discharge talks started from admission to hospital, but they were all aware of having had conversations that started soon after and included talking about extra help and support. No one was concerned that the conversations had taken place too late. Although one lady said they changed where she was to go and she didn't know this until the day of transfer.
- Some people felt that there wasn't enough staff at times at LCH and a couple of people commented that they would like more showers while they were there. There was an increase in this after the Christmas period when many residents said that LCH was now "very busy". This was also observed by the person doing the interviews and the day room was frequently full during January 2020. It should be noted that the care home has beds for residents in addition to the pathway 2 beds that the CCG commissions.
- Everyone reported that they felt safe at LCH and they also talked about how important it was for them to feel safe and confident when they left there.

The Experience Team concluded that overall the patient experience at Ladycross House for the patients surveyed was very positive.

6. Next Steps

Whilst early indications are that the changes are having the effect that were planned in terms of capacity and experience there are a number of actions that need to be taken to support ongoing effective delivery:

- Continue to monitor discharges to ensure patients are being discharged to the correct pathways and have all that is needed for their effective transfer from acute hospital to alternative pathways.
- Ensure that Standard Operating Procedures (SOP) which are being revised through system wide 'Improving Flow' work are adopted across Derby and Derbyshire to support safe and efficient utilisation Community Hospital beds (P3), Community Support Beds (P2) and support at home (P1).
- Continue to collect patient experience feedback across all 3 pathways
- In view of the Derbyshire County Council consultation 'Revised Vision and future strategy for direct care homes for older people 2020–2025' the CCG will work with DCC to understand the implications and potential alternative options should the consultation recommendations be agreed.
- Prepare to update the Governing Body in a further 6 months.

APPENDIX 1 - Patient Experience of Discharge to Assess Pathway

Background

Before leaving hospital in Derbyshire every patient is assessed to determine the type of care they need to support them with their recovery. We currently provide three types (pathways) of care to patients who require ongoing rehabilitation support when they are discharged from a major hospital, such as Royal Derby Hospital. Figures show that, in the Erewash area, we have too much of some types of care and not enough of other types, meaning patients don't always get what is best for them. More specifically this means that patients sometimes spend too long in bed based care which can cause physical, psychological, cognitive and social deconditioning resulting in lost independence.

It was decided that changes were needed to these types of care in Erewash. This included providing more community support beds in local care homes, increasing the number of care staff in the community and providing additional health input to support rehabilitation. The people who benefit from this were previously likely to have been admitted to Ilkeston Hospital in the absence of suitable alternatives. To ensure that we provide the highest quality and most up to date care possible the Clinical Commissioning Group (CCG) continues to work with all health and care providers in Derbyshire to improve the planning and delivery of services. This ensures that patients move quickly and easily between settings and services and that we make the best use of all available facilities.

A crucial aspect of the CCG's work in this area is to understand the impact these changes have had on the experiences of those patients who have been accessing these pathways.

The aim is to focus on identifying the experiences of those patients and their carers who have been through this process and to identify actions for future roll-out across Derbyshire.

Approach

The patient experience work forms part of the wider engagement approach which has already been defined through the Workstream Leads and the Communications and Engagement Teams The specific aim of the patient experience work is to identify, explain and understand the experience of patients (and carers) who have used these pathways and have experienced the discharge to assess process in Derbyshire

Two key aspects of the experience are looked at:

- Functional experiences of care *(what happened, when, where etc.. as described by the patient/carer)*

- Relational aspects of care *(how they felt through the process and explore emotional aspects including understanding, communications, triggers for concerns, elements of good care etc..)*

This enables us to identify aspects of the pathway that trigger concerns either functionally or relationally and identify good practice, gaps in services etc. Given these aims and the patients' demographics, the methodology used was as follows:

- Patient Stories and unstructured interviews to gather real life experiences and the impact on the individual's life and care decisions.
- Rating scale to identify how people felt on aspects of their experience on the pathway.
- Friends and Family test as an overall satisfaction measure
- Interview with patients who have left pathway 2 but find that things did not go "as planned" and they are either re-admitted to hospital or utilising an unplanned service provision. This is to identify what this change in experience has meant for them and understand what happened at the place they call home to result in the additional support

During October 2019 to February 2020 the focus was on gathering pathway 2 patient experience in Erewash as a priority.

A CCG Patient Experience Manager talked to pathway 2 patients and their carers while in Ladycross House Care Home, which is where these beds are based, using the story approach, the ratings scales, and the Friends and Family Test (FFT). The FFT is a set of questions to gauge satisfaction based on how likely someone is to recommend the service. They also spoke to staff and were able to witness the care and support packages in place including the transfer of patients to home.

Patient experience in the acute

The aim at this stage of the pathway is to understand the patients experience of acute care and ascertain how it worked for them, whether they felt it worked, what they felt could be done differently/better and whether they understand what has been happening and why. This includes things like communications, involvement, feeling safe, understanding what was happening and care involvement. This was done through conversation (story) and the use of ratings scales and was completed soon after the patient had transferred to Ladycross House

The next place – Ladycross House (LCH)

The aim at this stage is to understand their experience of the process in the care facility for pathway 2 patients, in this case LCH, including whether they felt it worked for them, what they felt could be done differently/better and whether they understood what had been happening. Again this was done through conversation (story) and the use of ratings scales.

Summary Findings

8 patients shared their "story" of what had been happening from admission to acute hospital care to the present day. They also completed rating scales and questions about the experience and how they felt at each stage of their care. Further patients (20) completed rating questions and friends and family ratings.

In December 2019 it was observed that there were two patients during the visits to LCH who were very unwell and confused and couldn't take part in either patient experience feedback route as described above.

From the stories and the questions the following key themes have emerged:

- Everyone understood why they needed hospital care and everyone (except one patient) understood why they came to Ladycross House for extra help

- Equally everyone agreed that they needed extra help after leaving hospital and agreed that a time in another care facility, in this case Ladycross House was right for them. Some patients felt they would have preferred a different location in closer proximity to their own home and so did not always agree that their thoughts on admission to Ladycross House had been considered

- Everyone talked about feeling safe and well supported in care facilities

- There is evidence of lots of activities taking place to support people and people talked about being much more mobile and safe since being in Ladycross House.

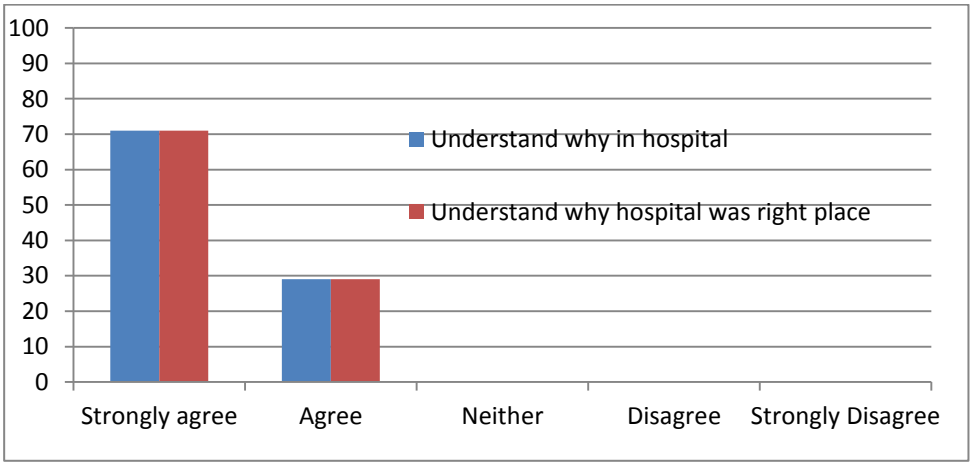
- Not everyone said that discharge talks started from admission to hospital, but they were all aware of having conversations that started soon after and included talking about extra help and support. No one was concerned that the conversations had taken place too late. Although one lady said they changed where she was to go and she didn't know this till the day of transfer.
- Some people felt that there wasn't enough staff at times at Ladycross House and a couple of people commented that they would like more showers while they were there. There was an increase in this after the Christmas period when many residents said that Ladycross House was now "very busy". This was also observed by the person doing the interviews and the day room was frequently full during January 2020.

- Everyone reported that they felt safe at Ladycross House and they also talked about how important it was for them to feel safe and confident when they left there.

Discharge to Assess – The Acute Experience

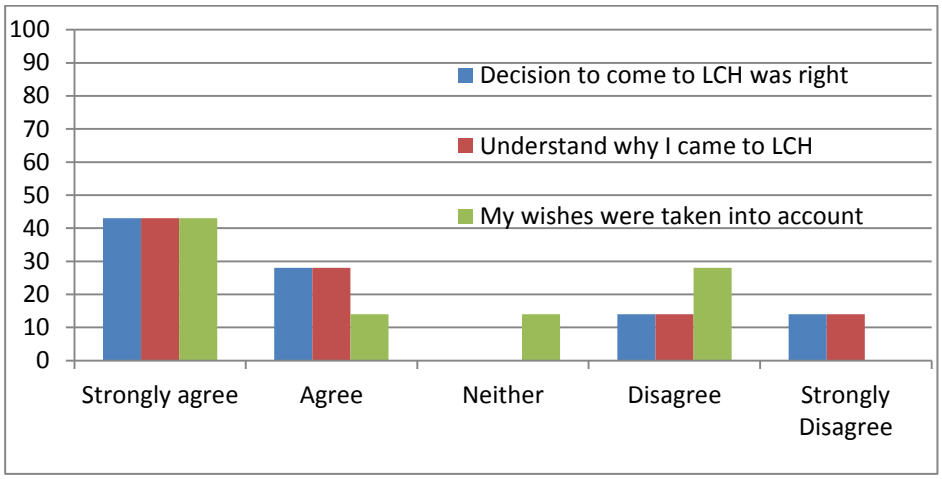
Information is illustrated as percentages

Patients had been in either Kings Mill Hospital (28%) or Royal Derby Hospital (72%) prior to transfer to the home (Ladycross House). Everyone strongly agreed or agreed that they knew why they were in hospital and agreed and understood it was the right place for them at the time.



When telling their patient story, everyone said they agreed that they needed extra help after leaving hospital and everyone agreed that a time in another care facility, was right for them. However, when

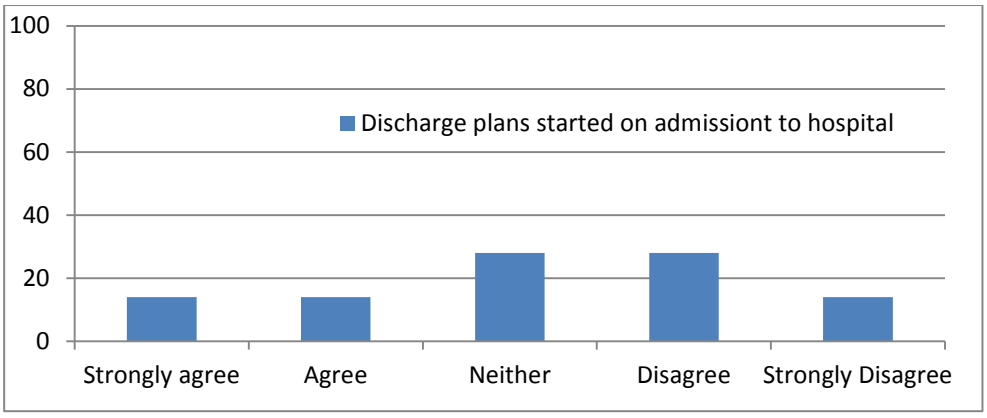
rating the decision making process, some patients felt they would have preferred a different location in closer proximity to their own home and so did not always agree that their thoughts on admission to Ladycross House had been considered. Additionally one patient strongly felt that she would have preferred a different type of environment and did not understand that this was a rehabilitation facility.



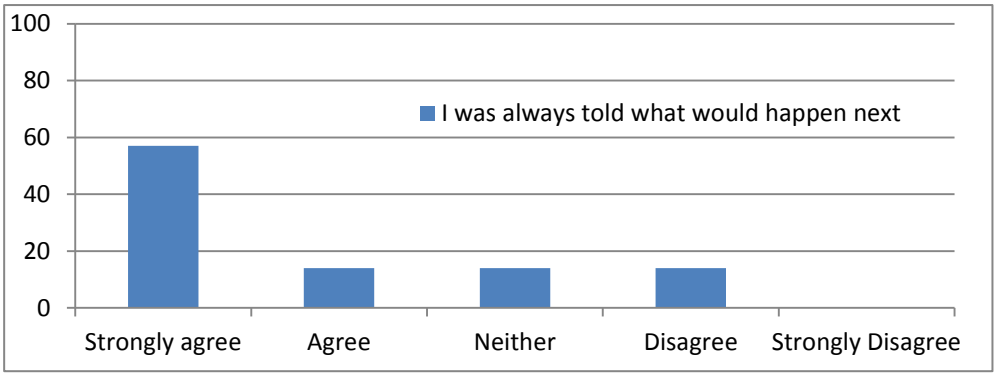
"I came to Ladycross House so they could assess me and decide when I could go home and what support and help I would need. I have a frame to stand and while in Royal Derby Hospital I couldn't stand at all unassisted so it was important for me to get this help"

"I understand why I was I hospital and I understand why I am here. Following a fall I need to be safe and I need to be ok when I leave here. I think I was in hospital for the right amount of time as I felt I was safe to leave as I had started to stand with my support which I couldn't do when I first went in. It's about safety."

Not everyone was completely clear when planning for discharge started in the acute hospital as they felt they had been having conversations about their longer term needs since they were admitted to hospital but they weren't clear that dates and places had been discussed until later on in their stay.



Most people strongly agreed or agreed that they were told what would happen next but a few people say they weren't told. Examples given were late changes to the location on discharge from hospital and one patient who thought she was going to a rehabilitation part of the hospital and not a "home".

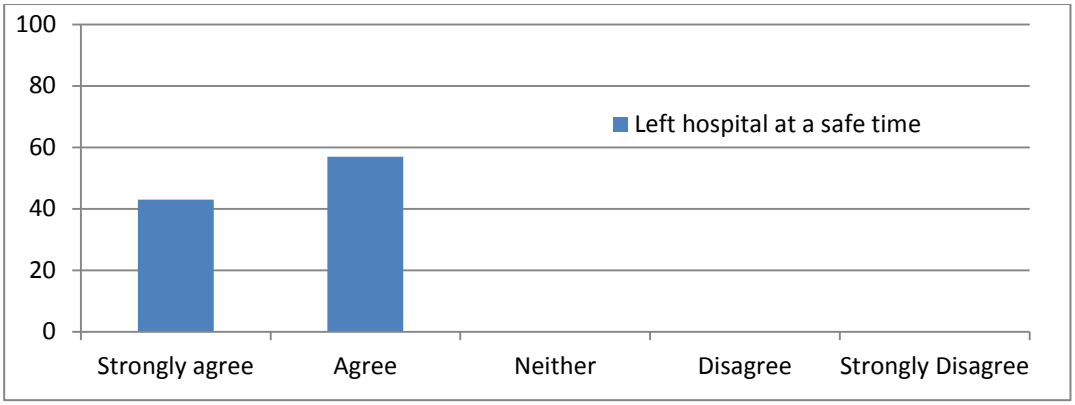


"I was in Kings Mill hospital for about three weeks overall. They started to talk to me about coming to LCH after a few weeks. They talked to me and my family about coming here and we have all been involved, it's been very good and it's been very good here."

No one was concerned that the conversations had taken place too late. Although one lady said they changed where she was to go and she didn't know this till the day of transfer.

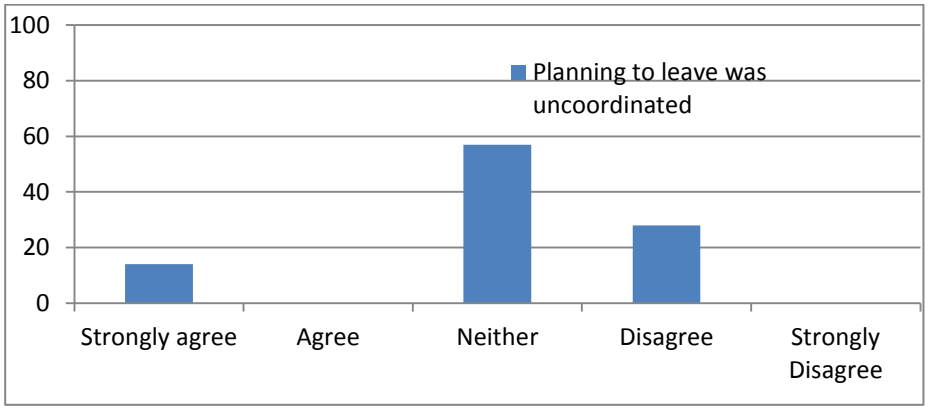
"Originally they said I would be going to Birch House, but them on the day (of transfer) they said I was coming here as it is nearer to my home, I live very near. I like it here but I would have liked to have tried somewhere else for a change. On the original day I was supposed to move at 11.30am and by 10pm at night it hadn't happened so I came the next day".

Everyone strongly agreed or agreed that they left hospital when it was safe for them.

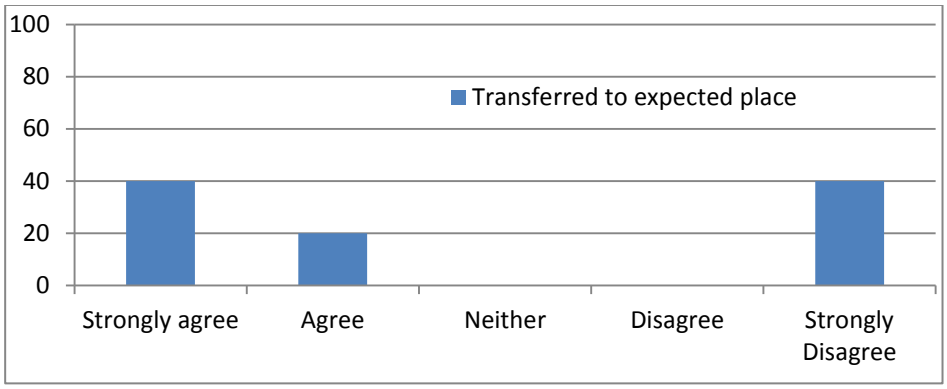


When asked about the actual transfer from hospital to Ladycross House everyone said it was a positive experience and not stressful for them. They reported that ambulance staff were very helpful and they were welcomed on arrival to the home.

When asked if the planning to leave hospital had felt uncoordinated the majority of people felt it hadn't. 14% felt it was uncoordinated but they had experienced a change of care location from that originally planned and one patient was not happy to go to a "home" facility

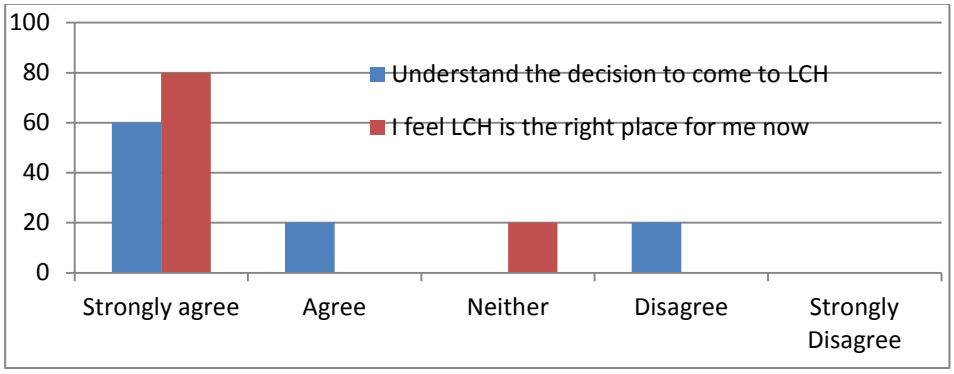


People were asked if they had transferred to the place they expected to and 2 people said they didn't. Again these were the patient who had a change of location the day before transfer and ones who thought they were going to different rehabilitation facilities (2 patients)

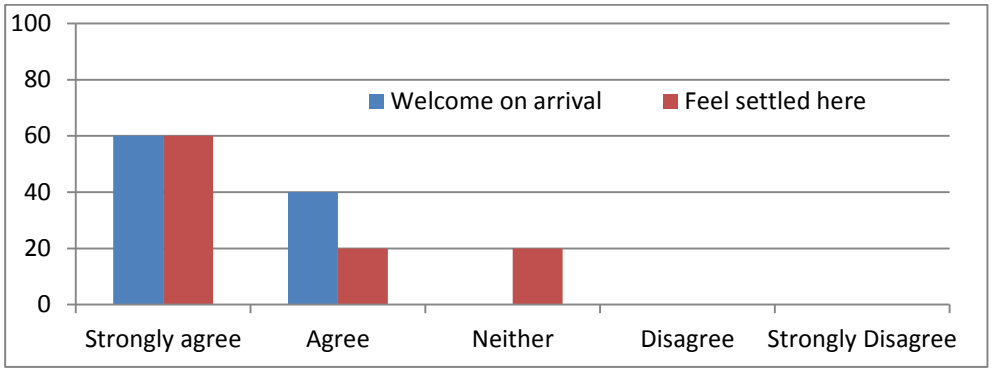


Ladycross House Experience

People were asked about the decision to come to Ladycross House and whether they felt it was right for them. Again most people understood the decision and felt it was right. One person felt they needed to be in a supported place and didn't mind where (responded neither) and one person who would have preferred a rehabilitation facility said they didn't understand the decision.



When asked to talk about their stay at Ladycross House most people were happy with the facilities and the support they had received. Three of the people who provided their story had been at Ladycross House before following a hospital stay on the discharge to assess pathway 2. Almost everyone felt welcome and said they were settled.



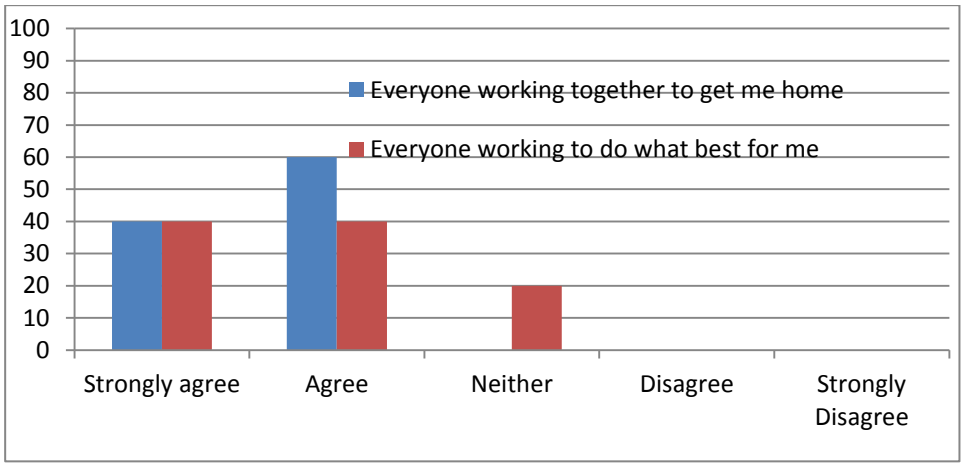
When asked about the support they had received so far in Ladycross House to enable them to go home, everyone reported having had lots of support to become more mobile and talked about doing lots of exercises to help them walk.

Many people said they could only just stand with a frame when they left hospital but were now walking, or beginning to walk, more confidently.

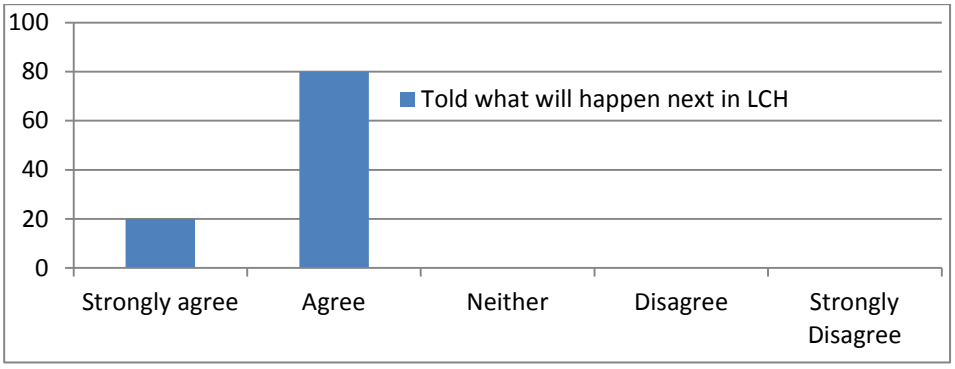
Some people felt that there wasn't enough staff at times and a couple of people commented that they would like more showers while they were there. There was an increase in this after the Christmas period when many residents said that Ladycross House was now "very busy". This was also observed by the person doing the interviews and the day room was frequently full during January 2020.

Everyone reported that they felt safe at Ladycross House and they also talked about how important it was for them to feel safe and confident when they left there.

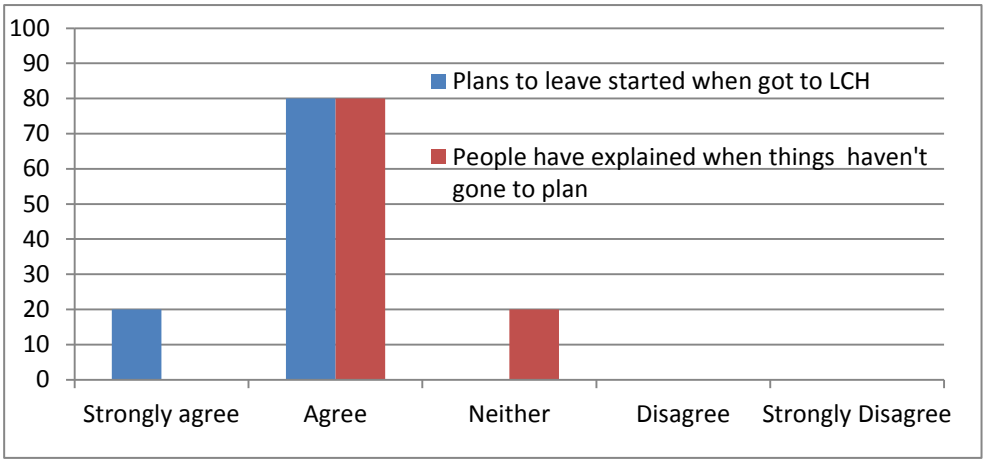
People were asked about planning to leave Ladycross House and whether they felt people were working together and working to do what's best for them. Almost everyone felt they were. One patient had raised her concerns about the alterations to her home and equipment there and she was upset that it didn't feel like a home anymore and she didn't feel staff were doing what was best for her and her husband.



Everyone strongly agreed or agreed that they were told what was going to happen next for them while they were in Ladycross House.

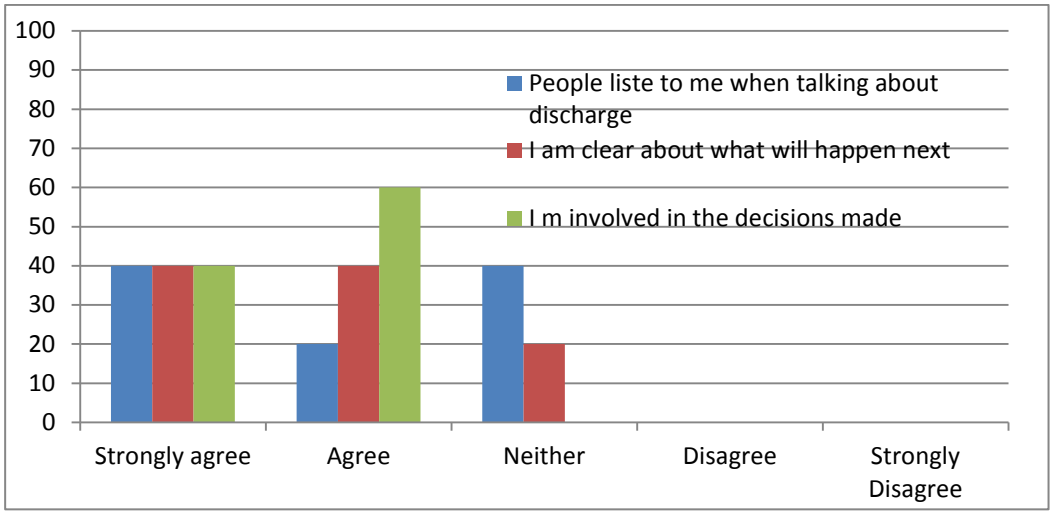


Everyone agreed or strongly agreed that planning for discharge from Ladycross House started as soon as they got there. Although only 3 people had a "firm " discharge date, others had an idea of when it would be and were aware that they were waiting for a couple more milestones to be met or equipment to be fitted. Whilst in Ladycross House the interviewer observed two discharge dates being changed with patients and their family for clinical reasons and for transport reasons.



Everyone (100%) said their family and carers had been involved in plans and discussions to leave Ladycross House.

60% said they felt they had the right level of support and therapy while they were in Ladycross House and talked about the great improvement they had made, especially in mobilising safely. Many patients had been struggling to stand alone when they arrived at Ladycross House and were now walking confidently with walking frames. Those who responded “neither” said it was too soon to tell as they had only been there a few days but said they were starting to do activities.



The majority of people are clear about what will happen next, feel they are being listened to and feel involved in the decisions made.

Friends and Family Test Questions

When asked about whether they would recommend the discharge to assess process, 20% said were extremely likely to, 60% likely and 20% responded “neither”. Three patients (30%) had been through this process before and rated it very highly, although one of them would have preferred to try a different home this time and one was negative about aspects of the experience as she was unhappy with the modifications made to her home.

Main Issues and Trends

An earlier review of patient and carer experiences in Derbyshire showed the key themes and trends that patients and carers report are problematic around discharge. This was based on a range of data including complaints, PALS, surveys, national surveys, patient stories and interviews. The table below identifies these and reports on how the experiences of those in Discharge to Assess Beds relate and compare to this Derbyshire wide discharge experience:

Theme identified in prior review	Experiences of those in Ladycross House for Discharge Assessment and Planning
People want discharge planning to account for them as a person and not just their current clinical concerns	People felt that planning started when they were in hospital and that their needs at home were taken into account. Only one person expressed concern that her wishes had not been taken into account and she was unhappy at the changes to her home. Patients also felt involved and understood what was happening.
Concerns about the available support after discharge and the delays to access this support	Patients weren't discharged until the care packages were in place. This was reported though the interviews and also witnessed by the interviewer on numerous visits. There were still some delays for items such as stair lift to be fitted but these patients were going home with care packages in place which included family and with beds downstairs till the necessary equipment was fitted.
Family and carer involvement in discharge	Partnership and engagement with carers and family during the assessment process was witnessed. Patients were asked about the involvement of their family and everyone said they had been involved.
Families having to problem solve and find their own solutions	Assessment to ensure that problems are discussed and resolved during pathway their stay at LCH is evident
Timeliness of discharge due to lack of support set up and in place	Everyone was aware of what was going to happen before they could go home and what sort of time that would take to put in place. There were some changes to discharge dates while support was set up
People feeling "rushed out the door"	No one reported this, although one person felt they had been transferred to Ladycross House because they needed the hospital bed. Everyone felt they were transferred at a safe time for them and that they would not have been safe or confident to go home from hospital. The interviewer witnessed clinical decisions to delay transfer from Ladycross House to ensure

Theme identified in prior review	Experiences of those in Ladycross House for Discharge Assessment and Planning
	that everything was in place for people
Patient involvement in their decisions post discharge	Everyone agreed and strongly agreed that they were involved in decision making both in the acute hospital and in Ladycross House. Not everyone agreed that they should be in Ladycross House but they all agreed they needed the additional support at that time.
Full consideration of needs not considered, for example housing, mental health	At this stage there was no evidence of anyone with mental health needs being part of the process. However there were very strong indications of housing needs being addressed and many patients were experiencing changes to their home environment and changes to types of housing, for example warden control etc
Openness and honesty with patients and carers about their needs, expectations and outcomes	This was evident in the discussions observed between staff and patients and carers especially in terms of realistic expectations of the capabilities of the patient on discharge.
Delays to home adaptations	These were not apparent for simpler developments although one person was waiting for a stair lift and reported a three week delay.
People want to move smoothly from hospital to onward support available in the community	
Discharge with wrong equipment, equipment they don't need or lack of equipment	Unable to assess and report on this aspect until any follow ups are made
Communications with family	This was reported as happening by patients and their carers and was witnessed at various times in the Ladycross House

Conclusion

The aim of the changes at Ilkeston Community Hospital was to address the issue of too much provision of some types of care and not enough of other types, so that patients spent less time in bed-based care with more likelihood of increased independence. The eight community support beds at Ladycross House Care Home were made available, together with an increase in the number of care staff providing additional health input to support rehabilitation, to enable the changes.

This report has attempted to understand the impact the changes have had on the experiences of those patients who have been discharged from an acute setting into, and through, Ladycross House. It has also sought the input of their families and carers. The CCG's Patient Experience Team visits to Ladycross House, during the period October 2019 to February 2020, enabled eight patients "stories" to be captured and the following key points can be made:

- People understood why they needed extra care and why they came to Ladycross House for that support.
- Conversations about discharge did not happen on admission to hospital but did soon after people being admitted and included conversations about the extra help and support at Ladycross House.
- Some patients would have preferred a location closer to home, and did not always agree that their thoughts on admission to Ladycross House had been considered.
- All eight people talked about feeling safe, well supported and being much more mobile – and confident – since being at Ladycross House.
- Family and carers were involved in conversations about patient assessment and care planning, including discussions around any issues arising – realistic expectations about discharge were discussed.
- While there were some delays for items such as stair lift to be fitted at home, patients indicated that housing needs were being addressed and they went home with appropriate care packages in place.

Based on these findings it can be concluded that the patient experience at Ladycross House has overall been very positive and many learnings can be drawn from the changes.

The CCG will take the learnings from this approach and implement actions for future roll-out across Derbyshire.

Sub Appendix One - Acute Care

I was in hospital for a month and didn't have any physiotherapy. I was admitted because the pain in my leg was too much so I went in there and then here again. Originally they said I would be going to Birch House, but them on the day of transfer they said I was coming here as it is nearer to my home, I live very near. I like it here but I would have liked to have tried somewhere else for a change. On the day of transfer I was supposed to move at 11.30am and by 10pm at night it hadn't happened so I came the next day.

The patient explained why she was in hospital and clearly understood that she was there for the right reasons and why she needed that help at that time. Although she was happy with the arrangements she was slightly concerned at the change in decision to take her to LC instead of Birch House and said there wasn't a lot of discussion about her discharge while in hospital, just confirmation she would go somewhere else to be assessed

When asked about the timing that discharge planning commenced in hospital, the patient felt it was about three weeks after admission, one week before her transfer, but she was unconcerned about that and felt involved.

I had a fall at home; I think it was the day after Boxing Day. I slipped in the shower and broke my ribs. It was really painful; I was in so much pain, I'm fine now. I think I was in hospital for about two weeks and then I came here about three weeks ago. I understood why I was in hospital, there's nowhere else you can go when you have an injury like that. I accepted it totally I was in such terrible pain.

I can't remember when the hospital people started talking about coming to this place, but I knew I couldn't go straight home. I couldn't walk a step while I was in hospital but now I can walk with a frame. I could go to the toilet without help but they won't let me yet.

I think I was in hospital for the right amount of time as I felt I was safe to leave as I had started to stand with my support which I couldn't do when I first went in. It's about safety.

The patient couldn't remember how soon discharge planning commenced in the acute hospital or which ward she was on due to her memory but she say she knew she was coming to Ladycross house and was told of a date.

They told me some things about coming here but not everything, but they were very good and always looked after me well there (Kings Mill). They didn't start making plans as soon as I went to KM, I didn't expect to have to stay in there. I do agree that hospital was the right place for me as I didn't stop bleeding.

I was in KM hospital for about three weeks overall. They started to talk to me about coming to Ladycross after a few weeks. They talked to me and my family about coming her and we have all been involved, it's been very good and it's been very good here. I live at Pinxton so I don't know whether this is the nearest home or not but it's been alright, I think there is somewhere at Shipley that would have been nearer for me.

Everything has been as expected I had a fall so I know I had to stay in hospital till I was well enough and I know that that is why I am here.

Sub Appendix Two - LCH

There is a home closer to my home but they were full so they arranged for me to come here. It's been lovely here and they are all very good.

I'm going home to my own house, I live alone, but I'm waiting for a stair lift to be put in. They say it will be about three weeks for that to be fitted, but I can home before that with a bed down stairs for a few weeks till it's all sorted out for me. My daughter will move in while it all gets sorted. I would be happier if the stair lift was already in but it will be sorted. I don't know the date I can go home though yet, I think it will be soon. My daughters coming in later today and will be discussing it with the staff here.

I feel confident to go home now, I definitely couldn't have gone home from hospital, I was too frightened and I couldn't walk. I'm not in pain any more. They have done brilliantly with me here, nothing could be better.

I can easily walk along the passage now. They have been brilliant with me here, they have done so much work, and I've done exercises every day. I couldn't walk when I got here and now I am going down the passage easily. I feel safe here, I couldn't have gone straight home and I'm not in pain any more.

I came to Ladycross House so they could assess me and decide when I could go home and what support and help I would need. I have a frame to stand and while in RDH I couldn't stand at all unassisted so it was important for me to get this help. In the past I have been in hospital a few times and have then gone to Ilkeston hospital for a time of rehabilitation and help. The last two times I have come here, which is fine, Ilkeston is nearer to my home, but I am happy here. I understand that there has been a change with Ilkeston hospital and there are less beds and that they are for different purposes than they used to be.

While in here I unfortunately suffered a fall in the night. It wasn't anyone's fault I buzzed for help and started to get out of bed but slipped on the floor. I didn't break anything but I was so shook up that I was shaking and couldn't get warm. I went back to RDH and then was discharged back to her again. I think I have been here about 2 weeks and I am now standing with my frame.

I am hopefully going home on Tuesday I just need another assessment. I want to go home but I won't push it, I want to be right when I go. My daughter will meet me on arrival home

Everything is good here but I value my independence at home.

It's been good here in that I can eat and move around when I want and go to bed when I want, there's no strict rules but it's not my own home.

I understand why I was I hospital and I understand why I am here. Following a fall I need to be safe and I need to be ok when I leave here. I have been made to feel very welcome here and I settled in quickly, but I have been before. I would prefer Ilkeston hospital as it's nearer for my family to visit, but I understand why I'm here.

The patient feels that the care and support she has had at Ladycross House has been right for her as it has helped her to get stable on her feet again and has enabled her enough independence

I'm not happy, it was wonderful here to start with but the second week they have been short staff and it shows. I have only had two showers in two weeks and I had to ask for those, you have to sit strapped in a box. Some staff are lovely and others are rude and abrupt.

I understand why I am here but I really would have liked to have been nearer to home, I live in South Normanton. They did talk to me at KM about coming here but I expected them to find somewhere nearer to home.

I have been doing exercises and I can go to the toilet alone now and can manage alone quite well, using my walking frame which is why I have been here. The only thing that really concerned me here is being able to shower more often.

The patient indicated that they feel the care and support they have had in Ladycross has been right for her because the exercises and help have meant she can go home alone.

Overall the patient feels she has improved here and agrees it was the right place for her, but would have liked to have been nearer to home

I think I am going home on Thursday and I will be having carers at home but I'm not sure yet how many or how frequently. I don't know exactly what they will be doing for me yet, but I know I need carers to help me. My husband is at home and we are making sure my support aids can go through the doorways; I think some extra work has been done.

When asked about the decision to come here the patient is very clear that she couldn't have gone home from hospital and needed the support of the home to recover due to a fall at home. She said she has had lots of exercises and therapy while here and she is able to do lots more.

I don't feel able to look after myself. The social worker will help me; she is coming to see me soon. I am worried about the finances and what I need to pay for as I will need extra help at home this time and I think I may have to pay for it.

I am happy here, everyone is really good and I feel safe. I have been made to feel welcome and this is the right place for me at the moment. I haven't got a date to go home yet but I wouldn't be well enough to go yet anyway

I was in hospital before Christmas for about four weeks, and then I came here on 24th December 2019. They said the medicines that I am on were making me sick and I have had lots of scans and things and they have had to keep altering my medicine, everything has come back clear but my leg is weeping. I am really angry as I was supposed to go home tonight. The nurse was supposed to come yesterday to my leg and she isn't coming till tomorrow so I can't go home will at least two more days. I am only here till my leg is dressed so I am really fed up.

This isn't the right place for me at all, I understand that it is right for some people, but it isn't a hospital and it isn't rehab, I don't know what they can do for me. I don't seem to be having any treatment here, everyone else is doing ok here but I'm just here because I'm older and they needed the hospital bed. I've never been anywhere like this before and it just doesn't suit me at all.

I had no idea I was coming here, they talked about me having some rehabilitation before going home and so I thought I would be going to a rehabilitation place, not a home. It was ok to start with here, but you can see how full it is and I don't like it, we are all watching the same tv and it's just too busy for me.

Lots of people come here and go home and then come back again. It's a long way from home for me (approx. 10 miles). I want to be in my own space this just isn't right for me, it's too full, you have to wait for everything including showers.

Sub Appendix Three - Patient Story (a carers experience)

My husband has spent the last 10 days at Florence Shipley and I feel I must contact you to express my appreciation for his care.

When a place at your centre was suggested to us we originally declined it never having heard of it or knowing anything at all about it and it being a distance away. Eventually we agreed to try it and are we glad we did.

He could not have been treated better by every single member of staff no matter what their role. They all seemed to care that they were doing their very best.

The building itself is like a hotel, very modern, spotless and with the most beautiful flower filled balconies.

The cafe served excellent food; in fact we had our lunch together there every day served by really attentive staff. I was able to take him out for walks in his wheelchair as and when we pleased and the staff fitted around us.

The therapists were amazing getting him back on his feet. We even got a home visit from Ula the day following his discharge.

I came to Heanor every day to spend the day with him and I was able to come home completely content and not worried about him which meant a great deal.

On his arrival he was “booked in” by xxx who asked him about his likes and dislikes and he asked if he liked to be woken with a cup of tea or did he prefer to wake up himself!!! The whole atmosphere contributed to his recovery.

I would appreciate you passing on my comments to all your staff members.
He had five star treatment and I thank you all very very much

Sub Appendix Four - Patient Story Template

Patient experience in the acute

Key areas to explore and understand through conversation (story) and ratings scales are:

- Your role in decision making, do you understand why you are there, do you agree with the decisions, if not why not
- Did you feel listened to
- Your involvement in planning your discharge to the "next place" or a place you call home.
- How involved were family
- What options were explored to get you to the place you call home, what other solutions were looked at (does the patient know what other options were considered and why they were ruled out)
- How soon after arrival on the ward was discharge discussed.
- Did it feel joined up and planned or scattered and random.
- Did you feel everyone was working together to get you to the place you call home
- Were you told what would happen next, did it happen, what didn't happen, were you told why it didn't happen?
- Length of time in the acute setting, how did that feel, was it t right for you
- Did you feel discharged from hospital at the right time, why was it right, why wasn't it right
- Did you feel you were discharged at a safe time for you
- When did the transfer happen (time of day or night), appropriate

The next place – where you went to after the acute

Key areas to explore and understand through conversation (story) and ratings scales are:

- Where did you think you were going to, has that happened, if not why not, have you understood why not, did the place you went to match up to what you expected, if not how is it different.
- Have your needs been met, if so how, if not what hasn't been met
- Family and carers involved to support rehabilitation and help you achieve what you want to achieve, working together to achieve this , family encouraged to be involved
- What happened on arrival and in the first days,
- How soon did the people caring for you start to plan for you to leave
- People focused and working together to get you to a place you call home (pathway 2)
- Planning to leave, family involvement in planning the next part of your care.
- Were you told what would happen next, did it happen, what didn't happen, were you told why it didn't happen?

- Length of time in the care facility (pathway 2 and 3), how did that feel, was it right for you
- Did you feel discharged from the care facility at the right time, why was it right, why wasn't it right (pathway 2 and 3)
- Did you feel you were discharged at a safe time for you
- When did the transfer happen (time of day or night), appropriate

Sub Appendix Five - Patient Questions

Gathering of key information on:

- time of admission
- length of stay
- time of discharge
- place of usual residence
- place at time of talking to patient/carer

Rating and value scales to accompany patient stories

For each question narrative will be explored on why they have answered that way and explore what didn't happen and why it didn't happen.

