Derby and Derbyshire
Clinical Commissioning Group

NHS DERBY AND DERBYSHIRE CCG

GOVERNING BODY – MEETING IN PUBLIC

Date & Time: Thursday 5th August 2021 – 9.30am to 11.15am

Via Microsoft Teams

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

Item	Subject	Paper	Presenter	Time
GBP/2122/096	**Welcome, Apologies & Quoracy** Apologies: Dean Wallace, Dr Buk Dhadda	**Verbal**	**Dr Avi Bhatia**	**9.30**
GBP/2122/097	**Questions from members of the public**	**Verbal**	**Dr Avi Bhatia**	
GBP/2122/098	**Declarations of Interest** • Register of Interests • Summary register for recording any conflicts of interests during meetings • Glossary	**Papers**	**Dr Avi Bhatia**	
PRESENTATION				
GBP/2122/099	**NHS People and Culture Workstream Update**	**Presentation**	**Linda Garnett**	**9.35**
CHAIR AND CHIEF OFFICER REPORTS				
GBP/2122/100	**Chair's Report – July 2021**	**Paper**	**Dr Avi Bhatia**	**9.55**
GBP/2122/101	**Chief Executive Officer's Report – July 2021**	**Paper**	**Dr Chris Clayton**	
GBP/2122/102	**Joined Up Care Derbyshire Board Update – July 2021**	**Paper**	**Dr Chris Clayton**	
FOR DECISION				
GBP/2122/103	**Remuneration Committee – Updated Terms of Reference**	**Paper**	**Helen Dillistone**	**10.15**

CORPORATE ASSURANCE				
GBP/2122/ 104	**Finance Report – Month 3**	**Paper**	**Richard Chapman**	**10.30**
GBP/2122/ 105	**Finance Committee Assurance Report – July 2021 and Annual Report**	**Verbal / Paper**	**Andrew Middleton**	
GBP/2122/ 106	**Clinical and Lay Commissioning Committee Assurance Report – July 2021 and Annual Report**	**Paper**	**Ian Gibbard**	
GBP/2122/ 107	**Derbyshire Engagement Committee Assurance – July 2021 and Annual Report**	**Paper**	**Martin Whittle**	
GBP/2122/ 108	**Governance Committee Assurance Report – July 2021 and Annual Report**	**Paper**	**Jill Dentith**	
GBP/2122/ 109	**Primary Care Commissioning Committee Assurance Report – July 2021 and Annual Report**	**Verbal / Paper**	**Professor Ian Shaw**	
GBP/2122/ 110	**Quality and Performance Committee Assurance Report – July 2021 and Annual Report**	**Paper**	**Andrew Middleton**	
GBP/2122/ 111	**CCG Risk Register – July 2021**	**Paper**	**Helen Dillistone**	
FOR INFORMATION				
GBP/2122/ 112	**Joined Up Care Derbyshire Board – ratified minutes – May 2021**	**Paper**	**Dr Chris Clayton**	**10.50**
GBP/2122/ 113	**Health and Wellbeing Boards – Ratified Minutes – Derby City Council – 18.3.2021**	**Papers**	**Dr Chris Clayton**	
GBP/2122/ 114	**Ratified Minutes of Corporate Committees:** • Derbyshire Engagement Committee – 15.6.2021 • Governance Committee – 20.5.2021 • Primary Care Commissioning Committee – 23.6.2021 • Quality and Performance Committee – 24.6.2021	**Papers**	**Committee Chairs**	
GBP/2122/ 115	**South Yorkshire and Bassetlaw Integrated Care System CEO Report – July 2021**	**Paper**	**Dr Chris Clayton**	

MINUTES AND MATTERS ARISING FROM PREVIOUS MEETING				
GBP/2122/ 116	**Minutes of the Governing Body Meeting in Public held on 1st July 2021**	**Paper**	**Dr Avi Bhatia**	**11.00**
GBP/2122/ 117	**Matters arising from the minutes not elsewhere on agenda:** • Action Log – July 2021	**Paper**	**Dr Avi Bhatia**	
GBP/2122/ 118	**Forward Planner**	**Paper**	**Dr Avi Bhatia**	
GBP/2122/ 119	**Any Other Business**	**Verbal**	**All**	

Date and time of next meeting: Thursday 2nd September 2021 from 9.30am to 11.15am – via Microsoft Teams

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

NHS Derby and Derbyshire Clinical Commissioning Group

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

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

Chapman, Richard	Chief Finance Officer	Governing Body	Clinical & Lay Commissioning Committee Finance Committee Primary Care Commissioning Committee	Nil							No action required
Clayton, Dr Chris	Chief Executive Officer	Governing Body	Clinical & Lay Commissioning Committee Primary Care Commissioning Committee	Spouse is a partner in PWC				✓	2019	Ongoing	Declare interest at relevant meetings
Cooper, Dr Ruth	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Finance Committee North East Derbyshire & Bolsover Place Alliance Group Derbyshire Primary Care Leadership Group CRHFT Clinical Quality Review Group GP Workforce Steering Group Conditions Specific Delivery Board	Locum GP at Staffa Health, Tibshelf Shareholder in North Eastern Derbyshire Healthcare Ltd Director of IS and RC Limited, providing medical services to Staffa Health and South Hardwick PCN, which includes the role of clinical lead for the Enhanced Health in Care Homes project Fundraising Activities through Staffa Health to support Ashgate Hospice and Blythe House	✓ ✓ ✓		✓		Dec 2020 2015 03/02/2021 Ongoing	Ongoing Ongoing Ongoing Ongoing	Declare interests at relevant meetings and Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Dentith, Jill	Lay Member for Governance	Governing Body	Audit Committee Governance Committee Primary Care Commissioning Committee Remuneration Committee System Transition Committee System People and Culture Group	Self-employed through own management consultancy business trading as Jill Dentith Consulting Providing part-time, short term corporate governance support to Rotherham NHS Foundation Trust Director of Jon Carr Structural Design Ltd Providing part-time, short term corporate governance support to Sheffield Teaching Hospitals NHS Foundation Trust	✓ ✓ ✓ ✓				2012 6 Oct 2020 6 Apr 2021 07.06.2021	Ongoing 8 April 2021 Ongoing End date tbc	Declare interests at relevant meetings
Dewis, Dr Robyn	Director of Public Health, Derby City Council	Governing Body	Clinical & Lay Commissioning Committee Clinical Policy Advisory Group Joint Area Prescribing Committee Conditions Specific Delivery Board CVD Delivery Group Derbyshire Place Board Derby City Place Alliance Group Respiratory Delivery Group	Nil							No action required
Dhadda, Dr Bukhtawar S	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Finance Committee Quality & Performance Committee UHDB Clinical Quality Review Group Clinical Policy Advisory Group	GP Partner at Swadlincote Surgery	✓				2015	Ongoing	Withdraw from all discussion and voting if organisation Is potential provider unless otherwise agreed by the meeting chair
Dillistone, Helen	Executive Director of Corporate Strategy & Delivery	Governing Body	Engagement Committee Governance Committee	Nil							No action required
Gibbard, Ian	Lay Member for Audit	Governing Body	Audit Committee Clinical & Lay Commissioning Committee Finance Committee Governance Committee Remuneration Committee Individual Funding Requests Panel	Nil							No action required
Jones, Zara	Executive Director of Commissioning & Operations	Governing Body	Clinical & Lay Commissioning Committee Quality & Performance Committee CRHFT Contract Management Board	Nil							No action required
Lloyd, Dr Steven	Medical Director	Governing Body	CVD Delivery Group Clinical & Lay Commissioning Committee Conditions Specific Delivery Board CRHFT Contract Management Board 999 Quality Assurance Group Derbyshire Prescribing Group Derbyshire System Flu Planning Cell Finance Committee Primary Care Commissioning Committee Quality & Performance Committee	GP Partner at St. Lawrence Road Surgery Clinical sessions at St. Lawrence Road Surgery Shareholder in premises of Emmett Carr Surgery, Renishaw; and St. Lawrence Road Surgery, North Wingfield	✓ ✓ ✓				2012 2012 Ongoing	Ongoing Ongoing Ongoing	Declare interests at relevant meetings
McCandlish, Simon	Lay Member for Patient and Public Involvement	Governing Body	Clinical & Lay Commissioning Committee Engagement Committee Primary Care Commissioning Committee Quality & Performance Committee Commissioning for Individuals Panel (Shared Chair)	Nil							No action required
Middleton, Andrew	Lay Member for Finance	Governing Body	Audit Committee Finance Committee Quality & Performance Committee Remuneration Committee Commissioning for Individuals Panel (Shared Chair) Derbyshire System Finance Oversight Group	Lay Vice Chair of East Riding of Yorkshire Clinical Commissioning Group Lay Chair of Performers List Decision Panels for NHS England Central Midlands Lay Chair of Appointment Advisory Committees at United Hospitals Leicester - chairing panels for appointing hospital consultants Independent Non-Executive Director for Finance and Governance for Barnsley Healthcare Federation	✓ ✓ ✓ ✓				Jan 2017 May 2013 Mar 2020 Aug 2021	Mar 2023 Ongoing Mar 2023 Jul 2022	Declare interests at relevant meetings Will not sit on any case which has knowledge of the GP or their practice, or a consultant at Leicester
Pizzey, Dr Emma	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Governance Committee Quality & Performance Committee Erewash Place Alliance Group	Partner at Littlewick Medical Centre Executive director Erewash Health Partnership	✓ ✓				2002 Apr 2018	Ongoing Ongoing	Declare interests at relevant meetings. The INR service interest is to be noted at Governance Committee due to the procurement highlight report, which refers to, for information only, the INR service re-procurement. No further action is necessary as no decisions will be
Shaw, Professor Ian	Lay Member for Primary Care Commissioning	Governing Body	Clinical & Lay Commissioning Committee Engagement Committee Primary Care Commissioning Committee Primary Care Enhanced Services Review Group	Professor at the University of Nottingham Subject Matter Expert and advisory panel member in relation to research and service development at the Department of Health and Social Care	✓	✓			1992 Jan 2020	Ongoing Jan 2021	Declare interests at relevant meetings

Stacey, Brigid	Chief Nurse Officer	Governing Body	Clinical & Lay Commissioning Committee Finance Committee Primary Care Commissioning Committee Quality & Performance Committee CRHFT Contract Management Board CRHFT Clinical Quality Review Group UHDB Contract Management Board UHDB Clinical Quality Review Group EMAS Quality Assurance Group	Daughter is employed as a midwifery support worker at Burton Hospital				✓	Aug 2019	Ongoing	Declare interest at relevant meetings
Strachan, Dr Alexander Gregory	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Governance Committee Quality & Performance Committee CRHFT Clinical Quality Review Group	GP Partner at Killamarsh Medical Practice Member of North East Derbyshire Federation Adult and Children Safeguarding Lead at Killamarsh Medical Practice Member of North East Derbyshire Primary Care Network Director of Killamarsh Pharmacy LLP - I do not run the pharmacy business, but rent out the building to a pharmacist	✓ ✓ ✓	 ✓		 ✓	2009 2016 2009 18.03.20 2015	Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair INR service interest is to be noted at Governance Committee due to the procurement highlight report, which refers to, for information only, the INR service reprocurement. No further action is necessary as no decisions will be made at this meeting and the information provided does not cause a conflict.
Wallace, Dean	Director of Public Health, Derbyshire County Council	Governing Body	Derbyshire Place Board	Nil							No action required
Watkins, Dr Merryl	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Quality & Performance Committee	GP Partner at Vernon Street Medical Centre Husband is Anaesthetic and Chronic Pain Consultant at Royal Derby Hospital	✓			 ✓	2008 1992	Ongoing Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Whittle, Martin	Lay Member for Patient and Public Involvement	Governing Body	Engagement Committee Finance Committee Governance Committee Quality & Performance Committee Remuneration Committee	Nil							No action required

SUMMARY REGISTER FOR RECORDING ANY INTERESTS DURING MEETINGS

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

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

Abbreviations & Glossary of Terms

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

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

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

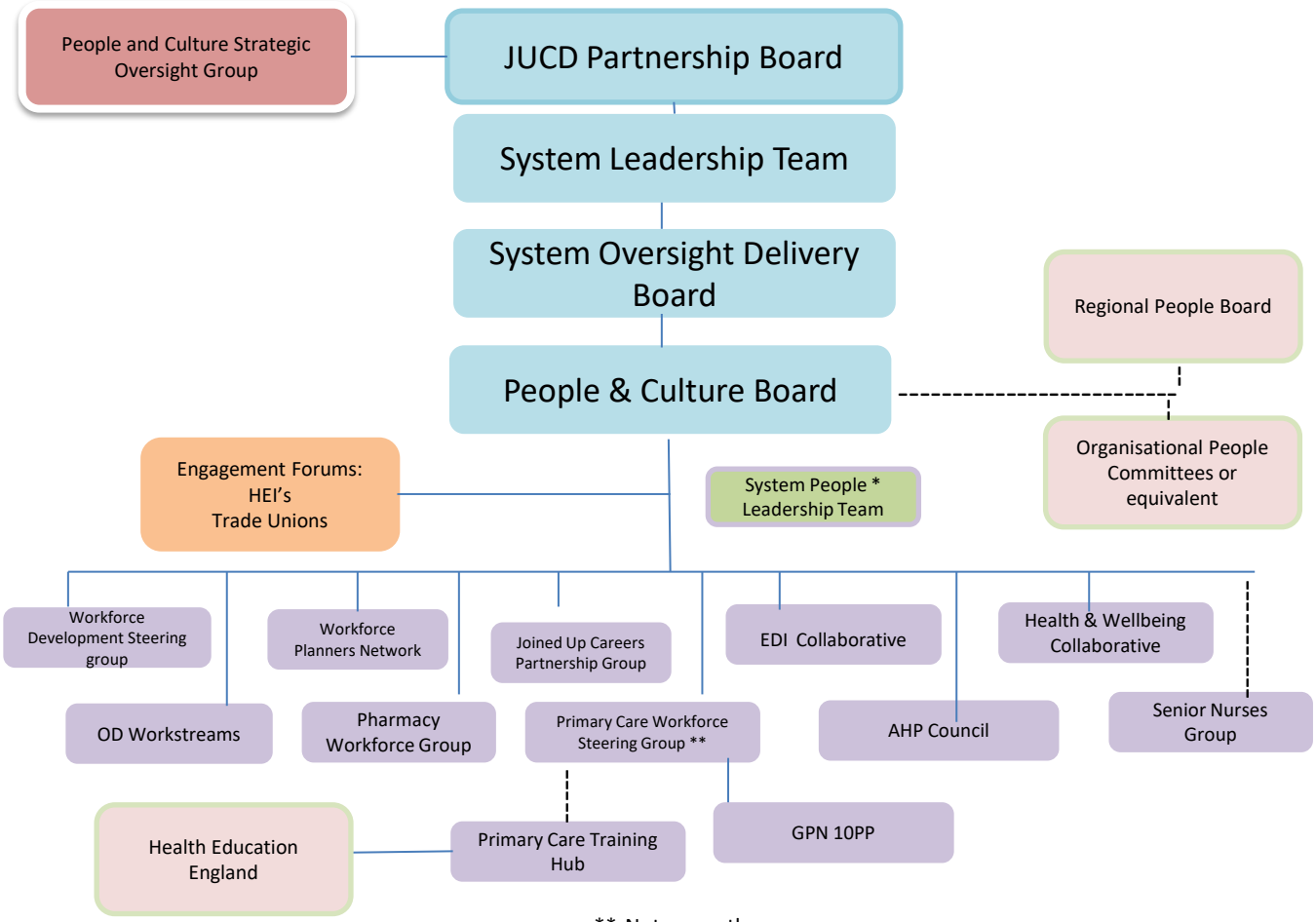
DTOC	Delayed Transfers of Care	MMT	Medicines Management Team	STAR PU	Specific Therapeutic Group Age-Sec Prescribing Unit
ED	Emergency Department	MOL	Medicines Order Line	STEIS	Strategic Executive Information System
EDEN	Effective Diabetes Education Now	MoM	Map of Medicine	STHFT	Sheffield Teaching Hospital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

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

People and Culture Workstream Update

August 2021

JUCD People and Culture Governance
July 2021



* Provider HRD's, System Workforce Lead, CCG HR Lead

** Not currently meeting, to be dissolved,

Joined Up Care Derbyshire

The national planning guidance builds on the People Plan

People Promise

2020/21 | 2021/22 | 2022/23 | 2023/24 | 2024/25

Strategic People Plan (2022/23 – 24/25+)

People Plan 20/21

Annual planning guidance & People Plan priorities

Planning guidance 21/22

Culture change

Joined Up Care Derbyshire

Summary of priorities for 2021/22

System and employer priorities in 2020/21	System and employer priorities for recovery 2021/22 (as set out in the Planning Guidance)	National actions for recovery 2021/22

Looking after our people

Supporting our people to be physically and mentally healthy and well during the pandemic through:
- Ongoing risk assessments
- COVID/flu vaccinations
- Access to psychological and physical support
- Health and wellbeing conversations.

Supporting our people to recover and promoting proactive health and wellbeing (HWB):
- Time off to recover in Q1 and Q2
- Individual HWB conversations and wellbeing plans, including: staff safety and protection, risk assessment, flexible working and access to preventative HWB support
- Enhanced occupational health and wellbeing and psychological support.

Staff safety and protection programme support including:
- Testing, PPE and vaccination support
- Death in service and long COVID

National health and wellbeing programme support for:
- Wellbeing Guardians
- line managers/teams
- Mental health hubs in each system
- enhanced health and wellbeing evaluation
- launch a new quarterly survey to track morale in the first quarter 2021/22.

Belonging in the NHS

Enabling diverse staff to have a voice during the pandemic and continuing to support their development by:
- Putting staff networks in place and ensuring they are prominent in decision-making
- Delivering model employer goals
- Eliminating disciplinary ethnicity gap
- Overhaul of recruitment practices.

Developing an inclusive and compassionate culture and addressing inequalities through:
- Developing improvement plans based on the latest WRES findings, including to improve diversity through recruitment and promotion practices
- Accelerating the delivery of the model employer goals.

EDI support, including:
- Trust-level model employer support on 1-2 identified actions
- Targeted support on 6 high impact actions to overhauling recruitment and promotion practice
- Establishing staff network governance frameworks and best practise guidance
- Leaders and line managers support to hold productive discussions on race and equality within their organisation
- Freedom to Speak Up - guidance for boards and refreshed national FTSU policy.

Leadership guidance support, including:
- New Leadership Compact and Competency framework for Boards
- Widen access leadership development for all managers at every career stage
- Launch a new, more inclusive approach to talent management
- Review how leadership has changed during COVID and engaging the service in a national conversation on the support leaders need
- Report on the future vision of HR & OD.

Summary of priorities for 2021/22

System and employer priorities in 2020/21	System and employer priorities for recovery 2021/22 (as set out in the Planning Guidance)	National actions for recovery 2021/22

New ways of working and delivering care

Making the most of the skills in our teams in response to the pandemic by:
- Ensuring safe staffing and training to support critical care and COVID vaccination
- Increasing digital and remote working
- Workforce sharing agreements to support flexible deployment.

Supporting new ways of working:
- Review ways of working across pathways and organisational boundaries for recovery and service improvements
- Enable e-rostering and support between providers
- Remote working plans, technology-enhanced learning and option of staff digital passports.

National support on:
- Releasing capacity in outpatients, diagnostics and patient pathways and general practice
- Implementing innovations from the national Beneficial Changes Network
- e-rostering
- e-learning materials
- Flexible working and supporting working carers
- COVID-19 digital staff passport and development of strategic digital staff passports
- Expanding clinical practice for nurses, AHPs, pharmacists and healthcare scientists
- Delivering proposals for medical education reform.

Growing for the future

Recruiting and retaining our people during the pandemic by:
- System-level recruitment and retention
- Competency-based workforce modelling and planning.

Continuing to attract and retain our people during recovery by:
- System-level workforce supply plans on recruitment, retention, widening participation and economic recovery
- System-level aligned supply interventions, including medical and health care support workers and international recruitment
- Support the recovery of the education and training pipeline
- Develop and implement robust postgraduate (medical and dental) training recovery plans
- Ensure workforce plans cover all sectors – mental health, community health, primary care and hospital services.

National support on:
- Capability and capacity in NHS workforce planning
- Increase healthcare support workers programme to raise the profile of the role and attract new candidates
- Increase nursing supply to help deliver 50,000 more nurses in the NHS by March 2024
- Increase the number of GP training places to 4,000
- Increase retention, including generational retention programme
- Support returners to the NHS into the vaccination recruitment pipeline and other frontline settings
- Develop proof of concept for an NHS Reserve Model
- Introduction of the new role of medical support worker
- NHS Cadets scheme and volunteering in the NHS.

Derby and Derbyshire Work Programme Leads 21/22

Looking after Our People	•Amanda Rawlings •Nicola Bullen
Belonging in the NHS	•Jaki Lowe •Beverley Smith
New Ways of Working	•Linda Garnett •Amanda Battey
Growing for the Future	•Zoe Lintin •Darren Tidmarsh

Senior colleagues from providers, the CCG, HEE and the ICS are taking a lead on one of the 4 pillars of the People Plan to respond to the Operational Planning Guidance, and to identify other areas for system collaboration where it will add value.

Joined Up Care Derbyshire

Future of NHS HR and OD

In the publication of the NHS People Plan in 2020 there was a commitment to undertake a review of the HR and OD profession. Tom Simons, the HRD for Chelsea and Westminster NHS Foundation Trust was appointed to take the Executive lead for this work reporting to Prerana Issar, Chief People Officer. Under Tom's leadership the scoped has advanced into an improvement programme and Amanda Rawlings, Director of People and OD for UHDB is a member of the national HRD Advisory Group shaping the programme and is working on the Digital workstream.

There are a number of external bodies involved in supporting this work programme, EY, Lancaster University, CIPD and Clever Together The programme has worked at pace since January 2021 to engage stakeholders within the profession and wider NHS, and has arrived at seven k**ey themes which** will form the structure of the final recommendations expected in June/July 2021.

		Aligns to 2030 Narrative…	Aligns to vision statement…	What will this theme address?
Strategic Themes	EDI	Belong	a. We will enable a culture of inclusion and belonging	*What is the role of People Services and the People Profession in creating an inclusive workplace?*
	Wellbeing		b. Wellbeing will be at the heart of everything we do	*What is the role of People Services and the People Profession with staff and in the wider communities (anchor org)*
	Employee experience, recruitment, NHS Brand		d. Our people will have an excellent and personalised employee experience	*How does People Services and the People Profession help define and articulate the unique EVP for working at the NHS and tackle inherent supply challenges?*
	Talent	Nurture	c. We will find and nurture the most caring and talented people	*How does People Services and the People Profession help create a learning culture to develop and deploy people across the NHS?*
Enabling Themes	Digital and Technology	Simplify	g. We will be digitally enabled	*What role does digital enablement play in unlocking capacity in People Services and the People Profession to focus on value add activity and improve employee experience? Data and information join up.*
	Target Operating Model [ICS / Collaboration]	Create	e. We will enable world-leading health and care innovation	*What are the principles for where HR and OD capabilities are delivered to maximise impact of People Services and the People Profession to enable world-leading health and care? How will we reduce inequalities of staff experience based on employer?*
	Development of the People Profession	Enable	f. Our people professionals will be empowered and developed to be their very best	*How do we develop a structured approach to development for the People Profession to meet the demands of the future?*

The *Integrating care* paper and DHSC's white paper set out an ambitious vision for ICSs and their role in achieving collaboration and integration

The white paper sets out the **four core purposes** for an ICS and the outcomes for its people:

1. Improving population health and healthcare
2. Tackling unequal outcomes and access
3. Enhancing productivity and value for money
4. Helping the NHS to support broader social and economic development

Managing the workforce system and designing a people operating model is complex because:

- We plan through different lenses – place, pathway, profession
- We consider 'place' at different levels – provider, system, region, national
- We plan for different time horizons
- Different organisations hold different levers for action relevant to different timeframes

To address workforce challenges we need to coordinate 'all levers at all levels'

The design of the **people operating model** for an ICS will be guided by the wider principles and areas of focus set out for ICSs:

- Population health and addressing wider determinants of health
- Strong partnership working in recognised 'places'
- Cultural and behavioural factors including system leadership
- National direction on "what" but local flexibility on "how"
- Subsidiarity – decisions taken as close as possible to the people served
- Resilient and sustainable design to enable effective response and management of crises, BAU and transformation

Developing an ICS people function
Vision, principles and ways of working

VISION: *where are ICSs going?*

The vision is for ICSs

- to make the health and care system a **great place to live and work** for their **'one-workforce'**…
- …through **more staff**, **working differently** across the whole ICS footprint, in a **compassionate and inclusive culture**…
- …in order to fulfil its statutory workforce requirements and achieve the four core purposes of: improving the health of the population; tackling health inequalities; enhancing productivity and value for money; supporting broader social and economic development.

PRINCIPLES: *how will the approach be guided?*

- ICSs will have clear people and workforce functions, and clear outcomes they are responsible for delivering, based on benefits of scale and to drive equity of action for 'one workforce'.
- There will be clear 'subsidiarity' of accountability and decision-making between national, regional and system levels, as well as within systems – with most decisions made as close as possible to the people and population they affect.
- Maximum local determination and flexibility for ICSs on how they deliver the outcomes listed below, enabled by clear oversight arrangements and a supportive regulatory environment.

WAYS OF WORKING: *what needs to be true for ICSs to deliver a People function?*

In order to carry out the functions listed below, ICSs will need to establish:

- strong local leadership with board level accountability for people across the breadth of the system, and prioritising people and workforce within ICS strategic plans
- culture and values that improve the experience of working in the health and care system for everyone
- mechanisms for directly listening to the voices of staff when carrying out its people functions (e.g. through use of staff networks, staff representative panels)
- horizontal collaborative arrangements within the system and across systems to deliver system outcomes at the scale that best meets local circumstances
- collaborative working arrangements for people and workforce with system partners (e.g. through system people boards, using the expertise of the new people profession) to agree local strategic and operational people priorities and how to implement them (in line with national priorities)
- sufficient/appropriate resource across the system (e.g. through pooled resourcing approaches) to support the development of capability and resilience
- an approach to gathering and analysing intelligence, data and insights to track outcomes and impact, and drive improvement
- a strong relationship with higher education institutions, further education colleges and schools
- clear ways of working with employing organisations in the system, to support them and be a point of escalation and facilitation
- clear ways of working with NHSEI and HEE regional teams, including through Regional People Boards
- a learning and continuous improvement m

Key risks and challenges:

- Managing the operational workforce pressures due to rising demand and reduced staff availability due to the on going effects of the pandemic, and the impact this is having on employee health and wellbeing
- Balancing the increasingly prescriptive national approach to people and culture with local needs and priorities
- Paying as much attention to the cultural and behavioural changes needed for the ICS to deliver its new functions as well as the structural and governance changes.
- Maintaining morale and retaining talent through the ICS transition process.

Joined Up Care
Derbyshire

NHS
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Clinical Commissioning Group

Governing Body Meeting in Public

5th August 2021

Item No: 100

Report Title	Chair's Report – July 2021
Author(s)	Dr Avi Bhatia – Clinical Chair
Sponsor (Director)	Dr Avi Bhatia – Clinical Chair

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

Recommendations

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

Report Summary

Our excellent track record of system partnership has come to the fore once again during July, as we have seen yet another set of circumstances challenge the resolve of our staff and the system's ability to cope. It has been evident in recent weeks that pressure in our system has been starting to build, and in the main this is not activity directly related to Covid-19. Our system has been responding and managing the demand so far, but there are concerns across all providers about the sustainability of the response. It has highlighted the interdependencies between many of our services, and how reliable one can be on another to maintain the balance so we can continue to treat all types of patients.

Overall, all services have seen a sharp rise in demand. Our Emergency Departments, general practice, urgent treatment centres, our 111 call centres and our 999 ambulance responses have reached pre-pandemic levels and beyond. The figure that put this into the starkest context was our colleagues at East Midlands Ambulance Service, who reported that they had received 4881 calls on Monday 19 July – more than 1400 calls more than they would expect to receive on a standard New Year's Eve. Our System Operational Resilience Group – essentially senior decision-makers from all partner organisations – meet twice a week to see where additional support is required to ensure we're able to manage any delays or staffing challenges in any sector of care. It works really well and generally is focussed on urgent and emergency care issues, as well as the flow of patients through our hospital pathways to ensure that we are admitting and discharging patients effectively and efficiently, and also making sure that their onward care is very well coordinated with partners in adult care and other sectors.

At the same time, our elective or planned care services – broadly speaking those services that undertake the diagnostics tests, operations and outpatient follow-ups – have been working hard to recover the backlog of care that had built up during the peaks of the pandemic, making really good progress in providing surgery for patients who had been assessed at the greatest clinical risk of delay, and working their way through to other patients whose surgery was a little less urgent but was equally important.

Although dealing with different 'sectors' of NHS care, there is a connection between the urgent care system and the planned care system: if demand in urgent care reaches certain levels, where there are so many patients who are so poorly and need to be admitted to a hospital bed, including our Intensive Care Units (ITU), then this can mean that space usually given over to surgical recovery beds needs to be utilised by urgent care. In extreme cases, as happened during the February wave of the pandemic where we were admitting significant numbers of Covid-19 patients, our operating theatres were also taken over by extended ITUs, to give us the space and access to the correct infrastructure and staff. We simply must treat patients quickly and appropriately who are very poorly, and this sometimes means that our less urgent operations are postponed to free up space within the hospital. Whilst it is nobody's preference to delay operations, it is sometimes necessary that we take over theatres, recovery areas and wards to help keep people alive. We have not quite yet reached the point where we've had to cancel operations for this purpose this summer, but this has been discussed as a possible contingency at this time.

We have also seen a significant increase in staff absence, largely through staff needing to self-isolate having been 'pinged' by the NHS Covid-19 app, or because their children have been sent home from school due to an outbreak, meaning they need unexpected childcare. Alongside the increases in demand, this has created the 'perfect storm' of a challenge for our services.

There are three things citizens can do to help:

1. The first is relating to our staff having to self-isolate having been 'pinged' by the NHS Covid-19 app. Clearly everyone is now able to mix following the removal of the lockdown measures in July, but I would make a plea to please continue to consider following the guidance about wearing a face covering in buildings, local transport and tighter spaces, continuing to wash your hands and observe social distancing where this can be done. There are no rules about this anymore, although many public bodies and service industry leaders have said that they will continue to require these steps to be in place, which we welcome. The outcome for the NHS is that, not only can we continue to help to reduce the spread of the virus, but this will itself knock on to NHS staff and their ability to stay out of contact with people who are infected and continue to be able to come to work.
2. The second thing citizens can do to help is to get your Covid-19 vaccine, to ensure that if you do become infected you are better able to keep your symptoms mild and stay out of hospital.
3. The third thing is to think carefully about using the right health services. In life and death situations then emergency departments and 999 are always available, but where it is not an emergency, please avoid using those services at all costs and leave them free for patients who are in real need. Try to self-care wherever you can, make full use of your pharmacy, visit NHS 111 online to get advice or to check symptoms and to also get appointments for your local urgent treatment centre, where your waiting times will be much shorter than ED.

I appreciate that few people can do very much about the pressure in the system in dealing with very poorly people, but we can all do a lot to ensure we are not adding to that pressure with conditions or issues that can be very easily treated elsewhere.

Best wishes, Avi Bhatia

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

NHS
Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

5th August 2021

Item No: 101

Report Title	Chief Executive Officer's Report – July 2021
Author(s)	Dr Chris Clayton, Chief Executive Officer
Sponsor (Director)	Dr Chris Clayton, Chief Executive Officer

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

Recommendations

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

Report Summary

The last month has again seen some important developments for the NHS both nationally and locally. On 19 July the country saw most of the remaining lockdown measures lifted, which is welcome in so many regards after the 16 months we have endured through the pandemic. People will appreciate that hospitals and other healthcare settings are still places where very vulnerable people visit to receive their care, and it is therefore correct that those settings will continue to expect all patients and visitors to wear a face-covering, observe social distancing measures and routinely wash their hands when on site.

The vaccination programme is clearly playing a very significant role in preventing the vast majority of people from becoming seriously ill with the virus and while we have seen positive cases rise steeply in June and July, thankfully hospital admissions have not risen so fast. However, we should not be fooled into thinking all is well; it is fact that hospital admissions are rising more quickly as time passes, and we are seeing an increase in patients who are seriously ill and requiring ventilated treatment in our Intensive Care Units. The majority of these people have not been vaccinated, but not all of them, which sends the message that while national measures are relaxed, this remains a very dangerous virus for people.

We have also seen the rise of cases of Covid-19 present another challenge, where along with many other sectors of the country we have seen staff needing to self-isolate having been 'pinged' by the NHS Covid-19 app. Combined with other colleagues needing to stay at home to provide emergency childcare following school closures, our staff absence rates across health and services in Derbyshire have rocketed. It has created an unexpected further pressure on our ability to cope, and at the same time as patient numbers are going up in Emergency Departments, GP practices and for our 111 and 999 service providers, we have seen a reduction in staff available to meet those growing demands. The pandemic has been very challenging for staff and services, but this period is being recognised as one of the most challenging so far, with multiple competing demands of the pandemic response, business as usual and staff absences creating somewhat of a 'perfect storm'.

In other developments, our progression towards a statutory Integrated Care System took a further step forward in July. The second reading of the draft Health and Social Care Bill was heard in the House of Commons on 16 July. This does not mark the final step for the new legislation, but the second reading is often taken as the point at which legislation is likely to be passed in some form, so it enables some processes to commence. These include the

steps to appoint the Chairs and Chief Executives of the ICSs, and we await details of how that will take place in due course. There are further discussions required on the legislation in the House of Lords, but the second reading taking place prior to the summer recess means the developments are on track for the laws to create ICSs to be in place by 1 April 2022.

A further development was that we were informed on 21 July of the Rt Hon Secretary of State for Health and Care, Sajid Javid's decision that Glossop should move from the Greater Manchester ICS into the Derbyshire ICS. Our CCG acted as neutral broker during a brief period of engagement on this matter in May and early June, ahead of NHS and Department of Health and Care consideration. We will work with colleagues in Tameside and Glossop CCG and the wider Greater Manchester system to enact this decision. NHS patients in the area will likely see little change to their day to day access to care.

Once again, I would also like to express my gratitude to all the health and social care colleagues across our system who continue to go above and beyond, day after day, to deliver excellent care to the people of Derby and Derbyshire.

Chris Clayton
Accountable Officer and Chief Executive

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

Meeting and purpose	Attended by	Frequency
NHS England and Improvement (NHSE/I)	Senior teams	Weekly
ICS and STP leads	Leads	Frequency tbc
Local Resilience Forum Strategic Coordinating Group meetings	All system partner CEOs	Weekly
System CEO strategy meetings	NHS system CEOs	Fortnightly
JUCD Board meetings	NHS system CEOs	Monthly
System Review Meeting Derbyshire	NHSE/System/CCG	Monthly
Executive Team Meetings	CCG Executives	Weekly
Accelerating our System Transformation	CCG/System/KPMG	Ad Hoc
2021/22 Planning – Derbyshire System	CCG/System/NHSE	Monthly
LRF/Derbyshire MPs	Members and MPs	Monthly
Derbyshire Quarterly System Review Meeting	NHSE/System/CCG	Quarterly
Derbyshire Chief Executives	System/CCG	Bi-Monthly
EMAS Strategic Delivery Board	EMAS/CCGs	Bi-Monthly
Joint Health and Wellbeing Board	DCC/System/CCG	Bi-Monthly
NHS Midlands Leadership Team Meeting	NHSE/System/CCG	Monthly
Joint Committee of CCG	CCGs	Monthly

Derbyshire Covid-19 SCG Meetings	CEOs or nominees	Weekly
Outbreak Engagement Board	CEOs or nominees	Fortnightly
Partnership Board	CEOs or nominees	Monthly
Clinical Services and Strategies workstream	System Partners	Ad Hoc
Collaborative Commissioning Forum	CCG/NHSE	Monthly
Urgent and emergency care programme	UHDB & CCG	Ad Hoc
System Operational Pressures	CCG/System	Ad Hoc
Clinical & Professional Reference Group	CCG/System	Ad Hoc
Derbyshire MP Covid-19 Vaccination briefings	CCG/MPs	Two per week
Regional Covid Vaccination Update	CCG/System/NHSE	Three per week
Gold Command Vaccine Update	CG/DCHS	Ad Hoc
Integrated Commissioning Operating Model	CCG/System/NHSE	Ad Hoc
System Transition Assurance Sub-Committee	CCG/System	Monthly
Primary Care Integration Operating Model Options	CCG/NHSE	Ad Hoc
East Midlands ICS Commissioning Board	Regional AOs/NHSE	Monthly
Team Talk	All staff	Weekly

3. National developments, research and reports

3.1 NHS awarded George Cross on its 73rd birthday
The NHS was awarded the George Cross for 73 years dedicated service and the response to COVID-19 by Her Majesty the Queen who thanked all NHS staff for their "courage, compassion and dedication". This was only the third time that the award had been bestowed collectively in its 80-year history. The 73rd anniversary of the NHS was celebrated in a service at St Paul's Cathedral.

3.2 NHS delivers over 70 million COVID-19 vaccinations
Since offering the first dose anywhere in the world outside of clinical trials in December, the health service has averaged almost 10 million doses given each month.

3.3 Researchers behind lifesaving Astra-Zeneca vaccine win at NHS Parliamentary Awards
Research teams at Oxford University who joined forces to fight coronavirus by developing a COVID vaccine in record time were among the winners at this year's NHS Parliamentary Awards.

3.4 NHS mental health crisis helplines receive three million calls
The dedicated 24/7 NHS mental health crisis helplines were fast-tracked to open a year ago so everyone could get rapid care they need without having to go to A&E.

The helplines were originally scheduled to go live by 2023/24 under the NHS Long Term Plan.

3.5 NHS workforce more diverse than any point in its history, as health service commits to more action on representation
A first of its kind report looking into race equality among England's doctors has found that the number from black and ethnic minority backgrounds working for the NHS is the highest on record.

3.6 NHS investment boost to ambulance staff numbers ahead of winter
Ambulance trusts in England will be given an extra £55 million to boost staff numbers ahead of winter. The funding will help services to recruit more 999 call handlers, crews and clinicians to work in control rooms. It will also cover the recruitment and retention of liaison officers who manage the handover of patients between ambulances and hospitals.

3.7 New Innovative Medicines Fund to fast-track promising new drugs
NHS patients are set to benefit from early access to potentially life-saving new medicines, including cutting-edge gene therapies, thanks to a new Innovative Medicines Fund and £680 million of ringfenced funding.

3.8 'Skin snaps' and rapid tests among £20 million NHS push to speed cancer diagnosis
'Skin snaps' and rapid tests for same day diagnosis are among a package of measures to get more people checked for cancer. The NHS is investing £20 million to speed up the rollout of these plans, so that thousands more people can get potentially lifesaving cancer checks.

4. Local developments

4.1 NHS Derby and Derbyshire CCG publish 2020/21 Annual Report and Accounts
NHS Derby and Derbyshire Clinical Commissioning Group published its second Annual Report and Accounts on Friday 9th July. The report reflects the breadth of work the CCG has delivered during the last year. The report details exactly what has been achieved in response to the pandemic and the new ways of working that emerged.

4.2 Joined Up Care Derbyshire (ICS) Update – July 2021
Key messages from the Joined Up Care Derbyshire board meeting in July 2021 are available at https://joinedupcarederbyshire.co.uk/news/board-updates.

4.3 Derbyshire resident honoured with National NHS Lifetime Achievement Award
Joe Sim received the Lifetime Achievement Award at the NHS Parliamentary Awards in recognition of his service over six decades at University Hospitals of Derby and Burton NHS Foundation Trust.

4.4 New outpatient facility at University Hospitals of Derby and Burton
On Friday 9 July, University Hospitals of Derby and Burton officially opened their new outpatient department, Clinic A, at the Florence Nightingale Community Hospital with a ribbon cutting ceremony. Outpatient Department A will initially welcome patients five days a week, between the hours of 08:00 to 17:00, and will

host a range of specialities over the next 12 months as part of the Trusts wider recovery plan.
See also: Staff at the community hospital on London Road, marked the hospital name change to 'Florence Nightingale Community Hospital', on 5th July 2021

4.5 Derbyshire Healthcare welcomes new Trust Chair
Derbyshire Healthcare NHS Foundation Trust announced the appointment of Selina Ullah as its new Trust Chair.

4.6 EMAS Paramedic appears in BBC One documentary
An EMAS paramedic based in Leicestershire has appeared in a BBC One documentary about healthcare workers coming to Britain from overseas to serve in the NHS.

4.7 New family health website is now live
Derbyshire Community Health Services have recently launched a new website to give parents and carers all the information they need to support their children from 0-19 - http://derbyshirefamilyhealthservice.nhs.uk.

4.8 Derbyshire Nursing and Midwifery Conference
A day-long celebration of nursing and midwifery in Derby and Derbyshire was held on Thursday 15 July. There were a number of leading national and local speakers and workshops for participants to join. The celebration took place using MS Teams and was open to all levels of nurses and midwifery.

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

4.10 Media update
You can see examples of recent news releases here.

Are there any Resource Implications (including Financial, Staffing etc.)?
Not Applicable
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?
Not Applicable
Has a Quality Impact Assessment (QIA) been completed? What were the findings?
Not Applicable
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
Not Applicable
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
Not Applicable

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

NHS
Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

5th August 2021

Item No: 102

Report Title	Joined Up Care Derbyshire Board Update – July 2021
Author(s)	Sean Thornton, Assistant Director Communications and Engagement
Sponsor (Director)	Dr Chris Clayton, Chief Executive

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

Recommendations

The Governing Body is requested to **NOTE** the update provided from the Joined Up Care Derbyshire Board meeting held on 15th July 2021.

Report Summary

Patient Story

The Board meeting opened with a patient story relating to Derbyshire's Quality Conversations programme, which empowers our staff to engage individuals in their own care and look after themselves, and to help us provide personalised, effective care across all system partners. The aim is to enhance listening and coaching to hold courageous conversations with patients to see things from a new perspective, co-produce their care and is evidenced to result in improved outcomes of care.

The Board heard two case studies: the first relating to Simon who having been through a period of anxiety and drinking heavily, was living in unstable housing and wasn't interacting with the proposed treatments. Taking control of the conversation, it helped identify what to tackle first and what were the goals for Simon in his care. The conversation steered away from advice and guidance and saw Simon reducing his alcohol intake and took more control. Simon is now in his own home, engaging with local community through his church and community projects and has received specialist support to set up his own business. Dave was a young stroke survivor having had two strokes. Using active listening to understand how Dave was feeling, the team was able to avoid setting goals for Dave and instead enabled Dave to be at the centre of his goal setting. Dave was able to recognise small improvements, helping him to strive for bigger goals for the future, including investigating driving and supporting his daughter to learn golf, both of which he hadn't believed initially could be achieved.

There are 595 staff trained, with the potential for nearly 12,000 conversations per week. The Board reflected that this was a true example of 'de-medicalised' care, with benefits to patients, staff and likely more financially effective care that doesn't rely on medical intervention with the social prescribing model.

System Performance
At the time of the Board, there was only a small number of patients in hospital with coronavirus, although this has risen since then from single figures to around 40. This is still low when compared to the height of the January peak when there were more than 700 inpatients with coronavirus. The Derbyshire vaccination programme has continued to expand, and vaccines are now being offered to all adults across Derby and Derbyshire, with good progress made in advance of the 19 July removal of lockdown restrictions. At the time of the Board 1.3 million vaccinations had been delivered (now more than 1.4million). Recovery from the pandemic also continues, with further progress made on reducing the surgery waiting lists for patients that have built up during the last 15 months. Supporting the recovery of our workforce remains our top priority, given the importance of their health and wellbeing and the impact this has on our ability to deliver our restoration and recovery plans.

At the time of the Board we were also starting to see the emergence of additional pressure on services, linked in part to large numbers of staff requiring time off to either isolation themselves having been 'pinged' by the NHS Covid-19 app, or needing to perform childcare duties as schools began sending pupils home from their Covid bubbles due to the rise in infection rates. This was impacting on our Emergency Departments, General Practice and 111 & 999 services.

Our journey towards a statutory ICS

Legislation
The second reading of the new Health and Social Care Bill was completed to schedule on 14th July. This means that national processes can start in earnest towards achieving the 1st April 2022 milestone of our ICS being established as a statutory organisation. A range of guidance and mandates from NHSE is expected during the summer, but JUCD is very well on the way to understanding the set up required to deliver the priorities of our system and continues to recognise that this is a continuation of the journey of the last few years.

The emerging guidance will enhance previous knowledge and helps to build upon and accelerate developments to join up health and care services for the people of Derbyshire; whilst embedding lessons learned from the pandemic. All arrangements and duties remain subject to legislation and parliamentary approval and the system will continue to review and adapt as necessary whilst factoring in opportunities for local flexibility.

The Board recognised that the draft Health and Care Bill legislation outlines the establishment of an Integrated Care Partnership (a partnership of health and care organisations) an Integrated Care Board (of NHS organisations) and maintains the statutory position of Health and Wellbeing Boards. Work is underway to devise the leadership and membership of these bodies.

Local Developments
Locally, the JUCD Board has agreed that our Quality Committee will become a Quality and Performance Committee and a Public Partnership Committee will be developed, which will replace the existing Derbyshire Engagement Committee with a broader remit.

The Board heard the latest thinking on how the statutory functions required of the ICS (planning, financial, governance, legal) have been mapped with an understanding of where they are currently delivered across existing organisations and how they need to transfer into the new ICS, along with any new functions required by legislation. While most staff have an employment protection during the transition phase, this will not be a simple 'lift and shift' of functions, as these will need to develop to reflect the new role for ICSs.

The central 'strategic intent' approach is taking shape as the operating model for health and care and aims to identify how the system will deliver its aim of reducing health inequalities, increasing life expectancy and increasing healthy life expectancy for our population. The four key functions within strategic intent are:

- strategic commissioning
- health protection & prevention
- population health and clinical strategy
- clinical & care standards, improvement & innovation and learning & development

Using the system's challenge in tackling obesity as a case study, the Board reflected on the roles of the component parts of the new ICS, with the ability to see how each element of work would contribute to improvements to local health and care. The system's progression is captured within a comprehensive System Development Plan.

Anchor Institution
Work has continued aligning the ambitions as a large public sector partnership with those other bodies in Derbyshire, both public and private where, by working together, there can be combined power to help local people. The development of an Anchor Charter is a way of securing commitment from individual organisations and provide a framework to make changes to benefit communities across the city and county. The adoption of a charter is not about duplicating or preventing work which is already taking place in Anchor Organisations, or assuming responsibility, but harnessing the power of anchor institutions and maximising their impact on delivering agreed strategic outcomes. The Charter will be taken through the system's respective Boards. Partners are working on employment as the first point of focus, developing approaches to entry-level recruitment and development pipelines, ensuring that we are creating a more inclusive and diverse workforce. There is also work to review the non-pay offers of anchors, including health and wellbeing provision and develop a marketing approach to maximise take up and social value in low pay groups.

ICS Boundary
Colleagues may recall that in May and June we ran an engagement exercise with people in the High Peak of Derbyshire and in Tameside following one of our partners proposing that Glossop should be incorporated within the Derbyshire ICS boundary. Our role in this was neutral, acting on behalf of NHS England in the matter and providing views to help the decision-making process at ministerial level. The Secretary of State has now made the decision for Glossop to move from the Greater Manchester ICS to the Derbyshire ICS. We'll be working with system colleagues to progress this matter during the coming weeks and months.

Digital & Data Strategy
This strategy aims to provide new digital services that improve the patient experience, transform the delivery of care models and reduces the overall cost of care. This includes delivering and extending our Shared Care Record programme, supporting and developing our citizens and workforce in the use and adoption of digital services and building our capability on understanding population health intelligence. The JUCD Board welcomed the strategy as an important step in our development.

Oversight Arrangements with NHS England/Improvement
Work has commenced to develop a Memorandum of Understanding (MoU) between JUCD and NHSEI/I setting out the future oversight relationship to be taken through respective governance processes for sign off by both parties by the end of July 2021. The NHS Oversight Framework 2021/22 subsequently published in June is being taken into consideration in these developments. It is important to note this initial MoU will cover the arrangements during 2021/22 as a transitional year and there will be further developments to confirm the arrangements for 2022/23, including confirmation of any delegated or transferred functions from NHSE/I to ICSs which are to be worked through as part of the transition process.

Derbyshire Dialogue
The Derbyshire Dialogue focusing on the 'Integration of Care in Derbyshire' took place on the 25th June which Chris Clayton and John McDonald (JUCD Chair) presented. Over 215 members of the public and staff from across the health and social care system were in attendance and received an insight and update into the next steps for Derbyshire's Integrated Care System (ICS). For those who may have missed it, the recording, questions posed and two explainer guides that have been developed: Guide One "The Vision" and Guide Two "The Process", are available on the JUCD public website.

Place Partnerships and Provider Collaboration at Scale
The JUCD Board Development session in June received an update in relation to Place Partnerships and Provider Collaboration at Scale developments. It was noted that significant progress continues to be made in both areas despite the absence of national definitive guidance.

Two Place Partnerships (Derby City and Derbyshire) had been previously agreed by the JUCD Board and these would be working through the eight Local Place Alliances (all partners at local level). Four core elements were being worked through; functions, leadership, governance arrangements and shared purpose and vision to build the development plan based on the key functions of a Place Partnership. It was noted that JUCD is part of a national pilot working with the Kings Fund on developing some measures to evidence delivery and impact, in terms of what it needs to do for our citizens. The intention was to focus on governance in the next few months.
National guidance in relation to Provider Collaboration at Scale was expected in June which would set out more explicitly what would be recognised as a collaborative; the sub-committee would work through and interpret any implications of the guidance. The Board were assured on the continued efforts to ensure alignment with the development of Place and Provider Collaboration and national guidance and supported the timescales and next steps in the developments.

Mental Health Capital Development
The JUCD Board at the June 2021 development session considered the Outline Business Cases (OBCs) to develop two new adult acute mental health developments for Derbyshire (North and South). The developments would be funded through £80m of national funding from the Dormitory Eradication fund. The OBCs had already been to the Mental Health Learning Disabilities and Autism Board (MHLDA), System Leadership Team (SLT), Directors of Finance group and through some of the required CCG governance. The Board was reminded and noted that this was a significant system opportunity and development to enable dormitory eradication. The timeline for approval of the Full Business Cases (FBCs) is May 2022.

It was confirmed that associated programme would impact on CDEL, but conversations with NHSE/I were underway to minimise the impact for the system. Regarding the revenue consequences, this sits with the MHLDA Board to manage within their revenue limit, and MHLDA will have ongoing investments in the form of Mental Health Investment Standards (MHIS) funding. The OBCs were supported and letters had been written from the Chair to confirm, following JUCD ICS Finance and Estates Sub-committee consideration and CCG Governing Body approval 1st July 2021.

Thanks to Caroline Maley
As a final item, thanks were expressed to Caroline Maley, who completes her term of office as Chair of Derbyshire Healthcare NHS Foundation Trust during the summer. Caroline has been a valuable contributor to the development of JUCD in recent years and the Board wished her well for the future.

Are there any Resource Implications (including Financial, Staffing etc)?
None as a result of this report.
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?
Not applicable to this report.
Has a Quality Impact Assessment (QIA) been completed? What were the findings?
Not applicable to this report.
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
Not applicable to this report.
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
Not applicable to this report.
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Not applicable to this report.

Have any Conflicts of Interest been identified/ actions taken?
Not applicable to this report.
Governing Body Assurance Framework
To support the development of a sustainable health and care economy that operates within available resources, achieves statutory financial duties and meets NHS Constitutional standards.
Identification of Key Risks
Not applicable to this report.

NHS
Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

5th August 2021

Item No: 103

Report Title	Remuneration Committee – Updated Terms of Reference
Author(s)	Suzanne Pickering, Head of Governance
Sponsor (Director)	Helen Dillistone, Executive Director of Corporate Strategy and Delivery

Paper for:	**Decision**	x	**Assurance**		**Discussion**		**Information**	

Assurance Report Signed off by Chair	N/A
Which committee has the subject matter been through?	Remuneration Committee – 22nd July 2021 (virtually)

Recommendations

The Governing Body is requested to **APPROVE** the Remuneration Committee Terms of Reference.

Report Summary

As part of the Governing Body's six-month review, the Remuneration Committee Terms of Reference has been reviewed and amended by the Remuneration Committee during July 2021.

The amendments and additions to the Terms of Reference have been agreed by the responsible Committee and are highlighted in tracked changes for information.

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

Not Applicable

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

Not Applicable

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

Not Applicable

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

Not Applicable

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

Not Applicable

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

Remuneration Committee

Terms of Reference

1. PURPOSE

1.1 The Remuneration Committee (the "Committee") is established by NHS Derby and Derbyshire Clinical Commissioning Group (the "CCG"). In accordance with section 14M and 14L(3) of the NHS Act.

1.2 Subject to any restrictions set out in the relevant legislation, the Remuneration Committee has the function of making recommendations to the governing body about the exercise of its functions under section 14L(3)(a) and (b), i.e. its functions in relation to:

- determining the remuneration, fees and allowances payable to employees of the CCG and to other persons providing services to it; and
- determining allowances payable under pension schemes established by the CCG.

1.3 The Remuneration Committee is accountable to the Governing Body. The purpose of the Committee is to make recommendations to Governing Body on the appropriate remuneration and terms of service for the Accountable Officer, Directors, other Very Senior Managers, Clinicians and Lay Members. The Committee will have delegated powers to act on behalf of the CCG within the approved Terms of Reference.

1.4 The Committee shall adhere to all relevant laws, regulations and policies in all respects including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate executive directors and senior staff whilst remaining cost effective.

2. ROLES AND RESPONSIBILITIES

The Committee will incorporate the following duties:

2.1 with regard to the Accountable Officer, Directors and other Very Senior Managers, make recommendations to Governing Body all aspects of salary (including any performance-related elements, bonuses);

2.2 make recommendations to Governing Body contractual arrangements for clinicians engaged to support the CCG Governing Body;

2.3 make recommendations on provisions for other benefits, including pensions and cars for all staff;

2.4 make recommendations for arrangements for termination of employment and other contractual terms for all staff (decisions requiring dismissal shall be referred to the Governing Body);

2.5 ensure that officers are fairly rewarded for their individual contribution to the organisation – having proper regard to the organisation's circumstances and performance and to the provisions of any national arrangements for such staff;

2.6 ensure proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate, advising on and overseeing appropriate contractual arrangements for such staff. This will apply to all CCG staff;

2.7 ensure proper calculation and scrutiny of any special payments.

3. CHAIR ARRANGEMENTS

The Committee will be chaired by a Lay Member other than the Audit Chair, and only Lay Members of the Governing Body shall be members of the Committee. It is recommended that the Committee shall be chaired by the Lay Member for Patient and Public Involvement and Lay Vice Chair of Governing Body.

4. MEMBERSHIP

4.1 Members of the Committee must be appointed from the CCG Governing Body.

4.2 To maintain the independence of members, the committee will comprise of four Lay members:

- Lay Member Patient and Public Involvement (Lay Vice Chair of GB and Chair of Remuneration Committee);
- Lay Member Audit;
- Lay Member Finance; and
- Lay Member Governance.

4.3 Only members of the Committee have the right to attend meetings, however, individuals such as the Accountable Officer, Chief Finance Officer, Clinical Governing Body Chair, HR Advisor and external advisors may be invited to attend for all or part of a meeting as and when appropriate but shall not have voting rights. No member or attendee shall be party to discussions about their own remuneration or terms of service.

5. DECLARATIONS OF INTEREST, CONFLICTS AND POTENTIAL CONFLICTS

5.1 The provisions of Managing Conflicts of Interest: Statutory Guidance for CCGs[1] or any successor document will apply at all times.

[1] https://www.england.nhs.uk/wp-content/uploads/2017/06/revised-ccg-coi-guidance-jul-17.pdf

5.2 Where a member of the committee is aware of an interest, conflict or potential conflict of interest in relation to the scheduled or likely business of the meeting, they will bring this to the attention of the Chair of the meeting as soon as possible, and before the meeting where possible.

5.3 The Chair of the meeting will determine how this should be managed and inform the member of their decision. The Chair may require the individual to withdraw from the meeting or part of it. Where the Chair is aware that they themselves have such an interest, conflict or potential conflict of interests they will bring it to the attention of the Committee, and the Deputy Chair will act as Chair for the relevant part of the meeting.

5.4 Any declarations of interests, conflicts and potential conflicts, and arrangements to manage those agreed in any meeting of the Committee, will be recorded in the minutes.

5.5 Failure to disclose an interest, whether intentional or otherwise, will be treated in line with the Managing Conflicts of Interest: Revised Statutory Guidance and may result in suspension from the Committee.

5.6 All members of the Committee shall comply with, and are bound by, the requirements in the CCG's Constitution, Standards of Business Conduct and Managing Conflicts of Interest Policy, the Standards of Business Conduct for NHS staff (where applicable) and NHS Code of Conduct.

5.7 In order to avoid any conflict in respect of the Lay Members who constitute the majority of the membership of the Remuneration Committee, their own remuneration and terms of service shall be set directly by the Governing Body.

6. QUORACY

6.1 The quorum necessary for the transaction of business shall be two Lay Members.

6.2 A duly convened meeting of the Committee at which quorum is present at the meeting, are contactable by telephone conference call or by other virtual medium, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

7. DECISION MAKING AND VOTING

7.1 The Committee will use its best endeavours to make decisions by consensus. Exceptionally, where this is not possible the Chair (or Deputy) may call a vote.

7.2 Only members of the Committee set out in section 4 have voting rights. Each voting member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

7.3 If a decision is needed which cannot wait for the next scheduled meeting or it is not considered necessary to call a full meeting, the Committee may choose to convene a telephone conference or conduct its business on a 'virtual' basis through the use of email communication or other virtual medium. Minutes will be recorded for

telephone conference and virtual meetings in accordance with relevant sections of the Derby and Derbyshire CCG Governance Handbook.

8. ACCOUNTABILITY

For the avoidance of doubt, in the event of any conflict the Standing Orders, the Standing Financial Instructions and the Scheme of Reservation and Delegation of the CCG will prevail over these Terms of Reference.

8.1 Review Role

8.1.1 The Committee may investigate, monitor and review activity within its terms of reference. It is authorised to seek any information it requires from any committee, group, clinician or employee (including interim and temporary members of staff), contractor, sub-contractor or agent, who are directed to co-operate with any request made by it.

8.1.2 The Committee will apply best practice in the decision making process. For example, when considering individual remuneration the Committee will:

- comply with current disclosure requirements for remuneration;
- on occasion, and where appropriate, seek independent advice about remuneration for individuals; and
- ensure that decisions are based on clear and transparent criteria and be able to withstand public scrutiny and audit.

8.1.3 The Committee will have authority to commission reports or surveys it deems necessary to help fulfil its obligations.

9. REPORTING ARRANGEMENTS

The Committee will provide an appropriate form of report of the meeting to the CCG Governing Body following each meeting, confirming all recommendations of decisions made.

10. FREQUENCY AND NOTICE OF MEETINGS

Meetings will be held at least four times a year and when required and may be called at any other such time as the Committee Chair may require.

11. ADMINISTRATIVE SUPPORT

The Governing Body Executive Assistant shall be secretary to the Committee and shall attend to provide appropriate support to the Chair and Remuneration Committee members. The secretary will be responsible for supporting the Chair in the management of the Committee's business and for drawing the Remuneration Committee's attention to best practice, national guidance and other relevant documents, as appropriate. The secretary will either take minutes or make arrangements for minutes to be taken.

12. REVIEW OF TERMS OF REFERENCE

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

Reviewed by Remuneration Committee:	~~December 2020~~ 22nd July 2021
Approved by Governing Body:	~~14th January 2021~~ 5th August 2021
Review Date:	~~July 2021~~January 2022

NHS
Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

5th August 2021

Item No: 104

Report Title	Finance Report – Month 3
Author(s)	Georgina Mills, Senior Finance Manager
Sponsor (Director)	Richard Chapman, Chief Finance Officer

Paper for:	**Decision**		**Assurance**	x	**Discussion**		**Information**	
Assurance Report Signed off by Chair				N/A				
Which committee has the subject matter been through?				Finance Committee – 29.7.2021				

Recommendations

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

- Allocations have been received for H1 at £1.017bn
- The YTD reported underspend at month 3 is £0.113m
- Retrospective allocations expected for Covid spend on the Hospital Discharge Programme is £2.697m
- The Elective Recovery Fund has a YTD estimated £0.448m and H1 forecast of £1.579m which is expected to be reimbursed.
- H1 is forecast to conclude at a breakeven position.

Report Summary

The report describes the month 3 position. The key points are listed in the recommendations section above.

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

N/A

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

N/A

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

N/A

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

None identified

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

No

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
No
Have any Conflicts of Interest been identified/ actions taken?
None identified
Governing Body Assurance Framework
Any risks highlighted and assigned to the Finance Committee will be linked to the Derby and Derbyshire CCG Board Assurance Framework
Identification of Key Risks
As detailed in the report

Financial Performance Summary
Month 3, June 2021

Derby and Derbyshire
Clinical Commissioning Group

Statutory Duty/ Performance	Target	Result	Achieved	Key	Comments/Trends
Achievement of expenditure to plan	£503.441m	£503.328m		Green <1%, Amber 1-5% Red >5%	YTD favourable variance of £0.113m includes the offset of the Covid HDP reimbursement of £2.697m and Elective Recovery allocation of £0.448m
Remain within the Delegated Primary Care Co-Commissioning Allocation	£39.004m	£39.147m		Green <1%, Amber 1-5% Red >5%	£0.143m adverse variance, this is being monitored and spend will be brought back in line with plan by month 6
Remain within the Running Cost Allowance	£4.471m	£4.097m		Green <1%, Amber 1-5% Red >5%	Running costs are £0.375m underspent against plan
Remain within cash limit	Greatest of 1.25% of drawdown or £0.25m	0.58%		Green <1.25%, Amber 1.25-5% Red >5%	Closing cash balance of £0.899m against drawdown of £154.0m
Achieve BPPC (Better Payment Practice Code)	>95% across 8 areas	Pass 8/8		Green 8/8 Amber 7/8 Red <6/8	In month and YTD payments of over 95% for invoices categorised as NHS and non NHS assessed on value and volume

Operating Cost Statement For the H1 Period Ending: June 2021

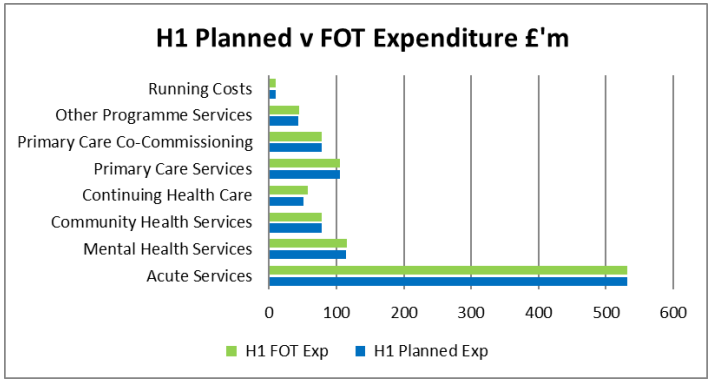
NHS
Derby and Derbyshire
Clinical Commissioning Group

	YTD Budget	YTD Actual	YTD Variance	YTD Variance as a % of YTD Budget	H1 Budget	H1 Forecast Outturn	Forecast Variance	FOT Variance as a % of Annual Budget
	£'000's	£'000's	£'000's	%	£'000's	£'000's	£'000's	%
Acute Services	265,811	265,465	347	0.13	531,622	531,135	487	0.09
Mental Health Services	56,671	56,823	(152)	(0.27)	114,287	115,413	(1,126)	(0.99)
Community Health Services	38,867	38,527	340	0.88	77,734	78,665	(931)	(1.20)
Continuing Health Care	24,882	28,550	(3,668)	(14.74)	50,402	56,852	(6,450)	(12.80)
Primary Care Services	52,798	53,001	(203)	(0.39)	105,109	105,254	(145)	(0.14)
Primary Care Co-Commissioning	39,004	39,147	(143)	(0.37)	78,166	78,302	(136)	(0.17)
Other Programme Services	20,937	20,865	72	0.34	43,896	43,933	(38)	(0.09)
Total Programme Resources	**498,970**	**502,377**	**(3,407)**	**(0.68)**	**1,001,216**	**1,009,554**	**(8,337)**	**(0.83)**
Running Costs	4,471	4,097	375	8.38	9,912	9,464	448	4.52
Total before Planned Deficit	**503,441**	**506,474**	**(3,033)**	(0.60)	**1,011,128**	**1,019,017**	**(7,889)**	(0.78)
In-Year Allocations	0	0	0	0.00	1,909	1,909	0	0.00
In-Year 0.5% Risk Contingency	0	0	0	0.00	4,244	2,558	1,686	39.73
Total Incl Covid Costs	**503,441**	**506,474**	**(3,033)**	(0.60)	**1,017,281**	**1,023,484**	**(6,203)**	(0.61)
Expected Covid Reimbursement in Future Months	0	2,697	(2,697)		0	4,624	(4,624)	
Expected Elective Recovery Fund Allocation	0	448	(448)		0	1,579	(1,579)	
Total Including Reclaimable Covid Costs	**503,441**	**503,328**	**113**	0.02	**1,017,281**	**1,017,281**	**0**	0.00

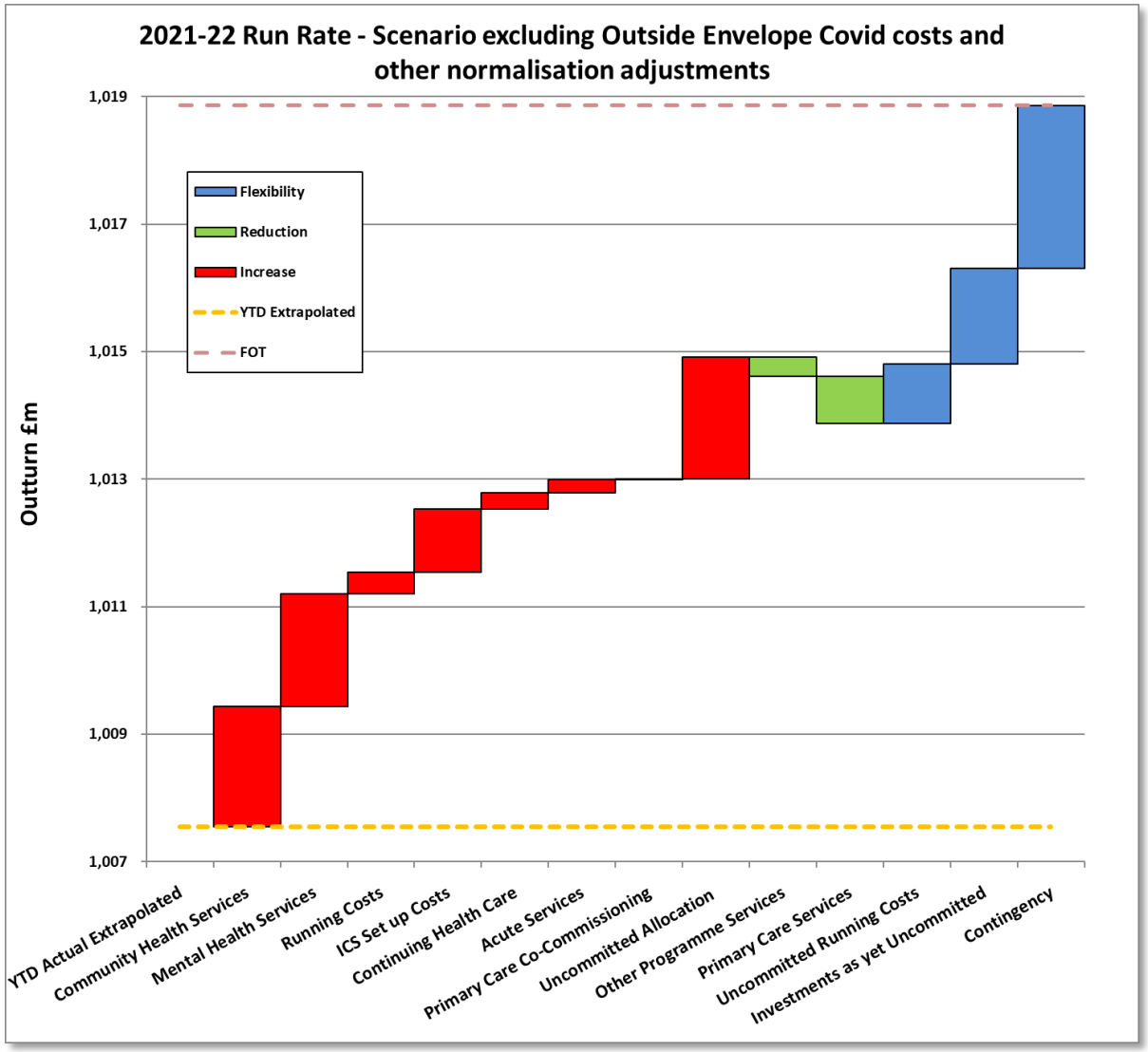
The reported position as at month 3 is a YTD underspend of £0.113m and a breakeven forecast position.

This position includes £2.697m YTD and £4.624m FOT relating to Covid expenditure for Hospital Discharge Programme which is expected to be reclaimed in full. It also includes an estimated amount of £0.448m YTD and £1.579m FOT for Elective Recovery Fund which is also expected to be reimbursed but has not yet been validated.

To balance the month 3 position the CCG has committed £1.686m of the H1 £4.244m contingency.



Run Rate based on H1 Expenditure



NHS
Derby and Derbyshire
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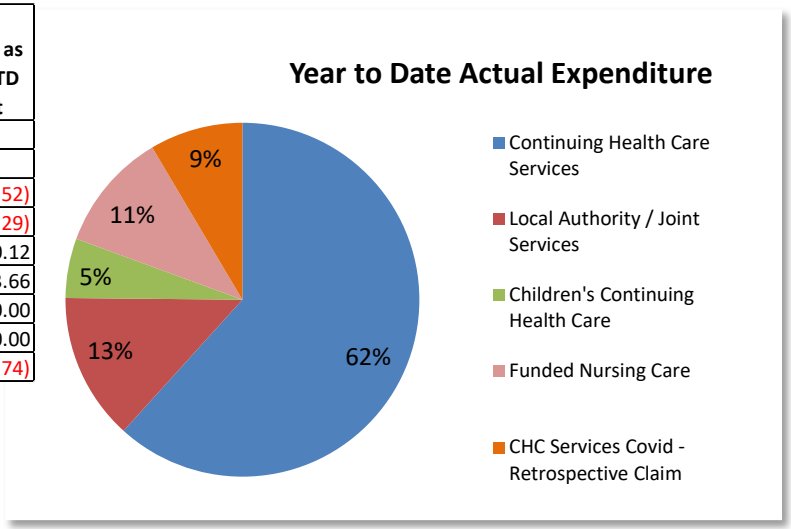
£11.308m variation between the H1 position to date continuing at its current rate and the H1 forecast.

