

**NHS DERBY AND DERBYSHIRE CCG  
GOVERNING BODY – MEETING IN PUBLIC**

**Date & Time: Thursday 7<sup>th</sup> April 2022 – 9am to 10.30am  
Via Microsoft Teams**

*Questions from members of the public should be emailed to [DDCCG.Enquiries@nhs.net](mailto:DDCCG.Enquiries@nhs.net) and a response will be provided within seven working days*

Item	Subject	Paper	Presenter	Time
GBP/2223/001	<b>Welcome, Apologies &amp; Quoracy</b>  Apologies: Professor Ian Shaw, Jill Dentith, Helen Dillistone, Dr Buk Dhadda, Dr Emma Pizzey, John MacDonald	Verbal	Dr Avi Bhatia	9.00
GBP/2223/002	<b>Questions from members of the public</b>	Verbal	Dr Avi Bhatia	
GBP/2223/003	<b>Declarations of Interest</b> <ul style="list-style-type: none"> <li>• Register of Interests</li> <li>• Summary register for recording any conflicts of interests during meetings</li> <li>• Glossary</li> </ul>	Papers	Dr Avi Bhatia	
<b>CHAIR AND CHIEF OFFICER REPORTS</b>				
GBP/2223/004	<b>Chair's Report</b>	Paper	Dr Avi Bhatia	9.05
GBP/2223/005	<b>Chief Executive Officer's Report</b>	Paper	Dr Chris Clayton	
<b>FOR DECISION</b>				
GBP/2223/006	<b>Joined Up Care Derbyshire ICS Green Plan</b>	Paper	Chrissy Tucker	9.20
<b>FOR DISCUSSION</b>				
GBP/2223/007	<b>2022-23 Operational Plan – draft submission</b>	Paper	Zara Jones	9.35

<b>CORPORATE ASSURANCE</b>				
<b>GBP/2223/008</b>	<b>Finance Report – Month 11</b>	<b>Paper</b>	<b>Richard Chapman</b>	<b>9.55</b>
<b>GBP/2223/009</b>	<b>Joint CCG Finance Committee and System Finance and Estates Committee Assurance Report – March 2022</b>	<b>Verbal</b>	<b>Andrew Middleton</b>	
<b>GBP/2223/010</b>	<b>Audit Committee Assurance Report – March 2022</b>	<b>Paper</b>	<b>Ian Gibbard</b>	
<b>GBP/2223/011</b>	<b>Clinical and Lay Commissioning Committee Assurance Report – March 2022</b>	<b>Paper</b>	<b>Ian Gibbard</b>	
<b>GBP/2223/012</b>	<b>Derbyshire Engagement Committee Assurance Report – March 2022</b>	<b>Paper</b>	<b>Simon McCandlish</b>	
<b>GBP/2223/013</b>	<b>Primary Care Commissioning Committee Assurance Report – March 2022</b>	<b>Paper</b>	<b>Simon McCandlish</b>	
<b>GBP/2223/014</b>	<b>Quality and Performance Committee Assurance Report – March 2022</b>	<b>Paper</b>	<b>Andrew Middleton</b>	
<b>GBP/2223/015</b>	<b>Governing Body Assurance Framework Quarter 4 2021/22</b>	<b>Paper</b>	<b>Chrissy Tucker</b>	
<b>GBP/2223/016</b>	<b>CCG Risk Register – March 2022</b>	<b>Paper</b>	<b>Chrissy Tucker</b>	
<b>FOR INFORMATION</b>				
<b>GBP/2223/017</b>	<b>Health and Wellbeing Board Minutes</b> <ul style="list-style-type: none"> <li>• Derbyshire County Council – 10.2.2022</li> </ul>	<b>Paper</b>	<b>Dr Chris Clayton</b>	<b>10.20</b>
<b>GBP/2223/018</b>	<b>Ratified Minutes of Corporate Committees:</b> <ul style="list-style-type: none"> <li>• Audit Committee - 20.1.2022</li> <li>• Derbyshire Engagement Committee - 18.1.2022</li> <li>• Primary Care Commissioning Committee - 23.2.2022</li> <li>• Quality and Performance Committee - 24.2.2022</li> </ul>	<b>Papers</b>	<b>Committee Chairs</b>	
<b>MINUTES AND MATTERS ARISING FROM PREVIOUS MEETING</b>				
<b>GBP/2223/019</b>	<b>Minutes of the Governing Body Meeting in Public held on 3<sup>rd</sup> March 2022</b>	<b>Paper</b>	<b>Dr Avi Bhatia</b>	<b>10.25</b>
<b>GBP/2223/020</b>	<b>Matters arising from the minutes not elsewhere on agenda:</b>	<b>Paper</b>	<b>Dr Avi Bhatia</b>	

	<ul style="list-style-type: none"> <li>Action Log – March 2022</li> </ul>			
<b>GBP/2223/021</b>	<b>Forward Planner</b>	<b>Paper</b>	<b>Dr Avi Bhatia</b>	
<b>GBP/2223/022</b>	<b>Any Other Business</b>	<b>Verbal</b>	<b>All</b>	

**Date and Time of Next Meeting – Thursday 5<sup>th</sup> May 2022 at 9am via MST**

NHS DERBY AND DERBYSHIRE CCG GOVERNING BODY MEMBERS' REGISTER OF INTERESTS 2022/23

\*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 Joined Up Care Derbyshire Long Term Conditions Workstream	GP Partner at Moir Medical Centre	✓				2000	Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair	
				GP Partner at Erewash Health Partnership	✓				April 2018	Ongoing		
				Spouse works for Nottingham University Hospitals in Gynaecology					✓	Ongoing		Ongoing
Blackwell, Dr Penny	Governing Body GP	Governing Body	Derbyshire Primary Care Leadership Group Derbyshire Place Board Dales Health & Wellbeing Partnership Dales Place Alliance Group Joined Up Care Derbyshire Long Term Conditions Workstream	Director of Flourish Derbyshire Dales CIC, which aims to provide creative arts and activity projects and to support others in this activity for the Derbyshire Dales		✓			Feb 2019	Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair	
				GP partner at Hannage Brook Medical Centre, Wirksworth. Interests in Drug misuse	✓				Oct 2010	Ongoing		
				GP lead for Shared Care Pathology, Derbyshire Pathology					2011	Ongoing		
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)	✓				Aug 2014	Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair	
				Employed by Nottingham University Hospital NHS Trust which is commissioned by the CCG to provide services to NHS patients.	✓				Aug 2000	Ongoing		Declare interest in relevant meetings
				Founder Member, Shareholder and Director of Clinical Services for Alliance Surgical plc which is a company that bids for NHS contracts.	✓				July 2007	Ongoing		Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Chapman, Richard	Chief Executive Officer	Governing Body	Clinical & Lay Commissioning Committee System Finance and Estates Committee Primary Care Commissioning Committee	Fellow of the Royal College Of Surgeons of England and Member of the Vascular Society of Great Britain and Ireland. Advisor to NICE on an occasional basis.		✓			Aug 1992	Ongoing	No action required	
				Honorary Associate Professor, University of Nottingham, involved in clinical research activity in the East Midlands.			✓		Aug 2009	Ongoing	No action required	
				Medical Director of Independent Healthcare Group which provides local anaesthetic services to NHS patients in Leicestershire, Gloucestershire, Wiltshire and Somerset.	✓				Oct 2020	Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair	
Clayton, Dr Chris	Chief Executive Officer	Governing Body	Clinical & Lay Commissioning Committee System Finance and Estates Committee Primary Care Commissioning Committee	Chief Medical Officer for Circle Harmony Health Limited which is part owned by Circle Health Group who run BMI and Circle Hospitals	✓				Aug 2020	Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair	
				Spouse is a partner in PWC						2019	Ongoing	Declare interest at relevant meetings
				Nil								No action required
Cooper, Dr Ruth	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Derbyshire Primary Care Leadership Group North East Derbyshire & Bolsover Place Alliance Group GP Workforce Steering Group Alliance for Clinical Transformation Dermatology System EAF Planned Care Delivery Board Enhanced Health in Care Homes Working Group	Locum GP at Staffa Health, Tibshelf	✓				Dec 2020	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	
				Shareholder in North Eastern Derbyshire Healthcare Ltd	✓				2015	Ongoing		
				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	✓				03/02/2021	Ongoing		
Cooper, Dr Ruth	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Derbyshire Primary Care Leadership Group North East Derbyshire & Bolsover Place Alliance Group GP Workforce Steering Group Alliance for Clinical Transformation Dermatology System EAF Planned Care Delivery Board Enhanced Health in Care Homes Working Group	Fundraising Activities through Staffa Health to support Ashgate Hospice and Blythe House			✓		Ongoing	Ongoing		

Dentith, Jill	Lay Member for Governance	Governing Body	Audit Committee Governance Committee Primary Care Commissioning Committee Remuneration Committee System Transition Committee System People and Culture Group	Self-employed through own management consultancy business trading as Jill Dentith Consulting Providing part-time, short term corporate governance support to Rotherham NHS Foundation Trust  Director of Jon Carr Structural Design Ltd  Providing part-time, short term corporate governance support to Sheffield Teaching Hospitals NHS Foundation Trust	✓ ✓ ✓ ✓				2012 6 Oct 2020 6 Apr 2021 07.06.2021 08.02.2022	Ongoing 8 April 2021 Ongoing 31.12.2021 TBC	Declare interests at relevant meetings
Dewis, Dr Robyn	Director of Public Health, Derby City Council	Governing Body	Clinical & Lay Commissioning Committee Clinical Policy Advisory Group Joint Area Prescribing Committee Conditions Specific Delivery Board CVD Delivery Group Derbyshire Place Board Derby City Place Alliance Group Respiratory Delivery Group	Nil							No action required
Dhadda, Dr Bukhtawar S	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee System Finance and Estates Committee Quality & Performance Committee UHDB Clinical Quality Review Group Clinical Policy Advisory Group	GP Partner at Swadlincote Surgery  Private GP work for Medical Solutions Online (Health Hero)	✓ ✓				2015 March 2022	Ongoing Ongoing	Withdraw from all discussion and voting if organisations are potential providers unless otherwise agreed by the meeting chair
Dillistone, Helen	Executive Director of Corporate Strategy & Delivery	Governing Body	Engagement Committee Governance Committee	Nil							No action required
Gibbard, Ian	Lay Member for Audit	Governing Body	Audit Committee Clinical & Lay Commissioning Committee System Finance and Estates 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	Clinical & Lay Commissioning Committee CVD Delivery Group Joined Up Care Derbyshire Long Term Conditions CRHFT Contract Management Board 999 Quality Assurance Group Derbyshire Prescribing Group Derbyshire System Flu Planning Cell System Finance and Estates Committee Primary Care Commissioning Committee Quality & Performance Committee GP Information Governance Assurance Forum Primary & Community Collaborative Delivery Board Information Governance Assurance Forum	Salaried sessions at Eyam Surgery  Shareholder in premises of Emmett Carr Surgery, Renishaw	✓ ✓	✓			Oct 2021 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	Finance Committee (Chair) Audit Committee System Finance and Estates Committee Quality & Performance Committee Remuneration Committee Commissioning for Individuals Panel (Shared Chair)	Lay Vice Chair of East Riding of Yorkshire Clinical Commissioning Group  Lay Chair of Performers List Decision Panels for NHS England Central Midlands  Lay Chair of Appointment Advisory Committees at United Hospitals Leicester - chairing panels for appointing hospital consultants  Independent Non-Executive Director for Finance and Governance for Barnsley Healthcare Federation	✓ ✓ ✓ ✓				Jan 2017 May 2013 Mar 2020 Aug 2021	Mar 2023 Ongoing Mar 2023 Jul 2022	Declare interests at relevant meetings  Will not sit on any case which has knowledge of the GP or their practice, or a consultant at Leicester
Plizey, Dr Emma	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Governance Committee Quality & Performance Committee Erewash Place Alliance Group	Partner at Littlewick Medical Centre  Executive director Erewash Health Partnership	✓ ✓ ✓				2002 Apr 2018	Ongoing Ongoing	Declare interests at relevant meetings. The INR service interest is to be noted at Governance Committee due to the procurement highlight report, which refers to, for information only, the INR service re-procurement. No further action is necessary as no decisions will be
Shaw, Professor Ian	Lay Member for Primary Care Commissioning	Governing Body	Clinical & Lay Commissioning Committee Engagement Committee Primary Care Commissioning Committee Primary Care Enhanced Services Review Group	Professor at the University of Nottingham  Subject Matter Expert and advisory panel member in relation to research and service development at the Department of Health and Social Care	✓ ✓	✓			1992 Jan 2020	Ongoing Jan 2021	Declare interests at relevant meetings

Stacey, Brigid	Chief Nurse Officer	Governing Body	Clinical & Lay Commissioning Committee System Finance and Estates 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 Mar 2020 2015 1 Apr 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 reprourement. 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 Merryll	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 System Finance and Estates Committee Governance Committee Quality & Performance Committee Remuneration Committee	Remunerated role of Chair of the Independent Gynae Review Panel relating to activities at UHDBFT	✓				13 December 2021	Ongoing	Declare interest if relevant

### SUMMARY REGISTER FOR RECORDING ANY INTERESTS DURING MEETINGS

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

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

## Abbreviations & Glossary of Terms

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

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

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

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

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

## Governing Body Meeting in Public

7<sup>th</sup> April 2022

Item No: 004

<b>Report Title</b>	Chair's Report – March 2022
<b>Author(s)</b>	Dr Avi Bhatia, CCG Clinical Chair
<b>Sponsor (Director)</b>	Dr Avi Bhatia, CCG Clinical Chair

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

### Recommendations

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

### Report Summary

Last month was a particularly poignant time for us all as the Covid Day of Reflection took place on Wednesday 22<sup>nd</sup> March. Alongside our colleagues across the Derbyshire health and care system, and also colleagues nationally, we paused for a one minute's silence to think back over the last two years and to remember the patients and colleagues we tragically lost to Covid. Our thoughts have been very much with their loved ones in recent days, and we also remember those who continue to suffer from the impact of Covid and lives that have changed as a result.

The Day of Reflection and the significant increase in Covid infection rates across our communities also served as a sharp reminder of the importance of the NHS patient and visitor guidance. This means that staff, patients and visitors will still be expected to continue to follow social distancing rules when visiting any care setting, as well as using masks or face coverings and other personal protection equipment. The updated testing plan introduced by the Government at the end of March includes free symptomatic testing for certain categories of patients in hospital, people who fall into vulnerable categories and people working in high-risk settings, which includes NHS staff. We are working through the detail and implications of this at the time of writing.

All parts of our Derbyshire health and care system remain incredibly busy and we continue to do all we can to support colleagues delivering our frontline services. It is vitally important that patients access the care most appropriate for their health needs across all health settings. We also continue to support our patients and the public with information and advice to help them identify which NHS service best reflects their needs so that they can go to the right point, first time. Key messages include that, where self-care is not a solution, NHS 111 online and the call centre can offer advice and a direct referral to key services and NHS 111 should be the first option in most scenarios. We are reminding people that A&E is for life threatening conditions only and that Urgent Treatment Centres can treat most urgent, but not life-threatening

conditions. GPs offer an extensive range of services delivered by their clinician colleagues in each practice and pharmacists are highly qualified and can offer advice and treatment for many conditions.

The demand for primary care services continues to be extremely high with the overall number of appointments now higher than they were pre-pandemic. In conjunction with the multiple challenges of Covid and winter pressures, our GP practice colleagues are working incredibly hard to ensure that they get people to the most appropriate clinician first time.

To support their efforts, we have extended our messaging around primary care with a campaign to remind people that their GP practice employs clinicians delivering a range of services and the aim is to encourage patients to make bookings with the practice colleague most appropriate to their needs. This in turn opens up access for patients to see GPs when this is required. The campaign is proving an invaluable source of patient feedback and we are using this intelligence to support service development. A campaign to remind people that their local pharmacy can offer advice and treatment without the need to make an appointment is also underway as part of reminding people of the options open to them.

Our overall aims are to enable patients to access information, advice and treatment from the service which best meets their needs in a minimum timescale, whilst simultaneously relieving pressure on our system. The British Social Attitudes Survey published at the time of writing is disappointing for colleagues who continue to give their all every day, particularly given how challenging and gruelling the pandemic has been for frontline staff, however this feedback is important and helps to inform our response across the Derby and Derbyshire health and care system.

Improving patient experience is at the core of our NHS principles and the campaigns we are currently running hopefully serve as a small example and also as a timely reminder that we are doing our absolute best under challenging circumstances. In the context of improving access to services, by going to the most appropriate place, first time, every one of us has a role to play in supporting this to ensure that our patient experience is enhanced, and we reduce the pressure on our system. Your support in sharing these key messages would be very much appreciated,

Thank you and as always, please do take care.

Dr Avi Bhatia  
Clinical Chair and CPRG Co-Chair

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

None

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

N/A

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

## Governing Body Meeting in Public

7<sup>th</sup> April 2022

Item No: 005

<b>Report Title</b>	Chief Executive Officer's Report – March 2022
<b>Author(s)</b>	Dr Chris Clayton, Chief Executive Officer
<b>Sponsor (Director)</b>	Dr Chris Clayton, Chief Executive Officer

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

### Recommendations

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

### Report Summary

March has seen some major developments and I am pleased to report significant progress as we prepare to move towards our transition to an Integrated Care System (ICS) on 1<sup>st</sup> July 2022. In recent months we have inevitably needed to focus our efforts on developing the infrastructure of our ICS and to set out how the Integrated Care Board (ICB) and Integrated Care Partnership (ICP) will work in our Derby and Derbyshire system. Alongside this, the recruitment programme for our Non-Executive Members is complete and recruitment for our Executive Directors is progressing well with two remaining posts to be appointed to. We have also set up an interim NHS System Strategic Oversight Board which will create a space for NHS partners to discuss performance and oversight issues and we held our first meeting of this group in March.

As we continue to address these fundamental priorities, it is also vital that we develop our other key functions such as decision-making mechanisms at every level. Ensuring that we empower Place colleagues to influence and make local decisions is a key component in our ICS development and our eight Places represent a cornerstone of our future planning. I recently spent the morning with the High Peak Place Alliance Group, which now includes Glossop, to listen and join in with their discussions. To see the twenty plus partners working so closely and constructively together to address challenges and identify solutions was a privilege. My reflection is that ensuring we have a consistent understanding of where and how we all contribute to development work and decision making is vitally important as we move fully into the ICS transition; this is a major focus for me as we move forward.

As we progress towards July, I am also very passionate about moving from a focus on the strategic planning and infrastructure work updates to a point where we can start to articulate how the ICS will work for our patients. To progress this intention, I want to bring to life some of the significant advantages of the new ways of working which will help to make our ICS more real for people.

Over the coming weeks I will be sharing some tangible examples through my Governing Body reports and other channels. For this month, I will focus on the Population Health Management System which we launched recently. This is a way of working to help planners and frontline teams across our system understand current health and care needs and predict what local people will need in the future. The data generated will help us to better understand what we need to do to address long-term challenges. Examples of these include issues such as smoking, obesity and harmful drinking that increase the risk of living with a long-term condition, or of dying prematurely, as well as things like housing and poverty.

The Population Health Management System is a really exciting piece of work which, in conjunction with other activities will help us to tailor care more effectively. This is part of our broader ambition to proactively support communities and individuals with more joined-up and sustainable health and care services. Being able to tackle the wider determinants of health, address health inequalities and make better use of public resources are key priorities for our ICS. This system and our other programmes of work will help us to deliver more effectively on these aspects.

During the month we have been reminded by events that as we plan for the future, we must also focus upon our immediate challenges. The situation that continues to unfold in the Ukraine will have an inevitable impact upon health systems as we see people continue to arrive and some will have complex needs which we must be prepared for. At the start of the month, we also responded quickly to review our data security to confirm and assure that everything is being done to protect our IT and data systems from any external intervention.

March has also seen a significant rise in Covid infection rates and hospitalisations, particularly towards the end of the month. Once again we see this impacting upon our capacity in both beds and staffing terms as we are doing our best to recover from the pandemic. As we roll out the vaccine boosters for the over 75's, and for the healthy 5–11-year-olds, we continue to advise in the strongest terms that taking precautions and the Covid vaccination are the most effective ways of keeping yourself and those around you safe. That message is as important as it ever has been, and we will continue to promote it.

I look forward to updating you on developments in my next report and in the meantime and as always, please do stay safe.