For each question there is a rating scale from strongly agree to strongly disagree

The acute hospital.

I understood why I was in hospital

I think hospital was the right place for me at that time

I feel everyone worked together to get me to a place I call home

I feel staff worked with me and my family to do what was best for me

I feel the decision for me to go home was right for me (pathway1)

I understand why the decision was made for me to go to another care facility after hospital (pathway 2)

I understand why the decision was made for me to go to have additional support in the place I call home (pathway 1)

I felt my wishes and views were taken into account when planning for me to leave hospital

Making plans for me to leave hospital started as soon as I was admitted to hospital *(when did this happen)*

While in hospital I was always told what would happen next and kept informed of plans (probe when this didn't happen)

I felt I left hospital too early *or* ;

I felt I was in hospital for the right length of time

I felt I was transferred from hospital at a safe time for me

I felt people listened to me when we discussed leaving hospital

I feel planning for me to leave hospital happened in a joined up and planned way

I feel planning for me to leave hospital was very uncoordinated and unplanned

The Next Place (home or care facility)

When I left hospital I transferred to the place I expected to go to

The place I came to after hospital is exactly what I thought it would be

I understand why the decision was made for me to go to *insert place name*

I feel the decision for me to go home was right for me (pathway1)

I think *insert name of place* was the right place for me at that time

While at *insert name of place* I feel everyone worked together to get me to a place I call home (pathway 2 and 3)

I feel staff worked with me and my family to do what was best for me

I feel the decision for me to spend some more time in a care facility was right for me

I feel my wishes and views were taken into account when planning for me to leave *insert name of place where pathway 2 or 3 care is delivered*

Making plans for me to leave *insert name of place* started as soon as I was transferred there.

I was always told what would happen next and kept informed of plans

When things haven't been exactly as I thought they would be people have explained why (ask them to provide examples of what hasn't gone as expected)

I feel my needs have been met here

My family/carers have been involved in helping me to get better

I feel I left *insert name of place* too early

I felt I was in *insert name of place* for the right length of time

I felt the package of care I received in my home was about right (pathway 1)

I felt I was transferred from *insert name of place* to the place I call home or a further care facility (if they move from pathway 2 to 3) at a safe time for me

I felt people listened to me when we discussed leaving *insert name of place*

NHS
Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

5th March 2020

Item No: 239

Report Title	Summary Finance and Savings Report 1st April 2019 – 31st January 2020
Author(s)	Richard Chapman, Chief Finance Officer Sandy Hogg, Executive Director of Turnaround
Sponsor (Director)	Richard Chapman, Chief Finance Officer Sandy Hogg, Executive Director of Turnaround

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

Recommendations

The Governing Body is recommended to:

- **NOTE** the year to date and forecast financial performance at month 10
- **NOTE** the month 10 savings position
- **NOTE** the level of risk to the outturn which is described within the report

Report Summary

At month 10 the CCG is reporting year to date and forecast positions that are in line with plan. The CCG remains on course to achieve its control total.

If the CCG's expenditure remains within plan it can receive up to £10.2m of further available Commissioner Sustainability Fund.

The month 10 savings information shows year to date delivery of £40.7m (against a phased plan of £54.8m) and a forecast savings delivery of £48.3m against the full year plan of £69.5m.

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 identified
Governing Body Assurance Framework
This paper supports the strategic objective of supporting the development of a sustainable health and care economy that operates within available resources, achieves statutory financial duties and meets NHS Constitutional standards.
Identification of Key Risks
Financial risks are identified in Section 5 of the report.

Governing Body – 5th March 2020

Summary Finance and Savings Report 1st April 2019 – 31st January 2020

Finance Summary

1. Introduction

The purpose of this report is to inform Governing Body members of the financial performance of NHS Derby and Derbyshire CCG, including delivery of the savings plan for the ten month period ending 31st January 2020. The detailed Finance and Savings Delivery reports will be presented to the Finance Committee on 27th February 2020. This report summarises the key messages from those reports.

The information in this report is based on the month 10 information provided to NHS England through the monthly Non-ISFE submission and to the Finance Committee via the Finance Report.

2. Financial Performance Summary

At month 10 the CCG is reporting a year to date and forecast position in line with its control total and financial plan.

Table 1 – Summary of performance against key CCG financial duties

Statutory Duty/ Performance	Target	Result	Achieved
Hold a 0.5% risk reserve (inc. PCCC)	£8.112m	£8.112m	✓
YTD achievement of control total in-year deficit (original plan)	(£5.317m)	(£5.215m)	✓
Forecast achievement of control total in-year deficit (original plan adjusted for CSF)	(£10.150m)	(£10.150m)	✓
Forecast delivery of the Savings Target	£69.500m	£48.299m	✗
Forecast - remain within the Running Cost Allowance	£22.457m	£18.060m	✓
Underlying Position	(£46.400m)	(£55.596m)	✗
Remain within cash limit	Greatest of 1.25% of Drawdown or £0.25m	0.18%	✓
Achieve BPPC (Better Payment Practice Code)	>95% across 8 areas	Pass 8/8	✓

3. Financial Position and Key Variances

Table 2 – Summary Operating Cost Statement

	YTD				Full Year and FOT			
	YTD Budget	YTD Actual	YTD Variance	YTD Variance as a % of YTD Budget	Annual Budget	Forecast Outturn	Forecast Variance	FOT Variance as a % of Annual Budget
	£'000's	£'000's	£'000's	%	£'000's	£'000's	£'000's	%
Acute Services	670,699	686,836	(16,137)	(2.41)	799,371	825,920	(26,549)	(3.32)
Mental Health Services	153,163	155,837	(2,674)	(1.75)	183,893	187,037	(3,144)	(1.71)
Community Health Services	117,930	116,350	1,580	1.34	141,496	139,692	1,804	1.27
Continuing Health Care	85,113	79,637	5,475	6.43	100,929	94,574	6,355	6.30
Primary Care Services	163,757	167,544	(3,787)	(2.31)	195,603	201,404	(5,801)	(2.97)
Primary Care Co-Commissioning	116,596	113,095	3,501	3.00	140,665	136,381	4,284	3.05
Other Programme Services	63,428	53,514	9,915	15.63	78,921	65,220	13,701	17.36
Total Programme Resources	**1,370,687**	**1,372,814**	**(2,126)**	**(0.16)**	**1,640,878**	**1,650,228**	**(9,350)**	**(0.57)**
Running Costs	15,994	14,966	1,028	6.43	19,598	18,060	1,538	7.85
In-Year Allocations	0	0	0		5,756	2,081	3,675	63.85
0.5% Contingency (excl co-comm)	1,200	0	1,200		7,409	3,272	4,137	55.83
In year Planned Deficit (Control Total)	(24,167)	0	(24,167)	100.00	(29,000)	0	(29,000)	100.00
CSF Received	18,850	0	18,850		18,850	0	18,850	
Total In-Year Resources	**1,382,565**	**1,387,780**	**(5,215)**	**(0.38)**	**1,663,491**	**1,673,641**	**(10,150)**	**(0.61)**

- The year to date and forecast overspend positions of £5.215m and £10.150m respectively are in line with the CSF adjusted control total.

- The year to date position includes savings under delivery of £14.151m and the forecast position includes savings under delivery of £21.201m.

- £4.840m of the CCG's £8.1m mandated contingencies have been used in the forecast position, with £1.2m used in the year to date position.

- If the CCG's overall position remains within plan it will receive up to a further £10.150m of Commissioner Sustainability Funding (CSF). £8.7m relating to quarter 3 was received in month 10.

- Any underspends or spare budget will not be re-committed without the approval of the Chief Finance Officer.

Within the reported financial position the key highlights are as follows:

Acute Services

- University Hospitals of Derby and Burton – The year to date position is an overspend of £3.336m and the forecast is an overspend of £4.183m. The forecast position is based on the agreed year end settlement value of £404.150m, a cost of £0.188m for a high cost paediatric patient outside contract and a credit of £0.888m for the agreed challenges raised in 2018-19.

- Chesterfield Royal Hospital has a year to date underspend of £1.588m. The month 9 activity data shows an underspend of £0.636m, with an improvement seen in month on planned care. A benefit of £0.914m from finalising the 2018-19 position has been

recognised. The forecast is an underspend of £0.829m which includes the prior year credit and a further anticipated credit relating to 2018-19 CQUIN failure and frailty activity.

- Sheffield Teaching Hospitals has a year to date overspend of £1.447m, with £1.183m relating to current year activity. There has been an adverse movement in month of £0.089m, mainly relating to elective activity. A cost of £0.264m following finalisation of previous year balances has been included in both the year to date and forecast positions. The forecast outturn is an overspend of £1.670m, and assumes that the overspend seen to date will continue at current levels with the exception of critical care which is expected to remain at planned levels for the remainder of the year.

Mental Health Services

- The mental health position shows a year to date overspend of £2.674m and forecast overspend of £3.144m. The main overspends relate to high cost patients and Section 117 cases due to caseload. These overspends are partially offset by a £2.1m forecast underspend against the investment budget held for the Mental Health Investment Standard (MHIS).

Community Services

- There is a year to date underspend of £1.580m and a forecast underspend of £1.804m. The position includes a year to date underspend of £1.758m and forecast underspend of £2.110m for Derbyshire Community Health Services FT (DCHS) reflecting the year-end settlement that has been reached. This underspend is partially offset by overspends for non-NHS providers, mainly relating to ophthalmology.

Continuing Healthcare

- The year to date variance is an underspend of £5.475m, with the majority of this relating to prior year benefits. A revised forecast from the Local Authority for the CCG's share of joint funded packages has been received in month and this has been reflected in the year to date and forecast positions. There is a forecast annual underspend of £6.355m, reflecting underspends relating to prior year benefits and 2019-20 activity forecasts based on confirmed current caseload, partly offset by pressures on children's packages and savings schemes that have not commenced as planned.

Primary Care

- The year to date variance is an overspend of £3.787m and the forecast position is an overspend of £5.801m. The prescribing budget shows a forecast overspend position of £6.037m, mainly due to cost pressures on Category M drugs along with cost and volume variances. An overspend of £2.380m is also forecast for primary care savings. These overspends are expected to be partly offset by underspends across other primary care areas.

Primary Care Co-Commissioning

- There is a year to date underspend of £3.501m and a forecast underspend of £4.284m. The majority of the underspends relate to prior year benefits, mainly for rent reviews. The position also includes an expected underspend for demographic growth on contracts and small underspends across a number of other areas.

Running Costs

- The running cost budget of £18.624m was set well below the running cost allocation of £22.457m. The streamline budget reflects savings and efficiencies. It also prepares the CCG for mandated Running Cost reductions in 2020-21. The latest forecast is an underspend of £1.538m, mainly relating to vacancy slippage and prior year benefits for premises.

4. Underlying Position

The CCG's underlying (UDL) position compares the recurrent funds available against the recurrent expenditure baseline. The difference between the two will result in either an underlying surplus or deficit for the CCG. This is an indicator of the underlying financial health of the organisation. The CCG's underlying position is directly affected by the delivery of recurrent savings and underspends against budget (improvement in position) or non-delivery of recurrent savings and overspends against budgets (deterioration).

Table 3 – Underlying Position Summary

	£'m
Control Total	(29.0)
Non-Recurrent Savings	(10.3)
Other Non-Recurrent Transactions	(16.3)
Forecast 2019/20 Exit Underlying Position	**(55.6)**
UDL as a Percentage of Recurrent Allocation	(3.4%)

These figures exclude the full year effect of savings.

5. Risks and Mitigations

The CCG is reporting a fully mitigated risk position. Identified activity/financial risks totalling £3.3m are mitigated by the remaining element of the 0.5% contingency.

Table 4 - Risks & Mitigations

	£'m
Risks	
Activity Risk	1.6
Acute Services	1.1
Continuing Care Services	0.3
Other Programme Services	0.1
Running Costs	0.2
Total Risks	**3.3**
Mitigations	
0.5% Contingency Held	3.3
Total Mitigations	**3.3**
Net (Risk) / Mitigation	**0.0**

6. Savings Programme Year to Date and Forecast Outturn Position at Month 9

- As at 31st January 2020 the CCG has delivered cash-releasing savings of £40.7m against a year to date target of £54.8m, an underperformance of £14.1 (26%).

- Based on the current forecast outturn at year-end, the CCG will deliver £48.3 million of savings against a target of £69.5million, an underperformance of £21.2 million. This is an improvement of £1.2m since Month 9. This position reflects the fact that the phasing of the CCG Efficiency programme included delivery of 65% of the financial benefit in the last two quarters of the year.

Table 5 compares the savings programme from Month 10 to Month 9, noting that the forecast outturn position has improved from Month 9 by £1.2m.

Table 5 – Summary of Savings Programme Results Month 10 and Month 9 on Annual Savings Target of £69.5 million

	YTD Plan £'m	YTD Actual £'m	YTD Variance £'m	Forecast Outturn £'m	Risk Inside FO £'m	Risk outside FO £'m	Total Risk £'m	CTAP Adjustment included in Forecast Outturn £'m
Month 8	39.8	32.3	(7.5)	48.1	21.4	0	21.4	2.2
Month 9	47.3	36.8	(10.5)	47.1	22.4	0	22.4	2.5
Month 10	54.8	40.7	(14.1)	48.3	21.2	0	21.2	2.5
Variance	7.5	3.9	(3.6)	(1.2)	1.2	0	1.2	0.0

At Month 10 the total risk assessment has decreased overall by £1.2m to £21.2m. This is shown as risk inside the forecast outturn position with no risk reported outside of forecast related to individual schemes. Table 6 summarises the risk reported to NHS England.

Table 6 – Summary of Savings Programme Risk Assessment

Total Savings Risk Reporting to NHS England	M3 £'m	M4 £'m	M5 £'m	M6 £'m	M7 £'m	M8 £'m	M9 £'m	M10 £m	Diff M9 – M10 £m
Risk included in FOT	Zero	2.2	9.4	13.7	20.3	21.4	22.4	**21.2**	**1.2**
Risk not included in FOT	10.6	10.6	3.3	3.9	0.0	0.0	0.0	**0.0**	**0.0**
Total Savings Risk	**10.6**	**12.8**	**12.8**	**17.6**	**20.3**	**21.4**	**22.4**	**21.2**	**1.2**

The current profile of risk relating to under-performing schemes is £29.8 million of the confirmed programme with an additional £1.6 million of governed closed schemes totalling £31.4 million. This is an increase of £0.1 million from the Month 9 position.

The current profile relating to over-performing schemes is £7.7m with an addition £2.5m CTAP schemes totalling £10.2m. This is an increase in performance of £1.3m from the Month 9 position.

Table 7 below summarises the programme performance from Month 8 through to Month 10, an improvement of £1.2m from Month 9.

Table 7 – Movement in Savings Delivery

	FOT -v- Variance M8 £000s	FOT -v- Variance M9 £000s	FOT -v- Variance M10 £000s	Difference FOT M9 to M10 £000s
Sub Total Negative Variances	-28,674	-29,695	-29,790	-95
Closed Schemes	-1,607	-1,607	-1,607	0
Total Negative Variance Schemes	-30,281	-31,302	-31,397	-95
Sub Total Positive Variances	6,663	6,360	7,670	1,310
Sub Total Positive Variance CTAP Mitigations	2241	2490	2509	19
Total Positive Variance Schemes	8,904	8,850	10,179	1,329
TOTAL OVERALL PERFORMANCE	**-21,377**	**-22,452**	**-21,218**	**1,234**

7. Summary and Recommendations

At month 10 the year to date and forecast positions are in line with plan.

£4.8m of the CCG's £8.1m mandated contingencies have been used in the forecast position, with £1.2m in the year to date position.

Any overspend or under delivery of savings at this point in the year will be supported by robust mitigation plans or alternative savings. These will be reported through the FRG and Finance Committee.

Risks of £3.3m are being mitigated by unused contingencies, whilst recovery actions are also continuing to be pursued.

The month 10 savings information shows year to date delivery of £40.7m (against a phased plan of £54.8m) and a forecast savings delivery of £48.3m against a planned total of £69.5m.

The Governing Body is recommended to:

- Note the year to date and forecast position as at month 10 (as shown in Table 2)
- Note the month 10 savings delivery of £40.7m and forecast of £48.3m described in section 6 - table 5
- Note the month 10 level of risk as shown in table 4

Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

5th March 2020

Item No: 240

Report Title	2020/21 Financial Outlook and Efficiency Savings
Author	Sandy Hogg
Sponsor (Director)	Sandy Hogg, Executive Director of Turnaround and Richard Chapman, Chief Finance Officer

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

Recommendations

The Governing Body is recommended to:

1. **CONSIDER** the financial outlook for 2020/21 in the context of our Medium Term Financial Plan, agreed with NHS England in February 2019.
2. **NOTE** that during March the Executive Team will finalise the proposed CCG's financial and savings plan for 2020/21 and triangulate this with the 2020/21 System Improvement Plan and Regulators.
3. **NOTE** that the final 2020/21 CCG and System Efficiency Plans will be presented to the Governing Body on 26th March 2020, for approval, ahead of the new financial year; the CCG's Finance Committee will assure the proposed plan on behalf of the Governing Body.

Report

This report updates the Governing Body on work to prepare a Financial and Savings Plan for NHS Derby and Derbyshire CCG ahead of the new financial year, 2020/21, which commences on 1st April, 2020. This is in the context of the CCG's agreed Medium Term Financial Plan, and work with System Partners through Joined up Care Derbyshire to develop the Year 1 Plan of the five year STP Strategic Plan.

NHS Derby and Derbyshire CCG Medium Term Financial Plan

NHS Derby and Derbyshire CCG agreed a **Medium Term Financial Plan** with NHS England in February 2019, in acknowledgement that we have a large in-year and cumulative deficit, that will take time to safely reduce; we are recurrently spending, year on year, more than the resources we receive. The Medium Term Financial Plan is the document that sets out how the CCG will operate within the national, financial business rules for CCGs; it sets out our financial recovery programme and primarily the delivery of a 1% in-year surplus and a 1% cumulative surplus over time.

The Medium Term Financial Plan set out how NHS Derby and Derbyshire CCG will move from a £61m underlying deficit in 2018/19 to an underlying surplus position in 2022/23. The CCG planned to return to delivering an in-year break-even position without national Commissioner Sustainability Funds in 2020/21.

Table 1 Summary of Medium Term Financial Plan agreed in February 2019 *(£ millions)*

Key figures	***17/18****	***18/19****	**19/20**	**20/21**	**21/22**	**22/23**
In-year position before CSF & QIPP	*(80.0)*	*(95.0)*	(98.5)	(76.5)	(50.4)	(34.1)
CSF	*0.0*	*39.0*	29.0	-	-	-
Cumulative surplus drawn down	*-*	*5.0*	-	-	-	-
QIPP	*38.0*	*51.0*	69.5	76.5	66.4	56.1
In-year surplus / (deficit)	*(42.0)*	*0.0*	0.0	0.0	16.0	22.0
Underlying surplus / (deficit)	*(45.0)*	*(61.0)*	(41.3)	(15.3)	2.8	10.8
QIPP %	*2.2%*	*3.3%*	4.5%	5.0%	4.3%	3.6%
Cumulative surplus / (deficit)	*(17)*	*(22)*	(22)	(22)	(6)	16

QIPP = Quality Innovation Productivity and Prevention = Savings

NHS Derby and Derbyshire CCG Resources – January 2019 Settlement

In January 2019 the NHS received a five year settlement; resources for NHS Derby and Derbyshire are summarised in Table 2.

- ❑ NHS Derby and Derbyshire will have resources of circa £1.6 billion throughout the period of financial recovery.
- ❑ The CCG received average growth in the national settlement - overall 5.73% in 2019/20 (5.43% core and 6.04% Primary Care) and between 3.36% and 3.92% overall growth in following four years.
- ❑ Of the 2019/20 allocation settlement a significant level related to "Pass Through" funding – money that our Providers previously received through other sources and now receives directly from the CCG. The CCG allocation also includes funding for Provider Tariff uplifts and other technical changes. The CCG's net real term growth in 2019/20 was therefore 0.16%, which taken together with the scale of our underlying deficit means that 2019/20 remained a very challenging year for the CCG.

Table 2 Allocations for NHS Derby and Derbyshire from 2019/20 to 2023/24

	Core allocation including other funding after pace of change (£'000)	Allocation Uplift %	Distance from Target	Primary Care (Medical) Allocations (£'000)	Allocation Uplift %	Distance from Target	Core + Primary Care Allocation Uplift %	Running Cost Allocations (£'000)	Total Allocation (£'000)
2018/19 Baseline	1,377,119	2.63%	3.18%	136,564	1.84%	1.13%	-	22,438	**1,536,121**
2019/20	1,455,566	5.43%	2.76%	144,807	6.04%	0.79%	5.73%	22,457	**1,622,830**
2020/21	1,512,418	3.91%	2.34%	150,679	4.06%	0.53%	3.92%	19,824	**1,682,921**
2021/22	1,569,601	3.79%	1.92%	158,297	5.06%	0.29%	3.90%	19,824	**1,747,722**
2022/23	1,625,441	3.56%	1.48%	164,467	3.90%	0.17%	3.59%	19,824	**1,809,732**
2023/24	1,678,995	3.30%	0.99%	171,038	4.00%	0.14%	3.36%	19,824	**1,869,857**

2019/20 Financial Plan

Based on the Medium Term Financial Plan, in 2019/20 the CCG had a planned deficit of £29 million; to deliver this level of planned deficit, and not exceed it, we planned to deliver £69.5 million of savings. The CCG will receive £29 million of national commissioner sustainability funding to offset this deficit, and report an in-year break-even position in our annual accounts, which avoids a further build-up of our cumulative deficit.

We planned for a £41.3 million underlying deficit at the end of 2019/20 in the Medium Term Financial Plan agreed in February 2019; through the monthly finance report the Governing Body has been advised that this has increased to £55.6 million, an adverse movement of £14.3 million, as a result of lower than planned recurrent savings, and non-recurrent management of recurrent cost pressures during 2019/20.

2020/21 Financial Outlook

In **2020/21** the CCG will have resources of £1.68 billion; based on planning assumptions we will spend £83 million more than this in 2020/21. The CCG has agreed with NHS England/Improvement that we can have a planned deficit of £11.2 million in 2020/21 as part of our financial recovery programme; we will need to deliver £71.8 million (4.5%) of savings to deliver this planned deficit.

Through the CCG's Medium Term Financial Plan the forecast savings requirement for 2020/21 was £76.5 million; the latest assessment is £71.8 million; although our underlying deficit increased during 2019/20, this adverse movement has been offset by agreement of a planned deficit (rather than breakeven for 20/21) and some other marginal changes to the baseline assumptions in our Medium Term Financial Plan.

The CCG is developing plans to ensure we can deliver our financial duties as a Sovereign Organisation and as part of this not exceed the £11.2 million planned deficit agreed with NHS England/Improvement.

Savings Strategy

The Strategic Commissioner's Savings Programme to support financial recovery will be a balance of **Transformationa**l and **Transactional** initiatives supporting delivery of the CCG's objectives of *Better Health, Better Care, and Better Value* and the Joined up Derbyshire quadruple aim to:

1. Improving experience of care (quality & satisfaction)
2. Improving the health of the population
3. Improving staff experience
4. Reducing the per capita cost of healthcare.

As Strategic Commissioners of healthcare we will ensure that there is enough money to maintain the essential health care services for our local population, and balance short and long-term requirements through:

- ❑ Optimising **Value for Money -** continue to review all services to optimise value for money, reduce duplication and waste and free up resources to respond to a level of population growth and increasing demand
- ❑ Maximising **Efficiencies** – reduce waste, time and effort
- ❑ Reducing **Unwarranted** clinical variation
- ❑ Developing a **New Care Model** – developing new ways of working with health, social care and the voluntary sector through Joined Up Derbyshire
- ❑ **Prioritisation** of NHS resource allocation, based on clinical and cost effectiveness – focusing on those which are the most effective

Our Savings Programmes will be aligned with the **NHS Long Term Plan**; we will improve the outcomes for our local population in most cases, whilst improving value for money on the Derbyshire pound, and overall efficiency.

Governing Body members are aware that we are trying to co-design a **System Improvement Plan** for the first time in Derbyshire – so instead of each NHS Organisation developing their own savings plan we are doing this together, so that we understand interdependencies and maximise the benefits that arise from partnership working, particularly in relation to transforming our clinical services. It is estimated that the **five NHS Organisations will spend £181 million more than available resources in 2020/21** without mitigating action; which includes the CCG's £71.8 million.

As part of this approach regular workshops are taking place with partners across the System to co-design the plan and agree our approach to delivery. The **System Savings Group** is meeting two-weekly to develop the plan, chaired by Dr Chris Clayton on behalf of System Chief Executives, working closely with **System Delivery Boards**, who are responsible for planning and delivering elements of the plan. The **Clinical and Professional Reference Group** is providing clinical oversight to the development of the plans, to ensure that we are focusing on the right strategic areas of transformation and safely change the ways our services are delivered. The **System Quality Comm**ittee is providing oversight of the quality impact assessments, again to ensure that all transformation proposals are risk assessed, and mitigated.

The **Joined up Derbyshire Partnership Board** on 20th February agreed that the System Improvement Plan should include four key domains:

i. **Organisational Savings Plans**
ii. **System Clinical Transformation Schemes**; a combination of transformation schemes that we have been trying to mobilise in 2019/20 and new areas of clinical transformation, including **four strategic themes**; **CVD, Respiratory and MSK, and a focus on reducing Non Elective Admissions** as one of the largest, and increasing, cost-drivers in our Health System.
iii. **System Financial Measures**; this will include consideration of how the allocation growth in 2020/21 is used to reduce the overall efficiency challenge, investment criteria, and our control environment.
iv. **System Clinical Prioritisation Framework** – system partners have agreed that (1) to (3) will not be sufficient to close the gap in 2020/21 and we will need to make some difficult decisions as a system.

The Joined Up Derbyshire Partnership Board also agreed that a key priority is the development of a robust System Demand and Capacity model for 2020/21, which will support the agreement of an affordable level of capacity in our Health System.

Working with our Partners to deliver our Financial Recovery Plan

NHS Derby and Derbyshire CCG will continue to work with the Health and Care System through the Joined Up Care Derbyshire (JUCD) partnership.

The CCG will work closely with our local Heath and Well Being Boards and Scrutiny Committees throughout the period of financial recovery, and continue to engage proactively with the public, patients and our stakeholders.

Summary
The CCG Executive Team will bring the 2020/21 Financial and Savings Plan for approval, to an extraordinary meeting of the Governing Body on 26th March 2020; the CCG's Finance Committee will assure the plans prior to submission.

Are there any Resource Implications?

NHS Derby and Derbyshire CCG have a planned deficit of £11.2 million in 2020/21 and must develop a financial and savings plan to deliver this control total. Derby and Derbyshire CCG has a savings requirement of £71.8 million in 2020/21; the target will be finalised as we finalise the CCG's Financial Plan for 2020/21, and agree contracts with our Providers for the delivery of Healthcare.

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?

All individual transformation and decommissioning schemes will have a QIA

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

All individual transformation and decommissioning schemes will have a EIA

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

The CCG and JUCD have developed an engagement strategy in relation to our clinical transformation schemes

Have any Conflicts of Interest been identified/ actions taken?

No conflicts identified

Governing Body Assurance Framework
This paper supports delivery of Governing Body Assurance Framework 6A and 6B – delivery of a sustainable financial position in the CCG and the wider System.
Identification of Key Risks
The key risks in delivering the CCG's planned deficit of £11.2 million in 2020/21 are the establishment and delivery of robust savings plans, and continued system partnership working to deliver these plans.

NHS
Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

5th March 2020

Item No: 242

Report Title	Quality and Performance Report Month 9
Author(s)	Jackie Carlile, Head of CCG Performance and Assurance Alison Cargill, Assistant Director of Quality - Acute
Sponsor (Director)	Brigid Stacey, Chief Nursing Officer Zara Jones, Executive Director of Commissioning Operations

Paper for:	**Decision**	X	**Assurance**	X	**Discussion**		**Information**	
Assurance Report Signed off by Chair				Dr Buk Dhadda, Chair				
Which committee has the subject matter been through?				Quality & Performance Committee				

Recommendations

The Governing Body is asked to **NOTE** the key performance and quality highlights and the actions taken to mitigate the risks.

In addition, the Governing Body is asked to **FORMALLY RATIFY** the Continuing Healthcare Policy.

Report Summary

The exception reports contained in the report show performance for our two main acute providers.

Key Messages

Performance:

Urgent & Emergency Care

- A&E standard was not met at a Derbyshire level (79.7%, Year to Date (YTD) 82.1%), with both main providers failing to achieve the 95% target in December 2019. Chesterfield Royal Hospital NHS Foundation Trust (CRHFT) achieved 80.0% (85.3%) which is a decrease from the December performance. University Hospitals of Derby & Burton NHS Foundation Trust (UHDB) performance was 79.6% (YTD 80.9%) an increase from the December performance. None of our associate providers achieved the standard during January with both East Cheshire and Stockport both under 70%.
- There were a total of 14 x 12 hour breaches for Derbyshire in January. All breaches took place at UHDB with 2 as a result of unavailability of appropriate mental health beds and 12 due to the unavailability of appropriate medical/surgical beds within UHDB.
- East Midlands Ambulance Service NHS Trust (EMAS) is non-compliant in 4 out of 6 national standards for Derbyshire during January.

Planned Care

- 18 Week Referral to Treatment (RTT) for incomplete pathways continues to be non-compliant at a CCG level at 79.7%.
- CRHFT performance was 88.4%, slightly lower than the previous month and UHDB performance is showing at 85.9%.
- Derby and Derbyshire CCG, and both acute providers, had no patients waiting over 52 weeks at the end of December – the fourth time since the merger of the CCGs. Un-validated data is showing that there were no 52 weeks at the end of January.
- Diagnostics – the CCG performance was 3.58%, with both of our main providers not achieving this standard during December – CRHFT 3.15% and UHDB 2.73%.

Cancer

- 5 of the 8 standards were non-compliant at Derbyshire level in December 2019.
- All Cancer Two Week Waits were met at Derbyshire level (95.3%).
- Breast symptomatic was non-compliant at 92.3%.
- 31 days diagnosis to treatment was compliant at 96.5%.
- 31 days subsequent surgery was non-compliant at 90.4%.
- 31 days subsequent radiotherapy was non-compliant at 87.0%.
- 62 day – Urgent GP Referral performance continues to be non-compliant at Derbyshire level (78.8%). Sherwood Forest were the only trust compliant.
- 62 day – Screening was non-compliant at 83.3%. None of our providers were compliant.
- The number of patients waiting over 104 days for treatment during December at our main providers was 3 at CRHFT and 4.5 at UHDB.

Quality

CRHFT

- 12 Hour trolley breaches: 17 breaches were reported in December 2019. They were due to bed capacity issues when the Trust where operating at OPEL 4.
- Care Quality Commission (CQC) Inspection: The Trust received an unannounced CQC Visit starting on the 4th February for three days. Verbal feedback was generally positive, with no reported areas of major concern.

UHDB

- Mixed Sex Accommodation (MSA) breaches: During December 2019 there were a total of 17 MSA breaches across 5 sites. 11 breaches occurred on the Derby sites and 6 occurred on the Burton site. The breaches were as a result of bed pressures and lack of capacity to transfer patients from specialist or high dependency areas.
- 12 hour trolley breaches: A total of 39 breaches were reported in December 2019, 5 at Royal Derby Hospital and 34 at Queens Hospital Burton. They were due to bed capacity issues when the Trust where operating at OPEL 4.

Derbyshire Community Health Services NHS Foundation Trust

- Appraisals: The Trust are below target for their appraisals, however some improvement from the November 2019 position. Compliance continues to be monitored via the Contractual monitoring meetings.
- The Delayed Transfer of Care (DTOC): The December 2019 figure was 1.6 % for in-patient and Older Peoples Mental Health combined. This is below the NHS England & Improvement Target of 3.5% and a reduction on the November 2019 figure of 5.9%. All agreed actions are ongoing and monitored through contractual routes.

Derbyshire Healthcare NHS Foundation Trust (DHcFT)

- Bed occupancy: The current average is 99% with Length of Stay exceeding the top quartile benchmark. This reflects the wider operational issues and capacity of the wider health and social care systems to support discharges.
- Out of area placements: 14 out of area placements were reported during December 2019. A dedicated Area Service Manager is now in post to manage the out of area team with targeted focus on admission and discharge processes.

EMAS

- National Standards: During November 2019, EMAS, as a region and at county level achieved one of the six national standards which was C1 90th centile. Contract performance notice remains in place for failure to deliver quarter 2 performance requirements.

Organisation Effectiveness & Improvement Programme Board (OEIPB) Update

Assurance Opinion from the Workstream Lead(s)

We are assured that there are appropriate plans and monitoring in place to ensure that the actions identified in the programme plan as reported to the OEIPB are on track.

Update following Quality and Performance Committee

The Committee noted that the CRHFT waiting list position will be achieved and there are no 52 week waits. At UHDB it is recognised that increased elective capacity has been secured and work is ongoing to hit the revised trajectory however there are risks attached. The CCG are assured that there will be no 52 week waits this year. The Committee will continue to review this on a monthly basis.

Continuing Healthcare (CHC) Policy – the Committee approved the CHC policy noting the high risk QIA; however due to the robustness of the governance around this policy and the fact that this has also been approved at Clinical & Lay Commissioning Committee; the Committee agreed to recommend to Governing Body to ratify the policy.

The Committee received a summary report on DHCFT and the Committee have asked for a deep dive into the performance outcomes and pathways.

Are there any Resource Implications (including Financial, Staffing etc)?
No
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?
N/A
Has a Quality Impact Assessment (QIA) been completed? What were the findings?
N/A
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
N/A
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
N/A
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
N/A
Have any Conflicts of Interest been identified/ actions taken?
None
Governing Body Assurance Framework
Quality and Performance address the first three risks, which are monitored by the Quality and Performance Committee.
Identification of Key Risks
Within the Nursing and Quality Directorate Risk Register

NHS
Derby and Derbyshire
Clinical Commissioning Group

Month 9
Quality & Performance Report
2019/20

27th February 2020

Contents Page

EXECUTIVE SUMMARY

Key Messages	• 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	• A&E standard was not met at a Derbyshire level (79.7%, YTD 82.1%), with both main providers failing to achieve the 95% target in December 2019. CRH achieved 80.0% (85.3%) which is a decrease from the December performance. UHDB performance was 79.6% (YTD 80.9%) an increase from the December performance. None of our associate providers achieved the standard during January with both East Cheshire and Stockport both under 70%. • There were a total of 14 x 12 hour breaches for Derbyshire in January. All breaches took place at UHDB with 2 as a result of unavailability of appropriate mental health beds and 12 due to the unavailability of appropriate medical/surgical beds within UHDB. • EMAS is non-compliant in 4 out of 6 national standards for Derbyshire during January.
Planned Care	• 18 Week Referral to Treatment (RTT) for incomplete pathways continues to be non-compliant at a CCG level at 79.7%. • CRHFT performance was 88.4%, slightly lower than the previous month and UHDB performance is showing at 85.9%. • Derbyshire CCG and both acute providers had no patients waiting over 52 weeks at the end of December – the fourth time since the merger of the CCGs. Un-validated data is showing that there were no 52 weeks at the end of January. • Diagnostics – The CCG performance was 3.58%, with both of our main providers not achieving this standard during December – CRH 3.15% and UHDB 2.73%.
Cancer	• 5 of the 8 standards were non-compliant at Derbyshire level in December 2019. • All Cancer Two Week Waits were met at Derbyshire level (95.3%). • Breast symptomatic was non-compliant at 92.3%. • 31 days diagnosis to treatment was compliant at 96.5%. • 31 days subsequent surgery was non-compliant at 90.4%. • 31 days subsequent radiotherapy was non-compliant at 87.0%. • 62 day - Urgent GP Referral performance continues to be non-compliant at Derbyshire level (78.8%). Sherwood Forest were the only trust compliant. • 62 day – Screening was non compliant at 83.3%. None of our providers were compliant. • The number of patients waiting over 104 days for treatment during December at our main providers was 3 at CRH and 4.5 at UHDB.

EXECUTIVE SUMMARY

Trust	Key Issues - Quality
Chesterfield Royal Hospital FT	12 Hour trolley breaches: 17 breaches were reported in December 2019. They were due to bed capacity issues when the Trust where operating at OPEL 4. CQC Inspection: The Trust received an unannounced CQC Visit starting on the 4th February for three days. Verbal feedback was generally positive, with no reported areas of major concern.
University Hospitals of Derby and Burton NHS FT	MSA breaches: During December 2019 there were a total of 17 MSA breaches across 5 sites. 11 breaches occurred on the Derby sites and 6 occurred on the Burton site. The breaches were as a result of bed pressures and lack of capacity to transfer patients from specialist or high dependency areas. 12 hour trolley breaches: A total of 39 breaches were reported in December 2019, 5 at Royal Derby Hospital and 34 at Queens Hospital Burton. They were due to bed capacity issues when the Trust where operating at OPEL 4.
Derbyshire Community Health Services FT	Appraisals: The Trust are below target for their appraisals, however some improvement from the November 2019 position. Compliance continues to be monitored via the Contractual monitoring meetings. The Delayed Transfer of Care (DTOC): The December 2019 figure was 1.6 % for in-patient and OPMH combined. This is below the NHSEI Target of 3.5% and a reduction on the November 2019 figure of 5.9%. All agreed actions are ongoing and monitored through contractual routes.
Derbyshire Healthcare Foundation Trust	Bed occupancy: The current average is 99% with LOS exceeding the top quartile benchmark. This reflects the wider operational issues and capacity of the wider health and social care systems to support discharges. Out of area placements: 14 out of area placements were reported during December 2019. A dedicated Area Service Manager is now in post to manage the out of area team with targeted focus on admission and discharge processes.
East Midlands Ambulance Trust	National Standards: During November 2019, EMAS, as a region and at county level achieved one of the six national standards which was C1 90th centile. Contract performance notice remains in place for failure to deliver quarter 2 performance requirements.

QUALITY & PERFORMANCE DEEP DIVE SCHEDULE

subject to change		
Month	Area	Lead
Sep-19	Patient Experience	Sarah Macgillvery
Oct-19	Mental Health	Phil Sugden
Nov-19	Medicines Safety	Steve Hulme
Dec-19	End of Life	Steph Austin
Jan-20	RTT- Elective Waiting List	Craig Cook
Feb-20	Maternity	Ali Cargill
Mar-20	CHC	Nicola MacPhail
Apr-20	Care Homes	Steph Austin
Jun-20	Patient Safety	Lisa Falconer
July-20	HCAI	Sally Bestwick
August-20	Childrens	Mick Burrows

PERFORMANCE OVERVIEW MONTH 10 (19/20) – URGENT CARE

NHS Derby & Derbyshire CCG Assurance Dashboard

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

EMAS Dashboard for Ambulance Performance Indicators

	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 2019/20				NHS England		
					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	Ambulance System Indicators	Ambulance - Category 1 - Average Response Time	00:07:00	Jan-20	↓	00:07:29	00:07:28	30	00:07:31	00:07:38	18	00:07:25	00:07:32	00:08:02		00:07:08	00:07:13	8
		Ambulance - Category 1 - 90th Percentile Respose Time	00:15:00	Jan-20	→	00:13:11	00:13:05	0	00:13:39	00:13:44	0	00:13:12	00:13:32	00:14:30		00:12:30	00:12:40	0
		Ambulance - Category 2 - Average Response Time	00:18:00	Jan-20	→	00:24:59	00:45:06	30	00:27:27	00:30:54	23	00:26:37	00:30:19	00:37:06		00:21:05	00:23:06	30
		Ambulance - Category 2 - 90th Percentile Respose Time	00:40:00	Jan-20	→	00:50:44	00:55:11	30	00:56:04	01:04:08	30	00:55:25	01:02:45	01:17:34		00:42:55	00:47:27	30
		Ambulance - Category 3 - 90th Percentile Respose Time	02:00:00	Jan-20	→	02:33:31	03:08:14	7	02:49:48	03:34:33	29	02:40:50	03:42:11	04:35:57		02:14:31	02:47:48	21
		Ambulance - Category 4 - 90th Percentile Respose Time	03:00:00	Jan-20	→	02:42:47	02:48:50	0	03:02:10	03:14:46	4	02:37:27	03:04:55	04:06:38		02:52:43	03:13:51	0

CCG Dashboard for NHS Constitution Indicators

	Area	Indicator Name	Standard	Latest Period	NHS Derby & Derbyshire CCG				Chesterfield Royal Hospital FT			University Hospitals of Derby & Burton FT			Derbyshire Community Health Services FT			NHS England		
					Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance
Urgent Care	Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	Jan-20	↑	79.7%	82.1%	52	80.0%	85.3%	19	79.6%	80.9%	52	100.0%	100.0%	0	83.5%	85.7%	52
		A&E 12 Hour Trolley Waits	0	Jan-20					0	31	0	14	80	23	0	0	0	2846	9629	52
	DToC	Delayed Transfers Of Care - % of Total Bed days Delayed	3.5%	Dec-19	↓				1.83%	1.53%	0	2.90%	3.46%	3	1.60%	4.46%	0	4.27%	4.18%	9

PERFORMANCE OVERVIEW MONTH 9 – PLANNED CARE

NHS Derby & Derbyshire CCG Assurance Dashboard

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

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

Part A - National and Local Requirements

CCG Dashboard for NHS Constitution Indicators

	Area	Indicator Name	Standard	Latest Period	NHS Derby & Derbyshire CCG				Chesterfield Royal Hospital FT			University Hospitals of Derby & Burton FT			Derbyshire Community Health Services FT			NHS England		
					Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance
Planned Care	Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Dec-19	↓	86.8%	89.2%	23	88.4%	90.4%	8	85.9%	88.1%	24	94.1%	95.2%	0	83.7%	85.2%	46
		Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Dec-19	↓	0	11	0	0	0	0	0	16	0	0	0	0	1467	10952	152
	Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Dec-19	↓	3.58%	5.81%	19	3.15%	0.93%	1	2.73%	7.19%	13	0.00%	0.00%	0	4.17%	3.69%	76
	2 Week Cancer Waits	All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	Dec-19	↓	95.3%	92.0%	0	Cancer 2 Week Wait Pilot Site - not currently reporting			95.1%	89.9%	0				91.9%	90.6%	10
		Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	Dec-19	↑	92.3%	73.0%	2				93.6%	61.2%	0				84.3%	83.2%	22
	31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	96%	Dec-19	↓	96.5%	95.7%	0	96.3%	97.8%	0	97.3%	96.2%	0				96.0%	96.1%	0
		Subsequent Surgery Within 31 Days Of Decision To Treat	94%	Dec-19	↓	90.4%	90.7%	1	100.0%	97.9%	0	95.5%	93.0%	0				91.6%	91.4%	17
		Subsequent Drug Treatment Within 31 Days Of Decision To Treat	98%	Dec-19	↓	98.7%	99.1%	0	100.0%	100.0%	0	99.2%	99.0%	0				99.3%	99.2%	0
		Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	Dec-19	↓	87.0%	93.2%	4				93.0%	93.2%	1				96.6%	96.5%	0
	62 Days Cancer Waits	First Treatment Administered Within 62 Days Of Urgent GP Referral	85%	Dec-19	↑	78.8%	75.4%	20	78.0%	78.9%	5	74.5%	74.1%	20				78.0%	77.7%	1
		First Treatment Administered - 104+ Day Waits	0	Dec-19	↑	12	206	45	3	26	20	4.5	128.5	45						
		First Treatment Administered Within 62 Days Of Screening Referral	90%	Dec-19	↓	83.3%	78.5%	1	83.9%	78.6%	8	80.6%	82.8%	9				85.2%	86.1%	21
		First Treatment Administered Within 62 Days Of Consultant Upgrade	N/A	Dec-19	↓	75.7%	87.6%		100.0%	95.3%		73.3%	85.3%					17.1%	82.6%	
	Cancelled Operations	% Of Cancelled Operations Rebooked Over 28 Days	N/A	19-20 Q3	↑				6.5%	10.5%		6.1%	10.0%					9.1%	9.3%	
		Number of Urgent Operations cancelled for the 2nd time	0	Dec-19	→				0	0	0	0	0	0				20	143	33

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PERFORMANCE OVERVIEW MONTH 9 – 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

	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		
					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
Patient Safety	Mixed Sex Accommodatio	Mixed Sex Accommodation Breaches	0	Dec-19	→	11	82	33	1	5	1	17	114	15	0	0	0	2054	14094	33
	Incidence of healthcare associated Infection	Healthcare Acquired Infection (HCAI) Measure: MRSA Infections	0	Dec-19	→	1	5	2	0	1	0	0	1	0				76	612	33
		Healthcare Acquired Infection (HCAI) Measure: C-Diff Infections	Plan	Dec-19	↓		235			39			149							
			Actual				184	0		12	0		59	0					10111	
		Healthcare Acquired Infection (HCAI) Measure: E-Coli	-	Dec-19	↓	69	687		16	203		59	466					3370	33399	
		Healthcare Acquired Infection (HCAI) Measure: MSSA	-	Dec-19	→	28	196		3	15		3	33					1108	9329	

PERFORMANCE OVERVIEW MONTH 9 – MENTAL HEALTH

NHS Derby & Derbyshire CCG Assurance Dashboard

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

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

CCG Dashboard for NHS Constitution Indicators

Mental Health

Area	Indicator Name	Standard	Latest Period	NHS Derby & Derbyshire CCG				Derbyshire Healthcare FT								NHS England		
				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
Early Intervention In Psychosis	Early Intervention In Psychosis - Admitted Patients Seen Within 2 Weeks Of Referral	50.0%	Dec-19	↑	100.0%	87.0%	0	100.0%	89.4%	0							74.3%	75.2%	0
	Early Intervention In Psychosis - Patients on an Incomplete Pathway waiting less than 2 Weeks from Referral	50.0%	Dec-19	↓	75.0%	84.5%	0	75.0%	84.5%	0							22.0%	34.9%	3
Mental Health	Dementia Diagnosis Rate	67.0%	Dec-19	↓	71.4%	71.9%	0										69.1%	68.6%	0
	Care Program Approach 7 Day Follow-Up	95.0%	19/20 Q3	↑	96.1%	96.2%	0	96.1%	96.7%	0							95.5%	96.1%	0
	CYPMH - Eating Disorder Waiting Time % urgent cases seen within 1 week		19/20 Q3	↓	79.3%	81.4%													
	CYPMH - Eating Disorder Waiting Time % routine cases seen within 4 weeks		19/20 Q3	↓	68.5%	75.0%													
	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		Nov-19	↑	520	4780													
	Physical Health Checks for Patients with Severe Mental Illness	60%	19/20 Q3	↑	30.1%	29.7%	3												

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)			NHS England (D&DCCG only)		
				Direction of Travel	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure
Improving Access to Psychological Therapies	IAPT - Number Entering Treatment As Proportion Of Estimated Need In The Population	Plan	Dec-19	↓	1.83%	16.50%													
		Actual			1.77%	20.08%	1												
	IAPT - Proportion Completing Treatment That Are Moving To Recovery	50%	Dec-19	↑	54.8%	54.8%	0	58.1%	54.3%	0	52.6%	55.1%	0	56.2%	55.1%	0	50.6%	52.1%	0
	IAPT Waiting Times - The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment	75%	Dec-19	↑	92.8%	87.8%	0	91.1%	97.1%	0	93.6%	72.2%	0	94.5%	97.4%	0	87.7%	89.4%	0
	IAPT Waiting Times - The proportion of people that wait 18 Weeks or less from referral to entering a course of IAPT treatment	95%	Dec-19	↑	100.0%	100.0%	0	100.0%	100.0%	0	100.0%	100.0%	0	100.0%	99.8%	0	98.2%	99.0%	0

Area	Indicator Name	Standard	Latest Period	Derbyshire Healthcare FT			
				Direction of Travel	Current Month	YTD	consecutive months of failure
DToC	Delayed Transfers Of Care - % of Total Bed days Delayed	3.5%	Dec-19	↑	0.79%	0.86%	0
Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Dec-19	↓	92.9%	93.4%	0
	Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Dec-19	→	0	0	0
Mixed Sex Accommodation	Mixed Sex Accommodation Breaches	0	Dec-19	→	0	0	0

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Quality Overview

QUALITY OVERVIEW M9

Trust	Key Issues
Chesterfield Royal Hospital FT	12 hour wait breaches ED: There were 17 adult breaches during December 2019. Breach length was between 13-20 hours with the majority of patients waiting no longer than 14 hours. The main reason for the breaches was lack of availability of in-patient beds on the appropriate wards. There were 6 patients who required isolation due to infection, and one patient who required a mental health bed. From the reports received, no clinical risk or harm was identified by the Trust. The patients were informed of the plans & reasons for the delay. The current breach process is under review and will be tabled for approval at the trust CQRG meetings in March 2020. Pressure Ulcer Deep Dive: In December the Trust carried out a Deep Dive review as they have seen an increase in the rate of hospital-acquired pressure ulcers. The deep dive considered the changes in definition, contributory factors and findings from investigations. Whilst the review did identify some opportunities for improvement ,the majority of incidents were not as a result of significant care delivery problems. A number of actions were identified and progress against these will be monitored through quality monitoring and SI reviews . CQC inspection The CQC carried out an unannounced visit on the 4th February 2020, and visited ED, medicine, surgery and maternity. High level verbal feedback received by the Trust was generally positive, with no reported major areas of concern. The Inspection continues throughout February.
University Hospitals of Derby and Burton NHS FT	MSA breaches: During December 2019 there were a total of 17 MSA breaches across 5 sites. 11 breaches occurred on the Derby sites (Ward 407). 6 occurred on the Burton sites (ICU). All breaches were due to lack of available beds to transfer patients into to commence their care, or delays in discharging from the high dependency areas to base wards when medically fit. There was no harm experienced and no adverse effects on experience or safety were reported. All appropriate apologies given. 12 hour wait breaches ED: 5 adult breaches were reported by the ED at Derby Hospital due to unavailability of appropriate mental health beds or a wait for bed on the MAU and onwards to a base ward (medical/surgical) within the hospital . 34 adult breaches were reported by the ED at Burton (all occurring on the 19th, 29th or 30th December 2019) due to unavailability of medical beds on base wards. The CCG Quality Team continue to be assured form the reports received that those affected by breaches are being cared for appropriately while awaiting transfer. Clostridium Difficile (CDiff) cases: Increase noted in CDiff cases compared to the same time period as last year which is being closely monitored (53 with 27 of these at QHB). Still under 117 threshold. Trust feel some of this may be due to current pressures meaning cleaning programmes are not being completed timely.