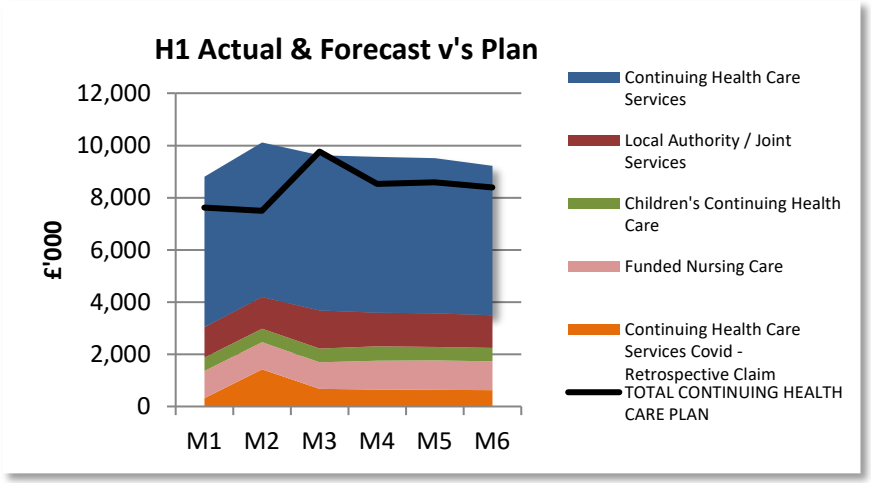
- **Community Health Services** – Ageing Well expenditure to be incurred in months 4 to 6.
- **Mental Health Services**– MHIS investments and allocations expenditure expected in months 4 to 6.
- **Running Costs** – Pay underspends not to continue at same rate due to vacancies being filled.
- **ICS Set up Costs –** One off expected expenditure to cover ICS set up.
- **Continuing Health Care**– Caseload and price growth phased later in period.
- **Acute Services** – Independent sector providers activity expected to increase in quarter 2.
- **PC Co-Commissioning** – Small movement relating to phasing of costs.
- **Uncommitted Allocation** –Non-recurrent allocations received not yet distributed to areas.
- **Other Programme Services** – 111 First expenditure has been phased into quarter 1, to match the funding. Staff vacancies starting to be filled.
- **Primary Care Services** – Prescribing forecast based on historic trends and GPFV allocations received for quarter 1 only.
- **Uncommitted Running Costs-** Expected to be utilised within patient care.
- **Uncommitted Investments**–Funding currently in reserves expected to be used by end of H1.
- **Contingency** – 0.5% H1 contingency of £4.244m with £2.558m forecast expenditure and £1.686m balance committed against financial position.

Continuing Health Care

Derby and Derbyshire
Clinical Commissioning Group

	YTD Budget	YTD Actual	YTD Variance	YTD Variance as a % of YTD Budget
	£'000's	£'000's	£'000's	%
Continuing Health Care				
Continuing Health Care Services	14,501	17,621	(3,120)	(21.52)
Local Authority / Joint Services	3,298	3,836	(537)	(16.29)
Children's Continuing Health Care	1,554	1,553	2	0.12
Funded Nursing Care	3,229	3,111	118	3.66
Continuing Health Care Services Covid - Retrospective Claim	0	2,430	(2,430)	0.00
Continuing Health Care Additional Efficiency Requirement Non-NHS	2,299	0	2,299	100.00
	24,882	**28,550**	**(3,668)**	(14.74)





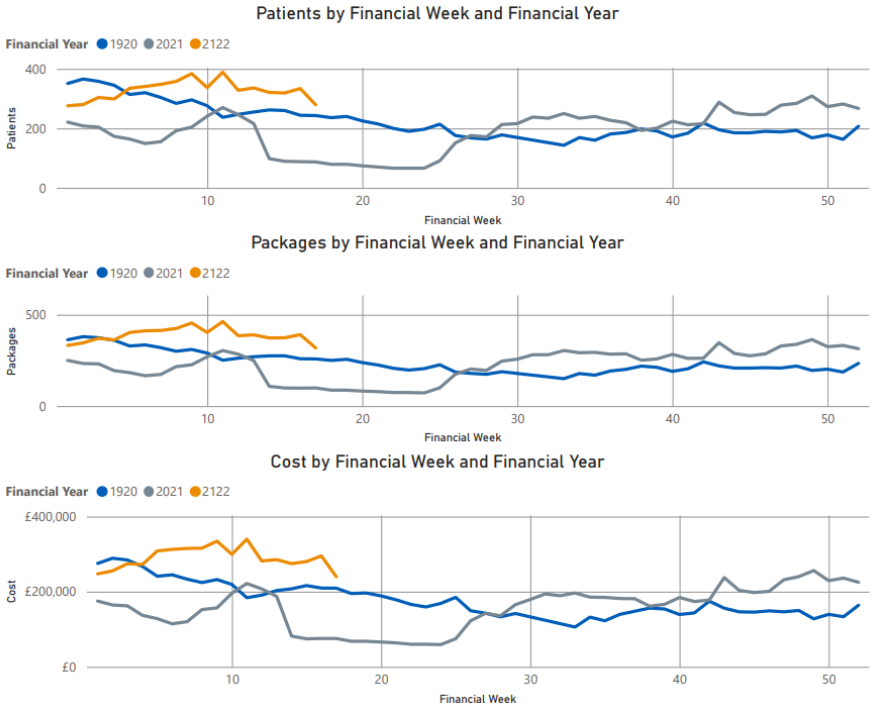
£2.430m of the reported overspend is due to Covid related costs for the Hospital Discharge Programme. The costs are expected to be reclaimed in full and will be funded by allocations received in month 4.

The main pressure relates to Fast Track with an overspend of £2.009m year to date and a forecast variance of £3.586m overspent.

Continuing Health Care

Derby and Derbyshire Clinical Commissioning Group

Fast Track Packages and Cost



Fast track costs at M3 are overspent by £2.009m year to date with a forecast overspend of £3.586m. The forecast assumes actions taken by colleagues in the Nursing and Quality team and the CSU impacts from M5 onwards. However, the latest data at July 19th shown in the charts here suggests the impact is already being seen in M4 as patient numbers have reduced by 57 and packages numbers have decreased by 72 in the last 4 weeks.

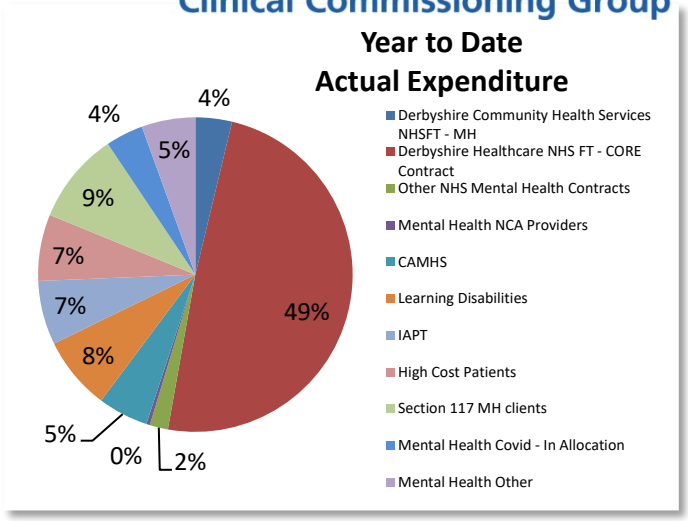
Actions taken to address the overspend this month include:

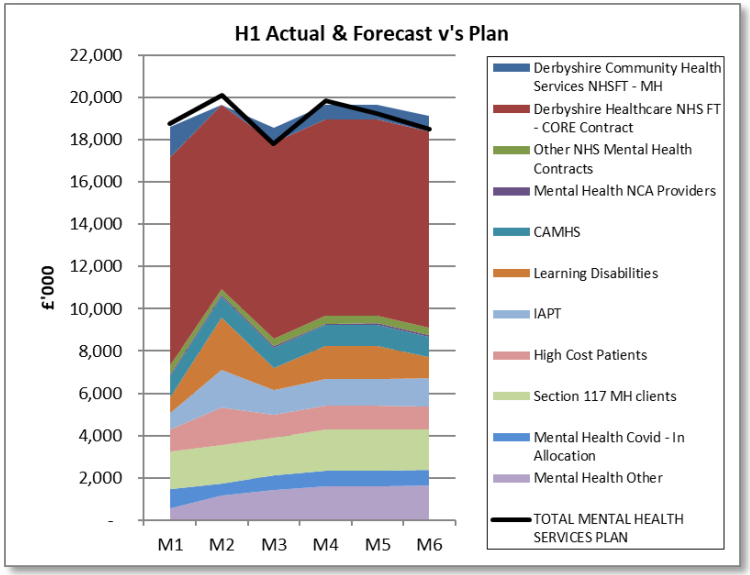
- MLCSU CHC team have increased the quality assurance of referral and clinical triage and clinical contact with referrers to improve the quality of referrals received.
- All FT packages are being reviewed by MLCSU at 10 days and again at 10 weeks. Assessments for CHC eligibility are being booked at 12 weeks if there is no evidence that the patient is approaching the end of life.
- Outstanding Fast track case are being prioritised for review.
- Comprehensive training of the appropriate use of the Fast Track Pathway is being rolled out to referring organisations by the CSU.
- Weekly internal CCG Fast track meetings taking place to review finance and activity and actions.

Mental Health Services

Derby and Derbyshire Clinical Commissioning Group

	YTD Budget	YTD Actual	YTD Variance	YTD Variance as a % of YTD Budget
	£'000's	£'000's	£'000's	%
Mental Health Services				
Derbyshire Community Health Services NHSFT - MH	2,136	2,136	0	0.00
Derbyshire Healthcare NHS FT - CORE Contract	27,865	27,865	0	0.00
Other NHS Mental Health Contracts	1,075	1,072	3	0.32
Mental Health NCA Providers	202	206	(4)	(2.12)
CAMHS	2,952	2,942	10	0.35
Learning Disabilities	4,054	4,288	(234)	(5.78)
IAPT	3,952	3,742	210	5.32
High Cost Patients	3,883	3,884	(2)	(0.04)
Section 117 MH clients	4,873	5,353	(481)	(9.86)
Mental Health Covid - In Allocation	2,400	2,197	203	8.46
Mental Health Other	3,280	3,138	142	4.33
	56,671	**56,823**	**(152)**	(0.27)





Mental Health Services has a total overspend to date of £0.152m.

Section 117 has an overspend of £0.481m to date relating to activity growth and learning disabilities has an overspend of £0.234m to date relating to plan differences.

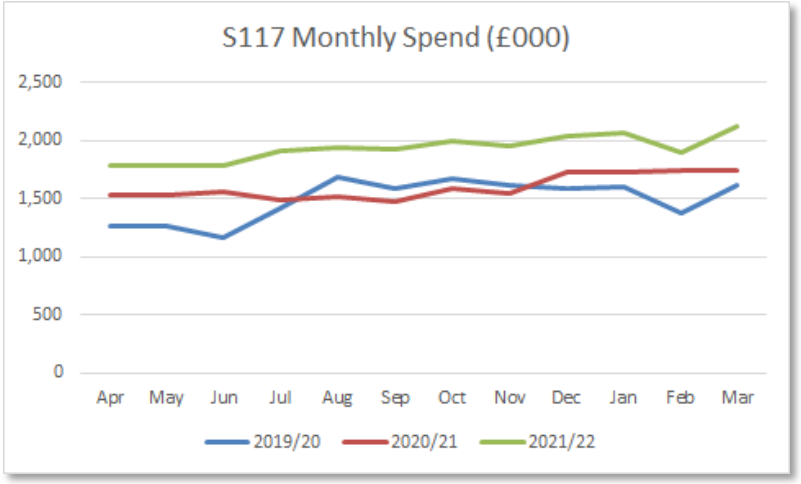
The variances are partly offset by underspends in other areas including IAPT with activity levels at a lower level than planned.

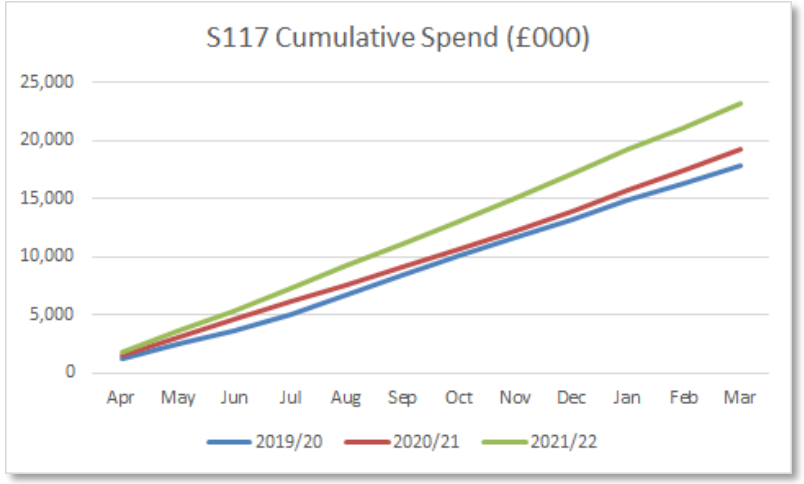
Mental Health Services

Section 117 Cost Pressure

NHS
Derby and Derbyshire
Clinical Commissioning Group

- The driver behind the forecast is additional caseload, the trend has continued over the last three years where the CCG has seen an average 20% increase.
- The national mental health planning guidance stated that S117 activity should not be above 2020/21 outturn, as a result the CCG was only allowed to apply an uplift of 1.71%. This is contradictory with local trends.
- In signing off the 21/22 plan the MHLDA Delivery Board recognised that this was a significant risk and accepted their responsibility to manage the whole MH and LDA programme budget at a system level.
- The system has invested in additional Case Management capacity and one area of their focus is on S117. Whilst that work will have a beneficial impact on S117 activity it will not be sufficient to bring back in line with the plan.
- As part of managing the overall programme budget the MHLDA Delivery Board are being asked to identify other mitigating actions to offset the section 117 pressure.

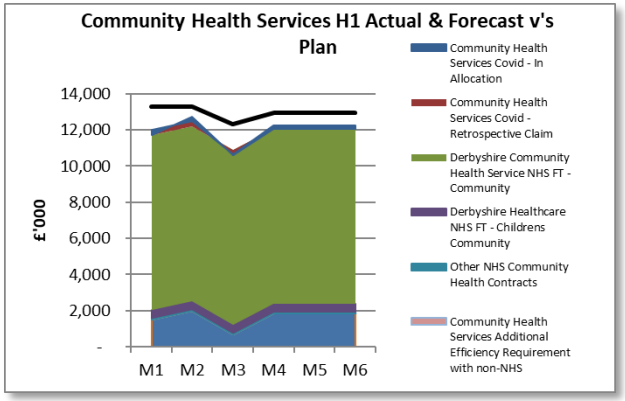




Community Health Services

Derby and Derbyshire Clinical Commissioning Group

	YTD Budget	YTD Actual	YTD Variance	YTD Variance as a % of YTD Budget
	£'000's	£'000's	£'000's	%
Community Health Services				
Derbyshire Community Health Service NHS FT - Community	28,556	28,541	15	0.05
Derbyshire Healthcare NHS FT - Childrens Community	1,370	1,370	0	0.00
Other NHS Community Health Contracts	284	284	0	0.00
Non- NHS Independent Care Providers	2,925	3,385	(459)	(15.70)
Other Non-NHS Community Care Providers	5,212	4,157	1,055	20.24
Community Health Services Covid - In Allocation	521	523	(3)	(0.53)
Community Health Services Covid - Retrospective Claim	0	268	(268)	0.00
	38,867	**38,527**	**340**	**0.88**

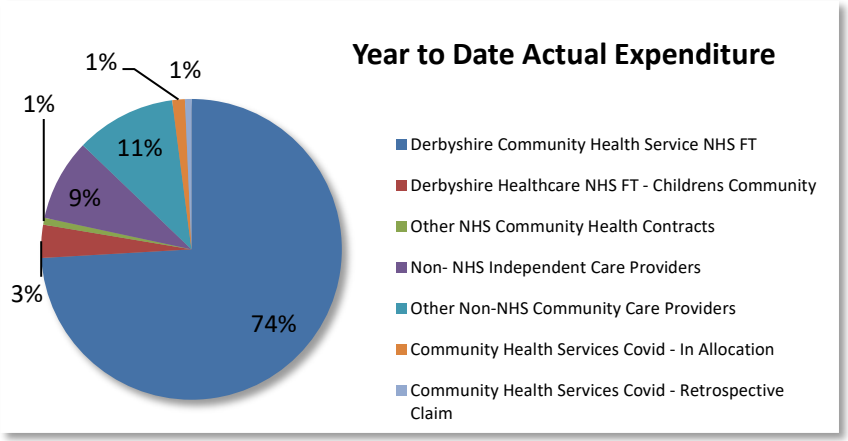


The year to date position for Community Health Services is a total underspend of £0.340m.

The main overspend is for non-NHS providers relating to ophthalmology due to activity for SpaMedica being significantly higher than planned.

The overspend of £0.268m for Covid – Retrospective Claim relates to costs incurred for Hospital Discharge Programme and these are expected to be fully reimbursed in month 4.

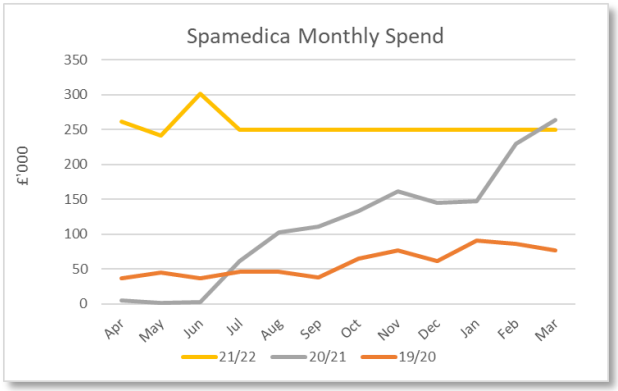
The overspends to date are offset by an underspend for Other Non-NHS Community Care Providers of £1.055m which mainly relates to Ageing Well costs which have not been incurred to date. However, the full allocation received is forecast to be spent by the end of H1.

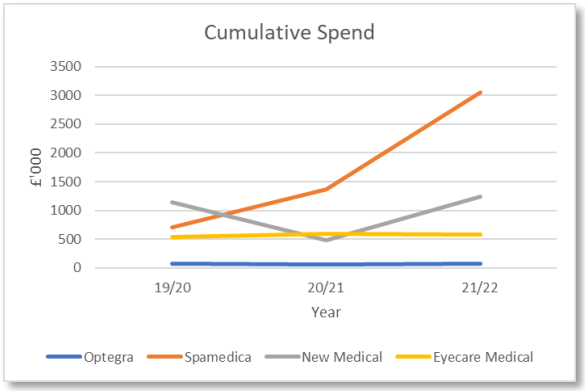


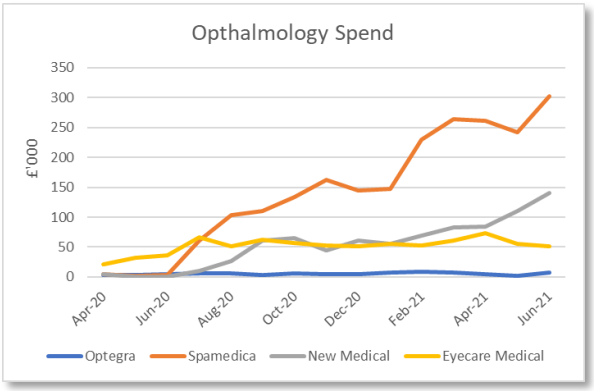
Community Health Services

Derby and Derbyshire
Clinical Commissioning Group

Non-NHS Ophthalmology







- SpaMedica an Independent Sector provider opened a new facility in Derby City in August 2020 and is operating at near maximum capacity.
- Currently there are over 100 patients who have been waiting more than 52 weeks on the Ophthalmology waiting list at UHDB who have not yet had a first appointment.
- NHS providers continue to operate under national block arrangements whilst Independent Sector providers are paid on an activity basis and so this is creating the financial pressure in the system.
- Independent Sector providers continue to be an important system resource for the COVID recovery. Much of the increase in SpaMedica activity appears to be coming from a drop in referrals to local NHS providers.
- The CCG is attempting to agree a contract that will manage performance, adherence to commissioning policies, quality oversight and manage waiting lists at a system level; SpaMedica are unwilling to sign a contract at the plan level given the activity that they are seeing.
- This activity is within the scope of the Elective Recovery Fund and the CCG is anticipating £1.579m additional resources in H1. Details have yet to be received which will confirm the what element will relate to this ophthalmology issue.

System Year to Date and Forecast Outturn

Derby and Derbyshire Clinical Commissioning Group

JUCD YTD and forecast by organisation

Month 03 Position	2021/22 Financial Year						
Surplus/(Deficit)	Plan YTD Month 03 £m's	Actual Month 03 £m's	Variance Month 03 £m's	H1 Plan £m's	H1 Forecast £m's	Forecast Variance £m's	Notes
NHS Derby and Derbyshire CCG	0.0	0.1	0.1	0.0	0.0	0.0	
Chesterfield Royal Hospital	0.0	1.1	1.1	0.0	0.6	0.6	Reduction in COVID costs offsetting core costs and ERF above planned level
Derbyshire Community Health Services	0.0	(0.2)	(0.2)	0.0	0.0	0.0	
Derbyshire Healthcare	0.0	0.0	0.0	0.0	0.0	0.0	
East Midlands Ambulance Service	0.0	(0.4)	(0.4)	0.0	(0.8)	(0.8)	Additional costs in relation to Flowers
University Hospitals Of Derby And Burton	4.1	4.9	0.8	0.0	0.0	0.0	
Intra System Reconciliation	0.0	0.0	0.0	0.0	0.0	0.0	
JUCD Total	**4.1**	**5.5**	**1.4**	**0.0**	**(0.2)**	**(0.2)**	

NHS
Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

5th August 2021

Item No: 105

Report Title	Finance Committee Annual Report 2020/21
Author(s)	Fran Palmer, Corporate Governance Manager Andrew Middleton, Finance Committee Chair
Sponsor (Director)	Richard Chapman, Chief Finance Officer

Paper for:	**Decision**		**Assurance**	x	**Discussion**		**Information**	
Assurance Report Signed off by Chair				Not applicable				
Which committee has the subject matter been through?				Finance Committee – 29th July 2021				

Recommendations

The Governing Body is requested to **NOTE** the Finance Committee Annual Report for 2020/21 for assurance.

Report Summary

It is a requirement for Committees of the CCG to produce an Annual Report each financial year, as set out in the terms of reference. This report provides the Governing Body with a review of the work that the Finance Committee has completed during the period 1 April 2020 to 31 March 2021.

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

Not applicable.

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

Not applicable.

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

Not applicable.

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

Not applicable.

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

Not applicable.

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Not applicable.
Have any Conflicts of Interest been identified / actions taken?
Not applicable.
Governing Body Assurance Framework
Not applicable.
Identification of Key Risks
Not applicable.

Finance Committee Annual Report 2020/21

FINANCE COMMITTEE ANNUAL REPORT 2020/21

1. INTRODUCTION AND BACKGROUND

1.1 This report reviews the work of the Finance Committee and covers the period from 1st April 2020 to 31st March 2021.

1.2 The report provides the Governing Body and Accountable Officer with evidence relevant to their responsibilities of reviewing both the financial and service performance of the CCG against financial control targets and the annual commissioning plan. The Committee also identifies where remedial action is needed, ensuring that action plans are put in place and delivery is monitored.

2. MEMBERSHIP AND QUORACY

2.1 In accordance with the terms of reference the membership of the committee during 2020/21 comprised of:

- 2 x GP Governing Body Members;
- 3 x Governing Body Lay Members;
- Chief Finance Officer;
- 1 x Clinical Representative (Chief Nurse Officer/Medical Director).

2.2 The quorum necessary for the transaction of business was four members, which included at least one Executive Lead (Chief Finance Officer or Deputy Chief Finance Officer), at least one Clinical Representative and at least two Governing Body Lay Members.

2.3 The Committee also requested attendance by appropriate individuals to present relevant reports and/or advise the Committee.

2.4 The full membership attendance can be found at Appendix 1.

3. FREQUENCY OF MEETINGS

The Finance Committee meeting is held on a monthly basis. Due to the pandemic, the meeting was stood down from the 1st April 2020. Meetings reconvened on the 25th June 2020, and by the 31st March 2021 the committee had met a total of 10 times.

4. KEY AREAS OF REVIEW

Throughout 2020/21, the Finance Committee reviewed, monitored and had oversight of finance in relation to work in the following areas:

4.1 Financial Position

- Reviewed monthly finance reports, which included information on the:
  - temporary financial regime for the period 1st April–31st July 2020
  - operational planning for Covid-19 scenarios
  - Year to Date overspend and savings
  - forecast overspend position
  - received allocations
  - Covid-19 and top-up allocations
  - full year expenditure forecast
- Had oversight of the Primary Care Out of Hours and NHS 111 ED Clinical Validation Contract Position
- Gained assurance from Deloitte's Covid-19 audit report

4.2 Financial Planning

- Noted the System Income and Expenditure for 2020/21
- Agreed the formal closure of the Turnaround Programme
- Noted the CHC Domiciliary Home Care and CHC Care Homes Financial Uplift for 2020/21
- Noted a report on the 2020/21 Financial Regime
- Accepted the CCG and System Financial Plan for September 2020–March 2021
- Endorsed the approach towards a value-focused health economy
- Noted the financial planning and budget setting for 2021/22

4.3 Recovery and Restoration

Received monthly updates on actions assigned to them within the Recovery and Restoration Programme.

4.4 Corporate Assurance

- Noted the step-down of temporary constitutional changes
- Reviewed an update of the financial governance elements of the Constitution and CCG Handbook
- Reviewed other CCG committees' meeting logs
- Produced a monthly corporate assurance report to the Governing Body, following each meeting of the Finance Committee

4.5 Risk Management

- Received monthly financial risk reports
- Agreed and regularly reviewed the Risk Register and Governing Body Assurance Framework for its area of remit, considering the adequacy of the submissions and whether new risks needed to be added to the Risk Register;

or whether any risks required immediate escalation to the CCG's Governing Body

5. CONCLUSION

The Finance Committee has discharged its duties effectively during the year, in this most challenging of corporate governance contexts resulting from non-standard financial arrangements resulting from the pandemic. Attendance has been good and we have had the added benefit of an additional GP board member, Dr. Merryl Watkins, observing the meetings for most of the year. This shadowing became inadvertent succession planning for 2001-22 when Dr. Ruth Cooper, had to relinquish her position on the Finance Committee because of other governance duties, and Dr. Watkins became a full member of the committee.

The committee continues to be well-served by incisive questioning by members, including informed clinical members. This success is firmly based on excellent committee papers, produced to governance timescales, and supported by comprehensive attendance by highly skilled and experienced senior finance officers. The officers have maintained an impressive grip on the highly dynamic special financial regime. Both the CCG and system financial outturns were in balance for the year, but this unusual position reflects the special funding arrangements.

A new, higher standard, of financial report presentation was achieved with the graphical enhancement of the monthly integrated finance and savings report. Shortly after each meeting of the committee the Governing Body has received reliable assurance reports of sound management of the CCG's resources.

The year 2021-22 sees the continuation of special funding arrangements, but both the CCG Finance Committee and the System Finance and Estates Committee (SFEC) are fully aware that the underlying financial challenges for the system require determined attention. Both are planning for the return of a normal financial regime and the SFEC has taken ownership of this most challenging of transitions, under a new ICS structure. CCG officers are key players in this reorganisation and future strategies.

Andrew Middleton
Chair of Finance Committee & Lay Member for Finance
July 2021

APPENDIX 1

Finance Committee Attendance Record 2020/21

Finance Committee Member	25 June 2020	30 July 2020	27 Aug 2020	24 Sep 2020	21 Oct 2020	26 Nov 2020	17 Dec 2020	28 Jan 2021	25 Feb 2021	25 Mar 2021
Andrew Middleton *Chair, Lay Member for Finance and Sustainability Champion*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Martin Whittle *Lay Member for Patient and Public Involvement*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ian Gibbard *Lay Member for Audit and Conflicts of Interest Guardian*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Ruth Cooper *Chair, GP Member*	X	✓	✓	✓	✓	✓	X	✓	✓	✓
Dr Bukhtawar Dhadda *GP Member*	X	✓	X	✓	✓	✓	✓	✓	✓	✓
Richard Chapman *Chief Finance Officer*	✓	X*	✓	✓	✓	✓	✓	✓	✓	✓
Sandy Hogg *Executive Turnaround Director*	✓	X								
Brigid Stacey *Chief Nurse Officer*	✓	✓	X*	✓	✓	✓	✓	✓	X*	X*

* Indicates where a member was deputised.

NHS
Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

5th August 2021

Item No: 106

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

Paper for:	**Decision**		**Assurance**	x	**Discussion**		**Information**	x
Assurance Report Signed off by Chair				Dr Ruth Cooper, Chair of the CLCC				
Which committee has the subject matter been through?				CLCC – 8.7.2021				

Recommendations

The Governing Body is requested to **RATIFY** the decisions made by the Clinical and Lay Commissioning Committee (CLCC) on 8th July 2021.

Report Summary

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

<u>CLC/2122/54 Clinical Policies</u>

CLCC APPROVED the following updated Position Statement:

Epidurals for all forms of Sciatica (Lumbar Radiculopathy).

<u>EBI2 Guidance Section 2 - interventions that are covered by pre-existing DDCCG policies/position statements</u>

CLCC NOTED the progress to date regarding the EBI2 Interventions and RATIFIED the following policies/position statements which have been updated to reflect the EBI2 proposals:

- Lumbar Discectomy
- Fusion Surgery for Mechanical axial low back pain
- Injections for Non-specific Back Pain

CLCC NOTED the following EBI2 interventions that are covered by existing policies/position statements to remain unchanged:

- Removal of adenoids for glue ear
- Low Back Pain Imaging

- Cholecystectomy
- Repair of minimally symptomatic Inguinal Hernia

Areas for Service Development

CLCC NOTED that CPAG have reviewed Individual Funding Request (IFR) cases submitted and Interventional Procedures Guidance (IPGs), Medtech Innovation Briefings (MIBs), Medical Technology Guidance (MTGs) and Diagnostic Technologies (DTs) for May 2021. CLCC were assured that no areas for service developments were identified.

CLCC NOTED the CPAG bulletin for May 2021.

CLC/2122/59 CLCC Risk Tracker Emerging Risks

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

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

NHS
Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

5th August 2021

	Item No: 106

Report Title	Clinical & Lay Commissioning Committee Annual Report 2020/21
Author(s)	Fran Palmer, Corporate Governance Manager Dr Ruth Cooper, Clinical & Lay Commissioning Committee Chair
Sponsor (Director)	Zara Jones, Executive Director of Commissioning Operations

Paper for:	**Decision**		**Assurance**	x	**Discussion**		**Information**	
Assurance Report Signed off by Chair				Not applicable				
Which committee has the subject matter been through?				Clinical & Lay Commissioning Committee – 8th July 2021				

Recommendations

The Governing Body is requested to **NOTE** the Clinical & Lay Commissioning Committee Annual Report for 2020/21 for assurance.

Report Summary

It is a requirement for Committees of the CCG to produce an Annual Report each financial year, as set out in the terms of reference. This report provides the Governing Body with a review of the work that the Clinical & Lay Commissioning Committee has completed during the period 1 April 2020 to 31 March 2021.

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

Not applicable.

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

Not applicable.

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

Not applicable.

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

Not applicable.

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

Not applicable.

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Not applicable.
Have any Conflicts of Interest been identified / actions taken?
Not applicable.
Governing Body Assurance Framework
Not applicable.
Identification of Key Risks
Not applicable.

NHS
Derby and Derbyshire
Clinical Commissioning Group

Clinical & Lay Commissioning Committee

Public Annual Report 2020/21

CLINICAL & LAY COMMISSIONING COMMITTEE PUBLIC ANNUAL REPORT 2020/21

1. INTRODUCTION AND BACKGROUND

1.1 This report reviews the work of the Clinical & Lay Commissioning Committee and covers the period from 1st April 2020 to 31st March 2021.

1.2 The report provides the Governing Body and Accountable Officer with evidence relevant to their responsibilities of:

1.2.1 developing and implementing the commissioning strategy and policy of the CCG and helping to secure the continuous improvement of the quality of services; and

1.2.2 retaining a focus on health inequalities, improved outcomes and quality; and ensuring that the delivery of the CCG's strategic and operational plans are achieved within financial allocations.

1.3 The Clinical & Lay Commissioning Committee has delegated authority to make decisions within the limits as set out in the CCG's Schemes of Reservation and Delegation.

2. MEMBERSHIP AND QUORACY

2.1 In accordance with the terms of reference the membership of the committee in 2020/21 was comprised of:

- 3 x GPs (GP Governing Body members providing appropriate geographical coverage and the Chair)
- 1 x Clinical representatives taken from clinical lead roles
- 1 x Secondary Care Doctor
- 3 x Lay Members
- 1 x Chief Nurse Officer
- 1 x Medical Director
- 1x Chief Finance Officer
- 1 x Public Health Representative
- 1 x Executive Director of Commissioning Operations

2.2 The quorum necessary for the transaction of business was six members, including four Clinicians (can include the Chair), one Lay Member and one Executive Lead.

2.3 The full membership attendance can be found at Appendix 1.

3. FREQUENCY OF MEETINGS

The Clinical & Lay Commissioning Committee meeting is held on a monthly basis. Due to the pandemic, the meeting was stood down from the 1st April 2020. Meetings reconvened on the 11th June 2020, and by the 31st March 2021 the committee had met a total of 10 times.

4. KEY AREAS OF REVIEW

In November, the Committee reviewed the format of its meetings to enable them to provide transparency on their decision-making in relation to public-facing matters.

Throughout 2020/21, the Clinical & Lay Commissioning Committee ensured that arrangements were in place to deliver on their duties, which included the review and approval of work in the following areas:

4.1 Commissioning

- Approved the following:
  - Future Commissioning Priorities
  - National Rehabilitation Centre – Public Consultation Response
  - VCS Contracting Intentions 2021/22

- Reviewed the following:
  - Phase 3 Recovery and Restoration – JUCD Plan Summary
  - Commissioning Intentions and Approach for 2021/22
  - Better Care Fund

4.2 Business Cases and Investments

Provided a clinical opinion on the following:

- MSK CATS and IS Physiotherapy
- Section 75 Pooled Budget with Derbyshire County Council for Care of Children with Complex Needs
- Emergency Medication Pathway
- CUES COVID-19 Urgent Eye Service
- Children and Young People Mental Health
- Care Homes Market Position
- AQP CHC Domiciliary Homecare Framework
- Urgent Treatment Centre Derby
- Ophthalmology
- Non-Scalpel Vasectomies
- Derbyshire Wheelchair Service
- Final contract extension decisions for Health Care Contracts expiring by September 2021
- Neurodevelopment
- Paramedic Rough Sleeper Response

4.3 Policies & Procedures

Ratified or made suggestions to a number of policies, which were reviewed and approved by the Clinical Policy Advisory Group. This included policies in the following areas:

- Bariatrics/General Surgery
- Dermatology
- Ear, Nose & Throat
- Gynaecology and Fertility

- Neurology
- Orthopaedics
- Urology
- Cosmetic
- Governance

4.4 **Risk Management**

Agreed and regularly reviewed the Risk Register and Governing Body Assurance Framework for its area of remit, considering the adequacy of the submissions and whether new risks needed to be added to the Risk Register; or whether any risks required immediate escalation to the CCG's Governing Body.

4.5 **Corporate Assurance**

Received minutes and highlights from the Joint Area Prescribing Committee; Derbyshire Prescribing Group; and Clinical Policy Reference Group.

5. CONCLUSION

We come to the end of another challenging year for all, managing the repeated waves of Covid-19 which has meant we have continued to meet virtually. Despite this, we achieve very good attendance from both our clinical and lay membership who continue to provide scrutiny and rigorous challenge during our discussion and decision making.

The additional challenge we have been grappling with this year is how the assurance that this committee provides currently to the CCG (and indirectly the whole health community and system) can be transferred to the new Integrated Care System: we continue with these discussions.

Finally can I once again thank colleagues for their continued dedication to the committee and their support.

Dr Ruth Cooper
Chair of Clinical & Lay Commissioning Committee & GP Governing Body Member
July 2021

APPENDIX 1

Clinical & Lay Commissioning Committee Attendance Record 2020/21

Clinical and Lay Commissioning Committee Member	11 June 2020	9 July 2020	13 Aug 2020	10 Sep 2020	8 Oct 2020	12 Nov 2020	10 Dec 2020	14 Jan 2021	11 Feb 2021	11 Mar 2021
Dr Ruth Cooper *Chair, GP Member*	✓	✓	✓	X	✓	✓	✓	✓	✓	✓
Professor Ian Shaw *Deputy Chair, Lay Member for Primary Care Commissioning*	✓	✓	✓	✓	✓	✓	✓	✓	X	X
Dr Bukhtawar Dhadda *GP Member*	✓	✓	X	✓	✓	✓	✓	✓	✓	✓
Dr Emma Pizzey *GP Member*	✓	✓	X	✓	✓	✓	✓	✓	✓	✓
Dr Greg Strachan *GP Member*	✓	✓	X	✓	✓	✓	✓	✓	✓	✓
Dr Merryl Watkins *GP Member*	✓	✓	✓	✓	X	X	✓	✓	X	✓
Dr Bruce Braithwaite *Secondary Care Consultant*	✓	✓	✓	✓	✓	X	X	✓	✓	X
Simon McCandlish *Lay Member for Patient and Public Involvement*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ian Gibbard *Lay Member for Audit and Conflicts of Interest Guardian*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Brigid Stacey *Chief Nurse Officer*	✓	✓	✓	X	✓	X*	X*	✓	✓	✓
Richard Chapman *Chief Finance Officer*	✓	X*	X*	✓	✓	✓	✓	✓	X*	X*
Dr Steven Lloyd *Executive Medical Director*	✓	X*	X	X*	✓	✓	X*	X*	X*	X*
Dr Robyn Dewis *Public Health Representative*	X*	X*	X*	X*	X	X*	X*	X	X	X
Sandy Hogg *Executive Turnaround Director*	✓	X								
Zara Jones *Executive Director of Commissioning Operations*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

* Indicates where a member was deputised.

Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

5th August 2021

Item No: 107

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

Paper for:	**Decision**		**Assurance**	x	**Discussion**		**Information**	
Assurance Report Signed off by Chair					Martin Whittle, Vice Chair/Lay Member for PPI			
Which committee has the subject matter been through?					Engagement Committee – 20.7.2021			

Recommendations

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

Report Summary

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

Proposed Sinfin Health Centre

The Committee was informed about emerging plans for new health centre in Sinfin. This was an identified need in the Derbyshire Primary Care Estates Strategy and has also been earmarked as part of a national programme to improve primary care estate, along with five other sites in England.

The project is at a very early stage of development, and the Committee heard of the steps taken so far to ensure there is robust patient and public involvement in the planning and delivery. It was noted that the programme requires further financial and estates governance in the development of a full business case between now and May 2022, steps which were outside the remit of the Engagement Committee. A full communications and engagement plan is in place to support the development and the Committee will be updated through the lifespan of the project.

St Thomas Road Surgery, Derby

St Thomas Road Surgery is a GP practice in Derby and the service contract is set to expire on 30th September 2022. A procurement process has started and a formal patient engagement period commenced on Monday 12 July 2021 and will run to Friday 17 September 2021. The key objectives of the Patient & Stakeholder Engagement period are:

- to inform patients and stakeholders of the procurement process, explain why it is required and to ensure they have a voice in the procurement process.
- to find out what they value from their current GP Practice and what they think could be improved.

- to collate the feedback and for the Procurement Board Panel to consider when deciding who manages the GP Practice in the future.
- to support the decision-making process to procure a high-quality primary care medical service for St Thomas Road Surgery patients.

A patient letter has been issued to every household, including the link to a survey and two focus virtual groups took place in the last week of July to seek views, with support offered to patients to access the sessions via laptop, tablet or mobile phone as required. The patient population served by St Thomas Road Surgery in this busy area of Derby City is extremely diverse. The practice has a list which in part is constantly changing due to the transient nature of multicultural population it serves, but also has an established population that is also very diverse. The engagement plan includes the development of multi-language social media posts, offering the patient questionnaire in different languages, providing interpreting services and during the virtual sessions and 1:1 virtual meeting as requested. British Sign Language and braille services will also be offered as required.

The Committee took assurance from the range of engagement planned to support this decision.

Communications and Engagement Draft Performance Metrics

Following the approval of the Communications and Engagement Strategy in May 2021, the Committee received a proposed schedule of measurements to support the development of communications and engagement activity. Including measures of engagement governance, engagement activity, internal communications and social media evaluation, the schedule was agreed and will now form the basis of a monthly dashboard prepared for the Committee.

It was noted that this dashboard will be further developed during the next few months, with particular focus on evaluation of system internal communications and other developmental measures to support the formation and achievement of objectives for the new statutory Integrated Care System.

S14Z2

The Committee received the latest log of completed engagement assessment form (known as S14Z2 forms after the sub-section of the health and Social Care Act relating to patient and public involvement). The log was received in part for assurance that programmes are now recommencing the assessment process following the intervening pandemic period, and also enabled the Committee to understand the breadth of programmes being assessed and to highlight where a deep dive might be required or desired. The two schemes for which the form had been completed were Sinfin Health Centre Development and St Thomas Road Procurement, projects which had already been fully reviewed by the Committee earlier in the meeting. The log will continue to be reviewed by to the Committee monthly.

Risk Report

There were no updates made to ratings of risks currently managed by the engagement committee, although further mitigations to the risk management plans could be added in line with the agreed performance reporting schedule.

Engagement Committee Annual Report The Committee received the latest annual report outlining its work during the course of the last year. In what has been a strange year during a pandemic, the Committee noted that it had needed to stand down for a period during the height of the pandemic, but had since re-established itself on a strong footing. Even with a reduced number of meetings, the Committee has overseen a significant amount of business.
Are there any Resource Implications (including Financial, Staffing etc)?
None identified.
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?
A PIA is not found applicable to this update. This report is for assurance and information.
Has a Quality Impact Assessment (QIA) been completed? What were the findings?
A QIA is not found applicable to this update. This report is for assurance and information.
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
An EIA is not found applicable to this update. This report is for assurance and information.
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
Not applicable to this update. This report is for assurance and information.
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Not applicable to this update. This report is for assurance and information but describes a range of patient, public communications and engagement activity across the breadth of CCG work.
Have any Conflicts of Interest been identified/ actions taken?
None identified.
Governing Body Assurance Framework
Risks assigned to the Engagement Committee are reviewed monthly and changes noted within this assurance report.
Identification of Key Risks
Noted as above.

NHS
Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

5th August 2021

Item No: 107

Report Title	Engagement Committee Annual Report 2020/21
Author(s)	Fran Palmer, Corporate Governance Manager Martin Whittle, Engagement Committee Chair
Sponsor (Director)	Helen Dillistone, Executive Director of Corporate Strategy and Delivery

Paper for:	**Decision**		**Assurance**	x	**Discussion**		**Information**	
Assurance Report Signed off by Chair				Not applicable				
Which committee has the subject matter been through?				Engagement Committee – 20th July 2021				

Recommendations

The Governing Body is requested to **NOTE** the Engagement Committee Annual Report for 2020/21 for assurance.

Report Summary

It is a requirement for Committees of the CCG to produce an Annual Report each financial year, as set out in the terms of reference. This report provides the Governing Body with a review of the work that the Engagement Committee has completed during the period 1 April 2020 to 31 March 2021.

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

Not applicable.

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

Not applicable.

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

Not applicable.

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

Not applicable.

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

Not applicable.

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Not applicable.
Have any Conflicts of Interest been identified / actions taken?
Not applicable.
Governing Body Assurance Framework
Not applicable.
Identification of Key Risks
Not applicable.

Engagement Committee Annual Report 2020/21

ENGAGEMENT COMMITTEE ANNUAL REPORT 2020/21

1. INTRODUCTION AND BACKGROUND

1.1 This report reviews the work of the Engagement Committee and covers the period from 1st April 2020 to 31st March 2021.

1.2 The report provides the Governing Body and Accountable Officer with evidence relevant to their responsibilities of ensuring the CCG is involving patients in decisions about health services and that robust processes are in place to ensure that the CCG is fully compliant with their statutory obligations.

1.3 The Engagement Committee can sign off the approach to all formal consultation programmes, either with delegated authority from the CCG's Governing Body or prior to their final sign off at those meetings.

2. MEMBERSHIP AND QUORACY

2.1 In accordance with the terms of reference the membership of the committee in 2020/21 comprised:

- Voting Members
  - Governing Body Lay Member – Patient and Public Involvement Lead (Chair)
  - Governing Body Lay Member - Patient and Public Involvement Lead (Vice-Chair)
  - Governing Body Lay Member - Primary Care Commissioning Lead
  - Foundation Trust Governor – Secondary Care – Chesterfield Royal Hospital NHS Foundation Trust
  - Foundation Trust Governor – Secondary Care – University Hospitals of Derby & Burton NHS Foundation Trust
  - Foundation Trust Governor – Community
  - Foundation Trust Governor – Mental Health
  - Derbyshire County Council representative
  - Derby City Council representative
  - Clinical representative
  - 8 x Integrated Care Partnership/Place Alliance/public representatives
  - Executive Director of Corporate Strategy and Delivery or Deputy
  - Derbyshire STP Director or Deputy
  - Voluntary Sector City and County representation – nominated infrastructure lead officer

- Non-voting Members
  - Healthwatch Derby Representative
  - Healthwatch Derbyshire Representative
  - CCG/Joined Up Care Derbyshire, Assistant Director Communications and Engagement (or deputy)
  - Joined Up Care Derbyshire Head of Engagement

2.2 The quorum necessary for the transaction of business was 5 members, including 2 CCG Lay Members including either the Chair or Vice Chair being present, 2 Place Engagement Representatives and 1 Executive Director or Deputy.

2.3 The full membership attendance can be found at Appendix 1.

3. FREQUENCY OF MEETINGS

3.1 The Engagement Committee meeting is held on a monthly basis. Due to the pandemic, the meeting was stood down from the 1st April 2020. Meetings reconvened on the 17th June 2020, and by the 31st March 2021 the committee had met a total of 7 times.

3.2 The meeting is split into two parts to reflect the joint approach to resourcing of Communications and Engagement being taken across the CCG and Joined Up Care Derbyshire (JUCD). The second part of the meeting has the addition of the Derbyshire Sustainability and Transformation Partnership Director to the non-voting membership of the group. This 'Part 2' does not represent a formal sub-committee of the CCG, but instead reports to the Joined Up Care Derbyshire Board. As the year progressed it became clear the committee was operating as a single Derbyshire System committee in support of the JUCD aspiration to transition to an Integrated Care System; as a result the committee reviewed its Terms of Reference and removed the two-part structure of the agenda and revised the membership to better reflect all partners in the JUCD system.

4. KEY AREAS OF REVIEW

Throughout 2020/21, the Engagement Committee ensured that arrangements were in place to deliver on their duties, which included the review and approval of work in the following areas:

4.1 Engagement

Received the following reports on the development, implementation and monitoring of a robust engagement infrastructure across the Derbyshire health and care system:

- Orthotics Engagement
- Insight Programme
- Winter Communications Planning and NHS111 First
- Winter Plan and Urgent Care Review
- Covid-19 Vaccination Communications
- System Pressures Communications
- NHS Oversight Framework Patient and Community Engagement Indicator

4.2 **Service Developments**

Championed patient and public engagement across the Derbyshire health and care system by scrutinising service developments in the following areas:

- Baron Ward and Babington Hospital
- Community Mental Health Framework
- System Insight Group Update
- Covid-19 testing across Derby and Derbyshire
- Ageing Well Programme
- NHSE/I Guidance on Legislation for Service Change
- Derbyshire Maternity and Neonatal Voices

4.3 **Consultations**

- London Road Wards 1 & 2

4.4 **CCG Policies**

Amended the Patient and Public Expenses Policy to recognise the continued support of the lay member during the pandemic and to reflect remote working.

4.5 **Joined Up Care Derbyshire**

- Received reports on the following:
  - Long Term Plan
  - JUCD Board Key Messages
  - System Insight Group
  - Waiting Time Risk Stratification
  - JUCD Communications and Engagement Strategy
  - ICS Development and White Paper
  - Evolving role of Governors in the ICS

4.6 **Risk Management**

Agreed and regularly reviewed the Risk Register and Governing Body Assurance Framework for its area of remit, considering the adequacy of the submissions and whether new risks needed to be added to the Risk Register; or whether any risks required immediate escalation to the CCG's Governing Body.

4.7 **Restoration and Recovery**

Received assurance on Recovery and Restoration through receiving the:

- Recovery and Restoration Plan
- Restoration and Recovery Engagement Strategy
- Restoration and Recovery and S14Z2 Triggers
- Covid-19 Service Recovery and Restoration Assessment Process
- Children's and Young People Restoration and Recovery
- Learning from Wave 1 Covid-19 Response

5. CONCLUSION

In its second year, the Engagement Committee has continued to evolve to the further development of integrated working across the Derbyshire System. The Committee agreed that it now works as a truly system-based committee, so much so that it could dispense with the two-part approach and genuinely work as one body.

It has clearly been a difficult year for everyone with the Covid-19 Pandemic changing many parts of our working and private lives; the Committee adapted extremely well to the challenges and met virtually when it needed to in order to carry out its important work. Whilst it has not seen the usual level of planned service change to scrutinise due to the Covid-19 Pandemic, it has needed to review both Covid-19 related and non-Covid-19 related plans, and provide assurance to the CCG Governing Body that standards of engagement remain high and involve patients appropriately.

The Committee has a majority of public and lay representation which helps provide rigorous scrutiny from a patient and public perspective, including the perspective from partner Governor colleagues from all the main Derbyshire providers. From this solid base the Committee is well placed to tackle the work ahead as Derbyshire moves to being a fully Integrated Care System, and to ensure that public and patient input is at the forefront of future healthcare planning.

Martin Whittle
Chair of Engagement Committee & Lay Member for Patient & Public Involvement
July 2021

APPENDIX 1

Engagement Committee Attendance Record 2020/21

Engagement Committee Member	17 Jun 2020	29 July 2020	16 Sep 2020	21 Oct 2020	18 Nov 2020	20 Jan 2021	16 Mar 2021
Martin Whittle *Chair, Lay Member for Patient and Public Involvement*	✓	✓	X	✓	✓	X	✓
Simon McCandlish *Deputy Chair, Lay Member for Patient and Public Involvement*	X	✓	✓	✓	✓	✓	✓
Professor Ian Shaw *Lay Member for Primary Care Commissioning*	✓	✓	✓	✓	✓	✓	✓
Maura Teager *Foundation Trust Governor – Secondary Care*				✓	✓	✓	✓
Denise Weremczuk *Foundation Trust Governor – Secondary Care*	✓	✓	X	✓	X		
Margaret Rotchell *Foundation Trust Governor – Secondary Care*						✓	✓
Bernard Thorpe *Foundation Trust Governor – Community*	X*	✓	X*	✓	✓		
Lynn Walshaw *Foundation Trust Governor – Community*						✓	✓
Kevin Richards *Foundation Trust Governor – Mental Health*	✓	✓	✓	✓	✓	✓	✓
Ram Paul *Derby City Council Representative*	X	X	X	X	X	X	X
Jocelyn Street *Place Engagement Representative*	✓	✓	✓	✓	✓	✓	✓
Ruth Grice *Place Engagement Representative*	✓	✓	✓	✓	✓	✓	X
Roger Cann *Place Engagement Representative*		✓	X	X	X	✓	✓
Trevor Corney *Place Engagement Representative*	X	X	X	X	X	X	X
Steve Bramely *Place Engagement Representative*	✓	✓	✓	✓	✓	✓	✓
Tim Peacock *Place Engagement Representative*	✓	✓	✓	✓	✓	✓	✓
Helen Dillistone *Executive Director of Corporate Strategy and Delivery*	✓	✓	✓	X*	X	✓	✓
Beth Soraka *Healthwatch Derby Representative*	✓	✓	X	✓	✓	✓	X
Helen Henderson-Spoors *Healthwatch Derbyshire Representative*	X*	✓	X	X	X	X	X
Kim Harper *Community Action Derby*	X	X	X	X	X	X	X
Vikki Taylor *Director, JUCD*	X*	X*	X	X*	X*	✓	✓
Sean Thornton *Assistant Director Communications and Engagement, CCG*	✓	✓	✓	✓	X*	✓	✓
Karen Lloyd *Head of Engagement, Joined Up Care Derbyshire*	✓	✓	X	✓	✓	✓	✓

* Indicates where a member was deputised.

NHS
Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

5th August 2021

Item No: 108

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

Paper for:	**Decision**		**Assurance**	x	**Discussion**		**Information**	
Assurance Report Signed off by Chair					Jill Dentith, Governance Lay Member and Chair of Governance Committee			
Which committee has the subject matter been through?					Governance Committee – 22.07.2021			

Recommendations

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

Report Summary

This report provides the Governing Body with highlights from the 22nd July 2021 meeting of the Governance Committee. This report provides a brief summary of the items transacted for assurance.

Derby and Derbyshire CCG Procurement Highlight Report

The Governance Committee RECEIVED and NOTED the Highlight report for Derby and Derbyshire CCG. The Committee NOTED the change in format of the Procurement Highlight Report and REVIEWED the key issues and activities over the current period.

Corporate Policies & Procedures for Approval

The Governance Committee APPROVED the following polices:

- Freedom of Information Policy;
- Standards of Business Conduct and Managing Conflicts of Interest Policy;
- Gifts and Hospitality Policy; and
- Procurement Policy.

Governance Committee Annual Report

The Governance Committee NOTED the contents of the Governance Committee Annual Report for 2020/21. The Chair thanked the Committee for their contributions.

CCG Recovery and Restoration Closure Report

The Committee NOTED the contents of the report and the completion or transfer of actions for Recovery and Restoration. The transfer of actions will be managed as business as usual.

The Committee APPROVED the closure of this programme and RECOMMENDED the removal of the Recovery and Restoration plan from the terms of reference. The terms of reference will be reviewed in September 2021 as part of its six monthly review. Formal approval will take place at Governing Body in October together with all Corporate Committee terms of references.

Human Resources Performance Report 2020/21

The Committee NOTED the HR Performance Report, covering the financial year 2020-21. Key points to note were:

- The CCG has experienced a small reduction in the number of leavers;
- Sickness absence levels have significantly reduced;
- The proportion of BME staff within the CCG has increased; and
- Vacancy levels have slightly increased across the CCG as at 1st June 2021.

The Committee requested a report on the number of fully vaccinated CCG staff for assurance purposes at the September 2021 meeting.

Staff Survey Action Plan

The Committee NOTED the progress in relation to the Staff Survey Action Plan since the last meeting.

Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap Report 2020/21

The Committee NOTED and APPROVED the contents of the WRES Action Plan and WDES Action Plan.

In relation to the 2020/21 Gender Pay Gap Report the Committee noted the combined gender profile for the 454 CCG employees as 81% female and 19% male. Regarding the Governing Body, Executives Team and GP leaders in the CCG, there was a relatively even split between male and female. However, for all other employees of the CCG the percentages were 84% female and 16% male. The Committee NOTED that the CCG has a mean gender pay gap of 35.1% and a median gender pay gap of 20.6%. The report went on to highlight actions being taken to reduce this gap, including strengthening work around equality and promoting flexible working options.

2020/21 Annual Complaints Report

The Governance Committee NOTED the content of the 2020/21 Annual Complaints Report. The Committee NOTED the consistent themes of complaints in relation to communication and process.

The Committee RECOMMENDED the publication of the annual report on the CCG website.

2021/22 Quarter 1 Complaints Report

The Governance Committee NOTED and received ASSURANCE on the content of the quarter 1 Complaints Report.

Freedom of Information (FOI) Quarter 1 Report
The Committee RECEIVED the quarter 1 Freedom of Information report on the CCG's performance in meeting its statutory duties in responding to requests made under the Freedom of Information Act.

The Committee NOTED that no requests were responded to outside the statutory 20 working day deadline.

Contract Oversight Report
The Governance Committee NOTED the contents of the report and the progress being made.

Procurement Decisions in ICS Transition
The Governance Committee RECEIVED ASSURANCE on the planned approach to the future management of procurement decisions in the ICS transition. The Committee NOTED that the responsibility for forming and recommending the course of action required to secure provision for the services will be devolved to the relevant Delivery Board/ICS Group within the ICS structure.

The Governance Committee AGREED that it will provide the oversight to decision-making processes in relation to the Provider Selection for the 20 services to give assurance that procurement processes are being followed and Conflicts of Interests are appropriately managed.

Estates Update July 2021
The Governance Committee NOTED the Estates Update Report and gained assurance of the work being undertaken to establish a hybrid operational model and new ways of working.

Business Continuity, Emergency Planning Resilience and Response 2020/21 and EU Exit Transition Update
The Governance Committee NOTED the contents of the report for information and assurance. The Committee RECEIVED ASSURANCE of the EU Exit Lessons Learnt report.

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

Violence Reduction Standards Update
The Governance Committee NOTED the report for assurance and information.

Information Governance Compliance Report
The Governance Committee APPROVED the recommendations made at the June Information Governance Assurance Forum meeting and RECEIVED an update regarding actions and compliance activities.

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

Electronic Eye Care Referral Service PID
The Committee NOTED the Project Initiation Document (PID) for the implementation of the Eyecare Electronic Referral Management Services (EeRS).

Risk Register Report July 2021
The Governance Committee RECEIVED the Governance risks assigned to the committee as at July 2021. The Committee NOTED the virtual approval received on 18th June 2021 from members for the closure of risk 29 relating to current contract management arrangements. The closure was also approved at Governing Body on 1st July 2021.

The Committee APPROVED new risk 40 relating to extension of contracts in the period of transition from CCG to ICS.

2021/22 Quarter 1 Governing Body Assurance Framework
The Governance Committee NOTED the 2021/22 Quarter 1 (April to June 2021) Governing Body Assurance Framework; and RECEIVED the new GBAF risks 7 and 8 reportable to the Governance Committee which were approved virtually by Governance Committee members on 18th June 2021.

Non-Clinical Adverse Incidents
No incidents were reported to the Committee.

Any Other Business
There were no items of any other business

Minutes of the Governance Committee 20th May 2021
The minutes of the 20th May 2021 were APPROVED as an accurate, true record.

Governance Committee forward planner
The forward plan was REVIEWED and AGREED.

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

None identified.

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

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

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

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

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

NHS
Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

5th August 2021

Item No: 108

Report Title	Governance Committee Annual Report 2020/21
Author(s)	Fran Palmer, Corporate Governance Manager Jill Dentith, Governance Committee Chair
Sponsor (Director)	Helen Dillistone, Executive Director of Corporate Strategy and Delivery

Paper for:	**Decision**		**Assurance**	x	**Discussion**		**Information**	
Assurance Report Signed off by Chair				Not applicable				
Which committee has the subject matter been through?				Governance Committee – 22nd July 2021				

Recommendations

The Governing Body is requested to **NOTE** the Governance Committee Annual Report for 2020/21 for assurance.

Report Summary

It is a requirement for Committees of the CCG to produce an Annual Report each financial year, as set out in the terms of reference. This report provides the Governing Body with a review of the work that the Governance Committee has completed during the period 1 April 2020 to 31 March 2021.

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

Not applicable.

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

Not applicable.

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

Not applicable.

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

Not applicable.

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

Not applicable.

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Not applicable.
Have any Conflicts of Interest been identified / actions taken?
Not applicable.
Governing Body Assurance Framework
Not applicable.
Identification of Key Risks
Not applicable.

NHS
Derby and Derbyshire
Clinical Commissioning Group

Governance Committee Annual Report 2020/21

GOVERNANCE COMMITTEE ANNUAL REPORT 2020/21

1. INTRODUCTION AND BACKGROUND

1.1 This report reviews the work of the Governance Committee and covers the period from 1st April 2020 to 31st March 2021.

1.2 The report provides the Governing Body and Accountable Officer with evidence relevant to their responsibilities of ensuring that NHS Derby and Derbyshire Clinical Commissioning Group (the "CCG") complied with the principles of good governance whilst effectively delivering the statutory functions of the CCG.

1.3 The Governance Committee has delegated authority to make decisions as set out in the CCG's Prime Financial Policies and the Scheme of Reservation and Delegation.

2. MEMBERSHIP AND QUORACY

2.1 In accordance with the terms of reference the membership of the committee is comprised of:

- 3 x Governing Body Lay Members;
- 2 x GP Governing Body Members; and
- Executive Director of Corporate Strategy and Delivery, or Deputy.

2.2 The quorum necessary for the transaction of business is four members, which include two Governing Body Lay Members, one Clinician and the Executive Director (or deputy).

2.3 CCG Officer subject experts are attendees at each meeting and the Committee can also request attendance by appropriate individuals to present relevant reports and/or advise the Committee.

2.4 The full membership attendance can be found at Appendix 1.

3. FREQUENCY OF MEETINGS

The Governance Committee meeting is held on a bi-monthly basis. Due to the pandemic, the meeting was stood down from the 1st April 2020. Meetings reconvened on the 9th July 2020, and by the 31st March 2021 the committee had met a total of 5 times.

4. KEY AREAS OF REVIEW

Throughout 2020/21, the Governance Committee ensured that arrangements were in place to monitor compliance with statutory responsibilities. This included reviewing and approving work in the following areas:

4.1 Emergency Preparedness, Resilience and Response

- Received regular updates on the CCG's approach to monitoring the recovery and restoration programme during the Covid-19 pandemic.
- Gained assurance that the CCG fulfilled its requirement in having an Incident Control Centre during the pandemic.
- Noted the revised process for the submission of a statement of assurance in regards to the Emergency Preparedness, Resilience and Response (EPRR) Core Standards submission for 2020/21.
- Approved the request to move the CCG from Business Continuity Level 3 to Level 4, and the required quoracy arrangements for the Governing Body and Corporate Committees while operating at this level.
- Approved the Primary Care Vaccine Handling and Management Business Continuity Plan.
- Approved the following key EPRR documentation:
    - Business Continuity Plan
    - Business Continuity Policy
    - EPRR Policy Statement

4.2 Corporate Governance

- Ensured that suitable policies and procedures were in place which complied with relevant regulatory, legal and code of conduct requirements. This included approval of the:
    - CCG Governance Handbook, which contained the CCG's:
        - Prime Financial Policies
        - Standing Financial Instructions
        - Corporate Governance Framework
    - Fraud, Corruption & Bribery Policy
    - Policy Management Framework
    - Whistleblowing Policy
    - Commercial Sponsorship and Joint Working with the Pharmaceutical Industry Policy
    - Standards of Business Conducts & Managing Conflicts of Interest Policy
    - Gifts, Hospitality & Sponsorship Policy
    - Procurement Policy
- Considered and approved the provision of the Derbyshire Maternity and Neonatal Voices committee as an inclusion for the CCG Governance Structure.
- Received updates on:
    - Audit Committee Value for Money Conclusion
    - Freedom to Speak Up Guardian Role

4.3 **Complaints and Patient Advise and Liaison Service**

- Noted the main themes/issues raised and the learning identified from the complaints received.
- Received quarterly update reports on complaints and the annual report.

4.4 **Digital Development and Information & Communications Technology (ICT) Assurance, including Cyber Security**

- Received assurance on the CCG's Cyber Operational Readiness Support Audit and Action Plan
- Approved the following policies:
  - Digital Obsolescence Policy
  - Information Handling and Classification Policy
  - IT Security and Equipment Policy
  - Removable Media Policy
  - Communication and Information Security Policy

4.5 **Information Governance**

- Approved the following key Information Governance documentation:
  - Information Governance Policy
  - NHS Network, Intranet and Electronic Mail Acceptable Use Policy
  - Records Management Policy
- Received updates on:
  - The CCG's response to the Control of Patient Information notice
  - Information Governance Strategy progress and incidents
  - Data Security and Protection Toolkit
  - Data Security and Protection Level One Training Compliance
  - Incidents that were reportable to the Information Commissioners Office
- Received the Information Governance Assurance Forum notes and actions.

4.6 **Equality, Human Rights and Inclusion**

- Approved the contents of the Workforce Race Equality Standard Action Plan and Workforce Disability Equality Standard Action Plan.
- Noted the findings from Topic 1 of 'Our Big Conversation' on inclusion and diversity within the CCG.

4.7 **Freedom of Information**

- Received quarterly updates on the CCG's performance in meeting statutory duties in responding to requests made under the Freedom of Information Act.

4.8 **Health, Safety, Fire and Security**

- Received regular Health and Safety reports to gain assurance that the CCG was coordinating work to meet its health and safety obligations to remain compliant with health and safety legislation, in particular the actions and work undertaken in response to the Covid-19 pandemic in supporting staff to work safely at home and CCG premises.

- Received assurance on progress made to fulfil mandatory requirements in relation to the safe use of CCG offices in readiness for a potential partial return to office use and considered the short and medium to long term approaches, including the feasibility of a return to office use and the timing of such a decision or return.
- Approved the CCG's Health & Safety Policy and Procedures.
- Received assurance that there were no Non-Clinical Adverse Incidents to report throughout 2020/21.

4.9 **Human Resources**

- Approved all Human Resources (HR) policies that were required in 2020/21.
- Received updates on the CCG's mandatory training.

4.10 **Procurement**

- Received regular reports on the CCG's compliance with the Procurement, Patient Choice and Competition Regulations 2013 and Public Contract Regulation 2015, in respect of Healthcare Contracts.
- Reviewed highlight reports on the status of procurement projects, including key issues and activities.

4.11 **Risk Management**

- Approved the CCG's Risk Management Strategy.
- Ensured good risk management was observed within the CCG and that robust controls were in place in accordance with the CCG's Risk Management Framework.
- Agreed and regularly reviewed the Covid-19 Risk Register, CCG Risk Register and Governing Body Assurance Framework for its area of remit, considering the adequacy of the submissions and whether new risks needed to be added to the Risk Register; or whether any risks required immediate escalation to the CCG's Governing Body.

4.12 **Recovery and Restoration**

At each meeting the Committee monitored the areas assigned to them within the Recovery and Restoration Programme. This included Staff Health and Wellbeing, Governance and Infrastructure, Estates, IT & Digital and Statutory Requirements.

5. CONCLUSION

This year (2020/21) has been a further challenging year for the Governance Committee. The Committee has been assured that, despite the CCG's incredible response to the pandemic, the governance agenda has been embedded into the work of the CCG. As detailed above the corporate governance agenda is wide and varied and committee members have contributed with knowledge and enthusiasm to the various discussions and debates over the range of subjects.

The Committee has, and continues to, diligently reviewed the corporate governance implications of the CCGs approach of the COVID-19 pandemic impact on the

organisation and supported it through its various stages of business continuity preparedness both in terms of escalation and de-escalation arrangements. The Committee has also been closely monitoring the CCG's ability to ensure "business as usual" continues through these challenging times. The Committee has also contributed to the wider governance debates linked to the work of the CCG and its relationship with the wider health and social care system as it transitions into the integrated care arena.

Finally I would like to thank my fellow committee members, subject experts and those who have been in attendance at the meetings of the Governance Committee throughout 2020/21 for their valuable and insightful contributions, challenges and comments.

Jill Dentith
Chair of Governance Committee & Lay Member for Governance
July 2021

APPENDIX 1

Governance Committee Attendance Record 2020/21

Governance Committee Member	9 July 2020	10 Sep 2020	12 Nov 2020	21 Jan 2021	11 Mar 2021
Jill Dentith *Chair, Lay Member for Governance and Freedom to Speak Up Guardian*	✓	✓	✓	✓	✓
Ian Gibbard *Lay Member for Audit and Conflicts of Interest Guardian*	✓	✓	✓	✓	✓
Martin Whittle *Lay Member for Patient and Public Involvement*	✓	✓	✓	X	✓
Dr Emma Pizzey *GP Member*	X	✓	✓	✓	✓
Dr Greg Strachan *GP Member*	✓	✓	✓	X	✓
Helen Dillistone *Executive Director of Corporate Strategy and Delivery*	X*	✓	X*	✓	✓

For those items with * above please note that a deputy was present to ensure quoracy.

NHS
Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

5th August 2021

Item No: 109

Report Title	Primary Care Commissioning Committee Annual Report 2020/21
Author(s)	Fran Palmer, Corporate Governance Manager Ian Shaw, Primary Care Commissioning Committee Chair
Sponsor (Director)	Dr Steven Lloyd, Executive Medical Director

Paper for:	**Decision**		**Assurance**	x	**Discussion**		**Information**	
Assurance Report Signed off by Chair				Not applicable				
Which committee has the subject matter been through?				Primary Care Commissioning Committee – 28th July 2021				

Recommendations

The Governing Body is requested to **NOTE** the Primary Care Commissioning Committee Annual Report for 2020/21 for assurance.

Report Summary

It is a requirement for Committees of the CCG to produce an Annual Report each financial year, as set out in the terms of reference. This report provides the Governing Body with a review of the work that the Primary Care Commissioning Committee has completed during the period 1 April 2020 to 31 March 2021.

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

Not applicable.

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

Not applicable.

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

Not applicable.

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

Not applicable.

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

Not applicable.

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Not applicable.
Have any Conflicts of Interest been identified / actions taken?
Not applicable.
Governing Body Assurance Framework
Not applicable.
Identification of Key Risks
Not applicable.

NHS
Derby and Derbyshire
Clinical Commissioning Group

Primary Care Commissioning Committee Annual Report 2020/21

PRIMARY CARE COMMISSIONING COMMITTEE

PUBLIC ANNUAL REPORT 2020/21

1. INTRODUCTION AND BACKGROUND

1.1 This report reviews the work of the Primary Care Commissioning Committee (PCCC) and covers the period from 1st April 2020 to 31st March 2021.

1.2 In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended); NHS England has delegated the exercise of the functions specified in Schedule 2 of the PCCC Terms of Reference to NHS Derby and Derbyshire CCG. The CCG established the PCCC to function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.

1.3 The report provides the Governing Body and Accountable Officer with evidence relevant to their responsibilities of the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the National Health Service Act 2006 (as amended). The Committee makes collective decisions on the review, planning and procurement of primary care services in the CCG, under delegated authority from NHS England. They also promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.

2. MEMBERSHIP AND QUORACY

2.1 In accordance with the terms of reference, the membership of the committee during 2020/21 was:

- 3 x Governing Body Lay Members
- Accountable Officer or nominated Deputy
- Chief Finance Officer or nominated Deputy
- Chief Nurse Officer or nominated Deputy
- Medical Director or nominated Deputy
- Turnaround Director or nominated Deputy

In November 2020, the membership of PCCC was reviewed, which resulted in the Accountable Officer (or nominated Deputy) and Turnaround Director (or nominated Deputy) being removed.

2.2 Representatives attended the Committee as regular attendees as follows:

- NHS England Primary Care Representative
- Local Medical Committee Representative
- Health and Wellbeing Board (County)
- Health and Wellbeing Board (City)
- Senior Healthwatch Representatives

2.3 The quorum necessary for the transaction of business was four voting members, at least two of whom were Lay Members (including the Chair or Deputy Chair).

2.4 Deputies were invited to attend in the place of the regular members as required.

2.5 The full membership attendance can be found at Appendix 1.

3. FREQUENCY OF MEETINGS

The PCCC meeting is held on a monthly basis. Due to the pandemic, the meeting was stood down from the 1st April 2020. Meetings reconvened on the 24th June 2020, and by the 31st March 2021 the committee had met a total of 10 times.

4. KEY AREAS OF REVIEW

Throughout 2020/21 the PCCC reviewed, monitored and had oversight of the commissioning, procurement and management of Primary Medical Services Contracts in relation to work in the following areas:

4.1 Primary Care Commissioning and Development

- GP Practice Premises
  - Reviewed and approved the closure of the branch surgery at Tuffnell Gardens, Mackworth
  - Received quarterly updates following the closure of the Pilsley Surgery
  - Approved Lease Value for Money reports
  - Approved practice rent reimbursements
  - Approved the Primary Care Estates Strategy Prioritisation Tool
  - Received Local Feasibility Studies for South West Derby, and Mickleover and Mackworth
  - Approved amendments to practice boundaries

- Primary Care Restoration and Recovery
  - Acknowledged the decisions and actions undertaken between March and June by the PCNs, GPA and LMC
  - Received regular updates on Covid-19 testing and the vaccination programme
  - Provision of GP Services Christmas 2020

- Primary Care Commissioning

  Approved the following:

  - Primary Care APMS New Contracts & Contract Extensions
  - Primary Care Enhanced Services Contract Extensions
  - Ageing Well and Care Homes – Programme Alignment
  - Primary Care Estates Strategy 2020–2025
  - GP Retention Scheme
  - Primary Medical Care Services Contract Oversight and Management Functions
  - Acute Home Visiting and Community Urgent Response
  - Memorandum of Understanding for General Medical Advice and Support Team Services

4.2 **Quality**

Ensured there was a focus on quality by receiving updates through the Primary Care Quality and Performance Assurance Reports.

4.3 **Finance and Savings**

Supported the CCG in formulating the Savings Plan for the next financial year by reviewing/approving monthly CCG Finance Reports.