Dr Chris Clayton, Accountable Officer and Chief Executive

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

<b>Meeting and purpose</b>	<b>Attended by</b>	<b>Frequency</b>
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
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
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
Gold Command Vaccine Update	CG/DCHS	Ad Hoc
System Transition Assurance Sub-Committee	CCG/System	Monthly
East Midlands ICS Commissioning Board	Regional AOs/NHSE	Monthly
Team Talk	All staff	Weekly
JUCD Finance & Estates Sub Committee	NHS/System CEOs	Monthly
JUCD Development Session	CCG/System	Ad Hoc
Midlands ICS Executive & NHSEI Timeout	System/CCG/NHSE	Ad Hoc
JUCD Executive Leadership Programme (Cohort 1 - Workshop 2)	System/CCG	Ad Hoc
Remuneration Committee	CCG	Ad Hoc
Co-Designing System Governance	System/CCG	Ad Hoc
Interim NHS System Strategic Oversight Board	NHSE/CCG/System	Monthly
High Peak Place Alliance Meeting	Public/CCG	Ad Hoc
Testing & refining Shadow Arrangements: Through the lens of Place	System	Ad Hoc
Strategic Intent Executive Group	CCG/System	Monthly

### 3.0 National developments, research and reports

#### 3.1 Thousands of people spared Type 2 Diabetes

Thousands of people have been spared Type 2 diabetes thanks to the world leading NHS Diabetes Prevention Programme (NHS DPP), new research shows today. New data suggests that the healthy living programme resulted in a 7% reduction in the

number of new diagnoses of Type 2 diabetes in England between 2018 and 2019. Find out more [here](#)

### **3.2 Spring booster invitations for 620,00 people**

More than 600,000 people will be invited for their life saving COVID jab from week commencing 4<sup>th</sup> April as the NHS COVID-19 Vaccination Programme spring booster campaign ramps up. Since rolling out spring boosters in March, more than 470,000 people have come forward for a jab, with hundreds of thousands more booking their slot via the National Booking Service. Read more [here](#)

### **3.3 Celebrities join force with NHS to encourage cancer checks**

Famous faces have come out in support of a new, first of its kind NHS campaign aimed at tackling fears and concerns about cancer. Former boxer Johnny Nelson, Love Islander Demi Jones and celebrity builder Tommy Walsh have all taken part in the new film, outlining their own experiences of cancer. You can find out more [here](#)

### **3.4 Public satisfaction with the NHS and social care in 2021**

The Kings Fund have published an article on the results of the British Social Attitudes Survey. To find out more information go [here](#)

### **3.5 NHS Race and Health Observatory | Ethnic inequalities in healthcare**

[This review](#) into ethnic inequalities in healthcare has revealed vast inequalities across a range of health services. Some of the largest inequalities were found for mental health care, where treatment for Black groups was particularly poor, and found there was a lack of research into the care of ethnic minority newborn babies.

### **3.6 New lung cancer treatment**

A targeted new drug for a rare and aggressive form of lung cancer will be fast-tracked to eligible patients within weeks and patients in England will be the first in Europe to access this new treatment. You can find out more [here](#)

## **4.0 Local developments**

### **4.1 Supporting the community on 5-11 year old vaccinations**

Joined Up Care Derbyshire has prepared a Covid-19 vaccinations support pack for teachers and others working with parents and guardians ahead of the start of vaccinations for children aged 5-11. NHS England expects to open up bookings for vaccinations for children in this age group in early April, and we want to inform and reassure parents about the process.

The pack includes example text, videos, social media and website artwork and photographs of Midland House's children's vaccination space and is being shared with schools via Local Authorities. It is also being shared with community groups via existing engagement channels, and can be [viewed on the Joined Up Care Derbyshire website](#).

## **4.2 Spring Booster Vaccinations**

The NHS is now offering spring booster vaccinations, giving extra protection for people who:

- are aged 75 and over
- live in older adult care homes
- are immunosuppressed, for example, following a transplant or because of an underlying health condition.

The NHS will invite eligible people to arrange a jab through the [National Booking Service](#) or by calling 119 when it is their turn.

Everyone who is eligible – around five million in total – will be offered this booster during spring and early summer.

Please visit [www.nhs.uk/covid-booster](http://www.nhs.uk/covid-booster) for more information on how to get your booster.

## **4.3 Promoting different roles in general practice**

Joined Up Care Derbyshire has launched a media campaign to promote the different clinical staff available to patients for appointments. The aim is to encourage patients to seek and make bookings with these clinical staff to open up access for patients to GPs and other clinicians.

The roles and the descriptive texts have been developed in partnership with Health Education Derbyshire and local GPs, enabling JUCD to create images and copy which will be used on social media, radio, print and web. This includes the following channels:

- Twitter
- Facebook
- Instagram
- JPI (Derby Telegraph) group of newspapers and associated websites
- Reach (Derbyshire Times) group and associated websites
- Global Media radio stations, including Capital and Gold

## **4.4 Campaign to encourage the appropriate use of NHS111 and Urgent Treatment Centres (UTCs)**

The campaign launched by Derbyshire Community Health Services NHS Foundation Trust has the key messages to "think NHS111 first" if you need medical help and you are not sure what to do, and that you can be booked a same-day appointment if a UTC is the appropriate place for treatment. It includes a household maildrop promoting the UTCs at Buxton, Derby, Ilkeston, Ripley and Whitworth, as well as iVan advertising and radio adverts on Global radio stations and streaming. It will be supported by geographically targeted advertising on Facebook. Find out more [here](#)

## **4.5 Latest vaccination statistics**

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

**4.6 Media update**

You can see examples of recent news releases [here.](#)

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

Not Applicable

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

Not Applicable

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

Not Applicable

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

Not Applicable

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

Not Applicable

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

Not Applicable

**Have any Conflicts of Interest been identified/ actions taken?**

None Identified

**Governing Body Assurance Framework**

Not Applicable

**Identification of Key Risks**

Not Applicable

## Governing Body Meeting in Public

7<sup>th</sup> April 2022

	<b>Item No: 006</b>
<b>Report Title</b>	Joined Up Care Derbyshire Integrated Care System (ICS) Green Plan
<b>Author(s)</b>	Suzanne Pickering, Head of Governance Helen Dillistone, Executive Director of Strategy and Delivery
<b>Sponsor (Director)</b>	Helen Dillistone, Executive Director of Strategy and Delivery Chrissy Tucker, Director of Corporate Delivery

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

### Recommendations

The Governing Body is requested to **APPROVE** the Joined Up Care Derbyshire ICS Green Plan.

### Report Summary

The purpose of the paper is to provide details of the new Joined Up Care Derbyshire (JUCD) ICS Green Plan and sets out our system ambition to reduce the carbon footprint of the local NHS.

The final ownership and approval of the plan will be the responsibility of the Derby and Derbyshire Integrated Care Board (ICB) once it has been formally established.

#### Background

In 2020, the NHS launched the campaign "For a Greener NHS " and an Expert Panel, chaired by Sir Simon Stevens set out a practical, evidence-based and quantified path to a 'Net Zero' NHS. In response to this call by the NHS for the ICS to develop a regional level approach to sustainability, the Derbyshire ICS Greener NHS Delivery Group, established by and chaired by Helen Dillistone has worked together with support from an external consultancy to develop this ICS Green Plan.

Each member organisation has its own individual Trust Green Plan, however this joint ICS Green Plan does not simply merge these individual plans; instead, it identifies elements which are better undertaken together, where co-ordination is required across organisations or where additional value can be brought to the system by working together. As such the ICS Green Plan sets out the sustainability plan and priorities for Derbyshire ICS for the next 3 years and will sit alongside, and build on, the individual Derbyshire Trust Green Plans.

## The JUCD ICS Green Plan

The Green Plan presents the regional-level carbon footprint data and outlines the national drivers, local drivers and targets, and the ICS's commitment to sustainability. It summarises the organisation-level Green Plans, including carbon hotspots and the sustainability strategies employed to address them.

The Green Plan describes a total of eleven interventions through which the strategies and priorities of Derbyshire NHS Trusts and Partners will be coordinated and integrated. A separate action plan outlines the ways and timescales by which our organisations will be held to account over reducing carbon emissions and making progress on achieving net-zero.

The draft Joined Up Care Derbyshire ICS Green Plan and Sustainable Action Plan is attached for information and approval.

The Derbyshire ICS Greener NHS Delivery Group is made up of the following organisations:

- Chesterfield Royal Hospital NHS Foundation Trust;
- Derby and Derbyshire Clinical Commissioning Group;
- Derbyshire Community Health Services NHS Foundation Trust;
- Derbyshire Healthcare NHS Foundation Trust;
- East Midlands Ambulance Service NHS Trust; and
- University Hospitals of Derby and Burton NHS Foundation Trust.

At the time of writing this report the Derbyshire ICS Green Plan has already been approved by the following Trust Boards.

- East Midlands Ambulance Services NHS Trust Board and Finance Committee approved the plan on the 1<sup>st</sup> March 2022. The feedback from the Board was positive and they asked how could the Board contribute more to the plan.
- Chesterfield Royal Hospital NHS Foundation Trust Board approved the plan on the 9<sup>th</sup> March 2022.
- Derbyshire Community Healthcare Services NHS Foundation Trust – The Trust Board gave delegated authority for the Quality Business Committee to approve the plan on their behalf on the 25<sup>th</sup> March 2022. The feedback from the Board was also positive however they had concerns regarding resources and funding to deliver the plan.
- University Hospitals Derby and Burton NHS Foundation Trust Board will approve the Derbyshire ICS Green Plan 10<sup>th</sup> May 2022.
- Derbyshire Healthcare NHS Foundation Trust Board will approve the Derbyshire ICS Green Plan on the 10<sup>th</sup> May 2022.

The Group, for certain areas of delivery, will also have a link to the work of the Anchor Institutions, and for estates related matters will link with to the system Finance and Estates Committee. The Derbyshire ICS Greener Group has representatives not just from each of the partner organisations, but also from relevant system workstream leads where there is natural link between priorities. For example, on strategic estates planning, and medicines management.

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

The successful delivery of this strategy may require commitment in resources both from within existing capacity but also may require additional funding for some of the actions. Where actions may require additional resource this will need to be assessed and agreed as appropriate by the relevant organisations and through appropriate system governance.

Currently, this Green Plan still has some unknowns. It indicates a need to provide ICS lead roles across some areas, such as communication and transport, as well as an overall ICS Sustainability Co-ordinator role.

There may also be other national or regional funding made available to support such roles, but this is unclear at present. Approval for this plan will need to be given on the basis that some funding or staff time could be requested in the future.

There are actions in this plan which imply other (non-staff) funding will be required. As these actions are taken forward each will be planned in more detail and costs identified. These plans will be managed at an ICS level, but the Board should be aware there may be a need to contribute funding or 'in-kind' resources to these plans as they develop. It is expected that any request for funding will only come after discussion with Member Trusts and the ICB and appropriate approvals have been given.

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

Individual projects within the action plan will require PIA as part of their planning.

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

Individual projects within the action plan will require PIA as part of their planning.

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

A good Green Plan should help to support equality and diversity as a sustainable system will work for all people. Individual projects will have full Equality Impact Assessments as part of their planning.

**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**

Patient, Public, Staff, Member and Stakeholder Involvement is crucial to the success of our Green Plans. Stakeholders will be involved as required within each area of action and further engagement will take place as projects develop.

**Have any Conflicts of Interest been identified / actions taken?**

Provide details as appropriate

<b>Governing Body Assurance Framework</b>
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GBAF Risk 3 - Ineffective system working may hinder the creation of a sustainable health and care system by failing to deliver the scale of transformational change needed at the pace required
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<b>Identification of Key Risks</b>
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Risk 42 - If the CCG does not prioritise the importance of climate change it will have a negative impact on its requirement to meet the NHS's Net Carbon Zero targets and improve health and patient care and reducing health inequalities and build a more resilient healthcare system that understands and responds to the direct and indirect threats posed by climate change
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# Joined Up Care Derbyshire

## ICS Green Plan 2022 - 2025



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## 1.0 FOREWORD

There is increasing evidence of the impacts of climate change upon the environment and human health. The UK's Climate Change Act 2008 sets a national target to achieve net-zero carbon emissions by 2050. The NHS has acknowledged its responsibility in this agenda and has committed to achieving a net-zero health service by 2045.

As part of this commitment, NHS England has made it mandatory for all Trusts and Integrated Care Systems (ICSs) to produce a board-approved Green Plan which establishes a sustainability strategy for the next 3 years.

This Green Plan is our response to this call, establishing the system-level strategy for sustainability at Joined Up Care Derbyshire ICS. Firstly, it presents our regional-level carbon footprint data and outlines our commitment to sustainability. Then it summarises our organisation-level Green Plans, including our carbon hotspots and the sustainability strategies employed to address them.

Lastly, we present a total of 11 interventions through which the strategies and priorities of Derby and Derbyshire Integrated Care Partnership (ICP) will be coordinated and integrated. A separate document outlines the ways and timescales by which our organisations will be held to account over reducing carbon emissions and making progress on net-zero.

Organisations across the Derbyshire ICP stand ready to tackle the causes of climate change and are collectively committed to improving our sustainability credentials. This Green Plan provides the framework and pathway to embed sustainability at an ICS level and delivering these partnership actions, alongside individual organisational commitments, must be a shared priority.



**Helen Dillistone**  
Net Zero Senior Responsible Officer, Derbyshire Integrated Care System

## 2.0 INTRODUCTION

### 2.1 Our ICS

Joined Up Care Derbyshire Integrated Care System is Derby and Derbyshire's recently formed ICS. We are constituted of a range of health and social care organisations, including local GP practices and NHS Trusts, which work collectively to plan, commission, and provide services to meet the needs of Derby and Derbyshire. We serve more than 1 million people across the East Midlands, including the populations of Derby city, Chesterfield, Ilkeston and Long Eaton, Amber Valley, the Derbyshire Dales, Bolsover District, High Peak, and Glossop (see Figure 1).

Our specialised services include treating cardiovascular, respiratory, and musculoskeletal diseases; strokes and cancers; and mental health problems. In addition, we have a core focus on preventative care, and work to ensure that factors contributing to poor health and health inequalities are addressed. We are passionate about our role in the local communities in which we serve and are keen to ensure that our impact on the environment is reduced.



Figure 1: Our Communities

### 2.2 What is Sustainability?

Sustainability has been defined by the United Nations Brundtland Report (1987) as:

*“...development that meets the needs of the present without compromising the ability of future generations to meet their own needs...”*

Sustainability is based upon environmental, economic, and social considerations. These three issues are often referred to as the ‘three pillars of sustainability’. To maximise the sustainability of our organisation, all three of these pillars must be aligned. An intervention which focuses on the environment but neglects economic and social aspects cannot be considered sustainable. Therefore, a sustainability strategy, such as this Green Plan, must look to integrate all three pillars of sustainability as far as possible.

A sustainable health and care system can be achieved by delivering high quality care and improved public health without excessively depleting natural resources, costing too much, or negatively impacting the health and wellbeing of staff and patients (see Figure 2).



**Figure 2:** Model of Sustainability for the Health and Care Sector

Addressing a single issue like air pollution provides a strong example of how all three pillars of sustainability can be improved as per the example below.

Air pollution is caused by excess emissions of pollutants such as particulate matter and harmful gases. This creates a negative environmental impact, through the consumption of fossil fuels and natural resources, the pollution of the environment, and by contributing to climate change.

From a social perspective, air pollution causes and exacerbates cardiovascular, respiratory, and mental health issues. It is estimated that high levels of air pollution contribute towards an annual 40,000 premature deaths in the UK. Air pollution also disproportionately impacts more deprived communities, creating health inequalities.

The increased incidence of illness also creates an economic impact. People suffering illness caused by air pollution may become so ill that they cannot work, negatively impacting their financial status. Additionally, high rates of illness within a population place increased stress on the NHS due to higher patient numbers and associated costs. NHS activity leads to an increase in carbon emissions, which in turn contributes to air pollution and more illness which places yet more demand on NHS services.

Consequently, working to reduce carbon emissions from NHS activities can deliver a more sustainable and equitable health and care system, as reduced air pollution will reduce the environmental, social, and economic impacts of Joined Up Care Derbyshire ICS.

### 2.3 What is Carbon Net-Zero?

Carbon net-zero, often referred to as being 'carbon neutral', is defined as a state in which an organisation avoids emitting greenhouse gases (GHGs) through its generation and use of energy, travel, waste, medicines, and supply chain. Achieving net-zero carbon emissions is a core aim of national and local policy and a key driver of this Green Plan.

To achieve net-zero emissions, Joined Up Care Derbyshire ICS must reduce emissions as much as possible, and then offset the remaining emissions. Within the NHS, there are instances where the generation of carbon emissions is unavoidable, for example, the need for anaesthetics. Where emissions cannot be reduced to zero, carbon offsetting through investment into bio sequestration (e.g. tree planting) and technology-based carbon capture and storage can be utilised to offset the residual emissions and achieve carbon net-zero.

## 2.4 Our System Strategy

Delivering a net-zero NHS has the potential to secure significant benefits across the population, and particularly for vulnerable and marginalised populations, addressing existing health inequalities. These benefits will only be fully realised through public participation, involvement, and engagement with those communities as this work progresses, having regard to the need to reduce health inequalities and considering the public sector equality duty.

As a key priority, the NHS and the local system will be working to reduce air pollution and improve local environments, thereby supporting the development of local economies in geographical areas of deprivation.

The agenda of Joined Up Care Derbyshire ICS is summarised in the ICS's Health Inequalities Green Plan on a Page (see Appendix B). The ICS seeks to reduce the avoidable and unjust differences in health outcomes for the population of Derby and Derbyshire. To fulfil this vision, the ICS aims to ensure that all people of Derby and Derbyshire have an equal chance to start life well, live well and remain well. The workstreams that Joined Up Care Derbyshire ICS will undertake to support this agenda comprise several key actions.

### 2.4.1 *Improve the estate and travel to increase access for staff and patients*

The NHS estate and its supporting facilities services – including primary care, trust estates and private finance initiatives – comprises 15% of the total carbon emissions profile. There are opportunities for emissions reductions in the secondary and primary care estates respectively, with significant opportunities seen in energy use in buildings, waste and water, and new sources of heating and power generation.

Delivering a net-zero health service will require work to ensure that new hospitals and buildings are net-zero compatible, as well as improvements to the existing estate. Joined Up Care Derbyshire ICS's strategy will support the capital and estates elements of the net-zero agenda in several ways. To ensure that the most disadvantaged communities, staff, and patients can have equal access to the NHS estate, Joined Up Care Derbyshire ICS will promote active travel – through, for example, using salary sacrifice schemes – and next-best low carbon alternatives where possible.

To improve access to a greener estate, Joined Up Care Derbyshire ICS will also ensure that all opportunities to 'green' the estate are maximised, with a focus on those areas within the most deprived communities. Joined Up Care Derbyshire ICS are planning for all major refurbishments and new builds to consider the need to reduce emissions, and that wherever possible maintenance or the replacement of equipment is undertaken in a way that improves energy efficiency and reduces emissions. For example, in the coming years, a series of new developments within Derbyshire Healthcare NHS Foundation Trust will be built with the aspects of greenery and greenspace at the heart of its estate.

### 2.4.2 *Align with the role of an anchor institution*

An anchor institution is an institution that, alongside its main function, plays a significant and recognised role in a locality by making a strategic contribution to the local economy through sizeable assets used to build wealth through spending power, workforce, buildings, and land. Anchor institutions can make a positive impact on wider determinants of health, for example in terms of supporting improvements to socioeconomic factors. By adopting the role of an anchor institution, ICSs therefore can have greater capacity to reduce health inequalities.

The role of an anchor institution is one that Joined Up Care Derbyshire ICS is looking to align to, and is considered a core component of the ICS's development. Joined Up Care Derbyshire ICS has established a System Anchor Group to develop its plans and approaches as anchor institutions. The System Anchor Group has linked formally with the NHS Derby and Derbyshire Integrated Care Board (ICB), as well as other system groups such as the People and Culture Board and the Derby City and Derbyshire County Health and Wellbeing Boards (HWBs).

Through this group, a range of priorities and opportunities that exist for Derbyshire's people and communities have been identified and progressed. These opportunities mainly pertain to our workforce and employability, due to the significant impact that Covid has had on the employment, health, and wellbeing of communities across the county. Recruitment, pay and working conditions, training and development, and health and wellbeing all form key priorities moving forward, and alongside our estate plans form a core component of our Green Plan.

## **2.5 About this Green Plan**

This Green Plan sets out the organisational strategy for sustainability at Joined Up Care Derbyshire ICS for the next 3 years, and responds to a call by the NHS for the ICS to develop a regional level approach to sustainability based on the sustainability strategies of their member organisations. It summarises and presents the interventions through which the strategies of the NHS Trusts of Joined Up Care Derbyshire ICS will be coordinated and integrated, whilst addressing the priorities of system-wide partners.

This Green Plan is structured as follows. Section 3.0 reviews the local and national legislative drivers and contractual requirements with which Joined Up Care Derbyshire ICS must align and establishes several targets to achieve a more sustainable performance. Section 4.0 details the carbon footprint of Joined Up Care Derbyshire ICS on both regional and Trust-level scales; discusses data on carbon emissions associated with the ICS's procurement processes; and provides narration on the actions that the Trusts of Joined Up Care Derbyshire ICS have determined in their Green Plans to address their respective environmental aspects. Section 5.0 outlines Joined Up Care Derbyshire ICS's commitment to sustainability and the methodology by which the ICS has gone about determining its combined sustainability strategy. Lastly, section 6.0 details Joined Up Care Derbyshire ICS's strategic sustainability objectives, the interventions that the ICS will deliver, and an explanation for how they will be delivered in an integrated way. It also outlines the benefits of the joint interventions and by whom they shall be led.

The successful delivery of this strategy will require commitment in resources both from within existing capacity but also may require additional funding for some of the actions. Where actions may require additional resource this will need to be assessed and agreed as appropriate by the relevant organisations and through appropriate system governance.

A separate Sustainable Action Plan to be delivered at the ICS level has also been provided as a framework to support the implementation of specific interventions and help monitor Joined Up Care Derbyshire ICS's sustainability progress (see Appendix A). It details how and by when the Trusts of Joined Up Care Derbyshire ICS will be held to account over reducing carbon emissions and making progress on net-zero.