QUALITY OVERVIEW M9 continued

Trust	Key Issues
Derbyshire Community Health Services FT	Appraisals: Compliance has risen marginally during the month of December to 91.5%, up from 89.3% in November 2019. However, it is still 4% lower than target (96%) . Divisional People Leads for each of the Divisions have undertaken an exercise to chase up every outstanding Appraisal with the management team responsible for that individual. All management teams are booking outstanding Appraisals in for January. Compliance is monitored through the normal contractual monitoring meetings. Delayed Transfer of Care (%):The Derbyshire Delayed Transfer of Care (DTOC) figure for December 2019 was 1.6% for Inpatient and OPMH combined. This is below the NHSEI target of 3.5% and below the November figure of 5.9%. All agreed actions are ongoing and monitored through contractual routes.
Derbyshire Healthcare Foundation Trust	Bed Occupancy: Current occupancy averages at 99% with length of stay exceeding the top quartile benchmark. This reflects operational issues and the capacity of wider health and social systems to support discharges. A program of workstreams is in place to focus on improving inpatient flow, crisis admission and step down as a way to bring occupancy levels closer to the 85% considered optimal. Progress is monitored through Contract Delivery Management and Clinical Quality Review Groups. Out of area placements: During December there were 14 patients in out of area acute placements owing to local adult acute bed availability and occupancy levels. An Area Service manager is now in post with responsibility for managing the out of area Band 7 nurses and the flow coordinators with specific targeted action to impact on admission and discharge pathways. Progress is monitored through Contract Delivery Management and Clinical Quality Review Groups.
East Midlands Ambulance Trust	National Standards: During the month of December 2019, EMAS as a region achieved one of the six national standards: C1 90th centile. Derbyshire, Leicestershire and Nottinghamshire each achieved one of the six national performance standards (C1 90th centile). The Coordinating Commissioning Team issued a Contract Performance Notice (CPN) on the 18th October 2019 under General Condition 9 of the NHS Standard Contract, due to the failure to deliver the agreed performance levels in Quarter Two. The Contract Performance Notice for failure to deliver the Quarter Two contractual performance standards remains in place with action plans being developed. A further Contract Management Meeting is expected to take place in February 2020. Handover Delays: The regional pre-hospital handover positon during December 2019 was 30 minutes and 15 seconds which was a deterioration compared to November 2019 (26 minutes and 43 seconds). At a county level the average post-hospital handover position was lowest within Derbyshire at 16 minutes and 6 seconds with the highest being in Lincolnshire at 19 minutes and 21 seconds. There are a number of actions in place to reduce pre- and post-handover delays, with further necessary actions being agreed as part of the four pillar action plans.

QUALITY OVERVIEW M9

Derbyshire Wide Integrated Report
Part B: Provider Local Quality Indicators

Dashboard Key:	
CCG assured by the evidence	
CCG not assured by the evidence	

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

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

Section	Area	Indicator Name	Standard	Chesterfield Royal Hospital FT					University Hospitals of Derby & Burton FT					Derbyshire Community Health Services					Derbyshire Healthcare FT				
				Latest Period	Direction of travel	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
Ratings	CQC Ratings	Inspection Date	N/A	Aug-19					Jun-19					May-19					Jul-18				
		Outcome	N/A	Good					Good					Outstanding					Requires Improvement				
Adult	FFT	Staff 'Response' rates	15%	19-20 Q2	↓		7.6%	8.6%	19-20 Q2	↓		10.1%	10.2%	19-20 Q2	↓		2.7%	21.7%	19-20 Q2	↓		3.2%	18.1%
		Staff results - % of staff who would recommend the organisation to friends and family as a place to work		19-20 Q2	↓		56.4%	64.5%	19-20 Q2	↓		70.2%	65.7%	19-20 Q2	↓		50.4%	70.5%	19-20 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%	Dec-19	↓		97.9%	97.7%	Dec-19	↑		97.2%	96.2%	Jan-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%	Dec-19	↑		77.8%	77.5%	Dec-19	↓		76.0%	80.0%	Jan-20	↑		99.6%	99.4%					
	Complaints	Number of formal complaints received	N/A	Dec-19	↑		24	283	Sep-19	↑		63	420	Dec-19	↑		8	97	Dec-19	↔		6	109
		% of formal complaints responded to within agreed timescale	N/A	Dec-19	↔		97.0%	99.0%	Sep-19	↓		65.2%	59.0%	Dec-19	↔		100.0%	93.9%	Dec-19	↔		100%	89.90%
		Number of complaints partially or fully upheld by ombudsman	N/A	Dec-19	↔		0	0	19-20 Q2	↔		1	2	Dec-19	↔		0	0	Dec-19	↔		0	0
	Pressure Ulcers	Category 2 - Number of pressure ulcers developed or deteriorated	N/A	Dec-19	↓		13	82	Sep-19	↑		48	302	Dec-19	↓		82	871	Dec-19	↔		0	1
		Category 3 - Number of pressure ulcers developed or deteriorated	N/A	Dec-19	↑		4	37	Sep-19	↓		20	106	Dec-19	↓		35	366	Dec-19	↔		0	0
		Category 4 - Number of pressure ulcers developed or deteriorated	N/A	Dec-19	↑		0	1	Sep-19	↑		0	1	Dec-19	↔		5	39	Dec-19	↔		0	0
		Deep Tissue Injuries(DTI) - numbers developed or deteriorated		Dec-19	↑		3	24	Sep-19	↑		16	94	Dec-19	↓		54	402	Dec-19	↔		0	0
		Medical Device pressure ulcers - numbers developed or deteriorated							Sep-19	↓		4	20	Dec-19	↓		10	77	Dec-19	↔		0	0
		Number of pressure ulcers which meet SI criteria	N/A	Dec-19	↑		0	20	Sep-19	↔		0	4	Dec-19	↑		0	19	Dec-19	↔		0	0
	Falls	Number of falls	N/A	Dec-19	↑		95	977	Data Not Provided in Required Format					Dec-19	↑		19	301	Dec-19	↓		28	236
		Number of falls resulting in SI criteria	N/A	Dec-19	↑		2	18	Sep-19	↑		0	19	Dec-19	↑		0	6	Dec-19	↔		0	0
	Medication	Total number of medication incidents	?	Dec-19	↑		53	604	Sep-19	↑		180	1314	Dec-19	↔		0	0	Dec-19	↓		91	614
	Serious Incidents	Never Events	0	Dec-19	↔		0	4	Sep-19	↑		0	6	May-19	↔		0	0	Dec-19	↔		0	0
		Number of SI's reported	0	Dec-19	↑		6	65	Sep-19	↑		7	115	Dec-19	↑		9	112	Dec-19	↑		1	61
		Number of SI reports overdue	0	Dec-19	↔		0	0	May-19	↓		19	28	May-19	↔		0	0					
		Number of duty of candour breaches which meet threshold for regulation 20	0	Dec-19	↑		0	3	May-19	↔		0	0	Dec-19	↔		0	0					

QUALITY OVERVIEW M9

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

Section	Area	Indicator Name	Standard	Chesterfield Royal Hospital NHS Foundation Trust					University Hospitals of Derby & Burton FT					Derbyshire Community Health Services					Derbyshire Healthcare FT				
				Latest Period	Direction of travel	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
Adult	VTE	Number of avoidable cases of hospital acquired VTE		Dec-19	↑		0	11	18 - 19 Q1	↔		2	2						Dec-19	↔		0	0
		% Risk Assessments of all inpatients	90%	19-20 Q2	↑		97.5%	97.7%	19-20 Q2	↓		96.6%	96.2%	19-20 Q2	↑		99.6%	99.8%					
	Mortality	Hospital Standardised Mortality Ratio (HSMR)	Not Higher Than Expected	Dec-19	↓		106.7		Jun-19	↔		92.7	92.7										
		Summary Hospital-level Mortality Indicator (SHMI): Ratio of Observed vs. Expected		Sep-19	↓		0.982		Sep-19	↓		0.938											
		Crude Mortality		Dec-19	↓		1.96%	1.52%	Sep-19	↔		1.20	1.28										
Maternity	FFT	Antenatal serivce: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Dec-19	→		100.0%	98.5%	Dec-19	↑		97.6%	94.9%										
		Labour ward/birthing unit/homebirth: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Dec-19	→		100.0%	98.9%	Dec-19	↓		97.7%	98.0%										
		Postnatal Ward: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Dec-19	↑		97.4%	98.5%	Dec-19	↑		99.1%	97.9%										
		Postnatal community service: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Dec-19	→		100.0%	98.8%	Dec-19	→		100.0%	97.2%										
Mental Health	Dementia	Dementia Care - % of patients ≥ 75 years old admitted where case finding is applied	90%	Nov-19	↓		99.3%	98.7%	Nov-19	↓		90.6%	90.6%										
		Dementia Care - % of patients identified who are appropriately assessed	90%	Nov-19	↓		100.0%	100.0%	Nov-19	↑		86.8%	83.0%										
		Dementia Care - Appropriate onward Referrals	95%	Nov-19	↓		100.0%	100.0%	Nov-19	↓		92.5%	99.0%										
	Inpatient Admissions	Under 18 Admissions to Adult Inpatient Facilities	0																Dec-19	↔		0	0
Workforce	Staff	Staff turnover (%)		Dec-19	↓		8.8%	9.1%	Sep-19	↔		9.7%	9.95%	Dec-19	↔		9.0%	9.0%	Dec-19	↓		10.4%	10.1%
		Staff sickness - % WTE lost through staff sickness		Dec-19	↑		5.3%	5.0%	Sep-19	↓		4.4%	4.3%	Dec-19	↓		5.3%	4.8%	Dec-19	↑		7.2%	7.2%
		Vacancy rate by Trust (%)		Sep-17	↓		1.9%	1.3%	Dec-18	↓		8.3%	7.3%	Dec-19	↓		5.9%	5.9%	Dec-19	↑		9.86%	10.07%
		Agency usage	Target																Dec-19	↓			
			Actual																			9.86%	10.07%
		Agency nursing spend vs plan (000's)		Dec-19	↓		£461	£2,986	Oct-18	↑		£723	£4,355	Dec-19	↓		£162	£1,499					
		Agency spend locum medical vs plan (000's)		Dec-19	↓		£693	£6,176															
	Training	% of Completed Appraisals	90%	Dec-19	↔		95.9%	79.6%	Sep-19	↓		86.3%	89.1%	Dec-19	↑		91.5%	90.5%	Dec-19	↓		84.4%	80.6%
		Mandatory Training - % attendance at mandatory training	90%	Dec-19	↑		76.6%	71.1%	Aug-19	↓		85.4%	89.1%	Dec-19	↑		97.9%	97.0%	Dec-19	↑		87.1%	86.6%
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																				

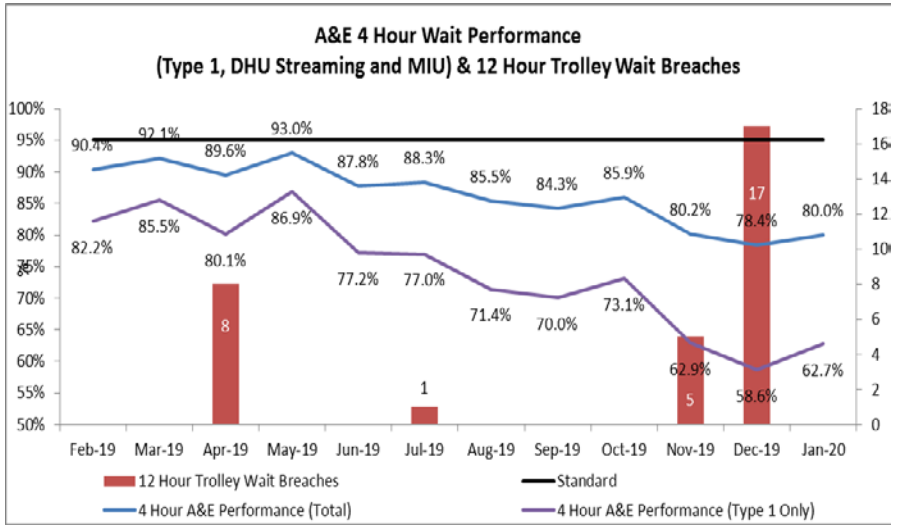
Urgent & Emergency Care

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

Performance Analysis

During January 2020 the trust did not meet the 95% standard, achieving 80.0% which is a marginal improvement on the December performance of 78.4%. The Type 1 element of these were 62.7% for January, also an improvement on December (58.6%).

There were no 12 hour breaches during January.



Metric	Oct	Nov	Dec	Jan	Actual change	%change
A&E attendances (Type 1)	6,427	6,458	6,382	6,230	-152	-2%
A&E Breaches (Type 1)	1,728	2,399	2,641	2,320	-321	-12%
Primary Care Streaming	1,807	1,749	2,027	1,776	-251	-12%
MIU attendances	2,893	3,173	3,329	3,189	-140	-4%
Total Att.	11,127	11,380	11,738	11,195	-543	-5%

What are the issues?

	18/19	19/20	Diff	%Diff
Oct-19	6,075	6,427	352	5.8%
Nov-19	5,784	6,458	674	11.7%
Dec-19	5,907	6,382	475	8.0%
Jan-20	6,117	6,230	113	1.8%

- The Trust continue to experience a high number of Type 1 attendees compared to 2018/19 with 1.8% more attendances during Jan2020, with OPEL3 status being declared during the month.
- The acuity of the attendances is increasing, with 27.6% of A&E attendances resulting in admission to either an assessment unit or a ward in January (27.2% for December).
- Confirmed cases of flu result in reduced capacity when patient areas need deep cleaning once vacated by a flu patient.
- Staff shortages due to sickness and difficulty recruiting to middle grade or consultant medical posts.

What actions have been taken?

- The ORG (Organisational Resilience Group) meet on a weekly basis with representation from all relevant Urgent Care providers in the Derbyshire System. In addition to standard escalation and winter planning the group are currently also streamlining the Patient Choice process across all providers, reviewing escalation processes and reviewing GP referrals to understand if there are alternative pathways.
- A MADE week held w/c 13th Jan as an ideal week of maximising patient flow. It highlighted the need for whole system working, found benefit in reviewing super-stranded patients in a ward setting and led to proposals for weekly 21day LLOS patient & 14day LOS patient reviews.
- The Long Length Of Stay (LLOS) meeting now includes wider system partners.
- Senior Review in the ED Pitstop area is now established as Business As Usual.
- The High Intensity Users service is now operational in North-East Derbyshire & Bolsover, which should reduce attendances.
- Additional beds were opened over winter and have remained open since, with additional capacity opened ahead of schedule to cope with demand.
- Discharge hub working with frailty to expedite packages of care.
- Roll-out of the Ticket To Ride scheme in Orthopaedics and EMU, whereby HCAs are able to take patients to base wards and free up space in assessment areas.

What are the next steps and when will they impact?

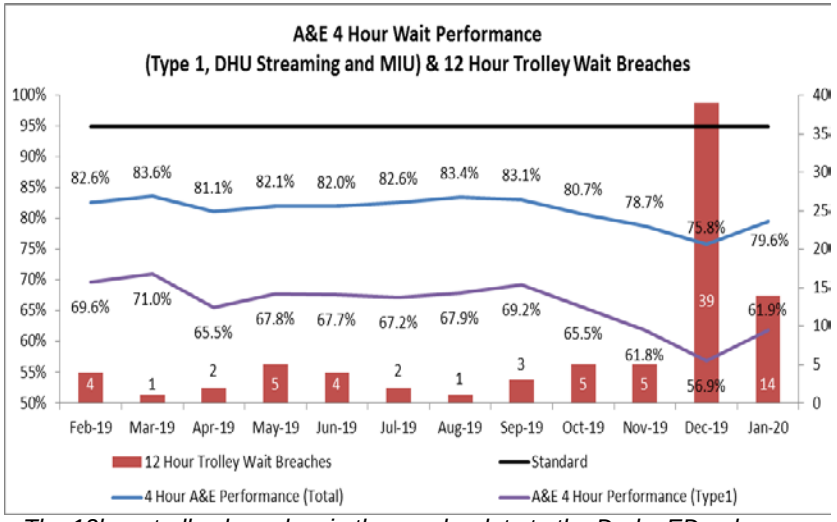
- Increased availability of GP Streaming services (through various ongoing initiatives) to support patient flow and same day discharge.
- The Business Case for Front Door redesign is awaiting NHSE/I sign off and cannot proceed until this approval is received.
- Establishing a Surgical Assessment Unit to improve flow.
- PTS Stakeholder meetings actively seeking to improve transport bookings and hospital processes.
- The ORG take a PMO approach for projects improving urgent care. These include: Capacity & Demand analysis, direct booking of GP appointments via 111, reduced ambulance conveyances, focussing on High Intensity Users & Care Home patients, increasing input from mental health services and increasing capacity to administer IV antibiotics in the community. The ORG report to the A&E Delivery Board.

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

Performance Analysis

During January 2020 performance overall did not meet the 95% standard, achieving 79.6% (Network figure) and 61.9% for Type 1 attendances, an improvement on the December positions.

At RDH there were 14 x 12 hour trolley breaches during January 2020 due to unavailability of appropriate mental health beds (2) or appropriate medical/surgical beds within UHDB (12).



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

Metric	Oct	Nov	Dec	Jan	Actual change	% change
A&E attendances (Type 1)	12,644	12,399	12,482	11,579	-903	-7%
A&E Breaches (Type 1)	4,893	5,173	5,890	5,041	-849	-14%
Primary Care Streaming Attendances	1,123	1,281	1,377	1,428	51	4%
DUCC attendances	4,981	4,928	5,147	4,644	-503	-10%
MIU attendances	5,490	5,316	5,753	5,560	-193	-3%
Total Att.	24,238	23,924	24,759	23,211	-1,548	-6%

What are the issues?

- The volume of patients has increased with an annual 2.4% increase of Type 1s, averaging at 18 more patients per day. Attendances in the Derby network (i.e. including Type 1s, MIUs, DUCC & GP Streaming) averaged at 749 per day during January 2020.
- The acuity of the conditions presented has also increased, with attendances classed as Major/Resus making up 53.0% of patients at Derby (222 attendances per day).
- 25.6% of attendances result in admission to either an assessment unit or an inpatient ward.
- 13 of the 12hour breaches occurred over a few days (3rd-7th January). During this time the Trust reported OPEL4 level and bed occupancy exceeded 100%.
- There has been an overall rise in Major patients being treated by the appropriate clinicians but in the Minors area.

What actions have been taken?

- The ORG (Organisational Resilience Group) meet on a weekly basis with representation from all relevant Urgent Care providers in the Derbyshire System. In addition to standard escalation and winter planning the group are currently also streamlining the Patient Choice process across all providers, reviewing escalation processes and reviewing GP referrals to understand if there are alternative pathways.
- A focus on increasing the numbers of patients accessing GP streaming to reduce the numbers of unnecessary attendances. At times of pressure the opening hours were extended until 2am.
- Some non-urgent elective surgery was cancelled to increase potential capacity elsewhere in the Trust.
- The High Intensity Users service is now operational in Derby City, which should reduce attendances.
- Derby City LA Night Service is now operational, whereby patients are safely monitored overnight at home (or in designated accommodation) instead of a hospital bed.
- Additional agency staff employed to cover sickness and staff moved from other areas at times of pressure.
- Development of the Pit-Stop model to provide senior clinician triage earlier in the patient pathway.
- Piloting of an ED Nurse directly streaming patients via ACC pathways or directly to specialties (e.g. directing gynae patients to Gynaecology Assessment Unit who would normally go via GP streaming).

What are the next steps

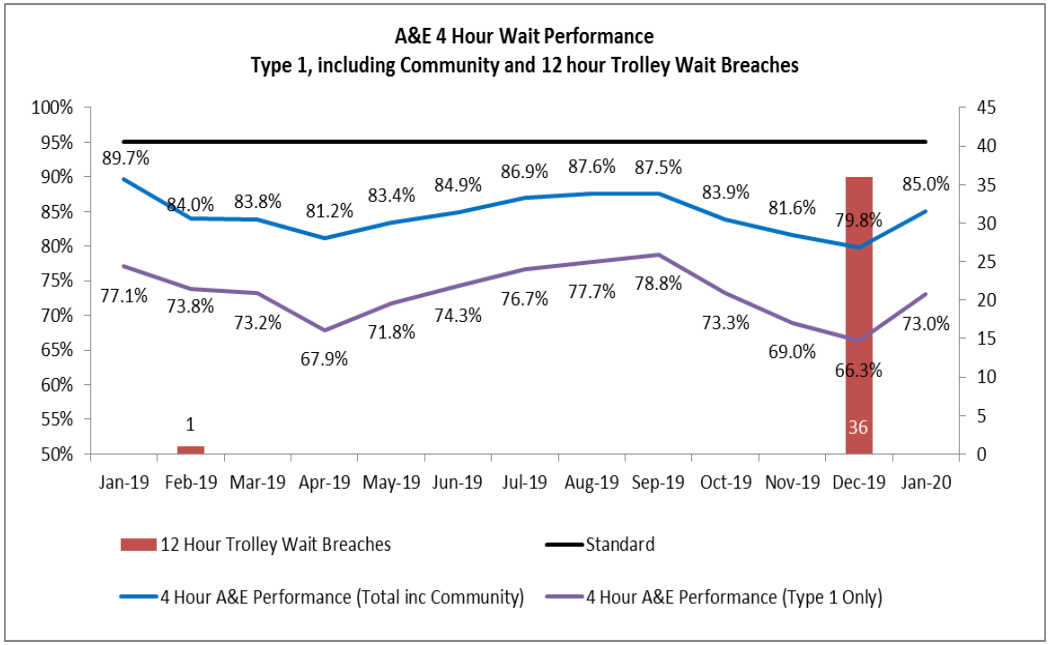
- Increased availability of GP Streaming services (through various ongoing initiatives) to support patient flow and same day discharge.
- Establishing an Orthopaedic Assessment Unit to improve flow from the ED.
- Named clinician to support and embed the patient choice policy for packages of care.
- PTS Stakeholder meetings actively seeking to improve transport bookings and hospital processes.
- Within ED the Trust are investigating physical expansion of Majors into current Minor's space. Outside of ED the Trust are looking to expand physical capacity within the current footprint. These are long term plans that require various sign-offs before being able to proceed.
- The ORG (Organisational Resilience Group) take a PMO approach for projects improving urgent care. These include: Capacity & Demand analysis, direct booking of GP appointments via 111, reduced ambulance conveyances, focussing on High Intensity Users & Care Home patients, increasing input from mental health services and increasing capacity to administer IV antibiotics in the community. The ORG report to the A&E Delivery Board.

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

Performance Analysis

During January 2020 performance overall did not meet the 95% standard, achieving 73.0% A&E or 85.0% including community hospitals. The Type 1 performance is a significant improvement on December 2019's performance of 66.3%.

There were no 12 hour breaches during January.



What are the issues?

- The volume of attendances has increased by 9.9% year on year, with attendances averaging 194 per day and getting as high as 220 attendances.
- The acuity of attendances has increased – during January 49.8% were classed as Major/Resus (97 per day) and 54.1% of Type 1 attendances resulted in an inpatient admission (up from 35.2% in December).
- A shortage of mid-grade medical staff has reduced departmental activity.
- Delayed inpatient discharges reduce the bed availability and therefore delays admissions from A&E.

What actions have been taken?

- Ambulatory Emergency Care provision has been 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.
- Extra capacity created by :
  - Opening the Medical Day Case Unit as an 8 bed area.
  - Opening 2 additional trolleys in the Acute Assessment Centre.
  - Overnight opening of the Endoscopy Unit and Surgical Assessment Unit.
- All extra escalation ward beds were opened in line with the Bed Escalation Plan.
- Some elective surgery was cancelled.
- Analysis of potential streaming processes and development of a Business Case to implement them substantially.
- Working groups review the attendance data, clinician throughput and productivity to align staff rotas.
- Active covering of vacant shifts by local middle grades.
- Single Point of Access (SPA) process and initial phone assessment process both revised and relaunched, based on findings during the Test Of Change week.

What are the next steps?

- Continued 7day Ambulatory Emergency Care provision with a review at the March 2020 Non-Elective Improvement Group.
- Continued use of the Medical Triage Model with a review at the March 2020 Non-Elective Improvement Group.
- The WMAS HALO is funded by winter monies so work is needed to secure further funding from April 2020 onwards.
- Piloting GP triage models to manage patients who attend the hospital having been discussed with another clinician. This is being conducted as part of a PDSA cycle.
- Deliver the proposed model by NHS England for streaming and achieve improvement in the number of patients streamed.
- The ORG (Organisational Resilience Group) take a PMO approach for projects improving urgent care. These include: Capacity & Demand analysis, direct booking of GP appointments via 111, reduced ambulance conveyances, focussing on High Intensity Users & Care Home patients, increasing input from mental health services. The ORG report to the A&E Delivery Board.

DELAYED TRANSFERS OF CARE (<3.5%)

Performance Analysis
The Delayed Transfer of Care (DTOC) standard (<3.5%) was met by all four of the main providers during December 2019.

NHS 111 – Month 9

Performance Summary

- DHU111 have achieved their contractual KPIs of average speed of answer and abandonment rate each month in Year Four, Quarter One (October 2019 to December 2019).
- The 95% of all calls answered in 60 seconds national standard has not been fully achieved since June 2019.

What are the issues?

- DHU111 are achieving the contractual performance standards of average speed of answer and abandonment rate. DHU111 are not contracted to deliver the answered in 60s national standard, at the time of contract award this standard was not a national must do.
- Performance against this standard is reported on a daily basis and monitored by the Coordinating Commissioning Team, this is compared with national performance also. Although DHU111 are not meeting the standard their performance when compared with others nationally is very good.
- The beginning of December 2019 was challenging, with DHU111 taking the second highest volume of calls across the Country.
- Actual activity for December 2019 is over plan for Call Offered by 0.87% and Clinical Calls are significantly over plan at 21.0%.

Key performance indicator	Standard	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Average speed of answer (seconds)	≤27 s	8	24	16	15	11	26	26
Abandonment rate (%)	≤5%	0.9	3%	2.1%	1.6%	1.2%	1.9%	1.9%
Calls answered in 60 seconds DHU111 (%)	≥95%	96.5	87.4	90.5%	91.3%	94.0%	87.2%	87.3%
Calls answered in 60s England Ave. (%)	≥95%	86	80.5	83.30%	82.20%	82.00%	77.80%	75.70%

What actions have been taken?

- DHU111 completed a comprehensive winter plan with expected call volumes for the winter period.
- Staffing for the Christmas period was put in place and DHU111 utilised the additional money from NHSE to support performance during this time.
- DHU111 increased their staffing levels in December 2019 in order to achieve performance and support the increase in call volumes. DHU111 recovered particularly well in the second half of December 2019.
- Activity is being monitored on a daily basis.

What are the next steps?

- Continue to monitor performance against contractual standards and review impact of winter plan in February to ascertain impact of actions and of recruitment.
- A Deep Dive will take place in 2020 to review Clinical Call activity.
- Await the publication of the NHSE/I revised IUC KPIs which should remove the answered in 60 seconds standard and replace it with an average speed of answer standard. The proposed threshold for average answered time has not been confirmed by NHSE/I. Expected for April 2020.

AMBULANCE – EMAS PERFORMANCE

December 2019		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		00:08:09	00:14:36	00:41:43	01:27:19	05:14:48	**04:16:33**
Derbyshire	**Actual**	00:07:56	00:13:58	00:33:41	01:09:48	04:42:17	03:47:01

December 2019	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	00:30:07	168:22:51	00:13:33	34:00:08	00:43:40	170:38:04
Chesterfield Royal	00:22:45	414:53:54	00:15:53	206:34:04	00:38:38	503:12:53
Macclesfield District General Hospital	00:30:07	26:40:32	00:09:56	0:52:17	00:40:03	20:30:40
Royal Derby	00:24:13	834:34:44	00:16:53	416:38:05	00:41:06	1049:03:13
Sheffield Northern General Hospital	00:24:41	25:08:18	00:15:56	11:07:13	00:40:37	30:39:44
Stepping Hill	00:33:16	115:24:48	00:13:22	17:21:49	00:46:38	109:41:47
Derbyshire TOTAL	00:24:35	1585:05:07	00:16:06	686:33:36	00:40:42	1883:46:21

December 2019	NTPS Activity						
DERBYSHIRE	**2019/20 Actual**	**18/19 Actual**	**19/20 Actual vs 18/19 Actual**	**19/20 Actual vs 18/19 Actuals (%)**	**19/20 Plan**	**19/20 Actual vs 19/20 Plan**	**19/20 Actual vs 19/20 Plan (%)**
Calls	20,654	18,529	2,125	11.5%	18,539	1,145	11.4%
Total Incidents*	14,427	-	-		13,707	206	5.3%
Total Responses	13,293	12,285	1,008	8.2%	12,529	-13	6.1%
Duplicate Calls	4,341	3,522	819	23.3%	3,196	777	35.8%
Hear & Treat	3,020	2,722	298	10.9%	2,814	1,145	7.3%
See & Treat	3,696	3,496	200	5.7%	3,709	206	-0.4%
See & Convey	9,597	8,789	808	9.2%	8,820	-13	8.8%

**Please note that the incident count cannot be compared to the 18/19 incident count due to changes in the way incidents are counted for 19/20.*

What are the issues?

- The contractual standard is for the division to achieve national performance on a quarterly basis. In Quarter Three, Derbyshire achieved one of the six national standards; C1 90th centile .
- Derbyshire did not meet the quarterly national standards for C1 mean, C2 mean, C2 90th centile , C3 90th and C4 90th centile during December 2019.
- Activity in December 2019 was above plan for all currencies with the exception of S&T which was marginally under plan.
- Lost hours due to Vehicle off Road (VoR) continues to see an increase; in December 2019 this rose to (2,568 hours) compared to November 2019 (2,171 hours). This as a percentage of monthly vehicle hours output has increased by c1%
- Average Pre hospital handover times during December 2019 were above the 15 minute national standard across Derbyshire (24 minutes and 35 seconds), which is a deterioration compared to November 2019 (21 minutes and 41 seconds). The average times for total hours lost in December 2019 are above standard for all hospitals, with Chesterfield Royal Hospital and Royal Derby Hospital being the highest. Royal Derby Hospital saw a significant increase in lost hours in December 2019 (834.34 hours) when compared to November 2019 (561:23 hours).
- Average Post handover times during December 2019 were above the 15 minute national standard across Derbyshire (16 minutes and 6 seconds), which is comparable to November 2019 (16 minutes and 16 seconds).

What actions have been taken?

- A Contract Performance Notice was raised by the coordinating commissioning team as a result of failure to achieve Quarter Two performance standards. As a result, action plans have been developed which summarise the actions being undertaken in each County and as a region. These plans will be reviewed and monitored monthly at each of the divisional County Contract Meetings (CCMs) to ensure that all actions that can be taken are being taken, and further analysis / deep dives may be agreed as part of this review.
- With regards increased activity-work continues looking at alternative pathways, activity being passed from 111 to 999, and analysis of patients who were conveyed to A&E and discharged with no intervention with the aim of being able to reduce demand
- VoR continues to increase in terms of lost hours and as a percentage of vehicle hours. It is reported that the increase is partly due to VoR for meal breaks and end of shift which is increasing due to resources drifting into other areas and therefore taking the crews longer to return to base.
- With regards handovers, EMAS attend the monthly Royal Derby Hospital Handover meeting and these have become more focused now that commissioners are also involved in the meeting. Commissioners requested action plans from both Chesterfield Royal and Royal Derby addressing pre hospital handover delays , the action plans have been submitted and will be shared once they have been reviewed by the Urgent Care Team.

What are the next steps

- The Contract Performance Notice remains open and discussions continue to take place at the County Contract Meetings in order to capture the current actions being taken across all four pillars and to determine if further actions are required.
- Following on from the work undertaken to review the activity being passed from 111 to 999 it has being recommended that further analysis should be undertaken looking at the C3 activity that is closed a Hear and Treat. .

Planned Care

DERBYSHIRE COMMISSIONER – INCOMPLETE PATHWAYS (92%)

Performance Analysis

During December 2019 Derbyshire RTT performance was 86.8%. A slight decrease on the November figure of 87.8%.
The Derbyshire waiting list at end of December 2019 was 64,078. The March 2019 figure was 60,340.

Treatment Function Name	Total Incomplete Waiting List	Number < 18 Weeks	Backlog (+18 Weeks)	% <18 Weeks	March 2019 Waiting List	Movement from March 19
General Surgery	4891	4225	666	86.38%	4891	0
Urology	3136	2723	413	86.83%	3314	-178
Trauma & Orthopaedics	9392	7698	1694	81.96%	7477	1915
ENT	4209	3731	478	88.64%	3820	389
Ophthalmology	7628	6704	924	87.89%	6367	1261
Oral Surgery	0	0	0	Nil	0	0
Neurosurgery	436	387	49	88.76%	299	137
Plastic Surgery	504	415	89	82.34%	468	36
Cardiothoracic Surgery	114	102	12	89.47%	101	13
General Medicine	1364	1093	271	80.13%	1275	89
Gastroenterology	3172	2848	324	89.79%	3492	-320
Cardiology	3118	2743	375	87.97%	2627	491
Dermatology	4138	3366	772	81.34%	3725	413
Thoracic Medicine	1370	1249	121	91.17%	13896	-12526
Neurology	1760	1577	183	89.60%	1085	675
Rheumatology	1400	1158	242	82.71%	1651	-251
Geriatric Medicine	195	191	4	97.95%	1654	-1459
Gynaecology	3886	3605	281	92.77%	367	3519
Other	13365	11790	1575	88.22%	3831	9534
All specialties	64078	55605	8473	86.78%	60340	3738

What are the issues?

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 standard was not achieved by CRH, UHDB, East Cheshire, Sherwood Forest Hospital and Stockport FT. In addition Nottingham University Hospitals did not achieve it for only the second time since 2010.

NHSE mandate states that the total number of incomplete pathways at March 2020 should be at or below the March 2019 figure. This is being measured at CCG and provider level.

The number of CCG patients on an incomplete waiting list has increased at UHDB, NUH and Sheffield Teaching Hospital.

CCG Actions

- Recovery plans / Trajectories are all in place for each provider.

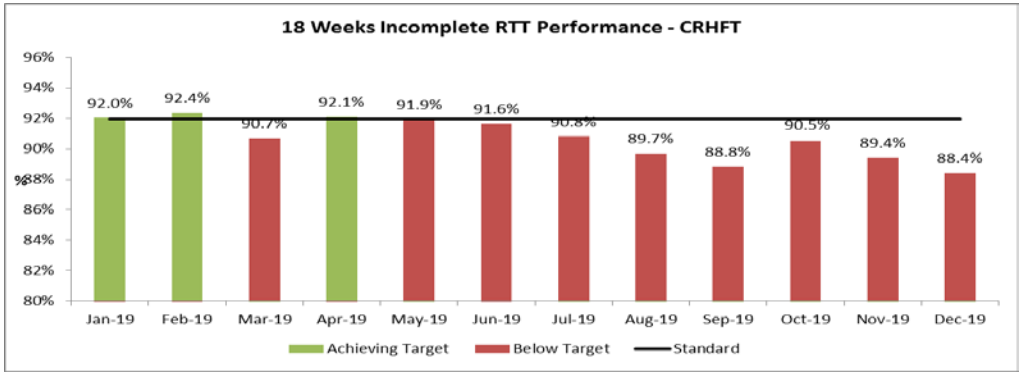
What are the next steps and the point of impact?

The CCG will continue to performance manage the main providers within Derbyshire for the RTT target and to also review waiting list numbers.
Associate providers will continue to be monitored through our associate CCG colleagues.

CRHFT – INCOMPLETE PATHWAYS PERFORMANCE (92%)

Performance Analysis (un-validated)
During November CRHFT failed the RTT standard, achieving 89.41% slightly gone down compared to October figure of 90.51%.

The waiting list figure at the end of December was 14,564, which is 272 below the March 2019 figure.



Treatment Function Name	Total Incomplete Waiting List	Number < 18 Weeks	Backlog (+18 Weeks)	% <18 Weeks	March 2019 Waiting List	Movement from March 19
General Surgery	2141	1886	255	88.09%	2251	-110
Urology	1094	947	147	86.56%	1193	-99
Trauma & Orthopaedics	983	905	78	92.07%	800	183
ENT	1151	1044	107	90.70%	1312	-161
Ophthalmology	1580	1398	182	88.48%	1332	248
Oral Surgery	762	614	148	80.58%	571	191
General Medicine	635	564	71	88.82%	586	49
Gastroenterology	951	767	184	80.65%	1263	-312
Cardiology	616	541	75	87.82%	593	23
Dermatology	1214	1148	66	94.56%	1298	-84
Thoracic Medicine	431	383	48	88.86%	393	38
Rheumatology	384	343	41	89.32%	405	-21
Gynaecology	1055	927	128	87.87%	1090	-35
Other	1567	1411	156	90.04%	1749	-182
All specialties	14564	12878	1686	88.42%	14836	-272

92

What are the issues?
Urology – Demand and capacity issues continue due to the increasing referrals. Cancer patients take priority which is affecting elective patients. A locum left in January which has caused more issues.
Gastro – ASIs are no longer an issue although there is a backlog of patients waiting to be seen. Consultant now gone off on maternity leave.
Rheumatology – Continued Increase in referrals although managing to maintain waiting list. Specialist Nurse to commence in post February 2020 and a paper for growth will be incorporated as part of the planning round.
Dermatology – Referrals have continued to stabilised despite still struggling with the backlog. There are around 750 patients currently on the backlog awaiting follow ups. 2 consultants have left at the same time. The service continues with vacant posts.
Waiting List – This further reduced during December but is expected to rise at the end of January 2020 due to the unexpected pressures on non-elective care.

What actions have been taken?
Urology – Reviewing capacity and currently recruiting for additional consultant capacity. Additonal clinics put on when able to do so.
Gastro - Medinet continues to provide clinical support. Team to review capacity at the trust to enable this activity to take place in-house.
Rheumatology – Medinet continuing to provide additional support. Staffing structures are to be reviewed.
Dermatology – Additional clinics are being reviewed for February. Business case has been submitted for a second specialist nurse, this is still at DLT stage. Priority is to implement tele-dermatology in connection with clinical connect. It is hoped that Tele dermatology will start in the next financial year which will assist.
Waiting List – Validation team are reviewing the waiting list now that they are at full capacity again, although two still in training. No external validation has been necessary.

