

NHS DERBY AND DERBYSHIRE CCG

GOVERNING BODY – MEETING IN PUBLIC

Date & Time: Thursday 6th May 2021 – 9.30am to 11.00am

Via Microsoft Teams

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

Item	Subject	Paper	Presenter	Time
GBP/2122/026	Welcome, Apologies & Quoracy Apologies: Brigid Stacey	Verbal	Dr Avi Bhatia	9.30
GBP/2122/027	Questions from members of the public	Verbal	Dr Avi Bhatia	
GBP/2122/028	Declarations of Interest <ul style="list-style-type: none"> • Register of Interests • Summary register for recording any conflicts of interests during meetings • Glossary 	Papers	Dr Avi Bhatia	
CHAIR AND CHIEF OFFICER REPORTS				
GBP/2122/029	Chair's Report	Paper	Dr Avi Bhatia	9.35
GBP/2122/030	Chief Executive Officer's Report	Paper	Dr Chris Clayton	
GBP/2122/031	Joined Up Care Derbyshire Board Update	Paper	Dr Chris Clayton	
FOR DECISION				
GBP/2122/032	DDCCG Corporate Committees' Updated Terms of Reference	Paper	Helen Dillistone	9.50
FOR DISCUSSION				
GBP/2122/033	Financial Planning and Budget Setting 2021/22 Update	Paper	Richard Chapman	10.05

GBP/2122/034	South Yorkshire and Bassetlaw Integrated Care System ICS Development Update	Papers	Dr Chris Clayton	
CORPORATE ASSURANCE				
GBP/2122/035	Finance Report – Month 12	Paper	Richard Chapman	10.30
GBP/2122/036	Finance Committee Assurance Report – April 2021	Verbal	Andrew Middleton	
GBP/2122/037	Audit Committee Assurance Report – April 2021	Paper	Ian Gibbard	
GBP/2122/038	Clinical and Lay Commissioning Committee Assurance Report – April 2021	Paper	Dr Ruth Cooper	
GBP/2122/039	Primary Care Commissioning Committee Assurance Report – April 2021	Verbal	Professor Ian Shaw	
GBP/2122/040	Quality and Performance Committee Assurance Report – April 2021	Paper	Dr Buk Dhadda	
GBP/2122/041	CCG Risk Register – April 2021	Paper	Helen Dillistone	
FOR INFORMATION				
GBP/2122/042	Joined Up Care Derbyshire Board – Ratified Minutes – March 2021	Paper	Dr Chris Clayton	10.45
GBP/2122/043	Ratified Minutes of Corporate Committees: <ul style="list-style-type: none"> • Audit Committee – 18.3.2021 • Primary Care Commissioning Committee – 24.3.2021 • Quality and Performance Committee – 25.3.2021 	Papers	Committee Chairs	
GBP/2122/044	South Yorkshire and Bassetlaw Integrated Care System CEO Report – April 2021	Paper	Dr Chris Clayton	
MINUTES AND MATTERS ARISING FROM PREVIOUS MEETING				
GBP/2122/045	Minutes of the Governing Body Meeting in Public held on 1 st April 2021	Paper	Dr Avi Bhatia	10.55
GBP/2122/046	Matters arising from the minutes not elsewhere on agenda: <ul style="list-style-type: none"> • Action Log – April 2021 	Paper	Dr Avi Bhatia	
GBP/2122/047	Forward Planner	Paper	Dr Avi Bhatia	

GBP/2122/ 048	Any Other Business	Verbal	All	
--------------------------	---------------------------	---------------	------------	--

Date and time of next meeting: Thursday 3rd June 2021 from 9.30am to 11am – via Microsoft Teams

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

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

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

Cooper, Dr Ruth	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Finance Committee North East Derbyshire & Bolsover Place Alliance Group Derbyshire Primary Care Leadership Group CRHFT Clinical Quality Review Group GP Workforce Steering Group Conditions Specific Delivery Board	Locum GP at Staffa Health, Tibshelf Shareholder in North Eastern Derbyshire Healthcare Ltd Director of IS and RC Limited, providing medical services to Staffa Health and South Hardwick PCN, which includes the role of clinical lead for the Enhanced Health in Care Homes project Fundraising Activities through Staffa Health to support Ashgate Hospice and Blythe House	✓ ✓ ✓				Dec 2020 2015 03/02/2021 Ongoing	Ongoing Ongoing Ongoing Ongoing	Declare interests at relevant meetings and Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Dentith, Jill	Lay Member for Governance	Governing Body	Audit Committee Governance Committee Primary Care Commissioning Committee Remuneration Committee	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	✓ ✓				2012 6 Oct 2020	Ongoing 8 April 2021	Declare interests at relevant meetings
Dewis, Dr Robyn	Director of Public Health, Derby City Council	Governing Body	Clinical & Lay Commissioning Committee Clinical Policy Advisory Group Joint Area Prescribing Committee Conditions Specific Delivery Board CVD Delivery Group Derbyshire Place Board Derby City Place Alliance Group Respiratory Delivery Group	Nil							No action required
Dhadda, Dr Bukhtawar S	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Finance Committee Quality & Performance Committee UHDB Clinical Quality Review Group Clinical Policy Advisory Group	GP Partner at Swadlincote Surgery	✓				2015	Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Dillstone, Helen	Executive Director of Corporate Strategy & Delivery	Governing Body	Engagement Committee Governance Committee	Nil							No action required
Gibbard, Ian	Lay Member for Audit	Governing Body	Audit Committee Clinical & Lay Commissioning Committee Finance Committee Governance Committee Remuneration Committee Individual Funding Requests Panel	Nil							No action required
Jones, Zara	Executive Director of Commissioning & Operations	Governing Body	Clinical & Lay Commissioning Committee Quality & Performance Committee CRHFT Contract Management Board	Nil							No action required
Lloyd, Dr Steven	Medical Director	Governing Body	CVD Delivery Group Clinical & Lay Commissioning Committee Conditions Specific Delivery Board CRHFT Contract Management Board 999 Quality Assurance Group Derbyshire Prescribing Group Derbyshire System Flu Planning Cell Finance Committee Primary Care Commissioning Committee Quality & Performance Committee	GP Partner at St. Lawrence Road Surgery Clinical sessions at St. Lawrence Road Surgery Shareholder in premises of Emmett Carr Surgery, Renishaw; and St. Lawrence Road Surgery, North Wingfield	✓ ✓ ✓				2012 2012 Ongoing	Ongoing Ongoing Ongoing	Declare interests at relevant meetings
McCandlish, Simon	Lay Member for Patient and Public Involvement	Governing Body	Clinical & Lay Commissioning Committee Engagement Committee Primary Care Commissioning Committee Quality & Performance Committee Commissioning for Individuals Panel (Shared Chair)	Nil							No action required
Middleton, Andrew	Lay Member for Finance	Governing Body	Audit Committee Finance Committee Quality & Performance Committee Remuneration Committee Commissioning for Individuals Panel (Shared Chair) Derbyshire System Finance Oversight Group	Lay Vice Chair of East Riding of Yorkshire Clinical Commissioning Group Lay Chair of Performers List Decision Panels for NHS England Central Midlands Lay Chair of Appointment Advisory Committees at United Hospitals Leicester - chairing panels for appointing hospital consultants	✓ ✓ ✓				Jan 2017 May 2013 Mar 2020	Mar 2023 Ongoing Mar 2023	Declare interests at relevant meetings Will not sit on any case which has knowledge of the GP or their practice, or a consultant at Leicester
Pizzey, Dr Emma	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Governance Committee Quality & Performance Committee Erewash Place Alliance Group DCHS Clinical Quality Review Group	Partner at Littlewick Medical Centre Executive director Erewash Health Partnership Involvement with INR service	✓ ✓ ✓				Mar 2002 Apr 2018 1 Apr 2021	Ongoing Ongoing Ongoing	Declare interests at relevant meetings. The INR service interest is to be noted at Governance Committee due to the procurement highlight report, which refers to, for information only, the INR service re-procurement. No further action is necessary as no decisions will be made at this meeting and the information provided does not cause a conflict.
Shaw, Professor Ian	Lay Member for Primary Care Commissioning	Governing Body	Clinical & Lay Commissioning Committee Engagement Committee Primary Care Commissioning Committee Primary Care Enhanced Services Review Group	Professor at the University of Nottingham Subject Matter Expert and advisory panel member in relation to research and service development at the Department of Health and Social Care	✓		✓		1992 Jan 2020	Ongoing Jan 2021	Declare interests at relevant meetings

Stacey, Brigid	Chief Nurse Officer	Governing Body	Clinical & Lay Commissioning Committee Finance Committee Primary Care Commissioning Committee Quality & Performance Committee CRHFT Contract Management Board CRHFT Clinical Quality Review Group UHDB Contract Management Board UHDB Clinical Quality Review Group EMAS Quality Assurance Group Maternity Transformation Board (Chair)	Daughter is employed as a midwifery support worker at Burton Hospital				✓	Aug 2019	Ongoing	Declare interest at relevant meetings
Strachan, Dr Alexander Gregory	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Governance Committee Quality & Performance Committee CRHFT Clinical Quality Review Group	GP Partner at Killamarsh Medical Practice Member of North East Derbyshire Federation Adult and Children Safeguarding Lead at Killamarsh Medical Practice Member of North East Derbyshire Primary Care Network Director of Killamarsh Pharmacy LLP - I do not run the pharmacy business, but rent out the building to a pharmacist Involvement with INR service	✓ ✓ ✓ ✓ ✓	✓			2009 2016 2009 18.03.20 2015 1 April 2021	Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair INR service interest is to be noted at Governance Committee due to the procurement highlight report, which refers to, for information only, the INR service reprocurement. No further action is necessary as no decisions will be made at this meeting and the information provided does not cause a conflict.
Wallace, Dean	Director of Public Health, Derbyshire County Council	Governing Body	Derbyshire Place Board	Nil							No action required
Watkins, Dr Meryl	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Quality & Performance Committee	GP Partner at Vernon Street Medical Centre Husband is Anaesthetic and Chronic Pain Consultant at Royal Derby Hospital	✓			✓	2008 1992	Ongoing Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Whittle, Martin	Lay Member for Patient and Public Involvement	Governing Body	Engagement Committee Finance Committee Governance Committee Quality & Performance Committee Remuneration Committee	Nil							No action required

SUMMARY REGISTER FOR RECORDING ANY INTERESTS DURING MEETINGS

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

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

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

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

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

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

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

Governing Body Meeting in Public

6th May 2021

Item No: 029

Report Title	Chair's Report – May 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					
<p>Our Governing Body meetings provide us with a measure of progress with our ongoing fight against the pandemic. Looking back to last month, I referenced the forthcoming lifting of lockdown, 500,000 vaccinations delivered and our issues with the challenges to the future of the AstraZeneca vaccine. This month we have seen the first stage of the lifting of lockdown apparently working well, around 800,000 vaccinations delivered and a move to maintain confidence in the AstraZeneca vaccine.</p> <p>From the darkest days of the second wave and long periods of lockdown, there is a sense of positive change as we carefully resume activities which we have been unable to do along with the added benefit of warm and sunny weather. From a clinical perspective, our system has been looking closely at non-Covid issues, particularly restoration and recovery. From a clinical perspective, colleagues in primary and secondary care are working to balance our efforts and resources across these priorities, recognising that the vaccination programme is vitally important and particularly with the real and present danger of a third wave later in the year.</p> <p>The last month saw an important milestone for primary care in the context of the vaccination programme. Our Primary Care Networks (PCNs) had to make a decision on whether delivering our core GP services together with a longer-term commitment to delivering vaccinations to cohorts 10 to 12 of the vaccination programme would be sustainable. I am delighted to say that all but one of our PCNs opted to continue and we fully understand and respect the decision of our colleagues in Swadlincote to decline the option. The level of collaboration across our system meant that this potential gap was immediately filled by Derby City PCN, with options to deliver pop-up vaccination sites and additional community pharmacy sites if they are needed.</p>					

April has also seen the second dose programme move forward confidently despite vaccine supply issues, the roll-out to Cohort 10 (at the time of writing to those aged 44+ and the offer of vaccinations to the households of immuno-suppressed patients. Our work on vaccine hesitancy and inequality alongside system partners, community leaders and our wider networks has seen us deliver information sessions and vaccinations to seldom heard groups across our demographic. Examples include three pop-up vaccination sessions at the Pakistan Community Centre in Derby prior to Ramadan, outreach-based vaccinations for the homeless, information sessions to a range of groups, including the West Indian Centre in Derby. There are many others. There is a lot more to do, but we are seeing a significant increase in take-up in some of our communities where vaccine hesitancy has been a concern and we are grateful to our system partners for helping us to make these important developments happen.

As our system works together on the restoration and recovery of services whilst continuing to deliver the vaccination programme for the foreseeable future, supporting our patients to access the health and care services most appropriate for their needs is really important. Maximising our available resources and supporting our staff is vital as they as they work to provide the best care they can and we all have a part to play in this.

My overwhelming message to everyone is, if you have symptoms that concern you and may indicate a serious condition, please seek help immediately. If you have less serious symptoms, please think carefully before automatically calling your GP. Self-care is a good starting point, but if you feel that you need medical advice you can call NHS 111, and local pharmacists are a great way to access advice and treatment. If you feel that you need advice from your GP, they may offer you a remote consultation subject to your symptoms. Please do remember that Urgent Treatment Centres are for urgent conditions and A&E is for life-threatening conditions only. Please share this message with those around you and thank you for helping us to help you.

As always, please do stay safe.

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

None

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

N/A

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

N/A

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

N/A

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

N/A

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
N/A
Have any Conflicts of Interest been identified/actions taken?
None
Governing Body Assurance Framework
N/A
Identification of Key Risks
N/A

Governing Body Meeting in Public

6th May 2021

Item No: 030

Report Title	Chief Executive Officer's Report – May 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					
<p>April has seen a significant shift in terms of the pandemic as the sharp fall in Covid-19 incidences continued alongside the ongoing momentum of the vaccination programme. As always, there can never be room for complacency in our current scenario, but these positive developments alongside the progressive lifting of lockdown offer us a real sense of optimism.</p> <p>Our system performed well over the Easter break and the additional pressures that public holidays inevitably bring were managed effectively across all service lines. The Easter weekend was busy for the vaccination programme, with over 12,000 vaccinations delivered by the Derby Arena Local Vaccination Service (PCN) alone.</p> <p>On 9 April we welcomed Sir Simon Stevens, Chief Executive of the NHS, to the Derby Arena Local Vaccination Service site. This is the Primary Care Network-led part of the operation, which operates alongside the Vaccination Centre led by Derbyshire Community Healthcare Services. Sir Simon was keen to see the Derbyshire model, which is a great example of collaborative working and was the busiest site at that scale in the country during early April. The visit coincided with the sad passing of Prince Philip, and we adopted the NHS national position of essential proactive communications only in conjunction with condolences messages.</p> <p>Last month also saw us progress to the next stage of our journey towards becoming an Integrated Care System, with clear priorities and actions emerging for the CCG and the system over the coming weeks and months. The Joined Up Care Derbyshire board meetings have a critical role in our system development and our April meeting included a sharp focus on system priorities.</p> <p>Conveying the messages that emerge from our system governing bodies and boards is increasingly important in ensuring that we move forward together. Current</p>					

information shared in a timely manner with our public, patients, system colleagues, partners and stakeholders is vital. Speaking for the system, we have a shared commitment to deliver on this.

Key messages from the Joined Up Care Derbyshire Board for this month include our developing roadmap as part of the journey to becoming an ICS and key milestones such as the importance of forging of strong links with Health and Wellbeing Boards. Provider collaboration is a critical success factor both at scale and place level.

Alongside these, we must factor in our most immediate challenges, such as the new planning guidance, recovery of waiting lists and finance. These are in conjunction with the challenges of reducing demands for Covid-19 related services whilst being extremely mindful of staff welfare and absence and the real risk of a third wave of Covid-19 later in the year.

Our challenges are multi-dimensional and complex with some factors that we cannot always directly control, but it is so important that we bring people with us on our journey. Sharing information, developments, challenges, our successes and also our learning will be a key feature of the coming months. Our challenge is to share these different aspects in context for people so that it resonates with you as a patient, a member of staff or as a partner with a specific interest.

We have an increasing range of system communications channels which we have developed over recent months, and the pandemic has helped us to think differently and innovatively in terms of reaching our audiences. I regularly make reference to these in my reports and I am delighted to say that we continue to see increased uptake for the expanding programme of virtual sessions covering a range of current issues. As an example, our most recent Derbyshire Dialogue session on the vaccination programme attracted over 70 acceptances. We continue to meet virtually with our MPs every two weeks and also meet regularly with councillor colleagues and other local politicians. These will remain an important priority for us.

We have significantly expanded our reach into community groups over recent months, and we are grateful to community leaders and other partners for inviting us to join their regular sessions. As part of our joint approach and the benefits that collaboration will offer, I see our ability to interact and engage with our public, patients, partners and stakeholders going from strength to strength. Whilst the restrictions to date have resulted in everything being virtual, I hope that we will be able to revisit face-to-face arrangements at some point, but this will only be when it is safe and we are allowed to do so.

Finally, as always, I want to formally acknowledge the incredible efforts of colleagues across the system and thank you for your commitment, fortitude and resilience in an incredibly difficult year. Thank you too to our public and patients for your support in our endeavours and, as always, please stay safe.

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

Gold Command Vaccine Update	CG/DCHS	Three per week
Integrated Commissioning Operating Model	CCG/System/NHSE	Ad Hoc
Team Talk	All staff	Weekly

3.0 National developments, research and reports

3.1 JCVI issues new advice on Covid-19 vaccination for pregnant women

The JCVI has advised that pregnant women should be offered the COVID-19 vaccine at the same time as the rest of the population, based on their age and clinical risk group. See more [here](#)

3.2 “Nightingale” effect for NHS recruitment

The NHS has boosted support for patients, their families and staff by recruiting 10,000 healthcare support workers (HCSWs) in the first three months of the year. The new staff will support the workforce and assist nurses, midwives and other healthcare professionals to perform health checks, update patient records, help patients wash, dress and move around. See more [here](#)

3.3 Ramadan and the Covid-19 vaccination

Two leading Muslim figures working in the NHS joined other medical leaders and Islamic scholars in stressing that Ramadan should not stop anyone from getting the COVID-19 vaccination. Getting the jab does not break the fast observed by Muslims during daylight hours over Ramadan. See more [here](#)

3.4 Facebook campaign to prevent Diabetes in men 40 and over

The NHS is using Facebook to reach millions of men aged 40 and over who are at risk of developing Type 2 diabetes, to help them to change their lifestyle and avoid the condition. See more [here](#)

3.5 Government launches COVID-19 Antivirals Taskforce to roll out innovative home treatments this autumn

The Antivirals Taskforce will identify treatments for UK patients who have been exposed to Covid-19 to stop the infection spreading and speed up recovery time. See more [here](#)

3.6 Stopping the spread of Coronavirus

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

3.7 National campaign to encourage people to follow guidance

The national campaign featuring hospital staff and COVID-19 patients is designed to remind the public of the extreme pressures still facing the NHS. Find more about the campaign [here](#)

4.0 Local developments

4.1 People should call 111 if experiencing worsening vaccine side effects

Dr Susie Bayley talked with Radio Derby's Ian Skye about the pressures on GPs, especially around the vaccination programme and concerns from patients about vaccine side effects.

4.2 Latest vaccination statistics

Since 21 January, NHS England and Improvement has published data on the vaccination programme at system level [here](#).

4.3 Find out more about the vaccination programme and regular bulletins

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

4.4 Media update

We continue to see extensive media coverage of the vaccination programme. You can see examples of recent news releases on the vaccination programme and other issue [here](#)

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

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

4.6 Pop-up clinics at Pakistan Community Centre

A series of pop-up clinics at the Pakistan Community Centre continued the good work to reach out to local communities. The centre is expecting to hold more clinics after Ramadan has ended. You can [read more about it here](#).

4.7 Derby leads the way with vaccination clinic for homeless people

Derby city GPs worked with partners in several organisations to set up vaccination clinics for homeless people. The initiative was widely praised and anticipated the addition of homeless people to the JCVI's list of those considered “at risk” of Covid infection and therefore prioritised for vaccination. [Read more here](#).

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

Not Applicable

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

Not Applicable

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

Not Applicable

Has an Equality Impact Assessment (EIA) been completed? What were the findings?
Not Applicable
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
Not Applicable
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Not Applicable
Have any Conflicts of Interest been identified/ actions taken?
None Identified
Governing Body Assurance Framework
Not Applicable
Identification of Key Risks
Not Applicable

Governing Body Meeting in Public

6th May 2021

		Item No: 031
Report Title	Joined Up Care Derbyshire (JUCD) Board Update – April 2021	
Author(s)	Dr Chris Clayton, Executive Lead JUCD	
Sponsor (Director)	Dr Chris Clayton, Executive Lead JUCD	

Paper for:	Decision	Assurance	Discussion	Information	x
Assurance Report Signed off by Chair			N/A		
Which committee has the subject matter been through?			JUCD Board – 15.4.2021		
Recommendations					
The Governing Body is requested to NOTE the report.					
Report Summary					
Linking with Health and Wellbeing Boards, towards a statutory Integrated Care System					
<p>The Board welcomed Cllr Carol Hart and Cllr Roy Webb as representatives of the aligned Derby and Derbyshire Health and Wellbeing Boards, to reflect the further collaboration on agendas between those Boards and the Integrated Care System (ICS), in line with the merging policy direction in the Health and Care Bill. Our development plan towards proposed statutory ICS status continues, reinforcing partnership working and understanding how the likely NHS ICS Board and Partnership Board will operate, and setting out a clear business plan and roadmap that the Board will follow to track progress. Works continues in earnest on the pillars of our development: the outline of our strategic intent; provider collaboration at scale; provider collaboration at place; and the JUCD role as an anchor institution.</p>					
Current System Position					
<p>Covid-19 cases continue to decline across Derby and Derbyshire. The number of daily GP appointments related to Covid-19 is currently at 72% of the peak volume seen in late April 2020, whilst the overall bed base occupied by confirmed Covid-19 patients is also improving. This stands at less than 2% across both Chesterfield Royal Hospital and University Hospitals of Derby and Burton, and 0% in Derbyshire Community Health Services and Derbyshire Healthcare). The Derbyshire system also continues to make good progress in delivering the rollout of the Covid-19 Vaccination Programme, with an average of 92% coverage for the over 60 year old age groups.</p>					

Whilst welcoming the further lifting of lockdown measures, the risk of a further wave and the impact of these changes will be monitored closely over the coming months. Staff welfare and staff absence levels remain concerning with 39% of hospital staff absences related to Covid-19. In addition, it is clear that the impact of the pandemic on the people of Derby and Derbyshire has been extensive and will continue to impact in future years, and we are working to understand how we can quantify this and plan for the recovery of waiting lists for operations and other services.

Understanding our priorities and finances

The planning guidance for 2021/22 was published in March and sets out the requirements of systems over the coming year, identifying the following key areas of focus for the first half of 2021/22:

- Supporting the health and wellbeing of staff and taking action on recruitment and retention
- Delivering the NHS COVID vaccination programme and continuing to meet the needs of patients with Covid-19
- Building on what we have learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care and manage the increasing demand on mental health services
- Expanding primary care capacity to improve access, local health outcomes and address health inequalities
- Transforming community and urgent and emergency care to prevent inappropriate attendance at emergency departments (ED), improve timely admission to hospital for ED patients and reduce length of stay
- Working collaboratively across systems to deliver on these priorities

Important to our planning is creating a common understanding of the system financial position, given that we know there continues to be a significant underlying system financial pressure. The first six months of the year will operate under the existing pandemic funding regime, where costs pressures have been absorbed in support of delivering a pandemic response. From October, we will likely revert to traditional financial management and must understand where the system will stand financially at that time, and what we need to do about it in line with our transformation programme. Partners were clear that there must be a collective understanding of the root of the underlying financial challenge, and that it is a symptom of a broader issue and not the problem itself. The need to recover services whilst at the same time supporting staff who have worked tirelessly to tackle the pandemic for more than a year must be the context in which we understand how we balance the books.

Broadening the input of Governors

Our foundation trust governors have a very important role in holding Boards to account. The Derbyshire system recognises that the skills and knowledge of our governors can support the development of our transformation programme, especially in our communities at Place level. Discussion on this important step will continue with Governors to ensure that their primary assurance role is not compromised, and that Governors are supported appropriately to get involved where desired.

The next Board Meeting in public will be held on Thursday, 20th May at 9am.

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

Governing Body Meeting in Public

6th May 2021

Item No: 032

Report Title	DDCCG Corporate Committees' 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?			Audit Committee - 18.3.2021 Clinical & Lay Commissioning Committee - 8.4.2021 Engagement Committee - 16.3.2021 Finance Committee - 25.3.2021 Governance Committee - 10.3.2021 Quality & Performance Committee - 25.3.2021		
Recommendations					
The Governing Body is requested to APPROVE the Corporate Committee Terms of References.					
Report Summary					
<p>As part of the Governing Body's six month review of all Committee Terms of Reference, the following Terms of Reference have been reviewed and agreed by their respective Committee, and any amendments are shown in red font within the document.</p> <p>The following Corporate Committee Terms of References are presented for approval:</p> <ul style="list-style-type: none"> • Audit Committee • Clinical and Lay Commissioning Committee; • Engagement Committee; • Finance Committee • Governance Committee; • Quality and Performance Committee. <p>The Primary Care Commissioning Committee Terms of Reference are being reviewed by the Committee in May 2021 and will therefore be presented to Governing Body in June 2021.</p>					

Are there any Resource Implications (including Financial, Staffing etc)?
None identified
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?
Not applicable
Has a Quality Impact Assessment (QIA) been completed? What were the findings?
Not applicable
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
Not applicable
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
Not applicable
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Not applicable
Have any Conflicts of Interest been identified / actions taken?
None identified
Governing Body Assurance Framework
Not applicable
Identification of Key Risks
Not applicable

NHS Derby and Derbyshire Clinical Commissioning Group

Committee Terms of Reference

CONTENTS

	Page
Audit Committee	29
Clinical and Lay Commissioning Committee	37
Finance Committee	42
Governance Committee	47
Derbyshire Engagement Committee	52
Quality & Performance Committee	58

Audit Committee

Terms of Reference

1. PURPOSE

- 1.1 The Governing Body of Derby and Derbyshire CCG (the “CCG”) has established a committee of the Governing Body to be known as the Audit Committee (the “Committee”). The Committee has no executive powers, other than those specifically delegated in these terms of reference.
- 1.2 The Committee is established in accordance with the CCG’s constitution and Schedule 1A of the National Health Service Act 2006 (as amended) (the “NHS Act”). These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the Committee and shall have effect as if incorporated into the constitution.

2. ROLES AND RESPONSIBILITIES

- 2.1 The Committee will incorporate the following duties:

- 2.1.1. Integrated governance, risk management and internal control

The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the CCG’s activities that support the achievement of the CCG’s objectives. Its work will dovetail with that of the Quality and Performance Committee which the CCG has established to seek assurance that robust clinical quality is in place.

In particular, the Committee will review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the governance statement), together with any appropriate independent assurances, prior to endorsement by the CCG;
- the underlying assurance processes that indicate the degree of achievement of the CCG’s objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification; and
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.

In carrying out this work the Committee will agree an annual audit plan and primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness. This will be evidenced through the Committee's use of an effective assurance framework to guide its work and that of the audit and assurance functions that report to it.

2.1.2 Internal Audit

The Committee shall ensure that there is an effective internal audit function that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Committee, Accountable Officer and CCG. This will be achieved by:

- consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal;
- review and approval of the internal audit strategy, operational plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation, as identified in the assurance framework;
- considering the major findings of internal audit work (and management's response) and ensuring co-ordination between the Internal and External Auditors to optimise audit resources;
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the CCG;
- an annual review of the effectiveness of internal audit.

2.1.3 External Audit

The Committee shall review the work and findings of the External Auditors and consider the implications and responses by officers of the CCG to their work. This will be achieved by:

- consideration of the performance of the External Auditors, as far as the rules governing the appointment permit;
- discussion and agreement with the External Auditors, before the audit commences, on the nature and scope of the audit as set out in the annual plan, and ensuring coordination, as appropriate, with other external auditors in the local health economy;
- discussion with the External Auditors of their local evaluation of audit risks and assessment of the CCG and associated impact on the audit fee;
- review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the CCG and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

2.1.4. Other assurance functions

The Committee shall review the findings of other significant assurance functions, both internal and external and consider the implications for the governance of the CCG. These will include, but will not be limited to any reviews by Department of Health arm's length bodies or regulators/inspectors (for example, the Care Quality Commission and NHS Resolution) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges and accreditation bodies).

2.1.5. Counter fraud

The Committee shall satisfy itself that the CCG has adequate arrangements in place for countering fraud and shall review the outcomes of counter fraud work. It shall also approve the counter fraud work programme.

2.1.6. Management

The Committee shall request and review reports and positive assurances from directors and officers of the CCG on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the CCG as they may be appropriate to the overall arrangements.

2.1.7. Financial reporting

The Committee shall monitor the integrity of the financial statements of the CCG and any formal announcements relating to the CCG's financial performance.

The Committee shall ensure that the systems for financial reporting to the CCG, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the CCG.

The Committee shall review and approve the annual report and financial statements on behalf of the Governing Body and the CCG, focusing particularly on:

- the wording in the governance statement and other disclosures relevant to the terms of reference of the Committee;
- changes in, and compliance with, accounting policies, practices and estimation techniques;
- unadjusted mis-statements in the financial statements;
- significant judgements in preparing of the financial statements;
- significant adjustments resulting from the audit;
- letter of representation; and
- qualitative aspects of financial reporting.

2.1.8. Whistleblowing

The Committee shall review the effectiveness of arrangements in place for allowing staff to raise concerns (in confidence) about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

2.1.9. Conflicts of Interest

The Committee shall receive reports in respect of any Conflicts of Interest breaches. The Committee shall review the impact and actions taken.

3. CHAIR ARRANGEMENTS

The CCG Governing Body shall appoint the Chair of the Committee from its Lay or Independent members. The Chair shall have the lead independent role in overseeing audit in the CCG. In the event that the Chair is unavailable to attend, a Lay Member of the Committee will deputise and Chair the meeting.

4. MEMBERSHIP

4.1 Members of the Committee shall be appointed by the CCG Governing Body. Good practice recommends at least three Lay Members.

4.2 Membership will comprise:

- Governing Body Lay Member with responsibility for Audit
- Governing Body Lay Member with responsibility for Finance
- Governing Body Lay Member with responsibility for Governance
- Secondary Care Doctor ('by invitation' in accordance with the Committee's workplan or where clinical input is required)

The Chair of the Governing Body, the Accountable Officer and the Chief Finance Officer shall not be members of the Audit Committee and will be invited to attend.

5. DECLARATIONS OF INTEREST, CONFLICTS AND POTENTIAL CONFLICTS

5.1 The provisions of Managing Conflicts of Interest: Statutory Guidance for CCGs¹ or any successor document will apply at all times.

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.

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

- 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.

6. QUORACY

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

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. 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

The Committee is authorised by the Governing Body to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Governing Body to obtain outside legal or other independent professional advice and secure the attendance of external personnel with relevant experience and expertise if it considers this necessary.

9. REPORTING ARRANGEMENTS

- 9.1 The Committee shall report to the Governing Body on how it discharges its responsibilities. The minutes of the Committee's meetings shall be formally recorded by the secretary and submitted to the Governing Body. The Chair of the Committee shall draw to the attention of the Governing Body any issues that require disclosure to the full Governing Body, or that require executive action.
- 9.2 The Committee will report to the Governing Body at least annually on its work in support of the annual governance statement, specifically commenting on the:
- fitness for purpose of the assurance framework;
 - completeness and 'embeddedness' of risk management in the organisation;
 - integration of governance arrangements;
 - appropriateness of the evidence that shows the organisation is fulfilling regulatory requirements relating to its existence as a functioning business;
 - robustness of the processes behind the quality accounts.
- 9.3 The annual report should also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the Committee has considered in relation to the financial statements and how they were addressed.

10. ATTENDANCE AT MEETINGS

The Chief Finance Officer and appropriate Internal and External Audit representatives shall normally attend meetings but shall not have voting rights. In addition, the following good practice will be followed:

- 10.1 at least once a year the Audit Committee should meet privately with the External and Internal Auditors;
- 10.2 representatives from NHS Counter Fraud Authority may be invited to attend meetings and will normally attend at least one meeting each year;
- 10.3 regardless of attendance, external audit, internal audit, local counter fraud and security management (NHS Counter Fraud Authority) providers will have full and unrestricted rights of access to the Committee;
- 10.4 the Accountable Officer will be invited to attend and discuss, at least annually with the Audit Committee, the process for assurance that supports the annual governance statement. He or she would also normally attend when the Audit Committee considers the draft internal audit plan and the annual accounts;
- 10.5 any other officers of the CCG who have responsibility for specific areas (or similar) may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director; and

- 10.6 the chair of the Governing Body may also be invited to attend one meeting each year in order to form a view on, and understanding of, the Audit Committee's operations.

11. FREQUENCY AND NOTICE OF MEETINGS

- 11.1 The Audit Committee must consider the frequency and timing of meetings needed to allow it to discharge all of its responsibilities. Meetings of the Committee shall be held at regular intervals, at such times and places that the CCG may determine, but not less than four times per year. The External Auditors or Head of Internal Audit may request a meeting if they consider that one is necessary. The Committee will agree an annual programme of meetings in advance to link with key business to be transacted. Papers will be issued at least five working days in advance of the meetings wherever possible.
- 11.2 The Chair of the Committee, Governing Body or Accountable Officer may call additional meetings as required, giving not less than 14 days' notice.

12. SUB-COMMITTEES

- 12.1 Committee may delegate responsibility for specific aspects of its duties to sub-committees or working groups. The Terms of Reference of each such sub-committee or working group shall be approved by the Committee and shall set out specific details of the areas of responsibility and authority.
- 12.2 Any sub-committees or working groups will report via their respective Chair's following each meeting or at an appropriate frequency as determined by the Committee.

13. ADMINISTRATIVE SUPPORT

The CCG's governance lead shall be secretary to the Committee and shall attend to provide appropriate support to the Chair and Audit Committee members. The secretary will be responsible for supporting the Chair in the management of the Audit Committee's business and for drawing the Audit 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.

14. REVIEW OF TERMS OF REFERENCE

These terms of reference and the effectiveness of the Committee will be reviewed at least annually or more frequently as 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 Audit Committee:

18th March 2021

Approved by Governing Body:

6th May 2021

Review Date:

September 2021

Clinical and Lay Commissioning Committee

Terms of Reference

1. PURPOSE

The purpose of the Clinical and Lay Commissioning Committee (the “Committee”) is to:

- 1.1 provide a clinical and lay forum within which discussions can take place to develop and implement the commissioning strategy and policy of NHS Derby and Derbyshire Clinical Commissioning Group (the "CCG") and to help secure the continuous improvement of the quality of services;
- 1.2 retain a focus on health inequalities, improved outcomes and quality and ensure that the delivery of the CCG's strategic and operational plans are achieved within financial allocations;
- 1.3 have delegated authority to make decisions within the limits as set out in the CCG's Schemes of Reservation and Delegation.

2. ROLES AND RESPONSIBILITIES

The Committee will incorporate the following duties:

- 2.1 support and advise on the development of the strategic commissioning plan;
- 2.2 develop and agree commissioning policy for the CCG, within the agreed financial envelope, (for example, the CCG's approach to access to services, treatment thresholds, interpretation of national policy etc.);
- 2.3 have clinical oversight of the savings programme and the responsibility for the approval of new savings Schemes;
- 2.4 act as the gateway of invest to save savings schemes to Governing Body;
- 2.5 consider full business cases for schemes detailed in the CCG's Financial Plan. The Committee will provide a clinical opinion and decision on schemes already contained within the annual Financial Plan. For schemes out with the Financial Plan, the Committee will provide a clinical opinion with the decision to be escalated to the Governing Body;
- 2.6 oversee, as part of the development of the Commissioning Plan, a prioritisation process for both investment and savings that supports the CCG in formulating the Savings Plan for the next financial year;
- 2.7 oversee the development of the Savings Plans and services as detailed in the CCG's Operational Plan, approving the appropriate business cases and mobilisation plans, subject to appropriate evidence being provided (with particular reference to statutory equality and engagement duties) to support the decisions made;

- 2.8 prioritise service investments/disinvestments arising from strategic and operational plans, underpinned by value based decisions and against available resources;
- 2.9 support the development of the CCG's annual commissioning intentions which identify to providers the service changes that the CCG wishes to negotiate in the forthcoming year;
- 2.10 ensure appropriate evaluation is in place for new and existing investments;
- 2.11 ensure all procurements are undertaken in accordance with national policy and legal requirements;
- 2.12 ensure the CCG appropriately identifies and addresses inequalities;
- 2.13 ensure commissioning decisions are underpinned and informed by communications and engagement with the membership and local population as appropriate;
- 2.14 review the risk register for its area of remit, considering the adequacy of the submissions and whether new risks need to be added or whether any risks require immediate escalation to the Governing Body;
- 2.15 ensure that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements;
- 2.16 review the adequacy and effectiveness of their responsible policies and procedures for ensuring compliance and related reporting;
- 2.17 review the Committee forward planner to assist with the Committee in discharging its duties effectively; and
- 2.18 oversight of the development of the CCG Recovery and Restoration Plan in relation to Health and Care delivery.

3. CHAIR ARRANGEMENTS

The Chair shall be a Governing Body GP nominated by the Committee from the membership of the Committee and endorsed by the CCG Chair. In the event that the Chair is unavailable to attend, the Vice Chair who shall be the Lay Member for Primary Care Commissioning will deputise and Chair the meeting.

4. MEMBERSHIP

- 4.1 Members of the Committee may be appointed from the Governing Body of the CCG, officers of the CCG or other external bodies as required to enable the Committee to fulfil its purpose.
- 4.2 The membership of the Committee will comprise of:
 - At least 3 x GPs (to include 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; and
- 1 x Executive Director of Commissioning Operations.

4.3 CCG Officer subject experts will be attendees at each meeting.

4.4 Committee members may nominate a suitable deputy when necessary and subject to the approval of the Chair of the Committee. All deputies should be fully briefed and the Committee secretariat informed of any agreement to deputise so that quoracy can be maintained.

4.5 The Committee may also request attendance by appropriate individuals to present relevant reports and/or advise the Committee.

5. DECLARATIONS OF INTEREST, CONFLICTS AND POTENTIAL CONFLICTS

5.1 The provisions of Managing Conflicts of Interest: Statutory Guidance for CCGs² or any successor document will apply at all times.

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 Vice Chair will act as Chair for the relevant part of the meeting (or another non-conflicted member of the meeting if the Vice Chair is also conflicted).

5.4 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 interest they will bring it to the attention of the Committee, and the Vice Chair will act as Chair for the relevant part of the meeting (or another non-conflicted member of the meeting if the Vice Chair is also conflicted).

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

5.6 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.

² <https://www.england.nhs.uk/wp-content/uploads/2017/06/revised-ccg-coi-guidance-jul-17.pdf>

- 5.7 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.

6. QUORACY

- 6.1 The quorum necessary for the transaction of business shall be six members, to include four Clinicians (can include the Chair), one Lay Member and one Executive Lead.
- 6.2 A duly convened meeting of the Committee at which quorum is present at the meeting, or are contactable by telephone conference call, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

7. 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 Vice Chair) may call a vote. Any member where there is a conflict of interest will be excluded from voting for the proposal where there is a conflict.
- 7.2 Only members of the Committee set out at paragraph 4.2 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. Minutes will be recorded for telephone conference and virtual meetings in accordance with the CCG's Corporate Governance Framework at Section 5.4.

8. ACCOUNTABILITY

The Committee is accountable to the CCG's Governing Body.

9. FREQUENCY AND NOTICE OF MEETINGS

Meetings will be held monthly, but may be called at any other such time as the Committee Chair may require. The agenda and supporting papers will be sent to all members at least five working days before the meeting either manually or electronically, whichever is appropriate at the time.

10. REPORTING ARRANGEMENTS

The Committee will report to the CCG's Governing Body following each meeting, confirming all decisions made. The report will include recommendations that are outside the delegated limits of the Committee and which require escalation to, and approval from the Governing Body, if not already approved by them.

11. SUB-COMMITTEES

- 11.1 The Committee may delegate responsibility for specific aspects of its duties to sub-committees or working groups. The Terms of Reference of such sub-committee or working group shall be approved by the Committee and shall set out specific details of the areas of responsibility and authority.
- 11.2 Any sub-committees or working groups will report via their respective Chairs following each meeting or at an appropriate frequency as determined by the Committee.

12. ADMINISTRATIVE SUPPORT

- 12.1 The CCG will provide appropriate administration resource to ensure meetings are fully supported and business is conducted efficiently and effectively.
- 12.2 The meetings will be clearly minuted with particular attention paid to noting the declaration and management of any potential or actual conflicts of interest.

13. REVIEW OF TERMS OF REFERENCE

These terms of reference and the effectiveness of the Committee will be reviewed at least annually or sooner if required.

Reviewed by Clinical and Lay Commissioning Committee: 8th April 2021

Approved by Governing Body: 6th May 2021

Review Date: September 2021

Finance Committee

Terms of Reference

1. PURPOSE

The purpose of the Finance Committee is to:

- 1.1 oversee delivery of the financial plan including the financial performance of the NHS Derby and Derbyshire Clinical Commissioning Group (the “CCG”) against financial targets, financial control targets and the annual commissioning plan, identifying where remedial action is needed, ensuring that action plans are put in place and delivery is monitored;
- 1.2 consider full business cases for material service change or efficiency schemes as required, where these do not fall within the Executive Team’s delegated limits as detailed in the CCG’s Constitution at Appendix 4 – Standing Financial Instructions – Financial Limits for Delegated Authority;
- 1.3 receive reports from the Executive Team and escalate risks to the Risk Register;
- 1.4 review, confirm and challenge the Efficiency programme managed by the Executive Team;
- 1.5 oversee achievement and receive assurance of delivery against the Financial Plan. The Committee can recommend to the Governing Body that the Financial Plan continues; changes or stops; and
- 1.6 provide a framework which proactively manages the CCG’s Financial and Efficiency agenda and provides assurance in the delivery of all these areas to the CCG’s Governing Body.

2. ROLES AND RESPONSIBILITIES

The Committee will incorporate the following duties:

- 2.1 oversee and recommend to the Governing Body the annual financial plan that reflects the prioritised commissioning plan for the CCG;
- 2.2 oversee and gain assurance on the delivery of the Financial Plan ensuring that it provides the desired strategic outcomes for the CCG in accordance with the short and long term recovery plans approved by NHS England;
- 2.3 review, monitor and have oversight of finance in relation to the following areas:
 - 'In year' financial position – receiving a detailed report of the financial position, variances and progress towards meeting the targets within the CCG’s financial plan, statutory financial targets and financial control targets; and
 - implementation of the CCG’s Operational Plans;

- 2.4 to review exception reports on any material breaches of the delivery of agreed Savings Schemes including the adequacy of proposed remedial action plans;
- 2.5 to review exception reports on any material in-year overspends against delegated budgets, including the adequacy of proposed remedial action plans;
- 2.6 to have responsibility to the Governing Body for oversight and advice on the current risk exposures with regard to the short and long term financial plans and the associated recovery strategies;
- 2.7 identify resource allocation in relation to mitigation plans and risks identified within programmes as appropriate;
- 2.8 identify and allocate resources where appropriate to improve performance of identified schemes or ad-hoc finance and performance related issues that may arise;
- 2.9 review the risk register for its area of remit, considering the adequacy of the submissions and whether new risks need to be added or whether any risks require immediate escalation to the Governing Body;
- 2.10 investment or disinvestment decisions made by the Executive Team will be reported to the Finance Committee for them to discuss and to ensure they are in line with the Executive Team delegated limits for decision making; and hold the Executive Team to account;
- 2.11 have oversight of the CCG Recovery and Restoration work related to the Finance and Efficiency Pillar and will receive assurance regarding progress;
- 2.12 review the forward planner for the Committee to ensure preparatory work to meet national planning timelines are appropriately scheduled;
- 2.13 ensure that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements;
- 2.14 review the adequacy and effectiveness of their responsible policies and procedures for ensuring compliance and related reporting; and
- 2.15 to increase system working with our system partners to create a sustainable health and care system to deliver transformational change and refer system issues to the System Savings Group.

3. CHAIR ARRANGEMENTS

The Chair of the Committee shall be the Finance Lay Member (not the Audit Chair), nominated by the Accountable Officer and endorsed by the CCG Chair. In the event that the Chair is unavailable to attend, the Vice Chair, who shall be a Lay Member will deputise and Chair the meeting.

4. MEMBERSHIP

- 4.1 Members of the Committee may be appointed from the CCG's Governing Body, officers of the CCG or other external bodies as required to enable the Committee to fulfil its purpose.
- 4.2 The membership of the Committee will comprise:
- 2 x Governing Body GPs;
 - 3 x Governing Body Lay Members;
 - Chief Finance Officer: and
 - 1 x Clinical Representative (Chief Nurse Officer/Medical Director).
- 4.3 CCG Officer subject experts will be attendees at each meeting (i.e. Governance Lead).
- 4.4 Committee members may nominate a suitable deputy when necessary and subject to the approval of the Chair of the Committee. All deputies should be fully briefed and the Committee secretariat informed of any agreement to deputise so that quoracy can be maintained.
- 4.5 The Committee may also request attendance by appropriate individuals to present relevant reports and/or advise the Committee.

5. DECLARATIONS OF INTEREST, CONFLICTS AND POTENTIAL CONFLICTS

- 5.1 The provisions of Managing Conflicts of Interest: Statutory Guidance for CCGs³ or any successor document will apply at all times.
- 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 Vice Chair will act as Chair for the relevant part of the meeting (or another non-conflicted member of the meeting if the Vice Chair is also conflicted).
- 5.4 Any declarations of interest, conflicts and potential conflicts, and arrangements to manage those agreed in any meeting of the Committee, will be recorded in the minutes.

³ <https://www.england.nhs.uk/wp-content/uploads/2017/06/revised-ccg-coi-guidance-jul-17.pdf>

- 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.

6. QUORACY

- 6.1 The quorum shall be four members, to include 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.
- 6.2 A duly convened meeting of the Committee at which quorum is present at the meeting, or are contactable by telephone conference call, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

7. 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 Vice Chair) may call a vote. Any member where there is a conflict of interest will be excluded from voting for the proposal where there is a conflict.
- 7.2 Only members of the Committee set out at paragraph 4.2 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. Minutes will be recorded for telephone conference and virtual meetings in accordance with the CCG's Corporate Governance Framework at Section 5.4.

8. ACCOUNTABILITY

The Committee is accountable to the CCG's Governing Body.

9. REPORTING ARRANGEMENTS

The Committee will report to the CCG's Governing Body following each meeting, confirming all decisions made. The report will include recommendations that are outside the delegated limits of the Committee and which require escalation to, and approval from the CCG's Governing Body, if not already approved by them.

10. FREQUENCY AND NOTICE OF MEETINGS

Meetings will be held monthly. Agenda items and papers must be circulated five working days before the meeting date.

11. SUB-COMMITTEES

The Committee may delegate responsibility for specific aspects of its duties to sub-committees or working groups. The Terms of Reference of each sub-committee or working group shall be approved by the Committee and shall set out specific details of the areas of responsibility and authority.

12. ADMINISTRATIVE SUPPORT

- 12.1 The CCG will provide appropriate administration resource to ensure meetings are fully supported and business is conducted efficiently and effectively.
- 12.2 The meetings will be clearly minuted with particular attention paid to noting the declaration and management of any potential or actual conflicts of interest.

13. REVIEW OF TERMS OF REFERENCE

These terms of reference and the effectiveness of the Committee will be reviewed at least annually or sooner if required.

Reviewed by Finance Committee:	25 th March 2021
Approved by Governing Body:	6 th May 2021
Review Date:	September 2021

Governance Committee

Terms of Reference

1. PURPOSE

- 1.1 The purpose of the Committee is to ensure that NHS Derby and Derbyshire Clinical Commissioning Group (the “CCG”) complies with the principles of good governance whilst effectively delivering the statutory functions of the CCG.
- 1.2 The 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. ROLES AND RESPONSIBILITIES

- 2.1 The Committee will discharge the CCG’s responsibilities in respect of the following functions:
 - Business Continuity;
 - Corporate Governance;
 - Complaints and PALS;
 - Digital Development and ICT Assurance, including Cyber Security;
 - Emergency Preparedness Resilience and Response;
 - Equality, Human Rights and Inclusion;
 - Estates;
 - Health, Safety, Fire and Security;
 - Human Resources;
 - Information Governance;
 - Organisational Development;
 - Procurement;
 - Research Governance; and
 - Risk Management – oversight of the development and implementation of the risk management framework.
- 2.2 In order to discharge these duties, the Committee will:
 - produce an annual work programme;
 - ensure that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements;
 - review the adequacy and effectiveness of their responsible policies and procedures for ensuring compliance and related reporting;
 - ensure that arrangements are in place to monitor compliance with statutory responsibilities;
 - promote good risk management and ensure robust controls are in place in accordance with the CCG’s Risk Management Framework;

- establish and approve the terms of reference of such reporting sub-groups or task and finish groups as the Committee believes are necessary to fulfil its terms of reference;
- review the risk register for its area of remit, considering the adequacy of the submissions and whether new risks need to be added or whether any risks require immediate escalation to the CCG's Governing Body;
- review the Committee forward planner to assist with the Committee in discharging its duties effectively;
- have oversight of the CCG Recovery and Restoration work related to the Staff Health and Wellbeing, Governance and Infrastructure, Estates, IT & Digital and Statutory Requirement Pillar and will receive assurance regarding progress;
- scrutinise the performance of the ICT service provider against national requirements, reported KPIs, cyber security, GP IT delivery assurance, business as usual requirements and project delivery, (as identified in the CCG digital strategy) ensuring risks are identified and managed appropriately.

3. CHAIR ARRANGEMENTS

The Chair of the Committee shall be the Lay Member for Governance, nominated by the Accountable Officer and endorsed by the CCG Chair. In the event that the Chair is unavailable to attend, the Vice Chair, who shall be a Lay Member will deputise and Chair the meeting.

4. MEMBERSHIP

- 4.1 Members of the Committee may be appointed from the CCG's Governing Body, Officers of the CCG or other external bodies as required to enable the Committee to fulfil its purpose.
- 4.2 The membership of the Committee will comprise of:
- 3 x Governing Body Lay Members;
 - 2 x GP Governing Body Members;
 - Executive Director (Corporate) or Deputy.
- 4.3 CCG Officer subject experts will be attendees at each meeting.
- 4.4 Committee members may nominate a suitable deputy when necessary and subject to the approval of the Chair of the Committee. All deputies should be fully briefed and the Committee secretariat informed of any agreement to deputise so that quoracy can be maintained.
- 4.5 The Committee may also request attendance by appropriate individuals to present relevant reports and/or advise the Committee.

5. DECLARATIONS OF INTEREST, CONFLICTS AND POTENTIAL CONFLICTS

- 5.1 The provisions of Managing Conflicts of Interest: Statutory Guidance for CCGs⁴ or any successor document will apply at all times.
- 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 Vice Chair will act as Chair for the relevant part of the meeting (or another non-conflicted member of the meeting if the Vice Chair is also conflicted).
- 5.4 Any declarations of interest, 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.

6. QUORACY

- 6.1 The quorum necessary for the transaction of business shall be four members, to include two Governing Body Lay Members, one Clinician and the Executive Lead (or deputy).
- 6.2 A duly convened meeting of the Committee at which quorum is present at the meeting, or are contactable by telephone conference call, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

7. 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 Vice Chair) may call a vote. Any member where there is a conflict of interest will be excluded from voting for the proposal where there is a conflict.

⁴ <https://www.england.nhs.uk/wp-content/uploads/2017/06/revised-ccg-coi-guidance-jul-17.pdf>

- 7.2 Only voting members of the Committee set out at paragraph 4.2 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. Minutes will be recorded for telephone conference and virtual meetings in accordance with the CCG's Corporate Governance Framework at Section 5.4.

8. ACCOUNTABILITY

The Committee is accountable to the CCG's Governing Body.

9. REPORTING ARRANGEMENTS

The Committee will report to the CCG's Governing Body following each meeting, confirming all decisions made. The report will include recommendations that are outside the delegated limits of the Committee and which require escalation to, and approval from the CCG's Governing Body, if not already approved by them.

The Committee will provide an annual report to the CCG's Governing Body on the effectiveness of the Committee to discharge its duties.

10. FREQUENCY AND NOTICE OF MEETINGS

Meetings will be held bi-monthly, but may be called at any other such time as the Committee Chair may require.

11. SUB-COMMITTEES

- 11.1 The Committee may delegate responsibility for specific aspects of its duties to sub-committees or working groups. The Terms of Reference of each such sub-committee or working group shall be approved by the Committee and shall set out specific details of the areas of responsibility and authority.
- 11.2 Any sub-committees or working groups will report via their respective Chairs following each meeting or at an appropriate frequency as determined by the Committee.

12. ADMINISTRATIVE SUPPORT

The CCG will provide appropriate administration resource to ensure meetings are fully supported and business is conducted efficiently and effectively. The meetings will be clearly minuted with particular attention paid to noting the declaration and management of any potential or actual conflicts of interest.

13. REVIEW OF TERMS OF REFERENCE

These terms of reference and the effectiveness of the Committee will be reviewed at least annually or sooner if required.

Reviewed by Governance Committee: 11th March 2021

Approved by Governing Body: 6th May 2021

Review Date: September 2021

Derbyshire Engagement Committee

Terms of Reference

1. PURPOSE

The purpose of the ~~Derby and~~ Derbyshire Engagement Committee (the “Committee”) is to:

- 1.1 ensure any service changes and plans are developed and delivered through effective engagement with those affected by change and that patients, carers and the public are at the centre of shaping the future of health and care in Derbyshire;
- 1.2 provide a lay forum within which discussions can take place to assess levels of assurance and risk in relation to the delivery of statutory duties in public and patient involvement and consultation, as defined within the Health & Social Care Act 2012;
- 1.3 retain a focus on the need for engagement in strategic priorities and programmes, to ensure the local health system is developing robust processes in the discharging of duties relating to involvement and consultation;
- 1.4 promote innovation and improvement in public and patient engagement;
- 1.5 provide update reports to NHS Derby and Derbyshire Clinical Commissioning Group’s (the “CCG”) Governing Body and Joined Up Care Derbyshire Board on assurance and risk; and on the delivery of duties and activities relating to patient and public engagement and involvement;
- 1.6 champion Patient and Public Involvement in all processes relating to Joined Up Care Derbyshire decisions;
- 1.7 seek assurance that the Derbyshire system is following defined processes to take due regard when considering and implementing service changes as defined by the Equality Act 2010 and delivered through targeted engagement.

2. ROLES AND RESPONSIBILITIES

The Committee is asked to:

- 2.1 champion patient and public engagement across the Derbyshire health and care system, providing a watchful eye in scrutinising service developments;
- 2.2 seek assurance, through reports, reviews and presentations that patients and the public are an integral part of designing, commissioning, transforming and monitoring services;
- 2.3 seek assurance that the CCG and wider system are meeting statutory duties relating to Patient and Public Engagement, as laid out in the Health & Social Care Act 2012, including those relating to Local Authority Scrutiny;

- 2.4 seek assurance that the system has robust mechanisms for training relevant staff on statutory duties relating to Patient and Public Engagement, as laid out in the Health & Social Care Act 2012;
- 2.5 oversee the development and delivery of a robust infrastructure of engagement mechanisms including, but not limited to, place-level engagement, reference groups to provide insight on emerging issues, a citizen's panel from which can be drawn individuals across a matrix of geography/conditions/protected characteristics, project-specific lay representation and other mechanisms as required;
- 2.6 ensure due process and appropriate methodologies have been followed in terms of involving patients and the public in system projects, including providing constructive advice and challenge on proposed methods;
- 2.7 seek assurance that all commissioners and providers 'design health and care services to meet the needs and wants of the people who use them, not the organisations who provide them' as per the *Joined Up Care Derbyshire 5 Year Strategy Delivery Plan: 2019/20 to 2023/24*;
- 2.8 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;
- 2.9 seek assurance that the system has processes to ensure that adherence to the Equality Act duties of due regard is informing engagement programmes accordingly;
- 2.10 report to the CCG's Governing Body and Joined Up Care Derbyshire Board with regard to key risk areas and monitoring actions;
- 2.11 make recommendations for improvements and innovations in the way the system works with patients and the public;
- 2.12 oversee the development, completion and action planning of any internal or external audits relating to patient and public engagement;
- 2.13 respond to external reviews and National Lessons Learnt reviews and bulletins especially with regards to the way patients and the public are engaged;
- 2.14 ensure that all voices are heard at committee and programme meetings and that all groups are given appropriate opportunity to shape local services;
- 2.15 act as an advocate for the engagement work being carried out for the future of health and social care in Derbyshire through appropriate networks;
- 2.16 have oversight of the CCG Recovery and Restoration work related to the Engagement Pillar and will receive assurance regarding progress.

3. CHAIR ARRANGEMENTS

The Chair of the Committee shall be one of the Lay Members for Patient and Public Involvement (PPI), nominated by the CCG Accountable Officer and ratified by the Derbyshire STP Director and Chair of the Joined Up Care Derbyshire Board. In the

event that the Chair is unavailable to attend, the second CCG Governing Body Lay Member for PPI shall be the Vice Chair.