This Green Plan was developed over the winter of 2021-22 and [has been approved by the ICS's respective NHS Trusts]. These include Chesterfield Royal Hospital NHS Foundation Trust (CRHFT), Derbyshire Community Health Services NHS Foundation Trust (DCHS), Derbyshire Healthcare NHS Foundation Trust (DHCFT), East Midlands Ambulance Service NHS Trust

(EMAS), and University Hospitals of Derby and Burton NHS Foundation Trust (UHDB). The Green Plan [will also be approved by the formal statutory NHS Derby and Derbyshire ICB in July 2022]. The actions and interventions included within this plan will start to be implemented from early 2022, with the timeframe of delivering the activity being 2022 to 2025.

### 3.0 THE REQUIREMENT FOR SUSTAINABLE HEALTHCARE ORGANISATIONS

A report published last year by the Intergovernmental Panel on Climate Change (IPCC) followed decades of updates which stressed the threats that climate change poses to the environment. In recent years, climate change has also been recognised as a significant risk to human health. The World Health Organisation (WHO), British Medical Association, and various Royal Colleges are just some of the organisations which view climate change as the greatest threat to global health of the 21st century. The urgency to act on sustainability is mirrored by various levels of guidance and legislation to which Joined Up Care Derbyshire ICS and this Green Plan responds.

#### 3.1 Driving the Net-Zero Transition in Healthcare

##### 3.1.1 National Drivers

In accordance with the Climate Change Act 2008, the UK has established a mandatory target to reduce carbon emissions to net-zero by 2050. The NHS is the UK's largest public sector employer and contributes up to 5% of the nation's carbon emissions. Therefore, it is essential that the organisation plays a vital role in supporting this national target.

In 2020, NHS England and Improvement (NHSE&I) released a report called *Delivering A Net Zero National Healthcare Service* which provides a sector-wide approach for achieving decarbonisation objectives in healthcare settings. Alongside a range of potential pathways, the plan sets two net-zero targets – to achieve net-zero by 2040 for the NHS Carbon Footprint and by 2045 for the NHS Carbon Footprint Plus. Figure 3 illustrates the scope of these two carbon footprints.

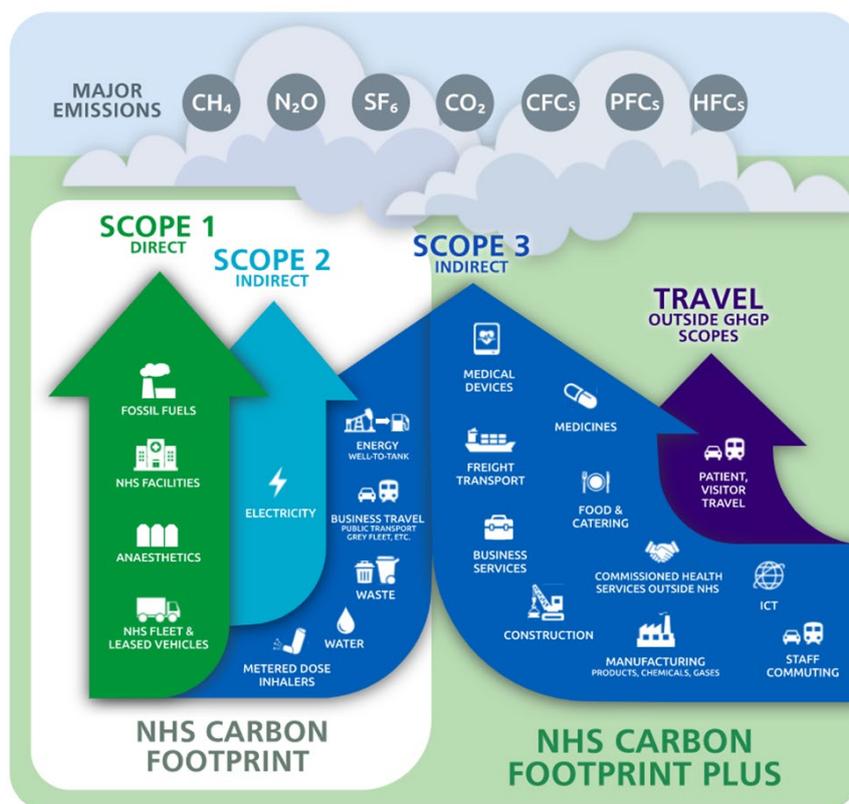


Figure 3: NHS Greenhouse Gas Emission Scopes

Simultaneously, the “For a Greener NHS Campaign” was published by the Chief Executive Officer (CEO) of NHSE&I, which provides top-down support to NHS organisations to decarbonise their operations, reduce their impact on the environment, and improve health. The campaign builds upon the work already being carried out within the NHS to improve sustainability, and will ensure that high-level backing is provided to support NHS organisations in their work to become net-zero.

To become a net-zero health service, reduce air pollution, and reduce waste the NHS requires the commitment of all Trusts, staff, and partners. An expert panel has subsequently been formed to map the best path for the NHS to become carbon net-zero, the findings of which shall be continually reviewed by the ICS and used to update this plan as required.

Additional drivers for sustainability in the NHS are set out in a suite of organisation-specific documents, which include the following:

- NHS Long Term Plan
- NHS Standard Service Contract 2021/22
- NHS Operational Planning and Contracting Guidance
- Delivering a Net Zero National Health Service

The *NHS Long Term Plan* details the method by which the NHS will develop until 2030, and includes considerations pertaining to sustainable development. The *NHS Standard Service Contract 2021/22* highlights several targets and objectives associated with sustainability within the NHS, including the reduction of water used and waste generated. The *NHS Operational Planning and Contracting Guidance* provides advice on the actions required to assist the organisation in achieving the national carbon reduction targets and to improve the NHS's resilience.

*Delivering a Net Zero National Health Service* provides details on the modelling and analytics that have been used to determine the NHS carbon footprint and future projections. It also covers the actions that will be implemented by the organisation to reduce emissions, including a series of immediate actions that must be taken to meet the 2040 net-zero target. To ensure that the NHS is on track to meet its long-term commitments and retains the ambition it requires to achieve them, this report will be continuously reviewed.

Significant progress has already been made on reducing carbon emissions within the NHS, with a 62% reduction between 1990 and 2020 having been achieved nationally through the implementation of several strategies. However, as climate change is growing in significance and the time available to address the problem diminishes, the number and scope of drivers for change are expected to increase. The NHS is continually updating guidance to ensure the organisation is tackling climate change effectively. This includes the new *Net Zero Carbon Hospital Standard*, which establishes best practice requirements for the integration of sustainability in capital projects and energy efficiency. Joined Up Care Derbyshire ICS will continue to engage with the NHS's sustainability agenda and will monitor legislation and guidance changes as progress towards net-zero is made.

### **3.1.2 Local Drivers**

The Local Authorities across the region in which the Trusts of Joined Up Care Derbyshire ICS operate have responded to the increasing pressure to act on climate change. In 2019, Derby City Council formally declared a climate emergency. Both Derby City Council and Derbyshire County Council have also established targets in accordance with national guidance to achieve carbon neutrality across the region.

Achieving the targets established across the above local authority areas will require all actors to make a sustained effort, and there is a clear commitment to reducing carbon emissions to net-zero throughout the region with the offering of support from the above partner organisations. Across the broad network of members in which Joined Up Care Derbyshire ICS operates, a collaborative approach will be taken to reducing emissions, as set out in this Green Plan.

## **3.2 Our Targets**

In line with the series of national and local drivers outlined above, the Trusts of Joined Up Care Derbyshire ICS will aim to achieve the following targets:

### **3.2.1 Carbon Reduction**

- Achieve a 100% reduction of direct carbon dioxide equivalent (CO<sub>2</sub>e) emissions by 2040. An 80% reduction (from a 1990 baseline) will be achieved by 2032 at the latest.
- Achieve a 100% reduction of indirect CO<sub>2</sub>e emissions by 2045. An 80% reduction (from a 1990 baseline) will be achieved by 2039 at the latest.

### **3.2.2 Air Pollution**

- Convert 90% of the fleet to low, ultra-low and zero-emission vehicles by 2028.
- Cut air pollution emissions from business mileage and fleet by 20% by March 2024.

### **3.2.3 Waste**

- Adopt a Zero to Landfill policy.

## 4.0 OUR ENVIRONMENTAL ASPECTS & STRATEGIES

Joined Up Care Derbyshire ICS is formed of five NHS Trusts, each of which accounts for a portion of the regional carbon footprint. Recent data reveals that the ICS's 2019-20 NHS Carbon Footprint emissions (Scopes 1 and 2) totalled 94,920 tCO<sub>2</sub>e, much of which derived from electricity and gas used to power buildings, business travel, and metered dose inhalers (see Figure 4). The carbon emissions associated with EMAS's fleet, data for which has been absorbed by Joined Up Care Derbyshire ICS due to its role as lead commissioner, also equalled 7,500 tCO<sub>2</sub>e in 2020-21, which in addition to the above equals an annual Carbon Footprint of roughly 102,420 tCO<sub>2</sub>e.

Meanwhile, Joined Up Care Derbyshire ICS's NHS Carbon Footprint Plus emissions (Scope 3) totalled 444,250 tCO<sub>2</sub>e in 2019-20, the majority of which came from the procurement of medicines and equipment, and some of which related to the commuting patterns of the ICS's workforce (see Figure 5). It is important to note that the Carbon Footprint Plus data below is not fully representative of the ICS's indirect emissions, and further information regarding the ICS's procurement related emissions can be found in the following section. Data is being continuously refined, and Joined Up Care Derbyshire ICS seeks to improve the reporting of its carbon footprint in years to come.

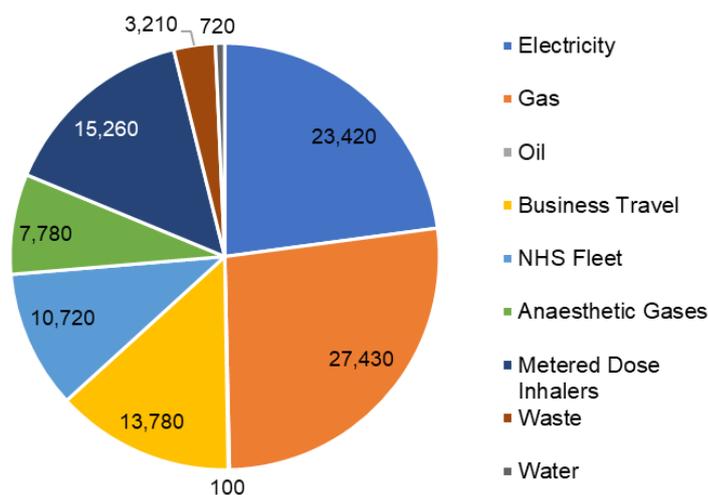


Figure 4: JUCD ICS Carbon Footprint (tCO<sub>2</sub>e)

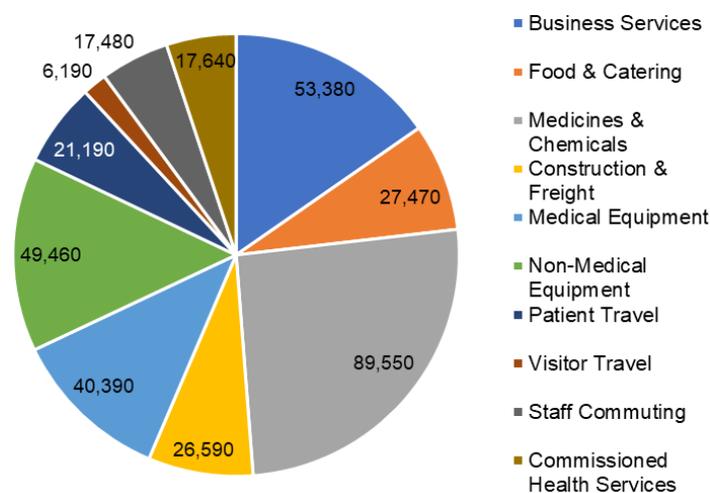


Figure 5: JUCD ICS Carbon Footprint Plus (tCO<sub>2</sub>e)

These graphs show Joined Up Care Derbyshire ICS's Carbon Footprint (Figure 4) and Carbon Footprint Plus (Figure 5) emissions from 2019-20 (including more recent data where necessary). The footprints are broken down into several categories, each of which is listed to the right of the graphs and represented by a colour.

The order by which these categories are listed corresponds to the order by which they appear in a clockwise sequence within the graphs. For example, in Figure 4, the first listed category of 'Electricity', represented by a medium blue, corresponds to the first wedge from the top of the graph reading '23,420 tCO<sub>2</sub>e'. The second listed category of 'Gas' corresponds to the orange wedge as found in clockwise direction after the 'Electricity' wedge.

In some cases, the quantity of carbon emissions associated with a particular category is comparatively small. For example, the use of oil across the ICS, which has been largely phased out and only used as a back-up energy supply, produced a total of only 100 tCO<sub>2</sub>e in 2019-20. Consequently, the grey coloured category of 'Oil' in Figure 4 is difficult to visualise. In such instances, the associated carbon emissions are represented only by the numerical figure which can be found around the edge of the graph next to the thin non-visible wedge it relates to.

## 4.1 CO2 Procurement Analysis

*[Placeholder for procurement analysis]*

The following sections provide summaries of each of Joined Up Care Derbyshire ICS's organisation-level Green Plans. Firstly, the Trusts' main environmental aspects and carbon hotspots are highlighted. Following this, each organisation's key actions, which have been determined at a Trust-level to address these aspects, are detailed. It is important to note that the data included has been provided by each Trust and has not been verified at a system-level. It is also important to note that the carbon data provided by each Trust was varied in size and scope. As such, the data discussed is indicative of our organisations' impacts and requires further analysis, a factor we are committed to working on, as will be outlined in Section 6.9.

### 4.1 Chesterfield Royal Hospital NHS Foundation Trust (CRHFT)

CRHFT is a medium-sized Trust employing around 3,400 staff and providing a range of health services to over 375,000 people. Its role as an acute care provider means that its carbon footprint large and diverse.



In 2019/20, its NHS Carbon Footprint totalled 9,567 tCO<sub>2</sub>e, formed mainly from the consumption of gas (5,757 tCO<sub>2</sub>e) and electricity (3,693 tCO<sub>2</sub>e). A reduction of 19% in total carbon emissions has been achieved since the Trust's baseline year of 2013/14. However, it is important to note that the Trust's Carbon Footprint does not include emissions other than those related to energy use in buildings, whilst its NHS Carbon Footprint Plus emissions have not been quantified. Consequently, there remains work to be done by the Trust to make progress on the NHS's 2040 and 2045 net-zero targets.

Over the next 4 years, the organisation will undertake actions across several areas to address its carbon footprint more urgently. CRHFT's Green Plan underlines the importance of its workforce in becoming a more sustainable organisation, with actions such as the integration of sustainability within recruitment processes and staff training. The Green Plan also has a focus on continuous improvement, with ambitions to replace carbon-intensive anaesthetic gases and assess the efficiency of delivery pathways concerning metered dose inhalers. The most pertinent action to address its quantified sources of carbon are the Trust's plans surrounding asset management and utilities. Emissions associated with energy usage will be reduced through a series of energy efficiency schemes, a switch to 100% renewable energy, and the use of more sustainable approaches to generating heat and power across its estate.

### 4.2 Derbyshire Community Health Services NHS Foundation Trust (DCHS)

DCHS is one of the largest Community Trusts in England providing specialist community health services. It employs over 4,200 staff and serves an average of 4000 patients per day across a range of community hospitals, clinics, GP practices, schools, care homes, and through visits to homes. Due to the wide geography across which its services are delivered, its carbon footprint is equally as expansive.



In 2020/21, its NHS Carbon Footprint totalled 7,775 tCO<sub>2</sub>e, formed mainly from the use of gas and oil (4,890 tCO<sub>2</sub>e), electricity (1,703 tCO<sub>2</sub>e), and business travel (1,057 tCO<sub>2</sub>e). Meanwhile, its NHS Carbon Footprint Plus adds 22,300 tCO<sub>2</sub>e, derived from the inclusion of

Procurement (20,489 tCO<sub>2</sub>e), commuting (1,557 tCO<sub>2</sub>e) and patient and visitor travel (254 tCO<sub>2</sub>e). This means that the Trust's total combined Carbon Footprint Plus for 2020/21 equaled 30,074 tCO<sub>2</sub>e. It should be noted that the above data does not yet include emissions from areas such as anaesthetic gases and metered dose inhalers, but these are relatively low for DCHS as a community trust. The Procurement emissions figures have only just been calculated, so further analysis is still required on these figures.

DCHS's Green Plan outlines the Trust's plans to undertake action on several key areas to reduce its carbon emissions over the next 3 years. First and foremost, the Trust will move away from unsustainable forms of heating and lighting through increased use of renewable energies, and improve the energy efficiency across its buildings through measures such as estate rationalisation. The Trust's reliance on business travel and outpatient visits has also led the Green Plan to highlight the need to reduce the use of transport by staff and patients. Consequently, actions include delivering services through digital means such as telehealth wherever appropriate, through optimised arrangements such as mobility hubs and centrally located treatment rooms, and offering staff alternative means of transport. Additionally, to make progress on the monitoring of Scope 3 emissions, DCHS will work with partners to comprehensively assess procurement-related carbon to identify the areas to be targeted for the most significant future reductions.

#### 4.3 Derbyshire Healthcare NHS Foundation Trust (DHCFT)

DHCFT provides mental health, learning disabilities, substance misuse services, and children's services to a population of around 1 million people. It employs over 2,800 staff operating from a series of community bases across the county. Its role as a mental health and community services provider means that its carbon footprint is reasonably small.



In 2020/21, its NHS Carbon Footprint totalled 3,226 tCO<sub>2</sub>e, formed from the use of energy across its sites. However, this figure does not include those carbon emissions associated with other primary sources such as business travel which may be significant due to the wide area across which the Trust travels and operates. The Trust plans to transform its existing estate in future years through the addition of new builds and upgrades. Resultingly, efforts to achieve the NHS's 2040 and 2045 net-zero targets must continue to be made by DHCFT.

The organisation's Green Plan outlines the actions it will take over the next 3 years to reduce carbon emissions and make progress on sustainability. To tackle the emissions associated with energy use across its estate, several key interventions involve running energy efficiency schemes and embedding a sustainability philosophy into all capital projects. To counter the emissions associated with business travel, a core element of DHCFT's sustainability strategy also involves taking advantage of digital solutions to increase the efficiency and flexibility of working processes and the delivery of care.

#### 4.4 East Midlands Ambulance Service NHS Trust (EMAS)

EMAS provides emergency and non-emergency services for approximately 4.8 million people across 5 counties. The Trust operates from over 70 premises across the East Midlands, including ambulance stations, control centres, fleet workshops, educational centres, and administrative offices.



In its Green Plan, EMAS provides an overview of the actions it will take throughout the next 3 years to tackle its carbon footprint. Operating 800 vehicles, the trust's fleet makes up 65% of the trust's direct emissions. Electric vehicle charging is therefore a priority to support the decarbonisation of the fleet which will have the biggest impact on reducing emissions. Some of the Trust's fleet-based emissions are currently largely unavoidable until technology develops, so non-emergency vehicles are being transitioned to zero emission first.

To tackle business travel emissions, travel policies will be revised to include environmental considerations, work will be conducted online where possible, and awareness over the impact of avoidable business travel will be promoted amongst staff.

EMAS will explore initiatives to reduce the climate impact of anaesthetic gas use, whilst building energy will be made more sustainable through the procurement of renewable alternatives and improvements to building efficiency.

#### 4.5 University Hospitals of Derby and Burton NHS Foundation Trust (UHDB)

UHDB is one of the largest hospital Trusts in the UK, comprised of hospitals located across 5 sites. It is responsible for managing acute, obstetrics and neonatal healthcare for a population of over 750,000 people. Given its significant size and scope, The Trust has a correspondingly large carbon footprint.



In 2020/21, its overall carbon footprint totalled 131,148 tCO<sub>2</sub>e, primarily constituted from procurement (122,994 tCO<sub>2</sub>e), utilities (4657 tCO<sub>2</sub>e), and food (2488 tCO<sub>2</sub>e). UHDB has managed to reduce its emissions by 35% since 2018/19, however there is clearly much greater progress to be made to achieve the NHS's 2040 and 2045 net-zero targets.

UHDB's Green Plan details of several key areas in which its carbon emissions shall be reduced over the coming years. A significant action focuses on the mobilisation of its workforce in the sustainability agenda, underpinned by interventions such as raising awareness of topics like sustainable procurement and waste management. Another important set of actions are focused on travel, with interventions such as offering cycling facilities and developing expenses policies to incentivise use of sustainable transport. Finally, the Trust has a core interest in enhancing the quality of greenspace through biodiversity plans, monitoring, and grounds work for the dual benefit of improving physical and mental wellbeing and carbon sequestration.

## 5.0 OUR COMMITMENT TO SUSTAINABILITY

As an ICS of diverse organisations, we recognise our responsibility to urgently minimise our contribution to climate change to improve the wellbeing of our local population. The health of Derbyshire's communities is notably affected by issues like air pollution, and are thus more vulnerable to the health problems it creates.

The Trusts of Joined Up Care Derbyshire ICS already have a strong commitment to sustainability. We want to ensure that high-quality care is provided in a way which does not negatively impact the environment, achieves positive financial performance, and contributes to the wellbeing of our communities. We have formed a series of strategic sustainability objectives to demonstrate this commitment and make progress on our targets.