What are the next steps –
The CCG will continue to monitor the size of the waiting list.

UHDB – INCOMPLETE PATHWAYS PERFORMANCE (92%)

Performance Analysis

During December the Trust failed to achieve the incomplete pathway standard of 92% with a reported achievement of 85.9%. Site performance was: Derby 85.92%, Burton 88.50%.

At the end of December the un-validated waiting list figure was 56,203 which is above their trajectory however, this figure now includes those patients transferred from DCHS. The normal level of validation continues to be delayed due to the transition of the DCHS patients to the Lorenzo IT programme as part of the strategic shift and gaps in staff provision.

Treatment Function Name	Total Incomplete Waiting List	Number < 18 Weeks	Backlog (+18 Weeks)	% <18 Weeks	March 2019 Waiting List	Movement from March 19
General Surgery	3255	2751	504	84.52%	2955	300
Urology	2230	1988	242	89.15%	2090	140
Trauma & Orthopaedics	9653	7711	1942	79.88%	7264	2389
ENT	3809	3433	376	90.13%	3580	229
Ophthalmology	6736	5722	1014	84.95%	5457	1279
Oral Surgery	787	704	83	89.45%	780	7
Neurosurgery	91	45	46	49.45%	73	18
Plastic Surgery	314	249	65	79.30%	289	25
Cardiothoracic Surgery	10	9	1	90.00%	11	-1
General Medicine	142	136	6	95.77%	35	107
Gastroenterology	2542	2417	125	95.08%	2189	353
Cardiology	2812	2533	279	90.08%	1886	926
Dermatology	3256	2540	716	78.01%	2994	262
Thoracic Medicine	722	660	62	91.41%	514	208
Neurology	1112	1050	62	94.42%	1192	-80
Rheumatology	1347	1060	287	78.69%	1413	-66
Geriatric Medicine	218	214	4	98.17%	159	59
Gynaecology	3337	3085	252	92.45%	2999	338
Other	12830	11126	1704	86.72%	11553	1277
All specialties	55203	47433	7770	85.92%	47433	7770

What are the issues?

UGI & Bariatrics - Ongoing long waits particularly for bariatric surgery which are mainly due to ongoing capacity issues and complex pathways.

Urology – ASIs remain the biggest cause for concern on this service alongside staff vacancies which is now impacting on clinic utilisation.

Ophthalmology – Staffing issues continue across both sites to include a range of staff groups. WLIs are not matching demand and equipment failure has resulted in cancellations of appointments. Significant gaps in services across the community have been identified. A virtual glaucoma service has been delayed this financial year due to building works not being complete at LRCH.

Trauma and Orthopaedics – A total of 56 T&O beds at RDH and 28 T&O beds at QHB remain with medicine in support of the winter plan. There is no indication of when these will start to be returned. This is resulting in the waiting list for electives increasing by 80-100 with up to 310 since 1st January. 10 beds continue to be clinically prioritised to support urgent cases and 52 week waiters.

Actions:

UGI & Bariatrics - Additional clinics continue to include converting clinic/day case time to inpatient theatre lists where possible.

Urology - Clinics are being converted where appropriate to manage ASIs and recruitment is underway to address the staffing issues.

Ophthalmology – Two further consultants are due to commence in Summer 2020 and 4 speciality Doctor have been appointed with staggered start dates to include 3 at Derby and 1 at Burton over the coming months. WLIs will continue until these posts have commenced.

Trauma and Orthopaedics – mitigation plans are being undertaken, with additional sessions in place at Ilkeston and Burton. Further sessions will commence at Barlborough from February and at the Treatment Centre from April.

What are the next steps?

- Long waiters in particular those approaching 52wks are being managed via weekly calls with NHSE/I.
- The CCG are continuing to have weekly conversations with the Trust around the management of the overall waiting list position.
- March 19 baseline and target for March 2020 is to be adjusted as a result of the strategic shift of patients from DCHS to UHDB.
- ERS capacity alerts will continue on the choose and book system for T&O Lower Limb procedures until further notice.

DERBYSHIRE COMMISSIONER - 40+ WEEK WAITERS

Performance Analysis

At the end of December there were 240 patients declared at waiting over 40 weeks for treatment in Derbyshire. This is a marked increase from the 63 reported in November. The increase in December was expected due to patient choice and staff leave over the Christmas period.

Out of the 240 patients, 164 were Derbyshire CCG patients, 21 specialised commissioning cases waiting for Maxillo Facial surgery at UHDB and CRH, leaving 55 Derbyshire patients waiting for treatment at associate providers.

52 week waits:

52 week waits continues to be 0 in November, resulting in four consecutive months of no Derbyshire patients waiting 52weeks or over for treatment.

Un-validated reports indicates there will also be no Derbyshire patients waiting over 52 weeks at the end of January. However, there are concerns for February and March following the reduction of elective beds in support of the winter pressures.

NB: UHDB/CRH figures for all patients. Associates – DDCCG Patients only

Provider	40-51 ww		Total 40+ww	Total 52+ww
	TCI	No TCI		
Derby & Burton	55	99	**154**	**0**
Chesterfield	16	22	**38**	**0**
Nottingham	26	11	**37**	**0**
Sheffield Teaching	0	1	**1**	**0**
Sherwood Forest	4	2	**6**	**0**
Stockport	1	1	**2**	**0**
East Cheshire	0	2	**2**	**0**
Total	**102**	**138**	**240**	**0**

CCG patients – Trend – 52 weeks													
	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
DCCG	11	9	8	4	2	3	3	2	2	0	0	0	0

Issues and actions:

UHDB - 154 of the 240 waiting over 40 weeks are patients at UHDB.

Upper Gastrointestinal are continuing to report high numbers of long waits in particular for Bariatrics, mainly due to ongoing capacity issues and complex pathways.

Actions: Converting clinic/day case time to inpatient theatre lists where possible is still ongoing.

T&O is one of the highest reporting specialities on the waiting list which has been un-avoidable due to the loss of elective beds to support the winter plan.

Actions: Ten beds have been protected at the Derby site for urgent electives and long waiters and plans are in place for the use of Barlborough site from February.

CRH - There are 38 of the 240 patients waiting for treatment at CRH.

The highest reporting specialities at CRH is Maxillo-Facial which is specialised commissioning.

Actions: Weekly meetings are continuing to include all patients over 36 weeks.

Next steps

- The CCG have weekly engagement with the two main providers to ensure sufficient monitoring is in place for all patients waiting over 40 weeks.
- Following the prediction of 52 week breaches during winter additional engagement is in place with UHDB and NHS/EI to ensure sufficient context is provided to explain the reasons and actions being taken for each potential 52ww.
- Regular reporting processes are in place with associate providers to ensure all Derbyshire patients across the country who are waiting for treatment over 40weeks is captured and reported.
- A summary of the overall CCG position to include all providers is reported to NHSE/I on a weekly basis.

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

Performance Analysis

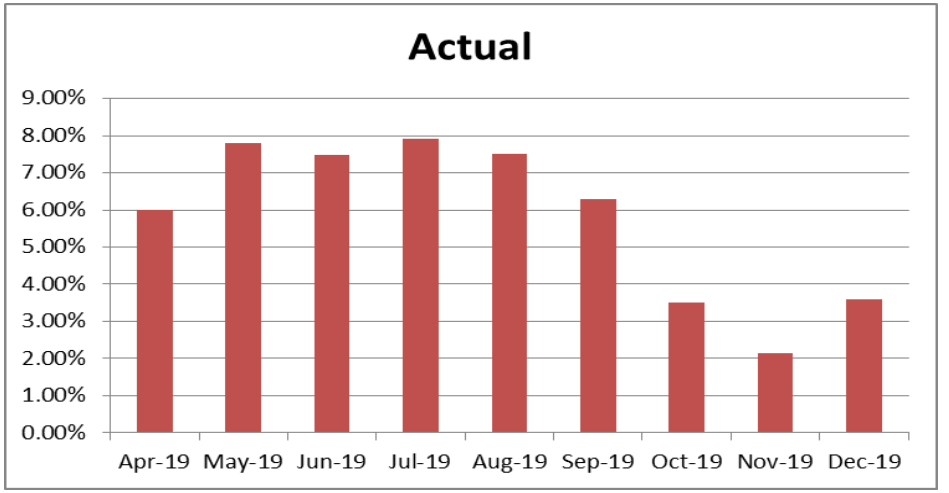
Derbyshire CCG diagnostic performance during December 2019 was 3.6% which is non-compliant against the target of 1% and has further deteriorated in December compared to November, which stood at 2.1%. The providers impacting on the non-compliance include UHDB and Stockport.

UHDB areas of high reporting rates for non-compliance include Echocardiography, Cystoscopy and Urodynamics.

Stockport areas of high reporting rates for non-compliance continue to include Colonoscopy and Gastroscopy. (although the performance of these service areas affect the overall compliance of Diagnostics the numbers within these two areas are relatively small compared to other tests).

CCG Actions

- The CCG will continue to performance manage the main providers within Derbyshire and gain assurance that plans are in place to support improvement of the position.
- Associate providers will continue to be closely monitored.



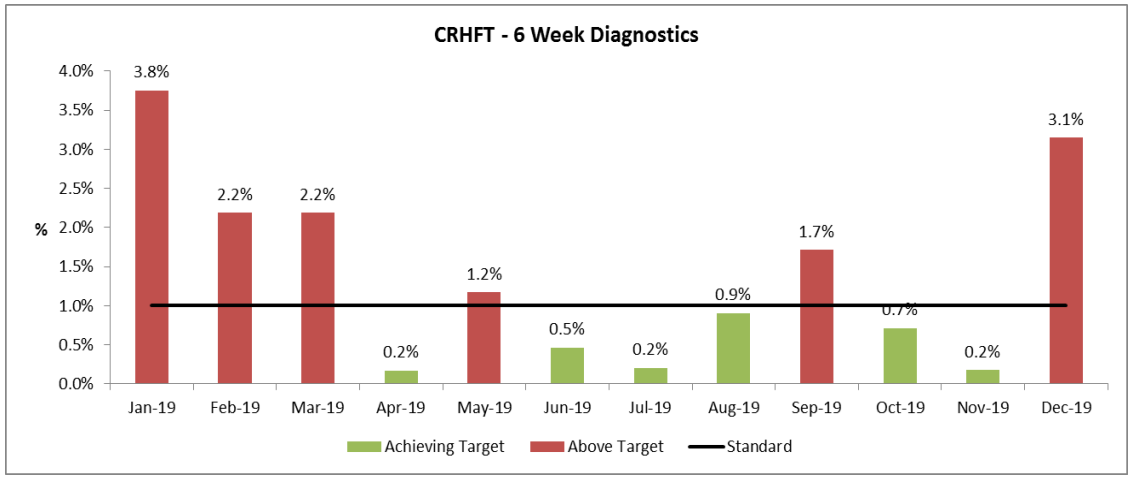
Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Nov +6 Weeks	Movement November to December 6+ Weeks	Percentage waiting 6+ Weeks
Audiology - Audiology Assessments	529	6	1	641	6	1.13%
Barium Enema	1	0	0	2	0	0.00%
Cardiology - Echocardiography	1,959	315	19	1,998	206	16.08%
Colonoscopy	597	39	14	589	23	6.53%
Computed Tomography	2,001	12	0	2,132	3	0.60%
Cystoscopy	293	13	0	337	12	4.44%
DEXA Scan	378	0	0	333	0	0.00%
Flexi Sigmoidoscopy	226	8	1	239	4	3.54%
Gastroscopy	705	45	12	719	22	6.38%
Magnetic Resonance Imaging	2,740	12	0	3,000	16	0.44%
Neurophysiology - Peripheral Neurophysiology	327	4	1	299	1	1.22%
Non-obstetric Ultrasound	3,850	3	0	4,329	2	0.08%
Respiratory physiology - Sleep Studies	165	24	0	123	5	14.55%
Urodynamics - Pressures & Flows	71	15	1	87	17	21.13%
Total	13,842	496	49	14,828	317	3.58%

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	0.13%	0.97%	0.00%	0.00%	1.22%	0.97%	0.00%
Computed Tomography	0.15%	0.39%	2.33%	0.00%	1.02%	0.90%	0.00%
Non-obstetric Ultrasound	0.13%	0.16%	0.10%	0.00%	0.07%	0.00%	0.00%
Barium Enema	0.00%						0.00%
DEXA Scan	0.00%	0.00%	0.00%	0.57%	0.31%	0.00%	
Audiology - Audiology Assessments	0.38%	0.78%	0.00%	2.31%	0.00%	5.61%	0.84%
Cardiology - Echocardiography	15.31%	15.70%	2.95%	0.10%	0.13%	0.00%	0.00%
Neurophysiology - Peripheral Neurophysiology	2.58%		0.00%	0.00%		0.00%	
Respiratory physiology - Sleep Studies	9.82%		23.61%	1.55%	9.34%	1.15%	
Urodynamics - Pressures & Flows	18.33%	18.75%	0.00%	0.00%	6.67%	0.00%	100.00%
Colonoscopy	0.81%	0.00%	42.63%	0.00%	0.57%	0.89%	3.29%
Flexi Sigmoidoscopy	0.68%	0.00%	42.00%	0.00%	1.02%	0.00%	1.69%
Cystoscopy	6.55%	2.00%	0.00%	0.00%	4.27%	0.00%	0.00%
Gastroscopy	2.52%	0.00%	39.32%	0.00%	0.57%	3.00%	0.57%
Total	2.73%	3.15%	11.21%	0.10%	0.96%	0.99%	0.63%

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

Performance Analysis

The trust did not achieve the required standard for December 2019 which a performance of 3.1%.



What are the issues?

Echocardiography is the service identified as the reason for non-compliance in CRH diagnostics.
This has been a combination of an increase in referrals and staff capacity due to sickness leave.

Additional support has now been put in place and the trust expect to return to compliance at the end of March 2020.

Urodynamics – This is a small service at the trust and there is only one person who undertakes these procedures who was off unexpectedly. Extra capacity has now been put in place to bring this service back to compliance.

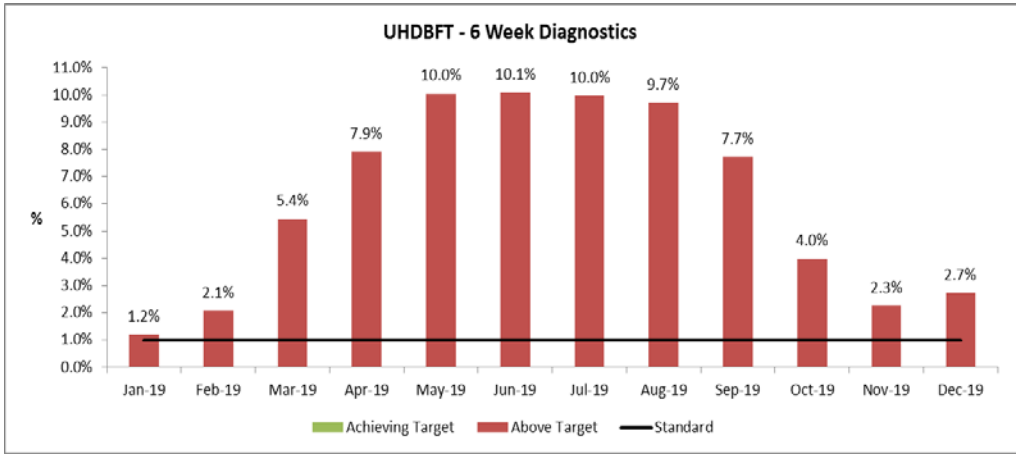
What actions have been taken?

The Contract Performance notice issued in March 2019 due to the non compliance of this standard remains open and the CCG will continue to monitor the performance of the trust and actions undertaken to return to compliance.

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

Performance Analysis
UHDB continue to fail the diagnostic standard and have done so for a total of 12 consecutive months. The performance figure for December is 2.7% which has deteriorated since Novembers position which stood at 2.3% non compliant. Unfortunately it is anticipated that the target to hit the trajectory in January will not be met. However, assurance has been provided to support a full recovery by February.

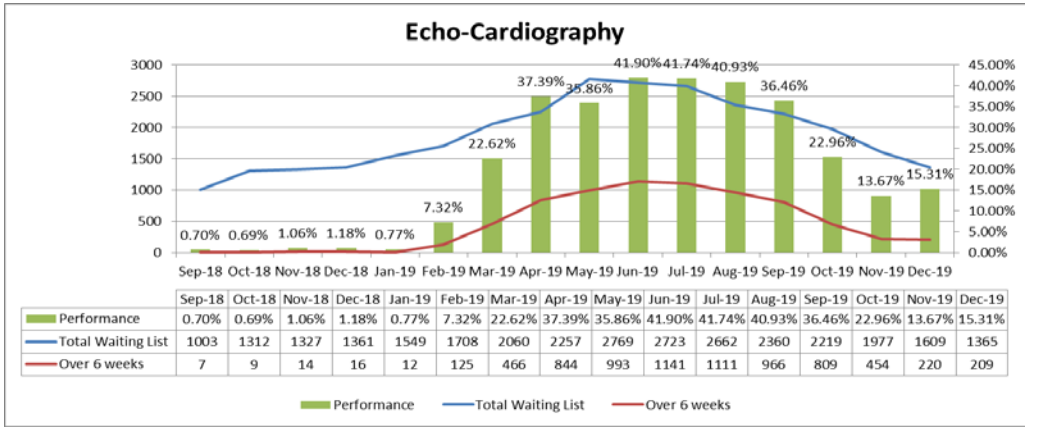
The main contributors for non-compliance in Diagnostics include Echo-Cardiography and Cystoscopy. However, Urodynamics waiting list has also increased slightly with 11 patients waiting over 6 weeks for a diagnostic, resulting in a worsened performance.



Echo-Cardiography continues to be the biggest contributor to the Trust's non-compliance of the diagnostics target.

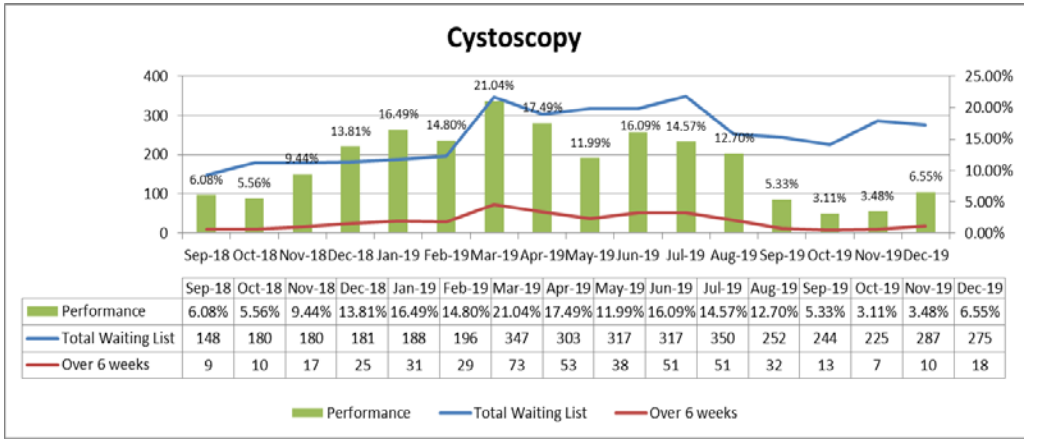
Echocardiography
Although the waiting list has continued to decrease in December the activity has been limited due to the impacts of the festive period resulting in a negative impact on performance with a report of 15.3% for December in comparison to 13.6% in November.
The number of patients waiting over 6 weeks stands at 209, calculating at a reduction of 11 since November.

Issues/Actions:
Recovery – the Recovery plan with a trajectory for the Echo waiting list to all be below 6 weeks by the end of December 2019 has not been met nor is it expected to be met in January. This is mainly due to patient choice and the recovery from the impact of Christmas. Clinics in January and February have been planned to support the trajectory to be met by the end of February.
External Contractor – Two external contractors are continuing to work through outstanding capacity.
Recruitment – Workforce issues are being actioned accordingly in particular with overseas recruitment being considered.



	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Performance	0.70%	0.69%	1.06%	1.18%	0.77%	7.32%	22.62%	37.39%	35.86%	41.90%	41.74%	40.93%	36.46%	22.96%	13.67%	15.31%
Total Waiting List	1003	1312	1327	1361	1549	1708	2060	2257	2769	2723	2662	2360	2219	1977	1609	1365
Over 6 weeks	7	9	14	16	12	125	466	844	993	1141	1111	966	809	454	220	209

Cystoscopy
The waiting list for patients waiting over 6 weeks for Cystoscopy in December has increased slightly despite the overall waiting list decreasing. This has resulted in a negative impact on performance which is due to the impacts of the festive period. Historically diagnostics is affected during the Christmas period therefore the Trust are confident the performance will improve in January.
Issues/Actions: Additional clinics are continuing to be utilised where possible. Robust booking processes and validation of patients are ongoing. The possibility of running cystoscopy lists in outpatients is still being explored however, the concern is that staffing restraints may prevent this.



	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19
Performance	6.08%	5.56%	9.44%	13.81%	16.49%	14.80%	21.04%	17.49%	11.99%	16.09%	14.57%	12.70%	5.33%	3.11%	3.48%	6.55%
Total Waiting List	148	180	180	181	188	196	347	303	317	317	350	252	244	225	287	275
Over 6 weeks	9	10	17	25	31	29	73	53	38	51	51	32	13	7	10	18

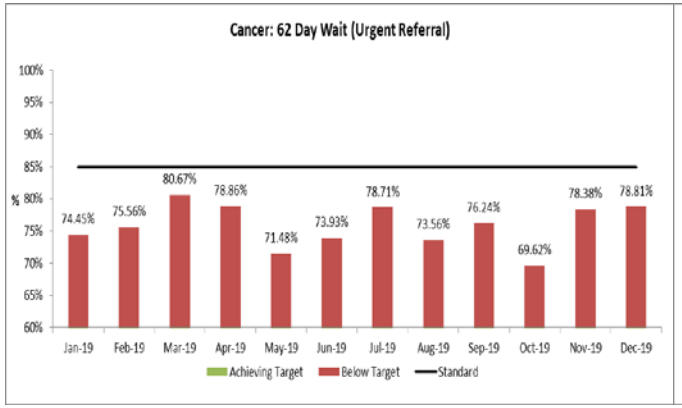
Next Steps:
- NHSE/I and the CCG are working closely with the Trust with a view to meet the trajectory by February 2020.

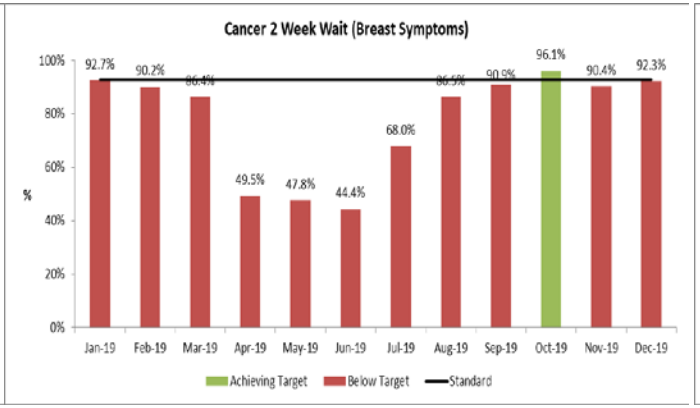
DERBYSHIRE COMMISSIONER – CANCER WAITING TIMES

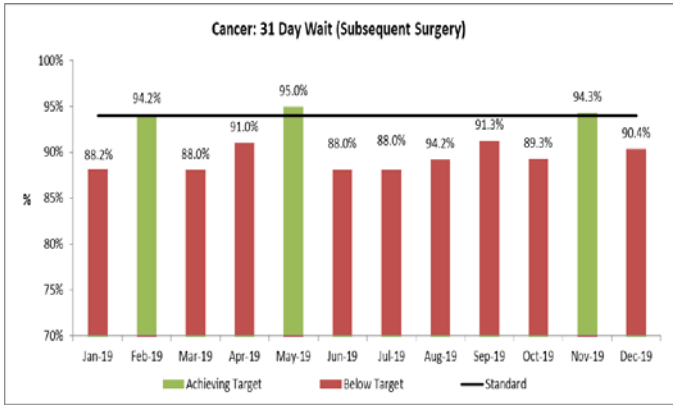
Performance Analysis

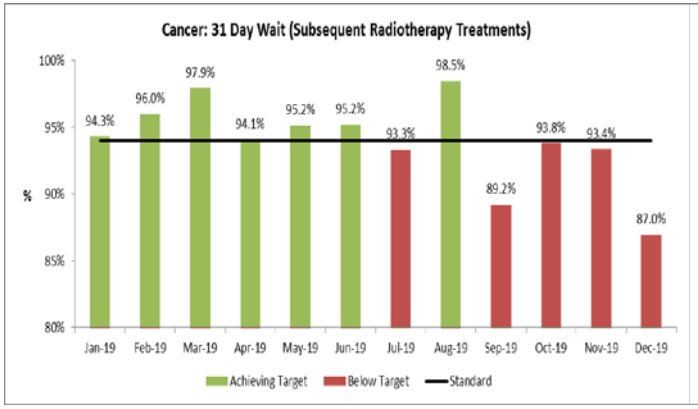
During December 2019 Derbyshire was non-compliant in 5 of the 8 Cancer standards:

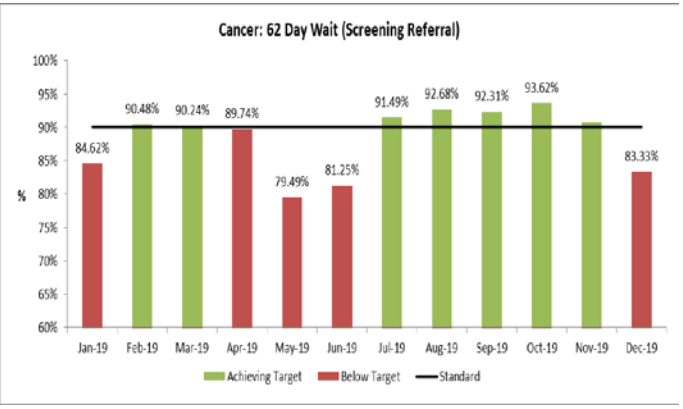
- **62 day Urgent GP Referral** – 78.8% (85% standard) – Sherwood Forest Hospitals was the only compliant trust.
- **2 Week Wait (Breast Symptoms)** – 92.3% (93%) – All trusts compliant except East Cheshire and Sheffield Teaching Hospitals.
- **31 day Subsequent Surgery** – 90.4% (94% standard) – All trusts compliant except NUH and Sherwood Forest Hospitals.
- **31 day Subsequent Radiotherapy** – 87% (94% standard) – UHDB and Sheffield Teaching Hospitals non compliant.
- **62 day Treatment from Screening Referral** – 83.3% (90% standard) – NUH and Stockport were the only compliant trusts.











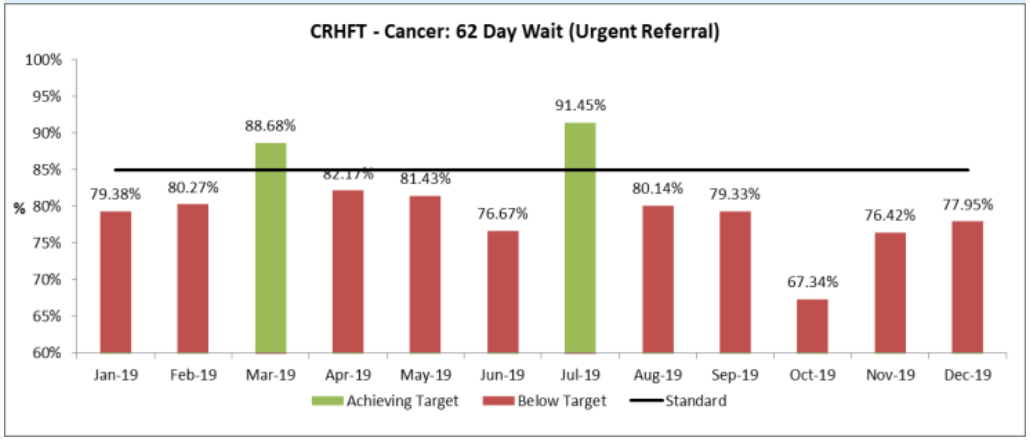
CCG performance data reflects the complete cancer pathway which for many Derbyshire patients will be completed in Sheffield and Nottingham.

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

Performance Analysis

The trust performance continued to improve during December at 77.95% (target of 85%).

There were 3 patients that breached the pathway by over 104 days in December. The breaches were due to patient choice, medical reasons and a complex diagnostic pathway.



Tumour Type	Total Pts seen	> 62 days	% Performance
Breast	1	0	100.00%
Gynaecological	4.5	0	100.00%
Haematological (Excluding Acute Leukaemia)	7	1	85.71%
Head and Neck	2.5	1.5	40.00%
Lower Gastrointestinal	9.5	3	68.42%
Lung	5	0	100.00%
Other	1.5	0	100.00%
Skin	11	0	100.00%
Upper Gastrointestinal	3.5	1.5	57.14%
Urological (Excluding Testicular)	18	7	61.11%
Totals	63.5	14	77.95%

99

What are the issues?

- Delays continue to imaging and reporting, particularly for CT scans.
- The Trust continue to report delays as a result of outpatient capacity at STH.
- Head & Neck – 1 breach due to imaging delays, 1 due to medical reasons, 1 breach due to patient choice.
- Lower GI – Health care provider delays to diagnostic tests due to CT scan waits.
- Upper GI – Health care provider delays for imaging at CRH.
- Urological – Health care provider delays for imaging and delays due to medical reasons.

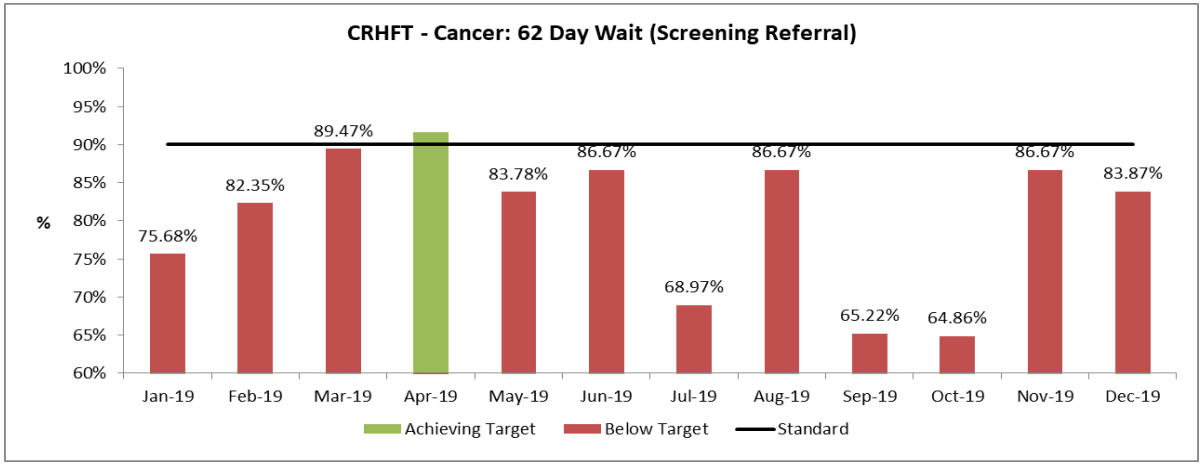
What actions have been taken?

- Extra clinics continue for CT scans and the trust outsourced some CT scans during December and January.
- In relation to reported delays at STH, the CCG are monitoring and discussions are being held with the oncology team to aim to reduce delays.
- The trust are reviewing the pathways for referrals to ensure Inter-provider transfer (IPT) patients are referred within 38 days.
- Imaging reporting continues to be outsourced to pull waiting times down (also covers patients on RTT pathway).
- Improvement plans are in place and are reviewed at the bi-monthly cancer steering group which is attended by CCG representatives.

What are the next steps

- Alongside the trust during late February/Early March review breach reports to understand if there are delays to treatment for those patients who are referred to Sheffield Teaching Hospital.
- Any delays will then be discussed with Sheffield CCG at the end of March as part of the monthly CCG performance meeting.
- Trust representatives have been invited to be part of the Improvement group at UHDB.

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



Performance Analysis

62 day screening performance was 83.9% (against a target of 90%) during December, a decrease in performance since the previous month (86.67%).

There were 16 treatments in December with 2.5 breaches (relating to three patients).

If 1 more patient had been seen within the 62 days then the trust would have been compliant with this standard.

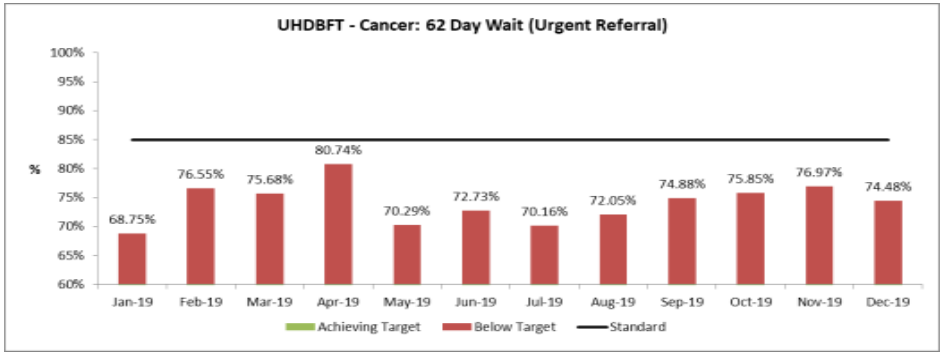
What are the issues?

1 x Breast – due to patient choice.
1.5 LGI - 1 due to elective capacity issues and 0.5 due to healthcare provider delay.

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

Performance Analysis –
62 day performance during December 2019 was non compliant at 74.48%. This is a decrease from last month's figure of 76.97%. The trust has failed this standard (of 85%) for the 20th consecutive month.

There were 4.5 patients that breached the pathway by over 104 days in December, a reduction from 13 in the previous month. The breaches were due to outpatient capacity issues, complex diagnostic pathways and patient choice.



Tumour Type	Total Pts seen	> 62 days	% Performance
Breast	29	0	100.00%
Gynaecological	12	2	83.33%
Haematological (Excluding Acute Leukaemia)	18	6	66.67%
Head and Neck	9	3.5	61.11%
Lower Gastrointestinal	27.5	13.5	50.91%
Lung	12.5	2.5	80.00%
Other	1	1	0.00%
Sarcoma	1	0	100.00%
Skin	28	7	75.00%
Upper Gastrointestinal	11	6	45.45%
Urological (Excluding Testicular)	45	8	82.22%
Totals	194.0	49.5	74.48%

What are the issues?
- Oncology capacity – delays continue across tumour sites particularly within Urology Clinical Oncology clinics due to demand and workforce / recruitment issues.
- Gynaecology – 1 breach due to a healthcare provider delay and 1 due to patient choice.
- Haematology – 2 breaches due to healthcare provider delays, 2 due to outpatient capacity, 1 due to complex pathway, 1 due to an inconclusive diagnostic result.
- Head & Neck – 1 due to outpatient capacity, 3 due to patient choice, 1 due to medical complexity.
- Lower GI – Capacity issues due to staffing issues and increased number of referrals. The speciality continues to raise concerns over incomplete 2ww referrals being received.
- Lung – 2 breaches due to medical complexity.
- Skin – 3 breaches due to outpatient capacity, 3 due to elective capacity, 1 due to patient choice.
- Upper GI – 4 breaches due to medical complexity, 1 due to elective capacity, 1 due to patient choice.

What actions have been taken?
- As previously reported, medical oncology capacity due to staffing issues has been escalated within the trust and added onto the trust's Risk Register. A locum lung clinical Oncologist has been recruited who also has experience of Prostate which will increase capacity and help to clear the backlog in Urology & also help in Upper GI.
- The Trust have reduced the time for prostate patients to be seen for their 1st Outpatient appointment to 7 days. In December 2019 the trust saw 99.08% of prostate patients within 7 days – it is expected this will reduce delays within the prostate pathway.
- Lower GI – extra clinics in place to increase capacity. The trust are working with DDCCG to implement the 'Straight to Test' pathway for Lower GI as a priority with site specific 2ww referral forms so that GPs can send appropriate patients 'Straight to Test'. Roll out to GPs planned in February 2020.
- DDCCG continue to support to improve the quality of 2WW referrals from GPs to the trust and a GP education event regarding the 2WW referral forms took place on 22nd January 2020.
- Robotic capacity - extra urology lists are being facilitated. 2nd robot is planned and funding for this is in the process of being secured.

What are the next steps?
- A high level Remedial Action Plan was previously received from the Trust for the original CPN and fortnightly calls are in place. Following a reissue of the CPN, a revised Remedial Action Plan has been requested.
- Monthly cancer improvement group workshops have been implemented and started on 7th November.
- December breaches are to be reviewed by DDCCG and the trust on 21st February 2020.

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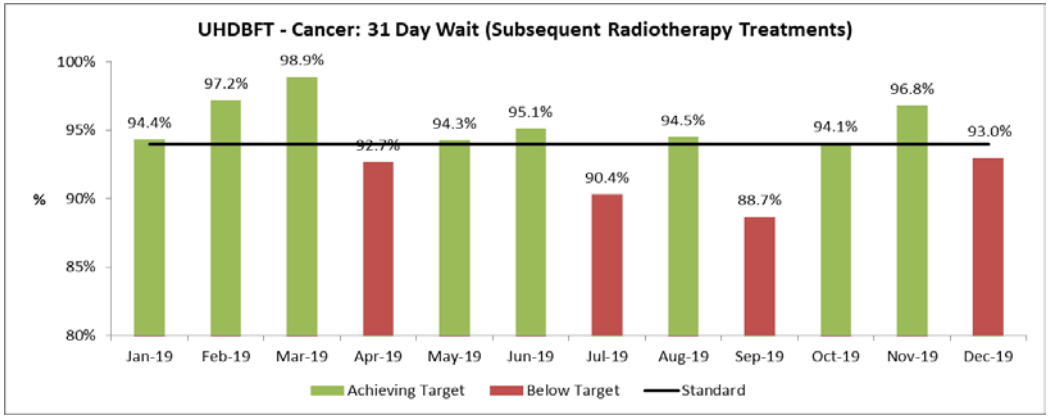
UHDB – 31 Day CANCER WAITING TIMES (Subsequent Radiotherapy)

Performance Analysis –
Performance for 31 day for subsequent radiotherapy during December 2019 was non compliant at 93% (standard is 94%), a decrease from last month's figure of 96.8%.

There were 7 breaches for 31 day for subsequent radiotherapy (4 breaches in Breast - 2 due to patient choice and 2 due outpatient capacity, 2 breaches in Sarcoma - both due to complex planning and 1 breach in Urology due to an administrative delay). If 1 more patient had been treated within the 31 days then the trust would have been compliant with this standard (achieving 94%).



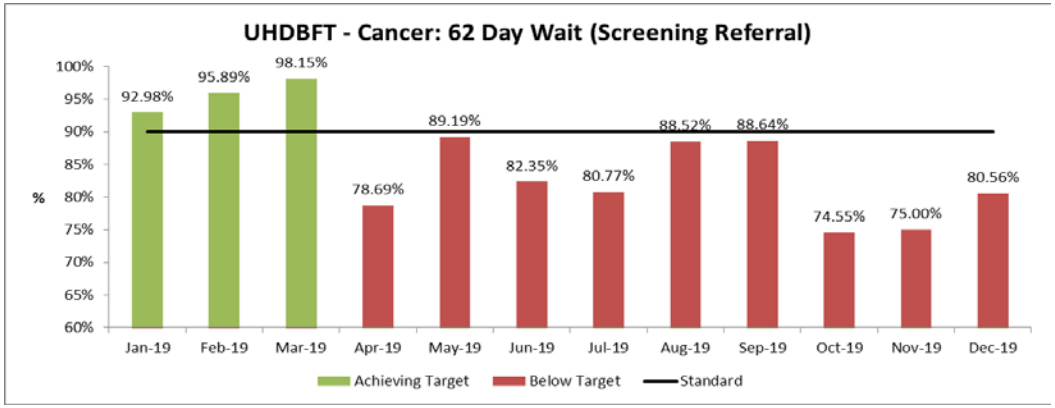
UHDB - CANCER WAITING TIMES (First Treatment Administered within 62 Days of Screening)

Performance Analysis –
62 day screening performance during December was non compliant at 80.56% (against a standard of 90%), an increase from last month's figure of 75%.

There were 7 breaches for 62 day screening performance in December (5 in Lower GI, 1 in Breast and 1 in Haematology).

The Trust treated 36 patients and 7 were treated after 62 days of screening. If 4 more patients had been treated within the 62 days then the trust would have been compliant with this standard.

- 2 breaches in Lower GI were due to patient choice, 2 due to outpatient capacity and 1 due to medical complexity.
- The breach in Breast was due to medical reasons.
- The breach in Haematology (breached by 1 day) and was due to public holidays over the Christmas period.



Appendix

APPENDIX 1: PERFORMANCE OVERVIEW M8 – ASSOCIATE PROVIDER CONTRACTS

Derbyshire Wide Provider Assurance Dashboard

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

Part A - National and Local Requirements

Provider Dashboard for NHS Constitution Indicators

	Area	Indicator Name	Standard	Latest Period	East Cheshire Hospitals				Nottingham University Hospitals				Sheffield Teaching Hospitals FT				Sherwood Forest Hospitals FT				Stockport FT			
					Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance
Urgent Care	Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	Jan-20	↓	69.3%	75.5%	19	A&E pilot site - not currently reporting 4 hour breaches				↓	81.6%	83.5%	45	↑	89.6%	90.3%	16	↑	64.0%	68.7%	56
		A&E 12 Hour Trolley Waits	0	Jan-20	↓	6	24	2	↑	92	150	4	↑	1	1	1	↑	22	46	3	↓	174	649	10
	DToC	Delayed Transfers Of Care - % of Total Bed days Delayed	3.5%	Dec-19	↑	5.39%	5.61%	32	↑	3.01%	3.16%	0	↓	3.91%	3.01%	1	↑	3.79%	4.72%	7	↓	5.08%	4.01%	4
Planned Care	Referral to Treatment for non-urgent consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Dec-19	↑	86.3%	84.1%	28	↓	90.0%	91.9%	3	↓	92.0%	92.8%	0	↓	86.0%	88.1%	28	↓	78.2%	81.8%	23
		Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Dec-19	→	0	10	0	→	0	12	0	→	0	0	0	→	0	0	0	↓	5	37	20
	Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Dec-19	↓	0.63%	4.55%	0	↑	0.99%	2.10%	0	↓	0.10%	0.81%	0	↓	0.96%	1.35%	0	↓	11.21%	4.73%	6
	2 Week Cancer Waits	All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	Dec-19	↑	97.3%	82.3%	0	↑	94.0%	93.6%	0	↑	95.4%	94.7%	0	↑	96.3%	94.3%	0	↓	95.0%	91.5%	0
		Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	Dec-19	↑	79.5%	52.7%	12	↑	99.1%	99.0%	0	↓	91.0%	93.2%	1	↑	100.0%	96.3%	0	↓	100.0%	19.7%	0
	31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	96%	Dec-19	↓	100.0%	100.0%	0	↑	93.2%	92.9%	12	↓	94.8%	94.6%	5	↓	95.8%	96.4%	1	↑	97.6%	97.4%	0
		Subsequent Surgery Within 31 Days Of Decision To Treat	94%	Dec-19	↓	100.0%	100.0%	0	↓	81.1%	82.1%	20	↑	98.9%	91.9%	0	↓	77.8%	82.2%	2	↓	100.0%	96.3%	0
		Subsequent Drug Treatment Within 31 Days Of Decision To Treat	98%	Dec-19	↓	100.0%	94.1%	0	↓	98.8%	99.5%	0	↓	99.6%	99.6%	0	↓	100.0%	100.0%	0	↓	100.0%	100.0%	0
		Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	Dec-19					↓	99.0%	99.0%	0	↓	80.1%	92.0%	4								
	62 Days Cancer Waits	First Treatment Administered Within 62 Days Of Urgent GP Referral	85%	Dec-19	↑	71.8%	73.3%	3	↓	74.2%	75.9%	19	↑	74.3%	73.4%	52	↑	85.7%	77.6%	0	↑	69.2%	74.3%	8
		First Treatment Administered - 104+ Day Waits	0	Dec-19	→	1.0	18.5	10	↓	15.5	95.0	45	↓	11.5	106.0	45	↓	4.5	44.0	20	↓	6.0	31.5	8
		First Treatment Administered Within 62 Days Of Screening Referral	90%	Dec-19	↓	85.7%	90.3%	1	↑	100.0%	84.9%	0	↓	85.2%	88.0%	4	↑	88.9%	79.5%	6	↓	100%	64.3%	0
		First Treatment Administered Within 62 Days Of Consultant Upgrade	N/A	Dec-19	↓	80.0%	84.8%		↓	80.1%	84.3%		↑	82.0%	78.2%		↓	75.0%	87.2%		↑	83.9%	76.8%	
	Cancelled Operations	% Of Cancelled Operations Rebooked Over 28 Days	N/A	19-20 Q3	↑	0.0%	0.0%		↓	9.5%	4.6%		↓	2.3%	5.0%		↑	2.3%	10.4%		↓	2.9%	7.6%	
		Number of Urgent Operations cancelled for the 2nd time	0	Dec-19	→	0	0		→	0	0		→	0	2		→	0	0		→	0	0	
Patient Safety	Mixed Sex Accommodation	Mixed Sex Accommodation Breaches	0	Dec-19	↑	26	325	18	→	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	Dec-19	↑	0	2	0	↑	0	2	0	↑	0	1	0	→	0	0	0	→	0	0	0
		Healthcare Acquired Infection (HCAI) Measure: C-Diff Infections	Plan	Dec-19	→		2		↓		10		↓		14		→		6		→		4	
			Actual				0	0			15	0			10	0			2	0			3	0
		Healthcare Acquired Infection (HCAI) Measure: E-Coli	-	Dec-19	↑	8	117		↑	53	576		↑	36	523		↓	35	259		↑	16	159	
		Healthcare Acquired Infection (HCAI) Measure: MSSA	-	Dec-19	→	0	4		↑	8	74		↑	8	53		↓	3	18		↓	2	9	

Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

5th March 2020

Item No: 243

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

Paper for:	**Decision**		**Assurance**	X	**Discussion**		**Information**	x
Assurance Report Signed off by Chair				Gillian Orwin, Chair (Deputy)				
Which committee has the subject matter been through?				Primary Care Commissioning Committee				

Recommendations

The Governing Body is requested to **NOTE** the following report, which was presented to the Primary Care Commissioning Committee (PCCC) public meeting held on Wednesday 26th February 2020:

- Closure of Staffa Health branch surgery at Pilsley – The committee approved the closure of the GP branch surgery at Pilsley following a 60 day consultation. The proposed closure date for the branch is 1st April 2021 to enable a phased reduction of service, enable additional clinical space to be put in place at Tibshelf, address car parking and transport concerns. For information, the outcome of the consultation was considered at Health and Scrutiny Committee and the CCG Engagement Committee. 19 members of the public, including the MP, councillor and the media were in attendance for this agenda item only during the public meeting.