4. MEMBERSHIP

4.1 The membership of the Committee will comprise of the following voting and non-voting members:

Voting Members

- CCG Governing Body Lay Member – PPI lead (Chair)
- CCG Governing Body Lay Member – PPI lead (Vice-Chair)
- CCG Governing Body Lay Member – Primary Care Commissioning
- 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
- 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

4.2 System subject experts will be attendees at each meeting as required.

5. DECLARATIONS OF INTEREST, CONFLICTS AND POTENTIAL CONFLICTS

5.1 The provisions of Managing Conflicts of Interest: Statutory Guidance for CCGs⁵ or any successor document will apply at all times.

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

⁵ <https://www.england.nhs.uk/wp-content/uploads/2017/06/revised-ccg-coi-guidance-jul-17.pdf>

interest, conflict or potential conflict of interests they will bring it to the attention of the Committee, and the Vice Chair will act as Chair for the relevant part of the meeting (or another non-conflicted member of the meeting if the Vice Chair is also conflicted).

- 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.

6. QUORACY

- 6.1 The quorum necessary for the transaction of business shall be 5 members:
 - 6.1.1 2 x CCG Lay Members including either the Chair or Vice Chair is present;
 - 6.1.2 2 x Place Engagement Representatives; and
 - 6.1.3 1 x Executive Director or Deputy.
- 6.2 A duly convened meeting of the Committee at which quorum is present at the meeting, or are contactable by telephone conference call, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

7. 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 Vice Chair) may call a vote. Any member where there is a conflict of interest will be excluded from voting for the proposal where there is a conflict.
- 7.2 Only voting members of the Committee set out at paragraph 4.1 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. Minutes will be recorded for telephone conference and virtual meetings in accordance with the CCG's Corporate Governance Framework at Section 5.4.

- 7.4 To reflect the CCG's specific statutory duties under Section 14Z2 of the Health & Social Care Act 2012, Committee outcomes in relation to commissioning decisions may require referral to the CCG Governing Body for ratification or onward discussion. The Committee reserves the right to make such referrals to the CCG following a committee vote, even where a majority vote is taken, to ensure that a legally compliant decision is taken. A decision to refer will be taken in conjunction with the guidance on Committee Conflicts of Interest.

8. ACCOUNTABILITY

- 8.1 The Committee is accountable to the CCG's Governing Body and Joined Up Care Derbyshire Board.
- 8.2 The Engagement Committee is authorised by the Governing Body to provide the Governing Body with appropriate assurances in respect of ensuring the voice of patients and the public is heard throughout the CCG processes in the planning, commissioning, transformation and monitoring of services and to provide advice and support in the delivery of appropriate and effective PPI methodologies.

9. REPORTING ARRANGEMENTS

- 9.1 The committee will report items for consideration by the CCG's Governing Body and Joined Up Care Derbyshire Board through submission of minutes, papers and reports to relevant meetings.
- 9.2 The Chair and/or Vice Chair of the committee will have a seat at the CCG Governing Body and Joined Up Care Derbyshire Board to ensure feedback from the committee is heard.

10. FREQUENCY AND NOTICE OF MEETINGS

Meetings will be held monthly, but may be called at any other such time as the Committee Chair may require.

11. SUB-COMMITTEES

- 11.1 The Committee may delegate responsibility for specific aspects of its duties to sub-committees or working groups. The Terms of Reference of each such sub-committee or working group shall be approved by the Committee and shall set out specific details of the areas of responsibility and authority.
- 11.2 Any sub-committees or working groups will report via their respective Chair's following each meeting or at an appropriate frequency as determined by the Committee.

12. ADMINISTRATIVE SUPPORT

- 12.1 The Personal Assistant to the CCG's Executive Director Corporate Strategy and Delivery shall provide the administrative support.
- 12.2 Agenda and supporting papers will be circulated to members at least five working days prior to any meeting.
- 12.3 Minutes shall be prepared and distributed in draft within 14 working days of the meeting.

13. REVIEW

The terms of reference and the effectiveness of the Committee shall be reviewed at least annually or sooner if required.

Reviewed by Engagement Committee:

16th March 2021

Approved by Governing Body

6th May 2021

Review Date:

September 2021

Quality & Performance Committee

Terms of Reference

1. PURPOSE

- 1.1 The prime function of the Quality & Performance Committee (the “Committee”) is to provide assurance to the NHS Derby and Derbyshire Clinical Commissioning Group (the “CCG”) Governing Body in relation to the quality, performance, safety, experience and outcomes of services commissioned by the CCG.
- 1.2 It shall ensure that the CCG discharges the statutory duties in relation to the achievement of continuous quality improvement and safeguarding of vulnerable children and adults.
- 1.3 It shall pro-actively challenge and review delivery against the performance expectations for the CCG against the Constitution, NHS Mandate, Public Health Outcomes Framework and associated NHS performance regimes, agreeing any action plans or recommendations as appropriate.
- 1.4 Monitor progress in the delivery against the Improvement and Assessment Framework (IAF), challenge variances from plan and ensuring actions are put in place to rectify adverse trends.
- 1.5 It shall receive and scrutinise performance delivery information against key performance trajectories ensuring delivery and where necessary corrective actions are followed up.
- 1.6 It shall review the performance of the main services commissioned by the CCG; and the review of the Key Performance Indicators (KPI's) as necessary. It will provide members with greater clarity and detailed information about the underlying performance on key services commissioned by the CCG and on delivery of the annual commissioning programme set out in the CCG’s Operational Plan.

2. ROLES AND RESPONSIBILITIES

2.1 Quality

- 2.1.1 Ensure that processes are in place to provide assurance that CCG commissioned services are high quality, safe, effective, and provide patients and carers with positive experiences of care.
- 2.1.2 Ensure that quality assurance data is used to inform commissioning decisions and drive improvements in quality.
- 2.1.3 Have oversight of the process and compliance issues concerning serious incidents requiring investigation (SIRIs); being informed of all Never Events and informing the governing body of any escalation or sensitive issues in good time.

To seek assurance on the performance of NHS organisations in terms of the Care Quality Commission (CQC) and any other relevant regulatory bodies.

- 2.1.4 Continually develop the approach to quality improvement.
- 2.1.5 Ensure processes are in place to interpret and implement local, regional and national policy (e.g. Quality Accounts, Safeguarding etc.) and provide assurance that policy requirements are embedded in commissioned services.
- 2.1.6 Take responsibility for the development, implementation and monitoring of quality schedules and any quality improvement schemes for commissioned services; [including the review of KPI's](#).
- 2.1.7 Receive reports from provider Quality Assurance Groups and ensure that a clearly defined escalation process is in place.
- 2.1.8 Take action where required to investigate any quality, safety or patient experience concerns and to ensure that a clearly defined escalation process is in place, taking action to ensure that improvements in quality are implemented where necessary.
- 2.1.9 Ensure a clear escalation process, including appropriate trigger points, is in place to enable appropriate engagement of external bodies on areas of concern.
- 2.1.10 Ensure considerations relating to safeguarding children and adults are integral to commissioning services and robust processes are in place to deliver statutory functions, including Safeguarding Children, Looked After Children, Deprivation of Liberty Safeguarding (including Adult Safeguarding) and the Duty to Consult.
- 2.1.11 Commission any reports, surveys or reviews of services it deems necessary to help it fulfil its obligations.
- 2.1.12 Receive and scrutinise independent investigation reports relating to patient safety issues and agree any further actions.
- 2.1.13 Support the role of CCG Medicines Safety and Medical Devices Safety Officer to monitor, and to respond to, national and local requirements.
- 2.1.14 Provide a view on the quality aspects of the Sustainability and Transformation Partnership plans.
- 2.1.15 Review the Committee forward planner to assist with the Committee in discharging its duties effectively.
- 2.1.16 To increase system working with our system partners to create a sustainable health and care system to deliver transformational change and refer system issues to the System Quality and Performance Group.
- 2.1.17 Ensure that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements.
- 2.1.18 Review the adequacy and effectiveness of their responsible policies and procedures for ensuring compliance and related reporting.

2.1.19 Have oversight of the CCG Recovery and Restoration work related to the Health and Care and Statutory Requirement Pillars and will receive assurance regarding progress.

2.2 Performance

2.2.1 Monitor contract and operational performance across all commissioned services from key partners on an exception basis, assessing potential shortfalls and risk and to identify recommended actions. Review, challenge and scrutinise exception reports against delivery of targets or improved performance in accordance with agreed Recovery Action Plans (RAPs).

2.2.2 Monitor Key Performance Indicators (KPIs) relating to CCG performance, for example outlined in the CCG's Assurance Framework and the Public Health Outcomes Framework.

2.2.3 Review monthly reports detailing performance of commissioned services against contract standards, national and local targets and the CCG's Strategic Plans.

2.2.4 Review the risk register for its area of remit, considering the adequacy of the submissions and whether new risks need to be added or whether any risks require immediate escalation to the Governing Bodies.

3. CHAIR ARRANGEMENTS

The Chair of the Committee shall be a GP, nominated by the Accountable Officer and endorsed by the CCG Chair. In the event that the Chair is unavailable to attend, a Lay Member of the Committee will act as the Vice Chair and Chair the meeting, unless there is a conflict of interest.

4. MEMBERSHIP

4.1 Members of the Committee may be appointed from the CCG's Governing Body, Officers of the CCG or other external bodies as required to enable the Committee to fulfil its purpose.

4.2 The membership of the Committee will comprise:

- 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).

4.3 CCG Officer subject experts will be attendees at each meeting.

4.4 Committee members may nominate a suitable deputy when necessary and subject to the approval of the Chair of the Committee. All deputies should be fully briefed

and the Committee secretariat informed of any agreement to deputise so that quoracy can be maintained.

- 4.5 The Committee may also request attendance by appropriate individuals to present relevant reports and/or advise the Committee.

5. DECLARATIONS OF INTEREST, CONFLICTS AND POTENTIAL CONFLICTS

- 5.1 The provisions of Managing Conflicts of Interest: Statutory Guidance for CCGs⁶ or any successor document will apply at all times.
- 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 interest they will bring it to the attention of the Committee, and the Vice Chair will act as Chair for the relevant part of the meeting (or another non-conflicted member of the meeting if the Vice Chair is also conflicted).
- 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.

6. QUORACY

- 6.1 The quorum shall be five members, to include two Clinicians, two Lay Members and one Executive Lead (Chief Nurse Officer, Executive Director of Commissioning and Operations or Deputy). Nominated deputies are invited to attend in place of the regular member as required.
- 6.2 A duly convened meeting of the Committee at which quorum is present at the meeting, or are contactable by telephone conference call, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

⁶ <https://www.england.nhs.uk/wp-content/uploads/2017/06/revised-ccg-coi-guidance-jul-17.pdf>

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 Vice Chair) may call a vote. Any member where there is a conflict of interest will be excluded from voting for the proposal where there is a conflict.
- 7.2 Only members of the Committee set out at paragraph 4.2 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. Minutes will be recorded for telephone conference and virtual meetings in accordance with the CCG's Corporate Governance Framework at Section 5.4.

8. ACCOUNTABILITY

- 8.1 The Committee is accountable to the CCG's Governing Body.
- 8.2 It shall maintain an annual work programme, ensuring that all matters for which it is responsible are addressed in a planned manner, with appropriate frequency across the year.
- 8.3 The Committee may investigate, monitor and review any 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), who are directed to co-operate with any request made by it.

9. REPORTING ARRANGEMENTS

The Committee shall report to the CCG's Governing Body following each meeting. The report shall highlight any recommendations and matters which require escalation.

10. FREQUENCY AND NOTICE OF MEETINGS

- 10.1 Meetings will be held monthly, but may be called at any other such time as the Committee Chair may require.
- 10.2 Agendas and papers will be circulated five working days before the meeting date.

11. SUB-COMMITTEES

- 11.1 The Committee may delegate responsibility for specific aspects of its duties to sub-committees or working groups. The Terms of Reference of each such

sub-committee or working group shall be approved by the Committee and shall set out specific details of the areas of responsibility and authority.

- 11.2 Any sub-committees or working groups will report via their respective Chair's following each meeting or at an appropriate frequency as determined by the Committee.

12. ADMINISTRATIVE SUPPORT

- 12.1 The CCG will provide appropriate administration resource to ensure meetings are fully supported and business is conducted efficiently and effectively.
- 12.2 The meetings will be clearly minuted with particular attention paid to noting the declaration and management of any potential or actual conflicts of interest.

13. REVIEW

The terms of reference and the effectiveness of the Committee shall be reviewed at least annually or sooner if required.

Reviewed by Quality and Performance Committee:	25 th March 2021
Approved by Governing Body:	6 th May 2021
Review Date:	September 2021

GOVERNING BODY MEETING IN PUBLIC

6th May 2021

Item No: 033

Report Title	Financial Planning & Budget Setting 2021/22 - Update
Author(s)	Niki Bridge, Deputy Chief Finance Officer Darran Green, Associate Chief Finance Officer
Sponsor (Director)	Richard Chapman, Chief Finance Officer

Paper for:	Decision	Assurance	Discussion	X	Information
Recommendations					
The Governing Body is requested to NOTE the progress to date on producing a Joined Up Care Derbyshire Financial Plan for 2021/22.					
Report Summary					
This update is to inform the Governing Body of the changes to the financial planning assumptions made to date by the CCG and Joined Up Care Derbyshire partners in anticipation of the completion of a final System Financial Plan to be submitted to NHSEI on 6 th May 2021.					
A slide pack summarising the latest planning figures and their development will be presented to the Governing Body during the meeting.					
Are there any Resource Implications (including Financial, Staffing etc.)?					
N/A					
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?					
N/A					
Has a Quality Impact Assessment (QIA) been completed? What were the findings?					
No					
Has an Equality Impact Assessment (EIA) been completed? What were the findings?					
No					
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below					
No					

Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
No
Have any Conflicts of Interest been identified/ actions taken?
None identified
Governing Body Assurance Framework
Which of the CCG's objectives does this paper support? 4A & 4B – delivering a sustainable financial position for the CCG and JUCD system.
Identification of Key Risks
As identified in the report

NHS Derby and Derbyshire CCG

Financial Planning and Budget Setting 2021/22

1. Introduction

The purpose of this paper is to:

- update members of the Governing Body of the changes to the financial regime for 2020/21 after receiving the ‘Supplementary guidance on H1 2021/22 finance and payments arrangements’ on 26th March 2021;
- set out how the CCG and Joined Up Care Derbyshire (JUCD) system partners have identified an efficiency gap and the proposed delivery and management of the risk to delivering; and
- demonstrate how the CCG is progressing planning and budget setting in the context of the overall system position.

2. System Financial Planning Guidance

The guidance recently received only covered an H1 period to 30th September 2021. Governing Body members will recall a paper that set out the assumptions that had been made at that point based on the limited guidance we had at that time. At that time it was thought that the 2021/22 financial year would be divided into periods covering Q1 and Q2-4. JUCD will be expected to enter H2 with an agreed Operational Plan, with an agreed Control Total and an efficiency requirement to deliver that Control Total. As mentioned in the planning paper last month the system also needs to develop a clear understanding of the capacity it is able to provide and understand the demand that will be placed on the Derbyshire healthcare system.

The system financial envelope for the 2021/22 H1 period is based on Q3 system expenditure in H2 2020/21 and is adjusted for known pressures and key policy priorities (including inflation, primary care and mental health services). Like 2020/21 there is Top up funding and a system COVID fixed allocation along with Growth funding at system level (for distribution across organisations), all subject to a 0.28% efficiency requirement.

The contracting arrangements in H1 will be similar to those in 2020/21. Block contract payments will remain in place for NHS providers with no formal signed contracts required for H1 2021/22. Unlike last year where contracts were held nationally, CCG contracts with independent Sector / Non NHS providers will be in place from 1 April 2021. All contracts will be uplifted, following any required adjustments, by 0.5% inflation. This may be flexed for system providers to meet specific pressures.

Other key elements of the guidance include:

- systems by mutual agreement and on a net neutral basis, can amend the planned surplus/deficit positions of individual within their system funding envelope. A balanced plan is expected for H1;

- CCGs are advised to set aside a contingency of up to 0.5% of their allocation to support risks to expenditure that may not otherwise be mitigated. Where setting of a contingency fund is neither considered affordable nor required – for example, where financial risks are fully mitigated – it is allowable to not set a contingency; this will be subject to regional assurance;
- organisations will be monitored against the final positions reported on the system plan template, including any agreed amendments.
- the funding for IS services has been included within the allocations as the responsibility for IS provision reverts to local management. It is expected that systems will continue to make best use of the NHS Increasing Capacity Framework (the 'Framework'). The Framework covers over 90 providers of acute elective services at present and allows a commissioner to put in place a contract, or a trust to put in place a subcontract, with one of the identified providers, either by a direct award (in the circumstances described in the Framework documentation) or by undertaking a mini-competition. These are 6 month contracts and the situation will change in when we are in the H2 period;
- an allowance for Non Contracted Activity (NCA) for out of area activity will continue to be included within the system envelope to remove the need for separate invoicing to CCGs outside the block payment arrangements;
- there will be no 2021/22 CQUIN scheme (either CCG or specialised) published at this stage. Block payments to NHS providers are deemed to include CQUIN. Funding must not be withheld from any provider in H1 in relation to failure to meet CQUIN requirements.

More detailed guidance on specific areas of Commissioning includes:

Mental Health

- CCGs must continue to meet the Mental Health Investment Standard (MHIS) as a minimum in 2021/22. For 2021/22, the MHIS requires CCGs to increase their spend on mental health services by at least 2021/22 published allocation growth.
- In addition, systems must progress towards their Long Term Plan goals through use of their available Service Development Funding (SDF) and additional funding secured through the Spending Review to aid recovery of services from Covid-19.

Primary Care

- CCG allocations will be uplifted to fund the growth between 2020/21 and 2021/22 published primary care allocations.
- There will be additional national allocations for the GP contract, to fund:
 - £20m practice contract funding, continuing to fund the impact of changes in the 2020/21 GP contract;
 - £24m for the new QOF indicator for mental health – severe mental illness (new for 2020/21);
 - £58m for the new QOF indicators for vaccinations and immunisations, previously funded from public health budgets (new for 2020/21);

- £50.7m for the first tranche of the Impact and Investment Fund (IIF) indicators introduced from April. Up to a further £99.3m for IIF is also expected.
- Allocations for Improving Access funding will continue to be transacted through the same mechanism as in 2020/21, which comprised funding already embedded in CCG core allocations and additional SDF allocations to give a total of £6 per head.

Primary Care Networks (PCNs)

- The Additional Roles Reimbursement Scheme (ARRS) funding of £415m is already included in allocations. An additional £331m will be held centrally by NHSE/I for CCGs to access based on need.
- £134m support for PCNs, of which £91m for the £1.50 per head is included in the published CCG core allocations.
- £43m for the clinical director roles ring-fenced from CCG primary medical care allocations.
- Additional funding of £55m Care Home Premium funding to support PCN delivery of the Enhanced Health in Care Homes services.
- £87m for the PCN Extended Access DES from CCG primary medical care allocations.
- SDF funding supporting primary care transformation programmes.

Better Care Fund

The government has confirmed that the Better Care Fund (BCF) will continue in 2021/22 and that the CCG minimum contribution will grow (in line with the planned Long Term Plan settlement) by 5.3%. CCG envelopes include funding for growth to enable CCGs to meet their 2021/22 BCF commitments.

MedTech mandate

The MedTech Funding Mandate (MTFM) policy was published in January 2021 and is effective from 1 April 2021. This policy requires NHS providers to make four technologies available to patients:

- HeartFlow;
- Placental Growth Factor Based Testing;
- SecurAcath; and
- gammaCore.

These technologies are supported by NICE guidance, deliver cost savings within 12 months and reduce hospital visits and clinical interventions, which is vital in the current COVID-19 pandemic. Systems will be expected to fund these technologies from within the system funding envelopes allocated and from core allocations thereafter.

3. JUCD Financial Planning

Finance teams across the JUCD system have been working with NHSE/I to develop a financial system plan in line with the guidance received and there remains significant uncertainty that will continue to be experienced in the NHS in 2021/22 as a result of the enormous impact of COVID. This planning continues to be work in progress and assumptions for 2021/22 are moving quickly.

The system has worked together closely to establish a full understanding of the underlying recurrent position exiting 2019/20 and the movement from 2019/20 underlying expenditure to a “do nothing” 2021/22 plan. A process has then been undertaken to incorporate the impact of the H1 finance regime on that plan, which was initially compiled using Q1/Q2-4 assumptions and to check and challenge system partners’ assumptions. The system has developed a more “open book” approach than has previously been the case.

Initially this work in January had identified a potential JUCD financial system gap at £243.1m. Working closely together, challenging each other’s assumptions this gap has been reduced to £53.3m and we continue to identify solutions and mitigations to this efficiency challenge.

The table below sets out how the financial gap has developed over recent weeks:

Derbyshire Financial Gap (29th January 2021)	£m	£m
		243.1
CHC income review	(4.3)	
EMAS top up review	(0.7)	
Removal of Covid income and costs	(15.1)	
JUCD Q1 top up funding	(34.2)	
Reduction of pay inflation to 1%	<u>(17.7)</u>	<u>(72.0)</u>
Derbyshire Financial Gap (15th March 2021)		171.1
Outcome of round one 'Check & Challenge'	(26.2)	
Inflation revision	3.0	
Ambulance top up review	0.7	
Allocation reviews	(2.5)	
Removal of Covid Income and Costs	<u>(1.1)</u>	<u>(26.1)</u>
Derbyshire Financial Gap (6th April 2021)		145.0
LTP allocations	(5.5)	
System Top up	(34.2)	
Additional Provider Income	<u>(5.0)</u>	<u>(44.7)</u>
Revised Derbyshire Financial Gap		100.3
Additional Efficiency at 3%		(47.0)
Deficit including additional efficiency challenge		<u><u>53.3</u></u>

Work is on-going involving detailed work linking with operational areas to understand the:

- linkage between capacity and the system cost base
- extent to which affordable capacity will meet ongoing demand
- overall triangulation between workforce, non-workforce capacity and cost
- system's underlying affordability position and the likely 21/22 exit-rate which must play into a medium term financial recovery plan

4. Budget Setting

The budget setting process is developed as part of the operational planning process and would normally be presented to the Governing Body for approval in March. Due to the two different periods in 2021/22 described above, the first of which is very prescriptive, it is anticipated that budgets may be set in a more usual way for the H2 period. These will be developed in line with the System Operational Plan and presented to Finance Committee and the Governing Body along with the System Operational Plan during the H1 period.

If approved by the Governing Body, the relevant Executive Directors will be given a Budget Manual along with a copy of their delegated budgets, which they will sign off and these will be monitored, in support with the Finance Department and reported to the Finance Committee and Governing Body throughout the year.

5. Conclusion

This is the second financial year that has been affected by the pandemic the CCG continues to adapt to the ever changing environment. Guidance continues to be received, although there remains considerable uncertainty and the CCG and JUCD partners are working together on that to deliver a final System Financial Plan to be submitted to NHSEI on 6th May 2021. The Governing Body will be presented with the latest information available and will also have the opportunity to review the final version of the plan before it is submitted.

6. Recommendations

The Governing Body is requested to **NOTE** the progress to date on producing a Joined Up Care Derbyshire Financial Plan for 2021/22.

Governing Body Meeting in Public

6th May 2021

Item No: 034

Report Title	South Yorkshire and Bassetlaw (SYB) Integrated Care System (ICS) Development Update
Author(s)	Dr Chris Clayton, Chief Executive Officer
Sponsor (Director)	Dr Chris Clayton, Chief Executive Officer

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

Recommendations

The Governing Body is requested to:

1. **NOTE** the progress made on the SYB ICS development work across all of the work streams

2. **COMMENT** on the outputs of the SYB ICS design group by, specifically the:
 - a. Health and Care Compact;
 - b. Health and Care Partnership Terms of Reference;
 - c. Place Development Matrix.

3. **PROVIDE COMMENTS BACK** to the SYB ICS on the above by Friday, 28th May 2021

Report Summary

Partners in the SYB health and care system have been taking forward development work since November 2020. This follows the engagement exercise led by NHS England and Improvement (NHSE&I) on the future of ICSs. The subsequent NHSEI recommendations and Department of Health and Social Care White Paper *Integration and Innovation: working together to improve health and social care for all* set out the proposed way forward with greater clarity.

Over the last 4 months, an overarching Steering Group, formed from members of the SYB ICS partnership, has been overseeing work that builds on the existing ways of working. Specifically, this has been looking at:

- Establishing place-based partnerships
- How provider collaboratives will operate across systems
- How the nature of commissioning will change; and
- An integrated care system operating model.

This paper provides the background to the work of the Steering Group, its progress over the last few months and seeks comments on several draft key products to shape the next phase of the ICS during transition to a statutory authority from April 2022.

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

South Yorkshire and Bassetlaw Integrated Care System ICS Development – update

1. Introduction

Partners in the South Yorkshire and Bassetlaw (SYB) health and care system have been taking forward development work since November 2020. This follows the engagement exercise led by NHS England and Improvement (NHSEI) on the future of Integrated Care Systems (ICSs). The subsequent NHSEI recommendations and Department of Health and Social Care White Paper *Integration and Innovation: working together to improve health and social care for all* set out the proposed way forward with greater clarity.

Over the last four months, an overarching Steering Group, formed from members of the SYB ICS partnership, has been overseeing work that builds on the existing ways of working. Specifically, this has been looking at:

- Establishing place-based partnerships
- How provider collaboratives will operate across systems
- How the nature of commissioning will change; and
- An integrated care system operating model.

This paper provides the background to the work of the Steering Group, its progress over the last few months and seeks comments on several draft key products to shape the next phase of the ICS during transition to a statutory authority from April 2022.

2. Background

On February 11th 2021, the Department for Health and Social Care (DHSC) published its White Paper *Integration and Innovation: working together to improve health and social care for all*.

The proposals follow the journey of integrating care and that which South Yorkshire and Bassetlaw, as a partnership, has been on since 2016. Its design intentions support removal of many of the obstacles and barriers which are seen to stand in the way of integration in neighbourhoods, local places and across the system.

The proposals build on the NHS Long-Term Plan, with a strong emphasis on improving population health and tackling health inequalities through a whole population approach. They are supported by a broad duty to collaborate and a triple aim on health bodies of:

- Better health and wellbeing for everyone
- Better quality of health services for individuals, and
- Sustainable use of NHS resources

The proposals also respond to the recommendation to strengthen governance, transparency and public accountability and to give the opportunity to develop an even deeper relationship with Local Authority partners in ICSs.

ICSs of the future are expressed as a NHS Statutory Body with a NHS Board and separately a statutory Health and Care Partnership, together they form ICSs.

In summary, the NHS statutory body will be responsible for:

- Developing a plan to meet the needs of the population
- Developing a capital plan for NHS providers within their geography
- Securing the provision of health services for the system population, and;
- Day to day responsibility for the new organisation and its people

The Health and Care Partnership will be responsible for:

- Developing a plan that addresses the wider health, public health and social care needs of the system, with the NHS ICS Board and Local Authorities having regard to that plan when making decisions.

The current indicative timeline for progression of the proposals through parliamentary process sees the earliest that the Bill will become an Act of Parliament is January 2022, with the provisions of the Act brought into effect in April 2022.

3. ICS Steering Group progress

In November 2020, an overarching Steering Group was formed from members of the SYB ICS partnership and includes the full range of health and care partners including senior leadership of local authorities, the voluntary sector, Healthwatch, health and care providers and commissioners and include clinical and professional leadership and representation. Hill Dickinson was commissioned to provide facilitation to the Steering Group and design groups and expert legal support in production of key documents and products. The Steering Group agreed to meet three times over February, March and April to oversee the initial phase of this work and to then review its role.

It has been overseeing work that builds on the existing four areas of working. Specifically, these are:

- Establishing place-based partnerships
- How provider collaboratives will operate across systems
- How the nature of commissioning will change; and
- An integrated care system operating model.

This work has, of course, been taking place alongside the development work concurrently going on in Place partnerships, within Provider Collaboratives etc. It is envisaged that all of the above will come into operation in shadow form from 1 October 2022 (Quarter 3).

The Steering Group also set up a design sub-group, established from its membership to co-design several key products to shape the next phase of the ICS during transition to a statutory authority from April 2022. The first of these products would come into operation from July 2021 (Quarter 2) in the transition year and include:

- Health and Care Compact

- Health and Care Partnership Terms of Reference
- Place Development Matrix
- A Route Map for 2021/22

The Compact and Terms of Reference aim to enshrine the collaboration and principles of working together during the transition year of 2021-22. Whilst the Compact is not a legally binding document, it is intended to be a ‘golden thread’ and which, through members’ engagement, partners can hold each other to account. The Place Development Matrix is a tool to support development across provider collaboratives and place-based partnerships and will continue to evolve through testing and self-assessment.

Since establishing the framework, a number of other key documents have now been published including proposals for the draft Bill, NHS England and Improvement Operational Planning Guidance, and an outline of further detail of expected guidance from the Department of Health and Social Care (DHSC) and NHS England and Improvement which will shape and inform the work. With this in mind it is recognised that whilst all partners will want and need to progress the work they have been doing as a set of partners over a number of years, they will need to review and reflect on the legislative process and guidance to establish statutory ICSs over 2021. Partners will therefore need to be pragmatic and agile in their approach.

Development work for Provider Collaboratives, Place-based Partnership and how commissioning will change is being taken forward in respective work streams. Initial work shared with the Steering Group and updated output of this work will follow in the next stage of ICS development work.

Next steps for the Steering Group include consideration of the interim governance arrangements, with a view to making as few changes to the existing arrangements (see Appendix C) as possible and finalising the Compact, Health and Care Partnership Terms of Reference and Place Development Matrix following your comments.

4. Key outputs for consideration:

Appendix A - Health and Care Compact and Health and Care Partnership Terms of Reference

Health and Care Compact

The Health and Care Compact captures the commitment of South Yorkshire and Bassetlaw’s (SYB) health and care partners to focus on the shared purpose of the ICS to deliver what it sees as the **quadruple aim** of better health and wellbeing for the whole population, better quality care for all patients, sustainable services for the taxpayer and the reduction of health inequalities. The Compact is intended as a golden thread and its commitment is an underpinning principle of the system and way of working.

In co-producing the Compact, partners acknowledge the gross state of inequalities in SYB, that these have widened during Covid and as reflected in the Marmot Review. There is therefore a compelling need for partners of the ICS to come together to

better address these inequalities using a collaborative approach with their combined resources. This will be through the prevention of ill health and provision of safe and high-quality needs led/outcome-focused public services that work well together, looking after staff and managing health and ill health and to make SYB the best place to be born, live and work.

Health and Care Partnership Terms of Reference

The Health and Care Partnership is a significant opportunity for the ICS to realise its wider ambitions to address broader health outcomes and inequalities. Health and Care Partnerships will have a key role in promoting partnership working and collaboration and developing a plan that addresses the wider health, public health and social care needs of the system, with the NHS ICS Board and Local Authorities having regard to that plan when making decisions. A draft Terms of Reference has been co-produced with partners with the transition year in mind and to be revised following DHSC guidance due later in the year to take it into the statutory form ready for April 2022.

It is proposed that the Health and Care Partnership meets between four and six times per year to coincide with key budgetary, planning and priority setting timetables and that potentially two of these meetings are broadened out to include a wider membership and format which facilitates input to developing the wider system plan and priority setting and sharing of progress, innovation, learning and best practice. It is proposed that the development Steering Group continues to meet and serve as a sub-group of the Health and Care Partnership during transition and to support its business.

Further input is required to the membership. The approach to drafting so far has been to be more inclusive for the transition year, to then be refined following guidance from DHSC and from learning across SYB as to what works well for partners and to allow further conversation with partners.

Appendix B - A Place Development Matrix to support a self-assessment of the key features and design of place partnerships and provider collaboratives

The place development matrix has been co-produced with partners to support places and provider collaboratives with development arrangements. The aim is to support the development of plans through the transition year and to build on the significant progress made in each of our places and across the system, understanding that this journey is continuous and will go beyond April 2022.

It will continue to evolve as places and collaboratives use it to develop their thinking further. As more guidance for statutory ICSs is received and elements of national frameworks set some of the parameters within which systems will work, this will become clearer and inform the Development Matrix. The current draft proposed is for local places and collaboratives for testing during April and May. There have been some requests for this to include sharing and learning approach, to both identify key enablers and share good practice to support the developmental journey.

Appendix C - Summary of wider ICS governance arrangements

A range of statutory and non-statutory governance forums have been agreed with partners over time which facilitate system and collaborative working which are summarised. These groups work in conjunction with individual organisational

statutory governance. It is anticipated these will continue to operate during the transition. Respective organisations may choose to review and amend these. For those affected by the legislation these will be reviewed as national guidance to establish ICSs is published, which is signalled from Q2 onwards.

5. Recommendations:

Board/Governing Body/Committee members are asked to:

1. Note the progress made on the ICS development work across all of the work streams
2. Comment on the outputs of the ICS design group by, specifically the:
 - a. Health and Care Compact
 - b. Health and Care Partnership Terms of Reference
 - c. Place Development Matrix
3. Provide comments back to the ICS on the above by Friday 28th May 2021

Table, 1

From NHSEI operational planning guidance 2021/22

Statutory ICS establishment planning timetable 		
Planning timetable 2021/22	National expectations / Action required	Working draft SYB actions
By End Q1	<ul style="list-style-type: none"> Update SDPs and confirm proposed boundaries, constituent partner organisation and place-based arrangements Set out the delivery and governance arrangements that support delivery priorities in and MoU 	<ul style="list-style-type: none"> Health and Care Compact New Health and Care Partnership Outputs from wider ICS development workstreams Development matrix Review of wider ICS non statutory governance HOB, HEG, IAC and any statutory governance e.g. JCCCG Refreshed ICS executive team Submit System Development Plan and agree MoU with NHSEI for NHS priorities
By End Q2	<ul style="list-style-type: none"> Confirm designate ICS appointments: chair, chief executive inline with senior appointments guidance to be issued by NHSEI Confirm proposed governance arrangements for health and care partnership and NHS ICS body 	<ul style="list-style-type: none"> Appointment of designate ICS chair and CEO Review Health and Care Compact and HnCP terms of reference Begin to draft ICS body constitution and governance arrangements Confirm place-based governance arrangements and operating model Confirm provider collaborative arrangements Review SDP and MoU
By End Q3	<ul style="list-style-type: none"> Confirm other designate appointments to the ICS NHS Body executive leadership roles and non-executive roles 	<ul style="list-style-type: none"> Confirm designate ICS NHS body leadership and senior teams Confirm designate appointment to any remaining senior ICS roles Review SDP and MoU
By End Q4	<ul style="list-style-type: none"> Confirm designate appointment to any remaining senior ICS roles Complete due diligence and preparations for staff and property (assets and liabilities) transfer from CCGs to new ICS bodies) Submit ICS NHS Body Constitution for approval and agree MoU with NHSEI 	<ul style="list-style-type: none"> Complete due diligence and preparations for staff and property (assets and liabilities) transfer from CCGs to new ICS bodies) Review SDP, submit ICS NHS Body Constitution for approval and agree MoU with NHSEI
1 April 22	<ul style="list-style-type: none"> Establish new ICS NHS Body, with staff and property (assets and liabilities transferred and boards in place) 	<ul style="list-style-type: none"> Establish new ICS NHS Body, with staff and property (assets and liabilities transferred and boards in place)

NHSE/I 2021/22 planning – provider governance

During 2021/22 we will also update guidance on provider governance (to support providers to work collaboratively), including:

- Updated FT Code of Governance
- Updated guidance on the duties of FT council of governors
- Updated memorandums for accounting officers of FTs and NHS trusts
- New guidance issued under the NHS Provider Licence that good governance for NHS providers includes a requirement to collaborate.

South Yorkshire & Bassetlaw Integrated Care System
722 Prince of Wales Road
Sheffield
S9 4EU
Programme Office: 0114 3051905

22 April 2021

Letter to: Clinical Chairs and Accountable Officers, South Yorkshire and Bassetlaw Clinical Commissioning Groups

Letter sent by email

Dear colleague

Health and Care Compact, Health and Care Partnership and Place Development Matrix

As you may know, all the partners in the South Yorkshire and Bassetlaw (SYB) health and care system have been taking forward development work since November 2020. This follows the engagement exercise led by NHS England and Improvement (NHSEI) on the future of Integrated Care Systems (ICSs). The subsequent NHSEI recommendations and Department of Health and Social Care White Paper *Integration and Innovation: working together to improve health and social care for all* set out the proposed way forward with greater clarity.

Over the last four months, an overarching Steering Group, formed from members of the SYB ICS partnership, has been overseeing work that builds on the existing ways of working. Specifically, this has been looking at:

- Establishing place-based partnerships
- How provider collaboratives will operate across systems
- How the nature of commissioning will change; and
- An integrated care system operating model.

This work has, of course, been taking place alongside the development work concurrently going on in place partnerships, within provider collaboratives and so on. It is envisaged that all of the above will come into operation in shadow form from 1 October 2021 (Quarter 3).

The Steering Group has also set up a design sub-group, established from its membership to co-design several key products to shape the next phase of the ICS during transition to a statutory authority from April 2022. The first of these products would come into operation from July 2021 (Quarter 2) in the transition year and include:

- Health and Care Compact

- Health and Care Partnership Terms of Reference
- Place Development Matrix

Further products such as interim governance arrangements for 2021/22 will follow shortly in the next four weeks.

As you will see from the attached documents, there is a strong shared commitment from all partners to the SYB quadruple aim of better health and wellbeing for the whole population, better quality care for all patients, sustainable services for the taxpayer and a reduction in health inequalities.

The Compact and Terms of Reference aim to enshrine the collaboration and principles of working together during the transition year of 2021-22. Whilst the Compact is not a legally binding document, it is intended to be a 'golden thread' and which, through members' engagement, partners can hold each other to account. The Place Development Matrix is a tool to support development across provider collaboratives and place-based partnerships and will continue to evolve through testing and self-assessment.

At its April meeting, the Steering Group received and endorsed these products, and I am now sharing them with you for discussion and consideration at your next Governing Body meeting. I would be grateful if you could respond to me by Friday 28th May 2021 confirming your agreement to them along with any comments/amendments you may wish to make. This will allow the Steering Group to take a further round of revision in June before the documents are then finalised and signed off in readiness for a formal start of the Health and Care Partnership in July 2021 (which will succeed the South Yorkshire and Bassetlaw Collaborative Partnership Board).

The Steering Group has agreed to continue to meet and progress the development agenda as outlined in the timetable below (taken from the NHS 2021/22 priorities and Operational Planning Guidance implementation guidance).

Route Map for ICS Development 2021/22	
By end Q1	Update System Development Plans and confirm proposed boundaries, constituent partner organisations and place-based arrangements.
By end Q2	Confirm designate appointments to ICS chair and chief executive positions (following the second reading of the Bill and in line with senior appointments guidance to be issued by NHSEI). Confirm proposed governance arrangements for health and care partnership and NHS ICS body.

By end Q3	Confirm designate appointments to other ICS NHS body executive leadership roles, including place-level leaders, and non-executive roles.
By end Q4	<p>Confirm designate appointments to any remaining senior ICS roles.</p> <p>Complete due diligence and preparations for staff and property (assets and liabilities) transfers from CCGs to new ICS bodies.</p> <p>Submit ICS NHS body Constitution for approval and agree “MOU” with NHS England and NHS Improvement.</p>
1 April	Establish new ICS NHS body; with staff and property (assets and liabilities) transferred and boards in place.

Next steps for the Steering Group include consideration of the interim governance arrangements, with a view to making as few changes to the existing arrangements as possible and finalising the Compact, Health and Care Partnership Terms of Reference and Place Development Matrix following your comments.

As you know, our journey to becoming a statutory integrated care system goes well beyond the development work that has been underway since November. I would like to thank all colleagues across partner organisations for their continued input and commitment to this agenda over the last few years, particularly so more recently when there have been so many competing priorities.

Best wishes,



Sir Andrew Cash
System Leader
South Yorkshire & Bassetlaw Integrated Care System

Appendix A

Steering Group membership

Member	Workstream	Designation
Richard Parker	Bassetlaw Place Partnership	Chief Executive, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
Sarah Norman	Barnsley Place Partnership	Chief Executive, Barnsley Metropolitan Borough Council
Damian Allen	Doncaster Place Partnership	Chief Executive, Doncaster Metropolitan Borough Council
Sharon Kemp	Rotherham Place Partnership	Chief Executive, Rotherham Metropolitan Borough Council
Kirsten Major	Sheffield Place Partnership	Chief Executive, Sheffield Teaching Hospitals NHS Foundation Trust
Kathryn Singh	System Mental Health Alliance	Chief Executive, Rotherham, Doncaster and South Humber NHS Foundation Trust
Richard Jenkins	System Acute Federation	Chief Executive, Barnsley Hospital NHS Foundation Trust and Interim Chief Executive, The Rotherham NHS Foundation Trust
John Somers	System Children's and Young People Collaborative	Chief Executive, Sheffield Children's NHS Foundation Trust
Jackie Pederson	Commissioning (Doncaster) and Primary Care System Alliance	Accountable Officer, Doncaster Clinical Commissioning Group
Idris Griffiths	Commissioning (Bassetlaw)	Accountable Officer,

		Bassetlaw Clinical Commissioning Group
Chris Edwards	Commissioning (Rotherham)	Accountable Officer, Rotherham Clinical Commissioning Group
Nick Balac	Commissioning (Barnsley)	Clinical Chair, Barnsley Clinical Commissioning Group
Lesley Smith	Commissioning (Sheffield) SYB ICS	Accountable Officer, Sheffield Clinical Commissioning Group and SYB ICS Deputy System Lead
Catherine Burn	SYB ICS – Voluntary Sector	Voluntary Sector Representative
Adrian England	SYB ICS – Healthwatch	Healthwatch Representative
Andrew Cash	SYB ICS	System Lead
Will Cleary-Gray	SYB ICS	Chief Operating Officer
In attendance		
Mike Farrar	-	Independent Consultant
Robert McGough	-	Partner, Hill Dickinson
Helen Stevens-Jones	SYB ICS	Director of Communications and Engagement
Sophia Malik	-	Attain
Chris Walker	-	Attain

Design Group membership

Member	Workstream	Designation
Damian Allen	Doncaster Place Partnership	Chief Executive, Doncaster Metropolitan Borough Council

Sharon Kemp	Rotherham Place Partnership	Chief Executive Officer, Rotherham Metropolitan Borough Council
Alexis Chappell	Sheffield Place Partnership (nominated by Sharon Kemp)	Director of Adult Social Services, Sheffield City Council
Kirsten Major	Sheffield Place Partnership	Chief Executive, Sheffield Teaching Hospitals NHS Foundation Trust
Kathryn Singh	System Mental Health Alliance	Chief Executive, Rotherham, Doncaster and South Humber NHS Foundation Trust
Richard Jenkins	System Acute Federation	Chief Executive, Barnsley Hospital NHS Foundation Trust and Interim Chief Executive, The Rotherham NHS Foundation Trust
Jackie Pederson	Commissioning (Doncaster) and Primary Care System Alliance	Accountable Officer, Doncaster Clinical Commissioning Group
Idris Griffiths	Commissioning (Bassetlaw)	Accountable Officer, Bassetlaw Clinical Commissioning Group
Chris Edwards	Commissioning (Rotherham)	Accountable Officer, Rotherham Clinical Commissioning Group
Nick Balac	Commissioning (Barnsley)	Clinical Chair, Barnsley Clinical Commissioning Group
Lesley Smith	Commissioning (Barnsley) and SYB ICS	Accountable Officer, Sheffield Clinical Commissioning Group and SYB ICS Deputy System Lead
Catherine Burn	SYB ICS	Voluntary Sector

		Representative
Adrian England	SYB ICS – Healthwatch	Healthwatch Representative
Andrew Cash	SYB ICS	System Lead
Will Cleary-Gray	SYB ICS	Chief Operating Officer
In attendance		
Robert McGough	-	Partner, Hill Dickinson
Helen Stevens-Jones	SYB ICS	Director of Communications and Engagement
Sophia Malik	-	Attain
Chris Walker	-	Attain



South Yorkshire and Bassetlaw Integrated Care System

Health and Care Compact

Health and Care Partnership

Terms of Reference

Contents

Introduction	3
Health and Care Compact	
Background and purpose	10
The integrated care system	11
Values and principles for the ICS partnership	12
Signatories to the compact	14
Health and Care Partnership Terms of Reference	
Introduction	18
Roles and responsibilities	19
Health and Wellbeing Board Interface	20
Membership	21
Meetings	23
Accountability and reporting	25
Review	25

Introduction

On February 11th 2021, the Department for Health and Social Care published its White Paper *Integration and Innovation: working together to improve health and social care for all*.

The proposals within the White Paper follow the journey of integrating care - a journey that South Yorkshire and Bassetlaw (SYB) has been on since 2016. They take account of NHS England and Improvement's recommendations to government following its engagement on Integrating Care – the Next Steps in November 2020.

The White Paper builds on the NHS Long-Term Plan with a strong emphasis on improving population health and tackling health inequalities through a whole population approach. The shared purpose of our Integrated Care System (ICS) is to deliver the quadruple aim of;

- Better health and wellbeing for the whole population
- Better quality care for all patients
- sustainable services for the taxpayer; and
- a reduction in health inequalities.

The White Paper also responds to the recommendation to strengthen governance, transparency and public accountability, to remove barriers and to give the opportunity to develop an even deeper relationship with Local Authority partners in ICSs. It includes the formal merger of NHS England and Improvement as a new statutory body, NHS England.

ICSs of the future are expressed as a NHS Statutory Body with an NHS Board and separately, a statutory Health and Care Partnership.

The Health and Care Partnership is an opportunity to address the wider health, public health and social care needs of the system, with the NHS ICS Board and Local Authorities having regard to that plan when making decisions.

The current indicative timeline for progression of the proposals through parliamentary process sees the earliest that the Bill will become an Act of Parliament is January 2022, with the provisions of the Act brought into effect in April 2022.

This document sets out an agreed way of working in South Yorkshire and Bassetlaw for the Health and Care Partnership during the transition year 2021-22 as partners get ready to set up a statutory organisation. Partners will continue to work within existing statutory frameworks during this time while developing future ways of working which will cover:

- Provider collaboratives
- Place-based partnerships
- How the nature of commissioning will change
- Integrated care system operating model

SYB partners formed a Steering Group to oversee the development work. The Group has been meeting regularly to co-produce the Compact and the roles and responsibilities, scope, accountability and reporting of the Health and Care Partnership for the transition year 2021/22.

The Compact captures the commitment of SYB health and care partners in focussing on the key purposes of an ICS and quadruple aim of better health and wellbeing for the whole population, better quality care for all patients, sustainable services for the taxpayers and reduction in health inequalities.

The new Health and Care Partnership for 2021/22 has a terms of reference and membership with a golden thread from the Health and Care Compact.

The Compact and Health and Care Partnership are interim arrangements for the year 2021/22 and will be refreshed as guidance and legislation is published.

The Steering Group has agreed to continue to meet during the transition year and continue to progress the development agenda as outlined in the timetable below (taken from the NHS 2021/22 priorities and operational planning guidance implementation guidance).

Route Map for ICS Development 2021/22

Route Map

By end Q1 Update System Development Plans and confirm proposed boundaries, constituent partner organisations and place-based arrangements.

By end Q2 Confirm designate appointments to ICS chair and chief executive positions (following the second reading of the Bill and in line with senior appointments guidance to be issued by NHSEI).

Confirm proposed governance arrangements for health and care partnership and NHS ICS body.

By end Q3 Confirm designate appointments to other ICS NHS body executive leadership roles, including place-level leaders, and non-executive roles.

By end Q4 Confirm designate appointments to any remaining senior ICS roles.

Complete due diligence and preparations for staff and property (assets and liabilities) transfers from CCGs to new ICS bodies.

Submit ICS NHS body Constitution for approval and agree "MOU" with NHS England and NHS Improvement.

1 April - Establish new ICS NHS body; with staff and property (assets and liabilities) transferred and boards in place.

Steering Group

Steering Group Member	Workstream	Designation
Richard Parker	Bassetlaw Place Partnership	Chief Executive, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
Sarah Norman	Barnsley Place Partnership	Chief Executive, Barnsley Metropolitan Borough Council
Damian Alan	Doncaster Place Partnership	Chief Executive, Doncaster Metropolitan Borough Council
Sharon Kemp	Rotherham Place Partnership	Chief Executive, Rotherham Metropolitan Borough Council
Kirsten Major	Sheffield Place Partnership	Chief Executive, Sheffield Teaching Hospitals NHS Foundation Trust
Kathryn Singh	System Mental Health Alliance	Chief Executive, Rotherham, Doncaster and South Humber NHS Foundation Trust
Richard Jenkins	System Acute Federation	Chief Executive, Barnsley Hospital NHS Foundation Trust and Interim Chief Executive, The Rotherham NHS Foundation Trust
John Somers (Deputy Ruth Brown)	System Children's and Young People Collaborative	Chief Executive, Sheffield Children's NHS Foundation Trust
Jackie Pederson	Commissioning (Doncaster) and Primary Care System Collaborative	Accountable Officer, Doncaster Clinical Commissioning Group
Idris Griffiths	Commissioning (Bassetlaw)	Accountable Officer, Bassetlaw Clinical Commissioning Group
Chris Edwards	Commissioning (Rotherham)	Accountable Officer, Rotherham Clinical Commissioning Group
Nick Balac	Commissioning (Barnsley)	Clinical Chair, Barnsley Clinical Commissioning Group
Lesley Smith	Commissioning (Sheffield)	Accountable Officer, Sheffield Clinical Commissioning Group and SYB ICS Deputy System Lead
Catherine Burn	System – Voluntary Sector	Voluntary Sector Representative
Adrian England	System – Healthwatch	Healthwatch Representative
Andrew Cash	System	System Lead, SYB ICS
Will Cleary-Gray	System	Chief Operating Officer, SYB ICS
In attendance		
Mike Farrar	-	Independent Consultant
Robert McGough	-	Partner, Hill Dickinson
Helen Stevens-Jones	System	Director of Communications and Engagement, SYB ICS
Chris Walker	-	Attain
Sophia Malik	-	Attain

Design Group

Steering Group Member	Workstream	Designation
Damian Alan	Doncaster Place Partnership	Chief Executive, Doncaster Metropolitan Borough Council
Sharon Kemp	Rotherham Place Partnership	Chief Executive, Rotherham Metropolitan Borough Council
Alexis Chappell	Sheffield Place Partnership (Nominated by Sharon Kemp)	Director of Adult Social Services Sheffield City Council
Kirsten Major	Sheffield Place Partnership	Chief Executive, Sheffield Teaching Hospitals NHS Foundation Trust
Kathryn Singh	System Mental Health Alliance	Chief Executive, Rotherham, Doncaster and South Humber NHS Foundation Trust
Richard Jenkins	System Acute Federation	Chief Executive, Barnsley Hospital NHS Foundation Trust and Interim Chief Executive, The Rotherham NHS Foundation Trust
Jackie Pederson	Commissioning (Doncaster) and Primary Care System Collaborative	Accountable Officer, Doncaster Clinical Commissioning Group
Idris Griffiths	Commissioning (Bassetlaw)	Accountable Officer, Bassetlaw Clinical Commissioning Group
Chris Edwards	Commissioning (Rotherham)	Accountable Officer, Rotherham Clinical Commissioning Group
Nick Balac	Commissioning (Barnsley)	Clinical Chair, Barnsley Clinical Commissioning Group
Lesley Smith	Commissioning (Sheffield)	Accountable Officer, Sheffield Clinical Commissioning Group and SYB ICS Deputy System Lead
Catherine Burn	System – Voluntary Sector	Voluntary Sector Representative
Adrian England	System – Healthwatch	Healthwatch Representative
Andrew Cash	System	System Lead
Will Cleary-Gray	System	Chief Operating Officer, SYB ICS
In attendance		
Robert McGough	-	Partner, Hill Dickinson
Helen Stevens-Jones	System	Director of Communications and Engagement, SYB ICS
Chris Walker	-	Attain
Sophia Malik	-	Attain

Health and Care Compact



The aim of partners in the South Yorkshire and Bassetlaw Integrated Care System is to bring about better health and wellbeing for the whole population, better quality care for all patients and sustainable services for the taxpayer.

The Compact enshrines the collaboration and principles of working together and is intended to be a golden thread during the transitional year 2021/22.

Health and Care Compact

Background and Purpose

The South Yorkshire and Bassetlaw Integrated Care System (ICS) has evolved from the establishment of a Sustainability and Transformation Partnerships in January 2016, Accountable Care Systems, April 2017, to become one of the first ICS systems in England. The ICS comprises of five places, Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield.

The ICS vision is for everyone in South Yorkshire and Bassetlaw to have the best possible start in life, with support to be healthy and live well, for longer.

The partners of the ICS acknowledge the gross state of inequalities in South Yorkshire and Bassetlaw (SYB) and that these have widened during the Covid-19 pandemic. The Marmot Review highlighted that the health gap has grown between wealthy and deprived areas and that place matters in terms of deprivation and life expectancy. This is also reflected in the wider socio-economic challenges for the development of the SYB region.

There is a compelling need for the partners of the ICS to come together to better address the inequality issue using a transformational collaborative approach with their combined resources.

The shared purpose of the ICS is to deliver the quadruple aim (better health, care, value and reduced inequalities) in order to;

- Improve population health outcomes and;
- Reduce health inequalities for the population of SYB.

This will be through the prevention of ill health and provision of safe and high quality needs led/ outcome-focussed public services that work well together, looking after staff and managing health and ill health.

Data, technology and innovation will be harnessed across the ICS and at place to achieve this and enable transformational change to make SYB the best place to be born, live and work ('the Shared Purpose').

The Integrated Care System

Partners of the ICS now (those set out as signatories to this Compact below) are wishing to develop the ICS in response to the changes to the system set out in the White Paper:

Integration and Innovation:
working together to improve
health and social care for all

(the **White Paper**) and the forthcoming legislative changes from a Health and Care Bill to better meet the Shared Purpose.

The current core ICS arrangements consist of Collaborative Partnership Board, Health Oversight Board, Health Executive Group and Integrated Assurance Committee, together with a clinical forum, citizens' forum and a number of Programme Boards working with existing statutory governance. Partners of the ICS are seeking to transition to an appropriate approach to the ICS NHS Body and the Health and Care Partnership through 2021/22 and the adoption of the new Bill and this Compact will be reviewed during the course of the year to ensure that it and its membership reflects the current position and constituency of the ICS.

The new arrangements will include the development of a statutory ICS NHS Body and an associated ICS Health and Care Partnership (the **Partnership**). The Partnership will bring together health, social care, public health (and potentially representatives from the wider public space where appropriate, such as social care providers or housing providers) and the voluntary and community sector. Amongst its roles, it will be responsible for developing a plan that addresses the wider health, public health, and social care needs of the system - the ICS NHS Body and Local Authorities will have regard to the plan when making decisions.

This Compact sets out the underlying values and principles amongst the partners on matters that will guide the development of the ICS. It is not intended to be a legally binding document but rather a shared commitment. It should be used as a guide in discussions and for holding each other to account when developing the ICS and the Partnership.

The partners intend to work together in a collaborative and integrated way across system, place and neighbourhoods in SYB in line with the Values and Principles set out below, for the Shared Purpose.

Values and Principles for the ICS Partnership

The partners recognise that achieving the Shared Purpose will depend on their ability to effectively co-ordinate themselves in order to deliver an integrated approach to the provision of services across the ICS. This may include (if partners choose) combining expertise, workforce and resources and also a review of how the Health and Wellbeing Boards in each of the five Places can play a key role in the development and structure of the Partnership.

The partners also wish to support each other in the development of successful place based systems within the ICS for Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield, which will each work as an effective part of the wider system and key building block. Members will also deploy appropriate resource to support the Partnership (each member retains ownership of its resources and is solely responsible for decisions about how those resources are used).

The members will embrace the following values:

- The **'quadruple aim'** of 'better health and wellbeing for the whole population, better quality care for all patients and sustainable services for the taxpayer alongside the reduction of health inequalities
- To play their part in social and economic development and environmental sustainability of the SYB region
- Committing to making decisions

- Always keeping citizens at the centre of everything the partners do
- Ensuring that the children's, young people and families agenda is a key element of this work
- Supporting each other and working collaboratively to take decisions at the most local level as close as possible to the communities that they affect whether that be system, place or neighbourhood (subsidiarity) and not to simply replicate what is at place in the ICS
- Developing collaborative leadership to deliver the Shared Purpose, and a culture and values to support transformation. All partners are respected and valued. They understand their own contribution and support the contributions of other partners to the Shared Purpose
- Strengthen the links between Place and ICS as well as other local representative structures such as Health and Wellbeing Boards and demonstrate inclusivity and shared ownership
- Making time and other resources available to develop the Partnership and deepen working relationships between partners at all levels
- Being transparent with each other and the people of SYB around decisions and appointments
- Using the best available data to inform priorities and decision-making
- Looking for simplicity and effectiveness in any Partnership structures and governance and follow the rule of form following function

- Acting with honesty and integrity and trusting that each other will do the same; This includes each member being open about the interests of their organisation and any disagreement they have with a proposal or analysis. Partners will assume that each acts with good intentions; and
- Working to understand the perspective and impacts of their decisions on other parts of the health and social care system
- Decisions should be taken together at the right level to deliver the Shared Purpose and benefit the population of SYB. Decisions around resource at place should be made with the relevant partners at the place level and when decisions are taken together across the SYB system they should not adversely affect the outcomes or equity for populations within SYB ICS
- Communicating openly about major concerns, issues or opportunities relating to this Compact and adopting transparency as a core value, including through open book reporting and accounting, subject always to appropriate treatment of commercially sensitive information if applicable
- Having conversations about supporting the wider health and care system, not just furthering their own organisations’ interests
- Undertaking more aligned decision-making across the partners and trying to commission and deliver services in an integrated way wherever reasonably possible
- Routinely using insights from data to inform decision making
- Positive engagement with other partners in other geographies in pursuit of the quadruple aim and effective planning and delivery including Clinical and Professional Networks
- Ensure that problems are resolved where possible rather than being moved around the system
- Acting promptly. Recognising the importance of integrated working and the Partnership and responding to requests for support from other partners

...together these are the ‘Values’.