### 5.1 Methodology

Our sustainability strategy has been developed using a structured process. Firstly, a review of sustainability across Joined Up Care Derbyshire ICS was undertaken. This involved scoping each Trust's Green Plan to understand the environmental impacts of the ICS's members and list the actions that have been formed by each to address carbon reduction. A combined total of 251 actions were identified and then grouped under thematic headings to assist their interpretation. These thematic headings were based on the Sustainable Development Action Tool (SDAT), a framework created by the NHS's Sustainable Development Unit (SDU) for exploring and tracking progress made on sustainability within the NHS. A new sustainability action framework is currently being developed for the NHS. Consequently, some of our Trust-level Green Plans have used the SDAT to categorise their actions, whilst some have not. To make our data collection consistent and enable the simplification and streamlining of the resulting analysis, the SDAT was selected as a thematic tool.

Secondly, an analysis was conducted of the actions identified. A trust-action matrix tool (see Figure 6) was used to uncover common themes and opportunities between Trusts which demonstrated potential for partnership working and collective implementation. These overlapping action areas are underpinned by a combined total of 213 relevant actions which were sourced from the prior review of individual Trust Green Plans (and do not constitute an action plan for the ICS Green Plan). The resulting action summaries are by no means exhaustive in agglomerating interventions committed to at an individual level. Where Trusts have committed to actions which diverge from the interests of others, these were excluded unless they reasonably contributed towards system-level priorities. Conversely, some of the action areas may indeed be new for organisations within Joined Up Care Derbyshire ICS. In these cases, the action areas resemble a work-in-progress for the Trusts who will look to progress their own actions to achieve synergy with Joined Up Care Derbyshire ICS's areas of interest.

SDAT Module	Action Summary	Relevant Actions
Our People	Education, training & engagement	35
	Transformation & continuous improvement	47
	Anchor institution & community focus	15
Sustainable Care Models	Digitisation of work & practice	19
Travel & Logistics	Active travel	16
	Electric vehicles & infrastructure	19
Asset Management & Utilities	Energy efficiency	10
Adaptation	Adaptation planning	7
Carbon & GHGs	Data monitoring & analysis	7
Corporate Approach	System sustainability	20
Sustainable Use of Resources	Waste management	18

**Figure 6:** Joined Up Care Derbyshire ICS's Current Organisation Sustainability Themes and Actions

The development of the strategic sustainability objectives was then established, with the resulting interventions developed through an assessment of their deliverability. This included a consideration of the roles required to coordinate the interventions at a system-wide level and the organisations best placed to adopt these roles, and the benefits that each intervention may present such as carbon or cost savings and social value aspects. A risk assessment of each intervention and the generation of associated mitigation measures was also undertaken.

To inform the plan and shape a joined-up sustainability strategy, a workshop was conducted with senior leaders and colleagues from across Joined Up Care Derbyshire ICS. A discussion was held over the merits of each intervention being jointly delivered, which enabled the further shortlisting and refinement of the interventions. The workshop concluded with the establishment of consensus amongst partners on the interventions to be pursued and the ICS-wide strategic objectives to be expressed. To ensure the strategy reflects the priorities of wider regional actors, further discussions were held with key partners such as Derbyshire County Council, Derby City Council, and GP Practices which play a significant role in meeting sustainability targets.

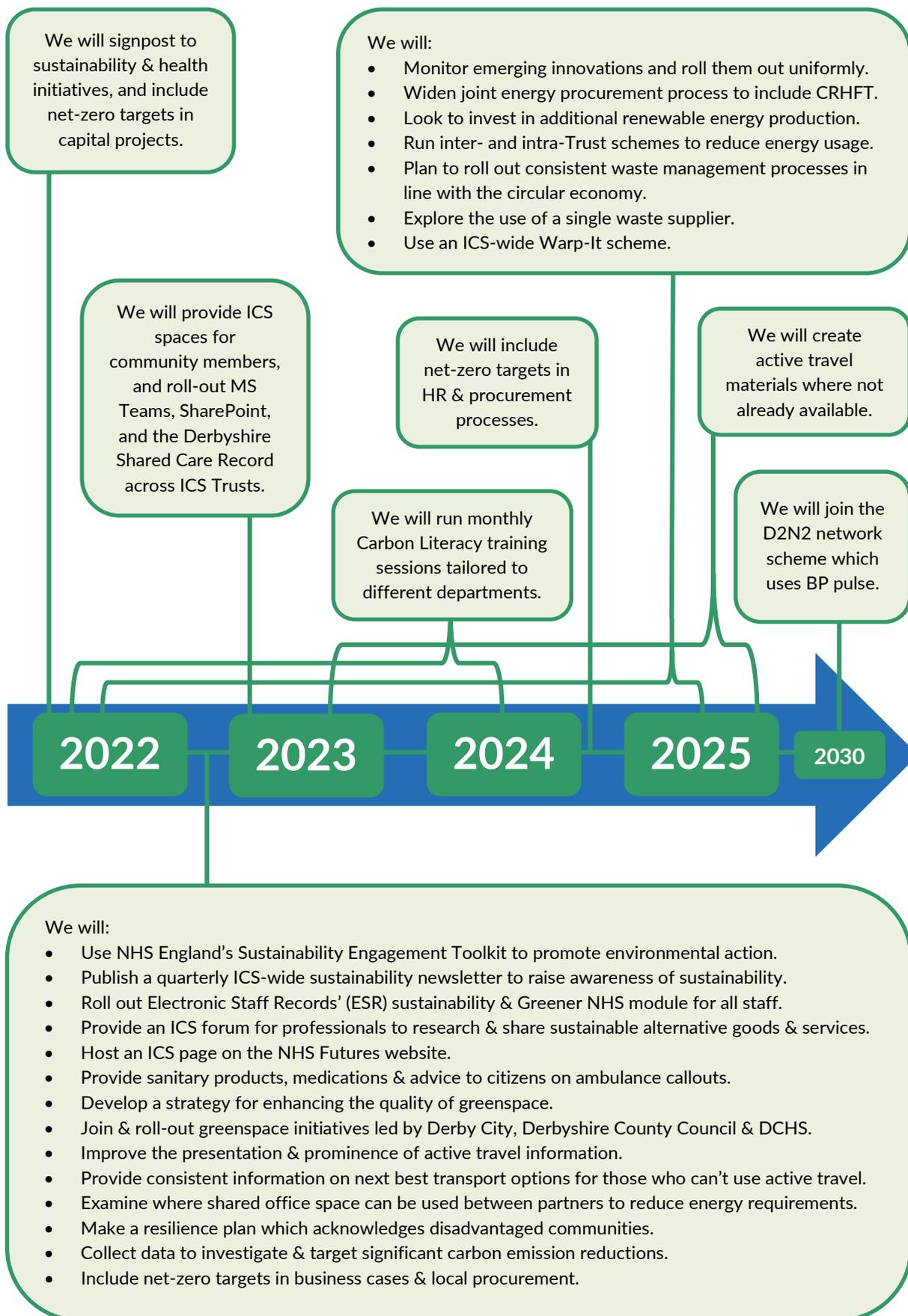
Our strategic sustainability objectives have been created to support Joined Up Care Derbyshire ICS's overall strategic objectives on improving health and patient care, addressing health inequality, and building a resilient healthcare system. By undertaking the interventions outlined in the following section, the ICS will make progress on realising its vision to become a sustainable healthcare organisation.

## 6.0 OUR JOINED-UP SUSTAINABILITY INTERVENTIONS

The visions and strategic sustainability objectives of Joined Up Care Derbyshire ICS are presented in Table 1. A timeline for the associated interventions and their expected completion dates has also been provided (see Figure 7). Further details of these objectives are presented in Appendix A.

Vision	Strategic Objective
An agile and informed workforce which understands sustainability and is empowered to make sustainable choices in their professional and personal lives.	Promote and increase awareness of sustainability through communications, education, and training.
An ICS where low-carbon best practice is readily identified, shared, and rolled out between partners.	Provide an ICS-wide forum for discipline-specific collaborative professional networks.
An anchor institution which improves the physical and mental health of its patients and communities, addresses health inequalities, and helps to build a resilient healthcare system.	Create and operate an ICS-level community outreach hub through which initiatives can be promoted and signposted to those disadvantaged by health inequalities.
An ICS which strategically utilises digital innovation.	Collectively utilise and share digital platforms and applications to increase the efficiency of working practices and care.
An inspired workforce and patient base who feel confident and incentivised to make active transport choices where able to do so.	Collectively promote, encourage, and provide access to active travel options through consistent communications.
An ICS which is prepared for the nation-wide transition to zero emission vehicles.	Establish and consolidate an ICS-wide system of shared charging point infrastructure for staff and Trust electric vehicles.
An ICS of driven and committed partners which pursue energy reduction and efficiency measures.	Collectively utilise a 100% renewable energy provider and seek additional energy efficiency opportunities.
An ICS which is prepared for a future of uncertain climatic conditions.	Collectively develop a strategy for enhancing the resilience of care to extreme weather events.
An ICS which has detailed oversight and knowledge of its carbon footprint to drive systemic change through data-led intelligence.	Build a network of accountable trans-departmental figures to investigate, monitor, and collate carbon data associated with the ICS's activities.
An ICS where sustainability has been mainstreamed into systems and processes to improve environmental health, social value, and staff experiences.	Create a strategy for developing and embedding sustainability throughout all ICS activities.
An ICS which adopts the circular economy.	Develop guidelines for dealing with materials and waste in an environmentally sound and uniform approach.

**Table 1:** Our Strategic Sustainability Objectives



**Figure 7: Joined Up Care Derbyshire ICS's Timeline for Sustainability Interventions**

## **6.1 Promote and increase awareness of sustainability**

A common vision amongst Joined Up Care Derbyshire ICS is that of workforce which feels empowered to make sustainable lifestyle choices as a result of an increased understanding of sustainability. To achieve this, we will jointly promote and increase awareness of sustainability through communications, education, and training arrangements. Overseen by our ICS HR Lead, our actions will include publishing a quarterly sustainability newsletter, running monthly Carbon Literacy sessions across different departments, and rolling out sustainability and Greener NHS modules for all staff. Awareness-raising efforts will also be underpinned by the Greener NHS Campaign Toolkit, which provides guidance and resources for engaging staff in sustainability. Joined Up Care Derbyshire ICS is hopeful that the collective mobilisation of our workforce across the region will build a regional culture shift and create greater savings in both carbon emissions and costs.

## **6.2 Provide an ICS-wide forum for professional networks**

Joined Up Care Derbyshire ICS seeks to become an ICS where best practice concerning low-carbon products and practices is readily identified, shared, and rolled out. To achieve this, the ICS will provide a regional forum for discipline-specific professionals to collaborate and share knowledge. A new ICS-level Sustainability Coordinator will create, facilitate, and coordinate a forum for staff to research and assess sustainable alternatives to carbon-intensive works, goods, and services. To build interest in the forum, we will host an ICS page on the NHS Futures website, and use the quarterly sustainability newsletter to promote the forum's activities and achievements. The sharing of best practice will increase the likelihood that goods are purchased by Trusts in the most environmentally and financially efficient manner.

## **6.3 Create an ICS-level community outreach hub**

An overlapping vision of the Trusts of Derbyshire ICS is for all Trusts to enhance their roles as anchor institutions which improve the health of their communities, address health inequalities, and help to build a resilient healthcare system. This agenda is summarised in Joined Up Care Derbyshire ICS's Health Inequalities Green Plan on a Page (see Appendix B). To realise this ambition, the ICS will create and operate a system-level community outreach hub where initiatives and opportunities can be promoted to enable disadvantaged groups to access them. We will signpost, join, and roll-out a series of existing initiatives such as 'Warmer Derbyshire' led by Derbyshire County Council to address the wider environmental determinants of health. However, our actions will extend beyond mere promotion. We will also seek to provide spaces such as meeting rooms for community group activities, and sanitary products, medications, and advice on ambulance callouts. Lastly, we plan to develop an ICS-wide strategy for enhancing the quality of greenspace across our Trusts to realise the co-benefits of reduced air pollution and carbon emissions, and increased physical and mental health. The involvement of local people in the ICS's activities, including greenspace initiatives, will enhance relationships within and between the organisation and communities.

## **6.4 Collectively utilise digital platforms and applications**

Joined Up Care Derbyshire ICS aspires to become an ICS which strategically utilises digital innovation for the benefit of its workforce, patients, and the environment. To achieve this, we plan to collectively use and share digital platforms and applications to increase the efficiency of working practices and care. Overseen by the Derbyshire Digital and Data Board, we plan to roll out applications such as MS Teams, SharePoint, and the Derbyshire Shared Care Record across our Trusts, as well as uniformly monitoring emerging technological approaches and

digital innovations. The transition to digital services in care will lead to increased carbon savings, whilst sharing applications may save costs on subscriptions.

### **6.5 Collectively promote, encourage, and provide access to active travel**

Joined Up Care Derbyshire ICS has a vision of an inspired workforce and patient base who feel confident and incentivised to make active transport choices. To realise this ambition, we will seek to collectively promote, encourage, and provide access to active travel through consistent communications across the ICS. Led by our organisation-level Travel and Transport Leads, our actions will include the creation of active travel information and materials, and provision of signposting across our Trusts and partners to ensure the information is available and accessible. For those who cannot use active transport methods, the ICS will provide information on next-best alternatives. Joined Up Care Derbyshire ICS hopes that the collective promotion of active travel will lead to healthier communities and reduced future pressures on the region's health services.

### **6.6 Establish an ICS-wide system of charging points**

Joined Up Care Derbyshire ICS aspires to become an ICS which is prepared for the nation-wide transition to zero emission vehicles. A timely opportunity has arisen for the ICS to achieve this by aligning itself with regional plans for a system of shared EV infrastructures. Once more led by our Travel and Transport Leads, early-stage discussions are currently being held regarding the opportunity for the ICS to join Derbyshire County Council's D2N2 network scheme. This scheme will see the construction of an additional 782 BP pulse charging points to an existing 218 by 2025 for sharing between NHS staff and patients, other public sector organisations, and wider communities. If successful, the upscaling and standardisation of charging points across the region will provide Joined Up Care Derbyshire ICS with a reliable, secure, and consistent supply of electricity underpinned by joint procurement costs.

### **6.7 Collectively utilise a 100% renewable energy provider**

Joined Up Care Derbyshire ICS strives to become an ICS of driven and committed partners which pursue energy reduction and efficiency opportunities. To fulfil this ambition, we will seek to collectively utilise a 100% renewable energy provider and explore other energy efficiency measures. Our organisation-level Energy Managers will oversee the integration of CRHFT into our existing joint energy procurement process. In addition to purchasing REGO-backed energy, we will also look to invest in increased renewable energy production through PPAs at a local scale for private use by the ICS. Our other actions involve examining where office space can be shared between partners, and running a series of inter-and-intra Trust schemes to both optimise and drive down energy usage. The collective use of a single energy supplier and competitions will lead to savings in both carbon and costs.

### **6.8 Collectively develop a strategy to enhance the resilience of care**

The potential impacts of climate change pose a threat to the health and safety of future generations. Joined Up Care Derbyshire ICS seeks to be prepared for a future climatic uncertainty through the collective development of a strategy to enhance the resilience of care to extreme weather events. Our emergency planning group Leads will create a resilience plan – scoped with the assistance of the National Audit Office's Climate Change Risk Assessment Guide, and applied through an ICS workshop – which pays particular attention to the potential impacts of climate change on disadvantaged communities. An ICS-wide approach to adaptation is hoped to enhance the resource security of our Trusts across the region.

## **6.9 Build a network of trans-departmental figures to collate carbon data**

A common vision amongst the members of Joined Up Care Derbyshire ICS is that of an ICS which has extensive oversight and knowledge of its carbon footprint to drive associated reductions in emissions. As seen in Section 4.0, the data we have on our carbon footprint is limited in that we haven't been able to explore our emissions in detail. To target the most significant carbon reductions, our ICS Lead will build and lead a network of accountable trans-departmental figures to investigate, monitor, and collate carbon data associated with our activities. To support the intervention, we will call upon the assistance of our Clinical Support Unit through which the ICS commissions data intelligence services. An ICS-level approach to tracking and targeting carbon hotspots is hoped to offer a considerable improvement to the data currently amalgamated under the banner of NHS Midlands.

## **6.10 Create a strategy for embedding sustainability throughout the ICS**

Carbon emissions cannot be reduced solely through promotion and awareness raising. To improve environmental health, social value, and staff experiences, Joined Up Care Derbyshire ICS envisions becoming an ICS where sustainability has been embedded into all organisational systems and processes. Our new Sustainability Coordinator will create a strategy which focuses on the inclusion of net-zero targets across staff recruitment, employment, and appraisal processes; capital projects; and business cases, as well as focusing on the procurement of local goods and services where possible. Joined Up Care Derbyshire ICS is hopeful that the collective use of metrics to integrate sustainability across ICS would lead to a more equitable landscape of employment benefits and potentially lead to increased staff retention.

## **6.11 Develop guidelines for dealing with materials and waste**

A common theme amongst our members' Green Plans is the need for effective and sustainable waste management. Joined Up Care Derbyshire ICS has a vision to become an ICS which adopts the circular economy. To achieve this, we will develop guidelines for dealing with materials and waste in an environmentally sound and uniform approach. Our organisation-level Waste Managers will plan for the roll out of consistent waste management processes across the ICS in line with circular economy principles. Other actions will include the exploration of the use of a single waste management supplier, as well as the collective use of the Warp-It re-use application at an ICS level. The standardisation and promotion of waste management measures across Joined Up Care Derbyshire ICS is hoped to enable staff to intuitively deal with waste through the appropriate method, making considerable savings on carbon emissions and disposal costs.

## 7.0 GLOSSARY OF TERMS

**Air Pollution:** the presence and introduction into the air of a substance which is harmful to human health.

**Carbon Intensity:** a means of calculating the amount of carbon generated for a specific energy source (e.g. electricity).

**Carbon Net-Zero:** a state in which an organisation emits no carbon emissions from its activities. Or a state in which all remaining carbon emissions are offset.

**CO<sub>2</sub>e (Carbon Dioxide Equivalent):** a unit used to express total greenhouse gas emissions. There are multiple GHGs, each with a different impact on climate change. CO<sub>2</sub>e equates all GHGs to the impact of carbon dioxide. CO<sub>2</sub>e is used to report all GHG emissions.

**Greenhouse Gas (GHG):** a gas that contributes to the greenhouse effect, leading to climate change (e.g. CO<sub>2</sub>).

**Global Warming Potential (GWP):** a measurement that enables the comparison of global warming impacts of different greenhouse gases.

**kWh (Kilowatt Hours):** a unit of measurement for energy usage (e.g. gas and electricity).

**Direct Emissions:** CO<sub>2</sub>e emissions from sources which are owned or controlled by the Trust.

**Indirect Emissions:** CO<sub>2</sub>e emissions from sources which are not owned or controlled by the Trust, but are generated due to the Trust's activities (e.g. purchase of electricity, procurement, waste disposal).

**Scope 1 Emissions:** direct emissions from owned or controlled sources (e.g. on-site fuel combustion, company vehicles, anaesthetic gases).

**Scope 2 Emissions:** indirect emissions from the generation of purchased electricity, steam, heating, and cooling.

**Scope 3 Emissions:** all other indirect emissions that occur in an organisation's supply chain (e.g. purchased goods, employee commuting, waste disposal).