Report Summary

The monthly finance report with the month 9 position, quarterly Primary Care Quality and Performance Assurance Report Quarter 3 Update and quarterly update from Primary Care Leadership Group was presented to the PCCC public meeting for assurance.

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 ratified minutes from the January public 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 February 2020 will therefore be received at the next Governing Body meeting.

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?
Declaration provided at the beginning of the meeting and raised for any specific agenda items and recorded in the minutes. Dr Steve Lloyd raised a Conflict of Interest and left the meeting for the discussion around the Pilsley Branch Closure.
Governing Body Assurance Framework
Considered for each agenda item.
Identification of Key Risks
Considered for each specific agenda item – no risks identified for the PCCC finance report this month.

Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

5th March 2020

Item No: 245

Report Title	Risk Register Report as at 28th February 2020
Author(s)	Rosalie Whitehead, Risk Management & Legal Assurance Manager.
Sponsor (Director)	Helen Dillistone – Executive Director of Corporate Strategy & Delivery

Paper for:	**Decision**		**Assurance**	X	**Discussion**		**Information**	
Assurance Report Signed off by Chair				N/A				
Which committee has the subject matter been through?				Engagement Committee – 19th February 2020. Clinical & Lay Commissioning Committee – 13th February 2020. Primary Care Commissioning Committee – 26th February 2020. Finance Committee – 27th February 2020. Quality and Performance Committee – 27th February 2020.				

Recommendations

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

- The Risk Register Report;
- Appendix 1 as a reflection of the Very High Risks of the organisation as at 28th February 2020; and
- Appendix 2 which summarises the movement of all risks during February 2020.
- The new Risk 043, which is the responsibility of the Quality & Performance Committee.

Report Summary

This report presented to the Governing Body is to highlight the areas of organisational risk that are recorded in the Derby and Derbyshire CCG Corporate Risk Register (RR) as at 28th February 2020.

The RR is a live management document which enables the organisation to understand its comprehensive risk profile, and brings an awareness of the wider risk environment. All risks in the Risk Register are allocated to a Committee who review new and existing risks each month and agree removal of fully mitigated risks. The Very High Scoring Risks (15-25) are presented to the Executive Team meeting on a

monthly basis.
Are there any Resource Implications (including Financial, Staffing etc)?
Derby and Derbyshire CCG prioritises 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 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.
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
Risks recorded in the Risk Register are aligned to the appropriate Strategic Risk recorded in Governing Body Assurance Framework.
Identification of Key Risks
The paper provides a summary of the very high scoring risks as at 28th February 2020 detailed in Appendix 1.

NHS DERBY AND DERBYSHIRE CCG GOVERNING BODY MEETING

RISK REPORT AS AT 28 FEBRUARY 2020

1. INTRODUCTION

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

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

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

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

2. RISK PROFILE – FEBRUARY 2020

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

Risk Register as at February 2020

Risk Profile	Very High (15-25)	High (8-12)	Moderate (4-6)	Low (1-3)	Total
Total number on Risk Register reported to GB for February	6	15	2	1	24
New Risks	1	0	0	0	1
Increased Risks	0	0	0	0	0
Decreased Risks	0	1	0	0	1
Closed Risks	0	0	0	0	0

Appendix 1 to the report details the very high scoring risks (15-25) for the CCG. Appendix 2 to the report details all the risks for the CCG and the movement in score and the rationale for the movement.

3. COMMITTEES – FEBRUARY VERY HIGH RISKS OVERVIEW

3.1 Quality & Performance Committee

Three Quality and Performance Committee risks are rated as very high (15-25).

Risk 002: The risk score is 20 (Probability 5, impact 4):

The Acute providers may breach thresholds in respect of the A&E operational standards of 95% to be seen, treated, admitted or discharged within 4 hours, resulting in the failure to meet the Derby and Derbyshire CCGs constitutional standards and quality statutory duties.

February update:

Chesterfield Royal Hospital Foundation Trust (CRH) reported 80.0% (YTD 85.3%) and University Hospitals of Derby and Burton NHS Foundation Trust (UHDB) reporting 79.6% (YTD 80.9%).

CRH - The Trust continue to experience a high number of Type 1 attendees compared to 2018/19 with 1.8% more attendances during January 2020, with Operational Pressures Escalation Level OPEL 3 status being declared during the month.

The acuity of the attendances is increasing, with 27.6% of A&E attendances resulting in admission to either an assessment unit or a ward in January (27.2% for December).

Confirmed cases of flu result in reduced capacity when patient areas need deep cleaning once vacated by a flu patient.

Staff shortages are due to sickness and difficulty recruiting to middle grade or consultant medical posts.

UHDB - The volume of patients has increased with an annual 2.4% increase of Type 1s, averaging at 18 more patients per day. Attendances in the Derby network (i.e. including Type 1s, Minor Injury Units (MIUs), Derby Urgent Care Centre (DUCC) & GP Streaming) averaged at 749 per day during January 2020.

The acuity of the conditions presented has also increased, with attendances classed as Major/Resus making up 53.0% of patients at Derby (222 attendances per day). 25.6% of attendances result in admission to either an assessment unit or an inpatient ward. 13 of the 12 hour breaches occurred over a few days (from 3rd to 7th January). During this time the Trust reported OPEL4 level and bed occupancy exceeded 100%.

There has been an overall rise in Major patients being treated by the appropriate clinicians but in the Minors area.

Risk 007: The risk score is 16 (Probability 4, impact 4):

Transforming Care Plans (TCP) are unable to maintain and sustain the performance, pace and change required to meet national TCP requirements. The Adult TCP is on a recovery trajectory and rated amber with confidence, whilst the CYP TCP is rated Green. The main risks to delivery are within market resource and development, with workforce provision as the most significant risk for delivery.

February update

The CCG does not anticipate achievement of the trajectory at Quarter 4 2019/20.

A revised trajectory was been submitted to NHS England / Improvement (NHS E/I) on 11th February 2020 along with a detailed letter providing assurance of the actions being taken to deliver performance.

New national monitoring arrangements were announced in September 19, it is a CCG requirement to visit all Out Of Area (OOA) placements every 6/8 weeks – a visit schedule is in place and being delivered.

A Specialist Supported Living provider's development session will be held during February 2020.

Additional monies have been received from NHS E/I to support accelerated discharges and admission avoidance.

New services have been commissioned to support 'transition to discharge' for two individuals receiving care in Learning Disabilities Assessment and Treatment Unit (LD ATU).

New Risk 043: The risk score is 15 (Probability 3, impact 5):

Loss of Service/Savings delivery and reputational damage due to notice given on Toll Bar House prior to finalising alternative premises with adequate IT infrastructure in place for South Medicines Order Line (MOL). Plans had been made prior to notice being given to Toll Bar House however these fell through and an alternative accommodation at Ilkeston Health Centre was identified.

This risk has been escalated by the Medicines Management Delivery Board. Void space has been identified at Ilkeston Health Centre. Confirmation from NECS has now been received that the Health Centre IT system can be upgraded to allow the function of the MOL to be carried out. This can be achieved within the next four weeks.

3.2 Finance Committee – Very High Risks

One Finance Committee risk is rated as very high.

Risk 027: The risk score is 15 (Probability 3, impact 5):

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.

February Update

This risk remains live and continues to be discussed in relevant meetings to ensure financial risks are mitigated and understood.

At month 10 the CCG reported a year to date (YTD) overspend of £5.2m which is in line with the plan. The CCG has received the 3rd quarter of the Commissioner Sustainability Fund (CSF), which means the forecast outturn is £10.2m overspent which is again in line with the planned CSF adjusted Control Total. At month 10 the financial position remains in line with the plan and the CCG remains eligible for £29m of CSF, of which £18.8m has been received to date. If this happens the CCG will be able to report a breakeven position. Within this position the CCG has reported £3.3m of risk, which includes £2.0m related to Acute Provider activity, £0.6m on Mental Health commissioning and £0.3m on Continuing Health Care. This is being mitigated by contingencies, none of which is being used to support the YTD position.

There remains a genuine risk that the CCG will fail to meet its statutory financial duties in 2019/20, although as we get closer to the end of the financial year this risk reduces. We have entered the winter months and are already seeing increases in activity; therefore it is not possible to fully assure the delivery of the financial position. After assessing the month 10 QIPP savings delivery position the CCG is now reporting a £21.2m end of year under-delivery against the £69.5m plan. The CCG has undertaken a thorough assurance process of all QIPP savings schemes and all risk is now included in the forecast position. No additional risk to QIPP savings has been reported but should any risk materialise, sufficient mitigation should be available.

Whilst the current level of forecast risk can be mitigated there is no other mitigation available if the forecasted financial position were to deteriorate further.

3.3 Primary Care Commissioning Committee – Very High Risks

Two Primary Care Commissioning Committee risks are rated as very high.

Risk 009: This risk score is 16 (Probability 4, impact 4*):*

Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services, resulting in negative impact on patient care.

February Update

We continue with the mitigations of:

Early warning systems: CCG works with the LMC and other partners to systematically identify and support practices that may be in trouble, including: reviewing information on practice performance via an internal, cross directorate review of practices looking at a range of data sources; linking with the LMC to pool soft intelligence on practice 'health' and to jointly support struggling practices; directly approaching practices identified as at risk

CCG support: The CCG commissions and funds a range of supportive measures designed to increase the resilience of General Practice, in line with the GP Forward View and GP Contract. Key working groups and committees have been established to support the delivery of the work programmes, these include:

- Primary Care Leadership Committee
- Primary Care Workforce Steering Group - sub group GPN 10 Group
- Primary Care Estates Steering Group
- General Practice Digital Steering Group

The groups have a wide range of objectives and outcomes to mitigate this corporate risk, these include, managing allocation and monitoring of additional funding to support the Primary Care workforce (recruitment and retention, new roles) Funding of practice nurses to promote the National GPN.

Identification and delivery of training to support and improve GP practice resilience; funding increased capacity; supporting practices to manage workload, development of leadership roles. Utilisation of the GP Task Force and Health Education Derbyshire to support the delivery of these objectives

Peer support: the Primary Care Networks will provide a way that practices can support each other in smaller groups. Over time this will provide a safe forum for practices to seek help from peers and another route for help for struggling practices who are not willing to approach the CCG directly

Strategy: Implementation of the CCG's primary care strategy will bring additional resources, capacity and support to General Practice, and develop its role at the centre of an integrated system, thus increasing resilience and mitigating against individual practice failure. The CCG has financially supported the development of the GP alliance, which have supported the

development of the PC strategy and are also undertaking a review of PC demand and capacity in order to have an understanding of access to Primary Care in Derbyshire.

Risk 015: This risk score is 20 (Probability 4, impact 5):

Due to the increased pressures around workload, workforce and financial concerns, there is a risk to General Practice in providing quality primary care services to patients.

February Update

We continue with the mitigations of:

Primary Care Quality Team: Team providing monitoring of and support to practices county wide, proactive and reactive, direct contact available to practices to clinical team members, via telephone and email, for advice and support of any clinical queries and patient safety issues. Communication pathways established including membership bulletin, Information Handbook, web site development and direct generic inbox.

Primary Care Quality and Performance Committee: The Committee will oversee monitoring support and action plans for the delivery of Primary Medical Services, gain assurance regarding the quality and performance of the care provided by GP practices, identify risks to quality at an early stage. Monthly meetings established.

Cross directorate internal review (hub) process: Primary Care Quality dashboard and matrix developed, discussed monthly at Hub meeting, integration, sharing and triangulation of PC data from Primary Care Quality, Contracting and Transformation.

Provides the opportunity to oversee multiple data sources and gain information from wider CCG teams in order to gain collective view on quality of care offered and to identify areas of best practice and areas of concern where support or intervention is needed. Provides the opportunity to review and create action plans to support practices who may be experiencing / demonstrating difficulty or signs of potential deficit in quality or unwarranted variation of care provision.

Supporting Quality Improvement visits: An 18 month rolling programme of practice visits with a focus on quality and support is being delivered; this provides the opportunity of direct clinical face to face discussion between individual GP practices and CCG. Provides a safe opportunity to discuss individual practice quality metrics and for the practices to highlight / raise any issues or concerns directly to the CCG.

Clinical Governance leads meetings: Established and held quarterly across Derbyshire PCN footprint, provides the interface between CCG and individual practices, opportunity to share best practice, practice concerns, learning and recommendations, support the implantation of GP practice governance.

Quality Schedule: Being developed as part of the enhanced service review to provide a formal mechanism to contract for improved quality standards in areas such as sepsis and safeguarding. Primary Care Quality Schedule has been included to DDCCG Commissioned Primary Care Contracts, to maintain and support the delivery of continuous quality improvement in Primary Care.

4. FEBRUARY OVERVIEW

4.1 Increased risk(s) since last month

No risks have increased in score since last month.

4.2 Decreased risk since last month

One risk has decreased in score since last month.

1. Risk 030: Non-compliance of completion of initial health assessments (IHAs) within statutory timescales for children in care due to the increasing numbers of children/young people entering the care system. This may have an impact on children in care not receiving their initial health assessment as per statutory framework.

   This risk has reduced from a very high 15 (probability 5, impact 3) to a high 12 (probability 4, impact 3). The reason for the reduction in score is that the multi-agency pathway is now in place and performance is showing some improvement, therefore the risk probability has lowered.

4.3 Target Risk Scores

There are no risks with a risk score lower than the target score.

4.4 Closed risk since last month

There are no risks recommended for closure since last month.

4.5 New risks since last month

One new risk has been identified since last month and has been assigned to and approved by the Quality and Performance Committee.

1. Risk 043: Loss of Service/Savings delivery and reputational damage due to notice given on Toll Bar House prior to finalising alternative premises with adequate IT infrastructure in place for South Medicines Order Line. Plans had been made prior to notice being given to TBH however these fell through and an alternative accommodation at Ilkeston Health Centre was identified.

   This risk has been scored at a very high risk of 15 (Probability 3, impact 5). This risk is detailed in section 3.1.

5. RECOMMENDATION

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

- The Risk Register Report;
- Appendix 1 summary as a reflection of the very high risks facing the organisation as at 28th February 2020;
- Appendix 2 which summarises the movement of all risks in February 2020;
- The new Risk 043, which is the responsibility of the Quality & Performance Committee.

Appendix 1 - Very High Risks - as at 28th February 2020

NHS
Derby & Derbyshire
Clinical Commissioning Group

Risk Reference	Yr+#	Risk Description	Responsible Committee	Type - Corporate or Operational	Initial Risk Rating: Probability	Initial Risk Rating: Impact	Initial Risk Rating: Rating	Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating: Probability	Previous Rating: Impact	Previous Rating: Rating	Residual/ Current Risk: Probability	Residual/ Current Risk: Impact	Residual/ Current Risk: Rating	Target Risk: Probability	Target Risk: Impact	Target Risk: Rating	Target Date	Link to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
002	19/20	The Acute providers may breach thresholds in respect of the A&E operational standards of 95% to be seen, treated, admitted or discharged within 4 hours, resulting in the failure to meet the Derby and Derbyshire CCGs constitutional standards and quality statutory duties.	Quality and Performance	Constitutional Standard/ Quality	3	4	12	1) **Governance of Operational/Performance Management:** Derby and Derbyshire CCG representatives chair the monthly Operational Resilience Group (ORG) which is represented by all NHS Provider Organisations and both Local Authorities. The ORG is charged with the responsibility of proposing a series of mitigating actions to the drivers of adverse A&E 4 hour performance, to the A&E Delivery Board. 2) **Provider led mitigations:** The CRH, working closely with Community and Local Authority Organisations, are focussing on methods to reduce Delayed Transfers of Care as a means to provide bed capacity to promote better flow. In addition, the CRH continue to open a number of extra "winter" beds to meet demand. The UHDB are using agency staffing as a way of mitigating the shortfall in Tier 4 Registrar Capacity (where the current vacancy rate is 3.44 WYE).	ORGI/A&E Delivery Board Actions: Taking a PMO approach to system-wide projects including: - Undertake a system wide demand and capacity analysis to understand the drivers of performance at both the CRH and UHDB. - Enabling the direct booking of GP appointments via 111, when clinically appropriate. - Increased Clinician to Clinician contact availability to assist EMAS clinical decision making and avoid unnecessary conveyances. - Identifying other failed pathway referrals that lead to unnecessary ambulance conveyances, forming a plan to remedy these. - Proactively manage High Intensity Users of urgent care to avoid their need to use emergency services. - Providing PCN-based enhanced care in Care Homes to improve quality and reduce unwarranted referrals. - Improving ambulance handover times through increased senior ownership within EDs and applying Releasing Time To Care principles in EMAS. - Expanding the mental health Crisis Service and enhancing the home treatment offer to improve gatekeeping. - Increasing A&E Mental Health Liaison team capacity to speed up response times. - Taking a system-wide approach to Same Day Emergency Care working to increase same-day discharges to improve patient flow. - Establishing an Orthopaedic Assessment Unit at RDH to treat patients in a more appropriate setting and improve flow. - Establishing a Surgical Assessment Unit at CRH to treat patients in a more appropriate setting and improve flow. - Increased GP Streaming at UHDB through commissioning changes and staff upskilling. - Embedding a weekly review process for patients with a length of stay of 21+ days in acute trusts. - Understanding Community demand and capacity to support the Improving Flow D2A pathways in South and City. - Increase OPAT capacity to enable more patients to be discharged from acute hospitals on IV antibiotics. - Altered handovers to enable more timely transfers from MAU/AAC to base wards at UHDB. CRH Actions: Maintain a level of "winter" bed provision as necessary and focus on Red2Green delivery. UHDB Actions: Maintain a level of "winter" bed provision as necessary and focus on Red2Green delivery. In addition, all staff, except for ANP staff, are now using the MetricAid electronic rostering system to ensure maximum staffing of shifts.	January Updated (Provided February 2020) CRH reported 80.0% (YTD 85.3%) and UHDB reporting 79.6% (YTD 80.9%). CRH - The Trust continue to experience a high number of Type 1 attendees compared to 2018/19 with 1.8% more attendances during Jan2020, with OPEL3 status being declared during the month. The acuity of the attendances is increasing, with 27.6% of A&E attendances resulting in admission to either an assessment unit or a ward in January (27.2% for December). Confirmed cases of flu result in reduced capacity when patient areas need deep cleaning once vacated by a flu patient. Staff shortages due to sickness and difficulty recruiting to middle grade or consultant medical posts. UHDB - The volume of patients has increased with an annual 2.4% increase of Type 1s, averaging at 18 more patients per day. Attendances in the Derby network (i.e. including Type 1s, MIUs, DUCC & GP Streaming) averaged at 749 per day during January 2020. The acuity of the conditions presented has also increased, with attendances classed as Major/Resus making up 53.0% of patients at Derby (222 attendances per day). 25.6% of attendances result in admission to either an assessment unit or an inpatient ward. 13 of the 12hour breaches occurred over a few days (3rd-7th January). During this time the Trust reported OPEL4 level and bed occupancy exceeded 100%. There has been an overall rise in Major patients being treated by the appropriate clinicians but in the Minors area.	5	4	20	5	4	20	3	3	9	CRH - March 2019 - UHDB ongoing issues	Linked to Strategic Risks 1, 3, 4, 5, 6	Feb-20	Mar-20	Zara Jones Executive Director of Commissioning Operations	Craig Cook Director of Contracting and Performance / Deputy Director of Commissioning Operations
007	19/20	TCP Unable to maintain and sustain performance, Pace and change required to meet national TCP requirements. The Adult TCP is on recovery trajectory and rated amber with confidence whilst CYP TCP is rated Green, main risks to delivery are within market resource and development with workforce provision as the most significant risk for delivery.	Quality and Performance	Quality/ Reputational	3	4	12	• System leadership group meets bi-monthly to review performance and address system issues, chaired by CCG SRO. • System wide plan developed identifying priorities for joint action and delivery • Additional funding and capacity in place for crisis response and forensic • Quality standards in place within contracts for NHS providers monitored monthly • Investment in Speech and Language Therapist for mental health wards to improve formulation in mental health care. • Contractual recovery plan for NHS LD specialist inpatient assessment and treatment to be completed by end June with expert input from national leads 9 July 2019. • Weekly system pressures meetings in place with CCG and system partners.	* NHSE assurance meetings continue monthly. * TCP Executive Board has increased frequency to meet monthly * TCP Delivery Group agreed to meet weekly during October/November * AMH OOA plan in place and agreed with NHS E/I * Reduction in monthly admissions into AMH beds required * Improvements in discharge planning required	* We remain non-compliant to the revised national trajectory. * New national monitoring arrangements announced in September 19, CCG requirement to visit all OOA placements every 6/8 weeks * Programme identified as "challenged" by NHS E/I in relation to achievement of trajectories. * Detailed stock-take undertaken and recovery action plan completed and submitted to NHS E/I * Monthly review and monitoring of agreed actions through programme delivery group * Qualitative service review visit undertaken 17 & 18th Sept by national LD leads, EBE and regional TC manager confirmed system wide areas for improvements * £245k Additional monies received from NHS E to support reduction in admissions and expediting discharges. * Attendance at regional meeting with national TCP lead and regional perfotmance lead highlighting areas for improvements * Additional monies available to expedite discharge. All cases beign reviewed to confirm clinical appropriateness of expediting discharge plans * New guidance expected following publication of findings following review of Bethany's case by NHS i/E and House of commons human rights committee * TCP Executive Board meeting monthly * TCP Delivery Group meeting weekly * December 19 Update - No further update required January 2020 - No update to be added * We do not anticipate achievement of the trajectory at Q4 2019/20. * Revised trajectory has been submitted to NHS E/I 11/2/20 along with detailed letter providing assurance of actions being taken to deliver performance * New national monitoring arrangements announced in September 19, CCG requirement to visit all OOA placements every 6/8 weeks - Visit schedule in place and being delivered * Specialist Supported living providers development session to be held Feb 2020. * Additional monies received from NHS E/I to support accelerated discharges and admission avoidance * New services commissioned to support 'transition to discharge' for two individuals receiving care in LD ATU	4	4	16	4	4	16	2	3	6	April 2020	Links to Strategic Risks 1, 3, 4, 5, 6	Feb-20	Mar-20	Brigid Stacey - Chief Nursing Officer	Jennifer Stothard - Transforming Care Delivery Manager for Learning Disabilities and/or Autism Programme Derbyshire Partnership
009	19/20	Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care. There are 115 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 experiancing increased pressures which are multi facited and include the following areas :- *Workforce - recruitment and retention of all staff groups *Recruitment of GP Partners *Capacity and Demand *Access *Premises *New contractual arrangements	Primary Care Commissioning	Primary Care	5	4	20	**Early warning systems**: CCG works with LMC and other partners to systematically identify and support practices that may be in trouble, including: reviewing information on practice performance via an internal, cross directorate review of practices looking at a range of data sources; linking with the LMC to pool soft intelligence on practice 'health' and to jointly support struggling practices; directly approaching practices identified as at risk **CCG support:** CCG commissions and funds a range of supportive measures designed to increase the resilience of General Practice, in line with the GP Forward View and GP Contract. Key working groups and committees have been established to support the delivery of the work programmes, these include: *Primary Care Leadership Committee *Primary Care Workforce Steering Group - sub group GPN 10 Group *Primary Care Estates Steering Group *General Practice Digital Steering Group The groups have a wide range of objectives and outcomes to mitiagate this corporate risk, these include , managing allocation and monitoring of additional funding to support the PC workforce (recruitment and retention, new roles) Funding of practice nurses to promote the National GPN , work with CCG nursing team. Identification and delivery of training to support and improve GP practice resilience; funding increased capacity; supporting practices to manage workload, development of leadership roles. Utilisation of the GP Task Force and Health Education Derbyshire to support the delivery of these objectives **Peer support:** the Primary Care Networks will provide a way that practices can support each other in smaller groups. Over time this will provide a safe forum for practices to seek help from peers and another route for help for struggling practices who are not willing to approach the CCG directly **Strategy**: implementation of the CCG's primary care strategy will bring additional resources, capacity and support to General Practice, and develop its role at the centre of an integrated system, thus increasing resilience and mitigating against individual practice failure. The CCG has financially supported the development of the GP alliance, who have supported the development of the PC strategy and are also undetaking a review of PC demand and capacity in order to have a understanding of access to Primary Care in Derbyshire .	The Derbyshire wide Primary Care Strategy agreed and in place. Primary Care Networks (PCNs) established county wide. PCNs undertaking self-diagnostic to establish current position and development needs. Funding identified to support development. First cross directorate review meeting of practice data set for September. Primary Care Team to continue to work closely with practices to understand and respond to early warning signs including identification of support/resources available including practice support in discussions around workload transfer from other providers. Derbyshire wide Primary Care Commissioning Committee to oversee commissioning, quality and GPFV workstreams. Assurance provided to NHS England/JUCD through monthly returns and assurance meetings.	Development and implementation of Derbyshire wide Primary Care Strategy. Implement STP/Derbyshire wide plans to invest in and develop practices at scale Continue to work with LMC, Federations and emerging groups to support sustainability of general practice. Primary Care Team to continue to work closely with practices to understand and respond to early warning signs including identification of support / resources available including practice support in discussions around workload transfer from other providers. Derbyshire wide Primary Care Commissioning Committee to oversee commissioning, quality and GPFV workstreams. Assurance provided to NHS England / JUCD through monthly returns and assurance meetings. Rationale for the Very High Risks Scores It is the view of the Primary Care Team and the Primary Care Commissioning Committee that the risks need to remain at their current risk scores. Whilst the CCG continues to mitigate the risks in this area we do not feel we can downgrade the risk at the moment. There are a number of reasons for this: the number of GP practices; the independent nature of GP practices; the disproportionate effect that even a single practice closure would have on its registered patients. Even one small practice out of the 115 failing to deliver can have a disproportionate effect on the registered list population. The Primary Care Commissioning Committee will keep the very high risks scores under review and will update the Governing Body accordingly. Reviewed September 2019, no further update but revised target date. The risk is discussed at PCCC every month , currently the committee is satisfied by the mitigation that are being applied to manage the risk It is the opinion of the committee that the risk is maintained at this level January / February update: •The mitigations for the risk have been reviewed and updated , providing more detail of the individual mitiagations and presented to PCCC 22/01/2020 reassesment of the Risk scores undertaken GP practices are Independent Contractors, with numerous diverse interlinked elements that can affect their business delivery and sustainability, whilst actions can be established to mitigate the identified risk , ultimately the functionality of GP provision remains an independent business decision. The risk will be reviewed at February PCCC and updated accordingly	4	4	16	4	4	16	4	3	12	November 2019	Links to Strategic Risks 1, 3, 4, 5, 6	Feb-20	Mar-20	Dr Steve Lloyd - Medical Director	Hannah Belcher, Head of GP Commissioning and Development (Primary Care)
015	19/20	There are 115 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 experiancing increased pressures which are multi facited and include the following areas :- *Workforce - recruitment and retention of all staff groups *Recruitment of GP Partners *Capacity and Demand *Access *Premises *New contractual arrangements *New Models of Care	Primary Care Commissioning	Primary Care	4	5	20	**Primary Care Quality Team**: team providing monitoring of and support to practices county wide, proactive and reactive, direct contact available to practices to clinical team members, via telephone and email, for advice and support of any clinical queries and patient safety issues. Communication pathways established including membership bulletin, Information Handbook, web site development and direct generic inbox **Primary Care Quality and Performance Committee**: The Committee will oversee monitoring support and action plans for the delivery of Primary Medical Services, gain assurance regarding the quality and performance of the care provided by GP practices, identifying risks to quality at an early stage. Monthly meetings established. **Cross directorate internal review (hub) process** - Primary Care Quality dashboard and matrix developed, discussed monthly at Hub meeting, integration, sharing and triangulation of PC data from Primary Care Quality, Contracting and Transformation. Provides the opportunity to oversee multiple data sources and gain information from wider CCG teams in order to gain collective view on quality of care offered and to identify areas of best practice and areas of concern where support or intervention is needed. Provides the opportunity to review and create action plans to support practices who may be experiencing / demonstrating difficulty or signs of potential deficit in quality or unwarranted variation of care provision. **Supporting Quality Improvement visits:**18 month rolling programme of practice visits with a focus on quality and support is being delivered, this provides the opportunity of direct clinical face to face discussion between individual GP practices and CCG. Provides an safe opportunity to discuss individual practice quality metrics and for the practices to highlight / raise any issues or concerns directly to the CCG. **Clinical Governance leads meetings:** Established and held quarterly across Derbyshire PCN footprint, provides the interface between CCG and individual practices, opportunity to share best practice, practice concerns, learning and recommendations, support the implentation of GP practice governance. **Quality Schedule**: being developed as part of the enhanced service review to provide a formal mechanism to contract for improved quality standards in areas such as sepsis and safeguarding - following model developed with acute and other provider organisations. Primary Care Quality Schedule Included (April 2020) to DCCG Commisoned Primary Care Contracts, to maintain and support the delivery of continuous quality improvement in Primary Care.	Primary Care Quality Team now fully recruited to and delivering on quality programme including SQI visits. Continuing work to track and support quality of General Practice - Primary Care Quality and Performance Committee established and functioning well. Work is ongoing on development of quality schedule. Production of a Primary Care dashboard being finalised, review of quality resporting methodology and governance structures to PCCC being undertaken. Primary Care Dashboard and Matrix established. Supporting Governance Framework implemented.	Primary care quality team now fully recruited to and delivering on quality programme including SQI visits. Continuing work to track and support quality of General Practice - Primary Care Quality and Performance Committee established and functioning well Work ongoing on development of quality schedule Production of a Primary care dashboard being finalised , review of quality reporting methodology and governance structures to PCCC being undertaken. Rationale for the Very High Risks Scores It is the view of the Primary Care Team and the Primary Care Commissioning Committee that the risks need to remain at their current risk scores. Whilst the CCG continues to mitigate the risks in this area we do not feel we can downgrade the risk at the moment. There are a number of reasons for this: the number of GP practices; the independent nature of GP practices; the disproportionate effect that even one small practice out of the 115 failing to deliver can have a disproportionate effect on the registered list population. The Primary Care Commissioning Committee will keep the very high risks scores under review and will update the Governing Body accordingly. No update for September 2019. The risk is discussed at PCCC every month , currently the committee is satisfied by the mitigation that are being applied to manage the risk It is the opinion of the committee that the risk is maintained at this level Update will be provided for December following Primary Care Commissioning Committee on 18th December 2019 This risk remains static. January / February update: The mitigations for the risk have been reviewed and updated , providing more detail of the individual mitiagations and presented to PCCC 22/01/2020 reassesment of the Risk scores undertaken . GP practices are Independent Contractors , with numerous diverse interlinked elements that can affect their business delivery and sustainability, whilst actions can be established to mitigate the identified risk , ultimately the functionality of GP provision remains an independent business decision. The risk will be reviewed at February PCCC and updated accordingly.	4	5	20	4	5	20	4	4	16	March 2020	Links to Strategic Risks 2, 3, 4, 5	Feb-20	Mar-20	Dr Steve Lloyd - Medical Director	Marie Scouse - Assistant Chief Nurse Primary Care
027	19/20	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	Finance	Finance	5	5	25	• The CCGs have in place a medium term financial recovery plan that sets out the projected financial 'do nothing' position and the QIPP schemes to mitigate this position to enable delivery of the assumed control total. • The GB have approved £69.5m of savings in 2019/20. These schemes are support by PIDs and where possible have been included in provider contracts • The Executive led Finance Recovery Group, accountable to the Derbyshire Finance Committee, meets weekly to oversee progress on the plan and instigate actions where necessary. • The JUCD Chief Executives meet regularly to oversee progress against setting, agreeing and delivering a system 2019/20 plan. • At plan stage the Derbyshire CCGs are holding a 0.5% uncommitted risk contingency • Medium term financial plan and annual financial plan have been signed off by the Governing Body • Budgets have been set with budget holders and then approved by the Governing Body • The budgets are aligned to Executive Directors ensuring senior oversight and management of budgets. • There is a budget escalation process in place overseen by the FRG and the Derbyshire Finance Committee	• Regular reporting to Derbyshire Finance recovery Group, Finance Committee and Governing Body. • Regular reporting on planning progress to JUCD Board • Regular discussions internally and externally to assess the delivery and robustness of the system finances	This risk remains live and continues to be discussed in relevant meetings to ensure financial risks are mitigated and understood. At month 10 the CCG reported a YTD overspend of £5.2m which is in line with plan. The CCG has received the 3rd quarter of Commissioner Sustainability Fund (CSF), which means the forecast outturn is £10.2m overspent which is again in line with the planned CSF adjusted Control Total. At month 10 the financial position remains in line with plan and the CCG remains eligible for £29m of CSF, of which £18.8m has been received to date. If this happens the CCG will be able to report a breakeven position. Within this position the CCG has reported £3.3m of risk, which includes £2.0m related to Acute Provider activity and £0.6m on Mental Health commissioning and £0.3 on Continuing Health Care. This is being mitigated by contingencies, none of which is being used to support the YTD position. There remains a genuine risk that the CCG will fail to meet its statutory financial duties in 2019/20, although as we get closer to the end of the financial year this risk reduces. We have entered the winter months and are already seeing increases in activity, therefore it is not possible to fully assure the delivery of the financial position. After assessing the M10 QIPP savings delivery position the CCG is now reporting a £21.2m end of year under-delivery against the £69.5m plan. The CCG has undertaken a thorough assurance process of all QIPP savings schemes and all risk is now included in the forecast position. No additional risk to QIPP savings has been reported but should any risk materialise, sufficient mitigation should be available. Whilst the current level of forecast risk can be mitigated there is no other mitigation available if the forecasted financial position were to deteriorate further.	3	5	15	3	5	15	2	5	10	March 2020	Links to Strategic Risks 1, 2, 6	Feb-20	Mar-20	Richard Chapman, Chief Finance Officer	Darran Green-Assistant Chief Finance Officer
043 New Risk	19/20	Loss of Service / Savings delivery and reputational damage due to notice given on Toll Bar House prior to finalising alternative premises with adequate IT infrastructure in place for South Medicines Order Line	Quality & Performance	Corporate	3	5	15	Close working with IT and Corporate Delivery to review options. All options considered. Escalation to Execs for options approval.	Discussions with council re: potential to extend lease whilst IT infrastructure put in place. IT requirements for different options scoped. Paper drafted for discussion at Execs 27th January 2020. Risk escalated by Medicines Management Delivery Board.	Approval gained from execs to pursue short-term extension lease at Toll Bar House for South MOL with council agreed. Agreement gained from council for 3 month extention for MOL to remain on site at Toll Bar House if necessary. Contract being finalised. Void space has been identified at Ilkeston Health Centre. Discussions in place with Properly Services Ltd re contract for lease agreement for Ilkeston Health Centre. Confirmation from NECS now received that the network team has visited Ilkeston Health Centre and carried out a number of tests, the results of which all positively indicate that the circuit has been successfully uplifted from 20Mbps to 100Mbps, and from an IT perspective the relocation should be able to proceed.	3	5	15	3	5	15	2	2	4	31-Mar	Bsc	Feb-20	Mar-20	Steve Hulme, Director of Medicines Management and Clinical Policies	Steve Hulme, Director of Medicines Management and Clinical Policies / Birgitte Waring, Head of Medicines Optimisation - QIPP Delivery

Appendix 2 - Movement during February 2020

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason for Movement	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
002	19/20	The Acute providers may breach thresholds in respect of the A&E operational standards of 95% to be seen, treated, admitted or discharged within 4 hours, resulting in the failure to meet the Derby and Derbyshire CCGs constitutional standards and quality statutory duties.	5	4	20	5	4	20	⟷		Zara Jones Executive Director of Commissioning Operations	Quality and Performance	Craig Cook Director of Contracting and Performance / Deputy Director of Commissioning Operations
005	19/20	Changes to the interpretation of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) safeguards, results in greater likelihood of challenge from third parties, which will have an effect on clinical, financial and reputational risks of the CCG	3	4	12	3	4	12	⟷		Brigid Stacey - Chief Nursing Officer	Quality and Performance	Ed Ronayne - Safeguarding Adults Manager
007	19/20	TCP Unable to maintain and sustain performance, Pace and change required to meet national TCP requirements. The Adult TCP is on recovery trajectory and rated amber with confidence whilst CYP TCP is rated Green, main risks to delivery are within market resource and development with workforce provision as the most significant risk for delivery.	4	4	16	4	4	16	⟷		Brigid Stacey - Chief Nursing Officer	Quality and Performance	Jennifer Stothard - Transforming Care Delivery Manager for Learning Disabilities and/or Autism Programme Derbyshire Partnership
009	19/20	Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care.	4	4	16	4	4	16	⟷		Dr Steve Lloyd - Medical Director	Primary Care Commissioning	Hannah Belcher, Head of GP Commissioning and Development (Primary Care)
013	19/20	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)	4	3	12	4	3	12	⟷		Zara Jones Executive Director of Commissioning Operations	Quality and Performance	Dave Gardner - Assistant Director of Procurement & Commissioning
014	19/20	Demand for Psychiatric intensive Care Unit beds PICU has grown substantially over the last five years. This has a significant impact financially with budget forecast overspend, in terms of poor patient experience , Quality and Governance arrangements for uncommissioned independent sector beds. The CCG cannot currently meet the KPI from the Five year forward view which require no out of area beds to be used from 2021.	4	3	12	4	3	12	⟷		Zara Jones Executive Director of Commissioning Operations	Quality and Performance	Dave Gardner - Assistant Director of Procurement & Commissioning
015	19/20	Due to the increased pressures around workload, workforce and financial concerns, there is a risk to General Practice in providing quality primary care services to patients.	4	5	20	4	5	20	⟷		Dr Steve Lloyd - Medical Director	Primary Care Commissioning	Marie Scouse - Assistant Chief Nurse Primary Care
018	19/20	There is a risk of failure to implement and embed compliance activities required in UK Data Protection Legislation.	2	4	8	2	4	8	⟷		Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Chrissy Tucker, Director of Corporate Delivery
019	19/20	There is a risk of a successful cyber-attack, causing widespread disruption to systems and therefore the provision of services.	3	4	12	3	4	12	⟷		Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Paul Hetherington - Associate Director of Digital Development, Chrissy Tucker - Director of Corporate Delivery

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason for Movement	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
020	19/20	If the CCG does not maintain and review existing business continuity contingency plans and processes, strengthen its emergency preparedness and engage with the wider health economy and other key stakeholders then this will impact on the known risks to the Derby and Derbyshire CCG, which may lead to an ineffective response to local and national pressures.	2	4	8	2	4	8	⟷		Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Chrissy Tucker - Director of Corporate Delivery
024	19/20	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.	1	3	3	1	3	3	⟷		Helen Dillistone, Executive Director of Corporate Strategy and Delivery	Governance	Beverley Smith, Director of Corporate Strategy & Development
027	19/20	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	3	5	15	3	5	15	⟷		Richard Chapman, Chief Finance Officer	Finance	Darran Green-Assistant Chief Finance Officer
028	19/20	Inability to deliver current service provision due to impact of service review. The CCG has initiated a review of NHS provided Short Breaks respite service for people with learning disabilities in the north of the county without recourse to eligibility criteria laid down in the Care Act. Depending on the subsequent actions taken by the CCG fewer people may have access to the same hours of respite, delivered in the same way as previously. There is a risk of significant distress that may be caused to individuals including carers, both during the process of engagement and afterwards depending on the subsequent commissioning decisions made in relation to this issue. There is a risk of organisational reputation damage and the process needs to be as thorough as possible. There is a risk of reduced service provision due to provider inability to retain and recruit staff. There is a an associated but yet unquantified risk of increased admissions – this picture will be informed by the review.	3	3	9	3	3	9	⟷		Zara Jones Executive Director of Commissioning Operations	Quality and Performance	Mick Burrows Director for Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning /Jennifer Stothard, TCP Delivery Manager
'029	19/20	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.	3	3	9	3	3	9	⟷		Brigid Stacey - Chief Nursing Officer	Quality and Performance	Nicola MacPhail, Assistant Director of Quality
030	19/20	Non-compliance of completion of initial health assessments (IHA's) within statutory timescales for Children in Care due to the increasing numbers of children/young people entering the care system. This may have an impact on Children in Care not receiving their initial health assessment as per statutory framework.	5	3	15	4	3	12	↓	The multi-agency pathway is now in place and performance is showing some improvement, therefore the risk has lowered.	Brigid Stacey - Chief Nursing Officer	Quality and Performance	Heather Peet, Designated Nurse Looked After Children.
031	19/20	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.	2	3	6	2	3	6	⟷		Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Engagement	Sean Thornton Assistant Director Communications and Engagement
032	19/20	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.	2	4	8	2	4	8	⟷		Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Engagement	Sean Thornton Assistant Director Communications and Engagement

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason for Movement	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
036	19/20	Because the CCG has not yet made a decision regarding the provision of a Data Protection Officer for General Practice a required by NHS England, 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.	2	3	6	2	3	6	⟷		Steve Lloyd, Medical Director	Governance	Paul Hetherington - Associate Director of Digital Development
038	19/20	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.	2	4	8	2	4	8	⟷		Helen Dillistone, Executive Director of Corporate Strategy and Delivery	Governance	Paul Hetherington - Associate Director of Digital Development
039	19/20	The CCG and the System is facing significant pressure in relation to S117 aftercare costs. At M10, 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 are also seeing O/S against budget. (Generally S117 costs are split 50-50). S117 will also become a right to have as a Personal Health Budget from December 2019.	3	4	12	3	4	12	⟷		Zara Jones, Executive Director of Commissioning Operations	Quality and Performance	Mick Burrows Director for Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning /Dave Stevens, Head of Finance
040	19/20	Data Quality issue with University Hospitals Derby Burton (UHDB) with incorrect data being provided for several consecutive months during the current financial year.	3	4	12	3	4	12	⟷		Zara Jones, Executive Director of Commissioning Operations	Quality and Performance	Helen Wilson, Deputy Director of Contracting and Performance
041	19/20	Lack of peer support for nursing home bedside manufacture of syringe drivers after 31.01.20	2	4	8	2	4	8	⟷		Dr Steve Lloyd Medical Director	Quality and Performance	
042	19/20	Derby City patients with complex wounds will not receive timely care or will face sub-optimal outcomes to their condition. There may also be an impact on patients with long term conditions who will also face longer waits for their care due to GP practices managing caseloads of complex wound care.	3	3	9	3	3	9	⟷		Dr Steve Lloyd Medical Director (for Clinical risk management and Primary Care operations) and Zara Jones, Executive Director of Commissioning Operations (for DCHS Contract Management)	Quality and Performance	Louise Swain Assistant Director of (Joint and Community Commissioning)

MINUTES OF ENGAGEMENT COMMITTEE MEETING HELD ON 8 JANUARY 2020
IN ROOM 16, STRUTTS CENTRE, DERBY ROAD, BELPER DE56 1UU
AT 10:00 TO 12:30

Present:		
Martin Whittle – Chair	MW	Governing Body Lay Member, DDCCG
Beth Soraka	BSo	Engagement Officer, Healthwatch, Derby
Beverley Smith	BSm	Director of Corporate Strategy & Development, DDCCG
Gill Orwin	GO	Governing Body Lay Member, DDCCG
Ian Mason	IM	Lay Representative, Chair of High Peak PPG Network
Ian Shaw	IS	Governing Body Lay Member, DDCCG
Jocelyn Street	JS	Lay Representative
Katy Hyde	KH	Engagement Manager, DDCCG
Ruth Grice	RG	Lay Representative
Sean Thornton	ST	Assistant Director Communications and Engagement, DDCCG and JUCD
In Attendance:		
David Gardner for Mick Burrows	DG	Assistant Director of Mental Health, Learning Disabilities and Children's Commissioning (part meeting)
Ilona Davies – Minutes	ID	Executive Assistant to the Executive Director of Corporate Strategy and Delivery, DDCCG
Ruth Cater	RC	Practice Manager, Staffa Health (part meeting)
Apologies:		
Andrew Kemp	AK	Head of Communications and Engagement, DDCCG
Bernard Thorpe	BT	DCHS Lead Governor
Denise Weremczuk	DW	Public Governor and Lead Governor, CRH
Helen Dillistone	HD	Executive Director of Corporate Strategy and Delivery, DDCCG
Karen Ritchie	KR	Head of Engagement, Joined Up Care Derbyshire
Vikki Taylor	VT	Director, STP

Item No.	Item	ACTION
EC/1920/132	**WELCOME, APOLOGIES AND QUORACY** MW introduced himself as the Chair of the Committee and welcomed all to the meeting. Apologies were noted as above. MW declared the meeting quorate.	
EC/1920/133	**Standing Item: DECLARATIONS OF INTEREST** MW reminded Committee members of their obligation to declare any interest they may have on any issues arising at Committee meetings which might conflict with the business of the CCG. Declarations declared by members of the Engagement Committee are listed in the CCG's Register of Interests and included with the meeting papers. The Register is also available either via the corporate secretary to the Governing Body or the CCG website at the following link: www.derbyandderbyshireccg.nhs.uk Declarations of interest from today's meeting No declarations of interest were made.	