4.4 **National Policy**

Ensured that there was an awareness of the following policies and procedures to comply with relevant regulatory, legal and code of conduct requirements:

- Primary Medical Care Policy Guidance Manual 2019
- PCN Estates Guidance Report
- GP Forward View Programme Report

4.5 **Organisational Development**

Received and noted the CCG's Restoration and Recovery work.

4.6 **Corporate Assurance**

- Received assurance reports and/or minutes from the following sub-committees:
    - Primary Care Quality & Performance Review Committee
    - Primary Care Estates Steering Group
    - Primary Care Digital Sub-Committee
    - Primary Care Leadership Group
    - Primary Care IT Group
    - Primary Care Workforce Steering Group
- Approved the following sub-committees' Terms of Reference:
    - Primary Care Quality and Performance Review Sub-Committee
    - Primary Care Workforce Steering Group
    - General Practice Digital Steering Group
- Reviewed and received a report by 360 Assurance on the commissioning and procurement of primary medical care services, which provided a 'substantial assurance' rating.

4.7 **Risk Management**

Agreed and regularly reviewed the Risk Register, considering the adequacy of the submissions and whether new risks needed to be added to the Risk Register; or whether any risks required immediate escalation to the CCG's Governing Body.

5. CONCLUSION

This has been an extremely challenging period for primary care in both delivering on the Governments Covid-19 vaccination programme as well as on wider primary care health services. The activities outlined above illustrate the ways in which the Committee has supported the primary care and its role in developing a broader primary care agenda.

The Committee has its core aims of improving health of the community and reducing health inequalities, in enabling the improvement of primary care within available budget, in supporting services in ensuring that the development of primary care aligns with the strategic priorities of the CCG and the legislation from NHS England. I submit that this report shows the scope of the work of the committee, that it is effective and has patient benefit at the heart of its decision making.

Professor Ian Shaw
Chair of Primary Care Commissioning Committee & Lay Member for Primary Care Commissioning
July 2021

APPENDIX 1

Primary Care Commissioning Committee Attendance Record 2020/21

Primary Care Commissioning Committee Member	24 June 2020	22 July 2020	26 Aug 2020	23 Sep 2020	28 Oct 2020	25 Nov 2020	16 Dec 2020	27 Jan 2021	24 Feb 2021	24 Mar 2021
Professor Ian Shaw *Chair, Lay Member for Primary Care Commissioning*	X	✓	✓	✓	✓	✓	✓	✓	✓	X
Simon McCandlish *Deputy Chair, Lay Member for Patient and Public Involvement*	✓	✓	✓	X	✓	✓	✓	✓	✓	✓
Jill Dentith *Lay Member for Governance and Freedom to Speak Up Guardian*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Chris Clayton° *Chief Executive Officer*	X*	X	X*	X*	X*	X*				
Brigid Stacey *Chief Nurse Officer*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*
Richard Chapman *Chief Finance Officer*	✓	✓	X*	X*	X	X*	X*	X*	X*	X*
Dr Steven Lloyd *Executive Medical Director*	✓	X*	✓	✓	✓	✓	X*	✓	✓	X*
Sandy Hogg *Executive Turnaround Director*	X	X								

° Primary Care Commissioning Committee membership was amended in November 2020.
* Indicates where a member was deputised.

Derby and Derbyshire Clinical Commissioning Group

Governing Body Meeting in Public

5th August 2021

Item No: 110

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

Paper for:	**Decision**		**Assurance**	x	**Discussion**		**Information**	
Assurance Report Signed off by Chair				Not applicable				
Which committee has the subject matter been through?				Quality and Performance Committee – 29.07.2021				

Recommendations

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

Report Summary

Performance:

Urgent and Emergency Care:

- The A&E standard was not met at a Derbyshire level at 81.5% (YTD 82.7%). CRHFT exceeded the 95% target for the 4th consecutive month in June 2021, achieving 95.1% (YTD 96.0%) and UHDBFT achieved 73.3% (YTD 75.2%), which is a deterioration.
- UHDBFT had 4x 12hour breaches due to the unavailability of suitable mental health beds.
- EMAS were compliant in 1 of the 6 national standards for Derbyshire during June 2021.

Planned Care:

- 8 Week Referral to Treatment (RTT) for incomplete pathways continues to be non-compliant at a CCG level at 69.1% (YTD 67.2%). CRHFT performance was 69.1% (YTD 67.2%) and UHDB 61.5% (YTD 58.8%).
- Derbyshire had 6,859 breaches of the 52-week standard across all trusts - there were 7,490 the previous month so these have decreased by 8.4%.
- Diagnostics – The CCG performance was 25.0%, a deterioration from the previous month. Neither CRHFT nor UHDBFT have achieved the standard.

Cancer:

- During May 2021, Derbyshire was compliant in 2 of the 8 Cancer standards:
- 31-day Subsequent Drugs – 99.4% (98% standard) – Compliant all Trusts except
- Sherwood Forest.

- 1-day Subsequent Radiotherapy – 96.5% (94% standard) – Compliant for Derby &
- Burton and Sheffield, but not for Nottingham.
- During May 2021, Derbyshire was non-compliant in 6 of the 8 Cancer standards:
- 2-week Urgent GP Referral – 87.8% (93% standard) – Compliant for Sherwood Forest and Stockport.
- 2 week Exhibited Breast Symptoms – 57.1% (93% standard) - Compliant for Sherwood Forest and Stockport.
- 31 day from Diagnosis – 94.5% (96% standard) – Compliant for Chesterfield and
- Sherwood Forest.
- 31-day Subsequent Surgery – 93.1% (94% standard) - Compliant for Chesterfield,
- Derby& Burton and Stockport.
- 62-day Urgent GP Referral – 65.9% (85% standard) – Noncompliant for all trusts.
- 62-day Screening Referral – 64.5% (90% standard) – Compliant for Sherwood Forest and Stockport.

Update from Committee 29th July 2021

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

Cancer Deep Dive
Assurance provided despite some of the demands, comprehensive presentations detailing particular concerns and some positive constructive responses from GPs. Increased focus on how the communications message might increase to focus on the reluctance of patients to present, which leads to significant undiagnosed cases.

Integrated Quality and Performance Report
Comprehensive and detailed integrated quality and performance report, with good verbal updates from leads, good relationships are apparent to ensure challenges are met and supported. Assurance in relation to wave 3 received in relation to the capacity planning and modelling presented.

CQC Collaborative Provider Inspection of LD and Autism
The Committee received the CQC report and were assured regarding the number of areas of good practice highlighted by the CQC. Each of the 4 KLOEs highlighted areas for focus, which have been accepted by the Mental Health and LD Delivery Board, who will monitor progress against the action plan. Q&P Committee will also oversee progress.

CHC
Assured that good progress is being made to manage the increase in fast track referrals. This is a regular item at the finance committee due to the potential impact on budget, and progress is encouraging.

Glossop It is reassuring to note that the Chief Nurse from DDCCG is in contact with her counterpart at Glossop CCG to discuss the recent changes as announced by the Secretary of State, and how this will impact on the Derbyshire System.
Are there any Resource Implications (including Financial, Staffing etc)?
No
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?
N/A
Has a Quality Impact Assessment (QIA) been completed? What were the findings?
N/A
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
N/A
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
N/A
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
N/A
Have any Conflicts of Interest been identified/ actions taken?
None
Governing Body Assurance Framework
The report covers all of the CCG objectives
Identification of Key Risks
The report covers GBAFs 1, 2 and 6.

NHS
Derby and Derbyshire
Clinical Commissioning Group

Month 02
Quality & Performance Report
2021/22

July 2021

Contents Page

EXECUTIVE SUMMARY

Key Messages	• The tables on slides 5-8 show the latest validated CCG data against the constitutional targets. A more detailed overview of performance against the specific targets and the associated actions to manage performance is included in the body of this report.
Urgent & Emergency Care	• The A&E standard was not met at a Derbyshire level at 81.5% (YTD 82.7%). CRH exceeded the 95% target for the 4th consecutive month in June 2021, achieving 95.1% (YTD 96.0%) and UHDB achieved 73.3% (YTD 75.2%), which is a deterioration. • UHDB had 4x 12hour breaches due to the unavailability of suitable mental health beds. • EMAS were compliant in 1 of the 6 national standards for Derbyshire during June 2021.
Planned Care	• 18 Week Referral to Treatment (RTT) for incomplete pathways continues to be non-compliant at a CCG level at 69.1% (YTD 67.2%). CRHFT performance was 69.1% (YTD 67.2%) and UHDB 61.5% (YTD 58.8%). • Derbyshire had 6,859 breaches of the 52 week standard across all trusts - there were 7,490 the previous month so these have decreased by 8.4%. • Diagnostics – The CCG performance was 25.0%, a deterioration from the previous month. Neither CRH or UHDB have achieved the standard.
Cancer	During May 2021, Derbyshire was compliant in 2 of the 8 Cancer standards: • **31 day Subsequent Drugs** – 99.4% (98% standard) – Compliant all Trusts except Sherwood Forest. • **31 day Subsequent Radiotherapy** – 96.5% (94% standard) – Compliant for Derby & Burton and Sheffield, but not for Nottingham. During May 2021, Derbyshire was non-compliant in 6 of the 8 Cancer standards: • **2 week Urgent GP Referral** – 87.8% (93% standard) – Compliant for Sherwood Forest and Stockport. • **2 week Exhibited Breast Symptoms** – 57.1% (93% standard) - Compliant for Sherwood Forest and Stockport. • **31 day from Diagnosis –** 94.5% (96% standard) – Compliant for Chesterfield and Sherwood Forest. • **31 day Subsequent Surgery** – 93.1% (94% standard) - Compliant for Chesterfield, Derby& Burton and Stockport. • **62 day Urgent GP Referral** – 65.9% (85% standard) – Non compliant for all trusts. • **62 day Screening Referral** – 64.5% (90% standard) – Compliant for Sherwood Forest and Stockport. Additional standards include: • **28 day Diagnosis or Decision To Treat** – 75.5% (75% standard) – Compliant for Derby & Burton, Chesterfield, Nottingham & Sherwood Forest. • **104 day wait** – 25 CCG patients waited over 104 days for treatment.

Executive Summary

Trust	
Chesterfield Royal Hospital FT	The latest SSNAP Report and HSMR for Stroke reflected sustained improvement in outcomes for the Stroke service and patients with Acute Cerebrovascular Disease. The Trust are continuing to develop KPIs for Stroke and the Board monitor progress through their Quality assurance Committee.
University Hospitals of Derby and Burton NHS FT	Focussed work is being undertaken in relation to the health and wellbeing of the staff and leadership within ED. Staff are reporting feeling undervalued. UHDB are engaging the support of external consultants to work on these areas with staff. In relation to significant waiting list backlog the Trust are considering plans going forward in terms of IPC guidance specifically mask wearing, and other IPC measures, and the impact of staff numbers on service delivery when self-isolating. In June there were 4 breaches at Derby ED; all due to mental health bed availability. For July there have been 6 breaches at Derby ED as of 14th July. 4 due to mental health bed availability and 2 due to MAU capacity.
Derbyshire Community Health Services FT	As at 26th May 2021, 93.9% staff have had 1st vaccine, 86.6% staff have had 2nd vaccine. This will continue to be monitored at CQRG. Sickness absence has increased from 4.2% in late April to 5.2% (0.6%, up 0.2% of this being COVID related), but remains better than end of March position and pre-pandemic rate. COVID sickness rates were 0.5% for the month of April, was 0.4% as at 30th April. Absence attributed to stress and anxiety and MSK being monitored closely at CQRG.
Derbyshire Healthcare Foundation Trust	An increase in seclusion use has been noted at May 2021. A review has identified that that this is linked to a changed inpatient demographic due to an increase of new unknown psychosis presentations. Full review takes place where seclusion incidents occur. The current waiting list for ASD assessments is 1179, with the longest waits being for people who require face to face appointments. Recent difficulties have been experienced with regards to some individuals at the top of the waiting list not being contactable.
East Midlands Ambulance Trust	As of 23 June 2021 nine Serious Incidents (SI) have been reported year to date. Three of the SIs related to cardiac arrest management, two related to clinical assessment or care management, two related to delayed response to patients, another case related to equipment malfunction and the final case was a safeguarding concern. Cardiac arrest management has been identified as a theme and a review of these incidents is underway to inform future training and the development of the Trust's Cardiac Arrest Strategy. The continued roll out of the Cardiac Arrest Leader role will assist in mitigate the risk of further incidents.

PERFORMANCE OVERVIEW MONTH 3 – URGENT CARE

NHS Derby & Derbyshire CCG Assurance Dashboard

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

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

Part A - National and Local Requirements

CCG Dashboard for NHS Constitution Indicators

					Direction of Travel	NHS Derby & Derbyshire CCG Current Month	NHS Derby & Derbyshire CCG YTD	NHS Derby & Derbyshire CCG consecutive months non-compliance	Chesterfield Royal Hospital FT Current Month	Chesterfield Royal Hospital FT YTD	Chesterfield Royal Hospital FT consecutive months non-compliance	University Hospitals of Derby & Burton FT Current Month	University Hospitals of Derby & Burton FT YTD	University Hospitals of Derby & Burton FT consecutive months non-compliance	NHS England Current Month	NHS England YTD	NHS England consecutive months non-compliance
Urgent Care	Area	Indicator Name	Standard	Latest Period													
	Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	Jun-21	↑	81.5%	82.7%	69	95.1%	96.0%	0	73.3%	75.2%	69	83.0%	84.8%	69
		A&E 12 Hour Trolley Waits	0	Jun-21					0	0	0	4	9	11	1289	2506	69

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

					Direction of Travel	East Midlands Ambulance Service Performance (NHSD&DCCG only - National Performance Measure) Current Month	East Midlands Ambulance Service Performance (NHSD&DCCG only - National Performance Measure) YTD	East Midlands Ambulance Service Performance (NHSD&DCCG only - National Performance Measure) consecutive months non-compliance	EMAS Performance (Whole Organisation) Current Month	EMAS Performance (Whole Organisation) YTD	EMAS Performance (Whole Organisation) consecutive months non-compliance	EMAS Completed Quarterly Performance 2020/21 Q1 2020/21	EMAS Completed Quarterly Performance 2020/21 Q2 2020/21	EMAS Completed Quarterly Performance 2020/21 Q3 2020/21	EMAS Completed Quarterly Performance 2020/21 Q4 2020/21	NHS England Current Month	NHS England YTD	NHS England consecutive months non-compliance
Urgent Care	Area	Indicator Name	Standard	Latest Period														
	Ambulance System Indicators	Ambulance - Category 1 - Average Response Time	00:07:00	Jun-21	↓	00:08:21	00:07:53	12	00:08:23	00:07:52	11	00:06:32	00:07:18	00:07:35	00:07:22	00:07:54	00:07:26	2
		Ambulance - Category 1 - 90th Percentile Respose Time	00:15:00	Jun-21	↓	00:14:07	00:13:23	0	00:14:50	00:13:59	0	00:11:28	00:12:57	00:13:30	00:12:58	00:14:01	00:13:13	0
		Ambulance - Category 2 - Average Response Time	00:18:00	Jun-21	↓	00:37:48	00:29:31	11	00:41:35	00:33:25	12	00:15:36	00:23:12	00:28:19	00:25:56	00:30:42	00:25:11	11
		Ambulance - Category 2 - 90th Percentile Respose Time	00:40:00	Jun-21	↓	01:16:20	00:58:57	11	01:25:59	01:08:46	11	00:30:19	00:47:36	00:58:38	00:53:12	01:03:29	00:51:19	3
		Ambulance - Category 3 - 90th Percentile Respose Time	02:00:00	Jun-21	↓	05:21:59	04:01:53	11	05:54:58	04:34:57	11	01:40:16	02:38:30	03:31:37	03:06:38	04:35:23	03:24:32	3
		Ambulance - Category 4 - 90th Percentile Respose Time	03:00:00	Jun-21	↓	05:32:49	04:27:57	3	06:11:21	04:49:52	3	01:40:16	03:27:52	03:33:06	02:59:42	05:42:57	05:01:41	3

PERFORMANCE OVERVIEW MONTH 3 – PLANNED CARE

NHS Derby & Derbyshire CCG Assurance Dashboard

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

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

Part A - National and Local Requirements

CCG Dashboard for NHS Constitution Indicators

	Area	Indicator Name	Standard	Latest Period	Direction of Travel	NHS Derby & Derbyshire CCG Current Month	NHS Derby & Derbyshire CCG YTD	NHS Derby & Derbyshire CCG consecutive months non-compliance	Chesterfield Royal Hospital FT Current Month	Chesterfield Royal Hospital FT YTD	Chesterfield Royal Hospital FT consecutive months non-compliance	University Hospitals of Derby & Burton FT Current Month	University Hospitals of Derby & Burton FT YTD	University Hospitals of Derby & Burton FT consecutive months non-compliance	NHS England Current Month	NHS England YTD	NHS England consecutive months non-compliance
Planned Care	Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	May-21	↑	66.2%	64.1%	40	69.1%	67.2%	25	61.5%	58.8%	41	67.4%	66.0%	63
		Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	May-21	↑	6859	14349	16	1179	2457	14	8605	17210	15	336733	722223	169
	Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	May-21	↑	25.01%	24.93%	36	7.74%	7.27%	14	27.92%	28.37%	15	22.30%	23.15%	93
	2 Week Cancer Waits	All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	May-21	↑	87.8%	84.7%	9	Cancer 2 Week Wait Pilot Site - not currently reporting			84.1%	81.7%	9	87.5%	86.5%	12
		Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	May-21	↑	57.1%	53.5%	7				54.2%	50.0%	6	67.9%	64.9%	12
	28 Day Faster Diagnosis	Diagnosis or Decision to Treat within 28 days of Urgent GP, Breast Symptom or Screening Referral	75%	May-21	↑	75.5%	74.8%	0	76.0%	75.8%	0	75.3%	75.5%	0	74.3%	73.6%	2
	31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	96%	May-21	↑	94.5%	93.4%	5	97.4%	96.9%	0	95.3%	94.3%	10	95.1%	94.7%	5
		Subsequent Surgery Within 31 Days Of Decision To Treat	94%	May-21	↑	93.1%	79.7%	18	100.0%	92.6%	0	94.2%	89.0%	0	88.5%	86.6%	34
		Subsequent Drug Treatment Within 31 Days Of Decision To Treat	98%	May-21	↑	99.4%	99.1%	0	100.0%	100.0%	0	99.3%	99.3%	0	100.9%	99.9%	0
		Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	May-21	↑	96.5%	96.0%	0				94.1%	93.7%	0	97.1%	96.7%	0
	62 Days Cancer Waits	First Treatment Administered Within 62 Days Of Urgent GP Referral	85%	May-21	↓	65.9%	69.2%	27	75.2%	76.4%	22	64.9%	68.9%	37	73.0%	74.2%	65
		First Treatment Administered - 104+ Day Waits	0	May-21	↑	25	48	62	5	11	37	14	32	62	796	1722	65
		First Treatment Administered Within 62 Days Of Screening Referral	90%	May-21	↓	64.5%	71.4%	25	69.2%	67.7%	25	72.0%	78.3%	6	74.5%	74.4%	38
		First Treatment Administered Within 62 Days Of Consultant Upgrade	N/A	May-21	↓	75.5%	81.3%		66.7%	66.7%		78.3%	88.4%		83.6%	83.4%	

PERFORMANCE OVERVIEW MONTH 3 – PATIENT SAFETY

NHS Derby & Derbyshire CCG Assurance Dashboard

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

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

Part A - National and Local Requirements

CCG Dashboard for NHS Constitution Indicators

	Area	Indicator Name	Standard	Latest Period	Direction of Travel	NHS Derby & Derbyshire CCG			Chesterfield Royal Hospital FT			University Hospitals of Derby & Burton FT			NHS England		
						Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance
Patient Safety	Incidence of healthcare associated Infection	Healthcare Acquired Infection (HCAI) Measure: MRSA Infections	0	May-21	↔	0	0	0	0	0	0	0	1	0	45	80	26
		Healthcare Acquired Infection (HCAI) Measure: C-Diff Infections	Plan	May-21	↓		40			6			20				
			Actual				34	0		2	0		8	0		2144	
		Healthcare Acquired Infection (HCAI) Measure: E-Coli	-	May-21	↔	77	154		22	38		57	114		77	154	
		Healthcare Acquired Infection (HCAI) Measure: MSSA	-	May-21	↑	28	58		5	13		19	39		1041	1995	

PERFORMANCE OVERVIEW MONTH 2 – MENTAL HEALTH

CCG Dashboard for NHS Constitution Indicators

	Area	Indicator Name	Standard	Latest Period	Direction of Travel	NHS Derby & Derbyshire CCG Current Month	NHS Derby & Derbyshire CCG YTD	NHS Derby & Derbyshire CCG consecutive months of failure	Derbyshire Healthcare FT Current Month	Derbyshire Healthcare FT YTD	Derbyshire Healthcare FT consecutive months of failure				NHS England Current Month	NHS England YTD	NHS England consecutive months of failure			
Mental Health	Early Intervention In Psychosis	Early Intervention In Psychosis - Admitted Patients Seen Within 2 Weeks Of Referral	60.0%	Apr-21	↑	88.9%	88.9%	0	77.8%	77.8%	0				71.5%	71.5%	0			
		Early Intervention In Psychosis - Patients on an Incomplete Pathway waiting less than 2 Weeks from Referral	60.0%	Apr-21	↓	50.0%	50.0%	1	100.0%	100.0%	0				30.4%	30.4%	24			
	Mental Health	Dementia Diagnosis Rate	67.0%	May-21	↑	65.1%	65.1%	11							61.8%	62.8%	14			
		CYPMH - Eating Disorder Waiting Time % urgent cases seen within 1 week		2020/21 Q4	↑	96.2%	74.6%													
		CYPMH - Eating Disorder Waiting Time % routine cases seen within 4 weeks		2020/21 Q4	↑	95.1%	83.9%													
		Perinatal - Increase access to community specialist perinatal MH services in secondary care	4.5%	2020/21 Q3	↓	3.4%	3.9%	4												
		Mental Health - Out Of Area Placements		Apr-21	↓	670	670													
		Physical Health Checks for Patients with Severe Mental Illness	25%	2020/21 Q4	↓	17.9%	29.6%	4												
	Area	**Indicator Name**	**Standard**	**Latest Period**		**NHS Derby & Derbyshire CCG**			**Talking Mental Health Derbyshire (D&DCCG only)**			**Trent PTS (D&DCCG only)**			**Insight Healthcare (D&DCCG only)**			**Vita Health (D&DCCG only)**		
	Improving Access to Psychological Therapies	IAPT - Number Entering Treatment As Proportion Of Estimated Need In The Population	Plan	May-21	↑	2.10%	4.20%													
			Actual			2.42%	4.83%	0												
		IAPT - Proportion Completing Treatment That Are Moving To Recovery	50%	May-21	↓	53.6%	53.8%	0	54.9%	54.0%	0	54.1%	54.4%	0	44.5%	47.8%	1	56.4%	56.5%	0
		IAPT Waiting Times - The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment	75%	May-21	↓	98.1%	98.5%	0	97.7%	97.5%	0	98.3%	99.0%	0	98.0%	97.8%	0	98.8%	98.9%	0
		IAPT Waiting Times - The proportion of people that wait 18 Weeks or less from referral to entering a course of IAPT treatment	95%	May-21	↔	100.0%	100.0%	0	100.0%	100.0%	0	100.0%	100.0%	0	100.0%	100.0%	0	100.0%	100.0%	0
	Area	**Indicator Name**	**Standard**	**Latest Period**		**Derbyshire Healthcare FT**														
	Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	May-21	↔	96.2%	96.2%	0												
		Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	May-21	↔	0	0	0												

Quality Overview

QUALITY OVERVIEW M2

Trust	Key Issues
Chesterfield Royal Hospital FT	**Stroke Update** The latest SSNAP Report and HSMR for Stroke reflected sustained improvement in outcomes for the Stroke service and patients with Acute Cerebrovascular Disease. The Trust are continuing to develop KPIs for Stroke and the Board monitor progress through their Quality assurance Committee. The Trust have noted that as occupancy returns to pre-COVID levels the flexible enhanced support staffing plan is impacted and the ward/service is not always supported as planned. Staffing is being reviewed with a view to making key posts substantive within the establishment. **Staff well-being** This remains a key area of focus for the Trust and links to restoration of services. Corporate staff are meeting with teams to reflect and discuss and identify where support can be provided. All avenues for recruitment are being explored working in conjunction with JUCD. **12 hour DTA breaches** Nil for CRH.
University Hospitals of Derby and Burton NHS FT	**ED Performance** A lot of work being undertaken around the departments, focusing on the health and wellbeing of the staff and leadership models. Staff are reporting feeling undervalued. UHDB are engaging the support of external consultants to work on these areas with staff. The Chief Nurse is planning on visiting with the CCG Deputy Chief Nurse and progress on this piece of work will be monitored through CQRG. **Waiting lists** UHDB acknowledge the significant challenges in relation to waiting list backlog. Currently considering the plans going forward in terms of pending Government policy changes, in relation to mask wearing, and other IPC measures, and the impact of staff numbers on service delivery when self-isolating. UHDB will be considering what this looks like and where the risks are. **12 hour DTA breaches** In June there were 4 breaches at Derby ED; all due to mental health bed availability. For July there have been 6 breaches at Derby ED as of 14th July. 4 due to mental health bed availability and 2 due to MAU capacity. We have continued to support the harm review process on each occasion. For one incident we have asked the Trust to provide more information in relation to 121 monitoring and ligature risk management as one patient waiting for a mental health bed was found attempting to put a ligature around her neck in the department.

QUALITY OVERVIEW M2 continued

Trust	Key Issues
Derbyshire Community Health Services FT	**COVID-19 Vaccinations:** As at 26th May 2021, 93.9% staff have had 1st vaccine, 86.6% staff have had 2nd vaccine. This will continue to be monitored at CQRG. **RIDDOR**· There were a total of 4 reported injuries against a year to date target of 1. A workgroup was established May 2021 Work continues on slips trips and falls. This will be monitored at CQRG. **Sickness absence** has increased from 4.2% in late April to 5.2% (0.6%, up 0.2% of this being COVID related), but remains better than end of March position and pre-pandemic rate. COVID sickness rates were 0.5% for the month of April, was 0.4% as at 30th April. Absence attributed to stress and anxiety and MSK being monitored closely at CQRG. **Derby Vaccination Programme:** The programme will extend into 2022 as there will be a booster programme and a plan for those aged 12 – 18 years. It is a huge challenge to respond to this as staffing is reducing due to the furlough scheme coming to an end and staff returning to their pre-pandemic positions. This will be monitored at CQRG.
Derbyshire Healthcare Foundation Trust	**COVID-19:** The provider reports no current outbreaks or concerns. This is reviewed monthly with the provider and monitored at the CQRG. **Use of Seclusion:** An increase in seclusion use has been noted at May 2021. A review has identified that that this is linked to a changed inpatient demographic due to an increase of new unknown psychosis presentations. Full review takes place where seclusion incidents occur. This will be discussed further in the CQRG. **Waiting list for ASD assessments:** The current waiting list is 1179. There continues to be a significant waiting with the longest waits being for people who require face to face appointments. Recent difficulties have been experienced with regards to some individuals at the top of the waiting list not being contactable. This will be discussed in the CQRG.
East Midlands Ambulance Trust	**Performance:** EMAS achieved C1 90th centile during May 2021, this is consistent with April's performance when this standard was also achieved. Derbyshire matched the regional position during May 2021 achieving C1 90th centile. For Derbyshire, this is the same performance as seen in April 2021. This will be monitored at CQRG. **Serious Incidents: As** at 23 June 2021 nine Serious Incidents (SI) have been reported in the financial year to date. Three of the SIs related to cardiac arrest management, two related to clinical assessment or care management, two related to delayed response to patients, another case related to equipment malfunction and the final case was a safeguarding concern. Cardiac arrest management has been identified as a theme and a review of these incidents is underway to inform future training and the development of the Trust's Cardiac Arrest Strategy. The continued roll out of the Cardiac Arrest Leader role will assist in mitigate the risk of further incidents. **Covid-19 Outbreaks**: As at 24 June 2021 the Trust had one active Covid-19 Outbreak involving two positive cases.

QUALITY OVERVIEW M2

Derbyshire Wide Integrated Report

Part B: Provider Local Quality Indicators

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

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

Section	Area	Indicator Name	Standard	Chesterfield Royal Hospital FT				University Hospitals of Derby & Burton FT				Derbyshire Community Health Services				Derbyshire Healthcare FT			
				Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD
Ratings	CQC Ratings	Inspection Date	N/A	Aug-19				Mar-19				May-19				May-18			
		Outcome	N/A	Good				Good				Outstanding				Requires Improvement			
Adult	FFT	Staff 'Response' rates	15%	2019/20 Q2	↑	7.6%	8.6%	2019/20 Q2	↑	10.1%	10.1%	2019/20 Q2	↑	2.7%	21.7%	2019/20 Q2	↑	3.2%	18.1%
		Staff results - % of staff who would recommend the organisation to friends and family as a place to work		2019/20 Q2	↑	56.0%	64.1%	2019/20 Q2	↑	70.2%	70.2%	2019/20 Q2	↑	50.4%	70.5%	2019/20 Q2	↑	57.3%	66.7%
		Inpatient results - % of patients who would recommend the organisation to friends and family as a place to receive care	90%	Feb-20	↑	96.6%	97.7%	Feb-20	↓	97.1%	96.4%	Jul-20	↔	100.0%	98.6%				
		A&E results - % of patients who would recommend the organisation to friends and family as a place to receive care	90%	Feb-20	↓	83.5%	77.8%	Feb-20	↓	85.6%	80.3%	Jul-20	↓	N/A	99.3%				
	Complaints	Number of formal complaints received	N/A	May-21	↓	19	32	May-21	↑	23	75	Apr-21	↓	5	5	May-21	↓	22	40
		% of formal complaints responded to within agreed timescale	N/A	May-21	↑	89.0%	83.0%	May-21	↓		69.2%	Apr-21	↑	100.0%	100.0%	May-21	↑	100.0%	96.88%
		Number of complaints partially or fully upheld by ombudsman	N/A	May-21	↔	0	0	19-20 Q2	↔	1	2	Apr-21	↔	0	0	May-21	↔	0	0
	Pressure Ulcers	Category 2 - Number of pressure ulcers developed or deteriorated	N/A	May-21	↓	2	3	May-21	↑	19	55	Apr-21	↑	88	88	May-21	↑	0	1
		Category 3 - Number of pressure ulcers developed or deteriorated	N/A	May-21	↑	1	3	May-21	↑	5	19	Apr-21	↑	38	38	May-21	↔	0	0
		Category 4 - Number of pressure ulcers developed or deteriorated	N/A	May-21	↔	0	0	May-21	↔	0	0	Apr-21	↑	5	5	May-21	↔	0	0
		Deep Tissue Injuries(DTI) - numbers developed or deteriorated		May-21	↑	2	5	Sep-19	↑	16	94	Apr-21	↓	74	74	May-21	↔	0	0
		Medical Device pressure ulcers - numbers developed or deteriorated						Sep-19	↓	4	20	Apr-21	↓	12	12	May-21	↔	0	0
		Number of pressure ulcers which meet SI criteria	N/A	Sep-20	↑	0	3	Sep-19	↔	0	4	Apr-21	↑	1	1	May-21	↔	0	0
	Falls	Number of falls	N/A	May-21	↓	98	177	Data Not Provided in Required Format				Apr-21	↑	18	18	May-21	↑	21	47
		Number of falls resulting in SI criteria	N/A	Sep-20	↑	0	8	Sep-19	↑	0	19	Apr-21	↑	0	0	May-21	↔	0	0
	Medication	Total number of medication incidents	?	May-21	↓	82	149	Data Not Provided in Required Format				Apr-21	↔	0	0	May-21	↑	58	150
	Serious Incidents	Never Events	0	May-21	↔	0	0	May-21	↓	2	2	May-19	↔	0	0	May-21	↔	0	0
		Number of SI's reported	0	Sep-20	↑	4	26	Sep-19	↑	7	115	Dec-20	↔	1	34	May-21	↓	4	5
		Number of SI reports overdue	0	Apr-21	↔	0	0	May-19	↓	19	28	May-19	↔	0	0				
		Number of duty of candour breaches which meet threshold for regulation 20	0	Sep-20	↑	0	3	May-19	↔	0	0	Dec-20	↔	0	0				

QUALITY OVERVIEW M2

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

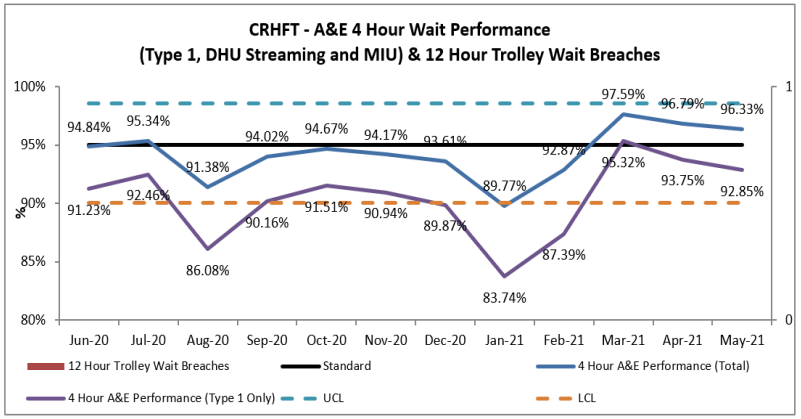
Section	Area	Indicator Name	Standard	Chesterfield Royal Hospital NHS Foundation Trust				University Hospitals of Derby & Burton FT				Derbyshire Community Health Services				Derbyshire Healthcare FT			
				Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD
Adult	VTE	Number of avoidable cases of hospital acquired VTE		Mar-20	↓	0	15	Feb-21	↔	0	TBC					May-21	↔	0	0
		% Risk Assessments of all inpatients	90%	2019/20 Q3	↓	96.9%	97.4%	2019/20 Q3	↓	95.9%	96.1%	2019/20 Q3	↓	99.5%	99.7%				
	Mortality	Hospital Standardised Mortality Ratio (HSMR)	Not Higher Than Expected	May-21	↓	109		Nov-20	↔	107.4									
		Summary Hospital-level Mortality Indicator (SHMI): Ratio of Observed vs. Expected		Feb-21	↓	0.953		Feb-21	↓	0.906									
		Crude Mortality		May-21	↓	1.45%	1.38%	May-21	↑	0.90%	1.10%								
Maternity	FFT	Antenatal serivce: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Feb-20	↑	95.5%	98.5%	Feb-20	↓	97.6%	95.1%								
		Labour ward/birthing unit/homebirth: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Feb-20	↑	97.8%	98.9%	Feb-20	↓	100.0%	98.1%								
		Postnatal Ward: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Feb-20	↓	100.0%	98.4%	Feb-20	↓	99.2%	98.0%								
		Postnatal community service: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Feb-20	↔	N/A	98.8%	Feb-20	↔	100.0%	97.8%								
Mental Health	Dementia	Dementia Care - % of patients ≥ 75 years old admitted where case finding is applied	90%	Feb-20	↑	100.0%	98.9%	Feb-20	↑	92.1%	90.9%								
		Dementia Care - % of patients identified who are appropriately assessed	90%	Feb-20	↔	100.0%	100.0%	Feb-20	↑	89.4%	85.4%								
		Dementia Care - Appropriate onward Referrals	95%	Feb-20	↔	100.0%	100.0%	Feb-20	↔	100.0%	99.3%								
	Inpatient Admissions	Under 18 Admissions to Adult Inpatient Facilities	0													May-21	↔	0	0
Workforce	Staff	Staff turnover (%)		May-21	↓	8.7%	8.3%	May-21	↓	10.2%	9.6%	Apr-21	↑	8.7%	8.7%	May-21	↓	10.55%	10.49%
		Staff sickness - % WTE lost through staff sickness		May-21	↓	4.4%	4.2%	May-21	↓	5.6%	5.2%	Apr-21	↔	4.1%	4.1%	May-21	↓	5.63%	5.53%
		Vacancy rate by Trust (%)		Sep-17	↓	1.9%	1.3%	Data Not Provided in Required Format				Apr-21	↓	9.4%	9.4%	May-21	↑	13.7%	14.0%
		Agency usage	Target													May-21	↑		
			Actual															2.47%	2.71%
		Agency nursing spend vs plan (000's)		May-21	↑	£157	£394	Oct-18	↑	£723	£4,355	Apr-21	↑	£124	£124				
		Agency spend locum medical vs plan (000's)		May-21	↑	£734	£1,488												
	Training	% of Completed Appraisals	90%	May-21	↑	43.7%	34.9%	May-21	↑		85.9%	Apr-21	↑	88.5%	88.5%	May-21	↓	76.7%	77.4%
		Mandatory Training - % attendance at mandatory training	90%	May-21	↓	84.8%	85.0%	May-21	↑		87.9%	Apr-21	↑	96.4%	96.4%	May-21	↓	81.8%	82.8%
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 June 2021 the trust met the 95% standard, achieving 95.1% and the Type 1 element achieving 90.1%. This is a slight decline but still above target.
There were no 12 hour breaches during June.



What are the next steps?

- Broadening the Same Day Emergency Care (SDEC) pathway offer, especially for surgical and Gynaecological conditions.
- Continue to implement actions recommended by the Missed Opportunities Audit. These could include other pathway alterations, increased access to diagnostics and alternative streaming options.
- Increased public communications regarding 111First and Urgent Treatment Centres as alternatives to automatic A&E attendances.
- Working with EMAS to improve virtual communications with crews to ensure that patients are directed to the appropriate treatment area and bypassing ED if possible.

What are the issues?

- At the start of the pandemic the volume of Type 1 attendances were much lower but are now approaching pre-pandemic levels, with an average of 198 attendances per day. However, June 2021 volumes were still around 93% of the June 2019 levels.
- Decreased bed capacity due to the high number of children attending the hospital with suspected RSV.
- Increased conveyances by ambulance requiring immediate attention.
- Same Day Emergency Care (SDEC) pathways not working to full effect.

The trust are still taking precautions against COVID-19 and still have these preventative measures in place:

- Streaming of patients at the physical front door to ensure that patients with COVID19 symptoms are treated in the most appropriate setting.
- Additional time required between seeing patients to turnaround the physical space ensuring increased strict infection control.

What actions have been taken?

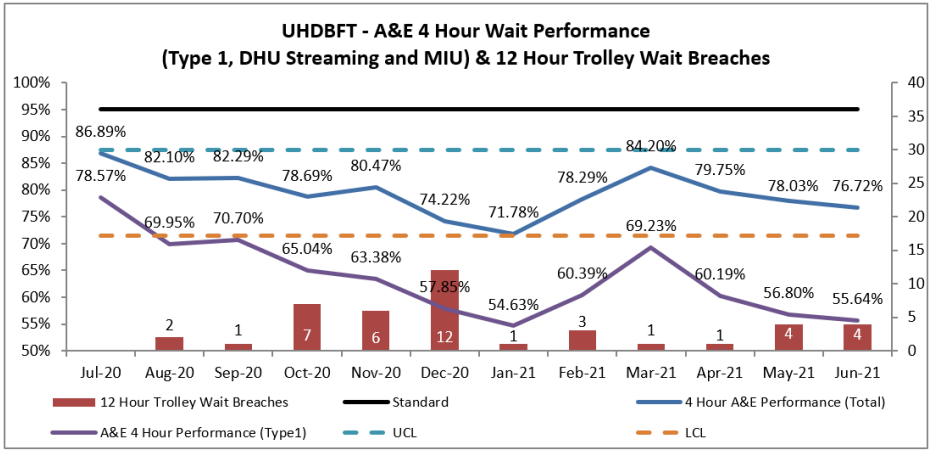
- Streamlining of front door and booking-in processes to support more timely clinical review.
- AN NHSI critical friend visit was undertaken during June 2021, with a focus on urgent & emergency care. The Trust are awaiting written feedback.
- RSV Surge accommodation plans have been made to include increased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

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

Performance Analysis

During June 2021, performance overall did not meet the 95% standard, achieving 76.7% (Network figure) and 55.6% for Type 1 attendances. This is following a continued decline.

There were 4x 12 hour breaches during June 2021 due to the availability of suitable Mental Health beds.



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

What are the next steps?

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

What are the issues?

- The volume of Type 1 attendances is high, with an average of 360 attendances per day. As a Network the numbers of attendances now exceed pre-pandemic levels by 3% (June 2021 compared to June 2019).
- The acuity of the attendances was high, with an average of 17 Resuscitation patients and 207 Major patients per day.
- Attendances at Children's ED have rapidly increased, with concerns about RSV being a major factor. Children's Type 1 attendances have averaged at 136 per day during June 2021 (compared to 92 per day in June 2019) with as many as 172 attending on one particular day (10th June).
- Staff absence due to sickness is high, with around a third of sickness being due to Covid related sickness or isolation.
- ED and Assessment areas are still separated in red/green areas according to Covid19 symptoms to ensure infection control. This limits physical space and therefore flexibility of patient flow. In addition, delayed Covid19 results have led to delays in transfers to the appropriate red/green assessment areas.

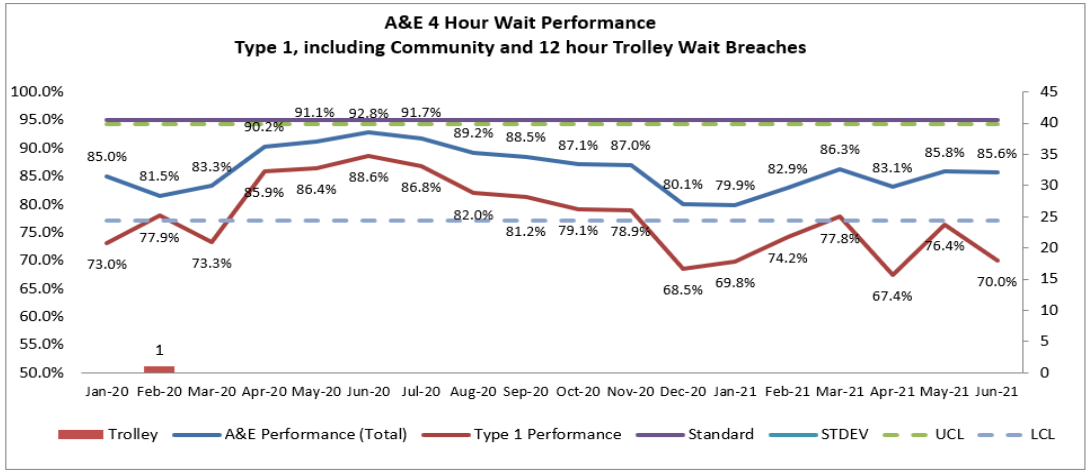
What actions have been taken?

- The opening of a co-located Urgent Treatment Centre (UTC), in collaboration with DHU. This is now open 24/7 (previously closed between 2am-7am) to provide support throughout the night. As an enhanced form of streaming this has been significant in reducing the number of patients attending the ED department unnecessarily. During June 2021 they saw an average of 132 patients per day.
- The UTC has established direct access for requesting diagnostic pathology testing which can be done through Lorenzo.
- The Same Day Emergency Care pathways are now in place, to stream patients directly into inpatient or assessment areas where appropriate.
- Development of the Discharge Assessment Unit, with more morning discharges meaning that beds are released for patients attending through the day.
- A major capital programme expanded physical ED capacity into an adjoining area to provide more physical capacity and to improve patient flow while ensuring infection control.

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

Performance Analysis

During June 2021, performance overall did not meet the 95% standard, achieving 70.0% for the Burton A&E and 85.6% including community hospitals. Performance has been fluctuating since winter.
There were no 12 hour breaches during June 2021.



What were the issues?

- The trust had been experiencing a decrease in attendances but now the attendances exceed the previous year by 38%, with an average of 184 Type 1 attendances per day.
- The acuity of the attendances is high, with an average of 118 Resuscitation/Major patients per day (64% of total attendances).

What actions have been taken?

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

What are the next steps?

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

DHU111 Performance Month 2 (May 2021)

Performance Summary

- DHU achieved all six contractual Key Performance Indicators (KPIs) in May 2021.
- Activity has been below plan throughout the contract year (Year 5, October 2020 to date). This is due to a combination of factors; Think 111 First activity not materialising as anticipated, and a significant reduction in the usual winter illnesses as a result of social distancing measures in particular flu and respiratory. This is not unique to DHU and has been experienced across the County, with all 111 providers citing that activity was down c.30% over the winter period.

Activity Summary

- Calls offered are 18.9% below plan year to date (October 2020 – May 2021). This is outside of the +/- 5% threshold, and it is therefore the contractual agreement is that the end of Q3. The credit due to commissioners based on October 2020 – May 2021 data is £1,347,616*.
- Clinical Calls are also below plan for the year to date to May by 9.3%. This again is outside of the +/- 5% threshold, which means a credit to commissioners is likely at the end of Q3. The credit due to commissioners based on October 2020 – May 2021 data is £214,869*.
- There were 14,316 Category 3 Ambulance Validations in May, with an associated cost of £258,117. This is an increase on April, when there were 12,574 validations with a cost of £226,709.
- The regional cost of COVID-19 activity for May was £72,402, taking the cumulative cost since October 2020 to £640,439. COVID-19 calls have increased from 3,062 in April to 7,486 calls in May, due to the increase in cases being seen and the rise of the Delta variant.

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

Regional Performance Year Five - Key Performance Indicators (KPI's)											
			Quarter One (October – December)			Quarter Two (January – March)			Quarter Three (April - June)		
KPI's		Standard	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21
Contract	Abandonment rate (%)	≤5%	0.50%	0.10%	0.20%	0.20%	0.20%	1.00%	1.00%	0.7%	
Contract	Average speed of answer (seconds)	≤27s	00:00:09	00:00:06	00:00:06	00:00:10	00:00:09	00:00:18	00:00:15	00:00:13	
Contract	Call Transfer to a Clinician	≥50%	66.00%	66.70%	69.60%	71.60%	70.40%	68.70%	66.5%	68.0%	
Contract	Self Care	≥17%	26.20%	23.60%	20.90%	20.60%	20.10%	20.40%	17.3%	17.1%	
Contract	Patient Experience	≥85%	88.00%	This data is updated on a six monthly basis					88.00%	This data is updated on a six monthly basis	
Contract	C3 Validation	≥50%	98.00%	98.90%	92.00%	98.90%	98.8%	98.4%	95.9%	98.7%	

DHU111 Performance Month 2 (May 2021)

What are the issues?

- Whilst activity during May remained below plan for calls offered (-7.8%) and clinical calls (-4.3%), this is a significant increase compared to April 2021 and this increase is expected to continue.
- DHU111 reported that they have continued to see an increase in the number of clinical validations that they are required to undertake.

What actions have been taken?

- DHU111 are working with the coordinating commissioning team and EMAS to conduct a deep dive into 111/999 pass through activity to understand pressures within the system and to look at what actions can be implemented to reduce when safe and appropriate.
- There have been no recent outbreaks of COVID-19 within DHU111 call centres and therefore the formal weekly COVID-19 Business Continuity Management Team (BCMT) meetings have been stood down.

What are the next steps?

- The DHU BCMT will continue to review cases of COVID-19 within the organisation throughout June whilst progressing through the government roadmap to 19th July 2021, with the option to reintroduce the formal weekly meetings if required.
- Discussions in relation to Year 6 contract negotiations are due to commence next month.

Activity		Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar -21	Apr -21	May -21	Year to date (Contract Year Oct 2020-Sep 2021)
Calls Offered	Actual	148,098	146,417	146,590	135,746	119,595	145,732	162,043	171,605	1,175,826
	Plan	152,299	153,848	203,460	199,210	177,571	188,612	188,704	186,048	1,449,752
	Variance	-2.8%	-4.8%	-28.0%	-31.9%	-32.6%	-22.7%	-14.1%	-7.8%	-18.9%
Clinical Calls	Actual	30,215	30,687	32,894	31,929	27,493	32,072	29,965	34,287	249,542
	Plan	29,898	30,333	39,528	36,350	31,639	35,140	36,518	35,809	275,217
	Variance	1.1%	1.2%	-16.8%	-12.2%	-13.1%	-8.7%	-18.0%	-4.3%	-9.3%

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

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

AMBULANCE – EMAS PERFORMANCE M2 (May 2021)

What are the issues?

- The contractual standard is for the division to achieve national performance on a quarterly basis. In Quarter one to date, Derbyshire are achieving one of the six national standards, C1 90th Centile. C1 mean was not achieved by 41 seconds, C2 mean was not achieved by 5 minutes and 33 seconds, C2 90th Centile was not achieved by 10 minutes and 53 seconds, C3 90th Centile was not being achieved by 1 hour, 14 minutes and 44 seconds and C4 90th Centile was not achieved by 1 hour, 5 minutes and 16 seconds.

- Average Pre hospital handover times during May 2021 remained above the 15 minute national standard across Derbyshire (20 minutes and 46 seconds) which was a slight deterioration compared to April 2021 (19 minutes and 17 seconds).

- Average Post handover times during May 2021 remained above the 15 minute national standard across Derbyshire with the exception of Stepping Hill (14 minutes and 33 seconds). Overall the post handover time in May 2021 (18 minutes and 14 seconds) was comparable to April 2021 (18 minutes and 54 seconds).

- Incidents in May 2021 saw an increase when compared to April 2021 (14,588 compared to 13,550). H&T and S&C as a percentage of incidents saw an increase, where S&T as a percentage of incidents saw a slight decrease. Duplicate calls in May 2021 were 20.2%, this is above the contractual threshold of 17.9% and a significant increase when compared to April 2021 (16.6%).

- S&C to ED specifically saw a slight decrease in May 2021, with S&C incidents to ED being 55.5% compared to 56.2% in April 2021. Combined with the statistic above (total S&C as a % has seen an increase) this shows a positive position as alternatives to ED are being utilised. S&C to ED in Derbyshire remains “middle of the pack” compared to other ICS within the East Midlands footprint, with the lowest ICS area being Leicestershire at 45% and the highest area being North and North East Lincolnshire at 65%.

Performance	Category 1		Category 2		Category 3	Category 4
	Average	90th centile	Average	90th centile	90th centile	90th centile
National standard	**00:07:00**	**00:15:00**	**00:18:00**	**00:40:00**	**02:00:00**	**03:00:00**
EMAS Actual – May	00:07:46	00:13:49	00:32:27	01:06:36	04:34:33	04:05:45
Derbyshire Actual - May	00:07:55	00:13:35	00:28:12	00:55:32	03:56:59	04:05:02
Derbyshire Actual - Quarter One to Date	00:07:41	00:13:06	00:25:33	00:50:53	03:14:44	04:05:16

May 2021	Pre Handovers		Post Handovers		Total Turnaround	
	Average Pre Handover Time	Lost Hours	Average Post Handover Time	Lost hours	Average Total Turnaround	Lost hours
Burton Queens	00:23:43	73:00:49	00:18:15	43:20:57	00:41:58	102:10:03
Chesterfield Royal	00:21:05	312:24:50	00:17:26	228:36:10	00:38:31	439:15:01
Macclesfield District General Hospital	00:24:38	9:16:56	00:15:10	3:19:43	00:39:47	10:30:16
Royal Derby	00:20:25	502:04:12	00:19:02	506:24:52	00:39:26	865:27:33
Sheffield Northern General Hospital	00:29:18	34:17:05	00:17:03	12:41:43	00:46:21	39:46:12
Stepping Hill	00:16:11	24:35:43	00:14:33	20:28:59	00:30:44	32:24:05
Derbyshire TOTAL	00:20:46	955:39:35	00:18:14	814:52:24	00:38:59	1489:33:10

AMBULANCE – EMAS PERFORMANCE M2 (May 2021)

What actions have been taken?

- Work continues nationally to ensure the most commonly referred into pathways by Ambulance services are profiled on the DoS so that ambulance crews can access available alternatives consistently across the Country.
- Missed Opportunity Audits have now taken place in every Trust across the Midlands, with the findings presented at the May EMAS Strategic Delivery Board. The presentation covered a wide range of points, but ultimately it determined that the majority of patients conveyed to ED (95%) were appropriate based on the alternatives available to them at that time. Conveyances could still be reduced if alternatives were available, and this is covered further in the recommendations from the audits.
- Work continues locally between EMAS, Commissioners and the Acute Trusts to look at how pre hospital handover delays can be reduced.
- Work continues with Trusts to roll out more Same Day Emergency Care (SDEC) pathways for EMAS to directly refer into.

What are the next steps

- EMAS have expressed concerns with increasing levels of activity being passed through from 111 to the 999 service. A joint deep dive between the coordinating commissioner, EMAS and DHU111 is underway to explore demand into 111, the percentage of calls that are passed through to 999, and then what happens to that activity within EMAS, all by acuity. This will also look at what actions are currently in place and what further actions could be taken. This will be presented at the Strategic Delivery Board meeting in July for discussion.
- Two dedicated senior transformation leads (one for the East Midlands, one for the West Midlands) have been jointly appointed by NHSEI and CCGs to support the work in relation to; pre-hospital pathways, reducing crowding and unwarranted variation within UEC, reduce variability of pathway options for the ambulance service and 111 clinicians. The East Midlands person commences on 21st June 2021.
- There is an option to implement a CAD upgrade which will result in the 'clear' clock being automatically enabled at 15 minutes unless overwritten. It is expected that this will reduce post handover delays, but may increase other internal efficiencies metrics such as Vehicle Off Road . This initiative has been paused whilst further work on the CAD is undertaken to support this process.

Derbyshire	Quarter Four 2020/2021	April	May	Quarter One to Date
Calls (Total)	53,290	17,643	20,461	38,104
Total Incidents	40,622	13,550	14,588	28,138
Total Responses	36,905	12,321	13,189	25,510
Duplicate Calls	9,018	2,936	4,129	7,065
Hear & Treat (Total)	7,367	2,386	3,143	5,529
See & Treat	13,306	4,134	4,433	8,567
See & Convey	23,599	8,187	8,756	16,943
Duplicates as % Calls	*16.9%*	16.6%	20.2%	18.5%
H&T ASI as % Incidents	9.2%	9.4%	*9.6%*	9.3%
S&T as % Incidents	*32.8%*	*31.9%*	*30.4%*	*30.4%*
S&C as % Incidents	*58.1%*	*58.7%*	*60.0%*	*60.2%*
S&C to ED as % of incidents	53.9%	56.2%	55.5%	55.8%

Planned Care

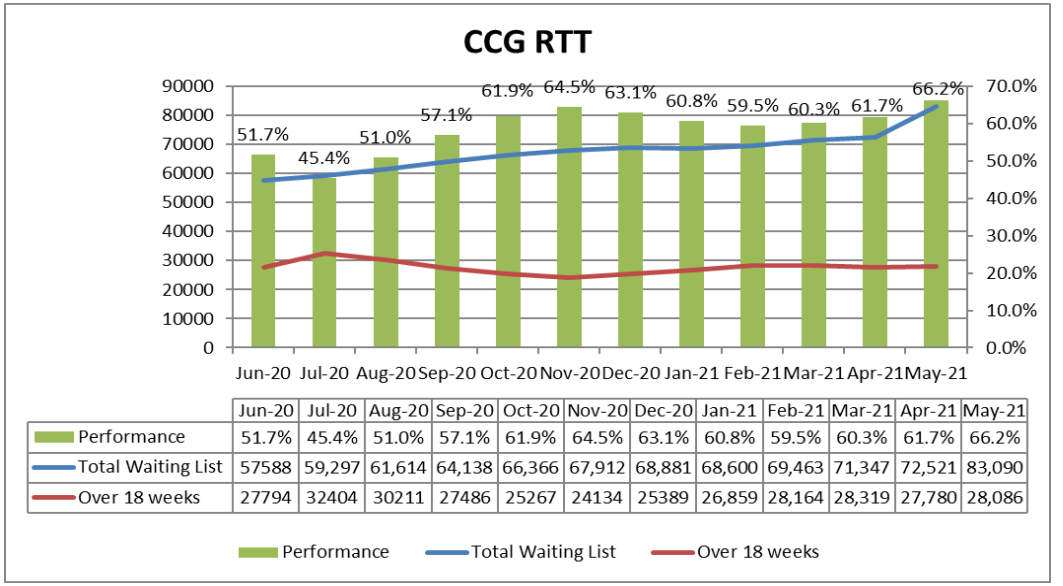
DERBYSHIRE COMMISSIONER – INCOMPLETE PATHWAYS (92%)

Performance Analysis

Performance for May 2021 was 66.2%, against a figure of 61.7% in April which is a slight improvement on the percentage of patients now waiting over 18 weeks.

The total incomplete waiting list for DDCCG was 83,090 which is an increase of 11,469 – this is due to the fact that the patients who are currently on an ASI list at UHDB are now included in the incomplete pathway numbers. The number of referrals across Derbyshire during May showed an increase of 7% of urgent referrals and a reduction of 20% for routine referrals when compared with the average weekly referral of the previous 51 weeks. (Urgent referrals are 6.1% lower and routine referrals 26% lower than the same month during 2019)

Treatment Function	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Total 52 plus weeks
General Surgery Service	4,518	2,401	53.1%	699
Urology Service	3,670	2,682	73.1%	252
Trauma and Orthopaedic Service	12,638	5,989	47.4%	2,305
Ear Nose and Throat Service	6,446	3,799	58.9%	634
Ophthalmology Service	11,361	6,797	59.8%	920
Oral Surgery Service	29	22	75.9%	0
Neurosurgical Service	460	310	67.4%	32
Plastic Surgery Service	597	360	60.3%	80
Cardiothoracic Surgery Service	178	111	62.4%	12
General Internal Medicine Service	357	274	76.8%	1
Gastroenterology Service	4,655	3,764	80.9%	136
Cardiology Service	2,390	1,902	79.6%	41
Dermatology Service	5,273	3,780	71.7%	121
Respiratory Medicine Service	1,369	1,128	82.4%	5
Neurology Service	2,229	1,746	78.3%	12
Rheumatology Service	1,631	1,237	75.8%	16
Elderly Medicine Service	255	231	90.6%	1
Gynaecology Service	5,828	4,111	70.5%	327
Other - Medical Services	5,504	4,741	86.1%	61
Other - Mental Health Services	301	286	95.0%	0
Other - Paediatric Services	5,803	3,921	67.6%	584
Other - Surgical Services	6,750	4,708	69.7%	572
Other - Other Services	848	704	83.0%	48
Total	83,090	55,004	66.2%	6,859



	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Performance	51.7%	45.4%	51.0%	57.1%	61.9%	64.5%	63.1%	60.8%	59.5%	60.3%	61.7%	66.2%
Total Waiting List	57588	59,297	61,614	64,138	66,366	67,912	68,881	68,600	69,463	71,347	72,521	83,090
Over 18 weeks	27794	32404	30211	27486	25267	24134	25389	26,859	28,164	28,319	27,780	28,086

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

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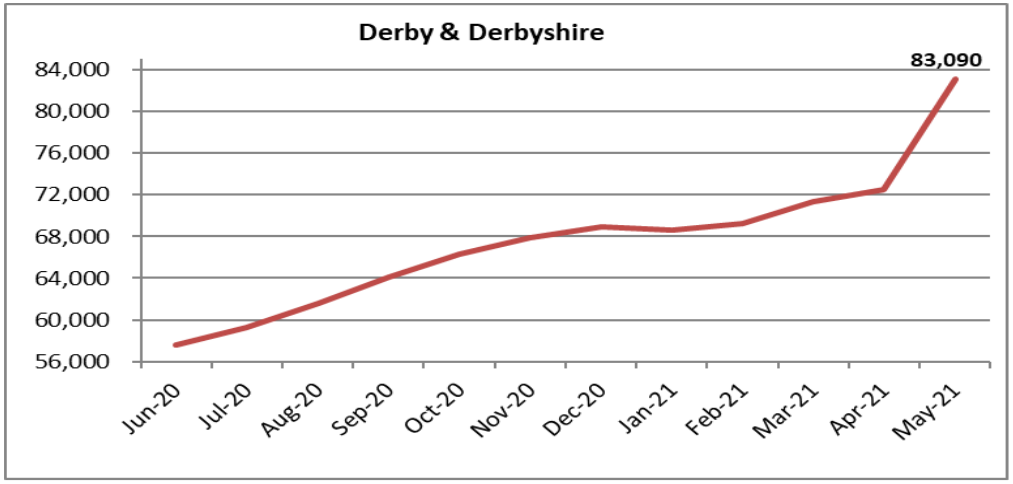
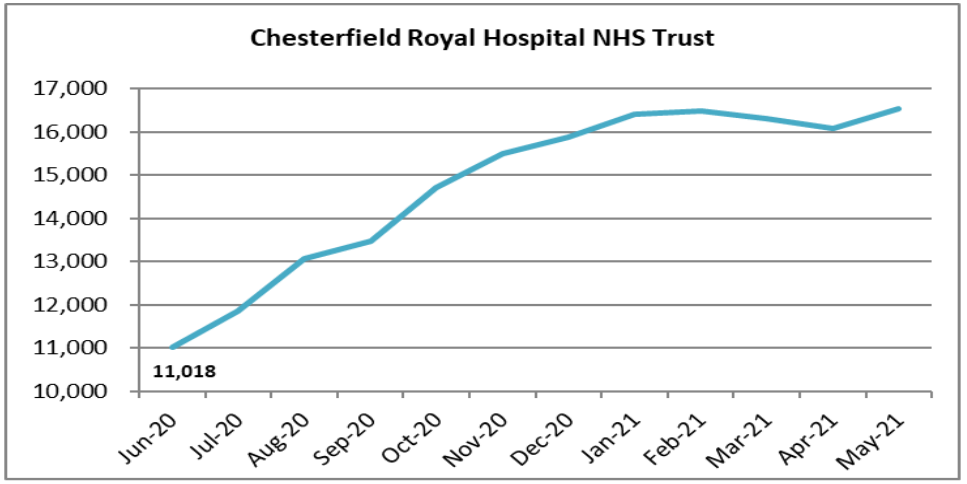
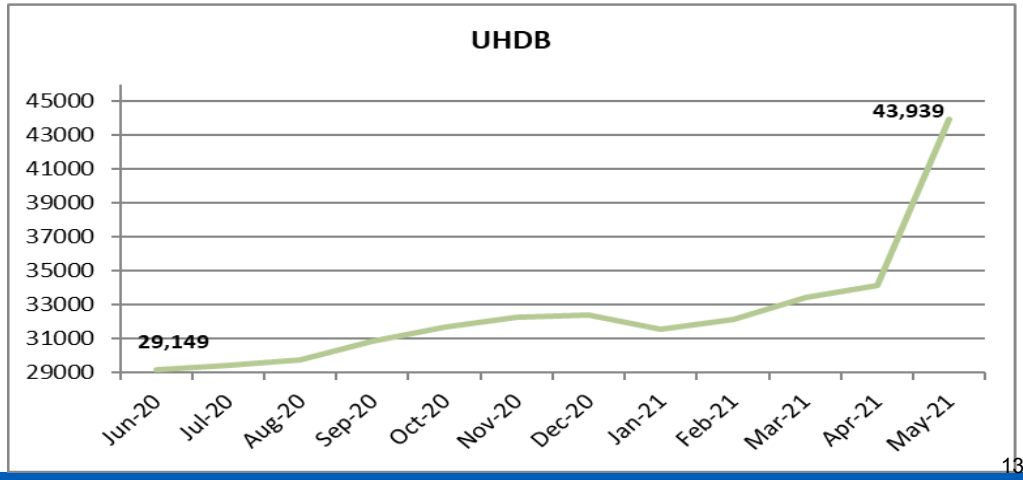
ELECTIVE CARE – DDCCG Incomplete Pathways

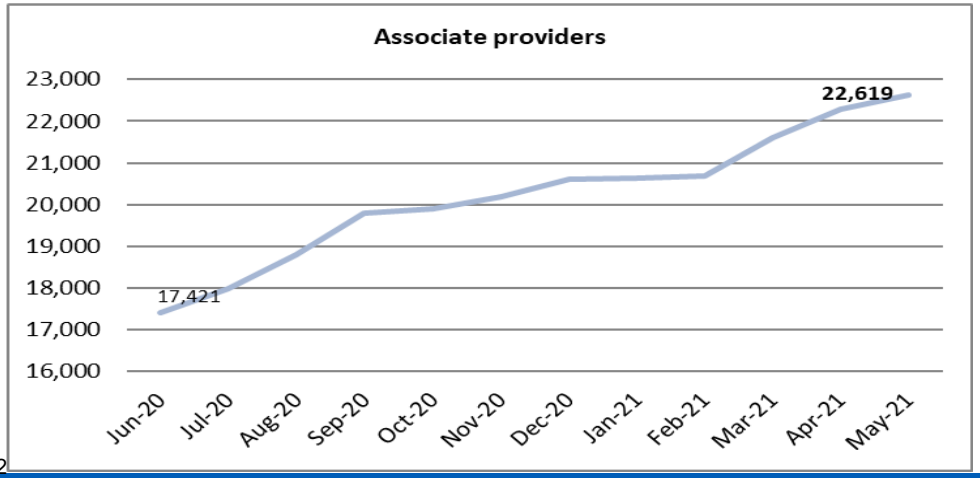
Derbyshire CCG incomplete waiting list at the end of May 2021 is 83,090. The increase main due to the those patients on the ASI list now added to the incomplete pathways at UHDB.

Of this number 60,291 Derbyshire patients are currently awaiting are at our two main acute providers CRH (16,352) and UHDB (43,939). The remaining 22,619 Derbyshire residents are on an incomplete pathways at other trusts out of Derbyshire. The graphs below show the current position and how this has changed over the last few months.





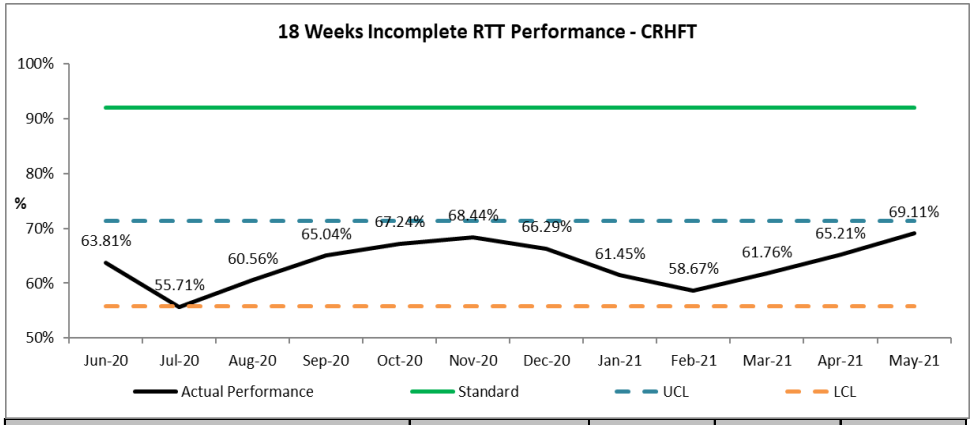


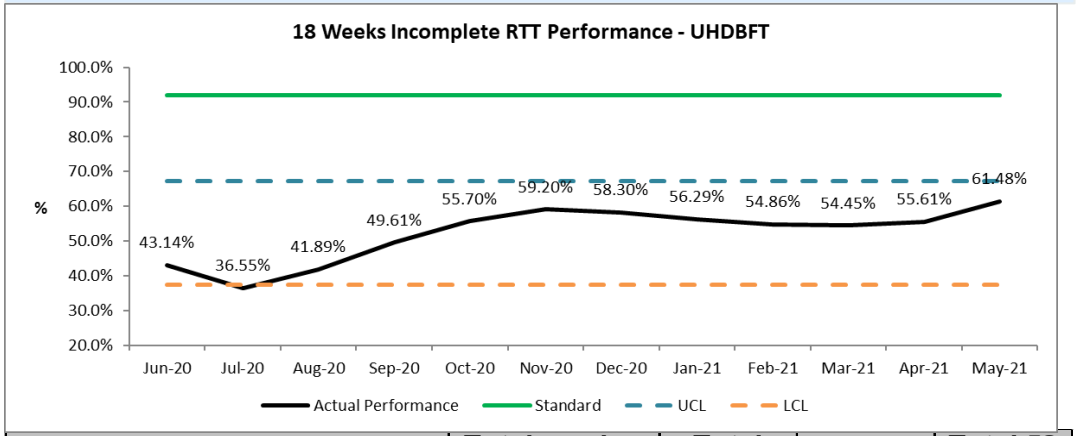


Referral to Treatment – Incomplete Pathways (92%).

CRH - During May 2021 the trust achieved performance of 69.1%, a further improvement compared to 65.2% during April.
The waiting list at the end of April stands at 17,989, an increase on the April figure.

UHDB - During May the trust achieved a standard of 61.5% an improvement on the April figure of 55.6%. There has been improvement on this standard each month since February. The waiting list at the end of April is 78,051 an increase of nearly 13,000 now that those patients on the ASI list are now included in the total figure.





Treatment Function	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Total 52 plus weeks
General Surgery Service	1,078	567	52.6%	135
Urology Service	1,082	914	84.5%	26
Trauma and Orthopaedic Service	1,584	859	54.2%	174
Ear Nose and Throat Service	1,647	1,093	66.4%	171
Ophthalmology Service	2,104	1,211	57.6%	180
Oral Surgery Service	1,157	740	64.0%	120
General Internal Medicine Service	245	182	74.3%	0
Gastroenterology Service	1,366	973	71.2%	21
Cardiology Service	587	413	70.4%	3
Dermatology Service	1,172	1,105	94.3%	21
Respiratory Medicine Service	426	345	81.0%	0
Rheumatology Service	465	302	64.9%	3
Gynaecology Service	1,543	1,003	65.0%	137
Other - Medical Services	885	711	80.3%	7
Other - Paediatric Services	907	782	86.2%	30
Other - Surgical Services	1,741	1,233	70.8%	151
Total	17,989	12,433	69.1%	1,179

Treatment Function	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Total 52 plus weeks
General Surgery Service	4,065	2,340	57.6%	603
Urology Service	3,116	1,913	61.4%	366
Trauma and Orthopaedic Service	13,740	6,065	44.1%	2,725
Ear Nose and Throat Service	6,875	3,857	56.1%	457
Ophthalmology Service	9,836	5,040	51.2%	1,032
Oral Surgery Service	3,203	1,722	53.8%	476
Neurosurgical Service	132	76	57.6%	4
Plastic Surgery Service	365	206	56.4%	60
Cardiothoracic Surgery Service	9	9	100.0%	0
General Internal Medicine Service	476	419	88.0%	1
Gastroenterology Service	3,263	3,014	92.4%	13
Cardiology Service	1,877	1,694	90.3%	10
Dermatology Service	5,336	3,223	60.4%	128
Respiratory Medicine Service	592	540	91.2%	4
Neurology Service	2,060	1,505	73.1%	12
Rheumatology Service	1,374	1,118	81.4%	8
Elderly Medicine Service	336	268	79.8%	2
Gynaecology Service	5,753	3,784	65.8%	331
Other - Medical Services	5,494	4,772	86.9%	52
Other - Mental Health Services	4	4	100.0%	0
Other - Paediatric Services	3,822	2,038	53.3%	607
Other - Surgical Services	5,370	3,621	67.4%	609
Other - Other Services	953	756	79.3%	73
Total	78,051	47,984	61.5%	7,573

DERBYSHIRE COMMISSIONER – OVER 52 WEEK WAITERS

52 Week Waits

May performance shows that there were 6,859 Derbyshire patients waiting over 52 weeks for treatment in Derbyshire. Of these 5,498 are waiting for treatment at our two main providers UHDB and CRH, the remaining 1,361 are waiting at various trusts around the country as outlined in the table on the following slide.

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

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

Main Providers:

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

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

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

Main Provider Actions:

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

Actions:

- System Planned Care Group are leading on the plans for restoration and recovery across the system.
- Patients are being treated in priority order and a number of patients currently waiting over 52 weeks are low priority.
- There is an increased focus by the National team at NHS England around the long waiters across Derbyshire. The CCG are working with the trusts reviewing those patients who have been waiting the longest time as there are a number over 104 weeks.