## Appendix A: strategic sustainability objectives of the Derbyshire ICS

No.	Vision	Strategic Objective	Intervention Detail	Timescale	Role	Benefits	Risks
1	An agile and informed workforce which understands sustainability and is empowered to make sustainable choices in their professional and personal lives.	Promote and increase awareness of sustainability through communications, education, and training.	Sustainability engagement toolkit from NHS England.	2022/23	[ICS HR Lead]	Collective mobilisation of the ICS workforce will lead to a regional culture shift which creates greater carbon and energy cost savings.	Must ensure interventions are tailored to Trust/department level for biggest impact.  Voluntary nature of interventions risks diminished focus on sustainability.  Intervention lead requires strong communication skills.
			Quarterly ICS-wide publication/sustainability newsletter.	2022/23	[Group of Trust-specific HR Leads]		
			Electronic Staff Records' (ESR) sustainability and Greener NHS module rolled out for all staff.	2022/23	[Sustainability Coordinator - NEW]		
			Monthly ICS-led Carbon Literacy training sessions tailored to different departments (e.g. Estates, Theatres, Procurement).	2022-2024			
2	An ICS where low-carbon best practice is readily identified, shared, and rolled out between partners.	Provide an ICS-wide forum for discipline-specific collaborative professional networks.	Provide, facilitate, and coordinate an ICS forum for groups of professionals to research, explore, review, and assess sustainable alternatives to carbon-intensive works, goods, and services.	2022/23	[Sustainability Coordinator - NEW]	Sharing best practice will ensure many works, goods, and services are not paid for multiple times, improving the financial sustainability of the ICS.	Time required of staff to collaborate and share ideas may be significant.
			ICS page hosted on the NHS Futures website.	2022/23			
			Quarterly ICS-wide publication/sustainability newsletter (including details of actions and news).	2022/23			
3	An anchor institution which improves the physical and mental	Create and operate an ICS-level community	Provision of ICS spaces for community members (e.g.	2023	[To be nominated by	Involvement of local people in ICS	Requires the commitment of

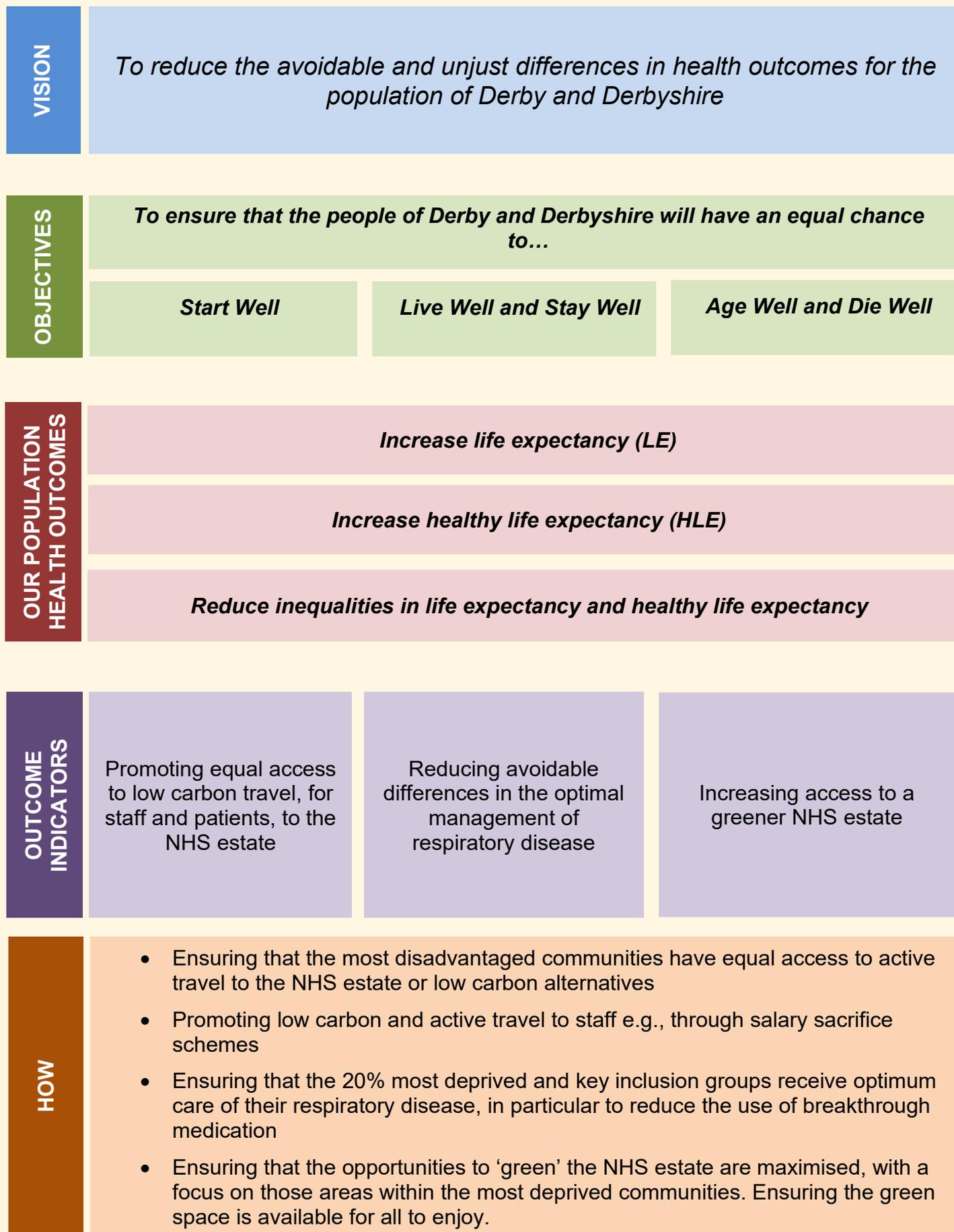
No.	Vision	Strategic Objective	Intervention Detail	Timescale	Role	Benefits	Risks
	health of its patients and communities, addresses health inequalities, and helps to build a resilient healthcare system.	outreach hub through which initiatives can be promoted and signposted to those disadvantaged by health inequalities.	meeting rooms for community group activities).		Directors of Public Health]	activities will enhance social value, community relationships and reputational benefits.  A regional approach to enhancing greenspace may lead to a more equitable distribution of physical and mental health benefits.	more time and resources.  Need to diversify greenspace strategy amongst Trusts due to differences in estate.
		Signposting to initiatives (e.g. Warmer Derbyshire).	2022				
		Provision of sanitary products, medications, and advice by ambulance staff to citizens.	2022/23				
		Collectively develop a strategy for enhancing the quality of greenspace which addresses air pollution, climate change, and adaptation aspects.	2022/23				
		Join/roll-out existing greenspace initiatives led by Derby City, Derbyshire County Council, and DCHS.	2022/23				
4	An ICS which strategically utilises digital innovation.	Collectively utilise and share digital platforms and applications to increase the efficiency of working practices and care.	Roll-out and use of MS Teams, SharePoint, and the Derbyshire Shared Care Record across ICS Trusts.	2023	Ged Connelly-Thompson	Transition to digital services and care will lead to carbon savings, whilst sharing applications will save on subscription costs.	Data protection and security risks.
			Monitoring emerging approaches and innovations and rolling them out uniformly.	2022-2025	Jim Austin		
5	An inspired workforce and patient base who feel confident and	Collectively promote, encourage, and	Improve the presentation and prominence of active travel information.	2022/23	[Travel & Transport Lead - NEW]	Promotion of active travel on wide scale	Must ensure active travel methods are compatible with

No.	Vision	Strategic Objective	Intervention Detail	Timescale	Role	Benefits	Risks
	incentivised to make active transport choices where able to do so.	provide access to active travel options through consistent communications.	Creation of materials where not already available.	2023-2025		will lead to healthier communities and reduced future health service pressures.	regional infrastructure and transport networks to avoid safety risks.
			Inter-organisation signposting to ensure that information is available (could be with external partners, e.g. Council).	2022/23			
			For those who cannot use active travel, the ICS will provide consistent information on next best transport options.	2022/23			
6	An ICS which is prepared for the nation-wide transition to zero emission vehicles.	Establish and consolidate an ICS-wide system of shared charging point infrastructure for staff and Trust electric vehicles.	Join D2N2 network scheme which uses BP pulse.	2030	[Travel & Transport Lead – NEW]	Shared charging points will provide staff and Trust vehicles with regional security of electricity supply.  Potential for shared procurement and reduced costs.	Must ensure same system (e.g. one card or application) is rolled out on regional level to support consistent site updates and usage.  Short-term expense.
7	An ICS of driven and committed partners which pursue energy reduction and efficiency measures.	Collectively utilise a 100% renewable energy provider and seek additional energy	Widen joint energy procurement process to include CRHFT.	2022-2025	[Procurement Managers]	Inter-trust schemes will lead to carbon reductions, whilst collectively signing on to	Risk of poor resilience should energy provider fail to provide service.
			Look to invest in additional renewable energy production (e.g. through a PPA) at a local level for private use by the ICS	2022-2025	[Energy Managers]		

No.	Vision	Strategic Objective	Intervention Detail	Timescale	Role	Benefits	Risks
		efficiency opportunities.	in addition to purchasing REGO-backed sources.			one renewable energy provider could save on financial costs.	
			Examine where shared office space can be used between partners to reduce overall energy requirements.	2022/23			
			Run intra- and inter-Trust schemes and competitions to drive down energy usage.	2022-2025			
8	An ICS which is prepared for a future of uncertain climatic conditions.	Collectively develop a strategy for enhancing the resilience of care to extreme weather events.	<p>A resilience plan which pays particular attention to disadvantaged communities, ensuring no one is left behind.</p> <p>Resilience plan to be scoped with National Audit Office's Climate Change Risk Assessment Guide, applied through an ICS workshop.</p>	2022/23	<p>[Lead of county-wide emergency planning groups]</p> <p>[Sustainability Coordinator – NEW]</p>	A regional approach to adaptation might enhance Trust relationships, resilience, and resource security.	Must ensure strategy accounts for all Trusts' individual circumstances and services.
9	An ICS which has detailed oversight and knowledge of its carbon footprint to drive systemic change through data-led intelligence.	Build a network of accountable trans-departmental figures to investigate, monitor, and collate carbon data associated with the ICS's activities.	<p>Widespread collation of data used to investigate and target the most significant carbon emission reductions.</p> <p>Call upon the Clinical Support Unit, through which the CCG commissions data intelligence services, to support intervention.</p>	2022/23	[ICS Lead]	An ICS-level approach to tracking carbon footprint to monitoring and identifying where further carbon reductions can be achieved would be a considerable	<p>Requires a lot of time and resources.</p> <p>Must ensure consistent information format and scope for uniform approach across ICS.</p>

No.	Vision	Strategic Objective	Intervention Detail	Timescale	Role	Benefits	Risks
						improvement to NHS Midlands carbon data.	
10	An ICS where sustainability has been mainstreamed into systems and processes to improve environmental health, social value, and staff experiences.	Create a strategy for developing and embedding sustainability throughout all ICS activities.	Inclusion of net-zero targets across:	2024/25	[Sustainability Coordinator – NEW]  [Senior Operational Lead]	Using shared metrics to integrate sustainability across ICS would lead to a more equitable employment and work benefits landscape.	Shared sustainability criteria may create non-ideal approach to addressing sustainability at Trust-level.
			Staff recruitment, employment, and appraisal processes				
			Capital projects	2022			
			Business cases	2022/23			
			Local procurement	2022/23			
Procurement contracts and tenders	2024/25						
11	An ICS which adopts the circular economy.	Develop guidelines for dealing with materials and waste in an environmentally sound and uniform approach.	Plan for the roll out of consistent waste management processes in line with circular economy principles across ICS.	2022-2025	[Waste Managers]	Enables staff to intuitively know and deal with waste in the appropriate way, saving carbon emissions and waste disposal costs.	Requires a lot of time and resources for minimal carbon savings.  Waste management processes are complex due to different arrangements in all Trusts, so may not be possible.
			Explore the use of a single waste management supplier.	2022-2025			
			Collectively use an ICS-wide Warp-It scheme.	2022-2025			
			Assess additional recyclable streams (e.g. toothpaste tubes, toothbrushes, medical blister packs), the outcome of which will allow the ICS to work with new start-ups to see if new collection scheme can support recycling activities.	2022-2025			

## Appendix B: JUCD Health Inequalities – Green Plan on a Page



# Joined Up Care Derbyshire



## Governing Body Meeting in Public

7<sup>th</sup> April 2022

		<b>Item No: 007</b>
<b>Report Title</b>	2022/23 Operational Planning – draft submission	
<b>Author(s)</b>	Helen Wilson, Deputy Director of Contracting and Performance	
<b>Sponsor (Director)</b>	Zara Jones, Executive Director of Commissioning Operations	

Paper for:	Decision	Assurance	Discussion	X	Information
<b>Assurance Report Signed off by Chair</b>			N/A		
<b>Which committee has the subject matter been through?</b>			JUCD SLT		
<b>Recommendations</b>					
The Governing Body is requested to <b>NOTE</b> the draft operational plan submitted to NHSE in March and <b>NOTE</b> the current gaps in compliance with NHSE targets and further work required before the final submission.					
<b>Report Summary</b>					
<b>22/23 Operational Planning Requirements</b>					
This paper provides a summary of the main 22/23 operational planning requirements and our draft submission completed in March. The main points of the submission are as follows:					
<ul style="list-style-type: none"> <li>• Elective activity requirements – Trusts are required to restore their elective activity to 104% of 19/20 levels and to eliminate 78 and 104 week waits and achieve improvement in 52 week waits. The activity plan submitted to date falls short of these targets. In some cases, this is due to differences between the recording of current and baseline activity but there are also shortfalls in planned delivery and work is ongoing to achieve improvement in compliance. We are hoping to submit a compliant plan by the final submission date.</li> <li>• Diagnostic activity requirements – Trusts are required to restore diagnostic activity to 120% of 19/20 activity. Plans submitted to date fall short of the planning requirements, but remodelling is continuing to identify whether the plan can be achieved. Introduction of Community Diagnostic Centres during the year will support later improvement of the position and we are modelling this impact into the final plan submission.</li> <li>• Outpatient Follow-up reduction – Work is continuing on the outpatient transformation plan to support this requirement.</li> <li>• Trajectories have been agreed with NHS England for the improvement of the Mental Health targets that are not currently compliant with requirements.</li> </ul>					

- Financial plan - The system is currently planning for a deficit position as a system, due to a reduction in non-recurrent income as a result of changes to COVID funding, as well as in year cost pressures.
- Workforce plan - The system is currently planning for an overall increase in its substantive workforce by 4%. This will be carefully managed by increasing recruitment, retention and growing our own workforce incentives. The plan is to reduce bank and agency staffing to ensure we deliver the growth required within the financial envelope. We plan to increase our nursing workforce by over 5%, supporting the achievement of the national target for growth in this workforce and ensuring safer staffing levels are achieved. It should be noted that whilst the overall plan is on target, there are pressured areas within the overall workforce that may impact on delivery of specific areas of the plan.

The DDCCG Governing Body is requested to confirm their understanding and approval of the current plan position.

**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**

GBAF Risk 3 - Ineffective system working may hinder the creation of a sustainable health and care system by failing to deliver the scale of transformational change needed at the pace required.

**Identification of Key Risks**

Key risks are identified within the report

# 2022/23 Planning Priorities

Draft Plan Update – DDCCG Governing Body  
– Public Meeting – 7.4.22

Date	Requirement
<b>24 December</b>	Planning guidance published
<b>w/c 14 January</b>	Detailed Planning Guidance released
<b>w/c 4 January</b>	Summary presentations to System Planning and Co-ordination Group and CCG SLT
<b>w/c 17 January</b>	Individual meetings with submission leads began
<b>21 January</b>	Gap Analysis for SODB
<b>w/c 24 January</b>	System Planning Task and Finish Group meetings begin
<b>28 February</b>	First narrative and metric returns to Planning team
<b>3 March</b>	NHSE draft plan discussion at System Planning and Coordination Group
<b>4 March</b>	Acute narrative and metric returns to Planning team
<b>11 March</b>	JUCD SLT draft plan review
<b>8-17 March</b>	Circulations to Delivery Boards by Programme Leads
<b>17 March</b>	Draft plan submission – Activity and Performance, Workforce, Finance, Narrative plan
<b>7 April</b>	CCG Governing Body – draft plan review
<b>26 April</b>	JUCD SLT final plan approval
<b>28 April</b>	Final plan - Activity and Performance, Workforce, MH Workforce draft, Finance, Narrative
<b>5 May</b>	CCG Governing Body – final plan review
<b>16 June</b>	ICB Board – final plan presentation
<b>23 June</b>	Final MH workforce submission

# 22/23 Planning – Draft Submission

## 22/23 Operational Planning Requirements

This paper provides a summary of the main 22/23 operational planning requirements and our draft submission completed in March. The main points of the submission are as follows:

- Elective activity requirements – Trusts are required to restore their elective activity to 104% of 19/20 levels and to eliminate 78 and 104 week waits and achieve improvement in 52 week waits. The activity plan submitted to date falls short of these targets. In some cases, this is due to differences between the recording of current and baseline activity but there are also shortfalls in planned delivery and work is ongoing to achieve improvement in compliance. We are hoping to submit a compliant plan by the final submission date.
- Diagnostic activity requirements – Trusts are required to restore diagnostic activity to 120% of 19/20 activity. Plans submitted to date fall short of the planning requirements but remodelling is continuing to identify whether the plan can be achieved. Introduction of Community Diagnostic Centres during the year will support later improvement of the position and we are modelling this impact into the final plan submission.
- Outpatient Follow-up reduction – Work is continuing on the outpatient transformation plan to support this requirement.
- Trajectories have been agreed with NHS England for the improvement of the Mental Health targets that are not currently compliant with requirements.
- Financial plan - The system is currently planning for a deficit position as a system, due to a reduction in non-recurrent income as a result of changes to COVID funding, as well as in year cost pressures.
- Workforce plan - The system is currently planning for an overall increase in its substantive workforce by 4%. This will be carefully managed by increasing recruitment, retention and growing our own workforce incentives. The plan is to reduce bank and agency staffing to ensure we deliver the growth required within the financial envelope. We plan to increase our nursing workforce by over 5%, supporting the achievement of the national target for growth in this workforce and ensuring safer staffing levels are achieved. It should be noted that whilst the overall plan is on target, there are pressured areas within the overall workforce that may impact on delivery of specific areas of the plan.

DDCCG Governing Body are asked to confirm their understanding and approval of the current plan position.

# 22/23 Planning – Submission Requirements

Priority	Narrative Required	Metrics Required
<b>A. Invest in our workforce</b>	Yes	Full workforce plan and separate MH workforce including narrative
<b>B. Respond to COVID-19 effectively</b>	No	None
<b>C. Deliver more elective care</b>	Yes, not Maternity	GP referrals, OP activity, Diagnostic activity, EL/DC activity, A&G, PIFU, NFTF, RTT admitted and non-admitted, New RTT, Waiting List, 52ww+, 78ww+, 104ww+, Cancer 28 days to diagnosis, First definitive treatment, 62+ day pathways, non-specific referrals
<b>D. Improve UEC responsiveness and build community capacity</b>	Yes	NEL activity, A&E activity, Ambulance C1-6, LoS, G&A beds, ACC, 111 to SDEC 2-hr community, community waiting lists, hospital discharge pathways, virtual wards
<b>E. Improve timely access to primary care</b>	No	GP appointments, extended access utilisation
<b>F. Improve MH services and LDA services</b>	No	AHCs, Inpatient LD&A, IAPT access, Dementia diagnosis, first psychosis, CYP access, ED RTT, OOA, SMI PHC, Perinatal, IPS, MHSDS DQMI, CMH access, Discharge FU
<b>G. Continue to develop approach to PHM, prevent ill health and address inequalities</b>	Yes, Introduction	PHBs, Social prescribing, PCSP Children's wheelchair access
<b>H. Exploit the potential of digital tech</b>	No	None
<b>I. Make the most effective use of our resources</b>	No	Financial plan submission
<b>J. Establish ICBs and collaborative working</b>	No	None

# 22/23 Planning

## A. Invest in Our Workforce – Planning submission

### Planning Requirements

#### Looking after our people

##### *Risks, Interdependencies, Support required*

Increase workforce supply by : -

- Recruitment and retention strategies with clear monitoring of progress in place
- Increase the diversity of our workforce to match that of the population
- Recruiting to substantive positions
- Support programme in place to support the health and well being of our workforce
- Recruiting to substantive positions
- Reduce the usage of agency staff
- Flexible working and making sure our people take their annual leave
- Ongoing risk around sickness and absence

Support required from NHSE/I and HEE re the tools available to monitor progress and improvement in data quality.

A clear understanding of workforce demand and capacity with a key set of metrics – improvement in data quality- HEE and NHSE/I tools.

#### Belonging in the NHS

##### *Risks, Interdependencies, Support required*

- Increase the diversity of our workforce to match that of the population
- Reduce workforce turnover
- Ensure diversity across all recruitment platforms
- Eliminating the ethnicity gap
- WRED/DES action plan building on the data from our staff surveys

It is noted that JUCD is the only system showing a decrease in their turnover rate

- Work with all Health and care providers

# 22/23 Planning

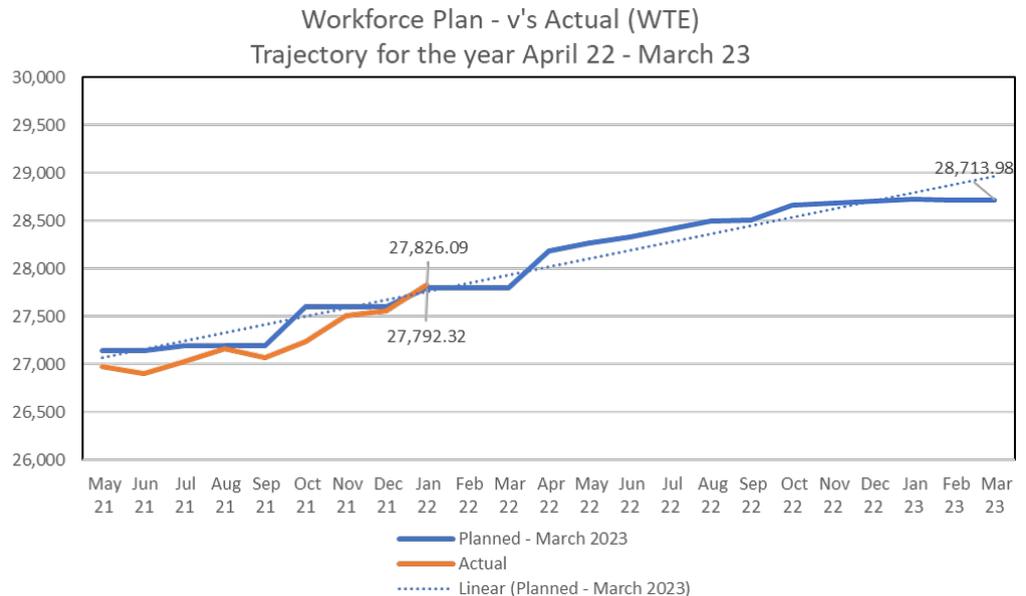
## A. Invest in Our Workforce – Planning submission

Planning Requirements	RAG Status
<b>New Ways of working</b>	
<p><i>Risks, Interdependencies, Support required</i></p> <ul style="list-style-type: none"> <li>• Education and Training opportunities and supporting our future workforce is paramount to achieving the workforce plan and we have a number of developmental programmes in place to help us accomplish this</li> <li>• Continuing to develop staff through career opportunities from support worker to registered professional</li> <li>• Support from HEE is required to help develop the right education programmes and workforce development programmes</li> </ul>	

The chart here shows the JUCD workforce position against the 21/22 plan and the plan trajectory for 22/23.