The ways in which the members will put the Values into practice include:

- Promoting and striving to adhere to the Nolan Principles of public life (selflessness, integrity, objectivity, accountability, openness, honesty and leadership) including:
- Specifically being accountable to each other for performance of respective roles and responsibilities for the Partnership and the ICS, in particular where there is an interface with other members; and

...together these are the ‘Principles’.



Signatories to the Compact

Organisation	Officer	Signature
Barnsley Clinical Commissioning Group		
Barnsley Hospital NHS Foundation Trust		
Barnsley Metropolitan Borough Council		
Bassetlaw Clinical Commissioning Group		
Bassetlaw District Council		
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust		
Doncaster Clinical Commissioning Group		
Doncaster Metropolitan Borough Council		
Healthwatch (signed on behalf of Healthwatch partners in SYB)		
Nottinghamshire Healthcare NHS Foundation Trust		
Nottinghamshire County Council		



Signatories to the Compact

Organisation	Officer	Signature
Rotherham Clinical Commissioning Group		
Rotherham Metropolitan Borough Council		
The Rotherham NHS Foundation Trust		
Rotherham, Doncaster and South Humber NHS Foundation Trust		
Sheffield Children's NHS Foundation Trust		
Sheffield City Council		
Sheffield Clinical Commissioning Group		
Sheffield Health and Social Care NHS Foundation Trust		
Sheffield Teaching Hospitals NHS Foundation Trust		
South West Yorkshire Partnership NHS Foundation Trust		
Voluntary, Community and Social Enterprise (VCSE) (signed on behalf of the VCSE partners in SYB)		



Health and Care Partnership Terms of Reference



The Health and Care Partnership is intended to be a springboard for bringing together health, local authorities and partners, to address the health, social care, and public health needs at a system level, and to support closer integration and collaborative working between health and social care.

Health and Care Partnership

Introduction

Transitional Phase to April 2022:

The South Yorkshire and Bassetlaw ICS Health and Care Partnership (H&CP) will replace the Collaborative Partnership Board. It will have a transitional role until the adoption of the statutory ICS in April 2022 (the Transitional Phase) and will be reviewed during this phase in the light of emerging legislation and guidance.

New statutory role post - April 2022:

As set out in the White Paper, ICSs will be established to include an NHS body and a Health and Care Partnership (H&CP).

The SYB H&CP has been co-produced and will be established in the transition year with the new structure in mind. Further guidance is expected from the Department of Health and Social Care which will inform its role.

Its role for this later period is expected to include promoting SYB partnership arrangements, and developing a plan to address the health, social care and public health needs of the SYB system. It is intended that (from April 2022) the ICS NHS Body and each local authority in SYB will have regard to this plan.

The role for the ICS H&CP post April 2022 will be developed by the members with reference to appropriate legislation and guidance during the Transitional Phase and the H&CP will support this process.

Roles and responsibilities

The H&CP is intended to be a springboard for bringing together health, local authorities and partners, to address the health, social care, and public health needs at a system level, and to support closer integration and collaborative working between health and social care.

In the Transitional Phase the H&CP's role and responsibilities will be to:

- a) **support delivery of the Shared Purpose (as set out in the Compact agreed between the ICS members)** working in partnership across the SYB ICS membership in particular around population health and the need for transformational changes to address health inequalities
- b) **engage with the Health and Wellbeing Boards at place** and have regard to their plans for their place as well as the plans from the place based partnerships in SYB in developing an ICS Health and Care Plan to address the systems' health, public health, and social care needs. (See Health and Wellbeing Board Interface section below)
- c) to set the framework within which the transitional ICS Executive and Health Executive Group (HEG) will operate in the Transitional Phase and to prepare for the transition to the new statutory structure for the ICS
- d) to involve, inform and engage patients, the public, staff and their representatives in the work of the partners of the ICS
- e) be responsible for the agreement and oversee the delivery of the SYB ICS Five Year Plan (and an annual refresh of this plan) as well as a finance plan and such other plans for SYB as may be agreed
- f) receive regular update reports from the transitional ICS Executive and Health Executive Group (HEG) on the ongoing progress of the transition to the new statutory form for the ICS on 1 April 2022
- g) provide a mutual assurance function and holding each other to account as outlined in the Compact
- h) support place-based joint working between the NHS, local government, community health services, and other partners such as the voluntary and community sector
- i) promote collaboration and the Values and Principles set out in the Compact across SYB through its constituent parts (organisational, provider collaboratives, place and neighbourhood)
- j) provide leadership across the SYB health economy to ensure that the values and principles for the SYB health and care system as set out in the Compact are followed

These roles and responsibilities will be reviewed during the Transitional Phase and will be periodically updated to reflect any agreed or required changes following legislation and guidance.

Health and Wellbeing Board Interface

We recognise the importance of bringing together ICSs and Health and Wellbeing Boards (HWB) as complementary bodies at system and place level. ICS NHS Bodies and Health and Care Partnerships will have formal duties to have regard to HWB plans.

The Health and Wellbeing Board Chairs (HWBC) for each of the constituent five places in SYB will be asked to meet to assure and agree the process and common format for the Joint Strategic Needs Assessments and Joint Health and Wellbeing Strategies as well as the timing for these to be presented to the H&CP in order to inform the H&CP planning process on the SYB plans for the forthcoming financial year.

In preparing the H&CP plan for SYB the H&CP will submit its draft plan to the HWBC at an agreed time in the planning process together with a summary of how the local HWB plans have been reflected in the SYB plan for review and comment.

The HWBC will have the option to either support the SYB plan or to make comments for consideration by the H&CP within an agreed timeframe.

The H&CP will also be required to inform the HWBC of how any of their documented concerns have been reflected in subsequent drafts or why they have not been included and provide the HWBC with a copy of the proposed final form of the H&CP plan when this is sent to the H&CP members for approval.

If the final form H&CP plan is not supported by the HWBC or they have specific concerns then they will have the option to attend and make representations at (or to table a document at the meeting reflecting their concerns) the H&CP Meeting where the H&CP plan is to be discussed or approved directly.

The intention of the members is to review this joint planning process over the Transitional Period and to consider prior to April 2022 whether the H&CP will require either the overview and review of the SYB plan by the HWB as set out above or alternatively the direct membership of the HWBC on the H&CP.

Membership

The H&CP will exercise its role in relation to the SYB ICS region.

Geographical scope

In the Transitional Phase it is acknowledged there will initially be a wider membership of the Health and Care Partnership (H&CP) building on places and recognising the current statutory framework including and up to April 2022. In the Transitional Phase the H&CP will facilitate the development of the H&CP to take on its statutory form and a refresh of the membership will take place following Department of Health and Social Care (DHSC) guidance expected in June/July. Membership will be reviewed in the light of this guidance and other local discussions in SYB, for example any other emerging provider collaboratives. At the same time, a small steering group will work to the Partnership in the transition year. In addition, the H&CP will engage Health and Wellbeing Boards to seek their views on how they wish to work with the H&CP in their respective statutory roles. We would seek to rotate the meeting in Local Authority premises where live streaming would be available and local people could attend. Meetings will be expertly facilitated, well-organised and with the opportunity for places to exchange ideas and all partners to agree on major system priority programmes. The H&CP will hold four meetings per year, with the possibility of two of the meetings having extended membership and

the format adapted to facilitate 1) input to the SYB strategic plan and priorities and 2) reviewing delivery against the plan and priorities.

The initial membership of the H&CP in the Transitional Phase will comprise of:

- a) Six nominations from each place, representing the views of commissioners and providers in each of our five places (30)

Nominations must include:

- Two nominations from the Local Authorities; Chief Executive and Director of Public Health
- Two nominations from CCGs, recognising the clinical leadership of these organisations; Clinical Chair and Accountable Officer
- GP Primary Care Collaborative representative for place (may take a few months to get in place)*
- One nomination from other Providers

- b) Provider collaboratives (6)

A Chair and Chief Executive from each provider collaborative:

- SYB Primary Care Programme Director and Community Pharmacy Representative*
- Mental Health Collaborative
- Acute Provider Collaborative

*NB primary care structures are still emerging.

- c) Yorkshire Ambulance Service and East Midlands Ambulance Service (2)
A Chair or Chief Executive nomination
- d) South Yorkshire Housing Association (1)
A Chair or Chief Executive nomination
- e) Voluntary, Community, Faith and Social Enterprise Sector (1)
 - One nomination representing voluntary, community, faith and social enterprise sector for SYB
- f) Clinical and professional representation (4)
 - One nomination representing adult social care for SYB
 - One nomination representing children, young people and families
 - One nomination representing Nursing and Midwifery for SYB
 - One nomination representing Allied Health Professionals for SYB
- g) Health Education England
 - One nomination representing Health Education England for SYB
- h) Healthwatch (1)
 - One nomination representing Healthwatch for SYB
- i) Strategic commissioning (2)
 - Clinical Chair Joint Committee of Clinical Commissioning Groups
NB Will also be a current CCG Clinical Chair
 - One nomination representing NHS England specialised commissioning
- j) South Yorkshire Combined Authority (1)
 - One nomination representing Sheffield City Region Combined Authority
- k) ICS system – seven nominations from SYB system to be determined by the ICS lead. (7)

Nominations must include:

 - ICS chair designate
 - ICS chief executive designate
 - ICS chief operating officer
 - ICS medical director
 - ICS digital lead (SRO)
 - ICS finance director

Lay member/Non Executive representatives of ICS programme priorities to include (for example) Equality, Diversity and Inclusion and public and patient involvement leads.

Meetings

The H&CP will operate in accordance with the SYB ICS Standing Orders.

The Chair may agree that members may participate in meetings by means of telephone, video or computer link or other live and uninterrupted conferencing facilities provided every member is able to be heard by every other member. Participation in a meeting in this manner shall constitute presence in person at such meeting.

The Chair may determine that the H&CP needs to meet on an urgent basis, in which case the notice period shall be as specified by the Chair acting reasonably. Urgent meetings may be held virtually, using any of the means specified above.

Secretariat support for the H&CP will be provided by the SYB ICS Programme Office hosted by NHS Sheffield CCG.

Quorum

The H&CP is considered quorate if there are representatives from each Place and the ICS Chair or lead are present along with at least two other system leadership members.

ICS Assembly Forum

The H&CP may opt to form an additional Assembly Forum sub-group of the H&CP which will have wider membership of organisations involved in health and care across SYB in order to allow them to participate in, influence and inform the work of the H&CP. The H&CP may decide on the terms of reference as well as how it will report to and receive input from the Assembly Forum.

Conflicts of interest

Members will ensure that they comply with the SYB ICS conflicts of interest policy and with their own host organisational requirements. Members will be transparent about any interest their organisation has in matters being discussed by the H&CP.

Registers of interest will be maintained for the H&CP and members are required to declare any interests annually, as well as on an ad-hoc basis as any should arise or become relevant in the context of their role on the H&CP.

Decision-Making

For the Transitional Phase the decision making is based on the consensus of the H&CP group and each member agrees to work together to seek to find agreement in accordance with the Values and Principles set out in the Compact.

It is acknowledged that the members will in many instances be the representatives for a wider group of organisations and will need to obtain approval from their appointing group on decisions in the H&CP. To assist in this members will be expected to communicate with their appointing groups prior to meetings and decisions of the H&CP in order to ensure that they are able to facilitate representation of their group in any discussions and decision making.

In the event that the members are unable to reach a consensus decision on a matter then they may refer this to dispute resolution whereby the matter will be discussed in a specific meeting of the H&CP to try to reach resolution working under the Values and Principles of the Compact. [If consensus has not been reached following this meeting then the consent of not less than [90]% of the eligible representative members will be taken as the decision of the H&CP.]

From April 2022 together with the ICS NHS Body the H&CP will constitute the ICS. It is intended that from April 2022 that the H&CP will be able to take its own decisions regarding matters within its remit such as the setting of the H&CP Plan for the SYB ICS.

The ICS NHS Body may also then delegate parts of its role to the H&CP. This will be done in accordance with the ICS NHS Body governance rules and these Terms of Reference will be updated accordingly prior to April 2022.

Frequency

It is proposed that the H&CP meets between four and six times per year to coincide with key budgetary, planning and priority setting timetables and that two of these meetings are broadened out to include a wider membership and format which facilitates input to developing the wider system plan and priority setting and sharing of progress, innovation, learning and best practice.

Deputies

Members will nominate deputies to attend on their behalf when they are unable to do so. Deputies should only be asked to attend a meeting in exceptional circumstances.

Public meetings

The members intend that the formal meetings of the H&CP from the end of the Transitional Phase shall be open to members of the public and that notice of these meetings will be provided via the ICS website. Members of the public may be excluded from a meeting for special reasons.

Where providing a record of a public meeting the H&CP minutes shall be made available to the public.

Accountability and reporting

In the Transitional Phase the H&CP will report on its work and the delivery of the H&CP plan into the Health Executive Group and transitional ICS Executive and members will be expected to ensure that the work of the H&CP is reported back into its member organisations directly.

From April 2022 the H&CP will form part of the statutory NHS South Yorkshire and Bassetlaw Integrated Care System.

The H&CP will then report on its work and the delivery of the H&CP plan into the SYB ICS NHS Body and members will be expected to ensure that the work of the H&CP is reported into member organisations.

The H&CP will also publish its plan to address the systems' health, public health, and social care needs and make this available to the public by such routes as the H&CP shall determine.

Review

These Terms of Reference will be reviewed after the draft Health and Care Bill is issued and following guidance on the structures for the ICS and thereafter on an annual basis from April 2022.

Reviewer

Date of review



South Yorkshire and Bassetlaw Integrated Care System

Health and Care Compact

Health and Care Partnership

Terms of Reference

www.healthandcaretogethersyb.co.uk

Email **helloworkingtogether@nhs.net**

Twitter **@SYBhealthcare**

Facebook **www.facebook.com/HealthandCareSYB**

Address **South Yorkshire and Bassetlaw Integrated Care System
722 Prince of Wales Road
Sheffield
S9 4EU**

Telephone: **0114 305 4487**

South Yorkshire and Bassetlaw Integrated Care System



**SYB ICS Development
Development Matrix
v1-4 08/04/21**



The South Yorkshire and Bassetlaw journey to becoming one of the first integrated care systems in the country has been one built on the foundations of strong partnerships formed over the last 5 years in each of our 5 Places, and across SYB, focusing together on delivering our ambitions for the population we serve.

The partnership has been co-created throughout this time and our vision has remained consistent: *For everyone in South Yorkshire and Bassetlaw to have the best possible start in life, with support to be healthy and live well, for longer.*

Integrated Care: Next steps to building strong and effective Integrated Care Systems and the White Paper, extended the requirements to develop Place models that build on the progress to date and support the journey across local systems. Importantly, the progress in the Barnsley, Bassetlaw, Doncaster, Rotherham and Sheffield Places has meant that the Places are already on this journey and have been for a number of years. The five Places are the cornerstone of the ICS and progressing jointly over the coming months, and throughout 21/22, is key to the success of the system and each of the Places.

Partners across SYB are working together to progress the transitional arrangements for 21/22 as per the guidance issued by NHS England and Improvement and ahead of legislative change for 2022. We have co-produced the Development Matrix to support partners on this journey and to help identify key requirements to evolve local models. The principle of subsidiarity has been agreed as fundamental to the model across SYB. However, to explore local decision making and delegated authority from the ICS NHS Board, there are likely to be key enablers that need to be implemented in each of the Places.

As part of the work to develop the ICS Operating Model, illustrative views of a potential form and approach have been developed. The following slides provide an overview of this. There is a shared understanding that this may evolve but importantly the slides set out some of the key areas in further developing Place Partnerships and Provider Collaboratives.

SYB System Priorities – Quadruple Aim

1. Better health and wellbeing for the whole population
2. Better quality care for all patients
3. Sustainable services for the taxpayer
4. Reduction of health inequalities

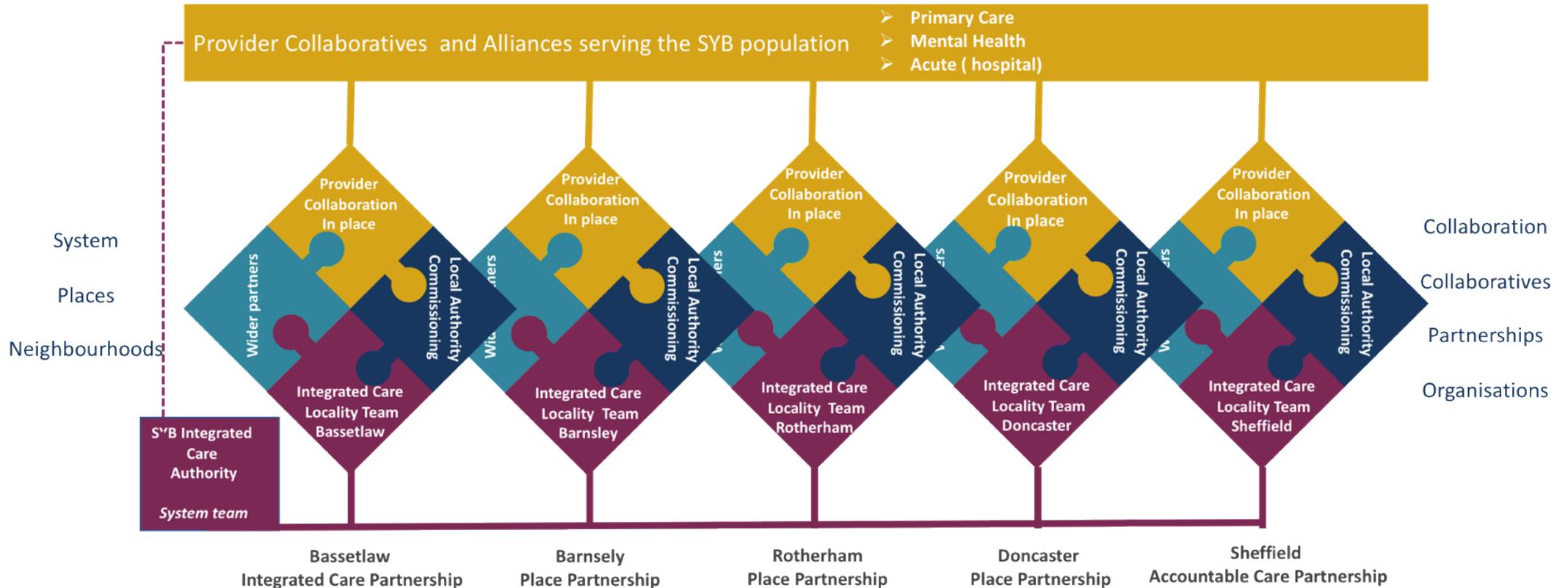
Place Developments

1. Joint Commissioning
2. Vertical Provider Collaborative
3. Place Partnership

High level illustration – Operating Model key components



A high level illustration of place partnerships and their key components in context of a future SYB NHS Integrated Care Authority



The ICS will be the new host employer for current CCG and ICS staff. The majority of staff will continue to work in place and continue to undertake similar roles as they do now and sometimes undertake functions wider than place where that is appropriate. Staff will take leadership and direction from place.

Providers of health care working in collaboration and collaboratives both in place and across the system to ensure the local place and total ICS population health and care needs are met.

NHS and Local Authorities working jointly and with other partners in place on population health, public involvement and coproduction supporting local integration, provider collaboration and service transformation



An illustration which helps us explore some of the key features of the emerging operating model

Providers of health and care are working together in Place:

- in collaboration,
- Collaboratives, and;
- As part of a wider strategic partnership

Local Authorities and the NHS are working Together in Place:

- Joint commissioning in place

How a wider strategic partnership in Place is bringing a wider set of partners together to:

- meet the needs of the place population



Delegation from the NHS Integrated Care Authority

- **Leadership, People capacity and skills to co-produce:**
 - Improving population health and reduce health inequalities
 - Development of primary care networks
 - Local integration, provider collaboration and services transformation
 - Coordinate local contribution to health, social and economic development
- **Financial resources, autonomy and decision-making capability including:**
 - Delegated budget to effectively discharge roles for the place population
- **Clear but flexible accountability framework including:**
 - Commissioning and risk management

SYB
Integrated
Care
Authority

And
system team

The Integrated Care NHS Authority will be the new host employer for current CCG and ICS staff. The majority of staff will continue to work in place and continue to undertake similar roles as they do now and they will take leadership and direction from place

South Yorkshire and Bassetlaw Integrated Care System



Development Matrix



The Development Matrix has been designed to support Places and Provider Collaboratives on their journey to achieve their ambition and place-based priorities. Its aim is to support the development of plans through the transition year. The key principles referenced below have been central to its development.

Key Principles

- 1. To enable flexibility, where this is required, to support Place Models and Provider Collaborative Models to deliver their ambitions for the local Place population**
- 2. To be reflective of the principle of subsidiarity**
- 3. To reflect the journey to date of the 5 Places in developing Partnerships**
- 4. To enable focus on the quadruple aim; supporting better health and well being, improving outcomes for the local population, focussing on the wider determinants of health and reducing health inequalities**
- 5. To further build the approach to the Matrix, understanding that the journey for Place and Provider Collaborative development will go beyond April 22**

The purpose of this document is to support development across Provider Collaboratives and Place Partnerships, and therefore a process for testing and using the tool to self-assess has been discussed. Throughout April and into early May, partners are encouraged to share their experiences of the tool and use this as a way to share good practice across the five Places and identify any areas where they may require further clarity and support as we further develop on this journey together.

Some of the areas included are applicable to both Place development and Provider Collaborative (vertical and horizontal) development; in time it may be that we start to split these out further to demonstrate the differences but as an initial draft we were keen to include all applicable areas to start to test our approach.

Development Matrix - approach

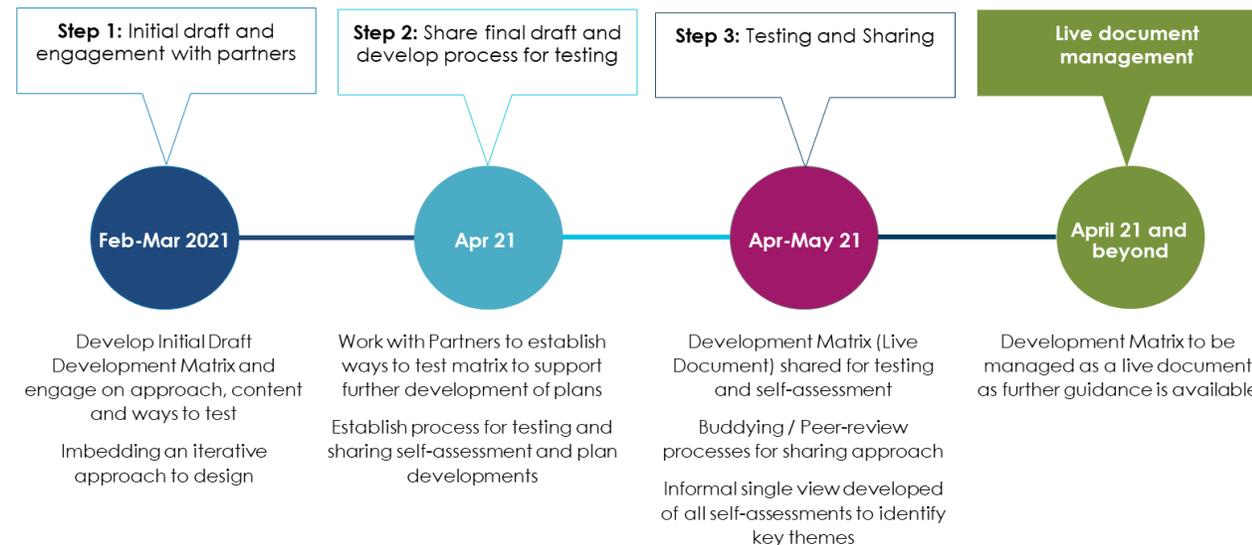


Central to the approach of the Development Matrix has been to engage with partners to establish an approach which is helpful to the development of Place and Provider Collaborative Plans, by taking an iterative approach and ahead of the testing phase in April/May 21.

This has included the following steps outlined in our approach.

Approach:

- 1. To work together across partners to co-produce a Matrix which supports the five Places and Provider Collaboratives in developing their plans for September 2021 and throughout 2021/22**
- 2. To identify key enablers and support from across the system to build on the successes to date**
- 3. To utilise the Matrix as a live document and update and evolve the approach as further clarity is provided nationally to best support local developments**
- 4. To develop a process for testing the Matrix in each of the five Places from April 21 and beyond, including a sharing and learning approach**





<u>1. Purpose and Vision</u>
<u>2. Leadership</u>
<u>3. Governance</u>
<u>4. Co-ordinated decision making and service design</u>
<u>5. Financial framework</u>
<u>6. Workforce and culture</u>
<u>7. Values and Behaviours</u>
<u>8. Integration of Services</u>
<u>9. Reporting, Quality and outcomes (contracting)</u>
<u>10. Population health management</u>
<u>11. BI and Digital Infrastructure</u>
<u>12. Defined population that is within scope of the Place</u>
<u>13. Public and patient engagement</u>

1. Purpose and vision



Purpose and Vision									
Thriving				The Place has a clear interface with the ICS to manage delegation/contracting and mechanisms for communication between ICS and Place are further developed.	All Partners have a shared vision and purpose that is agreed, documented and embedded throughout their organisations.	Alignment of the Place vision and purpose with the ICS vision and purpose, including as set out in any plans produced by the Place with the ICS (such as HWB and the ICS Health & Care Partnership). ICS Plans would reference Place developments	The strategy to achieve the shared vision and purpose is informed by PHM insights and the Place can demonstrate how it will use PHM techniques to help the place deliver improved outcomes	Partners are clear and can express the benefit the partnership work brings to the population at place and this is reflected in interactions and behaviours across the place and also between the place and the ICS.	Partners are developing relationships or working with wider partners (e.g. police, housing associations) to seek to address the wider determinants of health
Developing		All Partners have a shared vision and purpose that is agreed and documented though it may not yet have been embedded throughout the organisations themselves.	The strategy/plan is clearly aligned to the place-based Health and Wellbeing Board Strategy The strategy/ plan identifies key health inequalities and steps to tackle them.	The Place strategy/plan includes a road map for implementing population health management techniques across the Place.	There is an awareness at Place level of emerging plans of the ICS NHS Body and the ICS Health & Care Partnership	The Place has a clear interface with the ICS to manage delegation/contracting and mechanisms for communication between ICS and Place are being developed.			
Emerging	Partners have started coming together to develop a shared vision and purpose for their collaborative working. These working arrangements are informal currently and not binding.	Partners understand the need to embed tackling health inequalities and are exploring PHM approaches. strategy and objectives.	There is a clear strategy and/ or plan for the development of collaborative working and benefits of partnership working are recognised to achieve improved outcomes at Place and an ambition to share with other Partners across the ICS.						

2. Leadership



Leadership							
Thriving			The Place Partnership has developed structures and processes to enable both clinical and professional leaders to support the vision, strategy, plan and service design at Place	Partner leaders can demonstrate examples where they have taken action focused on collaboration across organisations to ensure greater benefit for the population and have not prioritised organisational interest or silo working.	Leadership team representation is agreed and reflected in governance. Partners have agreed to be represented by the single leadership team in wider ICS conversations with underpinning reporting and governance.	Leadership team is agreed and documented with roles defined and agreed across all organisations and reflected in governance structures with an associated track record for delivery.	Partner leaders are coming together to identify the common challenges facing them and are demonstrating that they are developing their responses to these together.
Developing		Leaders of Partners demonstrate their agreed values and behaviours in interactions with each other and the wider ICS.	Leaders of Partners are focused on collaboration across organisations and the value of collaborating for the population in line with the vision and shared purpose	Groups of clinical and professional leaders from Partners meet to discuss common issues of concern and are able in some instances to present a unified position for the Place/collaboration.	Leadership team at place/collaborative agreed by partner organisations.		
Emerging	Leaders work together to drive collaboration across the footprint though there is little formal structure around the place leadership.	Leadership groups at have begun to develop objectives for the Partnership / Collaborative.	Looking to increase engagement across key partners and sectors both at place and with the ICS and there is alignment forming with local Health and Wellbeing Boards.	Initial discussions are being held in relation to organisations representing each other on behalf of the Place or the collaborative in wider system discussions.	The Place has mechanisms to develop both clinical and professional leadership approaches.		



3. Governance



Governance							
Thriving			CEOs/AOs have delegated decision making authority from boards in agreed areas to allow common decisions to be taken by the Place Partnership Committee and/ or other groups	<p>The Place / Collaborative operating model has clear governance with lines of accountability alongside agreed terms of reference for the Partnership and associated groups. This is co-owned by the members and has reporting lines to the ICS NHS Body and constituent organisations for decision-making abilities (where appropriate). It should also have the ability to employ staff. The approach may include some of the following elements:</p> <p>Place Partnership Committee (with authority to make decisions on behalf of Partners, including if there is not consensus);</p> <ul style="list-style-type: none"> • Joint Commissioning Committee; • Collaborative of local providers; • a Partner willing and able to act as host; • a Vertical Provider Collaborative or suitable delivery entity that has the ability to hold and deliver contracts for services. 		An agreed infrastructure to support Place e.g. co-ordinated input from primary care networks and multi-professional teams to support delivery of plans.	Transparent and robust governance to support working and decision making in the system, connects to the democratic process through a strong relationship with the Health and Wellbeing Board.
Developing		<p>Governance structure agreed for Place Partnership which has agreed TOR and lines of accountability to ICS NHS Body and constituent organisations for decision-making abilities.</p> <ul style="list-style-type: none"> • Place Partnership Forum • Joint Commissioning Committee , • Vertical Provider Collaborative of local providers 	<p>Vertical Provider Collaborative is supported by formal governance arrangements e.g. a collaboration or alliance agreement with governance structures and representation to allow decision making</p>	<p>Partners are working towards a “weight-bearing infrastructure” that will enable joint appointments/ authorisation of a single leadership team across place or the collaborative.</p>			
Emerging	Local loose arrangements for a partnership forum enabling involvement and representation of all Partners. Ad hoc meetings of Partner leaders to discuss common issues of concern.	Discussions are being held regarding the development of a model for aligned and/ or joint decision-making that will enable the delivery of the place strategy/ plan.	Some joint decision-making through existing structures e.g. commissioners through BCF and section 75 arrangements	Issues that span different Partners are beginning to be addressed by all Partners working together and there are clear governance processes in place to address any issues.			



3. Co-ordinated decision making and service design



Co-ordinated decision making and service design				
Thriving		There is a shared infrastructure in development to enable the delivery of strategy and plans at place and neighbourhood.	<p>Primary Care is embedded in the working of the Place Partnership and wider system with clear alignment of plans.</p> <p>PCN leaders are participating at place and have access to required information.</p>	<p>Partners have developed structures to enable greater levels of co-ordinated decision-making with a focus on health outcomes and the wider determinants of health at Place level which could include:</p> <ul style="list-style-type: none"> • Joint commissioning: between the ICS and the Local Authority management of significant section 75 agreement (including Better Care Fund) or alternative joint committee arrangements with the local authority and other local partners for place integration. • Providers : wider place contracts (ICP or outcomes based) developed across groups of Providers with suitable legal structures in place across providers to manage delivery of specific services e.g. alliance or lead provider arrangements and/or provider joint committee • Providers: Partners have formed a Vertical Provider Collaborative to manage wider service delivery across the place or the collaborative as appropriate • Place Partnership: services and functions that Partners wish to work together on more closely are described in the shared governance arrangements
Developing	Primary Care is embedded in the processes for Place, and PCN Leaders are engaged in the Place Partnership and working at neighbourhood level.	Partners have co-ordinated their delivery where appropriate to the Place footprint	<p>Partners are developing structures to enable greater levels of co-ordinated decision-making at Place which could include:</p> <ul style="list-style-type: none"> • Joint commissioning: between the ICS and the Local Authority management of significant section 75 agreement (including Better Care Fund) or alternative joint committee arrangements with the local authority and other local partners. • Providers : wider place contracts (ICP or outcomes based) in development across groups of Providers with suitable legal structures in place across providers to manage delivery of specific services e.g. alliance or lead provider arrangements and/or provider joint committee • Providers: Partners are working to develop a Vertical Provider Collaborative to manage wider service delivery across the place or the collaborative as appropriate • Place Partnership: services and functions that Partners wish to work together on more closely are described in the shared governance arrangements 	
Emerging	<p>Developing an approach to co-ordinate decision-making and service delivery across the Place footprint by exercising functions in a co-ordinated way, which could include:</p> <ul style="list-style-type: none"> • Joint commissioning between the ICS and the Local Authority: increasing the level of joint commissioning e.g. through increasing the scope of the Better Care Fund section 75 arrangements. • Providers: working towards developing integrated pathways and models of care. • Providers: assessing the appetite for the creation of new joint committees e.g. between providers • Place Partnership: identifying the functions that they will want to explore exercising together at Place. 		Primary Care is engaged in the work and processes of the Place Partnership.	



5. Financial framework



Financial framework				
Thriving		Resources are targeted to system priorities through application of shared financial framework across the Place / Provider collaborative.	<p>Delivery against single financial plan with delegated authority/ contract from ICS NHS Board to manage budget and act within agreed financial framework</p> <p>Development of single budget to be managed by Place or Provider collaborative (e.g. via BCF or other contractual mechanisms)</p>	
Developing		<p>Documented financial plan across the Partnership / Collaborative as to how the financial arrangements will be managed across partners.</p> <p>Aligned/Pooled budgets and risk share agreements across place / collaborative</p> <p>Financial plans determined by individual Partners</p>		
Emerging	Small pooled or aligned budgets across specific pathways (with transparency of financial arrangements) that demonstrate integrated working.			

Development (Maturity) of Place Partnership / Provider Collaborative

NB: This section will be further developed as more information becomes available through national and regional work.

6. Workforce and culture



Workforce and culture							
Thriving				There is an OD culture of shared learning across the Place, sharing experience, best practice to support shared decision making alongside a clear programme to develop and support future system leaders.	There is a body that is able to employ staff where appropriate arrangements are in place e.g. one of the Partners acting as a host (it is unclear whether joint committees would be able to carry out this role)	Responsibilities for managing staff working are clearly allocated and where appropriate secondment arrangements are agreed. Joint appointments made where appropriate at all levels	There is a developed OD Plan which is supported by Leaders and socialised across the Place.
				Introducing a culture and mechanisms to support shared learning across Place, sharing experience and best practice.	Investment by Partners in the development of the relationships between Partners that underpin working at Place, at all levels of seniority. This includes investment of staff time and possibly also external resource to support organizational development	Staff feel they work for their local area not organisation	Plans to improve flexibility of movement between organisations. Joint appointments being explored to a leadership team and other posts
Developing							
Emerging	A documented shared ambition between the Partners to work towards representing each other as part of the Partnership / Collaborative.	Developing approach with ICS NHS Body and Partners to align CCG workforce and others to the Place / Collaborative.	Identifying areas where multi-professional working across organisations could be introduced or deepened	Developing an organisational development programme to deepen trust between Partner leaders	Partners are starting to build an understanding of the skills and capabilities required to deliver their aims and objectives jointly.		



7. Values and behaviours



Values and behaviours				
Thriving			Agreed values and behaviours are agreed and embedded across all staff working. Failure to adopt agreed values and behaviours is identified and addressed by Partners working together.	
Developing		Agreed values and behaviours are demonstrated by leaders and within their organisations and recognised by staff		
Emerging	Agreement across Partners on set of values and Behaviours			

8. Integration of services



Integration of services								
Thriving						Working in integrated teams has become the norm as the experience from “early adopter” pathways is extended	Integrated / aligned teams work across primary, secondary, social care, public health and other areas connected to the wider determinants of health e.g. housing, education	There are compelling plans to integrate primary care, mental health, social care, public health and hospital services further, and collaborate vertically to develop care design.
Developing		A deeper understanding within Partners of the challenges other Partners face in relation to care pathways that are within the areas of focus for the Place	A deeper understanding of how the actions of one Partner or Partners impact on others, including through public health and prevention measures	“Proof of concept” regarding the ability to work in a more collaborative and joined up way to obtain better outcomes for local populations has been achieved, although in limited areas	Plans to extend better integrated working to new areas (widening integrated care)	Plans to deepen existing integrated working e.g. through the use of multi-professional teams, co-located teams, shared budgets etc. in areas identified by the Partners.		
Emerging	Initial plans for, or limited provision of, ways of collaborative working between Partners that smooth the transition of service users into, through, out of and between organisations.	Conversations beginning between Partners regarding the impact their actions have on one another in relation to particular care pathways						



9. Reporting, quality and outcomes (contracting)



Reporting, quality and outcomes (contracting)				
Thriving			Routine reporting of the performance of the Place as a whole and its elements in a range of different formats, in alignment with the priorities identified by Place (alongside the ICS NHS Body, ICS Health & Care Partnership and Health & Wellbeing Board).	Quality and outcomes-based contracts/ delegation agreements with ICS NHS Body held at Place or by Provider Collaborative.
Developing	Reporting processes that allow the Place to report as one on some aspects of work/services to place partners and the ICS.	Single agreed set of outcomes across the Partnership to tackle priorities.	Small contracts/ delegation agreements in place for some services on an outcomes-based commissioning basis with ICS NHS body held at place or by Provider Collaborative.	
Emerging	Sets of target outcomes where joint or integrated working is in place, but such arrangements are limited.	Standard 'organisation-level' reporting on regular timetable, including to ICS NHS Body with limited evidence of interest in other methods for delivery of analysis for wider influence.		

10. Population health management



Population health management										
Thriving						Single view of population health and associated enabling dashboards	Health and Care outcomes feed into decisions about the allocation of resources e.g. where payment is linked to health outcomes	Commissioning/ service design, care interventions and outcomes at Place driven by population health and health inequalities considerations.	Insight derived from shared analysis is a key part of decision making by senior managers across Place.	Development of a common population health management support function that can be drawn on by Partners across the Place
Developing		Mechanism for decisions and outcomes to be driven by population health techniques and need to reduce health inequalities and focus on the wider determinants of health		Developing capacity to have a joint approach to data infrastructure, sharing and governance to enable: <ul style="list-style-type: none"> the forecasting of the population risk profile for the Place footprint; appropriate prioritisation of resources; further investment in prevention.; the tracking of health outcomes and health inequalities; and a “single version of the truth” to inform discussions about the above care interventions e.g. in groups experiencing high levels of health inequalities 			There is a clear understanding across Place / Provider Collaborative of the population health needs and this is driving the delivery of strategy / plans and approach			
Emerging	Focus on population health through local JSNA and the data that is available locally	Ad hoc generation, sharing and analysis of population health data where required.	Identification of key health inequalities that will be the focus of work by the Place	Partners are developing a shared understanding of their local population health needs.						



11. Business intelligence and digital infrastructure



Business intelligence and digital infrastructure								
Thriving				Data from across primary, secondary and social care is routinely linked, analysed and insights shared across Partners.	Linking with other data from other sources such as education and the police is being explored.	New ways of delivering analysis, to support decision-making, are starting to emerge, in particular using real time data and feeding straight to clinicians.	Joint approach to data infrastructure, sharing and governance Plans for the use of real-time linked data to inform service user care	Single digital approach with IT systems integrated across Partners
Developing			Data from across primary, secondary and social care is starting to be linked and there is proof of concept and imbedded within this is a view of the wider determinants of health.	Digital schemes being explored for joint implementation across organisations. Partners are beginning to align their decisions about IT infrastructure				
Emerging	Partners' IT and data infrastructures are not currently connected but a clear plan is in development to improve connectivity.	There is an approach developed to start to link Service user level data across different organisations						

12. Defined population that is within the scope of the Place



Defined population that is within the scope of the Place/ Provider Collaborative					
Thriving				<p>Shared understanding of both the Place population and high risk/target groups that are clearly defined and used as a basis for action and review, with specific cohorts and priorities clearly identified.</p> <p>Preventative measures used for target groups or specific cohorts.</p>	
Developing		Shared understanding of both the Place population and sub-groups.	Preventative measures starting to be considered for target groups or specific cohorts.		
Emerging	Population groups not clearly defined in terms of the whole Place, with a focus on historic organisational boundaries.				

13. Patient and public engagement



Patient and public engagement					
Thriving			The Partnership / Provider Collaborative has a shared engagement and involvement plan which is being enacted and enables, and delivers, co-production.	Demonstrate effective service user and public engagement and involvement. And a clear understanding by service users and public of the Partnership and its work	Shared communications and engagement support service that can be utilised
Developing		Coordinated and streamlined approach to public and service user engagement and involvement.	Engagement built in to emerging governance structures Engagement carried out regarding the new ways of working and used to inform development	There is a clear approach to engage and involve the patients and public in developing strategy and plans.	
Emerging	Awareness of public and service user engagement and involvement legal obligations and requirements.	Evidence of working together to discharge requirements.			

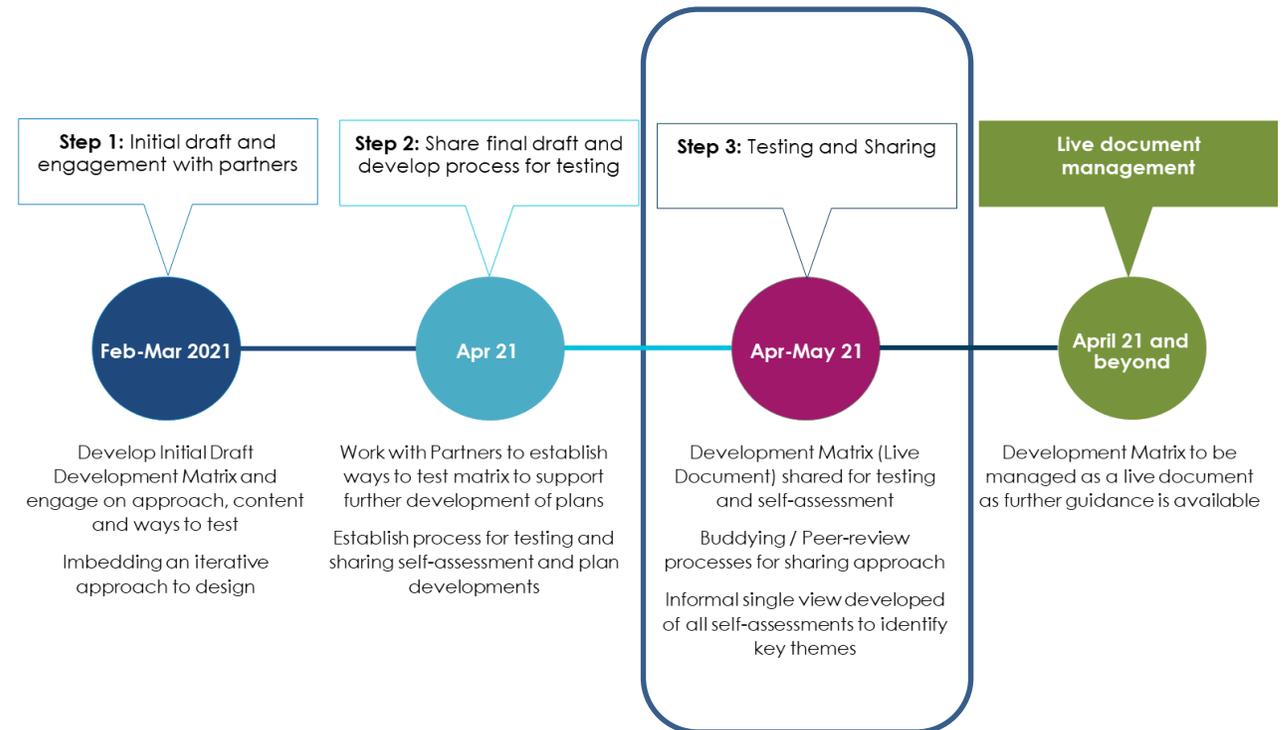


Next steps (April 2021)



To support the testing and sharing phase for the Development Matrix, the following key next steps will be implemented during April and early May:

- To share this final draft (live document) Development Matrix for testing with partners for April and in to early May
- To support us to enhance the use of the tool, we will develop a peer review process across partners to enable sharing and learning between Places and Provider Collaboratives
- The development of a single view of the self-assessments with support from Attain and Hill Dickinson colleagues to establish key themes and develop key areas that may be helpful to support
- To identify key enablers and requests for support and further clarity from partners
- As a separate piece of work, to develop an outline of potential processes around assessment and assurance in the development of a 'weight bearing Place Partnership' separate to this development tool



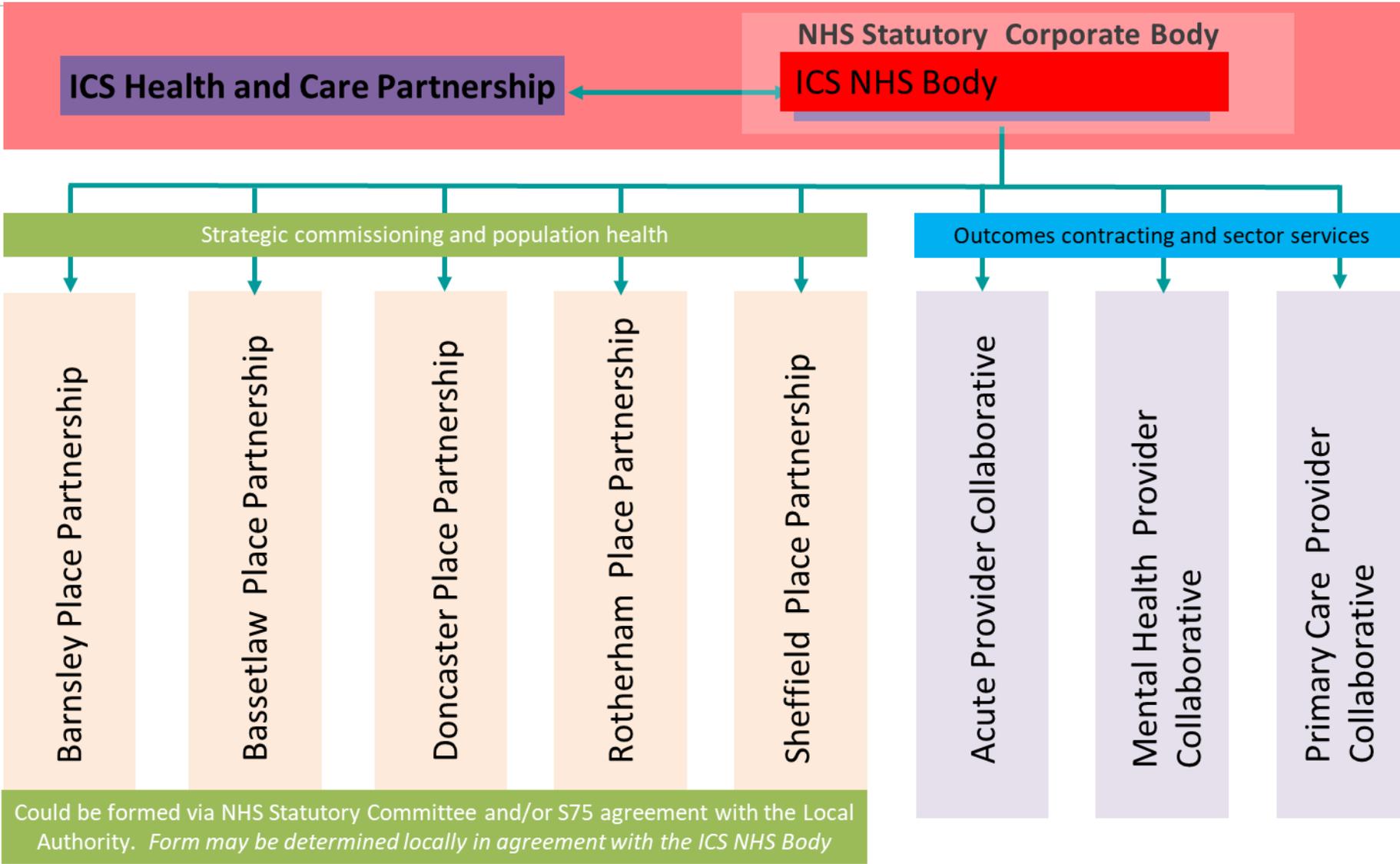
South Yorkshire and Bassetlaw Integrated Care System



Appendix 1- Background

ICS flow diagram - Illustrative example

Delegation and associated contractual relationships dependent on evolution (maturity) of both horizontal and vertical collaboratives



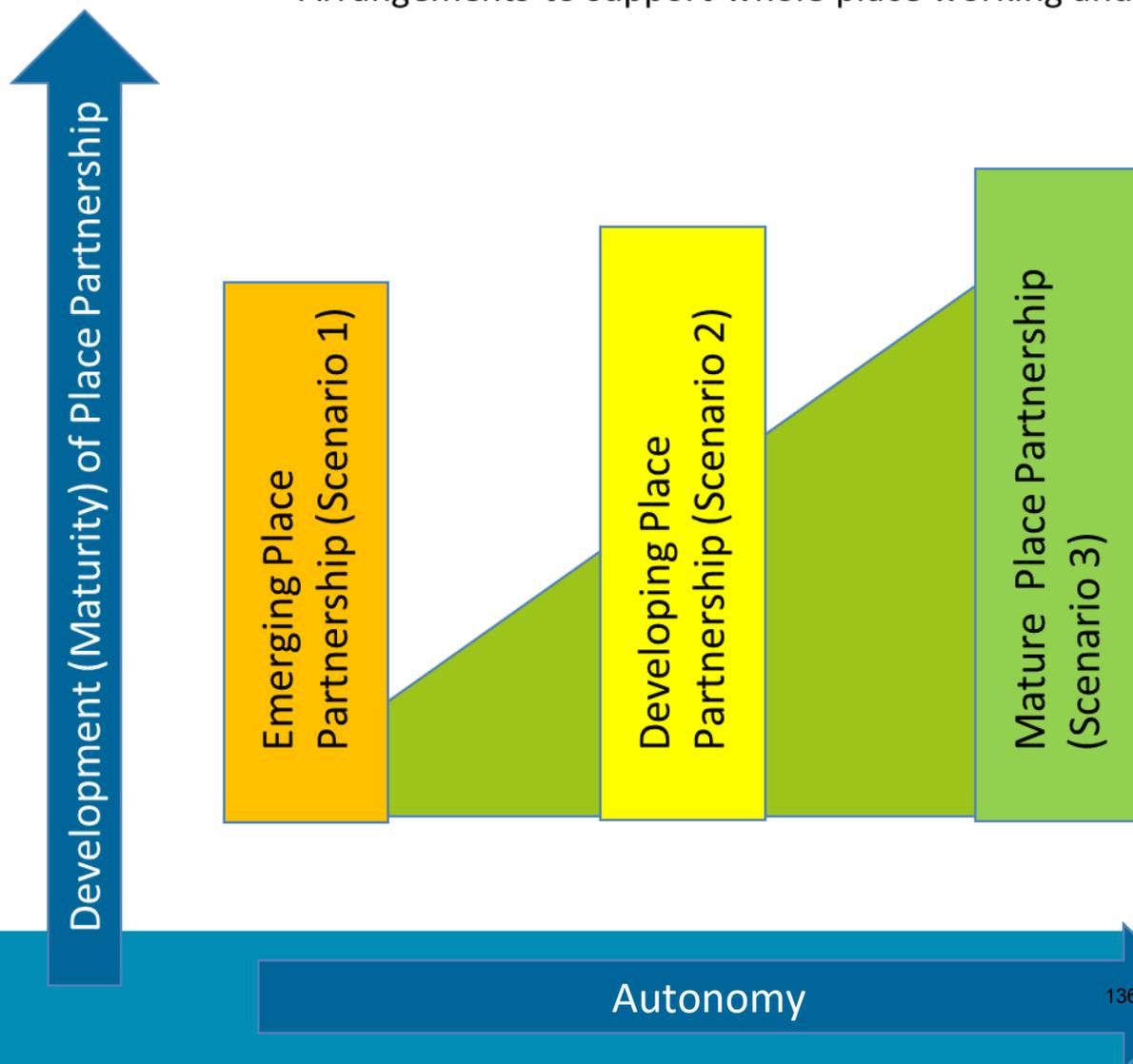
Statutory ICSs: ICS NHS Body and an ICS Health and Care Partnership (together referred to as the ICS)

Provider Collaboratives
Guidance on the main models for Provider Collaboratives is awaited

ICS and Place relationship – illustrative examples

Places have a number of key building blocks:

- Joint working with local authorities
- A provider partnership or collaborative
- Arrangements to support whole place working and integration



Assessment would be dependent on local position and development at place to manage delivery and accountability. Elements indicating the position of the place could include:

Place Partnership (Scenario 1) Emerging

- Informal arrangements in Place

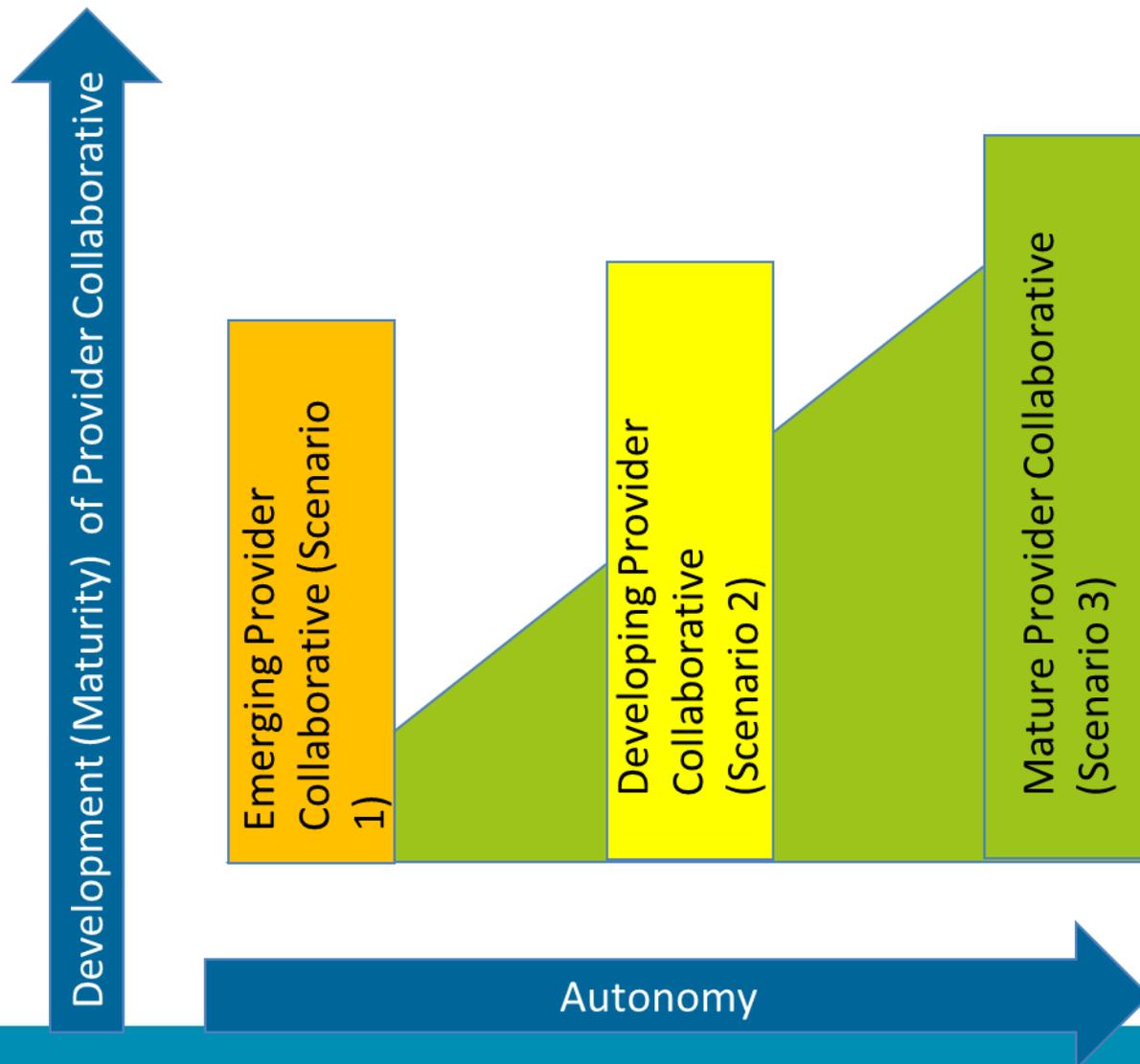
Place Partnership (Scenario 2) Developing

- More formal Provider Collaborative (vertical)
- Health and Social Care pooled budget with formal agreement

Place Partnership (Scenario 3) Mature

- Single voice or entity for place
- High level of delegation and autonomy to act

ICS and Provider Collaborative relationship - illustrative examples



Assessment would be dependent on local position and development of the collaborative to manage delivery and accountability. Elements indicating the position of the collaborative could include:

Emerging Provider Collaborative (Scenario 1)

- Provider Leadership Board
- Less formal arrangements

Developing Provider Collaborative (Scenario 2)

- Alliance agreement across organisations
- Lead Provider agreed

Mature Provider Collaborative (Scenario 3)

- Single Leadership across all organisations within collaborative
- Single organisation full merger

South Yorkshire and Bassetlaw Integrated Care System



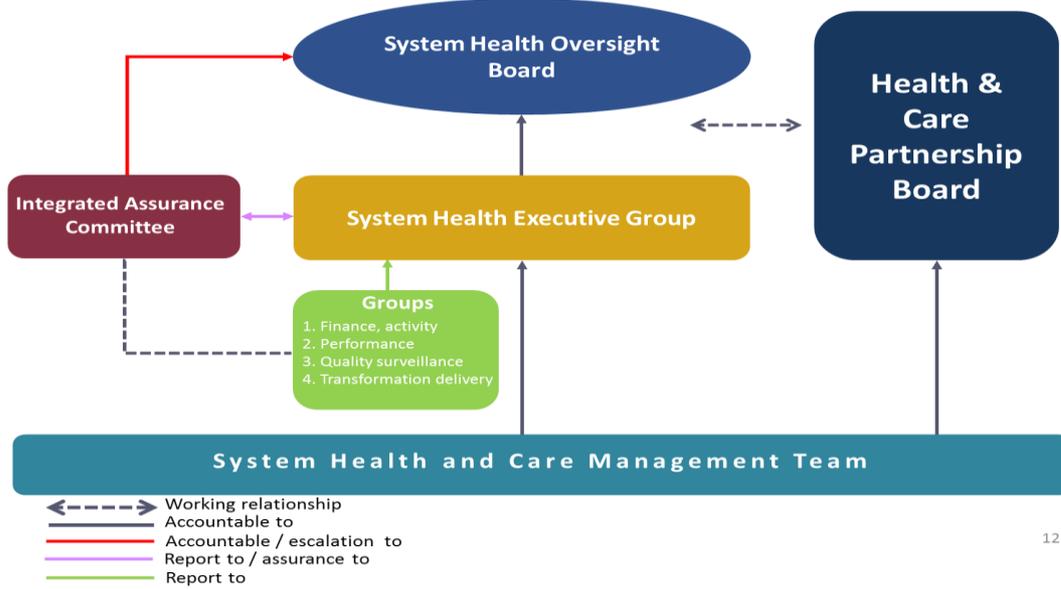
Appendix C – Summary of wider ICS governance

- i. **A Collaborative Partnership Board (CPB)** which is a guiding coalition, shaping strategy for health and care across SYB (covers the strategy of ICS members). Not decision making and wider than NHS partners.