	It was noted that John Morrisey's term as a public governor for Derbyshire Healthcare NHS Foundation Trust had finished and governor Carole Riley will be attending future meetings with governor Kevin Richards as her deputy. This information was conveyed in an email to ID dated 8 January 2020. The Committee noted its thanks to JM for his contribution to date.	
EC/1920/134	**REVIEW COMMITTEE'S TERMS OF REFERENCE** The Committee discussed the Terms of Reference noting the following: • It was agreed that the issues with achieving representation across the county remain due to Place still forming its composition and function and the emergence of Primary Care Networks and Integrated Care Partnerships. • It was noted that overall there was a shortage of a critical lay voice. • Recognising the benefits of wider membership, it was also noted that this may hinder discussions. An example of recent Lay Reference Group meeting was given that felt more productive with a reduced membership. The Committee agreed the membership had to be correct to allow productive discussion. • The Committee agreed its role was important in informing and supporting the CCG's Governing Body's decision making. • It was agreed that the purpose, role and responsibilities of the Committee have not changed. • All agreed that the Chair arrangement has not changed. *David Gardner arrived.* MW summarised the discussion that the Committee's role was to provide assurance to the CCG that they were doing the engagement process and the consultation correctly. The Committee does not question decisions but ensures the CCG's Governing Body makes an informed decision based on the robust information and assurance. The discussion was concluded with the following actions: ST to discuss with MW and HD the membership and approach to membership to be taken in terms of recruiting the right people. **ACTION: ST** The role relating to assurance on Equality & Diversity objectives would be reworded as this is partly within the Governance Committee's remit. **ACTION: ST** Clarification of voting and non-voting members from JUCD is required. **ACTION: ST** Add statement that TOR will be reviewed in 12 months unless there is more development of Place. **ACTION: ST** In conclusion ST and BSm will work on the revised version of TOR, which will be presented at the next meeting. **ACTION: ST** **The Engagement Committee DISCUSSED the Terms of Reference, and AGREED a revised version will be brought to the next meeting on 19 February 2020.** *A round of introductions took place.*	**ST** **ST** **ST** **ST** **ST**

EC/1920/135	**THE LIGHTHOUSE CONSULTATION REPORT** DG introduced the Lighthouse Consultation Report brought to the Committee as the consultation drew to a close on 3 December 2019. The substantive care is moving away from nurse led model to social care providing this care having been appropriately trained and ensuring the quality of the care is right. Key themes from the feedback were that new service should offer: • Better continuity of care for all children. • Consistency of service provision with appropriate levels of staffing. • A sustainable model which will help to ensure the continued operation of the residential short breaks service in the future. • A service that parents and carers are confident in and where they can be reassured that care is safe. The key issues from parents and carers where around the capacity to delivery respite allocations (reduced in the interim to maintain a safe service) and a positive experience for their children. The main concern from other responders/stakeholders who are not parents and carers was around the level of clinical support for children with the most complex health needs whilst staying at the Light House. The project is ready to proceed to Clinical and Lay Commissioning Committee to seek approval of the new model of care to be implemented. Derby City Council are happy to increase the number of days of care and reinstate weekend care. IM asked if there had been any complaints. DG said they received no complaints during the consultation. MW stated that the Committee's role was to be able to provide assurance to the CCG that the engagement process was robust and whilst there was a small number of issues to be considered, these were being addressed. MW concluded the discussion that the Committee was assured of the process followed in respect of the Lighthouse consultation and therefore makes a recommendation to the Clinical and Lay Commissioning Committee. **The Engagement Committee NOTED the report from the public consultation for Light House children's residential short breaks service, and NOTED that the recommendations reflect the outcome of the extensive pre engagement and the public consultation, and the benefits of the Light House described by parents are being maintained and mitigations put in place to meet concerns in the proposed new design.** *DG left the meeting.*	
EC/1920/136	**PILSLEY BRANCH SURGERY CONSULTATION REPORT** RC informed the Committee of the planned 60 days consultation on Pilsley branch surgery closure. Since 2017 Staff Health have struggled to retain GPs and therefore found it difficult to cover all sites. This led to a reduction in hours at a couple of sites, which in turn led to considering a reduction in a number of	

	sites. The proposed model will use the GP service differently across fewer sites. Consultation started off with staff and since has been launched to patients with a letter to all patients registered and any patients who have used surgery in the past. In addition a text communication was issued inviting to complete online questionnaire on the website. It was noted 900 people responded from 3000 questionnaires issued, which was very positive. RC said that the concerns were listed in the report but the main one was travel and transport to surgeries. The findings from the consultation were being reviewed and will be presented to the senior team, who will decide next steps. The proposal remains to close Pilsley branch however, to do it over a period of one year. It was concluded that the Committee was assured by the robust consultation process. **The Engagement Committee DISCUSSED and NOTED the report.** *RH left the meeting.*	
EC/1920/137	**Standing item: EXCEPTION RISK REPORT** It was noted that the Risk Register had not been updated despite the information having been communicated to the Governance Team. **The Engagement Committee DEFERRED the Risk Register until next meeting in February.**	
EC/1920/138	**Standing item: ORGANISATIONAL EFFECTIVENESS AND IMPROVEMENT ACTION PLAN AND HIGHLIGHT REPORT** ST presented the update on the short-term actions within the key areas of the Committee's oversight: public engagement, stakeholder relationship management and proactive communications. JS queried if section 14Z2 had been applied to all projects as there was an implication that in some areas it was not embedded as it should be. ST assured the Committee that in respect of all projects within Financial Recovery umbrella the section was adhered to and forms duly completed. There were no other questions. **The Engagement Committee RECEIVED an update on the communications and engagement actions identified for priority attention during quarter 4 of 2019/20.**	
EC/1920/139	**ANNUAL ENGAGEMENT REPORT AND ASSESSMENT INDICATOR** ST explained that NHS England had a legal duty (section 14Z16) to assess how well each CCG discharged its public involvement duty (section 14Z2) and in order to do this a CCG Improvement and Assessment Framework (IAF) for a Patient and Community Engagement Indicator was introduced. The CCG	

	produces an Annual Engagement Report, which forms the primary source of evidence for the IAF and its draft version is presented to the Committee for review. Given the timing of the meeting and dissemination of papers the Committee asked for more time to review the report. It was agreed that the Committee will review the draft report by next Tuesday, 14 January. Comments will be sent to ST. **ACTION: All Committee Members** ST and KH asked all present, if they could take a photo of the Committee meeting today for the purpose of including it in the report. All Committee members gave their consent to the photograph being taken and used for the purpose as stated. Final version of the report will be submitted to the next meeting. **ACTION: ST/KH** **The Engagement Committee NOTED the draft report and AGREED TO COMMENT by 14 January.**	**All Committee Members** **ST/KH**
EC/1920/140	**JUCD PLAN SUMMARY** ST informed the Committee that the JUCD plan had been submitted and would be published on 23 January. A draft summary version has been included in the pack. ST asked the Committee for comments on the draft summary version only by next Tuesday, 14 January. **ACTION: All Committee Members** **The Engagement Committee NOTED the JUCD Plan and AGREED TO REVIEW the draft summary of the STP submission by 14 January.**	
EC/1920/141	**JUCD PLAN REFRESH ENGAGEMENT SUMMARY** It was noted that the paper provided a useful summary and the Committee agreed with its recommendations. **The Engagement Committee NOTED the themes that emerged from the programme of engagement activities undertaken over the summer with regards to the STP Plan refresh and GAVE ASSURANCE that public feedback had been taken seriously and comprehensively considered in the writing of the plan. The Committee will keep these themes in mind for future reference in JUCD agenda items.**	
EC/1920/142	**MINUTES OF THE MEETING HELD ON 4 DECEMBER 2019** The Committee accepted the minutes as a true and accurate record of the meeting.	
EC/1920/143	**MATTERS ARISING** – None.	
EC/1920/144	**ACTION LOG FROM THE MEETING HELD ON 4 DECEMBER 2019** The Committee reviewed the action log. Actions were updated and recorded.	
EC/1920/145	**ENGAGEMENT COMMITTEE PLANNER** – No changes.	
EC/1920/146	**ANY OTHER BUSINESS**	

	There was no other business.	
EC/1920/147	**FUTURE MEETINGS IN 2020 – DATES AND TIMES (Updated post meeting)** Meetings will be held in Room 16, Strutts Centre, Derby Road, Belper, Derbyshire DE56 1UU Time: 10:00 – 12:30 Wednesday 19 February 2020 Wednesday 18 March 2020 Wednesday **29** April 2020 Wednesday 20 May 2020 Wednesday 17 June 2020 Wednesday **29** July 2020 Wednesday 19 August 2020 Wednesday 16 September 2020 Wednesday 21 October 2020 Wednesday 18 November 2020 Wednesday 23 December 2020 – *Meeting Room 1, BABINGTON HOSPITAL, Belper* Wednesday 20 January 2021 – Venue TBC Wednesday 17 February 2021 – Venue TBC Wednesday 17 March 2021 – Venue TBC	
EC/1920/148	**ASSURANCE QUESTIONS** 1. Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? Yes 2. Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? Yes noting issues with electronic version. 3. Were papers that have already been reported on at another committee presented to you in a summary form? Yes 4. Was the content of the papers suitable and appropriate for the public domain? Yes 5. Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? Yes 6. Is the Committee assured on progress regarding actions assigned to it within the Organisational Effectiveness and Improvement action plan? Yes 7. Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? No 8. What recommendations do the Committee want to make to Governing Body following the assurance process at today's Committee meeting? None	

NHS
Derby and Derbyshire
Clinical Commissioning Group

MINUTES OF PRIMARY CARE COMMISSIONING COMMITTEE

PUBLIC MEETING

HELD ON

Wednesday 22nd January 2020

VENUE: Robert Robinson Room, Scarsdale, Chesterfield

Present:

Ian Shaw (Chair)	IS	Lay Member Derby & Derbyshire CCG
Hannah Belcher	HB	Assistant Director GP Commissioning & Development
Niki Bridge	NB	Deputy CFO, Derby & Derbyshire CCG
Jill Dentith	JED	Lay Member Derby & Derbyshire CCG
Alison Kemp	AK	Director of Efficiency, Derby & Derbyshire CCG
Dave Knight	DK	GP Contracts Manager, NHS England
Steve Lloyd	SL	Executive Medical Director, Derby & Derbyshire CCG
Joe Lunn	JL	Head of Primary Care, NHS England
Kathryn Markus	KM	Chief Executive, Derby & Derbyshire LMC
Clive Newman	CN	Director of GP Development, Derby & Derbyshire CCG
Gillian Orwin	GO	Lay Member, Derby & Derbyshire CCG
Marie Scouse	MS	Assistant Director of Nursing & Quality, Derby & Derbyshire CCG

In Attendance:

Mr Stevens		Public - Member of Pilsley Parish Council
Tiffany Hey	TH	Assistant Client Manager, 360 Assurance
Ruth Thomason	RT	Corporate Administration Manager, Derby & Derbyshire CCG (Note Taker)

Apologies:

Richard Chapman	RC	Chief Finance Officer, Derby & Derbyshire CCG
Sandy Hogg	SH	Turnaround Director, Derby & Derbyshire CCG
Abid Mumtaz	AM	Head of Commissioning, Public Health
Brigid Stacey	BS	Chief Nurse, Derby & Derbyshire CCG

Item No.	Item	Action
PCCC/1920/01	**WELCOME AND APOLOGIES** Ian Shaw (IS) (Chair) welcomed those present, and apologies were received as noted. There was one member of the public who attended this session until agenda item reference **PCCC/1920/03.**	
PCCC/1920/02	**DECLARATIONS OF INTEREST** The Register of Interests was noted. No further declarations were made.	

FOR DISCUSSION		
PCCC/1920/03	**Pilsley – Practice Closure** Dave Knight (DK) introduced the report on the proposed closure of the Staffa GP Practice branch surgery at Pilsley. The proposed closure date of the branch surgery is requested in 12 months' time. Jill Dentith (JED) commented that the report demonstrated the amount of work and very detailed thinking that had gone in to this issue and that it is therefore very important to give due time of consideration. JED proposed to Committee we delay this decision for one month due to the late circulation of this paper to allow effective consideration particularly as this will not impact on the timescale suggested DK advised that an appendix was omitted from their report which contained correspondence from the parish council and from the consultation. DK therefore supported the suggestion to bring the updated report back to the Committee next month. JL advised that it is recommended that branches close at the end of the quarter and this will be amended in the updated report. Gill Orwin (GO) provided the committee with feedback from the Engagement Committee that was attended by Ruth Cater, (Practice Manager – Staffa Healthcare) who provided a details presentation of all the information around this closure. GO also provided additional background information on previous discussions in Hardwick CCG. GO reflected this is not a decision that the practice has made lightly and that Staffa have presented a solid plan. Staffa is a good practice with an outstanding rating from CQC. JED noted that there is reference to an enquiry from the local MP and sought clarity on this and also reference to this Committee receiving feedback from the Overview & Scrutiny Committee (OSC) as well as the Engagement Committee. Hannah Belcher (HB) confirmed that this was presented to the OSC on 20th January 2020. Ruth Cater also attended along with Jean Richards from the CCG. Clive Newman **(**CN**)** provided verbal feedback from the discussion which was similar to the Engagement Committee. The OSC were satisfied that the engagement and consultation process has been robust and that Staffa had acted on patient' views. HB confirmed that the OSC had requested an update in 12 months' time in line with the proposed closure date. Gill Orwin (GO) added that there had been an impact on the practice patient participation group (PPG) members as a couple had left due to a misunderstanding and information being incorrectly shared. GO explained and provided assurance that while this was an unfortunate outcome, the rest of PPG do now feel that they have been very well informed. JED requested that when the papers return to Committee to have the minuted feedback from the Engagement Committee and OSC included in the summary report. **Action: DK to include in the updated report for the February meeting.**	**DK**

	IS further explained why this was a discussion item and the decision is to be delayed to next month as not enough time was given for consideration of the detail of the paper. **The Primary Care Commissioning Committee RECEIVED and NOTED the report on the proposed closure of the Pilsley Branch Surgery. The updated paper is to be included on the public meeting of this Committee for a decision in February 2020.** (NB: The member of the public left the meeting at this point.)	
FOR DECISION		
PCCC/1920/03	**Park Medical Practice & Oakwood Merger** DK presented this paper in which Committee is requested to approve the full contractual merger of the two practices. DK explained that they have been working together closely for some time and the practices now wish to formalise the arrangement through merging the contracts. The practices will benefit from efficiencies in having a single contract and patient list. The Committee were in agreement to approve. **The Primary Care Commissioning Committee RECEIVED and APPROVED the full contractual merger of these practices with effect from 1 April 2020;**	
PCCC/1920/04	**Terms of references (TORs)** MS presented the paper and TORs to the Committee. MS advised that the TORs were originally submitted to PCCC in September 2019, and have been amended according to the recommendations made by the committee at that time. It was agreed that following the amendments the Terms of Reference for these groups would be re submitted to PCCC for information. JED commented that the cover sheet was missing from the agenda pack and also that it would be useful to have tracked changes on these documents. The following amendments are needed: **PCLC TOR** • JED suggested consistency needed across Sections 7 & 8 when referring to Assistant Medical Director (Chair) – in Section 7 this role is described as Deputy Medical Director. And in Section 8 there is reference to the Vice Chair which needs to clarified • Lay Member from CCG – query from JED and GO does this need to be removed from the membership as IS was only going to be able to attend according to his commitments. CN added that it is helpful to have a lay member on the committee. KM suggested that the membership remains as stated with the lay member copied in to the paperwork but currently with a recurring apology, rather than to have to have it formally added back in when circumstances change. Committee agreed this suggestion. • **JL** further queried if it is correct that an NHS E/I member attend	

	due to the organisational changes. CN updated that NHS E/I members role will change and this has been raised by IS with Chief Executive and will need to be worked through in the future. CN felt that until it has been formally communicated and information is in the public domain then this should remain as it is. • Section 13 – JED queried if this group had "decision making powers" as it is a sub group– does this need to be re-considered. CN explained that it was felt that all meetings have a function to form a decision for a formal recommendation although not necessarily taking decisions on behalf of the CCG and this was captured in this wording. **The Primary Care Commissioning Committee RECEIVED and NOTED the Terms of Reference for the PCLC with the amendments noted to come back to future committee for final approval.** **<u>GP Estates Steering Group TOR</u>** The following issues / amendments were discussed: • Niki Bridge (NB) led discussion around whether it is required to reference that there is a relationship with this Committee with regard to recommendations being made from this group. Steve Lloyd (SL) considered that it is not necessary to capture the direct relationship as it does capture it generically. JED noted at Audit Committee it was mentioned that Suzanne Pickering is working on a paragraph that looks at how the CCG as a statutory body start to link in with the wider system so it may be that we can use the same wording and put it in here. IS noted that at 1.3 delegated authority is here not the leadership group. JED recommended that the language is checked with governance colleagues to ensure consistency. MS agreed to discuss with Suzanne Pickering, CCG Governance Team to confirm wording of the paragraph around joint working. MS advised that we potentially need to look at the reporting arrangements of the sub groups of this committee. This was agreed by the committee and MS further explained that leadership committee was initially seen as a sub group of the STP and to supplement this we put a quarterly report into the framework of these groups but as a result the process may require further consideration. **The Primary Care Commissioning Committee RECEIVED and NOTED the Terms of Reference for the GP Steering Group the amendments noted to come back to future committee for final approval.** **<u>Primary Care Estates TOR</u>** There were no additional comments on these TOR but the Committee agreed the importance of ensuring the same level of governance as above **The Primary Care Commissioning Committee RECEIVED and NOTED the Terms of Reference for the Primary Care Estates group – the amendments noted to come back to future committee for final approval.**	**MS** **MS**

	Primary Care Commissioning Committee TOR No additional comment – these TOR were previously agreed in confidential session of this committee. **The Primary Care Commissioning Committee RECEIVED and APPROVED the Terms of Reference for the Primary Care Commissioning Committee**	
	FOR ASSURANCE	
PCCC/1920/04	**Finance Update Report** NB presented an update on the financial position highlighting salient areas of interest for the Committee to note. **The Primary Care Commissioning Committee RECEIVED and APPROVED the update on the Finance position.**	
	MINUTES AND MATTERS ARISING	
PCCC/1920/05	**Minutes of the Primary Care Commissioning Committee-in- Common meeting held on 18th December 2019** It was agreed the minutes of this meeting would be ratified at the next meeting.	
PCCC/1920/06	**Matters Arising and Decision Log** The Action Matrix was reviewed and updated as follows: Assurance needed that the Action Log is up to date. To be confirmed at the next meeting of this Committee. **Action: RT to review and update the Action Log to ensure all actions are captured and the log is up to date.** **Decision Log** The decision log is to be updated with decisions from this meeting and shared with the Governing Body.	
PCCC/1920/07	**Any Other Business** Assurance given by SL that work was being done to improve the administrative support for this committee	
PCCC/1920/08	**Assurance Questions** • Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance processes? Yes • Were the PCCC papers presented to the Sub-Committee of an appropriate professional standard, did they incorporate a detailed report with sufficient factual information and clear recommendations? No • Were the papers sent to Committee members at least 5 working days in advance of the meeting? No	

	• Does the Committee wish to deep dive any area on the agenda, in more detail at the next Sub-Committee meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? No • Is the Committee assured on progress regarding actions assigned to it within the Organisation Effectiveness and Improvement action plan? Yes • What recommendations does the Sub-Committee want to make to the Governing Body? None	
DATE & TIME OF NEXT MEETING		
Date: Wednesday 26 February 2020		
Time: 10:00-12:00		
Venue: Robert Robinson Room Scarsdale		

NHS
Derby and Derbyshire
Clinical Commissioning Group

MINUTES OF QUALITY AND PERFORMANCE COMMITTEE

HELD ON 30th January 2020, CONFERENCE ROOM, TOLL BAR HOUSE, AT 9.30AM

Present:		
Dr Buk Dhadda	BD	Chair, GP Governing Body Member
Zara Jones	ZJ	Executive Director of Commissioning Operations
Andrew Middleton	AM	Lay Member, Finance
Brigid Stacey	BS	Chief Nurse Officer - DDCCG
Gill Orwin	GO	Lay Member, Patient and Public Involvement
Jo Pearce (Minutes)	JP	EA to Brigid Stacey -DDCCG
Dr Greg Strachan	GS	GP North
Dr Steve Lloyd	SL	Medical Director - DDCCG
Helen Wilson	HW	Deputy Director Contracting and Performance - DDCCG
Harriet Murch (item 212)	HMu	Assistant Director Medicines Management - DDCCG
Suzanne Pickering	SP	Head of Governance- DDCCG
Taibah Yasin	TY	Commissioning Manager Operational
Jackie Jones	JJ	Director of Ambulance and 111 Commissioning
Craig Cook	CC	Deputy Director of Commissioning - DDCCG
Chloe Cannon	CCa	Healthwatch Derbyshire
Phil Sugden	PS	Assistant Director of Quality
Sharon Lane (item 201)	SLa	Senior Clinical Quality Manager
Helen Golding (item 200)	HG	Senior Clinical Quality Manager
Apologies:		
Richard Chapman	RC	Finance Director - DDCCG
Ali Cargill	AC	Assistant Director of Quality - DDCCG
Laura Moore	LM	Deputy Chief Nurse - DDCCG
Dr Emma Pizzey	EP	GP South
Martin Whittle	MW	Vice Chair and Lay Member, Patient and Public Involvement
Helen Hipkiss	HH	Deputy Director of Quality - DDCCG
Hannah Morton	HM	Healthwatch
Dr Meryl Watkins	MW	GP City
Jackie Carlile	JC	Head of Performance and Assurance -DDCCG

Item No.	Item	Action
Q&P 1920/195	**Welcome, Apologies & Quoracy** Apologies were received as above. BD declared the meeting quorate.	
Q&P 1920/196	**Declarations Of Interest** BD reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG. Declarations declared by members of the Quality and Performance Committee are listed in the CCG's Register of Interests and included with the meeting papers. The Register is also available either via the corporate secretary to the Governing Body or the CCG website at the following link: www.derbyandderbyshireccg.nhs.uk Declarations of interest from sub-committees No declarations of interest were made. Declarations of interest from today's meeting No declarations of interest were made.	
FOR ASSURANCE		
Q&P 1920/197	**Integrated Report and Activity Report** The paper was presented to the Committee members and taken as read. Referring to the three key areas of Urgent Care, Planned Care and Cancer CC noted the following; Urgent Care The reports show the position for type 1 attendances at A&E in December 2019 for CRHFT which is just over 58%. At UHDBFT it is 75.8%. Once the network statistics are included the figures improve. There were 8 x 12 hr trolley breaches reported. Six in CRHFT and two at UHDBFT. These were due to capacity issues rather than MH presentations which has been the case in previous months. Planned Care CRHFT are reporting 89.4% against target and UHDBFT 87.1%. The priority is to have no 52 week breaches. Planned Care is to have none. The report shows that there were no 52 week waits and there were none in December for either Trust. The overall waiting list position at UHDBFT is higher than it was at the beginning of the year by approx. 5000 patients. At CRHFT the waiting list position is performing in line with expectations of the March 2019 position. Cancer The report show that 4/9 standards were not met. The diagnostic position at UHDBFT has improved although targets are not being hit. At	

	CRHFT there are 3 patients waiting over 104 days and these are being treated as a priority. In summary the concerns are around urgent care, the A&E delivery board are exploring the drivers of poor performance and it has been identified that there are distinct differences in demand in the north and south of the county. Attenders at CRHFT are a mix of low level attenders and complex attenders. At UHDBFT the increase in demand is of a lower complexity. AM asked BS if the system is owning the issue as a system challenge. BS referred to the answer from a system quality and performance perspective, noting that the System Quality and Performance Group have been meeting since September 2019 and the focus has been on the development of the System Integrated Quality and Performance Report which was approved by JUCD Board in January 2020. A shadow report is planned to be submitted at the Quality and Performance Committee in February 2020. The long term vision is for each of the organisations quality Committee to flag to SQPG areas for consideration. SL confirmed there is system recognition of the issue and the key is around understanding the drivers of flow into A&E. ZJ added the A&E delivery board is carrying out a more strategic analysis of the performance issues rather than a siloed approach. The CCG, as Strategic Commissioner, has to be clear on its role as well as being clear on what steps are going to be taken as the strategic commissioner. BD noted the complexity of the issue and the need for a complex solution with all organisations within the system discussing what role they play. However there would still be a certain number of patients that present at A&E. GO remarked that her GP Practice, Wingerworth Surgery, operate a “turn up and you will be seen” policy. GO questioned how many patients from that practice result in going to A&E, as she felt it may be a low number due to this way of operating. GS referred to page 13 and the main reasons for cancellations for DHcFT in December 2019 is due to consultant sickness. GS asked about the recruitment plans and the also whether the absence management plan is working. PS responded to say this has been on the CCG radar and discussed at the DHcFT Quality Committee. A paper around the Trusts Safe and Well Policy will be coming to the Quality and Performance Committee meeting in February 2020. In terms of consultant sickness, a paper has been received from Carolyn Green around the recruitment of consultant and it is confirmed that the post in the North of the county has been filled, however there are ongoing struggles to recruit in the South of the county. PS confirmed that he would circulate the paper to Committee members as well as provide an update to the Committee when Mental Health is next scheduled on the agenda. BD stated he would like to receive assurance	

	on how providers put systems in place to minimise risks to patients and Primary Care. Referring to the quality section of the integrated report BS noted the breaches around mixed sex accommodation which are being monitored appropriately by UHDBFT. From January 2020 there is a new national protocol which is more realistic at managing mixed sex accommodation and therefore a reduction in the figures should be seen. The Committee noted and approved the contents of the Integrated Report.	
Q&P 1920/198	**OEIPB** BS referred to the paper and noted that progress has been made in terms of the Safeguarding Doctor element. The previous 4 CCGs had worked very differently in terms of Safeguarding however this has now been standardised with a standardised contract and job description which now comes under the remit of Steve Lloyd, Medical Director. BS also highlighted the new CDOP arrangements that have been put into place which has meant the agreement by GB of funding for a Safeguarding Doctor and Nurse post. The new statutory arrangements commenced in September 2019. There was a January 2020 deadline to reduce any outstanding cases which has been achieved. 4 outstanding cases which are related to inquests and are therefore permitted to be included in the trajectory. BS referred to the Primary Care workforce and informed the Committee of the recent Practice Nurse Conference which was held in Derby City and was well attended. A quarterly newsletter detailing the national agenda around professional working is circulated and the conference is being repeated in the north of the county in mid-February. BD asked if staffing levels within the individual PCN's are being reviewed. SL confirmed that conversations are taking place at the Primary Care Leadership Group.	
Q&P 1920/199	**TOR Approval** SP confirmed that the recommended changes have been made to the TOR. The inclusion of section 2.1.17 around the increase in system working with system partners and feeding into the SQPG group was noted. The Committee reviewed and agreed the revision to the TOR. The TOR will be presented at the GB meeting on 6th February 2020 for approval.	
Q&P 1920/200	**Quality Visit to Antenatal Department at Burton Site UHDBFT** HG presented the paper to the Committee. The visit to the ante natal department at the burton site of UHDBFT was	

	completed in early January 2020. HG noted the summary points outlined in the paper which included the following; • Omission of referral to fetal medicine • No anti-D administration. Recommended for rhesus negative ladies. • Increase in level of anti D antibodies over 3 consecutive blood tests. No referral to fetal medicine. • Missed opportunities to commence on treatment for raised TFT. • Late consultant referral to discuss treatment following a previous stroke resulting in intrauterine death at 19+weeks. GO asked if interactions with patients on the wards were conducted during the visit. HG confirmed that the visit included talking to the patients, looking at the patient journey and getting a feel for the department. The CCG team also observed how the staff interacted with patients during their stay. AM referred to the summary of findings and noted the majority of issues are around leadership and management. HG replied to say that a theme had been found around the merger of the two sites two years previous at which time the Trusts were also piloting The Portsmouth Model. The pilot had a significant impact on staffing and was therefore the pilot was abandoned. HG noted that this was a joint review with the Trust who had approached the CCG for input. Patient feedback from the review has been is positive. SL noted the internal issue around leadership in particular clinical leadership. Referring to incidents at the Burton site SL asked if the team looked at the interface between Primary Care and the ante natal service. HG replied to say that this is due to be carried out in February, a mapping process will be carried out and next steps will be decided. BS assured the Committee that Ali Cargill, Assistant Director of Quality, DDCCG, has set up a review group of maternity services and this visit is the first of a number of actions to take place which will report back to this Committee. In addition a new Head of Midwifery has been appointed to the Burton site and is working well.	
Q&P 1920/201	**IPC Visit to CRHFT** SL presented the report to the Committee. The report is around the visit carried out by NHSEI at CRHFT following the unannounced CQC visit it August 2019 where a number of concerns were raised in terms of environment and cleanliness. This triggered NHSI to rate CRHFT Red in terms of infection control which resulted in a full visit around infection control in December 2019. Main findings of the visit were around clinical engagement and that the investigations were very nurse led. The medical team are going to be more involved and the Deputy Medical Director will pick this up and	

	ensure there is appropriate representation at all meetings. There were issues around information held on the Trust website and this has been updated. There were no major concerns and the rating has now been moved to amber and a further visit will take place again in May 2020. SL will attend the infection control Committee and the strategic infection control Committee to monitor the engagement and ownership form the divisions. SL will also get an update from the action plan from CQRG in March 2020. BD asked if there is any learning that could be taken from UHDBFT around clinical engagement. SL commented that there has always been a struggle around clinical engagement at CRHFT. The difference is evident through the Committees and investigations and there could be some learning for CRHFT.	
Q&P 1920/202	**Care Homes** NMcP presented the paper to the Committee. This is the quarterly report on the activity of the care home quality team and the status of the quality in our commissioned care homes. NMcP highlight the following points; • 80% of the CCG commissioned care homes are rated green using the locally developed quality dashboard. • Four homes are highlighted in report. Two have a formal suspension of new admissions and two have a voluntary suspension in place. • An update has been provided for the Four Seasons Group. AM noted the trend in deregistering from nursing home to care home due to the difficulty in securing nursing staff, asking if this was a feature. NMcP replied that there is an ongoing issue along with the increasing complexity of residents which means homes are having problems with maintaining adequate staffing levels. The AQP framework is in place for nursing homes and the contract is due to be refreshed in the summer and tiered rates may be explored at this time. GO noted her complete assurance which the report provides and recognised the reactive work that the team have to carry out. NMcP left the meeting.	
Q&P 1920/203	**Review of Clinical Access Standards** CC presented the paper to the Committee. CC explained that this is a holding paper and a brief on what the CCG	

	currently know about the potential changes to the Clinical Access Standards. The revised A&E standards will move to measuring individual time points in the journey and there will be some time specifically standards for certain presentations. It is thought that the target will come in to play in April 2020. The RTT standard does not look very different to what is currently in place. In terms of Cancer the standards are being combined. There are many changes to the MH standards but these will not come into play until 2022.	
Q&P 1920/204	**Waiting List Update** CC presented the report to the Committee. The paper focuses on the size of the waiting list at both CRHFT and UHDBFT. The CCG are assured that CRHFT will hit the planned target of the March 2019 baseline. There are concerns for UHDBFT who have inherited some pathways from DCHS as part of the strategic shift. If the March 2019 position is recalculated to include the inheritance UHDBFT have a revises position of 55,000 pathways against a target of 50,000. The Trust feel they will keep within the position of 55,724. CC referred to the specialty breakdown and noted the T&O increase is 20% compared to March 19. The reason UHDBFT haven't been able to eat into the backlog is due to losing two wards. In terms of elective patient at UHDBFT the CCG are under plan. Going into 2021 the priority for UHDBFT will be to have a robust plan around T&O on how the backlog is managed whilst continuing to drive down demand. BD noted the risk is around 52 week wait breaches. CC confirmed there were no 52 week wait breaches in December, however there is the risk of some PICU waits in March and the Trust is prioritising any patient in the 45 week plus time frames. BS added the CCG are working with UHDBFT to ensure no harm comes to patients. BS requested details of patients who are approaching the 45 week mark so the CCG can carry out an individual case review to ensure no harm occurs. **ACTION** - CC will identify patients who are approaching the 45 week wait marker to enable the CCG to carry out an individual case review. CC continued to say the work is being done with both trusts around the priorities for 2021. Latest operational guidance, which has been formalised today, includes reducing the wait list position but does not set specific targets. BD asked for assurance and referred to the March 2019 position and asked what the impact would be on not reaching the position. CC confirmed that NHSE are aware if the issue and are present at the RTT Programme Boards held at the Trusts. There is work to be done at SQPG around a formal proposition to the regulators and ensuring that	**CC**

	all is being done at UHDBFT to hit this trajectory. ZJ suggested a summary paper be provided to Quality and Performance Committee for the next couple of months. **ACTION** – JP will add to the forward planner. CC will provide the paper. BS reflected back to last year and the validation that UHDBFT were carrying out on the waiting lists and asked if the validation process had continued throughout the year. CC confirmed that this has been happening although there have been some issues around activity inherited from DCHS but this has been resolved.	**JP/CC**
Q&P 1920/205	**EMAS Overview** JJ presented the Q3 paper to the Committee. December has been challenging for EMAS from a demand and performance perspective noting handover delays as being a significant issue and reporting deterioration in the December position. The position for January is improved in terms of demand, performance and handovers. Incidents are over plan by 5.2% and this is after the 3% increase put into the plan. See and Convey is an area of concern and the majority are Cat 2 patients. Referring to resourcing, comparing December 2018 to December 2019 EMAS resourced an additional 14,235 double crew hours. However 13,000 hours were lost in handover delays and so the benefits are not being seen. There is a trajectory in the contract that See & Convey has to be reduced by 1% in Q3 and 1.5% in Q4. EMAS have not been able to deliver the target in Q3. GO asked if there is any learning that EMAS can take from other ambulance services in the county. JJ confirmed EMAS do lose more hours due to handover delays than any other ambulance service in the country. This was discussed at the Strategic Delivery Board and the action is to do more focused work on Leicestershire Royal Infirmary. There is a new accountable officer across Leicester, Leicestershire and Rutland (LLR). JJ is meeting with NHSEI to understand the support that can be given and explore what else can be done. AM asked if the figure of 13,000 lost hours is being widely shared within the system. JJ stated that it was proposed a paper that was written by the Director of Operations at EMAS should be submitted to every A&E delivery board meeting so board members are sighted on the scale of the challenge. ZJ noted the importance of remembering the wider urgent care issues which are in the system. GO commented on the increase in prolonged waits and the impact on patients. JJ confirmed that EMAS have carried out a number of harm reviews to provide assurance to their board. The reviews have not highlighted any significant problems. A member of the team is at LLR	

	undertaking a review on 25 prolonged wait cases and the same is being done for Lincolnshire. JJ will share the report with the Committee when it is complete. SL noted the need to look at the detail of the acuity of see and convey and what can be done to mitigate. Data shows that C2 has remained static. If C3 and C4 conveyances can be reduced this will free up resource. JJ replied to say it is hoped, as part of the 2020/21 contract, each STP/ICS will set out the work that it will carry out with EMAS to support the aim of reducing demand so that all parties are committed to working in a different way. BD asked if data is available on the length of time it takes a crew to deal with a case. JJ confirmed that all staff now issue a PIN report for each call. Each division is reviewing the PIN reports to identify how they can be more efficient. JJ left the meeting	
Q&P 1920/206	**UHDB Dermatology Out-of-Area Closure Request** CC gave the Committee a verbal update. UHDBFT have approached the CCG and requested stopping accepting out of area referrals for dermatology given their current capacity issues. The CCG have asked the Trust for clarity on the following; • The impact stopping the referrals will have on solving the Trusts capacity pressures. • What the current gaps are around their current capacity and what action they are taking to create a substantive workforce. • From a clinical quality and safety perspective what is the impact on stopping referrals on the current wait list. The Committee noted the update.	
Q&P 1920/207	**Deep Dive – SI Reviews – UHDBFT** Gill Ogden, UHDBFT, gave the Committee an update on the Serious Incident reviews that have been carried out and the time it was taking the Trust to conduct the investigations. GOg explained the delays were increasing as the year went on and this was due to a number of factors. Following the merger different processes were in place across the two sites, the medical division had more SI than the other divisions and there were more challenges within the team. Additional support was put into the team as well as fortnightly meetings chaired by Executives to review each case and to ensure the control was not lost. The current position is good; the fortnightly weekly meetings continue to ensure the position stays in place. The focus is on the action plans and making sure they are signed off. The Trust is also part of the pilot around the new patient safety	

	framework and is working with Lisa Falconer, Patient Safety Lead for the CCG. BD noted the good work that had been carried out by the Trust. GO noted the information is very assuring and recognised the hard work behind the figures. BS asked for the figure of the current outstanding backlog. GOg confirmed there are three outstanding reviews. One LeDeR review which is quite complex with a key member of staff conducting the investigation is currently off sick, the review will be completed on their return. The other two reviews have been granted an extension, one to February and one to March 2020. GOg left the meet	
Q&P 1920/208	**Update on Wound Care** LS presented the paper to the Committee. Historically there have been significant inconsistencies around the service specification in relation to wound care delivery provided by DCHS and GP's. Over last 18 month the CCG have worked on a clinical model to address this issue. A task and finish group was created and facilitated by the CCG and included representation from Primary Care, LMC and DCHS. The conclusion and agreement from the task and finish group was that practices would provide basic would care and DCHS would provide the more complex would care. In the County the transition has been largely successful and has been aided by having available existing district nursing staff flexing into the new clinics as well as the successful recruitment of new staff, having access to clinic spaces and having accurate baseline data. In the City the transition has been less successful with problems in recruitment and resilience in the current DN teams, inaccurate data and difficulties in accessing clinic space. PCN, GP and practice managers, LMC, DN have all met and an interim plan has been agreed from 1stfebruary 2020 practices will refer all patient over the age of 18 with a complex would care issue to DCHS. The implementation was due to be complete however this is not the case and a collaborative approach has been taken to find a solution. There is an interim plan and from 1st February all practices will be referring electronically all patients over 18 year's old with wounds requiring specialist input. The current waiting list has been reduced from 138 to approx. 24 patients with many waiting less than two weeks. Practices have agreed to keep the daily activity for complex wound care until DCHS have space to take it on. London Road has 5 spaces which will be ready by October with most cases being transferred by this time.	