The month 10 position is positive and showing that the plan is most likely to be achieved for the full year.

We will therefore start 22/23 in a good position to further improve our workforce despite the many challenges and risks.



# 22/23 Planning

## C. Deliver More Elective Care – Planning Submission

Planning Requirements
<b>Deliver &gt;104% of 19/20 activity</b>
Activity modelling is underway and continuing to be refined. At this time, the Derbyshire system is working towards a compliant plan – but this is caveated with a number of risks to delivery and based upon interdependencies across the acute trusts. The main risks to delivery include theatre sessions not yet being fully optimised due to ongoing short and longer term workforce challenges, elective throughput is reduced based on change in complexity and case mix and there is a need for additional elective care beds. The elective hub TIF bids include submissions for additional beds and theatre capacity, specifically day case capacity.
<b>104 week wait elimination and maintenance of zero</b>
Modelling at this time suggests that we will eliminate 104ww (excluding patient choice) by end of July 2022 against a target of end of June. This is due to ongoing challenges with securing options for treatment for the bariatric cohort of patients but plans are in place and progressing.
<b>Reduction of 78 week wait</b>
The system is working towards an elimination of 78ww by end of March 2023 but this depends on the following assumptions: staff absence rate is stable, no increases in demand above that modelled, no significant equipment failure beyond planned downtime, elective cancellations due to increased NEL activity not going beyond that modelled and a reduction in delayed transfers of care
<b>OPFU reduction at least 25%</b>
Further modelling is required to review the opportunities to deliver against this requirement due to different challenges faced at each acute trust. Increased referral activity in 21/22 will likely increase the number of follow up appointments in the short term. The system is working on out-patient transformation as a priority to baseline the opportunity from delivering RAS, the next phase of PIFU and introducing a full A&G service across more specialties before committing to delivery of this requirement.
<b>PIFU 5% and referral optimisation expansion</b>
The system is working towards meeting this requirement. Some final modelling is required to achieve the 5% requirement from current YTD of 3.5%.

# 22/23 Planning

## C. Deliver More Elective Care – Background Information

### Current performance on Elective targets

ICS 104 week+ waits – currently above trajectory

104 week breaches	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Trajectory	282	262	233	197	170	117
<b>Actual (vs Trajectory)</b>	<b>370</b>	<b>422</b>	<b>459</b>	<b>551</b>	<b>630</b>	
Variance (Actual vs Trajectory)	-88	-160	-226	-354	-460	

- **RTT 104 week breaches position is 460 above the trajectory for February 2022**
- CRH position is 69 (83 vs 14) above target
- UHDB position is 391 (547 vs 156) above target

CRH – Current numbers of 78 week + waits as at 18 March

CRH	78ww+	CRH	78ww+
Breast Surgery	3	Orthopaedics	44
Colorectal Surgery	12	Paediatric ENT	8
Dermatology	1	Paediatric Max Fax	2
Ear Nose & Throat	39	Rheumatology	2
Gastroenterology	4	Trauma	2
General Surgery	7	Unknown: Unknown	4
Gynaecology	39	Upper Gastrointestinal Surgery	30
Ophthalmology	37	Urology	4
Oral Surgery	9	Vascular	1
Orthodontics	7	<b>Grand Total</b>	<b>255</b>

UHDB – Current numbers of 78 week + waits as at 18 March.

UHDB	78ww+	UHDB	78ww+
(blank)	2	Interventional Radiology	2
Anaesthetics	1	Lymphoedema	15
Bariatric Surgery	75	Maxillo-facial surgery	24
Breast Surgery	11	Ophthalmology	61
Cardiology	1	Orthodontics	1
Clinical Neurophysiology	2	Paediatrics	32
Colorectal Surgery	78	Plastic Surgery	1
Diabetic Medicine	1	Respiratory Physiology	1
ENT	27	Rheumatology	1
Gastroenterology	1	Spinal Surgery Service	122
General Surgery	174	Trauma and Orthopaedics	250
Gynaecology	41	Upper Gastrointestinal Surgery	58
Hand Surgery	63	Urology	43
Hepatobiliary and Pancreatic Surgery	7	Vascular Surgery	22
		<b>Grand Total</b>	<b>1117</b>

# 22/23 Planning

## C. Deliver More Elective Care – Background Information

*Current performance on Elective targets*

ICS Elective Activity – current position against 19/20 baseline – above trajectory and national target.

ALL ELECTIVE	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Target	70.0%	75.0%	80.0%	95.0%	95.0%	95.0%	89.0%	89.0%	89.0%	89.0%	89.0%	89.0%
Trajectory	89.1%	83.2%	94.1%	85.2%	90.0%	89.9%	85.5%	92.5%	95.2%	83.5%	93.1%	117.9%
Actual (vs Trajectory)	89.8%	85.6%	101.2%	83.1%	88.1%	92.8%	85.1%	90.9%	95.6%	85.8%	93.9%	
Variance (Actual vs Target)	19.8%	10.6%	21.2%	-11.9%	-6.9%	-2.2%	-3.9%	1.9%	6.6%	-3.2%	4.9%	

- **All Elective Care position is 4.9% above target** and 0.8% above the trajectory set for February 2022
- CRH position is 9.5% above target and 0.6% below trajectory (98.5% vs 99.1%)
- UHDB position is 3.7% above target and 1.3% above trajectory (92.7% vs 91.4%)

# 22/23 Planning

## C. Deliver More Elective Care – Planning Submission

Planning Requirements
<b>25% NFTF</b>
The system currently achieves 23% Non-Face-to-Face (NFTF) YTD. We anticipate achieving compliance with the 25% - however there is a risk of delivery based upon changes to case mix from the impact of advice and guidance which may cause a smaller cohort of patients who are suitable for NFTF. Ongoing clinical engagement is taking place to understand the scope to deliver against this.
<b>Cancer 62 day PTL return to Feb 20 level</b>
The system is aiming to hold the cancer waiting list position below the February 2020 position – assumptions and risks apply to delivery of this (no increased activity above that modelled, no further covid waves, no unplanned workforce challenges etc).
<b>Improvement against all cancer standards – 62 day</b>
Breast Screening recovery and ongoing issues with capacity will potentially impact on performance for 62 day screening. There is a system-wide breast screening and breast symptomatic working group in place to address these issues.
<b>Improvement against all cancer standards – 28 day Faster Diagnosis Standard</b>
The system anticipates achieving this requirement and has already made good progress against it in 21/22.
<b>Improvement against all cancer standards – 31 day to treatment</b>
Breast Screening recovery and ongoing issues with capacity will potentially impact on performance for 31 day. The system-wide working group will focus on these issues.
<b>Diagnostics at 120% pre-pandemic levels</b>
MRI, CT & Endoscopy are below target on 2019/20 activity levels, capacity is being reviewed to increase this to 120%. Ultrasound and echo capacity & performance require more work to understand workforce challenges and demand profiles. All modalities are suffering with short term and longer term workforce challenges plus the IP&C impact reduces capacity. We have a Community Diagnostic Centre and Community Diagnostic Hub plan with full engagement across the system.

# 22/23 Planning

## C. Deliver More Elective Care – Background Information

Current performance on Diagnostic and Cancer targets

ICS MRI activity – currently above local trajectory

MRI	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Target	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Trajectory	TBC	TBC	TBC	TBC	TBC	TBC	77.0%	79.4%	85.9%	82.2%	82.6%	84.0%
Actual (vs Trajectory)	127.1%	84.3%	86.9%	83.7%	77.2%	82.3%	79.1%	95.5%	87.6%	88.0%	94.0%	
Variance (Actual vs Target)	27.1%	-15.7%	-13.1%	-16.3%	-22.8%	-17.7%	-20.9%	-4.5%	-12.4%	-12.0%	-6.0%	

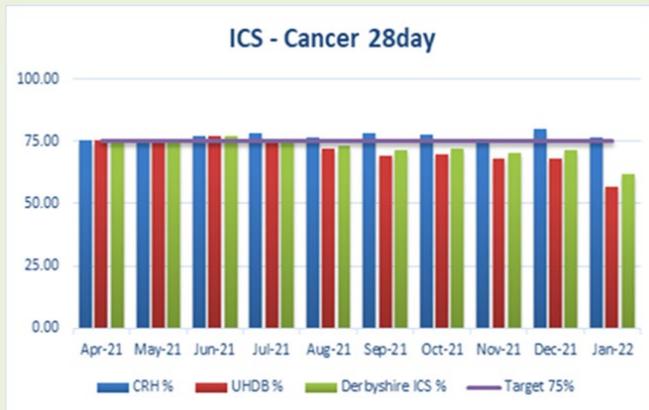
- **MRI position is 6% below target** and 11.4% above trajectory for February 2022
- CRH position is 5.6% above target and trajectory (105.6% vs 100%)
- UHDB position is 9.2% below target and 13% above trajectory (90.8% vs 77.8%)

ICS – CT activity – currently above national target

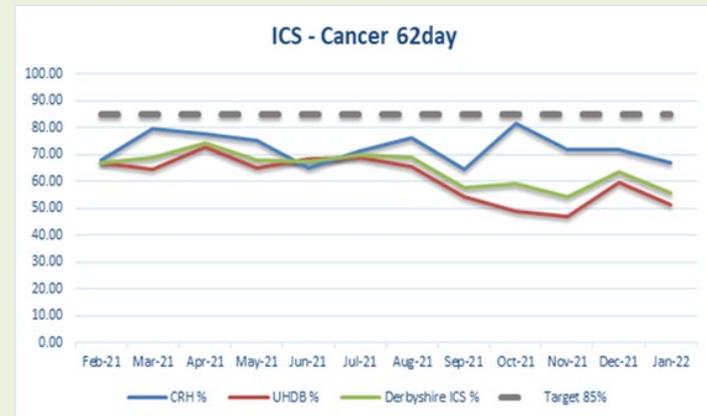
CT	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Target	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Trajectory	TBC	TBC	TBC	TBC	TBC	TBC	97.2%	99.5%	102.4%	97.5%	102.0%	109.3%
Actual (vs Trajectory)	129.4%	92.4%	95.5%	94.6%	90.3%	87.3%	96.9%	111.8%	104.7%	102.6%	113.9%	
Variance (Actual vs Target)	29.4%	-7.6%	-4.5%	-5.4%	-9.7%	-12.7%	-3.1%	11.8%	4.7%	2.6%	13.9%	

- **CT position is 13.9% above target** and 11.9% above trajectory for February 2022
- CRH position is 111.2% above target and trajectory (112.2% vs 100%)
- UHDB position is 14.9% above target and 12.1% above trajectory (114.9% vs 102.8%)

ICS – Cancer 28 day performance – currently below target



ICS - Cancer 62 day performance – currently below target

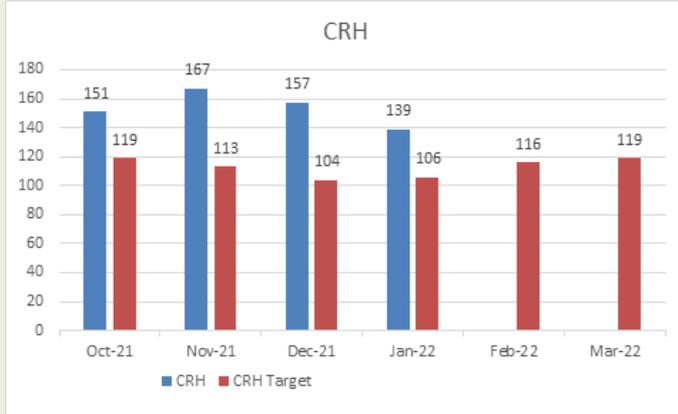


# 22/23 Planning

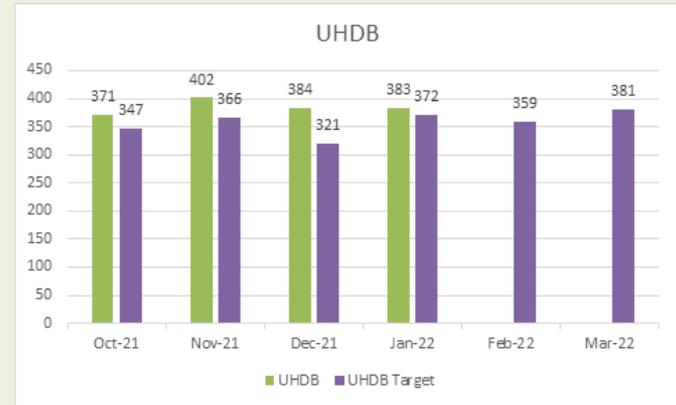
## C. Deliver More Elective Care – Background Information

Current performance on Cancer targets

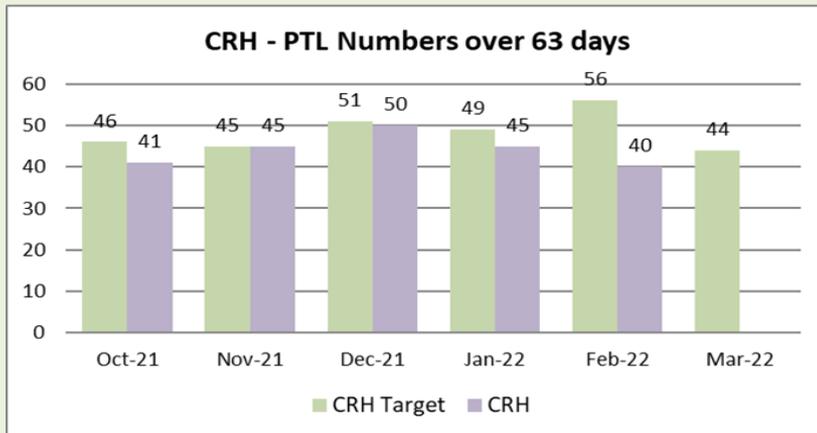
31 day to first treatment trajectory – CRH above target



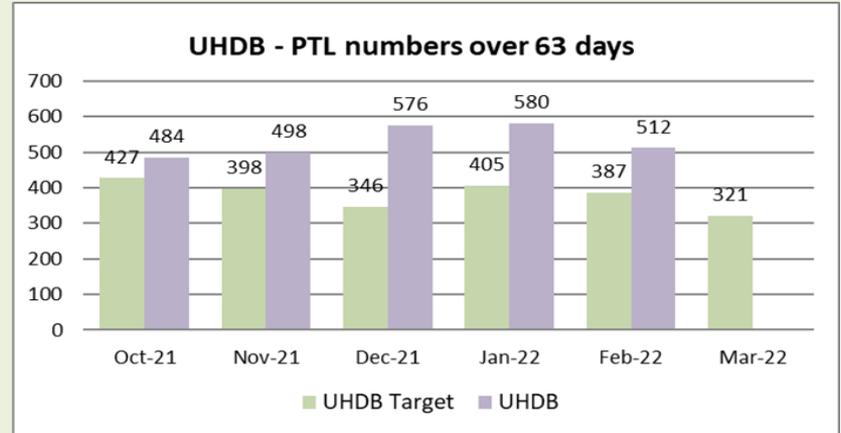
31 day to first treatment trajectory – UHDB above target



Cancer 62 day PTL – CRH are achieving their trajectory.



Cancer 62 day PTL – UHDB are above their required reduction.



# 22/23 Planning

## D. Improve UEC responsiveness and build community capacity – Planning Submission

### Planning Requirements

#### 12hr waits reduced to zero and no more than 2%

##### **CRH**

**Streaming and Primary Care Redirection:** The streaming tool is now operational, Pathways are under constant review and are being grown as required

**Staffing reconfiguration & rotas:** Additional B7 A&E nurses will take a lead in overseeing Resus majors and elements of UTC work. Roles are responsible for identification and escalation of issues and supporting the expediting of ambulance offload. new digital rota system

**Escalation:** Current process has been refreshed and relaunched, patients in the department are monitored for escalation to department meetings at 6 and 8 hr delay milestones, focusing on the prevention of further delay.

**SDEC:** Surgical and medical same day pathways are being reviewed and strengthened to increase access to SDEC and avoid hospital admissions.

Work continues with ambulance providers to ensure they support patient access to the right pathway from the outset

**SAFER:** Approach is being given a renewed focus on surgical and medical wards to avoid bed-based 12 hr delays.

**Discharge Lounge:** Dedicated discharge lounge space to support earlier discharge to be opened by end March 22.

**Virtual Wards:** Home Interventional Pathway Service (HIPS) has been introduced to ensure that patients who are awaiting tests but fit for discharge can be discharged into the care of a virtual ward to manage the delivery, reporting and decision-making around test results.

##### **UHDB**

**Operational organisation and effectiveness:** Focussed work on the improving the quality and consistency of ED daily operational huddles, now with clear roles and expectations which are embedded into daily practice.

**Staff Configuration:** Medical workforce plan for RDH ED completed and the full business case proposal is under development. Recruitment of a new role in the dept specifically to address 12-hour delay management – adding in a chaser role.

**IT Systems:** Lorenzo now implemented in the Emergency Department which is a slower system which increases patient processing time for clinicians. A clinical consultation group has now been established to agree the “best” way to use the system in ED. Training and awareness is planned from March onwards.

**Internal Professional Standards (IPS):** Re-engagement with divisional leadership teams is underway with a planned audit of performance against each standard. Medical-Director-led discussions on how improvements can be made to the assessment unit offer are underway.

**Urgent Treatment Centre (UTC):** Joint improvement work in partnership with DHU to make co-located UTC more effective at the RDH site. Staffing gaps are reducing, although there are still some gaps due to staff unavailability. Joint work on agreeing a standardised streaming and triage process and a robust staffing establishment plan is completing now.

**Streaming and Primary Care redirection:** April 22 launch is currently ‘paused’ during negotiations over funding of the clinical streaming roles

# 22/23 Planning

## D. Improve UEC responsiveness and build community capacity – Planning Submission

### Planning Requirements

#### Improvement against ambulance handover standards (0>60m, 95% <30m, 65% <15m)

EMAS continue to have a range of clinicians working within their Emergency Operation Centre (EOC) such as GP's, paramedics, and Mental Health nurses, to help increase Hear and Treat rates when safe and appropriate to do so. This is in addition to recruiting an additional 12wte Registered Mental Health Nurses (RMNs) to appropriately signpost patients with Mental ill Health and extending the C3/C4 National pilot to undertake more Hear and Treat of selected codes. By reducing dispatch when appropriate, this results in front line crews being able to respond to higher acuity activity in a more timely manner.

Systems are working with EMAS to ensure all alternative pathways (ie Non-ED) that accept ambulance referrals are known, and are profiled, visible and accessed via the most appropriate tool, ie NHS Service Finder. By increasing See and Treat rates and Conveyance to Non-ED alternatives, this will help reduce job cycle times and enable more operational hours to be put back into the system.

Work also continues as referred to above, with regards to improving pre-hospital handover delays. In addition, EMAS are also undertaking actions to improve post-hospital handover delays, such as clocking clear at 15 minutes unless crews have raised a delay with the EOC, and working with EMAS tactical cells to identify where any efficiencies can be made. By reducing total handover times, this will enable front line crews to handover patients in a more timely manner which will result in more operational hours being put into the system.

EMAS are recruiting additional call handlers and front-line crews utilising additional national monies, and are also working to reduce sickness levels. Additional hours that are put back into the system, either by working more efficiently as described above or by resourcing additional hours, will help EMAS respond to all category of patients in a more timely manner thus improving current performance levels.

The following present risks to the delivery of the urgent care plan:

- Primary care ability/capacity to meet on the day urgent demand could further increase ED attendances
- Workforce availability and recruitment (all sectors)
- Urgent Community discharge capacity, especially in P1 (including dom care), causing increased delays to discharge in acute beds
- 22/23 final financial envelopes / scope of CIP challenges
- EMAS have been operating at REAP level four during the majority of COVID. Any de-escalation of REAP measures may result in increased dispatches.

The following areas are interdependent with the urgent care plan:

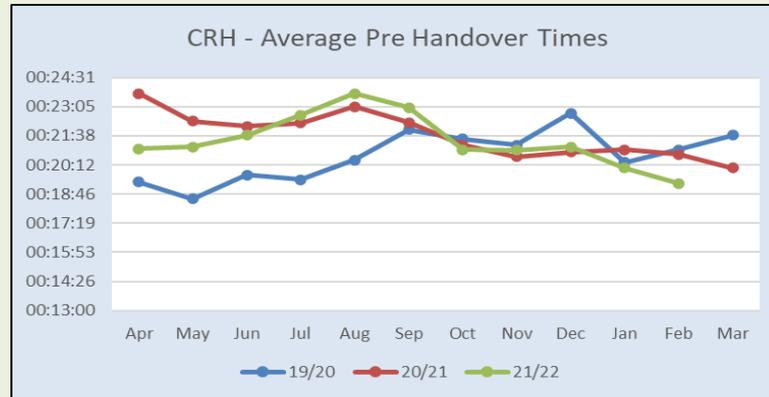
- Integrated Frailty workstream
- Team up developments and capacity
- Paediatric activity growth and market segmentation.
- LTC condition management

# 22/23 Planning

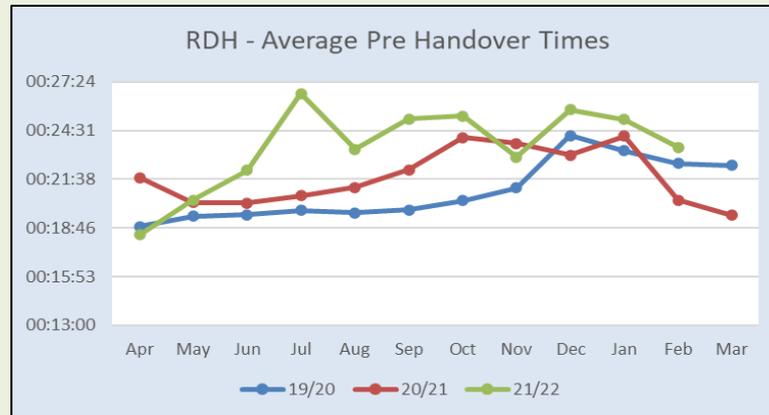
## D. Improve UEC responsiveness and build community capacity – Planning Submission

Current performance on Ambulance Handover targets

Handover times at CRH have recently improved but are still above the national target



Handover times at RDH have recently improved but are still above the national target



# 22/23 Planning

## D. Improve UEC responsiveness and build community capacity – Planning Submission

### Planning Requirements

#### Virtual ward development

##### *Virtual Ward (VW) Development*

**JUCD Stocktake (Review of VW and remote Monitoring Services):** Currently reporting NIL return for some services across Derbyshire (CRH and UHDB). Data available from DCHS, DHU, EMAS and reported weekly. Project Manager working with all Provider Data Analysts/Information leads to determine when remaining data can be submitted (issues escalated via Delivery Group, relevant ICS Board and SORG when required).