DERBYSHIRE COMMISSIONER – OVER 52 WEEK WAITERS

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

Provider	Total	Provider	Total
AIREDALE NHS FOUNDATION TRUST	1	SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	56
ASPEN - CLAREMONT HOSPITAL	44	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	144
BARTS HEALTH NHS TRUST	3	SPIRE BRISTOL HOSPITAL	1
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	5	SPIRE NOTTINGHAM HOSPITAL	2
BMI - THE ALEXANDRA HOSPITAL	8	SPIRE REGENCY HOSPITAL	10
BMI - THE PARK HOSPITAL	1	STOCKPORT NHS FOUNDATION TRUST	396
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	1	TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	3
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	10	THE ONE HEALTH GROUP LTD	8
EAST CHESHIRE NHS TRUST	36	THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FT	3
FRIMLEY HEALTH NHS FOUNDATION TRUST	1	THE ROTHERHAM NHS FOUNDATION TRUST	1
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	1	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	1
LEEDS TEACHING HOSPITALS NHS TRUST	8	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	1
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	3	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	21
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	19	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	3
NEWMEDICA COMMUNITY OPHTHALMOLOGY - BARLBOROUGH TREATMENT CENTRE	2	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	53
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	1	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	5
NORTH BRISTOL NHS TRUST	1	WOODTHORPE HOSPITAL	8
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	287	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	4
NUFFIELD HEALTH, DERBY HOSPITAL	92	HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST	9
NUFFIELD HEALTH, LEICESTER HOSPITAL	1	GLOUCESTERSHIRE HOSPITALS NHS FOUNDATION TRUST	1
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	1	LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	9
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	1	BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	2
ROYAL BERKSHIRE NHS FOUNDATION TRUST	1	PORTSMOUTH HOSPITALS UNIVERSITY NHS TRUST	1
ROYAL FREE LONDON NHS FOUNDATION TRUST	4	PRACTICE PLUS GROUP HOSPITAL - BARLBOROUGH	16
SALFORD ROYAL NHS FOUNDATION TRUST	11	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	1
SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	58	UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST	1
		Total	1361

Actions:

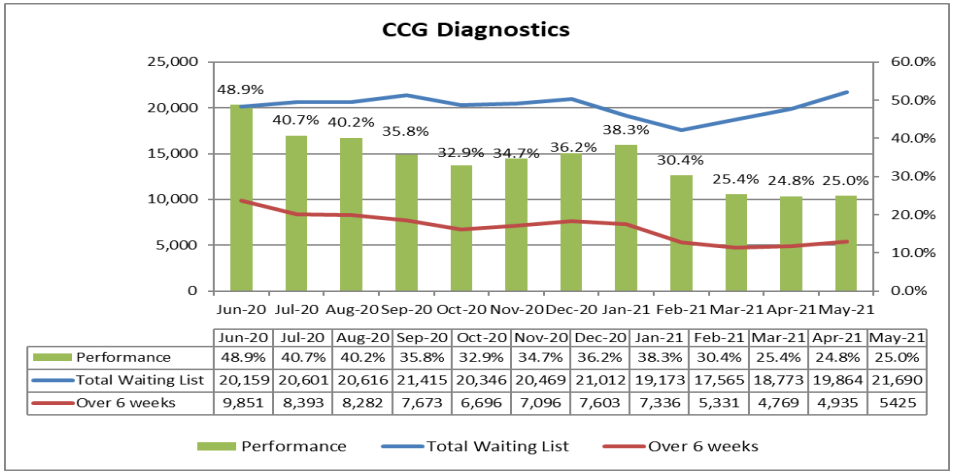
- The performance team make enquiries of the relevant CCGs and responses received back are that these patients are not clinically urgent but are being reviewed. We have not been informed of any TCI dates.

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

Performance Analysis

Derbyshire CCG Diagnostic performance at the end of May was 25.0% waiting over six weeks, a slight deterioration on the April position of 24.8%.

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



	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21
Performance	48.9%	40.7%	40.2%	35.8%	32.9%	34.7%	36.2%	38.3%	30.4%	25.4%	24.8%	25.0%
Total Waiting List	20,159	20,601	20,616	21,415	20,346	20,469	21,012	19,173	17,565	18,773	19,864	21,690
Over 6 weeks	9,851	8,393	8,282	7,673	6,696	7,096	7,603	7,336	5,331	4,769	4,935	5425

Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Percentage waiting 6+ Weeks
Magnetic Resonance Imaging	3,515	616	342	17.5%
Computed Tomography	2,731	390	160	14.3%
Non-obstetric Ultrasound	8,216	2,627	425	32.0%
DEXA Scan	691	133	58	19.2%
Audiology - Audiology Assessments	839	181	21	21.6%
Cardiology - Echocardiography	2,328	427	95	18.3%
Peripheral Neurophysiology	273	5	1	1.8%
Respiratory physiology - Sleep Studies	132	6	4	4.5%
Urodynamics - Pressures & Flows	125	69	28	55.2%
Colonoscopy	1,053	386	262	36.7%
Flexi Sigmoidoscopy	364	117	64	32.1%
Cystoscopy	229	54	31	23.6%
Gastroscopy	1,192	414	255	34.7%
Total	**21,690**	**5,425**	**1,746**	**25.0%**

	University Hospitals of Derby & Burton	Chesterfield Royal Hospital	Stockport	Sheffield Teaching Hospitals	Sherwood Forest Hospitals	Nottingham University Hospitals	East Cheshire
Magnetic Resonance Imaging	14.4%	0.5%	9.7%	1.6%	0.8%	64.8%	0.0%
Computed Tomography	20.0%	0.3%	1.9%	2.9%	25.6%	3.3%	0.0%
Non-obstetric Ultrasound	44.6%	0.1%	17.5%	0.3%	0.9%	48.2%	0.0%
DEXA Scan	8.8%	0.0%	68.0%	70.3%	1.9%	60.5%	50.4%
Audiology - Audiology Assessments	16.6%	22.3%	20.6%	41.7%	1.7%	9.9%	68.6%
Cardiology - Echocardiography	6.4%	14.0%	10.8%	24.9%	57.9%	0.1%	
Peripheral Neurophysiology	0.3%			11.0%		0.8%	
Respiratory physiology - Sleep Studies	0.0%		1.8%	8.6%	14.1%	4.0%	0.0%
Urodynamics - Pressures & Flows	55.8%	70.8%	39.3%	65.1%	1.9%	17.4%	
Colonoscopy	8.9%	23.8%	85.2%	32.9%	46.7%	3.3%	49.6%
Flexi Sigmoidoscopy	5.3%	38.1%	85.7%	33.5%	25.3%	0.6%	41.3%
Cystoscopy	29.6%	0.0%		6.6%	27.2%	3.9%	0.0%
Gastroscopy	10.4%	27.2%	80.2%	27.0%	41.2%	5.4%	57.5%
Total	**27.9%**	**7.7%**	**45.6%**	**13.1%**	**23.0%**	**40.6%**	**37.8%**

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

Performance Analysis

Performance during May was 7.7%, a deterioration on the April figure of 6.8%.

The numbers on the waiting list have increased during May as have the number waiting over six weeks. However, the number waiting over 13 weeks continue to decrease.

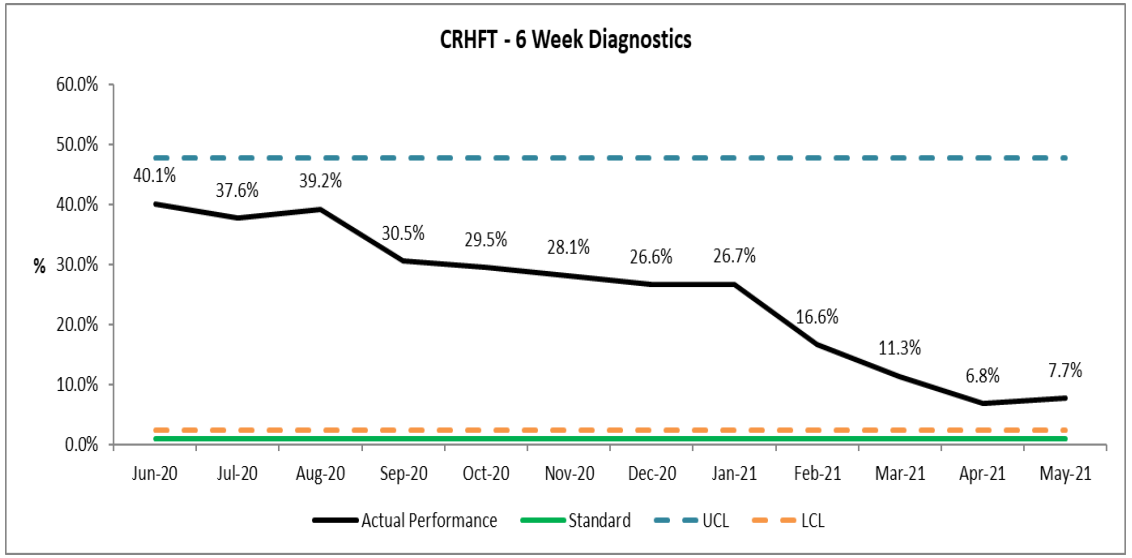
What are the issues?

Issues

- An increase in demand due to higher outpatient referrals and increased non-elective activity.
- Although Urodynamics have a low volume of patients the specialist nature of the area means that the cancellation of just 1 list can have a significant impact.
- Endoscopy capacity has been an ongoing issue, which was exacerbated when booking issues led to further delays of 2-3 days and this backlog has not yet recovered.

Actions

- Endoscopy dates are now booked immediately to prevent recurrence of the booking issues.
- Imaging and Endoscopy activity for those patients on a cancer pathway is prioritised.
- Further development of the clinical triage set and CAB.
- Roll out of the Attend Anywhere scheme, utilising phone and video. This approach also included patients being allowed the choice of how they receive diagnostic results.
- Local diagnostic departments continue to validate waiting lists to ensure data quality.



Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Percentage waiting 6+ weeks
Magnetic Resonance Imaging	628	3	0	0.5%
Computed Tomography	604	2	2	0.3%
Non-obstetric Ultrasound	1,755	2	0	0.1%
DEXA Scan	228	0	0	0.0%
Audiology - Audiology Assessments	346	77	12	22.3%
Cardiology - Echocardiography	681	95	0	14.0%
Urodynamics - Pressures & Flows	24	17	7	70.8%
Colonoscopy	328	78	20	23.8%
Flexi Sigmoidoscopy	113	43	13	38.1%
Cystoscopy	55	0	0	0.0%
Gastroscopy	265	72	33	27.2%
Total	**5,027**	**389**	**87**	**7.7%**

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

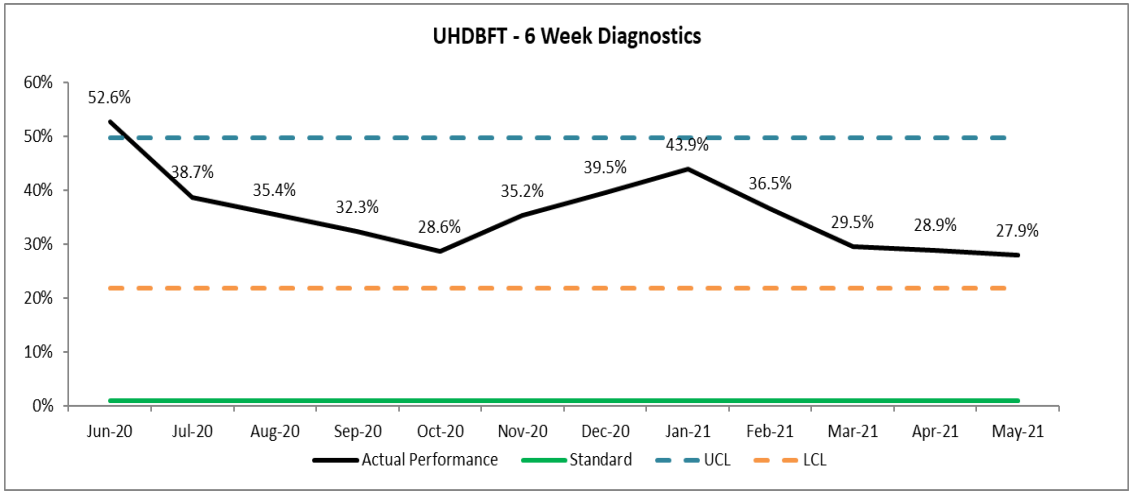
Performance Analysis
Performance during May was 27.9% an improvement on the April figure of 28.9%.

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

Non Obstetric ultrasounds , urodynamics and cystoscopy are experiencing the highest waits proportionally.

Issues
- An increase in demand due to higher outpatient referrals and increased non-elective activity.
- Capacity for TRUS (Trans-Rectal Ultrasounds) differs between sites with patients reluctant to travel to an alternative.
- MRI are staffing issues continue, affecting their capacity.
- More intense cleaning of CT Scans between patients has reduced CT capacity from 4 per hour to 3 per hour.

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

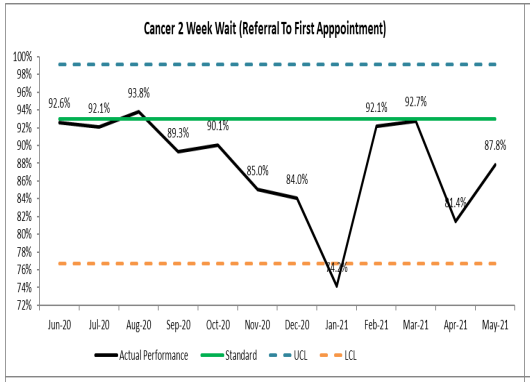


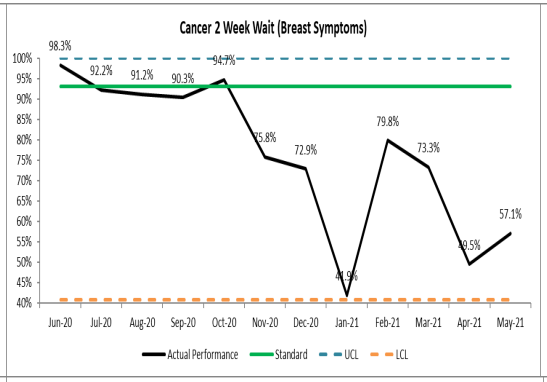
Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Percentage waiting 6+ weeks
Magnetic Resonance Imaging	3,111	447	108	14.4%
Computed Tomography	2,355	471	177	20.0%
Non-obstetric Ultrasound	8,699	3,881	567	44.6%
Barium Enema	27	0	0	0.0%
DEXA Scan	386	34	20	8.8%
Audiology - Audiology Assessments	751	125	16	16.6%
Cardiology - Echocardiography	1,526	98	20	6.4%
Peripheral Neurophysiology	321	1	0	0.3%
Respiratory physiology - Sleep Studies	152	0	0	0.0%
Urodynamics - Pressures & Flows	113	63	24	55.8%
Colonoscopy	507	45	24	8.9%
Flexi Sigmoidoscopy	226	12	5	5.3%
Cystoscopy	196	58	33	29.6%
Gastroscopy	608	63	25	10.4%
Total	**18,978**	**5,298**	**1,019**	**27.9%**

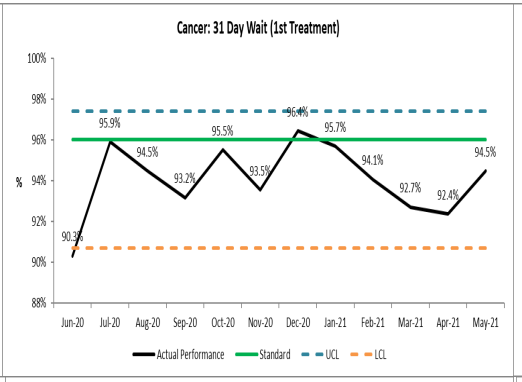
DERBYSHIRE COMMISSIONER – CANCER WAITING TIMES

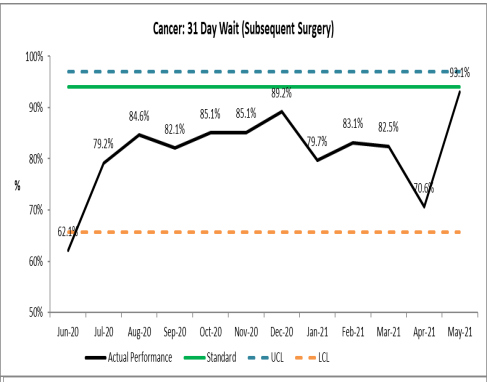
During May 2021, Derbyshire was compliant in 2 of the 8 Cancer standards:
31 day Subsequent Drugs – 99.4% (98% standard) – Compliant all Trusts except Sherwood Forest.
31 day Subsequent Radiotherapy – 96.5% (94% standard) – Compliant for Derby & Burton and Sheffield, but not for Nottingham.
During May 2021, Derbyshire was non-compliant in 6 of the 8 Cancer standards:
2 week Urgent GP Referral – 87.8% (93% standard) – Compliant for Sherwood Forest and Stockport.
2 week Exhibited Breast Symptoms – 57.1% (93% standard) - Compliant for Sherwood Forest and Stockport.
31 day from Diagnosis – 94.5% (96% standard) – Compliant for Chesterfield and Sherwood Forest.
31 day Subsequent Surgery – 93.1% (94% standard) - Compliant for Chesterfield, Derby& Burton and Stockport.
62 day Urgent GP Referral – 65.9% (85% standard) – Non compliant for all trusts.
62 day Screening Referral – 64.5% (90% standard) – Compliant for Sherwood Forest and Stockport.

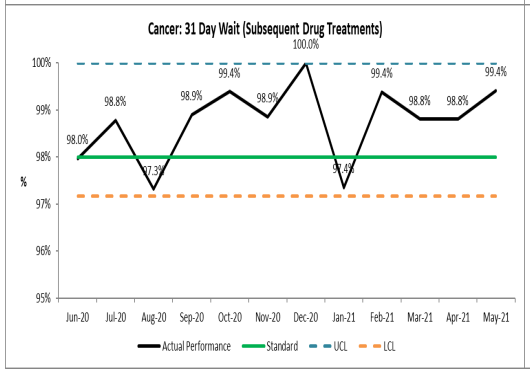
Additional standards include:
28 day Diagnosis or Decision To Treat – 75.5% (75% standard) – Compliant for Derby & Burton, Chesterfield, Nottingham & Sherwood Forest.
104 day wait – 25 CCG patients waited over 104 days for treatment.

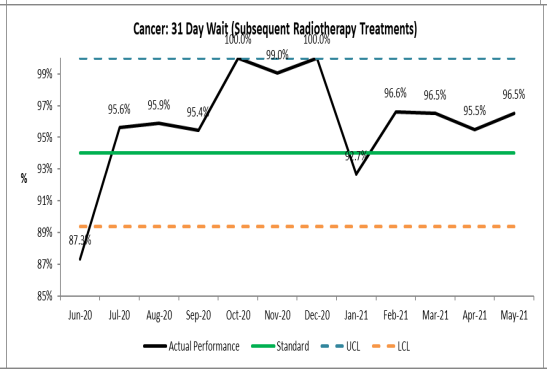


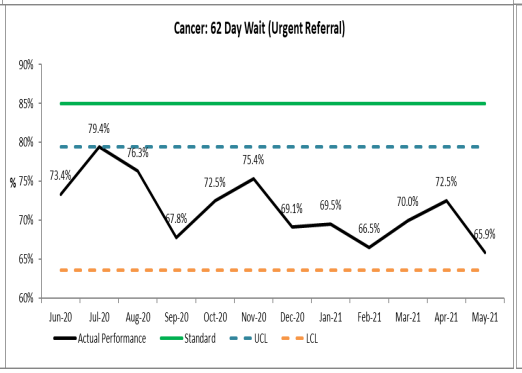


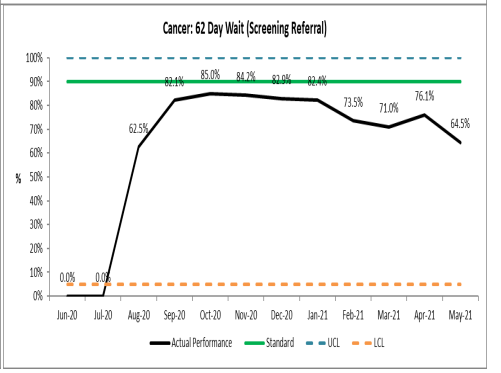












CCG performance data reflects the complete cancer pathway which for many Derbyshire patients will be completed in Sheffield and Nottingham.

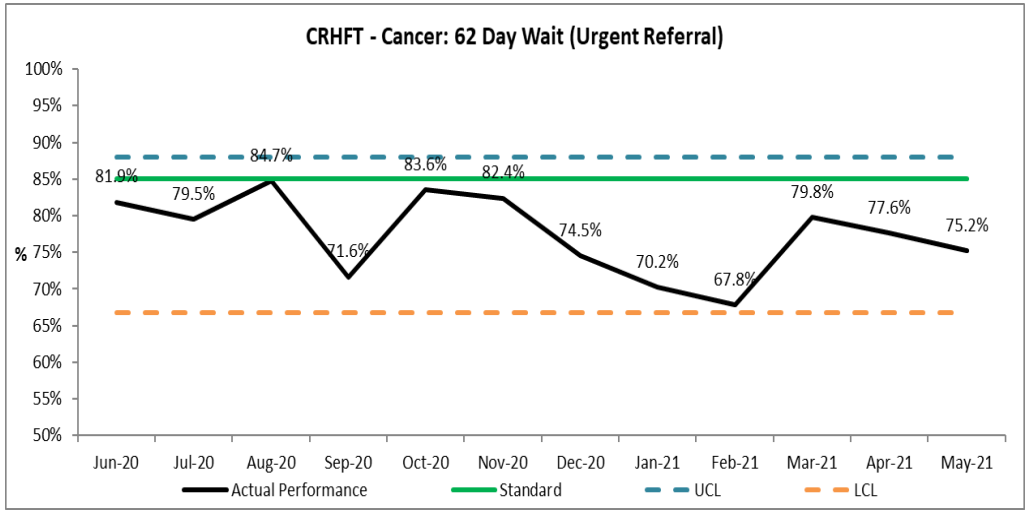
CRHFT - CANCER WAITING TIMES (First Treatment Administered within 62 Days of Urgent Referral)

Performance Analysis

CRH performance during May for first treatment within 62 days of urgent referral has decreased slightly to 75.2%, remaining non-compliant against the standard of 85%.

There were 74.5 patients treated along this pathway in May with 56 of those patients being treated within the 62day standard, resulting in 18.5 breaches.

Out of the 18.5 breaches 8 patients were treated after day 104 which were due to Complex Diagnostics and Patient Choice. Those treated between 62 and 104days were nearly all as a result of Complex Diagnostics.



Current Issues

- Breast Outpatient Capacity.
- Theatre Capacity to accommodate demand.
- Lower GI Backlog due to Endoscopy delays. .
- Long appointment waits for Template Biopsies.
- Recent increase of referrals in Head and Neck.
- Treatments booked after breach date.

Actions Being Taken

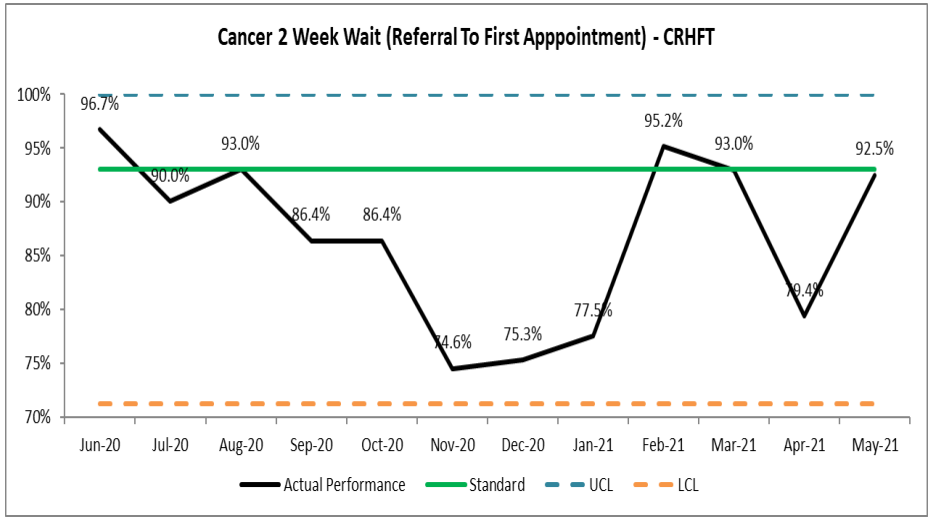
- Derbyshire Community Breast Pain Pathway went 'live' in June and is expected to help manage the level of referrals. The impact of this is under close review.
- Seeking mutual aid for Theatre capacity.
- Additional clinics in place to support the bladder pathway and alleviate the backlog to support lower GI.
- Consultant undertaking Template Biopsy training and once complete will help with capacity issues.
- Change to DTT process – once a patient is booked for treatment and it is going to breach all options reviewed to prevent the delay.

What are the next steps

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

CRH Tumour Type	Total referrals seen during the period	Seen Within 62 Days	Breaches of 62 Day Standard	% Performance
Breast	15.5	11.5	4	74.19%
Gynaecological	2	2	0	100.00%
Haematological (Excluding A	4	1.5	2.5	37.50%
Head and Neck	2	2	0	100.00%
Lower Gastrointestinal	8.5	4.5	4	52.94%
Lung	3	1	2	33.33%
Sarcoma	1	0	1	0.00%
Skin	16	16	0	100.00%
Testicular	1	1	0	100.00%
Upper Gastrointestinal	4.5	4.5	0	100.00%
Urological (Excluding Testic	17	12	5	70.59%
Totals	**74.5**	**56**	**18.5**	**75.17%**

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



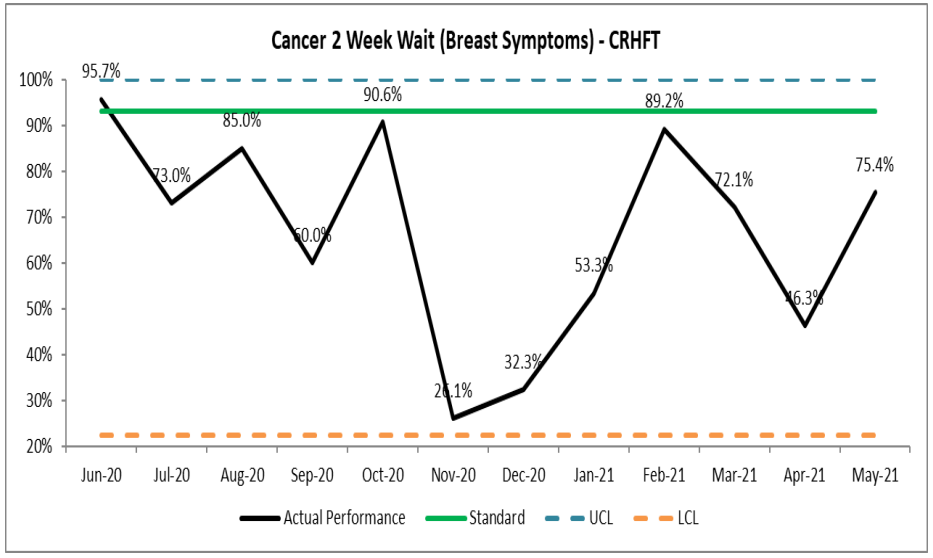
Performance Analysis

May Cancer 2 week wait performance at CRH has significantly improved to 92.5%, marginally failing the standard of 93%.

This service was mainly impacted on by failed performance in the breast service. The polling range was taken away on the choose and book system to enable all patients to be able to book an appointment which meant that patients could book after day 14. The trust are also not able to increase clinic slots for breast patients because of room capacity due to social distancing.

There were 259 patients seen during the month with 216 being seen within target, resulting in 43 breaches. This is a significant improvement to the 162 breaches reported in April.

CRHFT - CANCER WAITING TIMES – 2 Week Wait Breast Symptomatic



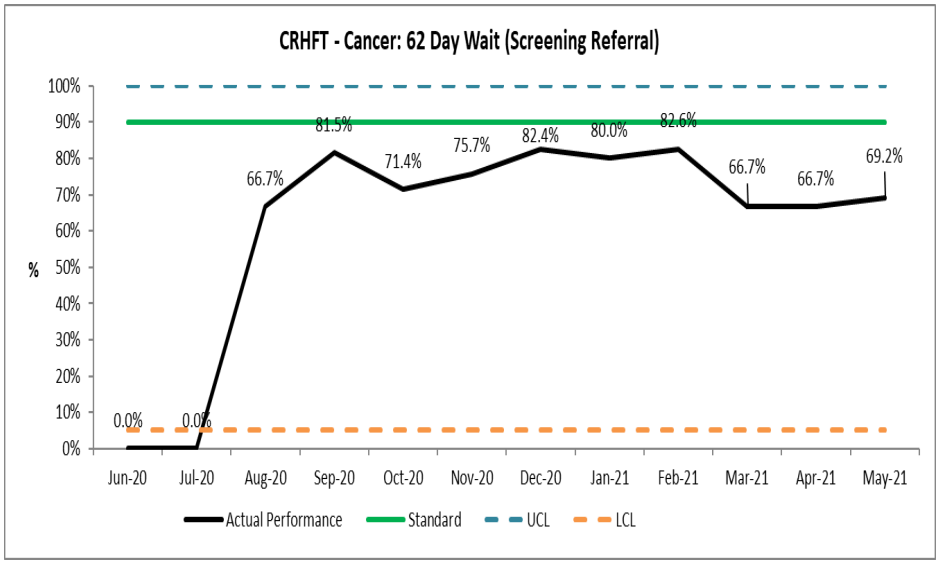
Performance Analysis

May performance at CRH for 2 Week Wait Breast Symptomatic has significantly improved to 75.4% when compared to April which reported 46.3%. However, it continues to remain non-compliant against the standard of 93% as Breast referrals continue to increase which is a national issue.

The total number of patients seen under this standard during May was 65, an increase on the previous month. Of the 65 patients 49 were seen within the 14 day standard resulting in 16 breaches. An improvement to the 29 breaches reported in April.

The same issues highlighted above regarding 2WW for breast applies to this cohort of patients also.

CRHFT - CANCER WAITING TIMES – 62day Screening Referral



Performance Analysis

Performance in May has increased slightly to 69.2%.

There were a total of 13 patients treated during May who had been referred through screening compared to 18 in April.

Out of the 13 patients treated there were 9 treated within the 62day standard resulting in 4 breaches (2x Breast and 2x Lower GI).

Reasons were Complex Diagnostic(1), Medical Reasons(1), Elective capacity (1) and Outpatient Capacity (1).

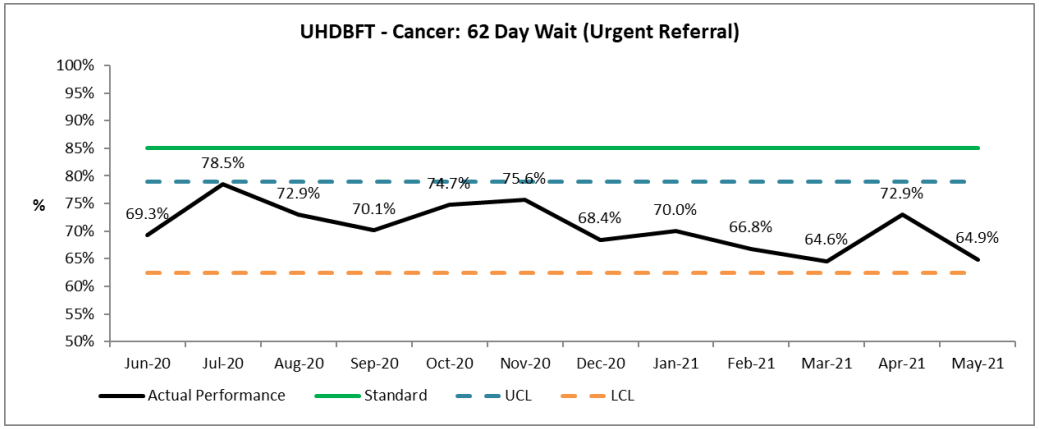
UHDB - CANCER WAITING TIMES (First Treatment Administered within 62 Days of Urgent Referral)

Performance Analysis

May Performance for first treatment within 62 days has decreased slightly to 64.9%, remaining non-compliant against the standard of 85%.

There was a total of 178 patients treated along this pathway in May with 115.5 of those patients being treated within the 62 standard resulting in 62.5 breaches.

Out of the 62.5 breaches 14 patients were treated after day 104 which were due to a mixture of Elective Capacity, Outpatient Capacity, Patient Choice, Administrative Delay and Medical Reasons. Those treated between 62 and 104days were mainly due to Outpatient Capacity and Complex Diagnostics.



Current Issues

- Outpatient Capacity due to increasing referrals, particularly in Breast, Gynaecology and Haematology all of which are being impacted on by urgent care and diagnostics as well as the loss of capacity due to government guidelines of social distancing and infection control.
- Restoration of all hospital services as part of the Covid recovery are all impacting on Cancer Performance.
- Histology in particular are occurring long waits.
- Inappropriate GP referrals.
- Patient Choice continues to be a reason for the breaches however, the patient choice is returning to pre-covid reasons such as work, holidays in oppose to being as a result of Covid.

Actions Being Taken

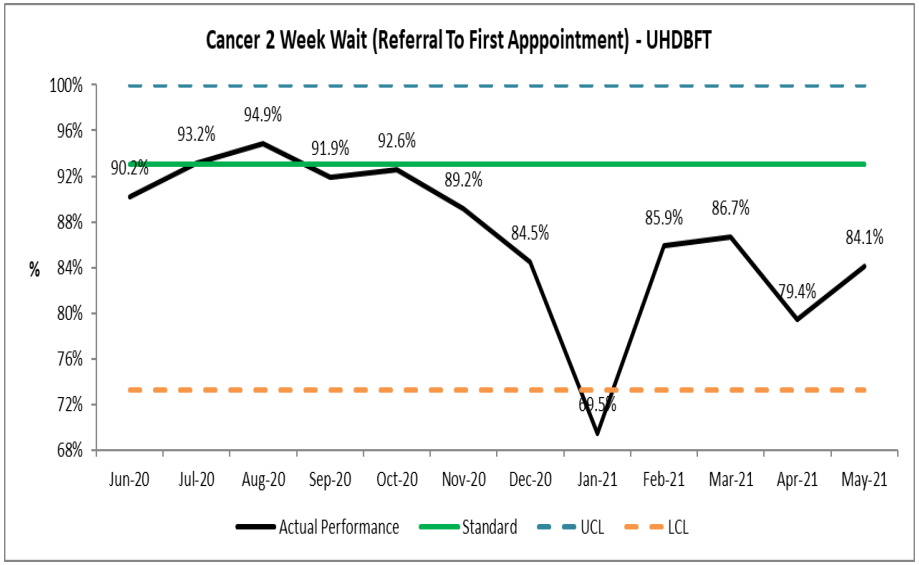
- Derbyshire Community Breast Pain Pathway went 'live' in June and is expected to help manage the level of referrals. The impact of this is under close review.
- Additional Clinics accommodating increasing referrals where possible.
- Inappropriate referrals under review.
- Histology pathway to be reviewed.

What are the next steps

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

UHDB Tumour Type	Total referrals seen during the period	Seen Within 62 Days	Breaches of 62 Day Standard	% Performance
Breast	26	24	2	92.31%
Gynaecological	14	3	11	21.43%
Haematological (Excluding Acute Leukaemia)	8	7	1	87.50%
Head and Neck	9	9	0	100.00%
Lower Gastrointestinal	17.5	7	10.5	40.00%
Lung	15.5	11	4.5	70.97%
Sarcoma	2	0	2	0.00%
Skin	27.5	24	3.5	87.27%
Testicular	1	1	0	100.00%
Upper Gastrointestinal	16	11	5	68.75%
Urological (Excluding Testicular)	41.5	18.5	23	44.58%
Totals	**178.0**	**115.5**	**62.5**	**64.89%**

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



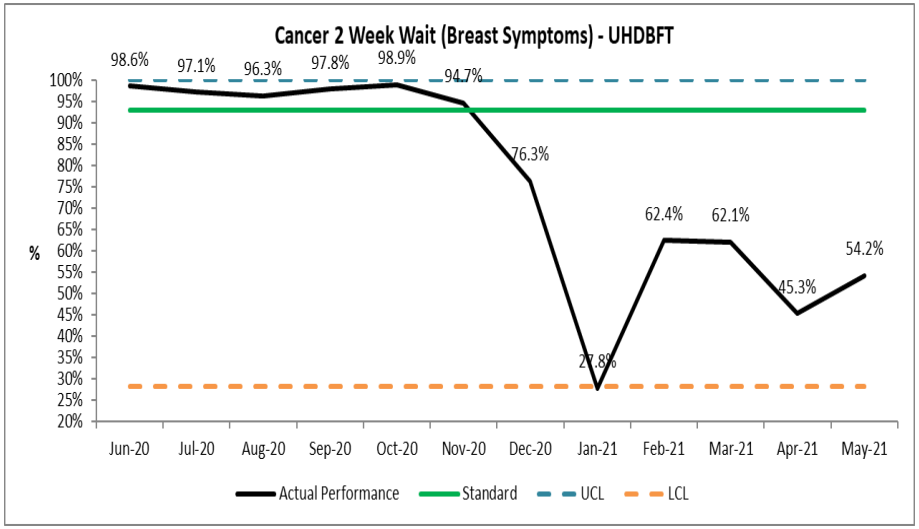
Performance Analysis

May performance at UHDB for 2 week wait has improved to 84.1%, and continues to be non-compliant against the standard of 93%. The main challenges for 2ww performance have been associated with Breast and Lower GI.

There were a total number of 2970 patients seen this month by way of GP Urgent referral to first appointment which is a slight reduction on the 3040 reported in April. May also remains with nearly 60% of the referrals being within Breast, Lower GI and Skin. Out of the 2970 patients referred in May, 2498 of these patients were seen within the 2 week wait standard, resulting in 472 breaches compared to the 626 reported in April.

The 472 breaches occurred in Breast(165), Gynaecology(138), Haematology(5), Head and Neck(4), Lower GI (76), Lung(1), Skin(27), Upper GI(54) and Urology(2). The majority of the breach reasons were due to Outpatient Capacity, with the remaining due to Patient Choice and Administrative delay.

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



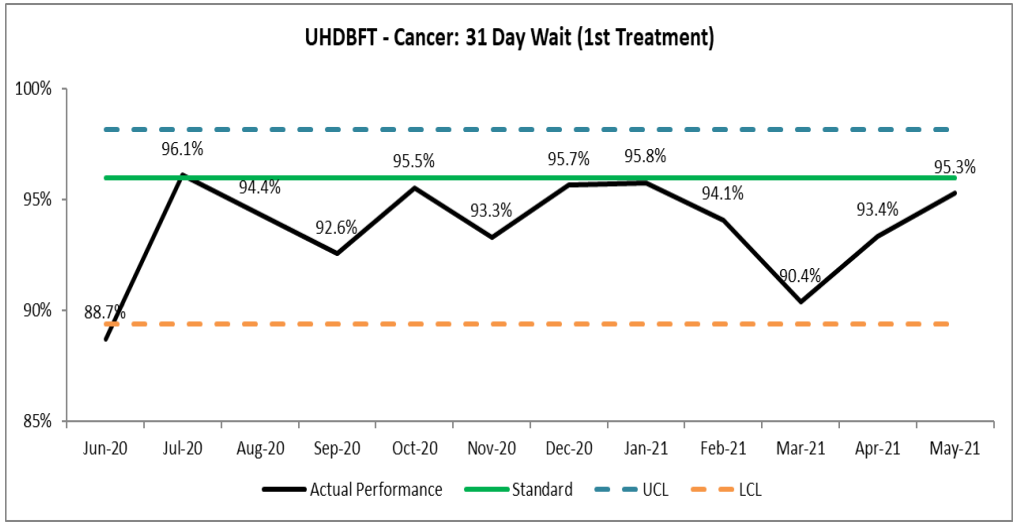
Performance Analysis

May performance at UHDB for 2 week wait Breast Symptomatic has improved to 54.2%, remaining non-compliant against the standard of 96%.

For all breast referrals, both 2WW and symptomatic, the polling range on Choose and Book was extended to more than 14 days to enable patients to book, even though the appointment would be after 14 days.

The total number of patients seen this month by way of referral to Breast Symptomatic was 212 with 115 of those patients being seen within 2 weeks, resulting in 97 breaches. Out of the 97 breaches 54 of the patients were seen within 21 days, 37 waiting up to 28 days and 6 waiting over 28days. The majority of the breach reasons were due to outpatient capacity, with the remaining being as a result of Patient Choice.

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



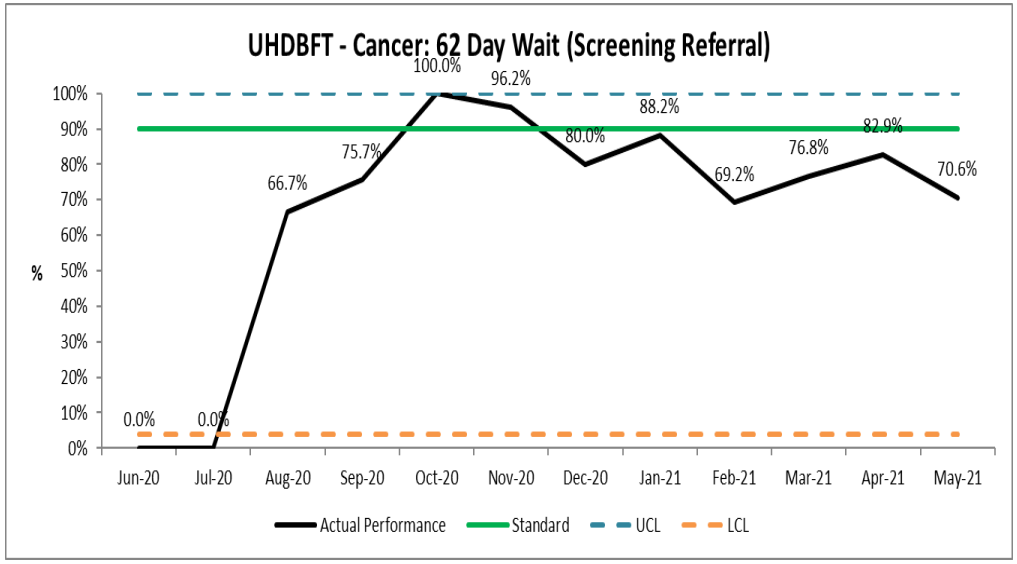
Performance Analysis

May performance at UHDB for 31 day from diagnosis to first treatment has increased on the previous month to 95.3%, just under the standard needed of 96%.

There were a total number of 340 patients treated along this pathway. With 324 of the patients being treated within 31 days, resulting in 16 breaches.

The 16 breaches occurred in Gynaecology(2), Lower GI (9), Skin(3), Upper GI(1) and Urology(1). The majority of the breach reasons were due to Elective Capacity.

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



Performance Analysis

Performance in May at UHDB has dropped slightly to 70.6%, remaining non-compliant against the standard of 90%.

There were a total of 25.5 patients treated this month who were referred from a screening service with 18 of those patients being treated within 62 days, resulting in 7.5 breaches.

Out of the 7.5 breaches, 7 occurred in Lower GI and 1 occurred in Gynaecology. The breaches occurred as a result of Elective Capacity(2), Outpatient Capacity(3), Complex Diagnostics(2) and Medical Reason(1).

The number of days the patients breached ranged between 73 and 100 days with two reporting at 155 and 196 days which were due to Complex Diagnostics.

Appendix

APPENDIX 1: PERFORMANCE OVERVIEW M2 – ASSOCIATE PROVIDER CONTRACTS

Provider Dashboard for NHS Constitution Indicators					East Cheshire Hospitals				Nottingham University Hospitals				Sheffield Teaching Hospitals FT				Sherwood Forest Hospitals FT				Stockport FT			
	Area	Indicator Name	Standard	Latest Period	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance
Urgent Care	Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	Jun-21	↑	66.3%	67.0%	36	A&E pilot site - not currently reporting 4 hour breaches				↑	75.5%	75.9%	62	↑	88.7%	91.2%	8	↑	69.7%	75.0%	13
		A&E 12 Hour Trolley Waits	0	Jun-21	↑	1	14	3	↑	0	5	0	↓	3	7	4	↓	3	5	7	↔	1	2	2
Planned Care	Referral to Treatment for non-urgent consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	May-21	↑	58.3%	56.4%	45	↑	68.5%	67.0%	20	↑	82.3%	81.6%	16	↑	66.2%	65.1%	45	↑	58.7%	57.5%	40
		Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	May-21	↓	535	3770	17	↓	3418	7190	14	↓	867	1877	14	↓	1340	2837	14	↓	4017	8288	37
	Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	May-21	↓	37.79%	53.82%	15	↓	40.63%	42.39%	15	↑	13.06%	12.59%	15	↓	23.05%	24.17%	17	↓	45.57%	46.54%	23
	2 Week Cancer Waits	All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	May-21	↑	67.9%	90.1%	3	↑	87.3%	84.9%	2	↑	80.5%	80.2%	2	↑	95.2%	95.2%	0	↑	98.0%	97.7%	0
		Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	May-21	↑	18.0%	76.4%	3	↑	68.5%	55.1%	2	↓	8.9%	23.6%	2	↔	100.0%	100.0%	0	↔	N/A	N/A	0
	28 Day Faster Diagnosis	Diagnosis or Decision to Treat within 28 days of Urgent GP, Breast Symptom or Screening Referral	75%	May-21	↑	69.6%	68.3%	2	↓	79.0%	79.3%	0	↑	65.8%	63.4%	2	↑	80.3%	79.3%	0	↑	62.0%	59.4%	2
	31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	96%	May-21	↑	73.6%	92.1%	5	↑	90.3%	90.2%	26	↑	92.7%	92.6%	2	↑	97.7%	96.9%	0	↑	97.5%	96.8%	0
		Subsequent Surgery Within 31 Days Of Decision To Treat	94%	May-21	↑	80.0%	92.3%	4	↑	69.9%	67.6%	37	↑	84.8%	84.2%	6	↑	100.0%	83.3%	0	↓	80.0%	89.5%	1
		Subsequent Drug Treatment Within 31 Days Of Decision To Treat	98%	May-21	↑	N/A	100.0%	0	↑	99.2%	98.8%	0	↓	98.6%	98.7%	0	↓	87.5%	88.9%	2	↔	100.0%	100.0%	0
		Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	May-21					↓	93.3%	94.3%	1	↑	98.0%	97.5%	0								
	62 Days Cancer Waits	First Treatment Administered Within 62 Days Of Urgent GP Referral	85%	May-21	↓	56.9%	63.0%	20	↓	71.8%	73.1%	14	↓	55.2%	58.0%	69	↓	70.2%	71.7%	17	↓	76.5%	78.4%	25
		First Treatment Administered - 104+ Day Waits	0	May-21	↓	2.0	32.0	9		0.0	16.5	0	↑	23.0	45.0	62	↓	4.5	12.5	37	↓	1.5	5.5	25
		First Treatment Administered Within 62 Days Of Screening Referral	90%	May-21	↑	50.0%	75.8%	6	↓	60.0%	64.0%	6	↓	68.4%	73.3%	6	↑	100.0%	88.5%	0	↑	N/A	50.0%	0
		First Treatment Administered Within 62 Days Of Consultant Upgrade	N/A	May-21	↓	79.4%	86.9%		↓	75.6%	75.9%		↑	88.8%	83.2%		↑	77.6%	76.9%		↓	80.6%	87.5%	
Patient Safety	Incidence of healthcare associated Infection	Healthcare Acquired Infection (HCAI) Measure: MRSA Infections	0	May-21	↔	0	2	0	↔	0	0	0	↔	0	0	0	↔	0	0	0	↔	0	0	0
		Healthcare Acquired Infection (HCAI) Measure: C-Diff Infections	Plan	May-21	↓		6		↓		20		↑		28		↑		14		↑		10	
			Actual				1	0			7	0			20	0			6	0			9	0
		Healthcare Acquired Infection (HCAI) Measure: E-Coli	-	May-21	↑	15	123		↑	44	112		↑	37	79		↔	30	60		↓	21	38	
		Healthcare Acquired Infection (HCAI) Measure: MSSA	-	May-21	↓	9	46		↓	31	47		↓	18	31		↓	10	18		↓	6	11	

NHS
Derby and Derbyshire
Clinical Commissioning Group

Governing Body Meeting in Public

5th August 2021

Item No: 110

Report Title	Quality & Performance Committee Annual Report 2020/21
Author(s)	Fran Palmer, Corporate Governance Manager Dr Buk Dhadda, Quality & Performance Committee Chair
Sponsor (Director)	Brigid Stacey, Chief Nurse Officer

Paper for:	**Decision**		**Assurance**	x	**Discussion**		**Information**	
Assurance Report Signed off by Chair				Not applicable				
Which committee has the subject matter been through?				Quality & Performance Committee – 29th July 2021				

Recommendations

The Governing Body is requested to **NOTE** the Quality & Performance Committee Annual Report for 2020/21 for assurance.

Report Summary

It is a requirement for Committees of the CCG to produce an Annual Report each financial year, as set out in the terms of reference. This report provides the Governing Body with a review of the work that the Quality & Performance Committee has completed during the period 1 April 2020 to 31 March 2021.

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

Not applicable.

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

Not applicable.

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

Not applicable.

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

Not applicable.

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

Not applicable.

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Not applicable.
Have any Conflicts of Interest been identified / actions taken?
Not applicable.
Governing Body Assurance Framework
Not applicable.
Identification of Key Risks
Not applicable.

NHS
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Clinical Commissioning Group

Quality & Performance Committee Annual Report 2020/21

QUALITY & PERFORMANCE COMMITTEE ANNUAL REPORT 2020/21

1. INTRODUCTION AND BACKGROUND

1.1 This report reviews the work of the Quality & Performance Committee and covers the period from 1st April 2020 to 31st March 2021.

1.2 The report provides the Governing Body and Accountable Officer with evidence relevant to their responsibilities in relation to the quality, performance, safety, experience and outcomes of services commissioned by the CCG. It also ensures that the CCG discharges its statutory duties in relation to the achievement of continuous quality improvement and safeguarding of vulnerable children and adults.

2. MEMBERSHIP AND QUORACY

2.1 In accordance with the terms of reference the membership of the committee during 2020/21 comprised of:

- 4 x GP Governing Body Members;
- 3 x Lay Members;
- 1 x Chief Nurse Officer or Deputy;
- 1 x Medical Director;
- 1 x Secondary Care Doctor;
- 1 x Executive Director of Commissioning and Operations; and
- 2 x Senior Healthwatch Representative (Derby City and Derbyshire County).

2.2 The quorum necessary for the transaction of business was five members, which included two Clinicians, two Lay Members and one Executive Lead (Chief Nurse Officer, Executive Director of Commissioning and Operations or Deputy).

2.3 Nominated deputies were invited to attend in place of regular members as required.

2.4 The full membership attendance can be found at Appendix 1.

3. FREQUENCY OF MEETINGS

The Quality & Performance Committee meeting is held on a monthly basis. Due to the pandemic, the meeting was stood down from the 1st April 2020. Meetings reconvened on the 25th June 2020, and by the 31st March 2021 the committee had met a total of 10 times.

4. KEY AREAS OF REVIEW

Throughout 2020/21, the Quality & Performance Committee reviewed, monitored and had oversight of work in the following areas:

4.1 Quality Assurance

Received reports for the following matters:

- The conclusion of the Syringe Driver Project
- Continuing Healthcare
- The effects of Covid-19 on provider activity and performance
- Care Homes
- Winter Plan 2020/21
- Maternity
- Autism
- Special Educational Needs and Disabilities
- Independent Review Panel outcomes
- Learning Disabilities Mortality Review
- Learning Disabilities Annual Report
- 3rd Wave Response to Covid-19

4.2 Provider Performance

Monitored contract and operational performance across all commissioned services from key partners through monthly integrated reports and by receiving reports on the following:

- Urgent and Emergency Care
- Planned Care
- Diagnostics
- Referral to Treatment Times
- Cancer
- Stroke Service at Chesterfield Royal Hospital NHS Foundation Trust
- ECHO Wait Lists
- Quality Accounts

4.3 Safeguarding

Ensured considerations relating to safeguarding children and adults were integral to commissioning services and robust processes were in place to deliver statutory functions, through receiving regular reports.

4.4 Patient Safety

Ensured that processes were in place to provide assurance that services were high quality, safe, effective, and provided patients and carers with positive experiences of care, through receiving regular reports on Infection, Prevention and Control.

4.5 Recovery and Restoration

Received regular updates on actions assigned to them within the Recovery and Restoration Programme.

4.6 **Corporate Assurance**

Noted the following for assurance:

- Update reports from the Clinical Quality Reference Group Interim meetings
- Approved the Clinical Quality Reference Group Terms of Reference

4.7 **Risk Management**

Agreed and regularly reviewed the Risk Register and Governing Body Assurance Framework for its area of remit, considering the adequacy of the submissions and whether new risks needed to be added to the Risk Register; or whether any risks required immediate escalation to the CCG's Governing Body.

5. CONCLUSION

The above provides a good summary of the areas of work that the Quality and Performance Committee have carried out in the past 12 months. This year has provided significant challenge to the whole of the NHS with the COVID pandemic and the effects of this is reflected in our performance data which is in line with what has been seen nationally. There continue to be additional challenges around the 4 hour A&E target, Referral To Treatment, Cancer Targets and EMAS but in addition to these we now have a significant challenge around 52 week waits. Again this is something which is a national issue and we will continue to work with all our providers to ensure we have a robust restoration and recovery process agreed and in place. The Committee has ensured that the Governing Body have been sighted on these and robust challenge has been offered around these and other areas that we cover.

A number of deep dives have also been requested around these and other areas, and the Committee have continued to seek assurance around both quality and performance as a result.

The Committee has also had assurance that the CCG is fulfilling its statutory obligation around safeguarding in the way of quarterly updates by both children's and adult's safeguarding teams. This has again been a very significant challenge during the COVID pandemic and our safeguarding teams have functioned exceptionally well to ensure and assure us of the processes that have been in place to mitigate any safeguarding risks that have emerged. We have also continued to seek assurance around a range of additional corporate assurance processes as outlined above.

I would like to extend my personal thanks to the hard work of both the Quality and Performance teams led by Brigid Stacey and Zara Jones, without whom our job as a Committee would be made far more challenging, particularly in the last 12 months that has seen the NHS function under such difficult circumstances due to the COVID pandemic. The confidence that I as Chair and the Committee as a whole have in them means that we are able to reflect on so much positive work that has been highlighted in this report despite facing significant challenges.

I would also like to thank everyone for being able to adapt to different ways of working remotely as a result of the pandemic whilst continuing to maintain such high standards, both from the Quality and Performance teams and all Committee members. It has

been an absolute pleasure to work with such professional and dedicated people in difficult, demanding circumstances and you all have my gratitude as Chair.

Dr Buk Dhadda
Chair of Quality and Performance Committee & GP Governing Body Member
July 2021

APPENDIX 1

Quality & Performance Committee Attendance Record 2020/21

Quality and Performance Committee Member	25 June 2020	30 July 2020	27 Aug 2020	24 Sep 2020	29 Oct 2020	26 Nov 2020	18 Dec 2020	28 Jan 2021	25 Feb 2021	25 Mar 2021
Dr Bukhtawar Dhadda *Chair, GP Member*	✓	✓	X	✓	X	✓	✓	✓	✓	✓
Dr Emma Pizzey *GP Member*	✓	✓	✓	✓	✓	✓	X	✓	✓	✓
Dr Greg Strachan *GP Member*	✓	✓	✓	✓	✓	✓	✓	✓	✓	X
Dr Merryl Watkins *GP Member*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Andrew Middleton *Lay Member for Finance and Sustainability Champion*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Simon McCandlish *Lay Member for Patient and Public Involvement*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Martin Whittle *Lay Member for Patient and Public Involvement*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Brigid Stacey *Chief Nurse Officer*	✓	✓	X	✓	✓	✓	✓	✓	✓	X
Dr Steven Lloyd *Executive Medical Director*	X	✓	✓	✓	✓	X	X	X	X	X
Dr Bruce Braithwaite *Secondary Care Consultant*	X	X	✓	✓	✓	✓	X	X	✓	X
Zara Jones *Executive Director of Commissioning Operations*	X	✓	✓	✓	X*	X*	X*	X*	X*	X
Helen Henderson-Spoors *Healthwatch Derbyshire Representative*	X	X	X	X	X*	X*	X	X*	X*	X

Governing Body Meeting in Public

5th August 2021

ITEM NO: 111

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

Paper for:	**Decision**	X	**Assurance**	X	**Discussion**		**Information**	
Assurance Report Signed off by Chair				N/A				
Which committee has the subject matter been through?				Engagement Committee – 20.07.21 Governance Committee – 22.07.21 Primary Care Commissioning Committee – 28.07.2021 Quality and Performance Committee – 29.07.2021 Finance Committee – 29.07.2021				

Recommendations

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

- The Risk Register Report;
- Appendix 1 as a reflection of the risks facing the organisation as at 31st July 2021;
- Appendix 2 which summarises the movement of all risks in July 2021;
- One new risk:
  - Risk 40 relating to relating to extension of contracts;
- The increase in risk score for Risk 06 relating to the demand for psychiatric intensive Care Unit beds (PICU).

APPROVE:

- The closure of Risk 28 relating to the increase in safeguarding referrals once the lockdown is lifted and children and parents are seen and disclosures / injuries / evidence of abuse are seen / disclosed.

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 31 July 2021.

The RR is a live management document which enables the organisation to understand its comprehensive risk profile, and brings an awareness of the wider risk

environment. All risks in the Risk Register are allocated to a Committee who review new and existing risks each month and agree removal of fully mitigated risks.
Are there any Resource Implications (including Financial, Staffing etc.)?
The Derby and Derbyshire CCG attaches great importance to the effective management of risks that may be faced by patients, members of the public, member practices and their partners and staff, CCG managers and staff, partners and other stakeholders, and by the CCG itself. All members of staff are accountable for their own working practice, and have a responsibility to co-operate with managers in order to achieve the objectives of the CCG.
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?
Not applicable to this update.
Has a Quality Impact Assessment (QIA) been completed? What were the findings?
Not applicable to this update.
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
Not applicable to this update; however, addressing risks will impact positively across the organisation as a whole.
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
Not applicable to this update.
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Not applicable to this update.
Have any Conflicts of Interest been identified/ actions taken?
Not applicable to this update.
Governing Body Assurance Framework
The risks highlighted in this report are linked to the Derby and Derbyshire CCG Board Assurance Framework.
Identification of Key Risks
The paper provides a summary of the very high scoring risks as at 31st July 2021 detailed in Appendix 1.

NHS DERBY AND DERBYSHIRE CCG GOVERNING BODY MEETING

RISK REPORT AS AT 31ST JULY 2021

1. INTRODUCTION

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

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

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

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

2. RISK PROFILE – JULY 2021

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

Risk Register as at 31st July 2021

Risk Profile	Very High (15-25)	High (8-12)	Moderate (4-6)	Low (1-3)	Total
Total number on Risk Register reported to GB for July 2021	6	18	4	0	28
New Risks	0	1	0	0	1
Increased Risks	0	1	0	0	1
Decreased Risks	0	0	0	0	0
Closed Risks	0	1	0	0	1

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

3. COMMITTEES – JULY VERY HIGH RISKS OVERVIEW

3.1 Quality & Performance Committee

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

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

   The current risk score is 20.

   June performance:

   - CRH reported 95.1% (YTD 96.0%) and UHDB reported 73.3% (YTD 75.2%).
   - CRH - At the start of the pandemic the volume of Type 1 attendances were much lower but they are now approaching pre-pandemic levels, with an average of 198 attendances per day. However, June 2021 volumes were still around 93% of the June 2019 levels.
   - UHDB - The volume of Type 1 attendances is high, with an average of 360 attendances per day. As a network the numbers of attendances now exceed pre-pandemic levels by 3% (June 2021 compared to June 2019).
   - Attendances at the Children's Emergency Department have rapidly increased, with concerns about Respiratory Syncytial Virus (RSV) being a major factor. Children's Type 1 attendances have averaged at 136 per day during June 2021 (compared to 92 per day in June 2019) with as many as 172 attending on one day (10th June).
   - The infection control measures required result in a longer turnaround time needed for patients . Measures include Red/Green streaming of patients, non-streaming of Paediatric patients or 111 patients and increased infection control procedures.
   - At Derby the acuity of the attendances was high, with an average of 17 Resuscitation patients and 207 Major patients per day, with the Urgent Treatment Centre treating most of the Minor patients.
   - The acuity at Burton is also high, with the attendances exceeding the previous year by 38%, with an average of 184 Type 1 attendances per day.
   - COVID-19 preparations had an effect on the system with increased pressure on 111 services and Emergency Departments devoting physical capacity to isolation areas.

- SORG manages operational escalations and issues if required.
- Meeting frequency has been stepped down from twice a week to weekly.
- GP Connect roll out is complete enabling direct booking of GP appointments via 111.

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

   The current risk score is 20.

   June update:

   Current bed position:

   - CCG beds = 29 (Q2 2021/22 target 25).
   - Adult Specialised Commissioning = 17 (Q2 2021/22 target 17).
   - Children and Young People (CYP) specialised commissioning = 3 (Q2 2021/22 target 3).
   - Of the 19 forecasted quarter 1 discharges, 14 occurred by the close of quarter 1. There has been, on average, 1 discharge per week. 63% of the planned discharges occurred as per their plan.
   - The TCP summit took place on 7th April with 16 commitments agreed. Senior leaders for all partners were present, along with operational managers and Experts by Experience. A follow up summit is planned for the 22nd June 2021 to review the achievements, co-produced with the Experts by Experience.
   - The CCG has commissioned a comprehensive diagnostic programme to identify key areas for improvement and recommendations for addressing issues of concern. The evaluation work commenced on the 12th July.
   - One of the very strong bids has been sent forward to NHSEI relating to the Expression of Interest for the Autism Diagnostic Pathway (Adults). The bid is for funding to work in partnership with the voluntary and community sector to co-design and implement a person-centred and community based post-diagnostic support.
   - The Interim TCP Programme Lead commenced on 25th June 2021. Interviews for a permanent TCP Programme Manager have

been completed and the successful candidate is due to start on 1st October 2021.

- A TCP Summit 2 was held on 29th June 2021.
- A policy/pathway is in development to ensure robust capture of funding for 'Commissioning for Individuals' in the community and funding agreed outside the Joint Funding panel.
- TCP remains on national escalation with regular calls with NHSE. Whilst much work is being done there won't be a significant impact until the Intensive Support Teams are recruited into for the revised autism offer. This is due to commence in August this year. Therefore the risk score will remain the same.

3. Risk 33: *There is a risk to patients on waiting lists as a result of their delays to treatment as a direct result of the COVID 19 pandemic. Provider waiting lists have increased in size and it is likely that it will take significant time to fully recover the position against these.*

   The current risk score is 16.

   July update:

   - The Planned Care Delivery Board and System Quality Group have been updated on the current position in relation to the assurance framework. There remains limited assurance overall regarding the ability to prevent harm due to the numbers of patients on the lists. A Derbyshire wide communications strategy is being worked up with Communications leads. The risk score is to remain.

3.2 Primary Care Commissioning Committee – Very High Risks

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

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

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

**Workforce - recruitment and retention of all staff groups*

**COVID-19 potential practice closure due to outbreaks*

**Recruitment of GP Partners*

**Capacity and Demand*

**Access*

**Premises*

**New contractual arrangements*

**New Models of Care*

**Delivery of COVID vaccination programme*

The current risk score is 16.

July update:

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

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

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

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

**Workforce - recruitment and retention of all staff groups*

**COVID-19 potential practice closure due to outbreaks*

**Recruitment of GP Partners*

**Capacity and Demand*

**Access*

**Premises*

**New contractual arrangements*

**New Models of Care*

**Delivery of COVID vaccination programme*

**Restoration and Recovery*

The current risk score is 20.

July update:

- Continuing work to track and support quality of General Practice, the Primary Care Quality and Performance Matrix is in place and is reviewed monthly.
- The Primary Care Quality and Performance sub-committee was re-established in June. This is supported by an escalation methodology to ensure consistency and timeliness of response.
- Pre meet Hub is also established and working well to support the identification of concerns and triangulate information across the CCG and national data.
- Quality Assurance visits are planned to re-commence in September, practices are in the process of being booked in, visiting GPs are in place and new supporting agenda is in place to reflect restoration and recovery and available data.
- Clinical Governance leads meetings are re-starting in July 2021.
- CQC refresh events are being delivered during July to support general practice awareness of the new visiting regime and preparation for CQC inspections.
- Risk description updated to include restoration and recovery.

3.3 Finance Committee – Very High Risks

One Finance Committee risk is rated as very high.

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

   The current risk score is 16.

   July update:

   June position:

   - The Derbyshire NHS system has a significant gap between expenditure assessed as required to meet delivery plans and notified available resource.
   - The CCG is working with system partners to establish a sustainable a long term financial position and deliver a balanced in-year position.
   - As at month 3 the CCG are not seeing any major financial pressures against planned expenditure with the exception of CHC fast track packages and a review is underway to understand the cause of this pressure.
   - Month 3 is reporting a YTD surplus of £0.133m and have not used any of our 0.5% contingencies.
   - The forecast position is breakeven and uses £1.686m of contingencies along with anticipated allocations for retrospective Covid and Elective Recovery Fund.
   - The CCG is working with system partners to understand the recurrent underlying position and early work suggests there is a £150m recurrent deficit.

4. JULY OVERVIEW

4.1 Increased risk since last month

One risk has increased in score:

1. Risk 06: *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.*

   This risk was proposed to be increased in score from a moderate 6 (probability 3 x impact 2) to a high score of 12 (probability 3 x impact 4).

This increase was approved at Quality & Performance Committee held on 29th July 2021.

- The procurement may not result in providers being able to deliver a localised service as intended. We are exploring alternative options however, the likelihood of achieving the KPI of no out of area PICU by last quarter is now uncertain.

- The risk has therefore increased as a consequence of procurement not meeting our needs as desired and therefore the possibility increasing of failing to meet the national requirement by quarter 4.

4.2 New risk

One new risk has been identified.

1. Risk 40: *In the period of transition from CCG to ICS, it is likely that a larger proportion of contracts will be extended on expiry rather than reprocured. The CCG is advised by Arden & GEM CSU on best practice for our procurement activity, but in some circumstances, the CCG may decide to proceed against best practice in order to give sufficient time for review of services within the framework of movement to an ICS. Proceeding against advice, carries a small risk of challenge from any providers who may have felt excluded from the process.*

   This new risk has been scored at a high score of 12 (probability 3 x impact 4) and was approved at Governance Committee on 22nd July 2021.

4.3 Closed risk

One risk is recommended to be closed.

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

   The reason for the proposed closure of this risk is that Safeguarding Children Partners are closely monitoring the number of referrals that are made to children's social care via the Derby and Derbyshire Safeguarding Children Partnership Quality Assurance subgroup (DDSCP) and via the Predicting Demand Group.

   With this close partnership monitoring and the evidence that referrals post lockdown have not grown significantly then the recommendation is that this risk is removed from the CCG register at this point.

   Closure of this risk was approved at Quality & Performance Committee on 29th July 2021.

5. RECOMMENDATION

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

- The Risk Register Report;
- Appendix 1 as a reflection of the risks facing the organisation as at 31st July 2021;
- Appendix 2 which summarises the movement of all risks in July 2021;
- One new risk:
    - Risk 40 relating to relating to extension of contracts;
- The increase in risk score for Risk 06 relating to the demand for psychiatric intensive Care Unit beds (PICU).

APPROVE:

- Closure of Risk 28 relating to the increase in safeguarding referrals once the lockdown is lifted and children and parents are seen and disclosures / injuries / evidence of abuse are seen / disclosed.