	The CCG have facilitated the payments to all practices that have been carrying out complex wound care and this will continue. In Derby City there are 16.1 WTE staff in the clinics and also dedicated admin staff which optimises clinical facing time. There is also extra input from the Tissue Viability Team giving support to practices. Practices have lead named contact within DCHS. SL asked that the Committee members note the context of the issue and compare to the position last year, stating that this should be treated as a good news story. SL noted his concern around the risk management of these patients and confirmed that the mitigations in place should be commended. BD agreed with SL comments and noted the progress that has been made. GS asked if there is a plan to provide individual practice data. LS replied to say that as part of the re specification of the delivery of wound care the CCG are working with the data that is available however this will be transitional. GO asked if any concerns have been raised from patients around travelling to GP practices. LS confirmed there has been an increase in requests for patient transport and this will be considered when looking at evaluation the service.	
Q&P 1920/209	**12 Hours Trolley Breaches** CC presented the report to the Committee. The paper is an exception report and has been written due to the high level (58) of 12 hour breaches in December across the system. The paper details the factors at all three sites in terms of volume of attendances coming into A&E with all three sites being on a high level of OPEL alert as well as having capacity issues. This re-emphasises the work that still needs to be done with providers to ensure all things that are in place are working effectively. Both Trusts have implemented some assessment unit interventions to divert patients away from A&E and manage demand. SLa and HG joined the meeting. LS left the meeting	
Q&P 1920/210	**CQC Report: Cygnet Health Care Limited: Well Led Inspection** PS presented the paper to the Committee. CQC carried out a well led assessment of Cygnet Healthcare in July and August 2019 and was published on 14th January 2020. Findings	

	from the report include five “must do” and five “should do” actions. In October 2019 the CCG met with the board members of Cygnet Healthcare to gain assurance from them and it was noted that the CCG did not see the same findings as CQC and noted some signs of improvement has already been made since the assessment had been carried out. The CCG has had sight of the action plan and this is being monitored. SL left the meeting	
Q&P 1920/211	**GBAF Q3** BS presented the paper to the committee. There are three risks relating to Quality and Performance on the GBAF. Additional assurance has been included in the paper however the risk ratings have not been reduced for this quarter. The Committee were happy with the current ratings which will be taken to the next Governing Body meeting on 7th February 2020.	
Q&P 1920/212	**Exception Risk Report** SP presented the paper to the Committee. There are three high risks relating to the Quality And Performance Committee. • Risk 002 around the A&E standard. • Risk 007 around TCP plans which is currently rated at 16 and has not been reduced. • Risk 030 around IHA which is still rated at 15 and has not been reduced. Two risks have been reduced this month; • Risk 014 around PICU has been reduced from 12 to 9. • Risk 039 around S117 aftercare costs has been reduced from 12 to 9. BS asked for more detail on the rationale behind Risk 039 being reduced. **Action** – SP will get the detail behind the rationale of Risks 039 being reduced. There are no closed risks this month. There are two new risks for the Quality and Performance Committee. • Risk 041 around the lack of peer support for care homes and syringe drivers. This risk has been escalated by the Medicines Management Delivery Board. • Risk 042 around Wound Care and Derby City patients, this has been rated a 9. HM attended the meeting to give more detail to members on Risk 041. Royal Derby Hospitals FT will stop the service provided at the moment and it is being aligned so that there is the same service across	**SP**

	Derbyshire which is for the District Nurses to make up the syringes at the bedside. This is a significant change which has proved successful in terms of DCHS supporting patients in their own homes and care homes. There has been more challenge in the nursing homes around issues with training and upskilling staff. It has been agreed that Royal Derby Hospitals FT will continue to provide the service to the smaller nursing homes until May. Three of the larger homes will transition to the new service and the remainder of the nursing homes will be supported for one year by Treetops. BD noted the assurance and mitigations put in place around the risk. The Committee members felt that with this in mind the risk should be reduced to an 8. **Action** – SP will amend Risk 041 to an 8 and update the Risk Register for the GB meeting on 7th February 2020.	**SP**
Q&P 1920/213	**Stockport Breast Surgery – Feedback Report** The paper was taken as read by the Committee. There were no questions raised.	
Q&P 1920/214	**Minutes Received from other sub-committees** The Committee noted the following minutes from the following sub Committees.	
Q&P 1920/215	**Minutes of the meeting held on 19th December 2019** The minutes of the meeting on 19th December 2019 were accepted as a true and accurate record of the meeting.	
Q&P 1920/216	**Matters Arising / Action Log not elsewhere on the agenda** The actions on the action log were reviewed. Updates were given and actions closed where appropriate.	
Q&P 1920/217	**Any Other Business** The Committee noted the possible quoracy issue for the February meeting which would be due to the lack of Lay Member availability. **Action** - JP will email the other Lay Members to ask if cover could be provided. SP raised the issue around the Quality and Performance report being available and ready for inclusion in the GB papers. BD confirmed that he is now meeting with either BS or LM directly after the Quality and Performance Committee meeting to compile a brief summary for inclusion in the GB papers.	**JP**
Q&P 1920/218	**Forward Planner** The Committee members noted the contents of the forward planner.	
Q&P 1920/219	**Assurance Questions**	

	• Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? Yes • Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? Yes • Were papers that have already been reported on at another committee presented to you in a summary form? N/A • Was the content of the papers suitable and appropriate for the public domain? Yes • Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? Yes • Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? No • What recommendations do the Committee want to make to Governing Body following the assurance process at today's Committee meeting? None • Is the Committee assured on progress regarding actions assigned to it within the Organisational Effectiveness and Improvement action plan? Yes	

DATE AND TIME OF NEXT MEETING
Date: Thursday 27th February 2020
Time: 9.30am to 12.30pm
Venue: Conference Room, Toll Bar House, Ilkeston

Joined Up Care Derbyshire Board
Minutes of the Meeting held on
Thursday 16 January 2020 09h00 to 12h00
Rooms 1&2, The Hub, South Normanton
UNCONFIRMED

Present:		Designation:	Organisation:	
Angie Smithson	AS	Chief Executive	Chesterfield Royal Hospital NHSFT	
Chris Clayton	CC	Chief Executive	NHS Derby & Derbyshire CCG	
Caroline Maley	CM	Chair	Derbyshire Healthcare NHSFT	
Duncan Gooch	DG	Chair	Derbyshire GP Alliance	
Fran Steele (part)	FS	Director of Strategy & Transformation	NHSE & I	
Gavin Boyle	GB	Chief Executive	University Hospitals Derby & Burton NHSFT	
Ifti Majid	IM	Chief Executive	Derbyshire Healthcare NHSFT	
John MacDonald (Chair)	JM	Chair	Joined Up Care Derbyshire	
Kath Markus	KM	Chief Executive	LMC Derbyshire	
Kathy Mclean	KMc	Chair	University Hospitals Derby and Burton NHSFT	
Lee Outhwaite	LO	JUCD Finance Lead & Director of Finance	Chesterfield Royal Hospital NHSFT	
Phil Cox	PC	GP & Non-Executive Director	Derbyshire Health United Healthcare	
Prem Singh	PS	Chair	Derbyshire Community Health Services NHSFT	
Stephen Bateman	SB	Chief Executive	Derbyshire Health United Healthcare	
Sukhi Mahil	SKM	STP Assistant Director	Joined Up Care Derbyshire	
Sean Thornton	ST	Assistant Director, Communications & Engagement	Joined Up Care Derbyshire; NHS Derby & Derbyshire CCG	
Tracy Allen	TA	Chief Executive	Derbyshire Community Health Services NHSFT	
Vikki Taylor	VT	STP Director	Joined Up Care Derbyshire	
William Legge	WL	Director of Strategy & Transformation	EMAS NHSFT	
In Attendance:		**Designation:**	**Organisation:**	**Deputy on behalf of:**
Angela Wright	AW	Assistant Director Place Development & Delivery	NHS Derby & Derbyshire CCG	
Anne Hayes	AH	Assistant Director of Public Health	Derbyshire County Council	Dean Wallace
Jane Careless	JC	Public Health Lead (Health Protection)	Derbyshire County Council	
Karen Ritchie	KR	Head of Engagement	Joined Up Care Derbyshire	
Martin Whittle	MW	Engagement Committee Chair	NHS Derby & Derbyshire CCG	
Penny Blackwell	PB	Place Lead	Derby & Derbyshire CCG	
Paddy Kinsella	PK	GP	GP Alliance	
Apologies:		**Designation:**	**Organisation:**	
Avi Bhatia	AB	GP & Chair	Derby & Derbyshire CCG	
Brigid Stacey	BS	Chief Nurse	Derby & Derbyshire CCG	
Dean Wallace	DWa	Director of Public Health	Derbyshire County Council	
Helen Phillips	HP	Chair	Chesterfield Royal Hospital	
Robyn Dewis	RD	Acting Director of Public Health	Derby City Council	
Shanice Bailey	SB	Programme Support Officer	Joined Up Care Derbyshire	

160120/1	Apologies and Minutes of Previous Meeting	Action
	The Chair welcomed members to the meeting and introductions were made. Apologies for absence were noted as reflected above. The Chair confirmed the meeting was quorate. It was noted that the meeting was being held in public for the first time. The minutes from the meeting held on Thursday 21 November 2019 were agreed as an accurate record; subject to the following amendment on Page 9, which should read *'HJ suggested there was an opportunity to look at aligning prevention budgets across Health and Local Government to look at how we make a more significant shift towards more prevention'.*	
160120/2	**Action Log**	
	VT advised that all actions on the action log were either in progress or future agenda items. Two specific actions were highlighted: *Item 191219/11 – Clinical Leadership:* VT advised that the deadline for this action to conclude had been deferred to the February Board meeting as there were further discussions taking place to finalise the proposals. *Item 181019/7 – System Risk Management:* JM suggested that whilst the approach to risk management was being developed through the Board Governance and Effectiveness review, it was still important that the Board revisit the risk appetite discussion going into next year and that a more detailed discussion was required at a future Board meeting.	
160120/3	**Declarations of Interest**	
	The Declarations of Interest were considered; the purpose was to record any conflicts of interest and note any other conflicts in relation to the meeting agenda. The Board reviewed the register and confirmed it was accurate and no further declarations pertinent to the agenda were made.	
160120/4	**Patient Story**	
	JM advised that today's story had been deferred to a future meeting due to illness.	
160120/5	**System Oversight: Chairs Report**	
	JM provided a verbal update on key developments related to the STP on the period since the last JUCD STP Board. The key points highlighted, were as follows: <u>Strengthening the partnership with the Voluntary Sector</u> JM advised that further to the update in the Directors report last month, positive discussions were progressing with key voluntary sector representatives to develop the partnership approach. KR advised that there were two strands which would be closely aligned. The first was the Integrated Volunteering Approaches Programme, for which national funding had been secured to enhance the role of the sector in strategy development and the design and delivery of integrated care. The second was the voluntary sector leadership approach which would develop an alliance of voluntary sector partners to support the Board going forwards. The focus of the last discussion was to consider how that would work in practical terms and the discussions were continuing. <u>Review meetings</u> *Chairs and CEOs* JM advised that he and VT were in the process of meeting with each statutory	

	organisation Chair and CEO to gather views on how the Board should operate moving forward. The outputs of these discussions would feed into the Board Governance and Effectiveness review and be brought back to the March meeting. *Workstream Challenge and Confirm* JM reported that meetings had now taken place with all of the workstreams; this was an excellent opportunity to take stock of where each of the workstreams were, what was working well and any challenges. The outputs of these meetings would be presented to the Board at a future meeting, to inform the approach for the system going forwards.	
160120/6	**System Oversight: Directors Report**	
	The STP Director's report provided an update on key developments related to the JUCD STP since the last JUCD STP Board. VT highlighted the following points: <u>Streamlining Our System Approach</u> It was recognised that developing 'system' working was often creating a significant call on staff time and the need to manage competing priorities within respective organisations. As a result, to aim to reduce this burden it had been agreed that Fridays would now be considered as the system 'corporate' day. This was intended to free up time and avoid double booking wherever possible to better coordinate the approach across the system. In addition, each organisation was being asked to review the timing and location of their main corporate meetings to ensure these could be aligned better to avoid obvious clashes. This would include board meetings, sub committees, programme boards, where often the same people were invited to attend. The Board were asked to note this important piece of work and support the approach within respective organisations. Other colleagues would also be reviewing the timings of workstreams and planning meetings to the same effect. Streamlining the amount of meetings was also planned; it was noted that the Mental Health Programme Board was now working in a new way to avoid duplication; this was a pilot which would be adopted in time by other groups. <u>System Winter Pressures</u> Derbyshire like many other parts of the country experienced significant pressures in managing urgent and emergency care (UEC) service provision during December and January. VT advised that a regular UEC escalation teleconference between system partners, led by Gavin Boyle, UEC SRO, was in place whereby current organisational pressures were reviewed alongside the available capacity in different parts of the system. These calls provided an opportunity to identify and agree mitigations in real time to ensure people could access and receive appropriate and safe care in a timely way. GB confirmed that as anticipated December was going to be a difficult month, but it was important to note that the winter plan which was agreed through this Board put the system approach in good stead. GB added the following points: • Although Derbyshire was in the middle in terms of performance across the midlands region, the performance challenges were recognised. Nationally, performance in the midlands overall was a significant challenge. • The important headline to note was that the system had come together to manage winter pressures more effectively. The priority was to continue to focus on ensuring the safety of patients. It was noted that there had been some long waits. Derbyshire accounted for only 5% of the 12 hours breaches in December in the midlands. • Despite EMAS and the Acute Trusts continuing to work well; Ambulance handovers continued to be a challenge at times. AS concurred with the points made by GB, and through the Board noted thanks to all our	

	operational staff who were continuing to work so hard. KMc suggested that it was important that the system reflected and took learning from the approach taken to inform how we could continue to make improvements into the future. VT advised that would be picked up in the winter review which would be brought to the Board in April. **Action: Review of Winter presented to Board in April 2020**	**GB**
160120/7	**Delivering Today: Derbyshire System Financial Delivery**	
	LO presented the update to the Board; the focus of this month's update was on planning and financial activities, specifically in readiness for 2020/21. *Finance* LO advised that due to the timing of the submission of the Q3 position to NHSE/NHSI, the in-year financial update would be discussed at the next JUCD meeting, following an initial discussion at the next scheduled JUCD Finance Sub-Committee meeting on the 7 February. The headlines at this time were: • The 2019/20 financial challenge was now valued at £151m which was worse than anticipated last month; as a result both Acute Trusts were in the process of changing the year-end forecast and regulators would be notified. • The control totals for UHDB and CRH were not going to be met and this would impact on the overall system control total as a consequence. • All organisations were continuing to work through together to achieve the best possible position for the system overall in 2019/20. This meant that the 2020/21 financial challenge based on the recurrent underlying position from 2019/20 was now in the process of being recalculated as the saving challenge in 2020/21 would be greater than anticipated based on the current position. **Action: Board Finance sub-committee to do detailed review of month 9 position and report to Board on implications for managing the financial position in 2019/20, changes in the system's underlying financial position entering 2020/21 and level of risk.** *Planning* Although the NHSE/NHSI operational planning guidance had not yet been issued formally; a high level indication of the requirements was now available, which the Derbyshire approach to planning was consistent with. The key principle that had been agreed was that all planning activities required as part of the next planning round would be undertaken collectively as a system. The overarching planning principles set out in the paper were supported by the Board. LO informed that work had been completed to articulate steps required between December and March in relation to operational planning, following the completion of our five year strategic plan. These steps as set out in the paper had been agreed by CEOs, also confirmed the responsible leads/ groups that would undertake the relevant tasks. It was recognised that there were gaps in terms of Primary Care and the Local Authority and it was noted this was due to the specific regulatory requirements. LO confirmed, should the formal operational planning specify anything over and above the current understanding this would be incorporated. LO advised that the operational plans to be developed for 2020/21 would function as annual plans for organisations and also as the delivery plan for year two of the five year strategic plan. There was an expectation that each organisation would be required to complete 2020/21 operational plans; these needed to triangulate as a system operational plan and be aligned to submissions made via the Strategic Planning and Long Term Plan Metrics tools to reflect finance, workforce, activity and associated metrics. LO confirmed that they system had agreed to construct the organisational plans in Derbyshire to form	**LO**

an aligned and interlocking system plan.

A discussion ensued and the following key points were made:

- It was confirmed that the System Savings Group would be considering opportunities to reduce waste in the system as part of the efficiency work.
- A joint approach for areas such as MSK, CVD and Respiratory would be developed based on the outputs of the system efficiency workshops.
- It was important that transformation leads were better engaged with each other and supported by a system PMO, which the system was moving towards.
- The size of the financial challenge in 2020/21 would be worked through in the DoFs meeting but it was important to recognise that the assumptions made during the strategic planning stage would be adjusted as part of this process.
- The System Savings Group would also be exploring further opportunities to close the gap in 2020/21 and the Board would be provided with an initial view at the next meeting of the overarching framework for the System Improvement Plan.
- Discussions with regulators would continue throughout and the timeline was for the System Operational Plan to be signed off through organisations during March so that by April the system was enacting the plan.
- For the next iteration of our plan to be successful there was a need to ensure ongoing and continued engagement with staff, the public, PCNs, Local Authority and wider stakeholders, in the same way as the strategic plan was developed. This was important to reinforce understanding of the challenges and the areas where we had the greatest potential to make an impact on the quadruple aim.
- Further consideration and clarification was required in relation to the approach to engagement and involvement of the workstream programme boards in the planning process; including PCNs. There were already links in place with PCNs, for instance in the Ageing Well programme through the Place Board and UEC workstream with a focus on community crisis response so this was an example of how interdependencies across different parts of the systems could be built upon.
- Concerns in relation to the sheer volume of work required were noted e.g. operational planning, ICP development, PCN development. There needed to be a sense of realism with regards to the capacity and capability available in the system to deliver to the timescales and the cross over between various elements of work would be really important in helping to manage this. The commitment to the system approach was considered essential in cutting our cloth differently to free up capacity.
- Given the projected shortfall there was a need to co-design further improvement areas to address the financial challenge.

LO summarised the next steps to confirm that based on the current understanding regulatory discussions in supporting our approach would be important. This would include how we approach a longer term financial recovery plan. FS advised that regionally an approach was being developed looking at specific systems and the associated risk; but ultimately the expectation was that it would come back to the LTP submissions. The midland was currently carrying the majority of the financial risk nationally. JM felt that there was a need to continue to be honest and up front in our discussions with regulators and come up with solutions to manage the position together. FS advised that the more the system shaped the submission together, with one voice, then that would be taken into account as the plan would be viewed as more credible.

FS left the room at 10am.

PS reflected on the capacity discussion further and said there was a need to be honest with ourselves in terms of the absolutes, phasing and where pace was required as there was a need to be clear about what that meant in terms of overall delivery. KMc concurred and added it was important to nail down a handful of key significant things where we had

	the greatest opportunity to reduce waste and costs; that did not mean as a system we would be saying we stop doing other things or they were not important but the key thangs should be those which were made a demonstrable commitment to pushing harder on. **Action: 2020/21 Operational Plan and risk assessment of the plan to come to the Board in April 2020** PK added that from a PCN perspective there was a need for realism too as the proposed national PCN specifications had a high degree of associated risk as there was no additional funding to support the additional requirements. DG added the aspirational aims set out were laudable but the specificity was a retrograde step in the advances made to do things differently in the PCNs. PB agreed the specifications appeared to be micro-managed so there was a need to make it work for Derbyshire and how we implement locally would be really important in supporting overall delivery of our overarching plan. KM agreed the specifications were aspirational but the lack of provisions made and the prescriptive nature of the specifications had the potential to rapidly lose the good work that had taken place in PCNs VT advised that she had been involved in local discussions with GPs and had fed back nationally to flag the concerns. JM felt there was a need for a greater understanding of the ask of PCNs and suggested this should be brought to the Board for further discussion. VT confirmed she would liaise with Duncan et al to confirm appropriate timing. **Action: Report to Board on PCN service specification out for consultation and potential implications for the system** PK requested that the Board support was noted as it was really important for the PCNs.	**LO/ SKM** **VT/ DG**
160120/8	**Delivering Today: System Risk Management**	
	SKM presented the report which was the quarterly review of system risks scoring above 12. The following points were highlighted. There had been a change in the risk score as follows: • *R001: There is a risk that the constituent STP organisations may not achieve collective financial balance in 2018/19 and beyond*. SKM advised that following discussion at the December JUCD Board meeting; reinforced by today's discussions, the risk score had increased from 16 to 20. This was primarily due to the forecast year-end financial position being off. It was important to note that whilst the system was continuing to ensure that the impact on the overall system year end position was as good as it could be; the risk level needed to be increased given the current position. • *R003: There is a risk that insufficient programme resourcing across the system compromises delivery and implementation at the pace and scale required.* SKM advised that workstream capacity had been reviewed and addressed through the CEOs group to ensure named leads identified by workstreams were now freed up to better resource delivery and a mechanism was in place for escalation of further resource requirements. In addition the BI and system PMO capacity review was now underway. In light of these developments the risk score had reduced from 20 to 16. It was important to note that although the BI capacity review was underway the specific risk in relation to analytics (R015: There is significant risk to effective planning, monitoring and use of resources, exacerbated by the lack of a whole system approach to knowledge and intelligence) remained unchanged given the	

	significant gap in the system in relation to effective BI to support transformation. The risk score for all remaining risks on the register also remained unchanged with a score of 12 or above; these were therefore highlighted to the Board. Particular attention was drawn to the following: • *R005: There is a risk that implementation will be compromised due to insufficient workforce plans and R013: There is a risk that insufficient emphasis and consideration of workforce challenges across the system will result in integrated care delivery being compromised.* SKM advised that feedback from the JUCD Board and the CPRG that the development of a strategy alone would not mitigate the significant workforce risks in the system was fully recognised, however at this present time the risk rating had not been amended. This was because the LWAB were now responding to the feedback by developing a system wide workforce risk register to manage the risks more effectively. This would involve a comprehensive review of workforce risks which would be reviewed at the February LWAB meeting. The risk scores would then be amended to reflect the outcomes of the review. SKM reiterated the point made by JM earlier in relation to the system approach to managing risks which would be strengthened as part of the Board Governance and Effectiveness review. IM said that a more strategic approach would be helpful as at present the risks were transactional and there was a need to ensure there was a stronger link to delivery of our plan going forward. The Board noted the update.	
160120/9	**Delivering Today: Integrated Care Partnerships**	
	IM provided a verbal update in relation to ICP development in Derbyshire. A series of workshops had taken place which had confirmed four ICPs in Derbyshire; the last working group meeting on 20 December had commenced work to consider the scope and operating framework requirements. IM advised that whilst all the ICP functions weren't necessarily clear at this stage, there was a need to continue evolving thinking to reach a consensus on the future operating model. Therefore it was concluded at that meeting that the supporting leadership team to progress the ICPs was a crucial first step to assist in developing the framework. CC agreed and said there was enough of a view now to focus on getting the leadership teams in place to support the development of the framework. A further working group meeting was taking place on 17 January; the focus would therefore be to agree the draft leadership framework which would include defining the leadership teams, how to ensure the democratic voice/mandate was heard in any new arrangements and the timeline to get the teams in place to mobilise the ICPs rapidly to commence working up the detail of the framework. IM stated that the ICPs needed to support and be part of what the system needed to deliver. He suggested the request for each workstream to identify how/ where delivery sat in relation to each tier of the emerging architecture that was sent out following the workstream confirm and challenge meetings was an important piece of work which should inform the ICP development. IM requested that each SRO ensured the mapping was undertaken for their respective workstreams to feed into the process. SKM confirmed she would recirculate to SRO's with a definitive timescale for return. GB suggested that there was a need to accelerate the ICPs by giving them something tangible to take forward and change. IM agreed but said there was a need to balance this with the local flexibilities so that the ICPs were driving forward changes themselves; the	**SKM**

	framework would be really important to ensure there was consistency and direction which linked to the system strategic priorities. The Board noted the progress made to date.	
160120/10	**Building for tomorrow: Place Strategy**	
	PB and AW were welcomed to the meeting to present the Place Board Strategy and update the Board on progress and current thinking regarding Place. PB advised that in response to the ambitions set out in the NHS Long Term Plan, the Place Board recognised the need to clarify the strategic vision and ambitions. As a result the Place Board had spent some time developing a shared purpose during a series of workshops in summer 2019. The outputs of these sessions had now been drawn together to form a refreshed vision and strategy for Place, which set out the ambitions and key deliverables; supported by a set of values and behaviours that were at the heart of effective integrated planning and delivery. The following key points were highlighted: • Essentially the Place approach was about getting effective system working established; moving away from top down thinking to a bottom up development approach. It was recognised that integrated working was extremely complex and the sessions helped identify key enablers to support transformation. These would be important regardless of any new structures for delivery. • The thinking drew significantly on national models of good practices for integrated care and looked specifically on the impact upon individuals. • The vision was defined as '*People who live and work in Derbyshire will have their health, care and well-being understood and supported by system leaders who create the conditions for organisations to work better together to improve health and wellbeing, to enhance quality of care, create flexibility and responsiveness, to ensure system value, sustainability and equity*'. • There were a number of key areas prioritised from previous strands of work which were now collectively grouped together under the 'Ageing Well Programme'. • Factors which influenced the Place strategy included clarity regarding the roles and functions of Primary Care Networks and, more recently, emergence of the proposals regarding Integrated Care Partnerships. • Leadership in Place was now more engaged and the right conversations were taking place with the right people. • Place should be seen as a system enabler as there was scope to enable transformation but if other supporting enablers such as digital infrastructure were not progressed then the challenges to date would continue to exist. • Interdependencies with workstreams were recognised as being critical. • The next stage was to focus on developing the delivery plan for 2020/21; a key area was the aging well programme which would be supported by national funding to deliver enhanced care in care homes, proactive anticipatory care and developing the urgent community response. • It was recognised that Place development and thinking now needed to move into ICP thinking; however it was important to note that each of the Places were all very different. • As Place moved forward there needed to be a clear framework to define the priorities but within that framework allow local flexibilities. • The local solutions were important in the wider ICS agenda as some Places were already linking in to wider determinants such as housing. • Place was seen as the conduit between PCNs and Health and Wellbeing Partnerships; the example of Derbyshire Dales was given where the agendas were now aligned. • Social Prescribing was identified as a priority area in Place, but contractually the responsibility was for PCNs to deliver. It was recognised that there was a need to better connect to support PCNs to deliver through improved connections with the	

	wider community. • In terms of digitally enabled care, there was feedback from the citizen's panel which demonstrated strong willingness for people to engage with digital approaches to care and this needed to be taken into consideration as traditionally there was a view that older people in particular would not want to use digital approaches. It was concluded that whether Place was seen as a system delivery vehicle or planning function mattered less as we move forward; the key was the change in behaviours to encourage people to work more closely together and that needed to be harnessed in future developments. **Action: PB was asked to work with IM to ensure that the good practice and learning for place work was embedded and supported as the system architecture was developed.**	**PB/ IM**
160120/11	**Building for tomorrow: Improving Derbyshire Air Quality**	
	Jane Careless was welcomed to the meeting to present the Derbyshire Air Quality Strategy and to agree the process for the development of a delivery plan with greater involvement from the Joined Up Care Derbyshire Board. The following points were highlighted in the presentation: • The impacts of air pollution and climate change pose some of the greatest risks to population health. Within Derbyshire County and City, air pollution contributes to an estimated 530 deaths and 5400 life years lost. • Long-term exposure to air pollution (over years) can reduce life expectancy, mainly due to cardiovascular and respiratory diseases and lung cancer. Short-term exposure (over hours or days) to high levels of air pollution can also cause a range of health impacts, including exacerbation of asthma, increases in respiratory and cardiovascular hospital admissions and mortality. • The impact of air pollution often disproportionately affects the young, older people, those with underlying health conditions and the most disadvantaged within our communities. • Air pollution levels vary across County and City due largely to proximity to source of pollution, this was evident mainly along the east side of the county and in the city; reflecting road transport as the largest contributing factor for Derbyshire. Other sources include solid fuel burning, brake and tyre wear. • Partners of the Joined up Care Derbyshire had a considerable role in the contribution of both air pollution and greenhouse gas emissions locally and nationally. NHS England alone was responsible for 4% of the UK's total greenhouse gas emissions, with 19% from energy use and 16% from staff and patient travel. • Even modest decreases in air pollution could lead to population impacts including increases in life expectancy and reduced morbidity, including hospitals admissions and GP consultations. • Interventions to address air quality would deliver wider public health benefits, including increases in physical activity, support reductions in health inequalities and support the strategy to address climate change impact. • The cumulative effect of a range of interventions to improve air quality has been shown to have the greatest potential to reduce impacts on health; the Derbyshire Air Quality strategy had therefore been developed which utilised a multi-organisational approach, involving a range of partners and disciplines. • The strategy had been developed by applying the Outcomes Based Accountability (OBA) approach so there were clearly identified population measures and performance measures to genuinely see whether the interventions were having an impact. • The strategy was based on three key strategic priorities:	

	○ Facilitate travel behaviours change ○ Reduce sources of air pollution ○ Mitigate against the health impact of air pollution • The partners of the Health and Wellbeing Boards in the City and County signed off the strategy at the end of 2019. • Monitoring of the strategy would be undertaken through the Derbyshire Air Quality Working group, reporting at least annually to Joined up Care Derbyshire and Health and Wellbeing Boards. JC advised that through the adoption of the Health and Wellbeing Board Air Quality Strategy by Joined up Care Derbyshire, partners could utilise their own and collective influence to reduce their impact and contribution to local air pollution, facilitate wider change, influence others and mitigate against impacts on health. The adoption of the Derbyshire Air Quality Strategy by both Health and Wellbeing Boards and Joined up Care Derbyshire would ensure consistency of approach and importantly, strengthened improvements in outcomes. To take this forward as a joint approach, JC asked the JUCD Board for a system partner representative from a health perspective. PS suggested that was a need to think about this in everything we do, for example if we develop the approach to more digital care this would reduce the need to travel and therefore have an impact on air quality. There was a need to think about how we all influence and changes processes within our respective organisations. PB added that it was important not to forget small organisations as there were opportunities for change there too and gave the example of Green GP Wessex where such changes had been made. WL said this was a particular area of importance for EMAS as there was a challenge in the sense that paramedics were treating people with breathing difficulties yet could not avoid the significant travel impact of the service. EMAS did have a fleet management strategy and had examined specialist vehicles to reduce the carbon footprint so he would be keen to represent JUCD and bring this into the Air Quality Working Group. The Board approved the Air Quality Strategy and action plan and confirmed WL as the representative to join the working group on behalf of the system; WL would link with other organisations to ensure feedback. It was agreed that organisations would ensure both the strategy and action plan be discussed within respective organisations.	**WL** **ALL**
160120/12	**Building for tomorrow: Equality Diversity & Inclusion Collaborative**	
	IM update the Board in relation to the development of a system approach to Equality Diversity & Inclusion (EDI). IM reminded the Board that there had been previous discussions about developing a greater focus on EDI as a system and this was now progressing, with the opportunity to become a national pilot site to progress the anticipated EDS3. EDS3 was the next iteration of EDS which would be done on a system basis, starting by looking at a couple of pathways across the system from an EDI perspective, from commissioning to delivery including health and social care and the voluntary sector. A system wide EDI collaborative had now been established, with involvement from health, local government, fire and rescue so far, which would steer the work. IM requested support from the Board to progress this work. The Board agreed.	

160120/13	**Standing Agenda Items: Any Other Business**	
	No items raised as requiring urgent consideration under AOB. The following key messages from today's meeting be shared with stakeholders and staff were confirmed as: • System Pressures • Financial and Operational Delivery • Primary Care Networks • Place Strategy • Improving Air Quality	
	Date of Next Meeting	
	The next meeting was scheduled to take place on Thursday 20 February 2020, 9.00am to 12.00pm, Rooms 1&2, The Hub, South Normanton, Alfreton DE55 2AA.	**All to Note**

Joint Committee of Clinical Commissioning Groups

Meeting held IN PUBLIC

29 January 2020 at the Boardroom, NHS Sheffield CCG

Action Summary DRAFT

168/20	**YAS Contractual MOU SYB 2020/21** a) Update the report to include page numbers. b) That a copy of the MOU be stored online as part of the formal Committee papers and a copy be available in all five CCGs.	**BH** **AOs**
169/20	**JCCCG Work Plan Progress Report** a) That the report is circulated to Governing Bodies Public sessions for consideration. b) Circulate the report to CCG Committee Secretaries and Personal Assistants for Governing Bodies meetings.	**AOs** **MM**
170/20	**Hyper Acute Stroke Service (HASU) Final Update** That both Barnsley and Rotherham residents are provided with adequate patient information in relation to the new HASU model.	**HS / MH**

Minutes of the Meeting of
The Joint Committee of Clinical Commissioning Groups
Public Session

Meeting held 29 January 2020,
at Boardroom, NHS Sheffield CCG DRAFT

Present:
Dr David Crichton, Clinical Chair, NHS Doncaster Clinical Commissioning Group (Chair)
Andrew Goodall, Healthwatch Representative
Lisa Kell, Director of Commissioning, South Yorkshire and Bassetlaw Integrated Care System
Jackie Mills, Director of Finance, NHS Sheffield Clinical Commissioning Group
Helen Stevens, Associate Director of Communications and Engagement, South Yorkshire and Bassetlaw Integrated Care System
Idris Griffiths, Accountable Officer, NHS Bassetlaw Clinical Commissioning Group
Chris Edwards, Accountable Officer, NHS Rotherham Clinical Commissioning Group
Dr Nick Balac, Clinical Chair, NHS Barnsley Clinical Commissioning Group
Dr Richard Cullen, Clinical Chair, NHS Rotherham Clinical Commissioning Group
Jeremy Budd, Director of Commissioning, NHS Barnsley Clinical Commissioning Group
Jackie Pederson, Accountable Officer, NHS Doncaster Clinical Commissioning Group
Brian Hughes, Director of Commissioning and Performance, NHS Sheffield Clinical Commissioning Group
Dr Terry Hudsen, Clinical Chair, NHS Sheffield Clinical Commissioning Group
Will Cleary-Gray, Chief Operating Officer, South Yorkshire and Bassetlaw Integrated Care System
Dr Eric Kelly, Clinical Chair, NHS Bassetlaw Clinical Commissioning Group
Dr Chris Clayton, Chief Executive Officer, NHS Derby and Derbyshire Clinical Commissioning Group
Philip Moss, Lay Member
Sir Andrew Cash, Chief Executive, South Yorkshire Bassetlaw Integrated Care System

Apologies:
Priscilla McGuire, Lay Member
Dr Avi Bhatia, Clinical Chair, NHS Derby and Derbyshire Clinical Commissioning Group
Matthew Groom, Assistant Director, Specialised Commissioning, NHS England
Lesley Smith, Accountable Officer, NHS Barnsley Clinical Commissioning Group and Interim Accountable Officer, NHS Sheffield Clinical Commissioning Group

In attendance
Mags McDadd, Corporate Committee Clerk, South Yorkshire and Bassetlaw Integrated Care System
Rachel Gillott, Programme Director, SYB ICS (agenda item 6)
Marianna Hargreaves, Transformation Programme Lead, SYB ICS (agenda item 8)

Public in attendance
Nora Everitt, SYBNAG
Elaine Borthwick, Pfizer
Steve Merriman, SYBNAG
Naveen Judha, SYBNAG

Minute reference	Item	ACTION
C162/20	**Welcome and introductions** The Chair welcomed members and attendees and deputies to the meeting. The Chair, on behalf of the Committee conveyed condolences to the public representatives on the passing of Ken Dolan, a regular attendee at JCCCG Public meetings. Public members present were thanked for the questions submitted in advance of the meeting.	
C163/20	**Apologies** Apologies were received and noted.	
C164/20	**Declarations of Interest** There were no declarations of interest.	
C165/20	**Questions from the public** Questions were submitted prior to the meeting. The JCCCG provided a response. Questions from SYBNAG members to the JCCCG January 2020 meeting: **Question 1** In the Minute C156/19 d) the question asked for information in "*in Plain English*" for the public explaining the difference between transformation and reconfiguration, but the question specifically asks for this information to be "in addition to the usual Easy Read versions of information". So please can you explain why: • minute C156/19 e) and the Action Summary both report something completely different which the question did not ask for (namely a "*simplified 'easy read' version of the Hospital Services Programme be produced for the public, explaining the difference between transformation and reconfiguration*.") • are you making work for yourselves, or a subcontractor, when the question only asked for a Plain English definition of the two terms 'transformation' and 'reconfiguration' (please note - a definition of the difference between Plain English and Easy Read can be provided) **<u>Response</u>** As with all the Hospital Services Review reports, we have produced an Easy Read version. The explanation for the difference between transformation and reconfiguration has been drafted in Plain English and we note your helpful comment regarding the minute. **Question 2 – JCCCG Progress Report** (a) Paragraph 3.4 says "all JCCCG meetings now held in public" this implies complete openness and transparency, in line with the Nolan Principles of Public Life; does this openness and transparency also apply to the delivery plan, the performance report and the specific decisions referred to in points 3.5 and 3.6?	

Response
The JCCCG Progress Report will be received quarterly at the JCCCG meetings held in public and also the CCG Governing Bodies held in public. Delegated decisions made by the JCCCG will continue to be made in meetings held in public.

2 (b) Given we are still awaiting a response from the Joint Scrutiny Health Committee concerning lack of access to public transport for families and visitors, the increases in patient transfers between hospitals and health facilities, the severe bed shortages and specialist facilities and the continuing centralisation of services causing many severe hardship and stress, isn't it essential that the ICS Transport group be reinstated with a democratically representative group, a meaningful brief and the facilities to support and inform the public of changes,
options and costs?

Response
A Transport Group was set up to support the potential for service change during the review of Hospital Services. Work also took place to look into transport issues during the Hyper Acute Stroke Services service change proposals.

With regards to the Hospital Services Review Transport Group, the Final Report did not recommend service changes and therefore the Group had no agenda and was stood down. With regards to the Hyper Acute Stroke Services as the pathway is now in place feedback is now routinely gathered as part of patient experience.

There are currently no JCCCG plans to change access to local services but if this changes the Transport Group will be reinstated.

The Chair asked to discuss outside the meeting, to consider holding a closure meeting or bring to attention at a patient forum.

Question on 3- HASU Update
(a) Post HASU transfers to Rotherham and Barnsley are working well in line with the agreed Regional Patient Flow Policy, with a very small number of delays reported. Could you tell us:

- Reasons for the above delay
- How will future delays be avoided?

Response
Overall Rotherham and Barnsley residents have flowed well through the new regional pathway since the changes were enacted. There are a number of reasons why transfers may not go ahead as originally planned including a change in patient circumstances.

Monitoring is in place to ensure oversight of patient flows and to promote proactive conversations and continuous quality improvement to aid timely flow through the regional pathway.

3 (b) Section Lessons learned
Very surprised and dismayed that the new model was installed on the agreed dates, when clinical leads were not properly ready to start the new model. Staff with the appropriate qualifications, skills and experience need to be in Place to respond to the clinical needs of the patient in a timely and effective manner.
Could you please answer following:

- Why did you decide to go ahead with the implementation of the new model on the agreed dates, when this very important element of the model was not

quite in place?

- Why is that it was decided that the risks involved in this, were not important enough to delay the starting date to ensure a safer implementation of the model?
- Provide details of workforce structures and plans to address the above

Response

Strong clinical leadership was in place as a key component of the HASU work programme and this enabled us to implement the changes in line with the agreed implementation dates.

All HASU units successfully recruited additional staff, including nurses and allied health professionals with the skills and expertise ahead of the planned changes to ensure safe implementation of the model.

Each HASU unit has a workforce model that supports their service delivery and is linked into the delivery of the wider stroke pathway.

Workforce planning is an area that will be taken forward by the new Stroke Hosted Network.

3 (c) Evaluation, assessment and monitoring of the new HASU service model

It is stated that the new HASU model was installed successfully, but we don't know the extent to which the new model is successful in terms of patient care, its impact on patients and the expected outputs and outcomes from the patient/carer perspective. Not just in the sense of staff being kind, understanding and caring, but also and very importantly, in the sense of timely clinical interventions and outcomes.
Could you please answer/ provide the following information:

- details of the evaluation system used to assess the above
- details of what is being evaluated/ assessed
- details of the monitoring system in place, including information of what is being monitored, who is involved in the monitoring, monitoring stages, data collation systems, products needed, reports systems etc.
- details of whether patients/ public have been engaged or consulted on this.

Response

The specification for the new SYB HASU model included reporting and monitoring requirements. Most quality indicators included in the reporting were based on the evidence based nationally identified indicators set out as part of the SSNAP (Stroke Sentinel National Audit Programme) to enable us to measure improvements in stroke care.

A monitoring dashboard has been developed to enable us to monitor these and the plan is for this to be monitored as part of routine contract monitoring.

The Stroke Hosted Network will have a key role in embedding the new model and enabling us to realise the benefits. This will need to include understanding the experience for patients and their families and using this to drive continuous quality improvement.

3 (d) If you did not have the above system in place, before the implementation of the new model (to start gathering systematic data from its incept), can you explain the reason for this. Such an important service, which in many cases deals with life and death, and whose interventions can have long term quality of life consequences for patients, it needs a rigorous, effective, timely evaluation and monitoring system, to be able to avoid unintended mistakes in the future, as well as serving as a tool for

	service improvement. **Response** The monitoring dashboard was developed ahead of implementing the new model. Data has been systematically gathered by providers in relation to key quality indicators set out in SSNAP. The dashboard aims to bring together data from a number of different data sources, including SSNAP, patient flows and activity data and there is a commitment to continuous quality and service improvement. **3 (e) Risk management** Risk management is a very important supporting element in delivering a new service model, and more so when people's lives depend on such a service. Awareness of risks, sharing and reporting on them are of paramount importance. Risk systems are key to ensure the service is as safe as possible. It is important that a risk system is in place in order to raise the "alarm" when needed, to avoid fatal consequences, Could you tell us why you think the decision to go ahead and implement the new model was a responsible one when a rigorous, well thought risk management system was not embedded in its structures, especially in its initial stages when anything could have gone wrong? **Response** The decision to change the way Hyper Acute Services is provided across South Yorkshire and Bassetlaw was made following a rigorous business case which addressed risks. Risk management was undertaken at both programme and organisation/service level throughout the programme.	
C166/20	**Ratification of previous meetings** The minutes of the public meeting held on 23 October 2019 were accepted as a true and accurate record.	
C167/20	**Matters Arising** Update on Hospital Services Programme The Group noted that NHS Derby and Derbyshire CCG confirmed that the report was signed off at their Governing Body meeting held on 7 November 2019.	
C168/20	**YAS Contractual MOU SYB 2020/21** RG presented a report on collaborative commissioning of Integrated Urgent and Emergency Care services, noting the key points for the JCCCG. The Committee noted that Integrated Urgent and Emergency Care Services are commissioned on a collaborative basis across Yorkshire and Humber (Y&H). These arrangements have been formalised through an overarching MOU, previously reviewed by the Committee, and signed off by all Yorkshire and Humber Clinical Commissioning Groups (CCGs) Governing Bodies on an individual basis. CCG representation within the overarching Y&H wide MOU is enabled through a nominated sub-regional lead CCGs from each of the three STP/ICSs, a responsibility undertaken by Sheffield CCG on behalf of other CCGs in the ICS footprint. The South Yorkshire and Bassetlaw MOU builds on the wider regional working agreements setting out the sub-regional working arrangements for South Yorkshire and Bassetlaw, formalising roles and responsibilities of both the lead CCG and the CCGs that it represents, building on the successful joint working arrangements that have taken	

	place in recent years. It does include a principle that requires the SYB CCGs to agree financial amounts and contract tolerances in advance of the annual Y&H wide negotiations, of which Sheffield CCG use to support and inform the discussions. RG confirmed that no decisions would be taken by Sheffield CCG outside of these parameters and issues requiring formal decisions would be presented to JCCCG as required as part of the agreed delegation arrangements. The Committee noted that a previous draft of the MOU was discussed at the Joint Committee Sub-Group which recommended that additional detail be included to clarify the process of agreeing contract tolerances. RG added that the MOU had been discussed with finance colleagues and has been amended to reflect their feedback. **Action**: 1. The Chair recommended that page numbers are added to the report. 2. The Committee recommended that a copy of the MOU be stored as part of the formal Committee papers and a copy be available at all five CCGs. Following discussion, the Committee noted the report and endorsed the recommendation to support the MOU and the proposal to collectively agree contract tolerances to support the annual contract negotiations.	**RG/BH** **AOs**
C169/20	**JCCCG Work Plan Progress Report** LK presented the newly formatted report, setting out the progress made by the Joint Committee during the last quarter on joint commissioning work within the five Places agreed on the JCCCG work plan. The group noted the key achievements and risks identified and escalated to the Joint Committee Sub-Group. The report will be shared with the Governing Bodies to update members on the current work of the JCCCG and delivery against the agreed work plan. LK added that the Joint Committee Sub-Group are responsible for managing the performance and risk assessment of the work plan, assuring the JCCCG of delivery against agreed timescales. The group noted that data on improved outcomes for patients would form part of the ongoing development of the report. **Action**: LK asked the Committee to ensure the report is circulated to Governing Bodies Public sessions. Circulate the report to CCG Committee Secretaries and Personal Assistants. The Manual Agreement and Terms of Reference will be reviewed at the end of March 2020 to incorporate any changes agreed by the Joint Committee for 2020/21.	AOs MM LK
C170/20	**Hyper Acute Stroke Service (HASU) Final Update** MH presented an update on the SYB Hyper Acute Stroke Service model implemented as planned in line with the agreed date, with changes taking place in Rotherham on 1st	

	July 2019 and Barnsley on 1st October 2019. MH added that providers continue to work together to enable the delivery of the HASU model, a daily teleconference call provides oversight of patient flow and a weekly call with providers to ensure issued identified are proactively managed. MH added that the HASU Implementation Group had representation from all key stakeholders, including Trusts, the ambulance service and Stroke Association, provided oversight of the implementation, coordinating capital/estates plans, workforce planning/recruitment and operational planning. The HASU Implementation Group was stood down in December 2019 and the Stroke Hosted Network is due to commence in early 2020. In year 1 the Stroke Hosted Network work programme will have a focus on embedding the new South Yorkshire and Bassetlaw HASU model focusing on quality improvement and benefits realisation. The Committee noted that CCGs will work together to monitor the HASU model through the dashboard as part of business as usual and will work with the Stroke Hosted Network to drive quality improvements and ensure that we realise the benefits of the new model including improved outcomes for patients. The Committee noted a summary table of lessons learnt with contributions from both providers and commissioners with key recommendations for consideration when approaching similar work programmes in future. Barnsley CCG and Rotherham CCG shared positive comments on the implementation of the new model. MH added that a regional patient leaflet is available and an "Easy Read" leaflet is to be available in HASU units. **Action**: The Committee asked to ensure that both Barnsley and Rotherham residents are provided with adequate patient information in relation to the new HASU model. The Committee noted the details of the report: • The implementation of the full SYB HASU model. • The transition plan to enable the new SYB HASU model to be managed as business as usual, with a focus on benefits realisation through the Stroke Hosted Network. • The lessons learned.	MH/HS
C171/20	**Yorkshire and Humber IVF Access Policy** IG presented a revised policy to inform the Committee that Clinical Commissioning Groups (CCGs) in the Yorkshire and Humber areas have agreed to a shared approach for specialist fertility services. The shared policy sets out who is eligible for specialised services and not how many cycles of fertility treatments are paid for by individual CCGs. IG added that the proposed changes are minimal and will not affect how people may be eligible for treatment, and will make access to specialist fertility treatment more equitable to people who are registered as patients with one of the CCGs. The Committee noted that the revised policy is currently going through Governing Boards Public sessions and all updates within it are in line with NICE guidance.	