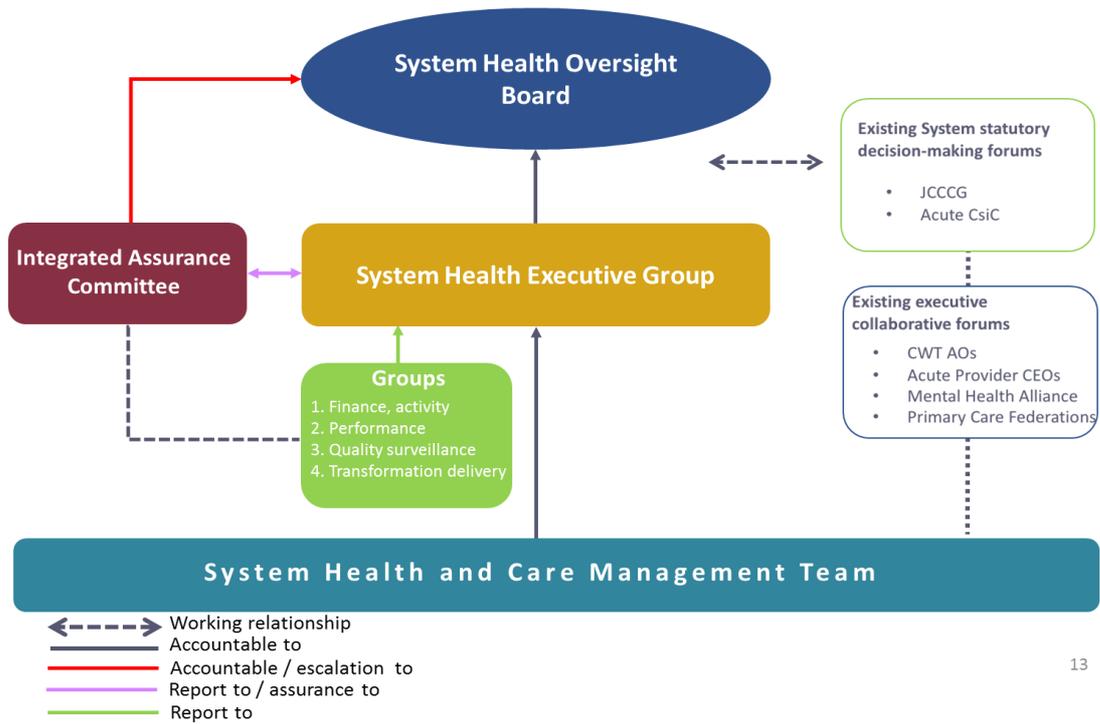
This forum will be replaced by the new Health and Care Partnership and its last meeting took place in May 2021.

- ii. **A Health Oversight Board (HOB)** and an **Integrated Assurance Committee (IAC)** which provide assurance on the collective performance of the system back to NHS England and Improvement (NHS E/I) and to member organisations predominantly NHS focused.
- iii. **A Health Executive Group (HEG)** which is the executive group which oversees collective performance, agrees the application of transformation funding in line with strategic direction and monitors system wide transformation programmes.
- iv. **Health and Care Management Team (HnCMT)**. Its role adapted during Covid-19, meeting weekly and serving as the regular touch point for system leaders in the strategic coordination of the Covid response and recovery.
- v. **An ICS Senior Management Team (SMT)** which is the core leadership team dedicated to system working, coordination and delivery of current ICS functions, responsibilities and transformation priorities.
- vi. **Joint Committee of Clinical Commissioning Groups (JCCCG)** which is a key component of ICS governance and the decision-making committee on service change and transformation covering the total allocation for SYB. It meets in public with oversight from the Joint Overview and Scrutiny Committee.
- vii. **Acute Federation and Acute Providers Committees in Common (CiC)** which is another key component of ICS governance, providing decision making on service change and transformation across SYB as delegated to it by Foundation Trusts.
- viii. **Governing bodies** and **FT Boards** for all joint developments and business cases which they have initiated, sponsored or funded or have been pump-primed by transformation funds, but not delegated to the JCCCG or CiC.

1. Summary schematic: SYB –ICS Interim governance arrangements for 2019/20



1a. Summary schematic: SYB –ICS Interim governance arrangements for 2019/20



Governing Body Meeting in Public

6th May 2021

Item No: 035

Report Title	Finance Report – Month 12
Author(s)	Georgina Mills, Senior Finance Manager
Sponsor (Director)	Richard Chapman, Chief Finance Officer

Paper for:	Decision	Assurance	x	Discussion	Information	x
Assurance Report Signed off by Chair			N/A			
Which committee has the subject matter been through?			Finance Committee – 29.4.2021			
Recommendations						
The Governing Body is requested to NOTE the following:						
<ul style="list-style-type: none"> the financial arrangements for H2, October 2020 to March 2021; a full year underspend of £0.298m has been delivered; cumulative allocations of £51.930m have been reimbursed for Covid-19 costs and Acute Independent Sector (IS), this includes a late NHSE/I reduction of a net £0.077m relating to a reduction in costs in month 12 in comparison to the month 11 forecast; and the top-up allocation stands at £6.865m. 						
Report Summary						
The report describes the year end 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 12, March 2021

Statutory Duty/ Performance	Target	Result	Achieved	Key	Comments/Trends
Achievement of expenditure to plan	£1,896.152m	£1,895.854m		Green <1%, Amber 1-5% Red >5%	Target achieved with a favourable variance of £0.298m.
Remain within the Running Cost Allowance	£18.986m	£18.210m		Green <1%, Amber 1-5% Red >5%	Running costs are underspent against planned expenditure with a favourable variance of £0.777m.
Remain within cash limit	Greatest of 1.25% of drawdown or £0.25m	0.21%		Green <1.25%, Amber 1.25-5% Red >5%	Closing cash balance of £0.326m against drawdown of £157.0m.
Achieve BPPC (Better Payment Practice Code)	>95% across 8 areas	Pass 8/8		Green 8/8 Amber 7/8 Red <6/8	In month and YTD payments of over 95% for invoices categorised as NHS and non NHS assessed on value and volume.

Operating Cost Statement For the H2 Period Ending: March 2021



Derby and Derbyshire Clinical Commissioning Group

	H2 (Months 7 to 12)			
	Months 7 to 12 Planned Expenditure	Months 7 to 12 Actual Expenditure	Months 7 to 12 Variance	Variance as a % of Planned Expenditure
	£'000's	£'000's	£'000's	%
Acute Services	516,702	521,241	(4,539)	(0.88)
Mental Health Services	115,023	110,245	4,778	4.15
Community Health Services	78,838	81,567	(2,729)	(3.46)
Continuing Health Care	88,405	56,923	31,482	35.61
Primary Care Services	116,698	107,798	8,900	7.63
Primary Care Co-Commissioning	76,892	77,880	(988)	(1.28)
Other Programme Services	47,899	45,912	1,986	4.15
Total Programme Resources	1,040,457	1,001,566	38,891	3.74
Running Costs	10,146	9,313	833	8.21
Total before Planned Deficit	1,050,603	1,010,879	39,724	3.78
In-Year Allocations	2,362	0	2,362	100.00
In year Planned Deficit (Control Total)	(33,900)	0	(33,900)	100.00
Total Incl Covid Costs	1,019,065	1,010,879	8,186	0.80
Allocations Adjustment Expected	(77)		(77)	
Total	1,018,988	1,010,879	8,109	0.80

The CCG received Covid and top up allocations relating to H1 in month 8 plus an additional £0.479m in month 11 relating to the Additional Roles Reimbursement Scheme.

In the ledger system, transactions cannot be backdated and therefore this gives a difference between the position shown in the ledger and the true position for H1 and H2. This is shown in the details below, which includes the final allocation adjustment of £0.077m.

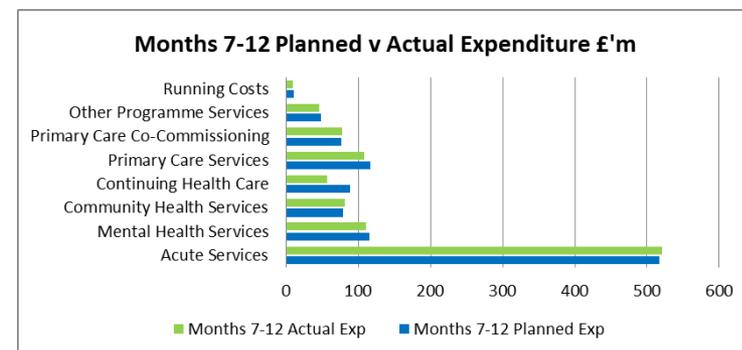
True Position Ledger Position

	£'000	£'000
H1	(2,822)	(7,811)
H2	3,120	8,109
	<u>298</u>	<u>298</u>

The reported variance for the second half of the financial year (H2) before planned deficit plus in-year allocations is an underspend of £39.724m. The CCG has a planned deficit for 2020-21 of £33.900m, and unused allocations of £2.362m giving an overall position of an underspend of £8.186m.

This position includes an amount of £0.077m relating to a reclaimable Covid underspend offset by the acute independent sector costs which are expected to be adjusted in a final allocation to remove this funding.

If the above amount is adjusted as expected this would give a surplus position of £8.109m for the second half of the financial year (H2).



Main Changes in Position – M11 to M12

Month 11 FOT Surplus	3.97
----------------------	------

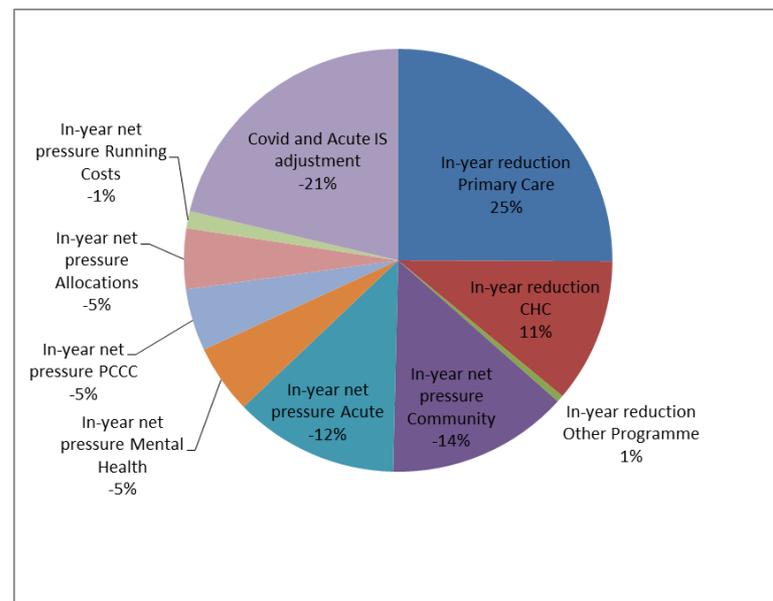
In-year reduction	Primary Care	3.44
	CHC	1.51
	Other Programme	0.07
In-year net pressure	Community	(1.89)
	Acute	(1.71)
	Mental Health	(0.72)
	PCCC	(0.65)
	Allocations	(0.64)
	Running Costs	(0.18)
	Covid and Acute IS Adjustment	(2.92)

Total Movement M11	(3.68)
--------------------	--------

Month 12 Position	0.30
-------------------	------

The forecast outturn movement mainly relates to:

- **Primary Care** – Prescribing actuals have reduced the position by £2.63m in addition to a net reduction of £0.38m in Covid and winter expenditure, £0.23m M12 allocations and a reduction in the expected GPIT outturn.
- **CHC** – Costs relating to Derby City and other funding packages materialised lower than expected in addition to the HDP reclaimable costs reducing from the forecast.
- **Other Programme** – A benefit arising from recharges for 111 activity offset by additional expenditure on BCF and a provision for EMAS PTS GAD fees.
- **Community** – A £2m non- recurrent contribution to care packages offset by lower activity on Independent Care providers for TOP and fertility.
- **Acute** – Additional £2m to CRH to cover cost of actual service delivery plus a small increase in One Health and Sheffield Teaching, partially offset by £0.543m allocation received for Acute IS spend.



- **Mental Health** – Increased expenditure on CAMHS covering cost of service delivery and a risk accrual on S117 partially offset by a Funded Transfer Agreement allocation and an improvement in PICU.
- **Co-Commissioning (PCCC)** – A provision for £1.06m to recognise the backlog of minor surgery activity in primary care as a result of Covid offset by a £0.3m benefit on an allocation for addition roles.
- **Allocations** – All required allocations have been transferred to the relevant service resulting in a reduction of those held centrally.
- **Running Costs** – Legal fees, premises and STP costs have increased offset by a reduction in CSU accruals due to an agreement on Telephony charges.
- **Covid and Acute IS Adjustment** – DHU testing services re categorised as Covid within the allocation envelope.

JUCD FINANCIAL SUMMARY

Month 12 Position	2020/21 Full Year		
	Plan £m	Mitigated Plan £m	Month 12 Actual £m
NHS Derby and Derbyshire CCG	(33.9)	(19.4)	0.298
Chesterfield Royal Hospital NHS Foundation Trust	(1.7)	1.4	(0.139)
Derbyshire Community Health Services NHS Foundation Trust	0.0	1.4	0.900
Derbyshire Healthcare NHS Foundation Trust	(0.6)	0.2	(2.100)
East Midlands Ambulance Service NHS Trust	0.0	0.4	0.900
University Hospitals Of Derby And Burton NHS Foundation Trust	(7.1)	(2.4)	0.500
JUCD Total	(43.3)	(18.3)	0.359

Note - All Number Above Assumed to be Based on NHS E Control Total Number, excluding impairments etc.

Governing Body Meeting in Public

6th May 2021

Item No: 037

Report Title	Audit Committee Assurance Report
Author(s)	Suzanne Pickering, Head of Governance
Sponsor (Director)	Ian Gibbard, Lay Member for Audit and Audit Committee Chair

Paper for:	Decision	Assurance	x	Discussion	Information
Assurance Report Signed off by Chair				Ian Gibbard, Audit Committee Chair	
Which committee has the subject matter been through?				Audit Committee – 28.4.2021	
Recommendations					
The Governing Body is requested to NOTE the contents of this report for information and assurance.					
Report Summary					
<p>This report provides the Governing Body with highlights from the 28th April 2021 meeting of the Audit Committee, and provides a brief summary of the items transacted for assurance.</p> <p>The focus of the meeting was to receive a thorough review and presentation of the Draft 2020/21 Annual Accounts.</p> <p>Internal Audit <u>360 Assurance Update Report</u> Audit Committee RECEIVED a verbal update of the 360 Assurance Internal Audit Report.</p> <p>The Audit Committee NOTED that there are two outstanding reports, the Data Security and Protection Toolkit report and the Joined Up Care Derbyshire report for 2020/21.</p> <p>The 2021/22 Internal Audit Plan will be delivered in the final 12 months of the CCG. Terms of References are in the process of being agreed.</p> <p>Draft 2020/21 Annual Accounts The Audit Committee RECEIVED a comprehensive review of the draft Annual Accounts and notes to the accounts, focusing on the areas of significant movement from 2019/20 to 2020/21.</p> <p>The draft 2020/21 Annual Accounts were submitted to NHSE and the External Auditors ahead of the deadline of 27th April.</p> <p>The Committee thanked the Finance team for their hard work.</p>					

Draft 2020/21 Annual Report

The Audit Committee RECEIVED the Draft Annual Report virtually prior to the Committee meeting for information and comments.

The Draft 2020/21 Annual Report was approved by the Accountable Officer and submitted to NHS England and the External Auditors ahead of the deadline on 27th April.

The Committee thanked the Governance team for their hard work,

Any Other Business

There was one item of any other business:

Forward Plan

The Audit Committee RECEIVED and NOTED no changes to the forward planner.

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

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

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

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

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

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

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

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

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

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

Have any Conflicts of Interest been identified/ actions taken?

None identified.

Governing Body Assurance Framework

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

Identification of Key Risks

Noted as above.

Governing Body Meeting in Public

6th May 2021

Item No: 038

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	x	Assurance	x	Discussion	Information
Assurance Report Signed off by Chair	Dr Ruth Cooper, CLCC Chair					
Which committee has the subject matter been through?	CLCC – 8.4.2021					
Recommendations						
The Governing Body is requested to RATIFY the decisions made by the Clinical and Lay Commissioning Committee (CLCC) on 8 th April 2021.						
Report Summary						
The following items had been circulated to CLCC previously for their virtual approval:						
<u>CLC/2122/07 CLCC Terms of Reference</u>						
CLCC were asked to AGREE the Terms of Reference and SUGGEST any further additions.						
CLCC AGREED the Terms of Reference, there were no additions.						
<u>CLC/2122/08 Clinical Policies to be ratified</u>						
CLCC VIRTUALLY ratified the Non-Standard MRI scan policy						
Areas for Service Development:						
CLCC VIRTUALLY 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 Guidance (DGs) for February 2021 and were ASSURED that no areas for service developments were identified.						
<u>CPAG Updates:</u>						
CLCC VIRTUALLY NOTED the following for information purposes:						
<ul style="list-style-type: none"> • Medtech Funding Mandate Policy 2021/22 • Evidence-based Interventions List 2 Guidance • Clinical Policies Specification • Orthotics Mobilisation Position Statement • Clinical Policies Specification • CPAG Policy Specification • CPAG Bulletin – February 						

<u>CLC/2123/10 CLCC Risk Tracker Emerging Risks</u>
CLCC RECEIVED AND NOTED the updated Emerging Risk Tracker.
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
Going forward any risks highlighted and assigned to the CLCC will be linked to the Derby and Derbyshire CCG Board Assurance Framework
Identification of Key Risks
As detailed in the report

Governing Body Meeting in Public

6th May 2021

Item No: 040

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

Paper for:	Decision	Assurance	x	Discussion	Information
Assurance Report Signed off by Chair				Dr Buk Dhadda, Quality and Performance Committee Chair	
Which committee has the subject matter been through?				Quality and Performance Committee – 29.4.2021	
Recommendations					
The Governing Body is requested to RECEIVE the paper for assurance purposes.					
Report Summary					
<u>Performance</u>					
Urgent and Emergency Care					
<ul style="list-style-type: none"> • The A&E standard was not met at a Derbyshire level at 87.7% (YTD 85.3%). CRH exceeded the 95% target in March 2021, achieving 97.6% (YTD 94.0%) and UHDB achieved 82.3% (YTD 80.0%), which is an improvement. • UHDB had 1x 12hour breach due to the availability of a mental health bed. • EMAS were compliant in 2 of the 6 national standards for Derbyshire during March 2021. 					
Planned Care					
<ul style="list-style-type: none"> • 18 Week Referral to Treatment (RTT) for incomplete pathways continues to be non-compliant at a CCG level at 59.5% (YTD 59.4%) CRHFT performance was 58.7% (YTD 60.0%) and UHDB 54.9% (YTD 53.2%). • Derbyshire had 7,562 breaches of the 52 week standard across all trusts - there were 5,903 the previous month so these have increased by a further 28%. • Diagnostics – The CCG performance was 30.35%, an improvement on the previous month of 38.5%. Neither CRH nor UHDB have achieved the standard. 					
Cancer					
During February 2021, Derbyshire was compliant in 2 of the 8 Cancer standards:					
<ul style="list-style-type: none"> • 31 day Subsequent Drugs – 97.4% (98% standard) – Compliant all Trusts except Sherwood Forest. • 31 day Subsequent Radiotherapy – 92.7% (94% standard) – Compliant for all 					

relevant Trusts.

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

- **2 week Urgent GP Referral** – 92.1% (93% standard) – Compliant for East Cheshire, Nottingham, Sheffield and Sherwood Forest.
- **2 week Exhibited Breast Symptoms** – 96.6% (93% standard) - Compliant for East Cheshire, Nottingham and Sherwood Forest.
- **31 day from Diagnosis** – 94.1% (96% standard) – Compliant for Chesterfield and Sherwood Forest.
- **31 day Subsequent Surgery** – 83.1% (94% standard) - Compliant for Chesterfield and Sherwood Forest.
- **62 day Urgent GP Referral** – 66.5% (85% standard) – Non compliant for all trusts.
- **62 day Screening Referral** – 73.5% (90% standard) – Non compliant for all trusts.
- **104 day wait** – 17 CCG patients waited over 104 days for treatment.

Quality

Chesterfield Royal Hospital FT

As highlighted last month HMSR in Congestive Heart Failure was highlighted as above expected levels. The CHF pathway has now been implemented and is having a positive impact. This is being monitored by the Trust's Mortality Committee to ensure further improvements are evidenced.

University Hospitals of Derby and Burton FT

The Trust have now completed a deep dive into falls. The report is first being shared with various Trust committees and will be shared with the DDCCG via CQRG once the internal reviews have taken place. Initial feedback indicates that the findings are of no surprise and relate to themes identified through incident management processes such as lying and standing BP not being undertaken.

Derbyshire Community Health Services FT

As at 24th March, 92.5% of frontline staff have received the first dose of the covid vaccination, 98% of Extremely Clinically Vulnerable (remainder exempt or declined). Uptake-up by colleagues from a BAME background is 83.6%; DCHS are continuing to work with the BAME network to try and close this gap and encourage take-up. This will be monitored through CQRG.

Derbyshire Healthcare Foundation Trust

The number of people inappropriately placed in acute mental health beds outside of Derbyshire reduced through March from a peak in February. February saw a rapid outbreak of COVID in a number of DHCFT wards, resulting in the rapid standing up of Audrey House as a cohorting facility. These actions limited the scale of the outbreak and Audrey House is again non-operational. The majority of patients placed outside the county are at Mill Lodge in Kegworth. Continuity of care arrangements with Mill Lodge are now in place. From April, all placements at Mill Lodge will not be reported as inappropriate out of area placements to NHSEI. Performance continues to be monitored weekly.

East Midlands Ambulance Trust

Two Serious Incidents (SIs) were reported in February 2021. These are the first SIs reported since December 2020. One related to management of a cardiac arrest and the other was related to non-conveyance of a patient with possible sepsis. Both cases are currently under investigation. Immediate supportive actions have been taken with the staff involved to reduce the risk of recurrence. In the year to date we have reported 37 SIs but 5 have since been downgraded, bringing the year to date total to 32, compared to 52 reported to the end of February 2020. will be monitored through QAG.

Update from the Committee held on 29th April 2021

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

The Committee noted the good performance in relation to cancer.

There is a deep dive on the patient referrals and waiting times underway. There is a recognition that this is affecting all in the system with appointments being backed up. For example, there has been an increase in ambulance response times.

The support for GPs with patients waiting for surgery was raised. This is not available on consultant connect. There is a working group that is addressing the need to expand the scope of consultant connect, including Stoke consultants.

In terms of activity the P2 and P3 patients are being reviewed and the two cohorts will be brought back to pre-covid figures by the end of September. The volume of A&E attenders is reported as below the activity at the start of the pandemic. At CRHFT the admission rate has significantly increased. This is linked to patients being redirected from A&E so patients attending A&E are more complex. As reported last month. Clinical urgency is used to prioritise the patients.

It was noted that whilst activity is not back to pre-covid rates the conversion rates are higher for example CRHFT conversion rate from A&E at CRHFT is 50% from pre covid rate of 30%.

The amendments to Governing Body Assurance Frameworks (GBAFs) 1 and 2 were approved by the committee. The risk register was reviewed, and the Psychiatric Intensive Care Unit (PICU) risk was reduced to 6. The covid second wave response report was discussed. It was noted that recovery will be restoration as quickly as possible alongside usual activity.

The CRHFT stroke report provided continued assurance on the development work taking place. The regional reporting has been stood down. It was agreed that the ongoing assurance will be through the Clinical Quality Review Group (CQRG) and any concerns will be escalated to Quality Committee. The national review rated CRHFT stroke at B, UHDBFT is rated as D. The scale is A (top) to E. The Medical Director at UHBDFT is seeking clarification on the rating. This will be reported to System Quality and Performance Committee.

The Committee noted that there will be a request for more emphasis on recovery

and restoration over the coming months.

The Committee was updated on the Children and Young People plan and the additional resources available to improve services particularly for vulnerable children. Managing children's mental health in General Practice was raised in terms of the recognition of the support they offer.

The Learning Disabilities Mortality Review (LeDeR) and Transforming care Partnership (TCP) reports were approved by the committee.

The minutes were signed off by the Chair as an accurate record. The assurance questions were reviewed and agreed by the Committee.

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

None identified.

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

N/A

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

N/A

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

N/A

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

N/A

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

N/A

Have any Conflicts of Interest been identified/ actions taken?

None

Governing Body Assurance Framework

The report covers all of the CCG objectives.

Identification of Key Risks

The report covers GBAFs 1-3.

Month 11

Quality & Performance Report

2020/21

April 2021

Contents Page

		Page
Executive Summary		3-4
Performance Overview		5-8
Quality Overview & Narrative		9-13
Urgent and Emergency Care	A&E	15-17
	NHS 111	18-19
	Ambulance	20-21
Planned Care	Referral to Treatment	23-25
	Over 52 Week Waits	26-27
	Diagnostic Waiting Times	28-30
	Cancer	31-39
Appendix: Associate Trust Performance Overview		41

EXECUTIVE SUMMARY

Key Messages	<ul style="list-style-type: none"> The tables on slides 5-8 show the latest validated CCG data against the constitutional targets. A more detailed overview of performance against the specific targets and the associated actions to manage performance is included in the body of this report.
Urgent & Emergency Care	<ul style="list-style-type: none"> The A&E standard was not met at a Derbyshire level at 87.7% (YTD 85.3%). CRH exceeded the 95% target in March 2021, achieving 97.6% (YTD 94.0%) and UHDB achieved 82.3% (YTD 80.0%), which is an improvement. UHDB had 1x 12hour breach due to the availability of a mental health bed. EMAS were compliant in 2 of the 6 national standards for Derbyshire during March 2021.
Planned Care	<ul style="list-style-type: none"> 18 Week Referral to Treatment (RTT) for incomplete pathways continues to be non-compliant at a CCG level at 59.5% (YTD 59.4%) CRHFT performance was 58.7% (YTD 60.0%) and UHDB 54.9% (YTD 53.2%). Derbyshire had 7,562 breaches of the 52 week standard across all trusts - there were 5,903 the previous month so these have increased by a further 28%. Diagnostics – The CCG performance was 30.35%, an improvement from the previous month. Neither CRH or UHDB have achieved the standard.
Cancer	<p>During February 2021, Derbyshire was compliant in 2 of the 8 Cancer standards:</p> <ul style="list-style-type: none"> 31 day Subsequent Drugs – 97.4% (98% standard) – Compliant all Trusts except Sherwood Forest. 31 day Subsequent Radiotherapy – 92.7% (94% standard) – Compliant for all relevant Trusts. <p>During February 2021, Derbyshire was non-compliant in 6 of the 8 Cancer standards:</p> <ul style="list-style-type: none"> 2 week Urgent GP Referral – 92.1% (93% standard) – Compliant for East Cheshire, Nottingham, Sheffield and Sherwood Forest. 2 week Exhibited Breast Symptoms – 96.6% (93% standard) - Compliant for East Cheshire, Nottingham and Sherwood Forest. 31 day from Diagnosis – 94.1% (96% standard) – Compliant for Chesterfield and Sherwood Forest. 31 day Subsequent Surgery – 83.1% (94% standard) - Compliant for Chesterfield and Sherwood Forest. 62 day Urgent GP Referral – 66.5% (85% standard) – Non compliant for all trusts. 62 day Screening Referral – 73.5% (90% standard) – Non compliant for all trusts. 104 day wait – 17 CCG patients waited over 104 days for treatment.

Executive Summary

Trust	
Chesterfield Royal Hospital FT	<p><u>Mortality Review</u> As highlighted last month HMSR in Congestive Heart Failure was highlighted as above expected levels. The CHF pathway has now been implemented and is having a positive impact. This is being monitored by the Trust's Mortality Committee to ensure further improvements are evidenced.</p>
University Hospitals of Derby and Burton NHS FT	<p><u>Falls deep dive</u> The Trust have now completed a deep dive into falls. The report is first being shared with various Trust committees and will be shared with the DDCCG via CQRG once the internal reviews have taken place. Initial feedback indicates that the findings are of no surprise and relate to themes identified through incident management processes such as lying and standing BP not being undertaken.</p>
Derbyshire Community Health Services FT	<p>COVID-19 Vaccination: As at 24th March, 92.5% of frontline staff have received the first dose of the covid vaccination, 98% of Extremely Clinically Vulnerable (remainder exempt or declined). Uptake-up by colleagues from a BAME background is 83.6%; DCHS are continuing to work with the BAME network to try and close this gap and encourage take-up. This will be monitored through CQRG.</p>
Derbyshire Healthcare Foundation Trust	<p>Patients placed out of area: The number of people inappropriately placed in acute mental health beds outside of Derbyshire reduced through March from a peak in February. February saw a rapid outbreak of COVID in a number of DHCFT wards, resulting in the rapid standing up of Audrey House as a cohorting facility. These actions limited the scale of the outbreak and Audrey House is again non-operational. The majority of patients placed outside the county are at Mill Lodge in Kegworth. Continuity of care arrangements with Mill Lodge are now in place. From April, all placements at Mill Lodge will not be reported as inappropriate out of area placements to NHSEI. Performance continues to be monitored weekly.</p>
East Midlands Ambulance Trust	<p>Serious Incidents (SIs): Two Serious Incidents (SIs) were reported in February 2021. These are the first SIs reported since December 2020. One related to management of a cardiac arrest and the other was related to non-conveyance of a patient with possible sepsis. Both cases are currently under investigation. Immediate supportive actions have been taken with the staff involved to reduce the risk of recurrence. In the year to date we have reported 37 SIs but 5 have since been downgraded, bringing the year to date total to 32, compared to 52 reported to the end of February 2020. will be monitored through QAG.</p>

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

NHS Derby & Derbyshire CCG Assurance Dashboard										Key:		Performance Meeting Target		↑ Performance Improved From Previous Period		Performance Not Meeting Target		→ Performance Maintained From Previous Period		Indicator not applicable to organisation		↓ Performance Deteriorated From Previous Period	
EMAS Dashboard for Ambulance Performance Indicators										Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Q1 2020/21	Q2 2020/21	Q3 2020/21	Q4 2020/21	Current Month	YTD	consecutive months non-compliance
Urgent Care	Area	Indicator Name	Standard	Latest Period	East Midlands Ambulance Service Performance (NHSD&DCCG only - National Performance Measure)				EMAS Performance (Whole Organisation)			EMAS Completed Quarterly Performance 2020/21				NHS England							
	Ambulance System Indicators	Ambulance - Category 1 - Average Response Time	00:07:00	Mar-21	↓	00:07:33	00:07:20	9	00:07:09	00:07:11	8	00:06:32	00:07:18	00:07:35		00:06:47	00:07:18	0					
		Ambulance - Category 1 - 90th Percentile Respose Time	00:15:00	Mar-21	→	00:12:38	00:12:44	0	00:12:41	00:12:56	0	00:11:28	00:12:57	00:13:30		00:11:58	00:12:50	0					
		Ambulance - Category 2 - Average Response Time	00:18:00	Mar-21	→	00:22:34	00:22:39	8	00:23:57	00:23:11	9	00:15:36	00:23:12	00:28:19		00:18:24	00:23:46	8					
		Ambulance - Category 2 - 90th Percentile Respose Time	00:40:00	Mar-21	↓	00:46:19	00:46:22	8	00:48:55	00:47:53	8	00:30:19	00:47:36	00:58:38		00:36:16	00:49:03	0					
		Ambulance - Category 3 - 90th Percentile Respose Time	02:00:00	Mar-21	→	02:28:23	02:38:01	8	02:36:43	02:41:37	8	01:40:16	02:38:30	03:31:37		01:53:37	02:51:15	0					
		Ambulance - Category 4 - 90th Percentile Respose Time	03:00:00	Mar-21	↓	01:35:06	02:45:27	0	02:42:57	03:03:01	0	01:40:16	03:27:52	03:33:06		02:54:34	03:23:41	0					

Part A - National and Local Requirements																	
CCG Dashboard for NHS Constitution Indicators																	
Urgent Care																	
Area	Indicator Name	Standard	Latest Period	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	
NHS Derby & Derbyshire CCG							Chesterfield Royal Hospital FT			University Hospitals of Derby & Burton FT			NHS England				
Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	Mar-21	↓	87.7%	85.3%	66	97.6%	94.0%	0	82.3%	80.0%	66	87.3%	88.1%	66	
	A&E 12 Hour Trolley Waits	0	Mar-21					0	0	0	1	34	8	688	14123	66	
DToc	Delayed Transfers Of Care - % of Total Bed days Delayed	3.5%	Feb-20	↓	Reporting on this indictor has been suspended due to COVID-19			5.05%	1.95%	1	4.13%	3.61%	2	4.68%	4.22%	11	

PERFORMANCE OVERVIEW MONTH 11 – PLANNED CARE

NHS Derby & Derbyshire CCG Assurance Dashboard

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

Part A - National and Local Requirements

CCG Dashboard for NHS Constitution Indicators

CCG Dashboard for NHS Constitution Indicators					Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance
Area	Indicator Name	Standard	Latest Period	NHS Derby & Derbyshire CCG				Chesterfield Royal Hospital FT			University Hospitals of Derby & Burton FT			NHS England			
				Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	
Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Feb-21	↓	59.5%	59.4%	37	58.7%	65.0%	22	54.9%	53.2%	38	64.5%	61.9%	60	
	Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Feb-21	↓	7562	29188	13	1475	5217	11	8767	32882	12	387885	1692572	166	
Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Feb-21	↓	30.35%	39.73%	33	16.58%	31.72%	11	36.55%	41.81%	12	28.46%	37.33%	90	
2 Week Cancer Waits	All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	Feb-21	↑	92.1%	88.6%	6	Cancer 2 Week Wait Pilot Site - not currently reporting			85.9%	88.5%	6	90.3%	88.4%	9	
	Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	Feb-21	↑	79.8%	81.2%	4				62.4%	82.7%	3	71.5%	75.8%	9	
31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	96%	Feb-21	↓	94.1%	94.3%	2	97.2%	96.1%	0	94.1%	93.8%	7	94.7%	94.9%	2	
	Subsequent Surgery Within 31 Days Of Decision To Treat	94%	Feb-21	↑	83.1%	81.3%	15	100.0%	88.0%	0	81.8%	77.6%	10	87.5%	88.1%	31	
	Subsequent Drug Treatment Within 31 Days Of Decision To Treat	98%	Feb-21	↑	99.4%	98.5%	0	100.0%	100.0%	0	99.2%	98.2%	0	99.1%	99.1%	0	
	Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	Feb-21	↑	96.6%	95.2%	0				96.9%	94.4%	0	98.1%	96.4%	0	
62 Days Cancer Waits	First Treatment Administered Within 62 Days Of Urgent GP Referral	85%	Feb-21	↓	66.5%	71.7%	24	67.8%	77.1%	19	66.8%	71.4%	34	69.7%	74.3%	62	
	First Treatment Administered - 104+ Day Waits	0	Feb-21	↓	17	255	59	3	57	34	14	174	59	615	8736	62	
	First Treatment Administered Within 62 Days Of Screening Referral	90%	Feb-21	↓	73.5%	69.5%	22	82.6%	69.8%	22	69.2%	69.3%	3	72.1%	75.0%	35	
	First Treatment Administered Within 62 Days Of Consultant Upgrade	N/A	Feb-21	↓	83.9%	87.9%		100.0%	87.5%		94.1%	85.7%		78.8%	82.5%		
28 Day Faster Diagnosis	Diagnosis or Decision to Treat within 28 days of Urgent GP, Breast Symptom or Screening Referral	75%	Feb-21	↑	78.8%	75.8%	0										
Cancelled Operations	% Of Cancelled Operations Rebooked Over 28 Days	N/A	2019/20 Q3	↑	Reporting on this indicator has been suspended due to COVID-19			6.5%	12.1%		6.1%	5.2%		9.1%	8.4%		
	Number of Urgent Operations cancelled for the 2nd time	0	Feb-20	↔	Reporting on this indicator has been suspended due to COVID-19			0	0	0	0	0	0	20	163	1	

PERFORMANCE OVERVIEW MONTH 11 – PATIENT SAFETY

NHS Derby & Derbyshire CCG Assurance Dashboard

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

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

Part A - National and Local Requirements

CCG Dashboard for NHS Constitution Indicators

				Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	
Patient Safety	Mixed Sex Accommodation	Mixed Sex Accommodation Breaches	0	Feb-20	↓	4	89	11	0	5	0	10	128	11	4929	21179	11
	Incidence of healthcare associated Infection	Healthcare Acquired Infection (HCAI) Measure: MRSA Infections	0	Feb-21	↑	1	6	2	0	2	0	0	1	0	65	632	23
		Healthcare Acquired Infection (HCAI) Measure: C-Diff Infections	Plan		Feb-21	↑		216			32			108		11407	
			Actual				231	2		13	1		64	0			
		Healthcare Acquired Infection (HCAI) Measure: E-Coli	-	Feb-21	↑	64	786		17	207		35	533		64	786	
		Healthcare Acquired Infection (HCAI) Measure: MSSA	-	Feb-21	↓	24	212		7	56		18	133		961	10628	

PERFORMANCE OVERVIEW MONTH 11 – MENTAL HEALTH

CCG Dashboard for NHS Constitution Indicators				Direction of Travel	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure	
Mental Health	Area	Indicator Name	Standard	Latest Period	NHS Derby & Derbyshire CCG			Derbyshire Healthcare FT			NHS England									
	Early Intervention In Psychosis	Early Intervention In Psychosis - Admitted Patients Seen Within 2 Weeks Of Referral	60.0%	Jan-21	↓	83.3%	85.4%	0	90.9%	86.9%	0				64.5%	74.3%	0			
		Early Intervention In Psychosis - Patients on an Incomplete Pathway waiting less than 2 Weeks from Referral	60.0%	Jan-21	↓	75.0%	83.2%	0	75.0%	85.6%	0				32.3%	30.5%	21			
	Mental Health	Dementia Diagnosis Rate	67.0%	Feb-21	↓	64.6%	66.5%	0							61.1%	63.0%	0			
		Care Program Approach 7 Day Follow-Up	95.0%	2019/20 Q3	↑	96.1%	96.1%	0	96.1%	96.7%	0				95.5%	95.0%	0			
		CYPMH - Eating Disorder Waiting Time % urgent cases seen within 1 week		2020/21 Q3	↑	92.2%	74.6%													
		CYPMH - Eating Disorder Waiting Time % routine cases seen within 4 weeks		2020/21 Q3	↓	95.0%	83.9%													
		Perinatal - Increase access to community specialist perinatal MH services in secondary care	4.5%	2020/21 Q2	↓	3.4%	3.9%	3												
		Mental Health - Out Of Area Placements		Jan-21	↓	620	7540													
		Physical Health Checks for Patients with Severe Mental Illness	25%	2020/21 Q3	↓	18.3%	29.6%	3												
Mental Health	Area	Indicator Name	Standard	Latest Period	NHS Derby & Derbyshire CCG			Talking Mental Health Derbyshire (D&DCCG only)			Trent PTS (D&DCCG only)			Insight Healthcare (D&DCCG only)			Vita Health (D&DCCG only)			
	Improving Access to Psychological Therapies	IAPT - Number Entering Treatment As Proportion Of Estimated Need In The Population	Plan	Feb-21	↓	2.10%	23.10%													
			Actual			2.07%	22.75%	1												
	Improving Access to Psychological Therapies	IAPT - Proportion Completing Treatment That Are Moving To Recovery	50%	Feb-21	↓	45.6%	55.3%	1	56.8%	54.5%	0	39.0%	55.9%	1	62.5%	54.8%	0	62.4%	53.7%	0
		IAPT Waiting Times - The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment	75%	Feb-21	↓	84.3%	92.1%	0	97.7%	84.6%	0	77.7%	95.3%	0	97.1%	94.5%	0	98.2%	99.3%	0
IAPT Waiting Times - The proportion of people that wait 18 Weeks or less from referral to entering a course of IAPT treatment		95%	Feb-21	↓	85.2%	98.4%	1	100.0%	99.9%	0	78.0%	97.4%	1	100.0%	99.6%	0	100.0%	100.0%	0	
Referral to Treatment for planned consultant led treatment	Area	Indicator Name	Standard	Latest Period	Derbyshire Healthcare FT															
	DToc	Delayed Transfers Of Care - % of Total Bed days Delayed	3.5%	Feb-20	↑	1.34%	0.90%	0												
	Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Feb-21	↑	96.9%	89.6%	0												
Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways		0	Feb-21	↔	0	4	0													

Quality Overview

QUALITY OVERVIEW M11

Trust	Key Issues
Chesterfield Royal Hospital FT	<p>Protect, respect, connect-decisions about living and dying well during COVID-19 (CQC review): CRH report that they have been sighted on the CQC's review and that the correct use of RESPECT forms at CRH is very well embedded. The blanket use of DNACPR has been highlighted and work is ongoing in relation to this with medical staff to raise awareness and improve patient experience.</p> <p>Restoration: The position continues to improve allowing focus on increasing activity in other areas and supporting staff wellbeing.</p> <p>Mortality Review: As highlighted last month HMSR in CHF was highlighted as above expected levels. The CHF pathway has now been implemented and is having a positive impact. This is being monitored by the Trust's Mortality Committee to ensure further improvements are evidenced.</p>
University Hospitals of Derby and Burton NHS FT	<p>Protect, respect, connect-decisions about living and dying well during COVID-19 (CQC review): UHDB report to be in a strong position regarding this and this area was being closely monitored via their ethics committee during each wave of the COVID pandemic. Further work is being planned with the safeguarding team to ensure all improvements become business as usual.</p> <p>Restoration: UHDB position is also an improved one. Particular focus at the moment on staff wellbeing and supporting staff is a Trust priority. Work has been undertaken which aims to ensure there are no HCA vacancies by the end of March 2021, this has been achieved. Project workstreams are looking at improving recruitment, Trust welcome and induction processes.</p> <p>Falls deep dive: The Trust have now completed a deep dive into falls. The report is first being shared with various Trust committees and will be shared with the DDCCG via CQRG once the internal reviews have taken place. Initial feedback indicates that the findings are of no surprise and relate to themes identified through incident management processes such as lying and standing BP not being undertaken.</p>

QUALITY OVERVIEW M11 continued

Trust	Key Issues
Derbyshire Community Health Services FT	<p>COVID-19 Vaccination: As at 24th March, 92.5% of frontline staff have received the first dose of the covid vaccination, 98% of Extremely Clinically Vulnerable (remainder exempt or declined). Uptake-up by colleagues from a BAME background is 83.6%; DCHS are continuing to work with the BAME network to try and close this gap and encourage take-up. This will be monitored through CQRG.</p> <p>IPC: On the 3rd March 2021 an external assurance visit took place by the CCG accompanied by an IP&C Lead from an Acute Trust. The feedback was positive and the report will be incorporated into the Board Assurance Framework.</p>
Derbyshire Healthcare Foundation Trust	<p>COVID-19 vaccinations: 72% of the frontline workforce are reported as vaccinated by the end of February 2021. Vaccination for ward and community patients continues with hub, roving and low stimulus vaccination clinics in place. Uptake figures will be monitored through CQRG.</p> <p>Patients placed out of area: The number of people inappropriately placed in acute mental health beds outside of Derbyshire reduced through March from a peak in February. February saw a rapid outbreak of COVID in a number of DHCFT wards, resulting in the rapid standing up of Audrey House as a cohorting facility. These actions limited the scale of the outbreak and Audrey House is again non-operational. The majority of patients placed outside the county are at Mill Lodge in Kegworth. Continuity of care arrangements with Mill Lodge are now in place. From April, all placements at Mill Lodge will not be reported as inappropriate out of area placements to NHSEI. Performance continues to be monitored weekly.</p> <p>Waiting list for Autistic Spectrum Disorder (ASD) assessment: The referral rate for 2020/21 is currently the lowest over the past 24 months but still averaging over 38 in 2020/21 so far. Work is underway to establish additional resources as agreed by the Mental Health, Learning Disability and Autism Service Delivery Board.</p>
East Midlands Ambulance Trust	<p>Serious Incidents (SIs): Two Serious Incidents (SIs) were reported in February 2021. These are the first SIs reported since December 2020. One related to management of a cardiac arrest and the other was related to non-conveyance of a patient with possible sepsis. Both cases are currently under investigation. Immediate supportive actions have been taken with the staff involved to reduce the risk of recurrence. In the year to date we have reported 37 SIs but 5 have since been downgraded, bringing the year to date total to 32, compared to 52 reported to the end of February 2020. will be monitored through QAG.</p> <p>IPC: In February 2021 the Trust was managing ten outbreaks (with the last new positive case associated with any outbreak being identified five days previously). Weekly meetings held with Public Health England, NHSE/I, commissioners to provide an update and assurance in relation to Covid-19 outbreak management at EMAS. Feedback from partners continues to be positive about the way in which EMAS is managing outbreaks and no further actions have been identified as being required. To support outbreak management activity seven days per week additional senior IPC specialist support has been recruited to provide an additional two to three days per week support from 11 February 2021. IPC performance is monitored through QAG.</p>

QUALITY OVERVIEW M11

Derbyshire Wide Integrated Report

Part B: Provider Local Quality Indicators

Dashboard Key:

CCG assured by the evidence

CCG not assured by the evidence

Performance Improved From Previous Period

Performance Maintained From Previous Period

Performance Deteriorated From Previous Period

↑

↔

↓

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

QUALITY OVERVIEW M11

Part B: Acute & Non-Acute Provider Dashboard for Local Quality Indicators cont.				Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD	
Section	Area	Indicator Name	Standard	Chesterfield Royal Hospital NHS Foundation Trust				University Hospitals of Derby & Burton FT				Derbyshire Community Health Services				Derbyshire Healthcare FT				
Adult	VTE	Number of avoidable cases of hospital acquired VTE		Mar-20	↓	0	15	Feb-21	↔	0	TBC					Feb-21	↔	0	0	
		% Risk Assessments of all inpatients	90%	2019/20 Q3	↓	96.9%	97.4%	2019/20 Q3	↓	95.9%	96.1%	2019/20 Q3	↓	99.5%	99.7%					
	Mortality	Hospital Standardised Mortality Ratio (HSMR)	Not Higher Than Expected	Feb-21	↓	105.9		Nov-20	↔	107.4										
		Summary Hospital-level Mortality Indicator (SHMI): Ratio of Observed vs. Expected		Oct-20	↑	0.964		Oct-20	↓	0.898										
		Crude Mortality		Feb-21	↓	3.21%	2.29%	Feb-21	↑	3.00%	TBC									
Maternity	FFT	Antenatal service: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Feb-20	↑	95.5%	98.5%	Feb-20	↓	97.6%	95.1%									
		Labour ward/birthing unit/homebirth: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Feb-20	↑	97.8%	98.9%	Feb-20	↓	100.0%	98.1%									
		Postnatal Ward: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Feb-20	↓	100.0%	98.4%	Feb-20	↓	99.2%	98.0%									
		Postnatal community service: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Feb-20	↔	N/A	98.8%	Feb-20	↔	100.0%	97.8%									
Mental Health	Dementia	Dementia Care - % of patients ≥ 75 years old admitted where case finding is applied	90%	Feb-20	↑	100.0%	98.9%	Feb-20	↑	92.1%	90.9%									
		Dementia Care - % of patients identified who are appropriately assessed	90%	Feb-20	↔	100.0%	100.0%	Feb-20	↑	89.4%	85.4%									
		Dementia Care - Appropriate onward Referrals	95%	Feb-20	↔	100.0%	100.0%	Feb-20	↔	100.0%	99.3%									
	Inpatient Admissions	Under 18 Admissions to Adult Inpatient Facilities	0													Feb-21	↔	0	0	
Workforce	Staff	Staff turnover (%)		Feb-21	↔	8.0%	8.2%	Feb-21	↓	10.1%	TBC	Feb-21	↔	8.8%	8.8%	Feb-21	↔	10.3%	10.4%	
		Staff sickness - % WTE lost through staff sickness		Feb-21	↓	5.1%	5.2%	Feb-21	↑	5.4%	TBC	Feb-21	↑	5.2%	5.1%	Feb-21	↑	5.1%	5.5%	
		Vacancy rate by Trust (%)		Sep-17	↓	1.9%	1.3%	Data Not Provided in Required Format				Feb-21	↔	4.2%	3.7%	Feb-21	↑	6.7%	8.7%	
		Agency usage	Target Actual														Feb-21	↓	2.44%	1.29%
		Agency nursing spend vs plan (000's)		Feb-21	↑	£252	£3,251	Oct-18	↑	£723	£4,355	Feb-21	↑	£109	£1,063					
		Agency spend locum medical vs plan (000's)		Feb-21	↑	£856	£7,516													
	Training	% of Completed Appraisals	90%	Feb-21	↔	92.9%	73.9%	Feb-21	↑		79.8%	Feb-21	↑	84.6%	83.7%	Feb-21	↑	75.5%	76.5%	
Mandatory Training - % attendance at mandatory training		90%	Feb-21	↓	83.2%	84.2%	Feb-21	↓		83.9%	Feb-21	↓	96.1%	96.8%	Feb-21	↓	82.9%	85.3%		
Quality Schedule	Is the CCG assured by the evidence provided in the last quarter?	CCG assured by the evidence																		
CQUIN	CCG assurance of overall organisational delivery of CQUIN	CCG not assured by the evidence																		

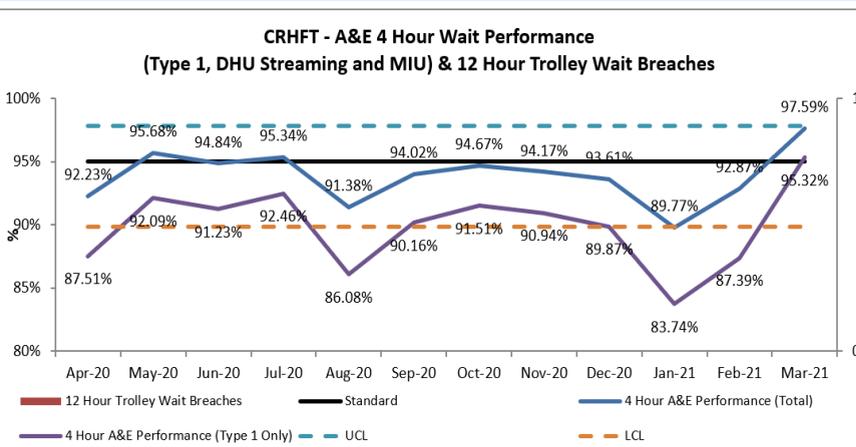
Urgent & Emergency Care

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

Performance Analysis

During March 2021 the trust met the 95% standard, achieving 97.6% and the Type 1 element achieving 95.3%. This is a significant improvement.

There were no 12 hour breaches during March.



What are the next steps?

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

What are the issues?

- At the start of the pandemic the volume of Type 1 attendances was much lower than for the same time last year (37.6% less in April) but the gap is now closing with only 1.8% less in March (an average of 157 attendances per day).
- Patient flow was affected by high numbers of confirmed Covid cases, with a third of inpatient beds taken up by these patients at peak times in February. However, the numbers have significantly reduced.

During the COVID-19 pandemic many A&E departments are highly pressured due to:

- The physical footprint of ED was increased to ensure social distancing but this can make it more difficult for the clinical lead to take a 'helicopter' view of the situation.
- Streaming of patients at the physical front door to ensure that patients with COVID19 symptoms were treated in the most appropriate setting.
- The redeployment of some staff to dedicated COVID19 wards.
- Staff absence due to sickness or self-isolation.
- Additional time required between seeing patients to turnaround the physical space ensuring increased strict infection control.

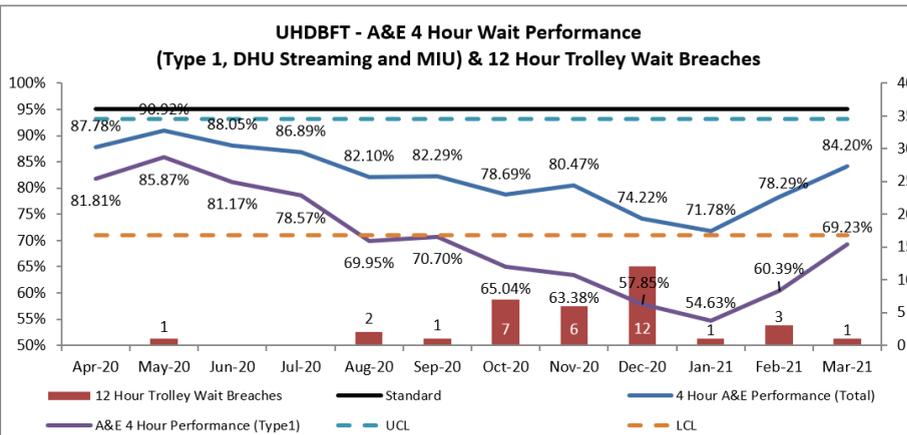
What actions have been taken?

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

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

Performance Analysis

During March 2021, performance overall did not meet the 95% standard, achieving 84.2% (Network figure) and 69.2% for Type 1 attendances. These show significant improvement since January. There was 1x12 hour breach during March 2021 due to the availability of a suitable mental health bed.



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

What are the next steps?

- Further development of the Urgent Treatment Centre, with an aspiration to operate 24/7.
- Improving the shared Pitstop area for patients arriving by ambulance.
- Increased public communications regarding 111First and Urgent Treatment Centres as alternatives to automatic A&E attendances.
- Identifying pathways where patients could be transferred to the Derby Urgent Treatment Centre instead of being seen in ED as Minors.
- Scoping the possibility of a co-located Urgent Treatment Centre.

What are the issues?

- At the start of the pandemic the volume of Type 1 attendances was much lower than for the same time last year (47.4% less in April) but the gap has now closed, with an average of 292 Type 1 attendances per day for March.
- The Trust declared OPEL Levels 3-4 throughout the month.
- The acuity of the attendances was high, with an average of 22 Resuscitation patients and 184 Major patients per day (8% and 63% of the total attendances respectively).
- Patient flow was affected by the high numbers of confirmed Covid cases during January & February, but are now significantly lower.
- ED and Assessment areas are separated in red/green areas according to Covid19 symptoms to ensure infection control. This limits physical space and therefore flexibility of patient flow. In addition, delayed Covid19 results have led to delays in transfers to the appropriate red/green assessment areas.

What actions have been taken?