**NHSE Requirement:** By December 2023, complete comprehensive development of virtual wards (including hospital at home) towards a national ambition of 40–50 virtual beds per 100,000 population.

##### *Risks (including mitigations):*

1. **Workforce:** Lack of trained staff across Derbyshire and the availability of staff in various services across the health and care system i.e., domiciliary care areas to support development of Virtual Wards. *With funding now available, Commissioners are working with system stakeholders to identify workforce needs to support VW working either on a temporary, fixed term, secondment basis if substantive staff are not available (including agency staff). National funding could be utilised for recruitment of Project Manager and data support in the long term to support with future priorities.*
2. **Project Management support:** Work currently undertaken by SCCP team to meet NHSE requirements. As a 2-year programme, we will need to recruit a fixed term Project/Programme manager and Project Support to meet the requirements of this workstream. *Executive Medical Director identified as Senior Reporting Officer (SRO), Programme Lead and interim Project Manager identified to manage this as this is now a system ask.*

**Interdependencies:** System ask from all stakeholders across JUCD (Acute, Community and MH providers, DHU, EMAS, Adult Social Care, CCG BI and NECs invited to Virtual Ward Delivery Group meetings with ongoing work to request support from Primary Care and additional workstream leads within the CCG).

**Support Required:** Virtual Wards Delivery Group has been implemented; system stakeholders invited whereby terms of reference agreed. The VW Delivery Group will report into the JUCD LTC Board and JUCD ICS Board and will be reviewed as the ICS structure is confirmed in July 2022. There are also options to escalate matters to the System Operational Resilience Group (SORG) as and when required.

# 22/23 Planning

## D. Improve UEC responsiveness and build community capacity – Planning Submission

### Planning Requirements

#### Delivery of Urgent Community Response 8-8, 7 days a week

*As a system we are forecasting achievement of the NHSE targets in this area. The following actions are in place to achieve this:*

- Workforce - The UCR 2 hour programme (as part of wider Ageing Well programme) has a dedicated workforce lead capacity to ensure integration and coordination across the JUCD system workforce plans. Actions include joint planning, recruitment and training across Health and Social care partners; in particular with regard to ANP/ACP training and exploration of hybrid health & social care roles, developing career & progression pathways, apprenticeship schemes, recruiting into generic roles and international recruitment for therapists.
- The Clinical Assessment Service for JUCD is in development. The central access point for UCR will need to dovetail with this development and will need to include an approach for access to multiple partner delivery of FRS. An interim approach to the expanded UCR central access point will be needed in advance of the full JUCD CAS development.
- CSDS submissions – Consideration will be needed for submission of CSDS activity for falls recovery services activity. An alternative arrangement may be needed to capture and submit data.
- Activity counts – Falls Recovery Service activity counts are based on assumptions of ambulance non conveyance data and could prove very different as services go live. Capacity and demand modelling and review will be undertaken throughout the year to adjust and plan service and workforce needs as required.

#### *Interdependencies*

There are key interdependencies with Ageing Well EHCH & anticipatory care, virtual wards development, same day emergency care, discharge pathways, frailty network and local CAS development. A Community Transformation plan is in development with the ambition to bring together many of these elements.

#### *National Support*

National campaign to support bringing care staff into workforce

National development of CSDS ability & support for non 'NHS' system partners; primary care, FRS providers, Local Authorities

# 22/23 Planning

## E. Improve timely access to primary care

### Planning Requirements

#### Planned number of appointments in General Practice

- General Practice in Derbyshire offer c612,000 appointments every month
- The number of appointments offered is at similar levels, or more than, before the pandemic
- The majority of appointments are face-to-face (c65%)
- The number of telephone appointments has increased since the pandemic to about 28% of the total
- Approx. 39% of appointments are offered for the same day – more appointments are offered on the same day than before the pandemic
- PCNs planning for additional c72k appointments January to March funded through £2.9m Winter Access Fund (WAF) as part of system WAF (c£5.4m 130k appointments)

#### Extended Access Utilisation

- Throughout the pandemic, most hubs diverted capacity from within this service to support other areas where GP Practices in their Primary Care Networks were seeing patients in local hubs with suspected Covid-19. This then progressed to delivering the vaccination programme.
- For those hubs which have continued to provide longer opening hours, appointments have been undertaken via telephone triage and treatment, virtual appointments and face-to-face for those who need it most.
- As of January 2022, General Practice in Derbyshire were providing c612,000 appointments every month which is similar, or more than, what was being delivered before the pandemic. Most appointments are face to face (c65%) and approx. 39% of patients are offered a same day appointment. Extended Access appointments are included within these statistics.
- The 2022/23 extended access specification is out now and PCNs are looking at how they will operate this from October 2022.
- The new enhanced access offer is based on PCNs providing bookable appointments between 18:30-20:00 weekday evenings and 9:00-17:00 on Saturdays, with some flexibility to deliver a proportion of services outside of these hours.

# 22/23 Planning

## F. Improve MH services and LDA services

Planning Requirements
<b>MH DQMI Score</b>
The compliance target for 22/23 is 90%. DHCFT is already compliant with this level and DCHS plan to achieve it from Q1 22/23.
<b>Follow-up after discharge from Adult MH Inpatient Setting</b>
The 72-hr post-discharge standard is 80% for 22/23 and both providers (DHCFT and DCHS) are planning compliance with the target in 22/23.
<b>Number of OAP bed days by quarter</b>
There are no OAP bed days at DCHS. DHCFT plan to continue to reduce OAP bed days during the first 2 quarters of 22/23 with elimination at Q3 when new facilities become available in area.
<b>Dementia Diagnosis Rates</b>
The system plan does not currently meet the requirement of 66.7%, ending Q4 22/23 at 65.24%. This trajectory is due to an increase in referral rates from 21/22, following low levels of primary care referrals in that year.
<b>CYP ED treatment – 1 week and 4 week standards</b>
The JUCD plan is non-compliant with the requirement for 95% of routine referrals to be seen within 4 weeks, but does meet the 95% standard for urgent referrals to be seen within 1 week. The trajectory assumes increased demand. Repurposing of clinical activities to meet wait time targets would have a negative impact on the ability to provide treatment interventions.
<b>Annual Health Checks for Patients with a Serious Mental Illness</b>
Whilst the SMI plan is not compliant with the planning requirement, the trajectory submitted was agreed with NHSEI in Q3 21/22.

# 22/23 Planning

## F. Improve MH services and LDA services

Planning Requirements
<b>Access to Perinatal Mental Health Services</b>
The plan is not compliant with the recovery plan agreed with NHSEI in Q3 21/22 based on the achievement of a 6% access rate for 22/23.
<b>Number of People Accessing IPS Services</b>
The plan submission is not currently compliant with the expected level but there are proposals in development for financial investment to achieve expected performance levels.
<b>Contacts from CMHS for Adults and Older Adults with an SMI</b>
The plan is in line with the average per quarter in prior years but is not compliant with the ambition tool.
<b>First Episode Psychosis Referrals seen within 2 weeks</b>
The plan is above target levels with 80% of packages of care received within 2 weeks against a target of 60%.
<b>CYP under 18 supported through MH Services</b>
Plan assumes an increase of 350/quarter and is compliant with the NHSE growth expectation.
<b>Total Access to IAPT services</b>
The plan is compliant with the expectation of increased access and reflects the annual modelling undertaken.

# 22/23 Planning

## F. Improve MH services and LDA services

Planning Requirements
<b>Annual Health Checks for people with LD (age 14+)</b>
The plan (at 72%) is not compliant with the NHSEI expectation of 75% but a trajectory has been agreed with 1care and further work will be undertaken in year to improve data capture and sharing of GP registers.
<b>Reliance on inpatient care for people with LD or A - CCG commissioned (age 18+)</b>
The submission is in line with the improvement trajectory agreed with NHSE.
<b>Reliance on inpatient care for people with LD or A - NHSE/Provider Collaborative commissioned (age 18+)</b>
The submission is in line with the improvement trajectory agreed with NHSE.
<b>Reliance on inpatient care for people with LD or A - NHSE/Provider Collaborative commissioned (under age 18)</b>
The submission is compliant with the NHSE requirement and an improvement trajectory has been agreed with NHSE.

Whilst the mental health and LD metrics are being submitted as part of the full operational planning submission, a separate narrative, financial and workforce submission is being managed through the Mental Health Delivery Board to NHSE.

# 22/23 Planning

## G. Continue to develop approach to PHM, prevent ill health and address inequalities

### Planning Requirements

**Improved data collection and reporting will drive a better understanding of local health inequalities in access to, experience of & outcomes from healthcare services.**

Planned changes to how we deliver on System Intelligence will support this development area for JUCD, and enable us to deliver this as a system. Interdependencies include the Population Health Management Programme and the Place Development Programme, updates to the JSNA, improving our baseline understanding of Core 20+ groups.

**Renew focus on reducing inequalities in access to and outcomes from NHS public health screening and immunisation services**

We have a well-established multi-agency Vaccine Inequalities Group which has co-ordinated our COVID-19 vaccination (inequalities) response. This group will extend to include the full immunisation schedule in scope from April 22, supported by a dedicated team in the CCG and LA public health (est. Feb 22). This group will identify priority quality improvement actions for immunisation uptake as part of a strategic review in Q1 22/23.

We have a well-established Cancer Alliance which has agreed to actions to reduce inequalities in screening working across partners. Both these programmes have a community engagement component working with the LA and VCSE leads.

**Continue to adopt culturally competent approaches to increase vaccination uptake in groups that have a lower than overall average uptake as of March 2022.**

As above this will be factored into Strategic planning for vaccine inequalities. Derby City has received investment from the DLUH Vaccine Champions programme which will facilitate improvement in our engagement activity (via community connectors and small grant funded projects), improve our use of insight to inform vaccination promotion and communications, and strengthen the influence of community voice in NHS planning.

# 22/23 Planning

## G. Continue to develop approach to PHM, prevent ill health and address inequalities

### Planning Requirements

#### Demonstrate how the ICS is developing PHM, preventing ill-health & addressing health inequalities

##### *Population Health Management Programme and Place Development Programme:*

The Population Health Management Development Programme is led by the Director of Public Health in Derbyshire County Council and delivered by Optum (for NHSE). It will run from March - June 2022 and has three aims: to develop and build PHM capacity and capability across our workforce; to advance our PHM infrastructure; and to support efficient and effective use of our resources. The cornerstone of the PHM approach is the use of linked data providing insights across individuals and communities rather than just activity across organisations or points in time. This will give us better insight into the complexity of need and service use enabling holistic and impactful interventions for individuals, cohorts and communities.

##### *The ICS Place Development Programme:*

Will work at Place level with clinical and care leaders, analysts, primary and secondary care, local government, social and community services, and the voluntary and charity sector. It will provide practical support to give us with the tools, techniques and approaches to enable us to deliver effective Population Health Management (PHM). The two programmes are fully complementary and will embed a consistent approach to PHM building up the skills and infrastructure we need to improve population health. They will both support prioritisation of actions to reduce health inequalities from Summer 2022 onwards.

#### Have personalised care approaches been considered in the development of your Core20PLUS5?

Joined Up Care Derbyshire has a Personalisation Delivery Board which has a key focus on integrating Personalisation across the system to ensure it is 'everybody's business'. The Board have recently agreed a draft Plan on a Page which focusses on giving people choice and control over the way their care is planned and delivered based on 'what matters' to them and their individual strengths, needs and preferences. The Personalisation board fully endorse the Quality Conversations approach outlined below.

##### Quality Conversations Programme:

The JUCD Quality Conversations programme, established in 2018 is our local health coaching and MECC programme, supporting personalised care. It has recently secured permanent substantive funding to allow expansion and growth of the many component elements in the next few years.

##### Actions in 2022/23 include:

Targeting Quality Conversation interventions to 'long waiters' in the CORE20+ demographic to support a personalised approach to self-care.

# 22/23 Planning

## I. Make the most effective use of our resources

<b>Planning Requirements</b>
<b>Bottom line of breakeven or surplus</b>
The system is currently planning for a deficit position as a system, due to a reduction in non-recurrent income as a result of changes to COVID funding, as well as in year cost pressures.
<b>Deliverable plans</b>
The Finance Deputies groups is meeting regularly to triangulate plans and align assumptions. These have been presented back through DoFs on 9 <sup>th</sup> March and at SLT on 11 <sup>th</sup> March and approved prior to draft submission. Further work will be undertaken before final submission on 28 <sup>th</sup> April.
<b>Underlying financial position</b>
The system continues to have a significant underlying deficit due to core business costs being higher than core allocations, with the system reporting reliance on COVID non-recurrent allocations.
<b>Efficiency Programme</b>
1.1% cost efficiencies are being planned for, however these do not cover the full system gap.

Further information on the financial plan is provided in a separate paper to this meeting.

# Contact Details

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## Governing Body Meeting in Public

7<sup>th</sup> April 2022

Item No: 008

<b>Report Title</b>	Finance Report – Month 11
<b>Author(s)</b>	Georgina Mills, Senior Finance Manager
<b>Sponsor (Director)</b>	Richard Chapman, Chief Finance Officer

Paper for:	Decision	Assurance	x	Discussion	Information
<b>Recommendations</b>					
The Governing Body is requested to <b>NOTE</b> the following:					
<ul style="list-style-type: none"> <li>• Allocations have been received for the full year at £2.102bn</li> <li>• The YTD reported underspend at month 11 is £0.142m</li> <li>• Retrospective allocations received for Q1-3 Covid spend on the Hospital Discharge Programme and vaccination inequalities were £7.768m; further funding is expected of £1.591m relating to months 10 and 11</li> <li>• Additional anticipated funding include: <ul style="list-style-type: none"> <li>○ Elective Recovery Fund reimbursed £0.820m for April to February</li> <li>○ Winter Access fund is forecast to spend and reimbursed and additional £0.964m</li> <li>○ Additional Roles Reimbursement Scheme £1.639m YTD and forecast to spend and receive £5.759m</li> </ul> </li> <li>• The year-end position is forecast at £0.571m underspent.</li> </ul>					
<b>Report Summary</b>					
The report describes the month 11 position. The key points are listed in the recommendations section above.					
<b>Are there any Resource Implications (including Financial, Staffing etc)?</b>					
N/A					
<b>Has a Privacy Impact Assessment (PIA) been completed? What were the findings?</b>					
N/A					
<b>Has a Quality Impact Assessment (QIA) been completed? What were the findings?</b>					
N/A					

<b>Has an Equality Impact Assessment (EIA) been completed? What were the findings?</b>
None identified
<b>Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below</b>
No
<b>Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below</b>
No
<b>Have any Conflicts of Interest been identified/ actions taken?</b>
None identified
<b>Governing Body Assurance Framework</b>
Any risks highlighted and assigned to the Finance Committee will be linked to the Derby and Derbyshire CCG Board Assurance Framework
<b>Identification of Key Risks</b>
As detailed in the report

## Financial Performance Summary Month 11, February 2022

Statutory Duty/ Performance	Target	Result	Achieved	Key	Comments/Trends
Achievement of expenditure to plan	£1923.059m	£1926.147m		Green <1%, Amber 1-5% Red >5%	Expected reimbursements of £1.591m for Covid and £1.639m for Additional Roles Reimbursement Scheme (ARRS) resulting in a YTD favourable variance of £0.142m.
Remain within the Delegated Primary Care Co-Commissioning Allocation	£148.332m	£149.952m		Green <1%, Amber 1-5% Red >5%	Primary Care Co-Commissioning YTD is showing as £1.619m overspent against plan. Expenditure of £1.639m has been incurred for ARRS, these costs are expected to be funded resulting in a small surplus of £0.02m
Remain within the Running Cost Allowance	£17.934m	£16.847m		Green <1%, Amber 1-5% Red >5%	Running costs are £1.087m underspent against plan. This is attributed to pay underspends due to staff vacancies.
Remain within cash limit	Greatest of 1.25% of drawdown or £0.25m	0.40%		Green <1.25%, Amber 1.25-5% Red >5%	Closing cash balance of £0.641m against drawdown of £159.0m.
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 99% for invoices categorised as NHS and non NHS assessed on value and volume.

## Operating Cost Statement For the Period Ending: February 2022

	Year to Date				Budget and Forecast			
	YTD Budget	YTD Actual	YTD Variance	YTD Variance as a % of YTD Budget	Annual Budget	Annual Forecast Outturn	Forecast Variance	FOT Variance as a % of Annual Budget
	£'000's	£'000's	£'000's	%	£'000's	£'000's	£'000's	%
Acute Services	1,014,392	1,007,540	6,851	0.68	1,106,304	1,098,772	7,532	0.68
Mental Health Services	220,157	216,128	4,029	1.83	241,042	238,408	2,635	1.09
Community Health Services	146,735	148,914	(2,179)	(1.48)	159,746	163,320	(3,574)	(2.24)
Continuing Health Care	101,402	102,273	(871)	(0.86)	110,628	112,770	(2,142)	(1.94)
Primary Care Services	194,071	195,150	(1,079)	(0.56)	212,531	213,765	(1,234)	(0.58)
Primary Care Co-Commissioning	148,332	149,952	(1,619)	(1.09)	162,176	168,890	(6,714)	(4.14)
Other Programme Services	76,271	88,589	(12,318)	(16.15)	82,137	92,197	(10,060)	(12.25)
<b>Total Programme Resources</b>	<b>1,901,360</b>	<b>1,908,546</b>	<b>(7,186)</b>	<b>(0.38)</b>	<b>2,074,563</b>	<b>2,088,121</b>	<b>(13,558)</b>	<b>(0.65)</b>
<b>Running Costs</b>	<b>17,934</b>	<b>16,847</b>	<b>1,087</b>	<b>6.06</b>	<b>19,950</b>	<b>18,877</b>	<b>1,074</b>	<b>5.38</b>
<b>Total before Planned Deficit</b>	<b>1,919,294</b>	<b>1,925,393</b>	<b>(6,099)</b>	<b>(0.32)</b>	<b>2,094,514</b>	<b>2,106,998</b>	<b>(12,484)</b>	<b>(0.60)</b>
In-Year Allocations	101	101	0	0.00	4,020	4,060	(40)	(0.99)
In-Year 0.5% Risk Contingency	4,244	653	3,591	84.61	4,244	0	4,244	100.00
In year Planned Deficit (Control Total)	(580)	0	(580)	100.00	(696)	0	(696)	100.00
<b>Total Incl Covid Costs</b>	<b>1,923,059</b>	<b>1,926,147</b>	<b>(3,088)</b>	<b>(0.21)</b>	<b>2,102,082</b>	<b>2,111,058</b>	<b>(8,976)</b>	<b>(0.43)</b>
<b>Expected Covid Reimbursement in Future Months</b>	<b>7,768</b>	<b>9,359</b>	<b>(1,591)</b>		<b>7,768</b>	<b>10,592</b>	<b>(2,824)</b>	
<b>Expected Elective Recovery Fund Allocation</b>	<b>820</b>	<b>820</b>	<b>0</b>		<b>820</b>	<b>820</b>	<b>0</b>	
<b>WAF Reimbursement</b>	<b>3,376</b>	<b>3,376</b>	<b>0</b>		<b>3,376</b>	<b>4,340</b>	<b>(964)</b>	
<b>ARRS Funding Above Baseline</b>	<b>7,226</b>	<b>8,865</b>	<b>(1,639)</b>		<b>7,226</b>	<b>12,985</b>	<b>(5,759)</b>	
<b>Total Reduced for Reclaimable Covid Costs, ERF and ARRS</b>	<b>1,903,869</b>	<b>1,903,727</b>	<b>142</b>	<b>0.01</b>	<b>2,082,892</b>	<b>2,082,321</b>	<b>571</b>	<b>0.03</b>

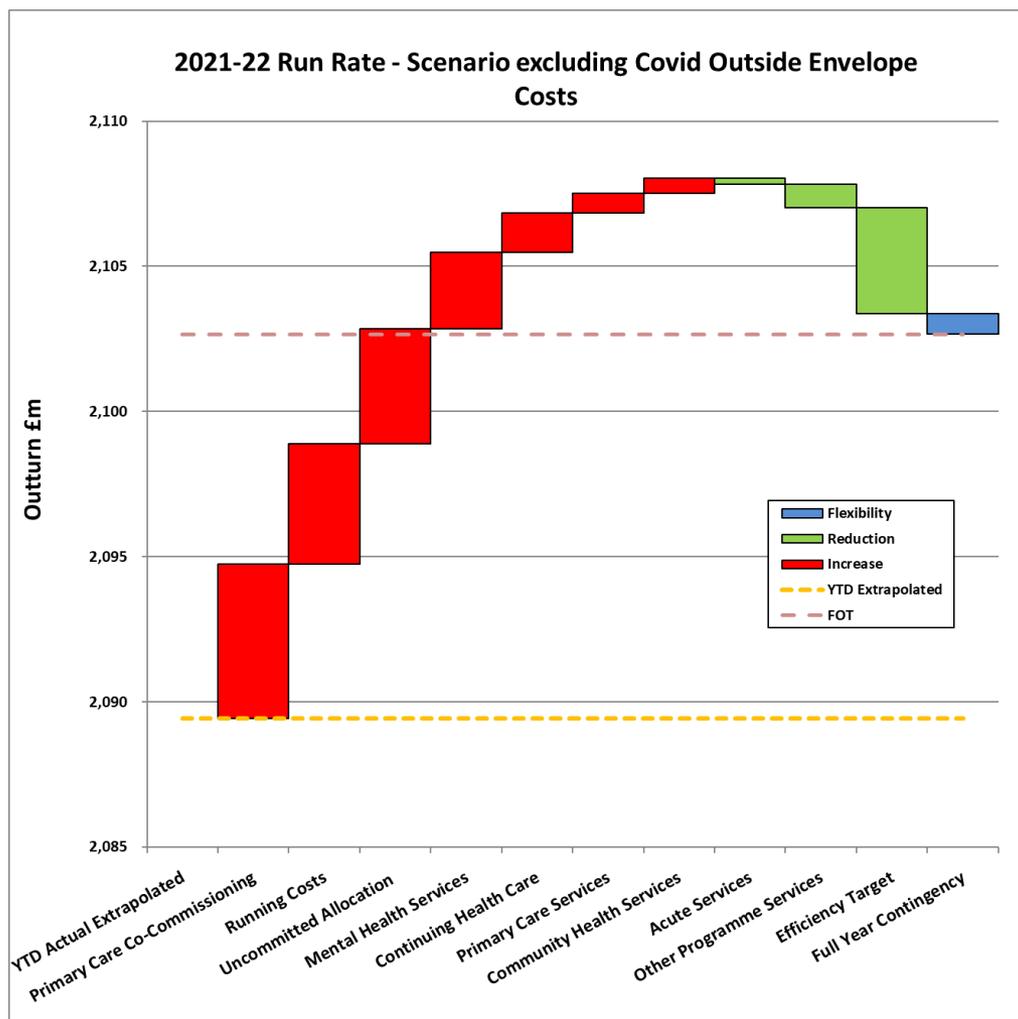
The reported position at month 11 is an underspend of £0.142m and favourable FOT underspend of £0.571m.