Derby and Derbyshire CCG Risk Register - as at July 2021

NHS Derby & Derbyshire Clinical Commissioning Group

Risk Reference	Yr++	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk Rating: Probability	Initial Risk Rating: Impact	Initial Risk Rating: Rating	Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identity assurance(s)	Progress Update	Previous Rating: Probability	Previous Rating: Impact	Previous Rating: Rating	Residual/ Current Risk Rating: Direction of Travel	Target Risk: Probability	Target Risk: Impact	Target Risk: Rating	Target Date	Link to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
01	21/22	The Acute providers may breach thresholds in respect of the A&E operational standards of 95% to be seen, treated, admitted or discharged within 4 hours, resulting in the failure to meet the Derby and Derbyshire CCGs constitutional standards and quality statutory duties.	Quality and Performance	Constitutional Standards/ Quality	3	4	12	Governance: • The CCG are active members of the Derbyshire A&E Delivery Board which has oversight and ownership of the operational standards. A performance dashboard has been produced to allow greater scrutiny of performance and any areas of concern to be highlighted and acted upon accordingly. • Providers update the OPEL reporting website daily by 11am and can escalate concerns and requests for support via the CCG urgent care team in hours, or the on-call director out of hours. - All providers participate in the COVID System Escalation Calls. - A robust Derbyshire System Winter Plan has been developed, and there will be an agreed process in order for this to be monitored and actioned throughout the Winter period - This will feed into the Derbyshire A&E Delivery Board. - Providers across the Derbyshire Health and Social Care System have now started to meet twice weekly as part of the System Operational Resilience Group. The purpose of this silver command level group is to co-ordinate and deliver the actions necessary to respond to significant issues which are affecting, or likely to affect, the functioning of an effective operation at a intra and inter sector level across the Health and Social Care System. This group reports into the System Escalation Group (SEC) which represents Gold Command.	Actions taken: • Review of the Directory of Services to ensure all appropriate patients go to UTCs rather than EDs • Imminent launch of the 111 First programme to move unheralded ED patients to more appropriate settings and embed a culture of patients calling 111 first • Work ongoing to develop digital consultations as part of the urgent care pathway • Enabling the direct booking of GP appointments via 111, when clinically appropriate and roll out of GP Connect to support this. • Increased Clinician to Clinician contact availability to assist EMAS clinical decision making and avoid unnecessary conveyances. - Identifying other failed pathway referrals that lead to unnecessary ambulance conveyances, forming a plan to remedy these. • Proactively manage High Intensity Users of urgent care to avoid their need to use emergency services. - Providing PCN-based enhanced care in Care Homes to improve quality and reduce unwarranted referrals. - Improving ambulance handover times through increased senior ownership within EDs and applying Releasing Time To Care principles in EMAS. - Expanding the mental health Crisis Service and enhancing the home treatment offer to improve gatekeeping. - Increasing A&E Mental Health Liaison team capacity to speed up response times. - Taking a system-wide approach to Same Day Emergency Care working to increase same-day discharges to improve patient flow. - Establishing an Orthopaedic Assessment Unit at RDH to treat patients in a more appropriate setting and improve flow. - Establishing a Surgical Assessment Unit at CRH to treat patients in a more appropriate setting and improve flow. - Increased GP Streaming at UHDB through commissioning changes and staff upskilling. - Embedding a weekly review process for patients with a length of stay of 21+ days in acute trusts. - Understanding Community demand and capacity to support the Improving Flow D2A pathways in South and City. - Increase OPAT capacity to enable more patients to be discharged from acute hospitals on IV antibiotics. - Altered handovers to enable more timely transfers from MAU/AAC to base wards at UHDB. - Same day emergency care (SDEC) and urgent treatment centre (UTC) pathways have been developed and in the process of increasing for EMAS to access, in order to reduce the number of patients directed to ED. - EMAS to undertake monthly audits with CRH and UHDB on patients that did not need to be conveyed to ED - in the process of starting to collate this data and then a system action plan will be developed, in order to make any necessary changes to reduce the number of unnecessary conveyances. - The SORG are currently reviewing the OPEL dashboard to support their operational discussion and to give a full picture on their operational resilience, which supports the system to understand where the pressures are, the impact this has and actions required to support. SEC stood down. SORG manages operational escalations and issues if required.	June 2021 performance CRH reported 95.1% (YTD 96.0%) and UHDB reported 73.3% (YTD 75.2%). CRH - At the start of the pandemic the volume of Type 1 attendances were much lower but are now approaching pre-pandemic levels, with an average of 198 attendances per day. However, June 2021 volumes were still around 93% of the June 2019 levels. UHDB - The volume of Type 1 attendances is high, with an average of 360 attendances per day. As a Network the numbers of attendances now exceed pre-pandemic levels by 3% (June 2021 compared to June 2019). Attendances at Children's ED have rapidly increased, with concerns about RSV being a major factor. Children's Type 1 attendances have averaged at 136 per day during June 2021 (compared to 92 per day in June 2019) with as many as 172 attending on one day (10th June). In addition the infection control measures required result in a longer turnaround time needed for patients . Measures include Red/Green streaming of patients, non-streaming of Paediatric patients or 111 patients and increased infection control procedures. At Derby the acuity of the attendances was high, with an average of 17 Resuscitation patients and 207 Major patients per day, with the UTC treating most of the Minor patients. The acuity at Burton is also high, with the attendances exceeding the previous year by 38%, with an average of 184 Type 1 attendances per day. COVID-19 preparations had an effect on the system with increased pressure on 111 services and ED departments devoting physical capacity to isolation areas. SORG manages operational escalations and issues if required. Meeting frequency has been stepped down from twice a week to weekly. GP Connect roll out complete enabling direct booking of GP appointments via 111.	5	4	20	5	4	20	3	3	9	On Going	Linked to Strategic Aims 1, 2, 3, 4, 5	Jul-21	Aug-21	Zara Jones Executive Director of Commissioning Operations	Craig Cook Director of Contracting and Performance / Deputy Director of Commissioning Operations Jackie Carlile Catherine Bainbridge, Head of Urgent Care Dan Merrison Senior Performance & Assurance Manager
02	21/22	Changes to the interpretation of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) safeguards, results in greater likelihood of challenge from third parties, which will have an effect on clinical, financial and reputational risks of the CCG	Quality and Performance	Statutory/ Financial	3	3	9	•The implementation date for LPS to replace DoL has been deferred until April 2022. The new code of practice is not expected until mid 2021. Midlands and Lancs CSU continue to re-review and identify care packages that potentially meet the 'Acid Test' and the MCA/DoLS staff member is preparing the papers for the CCG to take to the Court of Protection as workload allows. • CCG DoL policy will be updated when the LPS Code of Practice is available. • The CCG is required to submit 100% health funded packages of care that meet the DoL threshold to the Court of Protection (CoP) authorisation, there is an agreement with the LA for the joint funded cases which the LA submit on both our behalves and charge the CCG 50% of the submission fee. There is a reputational risk to CCG if found guilty of an unauthorised DoL for someone in receipt of CHC funding with associated compensation costs. • Due to the delay in the implementation of LPS until April 2022 the CCG will continue to make applications under the existing Re X process. There is still a large backlog of cases that the Court of Protection have not yet processed. • The Designated Nurse for Safeguarding Adults continues to meet once a fortnight with Midlands and Lancs to discuss ongoing management of cases. •The Designated Nurse for Safeguarding Adults sits on the CSU Operational Group where any issues in relation to this work are raised.	The Re X DoLS Options Paper was agreed by the December Governing Body meeting and is now being implemented. A further paper was taken Q & P to seek permission for the Safeguarding Adults Team and the CSU MCA/DoLS worker to submit Re X DoLS applications that are 100% funded directly to the CoP. This has been agreed and a framework for this to happen is being developed. The Safeguarding Adults Team continue to develop a framework for this to happen. This has been agreed and a framework for this to happen is being developed and an account with the COP has been set up.	January 2021: There is a current back log of Re X applications. February 2021: No change to the position for February. March 2021 Additional funding has been allocated from the CHC budget to allow recruitment of a band 6 nurse and an admin post to support the clearing of the backlog of Re X applications. Posts will be effective from April 2021 08.04.21 Risk still the same at the moment as new staff not yet in post. 17.05.21 Band 6 and Band 3 posts recruited to. June: There is no change to the risk grading the rationale being that it is an ongoing piece of work. Later in the year when we have more applications made there is the possibility that the risk grading can be reduced, but not currently. July: The CSU has received additional funding from the CCG to assist in clearing the backlog of Re X cases that we have that need to go to the CoP. The risk grading is stagnant as there is not enough movement in relation to this yet to be able to bring the risk down.	3	4	12	3	4	12	3	3	9	October 2021	Linked to Strategic Aims 1, 2, 3, 4, 5	Jul-21	Aug-21	Brigid Stacey - Chief Nursing Officer	Bill Nicol, Head of Adult Safeguarding Michelle Grant, Designated Nurse Safeguarding Adults/MCA Lead
03	21/22	TCP unable to maintain and sustain performance, pace and change required to meet national TCP requirements. The Adult TCP is on a recovery trajectory and rated amber with confidence, whilst CYP TCP is rated green. The main risks to delivery are within market resource and development with workforce provision as the most significant risk for delivery.	Quality and Performance	Quality/ Reputational	3	4	12	• System leadership group meets bi-monthly to review performance and address system issues, chaired by DH&FT SRO. • System wide plan developed identifying priorities for joint action and delivery • Additional funding and capacity in place for crisis response and forensic • Quality standards in place within contracts for NHS providers monitored quarterly at CQRG • Investment in Speech and Language Therapist for mental health wards to improve formulation in mental health care. • System Recovery & Restoration Plan implemented and ongoing • Weekly Discharge Review meeting to seek assurance against agreed trajectories • LD,MH,Autism delivery group have established a Provider development task and finish group to oversee the work to improve the capacity and resilience of local providers. - LD-A (Learning Disability and Autism) Delivery Group Meeting meet bi-weekly to monitor implementation of the seven 'lanes' on the improvement plan, with leads identified for the each workstream. - Weekly reconciliation meetings with DH&FT to ensure that admissions are appropriate with regards to confirmed diagnosis. - Mental health in-reach secondment: Funding agreed to establish a temporary in-reach post to acute mental health wards from Dec 2020 – May 2021. - Proposal to enhance the Derbyshire Autism offer: The System Delivery Board (via TCP SRO and Director of Quality) has requested a costed options proposal. This will go to the December meeting - Interim services to support Autistic people scoped and provided. The temporary secondment post and Case Managers will enhance oversight for people admitted with an ASD diagnosis. - Monthly NHSE/I regional Escalation assurance meetings - Weekly DDCCG TCP meeting • Derby and Derbyshire all-age Dynamic Support Register (DSR) for people with a formally diagnosed Learning Disability and/or Autistic Spectrum Disorder implemented • Weekly 1:1 – TCP Programme manager and NHSE TCP Lead Nurse • Covid-19 – impacting on transitions from Locked Rehab hospitals into community placements causing delays in discharges. Alternative transition planning being explored, • Case Managers redeployed to support DH&FT services – each Case Manager redeployed for 2 days per week to ensure they are able to continue to support case load.	TCP Recovery Action plan developed and monitored weekly: - Revised assurance systems and processes led by new TCP Programme Manager (Discharge Review Meeting (DRM), weekly NHS Provider meetings, appointment of two CCG Case Managers) - Mental health in-reach role: establish a temporary in-reach post to acute mental health wards from November 2020 – May 2021. - Weekly procurement updates: Multi agency weekly meetings with providers developing new services in Derbyshire led by Local Authority. • NHSE training sessions and case reviews for Ministry of Justice (MoJ) cases with Christine Hutchinson. - 1:1 support for TCP Programme Manager Admission avoidance - Proposal to enhance the Derbyshire Autism offer: The System Delivery Board (via TCP SRO and Director of Quality) has requested a costed options proposal is submitted to the group in December 2020. - Local Area Emergency Protocol (LAEP) notifications: It is an expectation that LAEPS are requested as part of meeting national and contractual expectations to notify about potential admissions. - Strengthen admissions avoidance in distress: These will focus on detailed review of care plans and provision for people with previous high levels of admissions & development of the Dynamic Support Register - Review of short breaks provision. - New Strategic Commissioner posts	Current bed position: CCG beds = 29 (Q2: 2021/22 target 25) Adult Specialised Commissioning = 17 (Q2 2021/22 target 17) Children and Young People (CYP) specialised commissioning = 3 (Q2 2021/22 target 3) Of the 19 forecasted Q1 discharges, 14 went by the end of Quarter 1. There has been on average 1 discharge per week. 63% of the planned discharges occurred as per their plan. The TCP summit took place on 7th April with 16 commitments agreed. Senior leaders for all partners were present, along with operational managers and Experts by Experience. A follow up summit is planned for the 22nd June 2021 to review that achievements, co-produced with the Experts by Experience. Comprehensive programme diagnostic to identify key areas for improvement and recommendations for addressing issues of concern. The evaluation work will commenced on the 12th July. EOI for Autism Diagnostic Pathway (Adults) one of the very strong bids sent forward to NHSEI. Interim TCP Programme Lead started 25 June 2021. Interviews for permanent TCP Programme Manager completed and successful candidate due to start 1 Oct 2021. TCP Summit 2 – 29th June 2021 held on Teams. Chaired by a person with experience. Clear actions agreed with stakeholders to take forward over next 12 months. The EbE feedback that it had been a positive meeting and they are appreciated everyone's reflections. Policy/pathway in development to ensure robust capture of funding for 'Commissioning for Individuals' in the community and funding agreed outside JF panel TCP remains on national escalation with regular calls with NHSE. Whilst a lot of work is being done their won't be a significant impact until the IST teams are recruited into for the revised autism offer. This is due to commence August this year. Therefore the risk score will remain the same.	5	4	20	5	4	20	2	3	6	2021	Linked to Strategic Aims 1, 2, 3, 4, 5	Jul-21	Aug-21	Zara Jones Executive Director of Commissioning Operations	Helen Hipkiss, Deputy Director of Quality / Phil Supplen, Assistant Director Quality, Community & Mental Health, DCHS
04A	21/22	Contracting: Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care. There are 112 GP practices in Derbyshire all with individual Independent Contracts GMS, PMS, APMS to provide Primary Medical Services to the population of Derbyshire. Six practices are managed by NHS Foundation Trusts and one by an Independent Health Care Provider. The majority of Derbyshire GP practices are small independent businesses which by nature can easily become destabilised if one or more core components of the business become critical or fails. Whilst it is possible to predict and mitigate some factors that may impact on the delivery of care the elements of the unknown and unexpected are key influencing dynamics that can affect quality and care outcomes. Nationally General Practice is experiencing increased pressures which are multi-faceted and include the following areas: *Workforce - recruitment and retention of all staff groups *COVID-19 potential practice closure due to outbreaks *Recruitment of GP Partners *Capacity and Demand *Access *Premises *New contractual arrangements *New Models of Care *Delivery of COVID vaccination programme	Primary Care Commissioning	Primary Care	5	4	20	**Early warning systems**: CCG works with LMC and other partners to systematically identify and support practices that may be in trouble, including: reviewing information on practice performance via an internal, cross directorate review of practices looking at a range of data sources; linking with the LMC to pool soft intelligence on practice 'health' and to jointly support struggling practices; directly approaching practices identified as at risk **CCG support:** CCG commissions and funds a range of supportive measures designed to increase the resilience of General Practice, in line with the GP Forward View and GP Contract. Key working groups and committees have been established to support the delivery of the work programmes, these include: *Primary Care Leadership Committee *Primary Care Workforce Steering Group - sub group GPN 10 Group *Primary Care Estates Steering Group *General Practice Digital Steering Group The groups have a wide range of objectives and outcomes to mitigate this corporate risk, these include , managing allocation and monitoring of additional funding to support the PC workforce (recruitment and retention, new roles) Funding of practice nurses to promote the National GPN , work with CCG nursing team. Identification and delivery of training to support and improve GP practice resilience; funding increased capacity; supporting practices to manage workload, development of leadership/pg roles. Utilisation of the GP Task Force and Health Education Derbyshire to support the delivery of these objectives **Peer support:** the Primary Care Networks will provide a way that practices can support each other in smaller groups. Over time this will provide a safe forum for practices to seek help from peers and another route for help for struggling practices who are not willing to approach the CCG directly **Strategy**: implementation of the CCG's primary care strategy will bring additional resources, capacity and support to General Practice, and develop its role at the centre of an integrated system, thus increasing resilience and mitigating against individual practice failure. The CCG has financially supported the development of the GP alliance, who have supported the development of the PC strategy and are also undertaking a review of PC demand and capacity in order to have a understanding of access to Primary Care in Derbyshire .	The Derbyshire wide Primary Care Strategy agreed and in place. Primary Care Networks (PCNs) established county wide. PCNs undertaking self-diagnostic to establish current position and development needs. Funding identified to support development. First cross directorate review meeting of practice data set for September. Primary Care Team to continue to work closely with practices to understand and respond to early warning signs including identification of support/resources available including practice support in discussions around workload transfer from other providers. Derbyshire wide Primary Care Commissioning Committee to oversee commissioning, quality and GPFV work streams. Assurance provided to NHS England/JUCD through monthly returns and assurance meetings.	19.10.20 Increasing COVID-19 activity in primary care. National portal now live for practice orders for PPE. From 1 October 2020, CCG continuing to reimburse additional cleaning costs and also COVID19 absence in practices where backfill is required for face to face appointments and roles. OPEL reporting being developed for primary care. Winter plan submitted for additional resource to support red hubs / activity. Risk remains the same and will be reviewed at PCCC on 28th October 2020 9.11.20 Letter from NHSE/I to outline draft enhanced service for COVID vaccine. In addition, £1.3million funding allocated to the CCG to support General Practice in additional capacity which will also support COVID vaccine rollout. Practice outbreaks are starting to be seen with business continuity plans enacted. Risk mitigated through the additional staffing to cover COVID absence. December - There are no changes to the existing levels of risk for this month. The pressures on Primary Care and General Practice remain the same along with the challenges of COVID-19 vaccine programme and whilst there are mitigations around the additional funding for general practice the risks remain the same as reported in November 2020. February 2021 - There are no changes to the existing levels of risk for this month. CCG letter and guidance issued 8th January 2021 which summarised the CCG position and support available to practices, locally, nationally and from the Derbyshire system. This included a comprehensive guidance document detailing all the available funding streams, income protections and additional resource available to our practices. NHS E/I issued a letter dated 7th January 2021 which recognises the pressure this puts practices and PCNs under and sets out the steps to be taken to free up practices to enable prioritisation of the Covid-19 vaccination programme. July no change to risk score. There is an increasing demand and pressure General Practice are facing as lockdown measures are being relaxed and removed. Appointment levels are already higher than pre pandemic levels as well as Primary Care delivering 75% of the COVID vaccination programme to date largely through the existing workforce. Following a meeting with the CCG, LMC and GP Alliance in July highlighting the significant concerns being reported in General Practice the CCG were asked to reinstate the weekly sitrep that reports staff absences and RAG rating. The sitrep will provide an accurate picture of the situation in General Practice that can be reported into the wider system meetings so partners have a clear understanding of what is happening in general practice and how it can be supported. It will also support requests for additional funding and resources in Primary Care. The CCG has also recommenced the 'battle box service' that was available through previous waves of Covid to provide temporary loans of equipment to GP Practices who need a rapid response to enable their staff to work remotely. No changes to the existing levels of risk this month.	4	4	16	4	4	16	3	3	12	On Going	Linked to Strategic Aims 1, 2, 4, 5	Jul-21	Aug-21	Dr Steve Lloyd - Medical Director	Hannah Belcher, Head of GP Commissioning and Development (Primary Care)
04B	21/22	Quality: Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care. There are 111 GP practices in Derbyshire all with individual Independent Contracts GMS, PMS, APMS to provide Primary Medical Services to the population of Derbyshire. Six practices are managed by NHS Foundation Trusts and one by an Independent Health Care Provider. The majority of Derbyshire GP practices are small independent businesses which by nature can easily become destabilised if one or more core components of the business become critical or fails. Whilst it is possible to predict and mitigate some factors that may impact on the delivery of care the elements of the unknown and unexpected are key influencing dynamics that can affect quality and care outcomes. Nationally General Practice is experiencing increased pressures which are multi-faceted and include the following areas: *Workforce - recruitment and retention of all staff groups *COVID-19 potential practice closure due to outbreaks *Recruitment of GP Partners *Capacity and Demand *Access *Premises *New contractual arrangements *New Models of Care *Delivery of COVID vaccination programme *Resources and Recovery	Primary Care Commissioning	Primary Care	4	5	20	**Primary Care Quality Team**: team providing monitoring of and support to practices country wide, proactive and reactive, direct contact available to practices to clinical team members, via telephone and email, for advice and support of any clinical queries and patient safety issues. Communication pathways established including membership bulletin, Information Handbook, web site development and direct generic inbox **Primary Care Quality and Performance Committee**: The Committee will oversee monitoring support and action plans for the delivery of Primary Medical Services, gain assurance regarding the quality and performance of the care provided by GP practices, identifying risks to quality at an early stage. Monthly meetings established. **Cross directorate internal review (hub) process** - Primary Care Quality dashboard and matrix developed, discussed monthly at Hub meeting, integration, sharing and triangulation of PC data from Primary Care Quality, Contracting and Transformation. Provides the opportunity to oversee multiple data sources and gain information from wider CCG teams in order to gain collective view on quality of care offered and to identify areas of best practice and areas of concern where support or intervention is needed. Provides the opportunity to review and create action plans to support practices who may be experiencing / demonstrating difficulty or signs of potential deficit in quality or unwarranted variation of care provision. **Supporting Quality Improvement visits:**18 month rolling programme of practice visits with a focus on quality and support is being delivered, this provides the opportunity of direct clinical face to face discussion between individual GP practices and CCG. Provides an safe opportunity to discuss individual practice quality metrics and for the practices to highlight / raise any issues or concerns directly to the CCG. **Clinical Governance leads meetings:** Established and held quarterly across Derbyshire PCN footprint, provides the interface between CCG and individual practices, opportunity to share best practice, practice concerns, learning and recommendations, support the implentation of GP practice governance. **Quality Schedule**: being developed as part of the enhanced service review to provide a formal mechanism to contract for improved quality standards in areas such as sepsis and safeguarding - following model developed with acute and other provider organisations. Primary Care Quality Schedule Included (October 2021) to DCCG Commissioned Primary Care Contracts, to maintain and support the delivery of continuous quality improvement in Primary Care.	Primary Care Quality Team now fully recruited to and delivering on quality programme including SQI visits. Continuing work to track and support quality of General Practice - Primary Care Quality and Performance Committee established and functioning well. Work is ongoing on development of quality schedule. Production of a Primary Care Dashboard being finalised, review of quality reporting methodology and governance structures to PCCC being undertaken. Primary Care Dashboard and Matrix established. Supporting Governance Framework implemented. July: Continuing work to track and support quality of General Practice - Primary Care Quality and Performance Matrix in place and reviewed monthly. Primary Care Quality and Performance Sub Committee re established June following return to BCS, supported by an escalation methodology to ensure consistency and timeliness of response. Hub (pre meet) also established and working well to support the identification of concerns/ triangulate information across the CCG/ national data.	• A range of mitigations have been put in place both Nationally and Locally to support general practice; Local services include • Red hubs and red home visiting service; • DHU support for practices to provide cover Long COVID pathway development System support to deliver COVID vaccination programme Intelligence both qualitative and quantitative continues to be captured to both support and monitor care provided by general practice from both a contractual and quality perspective Whilst the Primary Care Quality and Performance committee has been stepped down due to the level four CCG pandemic response a monthly meeting to determine / highlight any new risks / emerging themes continues. Any actions from this will be addressed with individual practices as required . Reporting arrangement will be undertaken directly to PCCC March - no change 08.04.21 GP services are moving towards recovery and restoration including reinstatement of CQC inspections, the risk will continue to be reviewed and amended as required. May update: Primary Care Performance and Quality Committee and monthly PC Hub meetings re starting June Practice Quality Visits re commencing July Clinical Governance Leads Meetings re starting July / August CQC Inspections commenced April June - No changes this month. July - Quality Assurance visits planned to re commence in September, practices in the process of being booked in, visiting GPs in place and new supporting agenda in place to reflect restoration/ recovery and available data. Clinical Governance leads meetings restarting July. CQC Refresh events delivered July to support general practice awareness of new visiting regime and preparation for CQC inspections.	4	5	20	4	5	20	4	4	16	On Going	Links to Strategic Aims 1, 2, 3, 4, 5	Jul-21	Aug-21	Dr Steve Lloyd - Medical Director	Marie Scouse, Assistant Director of Nursing & Quality - Primary Care Judy Derricott, Head of Primary Care Quality
05	21/22	Wait times for psychological therapies for adults and for children are excessive. For children there are growing waits from assessment to psychological treatment. All services in third sector and in NHS are experiencing significantly higher demand in the context of 75% unmet need (right Care). COVID 19 restrictions in face to face treatment has worsened the position.	Quality and Performance	Patient Experience/ Quality	4	3	12	A national mandated programme of community delivery with specific recommendations for psychological therapies is expected. This will change how DDCCG commissions current services and stopped the planned STP Psychological therapies review. . For children there are growing waits from assessment to psychological treatment .Some investment is being made through care CAHMS investment in 2019 and 2020 in both CRH and DH/CFT CAHMS linked to waiting times. A newly commissioned targeted intervention service was introduced in June 19 and digital offer for cyp in September 19 (KOOTH) . Funding for wave 2 Transformation from NHSE to support MH in school was successful with an intended start date of may 2020. A service for Looked after children was due to start in May 2020. These initiatives are intended to provide support without CAHMS being required to help manage waits. COVID 19 has reduced face to face therapies and increased waits delayed recruitment and investments and wait times have become longer. This is a concern raised by safeguarding board and partners and children's commissioner for England.	Once national research and guidance released recommission DH/CFT to deliver services to new model. Continue to monitor within contract meetings once these are restarted. For children introduce increased digital offer during pandemic . Consider Further services to manage expected demand when schools return in September 20202: Progress CAHMS review to a JUCD plan of improvement with if necessary provider improvement plans. report to safeguarding board and JUCD in September 20. Report to CLC on COVID19 arrangement analysis and potential mitigations .	May update The pathway to Helios is being finalised and CBT pathway incorporated. CYP transformation plan submitted and signed off . This supports psychological therapy wait times as without this support, wait times would have increased for adults still further. The expected delivery of a significant reduction of wait times has been put back to April22. This is because for CYP the COVID impact of increased referral rates and COVID delayed impact of wait time initiatives in 2020. For adults the impact of Community Mental Health Framework on psychological therapies will take a 3 year period to be realised in LTP. June update -Overall situation as described in May . Helios initiative has started , significant investment in CYP crisis developments agreed in financial return. Workforce will be a significant issue in delivery. Regional review of sexual violence services has been commissioned by NHSE&I that will help inform our Derbyshire approach. Expressions of interest in regional resource to review waiting lists for CYP neurodevelopment and look to alternative pathways is being pursued. July Update as June but note Helios unable to provide as much CBT intensively over 6month period as initially planned due to national demand.	4	3	12	4	3	12	3	3	9	Sept 21	Links to Strategic Aims 1, 2, 3, 4, 5	Jul-21	Aug-21	Zara Jones Executive Director of Commissioning Operations	Dave Gardner Assistant Director, Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning
06	21/22	Demand for Psychiatric intensive Care Unit beds (PICU) has grown substantially over the last five years. This has a significant impact financially with budget forecast overspend, in terms of poor patient experience , Quality and Governance arrangements for uncommissioned independent sector beds. The CCG cannot currently meet the KPI from the Five year forward view which require no out of area beds to be used from 2021.	Quality and Performance	Commissioning	5	3	15	Beds commissioned on block and to be extended for a further year. STP developing a plan for Derbyshire PICU. Use has escalated during COVID19 and funding recoverable from COVID funding this therefore has resulted in no change to the financial risk despite numbers doubling to 24 from 12. However plans will need to be in place to ensure numbers return to agreed baseline. 07.08.20 Length of stay rising is a factor in increased use mitigated by reduced use of additional observations. DH:CFT have submitted 250M capital funding Bid to national capital scheme. this includes a new build PICU for men. Options for Women will need to be considered within the estate changes made possible if the bid is successful.	Continue to Explore regional options for bed optimisation being taken forward with clinical network DH:CFT to take a lead provider role . OOA bed reduction plan to include PICU and manages through STP. Report on Options for Derbyshire PICU and controls to be brought back to DDCCG in September, Ensure plan in place to reduce PICU usage post COVID. Ensure that DH:CFT returns patients back to Derby as soon as possible. Maintain reduced additional observation costs with continued provider challenge. 07.08.20 Issue raised in MH recovery Cell . short life group formed to address . Report on Options for future dependent on outcome of 250Mcapital bid. Subgroup of recovery cell to produce plan to reduce numbers . Finance teams to discuss how COVID funding arrangements can be taken forward with DH:CFT as "top up funding" announced in phase 3 arrangements may be linked to provider costs not CCG costs. This is being investigated further.	April update. PICU bed use is within expected trends . All beds are still classed as out of area and will be until procurement is completed in June 21 and contract mobilised. DDCCG and JUCD will not meet Kpi for no OOA beds until contract mobilisation. DH:CFT proceeding with plans for Derbyshire PICU unit on Kingsway site. Risk rating reduced to 6 ,as financial risk reduced and patient care is sub optimal in terms of OOA but numbers reduced and pathway being managed with improved monitoring of LOS and repatriation. May Update - procurement window closed for PICU block beds and framework. Limited market response unlikely to resolve OOA PICU without an alternative sourcing strategy for PICU to be drawn up during MAY. NHSE/I will probably need a RAP June update As suspected the provider market has changed since the market test in part due to NHSE&I policy. We have met with NHSE&I and agreed we will seek closest possible bed to Derbyshire that meets quality requirements as an interim measure. Options on how to take this forward are being explored but further procurement is likely. Remains a risk against delivery of no beds by last quarter 2022 which is revised objective -for delivery from NHSE&I July - July Update as June .Options to take forward PICU following the market response in procurement being considered. Risk score increased to reflect the increased risk against KPI for no out of ares PICU for last quarter following procurement .The risk has increased as a consequence of procurement not meeting our needs as desired and therefore possibility increasing of failing to meet the national requirement by quarter 4 which is on the risk scale a 4 now 12 not 9.	3	2	6	3	4	12	2	3	6	July 22	Links to Strategic Aims 1, 2, 3, 4, 5	Jul-21	Aug-21	Zara Jones Executive Director of Commissioning Operations	Dave Gardner Assistant Director, Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning

Risk Reference	Year	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk Rating: Probability	Initial Risk Rating: Impact	Initial Risk Rating: Rating	Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating: Probability	Previous Rating: Impact	Previous Rating: Rating	Residual/ Current Risk: Probability	Residual/ Current Risk: Impact	Residual/ Current Risk: Rating	Target Risk: Probability	Target Risk: Impact	Target Risk: Rating	Target Date	Link to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
09	21/22	Sustainable digital performance for CCG and General Practice due to threat of cyber attack, network outages and the impact of migration of NHS Mail onto the national shared tenancy. The CCG is not receiving the required metrics to provide assurance regarding compliance with the national Cyber Security Agenda, and is not able to challenge any actual or perceived gaps in assurance as a result of this.	Governance	Corporate	3	4	12	• NECS receive and acts on CareCERT alerts, received in response to NHS Digital monitoring of threats to the external system. Actions taken are reported via the NECS contract management meetings, and escalated to the Digital Lead where required. • The network infrastructure is proactively monitored and anti-virus signatures are maintained adequately. • NECS actively provide compliance evidence for the DSPT and provides assurance to the CCG regarding network security. • The Governance Committee has responsibility to oversee the arrangements for ensuring that technology is secure and up-to-date and IT systems are protected from cyber threats. • The NECS contract management board receives routine assurance reports regarding cyber security preparedness and resilience. • Hygiene reports (progress against technical security measures) are provided to the NECS contract management board The CCG has agreed a local policy for the shared tenancy and Microsoft Office 365 that seeks to prevent the introduction of new functionality into Microsoft Teams and other associated software until the business case has been proven that this functionality would be beneficial and until such time as the Governance is in place. Where changes are known in advance, these are communicated to staff appropriately including the effect of the change. The CCG are also working with NECS to develop system policies at the local level to allow as much local control over changes as is feasible while feeding back to the national teams. Our CCG is also two/three weeks behind the rollout in other NECS Customers to enable us to learn lessons from their experiences and adjust accordingly.	CCG proposes to work closely with cyber awareness training provider / Cyber Resilience Support team which may include identification and recommendations of cyber issues that may impact on cyber security, for example developing and implementing further strategies and policies - and identification of practical opportunities where necessary to support operational awareness. Development of local policies and working with the national team to devolve as much responsibility as possible to the local level thereby allowing us to have more control over the deployment, removal and changes to functionality within the Microsoft Teams and other environments linked to the NHS shared tenancy and Microsoft Office 365. Additionally, the migration of the CCG and colleagues within General Practice away from the previous NHS Mail system and onto the NHS' national shared tenancy brings both benefits and risks. While there are economies of scale and additional functionality available, there is a lack of control over the launch of new functionality and removal of existing functionality. There are also configuration issues between settings at the national and local level, leading to a temporary pause in the deployment of Microsoft Office 365 within Derby & Derbyshire until these are remedied.	11.03.21 - We are assured that recent CareCERT that have been issued by the NHS Digital Data Security Centre have been implemented in an appropriate timescale and we await the completion of the rollout of Microsoft Office (N)365, Cisco ISE and the NHS Digital tools. As these systems begin to deploy, we will be able to reduce the risk, but until that point we suggest these remain in their current position. 21.04.21 - Preparatory work has begin for the upgrade to the CheckPoint system; this was due to be implemented last week, but required further change which had not previously been within scope. Full deployment of Microsoft Office 365 has begun with the Corporate estate, removing the risks relating to Microsoft Office 2010, but this is not yet complete. As with the previous update, deployment is more advanced than the last update, but are not yet fully implemented and hence the scores remain the same. 18.05.21 - CheckPoint VPN upgrade is underway and over 50% complete; the Cisco ISE endpoint protection has also been procured and deployment is starting. GP Practices are being booked in for their Microsoft Office 365 upgrade and currently around 40% of CCG devices have been updated. There are no Windows 7 devices left - all devices are Windows 10 and running advanced threat protection. There are no specific additional risks, but will look to reduce the score once all of the mitigation has been implemented. 14.06.21 - CheckPoint VPN upgrade has been completed and a timetable for Cisco ISE endpoint protection agreed. Deployment of Office 365 continues across GP and CCG devices and the CCG is going through the process of re-accreditation for Cyber Essentials with a view to securing Cyber Essentials Plus. We are aware of extended support arrangements that have been put in place with Microsoft for additional Windows 10 support and the local NECS team are in the process of upgrading all Windows 10 devices to the latest version of the application by the end of June 2021. 12.07.21 - No evidence of the recent (and ongoing) distributed denial of service attack penetrating any of our networks or devices and NECS has confirmed that geo-blocking is in place to prevent connections from countries and areas known to be active in attacks such as these. We are continuing to work with NECS on the 'PrintNightmare' vulnerability and we have tracked this from initially being of low significance to requiring action. NECS has mitigated the risk by removing the printing function from all unnecessary devices, but to fully secure the network we would need to suspend all printing from all devices which is impractical. We therefore continue to scan all devices connected to the network for any signs of the vulnerability being utilised - if found, the device will automatically be isolated from the network and the security team informed. To date, there have been no exploitations identified within the CCG or Primary Care. Risk remains the same, as there is the risk of exploitation, but no evidence of this being exploited - similar to the scenario with Microsoft Office 2010.	2	4	8	2	4	8	1	4	4	No target date added as Cyber Security is a continuing risk/threat and will need to be reviewed constantly	Links to Strategic Aim 4	Jul-21	Aug-21	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Ged Connolly-Thompson - Head of Digital Development, Chrissy Tucker - Director of Corporate Delivery
10	21/22	If the CCG does not review and update existing business continuity contingency plans and processes, strengthen its emergency preparedness and engage with the wider health economy and other key stakeholders then this will impact on the known and unknown risks to the Derby and Derbyshire CCG, which may lead to an ineffective response to local and national pressures.	Governance	Corporate	4	4	16	• CCG active in Local Health Resilience Partnership (LHRP) and relevant sub groups • On-call staff are required to receive Met Office Weather Alerts. These will be cascaded to relevant teams who manage vulnerable groups • Executive attendance at multi agency exercises. • Internal Audits have evaluated Business Continuity preparedness. • Derbyshire-wide Incident Plan in existence • Joint Emergency Services Interoperability Protocol (JESIP) training made available to on-call staff • Staff member trained in Business Continuity and member of professional body • Staff member competent to train Loggists internally and there are sufficient number now trained • Derby and Derbyshire CCG represented on LHRP and LRF sub-groups including, HEPOG, Training and Exercising sub-group. Risk Assessment Working Group, LRF Tactical, Human Aspects and Derbyshire Health Protection Response Group. • On-call rota being revised to introduce two tier system with improved resilience • Comprehensive training undertaken for On-call staff to National Standards Accountable Emergency Office and Deputy AEO attended EU Exit conference 17th September 2019 •On Call Forum has been established and has held productive meetings sharing knowledge and experience • Table top exercise took place in December 2019 to test the robustness of the CCG response to IT and Telephony failure and to Fuel Shortage leading to improvements in processes and procedures • CCG participating in local response to Coronavirus risks as part of the Derbyshire LHRP system following national guidance from PHE. • The Director of Corporate delivery and the Business Resilience manager took part in a national seminar Effective Communication Around Major Incidents Digital Forum on Friday 16 October, 2020. • The Director of Corporate Delivery and the Business Resilience Manager took part in a national seminar EU Exit End of Transition period workshop on 04 November 2020. This has resulted in key areas of work being identified and CCG Leads mobilised to provide a response • Senior Responsible Officer for EU Exit designated for the CCG and contact details made available to NHSEI • EU Exit now a standing item on weekly SEC Meetings	• Practices updating Business Continuity Plans to include consistent contact details for CCG in-hours and out of hours. • Business Resilience Manager developed a single operational Business Continuity Plan. This will now be reviewed in the light of learning from the COVID pandemic. • Confirm and challenge meeting with Providers and NHSEI took place on 2nd October 2019 and agreement reached with Providers on final level of assessment against the core standards. • CCG on call arrangements reviewed and CCG is operating a 2 tier on call system. Training has been provided to all on call staff from November to March 19. • Accountable Emergency Office and Deputy AEO attended EU Exit conference 17th September 2019, to gain assurance on EU Exit assurance. • CCG took part in daily SitRep reporting to NHSE until stood down on 28 October 19. • CCG provided exception reports on EU Exit through Local Resilience Forum. • Derbyshire System wide EU Exit Plan developed and distributed to Providers • Two "dry runs" at preparing for EU Exit date puts the CCG in a stronger position • Business Impact Assessments for each function within the CCG have been completed and approved the Governance Committee in March 2020. • Lessons learned from Toddbrook Reservoir will be incorporated into the Business Continuity plan when the EPRR review becomes available. • A review of the recent power outage situation at Cardinal Square is scheduled this month (November) and lessons learned incorporated into the Business Continuity Plan. • The On Call Forum has met regularly and has provided an opportunity to share experience and knowledge •The CCG has fully participated in the response to the COVID pandemic and submitted evidence to NHSEI as part of the 2020/21 EPRR National Core Standards • Continued collaborative working with Provider organisations and other stakeholders including the LRF and NHSEI Regional teams	•CCG and Derbyshire Provide Annual Assurance 20/21/ lessons learnt during first wave of COVID -19 and preparedness for Winter Planning process currently being undertaken, deadline for submission to NHSE is 31st October 2020. •CCG is working with members of SEC to design a Derbyshire wide system escalation process to enable swift and collective action regarding winter pressures and other key issues including EU Exit. • The CCG submitted the annual EPRR response for the National Core Standards to NHSE for itself and Derbyshire Provider organisations ahead of the deadline of 31 October 2020. The results showed a positive approach across all organisations in relation to response, evaluation and preparedness for winter pressures. Attended the End of Transition webinar where actions undertaken by NHSEI workstreams were shared and organisational actions recommended, and the CCG is currently working through those. Future webinars are planned and the CCG EU Exit team will be in attendance. Due to the uncertainty around EU End of Transition and what will transpire the probability is recommended to increase from 2 to 3 • The CCG is working with Provider organisations to identify any supplier contracts in place that fall outside national provisions ahead of EU Exit • CCG is complying with NHSEI request to submit a daily EU Exit Transition return via the NHSEI Data Collection Portal • CCG is undertaking a review of its functions to determine how best to support the COVID-19 vaccine roll out with CCG staff The risk score has been reduced due to our Business Continuity arrangement being enacted and embedded over the past year and the further development of strengthened partnership working both with health colleagues and other key stakeholders. 05.02.21 Updated Business Continuity Plan, Policy and EPRR Policy Statement was approved by January Governance Committee. March update: • EU Exit SitREP to NHSEI over 7 days • EU Exit SitREP now submitted each weekday and by exception at the weekend April Update • EU Exit SitREP stood down with effect from 1 April 2021. May Update - ICC has been stood down from weekend operating and has reduced weekday hours of 9am to 5pm The score is proposed to remain as it is due to how the risk is described. To reduce it any further would weaken the case for continued development internally and with wider stakeholders. June Update • Business Resilience Manger to attend x2 days training in June 2021 facilitated by the Emergency Planning College to enhance contribution to LRF Risk Sub Group • Current review of business continuity levels and the triggers for each level The score is proposed to remain as it is due to how the risk is described. To reduce it any further would weaken the case for continued development internally and with wider stakeholders. July Update • Business Resilience Manger attended x2 days training in June 2021 facilitated by the Emergency Planning College to enhance contribution to LRF Risk Sub Group. First meeting of the group to be held 21 July 21. • EU Exit Learning the Lessons report compiled at to be presented to Governance Committee The score is proposed to remain as it is due to how the risk is described. To reduce it any further would weaken the case for continued development internally and with wider stakeholders.	2	4	8	2	4	8	2	2	4	January 2021	Links to Strategic Aims 3, 4	Jul-21	Aug-21	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Chrissy Tucker - Director of Corporate Delivery / Richard Heaton, Business Resilience Manager
11	21/22	Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the CCG to move to a sustainable financial position.	Finance	Finance	4	4	16	Internal management processes – monthly confirm and challenge by Finance Committee Monthly reporting to NHSEI Development of system I&E reporting including underlying positions by organisation and for the system as a whole	Due to the uncertainty of the financial regime in the NHS it remains unclear what the impact on the CCG of failure to live within agreed resources for the 2021/22 financial year would be.	The Derbyshire NHS system has a significant gap between expenditure assessed as required to meet delivery plans and notified available resource. The CCG is working with system partners to establish a sustainable a long term financial position and deliver a balanced in-Year position. As at M3 the CCG are not seeing any major financial pressures against planned expenditure with the exception of CHC fast track packages and a review is underway to understand the cause of this pressure. We are reporting at M3 a YTD surplus of £0.133m and have not used any of out 0.5% contingencies. The forecast position is breakeven and uses £1.686m of contingencies along with anticipated allocations for retrospective Covid and Elective Recovery Fund. The CCG is also working with system partners to understand the recurrent underlying position and early work suggests there is a £150m recurrent deficit.	4	4	16	4	4	16	2	3	6	On going	Links to Strategic Aims 1, 2, 3, 4, 5	Jul-21	Aug-21	Richard Chapman, Chief Finance Officer	Darran Green- Assistant Chief Finance Officer
12	21/22	Inability to deliver current service provision due to impact of service review. The CCG has initiated a review of NHS provided Short Breaks respite service for people with learning disabilities in the north of the county without recourse to eligibility criteria laid down in the Care Act. Depending on the subsequent actions taken by the CCG fewer people may have access to the same hours of respite, delivered in the same way as previously. There is a risk of significant distress that may be caused to individuals including carers, both during the process of engagement and afterwards depending on the subsequent commissioning decisions made in relation to this issue. There is a risk of organisational reputation damage and the process needs to be as thorough as possible. There is a risk of reduced service provision due to provider inability to retain and recruit staff. There is a an associated but yet unquantified risk of increased admissions – this picture will be informed by the review.	Quality and Performance	Quality/ Reputational	3	4	12	• Joint working in place with Derbyshire County Council to quantify the potential impact on current service users. * Joint working in place with Derbyshire Community Health Services NHS Trust to ensure business continuity plans in place and operational risks mitigated * Communications and engagement teams are being involved throughout to manage consultation process and ensure information is shared within public domain to enable a balanced view. * Project team meeting weekly to monitor progress and resolve issues - Task and finish group has been established with representation from local authority, CCG, DCHS and DHFCT Action plan has been developed and sent to the BRS Delivery Group for comment. Task and finish group will now take the action plan forward The crisis element of respite has been discussed in the wider system and agreement has been reached The original short break review - a position statement paper has been produced and will be discussed with Director to agree on next steps. Work to be carried out by the Strategic Commissioners	• Working closely with Comms and Engagement Team. • Assurance of process received from Consultation Institute.	Covid-19 restrictions – impacting on discharge planning, inconsistent policies across different providers. - Orchard Cottage maintained significant damage by a patient unable to be used at moment,, This will not be re-opened until 2021 - Amberleigh - previously closed. Discussions have taken place to re-open to provide an urgent provision for transforming care patients. Discussions continue. - The third unit remains closed as not currently fit for purpose. The crisis element of respite has been discussed in the wider system and agreement has been reached The original short break review - a position statement paper has been produced and will be discussed with Director to agree on next steps. Ownership of 'Crisis' Lane as part of the Three Year LD/A Road Plan changed to DDCCG Strategic Commissioner. BRS LD A Delivery Group Extraordinary Meeting scheduled for the 21st April. Progress to be reviewed against: 1.The expansion of IST 2.Commissioning of crisis accommodation 3.Commissioning of crisis in reach 4.Review of approach to respite June update - CCG Specialised Commissioners developing Governing Board paper for short breaks The CCG Strategic Commissioners are writing a paper for GB which will provide an update and options. Therefore the risk remains the same at present. July - no update	3	3	9	3	3	9	2	3	6	September 2020	Links to Strategic Aims 1, 2, 3, 4, 5	Jul-21	Aug-21	Brigid Stacey - Chief Nursing Officer	Mick Burrows Director for Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning, Helen Hipkiss, Deputy Director of Quality /Phil Sugden, Assistant Director Quality, Community & Mental Health, DCHS
14	21/22	On-going non-compliance of completion of initial health assessments (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 the statutory framework.	Quality and Performance	Corporate	5	3	15	The CIC Collaborative Operational Meeting in Derbyshire (commenced March 2020) - meet on a - bi monthly basis - which continues to review the statutory IHA pathway and which works & delivers from a multi agency perspective (Health - CCG Designated Nurse & Doctor for CIC - CRH FT - DCHS FT and the LA - DCC), in order to address the IHA compliance issues and improve compliance (the reasons for non compliance are multi faceted and complex because of the nature and complexity of children and young people who are placed in care and this is why there has not been a speedy resolution to this risk. 'Back Stories' of all CIC who are not bought for their IHA within the 20 day statutory period are being collated by health and social care). The CIC Collaborative Operational Meeting has a RAG Rated Work plan in place and IHA Compliance is included within said work plan and will be reviewed at every meeting for progress. May 2021 Update: Assurance work is on-going as a collaborative approach between CCG, CRHFT and Local Authority - overseen by the CIC Collaborative Operational Group, CCG Quality meetings and Corporate Parenting Board. Remedial work and actions are on-going for the partners to ensure any obstacles and/or process issues are resolved in a timely manner. All breaches that occur - the children continue to have their health needs met within primary and secondary care as required and the vast majority of breaches are by a few days. It has to be acknowledged that CIC and the legislation surrounding them (eg: parental responsibility and the legal pathway) are complex and there will always be delays that Health or LA cannot control or mitigate against. CRHFT continue to monitor sickness rates and priorities/flex work plans accordingly, in the remaining CIC Health Provider Team but this can be difficult to do due to other clinical commitments/work plans & increasing numbers of children being bought into care by LA's (a noted 4.14%. increase in DCC numbers March 2020 - March 2021). July 2021 Update: The health data currently indicates that the majority of IHA's are completed in Derbyshire by the Medical Advisor within the statutory 20 working days but there remain, ongoing complex LA (at the beginning of the 20 work day pathway) and Health Provider issues (at the end of the 20 working day pathway) where the IHA is not always received back by the LA by 20 statutory working days. There is generally a delay for children in care living out of area whereby the IHA is completed by an external Health Provider late and DDCCG have no control over their performance. This has been discussed previously at CPB as being a concern for all externally placed CIC and this will continue to impact on timeliness of health assessments. IHA's continue to be reviewed by the CIC Collaborative Operational Meeting, The Improving Health Outcomes Meeting and by Children in Care Strategic Partnership (CICSP) & by Derbyshire CPB (next meeting 16/09/21 - where verbal update will be given by the new Designated Dr for CIC). Extensive partnership working continues to improve the IHA timeliness issue, which includes appropriate health and LA escalations, when required. The ability to escalate IHA issues early between both organisations, remains a real strength, in terms of collaborative partnership working, with the express intention of continuously improving IHA timeliness overall for all CIC living within the Derbyshire footprint (wherever they originate from).	Completion of Multi-agency IHA Action Plan. Increasing numbers of children/young people entering care & increasing numbers of Derbyshire CIC being placed externally by the Local Authority has been acknowledged at Derbyshire Corporate Parenting Board. The Designated Nurse CIC has highlighted the risk of external health provision (of IHA's & RHA's) being the responsibility of the external health provider and not with CRHFT or DDCCG (as stated by NHSE). Ongoing, sustained, multi-agency compliance with timescale pathway. Monthly and quarterly analysis of 'finer' IHA performance continues at this time by CRH FT CIC health provider and Designated CIC Professionals on behalf of the CCG. Review and Monitoring of the whole pathway/process via RAG Rated Action Plan, via multi-agency meeting - CIC Collaborative Operation Meeting - which meets on a bi monthly basis. Ongoing review by Derbyshire Corporate Parenting Board & the DDCCG Safeguarding Assurance Committee. Will be reviewed again at CPB in September 2021. Monthly review of figures/data from CRH FT & Quarterly Reporting of IHA progress by the Designated Nurse CIC (Derbyshire). Designated Doctor CIC (Derbyshire) remains responsible for IHA Quality Assurance and for liaison with external health providers who are identified to be providing late IHA's consistently. Performance of external health providers/CCG's delivering untimely IHA's (for Derbyshire Children placed externally outside of Derbyshire) remains the responsibility & risk of external health providers; to ensure that they are adhering to Statutory Guidance, as defined in Promoting the Health & Wellbeing of Looked After Children - March 2015) & as highlighted by NHSE. administration/medical tasks prioritised/re-allocated where possible. There is on-going progress with the implementation of SystmOne processes for Admin, Nursing and Medics which moving forwards should help to assist with the timeliness of returns to the LA. The risk score, remains the same at the current time .This will need to be sustained and continued increases in compliance seen before the risk can be lowered and eventually removed. Extensive ongoing work continues from a multi-agency perspective, with ongoing overview & review of a number of very complex issue's associated with IHA compliance; including ongoing review of individual breach reporting by both health (CCG & Provider) and the LA. This work is reviewed on an ongoing basis by Derbyshire Corporate Parenting Board, Improving Health Outcomes Group, CIC Strategic Partnership & the CIC Collaborative Operational Group & associated work plan. July 2021 Update: With regard to the proportion of identified breaches, the majority of children have actually been seen within the 20 working days but the appt is so close to the deadline that statutory timescale is breached due to report writing and admin time required to send the report back to the LA but usually only by a few days.CRHFT have been under pressure for the past few months due to staff absences because of sickness – both admin and medical teams but this has now resolved and a new Designated Dr CIC has just been appointed into post, who is already looking closely at the health pathways to ensure timely, statutory compliance. From a medical perspective the team are responding by planning additional clinics to try and adhere to the statutory timescales; although this is complex due to other work plan commitments. Administration & Medical sickness cover is reviewed & monitored by the provider (CRH FT) on a daily basis and administration/medical tasks prioritised/re-allocated where possible to fit in with numbers of IHA's required. There is on-going progress with the implementation of SystmOne processes for Admin, Nursing and Medics which moving forwards should help to assist with the timeliness of returns to the LA. DCC LA IHA Data shows a slow upward trajectory of an increase in compliance (Jan to June 2021 standing at 67% rolling compliance - only 5% behind Derby City compliance for the same period) NB there are differences in health and LA data reporting due to two different systems used & the Designated Dr CIC has already begun some work with CRHFT CIC Admin Team to streamline and enhance health data set reporting, to try to align it with LA reporting processes, this remains work in progress at the current time.	Extensive ongoing work continues from a multi-agency perspective, with ongoing overview & review of a number of very complex issue's associated with IHA compliance; including ongoing review of individual breach reporting by both health (CCG & Provider) and the LA. This work is reviewed on an ongoing basis by Derbyshire Corporate Parenting Board, Improving Health Outcomes Group, CIC Strategic Partnership & the CIC Collaborative Operational Group & associated work plan. Target date extended to September 2021, given the slow, upward trajectory of improvement in the timeliness of IHA's (despite ongoing extensive work).Recent health breaches have highlighted that these have been caused by provider CIC Health Team admin and medical advisor sickness issues (some pandemic related), which have caused delay in returning completed IHA's (completed within statutory timescales) back to the LA within 20 working days. Mitigation: Sickness absence rates and workload prioritisation are monitored on a daily basis by the CRH FT CIC Health Provider Service. May 2021 Update: An increase of 19% IHA timeliness compliance in March 2021 at 62% timeliness, on the previous month – February 2021 – which stood at 43%.Q4 2020/2021 Health Provider IHA Timeliness Summary. Quarter 4 2020/2021 Summary Compliance (January, February & March 2021) IHA's completed within timescales = 53.0% average a slight decrease of 0.33% from the previous Q3 (Previous Q1 2020/2021 = 63.33%, Q2 2020/2021 = 62.33% & Q3 2020/2021 = 53.33%) – CRH FT Data – Recorded Manually. Overall CRH FT CIC Health Provider yearly 2020/2021 IHA 20 working day statutory timeliness compliance stands at 58.0% overall (end of year Q4 2020/2021), 8.25% down on the previous year 2019/2020, which stood at 66.25%-year end & up 10.5% on year end 2018/2019, which stood at 47.5%. the score remains the same as the percentage of compliance has not improved overall due to the added pressures of ongoing MA sickness within CRHFT, the complexities surrounding CIC, impact of Covid (particularly on external Health Providers) and timely notifications from LA (SW workload capacity). However it has to be noted the vast majority of the delays are by a few days only and not on children having their health needs met. Extensive multi-agency work continues to address the IHA timeliness issues. July 2021 Update: May 2021 IHA Summary (latest available data) •There was a 69% IHA timeliness compliance rate in May 2021 (of CIC seen for their IHA within 20 working days), with 5 timeliness breach issues identified (a combination of both health (in one case) and LA (in 4 cases) timeliness breach issues). •All five (of the total 5 timeliness breaches) IHA's were not completed within 20 statutory working days, with one breach caused by health, being due to lack of clinic capacity (equating to 31% actual IHA completion rate for the CYP to not be seen, for their IHA within 20 working days). Because of this, they cannot be counted as being timely in DfE LA returns because they were not returned to the LA within 20 working days. •Q1 2021/2022, Month 1 April 2021/2022 = 50% overall IHA compliance (completed and returned to the LA within 20 working days). Q1 2021/2022 Month 2 May 2021/2022 = 69% seen and returned to the LA within 20 working days (a continuing upward trajectory of compliance noted). Several complicating factors have been identified from the health breach reporting that have affected the timeliness of IHA completion during this reporting period, which includes delay at the beginning of the IHA pathway by the LA and also at the end of the IHA pathway by health. The main complicating health provider factor, during this reporting period include, lack of provision of medical IHA clinics (on only one occasion in May 2021) and this has affected the ability of the CIC health provider MA and Admin teams to return IHA's, completed within the 20 working day timescale by the CIC Medical Team, back to the LA in a timely manner. This issue accounts for the one breach from the health provider during this period, with only one breach being identified in the final quarter of 2021, & 4 breaches in April 2021 & one in May 2021, due to insufficient clinic capacity. There was a noted large increase of CIC admitted into care by DCC in March 2021 & April 2021 and this has impacted on clinical capacity to undertake IHA's in a timely manner. This was appropriately escalated by the LA into health, at an early stage and Medical Advisers have been offering extra clinics, to support timely delivery of all IHA's. Additional clinic capacity has been arranged at CRH Hospital and Littlewick Medical Centre in Erewash to meet statutory requirements. The team are also looking to deliver extra IHA clinics in the South of the County (Willington Surgery) & at Buxton Health Centre in High Peak from September 2021 onwards and the new addition of a further Medical Advisor to undertake the increase in IHA's (anticipated due to the delivery of the new CIC Service Specification (from 1st July 2021) which covers all DCC LA CIC up to 20 miles over the border (of Derbyshire). All appointments for IHA's that were booked out of timescale have also been bought forward, wherever possible. CRH FT CIC Team have worked extremely hard to monitor the IHA clinic capacity and adjust it to the increase in demand during this period. This has not been an easy task due to the large fluctuation of numbers of Derbyshire & externally placed CIC into Derbyshire, admissions per month (ranging from 17 to 48 admissions) during this reporting period. CRH FT CIC Administration Team is also currently under review, to ensure that it has sufficient capacity to ensure that all IHA/RHA work is managed in a timely manner and that appropriate systems and processes are in place to support this, within the provider organisation. Improvements have been evidenced in IHA timeliness compliance but this will need to be sustained into the future NB A DCC LA ILACS inspection is due (anytime between September 2021 - Easter 2022) and IHA timeliness will no doubt be reviewed as part of that inspection process, therefore this need to remain on the Risk Register at this time to evidence the substantial ongoing quality assurance work undertaken by the Designated CIC Professionals (Dr & Nurse) & by DDCCG Nursing and Quality Team. Extensive multi-agency work continues to take place to improve IHA timeliness provision from a multi-agency perspective and in turn improve health outcomes for all CIC.	4	3	12	4	3	12	3	1	3	September 21	Links to Strategic Aims 1, 2, 3, 4, 5	Jul-21	Aug-21	Brigid Stacey - Chief Nursing Officer	Alison Robinson, Designated Nurse for Looked After Children
16	21/22	Lack of standardised process in CCG commissioning arrangements. CCG and system may fail to meet statutory duties in S14Z2 of Health and Care Act 2012 and not sufficiently engage patients and the public in service planning and development, including restoration and recovery work arising from the COVID-19 pandemic.	Engagement	Communications/ Engagement/ Statutory	3	4	12	Systematic completion of S14Z2 forms will provide standardised assurance against compliant decision making and recording of decisions at project level. Engagement Committee established to strengthen assurance and risk identification.	PMO processes are not being applied to restoration and recovery projects, therefore there are no checks and balances as projects proceed to ensure that they have completed either the S14Z2 or EIA forms. An equality and engagement policy is being developed to address this gap in part, for proposed adoption by all JUCD partners. EIA/QIA process adopted by JUCD. Not all projects follow a systematic project management/commissioning/transformation process to ensure standardisation of process and application of legal duties. June update: Engagement Governance Guide and training being developed to support consistency of approach for officers involved with transformational change. Meeting with new ICS Director of Transformation to be arranged to ensure processes embedded in future project management approaches.	Engagement Committee re-established in June 2020 following pause during peak of COVID-19 pandemic. Training for Engagement committee members on consultation law completed. Replacement lay members recruited to ensure sufficient lay voice on Engagement Committee following recent resignations. S14Z2 log reviewed regularly by Engagement Committee. CCG planning approach under review to identify potential annual commissioning business cycle, thus enabling rolling engagement programme in commissioning development and activity. No update to add for October November update - S14Z2 form is now going to the QEIA panel and therefore the probability rating was reduced to 2 and the overall score is now 8. March update: Being in Level 4 business continuity escalation means that tasks are suspended that would affect this risk. April update: QEIA panels are occurring once again, with associated S14Z2 forms being completed and reviewed by the engagement team. This process will continue through the next planning and transformation phase, ensuring that this risk continues to be mitigated. May: S14Z2 forms log to be presented to Engagement Committee for assurance. Business Continuity Level 4 is not preventing other projects from being commenced; this will need to be reviewed in context of capacity to deliver. June: JUCD Communications and Engagement Strategy now approved by Engagement Committee and Board, reinforcing S14Z2 process and engagement model. The risk will remain the same this month as we continue to seek to embed the processes within the organisation and ensure these are embedded into the ICS delivery too. On this basis, the likelihood remains the same for the time being, as does the impact. July: Consultation Law refresher training undertaken for engagement team to support governance process review and strengthen our approach to planning and delivery of engagement, including additional context of engagement requirements in a virtual world. Will feed Governance Guide production this month, to be reviewed by Engagement Committee in August 2021.	2	4	8	2	4	8	2	3	6	30.09.21	Links to Strategic Aims 1, 2, 3, 4, 5	Jul-21	Aug-21	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Sean Thornton Assistant Director Communications and Engagement
17	21/22	S117 package costs continue to be a source of high expenditure which could be positively influenced with resourced oversight, this growth across the system, if unchecked, will continue to outstrip available budget	Quality & Performance	Corporate	3	4	12	Although not overspent to budget at this time the rising cost of care under s117 is around 38m to the system. The CCG is investing in additional case managers, re-introducing S117 work stream under MHSDB when this is possible. It is anticipated that both of these measures will positively affect outturn at system level. 17.09.20 The CCG have agreed to employ a number of case ,managers, which will cover s117 packages of Care. This is being negotiated with the CSU to start in October. The Commissioning for Individuals panel is now in place. This includes s117 cases. Although not overspent to budget at this time the rising cost of care under s117 is around 38m to the system. The CCG is investing in additional case managers, re-introducing S117 work stream under MHSDB when this is possible. It is anticipated that both of these measures will positively affect outturn at system level.	There is slippage in the introduction of case managers, so the savings have slipped from October 2020 to January 2021. Further re-design of specification now means delivery start date now Q1 21-22	Recruitment challenges Investment is being made in additional case managers via CSU , re-introducing the S117 work stream under the MHDB to enhance the oversight will also help. 05.02.21 Recruitment ongoing, remains on track for commencement Q1 21-22 10.03.21 Posts now recruited and CV to main CCG CSU Contract being finalised, remains on track to commence Q1 21-22 08.04.21 CV discussed in CHC OPs Group last week, final tweaks in process then final sign off to be sought. Service now going live in Q1. The risk score needs to remain at 9 until the caseload has been reviewed. 18.05.21 Service now live, risk score unchanged until caseload review has been completed 15.06.21 Risk score unchanged pending completion of case load review 16.07.2021 Risk score remains unchanged pending completion of case load review, CSU asked to confirm timescale now second member of staff recruited	3	3	9	3	3	9	2	2	4	tbc	Links to Strategic Aims 1, 2, 3, 4, 5	Jul-21	Aug-21	Zara Jones, Executive Director of Commissioning Operations	Helen Hipkiss, Director of Quality / Dave Stevens, Head of Finance
20	21/22	Failure to hold accurate staff files securely may result in Information Governance breaches and inaccurate personal details. Following the merger to Derby and Derbyshire CCG this data is not held consistently across the sites.	Governance	Corporate	4	3	12	• Staff files from Scarsdale site are to be moved to a locked room at the TBH site. This is interim until the new space in Cardinal is available. There are still staff files at Scarsdale and Cardinal Square they are safely secured. Due to Covid-19 the work has been placed on hold as staff are all working from home. • EA's/PA's at Cardinal Square have been contacted and a list is being pulled together of names and files (current or leavers) held ensuring that these are all securely saved in locked filing cabinets. Work is being completed at Cardinal Square by staff who do regularly attend site to compile the list and confirm who may be missing. • Consider an electronic central document management system (DMS) This action remains once we are in a position to move the project forward.	• A project team has been organised to work on the risks, ensuring that a standardised format and tick list is developed of the relevant paperwork to keep in HR files. This piece of work will take a significant amount of time before the CCG can even consider looking at a document management system. • Information Governance are currently working to secure a contract for archiving, this will ensure that staff leavers files are securely archived with the correct paperwork. • Project team are obtaining guidance with other NHS organisations to consider a document management system.	15.07.20 update: This risk is still open, and valid for 20/21, the files are currently being collated and this is actively being worked on. Work was paused with the COVID 19 pandemic. Progress is now underway. 12.08.20 The files from Toll Bar House have now been relocated to Cardinal Square. To reduce the transmission of Covid-19 and mitigate health and safety risks, the majority of our staff are continuing to work from home. As the review and weeding of the hard copy HR files requires a physical presence in the workplace, this aspect of the project has been temporarily paused. 14.09.20 Project still paused due to staff working from home. 13.11.20 No further update due to home working December - No further update due to continued home working. January - No change due to continued home working. February - No change due to continued home working, paused.	3	3	9	3	3	9	1	2	2	Dec-20	Links to Strategic Aim 4	Jul-21	Aug-21	Beverley Smith, Director of Corporate Strategy & Development	Sam Robinson, Service Development Manager