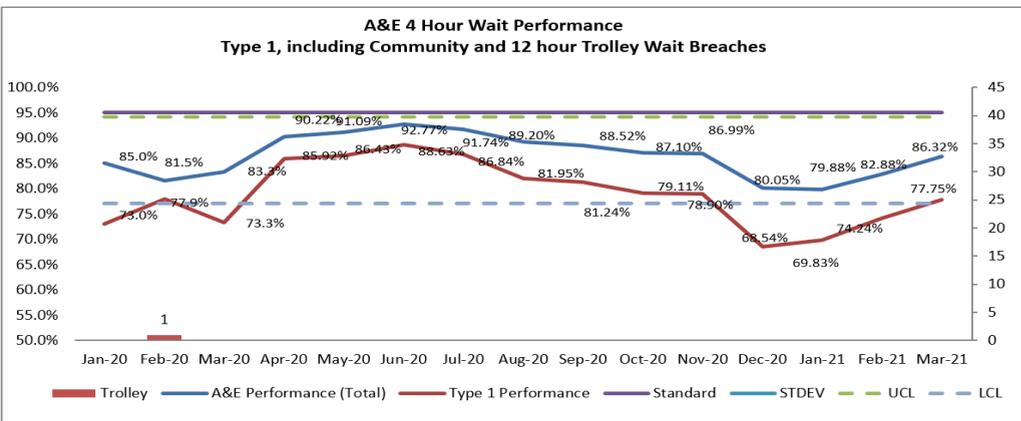
- The advanced booking of slots by 111-referred patients has made capacity much more manageable, with 70% of these patients arriving at expected times.
- The opening of a co-located Urgent Treatment Centre (UTC), in collaboration with DHU. As an enhanced form of streaming this has been significant in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

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

Performance Analysis

During March 2021, performance overall did not meet the 95% standard, achieving 77.8% for the Burton A&E and 86.3% including community hospitals. Performance has been improving since winter. There were no 12 hour breaches during March 2021.

There were no 12 hour breaches during March 2021.



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.
- Introducing the Community Rapid Independence Service (CRIS) in Spring 2021, whereby community staff hold virtual multi-disciplinary ward rounds.
- 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.

What were the issues?

- The trust had been experiencing a decrease in attendances but now the attendances exceed the previous year by 6%, with an average of 145 Type 1 attendances per day.
- The acuity of the attendances is high, with an average of 99 Resuscitation/Major patients per day (68.6% of total attendances).
- Patient flow was affected by surges in numbers of confirmed Covid cases, sometimes occupying a third of beds during January & February.
- The isolation of wards due to Covid outbreaks has limited capacity and therefore flow for those needing admission as an inpatient.

What actions have been taken?

- 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.
- 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.
- Improvements in IT enabled Meditech to identify patients Medically Fit For Discharge, improving patient flow processes.
- Internal Professional Standards were altered in regard to escalation plans and disputes procedures.

DHU111 Performance Month 11

Performance Summary

- Performance against the six contractual Key Performance Indicators was excellent in February 2021.
- The national standard for 95% of calls answered within 60 seconds was achieved in February 2021. Whilst DHU111 are not contracted to deliver the calls answered in 60 seconds national standard, as this was not a nationally mandated standard at the time of contract award, performance against this standard is monitored. When compared to other NHS 111 Providers DHU111 continue to rank first in the Country in February.

Activity Summary

- Calls offered are 21.4% below plan year to date (October – February). This is outside of the +/- 5% threshold, it is therefore likely that a credit will be due to commissioners at the end of Q2. The credit due to commissioners based on October 2020 – February 2021 data is £974,228*.
- Clinical Calls are also below plan the year to date to February at -8.7%. This again is outside of the +/- 5% threshold, which means a credit to commissioners is likely. The credit due to commissioners based on October 2020 – February 2021 data is £110,807*.
- There were 10,642 Category 3 Ambulance Validations in February, with an associated cost of £191,875.
- The regional cost of COVID-19 activity for February was £71,785, taking the cumulative cost since October 2020 to £500,268.

* The credit due is subject to change once actual data for March 2021 becomes available.

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

DHU111 Performance Month 11

What are the issues?

- Due to the high levels of underactivity and associated credit due to commissioners, DHU have written to commissioners formally outlining the financial pressure this places on them. It is unclear what is driving the underperformance as it cannot be distinguished explicitly from the data however we suspect it is due to a combination of 111 First activity not materialising and the usual winter illness not coming through. This position is not unique to DHU and this level of underactivity is being seen across the country.
- As a result of national contingency there has been pockets of low performance throughout February. Whilst this does not affect contractual performance (as times of contingency are not included within the count), it does have a short term impact as the volatility of the activity makes it difficult to predict staffing levels, which is difficult to recover from.
- COVID-19 related sickness remains an issue but has reduced significantly when compared to January 2021. 25% of DHU111 Staff have declined the COVID Vaccine.
- NHSE&I have now confirmed that the COVID-19 related activity will not be funded centrally and therefore it is for commissioners to fund these costs. This has been communicated to all associate CCG finance leads.

What actions have been taken?

- Lateral flow testing continues to be used in the call centre and has been effective in identifying those with COVID-19.
- An NHS111 pharmacist and CQI Lead have been seconded into DHU111 to contact those staff that have declined the vaccine to discuss further.

What are the next steps?

- Commissioners will be responding formally to DHU111 in response to their letter regarding under activity.
- The Coordinating Commissioning Team will continue to closely monitor performance and activity against contractual standards on a daily and monthly basis.

Activity		Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Year to date (Contract Year Oct 2020-Sep 2021)
Calls Offered	Actual	148,098	146,417	146,590	135,746	119,595	696,446
	Plan	152,299	153,848	203,460	199,210	177,571	886,388
	Variance	-2.8%	-4.8%	-28.0%	-31.9%	-32.6%	-21.4%
Clinical Calls	Actual	30,215	30,687	32,894	31,929	27,493	153,218
	Plan	29,898	30,333	39,528	36,350	31,639	167,749
	Variance	1.1%	1.2%	-16.8%	-12.2%	-13.1%	-8.7%

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

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

What are the issues?

- The contractual standard is for the division to achieve national performance on a quarterly basis. In Quarter Four to date, Derbyshire are achieving two of the six national standards, C1 90th Centile and C4 90th Centile. Currently, C1 mean is not being achieved by 48 seconds, C2 mean is not being achieved by 11 minutes and 15 seconds, C2 90th Centile is not being achieved by 20 minutes and 11 seconds and C3 90th is not being achieved by 1 hour 39 minutes and 19 seconds.
- Average Pre hospital handover times during February 2021 remained above the 15 minute national standard across Derbyshire (20 minutes and 33 seconds), this is a decrease compared to January 2021 (22 minutes and 50 seconds).
- Average Post handover times during February 2021 remained above the 15 minute national standard across Derbyshire with the exception of Stepping Hill (14 minutes and 8 seconds) and Macclesfield District General Hospital (12 minutes and 33 seconds). Overall the post handover time in February 2021 (19 minutes and 4 seconds) saw an increase when compared to January 2021 (18 minutes and 50 seconds).
- Derbyshire saw an overall decrease in incidents in February 2021 when compared to January 2021. The activity mix during February 2021 saw a decrease in H&T, S&T and S&C activity, when compared to January. We have also seen an decrease in duplicate calls, 14.6% in February 2021 compared to 19.3% in January 2021.
- It should be noted that the plan figure being used for February is based on a 29 day month (due to the contract carry over as a result of COVID-19), and is being compared to a month with 28 days actual activity.
- S&C to ED saw a slight increase in February 2021, with S&C incidents to ED being 53.5% compared to 52.4% in January 2021.

February 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	00:07:08	00:12:35	00:23:28	00:47:09	02:42:54	03:03:18
Derbyshire Actual	00:07:24	00:12:46	00:23:18	00:45:54	02:35:44	01:29:44
Derbyshire - Quarter Four to Date	00:07:48	00:13:32	00:29:15	01:00:11	03:39:19	02:18:23

February	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	00:19:38	37:59:07	00:18:31	38:09:00	00:38:09	64:26:29
Chesterfield Royal	00:20:43	261:38:05	00:18:39	232:07:00	00:39:22	411:57:54
Macclesfield District General Hospital	00:25:55	8:59:12	00:12:33	1:36:07	00:38:28	8:19:13
Royal Derby	00:20:24	390:57:29	00:19:55	451:46:25	00:40:19	730:27:54
Sheffield Northern General Hospital	00:28:25	23:23:28	00:17:34	10:21:49	00:45:59	28:51:35
Stepping Hill	00:19:13	32:53:20	00:14:08	16:29:00	00:33:20	37:59:11
Derbyshire TOTAL	00:20:33	755:50:41	00:19:04	750:29:21	00:39:37	1282:02:16

AMBULANCE – EMAS PERFORMANCE

What actions have been taken?

- The Strategic Development Board (SDB) have acknowledged that EMAS performance has improved and are keen to support this. It has been suggested that a deep dive is undertaken into how well are EMAS improving and against which areas.
- To reduce conveyance the regional team are looking to fund a region wide electronic system to be implemented to be able to gather intelligence that shows the pressures across all the acute trusts. This system will support EMAS with intelligent conveyancing.
- C3/C4 clinical triage pilot – EMAS have completed phase two but the work continues with an unofficial phase three. The final report into phase two is not due until May 2021. The updated UTC guidance, which is still to be published, will include information to support increased conveyance to a UTC by the ambulance service.

What are the next steps

- Phase three of the C3/4 pilot will start to explore the use of video conferencing within the clinical assessment process to explore whether this helps to reduce the number of ambulances dispatched.
- There is a national piece of work that is due to commence in April 2021 to review the level of C2 activity within AMPDS Trusts. The % of C2 activity is much lower in those services who use NHS Pathways. Discussions are taking place nationally as to the most appropriate triage tool to support a reduction in variation across codes and acuity.
- A piece of work taking place between EMAS and commissioners is focusing on identifying outliers in order to reduce variation – with regards Derbyshire a couple of areas have been RAG rated as red; On scene demand and post hospital handover times. One area has been identified as amber for Derbyshire; S&C to ED percentage (54%). This piece of work is in its infancy and will be going through the SDB meeting in March.

Derbyshire	Quarter Three	January	February	Quarter Four to date
Calls (Total)	55,053	19,880	15,932	35,812
Total Incidents	41,009	14,396	12,687	27,083
Total Responses	37,019	12,953	11,544	24,497
Duplicate Calls	10,493	3,832	2,330	6,162
Hear & Treat (Total)	7,541	3,095	2,058	5,153
See & Treat	12,831	4,869	4,242	9,111
See & Convey	24,188	8,084	7,302	15,386
Duplicates as % Calls	19.1%	19.3%	14.6%	17.2%
H&T ASI as % Incidents	9.7%	10.0%	9.0%	9.5%
S&T as % Incidents	31.3%	33.8%	33.4%	33.6%
S&C as % Incidents	59.0%	56.2%	57.6%	56.8%
S&C to ED as % of incidents	54.8%	52.4%	53.5%	52.9%

Planned Care

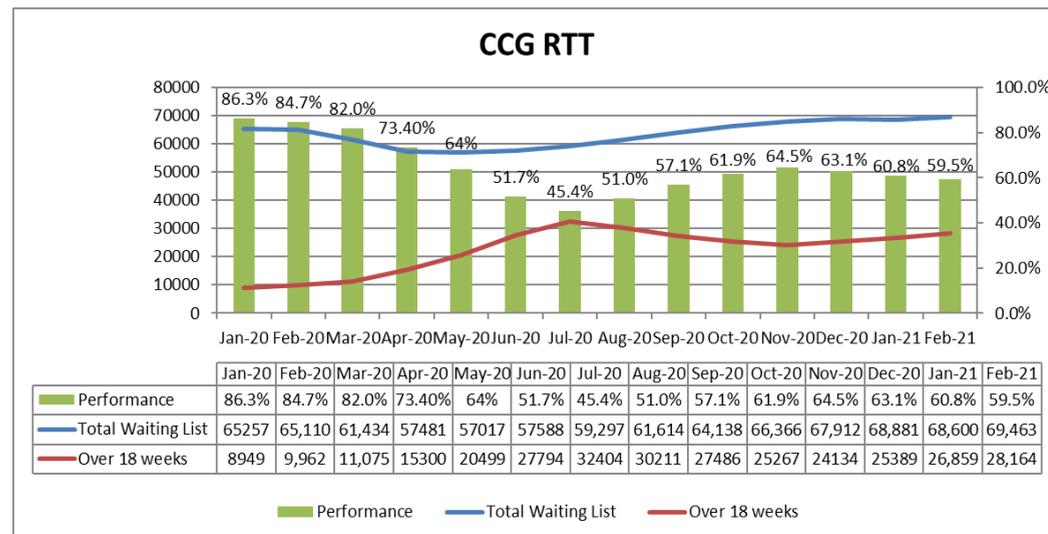
DERBYSHIRE COMMISSIONER – INCOMPLETE PATHWAYS (92%)

Performance Analysis

Performance for February 2021 was 59.5%, a deterioration from the January performance of 60.8%. The number of patients waiting over 18 weeks has decreased but the overall number of patients on the waiting list has increased.

The total incomplete waiting list for DDCCG was 69,463 at the end of February. The number of referrals across Derbyshire during February showed a 6% reduction for Urgent referrals and routine referrals showed a 29% reduction on the previous month in 2020.

Treatment Function	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Average (median) waiting time (in weeks)	92nd percentile waiting time (in weeks)
General Surgery	6,770	3,467	51.2%	17.4	52+
Urology	3,520	2,280	64.8%	12.5	52+
Trauma & Orthopaedics	11,974	4,916	41.1%	22.3	52+
Ear, Nose & Throat (ENT)	4,334	2,124	49.0%	18.4	52+
Ophthalmology	9,905	5,227	52.8%	16.8	52+
Oral Surgery	1	1	100.0%	-	-
Neurosurgery	439	273	62.2%	13.4	50.0
Plastic Surgery	478	253	52.9%	16.1	52+
Cardiothoracic Surgery	142	113	79.6%	7.1	41.6
General Medicine	1,468	1,043	71.0%	11.5	47.6
Gastroenterology	3,814	2,907	76.2%	9.7	30.4
Cardiology	2,037	1,531	75.2%	9.3	32.6
Dermatology	3,106	2,162	69.6%	9.7	47.5
Thoracic Medicine	1,175	811	69.0%	11.7	31.3
Neurology	991	683	68.9%	10.5	31.4
Rheumatology	1,291	950	73.6%	9.7	28.8
Geriatric Medicine	173	138	79.8%	7.8	28.2
Gynaecology	4,424	2,788	63.0%	12.7	52+
Other	13,421	9,632	71.8%	10.0	52+
Total	69,463	41,299	59.5%	13.9	52+

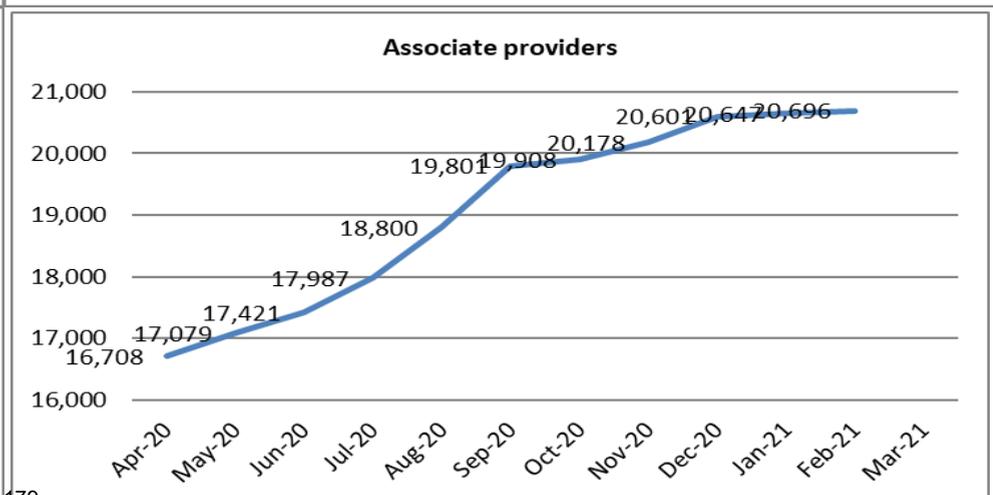
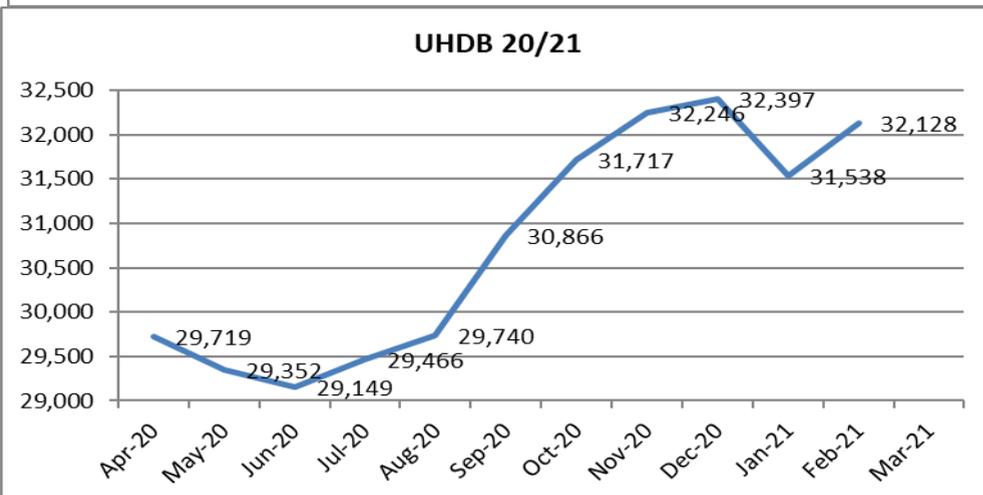
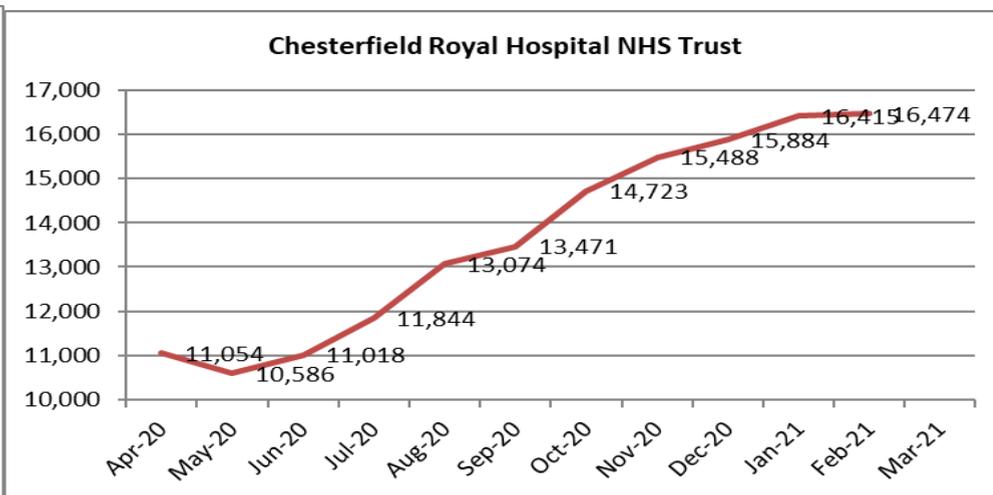
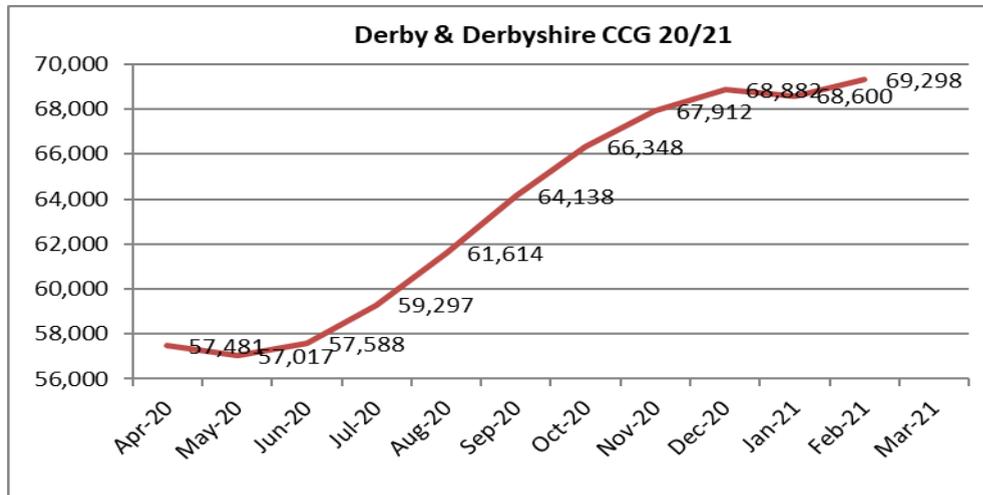


- The Derbyshire CCG position is representative of all of the patients registered within the CCG area attending any provider nationally.
- 70% of Derbyshire patients attend either CRHFT (25%) or UHDB (45%). The RTT position is measured at both CCG and provider level.
- The RTT standard of 92% was not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

ELECTIVE CARE – DDCCG Incomplete Pathways

Derbyshire CCG incomplete waiting list at the end of February 2021 is 69,298.

Of this number 48,602 patients are currently awaiting care at our two main acute providers CRH (16,474) and UHDB (32,128). The remaining 20,696 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.

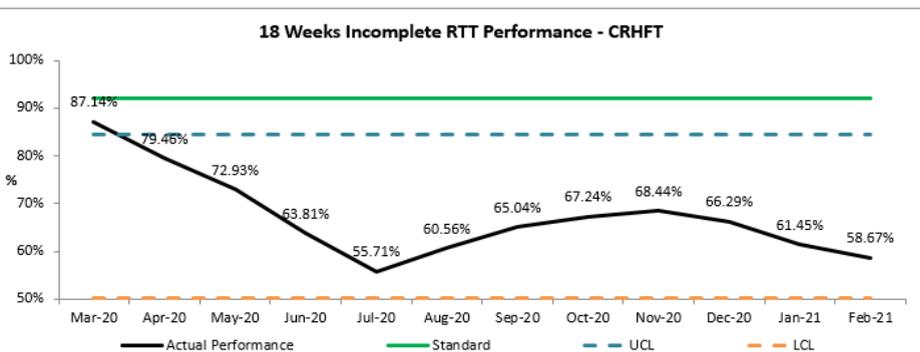


Referral to Treatment – Incomplete Pathways (92%).

CRH

During February the trust achieved performance of 58.7%. This is a deterioration from the previous month of January when 61.4% was achieved.

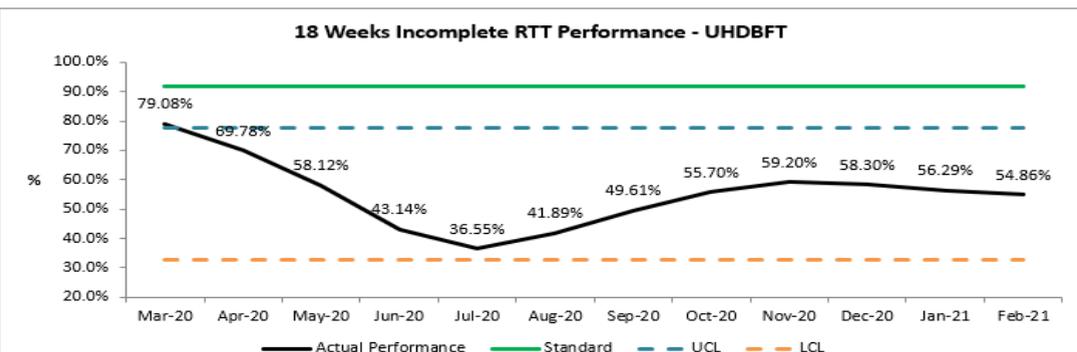
The waiting list at the end of February is at the same number as at the end of January.



UHDB

During February the trust achieved a standard of 54.9%, an deterioration from the January achievement of 56.3%.

The waiting list at the end of February is 60,992, which is an increase on the January figure. This does not take into account a large number of patients on the trust ASI list who have not yet received appointments.



Treatment Function	Total Incomplete Waiting List	Num ber < 18 weeks	Backlog (+18 weeks)	Mar-20	Movement from March 2020	% within 18 weeks
General Surgery	3,739	1,943	1,796	1,917	1,822	52.0%
Urology	1,305	874	431	1,183	122	67.0%
Trauma & Orthopaedics	1,562	724	838	1,157	405	46.4%
Ear, Nose & Throat (ENT)	1,305	834	471	1,204	101	63.9%
Ophthalmology	1,994	853	1,141	1,605	389	42.8%
Oral Surgery	906	521	385	780	126	57.5%
General Medicine	603	476	127	476	127	78.9%
Gastroenterology	1,276	748	528	873	403	58.6%
Cardiology	499	343	156	554	-55	68.7%
Dermatology	940	778	162	1,076	-136	82.8%
Thoracic Medicine	521	338	183	392	129	64.9%
Rheumatology	400	260	140	408	-8	65.0%
Gynaecology	1,483	861	622	944	539	58.1%
Other	1,431	986	445	1,447	-16	68.9%
Total	17,964	10,539	7,425	14,016	3,948	58.7%

Treatment Function	Total Incomplete Waiting List	Num ber < 18 weeks	Backlog (+18 weeks)	Mar-20	Movement from March 2020	% within 18 weeks
General Surgery	3,521	1,874	1,647	3,202	319	53.2%
Urology	2,735	1,476	1,259	2,309	426	54.0%
Trauma & Orthopaedics	12,486	4,606	7,880	10,622	1864	36.9%
Ear, Nose & Throat (ENT)	4,771	2,031	2,740	4,171	600	42.6%
Ophthalmology	8,098	3,966	4,132	8,623	-525	49.0%
Oral Surgery	104	26	78	401	-297	25.0%
Neurosurgery	67	28	39	74	-7	41.8%
Plastic Surgery	316	140	176	257	59	44.3%
Cardiothoracic Surgery	10	9	1	2	8	90.0%
General Medicine	358	340	18	118	240	95.0%
Gastroenterology	2,839	2,527	312	2,585	254	89.0%
Cardiology	1,655	1,421	234	2,500	-845	85.9%
Dermatology	3,041	1,673	1,368	3,323	-282	55.0%
Thoracic Medicine	376	273	103	628	-252	72.6%
Neurology	826	483	343	876	-50	58.5%
Rheumatology	1,126	855	271	1,693	-567	75.9%
Geriatric Medicine	201	138	63	280	-79	68.7%
Gynaecology	4,000	2,312	1,688	2,995	1005	57.8%
Other	14,462	9,281	5,181	12,504	1958	64.2%
Total	60,992	33,459	27,533	57,163	3,829	54.9%

DERBYSHIRE COMMISSIONER – OVER 52 WEEK WAITERS

52 Week Waits

December performance data reflects the impact of COVID with 7,554 patients reporting as waiting over 52 week waits for treatment in Derbyshire. Of these 6,117 are waiting at our two main providers UHDB and CRH, the remaining 1,437 are waiting at various trusts around the country as outlined in the table on the following slide.

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

CCG Patients – Trend – 52 weeks

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

Main Providers:

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

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21
UHDB	0	0	45	138	298	580	1,011	1,667	2,367	3,031	3,751	4,706	3,843	4,971
CRH	0	0	0	4	17	53	117	212	308	385	594	797	1,202	1,146

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. This will identify patients who are clinically appropriate to delay for periods and those who will need to be prioritised. This will aid the teams to use the limited elective capacity on the patients who are most at risk of harm, allowing us to tackle the growing backlog of long waiters. The validation guidance was updated on the 1st October 2020, to include 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.
- NHSEI engagement is in place to include fortnightly calls.

DERBYSHIRE COMMISSIONER – OVER 52 WEEK WAITERS

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

Provider	Total	Provider	Total
AIREDALE NHS FOUNDATION TRUST	1	SALFORD ROYAL NHS FOUNDATION TRUST	16
ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST	1	SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	60
ASPEN - CLAREMONT HOSPITAL	48	SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	56
BARLBOROUGH TREATMENT CENTRE	3	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	147
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	4	SPIRE NOTTINGHAM HOSPITAL	3
BMI - THE ALEXANDRA HOSPITAL	3	SPIRE REGENCY HOSPITAL	14
BMI - THE PARK HOSPITAL	3	STOCKPORT NHS FOUNDATION TRUST	378
DONCASTER AND BASSETLAW TEACHING HOSPITALS	17	TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	1
DORSET COUNTY HOSPITAL NHS FOUNDATION TRUST	1	THE DUDLEY GROUP NHS FOUNDATION TRUST	1
EAST CHESHIRE NHS TRUST	46	THE ONE HEALTH GROUP LTD	12
FRIMLEY HEALTH NHS FOUNDATION TRUST	1	THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL	4
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	1	THE ROTHERHAM NHS FOUNDATION TRUST	5
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	1	THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	1
LEEDS TEACHING HOSPITALS NHS TRUST	8	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	1
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	3	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	1
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	19	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	13
MOORFIELDS EYE HOSPITAL NHS FOUNDATION TRUST	2	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	1
NORTH BRISTOL NHS TRUST	2	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	48
NORTH WEST ANGLIA NHS FOUNDATION TRUST	1	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	9
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	293	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	4
NUFFIELD HEALTH, DERBY HOSPITAL	141	HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST	8
NUFFIELD HEALTH, NORTH STAFFORDSHIRE HOSPITAL	1	LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	5
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	2	BMI - THE CHILTERN HOSPITAL	1
PENNINE ACUTE HOSPITALS NHS TRUST	1	BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	2
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	1	PRACTICE PLUS GROUP HOSPITAL - BARLBOROUGH	40
ROYAL NATIONAL ORTHOPAEDIC HOSPITAL NHS TRUST	1	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	1
Total			7554

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.

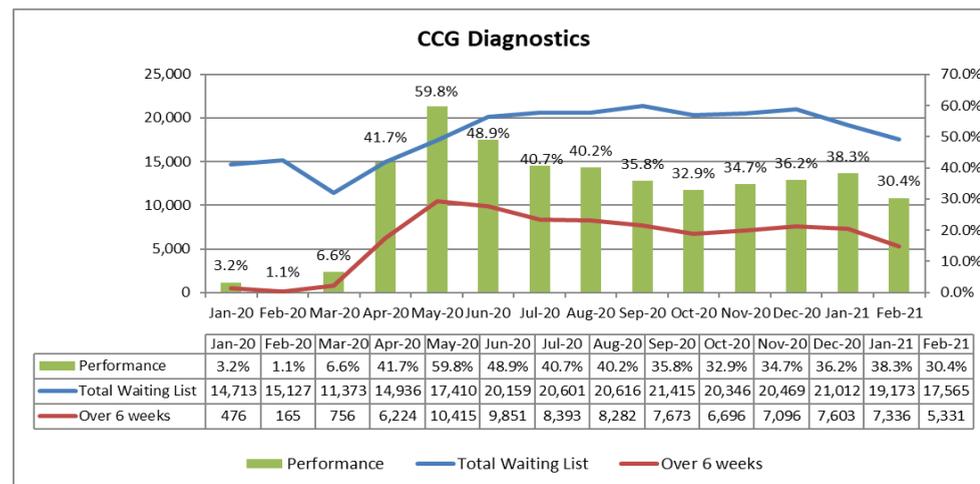
DERBYSHIRE COMMISSIONER – 6 WEEK DIAGNOSTIC WAITING TIMES (Less than 1%)

Performance Analysis

Derbyshire CCG Diagnostic performance at the end of February was 30.35% waiting over six weeks, an improvement on the January position of 38.26%.

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

As part of the Phase 3 Recovery plans the all trusts are expected to return to the same level of diagnostic activity for imaging and endoscopy procedures.



Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Percentage waiting 6+ Weeks
Magnetic Resonance Imaging	2,285	562	332	24.6%
Computed Tomography	1,894	324	172	17.1%
Non-obstetric Ultrasound	7,280	2,463	631	33.8%
Barium Enema	0	0	0	0.0%
DEXA Scan	314	87	30	27.7%
Audiology - Audiology Assessments	789	150	73	19.0%
Cardiology - Echocardiography	1,603	281	121	17.5%
Neurophysiology - Peripheral Neurophysiology	179	11	3	6.1%
Respiratory physiology - Sleep Studies	87	13	8	14.9%
Urodynamics - Pressures & Flows	127	88	51	69.3%
Colonoscopy	1,080	505	355	46.8%
Flexi Sigmoidoscopy	403	176	99	43.7%
Cystoscopy	230	59	38	25.7%
Gastroscopy	1,294	612	438	47.3%
Total	17,565	5,331	2,351	30.4%

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

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

Performance Analysis

Performance during February was 16.58%, an improvement on the January figure of 26.67%.

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

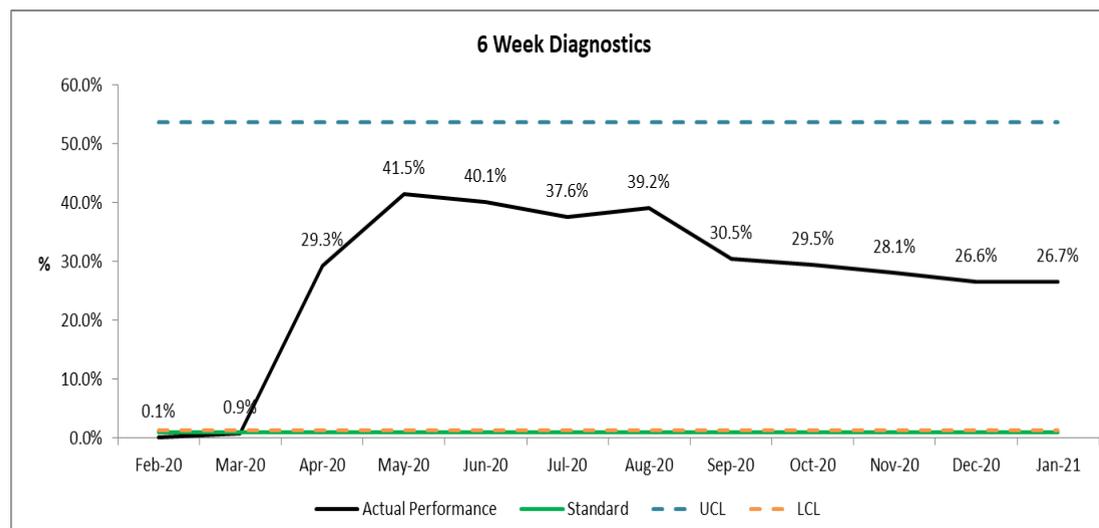
What are the issues?

Issues

- Endoscopy capacity is still proving to be difficult although all procedures going through endoscopy has improved on their performance.
- Some patients were reluctant to attend their appointments during February and it is hoped that with the decrease in COVID cases this will reduce.

Actions

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



Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Percentage waiting 6+ weeks
Magnetic Resonance Imaging	455	4	1	0.9%
Computed Tomography	453	8	1	1.8%
Non-obstetric Ultrasound	1,384	14	4	1.0%
DEXA Scan	73	2	1	2.7%
RH	418	93	59	22.2%
Cardiology - Echocardiography	398	30	5	7.5%
Urodynamics - Pressures & Flows	25	18	14	72.0%
Colonoscopy	348	161	103	46.3%
Flexi Sigmoidoscopy	128	78	49	60.9%
Cystoscopy	58	5	0	8.6%
Gastroscopy	451	282	199	62.5%
Total	4,191	695	436	16.6%

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

Performance Analysis

Performance during February was 36.55% an improvement on the January figure of 43.87%..

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

Issues

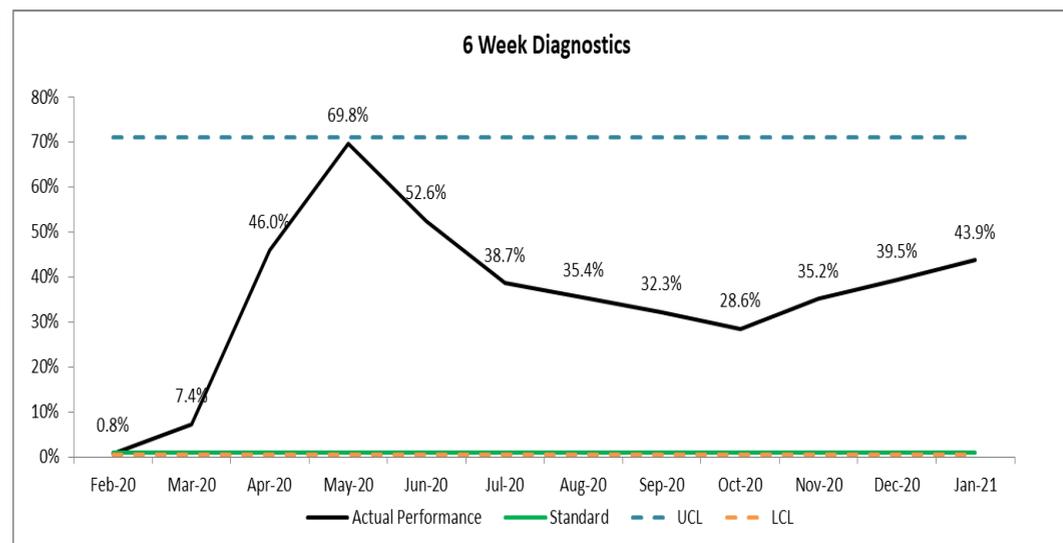
Ultrasound flagged as concern but all diagnostics tests conducted in endoscopy have improved during the month of February.

Imaging are continuing with the majority of scans focusing on cancer but because a number of other routine services have been switched off they are seeing a reduction in their activity.

Available capacity is being used to focus on cancer scans and them majority are being done within 2 weeks.

Actions

- New kit now been delivered to help with Ultrasound. Locums to be brought in and additional activity at weekends is planned.
- Gastroscopy patients are now being Covid19 swabbed to enable negative patients to be treated in the normal setting - positive results require the investigation to be carried out in the hand theatre space.
- NHSI supported CT van is being used until the end of March.
- Urodynamics is to recommence.
- Replacement programme for MRI scanners at LRCH has been brought forward. Mobile MRI without contrast at LRCH has completed all cases waiting. A further mobile MRI was situated at QHB.

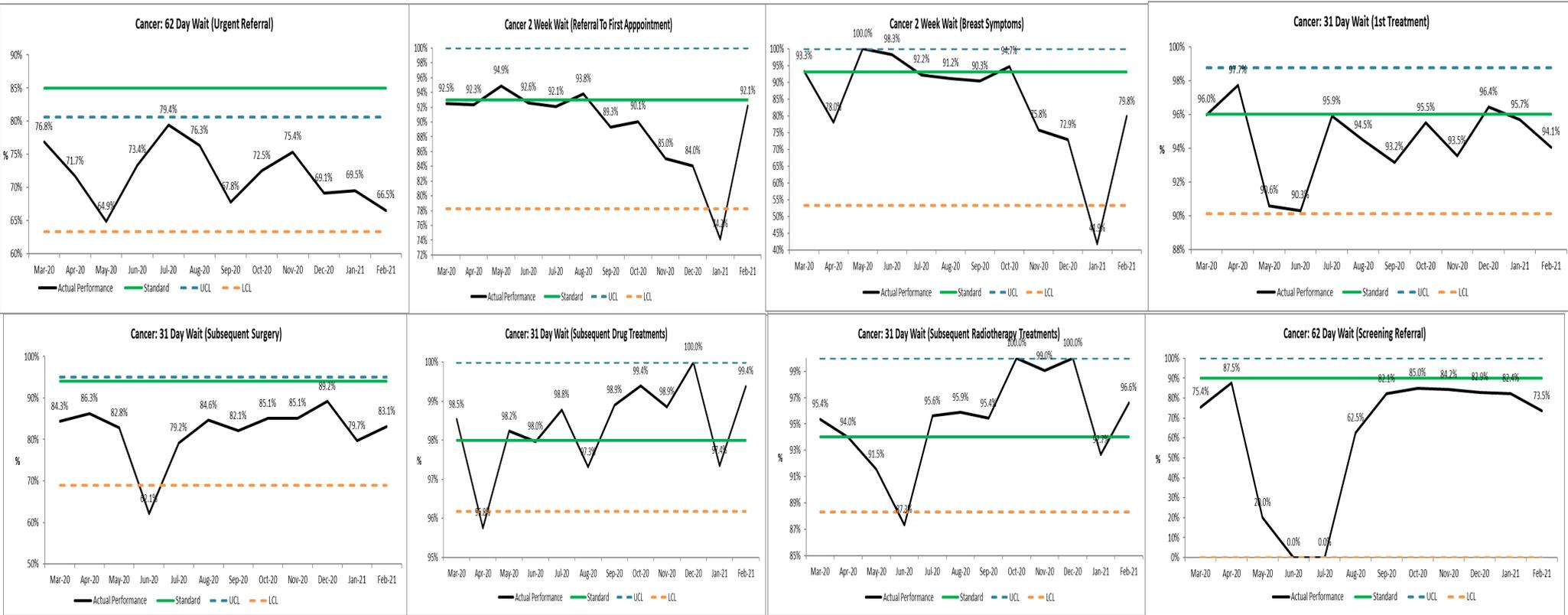


Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Percentage waiting 6+ weeks
Magnetic Resonance Imaging	1,362	186	90	13.7%
Computed Tomography	1,346	282	152	21.0%
Non-obstetric Ultrasound	8,857	4,545	1,409	51.3%
Barium Enema	9	1	0	11.1%
DEXA Scan	230	85	43	37.0%
Audiology - Audiology Assessments	418	82	16	19.6%
Cardiology - Echocardiography	1,004	24	2	2.4%
Neurophysiology - Peripheral Neurophysiology	213	7	1	3.3%
Respiratory physiology - Sleep Studies	75	4	0	5.3%
Urodynamics - Pressures & Flows	130	89	41	68.5%
Colonoscopy	462	48	14	10.4%
Flexi Sigmoidoscopy	256	43	5	16.8%
Cystoscopy	168	43	28	25.6%
Gastroscopy	569	79	31	13.9%
Total	15,099	5,518	1,832	36.5%

DERBYSHIRE COMMISSIONER – CANCER WAITING TIMES

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

- **2 week Urgent GP Referral** – 92.1% (93% standard) – Non-Compliant at UHDB, Compliant at CRH.
 - **2 week Exhibited Breast Symptoms** – 79.8% (93% standard) – Non-Compliant at UHDB and CRH. Compliant for East Cheshire, Nottingham and Sherwood Forest.
 - **31 day from Diagnosis** – 94.1% (96% standard) – Non-Compliant at UHDB, Nottingham, Sheffield, East Cheshire & Stockport. Compliant for CRH & Sherwood Forest.
 - **31 day Subsequent Surgery** – 83.1% (94% standard) – Non-Compliant at UHDB, Nottingham, Sheffield and Stockport. Compliant for CRH and Sherwood Forest.
 - **31 day Subsequent Drugs** – 99.4% (98% standard) – Compliant for UHDB, CRH, Nottingham, Sheffield and Stockport. Non-Compliant at Sherwood Forest.
 - **31 day Subsequent Radiotherapy** – 96.6% (94% standard) – Compliant for UHDB Nottingham and Sheffield.
 - **62 day Urgent GP Referral** – 66.5% (85% standard) – Non-Compliant for all trusts.
 - **62 day Screening Referral** – 73.5% (90% standard) – Non-Compliant for UHDB and CRH.
- 104 day wait** – 240 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.

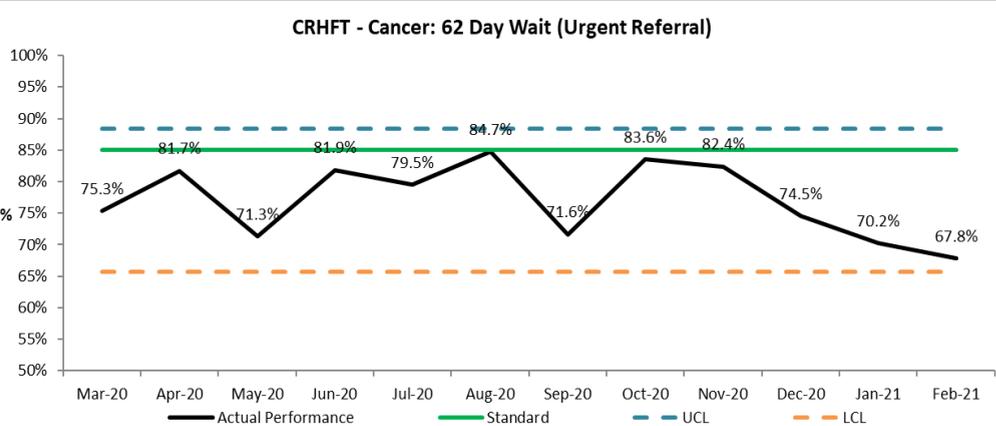
CRHFT - CANCER WAITING TIMES (First Treatment Administered within 62 Days of Urgent Referral)

Performance Analysis

CRH performance during February for first treatment within 62 days of urgent referral has reduced slightly since the month prior to 67.8% and remains non-compliant against the standard of 85%.

There were a total of 74.5 patients treated on this pathway with 50.5 of those patients being treated within the 62day standard, resulting in 24 breaches. The breaches related to Breast(4), Gynaecology(1), Haematology(1), Head and Neck(0.5), Lower GI(2.5), Lung(1), Skin(1), Upper GI(1), and Urology(12).

Out of the 24 breaches 3 were reported as waiting over 104 days for treatment.



What are the issues?

The main issues reported by the Trust were:

- Increasing demand in Breast.
- Recent increase in demand in Head and Neck.
- Outpatient capacity due to restrictions around social distancing in accordance with the national guidance.
- Theatre capacity to accommodate the demand.
- Patient choice including a proportion of patients being reluctant to attend the hospital due to Covid and choosing to wait until being vaccinated.

What actions have been taken?

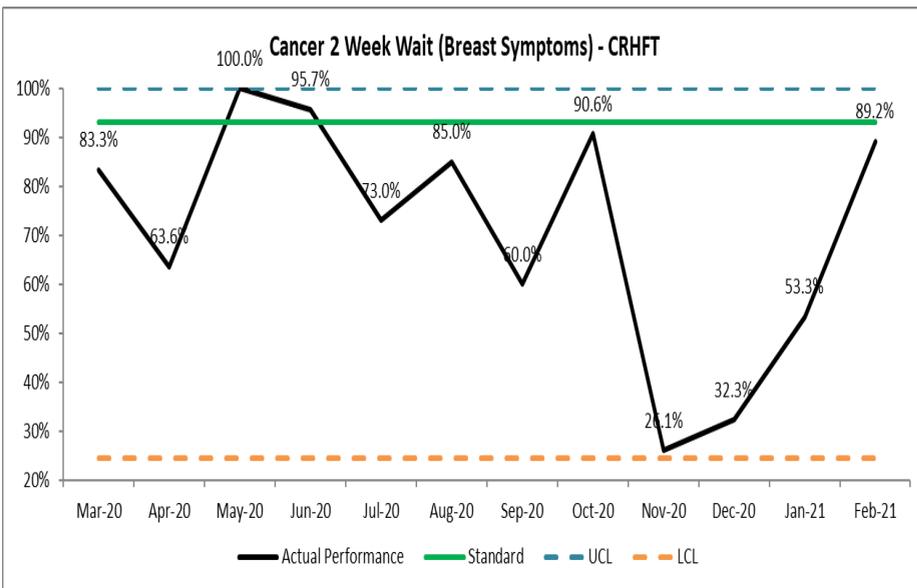
- Breast – one stop clinic continues to be in place to support demand.
- Community Breast Pain Clinic plans are underway for the Derbyshire system.
- Mutual aid discussions with South Yorkshire continue.
- Clinical prioritisation remains in place to support surgery waiting lists.
- Use of agency staff to fill lists to maintain capacity is in place.
- Independent sector is being sought where possible.
- Additional theatre capacity under review.

What are the next steps

- Continued focus on those patients over 62 day and 104 day on the PTL to include internal escalation processes and breach reviews via Provider/CCG are taking place on a monthly basis.
- Cancer services throughout the third wave are being protected where possible.

Tumour Type	Total referrals seen during the period	Seen Within 62 Days	Breaches of 62 Day Standard	% Performance
Breast	16	12	4	75.00%
Gynaecological	3	2	1	66.67%
Haematological (Excluding Acute Leukaemia)	5	4	1	80.00%
Head and Neck	1	0.5	0.5	50.00%
Lower Gastrointestinal	5.5	3	2.5	54.55%
Lung	2.5	1.5	1	60.00%
Skin	22	21	1	95.45%
Testicular	1	1	0	100.00%
Upper Gastrointestinal	3.5	2.5	1	71.43%
Urological (Excluding Testicular)	15	3	12	20.00%
Totals	74.5	50.5	24	67.79%

CRHFT - CANCER WAITING TIMES – 2 Week Wait Breast Symptomatic and 62day Screening Referral

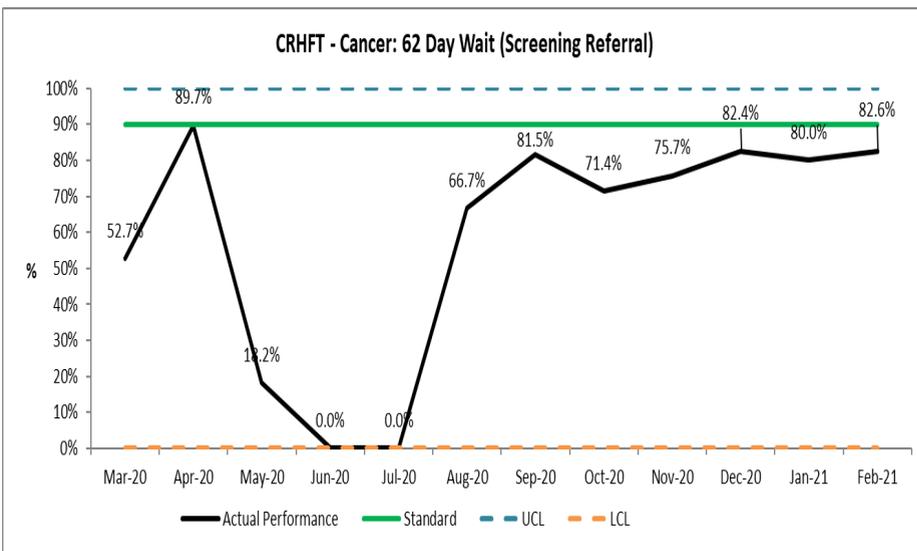


Performance Analysis

February performance at CRH for 2 Week Wait Breast Symptomatic has significantly increased since the month prior to 89.2% however, it remains non-compliant against the standard of 93%. The main challenges for being non-compliant is due to outpatient capacity and a high increase in demand. An increase in Breast referrals has been particularly evident across the region since October.

The total number of patients seen this month by way of referral to Breast Symptomatic was 37 with 33 of those patients being seen within the 2 week wait standard, resulting in 4 breaches which is a significant improvement to the 21 breaches reported last month. The reasons for the breaches include three being due to administrative delay and one being due to Patient Choice.

Out of the 4 breaches 3 of the patients were seen within 25 days. The patient choice breach was seen at day 49.



Performance Analysis – Screening Referral

62 day Screening performance in February has improved slightly to 82.6%, continuing to be non-compliant against the standard of 90%.

There were a total of 11.5 patients treated this month who were initially referred through the screening service with 9.5 of those patients being treated within the 62 day standard, resulting in 2 breaches.

The breaches related to Breast with the patient being treated at day 72 and Lower GI with the patient being treated at day 97. Both breaches were as a result of Elective Capacity.

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

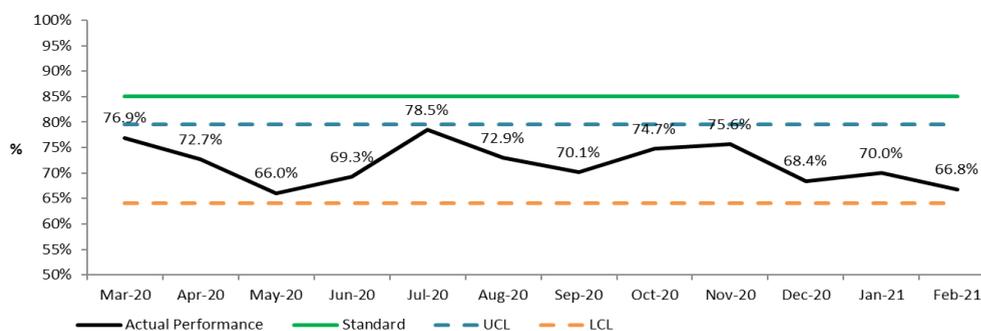
Performance Analysis

Performance during February for first treatment within 62 days has reduced slightly to 66.8%, remaining non-compliant against the standard of 85%.

There was a total of 155 patients treated on this pathway with 103.5 being treated within the 62 day standard, resulting in 51.5 breaches. The breaches related to Breast(4), Gynaecology(7), Haematology(4), Head and Neck(1), Lower GI(10), Lung(1), Sarcoma(4), Skin(2) Upper GI(6.5) and Urology(12).

Out of the 51.5 breaches 15 of these patients were reported as waiting over 104 days for treatment.

UHDBFT - Cancer: 62 Day Wait (Urgent Referral)



What are the issues?

- Increasing demand in Breast - media attention on a celebrity diagnosis further impacting on this service.
- Recent increase demand in Head and Neck.
- Theatre capacity.
- Template Biopsy Capacity due to Clinical Staff absence.
- Patient choice including a proportion of patients being reluctant to attend the hospital due to Covid and choosing to wait until being vaccinated.
- The number of patients over 62 days on the PTL is retaining however, patients waiting over 104days are currently increasing.

What actions are being taken?

- Additional clinics to support Breast demand remain ongoing.
- Community Breast Pain Clinic plans are underway for the Derbyshire system.
- Additional theatre capacity under review.
- Template Biopsy Clinician is due to return to work in March which will help manage the demand.
- Diagnostics relating to Cancer patients are being prioritised.
- Independent sector are being sought where possible.

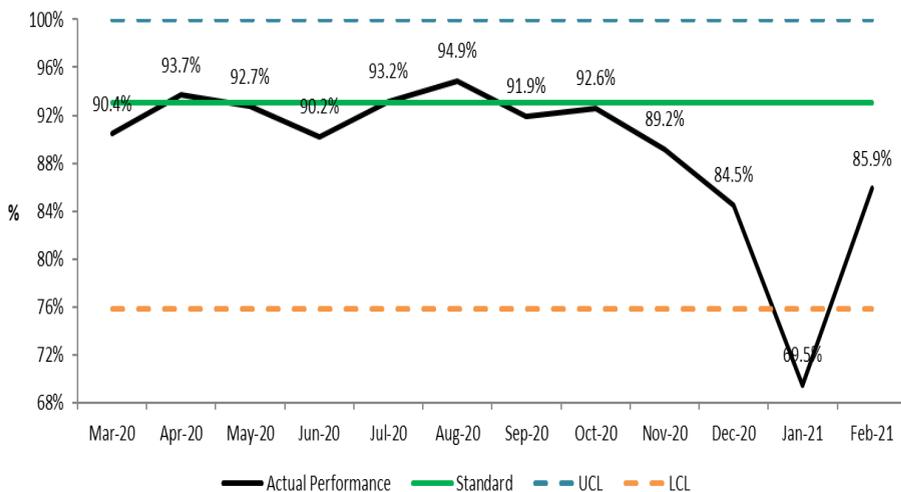
What are the next steps

- Continued focus on those patients over 62 day and 104 day on the PTL to include internal escalation processes and breach reviews via Provider/CCG taking place on a monthly basis.

Tumour Type	Total referrals seen during the period	Seen Within 62 Days	Breaches of 62 Day Standard	% Performance
Breast	30	26	4	86.67%
Gynaecological	11	4	7	36.36%
Haematological (Excluding Acute Leukaemia)	12.5	8.5	4	68.00%
Head and Neck	6	5	1	83.33%
Lower Gastrointestinal	25	15	10	60.00%
Lung	8	7	1	87.50%
Sarcoma	4	0	4	0.00%
Skin	12	10	2	83.33%
Upper Gastrointestinal	21.5	15	6.5	69.77%
Urological (Excluding Testicular)	25	13	12	52.00%
Totals	155.0	103.5	51.5	66.77%

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

Cancer 2 Week Wait (Referral To First Appointment) - UHDBFT



Performance Analysis

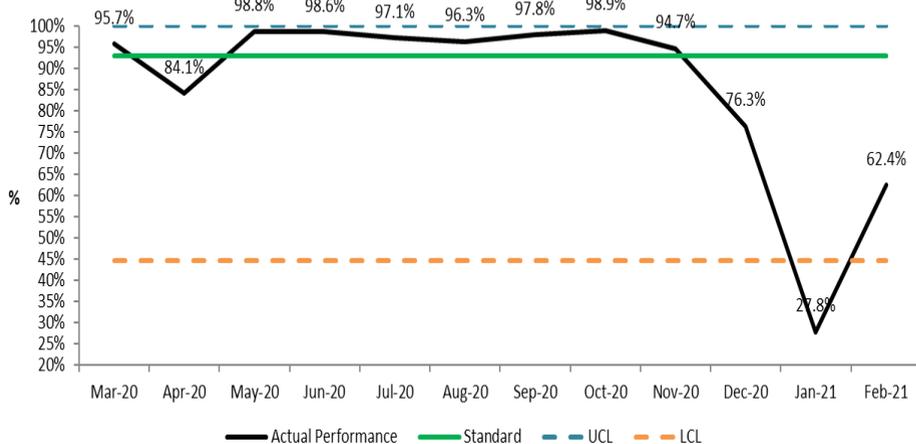
February performance at UHDB for 2 week wait has significantly improved to 85.9%, however, it continues to be -non-compliant against the standard of 93%. The main challenges for 2ww performance have been associated with Breast, Lower GI and Upper GI.

There were a total number of 2541 patients seen this month by way of GP Urgent referral to first appointment with 2182 of these patients being seen within the 2 week wait standard, resulting in 359 breaches which is a significant improvement to the 744 breaches reported last month.