	The Committee noted the contents and approved the revised Access to Fertility Policy.	
C72/20	**Local Elections, Purdah implications for service change decision making** The Committee noted that Sheffield, Barnsley and Rotherham local authorities will undergo council elections in May 2020, therefore, will enter into a period of purdah or pre-election period of sensitivity. During this period specific restrictions are placed on the use of public resources and the communication activities of public bodies, civil servants and local government officials. The Committee noted that some JCCCG business may be impacted during this period.	
C173/80	**Any other business** There was no further business noted.	
C174/80	Date and Time of Next Meeting The Chair informed the meeting that the next meeting will take place on 26th February 2020, NHS Sheffield CCG.	

South Yorkshire and Bassetlaw
Integrated Care System

Children's Surgery and Anaesthesia
Final Proposal

JCCCG Public Session
26 February 2020

Findings

- The Designation process has shown that overall safe, sustainable and quality services are in place across SYBND Trusts
- The learning from the Designation process has updated the views within the 2017 DMBC, and maintains the core principles of safety and wherever possible care close to home
- Designation found that:
  - Anaesthetic skills across the footprint were clinically effective and safe in managing paediatric cases
  - The current Ear, Nose and Throat (ENT) non-elective service models are clinically appropriate and should **stay as they are**
  - Torsion of the testis non-elective pathways should **stay as they are**. Additional clinical capacity is being put in place at DBHT to provide a local service
  - Appendicectomy is the most complex pathway, there had been inconsistency of approach around age ranges. Senior clinicians in all hospitals have developed a clinical pathway to address this

Proposed clinical pathway - Appendicectomies

- The Clinical Leads propose the following pathway:
- Children under 8 years of age, because of their anatomical / physiological difference to adults, will transfer to Sheffield Children's Hospital
- Children aged 8 and over, where there are identified complexities or co-morbidities will transfer to Sheffield Children's Hospital
- Transfers will only happen after a senior clinical discussion between the DGH and SCH
- For children aged 8 and over who remain in their local DGH additional elements will be put into place:
  - Every child will be admitted under a formal shared care arrangement between surgery and paediatrics. This means that the holistic needs of the child will always be considered
  - The operation will be performed by, or directly supervised by, the consultant surgeon

Impacts of the Appendicectomy Proposal

- Some children already transfer based on clinical need, although this is inconsistent. The proposal ensures consistent treatment and will marginally increase numbers:
  - It is expected that around **29 more children per year** will transfer to Sheffield Children's Hospital to have their operation
  - The impact in terms of beds and theatres in DGHs and in SCH can be managed within existing arrangements
  - There is a minimal impact in relation to costs in DGHs and SCH
  - The very small increase in ambulance transfers will be accommodated within the existing ambulance service contract
- We have spoken to the Yorkshire and Humber Clinical Senate and to NHS England, and they are satisfied that they do not formally need to review the new proposal, due to changes being so small
- The Joint Health and Scrutiny Oversight Committee will advise in March on whether the proposed changes require further consultation

South Yorkshire and Bassetlaw Integrated Care System

Chief Executive Report

Health Executive Group

11 February 2020

Author(s)	**Andrew Cash, System Lead**
Sponsor	

Is your report for Approval / Consideration / Noting

For noting and discussion

Links to the STP (please tick)

☑ **Reduce inequalities**	☑ **Join up health and care**	☐ **Invest and grow primary and community care**	☑ **Treat the whole person, mental and physical**
☑ **Standardise acute hospital care**	☑ **Simplify urgent and emergency care**	☑ **Develop our workforce**	☑ **Use the best technology**
☑ **Create financial sustainability**	☑ **Work with patients and the public to do this**		

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

N/A

Summary of key issues

This monthly paper from the South Yorkshire and Bassetlaw Chief Executive provides a summary update on the work of the South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) for the month of January 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

11 February 2020

1. Purpose

This paper from the South Yorkshire and Bassetlaw Integrated Care System Chief Executive provides an update on the work of the South Yorkshire and Bassetlaw Integrated Care System for the month of January 2020.

2. Summary update for activity during January 2020

2.1 ICS Leaders Update

The North East and Yorkshire STP/ICS Leaders meeting took place on Wednesday January 27th. Discussions covered performance over winter and the expected guidance on next steps for ICSs and the emerging England wide narrative on "system by default".

2.2 NHS Operational Planning and Contracting Guidance 2020/21

The NHS Operational Planning and Contracting Guidance for 2020/21 was published on 30 January. The Guidance sets out the expectations across system planning, operational requirements, people and financial settlements as the NHS plans to deliver the 2020/21 elements of the NHS Long Term Plan commitments, which local systems have developed through their strategic plans. This includes maintaining and improving access to services, expanding primary and community services, continuing to transform the way care is provided by working within systems which include both NHS and wider partners, meeting the mental health investment standard, continuing to improve outcomes and care for people of all ages with a learning disability or autism, beginning to implement the forthcoming People Plan, reducing the impact the NHS has on the environment by reducing its carbon footprint, living within agreed financial trajectories, and embedding and strengthening the governance of our systems as we move to a 'system by default' operational model.

Different systems are at different levels of maturity, however, there are some consistent operating arrangements that systems are expected to agree with regional directors and to put in place during 2020. These include system-wide governance arrangements to enable a collective model of responsibility and decision-making between system partners, a leadership model for the system, including an ICS leader and a non-executive chair appointed in line with NHS England and NHS Improvement guidance, system capabilities including population health management, service redesign, workforce transformation, and digitisation, agreed ways of working across the system in respect of financial governance and collaboration, streamlining commissioning arrangements, and capital and estates plans at a system level.

2.3 Sheffield City Region Devolution

With the support of each of the four councils in South Yorkshire, Sheffield City Region Mayor Dan Jarvis has reached an agreement with the Government to progress without delay the Devolution Deal that will deliver new powers and resources that would enable tangible benefits to communities across South Yorkshire.

The Mayor will be bringing forward a paper seeking approval to launch the public consultation as the first critical step in this process. The devolution deal would bring with it £30m a year in additional funding for economic growth, as well as power over the adult education budget totalling

around £35m each year. It would also mean additional powers for the Mayoral Combined Authority, in areas including transport, skills, and governance.

2.4 Royal Garden Party Nominations

Following a request from NHS England for the ICS to nominate three members of staff and three guests, we asked all our partner organisations to put forward their nominations for the Royal Garden Parties. The three staff selected from a hat are Chief Nurse at Rotherham CCG, Sue Cassin, Executive Assistant to the Directors, Bassetlaw District Council, Vanessa Cookson and Workforce Transformation Lead at Health Education England. Many congratulations to Sue, Vanessa and Linda who will be attending one of the Royal Garden Parties in May.

2.5 Meeting with the South Yorkshire and Bassetlaw Health and Wellbeing Board Chairs

My routine meeting with the South Yorkshire and Bassetlaw Health and Wellbeing Board Chairs took place on 7 January in Rotherham. Discussions included an update on the IC Five Year Plan, the expected guidance from NHS England and Improvement on next steps for ICSs. Chairs were particularly interested in developments in primary care and the voluntary sector scoping work to strengthen service delivery in neighbourhoods and Place.

2.6 Launch of the Advanced Wellbeing Research Centre

The new Advanced Wellbeing Research Centre based in Sheffield's Olympic Legacy Park, officially opened on 24 January. The Centre is dedicated to improving the health of the population through innovations that help people move.

It was officially opened by Dame Sarah Storey, the Active Travel Commissioner for Sheffield City Region and Britain's most successful female Paralympian. The Centre has been supported by £14million funding from the Department of Health and Social Care and £905k investment from the European Regional Development Fund.

The AWRC forms the centrepiece of the Sheffield Olympic Legacy Park and its mission is to prevent and treat chronic disease through co-designed research into physical activity – whilst also attracting new jobs and investment to the region.

2.7 Performance Scorecard

The attached scorecards show our collective position at January 2020 (using predominantly November and December 2019 data) as compared with other areas in the North of England and also with the other nine advanced ICSs in the country.

We are once again green in six of the ten constitutional standards: six week diagnostics, two week cancer waits, two week cancer breast waits and 31 day cancer waits, Early Intervention in Psychosis (EIP) and IAPT recovery. Our overall performance as a System, while still below the constitutional standard in four areas, remains one of the best in the country. We outperform other ICS in the North and also those that are First Wave, where there has been some deterioration in the standards over the last reporting month.

At month 9 the Year to Date position is £3.7 million ahead of plan. One organisation is forecasting a deficit against plan and we are looking at how we can offset this with over-performance in other organisations in order to balance as a system.

2.8 Commissioning Reform

The Clinical Chairs and Accountable Officers of the five CCGs within the ICS have met twice during January to continue their discussions on the expectations for commissioning as set out in the NHS Long Term Plan. They will continue to meet in February and March as they explore options for system and place commissioning.

2.9 National Healthwatch Annual Report

I am delighted to let you know that the engagement work of our Healthwatches in South Yorkshire and Bassetlaw features as a case study in the national Healthwatch 2018-19 Annual Report. You will recall that they were recognised as the winner in the Outstanding Achievement category at the annual Healthwatch awards and it is this work that has been singled out and featured in the Report. The Annual Report was laid before parliament in January and the link to it is here:

https://www.healthwatch.co.uk/report/2020-01-29/our-annual-report-201819

2.10 Appointments in our Partner Organisations

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust has appointed its next Medical Director. Dr Tim Noble, who is currently one of the Trust's Deputy Medical Directors, will become Medical Director in late March following the retirement of the current post holder Mr Sewa Singh, who has served the Trust for over 20 years.

Dr Noble oversees professional standards for medical teams throughout the organisation. Prior to this, he oversaw the hospitals' respiratory medicine service, as well as undertaking two Clinical Director posts from 2010 through to 2017.

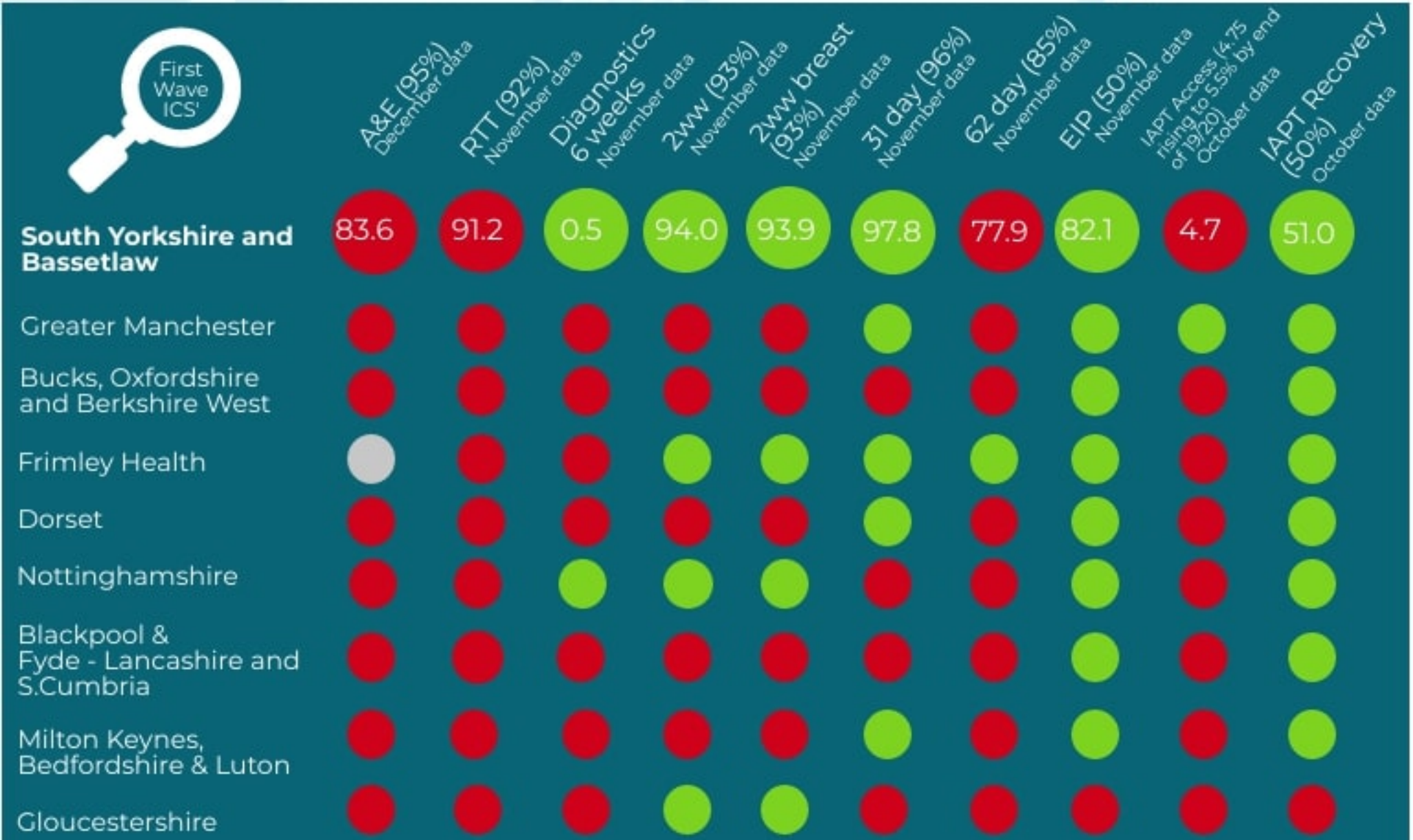
Andrew Cash
Chief Executive, South Yorkshire and Bassetlaw Integrated Care System

Date 4 February 2020

How are we doing? An overview

Key performance report: January 2020 (using predominantly Nov/Dec data)

South Yorkshire and Bassetlaw Integrated Care System



At month 9, the Year to Date position is £3.7m ahead of Plan. One organisation is forecasting a deficit against plan and we are looking at how we can offset this with overperformance in other organisations to balance as a system.

How are we doing? An overview

Key performance report: December 2019 (using predominantly Oct/Nov data

South Yorkshire and Bassetlaw Integrated Care System

At month 9, the Year to Date position is £3.7m ahead of Plan. One organisation is forecasting a deficit against plan and we are looking at how we can offset this with overperformance in other organisations to balance as a system.

How are we doing? An overview

Key performance report: January 2020 (using predominantly Nov/Dec data)

South Yorkshire and Bassetlaw Integrated Care System

Derby and Derbyshire
Clinical Commissioning Group

Derby and Derbyshire CCG Governing Body Meeting in Public
Held on
6th February 2020

UNCONFIRMED

Present:

Dr Avi Bhatia	AB	Chair
Dr Penny Blackwell	PB	Governing Body GP
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
Dr Buk Dhadda	BD	Governing Body GP
Helen Dillistone	HD	Executive Director of Corporate Strategy and Delivery
Ian Gibbard	IG	Lay Member for Audit
Sandy Hogg	SH	Executive Turnaround Director
Zara Jones	ZJ	Executive Director of Commissioning Operations
Dr Steven Lloyd	SL	Medical Director
Andrew Middleton	AM	Lay Member for Finance
Gill Orwin	GO	Lay Member for Patient and Public Involvement
Dr Emma Pizzey	EP	Governing Body GP
Professor Ian Shaw	IS	Lay Member for Primary Care Commissioning
Brigid Stacey	BS	Chief Nursing Officer
Dr Greg Strachan	GS	Governing Body GP
Dr Merryl Watkins	MWa	Governing Body GP
Martin Whittle	MWh	Lay Member for Patient and Public Involvement

Apologies

Dean Wallace	DW	Director of Public Health, Derbyshire County Council
Dr Bruce Braithwaite	BB	Secondary Care Consultant
Richard Chapman	RCp	Chief Finance Officer

In attendance:

Niki Bridge	NB	Deputy Chief Finance Officer
Suzanne Pickering	SP	Head of Governance
Dawn Litchfield	DL	Executive Assistant to the Governing Body /minute taker

Item No.	Item	Action
GBP/1920/203	**Welcome, Apologies & Quoracy** Dr Avi Bhatia (AB) welcomed members to the meeting. Apologies were received from Dean Wallace, Richard Chapman and Dr Bruce Braithwaite. It was confirmed that the meeting was quorate.	
GBP/1920/204	**Questions from members of the public** None received.	

GBP/1920/205	**Declarations of Interest** AB reminded committee members and visiting delegates of their obligation to declare any interests that they may have on any issues arising at committee meetings which might conflict with the business of the CCG. Declarations declared by members of the Governing Body are listed in the CCG's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Governing Body or the CCG website at the following link: www.derbyandderbyshireccg.nhs.uk. Items 217 and 218 – Engagement Committee Assurance Report / PCCC Assurance Report – Dr Ruth Cooper (RC) declared an interest in the Pilsley Surgery branch closure item. As the decision is being made outside of the Governing Body it was agreed that RC would remain in the room for this discussion. No further declarations of interest were made and no changes were requested to the Register of Interest.	
GBP/1920/206	**Chair's Report** AB provided a written report, a copy of which was circulated with the papers. The report was taken as read and no questions were raised. **The Governing Body RECEIVED and NOTED the report**	
GBP/1920/207	**Chief Executive Officer's Report** Dr Chris Clayton (CC) provided a written report, a copy of which was circulated with the papers. The report includes local, regional and national issues not covered on the agenda which may be of interest to the Governing Body. The report was taken as read and the following request was made: Time to talk day 2020 – Martin Whittle (MWh) requested feedback from this initiative. CC agreed to obtain this for presentation to the Engagement Committee. **The Governing Body RECEIVED and NOTED the report**	**CC**
GBP/1920/208	**The Light House Consultation Report** This paper builds on the previous paper presented to the Governing Body on 1st August 2019 where a public consultation into the long term service model of the Light House children's residential short break service was approved; the consultation ran from 5th September to 3rd December 2019. The outcome of the consultation was taken to both the Engagement Committee and the Clinical and Lay Commissioning Committee (CLCC) meetings in January 2020. Both Committees were assured that appropriate engagement had taken place and robust processes, with mitigations, were in place to address any issues raised by the members of the public and professionals.	

	Zara Jones (ZJ) advised that the pre-consultation and formal consultation details were included in the meeting papers. Zara confirmed that all social and health care needs will be met by care staff trained in child specific interventions and supervised by nurses. The children with the most complex needs will have a specific package of care set out by a panel of professionals to meet their needs on an individual basis. There is a need for some social care staff to be upskilled to undertake delegated health tasks, under the guidance of a CQC registered trainer and assessor, who will support them with training, governance and assurance thus ensuring the delivery of safe care. It was recommended to the Governing Body that the new model be implemented immediately as part of a detailed plan with an intention that it will be fully embedded by 1st April 2020. As the 1st April 2020 is a tight timescale, CC requested that the Governing Body also agree to allow the interim model to continue for longer if deemed necessary; the Governing Body were in agreement with this request. Gill Orwin (GO) confirmed that both the CLCC and Engagement Committee worked through this piece of work and considered it to be an exemplary example of how people's needs are being listened to, with parents and families involved at all levels. **The Governing Body:** • **NOTED the progress with implementing the interim arrangements in Section 1** • **Were ASSURED of the progress on the governance arrangements and process to review the health needs of children attending The Light House in Section 2** • **APPROVED the proposed future model of The Light House children's residential short breaks service which for most children will be care led in Section 3** • **AGREED to the continuation of the interim model as a contingency arrangement should it be deemed necessary**	
GBP/1920/209	**Corporate Committees Terms of Reference Review** Helen Dillistone (HD) advised that as part of the Governing Body's six month review of all Corporate Committees' Terms of Reference, each Corporate Committee has reviewed and amended its own Terms of Reference where necessary. Any amendments and additions have been agreed by the Committees and highlighted for information. It was confirmed that the Governing Body Members' survey had influenced this process. The following Corporate Committees' Terms of References were presented for approval: • Audit Committee • Clinical and Lay Commissioning Committee • Finance Committee • Governance Committee • Primary Care Commissioning Committee • Quality and Performance Committee.	

	Jill Dentith (JD) stated that the CLCC Terms of Reference have been amended to refer to savings rather than QIPP and asked that the other committee Terms of References are also amended to ensure consistency. **The Governing Body APPROVED the amended Corporate Committees' Terms of Reference.**	**SP**
GBP/1920/210	**Change of Scheme of Reservation and Delegation** As the CCG has now been operating for 9 months, a review of its Constitution, Annex 1: Decisions, Authorities and Duties Delegated to Officers of the CCG Governing Body has been undertaken. Niki Bridge (NB) advised that the review highlighted the inappropriately low level of delegated authority given to the Executive Director of Commissioning Operations with regard to the signing of healthcare contracts. It is recommended that the level of authority delegated to this Officer be increased to £1m, in line with the Chief Finance Officer's level of delegated authority. All other delegated limits remain unchanged and the Chief Finance Officer and Chief Executive Officer will be required to sign off all contracts valued over £1m. Andrew Middleton (AM), as Chair of the Finance Committee, confirmed that this paper has been reviewed by the Finance and Audit Committees, and both were recommended to the Governing Body for approval. **The Governing Body APPROVED the proposed change to the Scheme of Delegation to increase the delegated authority of the Executive Director of Commissioning Operations to £1m when signing healthcare contracts.**	
GBP/1920/211	**Dying to Work Charter** 'Dying to Work' is a voluntary charter developed to protect and support terminally ill employees; its aim is to remove any additional stress and worry relating to continued employment, by treating employees with dignity and respect and having processes in place to deal sensitively with their needs, and not dismissing them due to their condition. As much support, advice and guidance as possible will be offered to employees in each case. HD confirmed that the Executive Team and Governance Committee supported this Charter and recommended that the Governing Body signed up to it. Dr Merryl Watkins (MWa) supported this however raised concern in relation to those people that do not have mental capacity. It was confirmed that cases will be reviewed on a case by case basis. **The Governing Body APPROVED the CCG signing up to the Dying to Work Charter.**	
GBP/1920/212	**Finance and Savings Report – Month 9** NB confirmed that as at Month 9 the CCG is reporting year to date and	

	forecast positions which are in line with the plan and remains on course to achieve the control total. The following points of note were made: • The year to date and forecast overspend positions of £11.484m and £18.850m respectively are in line with the Commissioner Sustainability Funding (CSF) adjusted control total. • The year to date position includes a savings under delivery of £10.620m and the forecast year end position includes a savings under delivery of £22.418m. • The CCG's running costs budget reflects savings and efficiencies; the CCG remains within its cash limit and has achieved the Better Payment Practice Code. • To aid the financial position, year end settlements have been agreed for acute contracts in order to provide added security and confidence. • There is continued pressure on the Mental Health budget mainly relating to high cost patients and Section 117 cases. Work is being undertaken to reduce overspend within this area. • Primary care prescribing continues to demonstrate an overspend mainly due to cost pressures relating to Category M drugs, along with cost and volume variances. • The CCG is reporting a fully mitigated risk position and cost pressures continue to be covered with reserves and contingency. Sandy Hogg (SH) advised that there has been a deterioration in the savings positon of £1.1m due to adverse movement between Months 7 and 8, and Months 8 and 9 which is of significant concern to the leadership. The Month 9 savings information demonstrates a year to date delivery of £36.8m (against a phased plan of £47.3m) and a forecast savings delivery of £47.1m (against a planned total of £69.5m - a deficit of £22.4m). As a consequence, a leadership review is to be conducted and actions agreed. The key areas of deterioration are medicines management and primary care; deep dives are to be undertaken into these areas to understand what has occurred. A full year review is to be undertaken to assess how to reduce spend safely without impacting on patient care. Recommendations are to be made to the CEO in preparation for the review, which will take place next week. A financial recovery approach is to be applied in the CCG. A review has been initiated into all commitments and invoice approvals, and a review of all operational areas is to be undertaken. The whole leadership team will be involved in minimising spend. The underlying deficit needs to be a low as possible as the CCG will be expected to recover it next year. Ian Gibbard IG) highlighted the fact that Continuing Healthcare (CHC) is a good news story to some extent with a forecast annual underspend overall of £7m expected; however there have been some changes in the climate recently. Assurance was requested around the cost sharing with Local Authorities and whether this presents any further risk. Ian asked if there is anything else that could be done to manage costs. Brigid Stacey (BS) stated that bringing the expenditure into line was a success story for the CCG however there has been some recent variability. Provision was made for the challenges faced last year and it was hoped that the issues with the Local Authority, which caused the deviation, had been rectified however a further deviation occurred this month. NB confirmed that this was a timing issue. A change in forecast of £2m was notified with a further pressure of £1m. A meeting has been arranged to discuss this	

	matter and broker a deal. AM confirmed that a new CHC policy is in place and enquired if this will provide more certainty as to what could be included in a package. Next month a robust process is required for bringing costs in to line and defining what will be funded, in line with statutory responsibilities. This will be presented to the Governing Body. It was considered that closing down the contracts at year end was the right thing to do in order to reduce the overall risk in Derbyshire; if they were to be re-opened it would expose more risk. The non-Derbyshire contracts are also being examined. CC confirmed that the principle of shutting down contracts outweighs the risk for Commissioners and Providers. The resources saved will go into agreeing next year's contracts. **The Governing Body NOTED the Finance and Savings report.**	
GBP/1920/213	**Finance Committee Assurance Report – January 2020** AM provided a verbal update following the Finance Committee meeting held on 30th January 2020. The following points of note were made: • The CCG must meet the £29m control total; the Committee were reassured that this will be done. • It is pleasing to hear that an extra £1m - £2m can be accommodated and that the Executive Team has been looking for risks and setting contingencies. • Excellent work has been undertaken by the CCG in both CHC and Medicines Management in order to achieve a significant quantum of savings. • AM believed that it is right to close down the contracts early to prevent extra demand. • Disappointment was expressed on the slippage of the savings programmes but it was recognised that the majority of the slippage is within the system space; the proactive way the leadership is influencing the system to get ahead of the challenge was recognised and commended. • A fundamental rethink on the design of secondary and primary care pathways is required; the CCG and the system are facing a massive challenge next year. Demand is rising year on year and the costs are increasing without the budget to manage it. CC confirmed that the deep dive review will be on the shift in position of £1.1m during September/October and not on the totality, as system transformation schemes have already been locked down; the gearing in the system to understand the challenge is underway. **The Governing Body RECEIVED and NOTED the Month 8 Finance and Savings report.**	
GBP/1920/214	**Quality and Performance Committee Assurance Report – Month 8** Dr Buk Dhadda (BD) provided an update on the discussions held at the Quality and Performance Committee meeting on 30th January. The	

	report was taken as read and the following points of note were made: • An interim agreement has been made with practices on wound care. • IG highlighted an increased acuity of patients presenting at A&E, as demonstrated in the report. He enquired if the hospitals are getting better at triaging or whether other factors were involved. BD confirmed that the Committee received the findings of a deep dive on A&E which showed that there is no singular issue contributing to the A&E issues but many factors. More people are presenting with a higher level of acuity and not as many people are arriving who should not be there. 1:4 attendances result in an admission. **The Governing Body RECEIVED and NOTED the Quality and Performance Committee Assurance Report.**	
GBP/1920/ 215	**Audit Committee Assurance Report – January 2020** IG presented this report which was taken as read. The following points of note were made: • The results of a Governing Body Members' survey on risk management and the operation of the Governing Body Assurance Framework (GBAF) were discussed at the meeting. 17 responses were received giving a 74% response rate; the overall response was very positive and the results will form part of the Head Of Internal Audit's control arrangements. The Committee agreed that it could be useful for the Governing Body to look at its own effectiveness as part of a future Development Session. • The extent to which people felt confident on system working and partners' delivering strategic objectives is to be discussed further by the Audit Committee. • A review was undertaken to assess the effectiveness of the Joined Up Care Derbyshire (JUCD) operational planning process in 2019/20 in order to inform the process for 2020/21. The Audit Committee were confident that lessons could be learnt going forward. The report contained key messages which the Governing Body need to take on board. The report will be presented to the STP and other partner agencies for consideration. • MWh queried how CCGs will obtain feedback on the JUCD report from individual Audit Committees and how this will filter down to individual organisations. The CCG and Providers share a common Internal Audit partner who will provide a read across and work in a cooperative manner. This will be progressed as further movement is made into the system space. • AM considered this to be a fruitful area for further investigation. He enquired when it would be an appropriate point to request Internal Auditors to assess system accountability and governance arrangements – this is something that still needs to be agreed. There is a will and intent from the System Finance Oversight Group; it is considering how authority beyond individual organisations could be gained to provide a system first focus. The mechanism sets out to provide an opportunity to bring collective thoughts together and apply learning. • HD advised that the Audit Committee, together with the Remuneration Committee, are the only statutory committees required of the CCG.	

	This needs thinking through across the system space as there may be some benefit from bringing organisational related tasks together. A national event is scheduled shortly to allow Audit Chairs to contribute to the conversation. 360 Assurance is keen support this process. • SH recently attended the CFO forum where there was quite a lot of debate about system working. Discussions were held on the last planning round and the amount of direct input from those involved. • MWh requested the thoughts of individual organisations on the report be fed back to the Governing Body. • AM stated that having a System Finance Oversight Group was a valuable asset in understanding where partners are coming from. He suggested having an informal gathering of Audit Chairs. IG advised that if system level goals are to be introduced the Governing Body must have a formal recognition that it has the control to deliver its targets; this will not be resolved by discussions without formal structures. The Lead Commissioner needs to set out new strategic directions to ensure delivery. • Dr Penny Blackwell (PB) considered that the Governing Body needs to know that the conversations are being held. Cultures need to be developed to allow mandates to be delivered. AB concluded that system governance is challenging; there is a need to take both a proactive and reactive approach. Building upon the comments made, a Governing Body development session will be arranged to explore learning and the system position. **The Governing Body RECEIVED and NOTED the report.**	**IG** **HD**
GBP/1920/216	**Governance Committee Assurance Report – January 2020** JD presented this report which was taken as read. The following information governance policies were approved by the Committee: • IG Strategy • IG Policy • Network, Internet and Email Acceptance Use Policy • Records Management Policy • Information Security Strategy The following HR policies and procedures were approved by the Committee: • Special Leave Policy • Pay Progression Policy The Dying to Work Charter was supported and recommended to the Governing Body for approval. Mandatory training is an important issue and it needs to be ensured that it is undertaken by all staff. A good conversation was held by the Committee on the 6 risks assigned to it.	

	The Governing Body RECEIVED and NOTED the report.	
GBP/1920/ 217	**Engagement Committee Assurance Report – January 2020** RC declared an interest in the consultation to close the Pilsley Branch Surgery as she is a partner at Staffa Health; however as the decisions are being made elsewhere it was agreed that Dr Cooper would remain in the room for this item. MWh presented this report which was taken as read. The following points of note were made: • A review in the Committee's Terms of Reference has commenced in light of the impending changes to the Derbyshire system's structure with the advent of Integrated Care Partnerships and Primary Care Networks and the links these developments have to the work and membership of the Committee, and the Joined Up Care Derbyshire Board Governance Review currently underway. Appropriate geographical representation needs to be obtained for Committee membership. The Terms of Reference will be presented to the Governing Body in March. • The findings of the consultation to close the Pilsley Branch Surgery were presented to the Committee. The robustness of the engagement process was found to be strong. The comments made during the consultation period have been taken on board by the practice and the Committee endorsed the report. • A revision of the Communications and Engagement Strategy is being considered in connection with Joined Up Care Derbyshire. JD considered it to be important that individual Corporate Committees gain assurance from the discussions held at other Committees. It was noted that the Pilsley consultation was also considered by the Primary Care Commissioning Committee; there is a need to join these discussions together to prevent duplication and allow robustness of consideration. CC confirmed that each Committee has a particular function and there a mechanism to ensure that all of the different aspects are completed by the Corporate Committees in order to provide adequate assurance. **The Governing Body RECEIVED and NOTED the report.**	
GBP/1920/ 218	**Primary Care Commissioning Committee Assurance Report – January 2020** RC declared an interest in the consultation to close the Pilsley Branch Surgery as she is a partner at Staffa Health; however as the decisions are being made elsewhere it was agreed that Dr Cooper would remain in the room for this item. Professor Ian Shaw (IS) presented this item which was taken as read. The following points of note were made: • The following Terms of Reference were received, noted and approved:	

	• Primary Care Leadership Committee • General Practice Digital Steering Group • Primary Care Estates Steering Group • A key item for discussion was the Pilsley Branch Surgery closure. Due to illness there was a delay in getting the papers out to Committee members. As the report was very detailed and members required time to consider the contents, it was agreed that the decision would be deferred to the February meeting. **The Governing Body NOTED the report.**	
GBP/1920/ 219	**Risk Register Report – 31st January 2020** HD presented the Risk Register Report as at 31st January 2020. The report was taken as read and the following points of note were made: • There are 6 very high risks, 14 high risks, 2 moderate risks and 1 low risk being faced by the organisation as at the end of January. • 2 new high scoring risks have been identified which have been assigned to the Quality and Performance Committee: • Risk 041 – lack of peer support for nursing home bedside manufacture of syringe drivers after 31.1.2020, following the withdrawal of syringe driver manufacture by University Hospitals Derby and Burton NHS Foundation Trust (UHDB). This risk has been rated at 8. It relates to the workforce and is about ensuring that the right training is provided to staff to allow them to administer syringe drivers. • Risk 042 – Derby City patients with complex wounds will not receive timely care or will face sub-optimal outcomes to their condition. This risk has been rated at 9. **The Governing Body RECEIVED and NOTED:** • **The Risk Register Report** • **Appendix 1 as a reflection of the Very High Risks of the organisation as at 31st January 2020** • **Appendix 2 which summarises the movement of all risks during January 2020** • **APPROVED the two new Risks 041 and 042, which have been assigned to the Quality & Performance Committee**	
GBP/1920/ 220	**Governing Body Assurance Framework – Quarter 3** HD presented the Quarter 3 Governing Body Assurance Report which provides a structure and process to enable the CCG to focus on the strategic / principal risks that might compromise it in achieving its strategic objectives. It also maps out both the key controls that are in place to manage those objectives and associated strategic risks, providing the Governing Body with sufficient assurance around the effectiveness of the controls in place. Each risk has been assigned to	

	one the CCG's Corporate Committees for oversight and review. Any changes made to the risks have been noted in red in the papers. Risk 6 – 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 – this has been developed in 2 parts. Risk 6A relates to the CCG position; the risk score has reduced from a very high 25 to a very high 16. The rational for the reduction is that as the year end draws nearer, it is clearer where the position is likely to end, and year-end contract positons have been agreed, therefore the risk of not knowing what will happen is reduced. Risk 6B relates to the system element of the risk On behalf of Richard Chapman (RCp), SH advised that this is not the most up to date position for Risk 6B from the Finance Committee on 30th January 2020. Conversations in relation to risk 6B were held at length around delivering the 2019/20 system finance position. The Governing Body discussed the impact on the UHDBFT position at year end and should in the longer term UHDBFT not have credible plans for 2020/21, the Finance Committee agreed to retain the risk score of 6B at a very high 25. AM confirmed the risk should remain at a risk score of 25. The Finance Committee debated reducing the risk score however was cautious as to what could happen before the end of March. As a matter of accuracy CC requested that this risk be brought back in due course with the output of the Finance Committee discussion. This is a timing issue related to the close proximately of the Finance Committee and Governing Body dates. There was not enough information available to make a judgement today; system level information is required for consideration. During March thought will be given on what a system savings plan would look like in reporting and audit terms. SH suggested that the Finance Committee look in detail at risks 6A/6B and requested that the full system savings report received by the Finance Committee be presented to the Governing Body routinely. JD queried why risks 3 and 5 were not applicable to strategic objective 2 on the process map; Jill will discuss this further outside of the meeting. **The Governing Body RECEIVED and GAINED ASSURANCE from the Quarter 3 Governing Body Assurance Report.**	**RC/HD/ SH** **RC/HD**
GBP/1920/ 221	**Joined Up Care Derbyshire (JUCD) Board Update Report – January 2020** CC presented the JUCD Board Update Report. The paper sets out the route of the previous discussions in relation to a changing way of working and explains how the operating model in a statutory space will alter. There are significant changes afoot and partners are working hard to achieve them. Financial planning and efficiency generation are making progress. The work on understanding the concepts of demand and resources, the calving up of it and understanding the totality is good. Working through the winter period is helping the preparation for other health and social care challenges. Integrated Care Partnerships are	

	building on Place, grappling with change and making progress. It is recognised that it will be 2020/21 before all of the creases are ironed out. The Governing Body is asked to achieve a balance between managing uncertainty and working with it. BD considered the Clinical and Professional Reference Group (CPRG) to be an important driver of transformation; reassurance is attached to making this a driver within the system and having the right people around the table. AB reflected this to be a well-made point however the CPRG is not currently functioning to its best ability. SL and BD recently met with John MacDonald to discuss how to improve its function. Steering group meetings have been held to discuss this further and consider how to alter the membership, tightening it up by having senior clinicians in attendance from each organisation together with General Practice, social care, pharmacy and nursing representation. Organisations will be deferred from sending deputies and delegates will be required to attend 70% of meetings. Whilst the CPRG cannot block anything it is able to have a robust opinion. The dates will be altered to allow better attendance and co-chair arrangements will be implemented between Acute and Commissioning organisations. JD considered the report helpful to digest; however there may be an opportunity to improve its usefulness by including forward planning and a schedule of forthcoming items which will be beneficial when thinking about reassurance, and not assurance, in order to keep on track and target. The JUCD Board met in public for the first time in January 2020 which was well received and will continue; not many STPs currently do this. The East Midlands Ambulance Service NHS Trust has agreed to take the lead on improving air quality on behalf of the system. **The Governing Body NOTED the Joined Up Care Derbyshire Board January 2020 Update**	**CC**
GBP/1920/ 222	**Safeguarding Adults Annual Report** **The Governing Body RECEIVED the report and ASSURANCE from the Adult Safeguarding work undertaken on behalf of the CCG**	
GBP/1920/ 223	**Derby and Derbyshire Air Quality Strategy and Action Plan** HD was pleased to report that this strategy has been agreed by both Derby City and Derbyshire County Councils and the JUCD Board. A working group has been established to look at how this strategy may be supported. CC is the sustainability officer for the CCG. The Governing Body will see, through its sub committees, a substantial shift in the use of digital technology in order to reduce mileage. Investment is proposed into video/conferencing facilities; a cultural change is needed to shift to this modality. **The Governing Body RECEIVED the Air Quality Strategy for Joined**	

	Up Care Derbyshire for information and NOTED the process for the development of a delivery plan	
GBP/1920/ 224	**Ratified Minutes of Corporate Committees:** • Audit Committee – 21st November 2019 • Governance Committee – 14th November 2019 • Engagement Committee – 4th December 2019 • Quality and Performance Committee – 19th December 2019 **The Governing Body RECEIVED and NOTED these minutes**	
GBP/1920/ 225	**Minutes of the Joined Up Care Derbyshire Board Meeting – December 2019** **The Governing Body RECEIVED and NOTED these minutes**	
GBP/1920/ 226	**South Yorkshire & Bassetlaw Joint Committee of CCGs – October 2019 meeting minutes / Progress Report** **The Governing Body NOTED these minutes and progress report**	
GBP/1920/ 227	**Minutes of the Derby City Council Health and Wellbeing Board Meeting – November 2019** **The Governing Body NOTED these minutes**	
GBP/1920/ 228	**Minutes of the Governing Body meeting held on 9th January 2020** The minutes of the above meeting were agreed as a true and accurate record.	
GBP/1920/ 229	**Matters Arising / Action Log** The action log will be updated and amended accordingly.	
GBP/1920/ 230	**Forward Planner** Noted for information.	
GBP/1920/ 231	**Any Other Business** None raised.	

DATE AND TIME OF NEXT MEETING

Thursday 5th March 2020 – 9.15am – Charnos Hall, Ilkeston Community Hospital, Heanor Road, Ilkeston, Derbyshire DE7 8LN

Signed by: …… Dated: ……
(Chair)

Derby and Derbyshire
Clinical Commissioning Group

GOVERNING BODY MEETING IN PUBLIC
ACTION SHEET – February 2020 meeting in public

Item / Minute No.	Action Proposed	Lead	Action Required	Action still to be taken	Due Date
2019/20 Actions					
GBP/1920/170	Quality and Performance Committee Assurance Report	Dr Buk Dhadda / Brigid Stacey	The Transforming Care Partnership Update will be brought back to the Governing Body as a singular item.		April 2020
GBP/1920/207	Chief Executive Officer's Report - Time to Talk day 2020	Dr Chris Clayton	Martin Whittle requested feedback from this initiative.	Dr Clayton agreed to obtain this information for presentation to the Engagement Committee	April 2020
GBP/1920/209	Corporate Committee Terms of Reference	Helen Dillistone / Suzanne Pickering	Amend references to 'QIPP' in all committee terms of references to read 'savings'.		**Item complete**
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 one to explore learning and the system position.	To be included as part of a the Governing Body Development Session scheduled for May – included on the development session forward plan	May 2020
	JUCD operational planning process 2019/20	Ian Gibbard	Martin Whittle requested that the thoughts of individual organisations, on this report, be	Thoughts to be collated and fed back	May 2020

	effectiveness		fed back to the Governing Body.		
GBP/1920/220	Governing Body Assurance Framework – Q3	Richard Chapman / Helen Dillistone / Sandy Hogg Richard Chapman / Helen Dillistone	Dr Clayton requested that risk 6B be brought back in due course with the output of the Finance Committee discussions. Sandy Hogg suggested that the Finance Committee look in detail at risks 6A/B and requested that the full system savings report received by the Finance Committee be presented to the Governing Body routinely.	Update required for Quarter 4 which will be reported in May.	May 2020 March 2020
GBP/1920/221	Joined Up Care Board Update Report – January 2020	Dr Chris Clayton	Jill Dentith requested that forward planning and a schedule of forthcoming items be included in the JUCD report.		April 2020

NHS
Derby and Derbyshire
Clinical Commissioning Group

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 • 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 • Quality & Performance Report • Serious Incidents • Never Events	X	X	X	X	X	X	X	X	X	X	X	X
Governance Committee Assurance Report • Business Continuity and EPRR core standards		X		X		X		X		X		X

	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
AGENDA ITEM / ISSUE												
• Complaints • Conflicts of Interest • Freedom of Information • Health & Safety • Human Resources • Information Governance • Procurement												
Audit Committee Assurance Report	X	X				X		X		X		X
Engagement Committee Assurance Report	X	X	X	X	X	X	X	X	X	X	X	X
Clinical and Lay Commissioning Committee Assurance Report	X	X	X	X	X	X	X	X	X	X	X	X
Primary Care Commissioning Committee Assurance Report	X	X	X	X	X	X	X	X	X	X	X	X
Risk Register Exception Report	X	X	X	X	X	X	X	X	X	X	X	X
Governing Body Assurance Framework	X			X				X			X	
Strategic Risks and Strategic Objectives		X										
Annual Report and Accounts			X									
AGM						X						
Audit Committee Annual Report (All committee Annual Reports?)				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

	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
AGENDA ITEM / ISSUE												
Minutes of Health and Wellbeing Board Derby City+	X		X		X		X		X		X	
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												

+Meetings are on 16 Jan 2020, 19 Mar 2020 and 14 May 2020

https://cmis.derby.gov.uk/cmis5/Committees/tabid/101/ctl/ViewCMIS_CommitteeDetails/mid/550/id/1931/Default.aspx

***Meetings are on 2 Feb 2020 (moved from 30 Jan 2020) and 2 Apr 2020**

https://democracy.derbyshire.gov.uk/ieListMeetings.aspx?CId=175&Year=0