Risk Reference	Year	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk Rating			Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating			Residual/ Current Risk			Target Risk			Target Date	Link to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
					Probability	Impact	Rating				Probability	Impact	Rating	Probability	Impact	Rating	Probability	Impact	Rating						
22	21/22	The mental health of CCG staff and delivery of CCG priorities could be affected by remote working and physical staff isolation from colleagues.	Governance Committee	Corporate/ Clinical	3	3	9	Daily Team Meetings/catch up's held between Managers and their staff. Weekly All Staff virtual meeting held, led by Dr Chris Clayton, to update and inform CCG staff of developments etc. Weekly Staff Bulletin email from Dr Chris Clayton outlining the CCG activity which has occurred during the week, with particular focus on the people aspect of the CCG. Twice daily COVID-19 Staff update emails issued outlining all progress, news and operational developments. CCG employees trained as Mental Health First Aiders available for all CCG staff to contact for support and to talk to. This is promoted through the daily COVID-19 Staff updates. Included in the Staff update emails is the link to the Joined Up Care Derbyshire website staff support area which is available and continues to be updated. This now also includes a new section for leaders and a section for parents or carers of children. This also offers wellbeing, health advice and support for health, social care and community staff in relation to the Covid-19 virus. For confidential support and counselling the CCG employee assistance programme provider (EAP) can be accessed by all CCG colleagues and family members in the same household and is available 365 days a year, 24 hours a day. They have also launched a 25 minute web based "Working from Home and Resilience" seminar details of which have been included in the CCG Staff update email. 1 to 1 wellbeing checklist introduced for line managers to facilitate support for members of their team. Virtual tea breaks and initiatives to promote social connectivity introduced and ongoing.	08.04.20 A range of ideas to support the wellbeing of staff working from home will be launched shortly, with a toolkit to help staff all maintain a positive outlook and ensure interaction with colleagues 'off topic' to maintain spirits during the working week. Staff are encouraged that they should all take time to remember that they are not "working from home", but "at home, during a crisis, trying to work". 17.04.20 continue to monitor and assess sickness returns for trends and patterns and review good practice for staff H&WB e.g. NHS Employer, Social Partnership Forum etc. 12.05.20 The CCG will develop and run briefings for line managers to support them in undertaking 1 to 1 wellbeing checks with their team (to include wellness action plan, display screen equipment review and risk assessments for vulnerable staff).	All staff have the use of Microsoft Teams video conferencing on their remote device. This application has been rolled out throughout the NHS in England. This enables face to face meetings to take place and encourage interaction between colleagues and good working relationships. 10.2.21 - Addendum to Homeworking Policy published and ongoing support health and wellbeing support continues for CCG staff. A number of CCG staff have been redeployed to work at the vaccination centres in support of the system pressures and priorities. Risk assessments have been reviewed for all staff and measures put in place to mitigate risk of contracting Covid-19, including appropriate PPE, priority access to vaccination and access to lateral flow rapid antigen tests. 08.3.21 - Confirmation of requirement for 1 to 1 wellbeing checks, linked to return to schools and need to maintain flexibility around working hours and working times. Communication of social interaction groups and key messages to maintain positive health and wellbeing whilst working remotely (e.g. taking regular breaks, getting up and moving around etc.) 16.4.21 - Screen saver added as reminder to maintain positive health and wellbeing whilst working remotely (e.g. taking regular breaks, getting up and moving around etc.) .CCG mindful employer status renewed with promotion of half day Mental Health Awareness training sessions online for staff. Access to New 24/7 Derbyshire Mental Health Helpline and Support Service communicated to all staff. 17.5.21 - CCG promoted Mental health awareness week and communicated key messages from Mind to support positive mental wellbeing. MSK issues identified via staff survey and action plan to include wellbeing communication and initiatives to have a particular focus on good MSK health and healthy working practices. Continuation of wellbeing communication and initiatives for staff, including flexible working, social connectivity, relaxation sessions, Thrive app etc. 09.06.21 - Continuation of wellbeing communication and initiatives for staff, including flexible working, social connectivity, relaxation sessions, Thrive app etc. 13.07.21 - All staff requested to meet with line manager to complete a new ways of working: Individual preferences and risk assessment pro-forma, which combines wellbeing discussion with exploring individual preferences for working arrangements moving forwards. Continuation of wellbeing communication and initiatives for staff, including flexible working, social connectivity, relaxation sessions. Repeat of Thrive: Mental Wellbeing and Avoiding Burnout session.	2	3	6	2	3	6	1	3	3	On going	Links to Strategic Aims 1, 2, 3, 4, 5	Jul-21	Aug-21	Beverley Smith, Director of Corporate Strategy & Development James Lunn, Head of People and Organisational Development	Beverley Smith, Director of Corporate Strategy & Development James Lunn, Head of People and Organisational Development
23	21/22	CCG Staff capacity compromised due to illness or other reasons. Increased numbers of CCG staff potentially unable to work due to COVID 19 symptoms / Self isolation.	Governance Committee	Corporate	3	4	12	Staff asked to complete Skills Survey for redeployment. Detailed analysis of deployment within and outside of the CCG completed. Backup rota compiled for Incident Control Centre (ICC). Majority of CCG staff working from home. Business Continuity Plan escalation level increased to 4 allows for pausing of functions within the CCG.	Running a mixed model of remote/base work Possible shadowing of staff working in the ICC by backup rota staff. Greater capacity issues in covering staff absences. Staff illness could compromise the operation of the ICC. Develop a resilient rota for the ICC, PPE and Testing Cells over 7 days	16.4.21 - National level of escalation reduced from level 4 to level 3. Review of priorities across system & CCG , vaccination programme continues to be main priority. Bi-weekly monitoring of the deployment of CCG staff against the system priorities by Functional Directors. 17.5.21 - SLT review of CCG business continuity levels. The COVID-19 Vaccination Programme remains both a national and JUCD's priority and there is a requirement for our staff to continue the essential roll out of the Vaccine programme and to ensure the programme is not de stabilised by loss of expertise and experience. A review of existing redeployments has also been undertaken on a case by case basis with risks to business critical functions/delivery within the CCG and vaccination delivery identified. Where possible discussions have taken place with the respective managers to identify alternative solutions, such as commencing recruitment to back fill roles to enable staff to remain within the Vaccine Operations Cell or vaccination sites. Ongoing review of redeployments at SLT. 09.06.21 - Continuing review of existing redeployments and consideration of alternative solutions, including back filling roles via recruitment and/or interim/agency. At the current time we are seeking through regular discussions with the FDs and seeking approval for temporary agency staff to back/fill roles within the CCG. 13.07.21 - Arrangements in place to back/fill two key roles for staff redeployed to the vaccine operational cell with interim/agency. Ongoing review of existing redeployments and consideration of alternative solutions.	1	4	4	1	4	4	1	3	3	On going	Links to Strategic Aims 1, 2, 3, 4, 5	Jul-21	Aug-21	Beverley Smith, Director of Corporate Strategy & Development James Lunn, Head of People and Organisational Development	Beverley Smith, Director of Corporate Strategy & Development James Lunn, Head of People and Organisational Development
24	21/22	Patients deferring seeking medical advice for non COVID issues due to the belief that COVID takes precedence. This may impact on health issues outside of COVID 19, long term conditions, cancer patients etc.	Quality & Performance	Clinical	5	4	20	National and local campaigns across all media platforms to promote access and availability of health services. Weekly performance brief to monitor patient attendance across providers (A&E, 111, NEL, Elective Care, Cancer etc.) Primary Care agreed to prioritise LTC reviews for all priority (red) patients and have agreed to see all amber patients by 31st March 2021. Includes messages to voluntary sector to strengthen messages to patients. COVID vaccination roll out to commence in December, based on a prioritisation framework.	On-going public communication campaigns regarding service provision as we move across each phase. To support winter pressures, PCN's are developing contingency plans to support patients that display COVID/ Flu symptoms. Learnings to be taken from the red hub concept. Proposals to restore services and reintroduce appointments by utilising digital technology and reviewing provision of service (acute v community) e.g. rehab services, diagnostics, phlebotomy, MDT's etc. System Cell leading on the co-ordination of vaccine roll out, commencing in early December.	14/06/21: To commence vaccinations for people aged 25-29, which will see us further add to the 1.2million vaccinations we have delivered in Derbyshire so far. 14/06/21- GP practices have seen an increase in appointments of between 10% and 20% than before the pandemic, March 2021 saw an average 9% increase or 40,000 more GP appointments than the same month in 2020 and 2019. We are seeing an increasing expectation for more face to face appointments. As we move forward, our plan is to reach a balance of face to face and other channels for delivering consultations which works for both our patients and our practices but we know this will require a process of adjustment. In the meantime, the CCG is delivering a campaign to raise awareness on how we can all help to support our practices as we work through this readjustment to new ways of working. The core purpose of the campaign is to inform our patients and the overriding message is that 'your GP is open for business and we are here when you need us. Evidence and data across the Health system identifies that patients 'in the main' are no longer deferring medical advice due to the belief that COVID takes precedence. Another discussion is required regarding reducing the probability to a '2' that will reduce the rating to a 6, the target rating. If the reduction in risk is accepted, we would advise to keep the risk on the tracker due to forthcoming winter pressures and the spread of COVID variants. 16/7/21- Target rating agreed at the last Board meeting. Advise to keep the risk on the tracker due to forthcoming winter pressures and the increasing spread of COVID variants. Since the unlocking of lockdown measures COVID infection rates have risen to January 21 levels. On 19th July almost all legal restrictions on social contact will be removed, risking a further increase in infections. Despite the increase cases the number of COVID patients within the Acute Trusts is below 30. However this figure has doubled in the past week.	2	3	6	2	3	6	2	3	6	On going	Links to Strategic Aims 1, 2, 3, 4, 5	Jul-21	Aug-21	Dr Steve Lloyd, Medical Director	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster Head of Strategic Clinical Conditions and Pathways
25	21/22	Patients diagnosed with COVID 19 could suffer a deterioration of existing health conditions which could have repercussions on medium and long term health.	Quality & Performance	Clinical	4	4	16	Derbyshire-wide Condition Specific Boards continue to review information, guidance, evidence and resources to understand the repercussions e.g. NHSE After-care needs of inpatients recovering from COVID-19, BTS Guidance. System working to co-ordinate and implement guidance. Primary Care agreed to prioritise LTC reviews for all priority (red) patients and have agreed to see all amber patients by 31st March 2021. NHSE have launched the 'Your COVID Recovery' service to provide advice and guidance (self-care) online, and a national COVID rehab service is in development Post COVID rehab pathways for admitted and non-admitted patients being developed, and criteria for referral to secondary care if patients have ongoing needs. vMDTs set up across the county in respiratory between Acute and Community Respiratory Teams. Working towards implementation with Acute and Primary Care. Post COVID Syndrome Assessment Clinic service implemented to support patients suffering with post/long COVID symptoms. MDT approach to provide physical and psychological assessments, to ensure patients access the required service and treatment.	Review COVID inpatient data to identify pre-existing LTCs to proactively support patients. Derbyshire-wide Condition Specific Boards to amend/ develop pathways through embedding new guidance and good practice to allow effective follow-up of patients. Keep virtual consultations / on-line support (amplify). Proposals to restore services and reintroduce appointments by utilising digital technology and reviewing provision of service (acute v community) e.g. rehab services, diagnostics, phlebotomy MDT's etc. To support the roll out of the 'Your COVID Recovery Service' throughout Derbyshire as required. To include communications and implementation of rehab service. Review and scoping of pan-Derbyshire end to end rehab pathway Develop and implement a Post COVID Assessment Clinic to ensure patients are referred to appropriate services. Post COVID integrated pathway (system) and Post COVID Assessment Clinic to be communicated across the health system. Including culturally relevant communications to raise awareness amongst patients and the public.	12/02/21- The Post COVID Syndrome Assessment Clinic MDT is continuously being strengthened with input from specialists such as Respiratory Consultants, Chronic Fatigue Services, Children's services etc. The MDT will continue to develop and broaden in expertise as we learn more about the condition. 12/02/21- A Derbyshire Dialogue event (12/02/21- 120 attendees) was held with the public to discuss Post COVID Syndrome and the Derbyshire response to this condition. Feedback utilised to enhance services. Risk score reduced to 9 in line with target rating. This is due to the Post COVID Assessment Service being launched and embedded into system pathways. Strategic Clinical Conditions & Pathways Team (SCCP) are monitoring the impact of services and patient outcomes hence the risk remaining on the register. 08/03/21- £18.5m government funding to support research projects to better understand the causes, symptoms and treatment of the condition. 08/03/2- NHSE have confirmed PCS Assessment Clinic funding for 21/22 to support service continuity and to enhance the service offer. 16/04/21- 21/22 NHSE funding announced for Post COVID Assessment Clinic. CCG and DCHS undertaking workforce modelling, with funding to be utilised to enhance provision and clinical input. 17/05/21- CCG and DCHS continue to develop new PCS workforce model. Aim to finalise this month and commence recruiting additional capacity into the team. Includes additional GP/ AHP capacity to target 6/7 week waiting list. 17/05/21- Refreshed PCS Assessment Clinic Guidance launched by NHSE. DCHS and CCG have undertaken service review to ensure new guidance is embedded in SOP and pathways. 14/06/21- PCS Workforce model has been agreed by Execs. The service will be bolstered by additional GP input, a Clinical Psychologist, Nurse, and Service Co-ordinator. Funding will also be utilised to reduce the waiting list from 6 to 2 weeks by agreeing short-term additional GP hours. 14/06/21- Press release was launched w/c 7th July. Lead GP was interviewed by BBC Radio Derby. 16/07/21- £1.8m funding ringfenced for JUCD to support the ongoing treatment and rehabilitation of patients. Plans to develop a Long COVID Rehab pathway to support patients with Post COVID Syndrome are being worked up. A total of 600 patients have been referred to the Post Covid Assessment Clinic to date.	3	3	9	3	3	9	3	3	9	On going	Links to Strategic Aims 1, 2, 3, 4, 5	Jul-21	Aug-21	Dr Steve Lloyd, Medical Director	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster Head of Strategic Clinical Conditions and Pathways
26	21/22	New mental health issues and deterioration of existing mental health conditions for adults, young people and children due to isolation and social distancing measures implemented during COVID 19.	Quality & Performance	Clinical	5	3	15	o Derbyshire Healthcare NHS Foundation Trust have developed a 24 / 7 crisis helpline for people of all ages and their carers to seek advice regarding MH difficulties including those arising or being exacerbated by Covid-19. Helpline is accessible via 111 warm transfer. o Multi-agency approach in place collating all sources of support and advice that will also support the help line in terms of where people can be triaged to get the most appropriate help. o Working with Communications teams to ensure that information is disseminated effectively across all stakeholders and the system. o Actively working with providers to understand their business continuity measures and how they are planning for fluctuations in demand and capacity, e.g. to meet and respond to reduction in referrals and/or anticipated surge in demand going forward. o CYP services, targeted intervention predominantly online. CAMHS RAG rating and prioritising urgent cases. Digital offer Kooth and Qwell uplift continue until March 21. Ongoing CYP communications strategy with partners to send information out across the system. o IAPT providers fully operational and accepting referrals - Attend Anywhere utilised across the trust for online consultations Mental Health System Delivery Board to provide Covid oversight recovery and planning	o To further recruit and upskill clinical triage & assessment team staff responding to the helpline in CYP, LD & Autism o Additional community based LD beds -there needs to be an agreed list of identified staff that can be called on this responsibility lies with LA not CCG. Building needs to be furnished and cleaned. o Re above – need to develop a training programme for staff working in the specialised unit- being actioned via LD delivery group. o Need to finalise the LD & Mental Health All Age CoYD Recovery Planning Group process to feed into LRF across providers. o Wellbeing in education training to all schools Sept - March to include local MH resources and pathways . Close monitoring of service demand to be prepared to respond to any anticipated surge in referrals now CYP returned to school o IAPT providers are funded on AQP basis so there is no cap on activity - frontline staff vaccinations will support increase in face to face capacity and engagement in care and improve resilience of staff capacity reducing absences	April Update Urgent care work stream taking forward work on crisis care and alternatives to ED .CYP crisis plan has been developed and approved at Mental Health.LD,ASD,delivery Board. Plans for 3 year road map for ASD developed ,Transforming care summit held and actions agreed. Investment plans will be coming through DDCCG governance process in April. Digital offer for support in procurement and further engagement on adult offer in process .Funding for workforce Hubs received from NHSE and Hub continued to be developed by workforce leads. MH planning submission due 6 May with focus on areas impacted by Pandemic. May Update - IAPT continues to increase capacity and access including training for long COVID. June Update. Delivery of LTP is seen as approach to restoration for MH in operating framework and 12 months finance and workforce return for MH reflected investments in full. Road map Strategy for LD/ASD approved. July update -as June but CYP plan is being refreshed and sent out to strategic partners as draft .Additional funding streams applied for ,with success Noted in working with Nottinghamshire to deliver improved autism support in schools Project(100k each) .Proposals to support the delivery of the ambitious transformation requirements of LTP are being developed.	4	3	12	4	3	12	2	2	4	Aug 21	Links to Strategic Aims 1, 2, 3, 4, 5	Jul-21	Aug-21	Zara Jones, Executive Director of Commissioning Operations	Mick Burrows, Director of Commissioning for MH, LD, ASD, and CYP Helen O'Higgins, Head of All Age Mental Health Tracy Lee, Head of Mental Health - Clinical Lead Helen Van Ristell TCP Programme Manager Jenn Stothard Head of Mental Health
27	21/22	Increase in the number of safeguarding referrals linked to self neglect related to those who are not in touch with services. These initially increased immediately following COVID lockdown. The adult safeguarding processes and policy are able to respond to this type of enquiry once an adult at risk has been identified. Numbers are difficult to predict but are predicted to increase as COVID restrictions ease.	Quality & Performance	Clinical	5	4	20	Key statutory partners such as Health , Local Authority, Police and Voluntary Sector are working closely together to ascertain who are at enhanced risk. Safeguarding meetings and assessments are continuing to take place via virtual arrangements. Families and individuals are being signposted to relevant support services.	Domestic Abuse is likely to increase as family groups are forced to be together for extended periods of time, children are at home on a full time basis, there are financial pressures due to restrictions upon employment, and adults at risk from abusive partners become socially isolated. It remains at an early stage. Referrals are expected to increase with another sharp spike in activity predicted when COVID restrictions are eased and victims feel safer in making disclosures Self Neglect. Individuals are finding it problematic to obtain aids to daily living and basic essentials. They do not have the motivation or ability to access sources to access or replenish essential items. Scamming. Individuals are targeted due to their physical or cognitive vulnerability and persuaded and cajoled to trust unscrupulous individuals During the COVID19 pandemic the number of referrals to adult social care services has increased but not as yet at the rates envisaged and predicted at the outset of lockdown and enforced isolation. Ongoing close partnership working is required. The Derby and Derbyshire Safeguarding Adult Boards are continuing to work collaboratively to gather information / intelligence and data regarding domestic abuse and adult abuse prevalence during the COVID 19 pandemic to formulate relevant action / contingency plans. Police are undertaking safe and well checks as appropriate and will use powers of entry if deemed necessary and proportionate.	June - The risks regarding safeguarding adults remain an unknown quantity. We continue to see an increase in referral activity but are unable to predict what we will find as we come out of Covid restrictions. Too soon to change risk grading. July - The Safeguarding Adult focus during Covid has been to meet demands placed upon systems due to operational activity. The CCG has concentrated upon ensuring that all NHS providers have continued to meet their statutory responsibilities during these unique and demanding times. This has been achieved by maintaining robust and consistent relationships involving open and honest dialogue in identifying potential issues for attention and escalation. Inter-agency communication and joint-working has continued to be effective in reducing risk to adults at risk. Referral rates have fluctuated but in general terms we can be confident in stating the following; Marked increase in domestic abuse referrals (30)%. This is likely due to families being forced together for extended periods of time, children being at home due to schools closure, financial pressures due to furloughing, victims being isolated from support systems and extended family, and dysfunctional partnerships. Increase in staff requesting advice and assistance due to abuse within their personal domestic relationship Marked increase (34%)in self-neglect concerns as people have withdrawn from social contact. Many families have been unable to maintain relationships and adults at risk have become isolated. Many individuals have been unable to access community care and their living conditions have deteriorated as a consequence. It is likely that referral rates will continue to increase as lockdown restrictions are eased and isolated individuals are once again able to seek support and assistance. Both Safeguarding Adult Boards, and their respective sub structures, have continued to meet on a regular basis. Business has been influenced by the impact of Covid upon service provision, family relationships, and partnership arrangements. The SABs 3 priorities (Making Safeguarding Personal, Section 42 Enquiries, and Quality Assurance) have been maintained. Safeguarding Adult Training has re-commenced using Teams as a delivery method. This has been successful in attracting large numbers of attendees and is likely to be maintained as a future option.	4	3	12	4	3	12	3	3	9	Aug-21	Links to Strategic Aims 1, 2, 3, 4, 5	Jul-21	Aug-21	Brigid Stacey, Chief Nursing Officer	Bill Nicol, Head of Adult Safeguarding
28	21/22	Increase in safeguarding referrals once the lockdown is lifted and children and parents are seen and disclosures / injuries / evidence of abuse are seen / disclosed.	Quality & Performance	Clinical	4	4	16	Key statutory partners such as Health , Local Authority, Police and Education are working closely together to ascertain who are the vulnerable children we are aware of and undertaking risk assessments and reviews . Safeguarding meetings and assessments are continuing to take place via virtual arrangements. Families are being signposted to relevant support services.	o During the COVID19 pandemic the number of referrals to children social care has decreased but this is causing concern because children are not schools , nursery, play groups etc. therefore not being seen by others such as professionals who would be making referrals or raising safeguarding concerns. o It is difficult at this stage to really understand / know what the actual demand will be on children safeguarding services but what we are being notified of is the experience/ learning from other countries in that the risk of harm to adults and children is significant / increased due to the lockdown / social distancing/ isolation requirements placed upon families. o Ongoing close partnership working required. The Derby and Derbyshire Safeguarding Children Partnership and the Adult Safeguarding Boards are working together to gather information / intelligence and data regarding domestic abuse and child abuse prevalence during the COVID19 pandemic to formulate relevant action / contingency plans.	June update- Risk rating to remain the same until next month to re-evaluate with the new variant and lifting of further lockdown restrictions • A multi-agency task and finish group is currently looking into the number of contacts / referrals to the two Local Authorities and undertaking work • to review cases that do not meet the threshold for referral as part of work across the partnership to predict and manage demand, including improvements to the referral form and improvements in the information feedback to referrers. July 2021 update - The Safeguarding Children Partners are closely monitoring the number of referrals that are made to children social care via the DDSCP Quality Assurance group and via the Predicting Demand Group. With this close partnership monitoring and the evidence that referrals post lockdown have not grown significantly then the recommendation is that this risk is removed from the CCG register at this point.	3	3	9	3	3	9	3	3	9	June-21	Links to Strategic Aims 1, 2, 3, 4	Jul-21	Aug-21	Brigid Stacey, Chief Nursing Officer	Michelina Racioppi, Assistant Director for Safeguarding Children / Lead Designated Nurse for Safeguarding Children
30	21/22	There is an ever present risk of fraud and cybercrime; the likelihood of which may increase during the COVID emergency response period.	Finance	Corporate	4	5	20	The CCG is constantly exposed to fraud risk and cybercrime and works with 360 Assurance and NHS Counter Fraud to minimise and manage this risk. There has been a noticeable increase in the reported instances of fraud and cybercrime in recent months and the CCG must remain vigilant in this period working closely with our partners. Should the CCG be subject to a successful attempt at fraud or cybercrime information and assets could be taken that exposes us to Information Governance breaches, financial and reputational risk.	The CCG continue to work closely with 360 Assurance and NHS Counter Fraud to minimise and manage this risk. The CCG also has an accredited NHS Counter Fraud Authority 'Champion' who receives regular correspondence and training.	11.03.21 - There is evidence of increased activity at the perimeter of the network, but there is no evidence of penetration by third parties and CareCERT and other high profile security vulnerabilities are appropriately managed. We are assured that the system is secure and propose reducing the risk on this basis with a view to further reducing the risk following the Cyber Essentials and Cyber Essentials Plus exercises in which the CCG is currently engaged with the West Midlands Ambulance Service as auditors. 21.04.21 - The CCG has come to an agreement with NECS to support the Cyber Essentials re-accreditation process and work is ongoing to agree the process for Cyber Essentials Plus. This involves re-using some of the information captured as part of the NECS CE+ accreditation process to reduce the scope of the work and subsequently the cost. A revised KPI report is expected at the next Contract Management Board which provides additional information on cyber issues which picks up themes from the CORS report and provides greater detail. As per previous updates, scores remain the same until work progresses on CE/CE+. 18.05.21 - Cyber Essentials re-accreditation for the CCG is underway, currently awaiting technical information from NECS to complete the process. More detailed information is now being shared by NECS as part of the Contract Management Board which provides greater granularity on the design of the security systems and provides additional assurance of the various layers through which a malevolent third party would need to progress. There are no indications of the recent cyber attack in Ireland having any impact on any of our systems. Will consider reducing the risk when the NHS Digital tools are in place to allow us to monitor vulnerabilities through a third party tool. 14.06.21 - The CCG recently worked with NHS Digital to run a simulated phishing attack on 471 CCG email addresses with the result that only 1% of those contacted opened the email, clicked the link and attempted to enter credentials to access the document. We are assured by this result and the 84% of people that ignored the email entirely. There has also been work undertaken between IG, HR and Digital regarding the leavers/joiners process and ensuring appropriate closure of all aspects of a user account when an individual leaves the CCG's employment or moves roles. Recommend reduce the probability of this risk, as there is no evidence of an active threat, additional risk analysis has been undertaken and work done to address these. 12.07.21 - Cyber Essentials re-accreditation can progress now that we have confirmation of the removal of unsupported Microsoft Windows 10 devices from the network and there are not expected to be any further issues preventing this from being successfully completed. Work continues on ensuring the appropriate closure of all aspects of a user's account(s) following the triggering of the leavers/joiners process with the potential to automate some of the stages to provide assurances.	1	4	4	1	4	4	1	3	3	On going	Links to Strategic Aims 4	Jul-21	Aug-21	Richard Chapman, Chief Finance Officer	Darran Green-Assistant Chief Finance Officer / Ged Connolly-Thompson, Head of Digital Development
32	21/22	Risk of exploitation by malevolent third parties if vulnerability is identified within any of the Microsoft Office 2010 applications after October 14th 2020 and not patched, due to support for Microsoft Office 2010 officially ending, after which point Microsoft will cease to issue updates and patches for vulnerabilities found within this suite of applications	Governance	Corporate	4	4	16	Replace all instances of Microsoft Office 2010 with Microsoft Office 365; Additional Cyber Security communications to all CCG and Primary Care staff to raise awareness of the potential for increased phishing emails, suspicious attachments and downloading documents from unfamiliar web sites; Reinforce the message that devices should be connected to the network every two weeks to ensure that anti-virus and other system management software updates accordingly; Identify other mitigation which NECS have put in place to prevent the execution and spread of any malicious code or exploitation of any vulnerability;	Task and finish group has been established with NECS to develop the programme of work which removes the risk, but also ensure continuity of service across commissioning and Primary Care; Already under development as part of the response to the CORS report; information will be cascaded through the CCG Comms team for CCG and Primary Care colleagues and also shared with the LMC;	21.04.21 - Agreement has been reached with Accenture for the management of locum accounts, working with the LMC to understand the local context. Work is progressing with CCG colleagues and GP Practices to validate user lists to support validation of user lists, rationalise NHS Mail accounts and audit leavers/joiners processes. It is intended that the user audit within GP Practices will be undertaken on a monthly basis to ensure that access is appropriately managed, that accounts are closed/moved and that licences are managed effectively to reduce the risk of overspend on Office 365 deployment. Awaiting confirmation from NECS regarding removal of the last Windows 7 device from the network which was located within a GP Practice. Scores remain the same, as work is ongoing and progressing, but the risk has not yet been fully mitigated. 18.05.21 - CCG has begun migration onto Microsoft Office 365; GP Practices have begun to book in for their upgrades. Both programmes will be completed by the end of July, three months before the mandated deadline to allow for any unforeseen anomalies. Concerns have been raised with NHS Digital regarding the suitability of their policy based security systems, with users able to access functionality which is turned off locally and nationally. Therefore, while the Office 365 project is progressing, there are a number of concerns with the way in which NHS Digital has chosen to implement Microsoft Office 365 within the NHS Shared Tenancy, the amount of local control that we have and the tools that are being provided nationally to allow us to manage local variation. Scores will be reduced when the rollout programme is complete and again further when NHSD can evidence the issues identified have been addressed. 14.06.21 - There are no indications of any vulnerabilities that have been exploited and the implementation of Microsoft Office 365 continues across the GP and CCG devices. There are concerns over some variants of the Windows 10 operating system that were out of active support, but we understand that has now been rectified. NECS Engineers are continuing to upgrade devices to the latest version of Windows 10 to ensure that all devices are appropriately supported when this temporary extension ends. Once all of this work has been completed, the risk will be fully mitigated, but attacks on the infrastructure remain a possibility. 12.07.21 - All unsupported versions of Microsoft Windows 10 have now been removed from all devices currently connected to the network. There are three devices outstanding, but these are with colleagues not currently at work and the device will be required to be upgraded prior to re-connecting to the network. The installation of Microsoft Office 365 has been mandated across all CCGs as of 4pm on July 9th with personal follow-up from NECS for any outstanding. There are around 700 devices yet to be upgraded onto Microsoft Office 365 across Primary Care - NECS continue to work with Practice Managers to resolve and Engineer visits will be arranged where more convenient. Risk remains the same.	3	4	12	3	4	12	2	1	2	31.07.21	Links to Strategic Aims 4	Jul-21	Aug-21	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Ged Connolly-Thompson - Head of Digital Development, Chrissy Tucker - Director of Corporate Delivery

Risk Reference	Year	Risk Description	Responsible Committee	Type - Corporate or Clinical	Initial Risk Rating			Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating			Residual/ Current Risk			Target Risk			Target Date	Link to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner
					Probability	Impact	Rating				Probability	Impact	Rating	Probability	Impact	Rating	Probability	Impact	Rating						
33	21/22	There is a risk to patients on waiting lists as a result of their delays to treatment as a direct result of the COVID 19 pandemic. Provider waiting lists have increased in size and it is likely that it will take significant time to fully recover the position against these.	Quality & Performance	Clinical	4	4	16	• Risk stratification of waiting lists as per national guidance • Work is underway to attempt to control the growth of the waiting lists - via MSK pathways, consultant connect, ophthalmology, reviews of the waiting lists with primary care etc. • Providers are providing clinical reviews and risk stratification for long waiters and prioritising treatment accordingly.	• A task and finish group is in place to monitor actions being undertaken to support these patients which reports to PCDB and SQP • Providers are capturing and reporting any clinical harm identified as a result of waits as per their quality assurance processes • An assurance framework has been developed and completed by all providers the results of which will be reported to PCDB • A minimum standard in relation to these patients is being considered by PCDB • Work to control the addition of patients to the waiting lists is ongoing • Providers are contacting patients via letter	• Monthly reporting of progress against all work to control growth of waiting lists • Two weekly task and finish groups with all 4 providers represented • Completion of assurance framework has been undertaken by all providers and is being collated to go to PCDB for discussion • Identified harm has been reported on STEIS and all providers are monitoring this • All providers have completed the assurance framework and this is being collated to go back to PCDB for discussion re further risk mitigations • Work is ongoing around Consultant Connect, MSK and Ophthalmology 14.05.2021 update - Providers are all in the process of completing the assurance framework again to monitor progress. ToR now agreed and the next 3 meetings will focus on individual aspects of the minimum standard requirements to facilitate sharing and learning as all providers work to achieve this. Risk score to remain. 24.06.2021. Waiting lists remain a system issue and there continue to be significant numbers of patients on them, therefore the risk remains the same. 12.07.21 update - PCDB and System Quality Group have been updated on the current position in relation to the assurance framework. There remains limited assurance overall regarding the ability to prevent harm due to the numbers of patients on the lists. A Derbyshire wide communications strategy is being worked up with Comms leads. Risk score to remain	4	4	16	4	4	16	3	2	6	Feb-22	Links to Strategic Aims 1, 2, 3, 4	Jul-21	Aug-21	Brigid Stacey, Chief Nursing Officer	Laura Moore, Deputy Chief Nurse
37	21/22	The Royal College of Physicians identified that there is a risk to the sustainability of the Hyper Acute Stroke Unit at CRHFT and therefore to service provision for the population of North Derbyshire.	Quality & Performance	Clinical	4	5	20	Short term work has been undertaken and assurance re the safety of services has been provided by the Medical and Nursing Director at CRHFT, however the long term sustainability of the service now needs to be addressed. March update: CRH Stroke Service Contingency Plan has been implemented, with sign-off from impacted surrounding trusts (Kings Mill, Hallamshire, UHDB, and Stepping Hill). Short-term mitigations in place to support service continuity, reducing the risk of service suspension and patient divert.	• Locum Consultant cover is in place • Clinical Leadership support is being provided by Liverpool Consultant • Trust to go out for advert to recruit new Stroke Lead consultant & work being done to make advert attractive • CCG , NHSE & System working with Trust Medical Director to contact other organisations and the Stroke Network for support. • Trust reviewing staff daily and escalating as per safer staffing policy as required, including red flag acuity reporting • CRHFT and Integrated Stroke Delivery Network (ISDN) leads to develop service contingency plan to understand internal measures, mutual aid options, and patient divert impact. • SOP to operationalise the contingency plan. • A task and finish group to commence a service review of the HASU, including options appraisal. All options to be reviewed with the aim of providing a sustainable service.	Apr 21- SOP to operationise the contingency plan is circulated to surrounding Trusts. Apr 21- CRH HASU options appraisal to commence in May-21 and is to be chaired by the NHSE/I National Stroke Clinical Lead Deb Lowe. Membership includes all key stakeholders including surrounding Trusts (Sheffield Teaching Hospitals, Sherwood Forest Hospitals and UHDB). May-21- CRH's SSNAP rating has improved from an overall C rating (July-Sept 20) to B rating (Oct-Dec 20). An 'A' or 'B' SSNAP rating are indicative of first class quality of care and a good or excellent service in many aspects respectively. June-21- HASU service review is on-going. The T&F group have agreed to review 4 options that includes: Continuation of HASU with consultant workforce, conveyance and repatriation model, alternative workforce models or closure and conveyance to surrounding trust. Jo Keogh (CRH Divisional Director) is leading the review with support from CCG colleagues. July 21- HASU service review update- 5 options have been identified by the group that include:- 1.HASU provision continues as is delivered by the existing substantive Consultant, locum support and telemedicine. 2.The current HASU service is strengthened by redesign. 3.The Trust introduces a review and convey (drip and ship) model. 4.Decommission the CRH HASU element of the Stroke Service pathway, if workforce sustainability issues cannot be resolved, with either a single HASU provider or multiple providers.5.Review of the CRH HASU as part of a wider East Midlands review to rationalise sites; continuing to provide the service 'as is' at CRH. To support the identification of the preferred option and to provide transparency on decision making, the task and finish group have requested that an outcome matrix and criteria is developed and is to be presented at the August meeting for review.	3	4	12	3	4	12	3	3	9	Aug-21		Jul-21	Aug-21	Dr Steve Lloyd, Medical Director	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster Head of Strategic Clinical Conditions and Pathways
38	21/22	The quality of care could be impacted by patients not receiving a care needs review in a timely way as a result of the COVID pandemic and the requirement for some of the Midland and Lancashire Commissioning Support Unit (MLCSU) Individual Patient Activity /Continuing Health Care (CHC) services to redirect service delivery to support system wide pressures. This has had an impact on core CHC and Funded Nursing Care (FNC) service delivery in relation to care needs reviews.	Quality & Performance	Clinical	4	2	8	A prioritisation matrix was put in place to ensure the most high risk/complex case reviews were prioritised.	A service Proposal has been presented and agreed by the CCG. MLCSU will schedule and complete care reviews of all individuals who have a review that was due between 19th March 2020 and 31st March 2021. These will all be completed within 6 months	May 2021 - 600 overdue reviews. Recovery action plan in place and review activity commenced. July 2021 -Trajectory in place to complete all 600 reviews by November 2021. Workforce in place and 220 reviews completed in June so on target.	4	2	8	4	2	8	3	2	6	Sep-21	BC	Jul-21	Aug-21	Brigid Stacey Chief Nursing Officer	Nicola MacPhail Assistant Director of Quality
NEW RISK 40	21/22	In the period of transition from CCG to ICS, it is likely that a larger proportion of contracts will be extended on expiry rather than reprocured. The CCG is advised by Arden & GEM CSU on best practice for our procurement activity, but in some circumstances, the CCG may decide to proceed against best practice in order to give sufficient time for review of services within the framework of movement to an ICS. Proceeding against advice, carries a small risk of challenge from any providers who may have felt excluded from the process.	Governance	Corporate	4	4	16	All healthcare contract extensions or renewals are reviewed via SLT, Execs, CLCC and then Governing Body for larger contracts. Any procurements issues and risks are highlighted as part of that process and the risk is accepted when agreement is given to proceed with the extension. Risks of challenge are small in most markets and the size of the risk will have been factored in to decision-making. Healthcare contracts expiring within 12 months are reviewed at Commissioning Ops Directorate SMT to ensure that timely action is taken before expiry. Where any challenge occurred from a provider, if the challenge were valid the risk could usually be mitigated by including the provider in future stages of procurement. Legislation is currently going through parliament to remove the requirement for NHS bodies to comply with the Public Sector Procurement Regulations for the procurement of healthcare services. This requirement will be replaced with a Provider Selection Regime which requires adherence to a decision-making framework but removes the right of legal challenge from providers except by judicial review.	A monthly meeting has been established between AGEM and the contracting team to review the procurement report and ensure that any issues around risk, progress or lack of engagement are escalated appropriately. The redesign of the procurement report has reduced the number of contracts of concern.	A monthly meeting has been established between AGEM and the contracting team to review the procurement report and ensure that any issues around risk, progress or lack of engagement are escalated appropriately.	3	4	12	3	4	12	4	2	8	Mar-22	DC	Jul-21	Aug-21	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Chrissy Tucker - Director of Corporate Delivery

Appendix 2 - Movement during July 2021

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
01	21/22	The Acute providers may breach thresholds in respect of the A&E operational standards of 95% to be seen, treated, admitted or discharged within 4 hours, resulting in the failure to meet the Derby and Derbyshire CCGs constitutional standards and quality statutory duties.	5	4	20	5	4	20	⟷	COVID-19 preparations had an effect on the system with increased pressure on 111 services and ED departments devoting physical capacity to isolation areas.	Zara Jones Executive Director of Commissioning Operations	Quality & Performance	Craig Cook Director of Contracting and Performance / Deputy Director of Commissioning Operations Jackie Carlile Claire Hinchley Dan Merrison Senior Performance & Assurance Manager
02	21/22	Changes to the interpretation of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) safeguards, results in greater likelihood of challenge from third parties, which will have an effect on clinical, financial and reputational risks of the CCG	3	4	12	3	4	12	⟷	The risk score remains stable as there is not enough movement in relation to this yet to be able to b reduce the risk score	Brigid Stacey - Chief Nursing Officer	Quality & Performance	Bill Nicol, Head of Adult Safeguarding
03	21/22	TCP unable to maintain and sustain performance, Pace and change required to meet national TCP requirements. The Adult TCP is on recovery trajectory and rated amber with confidence whilst CYP TCP is rated green, main risks to delivery are within market resource and development with workforce provision as the most significant risk for delivery.	5	4	20	5	4	20	⟷	TCP remains on national escalation with regular calls with NHSE.	Brigid Stacey - Chief Nursing Officer	Quality & Performance	Helen Hipkiss, Deputy Director of Quality / Phil Sugden, Assistant Director Quality, Community & Mental Health, DCHS
04A	21/22	Contracting: Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care. There are 112 GP practices in Derbyshire all with individual Independent Contracts GMS, PMS, APMS to provide Primary Medical Services to the population of Derbyshire. Six practices are managed by NHS Foundation Trusts and one by an Independent Health Care Provider. The majority of Derbyshire GP practices are small independent businesses which by nature can easily become destabilised if one or more core components of the business become critical or fails. Whilst it is possible to predict and mitigate some factors that may impact on the delivery of care the elements of the unknown and unexpected are key influencing dynamics that can affect quality and care outcomes. Nationally General Practice is experiencing increased pressures which are multi-faceted and include the following areas: *Workforce - recruitment and retention of all staff groups *COVID-19 potential practice closure due to outbreaks *Recruitment of GP Partners *Capacity and Demand *Access *Premises *New contractual arrangements *New Models of Care *Delivery of COVID vaccination programme	4	4	16	4	4	16	⟷	There is an increasing demand and pressure General Practice are facing as lockdown measures are being relaxed and removed.	Dr Steve Lloyd - Medical Director	Primary Care Commissioning	Hannah Belcher, Head of GP Commissioning and Development (Primary Care)

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
04B	21/22	Quality: Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care. There are 112 GP practices in Derbyshire all with individual Independent Contracts GMS, PMS, APMS to provide Primary Medical Services to the population of Derbyshire. Six practices are managed by NHS Foundation Trusts and one by an Independent Health Care Provider. The majority of Derbyshire GP practices are small independent businesses which by nature can easily become destabilised if one or more core components of the business become critical or fails. Whilst it is possible to predict and mitigate some factors that may impact on the delivery of care the elements of the unknown and unexpected are key influencing dynamics that can affect quality and care outcomes. Nationally General Practice is experiencing increased pressures which are multi faceted and include the following areas: *Workforce - recruitment and retention of all staff groups *COVID-19 potential practice closure due to outbreaks *Recruitment of GP Partners *Capacity and Demand *Access *Premises *New contractual arrangements *New Models of Care *Delivery of COVID vaccination programme	4	5	20	4	5	20	⟺	Quality Assurance visits planned to re commence in September, practices in the process of being booked in, visiting GPs in place and new supporting agenda in place to reflect restoration/ recovery and available data.	Dr Steve Lloyd - Medical Director	Primary Care Commissioning	Judy Derricott, Head of Primary Care Quality
05	21/22	Wait times for psychological therapies for adults and for children are excessive. For children there are growing waits from assessment to psychological treatment. All services in third sector and in NHS are experiencing significantly higher demand in the context of 75% unmet need (right Care). COVID 19 restrictions in face to face treatment has worsened the position.	4	3	12	4	3	12	⟺	HASU service review update- 5 options have been identified by the group.	Zara Jones Executive Director of Commissioning Operations	Quality & Performance	Dave Gardner Assistant Director, Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning
06	21/22	Demand for Psychiatric intensive Care Unit beds (PICU) has grown substantially over the last five years. This has a significant impact financially with budget forecast overspend, in terms of poor patient experience , Quality and Governance arrangements for uncommissioned independent sector beds. The CCG cannot currently meet the KPI from the Five year forward view which require no out of area beds to be used from 2021.	3	2	6	3	4	12	↑	Risk score increased to reflect the increased risk against KPI for no out of area PICU's for the last quarter following procurement.	Zara Jones Executive Director of Commissioning Operations	Quality & Performance	Dave Gardner Assistant Director, Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning
09	21/22	Sustainable digital performance for CCG and General Practice due to threat of cyber attack and network outages. The CCG is not receiving the required metrics to provide assurance regarding compliance with the national Cyber Security Agenda, and is not able to challenge any actual or perceived gaps in assurance as a result of this.	2	4	8	2	4	8	⟺	Risk remains the same, as there is the risk of exploitation, but no evidence of this being exploited - similar to the scenario with Microsoft Office 2010.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Ged Connolly-Thompson - Head of Digital Development, Chrissy Tucker - Director of Corporate Delivery
10	21/22	If the CCG does not review and update existing business continuity contingency plans and processes, strengthen its emergency preparedness and engage with the wider health economy and other key stakeholders then this will impact on the known and unknown risks to the Derby and Derbyshire CCG, which may lead to an ineffective response to local and national pressures.	2	4	8	2	4	8	⟺	The score is proposed to remain as it is due to how the risk is described. To reduce it any further would weaken the case for continued development internally and with wider stakeholders.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Chrissy Tucker - Director of Corporate Delivery / Richard Heaton, Business Resilience Manager

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
11	21/22	Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the CCG to move to a sustainable financial position.	4	4	16	4	4	16		The Derbyshire NHS system has a significant gap between expenditure assessed as required to meet delivery plans and notified available resource.	Richard Chapman, Chief Finance Officer	Finance	Darran Green-Assistant Chief Finance Officer
12	21/22	Inability to deliver current service provision due to impact of service review. The CCG has initiated a review of NHS provided Short Breaks respite service for people with learning disabilities in the north of the county without recourse to eligibility criteria laid down in the Care Act. Depending on the subsequent actions taken by the CCG fewer people may have access to the same hours of respite, delivered in the same way as previously. There is a risk of significant distress that may be caused to individuals including carers, both during the process of engagement and afterwards depending on the subsequent commissioning decisions made in relation to this issue. There is a risk of organisational reputation damage and the process needs to be as thorough as possible. There is a risk of reduced service provision due to provider inability to retain and recruit staff. There is a an associated but yet unquantified risk of increased admissions – this picture will be informed by the review.	3	3	9	3	3	9		The CCG Strategic Commissioners are writing a paper for GB which will provide an update and options. Therefore the risk remains the same at present.	Brigid Stacey - Chief Nursing Officer	Quality & Performance	Mick Burrows Director for Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning, Helen Hipkiss, Deputy Director of Quality /Phil Sugden, Assistant Director Quality, Community & Mental Health, DCHS
14	21/22	On-going non-compliance of completion of initial health assessments (IHA's) within statutory timescales for Children in Care due to the increasing numbers of children/young people entering the care system. This may have an impact on Children in Care not receiving their initial health assessment as per statutory framework.	4	3	12	4	3	12		Several complicating factors have been identified from the health breach reporting that have affected the timeliness of IHA completion during this reporting period, which includes delay at the beginning of the IHA pathway by the LA and also at the end of the IHA pathway by health.	Brigid Stacey - Chief Nursing Officer	Quality & Performance	Alison Robinson, Designated Nurse for Looked After Children
16	21/22	Lack of standardised process in CCG commissioning arrangements. CCG and system may fail to meet statutory duties in S14Z2 of Health and Care Act 2012 and not sufficiently engage patients and the public in service planning and development, including restoration and recovery work arising from the COVID-19 pandemic.	2	4	8	2	4	8		Consultation Law refresher training undertaken for engagement team to support governance process review and strengthen our approach to planning and delivery of engagement, including additional context of engagement requirements in a virtual world.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Engagement	Sean Thornton Assistant Director Communications and Engagement
17	21/22	S117 package costs continue to be a source of high expenditure which could be positively influenced with resourced oversight, this growth across the system, if unchecked, will continue to outstrip available budget	3	3	9	3	3	9		Risk score remains unchanged pending completion of case load review, CSU asked to confirm timescale now second member of staff recruited	Zara Jones, Executive Director of Commissioning Operations	Quality & Performance	Helen Hipkiss, Director of Quality / Dave Stevens, Head of Finance
20	21/22	Failure to hold accurate staff files securely may result in Information Governance breaches and inaccurate personal details. Following the merger to Derby and Derbyshire CCG this data is not held consistently across the sites.	3	3	9	3	3	9		No change due to continued home working, paused.	Beverley Smith, Director of Corporate Strategy & Development	Governance	Sam Robinson, Service Development Manager

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
22	21/22	The mental health of CCG staff and delivery of CCG priorities could be affected by remote working and physical staff isolation from colleagues.	2	3	6	2	3	6	⇔	All staff requested to meet with line manager to complete a new ways of working: Individual preferences and risk assessment pro-forma, which combines wellbeing discussion with exploring individual preferences for working arrangements moving forwards.	Beverley Smith, Director of Corporate Strategy & Development	Governance	Beverley Smith, Director of Corporate Strategy & Development James Lunn, Head of People and Organisational Development
23	21/22	CCG Staff capacity compromised due to illness or other reasons. Increased numbers of CCG staff potentially unable to work due to COVID 19 symptoms / Self isolation.	1	4	4	1	4	4	⇔	Arrangements in place to backfill two key roles for staff redeployed to the vaccine operational cell with interim/agency	Beverley Smith, Director of Corporate Strategy & Development	Governance	Beverley Smith, Director of Corporate Strategy & Development James Lunn, Head of People and Organisational Development
24	21/22	Patients deferring seeking medical advice for non COVID issues due to the belief that COVID takes precedence. This may impact on health issues outside of COVID 19, long term conditions, cancer patients etc.	2	3	6	2	3	6	⇔	Advise to keep the risk on the tracker due to forthcoming winter pressures and the increasing spread of COVID variants.	Dr Steve Lloyd, Medical Director	Quality & Performance	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster Head of Strategic Clinical Conditions and Pathways
25	21/22	Patients diagnosed with COVID 19 could suffer a deterioration of existing health conditions which could have repercussions on medium and long term health.	3	3	9	3	3	9	⇔	Plans to develop a Long COVID Rehab pathway to support patients with Post COVID Syndrome are being worked up. A total of 600 patients have been referred to the Post Covid Assessment Clinic to date.	Dr Steve Lloyd, Medical Director	Quality & Performance	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster Head of Strategic Clinical Conditions and Pathways
26	21/22	New mental health issues and deterioration of existing mental health conditions for adults, young people and children due to isolation and social distancing measures implemented during COVID 19.	4	3	12	4	3	12	⇔	CYP plan is being refreshed and sent out to strategic partners as draft .Additional funding streams applied for, with success.	Zara Jones, Executive Director of Commissioning Operations	Quality & Performance	Mick Burrows, Director of Commissioning for MH, LD, ASD, and CYP Helen O'Higgins, Head of All Age Mental Health Tracy Lee, Head of Mental Health - Clinical Lead
27	21/22	Increase in the number of safeguarding referrals linked to self neglect related to those who are not in touch with services. These initially increased immediately following COVID lockdown. The adult safeguarding processes and policy are able to respond to this type of enquiry once an adult at risk has been identified. Numbers are difficult to predict but numbers are predicted to increase as COVID restrictions ease.	4	3	12	4	3	12	⇔	Marked increase in domestic abuse referrals (30)%. This is likely due to families being forced together for extended periods of time, children being at home due to schools closure, financial pressures due to furloughing, victims being isolated from support systems and extended family, and dysfunctional partnerships.	Brigid Stacey, Chief Nursing Officer	Quality & Performance	Bill Nicol, Head of Adult Safeguarding

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
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28	21/22	Increase in safeguarding referrals once the lockdown is lifted and children and parents are seen and disclosures / injuries / evidence of abuse are seen / disclosed.	3	3	9	3	3	9	⟺	Risk recommended for closure.	Brigid Stacey, Chief Nursing Officer	Quality & Performance	Michelina Racioppi, Assistant Director for Safeguarding Children / Lead Designated Nurse for Safeguarding Children
30	21/22	There is an ever present risk of fraud and cybercrime; the likelihood of which may increase during the COVID emergency response period.	1	4	4	1	4	4	⟺	Work continues on ensuring the appropriate closure of all aspects of a user's account(s) following the triggering of the leavers/joiners process with the potential to automate some of the stages to provide assurances.	Richard Chapman, Chief Finance Officer	Finance	Darran Green-Assistant Chief Finance Officer / Ged Connolly-Thompson, Head of Digital Development
32	21/22	Risk of exploitation by malevolent third parties If vulnerability is identified within any of the Microsoft Office 2010 applications after October 14th 2020 and not patched, due to support for Microsoft Office 2010 officially ending, after which point Microsoft will cease to issue updates and patches for vulnerabilities found within this suite of applications	3	4	12	3	4	12	⟺	There are around 700 devices yet to be upgraded onto Microsoft Office 365 across Primary Care - NECS continue to work with Practice Managers to resolve and Engineer visits will be arranged where more convenient. Risk remains the same.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Ged Connolly-Thompson - Head of Digital Development, Chrissy Tucker - Director of Corporate Delivery
33	21/22	There is a risk to patients on waiting lists as a result of their delays to treatment as a direct result of the COVID 19 pandemic. Provider waiting lists have increased in size and it is likely that it will take significant time to fully recover the position against these.	4	4	16	4	4	16	⟺	A Derbyshire wide communications strategy is being worked up with Communications leads. Risk score to remain	Brigid Stacey, Chief Nursing Officer	Quality & Performance	Laura Moore, Deputy Chief Nurse
37	21/22	The Royal College of Physicians identified that there is a risk to the sustainability of the Hyper Acute Stroke Unit at CRHFT and therefore to service provision for the population of North Derbyshire.	3	4	12	3	4	12	⟺	HASU service review update- 5 options have been identified by the group.	Dr Steve Lloyd, Medical Director	Quality & Performance	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster Head of Strategic Clinical Conditions and Pathways
38	21/22	The quality of care could be impacted by patients not receiving a care needs review in a timely way as a result of the COVID pandemic and the requirement for some of the Midland and Lancashire Commissioning Support Unit (MLCSU) Individual Patient Activity /Continuing Health Care (CHC) services to redirect service delivery to support system wide pressures. This has had an impact on core CHC and Funded Nursing Care (FNC) service delivery in relation to care needs reviews.	4	2	8	4	2	8	⟺	Trajectory in place to complete all 600 reviews by November 2021. Workforce in place and 220 reviews completed in June so on target.	Brigid Stacey Chief Nursing Officer	Quality & Performance	Nicola MacPhail Assistant Director of Quality
NEW RISK 40	21/22	In the period of transition from CCG to ICS, it is likely that a larger proportion of contracts will be extended on expiry rather than reprocured. The CCG is advised by Arden & GEM CSU on best practice for our procurement activity, but in some circumstances, the CCG may decide to proceed against best practice in order to give sufficient time for review of services within the framework of movement to an ICS. Proceeding against advice, carries a small risk of challenge from any providers who may have felt excluded from the process.	3	4	12	3	4	12	NEW RISK	NEW RISK	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Chrissy Tucker - Director of Corporate Delivery

Joined Up Care Derbyshire Board
Minutes of the Meeting held in PUBLIC on
Thursday 20 May 2021 (0900-1205 hours)
Via Microsoft Teams

CONFIRMED

Present:		Designation:	Organisation:
Lee Outhwaite	LO	JUCD Finance Lead & Director of Finance	Chesterfield Royal Hospital NHSFT
Helen Phillips	HP	Chair	Chesterfield Royal Hospital NHSFT
Angie Smithson	ASm	Chief Executive	Chesterfield Royal Hospital NHSFT
Avi Bhatia	AB	GP & Clinical Chair	Derby & Derbyshire CCG
Penny Blackwell	PB	Place Board Chair & Governing Body GP	Derby & Derbyshire CCG
Chris Clayton	CC	Chief Executive & ICS Executive Lead	Derby & Derbyshire CCG
Brigid Stacey	BS	Chief Nurse	Derby & Derbyshire CCG
Sean Thornton	ST	Assistant Director Communications & Engagement	Derby & Derbyshire CCG | JUCD
Martin Whittle	MW	Chair of the System Engagement Committee	Derby & Derbyshire CCG
Kath Markus	KM	Chief Executive	Derby & Derbyshire LMC
Robyn Dewis	RD	Director of Public Health	Derby City Council
Webb, Roy	RW	Councillor	Derby City Council
Carol Hart	CH	Councillor & Cabinet Member for Health & Communities	Derbyshire County Council
Helen Jones	HJ	Executive Director of Adult Social Care & Health	Derbyshire County Council
Dean Wallace	DW	Director of Public Health	Derbyshire County Council
Tracy Allen	TA	Chief Executive	Derbyshire Community Health Services NHSFT
Prem Singh	PS	Chair	Derbyshire Community Health Services NHSFT
Caroline Maley	CM	Chair	Derbyshire Healthcare NHSFT
Phil Cox	PC	Non-Executive Director	DHU Health Care
William Legge	WL	Director of Strategy & Transformation	EMAS NHSFT
Pauline Tagg	PT	Chair	EMAS NHSFT
John MacDonald (Chair)	JM	ICS Chair	Joined Up Care Derbyshire
Sukhi Mahil	SKM	ICS Assistant Director	Joined Up Care Derbyshire
Vikki Ashton Taylor	VT	ICS Director	Joined Up Care Derbyshire
Fran Steele	FS	Director of Strategic Transformation, North Midlands	NHS E/I – Midlands
Kathy Mclean	KMc	Chair	University Hospitals Derby & Burton NHSFT

In Attendance:		Designation:	Organisation:	Deputy on behalf of/Item No:
Helen Dillistone	HD	Executive Director of Corporate Strategy and Delivery	Derby & Derbyshire CCG	CCG Exec Lead Rep
Zara Jones	ZJ	JUCD Planning Lead & Exec Director of Commissioning Operations	Derby & Derbyshire CCG	
Gail Walton	GW	LMC & GPA Representative	Derbyshire GP Alliance	Deputy for Paddy Kinsella

Claire Wright	CW	Deputy Chief Executive, Executive Director of Finance & Board LGBT + Champion	Derbyshire Healthcare NHSFT	Deputy for Ifti Majid
Paul Tilson	PT	Managing Director	DHU Healthcare	Deputy for Stephen Bateman
Rebecca Gladstone	RG	GP Partner & Erewash Place GP Lead	Erewash Place	Patient Story
Naomi Martin	NM	GP Link Worker	Erewash Voluntary Action	Patient Story
Stella Scott	SS	Chief Executive Officer	Erewash Voluntary Action	Patient Story
Nancy Cooke	NC	System Workforce Planning Lead	Joined Up Care Derbyshire	
Jackie Counsell	JC	ICS Executive Assistant	Joined Up Care Derbyshire	Note taking
Linda Garnett	LG	ICS Workforce & OD Lead	Joined Up Care Derbyshire	Item 9
Karen Lloyd	KL	Head of Engagement	Joined Up Care Derbyshire	Deputy for Sean Thornton
Magnus Harrison	MH	Executive Medical Director	University Hospitals Derby & Burton NHSFT	Deputy for Gavin Boyle
Members of the Public in Attendance:				
		Several attempts from unnamed individuals were made to join parts of the meeting by phone (durations ranged from 8 mins up to 1 hour)		
Apologies:		**Designation:**	**Organisation:**	
Andy Smith	AS	Strategic Director of People Services	Derby City Council	
Paddy Kinsella	PK	Exec of GP Alliance	Derbyshire GP Alliance	
Riten Ruparelia	RR	GP Alliance Provider Representative	Derbyshire GP Alliance	
Ifti Majid	IM	Chief Executive	Derbyshire Healthcare NHSFT	
Stephen Bateman	SB	Chief Executive	DHU Health Care	
Rachel Gallyot	RG	Clinical Chair	East Staffordshire CCG	
Gavin Boyle	GB	Chief Executive	University Hospitals Derby & Burton NHSFT	

200521/1	**Welcome, Apologies and Minutes of Previous Meeting**	**Action**
	As per the Agenda, members were reminded that the meeting was being recorded purely for the purpose of minute accuracy. The Chair welcomed Board members to the meeting and apologies for absence were noted as reflected above; the meeting was confirmed as being quorate. The minutes of the last meeting held in public on 15 April 2021 were noted to be an accurate record. Today's meeting was confirmed as being held in public.	
200521/2	**Action Log**	
	VT advised that the 2 live actions on the action log were both future agenda items.	
200521/3	**Declarations of Interest**	
	The Chair asked for any changes to the Declarations of Interest to be identified in the meeting. The purpose was to record any conflicts of interest and note any other conflicts in relation to the meeting agenda. The DoI would be updated to reflect the following changes: • LO: Remove Honorary Treasurer/Trustee of Women's Work (Derbyshire) • PB: Add Clinical Director of the Derbyshire Dales PCN with effect from 1 April 2021.	**JC**
200521/4	**Patient Story – Social Prescribing: A Patient's Story (RG, SS, NM)**	
	RG, SS and NM were welcomed to the meeting to go through their presentation: Social Prescribing – Case Study 'Sue' (circulated in advance). The story described a patient's social prescribing journey through Erewash Voluntary Action using a pseudonym; highlighting that	

social prescribing is a way for GPs, nurses and other primary care professionals to refer patients with social, emotional or practical needs to a wider range of local, non-clinical services. It can help patients with various conditions: one or more long-term conditions; mental health support; loneliness, isolation; complex social needs affecting wellbeing; frequent primary/secondary care attendees and those not benefitting from clinical/drug treatment. Patients can be referred to social prescribing in SystemOne, following which a patient undergoes an initial assessment to agree the measures to be put in place to provide alternative support for the patient. The support offer can be at different levels and ranges from Chaplaincy, local peer support groups, various courses (including relaxation courses and/or counselling, where covid permits), connecting with volunteer buddies from Erewash Voluntary Action for meet ups/walks, tech buddy scheme to help with digital isolation, joining local social clubs, providing 24/7 contact numbers, pendent alarms, phone befrienders to help with loneliness/isolation etc. Regular contact is maintained with the patient to review progress and outcomes and agree any further measures required.

Evidence to date, showed a reduction in calls to the GP practice, ambulance attendances/hospital admissions post receiving social prescribing and was demonstrating that patients feel more supported with better ways of coping and experiencing a lot less bad days. However, it was noted that some patients' cases were complex which required lots of support and the interventions for each patient would vary depending on need.

The following key summary discussion points were highlighted:

- It was noted that the case study showed an inspiring and heart-warming journey with great social impact. Going forward it was important irrespective of GP practice that the same level of service, equity and approach be afforded to all patients across Derby and Derbyshire and necessary steps taken to overcome any barriers to this (HP). It was confirmed that Social Prescribing was available across all of Derbyshire but operating at different levels based on the different capabilities PCNs had in social prescribing which was built on local needs and services available (PB).
- With regards to barriers to social prescribing these could be multi-ranging from transport, anxiety of using public transport/travelling alone, digital exclusion, financial issues that can impact a patient's ability to join/be involved etc. It was important to continually promote social prescribing to ensure more GPs are aware of the service and benefits it can afford patients (RG, SS, NM).
- Underpinning social prescribing was strong partnership working and CH noted that in Erewash this connection to health was excellent and has improved further during the Covid. RW added that although models may be different in different areas there was strong development in this area e.g. Derby City were a supported pilot for Local Area Co-ordinators (RW).
- It was suggested that there was a need for true integration of social prescribing links between primary and secondary care. For instance, if a patient presented at hospital there could be a link back to the social prescribers where appropriate to ensure the patient was connected in with the service. It would be important to evaluate the outcomes to ascertain any areas that would benefit from a targeted approach (KMc).
- It was noted that focussed discussions were taking place through the Place Board, looking at social prescribing and how best to evaluate it, noting there was lots happening in this space. Work would continue to ensure the network of social prescribers across Derby/Derbyshire learn from each other, recognising that the amount of resource needed at the start of a patient's journey was high in terms of time/effort. However, patients who had undergone a successful journey would in turn become ambassadors for the social prescribing network (PB).
- WL suggested there was a significant opportunity for EMAS to understand more about social prescribing and incorporate this into the care provided by paramedics on the front line.

	• This is at the heart of local place-based partnership working and there are similar examples right across JUCD. The sharing of best practice, evaluation points are well made, and we can continue to encourage this as we develop the 2 Place Partnerships to ensure we nurture and support the great work going on (TA). The Chair thanked RG, SS, NM on behalf of the Board for sharing their valuable and impressive work, recognising there could be lessons learnt of how this level of support can be provided without having a too heavy governance structure.	
200521/5	**Chair and ICS Executive Lead Update (JM, CC)**	
	The Chair noted the following in addition to the content in the Chair and Executive Lead Report (previously circulated): • The format of Board meetings would change over the next few months as we see Assurance Committees start to establish and reports coming into the Board. • Thanks to colleagues involved in the meeting with Lord David Prior/Amanda Pritchard which by all accounts went well. • Health and Care Partnership discussions were ongoing with Councillors Hart and Webb. • A meeting was being arranged between Derbyshire, Nottinghamshire, Staffordshire ICS Chairs with NHSEI to look at how learning can be shared across the 3 ICSs. • We are expecting a plethora of guidance in relation to the establishment of a statutory ICS in the next few months; it was hoped this will allow flexibility to shape things to best fit our ambitions and not be too prescriptive. There was concern the passing of national legislation may not allow the April 2022 deadline to be met and the 2nd reading of the Bill had been delayed from the original timetable. It was agreed we need to continue as planned working within current legislation and adapt as/if necessary, as guidance emerges. There was a need to look at April 2022 as a start date to the new world and be mindful that the transition to a statutory ICS may take longer given all the changes. It was important that we do what we believe is right for our system now with the expectation we may need to adjust things slightly as the guidance emerges (JM, KMc, PS). • The 360 Assurance draft report attached to the Chairs Report (Appendix A) had been reviewed by the System Transition Assurance sub-committee who noted the findings and good progress made; the view was that that the questions posed in the report offered a helpful reference point for the development work underway to establish the building blocks of the statutory ICS. **The Board noted the report.** The following key summary discussion points were highlighted: • FS emphasised the working assumption is to still assume April 2022 transition date by which statutory ICS' will be established despite potential delays. • The delay to publication of some documents should be noted as a risk, for example, we are required to submit by end of June a revised System Development Plan (SDP) and completed progression tool self-assessment; however, the final progression tool and system design framework guidance to inform these was not yet published (VT). In addition, the initial tranche of workforce guidance had also been delayed several times; the current understanding was that the HR principles should be published by the end of May (LG). CC highlighted the salient points from Chair and Executive Lead Report: • Covid position: Remained fragile and we should not be complacent with the emerging Indian variant; he updated on the surge in 2nd vaccinations and the approach being taken to bring forward from 12 weeks to 8 weeks; recognition of the great work completed to date and ongoing – hitting 1 million vaccinations on Tuesday. Work was also progressing on Phase 3 of the vaccination programme for the Autumn and how this will sit alongside the flu vaccinations.	

	• ICS Boundary: DDCCG on behalf of JUCD had commenced a process of engagement with stakeholders in Derbyshire and Greater Manchester regarding the ICS boundary in relation to how it is determined in the White Paper. Stakeholder feedback would be collated and passed to NHSEI for review prior to a recommendation being made to the Secretary of State who would decide on 11 June 2021. It was noted that there were risks and benefits to any change and there was no perfect solution, so there would be a need to understand and manage those risks accordingly once the Secretary of State makes the decision. • QSRM: key areas highlighted were managing covid, UEC, the Elective position, MHLD and our financial position. The following key summary discussion points were highlighted: • There was a need to ensure we properly celebrate the achievements made around vaccination success and extract every possible ounce of learning from the process to build on the excellent collaborative ways of working and removing barriers, etc. (JM, KMc) • The vaccination programme had truly demonstrated system working. In terms of considering who would maintain the resourcing for a continuous vaccination programme without pulling resources away from other core services, steps were being taken to try and ensure this is managed within overall system workforce planning for the next 12 months; we had done well with a flexible staffing pool, but this was not sustainable longer term and therefore various longer term options were being explored in the forward planning. (TA) • Learning from the vaccine Inequalities programme was important as there were opportunities to adopt and apply the targeted approaches taken beyond the C19 vaccine into other Vaccination and Immunisation uptake and even screening programmes for example (SKM). It was confirmed that Flu and screening coordinators had joined the Vaccine Inequalities Group to join up thinking and learning (ST). • Balancing business as usual and the ongoing vaccine programme remained a big concern for general practice and the workforce is exhausted. • GW advised that there were 6 Trailblazer GP fellows in Derbyshire whose focus is on health inequality (digital/LD/mental health and other areas); funded by HEE. They should be included in ongoing health inequalities work in relation to the vaccine programme and wider.	
200521/6	**Developing ICS Operating Model: Strategic Intent (CC)**	
	CC went through his presentation *(previously circulated),* in three parts: **<u>Part One</u>: Recap / consolidation** of the current position and steps taken thus far, confirming the Strategic Outcome priority; key drivers for reduced LE and HLE; relative contribution of major determinants to health; Derbyshire's Key Influencing Groups on HIs; JUCD Function Map and Governance/operating model; Statutory Commissioning Changes; the close down of the CCG / creation of the statutory NHS ICS body; Phases of continued development; dissemination of CCG commissioning functions; regional developments; and next steps. The following key summary discussion points were highlighted: • CC confirmed that Commissioning Support Unit discussions would follow, once we have worked through provider collaboration at Place and at Scale and the Strategic Commissioning areas. • The Transition Assurance sub-committee have been engaged on the proposed Oversight Framework and will need to take account of this; along with the responsibility that will fall on the NHS ICS Board as a result (CC). • JM noted the importance and emphasis being placed on the case of this not being a 'lift and shift' of the CCG functions into the ICS, which is the approach some ICSs are taking. AB confirmed that the Transition Assurance sub-committee was fully aware of the risk of lift and shift from the CCG to ICS and would ensure this would not be the case.	

- RW reminded the Board that in terms of the ICS' relative contribution to the major determinants to health i.e. the 80% of factors (health behaviours, socioeconomic factors and built environment) all health professionals including GPs have the opportunity to feed into local authority to help tackle some of these issues; therefore there was a need to ensure sole focus was not on the 20% relating to Clinical Care. CC agreed and confirm this would be explored in the partnership working section (part 2) of today's agenda.

The Board were asked to:

- Note the developments to date with regards to statutory commissioning changes **– the Board NOTED developments**
- Support the Transition Assurance Group in bringing through to JUCD Board progress / developments in this regard **– the Board AGREED**

Part Two: Strategic Intent including Health Inequalities covering: Strategic Intent Function; Strategic Intent versus Strategic Commissioning; how Strategic Intent is linked in all we do; and next steps

The following key summary discussion points were highlighted:

- In terms of subsidiarity it was important that consideration be given to a bottom–upwards approach. Concern was raised that there was potential for lots of meetings/groups to be established and we should be reducing formality and making a lean structure, i.e., consider task and finish groups rather than formal committees (KMc)
- All things inter-relate with each other and are not stand alone; for instance, workforce needs to link into our strategic intent as our people are key to delivery and we need strategic focus on them (PS)
- Important that JUCD Board sets the direction and holds to account against the achievement; this would allow the Board more capacity to think about the health of the population of Derby/Derbyshire.
- In terms of subsidiarity, it's not about duplication and we can't replicate everything at system level; there was a need to get the right governance/accountability in place to make this happen. HP volunteered to provide support in considering this area further.
- Need to ensure what we are doing at the wider system level does not detract from our quadruple aim, ensuring we link the strategic framework to our vision/overall aims, recognising how we get there will largely be undertaken at local community level (KMc)
- Consideration would be required in relation any implications as a result of the Oversight Framework; it was suggested whether there was a need to map our strategic intent to the Oversight Framework and how the ICS will be measured by Regulators in the future (LO).
- Engagement with Local Government in the conversation on Strategic Intent and strategic commissioning was welcomed, recognising it is a complex area, but the dialogue had enabled identification of shared areas of interest which had enhanced the outline model put forward today (HJ).
- It was good to see consideration of health protection functions and section 7A arrangements as well as the opportunity to reinvigorate the JSNA which should be developed in such a way that it underpins system decision making, including investment (DW).
- We need to develop how Strategic Intent forms a two-way communication with the Delivery Boards, Place(s) Partnerships and Provider Collaboration at scale - this is a key source of the insight we need to include in understanding and developing priorities.
- A single strategy was required to define the WHAT with appropriate local flexibility about delivering the HOW (HP); this would be important to ensure those delivering change and services in Place, PCN, LA, social, voluntary care etc are engaged and able to influence and inform Strategic Intent (PB).

	• Strategic Intent sets system direction against improving population outcomes which align to priorities and the Outcomes Based Accountability (OBA) approach needs to be embedded throughout (DW, RD, SKM) • Delivering the system strategic intent would require sustainable workforce and there was a challenge in the system with regards to General Practice; struggling with workload and up to 30% of GPS retiring in the next year (PC). CC noted it was important to understand the early thinking on General Practice provider collaboratives with regards to future sustainability. Work was well under way on the formation of a GP Provider Board that includes GP Alliance and LMC leaders and act as a unified GP voice for Derbyshire. There would be an ask for system support in that moving forwards (GW). The Chair summarised there was support for this Framework, with a need to keep it strategic and do so in a lean way. The effectiveness of the strategic intent function would be based on feed in as well as outputs, to understand any constraints and critical issues which could affect the desired direction of travel e.g. workforce constraints. The Board were asked to agree: • Chris Clayton to remain as AO lead for this area of development at this time ***– the Board AGREED.*** • Confirm SRO leadership jointly between Robyn Dewis, Zara Jones & Steve Lloyd ***– the Board AGREED.*** • Consider the need for a NED / elected member chair for this development work in line with other areas; including the principle of subsidiarity which HP had come forward in the meeting to support. Any further interest should be confirmed to CC as co-leadership and LA support was important in addition to broader executive support. ***ACTION: CC/HP to discuss further to take forward a reference group for this work.***	**CC, HP**
	<u>Part Three</u>: Partnership approach/working – covering: Strategic Outcome Priority; Derbyshire's Key Influencing Groups on HIs; JUCD Governance/operating model; Statutory view of the ICS/how to reduce HIs; and next steps. The following key summary discussion points were highlighted: • There was a need to create a partnership around the broader ICS Health & Care Partnership (ICS H&CP) by consolidating NHS, Public Health and Local Authorities. It was noted that a small working group would be predominantly led and taken forward by LA with a small contribution from JUCD. • The role of the Health & Social Care Partnership was not clear from the White Paper and there were a number of complexities, i.e., where does local democratic accountability sit, 2 H&W Boards with agreed priorities, 2 Place Boards – some LAs have said the ICS H&CP will become the H&W Board and there was a need to take steps to bring it all together; as such small working group to do so was supported (HJ). Much preventative work being done in the LA space which connects all aspects together so would support a working group to help progress this (CH). • The functions of Place partnership span the full breadth of the major determinants of ill health and there is clear accountability into the H&W Boards. Support working group and the LA elect members /officers to lead the discussion linking in with Place (TA) • It was noted that H&W Boards are much wider than Health and Social Care and include community, Police, Fire service and lots of other representatives from local government, i.e., housing, public health which all effect the wider determinants of health (RW) • Consider reviewing membership of the H&WB board as nobody wanted a very large board but mindful there may be some partners that would enhance the work that are not included at present (CH). It was about finding that balance between ensuring broad enough representation in order to improve and influence population health and wellbeing and reduce inequality in outcomes (DW).	

	• Need to consider how the Anchor work/discussions can feed into the ICS H&CP (JM). This was supported, as Health and Local Authorities are such big employers, we could do good things in some of the other 50%: through our anchor organisations impact: socioeconomic determinants - employment/income etc (CW). • It may help to consider the functions of each board. H&W Boards are statutory bodies whereas the ICS H&CP will translate and guide the system and NHS ICS Board within this the value of the JSNA must be recognised as it is a much underused resource that should be tapped into (KMc). We need to be careful that JSNA is not seen as just a public health thing; the statutory duty at present is on the LA and CCG, yet mainly it is only public health that actively contribute. We need to change that, so it is a "live" thing that is the go-to place for local data, intelligence and evidence, but it requires a collective contribution/ownership (DW). • Need clarity about who is accountable for what and the H&C partnership needs to be integrated into/working towards the wider JSNA and broader H&W partners (TA). An enhanced JSNA based approach could help with that (HJ). • JSNA should be the top level overview, from that you can move into population health management etc, if we get it right the whole data, intelligence, evidence should flow from JSNA and then we can pick-up - decision support unit and population health management which is more tactically focused around variation vs. unwarranted variation in outcomes/outputs and can support quality and efficiency in shorter term time frames (DW). • It was important to understand that in some areas both Local Place Alliances and Health and Wellbeing Partnerships were truly aligned i.e., the Dales Place agenda is almost identical to the Dales LA agenda (PB) The Board were asked to: • Support a small working group approach to progress discussions regarding the roles and functions of the ICS H&CP and Health & Wellbeing Boards/Partnerships – providing an update to JUCD Board in July 2021 ***– the Board AGREED, noting this will be predominantly led by LA with a small contribution from 2-3 JUCD members.***	
200521/7	**Developing ICS Operating Model: Transition to a statutory ICS (AB, VT)**	
	AB went through the presentation (previously circulated), highlighting that the role of the Transition Assurance sub-committee was to ensure coherence and integrity of the system transition; comprising the various building blocks (Place Partnerships, Collaboration at Scale, Strategic Intent, Corporate ICS etc) ensuring the function of the ICS was fit for purpose. VT was ICS Transition SRO and Helen Dillistone was CCG Transition SRO. The CCG also had a Transition working group for the close down/dissemination of its functions. AB emphasised, it was a very complex change programme and the work required should not be underestimated, it was important to ensure nothing slips and the assurance committee would be managing transition risks, with clear oversight and assurance that the ICS building blocks are ready to receive functions and resource (including staff). Two meetings had been held thus far, which had comprised NED and LA representation; further updates on developments would be brought back to the Board going forward. VT advised that slides 2-4 outlined the key components of the system ICS transition plan that would be considered over the coming months. For each of the 11 key areas of priority focus there were more detailed activities which sit beneath the high level detail; together with a complimentary CCG transition plan for the close down of the organisation and transfer of functions including staff into the ICS space incorporating timelines to enable progress monitoring. There is considerable alignment and overlap between and across areas. As such a small working group/executive engine room had been established with the key leaders of the building blocks to work through and gain a better understanding of the building blocks and	

	how best to align them moving forwards with subsidiarity to enable assurance to be provided to the Board through the Transition Assurance sub-committee. The following key summary discussion points were highlighted: • It was noted that the NEDs/lay members were a helpful resource. There was a need to ensure clarity as to who is doing what to avoid any duplication with work taking place elsewhere (CM). It was emphasised that the plan was not to undermine the work already progressing elsewhere but to enable a connected approach to bring together and manage the interdependencies. Names identified would not be asked to undertake different/ additional pieces of work by the assurance committee but to know where/ who was taking a key component forward (SKM). • Thanks to all concerned for the hard work/progress completed on this in such a short timeframe. However, we need to ensure all partner organisations are aware of the approach being taken and progress made (KMc) It was acknowledged that there was a challenge around how different sub-committees engage with each other and how this feeds back in discussions with all partner organisations (AB) • One of the strengths of the system is distributed leadership to take forward different areas and deliver complex work. It was the groups responsibility to ensure connectiveness, coherence and integrity of the way the system moves forward as opposed to doing the work (VT) The JUCD Board **SUPPORTED** the approach being taken.	
200521/8	**JUCD Communications and Engagement Strategy (MW, ST)**	
	MW presented the JUCD Communications & Engagement Strategy (previously circulated) and advised that a more accessible shorter public facing version was planned. The purpose of the strategy was to identify how the Derbyshire ICS will communicate, engage, consult and co-produce the solutions to our transformation, recovery and other agendas in partnership with the citizens of Derbyshire. It is underpinned by several key principles to help us develop in our relationship with the citizens of Derbyshire and sets out our approach to six priority areas (Patient and Public Involvement; Internal Engagement and Communication; Stakeholder Relationship Management; Health Campaigning and Behavioural Change; Supporting Collaboration at Place and Scale; and Digital Communications and Engagement), along with our ambition and initial actions for each. It highlighted the ICS-level stakeholder interest/influence matrix and the shared purpose public engagement and communications model (from NHS Confederation's 'Building Common Purpose, Learning on engagement and communications in integrated care systems'). MS also highlighted Communications Capacity; Governance and Oversight arrangements; Timelines; How we will measure/track if we are Communicating and Engaging successfully. It is a live iterative document and inherently flexible so that it can be adapted as we are presented with new challenges. Routine performance updates will be delivered to the Engagement Committee with risks escalated to Board as required and it will be formally reviewed/refreshed on an annual basis. Thanks, were placed on record to ST/KL and the wider team for all the hard work on this. The following key summary discussion points were highlighted: • Really good piece of work and support having a shorter public facing version. Need to ensure appropriate coordination/expertise in Communications capacity, as part of the transition to ICS and within the Strategic Intent function, there may be opportunities to better use the totality of the Comms & Engagement team, who already work well together (JM). • We could increase engagement in the H&C partnership and H&W Board, the crossover/ benefits could be huge (MW) • Excellent document and good to see the emphasis on engaging with staff, they are a key asset in public engagement, as well as in the main being Derbyshire citizens as well (LG)	

	• Similar conversations are ongoing about how this capability supports the development of the Place Partnerships - working with their local communities to develop a common Place purpose/ developing the integration index etc (TA) The JUCD Board **APPROVED** the Communications and Engagement Strategy, taking note of its direction and its ongoing status as a live document.	
200521/9	**Derby and Derbyshire People Plan (PS, LG)**	
	PS highlighted the following areas from the paper/presentation (previously circulated); noting the Appendix sets out the scale of direction; the four key areas set out in the National Planning guidance for Workforce 2021/22 (Looking after our people; Belonging in the NHS; New Ways of Working and delivering Care; and Growing for the Future). PS highlighted that there was a tendency to drive from the centre and we must not lose sight that statutory organisations have a responsibility for employing their staff, thus steps were being taken to look at pulling together what we can do well by working collectively as a system. Strong focus continues on the wellbeing of our workforce and senior leaders/HRDs are working well together on this agenda. It was noted that a plethora of information was coming from the centre including the NHS/HR/OD review, which would likely result in future recommendations. The newly established People and Culture Committee had its inaugural meeting is on 12th May and involved, PS, GB, LG, HRDs and NEDs (bringing expertise and a confirm/challenge role) from across the system. Key themes were to do things once and add value/avoid duplication; share learning; scope efficiencies around workforce; workforce transformation agenda - integrated care/what that means for our people. It was important to remember we already had the People and Culture Board (who did the 'doing/delivery' of our system People Plan) and as such it was proposed the People and Culture Committee would be more of a strategic oversight group on performance/adding value, giving assurance and acting as a sounding board/critical friend. The following key summary discussion points were highlighted: • Really good paper, clear and succinct. Recognition that this agenda is huge and not as well defined as for example Quality/Finance. As such happy to support a different approach. The key thing was for the Board to understand the priorities, as workforce was a critical area for the system (JM) • Confirmation that NEDs were also very happy with the proposed new approach and wanted to help add value. Meetings would be alternate months and will maintain real connectivity to the People and Culture Board agenda, working as ambassadors for the People agenda (PS) • Great progress being made on our system's biggest asset and risk (CC) • In terms of bringing in different professional disciplines into the executive working group, it was confirmed there had been good engagement from the senior nursing team (DCHS) and medics (CRH), who had put really good challenges to the group on how we engage with the medical workforce. Work was in progress to help develop/gain more engagement with other professional groups i.e., AHP, Pharmacy, General Practice (LG) • There is a very real danger that staff needing time to recover post pandemic will become a platitude and something we keep saying but can't deliver, especially as emergency and urgent care demand continues to grow "exponentially "(PT) • The strong link with NHSEI is important as many of those staff will be impacted too (FS) The JUCD Board **NOTED** the report on the future direction for People and Culture working and governance and **SUPPORTED** the new approach being taken with the People and Culture Committee.	