The 359 breaches occurred in Brain(1) Breast(218), Gynaecology(42), Haematology(2), Head and Neck(8), Lower GI (40), Skin(11), Upper GI(22) and Urology(15). The majority of the breach reasons were due to Outpatient Capacity with the remaining reasons being as a result of Patient Choice and Administrative Delay.

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

Cancer 2 Week Wait (Breast Symptoms) - UHDBFT



Performance Analysis

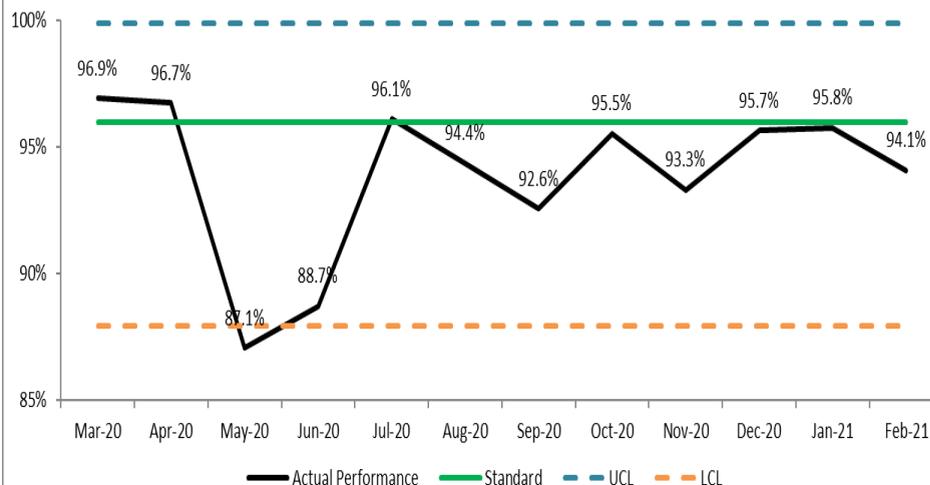
February performance at UHDB for 2 week wait Breast Symptomatic has significantly improved since last month to 62.4%, remaining non-compliant against the standard of 96%.

The total number of patients seen this month by way of referral to Breast Symptomatic was 210 with 131 of those patients being seen within 2 weeks, resulting in 79 breaches.

Out of the 79 breaches 62 of the patients were seen within 21 days, 13 waiting up to 28 days and 4 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

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



Performance Analysis

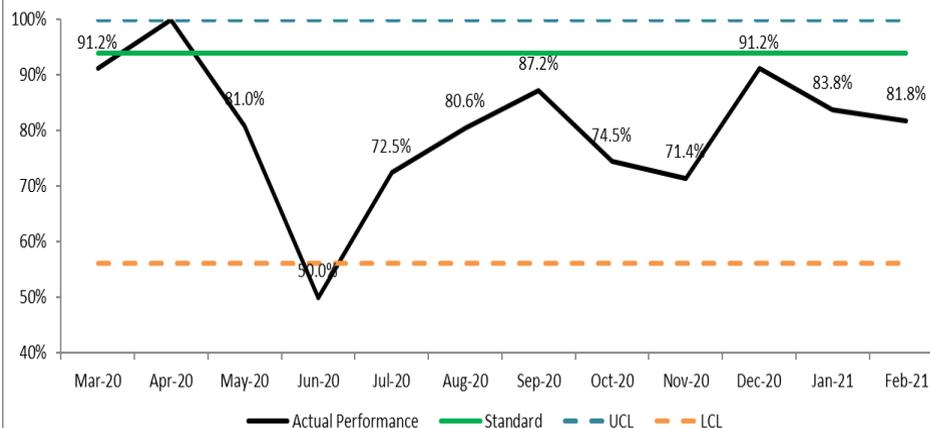
February performance at UHDB for 31 day from diagnosis to first treatment has reduced very slightly to 94.1%, continuing to be just below the standard of 96%.

There were a total number of 288 patients treated along this pathway with 271 of these patients being treated within 31 days, resulting in 16 breaches.

The 16 breaches occurred in Gynaecology(1), Lower GI (6), Upper GI(1), Skin(3) and Urology(5). The majority of the breach reasons were due to Elective Capacity with the remaining being due to Medical Reasons and Patient Choice.

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

UHDBFT - Cancer: 31 Day Wait (Subsequent Surgery)



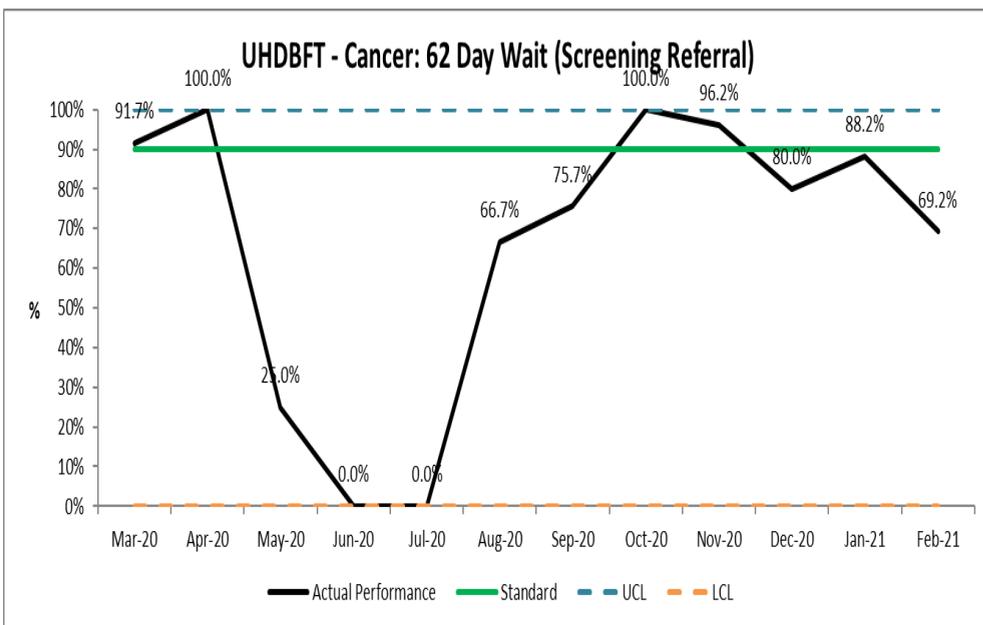
Performance Analysis

Performance of 31 day for Subsequent Surgery Treatment at UHDB in February has decreased slightly to 81.8%, remaining non-compliant against the standard of 94%.

There were 44 patients who received subsequent surgery this month with 36 of those patients having surgery within the 31 day standard, resulting in 8 breaches.

The reasons for these breaches were mainly due to Elective Capacity with the remaining being due to Medical Reasons. The number of days the patients breached ranged between 32 to 75 days.

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



Performance Analysis – Screening Referral

62 day Screening performance in February at UHDB has reduced to 69.2%, remaining non-compliant against the standard of 90%.

There were a total of 26 patients treated this month who were referred from a screening service with 18 of those patients being treated within 62 days, resulting in 8 breaches.

All 8 breaches related to Lower GI and breached as a result of Elective Capacity(2), Outpatient Capacity(1), Complex Diagnostics(1), Patient Choice(2) and Administrative Delay(2).

The number of days the patients breached ranged between 63 and 121 days.

Appendix

APPENDIX 1: PERFORMANCE OVERVIEW M11 – ASSOCIATE PROVIDER CONTRACTS

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

Governing Body Meeting in Public

6th May 2021

Item No: 041

Report Title	CCG Risk Register Report at 30 th April 2021
Author(s)	Rosalie Whitehead, Risk Management & Legal Assurance Manager
Sponsor (Director)	Helen Dillistone, Executive Director of Corporate Strategy and Delivery

Paper for:	Decision	Assurance	x	Discussion	Information
Assurance Report Signed off by Chair				N/A	
Which committee has the subject matter been through?				Clinical and Lay Commissioning Committee – 08.04.2021 Primary Care Commissioning Committee – 28.04.2021 Quality and Performance Committee – 29.04.2021 Finance Committee – 29.04.2021	
Recommendations					
<p>The Governing Body is requested to RECEIVE and NOTE:</p> <ul style="list-style-type: none"> • the Risk Register Report; • Appendix 1 as a reflection of the risks facing the organisation as at 30th April 2021; • Appendix 2 which summarises the movement of all risks in April 2021; and • the decrease in score for one risk: <ul style="list-style-type: none"> ○ <u>Risk 6</u> relating to the demand for Psychiatric Intensive Care Unit beds (PICU). 					
Report Summary					
<p>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 30th April 2021.</p> <p>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.</p>					
Are there any Resource Implications (including Financial, Staffing etc.)?					
<p>The CCG attaches great importance to the effective management of risks that may be faced by patients, members of the public, member practices and their partners and staff, CCG managers and staff, partners and other stakeholders, and by the CCG itself.</p> <p>All members of staff are accountable for their own working practice, and have a</p>					

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 30th April 2021 detailed in Appendix 1.

NHS DERBY AND DERBYSHIRE CCG GOVERNING BODY MEETING

RISK REPORT AS AT 30TH APRIL 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 – APRIL 2021

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

Risk Register as at 30th April 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 April	6	18	3	0	27
New Risks	0	0	0	0	0
Increased Risks	0	0	0	0	0
Decreased Risks	0	0	1	0	1
Closed Risks	0	0	0	0	0

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

3. **COMMITTEES – APRIL 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.

March performance:

- CRH reported 97.6% (YTD 94.0%) and UHDB reported 82.3% (YTD 80.0%).
- CRH - The Trust type 1 attendances were high during March and are now close to pre-Covid levels averaging 157 Type 1 attendances per day, there being 160 attendances per day during March 2020.
- Opel 2/3 status was declared through most of the month.
- UHDB - The volume of Type 1 patients were high, averaging at 438 attendances per day during March 2021 (Derby and Burton), whereas during March 2020 the attendances averaged at 430 per day.
- Since the start of the pandemic the numbers had been significantly lower but now the numbers surpass the previous years. In addition the infection control measures required result in a longer turnaround time needed for patients.
- Measures include Red/Green streaming of patients, non-streaming of Paediatric patients or 111 patients and increased infection control procedures.
- The acuity of the conditions presented is also high, with attendances classed as Major/Resus making up 63.1% of patients at Derby and 68.6% of patients at Burton.
- Covid-19 preparations had an effect on the system with increased pressure on 111 services and ED departments devoting physical capacity to isolation areas.
- SORG manages operational escalations and issues if required.

2. Risk 003: *TCP Unable to maintain and sustain performance, pace and change required to meet national TCP requirements. The Adult TCP is on a recovery trajectory and rated amber with confidence, whilst CYP TCP is rated green. The main risks to delivery are within market resource and development with workforce provision as the most significant risk for delivery.*

The current risk score is 20.

March update:

Current bed position:

- CCG beds = 30 (target 17).
 - Adult Specialised Commissioning = 18 (target 14).
 - Children and Young People (CYP) specialised commissioning = 3 (target 7).
 - A system wide root cause analysis is taking place to understand the reasons for admissions without Local Area Emergency Protocols (LAEPs). Weekly meetings with key stakeholders are being held to develop recommendations.
 - A TCP Summit meeting was held on 7th April 2021 which reviewed partners' commitment to deliver the changes and resources required. A number of delivery actions were developed and will be monitored through the Mental Health, Learning Disability & Autism Board.
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.

March update:

- The Planned Care Delivery Board held on 25th February 2021 agreed the minimum standard document and regular use of the associated assurance framework to monitor progress against the delivery of this for providers.
- The Task and Finish group has been stood down and a Programme group has been established with wider membership to continue to progress this work.
- The Terms of Reference are in draft form and the plan is to agree this at the next meeting on 21st April 2021.

- The size of the waiting lists and the length of time patients are waiting are increasing, as a direct result of COVID.
- The risk score has not been increased as we are working to put mitigations in place across the system and then plans in relation to performance and reducing the lists are being formulated.

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.

April update:

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

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

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

- *Workforce - recruitment and retention of all staff groups*
- *COVID-19 potential practice closure due to outbreaks*
- *Recruitment of GP Partners*
- *Capacity and Demand *Access*
- *Premises *New contractual arrangements*
- *New Models of Care*
- *Delivery of COVID vaccination programme*

The current risk score is 20.

April update:

- GP services are moving towards recovery and restoration including the reinstatement of CQC inspections.
- The risk will continue to be reviewed and amended as required.

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.

April update on March position:

- The Derbyshire NHS system had a gap of c.£43m between expenditure assessed as required to meet delivery plans and notified available resource.
- The CCG is working with system partners and the system will report a small surplus position (the value across the system could

not be confirmed at the time of writing the report due to the Providers reporting time-table). However the identified risk concerns the CCG and System having a sustainable financial position and while we have delivered successfully our in-year position a long term sustainable position is less clear.

- The CCG is working with system partners to understand the recurrent underlying position and early work suggests there is a £145m deficit going into 2021/22.

4. APRIL OVERVIEW

4.1 Decreased risk since last month

One risk has decreased 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 has been decreased in score from a high 9 (probability 3 x impact 3) to a moderate score of 6 (probability 3 x impact 2). This was approved at the Quality & Performance Committee meeting held on 29th April 2021.

- The risk rating was reduced to 6, as the financial risk is reduced and patient care is sub optimal in terms of Out of Area (OOA), but numbers are reduced and the pathway is being managed with improved monitoring of length of stay (LOS) and repatriation.
- 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 the contract mobilised.
- The CCG and Joined up Care Derbyshire will not meet the KPI for no Out of Area (OOA) beds until the contract mobilisation.
- DHcFT are proceeding with plans for a Derbyshire PICU unit on the Kingsway site for the year 2023-24.

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 30th April 2021;
- Appendix 2 which summarises the movement of all risks in April 2021; and
- the decrease in score for one risk:
 - Risk 24 relating to the demand for Psychiatric Intensive Care Unit beds (PICU).

Risk Reference	Year	Risk Description	Responsible Committee	Type of Control Measure	Initial Risk Rating	Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating			Residual/Current Risk			Target Risk			Link to Board Assurance	Date Reviewed	Review Due Date	Executive Lead	Action Owner	
									Probability	Impact	Reputation	Probability	Impact	Reputation	Probability	Impact	Reputation						
22	2021	The mental health of CCG staff and delivery of CCG services could be affected by remote working and physical staff isolation from colleagues.	Governance Committee	Control	4	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 Joint 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 a one-to-one 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.	06.04.20 a range of ideas to support the wellbeing of staff working from home will be launched shortly, with a toolkit to help staff maintain a positive outlook and ensure interaction with colleagues 'off topic' to maintain spirits during the working week. Staff are encouraged that they should still 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 Employee, Social Partnership Forum etc. 12.06.20 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 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. 10.21.21 - Addendum to Homeworking Policy published and ongoing support 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. 08.21.21 - 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 commissioned to start.	2	3	6	2	3	6	1	3	3	On going	Link to Strategic Plan: 1.2, 3, 4, 5	Apr-21	May-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	2021	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	Control	4	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. Proactive shadowing of staff working in the ICC by backup rota staff. General capacity issues in covering staff absences. Staff fitness could compromise the operation of the ICC. Develop a resilient rota for the ICC, PPE and Testing Cells over 7 days	10.21.21 - Following the escalation to level 4 business continuity there has been a step down in some CCG business activity and a corresponding review of staff availability for redeployment to support the system pressures and priorities (protect, prevent, treat). A number of staff identified as fully or partially available for redeployment have been released to support the Covid vaccination programme. Accordingly, staff in these categories are working from vaccination sites across the County, including Derby Arena. Several staff are also working at the DCHS People Hub to support the coordination to the vaccine response (e.g. support newcomers, e-referrals etc.). DCCCS will regularly monitor the deployment of CCG staff against the system priorities. 8.3.21 - Weekly monitoring of the deployment of CCG staff against the system priorities by Functional Directors. 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.	1	4	4	1	4	4	1	3	3	On going	Link to Strategic Plan: 1.2, 3, 4, 5	Apr-21	May-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	2021	Patients deferring seeking medical advice for non COVID issues due to the belief that COVID rules preclude this. This may impact on health issues outside of COVID 19, long term conditions, cancer patients etc.	Quality & Performance	Control	4	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 (AME, 111, NEL, Elective Care, Cancer etc.) NHS are asked to prioritise LTC reviews for all priority (red) patients and have agreed to see all amber patients by 31st March 2021. Primary Care 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, PCNs 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, physiotherapy, MDT's etc. System Cell leading on the co-ordination of vaccine roll out, commencing in early December.	29/02/20 - Help Us Help You social media campaign launched to support public knowledge of services. 09/07/20 - Draft papers to be submitted to present proposals for virtual MDT and LTC app (self management/virtual consultations). 09/07/20 - Working with community teams to undertake health and wellbeing calls for their LTCs, to ensure they receive the necessary support and treatment to prevent exacerbations of their symptoms and admission. 09/08/20 - Patient performance data identifies that elective and non-elective admissions is returning back to pre-COVID levels. 09/08/20 - Services continue to explore restoration of services and utilising digital tech where necessary e.g. virtual MDTs, Attend Anywhere, Teams etc. 03/12/20 - COVID vaccination roll out to commence in early December, based on a prioritisation framework. 15/01/21 - Approve the Pfizer vaccine, the Oxford/AZ and Moderna vaccine has been approved, increasing vaccine capacity and pace of roll out. 15/01/21 - A number of vaccination centres have been established across the county. No further update for February 08/03/21 - 40% of the adult population have now received at least one vaccination dose. 08/03/21 - Covid admissions related to COVID-19 have been reported as low and stable. Critical care bed occupancy back to normal levels, and non-COVID bed occupancy is increasing. 111 Calls Normal levels have resumed but are gradually increasing again. 08/03/21 - Primary Care appointments in Dec 20 are 2.1% higher than pre pandemic levels in Dec 19. Due to the introduction of technology to support virtual/telephone appointments during the pandemic and a change in patient behaviour, the number of face to face appointments have decreased from 80% in Dec 19 to 67% in Dec 20. 08/03 08/03/21 - Risk score reduced to 9. This is due to continued downward trend in Covid cases, access of vaccination roll out, and primary care appointments back at pre pandemic levels. Ongoing monitoring of risk required due to potential surge in Covid cases when lockdown measures are relaxed between March-June. No further update to add for April.	3	3	3	3	3	3	2	3	6	On going	Link to Strategic Plan: 1.2, 3, 4, 5	Apr-21	May-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	2021	Patients diagnosed with COVID 19 could suffer a deterioration of existing health conditions for adults, young people and children due to isolation and social distancing measures implemented during COVID 19.	Quality & Performance	Control	4	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. Keep virtual consultations / on-line support (ampify). Primary Care agreed to prioritise LTC reviews for all priority (red) patients and have agreed to see all amber patients by 31st March 2021. Proposals to restore services and reintroduce appointments by utilising digital technology and reviewing provision of service (acute v community) e.g. rehab services, diagnostics, physiotherapy, MDT's etc. NHS 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. JMT's 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 posturing 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 (ampify). Primary Care agreed to prioritise LTC reviews for all priority (red) patients and have agreed to see all amber patients by 31st March 2021. Proposals to restore services and reintroduce appointments by utilising digital technology and reviewing provision of service (acute v community) e.g. rehab services, diagnostics, physiotherapy, MDT's etc. NHS 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. JMT's 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 posturing COVID symptoms. MDT approach to provide physical and psychological assessments, to ensure patients access the required service and treatment. Review 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.	13/10/20 - Development of DCHS post COVID Cardiac Rehab Pathway 13/10/20 - Development of U-Tube Pulmonary and Cardiac Rehab advice and exercise videos for patient use 13/10/20 - Strongly improved access to diagnostic services 13/10/20 - Development of post COVID pathway, criteria to inform Primary Care when to refer post COVID patients with ongoing respiratory symptoms being defined. 13/10/20 - Virtual MDTs in place across the county between Secondary Care respiratory team and Community Respiratory Teams. Progressing now to set up virtual MDTs between Secondary Care and Primary Care. 02/11/20 - Post COVID age analysis submitted to NHSE to benchmark against region STPs. 11/11/20 - Establish a Derbyshire COVID Recovery Pathway task and finish group identified by system stakeholders to drive forward the Post COVID Integrated Pathway, and commence planning for the Post COVID Syndrome Assessment Clinics. Targeting mid-December implementation. 03/12/20 - A high level Post COVID pathway has been agreed by the system, and DCHS have been appointed as lead provider to deliver the Post COVID Syndrome Assessment Clinics. Targeting mid-December implementation. 15/01/20 - Post COVID Syndrome Assessment Clinic service launched Dec 20. The service is virtual by default. Two face to face clinics are being established in Buxton and Whitlow for patients that require further investigations. Once more evidence is gathered regarding the impact of Post COVID Syndrome Assessment Clinics this will potentially reduce the risk. 12/02/21 - Approx. 40% of all GP practices have referred into the Post COVID Syndrome Assessment Clinic. Referrals are increasing weekly. 12/02/21 - Post COVID Syndrome Assessment Clinic (PCS) has received approval. 70 referrals from across 40% of all GP Practices. Referrals are increasing weekly, and the system is engaged with the pathway. 12/02/21 - The Post COVID Syndrome Assessment Clinic (MDT) is continuing 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 its expertise as we learn more about the condition. 12/02/21 - A Derbyshire Dialogue event (12/02/21 - 12/02/21) 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 (SCOP) 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. 08/03/21 - NHSE have confirmed PCS Assessment Clinic funding for 21/22 to support service continuity and to enhance the service offer. 08/03/21 - £2.02m 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.	3	3	3	3	3	3	3	3	3	On going	Link to Strategic Plan: 1.2, 3, 4, 5	Apr-21	May-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	2021	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	Control	3	a 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 from being exacerbated by Covid-19. Helpline is accessible via 111 warm transfer. b 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 signposted to get the most appropriate help. c Working with Communications teams to ensure that information is disseminated effectively across all stakeholders and the demand. d 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. e CYP services, targeted intervention predominantly online. CAMHS RAG rating and prioritising urgent cases. Digital offer Kooth and Qwell split continue until March 21. Ongoing CYP communications strategy with partners to send information out across the system. f Need to finalise the LD & Mental Health All Age COVID Recovery Planning Group process to feed into LRF across providers. g 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. h WPT providers are funded on AQP basis so there is no cap on activity. i WPT providers fully operational and accepting referrals j Attend Anywhere utilised across the trust for online consultations k 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 p Additional community based LD beds - there needs to be an agreed list of identified staff that can be called on this responsibility lies with LD not CCG. Building needs to be furnished and cleaned. q Re above - need to develop a training programme for staff working in the specialised units being actioned via LD delivery group. r Need to finalise the LD & Mental Health All Age COVID Recovery Planning Group process to feed into LRF across providers. s 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. t WPT providers are funded on AQP basis so there is no cap on activity. u WPT providers fully operational and accepting referrals v Attend Anywhere utilised across the trust for online consultations w Mental Health System Delivery Board to provide Covid oversight recovery and planning	15/01/21 Escalation of Covid and tier restrictions means issues remain current. CYP Winter funding plan to support uplift in crisis response staff capacity February update - Pandemic lock down is escalating concerns for CYP, and for indicators of domestic violence and assault. MH urgent presentations remain high with Police 136 involvement increasing. Helpline receiving increasing numbers of calls and being utilised by EMAS crews. Crisis coronal meeting resumed with partners engaged in planning wider support responses for 2021. CYP access has increased despite lock down and digital offerings being utilised. Ongoing review in Mental Health System Delivery Board (MSDB) with continued transformational investment anticipated in 2021/22. March update - Evidence is increasing for increased Eating Disorder presentations in CYP as a result of COVID. This will be addressed in the investment plan. NHSE response in Long COVID training for WPT providers as been allocated. People with a diagnosis of autism have disproportionately been affected by Covid-19 restrictions. System is developing long term intentions for improving autism services including investment in crisis and preventative support. April Update Urgent care 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. Care summit held and actions agreed. Investment plans will be coming through DCCOG 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 4 May with focus on areas impacted by Pandemic.	4	3	4	3	4	3	2	4	Apr-21	Apr-21	May-21	Zara Jones, Executive Director of Commissioning Operations Tracy Lee, Head of Mental Health Operations Helen Van Risselt, CYP Programme Manager Jens Steward	Zara Jones, Executive Director of Commissioning Operations Tracy Lee, Head of Mental Health Operations Helen Van Risselt, CYP Programme Manager Jens Steward		
27	2021	Increase in the number of safeguarding referrals linked to self neglect related to those who are not in touch with services. These include 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	Control	4	Key statutory partners such as Health, Local Authority, Police and Voluntary Sector are working closely together to ascertain who are an 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. 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 of care or replenish essential items. Scamming: Individuals are targeted due to their physical or cognitive vulnerability and persuaded and coerced to fund unscrupulous individuals. During the COVID19 pandemic the number of referrals to adult social care services has increased but not as yet as 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. March - No update this month to add.	o Clear multi-agency plan of action is being developed in regard to gathering data / intelligence regarding domestic abuse and adult safeguarding. p Regular virtual meetings are taking place between key partner agencies to identify operational risks and demands placed upon safeguarding processes and systems due to Covid19 demands. q Operational systems are now in place that were not in evidence previously. Better experience and awareness of where the pressure areas and priorities are than previously. r Board meetings and supporting committees are now back in place when previously they were in absence. s There is an increase of 15% in annual volume over the last decade and an increase in COVID specific. t 2021/21 Monitoring of safeguarding referrals has confirmed an ongoing increase in concerns relating to self-neglect. Self-neglect is now the most common abuse category referred to both the Local Authorities. This is a trend duplicated across the region. u Derby City have, in total, received 615 safeguarding referrals in a 5 week period. v Key stakeholders continue to collaborate to ensure effective partnership working. w The CCG's adult safeguarding team are in the process of meeting with NHS providers to seek agreement that they continue to meet their statutory responsibilities during exceptional times. x April 2021 As Covid restrictions are eased organisations are preparing for an increase in operational referrals and enquiries. These are likely to be in relation to Domestic Abuse and Self Neglect. Recent meetings between the CCG and NHS providers provided assurance that statutory responsibilities are being met. Inter agency partnerships are robust and the work of the Safeguarding Adult Boards continues regardless of Covid activity. Safeguarding remains.	4	3	4	3	4	3	3	3	Apr-21	Apr-21	May-21	Brigid Stacey, Chief Nursing Officer	Bill Nicol, Head of Adult Safeguarding		
28	2021	Increase in safeguarding referrals on the lockdowns in child and children and parents are seen and disclosures / injuries / evidence of abuse are seen / disclosed.	Quality & Performance	Control	4	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 understanding 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 increased but not as yet as the rates envisaged and predicted at the outset of lockdown and enforced isolation. p Referrals 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. q 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. March - No update this month to add.	Progress update The number of contacts made to children social care from the public and professionals has increased at the beginning of January 2021. The proportion of contacts that meet the threshold for referral remains comparable to those seen pre lockdown. Work continues across the partnership to ensure that children and families are being helped at the earliest and most appropriate point. Schools are now closed to the majority of pupils as a result of the third lockdown. Work continues across the partnership to ensure that vulnerable children are being seen. The number of referrals made to children social care has increased since the start of the third lockdown. The high level of referrals seen last year has not recurred, as we have seen in previous lockdowns it is anticipated that this will increase again as restrictions are lifted. Referral places and community support services continue to experience a high level of demand. 16.03.21 We are still in the same position in regard to the impact / response - despite what happens with schools reopening etc. 16.03.21 Contacts from members of the public and professionals continued above the welfare of a child or young person in the County are significantly lower than the same period last year, while those in the City remain slightly higher. The proportion of contacts that meet the threshold for referral remains comparable to those seen pre lockdown. Work continues across the Derby and Derbyshire Safeguarding Children Partnership to understand the number of contacts that do not meet the threshold for referral, to ensure children and families receive the right help at the right time. Throughout this period schools were closed as a result of the third lockdown. Contacts and referrals from schools remain at a high level, however schools and other agencies continue to work together to ensure that children are seen and safe. The high level of referrals seen last year has not recurred, as we have seen in previous lockdowns it is anticipated that this will increase again as restrictions are lifted. Referral places and community support services continue to experience a high level of demand.	3	4	3	4	3	3	3	3	Apr-21	Apr-21	May-21	Brigid Stacey, Chief Nursing Officer	Michelle Ractopp, Assistant Director for Safeguarding Children / Lead Designated Nurse for Safeguarding Children		
29	2021	Current contract management arrangements do not provide full assurance that all providers are compliant with the Data Security and Protection Toolkit. Although explicitly listed in the contract requirements, this is not understood to be routinely part of assurance, particularly for non-healthcare contracts.	Contract	Control	4	The CCG are therefore at risk where this is a requirement of the quality schedule of contracts, but not actively managed in all cases. The CCG does not hold a complete list of all contracts. Therefore a validation exercise currently is not possible. The provision of a compliant DSPT is a minimum standard for the provision of NHS services, and is part of the Key Lines of Enquiry for the CCG. Not to undertake a comprehensive validation of this where we are asking providers to process patient data may have significant reputational damage for the CCG where contracts have been in place and this has not been validated. During the covid-19 response, the CCG had expanded the provision of counselling services for children and young people. The issue of online video contracts was discussed, and national guidance provided. However, digital, this was not a service that was provided and services were not provided. This guidance supported the risk based use of online services, where this was a risk assessed provision, and both parties were happy to have the arrangement. This would remain under review following the covid-19 response. The issue found was that an established provider of services for counselling or schools in Derby and Derbyshire had not provided a submission for the DSPT. This had never been submitted. Feedback had been to the commissioning leads that this was an exhaustive process and that they were too small to have this in place. This is a minimum standard, and is explicitly included in the current contract with the provider. There isn't a current comprehensive assurance mechanism in place to ensure that this is in place for each contract.	The CCG is working towards a complete list of contracts. Once this is in place a validation exercise can be undertaken. This will be for contract leads to take forward with providers. 11.11.20 DSPTs have been checked and are in place for healthcare contracts. A similar checking process needs to be undertaken for non-healthcare contracts once it has been established which suppliers we use regularly and therefore may require a contract putting in place, or other mechanism. In the long list of suppliers paid over the last 12 months there will be a proportion of one-off transactions which need to be removed. 07.12.20 Work continues on reviewing the list of suppliers paid against contracts in place. Expected to complete by end December. 14.01.21 Work is progressing on updating the database. However the project has not been frozen until April 2021 due to the pandemic. Work will continue on the DSPT to complete all elements save for the new contract requirements by March, with the new contract elements being completed by the end of June 2021. Project frozen due to COVID pandemic.	3	3	3	3	3	3	5	5	Apr-21	Apr-21	May-21	Zara Jones, Executive Director of Commissioning Operations Christy Tucker, Director of Corporate Delivery	Helen Wilson, Deputy Director of Contracting & Performance Christy Tucker, Director of Corporate Delivery			
30	2021	There is an ever present risk of fraud and cybercrime; the likelihood of which may increase during the COVID emergency response period.	Cybercrime	Control	4	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' which receives regular correspondence and training. L CCFI Targeted Awareness Month F Fraud Information Reporting System Toolkit (FIRST) used by LCFPS CCG's Data Security Toolkit Submissions and Internal Audit Reviews providing substantial assurance for 2019/20 - work plan and monitoring through IG Assurance forum in place. Internal Audit Priority Exercises Achievement of Cyber Essentials Accreditation in March with no delivery Cyber Essentials Plus. Regular cyber assurance reporting to the CCG Regular user communications and training. This has included frequent reminders to staff during the Covid-19 emergency response period in relation to the increased risk of cyber crime. (IT Infrastructure supported by NECS) (e.g. patches, updates, etc.) CCG's annual IG Work Programme. Ongoing training is provided to all staff to ensure they are aware of their obligations to be aware of and report fraud and cybercrime. Examples of the latest threats and cyberattacks that have been committed are also circulated to all staff. 09.12.20 - Reports issued at Contract Management Board allow us to track attempted system intrusions (TI) and the number of times the ransom proxy server blocked attempted intrusions (NBSS) across the NECS estate within a month. There has been a marked reduction in the number of Priority One calls which have been received, none of which relate to cyber security and are mainly focused around changes made by third parties within CYP Practices and subsequent loss of power to key systems. The CCG has had a bid for additional resources to support the Cyber Hub VPM model solution approved at regional level and progress is being made for final approval. If approved, this will allow the getting of the ransom and VPM services across dedicated hardware which will reduce the impact of the loss of a server or overload of any of the servers within that cluster. 16.01.21 - Received additional assurance from NECS during the CCRS report meeting around the status of attempts to access the infrastructure and how the various layers of security subsequently filter these attempts out. There are still virus and malware infections and hence the technical barriers should also be taken to staff training regarding the dangers of opening attachments received in email or other documents. As a result of the response to the CCRS report additional information has been published on the Intranet and awaiting additional resources from Derbyshire County Council regarding the wider danger of the potential for online scamming/awareness sessions depending upon the availability of staff and delivery team. 15.02.21 - The Bright and other functionality delivered against Risk 9 and the NECS collaboration with NHS Digital's Cyber Security team will deliver additional tracking tools, but there is no evidence of any vulnerability in the security of the infrastructure. CVECERT issued by the Cyber Security team are appropriately tracked and mitigated by NECS. Head of Digital Development has requested that the Cyber Assurance Network to receive more detailed information on relevant threats. Risk will be reduced once third party evidence of infrastructure security is available. 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 CVECERT 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 a sponsor. 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 ECR assessment process to reduce the scope of the work and addresses the cost. A revised RFP is expected to be issued to the next Contract Management Board which provides additional information to cyber assessors which are taken from the CCRS report and provides greater detail. As per previous updates, access review the next work programme on DCCCS.	4	4	4	4	4	3	3	Apr-21	Apr-21	May-21	Richard Chapman, Chief Finance Officer	Daman Green, Assistant Chief Finance Officer / GRC Commodity Team Lead, Head of Digital Development				

Risk Reference	Year	Risk Description	Type of Control	Initial Risk Rating	Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating			Residual/Current Risk			Target Risk			Link to Risk Assurance	Date Reviewed	Review Due Date	Executive Lead	Action Owner
								Probability	Impact	Rating	Probability	Impact	Rating	Probability	Impact	Rating					
								4	3	2	4	3	2	4	3	2					
32	2021	Risk of exploitation by malware third parties if vulnerability is identified within any of the Microsoft Office 2010 applications after October 14th 2020 and not patched, due to support for Microsoft Office 2010 officially ending, after which point Microsoft will cease to issue updates and patches for vulnerabilities found within this suite of applications	Operational Controls	4	<p>Replace all instances of Microsoft Office 2010 with Microsoft Office 365.</p> <p>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.</p> <p>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.</p> <p>Identify other mitigation which NECs have put in place to prevent the execution and spread of any malicious code or exploitation of any vulnerability.</p>	<p>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.</p> <p>Already under development as part of the response to the CORE report; information will be cascaded through the CCG Comms team to CCG and Primary Care colleagues and also shared with the LMC.</p> <p>15.03.21 - Policies have been agreed with NECs over the GP and CCG estates to manage the deployment of cloud based apps and services from the Microsoft Office 365 suite of applications. A process will be developed for colleagues to request access to apps not included in the initial agreement along with a process of evaluating the risk of implementation against business benefits. The ability for colleagues to also install third party apps through the Microsoft Office products is also being removed, as this would create variability in the estate and subsequent issues with troubleshooting any issues or updating of third party apps. There remain some issues around locums and temporary members of staff specifically within our GP Practices and we are awaiting a national decision on this; in the meantime, a local solution has been developed to allow GP Practices to keep a number of devices on Microsoft Office 2010 until the full project has deployed. After which time, the remaining machines will be updated and additional licences purchased if necessary to maintain flexibility within GP Practices.</p> <p>11.03.21 - The pilot projects have completed and Microsoft Office 365 will be made available to all CCG staff through the self-service portal - allowing them to download the application in line with their workload. However, there will be a cut-off point of July 2021 when the application will be forced onto all remaining devices, in line with the planned Cyber Essentials Plus audit. The suggestion is to keep the risk rating at the current level, as although the process has begun, there remain potential vulnerabilities while there is still Microsoft Office 2010 and one/two instances of Microsoft Windows 7 on the network.</p> <p>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/owners 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 unauthorised access to the system.</p>	<p>The version of Microsoft Teams and Microsoft Office 365 that was introduced as part of the COVID response earlier this year was a restricted version of the application. As users move onto the longer term Office 365 platform we are keen to ensure that no functionality is reduced and that the current level is maintained.</p> <p>There remain, a number of testing issues with the way that this "shared tenancy" is being implemented. This ranges from unexpectedly reducing mailbox sizes through to slow loading times, error messages, etc. There are also issues with the backdoor configuration of the application, as this can be controlled on both a national and local level. Where possible, we are pushing for more local control over functionality to allow us to be flexible and adapt to changing requirements.</p> <p>As a direct result of this, the deployment of Microsoft Office 365 has been paused with other NECs customer organisations. As part of the deployment project we have agreed a certain initial configuration.</p> <p>There are also issues around locums and other members of staff which we have asked NHS Digital to address and for which we have a local workaround. In the old licensing model, the device was licensed for all authorised users. In the new model, it is the individual that has the licence assigned. Hence, were a locum to log into a device within the GP Practice, while they would be able to access the clinical information system and other software, if they were not licensed by the CCG/GP Practice or by their existing employer then they would be unable to open any Microsoft Office applications. As mitigation against this, the project team has been instructed to leave a number of devices on Microsoft Office 2010 within the GP Practices awaiting the fix from NHS Digital. Should this fix not arrive in time, we would be able to implement a different licensing model for these devices to ensure GP Practices were able to continue to operate.</p>	4	3	4	3	4	3	2	1	2	31/03/21	Apr-21	May-21	Helena O'Halloran Executive Director of Corporate Strategy and Delivery	Ger Connolly-Thompson Head of Digital Development, Christy Tucker Director of Corporate Delivery
33	2021	There is a risk to patients on waiting lists as a result of their delays in 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	4	<p>Risk stratification of waiting lists as per national guidance</p> <p>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.</p> <p>Providers are providing clinical reviews and risk stratification for long waiters and prioritising treatment accordingly.</p>	<p>A task and finish group is in place to monitor actions being undertaken to support these patients which reports to PCDB and SOP</p> <p>Providers are capturing and reporting any clinical harm identified as a result of waits as per their quality assurance processes</p> <p>An assurance framework has been developed and completed by all providers the results of which will be reported to PCDB</p> <p>A minimum standard in relation to these patients is being considered by PCDB</p> <p>Work to control the addition of patients to the waiting lists is ongoing</p> <p>Providers are contacting patients via letter</p>	<p>Monthly reporting of progress against all work to control growth of waiting lists</p> <p>Two weekly task and finish groups with all 4 providers represented</p> <p>Completion of assurance framework has been undertaken by all providers and is being collated to go to PCDB for discussion</p> <p>Identified harm has been reported on STEEP and all providers are monitoring this</p> <p>All providers have completed the assurance framework and this is being collated to go back to PCDB for discussion re further risk mitigations</p> <p>Work is ongoing around Consultant Connect, MSK and Ophthalmology</p> <p>12.02.21 Update - PCDB on 25.02.21 agreed the Minimum standard document and regular use of the associated assurance framework to monitor progress against the delivery of this for providers. Task and finish group to be stood down and Programme group to be established with wider membership to continue to progress this work Task are in progress</p> <p>12.04.21 Update - PCDB on 25.02.21 agreed the Minimum standard document and regular use of the associated assurance framework to monitor progress against the delivery of this for providers. Task and finish group has been stood down and Programme group has been established with wider membership to continue to progress this work Task are in draft and plan is to agree at next meeting on 21.04.21 The size of the waiting lists and the length of time people are waiting is increasing, as a direct result of COVID. The risk score has not been increased as we are working to put mitigations in place across the system and then plans in relation to performance and reducing the lists are being worked up.</p>	4	4	4	4	4	3	2	6	16/03/21	Apr-21	May-21	Brigid Stacey, Chief Nursing Officer	Laura Moore, Deputy Chief Nurse	
37	2021	The Royal College of Physicians identified that there is a risk to the sustainability of the Hyper Acute Stroke Unit at CRHFT and therefore to service provision for the population of North Derbyshire.	Quality & Performance	4	<p>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.</p> <p>March update: CRH Stroke Service Contingency Plan has been implemented, with sign-off from impacted surrounding trusts (Kings Mill, Hallamshire, LHCDB, and Sheppings Hill). Short-term mitigations in place to support service continuity, reducing the risk of service suspension and patient divert.</p>	<p>Locum Consultant cover is in place</p> <p>Clinical Leadership support is being provided by Liverpool Consultant</p> <p>Trust to go out for advert to recruit new Stroke Lead consultant & work being done to make advert attractive</p> <p>CCG, NHSE, A System working with Trust Medical Director to contact other organisations and the Stroke Network for support.</p> <p>Trust reviewing staff daily and escalating as per safer staffing policy as required, including red flag acuity reporting</p> <p>CRHFT and Integrated Stroke Delivery Network (SDN) leads to develop service contingency plan to understand internal measures, protect and options, and patient divert impact.</p> <p>SOP to operationalise the contingency plan.</p> <p>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.</p>	<p>Stroke Delivery Group set up to feed in to JUCD LTC Board and lead on ST, MT and LT plans regarding the sustainability of the HASU and wider Stroke pathways for Derbyshire</p> <p>Stroke Delivery Group includes NHSE and neighbouring trusts</p> <p>Agreed TOR for Stroke Group with monthly highlight reports to progress</p> <p>The Trust is actively taking in with SVS Clinical network</p> <p>HASU Options Appraisal to shape future service at CRHFT</p> <p>CRHFT improvement plan in place to deliver against the RCP recommendations.</p> <p>Implementation/Improvement plan in place with CRHFT to mitigate risks and develop the service</p> <p>Progress against CRHFT plan agreed off at CRHFT Trust Board 25/11 and going to DCCCG Q&P 18/12</p> <p>Stroke Delivery Group set up, with agreed TOR, good clinical representation and NHSE involvement</p> <p>Jan 21: Interviews to recruit lead consultant (Dec 20 were unsuccessful). Trust to go back out to advert.</p> <p>Jan 21: Stroke Delivery Group Action Plan agreed off. This embeds the CRH Improvement Plan and Derbyshire-wide objectives to support the assurance process.</p> <p>Feb 21: Stroke admission data has been analysed to support development of CRH Contingency Plan, this includes full, partial and mimic divert data.</p> <p>Feb 21: The CRH Contingency Plan is in its final draft form and conversations have commenced with surrounding impacted trusts to understand CRH's internal measures and mitigations. Medical Director sign off to take place w/c 22/02/21</p> <p>Mar 21: CRH Stroke Service Contingency Plan has been implemented, with sign-off from impacted surrounding trusts (Kings Mill, Hallamshire, LHCDB, and Sheppings Hill). SOP being developed to operationalise the plan.</p> <p>Mar 21: The Stroke Delivery Group have appointed a task and finish group to commence a service review of the HASU, including options appraisal. All options to be reviewed with the aim of providing a sustainable service.</p> <p>Risk score reduced to 12 due to implementation of contingency plan and locum cover in place. The reduction in risk was agreed by the Stroke Delivery Group 03/21.</p> <p>Apr 21: SOP to operationalise the contingency plan is circulated to surrounding Trusts.</p> <p>Apr 21: CRH HASU options appraisal commences in May 21 and is to be chaired by the NHSE National Stroke Clinical Lead Deb Lowe. Membership includes all key stakeholders including surrounding Trusts (Sheffield Teaching Hospitals, Sheppard Forest Hospitals and LHCDB).</p>	3	4	12	3	4	12	3	3	9	12/03/21	Apr-21	May-21	Dr Steve Lloyd, Medical Director	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster, Head of Strategic Clinical Conditions and Pathways

Appendix 2 - Movement during April 2021

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
01	20/21	The Acute providers may breach thresholds in respect of the A&E operational standards of 95% to be seen, treated, admitted or discharged within 4 hours, resulting in the failure to meet the Derby and Derbyshire CCGs constitutional standards and quality statutory duties.	5	4	20	5	4	20	↔	COVID-19 preparations have 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	20/21	Changes to the interpretation of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) safeguards, results in greater likelihood of challenge from third parties, which will have an effect on clinical, financial and reputational risks of the CCG	3	4	12	3	4	12	↔	Risk still the same at the moment as new staff not yet in post.	Brigid Stacey - Chief Nursing Officer	Quality & Performance	Bill Nicol, Head of Adult Safeguarding
03	20/21	TCP unable to maintain and sustain performance, Pace and change required to meet national TCP requirements. The Adult TCP is on recovery trajectory and rated amber with confidence whilst CYP TCP is rated green, main risks to delivery are within market resource and development with workforce provision as the most significant risk for delivery.	5	4	20	5	4	20	↔	Whilst we have but a number of measures in place to reduce the risk it is still high. This will not probably change until the autism service is commissioned.	Brigid Stacey - Chief Nursing Officer	Quality & Performance	Helen Hipkiss, Deputy Director of Quality / Phil Sugden, Assistant Director Quality, Community & Mental Health, DCHS
04A	20/21	<u>Contracting:</u> Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care. There are 112 GP practices in Derbyshire all with individual Independent Contracts GMS, PMS, APMS to provide Primary Medical Services to the population of Derbyshire. Six practices are managed by NHS Foundation Trusts and one by an Independent Health Care Provider. The majority of Derbyshire GP practices are small independent businesses which by nature can easily become destabilised if one or more core components of the business become critical or fails. Whilst it is possible to predict and mitigate some factors that may impact on the delivery of care the elements of the unknown and unexpected are key influencing dynamics that can affect quality and care outcomes. Nationally General Practice is experiencing increased pressures which are multi-faceted and include the following areas: *Workforce - recruitment and retention of all staff groups *COVID-19 potential practice closure due to outbreaks *Recruitment of GP Partners *Capacity and Demand *Access *Premises *New contractual arrangements *New Models of Care *Delivery of COVID vaccination programme	4	4	16	4	4	16	↔	NHSE/I advised that Covid capacity expansion fund to continue until end of September 2021. QOF income protection is withdrawn from April 2021. No changes to the existing levels of risk for this month.	Dr Steve Lloyd - Medical Director	Primary Care Commissioning	Hannah Belcher, Head of GP Commissioning and Development (Primary Care)

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
04B	20/21	<p><u>Quality:</u></p> <p>Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care. There are 112 GP practices in Derbyshire all with individual Independent Contracts GMS, PMS, APMS to provide Primary Medical Services to the population of Derbyshire. Six practices are managed by NHS Foundation Trusts and one by an Independent Health Care Provider. The majority of Derbyshire GP practices are small independent businesses which by nature can easily become destabilised if one or more core components of the business become critical or fails. Whilst it is possible to predict and mitigate some factors that may impact on the delivery of care the elements of the unknown and unexpected are key influencing dynamics that can affect quality and care outcomes.</p> <p>Nationally General Practice is experiencing increased pressures which are multi faceted and include the following areas:</p> <ul style="list-style-type: none"> *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	↔	GP services are moving towards recovery and restoration including reinstatement of CQC inspections, the risk will continue to be reviewed and amended as required.	Dr Steve Lloyd - Medical Director	Primary Care Commissioning	Judy Derricott, Head of Primary Care Quality
05	20/21	Wait times for psychological therapies for adults and for children are excessive. For children there are growing waits from assessment to psychological treatment. All services in third sector and in NHS are experiencing significantly higher demand in the context of 75% unmet need (right Care). COVID 19 restrictions in face to face treatment has worsened the position.	4	3	12	4	3	12	↔	Both demand and wait times are increased. Funding approved to support reduction in internal waits.	Zara Jones Executive Director of Commissioning Operations	Quality & Performance	Dave Gardner Assistant Director, Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning
06	20/21	Demand for Psychiatric intensive Care Unit beds (PICU) has grown substantially over the last five years. This has a significant impact financially with budget forecast overspend, in terms of poor patient experience, Quality and Governance arrangements for uncommissioned independent sector beds. The CCG cannot currently meet the KPI from the Five year forward view which require no out of area beds to be used from 2021.	3	3	9	3	2	6	↓	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.	Zara Jones Executive Director of Commissioning Operations	Quality & Performance	Dave Gardner Assistant Director, Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning
09	20/21	Sustainable digital performance for CCG and General Practice due to threat of cyber attack and network outages. The CCG is not receiving the required metrics to provide assurance regarding compliance with the national Cyber Security Agenda, and is not able to challenge any actual or perceived gaps in assurance as a result of this.	2	4	8	2	4	8	↔	Full deployment of Microsoft Office 365 has begun with the Corporate estate, but this is not yet complete. Deployment is more advanced than the last update, but are not yet fully implemented and hence the scores remain 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
10	20/21	If the CCG does not review and update existing business continuity contingency plans and processes, strengthen its emergency preparedness and engage with the wider health economy and other key stakeholders then this will impact on the known and unknown risks to the Derby and Derbyshire CCG, which may lead to an ineffective response to local and national pressures.	2	4	8	2	4	8	↔	The score is proposed to remain as it is due to how the risk is described. To reduce it any further would weaken the case for continued development internally and with wider stakeholders.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Chrissy Tucker - Director of Corporate Delivery / Richard Heaton, Business Resilience Manager

Risk Reference	Year	Risk Description	Previous Rating		Residual/ Current Risk		Movement	Reason	Executive Lead	Responsible Committee	Action Owner		
			Probability	Impact	Probability	Impact						Rating	
11	20/21	Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the CCG to move to a sustainable financial position.	4	4	16	4	4	16	↔	The CCG is working with system partners to understand the recurrent underlying position and early work suggests there is a £145m deficit going into 2021/22.	Richard Chapman, Chief Finance Officer	Finance	Darran Green- Assistant Chief Finance Officer
12	20/21	Inability to deliver current service provision due to impact of service review. The CCG has initiated a review of NHS provided Short Breaks respite service for people with learning disabilities in the north of the county without recourse to eligibility criteria laid down in the Care Act. Depending on the subsequent actions taken by the CCG fewer people may have access to the same hours of respite, delivered in the same way as previously. There is a risk of significant distress that may be caused to individuals including carers, both during the process of engagement and afterwards depending on the subsequent commissioning decisions made in relation to this issue. There is a risk of organisational reputation damage and the process needs to be as thorough as possible. There is a risk of reduced service provision due to provider inability to retain and recruit staff. There is a an associated but yet unquantified risk of increased admissions – this picture will be informed by the review.	3	3	9	3	3	9	↔	The risk score remains the same due to the fact that during COVID the review of short break services was suspended by the LA.	Brigid Stacey - Chief Nursing Officer	Quality & Performance	Mick Burrows Director for Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning, Helen Hipkiss, Deputy Director of Quality /Phil Sugden, Assistant Director Quality, Community & Mental Health, DCHS
14	20/21	On-going non-compliance of completion of initial health assessments (IHA's) within statutory timescales for Children in Care due to the increasing numbers of children/young people entering the care system. This may have an impact on Children in Care not receiving their initial health assessment as per statutory framework.	4	3	12	4	3	12	↔	The score remains the same as the percentage of compliance has not improved overall due to the added pressures of sickness within CRHFT, the complexities surrounding CIC, impact of Covid (particularly on external Health Providers) and timely notifications from LA (workload capacity).	Brigid Stacey - Chief Nursing Officer	Quality & Performance	Alison Robinson, Designated Nurse for Looked After Children
16	20/21	Lack of standardised process in CCG commissioning arrangements. CCG and system may fail to meet statutory duties in S14Z2 of Health and Care Act 2012 and not sufficiently engage patients and the public in service planning and development, including restoration and recovery work arising from the COVID-19 pandemic.	2	4	8	2	4	8	↔	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.	Helen Dillstone - Executive Director of Corporate Strategy and Delivery	Engagement	Sean Thornton Assistant Director Communications and Engagement

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
17	20/21	S117 package costs continue to be a source of high expenditure which could be positively influenced with resourced oversight, this growth across the system, if unchecked, will continue to outstrip available budget	3	3	9	3	3	9	↔	This risk needs to remain scored at 9 until the caseload review has been finalised.	Zara Jones, Executive Director of Commissioning Operations	Quality & Performance	Helen Hipkiss, Director of Quality / Dave Stevens, Head of Finance
20	20/21	Failure to hold accurate staff files securely may result in Information Governance breaches and inaccurate personal details. Following the merger to Derby and Derbyshire CCG this data is not held consistently across the sites.	3	3	9	3	3	9	↔	No further update due to continued home working.	Beverley Smith, Director of Corporate Strategy & Development	Governance	Sam Robinson, Service Development Manager
22	20/21	The mental health of CCG staff and delivery of CCG priorities could be affected by remote working and physical staff isolation from colleagues.	2	3	6	2	3	6	↔	The mitigations do not entirely remove the risk of mental health problems for our staff and the probability remains at 2 as we are in the main continuing to work from home.	Beverley Smith, Director of Corporate Strategy & Development	Governance	Beverley Smith, Director of Corporate Strategy & Development James Lunn, Head of People and Organisational Development
23	20/21	CCG Staff capacity compromised due to illness or other reasons. Increased numbers of CCG staff potentially unable to work due to COVID 19 symptoms / Self isolation.	1	4	4	1	4	4	↔	The staff sickness has reduced and hence the probability reduced to 1 previously. The impact of reduced resources is still a 4 as would have a significant impact due to supporting vaccination programme, system in response to pandemic and core CCG business.	Beverley Smith, Director of Corporate Strategy & Development	Governance	Beverley Smith, Director of Corporate Strategy & Development James Lunn, Head of People and Organisational Development
24	20/21	Patients deferring seeking medical advice for non COVID issues due to the belief that COVID takes precedence. This may impact on health issues outside of COVID 19, long term conditions, cancer patients etc.	3	3	9	3	3	9	↔	Risk reduced in March due to continued downward trend in COVID cases, success of vaccination roll out, and primary care appointments back at pre pandemic levels. No further update to add for April.	Dr Steve Lloyd, Medical Director	Quality & Performance	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster Head of Strategic Clinical Conditions and Pathways
25	20/21	Patients diagnosed with COVID 19 could suffer a deterioration of existing health conditions which could have repercussions on medium and long term health.	3	3	9	3	3	9	↔	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.	Dr Steve Lloyd, Medical Director	Quality & Performance	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster Head of Strategic Clinical Conditions and Pathways

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
26	20/21	New mental health issues and deterioration of existing mental health conditions for adults, young people and children due to isolation and social distancing measures implemented during COVID 19.	4	3	12	4	3	12	↔	Funding for workforce Hubs received from NHSE and Hub continued to be developed by workforce leads	Zara Jones, Executive Director of Commissioning Operations	Quality & Performance	Mick Burrows, Director of Commissioning for MH, LD, ASD, and CYP Helen O'Higgins, Head of All Age Mental Health Tracy Lee, Head of Mental Health Clinical Lead
27	20/21	Increase in the number of safeguarding referrals linked to self neglect related to those who are not in touch with services. These initially increased immediately following COVID lockdown. The adult safeguarding processes and policy are able to respond to this type of enquiry once an adult at risk has been identified. Numbers are difficult to predict but numbers are predicted to increase as COVID restrictions ease. □	4	3	12	4	3	12	↔	As Covid restrictions are eased organisations are preparing for an increase in operational referrals and enquiries.	Brigid Stacey, Chief Nursing Officer	Quality & Performance	Bill Nicol, Head of Adult Safeguarding
28	20/21	Increase in safeguarding referrals once the lockdown is lifted and children and parents are seen and disclosures / injuries / evidence of abuse are seen / disclosed.	3	4	12	3	4	12	↔	The high level of domestic abuse calls to the Police seen late last year has reduced; as with previous lockdowns it is anticipated that this will increase again as restrictions are lifted.	Brigid Stacey, Chief Nursing Officer	Quality & Performance	Michelina Racioppi, Assistant Director for Safeguarding Children / Lead Designated Nurse for Safeguarding Children
29	20/21	There is a risk of significant reputational damage to the CCG where contracts have been in place and the current contract management arrangements do not provide assurance that providers are compliant with the Data Security and Protection Toolkit.	3	3	9	3	3	9	↔	Work is progressing on updating the database. However the project has now been frozen due to the pandemic.	Zara Jones Executive Director of Commissioning Operations	Governance	Helen Wilson, Deputy Director of Contracting & Performance Chrissy Tucker, Director of Corporate Delivery
30	20/21	There is an ever present risk of fraud and cybercrime; the likelihood of which may increase during the COVID emergency response period.	2	4	8	2	4	8	↔	Work is ongoing to agree the process for Cyber Essentials Plus. Risk scores remain the same until work progresses on CE/CE+.	Richard Chapman, Chief Finance Officer	Finance	Darran Green- Assistant Chief Finance Officer / Ged Connolly-Thompson, Head of Digital Development
32	20/21	Risk of exploitation by malevolent third parties If vulnerability is identified within any of the Microsoft Office 2010 applications after October 14th 2020 and not patched, due to support for Microsoft Office 2010 officially ending, after which point Microsoft will cease to issue updates and patches for vulnerabilities found within this suite of applications	3	4	12	3	4	12	↔	Work is ongoing and progressing, but the risk has not yet been fully mitigated.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Ged Connolly-Thompson - Head of Digital Development, Chrissy Tucker - Director of Corporate Delivery

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
33	20/21	There is a risk to patients on waiting lists as a result of their delays to treatment as a direct result of the COVID 19 pandemic. Provider waiting lists have increased in size and it is likely that it will take significant time to fully recover the position against these.	4	4	16	4	4	16	↔	The size of the waiting lists and the length of time people are waiting is increasing, as a direct result of COVID. The risk score has not been increased as we are working to put mitigations in to place across the system and then plans in relation to performance and reducing the lists are being formulated.	Brigid Stacey, Chief Nursing Officer	Quality & Performance	Laura Moore, Deputy Chief Nurse
37	20/21	The Royal College of Physicians identified that there is a risk to the sustainability of the Hyper Acute Stroke Unit at CRHFT and therefore to service provision for the population of North Derbyshire.	3	4	12	3	4	12	↔	SOP to operationise the contingency plan has been circulated to surrounding Trusts.	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

Joined Up Care Derbyshire Board
Minutes of the Meeting held in PUBLIC on
Thursday 18 March 2021 (0900-1130 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	
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 (Part meeting)	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	
Andy Smith	AS	Strategic Director of People Services	Derby City 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	
Paddy Kinsella	PK	Exec of GP Alliance	Derbyshire GP Alliance	
Riten Ruparelia	RR	GP Alliance Provider Representative	Derbyshire GP Alliance	
Caroline Maley	CM	Chair	Derbyshire Healthcare NHSFT	
Stephen Bateman	SB	Chief Executive	DHU Health Care	
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	
Gavin Boyle	GB	Chief Executive	University Hospitals Derby & Burton NHSFT	
In Attendance:		Designation:	Organisation:	Deputy on behalf of/Item No:
Amy Lampard	AL	Community GP	Chesterfield PCN	Patient Story
Anne-Marie Spooner	AMS	GP Clinical Lead and Chair of Chesterfield Place Alliance	Chesterfield Place Alliance	Patient Story
Hal Spencer	HS	Medical Director & Co-Chair of CPRG	Chesterfield Royal Hospital NHSFT	Item 6
Jayne Stringfellow	JS	Non-Executive Director	Chesterfield Royal Hospital NHSFT	Deputy for Helen Phillips
Helen Dillistone	HD	Exec Dir of Corp Strategy & Delivery	Derby & Derbyshire CCG	Item 6

Siobhan Horsley	SH	Senior Specialty Registrar in Public Health	Derby City Council	Item 9
Richard Wright	RW	Non-Executive Director	Derbyshire Healthcare NHSFT	Item 6
Jackie Counsell	JC	ICS Executive Assistant	Joined Up Care Derbyshire	Note taking
Linda Garnett	LG	ICS Workforce & OD Lead	Joined Up Care Derbyshire	Item 8
Lee Mellor	LM	Communications and Involvement Specialist	Joined Up Care Derbyshire	
Diane Gamble	DG	Deputy Director of Strategic Transformation, North Midlands	NHS E/I – Midlands	Deputy for Fran Steele
Members of the Public in Attendance:				
Marc Goddard <i>(Part meeting)</i>	MG	Attending as Member of the Public		
Katherine Hignett <i>(Part meeting)</i>	KH	Attending as Member of the Public		
Andrea Kemp	AK	Attending as Member of the Public / Chief Executive Officer, Shift		
Brian Martin	BM	Attending as Member of the Public		
Apologies:		Designation:	Organisation:	
Helen Phillips	HP	Chair	Chesterfield Royal Hospital NHSFT	
Helen Jones	HJ	Executive Director of Adult Social Care & Health	Derbyshire County Council	
Ifti Majid	IM	Chief Executive	Derbyshire Healthcare NHSFT	
Rachel Gallyot	RG	Clinical Chair	East Staffordshire CCG	
Fran Steele	FS	Director of Strategic Transformation, North Midlands	NHS E/I – Midlands	
Kathy Mclean	KMc	Chair	University Hospitals Derby & Burton NHSFT	

180321/1	Welcome, Apologies and Minutes of Previous Meeting	Action
	<p><i>As per the Agenda, members were reminded that the meeting was being recorded purely for the purpose of minute accuracy.</i></p> <p>The Chair welcomed Board members to the meeting and apologies for absence were noted as reflected above; the meeting was confirmed as being quorate.</p> <p>The Chair noted TA was in the HSJ top 50 NHS leaders list published today and offered congratulations on behalf of the Board.</p> <p>The minutes of the last meeting held in public on 21 January 2021 were noted to be an accurate record. Today's meeting was confirmed as being held in public.</p>	
180321/2	Action Log	
	VT advised that the 3 live actions on the action log were all future agenda items.	
180321/3	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. No changes were noted.	
180321/4	Patient Story – Integrating Community Care (AMS, AL)	
	AMS and AL were welcomed to the meeting and they went through their presentation 'The Journey of the Frailty Team, Chesterfield' (<i>circulated in advance</i>), highlighting how they had created one team across Health and Social Care to see all housebound patients in a neighbourhood. The team cover all urgent, planned or anticipatory care, delivering the service by teaming up existing services, taking a multi-skilled team	

approach involving: Advanced Care Practitioners (ACPs), Care Co-ordinators, Community Matrons, Community Paramedics, LTC Nurses/Nurse Associates, dedicated Community GP, Pharmacists Structured, Social Prescribers, Community Therapy and Nursing, and Palliative Care Nurses. The embryonic frailty team in one neighbourhood in Chesterfield was set up in early 2019 and had been testing the model of 'one team' to deliver reactive and proactive care; and the application of new roles (community GP, LTC nurse, proactive therapy involvement). Working in this way had enabled escalation/de-escalation within the team, better use of skills and clinical leadership to support decision making. The presentation also highlighted the case study of a residential patient in a nursing home and gave an overview of routine GP input and Frailty Team input between 16 December 2020 to 1st February 2021.