200521/10	Derbyshire System Financial Delivery (CM, LO)	
	CM placed on record thanks to Richard Wright for the excellent job of setting up the Finance oversight group and work achieved to date. The Finance and Estates Committee had its inaugural meeting last week chaired by CM. Half of the meeting was dedicated to Estates, which highlighted a lot of good work that has been achieved over the years and the need to now review if our Estate was fit for purpose and aligned to our strategy going forward and if we are getting value for money, mindful of inflation effects on money awarded previously and reviews were underway to check if schemes are doing as well as planned, plus the new large estates project *(eradication of dormitories for DHcFT - interest declared as Chair of DHcFT)*. In terms of the finance element of the meeting, the discussions concentrated on reviewing the year-end position and future financial planning for H1, H2 and the longer perspective and how clinical pathways interconnect and will be a key driver for finance in the future. The cycle of meetings would be reviewed to enable more timely information to be fed into the Board meetings. LO gave a more detailed update on the year end position (2020/21) and 2021/22 financial planning. A balanced plan had been submitted for H1 and although we were not clear on the funding regime for H2, a lot of sensible work had been undertaken in the interim, looking at the underlying financial challenge for JUCD. JUCD is one of 5 systems across the Midlands that have been escalated for national discussion and there was a meeting tomorrow with regional and national colleagues where a proposal will be made for a 3 year financial recovery trajectory for the system, rather than trying to deliver £200m savings in a single year. If successful we will need to step up the work around the underlying financial improvement to deliver an improved exit run rate c. £74m by year end, recognising there is a big challenge in that there were resources which have been diverted to deliver the vaccination programme. Stepping up the efficiency programme which will be governed by programme boards, will be a large undertaking and we should not underestimate the work required to remobilise the efficiency programme to get in a better place financially. The following key summary discussion points were highlighted: • The Board would benefit from understanding more practically, how we use our Estates in a more integrated manner as the ICS develops; what we can expect from each other and how these significantly expensive resources are better utilised (PB). • It was important to note that a One Public Estate (OPE) approach to the JUCD Estates strategy was being taken with joint support/management with colleagues from LAs (both upper and lower tier) (TA). • Need to consider how wide we make the overarching framework while allowing enough flexibility for Place, so it is not too restrictive (JM). • LO confirmed that in terms of the in-year financial challenge, we may have some non-recurrent flexibility in terms of 2021/22, however we needed to discuss the potential 3 year settlement with NHSEI to agree how quickly and realistically we can get finances back to a balanced position; a statement of intent was needed on how quick we can deliver, recognising there will be a range of variables, some of which we will need to commit to and some unknowns (LO). • Finance was a sizeable challenge, but we have good system governance overseeing finance and assurance from the approach being taking. We have an excellent group of DoFs who are genuinely looking at the problem who have a good understanding of the underlying issues and looking at the cost base driving the challenge. It was important to remember it was not a worsening problem and we have had, stabilisation and control. We needed to address the challenges ahead, setting ambitious but sensible and realistic plans with NHSEI and the system about our recovery (CC). • From a NED perspective it was recognised that we have had a year of challenge with the pandemic but an easier financial year, with a massive challenge ahead; assurance was required that we really do understand the drivers of the deficit including what is historically structural, areas where there is scope to influence, a deep understanding of	

	our base line, and benchmarking of the medium to long-term financial plan incorporating transformation involving all system partners (KMc). • We probably can't influence structural deficits. We are in a good situation as it is not getting worse, but need to monitor closely H1 as having a financial reprieve is merely stacking up the problem, when ramping up services with restoration/recovery/electives it will cause further challenge in H2 and beyond (PS). • With the scale of the financial challenge, it was recognised that staff costs are the system's biggest cost, yet we are mindful we feel we don't have enough staff. We need to take a virtual approach as a single system employer to review clinical pressures and possible changes to pathways in the interest of economies of scale/critical mass of skill and the flexibility to deploy the workforce accordingly, recognising issues around staff health and wellbeing/cultural factors that would apply (HP). • It was recognised that JUCD was not the only system with this issue and it was a really challenging time for all systems. JUCD needed to show system buy in and confidence in the plan put forward (that it is not going to disaggregate into the individual organisational entities and that it was not merely a tick box exercise). There had been good engagement at the QSRM and increased confidence in the system plan. Having a Board workshop/discussion around finance would be helpful to get full Board buy in to the challenging decisions that would be required ahead (FS). • Building of the medium-term recovery plan will need ICS Board sign off and the required Board discussion to support that (CC). **ACTION: The Chair asked CM, LO, CC to agree how to take Finance forward, so that all Board members understand the full picture and take ownership of the financial challenges ahead and to consider the best time for a Board workshop on Finance.**	**CM, LO, CC**
	For Information	
	No Items.	
200521/11	**Any Other Business**	
	<u>South Yorkshire and Bassetlaw (SYB) ICS</u> CC referred to the documentation (previously circulated) and advised the current relationship with SYB ICS was that DD CCG was an active member of a joint committee of CCGs for SYB due to interlink commissioning of hospital services linked to CRH and there was also linkage with being a member of SYB ICS. The formal relationship on the joint committee will naturally end on 31 March 2022 when CCGs will no longer exist and the linkage structurally between the 2 ICSs will probably end too. However, there was a need to consider how partnership working would continue between ICSs outside of the East Midlands region going forwards. It was proposed a dialogue would be entered into between the 2 ICS's in relation to future requirements for alignment and governance arrangements. The DD CCG governing body was supportive of this approach and CC had also agreed to bring this to the JUCD Board for a view before responding on behalf of both organisations. The JUCD Board gave **SUPPORT** in principle, recognising we need to ensure we are achieving Derbyshire's objectives and receive clarity on how it will work in practice, linking in with provider collaboration at Scale. It was noted similar discussions were happening with Staffordshire given UHDB's position.	
	The Chaired thanked the Board for the quality of the papers and meaningful discussion at today's meeting. Key messages to be drafted following the meeting would cover: • Patient Story – Social Prescribing • Strategic Intent including, health inequalities and the H&W Partnership • Transition Assurance sub-committee • JUCD Communications and Engagement Strategy	

	• People and Culture Board/how it will operate • Finance	
200521/12	**Questions from members of the public**	
	No questions had been received from members of the public.	
200521/13	**Date of Next Meeting**	
	The next formal JUCD Board meeting was scheduled to take place on Thursday 15 July 2021; to be held via MS Teams.	**All to Note**

Joined Up Care Derbyshire Board
Minutes of the Extraordinary Meeting held in PUBLIC on
Thursday 27 May 2021 (1130-1235 hours)
Via Microsoft Teams

CONFIRMED

Present:		Designation:	Organisation:
Lee Outhwaite	LO	JUCD Finance Lead & Director of Finance	Chesterfield Royal Hospital NHSFT
Angie Smithson	ASm	Chief Executive	Chesterfield Royal Hospital NHSFT
Avi Bhatia	AB	GP & Clinical Chair	Derby & Derbyshire CCG
Chris Clayton	CC	Chief Executive & ICS Executive Lead	Derby & Derbyshire CCG
Brigid Stacey	BS	Chief Nurse	Derby & Derbyshire CCG
Sean Thornton	ST	Assistant Director Communications & Engagement	Derby & Derbyshire CCG | JUCD
Kath Markus	KM	Chief Executive	Derby & Derbyshire LMC
Robyn Dewis	RD	Director of Public Health	Derby City Council
Webb, Roy	RW	Councillor	Derby City Council
Carol Hart	CH	Councillor & Cabinet Member for Health & Communities	Derbyshire County Council
Helen Jones	HJ	Executive Director of Adult Social Care & Health	Derbyshire County Council
Dean Wallace	DW	Director of Public Health	Derbyshire County Council
Tracy Allen	TA	Chief Executive	Derbyshire Community Health Services NHSFT
Prem Singh	PS	Chair	Derbyshire Community Health Services NHSFT
Ifti Majid (joined at 1212)	IM	Chief Executive	Derbyshire Healthcare NHSFT
Caroline Maley	CM	Chair	Derbyshire Healthcare NHSFT
Stephen Bateman	SB	Chief Executive	DHU Health Care
William Legge (joined at 1200)	WL	Director of Strategy & Transformation	EMAS NHSFT
John MacDonald (Chair)	JM	ICS Chair	Joined Up Care Derbyshire
Sukhi Mahil	SKM	ICS Assistant Director	Joined Up Care Derbyshire
Vikki Ashton Taylor	VT	ICS Director	Joined Up Care Derbyshire
Fran Steele	FS	Director of Strategic Transformation, North Midlands	NHS E/I – Midlands
Gavin Boyle	GB	Chief Executive	University Hospitals Derby & Burton NHSFT

In Attendance:		Designation:	Organisation:	Deputy on behalf of/Item No:
Richard Chapman	RC	CFO & MD	Derby & Derbyshire CCG	
Angela Deakin	AD	Programme Lead for JUCD LTC Board	Derby & Derbyshire CCG	
Zara Jones	ZJ	JUCD Planning Lead & Exec Director of Commissioning Operations	Derby & Derbyshire CCG	Item 3
Helen Hipkiss	HH	Director of Quality	Derby & Derbyshire CCG	
Duncan Gooch	DG	GP Partner & GP Lead of General Practice Alliance	Derbyshire General Practice Alliance	Deputy for Paddy Kinsella & Item 3

Jackie Counsell	JC	ICS Executive Assistant	Joined Up Care Derbyshire	Note taking
Linda Garnett	LG	ICS Workforce & OD Lead	Joined Up Care Derbyshire	Item 3
Members of the Public in Attendance:				
		No members of the public in attendance		
Apologies:		**Designation:**	**Organisation:**	
Helen Phillips	HP	Chair	Chesterfield Royal Hospital NHSFT	
Penny Blackwell	PB	Place Board Chair & Governing Body GP	Derby & Derbyshire CCG	
Martin Whittle	MW	Chair of the System Engagement Committee	Derby & Derbyshire CCG	
Andy Smith	AS	Strategic Director of People Services	Derby City Council	
Paddy Kinsella	PK	Exec of GP Alliance	Derbyshire GP Alliance	
Riten Ruparelia	RR	GP Alliance Provider Representative	Derbyshire GP Alliance	
Phil Cox	PC	Non-Executive Director	DHU Health Care	
Pauline Tagg	PT	Chair	EMAS NHSFT	
Rachel Gallyot	RG	Clinical Chair	East Staffordshire CCG	
Kathy Mclean	KMc	Chair	University Hospitals Derby & Burton NHSFT	

270521/1	**Welcome and Apologies**	**Action**
	As per the Agenda, members were reminded that the meeting was being recorded purely for the purpose of minute accuracy. The Chair welcomed Board members to the meeting and apologies for absence were noted as reflected above; the meeting was confirmed as being quorate.	
270521/2	**Declarations of Interest**	
	The Chair asked for any changes to the Declarations of Interest to be identified in the meeting. The purpose was to record any conflicts of interest and note any other conflicts in relation to the meeting agenda. No changes were noted.	
270521/3	**2021/22 Planning (CC, ZJ)**	
	ZJ was welcomed to the meeting to take the Board through the presentation on the 2021/22 Operational Plan *(circulated yesterday),* with input from relevant delivery board/programme leads. It was noted that there had been a change to slide 14–Primary Care *(updated slide pack circulated post meeting)*. It was recognised that an extraordinary amount of work had gone into creating this plan and ZJ highlighted key messages around the developmental work/impact we are trying to achieve; looking at what the plan delivers for our patients/local population particularly in terms of prevention and reducing health inequalities; with a strong people perspective around supporting our staff recovery/wellbeing and more workforce planning; financial plans; systemic risk appraisal and looking beyond the planning submission. The 2021/22 Plan was a strong integrated system plan with levels of compliance and considered the risks/challenges ahead. It had 6 core themes (Staff; Covid/vaccinations; Electives, cancer and mental health; Primary care capacity and outcomes; Community and UEC; and working collaboratively across the system to deliver these areas). In terms of being compliant/non-compliant ZJ highlighted the following areas of concern • One month not compliant within elective recovery (C1) –*noting a phenomenal amount of work had been undertaken on the elective recovery trajectory* • Not compliant in relation to LD/A use of inpatient facilities (C3b) – *noting we are working with NHSEI around the target and what is a realistic position with appropriate measures in place to address this.* • Ensuring the use of NHS111 as the primary route to access urgent care and the timely admission of patients from ED – *noting we were not quite complaint yet, however work was underway on this.*	

The draft plan had been reviewed by the System Leadership Team and had also been triangulated with assessment/feedback from NHSEI/QSRM which had been positive with key areas of focus identified as: Elective Recovery; LD&A Inpatients and Out of Area Placements; Financial Plan.

ZJ updated the Board on the detailed co-ordination process undertaken and outlined the submission elements split into components parts: a very detailed narrative plan; workforce plan; mental health plan, finance plan and activity/metric submission. ZJ outlined the timeline for the draft and final plans noting the process had commenced a long time ago and had been through due governance (i.e., Senior Leadership Team in early May, feedback from NHSEI following which it had been strengthened; delivery boards sign off and a confirm/ challenge session at SODB) and following approval from the JUCD Board the final submission would be made on 3rd June. In terms of what the plan delivers for our patients/local population – these were split into the following areas:

Planned Care/Cancer – ZJ highlighted the huge challenge with the impact of covid and that a very robust recovery plan had been developed for Planned Care/Cancer with real consistent prioritisation for those patients who require time critical surgery and to sustain/enhance transformation works for outpatient provision. There was encouraging data to add further validation, noting there were lots of risks/interdependencies, but overall, it showed a very good picture given the challenges we are faced with and lots of transformation. We are prioritising treatment of Cancer patients but recognise that we have a challenge in addressing 62 days plus waiting times.

AS added that we had exceeded the trajectory in April which had been a huge challenge with the number of over 52 week waiting lists and in terms of elective recovery we should get it to where it needs to be. The challenge around GIRFT programme was to focus on those areas with the biggest benefit across the system and great progress was being made to ensure it involved all providers not just focussing on the acutes. It was noted that the cancer alliance work needs to pull in with our own plan more and make stronger links in with the maternity plan to demonstrate the work in progress.

Urgent and Emergency Care (UEC) – ZJ highlighted the huge pressures on this pathway and A&E as steps are taken to restore to pre-pandemic levels over the next 6 months. The NHS 111 initiative and the transformation programmes (i.e., Team up/MDT approach) supporting our most vulnerable cohorts in the community were key. There was significant focus on the wider discharge processes and maintaining the level of flow/demand management and the challenging position preparing for winter.

GB reinforced that the demand activity was rapidly returning to pre-covid levels which had been clearly factored into the plan, together with the potential risk of further covid related activity aligned with national assumptions around the impact of covid. Transformation of the UEC pathway to reduce the burden on EDs was at the heart of the plan i.e., positive progress with direct booking through NHS 111 into primary care, same day EC service at hospital and trying to circumvent traditional A&E presentation. The focus on community, wider system partners, LA and steps to prevent crisis/admission to ED was a critical part of the plan in addition to trying to work in different ways to deliver better service to patients.

Mental Health, Learning Disabilities & Autism (MHLD&A) – ZJ highlighted that we were compliant with the financial plan and pre-commitments made as system to deliver on important priorities. There was a comprehensive 3-year road map of which we would like to do some of the initiatives sooner if possible, mindful of the risks/issues around this.

Primary Care (PC) - ZJ highlighted the national ambitions around growing the GP workforce, with new roles which would help to drive transformation and help mitigate some of the risks associated with PC. PC was facing a huge amount of pressure, with the volume of appointments, the significant effort around the covid vaccination programme and the huge effort to maintain level of performance.

DG noted the focus primarily on the delivery of GP, rather than primary healthcare (which included other gaps for example in dentistry that need addressing); we need to support the increase in access, whilst recognising that the workforce risk remains high, because of the stress on clinicians in the system. It was noted that details on the Phase 3 vaccination programme was still awaited, which made planning difficult for GP and Community services working alongside PCNs.

Health Inequalities (HI) – ZJ highlighted there was much to do across the whole ICS around meeting priority areas: Restoring NHS services inclusively; Mitigating against digital exclusion; Ensuring datasets are complete and timely; Acceleration preventative programmes which proactively engage those at greatest risk of poor health outcomes; Strengthening leadership and accountability. The plan narrative has been developed around how we will manage these being explicit on what action/impact there will be. A significant amount of work was being undertaken on this working with delivery boards/programme lead areas.

RD reinforced that HI was a key/important part of the plan and much of the direction/ expectations around HI had been received from NHSEI. The key things initially are to ensure we have the correct data/process around HI in right place with appropriate discussions around Strategic Intent, where the direction of HI sits/how it links through the system to get assurance/accountability within the system that appropriate actions are being taken. Thus, it was imperative to ensure we have the right governance in place. There was also a huge raft of work around waiting lists/preventative programmes (i.e., tobacco dependency programme) being undertaken.

People Plan – ZJ highlighted that the people plan was linked to: Recovery and was a comprehensive plan around health and wellbeing/supporting our staff; Addressing inequalities; Embedding new ways of working/learning from covid/adopting innovative ways of working; Growing for the future - where we need to increase the numbers of clinical staff/staff delivering direct patient care.

LG added that the headings had been taken from the NHS people plan and two of our system senior leaders had worked on areas to develop the plan collaboratively, with a focus on health and wellbeing, recognising the inherent tension between allowing staff sufficient time to recover/but at the same time stepping up services. LG pointed out that some of the mental health support currently offered to staff was funded non-recurrently, so we may not be able to continue with all the MH support over a longer period without further funding. It was also noted that today was the launch of the Midlands Workforce Race Equality and inclusion strategy, promoting a more culturally intelligent approach to recruitment across the system. In terms of growing for the future, our role of Anchor institutions is pivotal and will provide an avenue for widening participation and opening opportunities for disadvantaged people in the community, which in turn supports the HI agenda.

Finance – LO went through the financial headlines of the H1 plan with a breakeven position; Breakdown analysis of income/expenditure committed; Efficiencies being worked on noting £15.5m is included in the current H1 plan; and Risk - noting £22.2m identified but with mitigation. He also covered the key aspects of the MH financial plan. JUCD were one of five systems across the Midlands that have been escalated for national discussion regarding the financial challenge and a multiple year recovery plan, which the Board were aware of and had been discussed at last week's JUCD Board meeting.

Systemic Risk Appraisal – the planning group had linked in with key delivery boards/ workstreams to proactively manage risks, by setting indicators that can be monitored for the key top risk areas with the greatest impact, i.e., Capacity; Finance; Covid vaccination; and Health Inequalities.

Beyond the planning submission – ZJ highlighted that we need to consider what our strategic planning function needs to look like within the ICS compared to what we have now in order to help bolster areas where we need to develop/improve. The 3 core focusses identified were the need to streamline/produce a public facing version of the plan and for SODB to have oversight; overseeing the production of a H2 plan; and to co-ordinate the production of the ICS' Efficiency and Service Improvement Plan. There was a need to set out what the planning function for the ICS will look like at the different levels, i.e., planning function, planning at delivery boards, provider collaboration at Place and at Scale and Strategic intent.

ZJ advised it was important to try to balance the de-escalation and drive forward recovery work and focus on our improvement journey. She also highlighted the collective planning priority areas identified at the SODB confirm/challenge planning session and the need for clarity with our stakeholders/the public around what the challenges are/what that means.

The following key summary discussion points were highlighted:

- The plan was very reflective of the interactions with teams/QSRM and was perceived as a system plan which was a positive message. There were concerns around elective recovery and the 52 week waits (JUCD was one of biggest across the whole of the Midlands), as such there was a need to do as much as possible in H1 while maintaining a priority focus on H2, which meant a lot of triangulation to ensure workforce is available to deliver services, which was a common message across plans. The second area of concern was MHLD&A and the number of patients that remain as inpatients (a meeting this afternoon had been escalated to discuss this further). It was noted that in terms of mental health out of area placements, JUCD was the only system where we won't be down to zero because capital investment is required. This must continue to be a priority for the system. The third concern was not to see workforce as a risk for delivering services (FS). It was noted that it should state capacity including workforce on the risks and this would be updated accordingly (ZJ).

- Not deflecting on the significant challenges, it was recognised the different approach being taken, demonstrating system working/distributed leadership and as such the Board should have confidence in the plan. There was a need to consider how best to monitor the plan as a whole (not constituent parts), thinking about the role of the delivery boards/oversight groups have further. Thanks were placed on record to ZJ and colleagues for all the hard work on pulling the plan together, noting it was refreshing to see it as a whole plan including the GP element giving a holistic view (CC)

- Thanks was given for allowing the change to the PC slide at short notice. In terms of the people plan/slide 17 referencing a universal offer for wellbeing support – it was important to note that this was not universal access and won't happen without additional funding. In terms of all staff having undergone a risk assessment, this may not be the case for GP (KM). It was noted all staff had the opportunity for risk assessment around safety in working during the pandemic, with the intention now to embed regular wellbeing conversations with staff going forward in the future (LG).

- The UEC slide would be amended to reflect the 'community' element in the heading (ZJ). The transformation around discharge flow, UCR, and other Ageing Well priorities is at the heart of integrated place-based working and is broader than UEC in impact (TA)

	• The Chair agreed it was much more of system plan not individual organisational plans stapled together, which was really good. Reflecting on points made the two things the Board would need to consider further are around risks/workforce (how we oversee that risk, where it sits, what the impact/mitigation is/to review if we are delivering/managing risks appropriately) and also to consider how best to monitor performance. Looking forward it would be good to see what the total resource spend would be, to have a clearer picture should we need to consider moving boundaries i.e., if the health service can benefit by investing more in social care to enable people to be treated at home – **ACTION: LO/ZJ to work through to establish what the total resource spend would be.** He noted that in terms of Inequalities there was a specific objective and work around Anchor Institutions /and wider inequalities work, and the Board needed to review what are we doing to support wider HI/socioeconomic strategy, recognising it was a huge agenda. One area with very little mention was quality/safety – we need to make it explicit if it is sitting in individual organisations. In terms of the three objectives: Workforce, Inequalities, New ways of working – we need to establish what our baseline is and develop our own ways to monitor/measure these areas (JM) • It was noted that the broader aspects of Health inequality would become clearer once we have had those discussion regarding the relationship to the Health and Wellbeing Board (RD) • It was a very comprehensive plan and much more inclusive of partners. Inclusion of social care and what we can't afford to overlook was in every element of plan, it was a transformative process of changing how we do things and Inequalities and wellbeing of the community were critical areas. There had already been massive changes in how we are offering services (i.e., virtual consultations) and we shouldn't lose sight of the risk that we may leave some of our communities behind (PS). • The principles in the communications and engagement strategy agreed at the Board meeting last week include the transformation programme based on the identified priorities. It's a huge engagement agenda, so it needs breaking into achievable chunks and the support of comms and engagement teams in all partner organisations (ST) • In answer to WL's query on the people plan slide regarding the "increase the number of substantive clinical staff across acute, community and ambulance by 2.2% by the end of Sept 21" – it was confirmed that the workforce EMAS return was included in the numbers (LG) • It was a clear presentation of a comprehensive, integrated plan and credit was given to ZJ and planning leads across all system partners (TA). Our challenge will be to deliver the promise and the financial capacity to support the aims and ambitions (CM). • The investment in Mental Health PICU is a very live topic and the challenge to agree how to deliver it within the CDEL for the system needs to be agreed as soon as possible so that we can get on and build what is needed for the people of Derbyshire (CM). How we stand up the improvement and efficiency plan will be critical to realise the plans ambitions and discussions re CDEL are in place to progress (LO) The Chair summarised there had been a really positive and massive step forward in the development of the system 2021/22 plan and thanked all colleagues involved for their hard work on this. It was noted that individual delivery boards would review risks/approve for their individual organisations and on that basis the JUCD Board **APPROVED** the final draft of the system 2021/22 plan.	**LO/ZJ**

270521/4	**Any Other Business (JM)**	
	CC gave a brief update on the ICS boundary conversations and reminded the Board that we were still within a two-week period of engagement relating to Glossop, which will close on Tuesday 1st June 2021. The CCG had written out on behalf of JUCD to a set of key stakeholders in Greater Manchester and Derbyshire areas and feedback will be assimilated next week. A very small stakeholder group had been established to transparently review the feedback/sign off the return that will be made to NHSEI early June. CC agreed to keep the Board appraised of progress in this area.	
270521/5	**Questions from members of the public**	
	No questions had been received from members of the public.	
270521/6	**Date of Next Meeting**	
	The next formal JUCD Board meeting was scheduled to take place on Thursday 15 July 2021; to be held via MS Teams.	**All to Note**

Time Commenced: 1:00pm
Time Finished: 3:00pm

Health and Wellbeing Board
18 March 2021

Present:

Statutory Members: Chair: Councillor Chris Poulter (Leader of the Council) James Moore, (CEX, Derby Healthwatch), Robyn Dewis, Director of Public Health, Andy Smith, Strategic Director of Peoples Services

Non-Statutory Members:

Elected members: Councillors Care, Hussain, Webb, Williams

Appointees of other organisations: Stephen Bateman (DHU Healthcare), Gavin Boyle (Derby Hospitals NHS Foundation Trust), Kath Cawdell (3rd Sector representative Health and Wellbeing Network), Chris Clayton (DDCCG), David Cox (Derbyshire Constabulary) Hardyl Dhindsa (Derbyshire Police and Crime Commissioner), Jayne Needham (Derbyshire Community Healthcare Services), Perveez Sadiq (Director Adult Social Care Services), Vikki Taylor (Joined up Care Derbyshire)

Non board members in attendance: Alison Wynn, Assistant Director of Public Health, Gareth Harry (Derbyshire Healthcare NHS Foundation Trust), Adam Jones (Drinkaware), Victoria Newland (Drinkaware)

21/20 Apologies for Absence

Apologies were received from Merryl Watkins (Derbyshire CCGs), Cllr Lind, Ifti Majid (Chief Executive Derbyshire Healthcare Foundation Trust), Rachel North, (Strategic Director Communities and Place), Steve Studham (Chair Derby Healthwatch)

22/20 Late Items

There were none.

23/20 Declarations of Interest

There were none.

24/20 Minutes of the meeting held on 14 January 2021

The minutes of the meeting held on 14 January 2021 were agreed as a correct record.

25/20 COVID Outbreak Engagement Board and Health Protection Update Report

The Board received a report of the Director of Public Health, Derby City Council The report provided an update and overview of key discussions and messages from the COVID Outbreak Engagement Board and Derbyshire Health Protection Board and was presented by the Director of Public Health (DofPH).

The Board noted that there was no update from the Health Protection Board for this meeting but a general update would be provided for the next meeting.

The DofPH shared a presentation which included the weekly surveillance report which summarised data up to the 13th May 2021. Its was highlighted that there was a significant drop in the number of Covid cases in the City; currently there are 164 cases. Another slide showed the number of cases by area in the City, the highest number of cases being 17. There had been a significant decrease in numbers of cases from January. There were incidences related to workplaces, mainly in the health and social care sector where people are unable to work from home. The Board were informed that the Local Outbreak Management Plan was being refreshed being first published in June 2020. The Plan would include a Derby specific update. A draft for consultation would be circulated shortly. The Board were informed that this was not a static document, there being a need to amend and develop the Plan over time to enable response as the rules and regulations around the Pandemic are updated or changed.

The officer highlighted the areas under review:

- Summary of Governance – how we work together with the Derbyshire Joint Health Protection Board.
- Data and Survey Summary – examples from weekly surveillance. This was background work looking at different areas of the city and populations to . enable targeted communications, which could be related to age or activities as well as minorities and areas.
- Outbreak Protection and Response – Environmental Health have been working closely with local businesses helping with COVID secure restrictions.
- Testing and Contract Tracing – there are 4 symptomatic testing sites and 1 asymptomatic testing site in the City. There was now more contact by the local team who can now pick up all cases when given a diagnosis, have a local conversation with people to identify all contacts and ensure

that they are informed about support and services available for them to access.

- Communications and Community Engagement – significant development has taken place and the Communications Team have a large plan of work across the City. There was also close work with Community Action to reduce the prevalence of the virus by linking with groups of people.
- NHS Vaccination Programme – Public Health are involved in looking at inequalities around the delivery of the programme
- The Future – how we respond to the different picture of Pandemic, looking at cluster and outbreaks rather than sustained Covid transmission.

A councillor asked whether the data for take up of vaccinations by ethnic minorities in Derby differed from the national information. The DofPH explained that the data received gives a breakdown by numbers of ethnic groups, the numbers can be seen but not the denomination to work out percentages. However, it was not expected that Derby would deviate from the national picture. The CEX of Derbyshire CCGs explained that there was a programme of work in place to improve the position on vaccination uptake and suggested that data on the inequality side could be sent to Board members with the minutes of the meeting. The Chair felt that this would be useful and explained that the Council was also doing as much as possible to reach vulnerable groups to promote vaccination uptake.

A councillor suggested that if data was available councillors would be able to target messages to constituents in their wards. It was agreed that the CEX Derbyshire CCGs would liaise with the Director Communications and Engagement CCGs, to contact the DofPH to progress the communication of information to the Health and Wellbeing Board as statistics can help enforce the message for hard to reach groups.

Another councillor highlighted the issues of young people resisting vaccination; it was felt targeted messages would help tackle this situation. The Board also felt it was important to tackle groups of people who are not engaging in the vaccination process. The message should be understood by all that Covid 19 has a devastating impact on people affected. The DofPH indicated that a report regarding vaccine inequality was due to come to a Councillor Briefing Meeting in the future. A councillor asked if this information could be provided by local ward.

The Board felt it would be useful to monitor the positive results from testing centres. The officer confirmed that of the 700 tests undertaken at the Asymptomatic testing site at the Riverside Centre in Derby there were no positive results. With the Symptomatic Testing sites the positivity rate was 4% of tests. The Riverside Centre site was now at the end of its lease agreement and would be moving to a City Centre site from April to June.

The CEX of Derby Hospitals NHS Trust confirmed that there were less than 50

Covid cases in the Trust currently. The next challenge would be the recovery of services as there are still challenges around clinical pathways and PPE and backlogs for routine surgery. There was a need to be more open with the public about the scale of recovery which would probably take about one to two years. The CEX felt that it would be good to come back to the Health and Wellbeing Board at a future date to share detail about challenges and how they would be managed.

The Board resolved to note the report.

26/20 Joined Up Care Derbyshire Update – development of the Derbyshire Integrated Care System

The Board received a report of the Accountable Officer & Chief Executive, NHS Derby & Derbyshire Clinical Commissioning Group & Executive Lead Joined Up Care Derbyshire. The report provided the Board with an update from Joined Up Care Derbyshire (JUCD)

The officer highlighted the key items he was going to cover in the update which were White Paper developments; the position with developments in JUCD and actions going forward.

The officer explained that strategic partnership was increasingly a priority both internally and externally working with HWBs and other partner organisations to look at the wider determinants of health. There was a need to create leadership across the community to make this work, but this would I not happen unless “Places” are supported. The Officer confirmed that at a recent Joint Board Derby City had been affirmed as one of two key “Places”, the other being Derbyshire County. Work had also been undertaken over recent months to get a clear understanding of the assets in the system, one of the biggest assets being the people who work for our organisations.

The Officer explained the White Paper developments since he had last attended this Board. They were the creation of an NHS integrated care system (ICS) body, which formally brought together the NHS organisations and the dissolution of CCGs, and creating a formal partnership between health and social care. These developments link to how the NHS structurally and formally work with local authorities in future. The White Paper sets out the view from the LGA, who overall supported the views of NHS Derbyshire. The LGA response was positive and it agreed that creating health and care partnerships was a wise thing to do.

A joint JUCD meeting recently took place where the Governance was discussed and agreed. A Quality Committee for the whole system would be set up, the view on financial value over the whole system was re-affirmed, and the People and Culture Board which is currently in place would be further developed. The officer explained how JUCD would work with local authorities and HWB, and link to

broader partners in a more informed way. The officer added that councillors from both Derby City Council and Derbyshire County Councils would join the JUCD Board to discuss the “anchor institution approach”. Further discussion would take place to get to a shared vision of partnership.

In the short to medium term the JUCD Board would be looking at how the HWB interacts with “Places”. They would be going forward with the role of the “anchor institution approach” and refocusing work on the wider determinants. Looking further ahead, they would look at strategic commissioning and intent as JUCD, how to use resources and influence outcomes. There was also the need to re-organise health, as set out in the governance requirements. This would be done in a careful and non-disruptive way. The JUCD Board would also be looking at, what would become, the agreed relationship of the JUCD with local authorities and HWB in delivering integrated health and social care, addressing inequalities and contributing to the wider socio-economic strategies.

The officer highlighted that the NHS were just emerging from the latest COVID 19 wave, and were busy on the prevention and protection side with vaccination programmes. They were also still treating COVID cases, infections were still occurring and had to be reduced. The better working relationship between the local authority and health services was highlighted as a positive aspect of the Pandemic and it was hoped to build on this going forward.

A councillor agreed that local authorities and health are working better as a result of Covid. However, in the criminal justice system, there was a large area of work that overlapped. The councillor asked if that was something that had been looked at in terms of how the relationship could be enshrined in future; it was becoming more relevant to join up areas, like mental health and general offender health. The officer agreed that the criminal justice side and health should be connected despite lack of an official arrangement around that.

The officer highlighted other relationships/forums that have developed through the Pandemic, like the Local Resilience Forums (LRFs). The Pandemic was a different type of emergency for the LRF to manage. Usually in major incidents or emergencies their work would be short lived, but the LRF response has had to continue during the Pandemic. They needed to understand a broader challenge than normal, so a partnership with the local authority and Health was built up. Another forum was NHS England; one of the statutory changes will bring a much closer statutory relationship around health commissioning of Health and Justice services. JUCD is negotiating with NHS England about how the ICS will play a more local role in Health and Justice now that there was a mechanism to bring that into Derbyshire’s “Conversation” to formally bring the two together. The councillor welcomed the idea that the work of Health and Criminal Justice will be more joined up in future.

Another Councillor asked if the officer thought that the Government was looking

at closer collaboration between Health and Social Care or a complete merger of the two, including the budget and commissioning process and staff being based in one building. The officer felt that as of today he did not think an enforced merger would be seen between health and social care. The encouragement of joint working through the statute would be stronger than it had been so far, but it was felt that Health and Social care would not be merged in future; however there were relationships to discuss. The NHS and Social Care had a strong relationship already and there was also the partnership work between NHS and broader local authority and functions. However, the work of Local Authorities are not just limited to adult and childrens social care, they have a broader remit which plays into the wider determinants.

The Director of Adult Services explained that from information seen so far it would seem that there would not be full integration with joined up budgets and a single employing organisation. It was about a permissive relationship, one of sharing information and getting rid of barriers about joint health and care records, to enable professionals to have access to up to date information about the health and care of an individual. It was also about co-location of professionals to enable informal contact between health and social care colleages working in the same space. Cavell Centres were highlighted as an initiative from the NHS. These are multi agency and disciplinary developments, where there was potential for co-location of multi-disciplinary teams to act as a health and care hub for a locality. This type of model could be replicated across the City.

The Director of Adult Services was concerned about City GP Access on the ICS Board, and asked if would they have the same representation as their County colleagues on the ICS Board. The officer explained that there was ongoing work to bring together GPs from both “Places” (City and County) to work in a more cohesive and collaborative way, create a united voice/view at ICS level and also to enable them to have a voice in their own area or “Place”. This was a live conversation with the ultimate aim of a stronger GP provider voice coming together.

A councillor queried whether any complications would arise in Derby and Burton Hospitals Trust because it had commissioning arrangements that crossed different county boundaries; it was a part of Derby, Derbyshire and also East Staffordshire

The CEX of UDHB explained that there are always boundary issues as UDHB was a complicated organisation that spanned two ICS Boards and was also a part of East Staffordshire place, however, from a financial perspective UHDB was accounted for within the Derbyshire system. UDHB were excited about work in “local places” and with other NHS providers. The relationship could be managed but it would add complications. The councillor understood that these issues are replicated across the County; UDHB can’t be unique just because of boundaries.

The HWB were informed that there are some areas across the county that are applying for changes in their boundaries but Derby and Derbyshire was not one of them. There are challenges but boundaries won't be changed.

The Board resolved to note the update from JUCD

27/20 COVID Pandemic – Impact on Mental Health Services

The Board received a report of the Chief Executive, Derbyshire Healthcare NHS Foundation Trust. The report provided the Board with an overview of the impact on mental health services. The report was presented by the Director of Business Improvement and Transformation.

The officer explained that Wave one of the Pandemic had a significant effect on staff in the Mental Health Trust. Staff were isolating and working from home. Services had to be closed so that staff could be redeployed. There were a large number of empty beds from reduction in accessing services in the first lockdown; eighteen beds were unavailable due to social distancing and dormitories. Mental Health Urgent Care activity saw an increase in admissions from the 18th May 2021. The officer presented graphs which highlighted the general drop in activity in Accident and Emergency Liaison and Crisis Resolution and Home Treatment until June 2021. It was noted that with Inpatient Admissions there was a significant drop from mid March and then recovery towards late May. In Acute Inpatient Bed Occupancy approximately 13% of beds were closed due to the Covid restrictions but occupancy rose again in June. In Acute Inpatient Length of Stay there was a significant decrease in the average length of stay from 40 days to 30 days in June, this has now gone back to 32/33 days and has been sustained.

The Board were informed that there was a significant increase in mental health care activity from 25th May. There was increased use of section 136 suites, for people detained by the Police under Section 136 of the Mental Health Act. There was also increased use of seclusion on acute wards and Psychiatric Intensive Care Unit (PICU) placements. It was estimated that approximately half of the recent growth was coming from people who were previously unknown to secondary care mental health services; this was a potential impact of a sustained period of lockdown which has an impact on peoples mental health.

The officer then explained that during to July to October 2020, restoration and recovery took place from Wave 1. All of the closed mental health services were re-opened, staff were deployed back to their home services. By the start of October all of the mental health services were fully open but were still using non face to face contacts. The main form of contact was by phone and only 15% of activity was face to face.

During Waves 2 and 3 of the Pandemic the response was different to Wave 1. Services were reduced so that staff could be re-deployed where needed and service closures of the scale in Wave 1 were avoided. All staff had personalised risk assessments in place, which meant staff could stay safely in patient facing roles, and also received twice weekly lateral flow tests.

The officer informed the Board that Crisis and Home Treatment referrals increased during April and May, rising to a peak by the end of July; they have now reduced to pre-Covid levels. The growth in children and young peoples access to services was kept; the national target is 35%, in December 2020 Derbyshire had 36.9% CYP access. Specialist CAMHS services have restored all functions, delivering a blended approach of online and face to face appointments. However, there has been an increase in the severity and urgency of presentations.

The officer highlighted the situation with Inappropriate Out of Area Acute and PICU placements. There was a rise in the general Out of Area placements for May to June that went down during July and August, but, they have now begun to rise again. If there had been no Covid restrictions on wards then people would not have been sent out of the Derby area for general acute placements.

The officer then explained the plans for the next three to six months for mental health services. The services and staff had been under a period of intense pressure, they now needed to enter a period of rest, recovery and reflection. It was planned to go back to business as usual after the summer period. Staff would be encouraged to take accrued leave. Work would be undertaken looking at the benefits of changes to the way of working; staff time would be prioritized on key tasks such has updating changes in patients records. Services will have built up backlogs which would lead to increased waiting times for patients. However, improving waiting times and clearing the backlog would not start straight after the Pandemic.

The Chair thanked the officer for the detailed analysis provided. It was noted that a joint Health and Wellbeing Board was due to take place tomorrow to look at priorities, and it was likely that mental health issues would come through strongly at that meeting.

A councillor asked if funding for mental health impact from Covid 19 had been identified by the government and what were the challenges. The officer stated that in October an additional £500million had been invested by the government but a Use Agreement was still to be approved; they were still waiting to see what the additional funding could be used for. Some of the funding would be prioritising Childrens Services, there was an increase in demand for Early Disorder services, also in CAMHs services but they were still awaiting announcements for the rest of the funding. The councillor felt there was a need

to assess the demand from custody to Courts. The officer confirmed that there was a need to understand whether the focus of the funding would be on Covid recovery or something else such as Mental Health Services.

The Board noted the overview provided.

28/20 Drink Free Days Derby – Update on status and questions for discussion on future direction

The Board received a report from the Consultant in Publich Health which was presented by the Director of Business Development & Partnerships and the Head of Public Affairs, Drinkaware. The report provided the Board with an update on Drink Free Days Derby and invited consideration and discussion on future direction for the project.

The Board were informed that in 2019 Drinkaware approached Derby City Council Public Health Team to explore a project to test and evaluate the impact Drinkaware and other local partners could have on harmful drinking in a specific geographic area. The project evolved into “Drink Free Days Derby”. It was planned to launch the project in March 2020 at the Derby 10K, however the launch did not take place because of the Pandemic. The officer explained that due to the changing situation in relation to COVID 19, and the pressures on local health systems and local government services, community organisations and individuals, Drinkaware paused the project in March 2020.

The officer highlighted that the Pandemic meant that Drinkaware had lost a third of its income and needed to refocus and reassess priorities, which included furloughing staff, downsizing offices, restructuring and some redundancies. Drinkaware had come to the Board today to discuss and seek views on three possible options moving forward:

- Option 1 - Indefinite suspension of the project
- Option 2 - Progress as planned with the project
- Option 3 - Look at a deliberate and further suspension of the project whilst stakeholders are dealing with the Pandemic, and formally reassess towards the end of 2021

A councillor suggested discounting option 1 as this was totally unviable. There were four issues in the City, Smoking, Drugs, Obesity and Alcohol. All four issues affected the whole health system. The NHS have been tasked with reducing smoking and alcohol intake. The Health Wellbeing Board need to make sure those services are integrated. The Pandemic created an opportunity to talk with partner organisations to re-inforce the message about how partners, employers and businesses can all contribute to this outcome. It was suggested that Trade Unions have more contact with employees and can also influence

them with information and support to make better choices. The councillor felt it would be best to extend the temporary suspension and use the time to talk to partners to create a better strategy.

The officer again highlighted the reduction in funding and resources for Drinkaware. The Board were informed that funding for Drinkaware was largely from voluntary and unrestricted donations from UK alcohol producers, retailers and supermarkets and was governed by a Memorandum of Understanding (MOU) with the Government. As a national charity, all donations to Drinkaware must be spent on socially useful purposes that are independent from any external influence in their governance and decision-making. Drinkaware have forecast a significant reduction in income. The Board were concerned about the reduction in funding and asked where or who they could make representation of their concerns. The officer suggested that the Board's thoughts be put in writing to either the Chairman or Chief Executive of Drinkaware.

The Board were informed that this is a partnership project. Drinkaware therefore wished to update the Board on its current position, but also seek views of the project partners regarding their own available resource and focus for the coming year being conscious other partners may be in a different position to Drinkaware, keen to proceed and could potentially deliver a greater level of capacity to the project in 2021.

The Board noted

1. **the update provided in the report.**

2. **Agreed option three – to extend the temporary suspension of the project for 2021, allowing project partners to focus on the current pandemic led priorities and with a view to formally re-assess at the end of 2021.**

3. **Agreed that the Assistant Director of Public Health should draft a letter to be sent to either the Chairman or Chief Executive of Drinkaware, whichever was appropriate, regarding Drinkaware's lack of funding and resources for 2021.**

29/20 Healthwatch Derby Insight Report – GPs experiences of public behaviour and vaccination queries at primary care level

The Board received a report of the Chair of Healthwatch Derby which was presented by the Chief Executive of Healthwatch Derby. The report gave an overview of GPs experiences of public behaviour and vaccination enquiries at primary care level

The officer explained the aims of the report which were to consider; whether local GP Services had noticed any change in people's behaviour towards them and staff; to establish what enquiries GPs were receiving about Covid 19 vaccinations; to find out if there was any learning around themes or demographics that could lead to improvements.

The Board noted that GP practices are experiencing an increase in negative behaviour towards staff and practices. There were a number of enquiries about vaccinations, mainly when, why, where and how they would be vacinnated. There were also requests to be placed in a higher priority group.

The report was for information.

The Board noted the report and the key messages highlighted within it and requested that the Assistant Director of Public Health liaise with DCC Communications Team to ensure key messages regarding COVID vaccinations are re-publicised to the local population.

30/20 Brilliant Derby Update

The Board received a report of the Deputy Chief Executive (Communities and Place). The report was presented by the Assistant Director of Public Health Derby City Council. The report provided an update and overview of the Brilliant Derby Project.

The Board felt that this was a brilliant initiative and that the people who had engaged in the programme had benefitted; they also noted that there were now a variety of similar programmes in place. The Board felt that more people should be encouraged to take part and asked if information/messages about the project could be repeated to encourage more involvement. The Board considered that Derby City Council employees should be encouraged to join the programme,

The report was for information.

The Board noted the update and requested that the Assistant Director of Public Health liaise with the Communications Team to re-publicise the project again in order to encourage further engagement.

31/20 Derbyshire Shared Record and Analytics Platform

The Board received a report of the Chief Information and Transformation Officer Derbyshire Community Health Services. The report was presented by the Assistant Director of Public Health Derby City Council. The report provided an update to the Health and Wellbeing Board on the accelerated procurement

process for a Derbyshire Shared Care Record (DCSR) and Analytics Platform (AP).

The purpose of the report was to ensure that the Health and Wellbeing Board were aware of this significant digital development that would support the delivery of integrated and joined up care for the local population.

The report was for information.

The Board noted the report and the significant digital development progress.

Private Items

None were submitted.

MINUTES END

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

Present:		
Martin Whittle – Chair	MW	Governing Body Lay Member DDCCG
Beverley Smith	BSm	Director Corporate Strategy & Development DDCCG
Helen Dillistone	HD	Executive Director Corporate Strategy and Delivery DDCCG
Ian Shaw	IS	Governing Body Lay Member DDCCG
Maura Teager	MT	Lead Governor University Hospitals of Derby and Burton NHS Foundation Trust
Karen Lloyd	KL	Head of Engagement Joined Up Care Derbyshire
Kevin Richards	KR	Public Governor Derbyshire Healthcare NHS Foundation Trust
Lynn Walshaw	LW	Deputy Lead Governor DCHS
Margaret Rotchell	MR	Public Governor CRH
Roger Cann	RC	Lay Representative
Sean Thornton	ST	Assistant Director Communications and Engagement DDCCG and JUCD
Laura Moore	LM	DDCCG
Beth Soraka	BSO	Health Watch Derby
Simon McCandlish	SMc	Governing Body Lay Member DDCCG (Deputy Chair)
Steven Bramley	SB	Lay Representative
Tim Peacock	TP	Lay Representative
Vikki Taylor	VT	ICS Director Lead Joined Up Care Derbyshire
In Attendance:		
Lisa Walton	LWa	Personal Assistant DDCCG
Clare Haynes	CH	DDCCG
Sukhi Mahil	SM	ICS Assistant Director Derbyshire Healthcare NHS Foundation Trust
Apologies:		
Vikki Taylor	VT	ICS Director Lead Joined Up Care Derbyshire
Jocelyn Street	JS	Lay Representative

Item No.	Item	Action
EC/21/22-17	**WELCOME APOLOGIES AND QUORACY** MW welcomed everyone to the meeting and noted apologies as above. MW declared the meeting quorate and explained the protocol of virtual meetings. MW informed the group that, Ruth Grice has rendered her resignation due to commitment as a Governor for the Mental Health Trust. MW thanked Ruth for her input and wished her well for the future.	**MW**
EC/21/22-18	**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** MT will complete a new DOI form due to re-election to Governor at UHDB. LW sent the form to MT for completion.	
EC/21/22-19	**DRAFT JUCD COMMUNICATIONS AND ENGAGEMENT STRATEGY – UPDATE** ST verbally updated the strategy had gone to the JUCD board on the 20 May and was approved. It was noted that was a good document and the Board were pleased with the Content. The next steps are to produce a summary which ST has drafted to go in to the JUCD bulletin. Communications and Engagement team have a meeting Thursday to discuss additional development to areas and will bring back to July Engagement Committee meeting. **The Engagement noted the verbal update.**	**ST**
EC/21/22-20	**INTEGRATED CARE SYSTEM COMMUNICATIONS AND ENGAGEMENT PLAN** **The Committee was asked to receive and Comment on the shared paper.** KL updated on how things are progressing to The Communications and Engagement strategy into place. There is a lot of work to be done and the process will take place over the next 12 months or so being a sustained period of live engagement with guidance constantly evolving. There will be a need to regularly update on the progress and there is a plan in place to do this regularly. The newsletter will be bi-monthly now instead of quarterly. KL is setting up a roaming workshop to gain knowledge on what mattered most and to explain how an ICS might make that happen. A soft launch of an online engagement platform will go ahead next week. KL noted there had been a slide deck produced to accompany guides for a vision of the ICS and another on how to make that happen. This has been written for a wide range of stakeholders and not confined to members of the public. This will be sent to provider organisations so that we have a consistent message across the system about what the ICS is and what we hope to achieve.	**KL**

	TP praised the paper but felt that, there needed to be a simplified version edited down and shared via social media so that more people would read and understand the biggest change in health and social care in years. KL noted that integration is not a simplistic topic to explain and that was the idea behind the roaming workshop. MT enquired whether there would be any Governor involvement with the roaming workshops and KL assured that all the organisations needed to work as a system together to deliver these. It was suggested to try a plan on a page' approach giving some real high-level headlines to do the first engagement with the public. Key ambitions and component parts of the ICS are unlikely to change, and it is the detail we need to work through, in part influenced by anticipated national guidance. ST assured the committee this is a priority to get the message delivered in the right way to the wider public, but that the meat was on the bones with this paper as a starting point and the journey has only just begun. VT stated from a national perspective there will be some referred national documentation. One of these key documents is the ICS oversight framework, and that will set out the metrics and expectations that systems will have to work to be able to deliver evidence delivery against. VT is focusing on driving improving life expectancy and healthy life expectancy and there is a piece of work across the system happening at the moment, which is starting to identify what are the outcomes needed to monitor that will evidence we are making inroads in terms of improving those two areas. HD felt it was better to not get too caught up in guidance and ICS architecture, as people will want to know what the ICS is and what it is there to do, how will this improve services and patient experience, how it be publicly accountable and how people can get involved. • The Committee noted that there was a general feeling that a page on a plan summary would be useful. • Looking at opportunities which might be there for Governing Body meetings for core subjects. • It will be useful to see the objectives when more guidance is released to have the assurance framework. It was agreed to bring the matter back to the next meeting.	
EC/21/22-21	**SCRUTINY COMMITTEE UPDATE** **The Committee is asked to NOTE the new membership of the Derby and Derbyshire Adult Scrutiny Committees.** **ST** presented from the shared papers and informed that Committee of changes to the local scrutiny committees and information on projects which are due to be reviewed at the next round of meetings.	**ST**

	With local government elections recently completed, our local authority partners have announced the new membership for their adult scrutiny committees. Both committees have a new Councillor in the Chair. We retain excellent working relationships with the respective scrutiny officers and are in regular dialogue on planned agenda items and requests from committees. HD noted the supportive relationship with the committees and was pleased with the continuity and as well as new members to give fresh insight. **The Engagement Committee NOTED the update.**	
EC/21/22-22	**PRIMARY CARE ACCESS INSIGHT** **The Engagement Committee is asked to NOTE the approach to gathering insight on primary care access.** ST presented from the shared paper. There is an issue where there is a growing concern within the system about access to primary care. There appears to be some backlash among the public emerging about access to face to face appointments in primary care and a general sense that primary care has been closed during the pandemic, which clearly is not the case. At the same time, attendances at Emergency Departments are increasing, with a proportion of these being related to minor injuries and illnesses. There is a growing sense that service users are going to ED because they either experienced a lack of access to primary care or because they believe through perception that it may be a potential issue that they cannot access care otherwise. As a result, the Operational Resilience group, which is a mixture of all our partner organisations across the system, has picked this up. SORG has agreed to a budget of £75k for the research. The initial tender is for £50k to allow a remaining amount of funding to be available for any follow up work required. There is also a winter campaign budget nominally identified for £100k, which will support the implementation of the outcomes of this work. ST will bring back to the Committee with further updates following this. The committee agreed that it was crucial to understand what service users' views are in this instance. Some people may feel that not having a face to face appointment with a GP is more appropriate for them, particularly people who work full time or have other commitments. It was felt that these differing views were a sensitive area, and there are very mixed views, and so a segmented targeted approach is incredibly important. It appears that general practice across Derby and Derbyshire are currently dealing with more patients than at any other time even before the pandemic.	**ST**

	The Committee NOTED the approach to gathering insight on primary care access.	
EC/21/22-23	**LONDON ROAD WARDS 1 AND 2** **ST** gave a brief reminder of the proposed plan at London Road wards 1 and 2, and the temporary transfer is due to go ahead imminently. The older people's mental health service which will be moved to Kingsway is due to go for a formal consultation in September. A London Road Project groups has been formed and ST hopes to attend. London Road wards 4,5 and 6 will be brought to the next meeting. **The Engagement Committee NOTED the verbal update.** The Meeting was adjourned for a comfort break.	**ST**
EC/21/22-24	**S14Z2 LOG** **The Engagement Committee was requested to NOTE the recommendations that have been made following review of the latest 14Z2 forms.** ST informed the Committee that there had been four forms reviewed since the last meeting. • Specsavers AQP Audiology store re-location – Belper Requires only information provision to patients. No access issues. • Tier 3 Weight Management System Requires only information to clinicians. • Palliative Care Urgent Response Service (PCURS) - delivery of urgent palliative and EOL care 24/7 Requires only information to patients – be aware those likely to be unable to access this are those of whom English is not their first language. • Breast pain clinics Requires only information to patients. **The Engagement Committee NOTED the paper and provided ASSURANCE that the forms have been completed properly.**	**ST**
EC/2122-25	**DDCCG EXCEPTION RISK REPORT** **The Engagement Committee is asked to RECEIVE and DISCUSS the risk assigned to the committee as of June 2021.** BS updated on the risk of Lack of Standardised process in CCG commissioning arrangements, which may fail to meet statutory duties in S14Z2 of Health and Social Care act 2012 and not sufficiently engage patients and the public.	**BS**

	BS confirmed that the forms are being completed and additionally there is nothing currently preventing us from undertaking due diligence related to the pandemic. **The Engagement Committee RECEIVED and ACCEPTED the comments from the log.**	
EC/2122-25a	**GBAF** **The Engagement Committee is asked to DISCUSS and REVIEW the Quarter 1 Governing Body Assurance Framework Strategic Risk owned by the Engagement Committee.** BS stated that, on 6 May 2021, the Governing Body received and approved their strategic objectives, which are listed in shared paper. The Committee's risk relates to the Objective 7 to work in partnership with stakeholders and engage with our population to achieve that. Risk 5, states that the Derbyshire population is not sufficiently engaged to identify and jointly deliver the services that patients need. The current risk is 9 with the target to be 6. BS stated that the risk is being managed appropriately whilst transitioning to ICS going forward. It was a detailed report in terms of measures and controls in place. MW noted that the Engagement Strategy mentioned in the paper requires updating to state it has been approved. There was general discussion that, whenever a paper is shared that was originally in Excel, that it needs to be sent not in a PDF so that members can read additional comments. ST took this as an action. **The Committee REVIEWED and ACCEPTED the proposed risks and rationale for 2021/22.**	**BS**
EC/2122-26	**MINUTES OF THE MEETING HELD ON 18/05/2021** The Committee accepted the minutes of the previous meeting as a true and accurate record.	**MW**
EC/2122-27	**ACTION LOG FROM THE MEETING HELD ON 18/05/2021** The Committee reviewed the action log and updated accordingly.	**ALL**
EC/2122-28	**Engagement Committee Forward Planner 2021/22 for review and agreement.** The committee felt that the Forward Planner needed a thorough review.	**ALL**

	It was agreed to bring this to the next meeting as an action. **The Engagement Committee REVIEWED and AGREED the Forward Planner.**	
EC/2122-29	**ANY OTHER BUSINESS** ST informed the Committee of the formal closure of the CCG restoration and recovery group. There is an implication there for the TOR which will need amending at the next meeting. SB enquired if it was possible to share a presentation from a recent insight meeting and ST will liaise with Dean Wallace to arrange that. HD updated the Committee on the ICS Boundary Review conversation and that since the last meeting, there has been an agreed review between various named and agreed stakeholder strategy stakeholders across both Derbyshire and the Glossop Tameside area between ourselves in the Derbyshire ICS in the Manchester ICS. A report was sent at the end of last week and our understanding from NHS England is that they then have a national report that they will pull together. A national paper will then be presented to various relevant ministers and ultimately the Secretary of State will take the decision as to where the boundaries need to be drawn. MW enquired if with the resignation of Ruth Grice if the quoracy of the group needed to be reviewed to include preparing for the ICS. **ACTION: It was agreed to bring the conversation on that to the September meeting.** **ACTION: Review the Tor at the next meeting.**	
EC/2122-30	**FUTURE MEETINGS IN 2021/22** **Time: 11:15 – 13:15** **Meetings will be held as virtual meetings until further notice** Tuesday 20 July 2021 Tuesday 17 August 2021 Tuesday 21 September 2021 Tuesday 19 October 2021 Tuesday 16 November 2021 Tuesday 21 December 2021 Tuesday 18 January 2022 Tuesday 15 February 2022 Tuesday 15 March 2022	
EC/2122-31	**ASSURANCE QUESTIONS** 1. Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? Yes	

	2. Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? Yes 3. Were papers that have already been reported on at another committee presented to you in a summary form? Yes 4. Was the content of the papers suitable and appropriate for the public domain? Yes 5. Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? no 6. Is the Committee assured on progress regarding actions assigned to it within the Recovery & Restoration plan? Yes 7. Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? No 8. What recommendations do the Committee want to make to Governing Body following the assurance process at today's Committee meeting? The Committee gives assurances on the way they engage noting however, that today's meeting was about receiving updates rather than doing the assurance job which is the key role of the Committee.	

DATE AND TIME OF NEXT MEETING
Date: Tuesday 20 July 2021
Time: 11:15 – 13:15

NHS
Derby and Derbyshire
Clinical Commissioning Group

MINUTES OF GOVERNANCE COMMITTEE MEETING HELD ON 20 MAY 2021 AS A VIRTUAL MEETING VIA MICROSOFT TEAMS AT 13:00 TO 15:00

Present:		
Jill Dentith (Chair)	JED	Governing Body Lay Member – Governance, DDCCG
Dr Emma Pizzey	EP	Governing Body GP, DDCCG
Dr Greg Strachan	GS	Governing Body GP, DDCCG
Helen Dillistone	HD	Executive Director of Corporate Strategy and Delivery, DDCCG
Ian Gibbard	ICG	Governing Body Lay Member – Audit, DDCCG
Martin Whittle	MW	Governing Body Lay Member – Patient and Public Involvement, DDCCG
In Attendance:		
Chrissy Tucker	CT	Director of Corporate Delivery, DDCCG
Ged Connolly-Thompson	GCT	Head of Digital Development, DDCCG
James Lunn	JL	Head of Human Resources and Organisational Development, DDCCG
Lisa Butler	LB	Complaints and PALS Manager, DDCCG (part meeting)
Lisa Farier	LF	Head of Business Intelligence, DDCCG
Lisa Innes	LI	Head of Procurement, NHS Arden and GEM CSU (part meeting)
Ruth Lloyd	RL	Information Governance Manager, DDCCG
Suzanne Pickering	SP	Head of Governance, DDCCG
Richard Heaton	RH	Business Resilience Manager, DDCCG
Rosalie Whitehead	RW	Risk Management and Legal Assurance Manager, DDCCG
Maria Muttick	MM	Corporate Development Officer
Apologies:		
None		

Item	Subject	Action
GC/2122/01	**WELCOME, APOLOGIES & QUORACY** JED welcomed the members of the Committee to the meeting and confirmed that the meeting was quorate. There were no apologies. JED explained that Ilona Davies, Executive Assistant to the Executive Director of Corporate Strategy and Delivery had moved into a new role and would no longer be administrating this meeting. JED thanked Ilona for her previous help and support and wished her well in any future endeavours.	
GC/2122/02	**DECLARATIONS OF INTEREST** JED reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG. Declarations made by members of the Governance Committee are listed in the CCG's Register of Interests and included with the meeting papers. The Register is also available either via the corporate secretary to the Governing	

	Body or the CCG website at the following link: www.derbyandderbyshireccg.nhs.uk JED and EP confirmed the register has now been updated with EP's declarations and therefore EP no longer needs to declare separately at every meeting.	
GC/2122/03	**DERBY AND DERBYSHIRE CCG PROCUREMENT HIGHLIGHT REPORT** LI presented the report, which illustrates the CCG's status of projects in terms of services being in progress, pipeline or completed. **In progress** Updates on 'in progress' since report was circulated: • Digital Mental Health and Wellbeing Services – This service was due to go live 10/5/21 and be published 21/5/21. This has been delayed by a few days whilst some commissioning resourcing issues are resolved. • Ophthalmology Services – The procurement process has been undertaken and is in the governance sign off process to award decisions. This is highlighted as an amber alert as we are in non-contracted activity from 1/4/21 to 1/7/21. • Employment Advisory Services – It is planned to request Expressions of Interest on 24/5/21 for 10 days. The timeline is tight as the new service provision starts 1/9/21, therefore there is potentially a 1 month gap in service. **Pipeline** The services listed under 'Pipeline' are in red or amber if they have exceeded/ or are due to exceed their contract date, or there has been difficulty in engaging with commissioners. This is being worked on a day by day or week by week basis. The High Intensity Users/ Healthy Futures Service was decommissioned on 31/3/21 and will not be renewed. This will be removed from any future report. GS asked if there was any more information about the GP streaming services and why UHDB have opposed the alignment to the new contract. LI advised an update has been requested but not received. LI will update at the next Governance Committee. A discussion took place around the procurement report and any contract expiries and process for managing these. LI advised that whilst it is not best practice to operate outside of contract, some contract reviews had been delayed due to Covid and that an implied contract could be said to be in place. It was agreed that such contracts should be picked up with the CCG contracting team. **Action: CT to discuss the expired contracts listed on the highlight report with Helen Wilson.**	**CT**

	The Governance Committee REVIEWED the Highlight report for Derby and Derbyshire CCG, NOTED status of projects - Pipeline, In progress and Completed, NOTED the priority status of service and REVIEWED key issues and activities over the current period. *LI left the meeting.* *IG joined the meeting; the delay was due to IT issues.*	
GC/2122/04	**POLICIES AND PROCEDURES** **Fraud, Bribery and Corruption Policy** SP advised the new Government Functional Standard for Counter Fraud has recently been released on 1 April. To comply with the new standard the Fraud, Bribery & Corruption Policy has been reviewed by the CCG's Counter Fraud Specialist (Ian Morris, 360 Assurance). It has also been renamed from Fraud, Corruption and Bribery Policy to Fraud, Bribery and Corruption Policy as this is the order that is ordinarily used by the NHS Counter Fraud Authority. SP advised significant changes had been made throughout the policy and presented the policy with track changes so all changes were highlighted in red and blue. IG advised the update has been anticipated as Ian Morris discussed the changes to the functional standard at the last Audit Committee Meeting. IG confirmed this was a sensible approach, however he was unsure regarding the role title of Fraud Champion and felt it should be Counter Fraud Champion. JED agreed with this. **Action: SP to change role title of Fraud Champion to Counter Fraud Champion.** **The Committee APPROVED the NHS Derby and Derbyshire CCG's Fraud, Bribery & Corruption Policy**. **Policy Management Framework** SP advised the Policy Management Framework has been reviewed and updated prior to its audit review by 360 Assurance in June 2021. There have been slight changes but nothing material. **The Committee APPROVED the NHS Derby and Derbyshire CCG's Policy Management Framework**	**SP**
GC/2122/05	**BUSINESS CONTINUITY, EMERGENCY PLANNING RESILIENCE AND RESPONSE UPDATE** **Business Continuity – Escalation Level** RH advised the DDCCG remains at level 4 business continuity status with the vast majority of staff working remotely.	

	JED asked if any timescales had been agreed for staff to return to the office. RH confirmed that timescales have not been agreed yet. A staff survey is still open, discussing the hybrid model of working. **EPRR National Core Standards** RH confirmed that clarity is being sought on whether the CCG will need to complete the normal EPRR core standards assurance template for 2021 (A different assurance approach was adopted in 2020/21 due to the pandemic). **Transition to Integrated Care System (ICS)** RH advised responsibility for EPRR will move over to the ICS from April 2022. The Emergency Planning team from the Midlands region have held several informal meetings with Emergency Planners from across the region to scope how that might look post transition and are planning to hold more formalised meetings at a future date. In the meantime this has been raised internally and has been itemised for discussion as part of the work of the Transition Working Group. MW asked if there is any early indication on how the coordinating function will happen. RH confirmed that in its current format the CCG is a category two responder, however it is assumed that an ICS will be a category one responder which will bring its own responsibilities i.e. how the on-call process is managed. It has been brought to the attention of the Transition Working Group to pro-actively look at how that model will work. **The Governance Committee NOTED the contents of this report for information and assurance.**	
GC/2122/06	**CCG RECOVERY AND RESTORATION UPDATE** CT advised the CCG has reviewed the status of the Recovery and Restoration Plan. Most actions are now complete. Those outstanding are relating to when the CCG returns to a business as usual status. The proposal is to close as many actions as possible and identify future ownership of any open actions so that the Recovery and Restoration Plan can be closed. The closure plan will be brought to the Governance Committee at its July meeting for final review and the Terms of Reference amended to remove this responsibility. EP confirmed her support and commented that this was a sensible approach. JED asked SP to highlight this is the report to the Governing Body. **Action: SP to highlight the proposal around the Recovery and Restoration Plan in her report to the Governing Body.** **The Governance Committee NOTED and APPROVED the contents of this report for information and assurance.**	**SP**

GC/2122/07

Q4 2020/21 COMPLAINTS REPORT

LB presented the Complaints Report covering Q4: 1 April 2021 to 31 March 2021

Breakdown of all Complaints Received	Qtr4 (20/21)		Qtr3 (20/21)	Qtr 2 (20/21)	Qtr1 (20/21)	Qtr4 (19/20)
New CCG Complaints	7	↓	15	6	5	20
Commissioned services	5	↓	12	12	16	13
Other NHS Organisations	7	↑	5	3	4	5

LB confirmed that they have complied with the time frames and national time frames, closing most complaints down. The annual report will be presented at the next committee meeting.

LB highlighted that a complaint received in November 2019 regarding delays experienced with a care placement due to a disagreement with the Local Authority over the level of funding towards a joint package of care has been referred to the Ombudsman. JED asked if this was the local government Ombudsman rather than NHS. LB confirmed it was, explaining that in cases involving a Local Authority and the NHS, the local government Ombudsman takes leadership.

EP referred to the update below and asked if this implies we are moving away from using the MOL.

Medicines Management • Access	Work to be undertaken with GP practices, patient groups and local pharmacies to promote alternative methods for ordering prescriptions, which should reduce call numbers and enable the MOL to focus on the patients who cannot order by other means.

LB explained that the most discontented patients are those that have been asked to use the MOL when they do not need to i.e. for certain repeat prescriptions, such as asthma, which can be ordered online. It is now recognised that work must be done prior to roll out, to ensure the MOL service is targeting the right patients.

GCT confirmed that he is currently in discussions with the David Hodnett, Service Delivery Manager, NHS App. They are looking at ways in which the NHS App traffic can be transferred from the GP Practice to the MOL. They are also discussing with Information Governance the use of Microsoft Office and forms, and a conversation is taking place around the telephonist solution looking at Omnichannel. Overall, they are trying to provide more contact opportunities for patients which isn't just telephony, but also ensures that the request flows through the approval process.

MW commented that his practice has an automated message referring all patients to the MOL. LB advised that this seems to have been the approach by most GPs and the team definitely recognise that more work needs to take place with the practice and their patient participation groups.

The Governance Committee NOTED the contents of this report for information and assurance.

GC/2122/08	**Q4 FREEDOM OF INFORMATION REPORT** CT presented the above report. CT confirmed there have been 50 FOI requests made in Quarter 4, compared to 26 received in Quarter 3. There was one late response which was 26 days instead of the standard 20 days. It was a very complex enquiry that required several responders. An apology has been sent with the response. MP letters have increased, mainly due to the vaccination programme. **The Governance Committee RECEIVED the FOI quarterly report.**	
GC/2122/09	**MANDATORY TRAINING** CT presented the above report. CT confirmed the overall aim is to achieve 95% of staff completing mandatory training within the year. This is currently on track. Appraisals are being carried out now and part of the appraisal is that mandatory training must be complete; therefore the uptake in training will increase over the next few months. There is lower compliance for Modules 2 and 3 of Managing Conflicts of Interest – colleagues who have not yet completed this training are clinical leads many of whom will be prioritising work on the vaccination programme. GS asked if we know how the overall compliance compares with the compliance of the governing body. In 2019, the governing body achieved 100% which showed a good example. **Action: CT to check the mandatory training compliance of the governing body and advise at the next Governance Committee Meeting.** IG advised he understood the system (ESR) informed line managers of non-compliant staff and asked if this is still the case i.e. what is the instruction to line managers to ensure their staff remain compliant. CT confirmed the system does generate reminders to both the individual and their line manager. The team will get involved if an area is becoming non-compliant and sends messages of encouragement and offers support. JED asked if the gateway progress is still halted when staff are non-compliant. JL confirmed it is, increments will only proceed if staff have completed their mandatory training. **The Governance Committee NOTED the contents of this report for information and assurance.**	**CT**
GC/2122/10	**CONTRACT OVERSIGHT REPORT – MAY** CT presented the above report. CT advised that the Contract Oversight Group met for the first time this year on 26 April 2021 and reviewed progress made. The group had been paused due to COVID-19. Although we have progressed well with the DSPT requirements, there is further work to do on the finance aspects.	

	Next steps will include: • Agreement as to how the database will be maintained and kept current, including review of any new contract information emerging during the period this project was paused • Understanding the future offer with the Atamis tool and how long it will be free of charge • Incorporate the project into the CCG Transition Plan – the database will be needed as part of asset transfer work into the ICS IG asked if there are any issues in relation to supplier information being shared across the system as we transition into an ICS. CT advised that the Transition Working Group would look at this and confirmed that there are already conversations on conflicts of interest and how procurement will be managed in the System. HD confirmed that an approach for procurements generally was agreed through the Chief Executives Group last week and the Governance Committee will need to have oversight of this. **Action: CT/HD to confirm the procurement approach as the CCG transitions into an ICS at the next Governance Committee Meeting.** **The Governance Committee NOTED the contents of this report for information and assurance.**	**CT/HD**
GC/2122/11	**STAFF SURVEY RESULTS AND ACTION PLAN** JL confirmed the staff survey results were presented to the Governing Body. Concerns were expressed regarding the position for under-represented staff groups and particularly the black and minority ethnic (BME) staff had worsened. The Governing Body requested a staff survey action plan. The agreed actions will be incorporated into our CCG people plan and into the actions plans of the Workplace Race Equality Standard and the Workplace Disability Equality Standard. Both plans will be presented at the next Governance Committee Meeting. JL confirmed they had a joint workshop with members of the Organisational Effectiveness and Improvement Group and members of the Diversity and Inclusion Network. It was a very well attended, honest meeting which included robust discussions. Several issues were identified within the following themes: • Equality, Diversity & Inclusion/ Safe environment: Bullying & Harassment; • Morale & immediate managers; • Staff engagement & team working; and • Health & wellbeing. This resulted in several actions that will be incorporated in a Staff Survey Action Plan as mentioned above. **Action: Staff Survey Action Plan to be added to the July agenda/forward planner.**	**MM**

	Action: SP to include the work around the staff survey results and the Staff Survey Action Plan in the report for the Governing Body. **The Governance Committee NOTED and APPROVED the contents of this report and the action plan for information and assurance. The Committee PROPOSED that this action delegated to it from Governing Body be closed**.	**SP**
GC/2122/12	**APPRENTICESHIP SCHEME** JL updated the committee on the Apprenticeship Scheme providing the information below: **Apprenticeship Levy** The Apprenticeship Levy is 0.5% of the CCG's pay bill. Based on a pay bill of £20 million this would equate to a fund of £100k. The CCG can use the funds in our account to pay for apprenticeship training and assessment for apprentices. Since April 2019 the CCG has utilised approximately £50k of the Apprenticeship Levy to support existing staff in undertaking apprenticeships. Twelve members of staff are currently undertaking apprenticeships. These have covered a range of topics and levels of apprenticeship as outlined below: • 6 members of staff are currently undertaking a Level 4 Associate Project Manager apprenticeship • 1 member of staff is currently undertaking a Level 4 Business Administration Professional apprenticeship 1 • 1 member of staff is currently undertaking a Level 6 Chartered Manager degree apprenticeship • 1 member of staff is currently undertaking a Level 7 Accountancy Professional apprenticeship • 1 member of staff is currently undertaking a Level 7 MBA in Healthcare Leadership • 2 members of staff will be commencing a Level 4 Data Analysis apprenticeship in June 2021 In addition to the above the CCG has supported 2 new Level 2/3 Business Administration apprentices joining the CCG, both of which have now completed their apprenticeship and contracts with the CCG. The current CCG levy balance stands at £100k, with £7k being added monthly. Following this round of Annual Review Conversations, we will review the identified learning and development needs and look at whether these can be met via an apprenticeship route. For example, conversations are currently taking place with the CCG Medicines Order Line Senior Team to explore to	

	explore the possibility of supporting a number of staff to undertake a Customer Service/Team Leader apprenticeship. Within the Derbyshire system, the Joined Up Careers team run several apprenticeships, including the innovative integrated health and social care apprenticeship pilot. This programme is offering individuals a 15-month rotational apprenticeship scheme across health and social care organisations, including primary care and private and voluntary organisations. **The Governance Committee RECEIVED and GAINED ASSURANCE from the verbal update on the current position of the scheme. It was felt that this was a really positive initiative that the CCG had embraced and was using to support the scheme and individuals within it.**	
GC/2122/13	**INFORMATION GOVERNANCE & GDPR UPDATE REPORT** RL presented the above report. RL confirmed that approval is sought for the terms of reference that went through the Information Governance Assurance Forum. The report provides a summary of the activities of the Information Governance Assurance Forum held on the 23 April 2021, with agenda items presented for approval and an overview of the activity of the IG team including: DPIAs undertaken; IG Incidents reported; Data Security and Protection Toolkit activities and compliance with Data Security Level One Training. RL confirmed that the draft audit report from 360 Assurance is awarding substantial assurance for this year, which is really positive. RL thanked everyone who contributed to it. RL advised that the Information Governance Mandatory Training Compliance scores will differ to those presented earlier as they remove all staff that are not currently at work i.e. long term sick, maternity leave. RL encouraged everyone to read the new guidance on sharing data: https://www.gov.uk/government/publications/putting-good-into-practice-a-public-dialogue-on-making-public-benefit-assessments-when-using-health-and-care-data HD commented that it is a great report reflecting the hard work of the team. JED agreed. **The Governance Committee APPROVED the revised Terms of Reference for the IG Assurance Forum. RECEIVED the update regarding actions and compliance activities.**	
GC/2122/14	**DIGITAL DEVELOPMENT UPDATE** GCT presented the above update. GCT advised the headlines are the ongoing improvements to our cyber security. The checkpoint VPN and the firewall solution are rolling out.	

	Procurement has started for Cisco ISE solution which will provide additional endpoint protection. The new secure web hosting service prevents any hijacking or defacing of official sites and any sites that sit outside of this will be migrated. The removal of Office 2010 from corporate and GP estate has started. This will remove the risk of any attack through known vulnerabilities, and is on track to complete by July, which is 3 months ahead of the national deadline. Earlier this month, NHS Digital carried out a simulated phishing attack. 84% of colleagues entirely ignored the email. 1% clicked through to the email and entered their credentials for NHS mail. Those four colleagues have been identified through the report and will be following up on a 1 to 1 basis. The shortage of equipment is currently an issue. Orders are still outstanding from January. Therefore, some equipment has been sourced through Arden and GEM and GP practices have been emailed with a laptop and desktop amnesty, which is going well. This may help locate the 250 devices which have been identified as missing in the last 2 months. Discussions are ongoing regarding online consultation. As well as national and regional meetings, the team have met with GP practices and have been speaking to suppliers about their support for GPs. At the request of NHSEI the team canvassed opinions in Primary Care on online consultations. The main issue was around it being clinically unsafe given the amount of traffic coming through. There were reports of patients presenting with indications of a potential heart attack, which is an inappropriate use of this reporting system as it could be lost in the 100/200 messages received around less serious conditions. General Practitioners feel that the service should not be 24 hrs 7 days a week and instead be in normal office hours. The solution is to allow the practice to set its own hours which would also allow or staff training time and other events. Another concern was surge capacity, extended access hubs will be considered along with other support i.e. other practices or other digital tools. EP commented that she was really pleased that AccuRx has been installed in GP practices and personally uses it every day. Great communication tool. GS agreed with this. EP supports the online consultations only being available in the GP practices normal hours. GS agreed this with. EP is unable to open any attachments in the NHS mail. **Action: GCT to investigate why EP cannot open attachments** JED advised on page 6 of the Digital Development Update it is suggested that the governance of the Electronic Eyecare Referral Service is overseen by this Governance Committee for CCG assurance and asked if this was correct. GCT confirmed it was. The PID had requested details of the ICS Governance Board, however with this not in place and the DDCCG signing the PID the best way forward was through Planned Care and the Governance Committee. **Action: MM to add to the Electronic Eyecare Referral Service to the forward planner.** **Action: Ged to present the Electronic Eyecare Referral Service PID.**	**GCT** **MM** **GCT**

	The Governance Committee RECEIVED the contents of this report for information and assurance.	
GC/2122/15	**RISK REGISTER REPORT – APRIL 2021** RW presented the above report. RW confirmed as part of the check and challenges with various risk leads it has been validated that there are no changes to the risk scores this month. The risks remain for the Committee two moderate and five high risks. **The Governance Committee RECEIVED the Governance assigned governance risks.**	
GC/2122/16	**GOVERNING BODY ASSURANCE FRAMEWORK Q4 2020/21** RW presented the above report. RW confirmed this report was presented at Governing Body and is going to the Audit Committee next week. **The Governance Committee NOTED the Quarter 4 Governing Body Assurance Framework.**	
GC/2122/17	**HEALTH AND SAFETY REPORT** RH presented the above report. RH confirmed they are continuing with business as usual. A virtual Fire Warden refresher training session was delivered for Wardens and Marshals at Cardinal Square. The training was arranged by the Site Manager and was well attended. Annual Peninsula Health and Safety Audits have taken place over the last two weeks at Cardinal Square, Scarsdale and Ilkeston Health Centre. The feedback has been very good with just a few recommendations. The official report will be summarised and presented at the next Governance Committee. JED advised in the report staff are asked to complete a COVID-19 questionnaire before visiting any CCG site, however, it suggests that all requests are approved and asked whether this is the case. RH advised that staff wouldn't be allowed if they had been in contact with someone with COVID-19 or had symptoms. Normally line management and HR approval has been agreed prior to the form being submitted. Action: RH to present the results of the Annual Peninsula Health and Safety Audits at the next Governance Committee. **Action: MM to add Annual Peninsula Health and Safety Audit report to the agenda/forward planner.** **The Governance Committee RECEIVED ASSURANCE that NHS Derby and Derbyshire CCG is coordinating work to meet its health and safety obligations to remain compliant with health and safety legislation and RECEIVED ASSURANCE that Derby and Derbyshire CCG is responding**	**MM**

	effectively and appropriately to the changes in working practices as a consequence of the COVID-19 pandemic.	
GC/2122/18	**NON-CLINICAL ADVERSE INCIDENTS** CT confirmed there were none to report	
GC/2122/19	**LOCAL SECURITY – VIOLENCE REDUCTION STANDARDS** RH presented the above report. On 2 January 2021, NHSEI published the Violence Prevention and Reduction Standards which is applicable to all NHS organisations including Clinical Commissioning Groups (CCGs). The standards have been developed in partnership with the Social Partnership Forum and its subgroups, including trade unions and the Workforce Issues and Violence Reduction Groups. It was endorsed by the Social Partnership Forum on the 15/12/20 and replaces the previous NHS Protect Standards for Commissioners. The standards are broken down into Plan, Do, Check, Act. There will be two leads: • Local Security Management Specialist (LSMS) Support - TBC • Executive Lead for Violence Prevention and Reduction – Helen Dillistone 360 Assurance have been contacted to provide specialist support in implementing the Violence Prevention and Reduction Standards, however we are awaiting contact from our nominated LSMS. A conversation took place considering if this work is needed at this time as the CCG is scoring very highly in the staff survey that it is a safe place to work, also the DDCCG will be closed in March 2022 and transitioned into the ICS. It was agreed that this should proceed through the lens of the ICS if possible. **Action: MM to add to Violence Reduction Standards to the forward planner** The Governance Committee NOTED the contents of this report for information and assurance, AGREED to include the Violence Prevention and Reduction Standards as a standing agenda item for this Committee and AGREED that the Executive Director of Strategy and Corporate Delivery will act as the Executive Lead for Violence Prevention and Reduction including acting as conduit to the Integrated Care System (ICS).	**MM**
GC/2122/20	**MINUTES OF THE MEETING HELD ON 11 MARCH 2021** **The Governance Committee APPROVED the minutes of the meeting on 11 March 2021as a true and accurate record of the meeting.**	
GC/2122/21	**MATTERS ARISING** None	
GC/2122/22	**ACTION LOG FROM THE MEETING HELD ON 11 MARCH 2021**	

	The Governance Committee REVIEWED the action log. All actions were completed with the exception of GC/2021/58 which is due in July.	
GC/2122/23	**GOVERNANCE COMMITTEE FORWARD PLANNER 2021/22** CT presented the forward planner. MW asked whether the CCG Transition to an ICS would need to be added to the Governance Committee. HD confirmed that this is discussed at Governing Body instead. JED asked if the People and Culture Group report should be presented at Governance Committee. HD agreed it should. **Action: HD to arrange for a People and Culture Group report to be issued and presented at Governance Committee.** **Action: MM to consider adding the People and Culture Group report to the forward planner.**	**HD** **MM**
GC/2122/24	**ANY OTHER BUSINESS** SP confirmed that a new risk is currently being identified for the Derbyshire Shared Care Record. This will be sent to committee members in the coming weeks for virtual approval. **Action: SP to send the new Derbyshire Shared Care Record risk to Committee members for approval.**	**SP**
GC/2122/25	**FUTURE MEETINGS DATES** Time: 13:00 – 15:00 *NB. The meetings will be held as virtual meetings until further notice.* Thursday 22 July 2021 Papers due: Tuesday 13 July 2021 Thursday 23 September 2021 Papers due: Tuesday 14 September 2021 Thursday 11 November 2021 Papers due: Tuesday 2 November 2021 Thursday 10 February 22 Papers due: Tuesday 2 February 2022 Thursday 24 March 2022 Papers due: Tuesday 15 March 2022	
GC/2122/26	**ASSURANCE QUESTIONS** 1. Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? **Yes** 2. Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? **Yes** 3. Were papers that have already been reported on at another committee presented to you in a summary form? **Yes** 4. Was the content of the papers suitable and appropriate for the public domain? **Yes, however we need to bear in mind any matters arising**	

	from the procurement paper which may need to be brought forward in confidential session. 5. Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? **Yes** 6. Is the Committee assured on progress regarding actions assigned to it within the Recovery & Restoration plan? **Remove question no longer applicable.** **Action: MM to remove question 6 from the assurance questions.** 7. Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? **No** 8. What recommendations do the Committee want to make to Governing Body following the assurance process at today's Committee meeting? **The Recovery and Restoration Plan is being built into business as usual and the staff survey.**	**MM**

NHS
Derby and Derbyshire
Clinical Commissioning Group

MINUTES OF PRIMARY CARE COMMISSIONING COMMITTEE

PUBLIC MEETING

HELD ON

Wednesday 23rd June 2021

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

PRESENT

Simon McCandlish (Chair)	**SMc**	Deputy Chair, Lay Member, Derby & Derbyshire CCG
Kath Bagshaw (Part of Meeting)	**KB**	Deputy Medical Director (for Executive Medical Director)
Niki Bridge	**NB**	Deputy Chief Finance Officer, DDCCG (for CFO)
Jill Dentith	**JeD**	Lay Member Derby & Derbyshire CCG
Steve Lloyd (Part of Meeting)	**SL**	Executive Medical Director Derby & Derbyshire CCG

IN ATTENDANCE

Hannah Belcher	**HB**	AD GP Commissioning & Development Derby DDCCG
Judy Derricott	**JDe**	Head of Primary Care Quality Derby & Derbyshire CCG
Kath Markus	**KM**	Chief Executive Derby & Derbyshire LMC
Abid Mumtaz	**AM**	Derbyshire County Council
Jean Richards	**JR**	Senior GP Commissioning Manager DDCCG
Marie Scouse	**MS**	AD of Nursing & Quality Derby & Derbyshire CCG (for CNO)
Pauline Innes	**PI**	Executive Assistant to Dr Steven Lloyd

APOLOGIES

Clive Newman	**CN**	Director of GP Development Derby & Derbyshire CCG
Adam Norris	**AN**	Service Commissioning Manager Public Health, Derbyshire County Council
Ian Shaw	**IS**	Lay Member Derby & Derbyshire CCG
Brigid Stacey	**BS**	Chief Nurse Derby & Derbyshire CCG

ITEM NO.	ITEM	ACTION
PCCC/2021/104	**WELCOME AND APOLOGIES** The Chair (SmC) welcomed Committee Members and Ian Frankcom member of the Public to the meeting. Apologies were received and noted as above. The Chair confirmed that the meeting was quorate.	
PCCC/2021/105	**DECLARATIONS OF INTEREST** The Chair informed members of the public of the committee members' obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG. Declarations declared by members of the Primary Care Commissioning Committee are listed in the CCG's Register of Interests and included within the meeting papers. The Register is also available either via the corporate	

	secretary to the Governing Body or the CCG website at the following link: www.derbyandderbyshireccg.nhs.uk There were no Declarations of Interest made. The Chair declared that the meeting was quorate.	
FOR DECISION		
	No items for decision	
	FOR DISCUSSION	
	No Items for discussion	
FOR ASSURANCE		
PCCC/2021/106	**FINANCE UPDATE** Niki Bridge (NB) presented an update from the shared paper. The paper was taken as read and the following points of note were made. The Finance Report for M1 for 2021/22 and has been ratified through the Finance Committee and Governing Body. • The overall position for the CCG at Month 1 shows a slight overspend of £162k however, within this position there was COVID-19 costs included of £323k. • The year to date budget is based on the H1 plan which was submitted in May 2021. NB reminded the Committee that for 2020/21 the orgainsation worked in two halves of the year H1 and H2 with a similar approach for this year due to COVID-19 and restoration and Recovery. • There are no overall concerns at the moment as a system is an overall slight surplus for Month1. • Within the report indicators are showing all green apart from the Primary Care Co-Commissioning allocation which is showing a slight shortfall on allocations of just over £200k however this not a concern at the moment and awaiting a catch up from NHSE to correct the allocation therefore this is not being flagged as a concern. Jill Dentith (JeD) sought clarification on the Primary Care allocation stating that assurance can be taken from the fact that there is no concern at the moment as this is about reporting the first month, stating that the Committee can be assured that this will come in to balance as the system progresses. NB explained that the CCG do not have to report the first month in to NHSE/I however as a system and as an organisation chose to report this information stating there are no concerns as it stands at the moment. Simon McCandlish (SMc) queried as we move into September / October with regards phase 3 booster programme enquiring if monies have been allocated for this or is guidance still to be provided. NB confirmed that the system is awaiting guidance on Phase 3 stressing to the Committee the amount of planning required to look at the delivery and delivery models. The organisation are being asked for indications of indicative costs so that a case can be put forward to treasury with a view to receiving funding for the Phase 3 programme.	

	The Primary Care Commissioning Committee NOTED and RECEIVED the update on the DDCCGs financial position for Month 1.	
PCCC/2021/107	**RISK REGISTER EXCEPTION REPORT** Hannah Belcher (HB) presented an update from the shared paper. The paper was taken as read and the following points of note were made. The Committee noted that there has been no change to the level of risks from previous months. Risk 04A: *Contracting* HB reported that NHSE has continued the COVID-19 capacity expansion fund until the end of September 2021. Allocations have been received and practices will be written to inform them of the funding. Risk 04B: *Quality:* Marie Scouse (MS) reported that this risk remains static stating that the team are aware of the pressures on General Practice from both a contracting and quality point of view stressing that at this moment in time it would not be wise to decrease this risk. MS assured the Committee that the Contracting and Quality team continue to work on all avenues to support Practice and identify any concerns that may arise. Jill Dentith (JeD) referred to the CQC visits which resumed in April 2021 asking if there was any concerns likely to be seen, querying whether there is a need to increase Risk 04B rather than reduce at this point or is there assurance that systems and processes are in place to support should the need arise. MS clarified that CQC have resumed their inspection regime and in support of this the team will also recommence the quality and improvement visits from July / August 2021. Risk assessments are taking place with practices and, there will also be a CQC event with practices in July 2021 to raise awareness due to having no CQC inspections over an extensive period due to the pandemic. There is a new CQC framework which will be promoted with the practices. **The Primary Care Commissioning Committee NOTED and RECEIVED the update on the two outstanding risks and AGREED that the scores remain unchanged.**	
PCCC/2021/108	**GP CONTRACT (APMS) – ST THOMAS ROAD SURGERY** Hannah Belcher (HB) provided an update from the shared paper. The paper was taken as read and the following points of note were made. The GP Contract (APMS) was due to expire this year, the Committee will recall the agreement to extend the current contract to a year to enable feedback from patients and stakeholders prior to the commencement of the procurement process. The paper is to provide the Committee with assurance to provide the detail of the plans around the patient and engagement process. A letter will be sent to the head of every household at the surgery with a survey to ask for feedback on the service, meetings have also taken place with the PPG Chair and offered to do a patient forum due to COVID and the social distancing requirements as part of that process.	

	Jill Dentith (JeD) queried several points from the paper: 1. The Committee needs to be assured from a quality perspective that the Practice are still delivering to ensure due process is being followed. JDe reported that the practice continues to meet with CQC on a regular basis and continues to meet with the Primary Care team on a quarterly basis. The practice developed an action plan following prior to their CQC inspection and continue to refine this and work on areas identified. It was noted that the practice is pushing for a CQC visit in the hope of moving from Requires Improvement score to a score of Good. 2. Queried the sample letter within the pack of papers questioning if the letter should be in the Public domain at this point? HB explained that there is nothing contentious within the letter and it was felt that it was appropriate to bring to the Public session. **The Primary Care Commissioning Committee NOTED and RECEIVED the update on the GP Contract (APMS) – St Thomas Road Surgery**	
FOR INFORMATION		
	No items for information	
MINUTES AND MATTERS ARISING		
PCCC/2021/109	**Minutes of the Primary Care Commissioning Committee meeting held on 26th May 2021** The minutes from the meeting held on 26th May 2021 were agreed to be an accurate record of the meeting.	
PCCC/2021/110	**MATTERS ARISING MATRIX** There are no outstanding actions on the Action Matrix.	
PCCC/2021/111	**ANY OTHER BUSINESS** There were no items of any other business	
PCCC/2021/112	**ASSURANCE QUESTIONS** Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? **Yes** Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? **Yes** Were papers that have already been reported on at another committee presented to you in a summary form? **Yes** Was the content of the papers suitable and appropriate for the public domain? **Yes** Were the papers sent to Committee members at least five working days in advance of the meeting to allow for the review of papers for assurance purposes? **Yes** Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? **No**	

	Is the Committee assured on progress regarding actions assigned to it within the Recovery & Restoration plan? **N/A** What recommendations does the Committee want to make to Governing Body following the assurance process at today's Committee meeting? **None**	
	DATE AND TIME OF NEXT MEETING	
Wednesday 28th July 2021, 10:00-10:30am via Microsoft Teams Meeting		

NHS
Derby and Derbyshire
Clinical Commissioning Group

MINUTES OF QUALITY AND PERFORMANCE COMMITTEE
HELD ON 24th June 2021, 9AM TO 10.00AM
MS TEAMS

Present:		
Dr Buk Dhadda (Chair)	BD	Chair, Governing Body GP, DDCCG
Kath Bagshaw	KB	Deputy Medical Director
Niki Bridge	NB	Deputy Director of Finance
Mick Burrows	MB	Director of Commissioning for MH, LD, ASD, and CYP
Jackie Carlile	JC	Head of Performance and Assurance -DDCCG
Alison Cargill	AC	Asst Director of Quality, DDCCG
Simon McCalandish	SMcC	Lay Member, Patient Experience
Sarah MacGillivray	SMacG	Head of Patient Experience, DDCCG
Dan Merrison	DM	Senior Performance & Assurance Manager, DDCCG
Andrew Middleton	AM	Lay Member, Finance
Hannah Morton	HM	Healthwatch
Shaw Poxon (observing)	SPo	Senior Clinical Quality Manager
Brigid Stacey	BS	Chief Nurse Officer, DDCCG
Dr Greg Strachan	GS	Governing Body GP, DDCCG
Dr Merryl Watkins	MWa	Governing Body GP, DDCCG
Helen Wilson	HW	Deputy Director Contracting and Performance - DDCCG
Rosalie Whitehead	RW	Risk Management & Legal Assurance Manager
Martin Whittle	MW	Vice Chair and Governing Body Lay Member, Patient and Public Involvement, DDCCG
Helen Hipkiss	HH	Deputy Director of Quality - DDCCG
In Attendance:		
Jo Pearce (Minutes)	JP	Executive Assistant to Chief Nurse, DDCCG
Apologies:		
Laura Moore	LM	Deputy Chief Nurse, DDCCG
Dr Steve Lloyd	SL	Medical Director - DDCCG
Zara Jones	ZJ	Executive Director of Commissioning Operations, DDCCG
Dr Bruce Braithwaite	BB	Secondary Care GP
Dr Emma Pizzey	EP	GP South
Suzanne Pickering	SP	Head of Governance- DDCCG

Item No.	Item	Action
QP2122 /040	**WELCOME, APOLOGIES & QUORACY** Apologies were received as above. BD declared the meeting quorate.	
QP2122 /041	**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 KB made the Committee aware that her Declaration of Interest (DOI) was not listed within today's papers however they are listed as part of the CCG DOI. KB is attending todays meeting on behalf of Dr Steve Lloyd.	
	BD confirmed that the meeting will be conducted in a more abbreviated form. Some of the papers have been listed on the agenda for information only and Committee members were asked to submit questions relating to the papers before the meeting. Responses to the questions were circulated to the Committee members prior to the meeting. The questions are being collated for future reference if required.	
QP2122 /042	**INTEGRATED REPORT** **Performance** The paper was taken as read and the Committee were asked for any further questions. JC highlighted the acute trusts are now being measured against the 28 days to diagnosis standard, both trusts achieved this in April	

	2021. The CCG was slightly under plan which was due to out of area providers. The report shows a reduction in the number of patients who have been waiting over 52 weeks and unvalidated data for May indicates there will be a further reduction. However, this is caveated due to the fact the patients who were referred between June and August 2020 will soon transfer over to the 52WW list. AM referred to the Cancer Deep Dive paper, presented to UHDBFT Trust Board in May 2021, where several prostate conditions were found to be at a later stage of advancement and asked if this was due to the patient presenting to the GP later than usual or due to diagnostics delays. JC replied, stating that although cancer referrals were prioritized there were several patients who were reluctant to go into the trusts. AM asked for an explanation around the request for additional funding for backlog screening . JC replied, stating there is a large backlog for screening, specifically breast screening. NHSE have asked the trusts to clear their backlogs by March 2022. To achieve this would mean UHDBFT providing an extra 40 appointment slots per day. BS added that a request for a focused deep dive on cancer services and cancer waits will come to the Quality and Performance Committee in July. UHDBFT and CRHFT colleagues will be invited to the meeting. NB confirmed that block contracts are in place with both trusts and therefore finances would not be an issue. MWa noted her views around access being an issue. BD acknowledged and agreed this is something that needs to be considered from a Commissioner perspective. **Activity** HW offered some reassurance to the Committee confirming that referrals are back to pre-pandemic levels with patients coming back into the trust and significant recovery in the delivery of service. JC stated that as of 7th June 2021 UHDBFT had 896 2WW referrals which is their highest number ever reported and gives an indication of the levels of activity that are being seen. Urgent activity is significantly increased with both trusts experiencing pressures in May and June which is unusual for the time of year. This is a national picture with a resurgence in some minor infractions including non-covid related respiratory presentations that haven't taken place over winter. **Quality** HH informed the Committee of the good practice work that EMAS are undertaking with support from NHSE. The work is to help front	

	door workers reduce the time a patient has to wait in the ambulance to be admitted. BD **APPROVED** the Integrated Report.	
QP2122 /043	**GBAF Q1** The paper was taken as read. RW noted a new risk added to the GBAF. Risk 6 relates to achievement of national requirements for the Covid -19 vaccination program and has been scored at a very high 20. AM noted the Quality and Performance GBAF Task & Finish group had questioned the high score and asked for the view of Dr Steve Lloyd. RW confirmed that the score was initially 25 and following review by Dr Steve Lloyd has been reduced to 20. AM asked what action is needed to get the rating down to an acceptable score given the focus on addressing inequalities is a strategic objective and suggested discussions start early. BD recommended Dr Robyn Dewis, Director of Public Health, Derby City Council, be invited to a future Quality and Performance Committee to provide and update on the plans that are being put in place.	
QP2122 /044	**RISK REGISTER** The paper was taken as read. The Committee were asked to approve the reduction of Risk 24 from 9 to 6 and to approve the new Risk 38 relating to patient activity in CHC services which has been scored at an 8. The Committee supported and **approved** both recommendations.	
QP2122 /045	**CLOSURE OF THE RESTORATION AND RECOVERY PLAN** The paper was taken as read. The Committee were asked to note that any outstanding issues around recovery and restoration have moved into business as usual processed and the nursing and quality team are confident and outstanding issues are picked up.	
QP2122 /046	**DERBYSHIRE HEALTHCARE NHS FT DORMITORY ERADICATION CAPITAL PROGRAMME OUTLINE BUSINESS CASE (OBC)** The paper was taken as read.	

	MB explained that this is a significant venture for Derbyshire with a substantial upgrade of the current estate. The outline business cases include details of correcting substandard and unfit for purpose estate to meet current care standards. The areas that need correction are around • Sexual safety for in patients – no mixed ward areas. • Eradication of all dormitories. • Reduction of restricted practice. There will be a 136-bed wing in the north and south of the county and the improvements will help with observations and reducing the risk of deliberate self-harm. The smaller wards are more in line with best practice which will mean there is a difference in how staff are used to observe patients and are deployed across the estate which results in an increase in costs. There is a significant revenue impact, and this will be managed within the systems mental health investment standards. There is a working party in place who monitor on a monthly basis. A potential builder with extensive NHS build experience and who understands strict the timetables has been sourced. These plans represent £80m worth of investment which will be owned by the MH Trust. MB noted to the Committee there will be a further set of OBC for further developments which will be funded within the system to create more secure Psychiatric Intensive Care Unit (PICU) SMacG assured the Committee that QEIA for both north and south developments have been through the JUCD QEIA panel and were rated low risk and very positive with regards to patient experience. AM asked if this investment would reduce the number of external referrals. MB replied to say the new build will be designed with autism in mind which should help in reducing the length of stay and the number of escalations, this in turn should result in increased capacity along with the fact that there will be an in-county PICU. SMcC asked about the confidence in getting quality staff to man the beds. There is a staffing workforce plan in development with emphasis on grow your own. Revenue will commence when the buildings come into use which is likely to be the end of 2024. NB added that there will be a pressure of £5m linked to the build and it is believed that there is an underwriting by the MH Delivery Board. The Committee noted and **approved** the contents of the paper.	

QP2122 /047	**DDCCG QEIA POLICY ANNUAL REVIEW FOR APPROVAL** SMcG confirmed that the policy has been through the QEIA panel members for review. The Committee **approved** the DDCCG QEIA policy.	
QP2122 /048	**DFE AND NHSE/I – SEND REVIEW MEETINGS – MAY 2021** The paper was taken as read. The Committee noted the contents of the report and there were no questions raised.	
QP2122 /049	**QUALITY ACCOUNTS STATEMENTS** The paper was taken as read. The Committee noted the contents of the report and there were no questions raised.	
QP2122 /050	**CONTINUING HEALTH CARE (CHC)** The paper was taken as read. The Committee noted the contents of the report. GS highlighted the papers reports continued concerns around S117 however the paper does not evidence assurance around the actions that are being taken to manage the concerns. HH confirmed the number of patients coming through the system has significantly increased. A piece of work is being undertaken by the CSU to understand the S117 requests. HH assured the Committee that S117 patients are scrutinised at both operational and Contract management board meetings. Case managers are now in post to support with this work. The S117 budget is a joint budget between health and the local authority, and all cases are being reviewed to identify if there is still a S117 entitlement. AM noted the potential overspend should these levels be sustained. BS confirmed that the issue is around Fast Tracks. BS has written to all Chief Nurses across the system to note the disappointment around procedures being followed. The weekly run rate review meetings between the CHC team, BI and Finance have been reinstated. There are several actions that BS will feed back to the Finance Committee.	
QP2122 /051	**INFECTION PREVENTION & CONTROL** The paper was taken as read. The Committee noted the contents of the report and there were no questions raised.	

QP2122 /052	**CARE HOMES** The paper was taken as read. The Committee noted the contents of the report and there were no questions raised.	
QP2122 /053	**MINUTES FROM SUB COMMITTEES** The Committee noted the minutes from the following sub-Committees. • DPG 6th May 21 • Update reports from CRHFT CQRG UHDBFT CQRG DCHS CQRG	
QP2122 /054	**MINUTES FROM THE MEETING HELD ON 27th MAY 2021.** The minutes were approved as a true and accurate record.	
QP2122 /055	**MATTERS ARISING AND ACTION LOG** The action log was reviewed and updated.	
QP2122 /056	**AOB**	
QP2122 /057	**FORWARD PLANNER** The Forward Planner was reviewed. No updates were made.	
QP2122 /058	**ANY SIGNIFICANT SAFETY CONCERNS TO NOTE** None raised.	
	ASSURANCE QUESTIONS • Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? Yes • Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? Yes • Were papers that have already been reported on at another committee presented to you in a summary form? Yes	

	• Was the content of the papers suitable and appropriate for the public domain? Yes • Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? Yes • Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? No • What recommendations do the Committee want to make to Governing Body following the assurance process at today's Committee meeting? None	

DATE AND TIME OF NEXT MEETING
Date: 29th July 2021
Time: 9am to 10.30am
Venue: MS Teams

South Yorkshire and Bassetlaw Integrated Care System

Chief Executive Report

Health Executive Group

13th July 2021

Author(s)	**Andrew Cash**
Sponsor	

Is your report for Approval / Consideration / Noting

For noting and discussion

Links to the ICS Five Year Plan (please tick)

Developing a population health system

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

Strengthening our foundations

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

Building a sustainable health and care system

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

Broadening and strengthening our partnerships to increase our opportunity

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

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

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

N/A

Summary of key issues

This monthly paper from the System Lead of the South Yorkshire and Bassetlaw Integrated Care System provides a summary update on the work of the South Yorkshire and Bassetlaw health and care partners for the month of June 2021.

Recommendations

The SYB ICS Health Executive Group (HEG) partners are asked to note the update and Chief Executives and Accountable Officers are asked to share the paper with their individual Boards, Governing Bodies and Committees.

Chief Executive Report

SOUTH YORKSHIRE AND BASSETLAW
INTEGRATED CARE SYSTEM

Health Executive Group

13th July 2021

1. Purpose

This paper from the South Yorkshire and Bassetlaw (SYB) Integrated Care System (ICS) System Lead provides an update on the work of the South Yorkshire and Bassetlaw health and care partners for the month of June 2021.

2. Summary update for activity during June

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

Like other parts of the country, SYB is seeing a similar rapid increase in rates of Covid. This is linked to the increases in social mobility (back to pre-pandemic levels) and the Delta variant, now dominant throughout England.

Cases of Covid are doubling in SYB on average every seven days which is a strong indication of how quickly infections are rising. The spread is largest among unvaccinated groups with the 20-24s and under 20s attributing to the latest surge in cases.

Fortunately, we are still not seeing any significant concern across our acute trusts in terms of bed occupancy. Levels of occupancy are slowly rising, mostly with unvaccinated individuals but there have not been any Covid-related deaths for seven days.

Public health data is still showing no clear evidence of stacking (passing of the virus between younger to older and more clinically vulnerable members of the same household), but there is a strong consensus among public health teams that cases will continue to rise sharply over the next few weeks with current forecasting analysis anticipating cases will flatten-off during August.

In terms of our vaccination progress, SYB is performing well and targeting new eligible age groups and improving access for greater numbers of our population.

As at 6th June, 96% of cohorts 1-4 have had their first dose and 89.9% have had their second dose. For cohorts 5-9 this is 92% for first dose and 87.1% for their second. In cohort 10, the first dose is 85.6% and second dose is 69.4%. For cohorts 11 and 12 (30 to 39-year-olds and 18-24-year-olds), the first dose drops to 68.5% and 24.2% for second dose. This is not surprising given the vaccination offer has only recently been available to cohort 12 and there is a minimum eight-week gap between doses.

Additional locations across SYB, including Montgomery Hall (Rotherham), Priory Campus (Barnsley) and Bramall Lane (Sheffield), have been set up recently along with many others. This has been especially useful in increasing our numbers of 18-20 year-olds vaccination numbers which is encouraging, despite an overall slowing-down in the overall take-up of vaccines.

The ‘grab a jab’ campaign has enhanced the opportunities for individuals to come forward as this is being offered on a drop-in basis leading up to the planned easing on the 19th July. The SYB

programme is working hard to meet the targets set for each cohort by July 18th and every effort to promote the offer is being made in the final two weeks

I would like to acknowledge SYB's Vaccination Steering Group for co-ordinating the fantastic work of primary, community and secondary care colleagues and the incredible support of local authorities and volunteers throughout the vaccination programme.

2.2 Regional update

2.2.1 Leaders meeting

The North East and Yorkshire (NEY) Regional ICS Leaders meet weekly with the NHS England and Improvement Regional Director. During June, discussions focused on the ongoing Covid response and vaccination programme, urgent and emergency care and winter resilience, planning and recovery and ICS development (including feedback from the NEY transition oversight group).

2.3 National update

2.3.1 Health and Care Bill

The government has now published a bill setting out how it intends to reform the delivery of health services and promote integration between health and care in England. This is the first major piece of primary legislation on health and care in England since the Health and Social Care Act 2012.

The bill will now make its way through Parliament which includes a second reading in the House of Commons and then to Committee stage (expected in September).

It is structured in six parts:

Part 1: Health service in England: integration, collaboration and other changes
Part 2: Health and adult social care: information
Part 3: Secretary of State's powers to transfer or delegate functions
Part 4: The Health Service Safety Investigations Body
Parts 5 and 6: Miscellaneous and general

The bill is on course to pass into law by April 2022 but is recognised that timescales are tight and there much work to be done to finalise key elements of the bill.

The link to the bill is here: https://publications.parliament.uk/pa/bills/cbill/58-02/0140/210140.pdf

2.3.2 ICS Design Framework

NHS England and Improvement (NHSE/I) has set out the next steps for the development of integrated care systems (ICS') in the Integrated Care Systems Design Framework, which was published in June.

The document sets out the headlines for NHS leaders and organisations to operate with their partners in ICSs from April 2022. It is intended to help ICSs as they put in place the practical steps to prepare for new functions that are expected to be enabled by legislation in. In SYB, our system leaders had already started to sketch out future ways of working and are now carefully considering the Design Framework within the established design and transition workstreams. As these important areas of work progress, we will be incorporating both the framework and subsequent guidance and resources into the SYB approach.

2.4 Embrace Children's Transport Service re-accredited

Embrace Yorkshire and Humber Infant and Children's Transport Service has been re-accredited in recognition of its life-saving care and commitment towards delivering quality patient care and safety.

The transport service, part of Sheffield Children's NHS Foundation Trust, provides a team of specialist doctors and nurses who travel with their patients by road ambulances, helicopters and planes. It has been re-accredited by the Commission on Accreditation of Medical Transport Systems (CAMTS) Global after being assessed on patient care and safety in the transport environment.

2.5 Tailored approaches in primary care to support the support Covid vaccination delivery programme.

Firefighters from South Yorkshire Fire and Rescue have been supporting Sheffield GP practices with the Covid vaccination delivery programme. A number of fire service volunteers were trained up as vaccinators by St John Ambulance as part of a national effort from fire services across the country to help with the pandemic response.

This approach sits alongside the development of walk-in clinics in locations close to where people live to encourage as much uptake as possible. This includes locations such as the St Charles Borromeo Church in Attercliffe, Sheffield, leisure centres in Thorne, Adwick and the Dearne Valley in Doncaster, the market in Barnsley town centre, the leisure centre in Maltby and Rawmarsh customer services centre in Rotherham and the Kilton Forest Community Centre in Worksop.

2.6 Acute Provider Collaborative among the finalists for the Procurement Project of the Year at the Health Service Journal Partnership Awards.

During the early stages of the coronavirus outbreak a collaboration of nine trusts in South Yorkshire, Bassetlaw and Lincolnshire worked with Crown Commercial Services (CCS) to establish a single supplier contract for the purchase of multidisciplinary temporary healthcare personnel with the prime group being doctor locums.

As a result, more than £1 million pounds was saved, which is around 6 per cent of the total locum doctor spend. A collaborative tender on this scale is rarely seen across the NHS and a result, the Collaborative reached the finals in the Health Service Journal Partnership Awards.

Ongoing work as part of the collaboration is expected to see agency fees for doctors in the area fall which would deliver additional annual savings.

Congratulations to the procurement teams in each of the acute hospital trusts for reaching the final in the Procurement Project category.

2.7 Your Covid Recovery campaign

A localised 'Your Covid Recovery' campaign was launched across SYB in June following engagement with local people who said that they were unsure where to go or who to ask when they had health questions after having Covid.

Uncertainty over issues such as how long should the cough last, when would taste and smell come back, when to re-start exercising, and being unable to source advice and support from family members were issues raised by the members of the public taking part in the insight.

Partners in SYB came together to develop a local social media campaign using channels and connections already in place to raise awareness of the national website, which addresses the issues: https://www.yourcovidrecovery.nhs.uk/

2.8 SYB ICS Cancer Alliance

2.8.1 Virtual Showcase

The SYB ICS Cancer Alliance held a virtual showcase event on Friday, 25 June, which displayed the breadth of work taking place to provide high quality, personalised care for anyone affected by cancer in our region. After a challenging year, the event was an opportunity to reflect on the achievements and advancements made by the broad range of people involved in cancer care.

Over 70 people attended the event which heard from the National Director for Cancer, Professor Peter Johnson, Local MP and Mayor of the Sheffield City Region, Dan Jarvis, people directly involved in the work of the Alliance from primary through to secondary care and beyond as well as some key community and voluntary sector partners.

2.8.2 Do it For Yourself (DIFY) lung cancer awareness campaign launched

The pandemic has unfortunately impacted on the number of people coming forward with lung cancer symptoms. In partnership with MSD, the Alliance has launched a lung cancer awareness campaign to encourage people to make an appointment with their GP if they have had a cough or have been breathless for three weeks or more.

The campaign features targeted advertising in Barnsley and Rotherham on buses, at bus stops, at local amenities, on pharmacy bags and on local radio.

2.9 QUIT launches across SYB

The QUIT Programme, which has the potential to save up to 2,000 lives and 4,000 hospital readmissions a year, has launched across South Yorkshire and Bassetlaw.

As partners are aware, the groundbreaking stop smoking programme is being delivered by SYB ICS in partnership with Yorkshire Cancer Research, five local authorities and local Stop Smoking Services.

Based on evidence from successful smaller schemes in Ottawa and in Greater Manchester, QUIT is the largest project of its kind in the world and will transform the way smoking is tackled by the NHS in the region. Rather than seeing smoking as a lifestyle choice, hospital staff across the eight NHS Trusts in South Yorkshire and Bassetlaw now recognise it as tobacco addiction – a medical condition they have a responsibility to treat as part of patients' routine hospital care.

Every hospital patient in the region over the age of 12 years who smokes will now have access to nicotine replacement treatments (NRT) and specialist stop smoking support during their hospital stay from 45, trained Tobacco Treatment Advisers funded by Yorkshire Cancer Research.

Community-based stop smoking services will play a key role, ensuring medication and support is continued after patients leave hospital to give them the best chance of beating their tobacco addiction.

2.10 Queen's Birthday Honours

Nurse Adele Hague, team leader for Sheffield Children's 0-19 team, was awarded a British Empire Medal (BEM) in the Queen's Birthday Honours for her dedicated work in the community and for her work setting up a testing service and vaccination clinics at Sheffield Children's during the Covid pandemic.

Adele has worked at Sheffield Children's for six years. Her normal role supports the coordination of healthcare for children and young people across the city. She is a key part of the 0-19 service, which helps ensure children are on track with their development and supports parents with the challenges of parenthood, including helping them to learn new skills.

In March 2020, Adele volunteered to help with the Covid response. Adele trained as a Covid tester, oversaw the admin team who running the testing service, organised the logistics of the testing service and personally swabbed more than 2,000 people. Later in the year Adele was also instrumental in launching the Covid vaccination clinics, being part of the team and personally vaccinating hundreds of colleagues at Sheffield Children's.

Dr Thushan de Silva, Honorary Consultant Physician in Infectious Diseases at Sheffield Teaching Hospitals NHS Foundation Trust and Senior Clinical Lecturer at the University of Sheffield was appointed a Member of the Order of the British Empire (MBE).

Since the start of the pandemic in the UK, Dr de Silva spearheaded the University's research into SARS-CoV-2. He leads the Sheffield Covid-19 Genomics group, which was formed in March 2020 as part of the national Covid-19 Genomics UK (COG-UK) Consortium to track the spread and evolution of the virus.

Much of Dr de Silva's work has been done in collaboration with the South Yorkshire Department of Infection and Tropical Medicine at Sheffield Teaching Hospitals NHS Foundation Trust, where he is an Honorary NHS Consultant. He cared for some of the UK's first Covid-19 patients and has continued to do so throughout the pandemic.

The annual Birthday Honours recognise individuals in society who have committed themselves to serving and helping Britain. They often honour individual achievements such as making a difference to a community, or in a field of work which changes or improves lives.

2.11 Rainbow garden opens at Doncaster Royal Infirmary

A remembrance 'Rainbow Garden' in memory of all those who have lost their lives to Covid opened at Doncaster Royal Infirmary in June. It was made possible following donations of more than £50,000 from residents and businesses.

In June 2020, colleagues at Doncaster and Bassetlaw Teaching Hospitals (DBTH) started to fundraise with an ambition to create two spaces in honour of those affected by Covid, in particular colleagues, Kevin Smith, Dr Medhat Atalla and Lorraine Butterfield, who sadly passed away from the illness last year.

3. Finance

As at month two (May) the system has a surplus of £17.8m which is £14.2m favourable to plan. Financial plans at Month 2 exclude Elective Recovery Funding (ERF) and accelerator funding of £49m and £8.5m respectively. No margin has been assumed on ERF funding. This will be reflected in the Month 3 reporting. The ICS budgets including Cancer have a small underspend at month 2 (£3k). £9.8m has been spent on capital in the first 2 months which is £0.7m greater than plan. The ICS are still awaiting to hear what the financial framework for the second half of the year will look like.

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

Date: 7th July 2021

NHS
Derby and Derbyshire
Clinical Commissioning Group

Derby and Derbyshire CCG Governing Body Meeting in Public
Held on
1st July 2021 via Microsoft Teams

UNCONFIRMED

Present:

Dr Avi Bhatia	AB	Clinical Chair
Dr Penny Blackwell	PB	Governing Body GP
Richard Chapman	RCp	Chief Finance Officer
Dr Chris Clayton	CC	Chief Executive Officer
Dr Ruth Cooper	RC	Governing Body GP
Jill Dentith	JD	Lay Member for Governance
Dr Robyn Dewis	RD	Director of Public Health - Derby City Council
Dr Buk Dhadda	BD	Governing Body GP
Ian Gibbard	IG	Lay Member for Audit
Zara Jones	ZJ	Executive Director of Commissioning Operations
Dr Steven Lloyd	SL	Medical Director
Simon McCandlish	SM	Lay Member for Patient and Public Involvement
Andrew Middleton	AM	Lay Member for Finance
Dr Emma Pizzey	EP	Governing Body GP
Professor Ian Shaw	IS	Lay Member for Primary Care Commissioning
Brigid Stacey	BS	Chief Nursing Officer
Dr Greg Strachan	GS	Governing Body GP
Dr Merryl Watkins	MW	Governing Body GP

Apologies:

Dr Bruce Braithwaite	BB	Secondary Care Consultant
Helen Dillistone	HD	Executive Director of Corporate Strategy and Delivery
Dean Wallace	DW	Director of Public Health - Derbyshire County Council
Martin Whittle	MWh	Lay Member for Patient and Public Involvement

In attendance:

Dawn Litchfield	DL	Executive Assistant to the Governing Body/Minute Taker
Suzanne Pickering	SP	Head of Governance
Chrissy Tucker	CT	Director of Corporate Delivery
Andy Harrison	AH	SRO, Acute Care Capital Programme (DHcFT) - part meeting

Item No.	Item	Action
GBP/2122/076	**Welcome, Apologies & Quoracy** Dr Avi Bhatia (AB) welcomed members to the meeting. Apologies were received as above. It was confirmed that the meeting was quorate.	
GBP/2122/077	**Questions received from members of the public** No questions were received from members of the public this month.	

GBP/2122/078	**Declarations of Interest** AB reminded Committee members and visiting delegates of their obligation to declare any interests that they may have on any issues arising at Committee meetings which might conflict with the business of the CCG. Declarations declared by members of the Governing Body are listed in the CCG's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Governing Body or the CCG website at the following link: www.derbyandderbyshireCCG.NHS.uk No further declarations of interest were made and no changes were requested to the Register of Interests.	
GBP/2122/079	**Chair's Report – June 2021** AB provided a written report, a copy of which was circulated with the meeting papers; the report was taken as read and the following questions were raised: • The abuse being received by General Practice staff is completely unacceptable; it was asked if there is anything further that the Communications Team could do to help to highlight and prevent this. AB confirmed that the Communications Team is fully aware of the issue; it is hoped that by including it in today's report people will become more cognisant of the situation faced by General Practice staff. Clarity is required around acceptable behaviours on a national basis. There is a zero tolerance against the abuse of all NHS staff. It was suggested that the national Communications Team could pick this issue up. • The work being undertaken by General Practices on the vaccination programme was highlighted. Practice Teams have spent what amounts to hundreds of hours booking patients into the vaccination centres and following them up. The public needs to be made aware of the pathway in place behind the scenes which enables patients to be safely vaccinated. This work is being undertaken in addition to a 10% increase in activity levels. Staff have done a fantastic job coping with the pandemic whilst also doing their day-to-day activities and running the programme smoothly. It is about understanding on all sides. **The Governing Body NOTED the contents of the report provided**	**CT**
GBP/2122/080	**Chief Executive Officer's Report – June 2021** Dr Chris Clayton (CC) provided a written report, a copy of which was circulated with the meeting papers. The report was taken as read and the following points of note were made: • The report also highlights General Practice abuse and the efforts made locally to diffuse tensions. The current challenges across the whole NHS health and care sector are well understood and continue to be worked through. • This report was written over a week ago, and there have been many new developments over the past few days.	

	• When the report was written the 'Vaccination Super Weekend' was about to commence; this was a great success across Derbyshire, which continues to remain on track with its vaccination programme. The vaccination of the younger adult population is now a key priority. • The Integrated Care System (ICS) design framework has now been published by NHSEI; this Framework seeks to join up health and care services and embed lessons learned from the pandemic. The views of the new Secretary of State for Health are awaited, as is his ongoing response to the pandemic and agreement to the ICS in statute. • Section 2 of the report provided examples of the meetings attended by the CEO on behalf of the CCG, ICS and the System as a whole. • Section 3 of the report outlined the national developments, programmes and initiatives recently launched. • Section 4 of the report described local developments. Of note was the public engagement event undertaken last week; Joined Up Care Derbyshire (JUCD) hosted a 'Derbyshire Dialogue' session which provided an opportunity for the public to find out more about plans for the future of health and care services in Derby and Derbyshire. CC thanked CCG Colleagues for the significant contribution they made to arranging this event. The Long Covid Clinic and capital developments at CRHFT were also highlighted. The following questions were raised: • To this point the development of the ICS Design Framework has largely been autonomous in local areas, which have been encouraged to get on with it. It was enquired if the ICS Framework is helpful or whether it is something that will limit what is already being done. CC responded that the Design Framework is the view of NHSEI ahead of the parliamentary review of the bill, which was meant to be this week but has now been delayed to allow the new Secretary of State time to review it prior to publication. There are some important principles in the Framework, many of which will continue as a direction of travel with or without statute; JUCD has now been running for many years with the aim of improving local health outcomes; the work to integrate care and improve outcomes needs to continue as planned. There are implications for the CCG mentioned in the Framework; the creation of the ICS body itself is subject to parliamentary approval. • Should the Secretary of State postpone the bill, it was thought that the drive towards better integration should not be postponed as measures have already been implemented to collaborate as a System in many areas. The Framework emphasises permissiveness and local flexibility, therefore if anything can be done to improve outcomes and benefit patients, that does not breach the running cost envelope, they need to be continued with or without statute. • It was noted that emergency department activity is increasing whilst calls to 111 are down by 20%; it was asked if anyone has looked at the reasoning behind this, and whether anything could be done by the Communications Team to rejuvenate 111. CC advised that some elements of 111 activity have increased, therefore caution is needed when interpreting this data, particularly over last 18 months. It is important to note that there has been an increase in 111 activity during daytime opening hours with a shift away from General Practice. Both 111 and 999 are receiving significant amounts of calls; call handling has been busier than normally expected in June. This data needs to be	

	brought together and no conclusions drawn until the total collective is available. Zara Jones (ZJ) confirmed that at the start of the pandemic there was a spike in calls to 111 linked to COVID-19 symptoms, with a further spike in September due to concerns of parents with children returning to school. Discussions have been held with EMAS on 111 and 999 activity and this is being carefully watched. The urgent care pathway is currently very busy with pressure in the System. Emergency departments are seeing less patients than before the pandemic but more than this time last year. **The Governing Body NOTED the contents of the report provided**	
GBP/2122/081	**DHcFT Dormitory Eradication Capital project outline business case** Andy Harrison (AH) attended for this item ZJ advised that this report presents two Outline Business Cases (OBC) for the development of two 54 bedded adult acute mental health units by Derbyshire Healthcare NHS Foundation Trust (DHcFT). One located in the North of the County in the grounds of the Chesterfield Royal Hospital site in close proximity to the current Hartington Unit. The second will be in the grounds of the DHcFT Kingsway site in Derby. The Governing Body is requested to approve the content of the two letters of support to be sent to NHSEI for this Programme. There is a national and regulatory requirement to eliminate dormitory accommodation; DHcFT is currently an outliner in terms of this type of accommodation. The eradication of dormitories from the DHcFT estate is also a formal regulatory action by the Care Quality Commission (CQC). This is a 'must do' requirement which has a clear overall fit with the System Plan in terms of mental health improvement and delivery of the Long Term Plan. £80m funding for these developments has been secured, subject to approval of both the OBCs and Final Business Cases (FBC), from a NHSEI central funding allocation for Mental Health Dormitory Eradication. The funding conditions will require separate OBCs and FBCs for each scheme as any individual scheme over £50m requires Treasury approval. The timelines for the Programme are challenging, with a hard stop date of the 31st March 2024. There has been a full oversight into this Programme from a commissioning perspective including the Clinical and Lay Commissioning Committee, Quality and Performance Committee, Derbyshire Engagement Committee and the Mental Health Delivery Board which all supported the proposals. The proposals were reviewed at the JUCD Board on the 17th June 2021, where it was agreed to provide support for progression to the NHSEI gateway process. There are major benefits through developing the case based on quality of care and patient experience. The challenging position with out of area placements and the Derbyshire Psychiatric Intensive Care Unit (PICU) will also benefit as part of wider piece of work to be developed over the summer and presented separately to the Governing Body at the appropriate time. The new Mental Health Act legislative reforms put emphasis on purposeful safe admissions for therapeutic reasons to improve patient experience. The safety of patients in mental health services is a crucial concern. The NHS Long Term Plan committed to a new Mental Health Safety Improvement	

	Programme (MHSIP) which aims to tackle priority mental health safety issues: • Improving sexual safety • Reducing restrictive practices and violence for all our people • Reducing suicide and deliberate self-harm The demand and capacity modelling assumptions have been carefully considered; however, there is more work to do before the FBC stage. Assurance was provided that the assumptions are reasonable based on historical activity and transformational admission avoidance schemes. It was noted that, although the £80m capital build requirement will be provided centrally by NHSEI, there will be additional net revenue consequences of £5.4m per annum, relating to capital charges and premises costs. This will need to be funded through the Mental Health Minimum Investment Standard (MHMIS), leaving limited funding to support other mental health and learning disability Long Term Plan requirements and growth/cost pressures. This is fully known and owned through the System; however, the impact will not be seen until 2024/25 by which point it is anticipated that the Long Term Plan and transformation programme will be achieved, making services more efficient. Andy Harrison (AH) provided a presentation, a copy of which was circulated with the meeting papers. It was noted that the preferred option is for a new 54 bedded development on both the CRHFT Hartington Unit and Kingsway sites, and a refurbishment of the Radbourne Unit on the Royal Derby Hospital site. Engagement has been undertaken with the mental health service user forum from the outset; the Programme has been shaped by people with lived experience of mental health services. Stakeholder and public engagement is planned for July/August. The Chairs of the Derbyshire County and Derby City Overview and Scrutiny Committees have been briefed and are supportive. The Equality Impact Assessments have been completed and affordability assessments were provided for information. The impact summary concluded that the proposed developments offer the best design solution for a modern mental health facility for working age adults and best value for money for the local health economy. The following questions were raised: • It was enquired what the usual length of stay is in the dormitories. AH confirmed that it is currently 34 days but is being reduced to 32 days, to bring it in line with the national average. • It was queried if any of the support mechanisms found in the dormitory environment might get fractured when patients decant into single units. AH considered that it will be seen as a positive move that patients will have single rooms rather than being part of a 4 or 5 bedded ward with people they do not actually know. • As Co-Chair of the Commissioning for Individuals panel, Andrew Middleton (AM) sees this as good news. There has been frustration at not having facilities to offer to patients in the past, particularly with concerns about the quality of accommodation offered by some private providers. The sooner this Programme is implemented the better from	

	a patient experience perspective as it will create much needed capacity which will serve the local population for a long time to come. • The proposals are also being discussed by the System Finance and Estates Committee this afternoon. • It was enquired where the additional staff will be sourced from. AH confirmed that the Trust is looking at staffing levels and has introduced talent pipelines. Some Health Care Assistants have demonstrated their ability to become registered nurses and have commenced training; this training will deliver a cohort of registered nurses in 2 years' time which will provide a lead in time ready for when the new facilities become available. Additional staff will be recruited through the recruitment programme currently in place. The staffing situation is being closely monitored and any risks managed accordingly • It was asked if the capital costs were to overrun, how this will be mitigated against, and if there are any contingency funds available. AH confirmed that the programme aligns with the 6 pre-approved principal NHS contractors and that a maximum price will be identified prior to completion of the FBC; should the costs overshoot, this will be at the contractor's own risk. **The Governing Body:** • **NOTED the executive summary of the Outline Business Cases (OBC) relating to the provision of new acute mental health inpatient wards for a) Derby North and b) Derby South** • **REVIEWED the recommendations from the CCG sub committees of the Board** • **NOTED approval provided from JUCD Board** • **CONFIRMED support for the progress of the Business Cases through the HM Treasury Gateway** • **APPROVED the content of proposed draft letters of support** • **NOTED that the OBC relating to the proposed PICU build will be reviewed at future CCG Committees and Governing Body**	
GBP/2021/082	**Finance Report – Month 2** Richard Chapman (RCp) provided an update on the financial position as at Month 2. The following points of note were made: • All statutory targets have been met. • There is currently a £41k overspend but an increased budget is expected to ensure compliance. • There is a Year To Date (YTD) underspend of £487k**.** This position includes a £2.277m YTD and £6.550m Full year Outturn relating to COVID expenditure for the Hospital Discharge Programme expected to be reclaimed. It also includes an estimated amount of £0.478m YTD for the Elective Recovery Fund which is also expected to be reimbursed however this has not currently been validated. • In order to balance the Month 2 position, the CCG has committed £0.905m of the H1 £4.2m contingency, of which £0.478m has been phased into the YTD. • A breakeven position is expected both YTD and year-end outturn. • Mitigations have been made to reduce the Continuing Health Care (CHC) pressures which have arisen due to an increased number of fast-track referrals and subsequent expenditure. Brigid Stacey (BS)	

	explained that the way in which the appropriateness of referrals are assessed is to measure how may people are still alive after 3 months following referral; the point of fast-track referrals is to provide people with comfort in the last days of their lives. It was noted that the appropriateness levels have dropped from 75% to 35%. Action has been implemented and weekly meetings between the Quality, Finance and Business Intelligence teams have been reinstated. A response is now starting to be seen which BS is confident will bring it the position in line with expected activity. It was considered that this situation has resulted from the suspension of the framework during the COVID-19 pandemic which has produced poor practice which is now being addressed. • The JUCD YTD and forecast position was provided by organisation; this has been balanced for first 6 months of this financial year. **The Governing Body NOTED:** • **Allocations have been received for H1 at £1.014bn** • **The YTD reported underspend at Month 2 is £0.478m** • **Retrospective allocations expected for COVID-19 spend on the Hospital Discharge Programme is £2.777m** • **The Elective Recovery Fund has a YTD estimated £0.478m and H1 forecast of £1.87m which is expected to be reimbursed.** • **H1 is forecast to conclude with a £1.87m underspend**	
GBP/2122/083	**Finance Committee Assurance Report – June 2021** Andrew Middleton (AM) provided a verbal update following the Finance Committee meeting held on 24th June 2021. The following points of note were made: • The spike in CHC referrals received much attention; as well as assurance on the figures, what was doubly assuring was the skill and team expertise that already created being rejuvenated and starting to make an impact. This is a good example of creating a lasting structure which is called into play should there be a problem to solve. • Although it is good news on the balancing of H1, it would be remiss not to remind of the underlying efficiency gap. It was confirmed that a System Director of Efficiency has now been appointed which will help the System to develop its efficiency programme to achieve sustainability. The pandemic has helped to accelerate the effectiveness and positiveness of System collaboration. NHSEI has been fully appraised of the System challenge and a 3-year strategy has been agreed. RCp confirmed that a trajectory is currently being worked through. It is calculated that over a 3 year period there will be a need to exceed national efficiency targets by 1.5% per annum in order to bring it back in line. This is being worked through on a System basis. The following question was raised: • It was queried if there are any examples of hospitals previously having to make an additional efficiency saving of 1.5%. RCp stated that hospitals do have to make efficiency savings, however he is unsure if they have had to make 1.5% over the national efficiency requirements before. The focus is on the System position based on the resources	

	available and expenditure; now is the opportunity to deliver initiatives that have never been delivered before through the NHS. **The Governing Body NOTED the verbal update provided for assurance purposes**	
GBP/2122/084	**Clinical and Lay Commissioning Committee (CLCC) Assurance Report – June 2021** Dr Ruth Cooper (RC) provided an update following the CLCC meeting held on 10th June 2021. The report was taken as read and the following point of note was made: • Acupuncture – a decision was taken to not routinely commission acupuncture in Derbyshire for pain management, although the clinicians in attendance at the meeting expressed disappointment at this decision as they felt that good outcomes have been seen through the use of this intervention. Although the evidence does not support the use of acupuncture generally, clinicians highlighted the challenges of treating people with pain. There needs to be a wider review of Pain Management Services in both the North and South of the County. The Commissioning Team agreed to take comments back to the Delivery Board. **The Governing Body NOTED the contents of the report provided for assurance purposes**	
GBP/2122/085	**Derbyshire Engagement Committee Assurance Report – June 2021** Simon McCandlish (SM) provided an update following the Engagement Committee meeting held on 15th June 2021. The report was taken as read and the following points of note were made: The JUCD Communications and Engagement Strategy was approved by the JUCD Board in May. A plan is now in development to take forward the actions from the Strategy, the draft of which was shared with the Committee for assurance; it will return to a future Committee for review. Copies of the strategy are available upon request. • The Derbyshire Dialogue event was well attended. This led to a discussion of the need for all colleagues to have an appropriate forum to keep abreast of the ICS developments. • 'Britain Thinks' has been appointed to undertake independent research with patients who have accessed primary and emergency care, to understand their experiences and service choices, along with discussing similar perceptions with patients who have not recently accessed care to enable comparisons to be made. This work will be undertaken in July and will support both the ongoing GP access and winter communications and engagement planning and campaigns. The following questions were raised: • The Overview and Scrutiny Committees (OSC) have changed membership due to recent elections; it was asked if an invitation has been extended to the new members to provide them with a better understanding of some of the current pertinent issues in order to enhance their knowledge. SM confirmed that an engagement session is planned for 7th July which will provide information on the overall ICS	

	strategy; other sessions are also planned. A meetings' programme will be available shortly and will be included in next month's assurance report for information. • The achievement of 325 people attending the Derbyshire Dialogue is phenomenal and is all thanks to Microsoft Teams (MST) which addresses this specific demographic. It was asked if thought is being given to addressing other demographics that may not be receptive to this approach. There is opportunity to build on this success. • CC commented that engagement on the scale of the Derbyshire Dialogue would not have been possible prior to the use of MST. Although this may not be the right platform for everybody, he assured that colleagues are thinking about the different platforms available. There has been a significant amount of learning from the COVID vaccination programme and CC is confident that MST has added another string to the engagement bow. • On the statutory side, the CCG remains in a transition period. The Engagement Committee has worked hard to understand the statutory duties of the CCG and ICS. A session with Local Authority Leaders and Lead Officers is scheduled shortly to discuss what the formal move into an ICS will mean. CC will continue to attend both the City and County OSC meetings as required. **The Governing Body NOTED the contents of the report provided for assurance purposes**	
GBP/2122/086	**Primary Care Commissioning Committee (PCCC) Assurance Report – June 2021** Simon McCandlish (SM) provided a verbal update following the PCCC meeting in public held on 23rd June 2021. The following points of note were made: • The actions from the Restoration and Recovery Plan have either now been completed and closed or implemented as business as usual. • A paper was received on cyber resilience and the proposed changes. General Practice is to become part of the new system in terms of trialling the new software. It was suggested that this paper be circulated to Governing Body GPs in order to ensure Primary Care engagement. • Risk 30, relating to the risk of fraud and cybercrime, assigned to the PCCC, was reduced from a 12 to a 9 due to the progress made. **The Governing Body NOTED the verbal update provided for assurance purposes**	
GBP/2122/087	**Quality and Performance Committee (Q&PC) Assurance Report – June 2021** Dr Buk Dhadda (BD) provided an update following the Q&PC meeting held on 24th June 2021. The report was taken as read and the following points of note were made: • A deep dive will be undertaken into cancer performance at both Acute Trusts at the next Q&PC meeting with representatives attending from both UHDBFT and CRHFT to present their plans to restore cancer performance to pre-pandemic levels.	

	• Risk 24, relating to patients deferring seeking medical advice for non-covid reasons has been decreased in score • Risk 38, relating to Continuing Health Care (CHC) services, has been added as a new risk. **The Governing Body NOTED the key performance and quality highlights and the actions taken to mitigate the risks**	
GBP/2122/088	**Governing Body Assurance Report – Quarter 1 2021-22** Chrissy Tucker (CT) presented the Governing Body Assurance Framework for Quarter 1 2021/22 for agreement of the strategic risks included therein. The strategic objectives, which were agreed by the Governing Body in May, were detailed in the paper provided. The majority of the 2020/21 strategic risks remain for 2021/22, however three new strategic risks were identified as follows: Strategic Risk 6: The CCG does not achieve the national requirements for the Covid-19 Vaccination Programme and have robust operational models in place for the continuous sustainable delivery of the Vaccination Programme. The responsible Committee is the Quality and Performance Committee. Strategic Risk 7: CCG staff retention and morale during the transition will be adversely impacted due to uncertainty of process and implications of the transfer to the ICS, despite the NHSEI continuity of employment promise. The responsible Committee is the Governance Committee. Strategic Risk 8: If the CCG is not ready to transfer its functions or has failed to comprehensively and legally closedown the organisation, or if the System is not ready to receive the functions of the CCG, the ICS operating model cannot be fully established. The responsible Committee is the Governance Committee. The responsible Corporate Committees have scrutinised and approved their respective GBAF Strategic Risks at the Committee meetings held during April to June 2021. **The Governing Body AGREED the 2021/22 Quarter 1 (April to June 2021) Governing Body Assurance Framework**	
GBP/2122/089	**CCG Risk Register – June 2021** This report highlights areas of organisational risk recorded in DDCCG's Corporate Risk Register as at 30th June 2021. All risks in the Risk Register are allocated to one of the CCG's Corporate Committees which reviews them on a monthly basis. CT advised that since the last meeting there has been a decrease in score for two of the risks and a new risk has been added relating to CHC services, as detailed below. Risk 29 has been closed as assurance was provided that mitigations are in place and regular meetings are being held with NECS. **The Governing Body RECEIVED and NOTED:** • **The Risk Register Report**	

	• **Appendix 1 as a reflection of the risks facing the organisation as at 30th June 2021**
	• **Appendix 2 which summarises the movement of all risks in June 2021**
	• **The decrease in score for two risks:**
	  ○ **Risk 24 relating to patients deferring seeking medical advice**
	  ○ **Risk 30 relating to the risk of fraud and cybercrime.**
	• **The new risk 38 relating to Individual Patient Activity /Continuing Health Care (CHC) services.**
	
	And APPROVED the closure of risk 29 relating to current contract management arrangements.	

GBP/2122/090	**Ratified Minutes of DDCCG's Corporate Committees:** • Engagement Committee – 18.5.2021 • Primary Care Commissioning Committee – 26.5.2021 • Quality and Performance Committee – 27.5.2021 **The Governing Body RECEIVED and NOTED these minutes**	
GBP/2122/091	**South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) CEO Report – June 2021** CC is responding to Sir Andrew Cash's letter following the discussion at the May Governing Body meeting and the JUCD Board in relation to the health and care developments in SYB and the work currently being undertaken to address the requirements of the ICS transition. A copy of the response will be circulated to the Governing Body members. **The Governing Body RECEIVED and NOTED the report**	**CC**
GBP/2122/092	**Minutes of the Governing Body meeting in public held on 3rd June 2021** **The minutes of the above meeting were agreed as a true and accurate reflection of the discussions held**	
GBP/2122/093	**Matters Arising / Action Log** GBP/2122/031 - Engagement with Lay Members – This is well underway through the establishment of the System Transition Assurance Sub-Committee's work. It was agreed that this action should be closed as it is a specific part of transition assurance role to bring expertise and engagement into that Committee. Item Closed. GBP/2122/034 – Response to South Yorkshire and Bassetlaw (SYB) ICS Development Update – discussed earlier in the meeting. Item Closed.	
GBP/2122/094	**Forward Planner** **The Governing Body NOTED the Planner for information purposes**	

GBP/2122/095	**Any Other Business** None raised	
DATE AND TIME OF NEXT MEETING - Thursday 5th August 2021 – 9.30am to 11.15am via Microsoft Teams		

Signed by: …….. Dated: ……
(Chair)

NHS
Derby and Derbyshire
Clinical Commissioning Group

GOVERNING BODY MEETING IN PUBLIC
ACTION SHEET – July 2021

Item No.	Item title	Lead	Action Required	Action Implemented	Due Date
2021/22 Actions					
GBP/2122/ 031	JUCD Board Update – April 2021	Dr Chris Clayton	It was considered that it would be prudent for JUCD to also engage with the CCG's Lay Members, Consideration will be given to the engagement of all Lay Members / Non-executive Directors across the system. CC agreed to pick this up.	This is now well underway through the establishment of the System Transition Assurance Sub-Committee's work. It was agreed that this action should be closed as it is a specific part of transition assurance role to bring Lay Member expertise and engagement into that Committee.	**Item Complete**
GBP/2122/ 034	South Yorkshire and Bassetlaw (SYB) ICS Development Update	Dr Chris Clayton	CC will take this discussion to the next JUCD Board on 20th May for further comment and respond on behalf of both organisations. A copy of the response will be shared with Governing Body members.	This item was discussed during the July meeting. A copy of the response was circulated to Governing Body members.	**Item Complete**
GBP/2122/ 054	Joined Up Care Derbyshire Board Update – May 2021	Helen Dillistone	It was requested that a Governing Body Development / Transition Session be planned to ensure that Governing Body members are sufficiently sighted on the measures being taken to address the health inequalities in Derbyshire; Dr Robyn Dewis and Dean Wallace will be requested to provide input into this session.	To be scheduled in for the October Session	October 2021

GBP/2122/ 079	Chair's Report – June 2021	Chrissy Tucker	The abuse being received by General Practice staff is completely unacceptable. It was suggested that the national Communications Team could pick this issue up.	The CCG Communications and Engagement Team continues to issue messages through various channels of the availability of general practice, the comparative increase in appointments offered by general practice since pre-pandemic times and the additional workload on practices in delivering the Covid-19 vaccination programme. A regionally developed communications toolkit has been developed to support practices with consistent messages on their websites about the way in which practices are working; this has been shared with practices and we are checking what support might be required to help embed this. We have issued messages around the treatment expected of patients when dealing with general practice and have facilitated the media activity referred to in the chairs report. We have commissioned research with BritainThinks to seek to understand behavioural drivers and perceptions of patients in accessing general practice, and the potential knock-on to urgent and emergency care activity, which will report in early August. We will continue to promote these messages in support of general practice.	**Item complete**
			The public needs to be made aware of the pathway in place behind the scenes which enables patients to be safely vaccinated.	Delivery of the vaccination programme in Derbyshire has been a system effort between general practice, our hospitals, community and pharmacy partners, our committed volunteers and members of staff from the CCG. These teams have been very effective in ensuring our population has amongst the highest vaccination coverage in England, with Derbyshire the first system in the Midlands region to achieve 85% coverage of the vaccination among adults and is a credit to the system effort and the effectiveness of practice-	**Item complete**

				based teams in coordination at community level. Additionally, the vaccination programme has been one strand of Derbyshire's overall response to COVID-19, very successfully led by our Local Resilience Forum and with significant joint working between the NHS, Local Authority and other public and private sector partners.	

NHS
Derby and Derbyshire
Clinical Commissioning Group

Derby and Derbyshire CCG Governing Body Forward Planner 2021/22

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

	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
AGENDA ITEM / ISSUE												
• Conflicts of Interest • Freedom of Information • Health & Safety • Human Resources • Information Governance • Procurement												
Audit Committee Assurance Report	X	X	X				X		X		X	
Engagement Committee Assurance Report	X	X	X	X	X	X	X	X	X	X	X	X
Clinical and Lay Commissioning Committee Assurance Report	X	X	X	X	X	X	X	X	X	X	X	X
Primary Care Commissioning Committee Assurance Report	X	X	X	X	X	X	X	X	X	X	X	X
Risk Register Exception Report	X	X	X	X	X	X	X	X	X	X	X	X
Governing Body Assurance Framework	X	X		X		X		X			X	
Strategic Risks and Strategic Objectives		X		X	X							
Annual Report and Accounts			X			X						
AGM						X						
Corporate Committees' Annual Reports					X							
Joined Up Care Derbyshire Board Update	X		X		X		X		X		X	
FOR INFORMATION												
Director of Public Health Annual Report											X	
Minutes of Corporate Committees												
Audit Committee	X	X	X				X		X		X	
Clinical & Lay Commissioning Committee	X	X	X	X	X	X	X	X	X	X	X	X
Engagement Committee	X	X	X	X	X	X	X	X		X	X	X
Finance Committee	X	X	X	X	X	X	X	X	X	X	X	X
Governance Committee			X		X		X		X		X	
Primary Care Commissioning Committee	X	X	X	X	X	X	X	X	X	X	X	X
Quality and Performance Committee	X	X	X	X	X	X	X	X	X	X	X	X

	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		X		X	
Minutes of Joined Up Care Derbyshire Board	X		X		X		X		X		X	
Minutes of the SY&B JCCCG meetings – public / private	X	X	X	X	X	X	X	X	X	X	X	X
MINUTES AND MATTERS ARISING FROM PREVIOUS MEETNGS												
Minutes of the Governing Body	X	X	X	X	X	X	X	X	X	X	X	X
Matters arising and Action log	X	X	X	X	X	X	X	X	X	X	X	X
Forward Plan	X	X	X	X	X	X	X	X	X	X	X	X
ANY OTHER BUSINESS												