The findings showed numerous benefits:

Benefits to both the patient/ family (familiar faces, known background, patient remained in chosen place of care, avoided confusion associated with changing location); **Benefits to Clinicians** (clearer guidance about historical/ recurrent illnesses so treatment started promptly, Clinician/family focused on current symptoms not PPC as Respect form completed previously, access to support/expertise from a wider MDT regularly); **Benefits to care home** (single clinician builds efficient relationships/ systems for annual reviews; visits are more tailored/ responsive to patient's needs); **Benefits to system** (team knows about complex patients/ can provide support when usual clinician off, weekly MDT meetings enables input from specialists to be more streamlined, reduces time spent visiting/ admissions).

The following key summary discussion points were highlighted:

- It was noted that the biggest challenge had been to secure additional funding for the new roles i.e., community GP, LTC nurse, proactive therapy involvement and it was noted that funding would always likely be an issue.
- Thanks, were placed on record to Chesterfield Borough Council for helping with some of the funding for this initiative. That funding was, in part, a product of the Place Based OD work undertaken in Chesterfield and across Derbyshire (some time ago now. It was noted that finding pump priming funding for the "left shift" and a cast iron benefits case is tricky but not impossible (LO)
- It was noted there was a similar model in Derby City and that further help needed to come from emergency & secondary care services to fit into this model (RR)
- There was support for this Community GP model, which worked well as a conduit between community/practice staff, saves interruption of the surgery staff and provides continuity (AB). By having a community GP, it provides senior leadership to guide, bring together and support learning. It is a privileged position and allows a GP to be flexible with their time in terms of appointments/duration of appointment time, etc, with no clinic-based work in practice. Many issues can be more easily resolved for patients, it provided continuity of care and with the weekly MDT meetings appropriate advice can be sought as required, both at the meetings and in between (AL).
- In terms of the ideal footprint, AL was 0.4 WTE community GP for a footprint of c. 20k population, which seemed to work well. The aim was for 5 of these neighbourhoods across the whole of Chesterfield (c. 100k population), which may need some overlap.
- Social prescribing through the volunteering network, has been a central part of the model too, for this cohort of citizens/patients. (LO)
- In terms of how best to share the learning across the wider ICS and promote more widely initiatives such as this, we need mechanisms in place to ensure we can enable/build on this work and share learning; it was noted:

	<ul style="list-style-type: none"> ○ Place Alliance Leadership meets monthly with informal discussions in between, which was a forum to share learning/innovations and develop expertise across the system (PB). ○ PS suggested to consider the possibility of having a learning/innovation academy for Derbyshire which could act as a repository of good practice and learning. It was agreed this would be taken forward by the People & Culture Board. ○ The need to learn from other ICSs mindful JUCD have chairs involved in other ICSs: Derbyshire, Nottinghamshire and Staffordshire (JM). ○ The JUCD newsletter was a mechanism to share good practice with the wider system and the population it serves (VT) ○ Some of our communications channels will support some of that wider sharing (ST). <p>The Board thanked both AMS and AL for sharing their inspiring work and findings, recognising the theme was very much aligned to today's agenda.</p>	
180321/5	Chair and ICS Executive Lead Update (JM, CC)	
	<p>The Chair noted that in addition to the Chair and Executive Lead Report (<i>previously circulated</i>), he recorded his thanks to the vaccination programme recognising that Derbyshire was performing amongst the best in the Midlands/across the country and was a credit to the collaborative working demonstrated. In terms of ICSs and integrated commissioning, the ICS Chairs across the East Midlands had been pushing quite hard to ensure wider discussions/ engagement happens with NHSEI. A letter had been sent from himself, PS and KMc with the offer to lend support to engaging system leaders across the region in further developing the proposals and to ensure we can inform and shape how CCG commissioning responsibilities become part of the ICS and how the ICS is developed.</p> <p>CC highlighted some salient points from the report, around the White Paper and the need to come back to this more formally with the next stage of discussion at the April Board development session, particularly around partnership approach and Anchor Institutions. In terms of the Covid response (<i>included within the report appendices</i>) it was important to note our position in terms of community prevalence and that our numbers were reducing. The continuation of maintaining prevention/testing approach with local partners remains important as does restoration/recovery (elective/cancer provision). CC reflected that it may be useful for the Board to have a summit approach to Covid, the legacy we want and how we build on the learning going forward.</p> <p>The following key summary discussion points were highlighted around having a summit approach to Covid:</p> <ul style="list-style-type: none"> ● MW queried if there would be an opportunity to bring in patients/public in the summit process regarding learning from covid/setting priorities for the future from a patient perspective (either with members of the public/lay members from the engagement committee. ACTION: CC agreed to give further consideration on how best to do a summit approach around Covid, to ensure we are hearing community voices to bring back to the Board. ● A review of our Covid response, recognising that although individual organisations will be doing this, it would be good to get a system perspective. Particularly gathering the innovations and transformation that have occurred and how we build on this to meet the enormous challenge of recovery (GB). ● It would also help to build on learning for all about how we work as a system rather than organisationally as we will inevitably still do at times (AS) ● JUCD participated in a regional lessons learned review from the pandemic, this was system rather than organisation based, and the outputs shared with JUCD Board so it would be good to incorporate this into any summit approach. (VT) 	CC

	<ul style="list-style-type: none"> • Many of our Place Alliances have patients/ people on their local boards and regularly engage, certainly at the neighbourhood level (PB). <p>In terms of integrated commissioning, the report included an appendix which outlined some of the discussions that had already taken place, noting the need to plan further conversations in May to build on this and set our direction of travel, in order that the ICS can start to build ownership around the commissioning functions.</p> <p>CC also thanked colleagues working on the NHSE/I Derbyshire visit by Lord David Prior, Chair of the NHSE/I Board on 13 May 2021.</p>	
180321/6	<p>JUCD ICS Interim Operating Model (ASm, CM, RW, PS, AB, HS)</p>	
	<p>To review progress/approve Terms of Reference (ToR) as outlined below.</p> <p><u>System Quality sub-committee (ASm)</u></p> <p><u>Purpose:</u> To assure the JUCD Board of the quality of care provided by the system for the health and cared needs of the citizens of Derby and Derbyshire.</p> <p><u>Remit:</u></p> <ul style="list-style-type: none"> • To provide assurance to the JUCD Board on: • The delivery of a system wide Quality strategy, reviewing shared quality priorities for the system and ensuring they are delivered. • To assure progress against agreed quality outcomes. • To be assured that there is learning to inform improvement, understanding of and reduction in variation and level of risk. • Implications of Quality strategy implementation on performance for individual organisations. • To provide oversight of the framework and strategy for Quality planning to ensure that each of the system partners has an approach to Quality planning which is compatible and compliments the System approach. • To provide advice and scrutiny on the development of the System Quality framework and strategy. <p><u>System Finance & Estates subcommittee (CM, RW)</u></p> <p><u>Purpose:</u> To provide oversight and assurance to the JUCD Board in the development and delivery of a robust, viable and sustainable system financial and estates plan; and processes which meet the health and care needs of the citizens of Derby and Derbyshire and aid the implementation of the JUCD vision and strategy. This committee will operate through interim and emerging arrangements to support and manage the transition period to becoming a mature Integrated Care System (ICS) by April 2022 and will therefore review these ToR 6 monthly to ensure any new developments and emerging national guidance are fully reflected.</p> <p><u>Remit:</u> The Committee will gain assurance from the JUCD executive functions and provide assurance to the JUCD Board on:</p> <ul style="list-style-type: none"> • Transition and Development (from April 2021) • Delivery (from April 2022) • Statutory Oversight 	

People and Culture subcommittee (PS, GB)

It was noted that a meeting was scheduled later today with GB, LG and system HRDs to commence discussions and look at the approach, identifying gaps, how we can add further value, what we can do together for better outcomes, shape the future etc. GB already chairs the People and Culture Board and it was important to avoid duplication/overlap and to review how other non-executives can add value as critical friends to bring strategic oversight on people matters in the system. As things progress, further updates would be given to the Board. It was noted that this was the hardest group to get right, as its potentially such a huge area.

System Transition Assurance subcommittee (AB, HD, VT)

Purpose:

To oversee the transition of the current system into a statutory ICS

Remit:

- Not to second guess work of groups developing proposals but provide assurance and advice to Board that the system is coherent
- Provide oversight and assurance of the movement of functions and associated processes between statutory organisations and assure JUCD ICS Board that these influences, and are consistent with, the way the system will operate
- Advise Board on challenges and risks of White Paper: Health and Social Care and legislation
- Assure the JUCD ICS Board that there is cohesion in the transition of functions and structures in relation to the following programmes of work:
 - Provider collaboration at Place
 - Provider collaboration at Scale
 - CCG transfer of statutory functions (including CCG safe/ legal close down, i.e., technical close down arrangements and transfer arrangements into the wider system/ ICS)
 - Strategic Intent and integrated commissioning
 - ICS corporate remit and functions

The following key summary discussion points were highlighted around the draft ToRs:

- Monitoring, and assuring improvement in the ICS Outcomes Framework (for Derbyshire and at neighbourhood level) should be central to the Quality Committees role (LO)
- Integrated primary/community care is about relationships, and clear aims, recognising the scale needs to be right. (PK)
- The DoFs (CCG and NHS providers - could be wider to include others as desired), meetings are currently weekly, alternating with inclusion of Deputies each fortnight. The NED critical friend in the Finance Subcommittee has been very helpful and is helping to build a shared view on where we need to work more as a system, as opposed to organisationally. (LO)
- For all committees the challenge will be to keep thinking total system (not just the provider trusts and CCG) - i.e. primary care and local authority, and not forgetting third sector, have a role to play - how do we get a full system view. (CM)
- Workforce - as our biggest asset but biggest risk area, important to get the people & culture assurance group right and take the time required to work this through (CC)
- Lots of interplay between people and culture group and the developments of provider collaboration at scale and at place - given some of the choices we will need to make in terms of future workforce needs and the transition between our current ways of working and those in our future. Understanding and managing risk will be key (WL)

- JM will attend Transition Assurance subcommittee as independent Chair. We need to ensure we don't lose sight of any national guidance on constitutions of Boards when received, but we can shape the way we work in the interim (JM)
- It was noted that a strong executive function would sit under all the assurance subcommittees. There was also the need to understand how PC at Place and at Scale fit in and revisit accordingly (CC).
- If there were any significant points to raise following discussions within individual organisations, i.e., what we can do better together rather than separately, then this should be fed back to the respective subcommittee Chair/AO in order that the draft ToR can be developed further/ the approach refined (JM).
- All the assurance groups are at different stages of development, the Finance one has been meeting for a year, others not yet set up, but all reviewing what the role of the Board in assurance was, not duplicating work happening elsewhere and at Executive level and keeping "clear blue water" between Executive and Assurance functions (JM).

JUCD Board **APPROVED** proceeding based on the iterative draft ToR for the following committees, recognising that the ToR would be developed and refined in light of national guidance and experience:

- System Quality subcommittee
- System Finance and Estates subcommittee
- System Transition Assurance subcommittee

Contact with respective members of the subcommittees should be taken forward at pace to share how the subcommittees will move forward/ progress.

Clinical and Professional Leadership Group (HS, AB)

HS updated the Board on discussions taking place to strengthen clinical and professional leadership at the heart of the new ICS. Through these discussions, a vision had been developed; focusing on 5 key strategic areas (Strategic Intent inc. Health Inequalities, Advisory Role, Assurance Role, System Architecture, Enabling System Working). Underpinning the approach would be a transition from the current Clinical and Professional *Reference* Group (CPRG) to a Clinical and Professional *Leadership* Group (CPLG).

To develop a comprehensive picture of existing clinical and professional leadership in the system (who and what sits where and how this can be developed/ what could be replaced/ amalgamated, etc and scope to redefine things that should only be done once at a system level to avoid duplication); thus far over 90 groups have been identified. This had already begun highlighting complexities that will need to be worked through genuinely transition and embed. A 6-month timescale was envisaged to put some of the vision in place. National guidance was also being considered together with liaising with other ICSs (i.e., South Yorkshire and Bassetlaw ICS), sharing what works well/ does not, etc. The Board was asked to note and support the actions taken so far and to support next steps as outlined in the paper (*previously circulated*).

AB added that clinical and professional leadership was very broad, and we needed to be cognisant of that and the challenge of bringing it altogether under a single umbrella as a CPLG, noting one size does not fit all.

The following key summary discussion points were highlighted:

- Shift in emphasis from a reference group to an active leadership group across health and social care was important and would need the support from everyone to help this transition.
- Consideration required how CPLG would link with other subcommittees/groups to promote and share innovation and learning; this was supported and was already in

	<p>place to a degree e.g. through the ACT group linkages and link to Quality through BS as an integral member of CPRG/ CPLG.</p> <ul style="list-style-type: none"> • This would enable wider clinical engagement with a dispersed leadership model in a co-ordinated way, i.e., via Place/ Pathways • We must take every opportunity to learn and reflect and this should be extended to learning from other ICS areas; HS confirmed he was making links with South Yorkshire & Bassetlaw to learn from them. • It was important that our clinical and professional leadership governance and assurance mechanisms are proportionate/ streamlined to provide the space and bandwidth to have the necessary focus on learning/ development/ improvement; it was felt that there may be opportunities to streamline governance in both organisations and the system as Places evolve. <p>The JUCD Board SUPPORTED the CPLG vision outlined and next steps to push ahead with developing a work programme; setting out intentions of how to build mechanisms which genuinely embed and recognise clinical and professional leadership at all levels within the system.</p> <p>JM noted that through the discussions in relation to developing clinical and professional leadership and earlier items, there was common theme regarding the importance learning and reflection; there was a need to give more thought as to how to facilitate and support learning and development more widely across the system. CC recognised that learning and development hasn't featured significantly in the operating model thus far, which is an omission and there was a need to strengthen the approach within the overall structure in terms of clinical, quality and people.</p> <p>ACTION: CC to bring back to the Board in a couple of months, a more considered approach to learning and development and how this can be facilitated.</p>	CC, VT
180321/7	<p>Provider Collaboration at Scale and at Place (SB, TA, PB)</p>	
	<p>SB, TA and PB went through the presentation (<i>previously circulated</i>) which gave background context, plans and progress to date on the JUCD approach to Provider Collaboration (PC) at Scale and at Place and proposed next steps/recommendations, noting this may need to be adapted as required as further national guidance is made available to systems.</p> <p>It was noted that SB/TA were working closely together on PC at Scale and at Place to ensure key interfaces and a coherent ICS, strengthening Place leadership whilst supporting existing integrated work. Utilisation of KPMG transformation support was in place via JUCD ICS core team, which would entail a 6-8-week diagnostic across the system focusing on PC at Place and at Scale and once completed further priorities would be identified to build into the workplans.</p> <p><u>Next Steps - Provider Collaboration at Scale:</u> JUCD Board was asked to:</p> <ul style="list-style-type: none"> • Agree the recommendation to set up a time-limited sub-committee, overseeing the aims, developments and outline plan. • Agree that an initial investigative study be undertaken from April 2021 into existing collaborative working across JUCD, creating the baseline for future developments. • Support the broad principles and approach as outlined in the presentation both in terms of collaboration at scale but also regarding the interface with other key elements of the system. <p><u>Next Steps - Provider Collaboration at Place:</u> JUCD was asked to:</p> <ul style="list-style-type: none"> • Agree the recommendation to set up a time-limited sub-committee with the proposed draft membership, aims, ways of working and outline plan. 	

- Agree that the sub-committee will establish two formal Place Partnerships serving the City and County, with the local partnerships and delivery team architecture reflecting existing and evolving ways of working.
- Support the broad principles and approach as outlined in the presentation both in terms of collaboration at place but also regarding the interface with other key elements of the system.

The following key summary discussion points were highlighted:

- It was noted that urgent care board would incorporate critical care moving forward (CC).
- Further consideration needs to be given to implications for workstreams and how they may operate in a different way in the context of Provider Collaboratives both at Scale and at Place (JM).
- Need to be mindful that making this cultural shift in primary care (from dealing with patients on a 1:1 basis to looking at population health management at a system level) will take time (PK). It was noted that some engagement work with GPs and Place Lead GPs had already commenced and this could be ramped up (PB).
- This is an area where we need to work together across assurance committees e.g. estates and financial implications and consider how we ensure no duplication (CM).
- There was a suggestion for Committee chairs to meet regularly to ensure nothing slips through the gaps and to help avoid duplication across committees. A similar approach has been introduced at EMAS, and the feedback is positive (PT).
- Further work was required in relation to accountability of neighbourhoods to HWBBs; these interfaces are key.
- RD advised there was a need to define the responsibilities and accountability for addressing Health Inequalities. RD as system Inequalities Lead could help shape how we build in which actions sit where at all levels and help make connections/ genuinely embed inequalities in all we do. This would also ensure the requirements of NHSE/I are met and that we can evidence our progress.
- A session on health inequalities was planned for the May JUCD Board under Strategic commissioning / Strategic intent and CC would liaise directly with RD on this to clarify required input from her in advance.
- It will be important to link in with People, culture and system development work, to ensure appropriate support is built into the provider collaborative developments.
- There is a significant communications and engagement piece required across all this work, both formal and informal, as we work with stakeholders and the public to progress the aims. (ST) **ACTION: ST to link in with SB/TA to progress comms.**
- There are regional and national ICS Development programmes being set up which include system representatives. It was noted that both TA and Kate Brown (SRO for PC at Place) were involved in the Midlands group and it would be useful to link in with the development offers.

ST, SB, TA

The chair thanked those involved in the excellent and careful work on developing the proposals. The JUCD Board **APPROVED** proceeding with the development of Place and Provider Collaborative and specifically:

Provider Collaboration at Scale:

- Agree the recommendation to set up a time-limited sub-committee, overseeing the aims, developments and outline plan.
- Agree that an initial investigative study be undertaken from April 2021 into existing collaborative working across JUCD, creating the baseline for future developments.
- Support the broad principles and approach as outlined in the presentation both in terms of collaboration at scale but also regarding the interface with other key elements of the system.

	<p><u>Provider Collaboration at Place</u></p> <ul style="list-style-type: none"> • Agree the recommendation to set up a time-limited sub-committee with the proposed draft membership, aims, ways of working and outline plan. • Agree that the sub-committee will establish two formal Place Partnerships serving the City and County, with the local partnerships and delivery team architecture reflecting existing and evolving ways of working. • Support the broad principles and approach as outlined in the presentation both in terms of collaboration at place but also regarding the interface with other key elements of the system. <p>ACTION: The Chair requested CC to formally communicate to Region/ NHSE/I what JUCD has agreed to do regarding PC at Scale and at Place.</p>	CC
180321/8	<p>Derby and Derbyshire People Plan (GB, LG)</p> <p>GB advised that the papers circulated gave assurance to the Board of progress against the national, regional and system objectives set for 2020/21. The Plan was guided by three key assumptions that the health and social care system needs: More staff; Working differently; In a culture that is more compassionate and inclusive. Key actions set had been around: Looking after our People; Belonging to the NHS; New ways of working; Growing for the future. The plan highlighted good progress had been made around the health and wellbeing agenda and system collaboration, which was an important building block around recovery. There was also strong evidence around workforce flexibility.</p> <p>GB highlighted that the people agenda was strongly linked to the anchor institution developments; working together to focus on employment and employability opportunities e.g. the step into work programme was a good example of how we can play a bigger role in employment for the population of Derby and Derbyshire.</p> <p>The following key summary discussion points were highlighted:</p> <ul style="list-style-type: none"> • The White Paper refers to the Triple Aim; as a system we have previously recognised workforce as being an equally important factor and as such agreed to focus on our quadruple aim (as set out in our 5 year strategy, i.e., Quadruple Aim: Improving experience of care (quality & satisfaction), Improving the health of the population, Improving staff experience, Reducing the per capita cost of healthcare) and it was important not to lose sight of this and to retain the emphasis. It was agreed that when talking about our aims we must ensure People and Culture are included equally and a challenge was put to the Board to give more time and emphasis to Workforce as was the case with Finance as if we get our people aspects right, quality and efficiencies follow. • It is important for the Board to understand what the core challenges are and to think about the kind of updates the Board should have on People and Culture going forward, recognising that it is complex and large. 	
180321/9	<p>Derby and Derbyshire Childhood Obesity Strategy 2020-2030 (AS, SH)</p> <p>AS introduced SH to the Board to lead on the item. In addition to the papers previously circulated, SH went through a presentation (<i>circulated post meeting</i>), seeking Board approval for the Derby and Derbyshire Childhood Obesity Strategy 2020-2030. SH highlighted anecdotal evidence and emerging data which suggested that rates of obesity in children had increased in the last 12 months, including an increase in those who are severely obese. Further data will be collected during 2021/22 which will enable a new baseline to be set and agreement of outcomes/ targets. It was recognised that Childhood Obesity is a multi-faceted issue with long term consequences at individual level and at population level for the health and care system, therefore actions to reduce prevalence require involvement of multiple stakeholders acting at strategic and operational level.</p>	

The JUCD Board was asked to facilitate the implementation of the Derby and Derbyshire Childhood Obesity Strategy 2020-2030 by:

- Providing endorsement of approach.
- Acknowledging challenges in delivery during the COVID-19 Pandemic and supporting a staged approach, with an urgent and immediate focus on support for those who are obese and overweight, and longer term strategic preventative action.
- Supporting actions and measurable outcomes set by the Strategic Multi-agency Childhood Obesity Group based on a new baseline position as data becomes available.
- Supporting governance and the actions required by enabling governance and accountability of the Strategic Multi-agency Childhood Obesity group to sit with the JUCD Children's Board and alongside the Derby and Derbyshire Safeguarding Board to ensure the system is held to account for joint work on this issue.

The following key summary discussion points were highlighted:

- JM suggested there was a need for clarification of what health needed to do to support this, e.g. which services need reshaping; how could the NHS influence and support the strategy and address health inequalities? There was a need to agree where discussion items (such as this), fit going forwards between the ICS NHS Board and ICS Health and Care Partnership Board. The Board also needs to understand the local authorities (LA) key priorities and where we could make the biggest difference, most quickly. There were lots of factors that influenced population health, such as smoking, obesity, alcohol; there was a need to prioritise as we can't tackle them all at once.
- RD confirmed that this was one of the key priorities for the LA following requests from different services (including NHS/ community based), as Tier 3 interventions were currently unavailable unless obese children are suffering with diabetes, hypertension or mental health issues. It was noted the work had been paused due to Covid.
- CC reiterated that a session on health inequalities was planned for the May JUCD Board regarding Strategic commissioning / Strategic intent, which would also be looking at what could be done as a health and social care system to tackle the wider determinants of health; noting the previous work completed by Dean Wallace regarding interventions could be revisited to build on what we already do. We need to look at how we can get ahead on prevention with LA/ public health colleagues helping our understanding.
- Obesity in children is of paramount importance, as obese children grow into obese adults with all the associated co-morbidities. It was important to recognise that any investment into this area should reap longer term health benefits, but not immediately; this needed to be carefully considered and balanced in investment decision making.
- To address inequalities, it was important to identify which areas had the greatest need (geography) and working closely with schools was important too.
- LO suggested that when we review the strategic intent, it would be stark to see the correlation between poor lifestyle issues are (smoking prevalence, childhood obesity, etc.) and socio-economic factors which may help with what can the 80% versus the 20% fix? If we are really trying to narrow the gap between healthy and total life expectancy we'd probably radically change where resources are deployed.

The Chair summarised JUCD Board **SUPPORT** for the Derby and Derbyshire Childhood Obesity Strategy 2020-2030 as set out and wide recognition it was extremely important. In the meantime, JUCD would build on existing work that the health and social care system could do itself and/or contribute.

180321/10	Digital as an Enabler (TA) – INFO ITEM	
	It was noted that the papers circulated provided an update on the outcome of the Derbyshire shared care record (DSCR) accelerated procurement process, the implementation phases and the programme structure and approach. It was confirmed that the contract had been awarded and £1.7m of additional central funding had been received which had been effectively used in the context of the long-term contract. A paper would be taken to the April JUCD Board detailing confirmed costs regarding capital charges and programme management. It was noted that data/ digital was a critical enabler.	
180321/11	JUCD ICS Milestone and Implementation Plan (VT) – INFO ITEM	
	It was noted that the paper circulated, provided JUCD Board members with the revised milestone and implementation plan, which was an iterative document and reflected changes following February’s Board development session and the recently published White Paper. It was noted the Board will oversee delivery of the milestone plan as part of the broader ICS development plan and will receive assurance of delivery on a 6-monthly basis. The ICS Milestone and Implementation plan is viewed as a dynamic document with further iterations required as a result of the collaborative work with KPMG around accelerating transformation in the system. A draft programme of work for 2021/22 will be brought to the Board for consideration at the next meeting.	
180321/12	Any Other Business	
	No items were raised as requiring urgent consideration under AOB. The Chair placed on record his thanks for all the hard work that had gone into progressing the way forward as an ICS thus far, recognising that this has been completed whilst managing daily system pressures during the pandemic. Key messages to be drafted following the meeting.	
180321/13	Questions from members of the public	
	No questions had been received from members of the public.	
180321/14	Date of Next Meeting	
	The next formal JUCD Board meeting was scheduled to take place on Thursday 15 April 2021; to be held via MS Teams. It was noted the meeting would be held in two parts: Formal Board (held in public), followed by Board membership only Development session.	All to Note

**MINUTES OF DERBY AND DERBYSHIRE AUDIT COMMITTEE
HELD ON 18 MARCH 2021**

VIA MS TEAMS AT 9.30AM

Present:

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

In Attendance:

Niki Bridge	Deputy Chief Finance Officer
Andrew Cardoza	Director, KPMG
Richard Chapman	Chief Finance Officer
Debbie Donaldson	EA to Chief Finance Officer (minute taker)
Darran Green	Assistant Chief Finance Officer
Ian Morris	Anti-Crime Specialist, 360 Assurance
Frances Palmer	Corporate Governance Manager
Suzanne Pickering	Head of Governance
Chrissy Tucker	Director of Corporate Delivery
Kevin Watkins	Business Associate, 360 Assurance

Apologies:

Helen Dillistone	Executive Director of Corporate Strategy and Delivery
Tim Thomas	Director, 360 Assurance
Richard Walton	KPMG

Item No	Item	Action
AC/2021/345	Welcome and Apologies The Chair welcomed members to the Derby and Derbyshire Audit Committee. Apologies were received from Helen Dillistone, Richard Walton and Tim Thomas.	
AC/2021/346	Declarations of Interest The Chair reminded Committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG.	

	<p>Declarations made by members of the Derby and Derbyshire Audit Committee were listed in the CCG's Register of Interests and included with the meeting papers. The Register was also available either via the Corporate Secretary to the Governing Body or the CCG's website at the following link:</p> <p>www.derbyandderbyshireccg.nhs.uk</p> <p><u>Declarations of interest from today's meeting</u></p> <p>There were no declarations of interest made.</p> <p>The Chair declared that the meeting was quorate.</p>	
AC/2021/347	<p>Minutes of the Derby and Derbyshire Audit Committee held on 21 January 2021</p> <p>The Minutes of the Derby and Derbyshire Audit Committee held on 21 January 2021 were presented.</p> <p>The Minutes from the Derby and Derbyshire Audit Committee held on 21 January 2021 were agreed and signed by the Chair.</p>	
AC/2021/348	<p>Matters Arising – not elsewhere on agenda</p> <p>There were no further matters arising.</p>	
AC/2021/349	<p>Derby and Derbyshire Audit Committee Action Log</p> <p>The Audit Committee Action Log was reviewed and updated.</p> <p>There were no further actions.</p>	
AC/2021/350	<p>Internal Audit Reports:</p> <p>Counter Fraud Work Plan: Ian Morris presented the draft 2021-22 Counter Fraud Work Plan and sought approval for the Plan today.</p> <p>Ian Morris highlighted a case, encountered by accident by Counter Fraud Services, regarding an individual employed at a Derbyshire GP practice. The individual employed at the GP practice had taken advantage of the current pandemic in that his employment checks had not been thoroughly completed by the practice. This individual had a history of unethical behaviour in previous GP practices. Counter Fraud had now put out an alert to practices regarding this individual and had also referred it to NHSE/ Counter Fraud Authority. The individual could not be named at this current point, but was a practice manager, and assistance had been offered to the practice concerned. Richard Chapman reported that Ian Morris had produced a guidance document which would be distributed to GP practices, highlighting good</p>	

practice with regard to recruitment and what the minimum standards should be.

Ian Morris highlighted the following from the draft Counter Fraud Plan:

- Discussions had been undertaken with the Audit Chair, Richard Chapman and Darran Green regarding the work plan.
- The Functional Standard had been introduced by the Cabinet Office and exists to standardise how fraud was dealt with across Government.
- From April 2021 the NHS Counter Fraud Authority (NHSCFA) was required to report to the Cabinet Office in relation to the NHS response to the Functional Standard.
- As a result NHSCFA standards that have been followed in recent years had now been replaced by a document that follows the functional standard.
- The standards were different to those used in the past and would become live in April 2021, after having only been released in January of this year.
- The Self Reporting Tool (SRT) had been replaced by the Counter Fraud Functional Standard Return (CFFSR).
- From 2021 all NHS funded services would be required to provide assurance against the Functional Standard. It was acknowledged that the provision of returns for 2021 would represent a baseline measurement that would enable organisations to identify work required to progress towards compliance by March 2022.
- The Functional Standard vs NHSCFA Standards were mapped against each other within the Counter Fraud Plan indicating the changes required under the new components.
- The Plan had been developed on the basis of 60 counter fraud days being delivered during the year.
- There was a potential for additional work required by counter fraud as we transition from a CCG to ICS in the next 12 months. It was noted that this plan was flexible and if the CCG identified risk areas that needed addressing then these would be built into the plan at that point.
- Jill Dentith felt that the plan was comprehensive, appropriate and was flexible enough to meet the challenge
- The Audit Chair shared his frustrations with regard to the Standards changes, and that the CCG acknowledged as a result would be showing 'red' in a number of areas.
- It was hoped that KPMG would be mindful of these new Standards changes with regard to Counter Fraud when their work was completed.

Audit Committee NOTED:

- **The changes to the Counter Fraud Functional Standard.**

	<ul style="list-style-type: none"> • The SRT that would be prepared and presented to this Committee in due course, and • Confirmed that the Committee was content to approve the plan with an allocation of 60 days, with the flexibility that had been described as presented. <p>Internal Audit Progress Report: Kevin Watkins presented the Internal Audit Progress Report and highlighted the following:</p> <ul style="list-style-type: none"> • The pandemic continued to impact on the workloads of Officers and delivery of the CCG’s Internal Audit Plan. • Following discussions with the Director of Corporate Delivery, the Head of Governance and the Associate CFO, it had been agreed that two exercises that had been planned for completion in 2020/21 (support for completion by the Governing Body of a maturity matrix and amendments to financial governance & decision making) would be deferred, due to the pandemic. • Jill Dentith highlighted that the CCG had implemented 95% of actions within agreed timescales. All recommendations made in 2019/20 had either been implemented or superseded due to the Covid-19 pandemic – this was a phenomenal success and she asked that her sincere thanks be passed to the team. <p>Audit Committee NOTED the Internal Audit progress report and echoed Jill Dentith’s comments regarding passing on the Committee’s thanks to the team for the completion of 95% of actions within agreed timescales.</p> <p>Stage 2 Head of Internal Audit Opinion Report: Kevin Watkins presented Stage 2 Head of Internal Audit Opinion (HOIAO) Report and highlighted the following:</p> <ul style="list-style-type: none"> • The good response to the survey (Appendix A) which showed that the Governing Body as a whole understood the GBAF process and that it was working effectively. • Feedback with regard to this survey would be given to Governing Body in due course. Chrissy Tucker agreed to add this to the agenda for Governing Body. <p>Audit Committee NOTED Stage 2 Head of Internal Audit Opinion Report.</p> <p>Draft Head of Internal Audit Opinion: Kevin Watkins presented the draft Head of Internal Audit Opinion and highlighted the following:</p> <ul style="list-style-type: none"> • The draft Head of Internal Audit Opinion for 2020/21 was a strong Significant Assurance, which reflected the good work the CCG had done around the GBAF, the follow up of actions, and the Internal Audit Plan outturn. • There was no reason to believe that the final opinion would 	CT
--	---	----

change.

Audit Committee NOTED the Draft Head of Internal Audit Opinion (Significant Assurance), and thanked all the teams for making this happen whilst coping with the pandemic.

Draft 2021/22 Internal Audit Plan: Kevin Watkins presented the draft 2021/22 Internal Audit Plan and highlighted the following:

- Kevin Watkins had met with the Audit Chair, Richard Chapman and Darran Green to discuss the Internal Audit Plan.
- The Executive Team had reviewed the Plan.
- Planning this year had been very challenging.
- 45 days had been put in the plan for contingency/emerging risks.
- Transition to ICS had also been put in the plan – 20 days.
- JUCD Joint Audit Work – 25 days.
- Continuing Healthcare, Personal Health Budgets and Primary Care Networks were also in the plan.
- The phasing may be subject to change due to the pandemic and would be kept under constant conversation with the CCG.
- Governance and risk management were core, but there had been a reduction in time from previous years.
- Andrew Middleton asked a question with regard to timing (latter part of the year) of work on Primary Care Networks (PCNs), which was due in part to the very tenuous understanding of how the allocative and financial flows would work within the new era.
- Niki Bridge felt it was right that this work was timed for the back end of next year due to the huge part PCNs were playing in the vaccination programme and their recovery would be huge because of their backlogs. PCNs were still on their journey because of the pandemic, and they would need support going forwards.
- Andrew Middleton referred to the governance and risk management processes for Provider Collaboratives, how would they be able to give us assurance going forwards.
- The Audit Chair understood the concerns that Andrew Middleton had raised, but he was keen to maintain the core role of Audit Committee in supporting the Governing Body regarding our current systems of internal controls. He went onto add that there was a plan to have some transition governance oversight, which would not be this Committee's responsibility, but would, he hoped, be capable of taking this Committee's advice.
- Kevin Watkins referred to the PCN work; he was completely committed to a supportive Internal Audit process, and very happy to use that allocation to support in presentational and workshop work around governance controls. He went onto add that the time could be used flexibly, as the CCG sees best

	<p>fit, so that he could support PCNs in their understanding of risk management and governance.</p> <ul style="list-style-type: none"> • The Audit Chair asked to review the plan on a bi-monthly basis to ensure that we feel confident that it was reflecting the needs of the organisation. <p>Audit Committee APPROVED the current draft 2021-22 Internal Audit Plan as presented. The plan was to be reviewed on a bi-monthly basis to ensure that it was reflecting the needs of the organisation.</p>	KW
AC/2021/351	<p>KPMG Progress Report:</p> <p>Value for Money Audit Plan 2020-21: Andrew Cardoza presented the Value for Money Audit Plan 2020-21 and highlighted the following:</p> <ul style="list-style-type: none"> • Due to the current underlying deficit at both the CCG and ICS level, there was a risk that the CCG does not have in place adequate arrangements to achieve financial sustainability in the medium term. • KPMG would focus on this as part of the VFM work and reviewing the arrangements in place. • Governance arrangements – there were no significant risks identified • Improving economy, efficiency and effectiveness – there were no significant risks identified. • KPMG would publish their commentary when the VFM work was complete and would be issued at the same time as the Annual Audit letter which would need to be published on the CCG's website. • It was noted that KPMG were to issue an unqualified opinion on the Mental Health Investment Standard (MHIS). • Andrew Middleton reported that the CCG Finance Committee and System Finance Committee speak of the underlying deficit regularly and had material focus on it. • Richard Chapman reported that the CCG was absolutely focused on the underlying gap, and he did not disagree with anything that had been written in this report. <p>Audit Committee NOTED the Value of Money Audit Plan 2020-21.</p>	
AC/2021/352	<p>Covid-19 Update</p> <p>Richard Chapman gave a verbal update on the position with regard to Covid-19, and highlighted the following:</p> <ul style="list-style-type: none"> • An extract from the national intelligence report indicating the situation in the Midlands Region, showing a reducing demand picture. • The reduction was due in part to the lockdown and also the roll out of the vaccination programme. 	

	<ul style="list-style-type: none"> • There was a roadmap to come out of lockdown. • It was noted that there were Covid complacent attitudes arising. • There were also vaccination supply chain issues. • Critical Care Networks were back in their substantively funded capacity, as opposed to surge or super surge capacity. <p>Audit Committee NOTED the Covid-19 Update given by Richard Chapman.</p>	
<p>AC/2021/353</p>	<p>Single Tender Waivers</p> <p>Darran Green reported that following Audit Committee in January 2021, the CCG’s Single Tender Waiver (STW) form had been revised to reflect the latest Standing Financial Instructions (SFIs), and to gather further information surrounding the direct award.</p> <p>The requestor now needed to provide the following:</p> <ul style="list-style-type: none"> • an explanation as to how the CCG arrived at a situation where it was necessary for a STW, • details of how the CCG would prevent this situation from arising in the future, • assurances that Value for Money (VFM) had been obtained, and • details confirming the CCG continued to be legally compliant in a direct award (procurement advice should be sought). <p>This paper included a report of the STWs received and approved following those reported at the January Audit Committee and up to 10th March 2021.</p> <p>Jill Dentith reported that the new format of this paper was very clear and well-presented and she thanked Darran Green and his team for providing this new format.</p> <p>Audit Committee NOTED the report of Single Tender Waivers approved by the Chief Finance Officer.</p>	
<p>AC/2021/354</p>	<p>Mental Health Investment Standard - 2019/20 Audit</p> <p>Dave Stevens presented the Mental Health Investment Standard – 2019-20 Audit Report and highlighted the following:</p> <ul style="list-style-type: none"> • The paper provided assurance to Audit Committee that the CCG had processes in place around capturing mental health investment standard expenditure. • Development of robust processes during 2017/18 had allowed the CCG to accurately report and take necessary actions to ensure that the MHIS was achieved, whilst also allowing assurance to be provided, internally and externally, that the CCG had complied with national guidance. • The CCG had established systems and processes to ensure that total expenditure was recorded accurately within its ledger 	

	<p>and this was subject to both Internal and External Audit through existing governance arrangements.</p> <ul style="list-style-type: none"> • With regard to the MHIS, the CCG had processes to separately identify non-eligible expenditure in line with specifications set out within the national guidance, achieved through a combination of the following: <ul style="list-style-type: none"> • Ledger coding • In conjunction with NHS providers, an annual analysis of their contracts • Drug categorisation • Exclusion of non-recurrent expenditure. • It was noted that the CCG regularly revised its processes in response to changing guidance, and conversations with KPMG. • Following the audit by KPMG of each of the four former CCG's performance against the 2018/19 MHIS, one change was required to the reported position associated with prescribing data. • Following receipt in August 2020 of the guidance for the independent review of the CCG's 2019/20 MHIS performance, the Executive Team received a report re-confirming the achievement and identified a number of common issues that had been identified nationally during the 2018/19 reviews. • Building on the systems and processes already in place, the CCG had taken the following steps to address the issues identified: <ul style="list-style-type: none"> • using actual ePACT data to identify mental health-related drug expenditure. Subsequently, as part of the audit review of the 2019/20 Statement, CCGs had been requested to provide individual drug information as a question had arisen nationally about multi-use drugs (drugs that are prescribed for both mental health and non-mental health purposes). • The 2019/20 information had been provided and KPMG had confirmed that because it did not materially affect the Statement, no adjustment was required. • Where patients had multiple/dual diagnoses and one or more of them was out of scope of the MHIS, clinical judgement was to be applied to determine what proportion of the spend was in scope of the Standard. • The CCG had worked closely with Derbyshire Healthcare NHS Foundation Trust (DHcFT) and Derbyshire Community Health Services NHS Foundation Trust (DCHS), updated contract schedules had been agreed to reflect 2019/20 costs at individual service lines, to allow non-eligible expenditure to be excluded. • This was particularly relevant in looking at CHC or s117 spend. The CCG was able to identify whether s117 spend related to mental health or LD (excluded) and KPMG had confirmed that because it did not materially affect the Statement no adjustment was required. The expenditure 	
--	--	--

	<p>would be separately identified as necessary in 2020/21.</p> <ul style="list-style-type: none"> • The CCG had also provided a clinical judgement, that it did not believe that there was a clinical materiality of dual diagnosis within the treatment of our patients. • KPMG had given an unqualified opinion in their 2019-20 MHIS Audit. • The CCG not only provided assurance to Audit Committee, but it was reported through to NHSE, Mental Health Learning Disability and Autism Delivery Board and a Sub Committee of JUCD. • The Audit Chair felt this was a good outcome from a very tight schedule, which had been less than ideal. KPMG had fed this back to NHSE as they too had felt under pressure with the huge amounts of information and timescales given for this Audit. <p>Audit Committee NOTED the MHIS report presented by Dave Stevens and NOTED KPMG had provided an unqualified opinion for 2019-20 MHIS Audit.</p>	
AC/2021/355	<p>Losses and Special Payments</p> <p>Darran Green reported that there were no Losses or Special Payments to report.</p> <p>Audit Committed NOTED that there were no Losses or Special Payments to report.</p>	
AC/2021/356	<p>Aged Debt Reports</p> <p>Darran Green presented the Aged Debt report as at 28 February 2021 and highlighted the following:</p> <ul style="list-style-type: none"> • There had been an increase in the level of invoices raised in M11; this was not unexpected as we moved towards the end of the financial year. • Jill Dentith referred to the One Medical Group and asked whether we had received any feedback yet. • It was noted that at the time of writing the report there was no feedback with regard to this item, but Darran Green offered to email Committee members with the latest position after this meeting. <p>Audit Committee NOTED the current position in relation to Aged Debt and Receivables.</p>	DG
AC/2021/357	<p>Accounting Policies for 2020-21 Annual Accounts</p> <p>Donna Johnson reported that a set of draft accounting policies had been adapted for Derby and Derbyshire CCG, using a national template provided by NHSE. These would form the basis for the 2020-21 Annual Accounts and would become Note 1 to the Accounts.</p>	

	<p>The policies followed the guidance contained in the Group Accounting Manual (GAM), issued by the Department of Health and Social Care. Each policy had been reviewed against local circumstances. Where a policy currently had no relevance it had been removed (as permitted in the GAM). Additional comments had been added to describe local detail where required.</p> <p>The draft CCG accounting policies were included as appendix A within this report.</p> <p>The draft accounting policies would be reviewed by the external auditors when undertaking the year-end audit. Any adjustments to the policies would be shared with the Audit Committee prior to approval of the final Annual Report and Accounts, 25th May 2021 (proposed date).</p> <p>It was noted that due to the Covid-19 Pandemic, the adoption of the IFRS16 standard had been deferred until 1 April 2022.</p> <p>Audit Committee APPROVED the accounting policies to be adopted in the 2020-21 Annual Accounts of Derby and Derbyshire Clinical Commissioning Group.</p>	
AC/2021/358	<p>Write Off Reports</p> <p>Darran Green reported that since the last Audit Committee meeting there had been no write-offs.</p> <p>Audit Committee NOTED there had been no write-offs.</p> <p>It was noted that Audit Committee may need to virtually approve the 50% write off with regard to the Sandwell and West Birmingham CCG invoice detailed earlier in the meeting (Action Log item AC/2021/334) before the end of March 2021.</p>	DG
AC/2021/359	<p>Accrual Review</p> <p>Darran Green reported that the Year End Report 2019/20 (ISA260) produced by KPMG following their audit of the CCGs Annual Accounts recommended that the CCG should perform a detailed review over the use of accruals annually at a sufficient level to enable re-performance and identify in detail the accuracy of historic accruals. With the CCG agreeing to develop a system of monitoring and reviewing accruals on a more structured basis throughout the year, enabling a comparison for year-end and in supporting year-end working papers.</p> <p>Darran Green explained that this report provided a comparison between the levels of accruals at Operating Cost Summary level on a quarterly basis from 31st March 2020, describing the major variances between quarters.</p> <p>It was noted that it had not been possible to compare each quarter on a like for like basis but it had still been a useful exercise for the CCG to undertake and provided helpful management control. The</p>	

	<p>CCG would complete the exercise when the M12 position was finalised and share this with KPMG to assist them in the audit and also with this Committee. The CCG would also continue to undertake this process and propose to present it to the Audit Committee on a regular basis for assurance.</p> <p>The Audit Chair reported that he was surprised with the size of some of the figures of movement in accruals (£87m between M12 and M3); in terms of our materiality and bottom line, this was really significant. It was noted that this was why KPMG had wanted to work it through with Darran Green and his team to ensure that there was this additional comfort.</p> <p>Jill Dentith felt that this was a really helpful assurance process from a governance perspective and gave additional rigour when reviewing the final accounts.</p> <p>Darran Green reported that he would build accrual review into the forward planner for future months.</p> <p>The Audit Committee NOTED the accruals analysis following the recommendation in the Year End Report 2019/20 produced by KPMG following their audit of the CCGs Annual Accounts.</p>	DG
AC/2021/360	<p>Audit Committee Terms of Reference</p> <p>Suzanne Pickering presented the Audit Committee Terms of Reference which were to be reviewed by members as part of their six month review. Committee members were asked to suggest any amendments or additions to the Terms of Reference; they would then be presented to Governing Body for final agreement.</p> <p>It was noted that there were no amendments or additions required to the Audit Committee's Terms of Reference at this time.</p> <p>Audit Committee's Terms of Reference would be presented to Governing Body for final agreement at its next meeting.</p>	
AC/2021/361	<p>Freedom to Speak Up Report</p> <p>Jill Dentith reported that there was a nil return to report this month.</p> <p>The staff bulletin (No 95 on 5 March 2021) reminded staff of the role of the Freedom to Speak Up Guardian, and how to make contact if they needed help and advice.</p> <p>Andrew Middleton was puzzled by yet another nil return and asked whether the CCG was an outlier; he then asked what a normal expectation of responses looked like, and whether there was a national report that would inform us of numbers of Freedom to Speak Up responses received by other CCG Guardians. Jill Dentith in response reported that there was a different set up between Providers and Commissioners with regard to Freedom to Speak Up, and was also dependent on how individual</p>	

	<p>organisations functioned.</p> <p>Jill Dentith reported that from the CCG's staff survey, and the feedback we get from it, it would be possible to triangulate the evidence as to whether staff felt supported or not with regard to Freedom to Speak Up. Neither Suzanne Pickering nor Jill Dentith were aware of any national comparisons that could be reviewed.</p> <p>Audit Committee NOTED the nil return to the Freedom to Speak Up Report this month.</p>	
AC/2021/362	<p>Risk Register Exception Report</p> <p>Suzanne Pickering presented the Risk Register Report as at end of February 2021, and highlighted the following:</p> <ul style="list-style-type: none"> • The report highlighted the very high risks for the CCG and the movement in scores between January and February 2021 and detailed new and closed risks. • The risks had been reported to the individual corporate committees and Governing Body in March. <p>The Audit Committee RECEIVED and NOTED:</p> <ul style="list-style-type: none"> • The Risk Register Report; • Appendix 1 as a reflection of the risks facing the organisation as at 28th February 2021; and • Appendix 2 which summarised the movement of all risks during February 2021. 	
AC/2021/363	<p>Draft Annual Governance Statement 2020/21</p> <p>Suzanne Pickering presented the first draft of the Annual Governance Statement 2020-21. The draft Annual Governance Statement had been produced in accordance with the guidance and template as directed by NHSE.</p> <p>It was noted that for assurance purposes the Draft Head of Internal Audit Opinion would be received from the Internal Auditors and uploaded to Sharepoint by noon on the 12th March, as per the NHSE requirements.</p> <p>The deadline for the draft Annual Report to be submitted to NHS England and our External Auditors was by noon on the 27th April 2021.</p> <p>Jill Dentith asked that several amendments to the text of the draft Annual Governance Statement be made, all of which were highlighted to Suzanne Pickering. Suzanne Pickering agreed that the amendments would be incorporated into the report.</p> <p>It was noted that the impact of MS Teams had increased the improvement of attendance at meetings and Committees; it was hoped that this option would continue going forwards.</p>	

	<p>Andrew Middleton highlighted that Engagement Committee was bereft of PLACE representation on a regular basis; there was an absence of voice from Derby City and Healthwatch, and he asked whether this warranted a rethink of the membership and/or nominated representative from these organisations. Suzanne Pickering agreed to feed this back to the Chair of Engagement Committee.</p> <p>Kevin Watkins referred to page 5 of the AGS, (opening paragraph) which referred to the Maturity Matrix work that was being planned, it was noted that 360 Assurance were not proceeding with this now. Suzanne Pickering agreed to amend this section.</p> <p>Kevin Watkins referred to page 22; last sentence which referred to the DSPT Audit, the only work outstanding on the DSPT Audit was looking at the criteria of the list of contracts. Kevin hoped to be able to issue the work and give an opinion level before 30 June 2021; but he needed to check this internally beforehand.</p> <p>Suzanne Pickering requested that any other amendments should be forwarded to her or Francis Palmer via email after this meeting today.</p> <p>The Audit Committee:</p> <ul style="list-style-type: none"> • RECEIVED the initial draft Annual Governance Statement for information; and • PROVIDED comments and feedback to the Corporate Governance Team. 	<p>SP</p> <p>All</p>
<p>AC/2021/364</p>	<p>GBAF Q3</p> <p>Suzanne Pickering presented the Governing Body Assurance Framework Q3 and highlighted the following:</p> <p>The corporate committees responsible for their assigned strategic risks had scrutinised and approved their GBAF Strategic Risks at their Committee meetings during January 2021.</p> <p><u>Quality & Performance Committee:</u></p> <p><u>GBAF risk 1</u> had been increased in risk score from a high 9 (likelihood 3 x consequence 3) to a high score of 12 (likelihood 4 x consequence 3).</p> <p><u>GBAF risk 2</u> had been increased in risk score from a high 12 (likelihood 3 x consequence 4) to a very high score of 16 (likelihood 4 x consequence 4).</p> <p><u>Finance Committee:</u></p> <p><u>GBAF risk 4A</u> had been decreased in risk score from a very high 16 (likelihood 4 x consequence 4) to a high score of 8 (likelihood 2</p>	

	<p>x consequence 4).</p> <p><u>GBAF risk 4B</u> had been decreased in risk score from a high 16 (likelihood 4 x consequence 4) to a high score of 8 (likelihood 2 x consequence 4).</p> <p>The target risk score for both GBAF risks 4A and 4B were scored at 10, the current risk scores were now reduced to a score of 8. Therefore, the current risk scores were now lower than the target risk scores. This was on the basis that the CCG and System would retain ongoing risk to financial sustainability, where there remained considerable risk in the future.</p> <p><u>Engagement Committee:</u></p> <p><u>GBAF risk 5</u> had been reduced in risk score from a high 12 (likelihood 4 x consequence 3) to a high 9 (likelihood 3 x consequence 3). This reduction reflects the appetite and development to implement the Derbyshire Dialogue programme.</p> <p>Audit Committee RECEIVED and NOTED the 2020/21 Quarter 3 (October to December) Governing Body Assurance Framework.</p>	
<p>AC/2021/365</p>	<p>Committee Meeting Business Log</p> <p>Suzanne Pickering presented NHS Derby and Derbyshire CCG's Meeting Log. The Committee Meeting Log summarised discussions and approved items at the following NHS Derby and Derbyshire CCG's Committees:</p> <ul style="list-style-type: none"> • Clinical & Lay Commissioning Committee • Engagement Committee • Finance Committee • Governance Committee • Primary Care Commissioning Committee • Quality & Performance Committee <p>The Audit Chair asked that the Committee Logs be reviewed in order to standardise the information they contained. The CLCC log was very clear, and he felt should be used as the 'model'. Frances Palmer agreed to take this forward with the respective Executive Assistants responsible for the Committee Logs.</p> <p>Audit Committee NOTED NHS Derby and Derbyshire CCG's Committee Meeting Logs.</p>	<p>FP</p>

AC/2021/366	<p>Conflicts of Interest Update</p> <p>Frances Palmer explained that this report summarised the activity that the CCG had undertaken since January 2021 to fulfil its obligations in regards to managing its conflicts of interest.</p> <p>It was noted that the following key tasks had been undertaken:</p> <ul style="list-style-type: none"> • Gifts and Hospitality Register had not had any recent updates. • Updates on the Procurement Register were shown in blue. • Since the submission of the report we had increased the number of staff who had completed Module 1 Conflicts of Interest training and we were now back up to 90%. • Of the 10% who had not yet completed the training, this included 4 Governing Body members. • New Declaration of Interest Forms would be circulated for 2021-22 to Governing Body members in April; this would be followed by forms being circulated to Committee members and staff through May and June. • The Conflicts of Interest Policy was due to be reviewed and would be presented to Governance Committee. • Andrew Middleton felt that Governing Body members had a duty to demonstrate leadership, so he hoped that the four Governing Body members would be reminded to complete the training. • Jill Dentith hoped that where people were non-compliant with training, this would be picked up through the appraisals process. • In mitigation, some people did have technical issues with regard to carrying out the training. • Frances Palmer agreed to take the issue of non-compliance of staff re COI training up with respective line managers. • Richard Chapman agreed to take the issue of non-compliance of Governing Body members of COI training to Executive Team for further discussion. <p>Audit Committee NOTED the Conflicts of Interest Update and the two actions proposed with regards to non-compliance of Conflicts of Interest training.</p>	FP RC
AC/2021/367	<p>Any Other Business</p> <p>There was no further business.</p>	
AC/2021/368	<p>Forward Plan</p> <p>Audit Committee NOTED the Forward Plan.</p> <p>The date for April Audit Committee was to be reviewed.</p>	DG/DJ/ DD

AC/2021/369	<p>Assurance Questions</p> <ol style="list-style-type: none"> 1. Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance processes? Yes. 2. Were the papers presented to the Committee of an appropriate professional standard, did they incorporate a detailed report with sufficient factual information and clear recommendations? Yes. 3. Were papers that have already been reported on at another committee presented to you in a summary form? Yes. 4. Was the content of the papers suitable and appropriate for the public domain? Not entirely. 5. Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow Committee members to review the papers for assurance purposes? Yes. 6. Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? No. 7. Is the Committee assured on progress regarding actions assigned to it within the Recovery & Restoration plan? The Audit Chair assured members that each of the responsible corporate committees were issued with the Recovery & Restoration Plan as part of a standard item on their agendas and received regular updates. 8. What recommendations does the Committee want to make to the Governing Body following the assurance process at today's Committee meeting? Governing Body would be supplied with a standard Assurance Report from the meeting today, which would include reference to the draft HOIAO and risks identified in the External Audit Plan. Audit Committee would be able to provide assurance 	IG
-------------	--	----

	that it had reviewed the end of year process, and were confident that it would go through smoothly.	
AC/2021/370	<p>Date of Next Meeting: Provisionally Thursday 22 April 2021 at 9.30am-12.30pm.</p> <p>Dates for future meetings:</p> <p>*Tuesday 25 May 2021, 1.30-4.30 – (provisional to be confirmed)</p> <p>Thursday 16 September 2021, 9.30-12.30</p> <p>Thursday 18 November 2021, 9.30-12.30</p> <p>Thursday 20 January 2022, 9.30-12.30</p>	

Signed: Dated:
(Chair)

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

HELD ON

Wednesday 24th March 2021

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

PRESENT

Simon McCandlish	SMc	Deputy Chair, Lay Member, Derby & Derbyshire CCG
Kath Bagshaw	KB	Deputy Medical Director, DDCCG (For EMD)
Niki Bridge	NB	Deputy Chief Finance Officer, DDCCG (for CFO)
Jill Dentith	JeD	Lay Member Derby & Derbyshire CCG
Marie Scouse	MS	AD of Nursing & Quality Derby & Derbyshire CCG (for CNO)

IN ATTENDANCE

Hannah Belcher	HB	AD GP Commissioning & Development Derby DDCCG
Kathryn Markus (Part of meeting)	KM	Chief Executive Derby & Derbyshire LMC
Abid Mumtaz	AM	Service Commissioning Manager Public Health Derbyshire County Council
Jean Richards	JR	Senior GP Commissioning Manager DDCCG
Pauline Innes	PI	Executive Assistant to Dr Steven Lloyd

APOLOGIES

Richard Chapman	RC	Chief Finance Officer Derby & Derbyshire CCG
Judy Derricott	JDe	Head of Primary Care Quality Derby & Derbyshire CCG
Steve Lloyd	SL	Executive Medical Director Derby & Derbyshire CCG
Clive Newman	CN	Director of GP Development Derby & Derbyshire CCG
Adam Norris	AN	Service Commissioning Manager Public Health, Derbyshire County Council
Ian Shaw (Chair)	IS	Lay Member Derby & Derbyshire CCG
Brigid Stacey	BS	Chief Nurse Derby & Derbyshire CCG

ITEM NO.	ITEM	ACTION
PCCC/2021/78	<p>WELCOME AND APOLOGIES</p> <p>The Chair (SMc) welcomed Committee Members to the meeting and introductions took place. Apologies were received and noted as above.</p> <p>The Chair confirmed that the meeting was quorate.</p>	
PCCC/2021/79	<p>DECLARATIONS OF INTEREST</p> <p>The Chair informed members of the public of the committee members' obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG.</p> <p>Declarations declared by members of the Primary Care Commissioning</p>	

	<p>Committee are listed in the CCG's Register of Interests and included within the meeting papers. The Register is also available either via the corporate secretary to the Governing Body or the CCG website at the following link:</p> <p style="text-align: center;">www.derbyandderbyshireccg.nhs.uk</p> <p>There were no Declarations of Interest made.</p> <p>The Chair declared that the meeting was quorate.</p>	
FOR DECISION		
	No items for Decision	
FOR DISCUSSION		
	No Items for Discussion	
FOR ASSURANCE		
PCCC/2021/80	<p>FINANCE UPDATE</p> <p>Niki Bridge presented an update from the shared paper. This is Month 10 Finance position which has been signed off by the Finance Committee and Governing Body as the financial position for the organisation and has been submitted to NHS England and Improvement (NHSE/I) along with the monthly returns.</p> <p>Key points of interest were highlighted:</p> <ul style="list-style-type: none"> • As at Month 10 all targets have been achieved with a forecast outturn being reported surplus of £2.4m for the year end. The team continue to manage this and to try to maximize the benefits of economy using the resources appropriately; • Primary Care budgets are still seeing pressures within prescribing costs; • Primary Care Co-Commissioning budgets there is an expectation to see full recruitment to the additional roles. At the moment this is showing as committed however full expenditure is not being reported against this and it is forecast that all monies will be spent by the year end. <p>The M11 financial position has not yet been reported to the Governing Body and so will be reported to the public session of the Primary Care Commissioning Committee at the April 2021 meeting.</p> <p>The Primary Care Commissioning Committee RECEIVED and NOTED the update on the CCGs financial position for month 10.</p>	
PCCC/2021/81	<p>RISK REGISTER EXCEPTION REPORT</p> <p>Marie Scouse (MS) provided an update from the shared paper.</p> <p>As at March 2021, Primary Care Commissioning Committee are responsible for 2 Primary Care Commissioning risks, with both of these risks rated very high (red).</p> <ul style="list-style-type: none"> • Risk 04A - Contracting: Nationally General Practice is experiencing 	

	<p>increased pressures which are multi- faceted and include the following areas:</p> <ul style="list-style-type: none"> ○ Workforce - recruitment and retention of all staff groups ○ COVID-19 potential practice closure due to outbreaks ○ Recruitment of GP Partners ○ Capacity and Demand *Access ○ Premises *New contractual arrangements ○ New Models of Care ○ Delivery of COVID vaccination programme <p>• Risk 04B – Quality: Nationally General Practice is experiencing increased pressures which are multi-faceted and include the following areas:</p> <ul style="list-style-type: none"> ○ Workforce - recruitment and retention of all staff groups ○ COVID-19 potential practice closure due to outbreaks ○ Recruitment of GP Partners ○ Capacity and Demand *Access ○ Premises *New contractual arrangements ○ New Models of Care ○ Delivery of COVID vaccination programme <p>Marie Scouse (MS) reported that both risks remain to be static at this moment in time.</p> <p>The Primary Care Commissioning Committee RECEIVED and NOTED the update.</p>	
FOR INFORMATION		
	No items for information	
MINUTES AND MATTERS ARISING		
PCCC/2021/82	<p>Minutes of the Primary Care Commissioning Committee meeting held on 24th February 2021</p> <p>The minutes from the meeting held on 24th February 2021 were agreed to be an accurate record of the meeting.</p>	
PCCC/2021/83	<p>MATTERS ARISING MATRIX</p> <p>There are no outstanding actions on the Action Matrix.</p>	
PCCC/2021/84	<p>ANY OTHER BUSINESS</p> <p>There were no items of any other business</p>	
PCCC/2021/85	<p>ASSURANCE QUESTIONS</p> <p>Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? Yes</p> <p>Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? Yes</p> <p>Were papers that have already been reported on at another committee</p>	

	<p>presented to you in a summary form? Yes</p> <p>Was the content of the papers suitable and appropriate for the public domain? Yes</p> <p>Were the papers sent to Committee members at least five working days in advance of the meeting to allow for the review of papers for assurance purposes? Yes</p> <p>Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? No</p> <p>Is the Committee assured on progress regarding actions assigned to it within the Recovery & Restoration plan? N/A</p> <p>What recommendations does the Committee want to make to Governing Body following the assurance process at today's Committee meeting? None</p>	
DATE AND TIME OF NEXT MEETING		
Wednesday 28th April 2021, 10:00-10:30am via Microsoft Teams Meeting		

**MINUTES OF QUALITY AND PERFORMANCE COMMITTEE
HELD ON 25TH MARCH 2021, 9AM TO 10.00AM
MS TEAMS**

Present:		
Dr Buk Dhadda (Chair)	BD	Chair, Governing Body GP, DDCCG
Kath Bagshaw	KB	Deputy Medical Director
Niki Bridge	NB	Deputy Director of Finance
Jackie Carlile	JC	Head of Performance and Assurance -DDCCG
Craig Cook	CC	Deputy Director of Commissioning
Alison Cargill	AC	Asst Director of Quality, DDCCG
Simon McCalandish	SMcC	Lay Member, Patient Experience
Sarah MacGillivray	SMacG	Head of Patient Experience, DDCCG
Dan Merrison	DM	Senior Performance & Assurance Manager, DDCCG
Andrew Middleton	AM	Lay Member, Finance
Hannah Morton	HM	Healthwatch
Suzanne Pickering	SP	Head of Governance- DDCCG
Dr Emma Pizzey	EP	GP South
Dr Merryl Watkins	MWa	Governing Body GP, DDCCG
Martin Whittle	MW	Vice Chair and Governing Body Lay Member, Patient and Public Involvement, DDCCG
Helen Hipkiss	HH	Deputy Director of Quality - DDCCG
In Attendance:		
Jo Pearce (Minutes)	JP	Executive Assistant to Chief Nurse, DDCCG
Apologies:		
Brigid Stacey	BS	Chief Nurse Officer, DDCCG
Laura Moore	LM	Deputy Chief Nurse, DDCCG
Dr Greg Strachan	GS	Governing Body GP, DDCCG
Helen Wilson	HW	Deputy Director Contracting and Performance - DDCCG
Steve Lloyd	SL	Medical Director - DDCCG
Zara Jones	ZJ	Executive Director of Commissioning Operations, DDCCG
Dr Bruce Braithwaite	BB	Secondary Care GP

Item No.	Item	Action
QP20/21/ 181	<p>WELCOME, APOLOGIES & QUORACY</p> <p>Apologies were received as above. BD declared the meeting quorate.</p>	
QP20/21/ 182	<p>DECLARATIONS OF INTEREST</p> <p>BD reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG.</p> <p>Declarations declared by members of the Quality and Performance Committee are listed in the CCG's Register of Interests and included with the meeting papers. The Register is also available either via the corporate secretary to the Governing Body or the CCG website at the following link: www.derbyandderbyshireccg.nhs.uk</p> <p><u>Declarations of interest from sub-committees</u> No declarations of interest were made.</p> <p><u>Declarations of interest from today's meeting</u> No declarations of interest were made.</p>	
	<p>BD confirmed that the meeting will be conducted in a more abbreviated form. Some of the papers have been listed on the agenda for information only and Committee members were asked to submit questions relating to the papers before the meeting. Responses to the questions were circulated to the Committee members prior to the meeting and are included within these minutes.</p>	
QP2021/ 183	<p>INTEGRATED REPORT</p> <p><u>Performance</u></p> <p>JC took the paper as read and the Committee were asked for questions.</p> <p>BD raised concerns around the historical issues for breast performance. BD noted the need to monitor closely over the next two months whilst going through restoration and recovery and to evaluate the performance. This may result in a deep dive being on breast performance being discussed at a future Quality and Performance Committee meeting.</p>	

	<p>JC spoke about the new breast pain pathway and service which has been introduced in Derbyshire and is hoped to commence in April . JC will share the information with BD.</p> <p>BD requested that the Committee have sight of the number of patients on the ASI list. JC confirmed as of 7th March the number of patients on the ASI (Appointment Slot Issues) list at UHDBFT. JC will provide a split by speciality.</p> <p>EP referred to the breast two week wait data and asked for clarification on whether the new pathway will result in an improvement. BD replied to say that the pathway redesign will show the true two week waits and therefore a significant improvement in that performance should be seen.</p> <p>SM asked when there will a clearer picture in terms of timescales, for those patients on a waiting list and waiting for treatment. CC replied that the planning and coordination cell, which is represented by all providers are currently reviewing all waits to identify the size of the waiting lists as well as collecting a position statement from each provider. Both UHDBFT and CRHFT are still using into their surgical capacity. Therefore, it will be April to May before a clearer understanding of the demand and capacity will be available. This will form the context of future planning.</p> <p><u>Quality</u></p> <p>HH took the paper as read. There were no questions raised.</p> <p>The Committee approved the Integrated Performance Report.</p> <p><u>Activity</u></p> <p>CC took the paper as read and the Committee were asked for questions.</p> <p>Waiting list – Substantial work is being done by both acute trusts to focus on clinical urgency. The trusts are starting to operate on these patient at high priority. CC will bring more detail to the next meeting.</p> <p>Diagnostics - the pressure points are around ultrasounds and scopes with patients waiting for diagnostics over the 6-week standard. The solution is extra capacity being funded by NHSE which should be in place by the summer.</p> <p>Cancer – The priority is around the long wait position which has moved in Quarter 4 and getting these patients treated over the next quarter.</p> <p>CC then gave some insight into data collected which poses the question of whether the demand is understood well enough.</p>	
--	---	--

	<p>BD asked that the Committee is sighted on the clinical prioritisation process.</p> <p>AM referred to diagnostics and asked if the issues were related to staffing or equipment. If they are not staff related is out of hours clinics a possibility. CC confirmed that the issues are around staffing capacity, and this extra capacity will be sourced from the private sector using the funding from NHSE/I.</p> <p>MW referred to the patients who are on the wait lists and pursuing their appointments, who are generally told to refer to their GP. This is raising concerns around clogging up the system. LM stated this issue it is high on the agenda of the risk stratification group in terms of setting up a Single Point of Access for GPs and patients to contact.</p> <p>CC suggested that the practical option would be for the Trusts to feed back to GP Practices that status of the patients on the waiting lists. BD agreed that currently the lack of information is something that the GPs are missing.</p>	
<p>QP2021/184</p>	<p>RE -INSTAEMENT OF THE CLINICAL QUALITY REFERENCE GROUP MEETINGS</p> <p>The paper was taken as read.</p> <p>The CCG remain on Level 4 and the standing down of the CQRG meetings was part of the Level 4 agreement. Monthly interim meetings with providers have been working well with continued engagement. The recommendation to the Committee is to set up an initial meeting for May to look at what has been working well and the way forward prior to the quarterly meeting in July 2021. In the meantime, the monthly interim meetings will continue.</p> <p>BD and the Committee supported the recommendation.</p>	
<p>QP2021/185</p>	<p>QUALITY AND PERFORMANCE COMMITTEE AGENDA</p> <p>BD asked Committee members if they were happy to continue with the current format and structure of the meeting with the proviso that over time agenda items will be for discussion rather than for information. This will be reviewed again at the meeting in April.</p> <p>The Committee agreed with the proposal.</p>	
<p>QP2021/186</p>	<p>TERMS OF REFERENCE FOR REVIEW</p> <p>This is the required 6-month review of the Terms of Reference (TOR), with no further recommendations for any changes.</p>	

	<p>SMC referred to sections 1.6 and 2.6 and asked if a role of the Committee should be to review and amend to add the key performance indicators as necessary. SP noted the suggestions and agreed to make the necessary amendments prior to the ToR being presented to the Governing Body.</p> <p>AM noted the duties of the current CCG committees and Governing Body in ensuring the ICS successor committees can function properly without a loss of corporate knowledge and a smooth transition into the ICS. BD confirmed that he is planning to discuss with Brigid Stacey and agree a plan to go forward which will be brought back to the Quality and Performance Committee for discussion and agreement.</p> <p>HH confirmed that in terms of the system quality work there has been a clear direction from NHSE/I on how the committees will look going forward. A subgroup has been formed to look at the requirements from NHSE/I. There will be a direct feed into the national Quality Committee. This work will be brought back to Quality and Performance when appropriate.</p>	
<p>QP2021/ 187</p>	<p>GBAF Q4</p> <p>The paper was taken as read and there were no questions raised.</p>	
<p>QP2021/ 188</p>	<p>RISK REGISTER</p> <p>Reductions have been recommended to two risks</p> <p><i>Risk 24 – 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</i></p> <p><i>Risk 37 – 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.</i></p> <p>EP stated she was not supportive in reducing risk 24 and felt it was too early to make the reduction. BD responded to say that mitigations are in place and should the position change this can be increased again.</p> <p>The Committee supported the reduction in both risks noting the comments raised by EP.</p>	
<p>QP2021/ 189</p>	<p>THIRD WAVE RESPONSE TO COVID-19</p>	

	The paper was taken as read and there were no questions raised by the Committee.	
QP2021/190	<p>RISK STRATIFICATION</p> <p>The paper was taken as read.</p> <p>LM noted the conversations that have taken place with the Communications team in relation to the risk stratification work. The Risk Stratification and Quality Task and Finish Group meeting commences today. Healthwatch have been asked to participate. Outcomes from the meeting will feed into the Engagement Committee and to the Patient Participation Groups.</p> <p>BD agreed to the risk stratification paper to be reported to Quality and Performance Committee on a quarterly basis going forward. The next report being due in June 2021.</p>	
QP2021/191	<p>CRHFT STROKE UPDATE</p> <p>The paper was taken as read and there were no questions raised by the Committee.</p>	
QP2021/192	<p>CONTINUING HEALTH CARE (CHC)</p> <p>The paper was taken as read and there were no questions raised by the Committee.</p>	
QP2021/193	<p>INFECTION PREVENTION & CONTROL</p> <p>The paper was taken as read and there were no questions raised by the Committee.</p>	
QP2021/194	<p>CARE HOMES</p> <p>The paper was taken as read and there were no questions raised by the Committee.</p> <p>BD noted the contents of the report and suggested that it includes an updated on the COVID vaccination rates amongst residents and staff. HH assured the Committee that over 80% of residents and staff have currently been vaccinated and a mop up programme is in place. HH will ensure that this information is included in future reports.</p>	

<p>QP2021/ 195</p>	<p>UPDATE REPORTS FROM CLINICAL QUALITY REFERENCE GROUP INTERIM MEETINGS</p> <p>The papers were taken as read and there were no questions raised by the Committee.</p> <p>AM referred to the update report from UHDBFT noting the lack of attendance from the trust. BD commented that this is not unexpected given the level at which the trust is functioning. LM confirmed engagement is still satisfactory and there are no issues.</p>	
<p>QP2021/ 196</p>	<p>MINUTES FROM THE MEETING HELD ON 25TH MARCH 2021.</p> <p>The minutes were approved as a true and accurate record.</p>	
<p>QP2021/ 197</p>	<p>MATTERS ARISING AND ACTION LOG</p> <p>The action log was reviewed and updated.</p>	
<p>QP2021/ 198</p>	<p>AOB</p> <p>There were no matters of AOB raised.</p>	
<p>QP2021/ 199</p>	<p>FORWARD PLANNER</p> <p>The Forward Planner was reviewed. No updates were made.</p>	
<p>QP2021/ 200</p>	<p>ANY SIGNIFICANT SAFETY CONCERNS TO NOTE</p> <p>None raised.</p>	
	<p>ASSURANCE QUESTIONS</p> <ul style="list-style-type: none"> • Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? Yes • Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? Yes • Were papers that have already been reported on at another committee presented to you in a summary form? Yes • Was the content of the papers suitable and appropriate for the public domain? Yes 	

	<ul style="list-style-type: none"> • 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? No 	
DATE AND TIME OF NEXT MEETING		
Date: 29 th April 2021		
Time: 9am		
Venue: MS Teams		

APPROVED



Chief Executive Report

Health Executive Group

13 April 2021

Author(s)	Andrew Cash	
Sponsor		
Is your report for Approval / Consideration / Noting		
For noting and discussion		
Links to the ICS Five Year Plan (please tick)		
Developing a population health system	Strengthening our foundations	
<input checked="" type="checkbox"/> Understanding health in SYB including prevention, health inequalities and population health management	<input checked="" type="checkbox"/> Working with patients and the public	
<input checked="" type="checkbox"/> Getting the best start in life	<input checked="" type="checkbox"/> Empowering our workforce	
<input checked="" type="checkbox"/> Better care for major health conditions	<input checked="" type="checkbox"/> Digitally enabling our system	
<input checked="" type="checkbox"/> Reshaping and rethinking how we flex resources	<input checked="" type="checkbox"/> Innovation and improvement	
Building a sustainable health and care system	Broadening and strengthening our partnerships to increase our opportunity	
<input checked="" type="checkbox"/> Delivering a new service model	<input checked="" type="checkbox"/> Partnership with the Sheffield City Region	
<input checked="" type="checkbox"/> Transforming care	<input checked="" type="checkbox"/> Anchor institutions and wider contributions	
<input checked="" type="checkbox"/> Making the best use of resources	<input checked="" type="checkbox"/> Partnership with the voluntary sector	
	<input checked="" type="checkbox"/> Commitment to work together	
Are there any resource implications (including Financial, Staffing etc)?		
N/A		
Summary of key issues		
This monthly paper from the System Lead of the South Yorkshire and Bassetlaw Integrated Care		

System provides a summary update on the work of the South Yorkshire and Bassetlaw health and care partners for the month of March 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 April 2021

1. Purpose

This paper from the South Yorkshire and Bassetlaw Integrated Care System System Lead provides an update on the work of the South Yorkshire and Bassetlaw health and care partners for the month of March 2021.

2. Summary update for activity during March

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

The South Yorkshire and Bassetlaw (SYB) vaccination programme continues to make good progress with efforts recently focused on encouraging people to take up the offer in cohorts 1-9 who have not yet been vaccinated. While the overall uptake is high (86 per cent across cohorts 1-9) teams continue to work incredibly hard to encourage as many people as possible to take up the offer.

Cases continue to fall across Yorkshire and the Humber region. Three months ago the regional seven-day rolling average was between 2000-2200 cases a day and it is now between 850-650. In SYB, the latest data (April 6th) shows a 90 per cent reduction in COVID-19 cases in over-70s age groups. The over-50s and 60s age-ranges, school and working age groups are also showing a similar steady decline in new cases.

As the lockdown restrictions ease, it remains vital that communities across SYB continue to follow the public safety guidance.

2.2 Regional update

The North East and Humber Regional ICS Leaders meet weekly with the NHS England and Improvement Regional Director. During March discussions focused on the ongoing COVID-19 response and vaccination programme, the planning guidance and operational priorities for 2021/22, ICS development and People Framework.

2.3 National update

The NHS 2021/22 priorities and operational planning guidance were published on 25th March. The guidance sets out six priority areas for the year ahead:

- Supporting the health and wellbeing of staff and taking action on recruitment and retention
- Delivering the NHS COVID-19 vaccination programme and continuing to meet the needs of patients with COVID-19
- Building on what we have learned during the pandemic to improve the delivery of services, provide elective and cancer care, manage the increasing demand on mental health services, and continue to improve maternity care

- Expanding primary care capacity to improve access, local health outcomes and address health inequalities
- Transforming community and urgent and emergency care
- Working collaboratively across systems to deliver on these priorities

In SYB ICS, partners are now coming together to develop a plan for SYB which puts these priorities into action, with final plans expected to be completed by early June.

2.4 Voluntary, Community and Social Enterprise SRO Update

Following the departure of Catherine Burn as the Voluntary, Community and Social Enterprise Senior Responsible Officer (SRO, I am pleased to welcome Shafiq Hussein, as the new SRO. Shafiq, who is the CEO of Rotherham VCSE, was recommended by the SYB VSE Leaders Group as the new SRO.

Once again I would like to thank Catherine for her leadership and the instrumental role she has played throughout the last five years in establishing strategic partnerships both in the ICS and also in Bassetlaw.

2.5 Cancer Alliance: Supporting Rapid Diagnostics within the Lower Gastrointestinal (GI) Pathway and Lung Health Checks

Faecal Immunochemical Testing (FIT) has been used over the last few years to help assess the risk of colorectal cancer and since the COVID-19 pandemic the use of FIT has been expanded. From Monday 8th March, across SYB and Chesterfield, the change adopted during the pandemic (to cover more high risk patient groups) was enhanced further. The SYB Cancer Alliance agreed that GPs should request that a patient completes a FIT before they are referred for further investigations.

The SYB Cancer Alliance is also helping to support efforts in Doncaster to detect lung cancer earlier, with COVID-19 secure mobile scanning trucks servicing the local population. The new Lung Health Check service started at the end of March and will run for 12 months until March 2022.

2.6 Academic Health Science Network (AHSN) update

Richard Stubbs, Chief Executive Officer of Yorkshire and Humber Academic Health Science Network (AHSN), has taken on the role of Vice Chair of the AHSN Network. Richard will remain the CEO of the Yorkshire & Humber AHSN whilst in the new role and will be supporting Gary Ford who will take up the role of Chair. The Chair and Vice Chair remit is to lead and maintain the collective ambition of the Network's 15 AHSNs.

Richard has also recently published his reflections on the main findings that emerged from the AHSN's work to evaluate the impact of the rapid innovations adopted across health and care systems in North East and Yorkshire healthcare systems, including South Yorkshire and Bassetlaw. More information can be found here: <https://www.yhahsn.org.uk/news/understanding-covid-19/?ref=>

In addition, the national AHSN Network and LGBT Foundation have joined forces to launch a nationwide call for innovations to help address health inequalities facing lesbian, gay, bisexual and trans (LGBT+) communities. Examples of developments in this area will be showcased in a new report to be published later this year.

3. Finance update

The system is still on track to achieve operating within the system revenue and capital envelopes. The latest forecast is to achieve an adjusted revenue surplus of £32.4m and an underspend against the capital envelope of £13.7m. The system has been notified of its funding envelope for

the first half of the year which is £1.45b and represents a 1.9% increase over the system funding for the second half of 20/21. Work is ongoing to develop draft system plans for submission to NHS England and Improvement by 6 May.

Andrew Cash

System Lead, South Yorkshire and Bassetlaw Integrated Care System

Date: 8th April 2021

Derby and Derbyshire CCG Governing Body Meeting in Public
Held on
1st April 2021 via Microsoft Teams

UNCONFIRMED

Present:

Dr Avi Bhatia	AB	Clinical Chair
Dr Penny Blackwell	PB	Governing Body GP
Dr Bruce Braithwaite	BB	Secondary Care Consultant
Richard Chapman	RCp	Chief Finance Officer
Dr Chris Clayton	CC	Chief Executive Officer
Dr Ruth Cooper	RC	Governing Body GP
Jill Dentith	JD	Lay Member for Governance
Dr Buk Dhadda	BD	Governing Body GP
Helen Dillistone	HD	Executive Director of Corporate Strategy and Delivery
Ian Gibbard	IG	Lay Member for Audit
Zara Jones	ZJ	Executive Director of Commissioning Operations
Dr Steven Lloyd	SL	Medical Director
Simon McCandlish	SM	Lay Member for Patient and Public Involvement
Andrew Middleton	AM	Lay Member for Finance
Dr Emma Pizzey	EP	Governing Body GP
Professor Ian Shaw	IS	Lay Member for Primary Care Commissioning
Brigid Stacey	BS	Chief Nursing Officer
Dr Merryl Watkins	MW	Governing Body GP
Martin Whittle	MWh	Lay Member for Patient and Public Involvement

Apologies:

Dr Robyn Dewis	RD	Director of Public Health - Derby City Council
Dr Greg Strachan	GS	Governing Body GP
Dean Wallace	DW	Director of Public Health - Derbyshire County Council

In attendance:

Dawn Litchfield	DL	Executive Assistant to the Governing Body / Minute Taker
Suzanne Pickering	SP	Head of Governance
Andrew Kemp	AK	Head of Communications and Engagement

Item No.	Item	Action
GBP/2122/001	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/2122/002	Questions from members of the public No questions were received from members of the public.	

<p>GBP/2122/003</p>	<p>Declarations of Interest</p> <p>AB reminded Committee members and visiting delegates of their obligation to declare any interests that they may have on any issues arising at Committee meetings which might conflict with the business of the CCG.</p> <p>Declarations declared by members of the Governing Body are listed in the CCG's Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Governing Body or the CCG website at the following link: www.derbyandderbyshireCCG.NHS.uk</p> <p>No further declarations of interest were made and no changes were requested to the Register of Interests.</p>	
<p>GBP/2122/004</p>	<p>Chair's Report</p> <p>AB provided a written report, a copy of which was circulated with the papers; the report was taken as read. The main points to note were the significant one-year milestone of the UK in going into lockdown due to the COVID-19 pandemic, the positive vaccination programme undertaken in Derbyshire and the ongoing work on the restoration and recovery of services. A mark of respect was paid to those colleagues across the health and care system who have worked so hard during this period. The following points of note were made / questions raised:</p> <ul style="list-style-type: none"> • There has been a huge effort to get the vaccination programme underway, with many clinicians coming out of retirement to support the response. In terms of the backlog, and the recovery and restoration process, it was enquired whether these staff would be retained or whether there is a danger of a workforce crisis as they move back into retirement. AB confirmed that differing types of clinicians came forward to help manage the increased workload; their role was very important, and it is hoped that they can continue to be utilised going forward. • Examples are emerging that the experience of the pandemic has pushed some staff towards retirement, as they cannot go through this type of situation again; it was enquired if this is emerging as a factor in the workforce. Helen Dillistone (HD) advised that a huge amount of work is being undertaken across the System in development of the People Plan, led by the People and Culture Committee. There has been a massive effort to support the vaccination programme, by both clinical and non-clinical staff, with a large proportion of the CCG's staff being deployed in support of the vaccination effort. There is a need to harness the flexibility in the System to mobilise staff into key priority areas. Whilst the vaccination programme has been a great success, there will need to be a continuous effort to undertake the booster vaccines. Much has been learnt through working with volunteers and how best to utilise their skills. The CCG has not seen examples of staff wanting to leave as a result of the pandemic; it does not however have Trust data. <p>The Governing Body NOTED the contents of the report</p>	

**GBP/2122/
005**

Chief Executive Officer's Report

Dr Chris Clayton (CC) provided a written report, a copy of which was circulated with the papers. The report was taken as read and the following points of note were made / questions raised:

- COVID activity and admissions are reducing at both Acute Trusts in Derbyshire, and COVID levels in general are decreasing. The report describes the importance of keeping these levels down, with prevention being the most important thing to achieve this.
- Significant contributions have been made by many people in response to the pandemic, both inside and outside the Derbyshire Health and Social Care System; this has been an important contributor to the success of the delivery of the vaccination programme.
- The plans to restore non-COVID services and reduce waiting lists for routine care are now being enacted; work is underway to restore the backlog to pre-pandemic levels.
- The Capsule Camera pill was highlighted as an important innovation being trialled in the diagnosis of cancer; it can be taken by patients in their own homes, and the results provided within hours.
- The activities being undertaken locally across the Derbyshire System in support of the pandemic were highlighted.
- Dr Komal Raj, one of the Lead GPs at the Derby Arena Vaccination Centre, has produced a helpful video on what to expect when attending for a COVID vaccination; this has been well received.
- A video has been produced in recognition of achieving 100 days of the vaccination programme in Derbyshire which demonstrated the depth and breadth of engagement with both the community and staff. The Communications Team was thanked for its help in producing the video.
- It was queried at what point the public would find out about the next stage of the vaccination and booster programmes. CC advised that national guidance is awaited as to when the programme to vaccinate the remaining adult cohorts will be undertaken. Work is continuing to complete the current stages of the programme, both 1st and 2nd doses, against the national timelines set out. There is a need to better understand the requirements of a booster programme; no firm guidance has as yet been received.
- It was enquired how people are being motivated to join the NHS. It was suggested that this would be a good time to remind school leavers that working in the NHS is a very good career option. HD advised that the System People and Culture Committee will take ongoing learning from the pandemic and build upon it.
- AB emphasised the fact that it is not easy working in the NHS, especially during challenging times such as a pandemic; however, there has been many positives to take from it with staff working together and differently; increased applications have been seen for Health and Social Care Degrees, Student Nursing places, and GP applications, although there will be a lead time into benefitting from this. AB has not heard of any examples of people wanting to leave the NHS due to the COVID-19 pandemic, everyone has stepped up to the challenge, for which we are all thankful.

The Governing Body NOTED the contents of the report

**GBP/2122/
006**

Staff Survey 2020

HD advised that the NHS undertakes a national annual survey to collect staff views about working in their respective organisations. Last year DDCCG was a newly established organisation therefore this year's survey has enabled comparative results to be provided. The response rate of 83% of staff was higher than the average for similar organisations (80%) and demonstrated a highly engaged workforce.

A summary of the survey results was provided for information which demonstrated how the CCG compared to last year in 10 themed areas; the CCG has shown improvement in all of these areas.

DDCCG was shown to be the most improved organisation nationally when compared to the other organisations in its benchmarking group; this is something to be proud of and demonstrates the journey that the CCG has undertaken over the last 2 years. Significant improvements were demonstrated in 5 key areas, details of which were outlined in the report.

Areas of further thought and development include diversity and inclusion; there was a significant effort in the last 12 months to make this part of the organisation's DNA. A staff engagement exercise was undertaken, a Diversity and Inclusion Network implemented, unconscious bias training delivered and a programme of reverse mentoring commenced. Last year's survey suggested that the CCG had more to do to support under-represented staff. Compared to 2019, the data indicates that for the Black, Asian Minority Ethnic (BAME) staff, the situation had worsened with regard to increases in harassment, bullying and abuse, equal opportunities for career progression within the organisation and discrimination at work. This could be as a consequence of the increased focus on the inequalities faced by BAME colleagues due to the pandemic and Black Lives Matter. The Diversity and Inclusion Network may have also given staff more confidence to share their concerns; there is a need to understand what is driving this.

The results of the Survey have been shared with the Senior Leadership Team (SLT) and all staff and internal engagement forums; Directors are working with their respective areas in the ongoing development.

The following points of note were made / questions raised:

- This was an overall positive report. Although during the last year staff have been home working, they now feel better supported and more able to do their jobs. It was asked if the CCG needs to look at continuing with a home working/flexible working arrangement that suits staff. HD responded that the organisation feels more connected now although it has worked virtually for over a year. Structured ways to communicate with staff have been implemented to compensate for working virtually; the SLT has been made more visible to staff, which has been valued. The CCG is looking at a hybrid working model in order to prevent the loss of the investments made and the efficient ways of working achieved. The CCG would like to be able to reduce its carbon footprint further, and also lower its estates costs, thus protecting the environment and saving money which could be better utilised in providing patient care.
- Working from home with no loss of productivity or effectiveness is an important indicator to consider when looking at a flexible working policy.

	<ul style="list-style-type: none"> • It was acknowledged that these things do not happen without good leadership. The CCG has evidently tried interesting activities; reverse mentoring is an excellent idea. • Some Teams have a higher rating than others; it was asked why this was. HD advised that the SLT considers the improvements to be a joint team effort; it has led the organisation through a difficult year with many challenges, whilst creating a sense of oneness. Although there are ups and downs, which still need to be understood, they average out across the organisation which overall looks strong. Work is being undertaken by Directors to understand this better by analysing what some teams have done well and replicate it. • Concern was expressed at the BAME inclusion figures being so low; although efforts have been made over the last year to improve the situation, it has worsened; there needs to be a rethink on how best to address this. HD explained that work was undertaken in the latter part of last year to understanding the concerns of under-represented staff; at the time the survey was undertaken the work had not been fully embedded into the organisation; there is still more to do on this. • The good results are a credit to the whole organisation and the culture that underpins it. In terms of under-represented groups, it is important that the actions are implemented within the set timescales. Progress will be monitored through the Governance Committee with detailed conversations held on how to move forward. The learning from the merger of the 4 previous Derbyshire CCGs will be used in the transition arrangements over the next 12 months. • Members of the public should feel proud of these results; it was asked how far the momentum can be taken forward. HD concurred with this, stating that it was in the public session and on the CCG's website for openness and transparency purposes. The survey is used as a way of developing teams within the organisation. The CCG is entering another period of change as it transitions into an ICS; the transitioning of people element will be critical and only be successful if the CCG has motivated, skilled and supported staff with a drive for improvement and change. There is a need to take the enthusiasm into the ICS; if it is done well it will be an exciting time for staff. • The survey results could be used to help recruit people into the NHS. They will also demonstrate to the ICS that it will be getting a motivated group of staff to work within it. <p>The Governing Body NOTED and DISCUSSED the results from the 2020 NHS Derby and Derbyshire CCG staff survey</p>	
<p>GBP/2122/007</p>	<p>Finance Report – Month 11</p> <p>Richard Chapman (RCp) provided an update on the Month 11 financial position. The following points of note were made:</p> <ul style="list-style-type: none"> • The financial situation was discussed in detail at the 25th March 2021 Finance Committee meeting. • There is a reported year to date underspend of £6.001m, with a full year outturn underspend of £3.975m forecast. Although there are many moving parts to this, the CCG is confident that it will end the year with a surplus. • Guidance is still awaited on annual leave accruals for Provider staff. 	

	<ul style="list-style-type: none"> Retrospective COVID-19 funding has been received by the CCG, although there remains an element still to come. This 'top-up' is unique to the COVID-19 situation. <p>The Governing Body NOTED the following:</p> <ul style="list-style-type: none"> The financial arrangements for H2, October 2020 to March 2021 The reported YTD underspend is £6.001m Allocations of £5.77m for COVID-19 costs for M9 to M10 and £4.533m towards M11 to M12 were received in M10. No reimbursement for the COVID-19 Testing Service has been received in H2 The cumulative retrospective COVID-19 allocation stands at £52.501m The cumulative top-up allocation stands at £6.865m A reduction in allocation for a reduction in expenditure in Acute Independent Sector is £0.753m A full year underspend of £3.975m is forecast 	
<p>GBP/2122/008</p>	<p>Finance Committee Assurance Report – March 2021</p> <p>Andrew Middleton (AM) provided a verbal update following the Finance Committee meeting held on 25th March 2021. The following points of note were made:</p> <ul style="list-style-type: none"> This is an abnormal year therefore there is a need to look beyond it to establish a sustainable financial position for Derby and Derbyshire, which will from next year be a single System with a single Control Total. The Finance Team has got an excellent grip on the figures. The key point is to bank the good news and focus activity on ensuring that the System Finance and Estates Committee is fully operational, meeting on a regular basis and delivering development at pace once the organisation is fully functioning. <p>The Governing Body NOTED the verbal update for assurance purposes</p>	
<p>GBP/2122/009</p>	<p>Audit Committee Assurance Report – March 2021</p> <p>Ian Gibbard (IG) provided an update following the Audit Committee meeting held on 18th March 2021. The report was taken as read and the following points of note were made:</p> <ul style="list-style-type: none"> The Committee noted the significant assurance provided in the draft Head Of Internal Audit Opinion in relation to the tests conducted on the governance and financial controls during this year. The Committee received the audit plan to test Value For Money arrangements. The considerable underlying financial sustainability of the CCG and the System going forward due to the current underlying deficits at CCG and ICS level was highlighted as a significant risk. The process the CCG undertook to produce the Mental Health Investment Standard Statement of Compliance was noted. It was established to provide assurance to the Governing Body, Audit Committee, External Audit and NHSEI that national guidance is 	

	<p>followed. The unqualified opinion on the statement provided by KPMG and the CCG's endorsed letter of representation were noted.</p> <p>The Governing Body NOTED the contents of the report for assurance purposes</p>	
GBP/2122/010	<p>Clinical and Lay Commissioning Committee (CLCC) Assurance Report – March 2021</p> <p>Dr Ruth Cooper (RC) provided an update following the CLCC meeting held on 11th March 2021. The report was taken as read and the following points of note were made:</p> <ul style="list-style-type: none"> • The Committee virtually ratified the breast implants removal policy and the abdominoplasty policy. • The Committee noted the areas for service developments, which consider whether any pathways need to be developed due to gaps in service as a result of IFR submissions; this was not felt to be the case. • The CPAG updates and January bulletin were noted. <p>The Governing Body NOTED the contents of the report for assurance purposes</p>	
GBP/2122/011	<p>Engagement Committee Assurance Report – March 2021</p> <p>Martin Whittle (MWh) provided an update following the Engagement Committee meeting held on 17th March 2021. The report was taken as read and the following points of note were made:</p> <ul style="list-style-type: none"> • The Terms of Reference of the Committee were reviewed, and no major changes were made; however, it was noted that the forthcoming transition to ICS status may bring changes in the future. • As this is now a System Committee, it is to be re-named the Derbyshire Engagement Committee. • The CCG's Improvement and Assessment Framework for patient and community engagement rating in 2019/20 has reduced from green to amber. It was considered that the CCG is better than the amber rating given. Evidence for the Assessment is submitted to support the required indicators, however the evidence provided did not give a complete picture of the achievements made by the CCG and System. The CCG undertook a considerable amount of engagement work during this period which was unfortunately not reported in the submission. Processes have been implemented to prevent this from occurring in future. There will be a handing over to the ICS of a good, strong legacy of work undertaken by the communications and engagement teams. • The Trusts' Governors will be utilised to provide valuable contributions into debates; their combined wealth of local knowledge and experience will be harnessed in the wider work of the ICS going forward. <p>The Governing Body NOTED the contents of the report for assurance purposes</p>	

<p>GBP/2122/012</p>	<p>Governance Committee Assurance Report – March 2021</p> <p>Jill Dentith (JD) provided an update following the Governance Committee meeting held on 11th March 2021. The report was taken as read and the following points of note were made:</p> <ul style="list-style-type: none"> • The Committee approved the Flexible Working and Learning Development Policies. • The CCG's Recovery and Restoration plan was received and the actions noted. • The health and safety obligations on the CCG are being coordinated to ensure full compliance with legislation. This is important to note as the CCG moves out of lockdown and responds effectively and appropriately to changes in working practices. • The CCG is thinking creatively around the spare capacity available at Cardinal Square and working collaboratively with its System partners. • A vote of thanks was recorded to the subject experts present at the meeting. Although smaller than usual, the meeting was very effective. <p>The Governing Body NOTED the contents of the report for assurance purposes</p>	
<p>GBP/2122/013</p>	<p>Primary Care Commissioning Committee (PCCC) Assurance Report – March 2021</p> <p>Professor Ian Shaw (IS) provided a verbal update following the PCCC meeting in public held on 24th March 2021. The meeting mainly consisted of discussion of the standing agenda items.</p> <p>The Governing Body NOTED the verbal update for assurance purposes</p>	
<p>GBP/2122/014</p>	<p>Quality and Performance Committee (Q&PC) Assurance Report – March 2021</p> <p>Dr Buk Dhadda (BD) provided an update following the Q&PC meeting held on 25th March 2021. The report was taken as read and the following points of note were made:</p> <ul style="list-style-type: none"> • The Committee reviewed its Terms of Reference, which it agreed with the addition of the development of the Key Performance Indicators (KPIs). The role of the Committee in ensuring that the ICS is fit for purpose in terms of oversight was also discussed. • There has been a high rise in waiting times during the COVID-19 pandemic. A risk stratification process is in progress to review clinical priority and ascertain if patients are being seen based on medical need; it is reassuring to know that this is happening. General Practice support into this is important, especially in reassuring patients. <p>The Governing Body NOTED the key performance and quality highlights and the actions taken to mitigate the risks</p>	

<p>GBP/2122/015</p>	<p>Governing Body Assurance Framework – Quarter 4 2020/21</p> <p>The Governing Body Assurance Framework (GBAF) provides a structure and process that enables the CCG to focus on the strategic and principal risks that might compromise it in achieving its corporate objectives. It also maps out both the key controls that should be in place to manage those objectives and any associated strategic risks, and provides the Governing Body with assurance on the effectiveness of the controls. The CCG's Corporate Committees have proactively taken the responsibility and ownership of their GBAF risks in order to scrutinise and develop them further. Discussions were held at the January to March 2021 Committee meetings and the year-end position has been reviewed.</p> <p>HD presented the GBAF for Quarter 4 advising that 360 Assurance recently published a benchmarking exercise report for the 2020/21 GBAF. The report advises that 360 Assurance expect the GBAF to remain a dynamic document and that the COVID-19 risks will be integrated into the current risk management processes.</p> <p>Of particular note are risks 4A and 4B, which are overseen by the Finance Committee, relating to the ongoing management of the 2020/21 financial position and the underlying position, recognising whilst this year has been managed well there is still an underlying problem. These risks have been increased in score from a high 8 to a very high 16. Work remains ongoing to monitor and manage the 2020/21 position, but also to understand the recurrent expenditure position as the CCG and System partners begin planning for 2021/22.</p> <p>The Governing Body Risk Management and GBAF Survey is an important measure which helps to inform the auditors on the systems and processes in place within the CCG and tests the understanding of Governing Body members on the importance of the framework and management of it. This was a helpful survey, with good feedback received. It will be used to inform the Head Of Internal Audit Opinion and the CCG is likely to end the year with significant assurance; this is a strong position in which to be.</p> <p>A comment was made that the long term sustainable financial position depends on the transfer to and ownership of the System Finance and Estates Committee; AM urged for these meetings to be established on a regular basis as soon as possible. RCp confirmed that the Terms of Reference of this Committee were signed off by the JUCD Board at its last meeting and the invites will be sent out shortly. AM also suggested that sustainability be added to this portfolio. CC responded that sustainability is a complex issue and not the sole remit of finance.</p> <p>The Governing Body AGREED the 2020/21 Quarter 4 (January to March 2021) Governing Body Assurance Framework</p>	
<p>GBP/2122/016</p>	<p>CCG Risk Register – March 2021</p> <p>This report highlights areas of organisational risk recorded in DDCCG's Corporate Risk Register as at 31st March 2021. All risks in the Risk Register are allocated to one of the CCG's Corporate Committees which reviews them on a monthly basis. HD presented the end of year Risk Register noting a decrease in 3 risks as detailed below.</p>	

	<p>The Governing Body RECEIVED and NOTED:</p> <ul style="list-style-type: none"> • The Risk Register Report • Appendix 1 as a reflection of the risks facing the organisation as at 31st March 2021 • Appendix 2 which summarises the movement of all risks in March 2021 • The decrease in score for 3 risks: <ul style="list-style-type: none"> • Risk 24 - relating to patients deferring seeking medical advice for non-COVID issues, owned by the Quality & Performance Committee • Risk 30 - relating to the risk of fraud and cybercrime, owned by the Finance Committee • Risk 37 - relating to the sustainability of the Hyper Acute Stroke Unit at CRHFT, owned by the Quality & Performance Committee 	
<p>GBP/2122/017</p>	<p>Joined Up Care Derbyshire (JUCD) Board Update – March 2021</p> <p>CC provided an update on the discussions held at the JUCD Board meeting held on 18th March 2021. The following points of note were made:</p> <ul style="list-style-type: none"> • The Board opened with a patient story relating to joining up care in Chesterfield as part of the Ageing Well programme. The holistic model of care has been developed since 2017 through the Place Alliance, specifically supporting housebound patients. This helped the Board think through how the System could enable this type of approach to be used for other models of care. • The System has faced unprecedented challenges in terms of responding to the pandemic; its collective response to the vaccination programme reflects the increasing collaborative ways of working between System partners, for which the staff were applauded. • The Board reviewed the Terms of References of the proposed sub-committees to support the way the ICS works, ahead of potentially taking on statutory responsibilities in 2022. The proposed interim subcommittees are: <ul style="list-style-type: none"> • System Quality sub-committee • System Finance & Estates sub-committee • People and Culture sub-committee • System Transition Assurance sub-committee • Clinical and Professional Leadership Group • The Terms of Reference of the People and Culture Committee have not yet been agreed. There is an existing approach to developing this strategy across the System which will be built upon. Further thought is to be given to System assurance and governance arrangements. • The Terms of Reference of the System Transition Assurance Committee were approved; the process undertaken for the merger of the 4 previous Derbyshire CCGs will be invaluable when working through the transition from CCG to ICS. This Committee will be Chaired by AB. • The Terms of Reference of the Clinical and Professional Leadership Group (CPLG) will build upon the existing Clinical and Professional Reference Group (CPRG) to lead the development and delivery of the clinical model across the system. The starting point is to build upon 	

	<p>what works well now, what can be consolidated and what will need to change. The CCG and its General Practice membership are keen to ensure that all professional issues are captured. AB considered it encouraging that JUCD is noting the requirement for clinical leadership going forward; the CCG has this woven into its DNA however the ICS does not as yet; this is one of the concerns for the transition. Work is being undertaken in the clinical community to bring this together across the System.</p> <ul style="list-style-type: none"> • Sustainability continues to be thought through. It was agreed that environmental sustainability will form part of the anchor work with Local Authorities. • The NHS Long Term Plan and recent Government White Paper recognise the importance and priority of provider collaboration at scale. This is where provision of care can be best delivered at either a System or pan-System level. The main focus of this work is on acute, mental health/learning disabilities and ambulance/111, plus in and out of hours primary care. General Practice provider collaboration at scale will be given thought to review further possibilities. • The proposed model for two Place Partnerships in Derbyshire (One for Derby City and one for Derbyshire County) was agreed; this does not remove the current 8 Places but enhances them. Conversations are to be held on how the Place Alliance Groups continue to contribute to the wider partnership. • The breadth and depth of the work currently going on has been demonstrated. It is important to retain clinical leadership and engagement into this learning, as well as capturing the knowledge and corporate memory from the CCG to take forward. • The purpose of the Derbyshire People Plan is to ensure that plans for recovery and stepping services back up have a strong focus on looking after staff. It was queried whether more staff are actually needed or whether existing staff will just be required to work differently. CC advised that this Plan would evolve as it is worked through. Staff will have to work differently therefore the assumptions may well need to change; this is why having a System-wide group is so important. The ICS need to give thought to the staff and skills required across the System. <p>The Governing Body NOTED the update for assurance purposes</p>	
GBP/2122/018	<p>Joined Up Care Derbyshire Board – Ratified Minutes – January 2021</p> <p>The Governing Body RECEIVED and NOTED these minutes</p>	
GBP/2122/019	<p>Derby City Council Health and Wellbeing Board (H&WB) – Ratified Minutes – January 2021</p> <p>Dr Merryl Watkins (MW), Chair of the Derby City H&WB, advised that the Committee is looking at opportunities as to what can be done differently and how this could be tapped into to help Derby revitalise itself post-COVID-19.</p> <p>The Governing Body RECEIVED and NOTED these minutes</p>	
GBP/2122/020	<p>Ratified Minutes of DDCCG’s Corporate Committees:</p> <ul style="list-style-type: none"> • Audit Committee – 21.1.2021 	

	<ul style="list-style-type: none"> • Engagement Committee – 20.1.2021 • Governance Committee – 21.1.2021 • Primary Care Commissioning Committee – 24.2.2021 • Quality and Performance Committee – 25.2.2021 <p>The Governing Body RECEIVED and NOTED these minutes</p>	
GBP/2122/021	<p>South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) CEO Report – March 2021</p> <p>It was enquired how DDCCG could learn from SYB ICS going forwards. CC advised that SYB ICS has a different architectural construct in its number of CCGs, unitary authority relationship and Places; although there is mutual learning to be had, it is not all transferable. CC continues to be connected and attend SYB ICS Committee meetings. DDCCG could learn from SYB ICS's strong presence into defined Places, whilst SYB ICS could learn from DDCCG's commissioning at scale.</p> <p>The work that this Governing Body has done, and the 4 Governing Bodies before it, in bringing the commissioning function together will help the Derbyshire ICS think through how to undertake strategic commissioning at an ICS level. Work needs to be undertaken to support Places and define what commissioning functions should be done by them.</p> <p>The Governing Body RECEIVED and NOTED these reports</p>	
GBP/2122/022	<p>Minutes of the Governing Body meeting in public held on 4th March 2021</p> <p>The minutes of the above meeting were agreed as a true and accurate record.</p>	
GBP/2122/023	<p>Matters Arising / Action Log</p> <p>There were no outstanding action items for consideration at this meeting.</p>	
GBP/2122/024	<p>Forward Planner</p> <ul style="list-style-type: none"> • The May meeting will focus on strategic objectives for the next year. • The Governing Body will be kept informed of the discussions of the transition sub-committees. • In future the JUCD report will be placed higher up the agenda to facilitate adequate discussion time. <p>The Governing Body NOTED the Planner for information</p>	
GBP/2122/025	<p>Any Other Business</p> <p>None raised.</p>	
<p>DATE AND TIME OF NEXT MEETING - Thursday 6th May 2021 – 9.30am to 11am via Microsoft Teams</p>		

Signed by:
(Chair)

Dated:



GOVERNING BODY MEETING IN PUBLIC
ACTION SHEET – April 2021

Item No.	Item title	Lead	Action Required	Action Implemented	Due Date
2020/21 Actions					
There are currently no outstanding action items.					

Derby and Derbyshire CCG Governing Body Forward Planner 2021/22

	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
AGENDA ITEM / ISSUE												
WELCOME/ APOLOGIES												
Welcome/ Apologies and Quoracy	X	X	X	X	X	X	X	X	X	X	X	X
Questions from the Public	X	X	X	X	X	X	X	X	X	X	X	X
Declarations of Interest <ul style="list-style-type: none"> Register of Interest Summary register of interest declared during the meeting Glossary 	X	X	X	X	X	X	X	X	X	X	X	X
CHAIR AND CHIEF OFFICERS REPORT												
Chair's Report	X	X	X	X	X	X	X	X	X	X	X	X
Chief Executive Officer's Report	X	X	X	X	X	X	X	X	X	X	X	X
FOR DECISION												
Review of Committee Terms of References		X					X					
FOR DISCUSSION												
360 Stakeholder Survey												X
Mental Health Update								X				
CORPORATE ASSURANCE												
Finance and Savings Report	X	X	X	X	X	X	X	X	X	X	X	X
Finance Committee Assurance report	X	X	X	X	X	X	X	X	X	X	X	X
Quality and Performance Committee Assurance Report <ul style="list-style-type: none"> Quality & Performance Report Serious Incidents Never Events 	X	X	X	X	X	X	X	X	X	X	X	X
Governance Committee Assurance Report <ul style="list-style-type: none"> Business Continuity and EPRR core standards Complaints 	X		X		X		X		X		X	

	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
AGENDA ITEM / ISSUE												
<ul style="list-style-type: none"> Conflicts of Interest Freedom of Information Health & Safety Human Resources Information Governance Procurement 												
Audit Committee Assurance Report	X	X	X	X			X		X		X	
Engagement Committee Assurance Report	X	X	X	X	X	X	X	X	X	X	X	X
Clinical and Lay Commissioning Committee Assurance Report	X	X	X	X	X	X	X	X	X	X	X	X
Primary Care Commissioning Committee Assurance Report	X	X	X	X	X	X	X	X	X	X	X	X
Risk Register Exception Report	X	X	X	X	X	X	X	X	X	X	X	X
Governing Body Assurance Framework	X	X		X		X		X			X	
Strategic Risks and Strategic Objectives		X		X	X							
Annual Report and Accounts			X			X						
AGM						X						
Audit Committee Annual Report				X								
Joined Up Care Derbyshire Board Update	X		X		X		X		X		X	
FOR INFORMATION												
Director of Public Health Annual Report						X						
Minutes of Corporate Committees												
Audit Committee	X	X	X				X		X		X	
Clinical & Lay Commissioning Committee	X	X	X	X	X	X	X	X	X	X	X	X
Engagement Committee	X	X	X	X	X	X	X	X		X	X	X
Finance Committee	X	X	X	X	X	X	X	X	X	X	X	X
Governance Committee			X		X		X		X		X	
Primary Care Commissioning Committee	X	X	X	X	X	X	X	X	X	X	X	X
Quality and Performance Committee	X	X	X	X	X	X	X	X	X	X	X	X
Minutes of Health and Wellbeing Board Derby	X		X		X		X		X		X	

	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
AGENDA ITEM / ISSUE												
City												
Minutes of Health and Wellbeing Board Derbyshire County	X		X		X		X		X		X	
Minutes of Joined Up Care Derbyshire Board	X		X		X		X		X		X	
Minutes of the SY&B JCCCG meetings – public / private	X	X	X	X	X	X	X	X	X	X	X	X
MINUTES AND MATTERS ARISING FROM PREVIOUS MEETNGS												
Minutes of the Governing Body	X	X	X	X	X	X	X	X	X	X	X	X
Matters arising and Action log	X	X	X	X	X	X	X	X	X	X	X	X
Forward Plan	X	X	X	X	X	X	X	X	X	X	X	X
ANY OTHER BUSINESS												