This position includes an expected reimbursement of £1.591m YTD and £2.824m FOT relating to Covid expenditure for the Hospital Discharge and Vaccine Inequalities Programmes. Allocations totalling £7.683m for out of envelope covid expenditure have been received relating to quarters 1-3. Quarter 4 funding is anticipated to be received in month 12.

The Primary Care Co-Commissioning position shows an YTD overspend of £1.619m and £6.714m forecast overspend. This includes expenditure of £5.759m relating to Additional Roles Reimbursement Scheme (ARRS) and £0.964m for Winter Access Funding (WAF) above the baseline received and both amounts are expected to be funded. WAF has been allocated £1.507m to cover the year to date expenditure.

The CCG has released £3.591m of the H1 £4.244m contingency into the month 11 position.

## Run Rate based on Year to Date Expenditure



**£9.424m variation between the position to date excluding out of envelope covid costs, continuing at its current rate and the forecast outturn for the full financial year.**

- **PC Co-Commissioning** – Costs relating to ARRS, the Investment and Impact Fund and Winter Access Funds spent later in the year.
- **Running Costs** – Expected use of Finance Reserves by year end.
- **Uncommitted Allocations** – Allocations received still awaiting distribution to areas forecast to be spent.
- **Mental Health Services** – Complex care costs in CAMHS and Learning Disabilities and growth on Section 117 through out the year.
- **Continuing Health Care** – Differences relating to caseload phasing, potential AQP rate disputes and a month 10 release of prior year accruals.
- **Primary Care Services** – Expenditure expected in M12 for Primary Care Transformation Fund and GP IT.
- **Community Health Services** – DCHS commitment in M12 offset by a reduction relating to the Ophthalmology costs transferring to Acute in H2.
- **Acute Services** – Non recurrent system support payment and increased activity independent sector providers due to Ophthalmology contracts offset by a reduction in system top up in H2
- **Other Programme Services** – Non recurrent contribution to Better Care Fund.
- **Efficiency Target** – Efficiencies expected to be achieved in H2.
- **Contingency** – Balance of H1 contingency funding to be utilised in H2.

## Main Changes in Forecast Outturn – Month 10 to Month 11

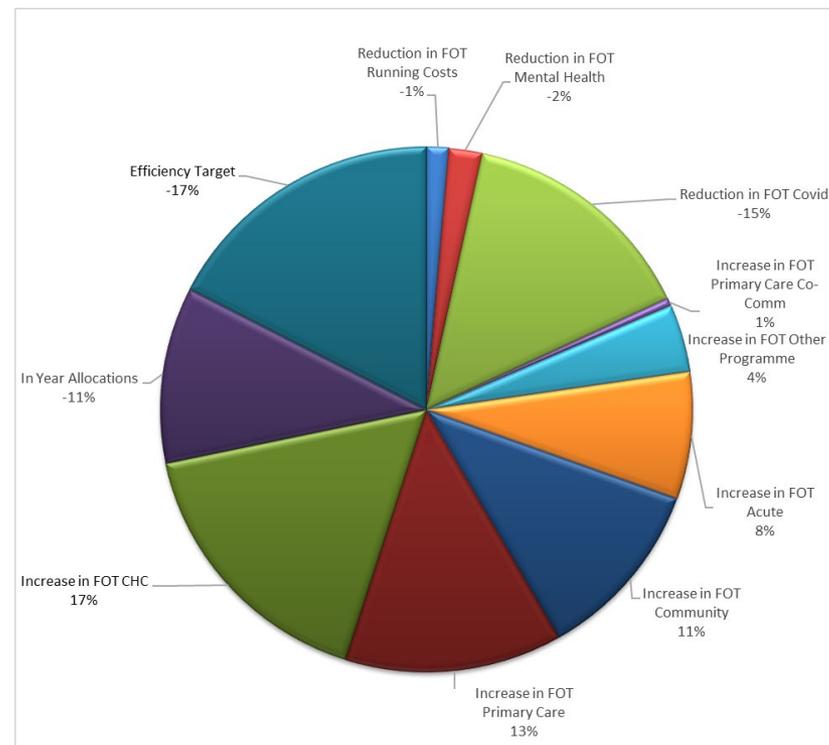
	£m	£m
Month 10 Annual Forecast Outturn		2,110.6

Reduction in FOT	Running Costs	(0.08)
	Mental Health	(0.12)
	Covid	(0.88)
Increase in FOT	Primary Care Co-Comm	0.03
	Other Programme	0.25
	Acute	0.47
	Community	0.68
	Primary Care	0.80
	CHC	1.01
In Year Allocations		(0.66)
Efficiency Target		(1.05)

Total Movement		0.44
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Month 11 Annual Forecast Outturn		2,111.1
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- **Running Costs** – Payroll underspends due to vacancies
- **Mental Health** – Reduction in MHIS spend, IAPT activity and costs in voluntary sector.
- **Covid out of envelope** – Reduction in covid costs in CHC offset by increase in Community Health Services.
- **Primary Care Co- Comm** – Increase in expenditure for Access Improvement.
- **Other Programme** – Transition costs have increase in month and expenditure for the Alcohol Care Team has increased in line with the allocation received.
- **Acute** – Pass through of allocations to EMAS, CRH and UHDB.



- **Community** – Increase in expenditure on MSK Digital Hub, wheelchair waiting list and DCHS pass through of allocations.
- **Primary Care Costs** – Increase in expenditure relating Afghan Resettlement scheme, an increase in GPIT equipment and Primary Care Transformation Fund.
- **In Year Allocations** – Non-recurrent allocations received in month awaiting distribution to areas.
- **Efficiency Target** – Efficiency savings expected to be made by end of financial year.
- **CHC** – Expected increase in providers costs backdated for 21/22, Derby City Children's management costs with CSU, offset by a reduction in prior year accruals.

## Governing Body Meeting in Public

7<sup>th</sup> March 2022

Item No: 010

<b>Report Title</b>	Audit Committee Assurance Report – March 2022
<b>Author(s)</b>	Suzanne Pickering, Head of Governance
<b>Sponsor (Director)</b>	Ian Gibbard, Audit Lay Member and Audit Committee Chair

<b>Paper for:</b>	<b>Decision</b>	<b>Assurance</b>	x	<b>Discussion</b>	<b>Information</b>
<b>Assurance Report Signed off by Chair</b>			Ian Gibbard, Audit Committee Chair		
<b>Which committee has the subject matter been through?</b>			Audit Committee – 17.3.2022		

### Recommendations

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

### Report Summary

This report provides the Governing Body with highlights from the 17<sup>th</sup> March 2022 meeting of the Audit Committee. This report provides a brief summary of the items transacted for assurance.

### External Audit Progress Report

The Audit Committee RECEIVED and NOTED the Progress Report.

The Audit Committee RECEIVED and NOTED the Value for Money Risk Assessment and NOTED the two significant risks identified in relation to Financial Sustainability and Governance relating to the transition of the ICB and Glossop boundary change.

### Internal Audit

#### 360 Assurance Progress Report

The Committee:

- NOTED the Internal Audit Progress Report and discussion in relation to the recent benchmarking work and 2022/23 Internal Audit Plan;
- RECEIVED and GAINED ASSURANCE on the strong significant assurance of the Interim Head of Internal Audit Opinion and NOTED that no recommendation were made within the opinion;
- RECEIVED and GAINED ASSURANCE on the significant assurance of the Data Security Standards Review Report, and NOTED that no recommendation were made within the report;
- NOTED the ongoing work on the ICB Transition process; and
- RECEIVED the Counter Fraud Progress Report and NOTED the progress made in relation to completion of work from the CCG's Counter Fraud, Bribery and Corruption Plan.

## **Finance**

### **Finance Report**

The Committee NOTED and GAINED ASSURANCE from the verbal update of the Finance Report.

### **IFRS 16 Update Report**

The Audit Committee NOTED the contents of this report for assurance. The Committee GAINED ASSURANCE over the procedures in place to ensure the CCG's readiness for the deferred implementation of IFRS 16 on 1st April 2022.

### **Single Tender Waivers**

The Committee NOTED the Single Tender Waivers approved by the Chief Finance Officer from January 2022 to March 2022.

### **Aged Debt Report**

The Audit Committee NOTED the report contents regarding the level of debt owed to the CCG and the number of days this has been outstanding.

### **Update on Accounting Policies**

The Audit Committee RECEIVED a verbal update on the position on Accounting Policies and NOTED that guidance has still not been received.

### **Financial Transition Update**

The Audit Committee NOTED the revised transition date of 1<sup>st</sup> July 2022, and the impact of the deferred transition date on the financial transition project.

The Committee GAINED ASSURANCE on the actions taken to date, and the progress of the project, to ensure the smooth transition of financial systems and banking arrangements.

## **Governance**

### **Freedom to Speak Up Report**

The Audit Committee NOTED the verbal update and that no concerns were raised during January to March 2022. The Committee RECEIVED an update on the role of the CCG's Freedom to Speak Up Ambassadors within the CCG.

### **Draft Annual Governance Statement 2021/22**

The Audit Committee RECEIVED and assurance the initial draft Annual Governance Statement for information; and REQUESTED the Committee to provide comments and feedback to the Corporate Governance Team.

### **Risk Register Report**

The Audit Committee RECEIVED and NOTED the CCG Risk Register Report for risks during February 2022

The Committee NOTED:

- The decrease in risk score for Risk 16 relating to lack of standardised process in CCG commissioning arrangements. The Committee REQUESTED further information to understand the rationale for the decrease in risk score.

- The closure of risk 32 relating to the risk of exploitation by malevolent third parties If vulnerability is identified within any of the Microsoft Office 2010 applications after 14th October 2020.

**Committee Meeting Business Log**

The Audit Committee NOTED the CCG’s Committee Meeting Log for information.

**Conflicts of Interest Report**

Audit Committee NOTED the Conflicts of Interest Update Report for assurance and RECEIVED the following:

- Conflicts of Interest Forward Planner 2021/22
- Decision Makers’ Register of Interests
- Governing Body & Committee Members’ Register of Interests
- Confidential Register of Interests – no further updates since last meeting
- Summary Register for Recording Any Interests During Meetings
- Gifts & Hospitality Register
- Procurement Register
- Breach Register

**Forward Plan**

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

**Any Other Business**

The Committee discussed the future committee meeting dates in respect of the key documentation and deadlines for year-end accounts and reporting.

**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

<b>Have any Conflicts of Interest been identified/ actions taken?</b>
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None identified
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<b>Governing Body Assurance Framework</b>
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Any risks highlighted and assigned to the Audit Committee will be linked to the Derby and Derbyshire CCG GBAF and risk register
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<b>Identification of Key Risks</b>
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Noted as above
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## Governing Body Meeting in Public

7<sup>th</sup> April 2022

Item No: 011

<b>Report Title</b>	Clinical and Lay Commissioning Committee Assurance Report – March 2022
<b>Author(s)</b>	Zara Jones, Executive Director of Commissioning Operations
<b>Sponsor (Director)</b>	Zara Jones, Executive Director of Commissioning Operations

<b>Paper for:</b>	<b>Decision</b> x <b>Assurance</b> x <b>Discussion</b>	<b>Information</b>
<b>Assurance Report Signed off by Chair</b>	Ian Gibbard, Chair of the CLCC Committee	
<b>Which committee has the subject matter been through?</b>	CLCC – 10.3.2022	

### Recommendations

The Governing Body is requested to **RATIFY** the decisions made by the Clinical and Lay Commissioning Committee (CLCC) on the 10<sup>th</sup> March 2022.

### Report Summary

#### **CLC/2122/208 Derby City Community Mental Health Framework – Facilitation and Service Design Contract**

The CLCC were asked to note the:

- Proposal agreed - to direct award £180k inclusive of VAT (Community Mental Health Transformation funding) to the Innovation Unit for continuity of facilitation and service design for the transformation of Community Mental Health Services for a 6-month period.
- Agreement given to review and procure contract for remainder of the programme (2 years) following the transition to an ICB.
- Note that the proposal has been reviewed and is supported by the contracting and procurement specialists within and available to the DDCCG.
- Note that the proposal has been agreed by Executive Team on 16 February.

**CLCC SUPPORTED and NOTED the Proposal.**

#### **CLC/2122/211 CPAG Policies**

**CLCC RATIFIED the following Clinical Policies:**

- 1a. Surgical Treatment of Sleep Apnoea Policy
- 1b. Breast Reduction Surgery Policy
- 1c. Hip and Knee Replacement Policy
- 1d. Hip & Knee Revision Policy
- 1e. Hip Resurfacing Policy

- 1f.** Surgical Haemorrhoidectomy Policy
- 1g.** Adult Snoring in the absence of Obstructive Sleep Apnoea Policy
- 1h.** Removal of Benign Skin Lesions Policy
- 1i.** Continuous Glucose Monitoring Policy
- 1j.** Cough Assist Machine (mechanical Insufflation-exsufflation MI-E)

The CLCC were asked to note that updated policy **1h excluded** the removal of facial warts in children as a decision had been made in line with what the EBI and the possible psychological effects, particularly around bullying in schools which could lead to further health interventions and costs.

The CLCC were asked to note the following for updated policy **1j**:

Following an increase in requests at the IFR panel for cough assist machines there would now be limited use of cough machines through certain criteria. This would be managed through the continuing healthcare team and reviewed over time.

### **Areas of Service Development**

CLCC NOTED that CPAG have reviewed Individual Funding Request (IFR) cases submitted and Interventional Procedures Guidance (IPGs), Medtech Innovation Briefings (MIBs), Medical Technology Guidance (MTGs) and Diagnostic Technologies (DTs) for December 2021 and January 2022

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

CLCC RATIFIED the minor amendments to Cosmetic policies and Clinical Policies website functionality following recommendations made in the Cosmetics Policy review report which has been approved by CPAG. Amendments included changes to:

- Additional Resource Section
- References to other policies by providing hyperlinks
- Website context
- Categorisation of policies
- Removal of List of procedures which fall under same policy
- Grouping of procedures with individual policies into anatomical subsections
- Terminology and definitions

**CLCC NOTED the following:**

### **Update to Glossop transition process/comms plan for Individual Funding Requests (IFR) /Prior Approval and Cosmetics**

- An update relating to the current position on the Glossop transition process / Communications plan for IFR / Prior Approval and Cosmetics

**Update to Glossop transition for Clinical Policies**

- An update in relation to the current position on the Glossop transition process for Clinical Policies

**EMACC update**

CLCC NOTED the update provided by EMACC.

CLCC NOTED THE CPAG Bulletin for December 2021

**CLCC/2122/214 GBAF 3**

CLCC were asked to:

- **DISCUSS** and **REVIEW** for Quarter 4 (January to March) Governing Body Assurance Framework Strategic Risk 3 owned by the CLCC.
- **REVIEW** and **UPDATE** any further mitigating actions and assurances.
- **REVIEW** and **UPDATE** the current risk score.

**CLCC reviewed and NOTED GBAF Risk 3. There were no amendments.**

**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

<b>Have any Conflicts of Interest been identified/ actions taken?</b>
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N/A
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<b>Governing Body Assurance Framework</b>
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N/A
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<b>Identification of Key Risks</b>
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N/A
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## Governing Body Meeting in Public

7<sup>th</sup> April 2022

Item No: 012

<b>Report Title</b>	Derbyshire Engagement Committee Assurance Report – March 2022
<b>Author(s)</b>	Sean Thornton, Deputy Director Communications and Engagement
<b>Sponsor (Director)</b>	Martin Whittle, Vice Chair/Lay Member for PPI

Paper for:	Decision	Assurance	x	Discussion	Information
<b>Assurance Report Signed off by Chair</b>				Simon McCandlish, Vice Chair of Engagement Committee/Lay Member for PPI	
<b>Which committee has the subject matter been through?</b>				Engagement Committee – 15.3.2022	

### Recommendations

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

### Report Summary

This report provides the Governing Body with highlights from the meeting of the Engagement Committee, held on 15<sup>th</sup> March 2022. This report provides a summary of the items transacted for assurance.

#### Older People's Mental Health Services Consultation Report

The Committee approved the formal report describing the outputs from a period of formal consultation which ran for 60 days from December to February, proposing the relocation of existing older people's mental health provision from existing wards at Florence Nightingale Community Hospital and Chesterfield Royal Hospital to Kingsway Hospital and Walton Hospital, Chesterfield respectively. The consultation received fewer responses than had been expected, but these were overwhelmingly positive, and it was noted that through engagement with patients and carers on the wards the moves had been supported.

The Committee were fully assured of the process and the use of patient advocates for this vulnerable cohort of patients had been good practice. The changes are part of a broader programme of estates development for mental health services, including the implementation of the nationally dormitories eradication process, and further engagement would be taking place in due course.

#### Dormitory Eradication Programme

The system is currently developing a business case to secure £80m investment from NHSE to change existing service accommodation from the dormitory style provision to single room, en-suite facilities, in addition to a new build for psychiatric intensive care to support people in Derbyshire that currently have to leave Derbyshire to receive those services. The business cases are in development and can progress following the conclusion of the OPMH consultation described above. The programme aims to rebuild the Hartington Unit Facility on the Chesterfield Royal Hospital site, to refurbish parts of the Radbourne Unit on the Royal Derby Hospital

site and to make changes to accommodation on the Kingsway Hospital site. The Committee noted the update, and that further engagement will take place as the business case progresses.

### **Equality Delivery System**

The Committee reviewed the draft submission of the CCG's Equality Delivery System for 2021/22. The Equality Delivery System (EDS) was commissioned by the national Equality and Diversity Council in 2010 and launched in July 2011. It is a system that helps NHS organisations improve the services they provide for their local communities and provide better working environments, free of discrimination, for those who work in the NHS, while meeting the requirements of the Equality Act 2010. The EDS was developed by the NHS, for the NHS, taking inspiration from existing work and good practice.

Through recognition of the impact of the pandemic and ongoing NHS pressures a new tool has been drafted providing a more proportionate way to illustrate required evidence. In Derby and Derbyshire, it has been decided to use this draft tool for this year's submission. There are three sections:

- Domain 1: Commissioned or provided services
- Domain 2: Workforce Health and Wellbeing
- Domain3: Inclusive leadership

Reviewing Domain 1, the Committee noted that the submission included references to the efforts made to reach community groups with reliable information about the Covid-19 vaccination, the recent engagement work on the local urgent treatment centres, linking with seldom heard groups as we progress the outpatient's modernisation programme and the embedding of the Equality Impact Assessment process across all system projects. The Committee were assured by the information contained within the submission, which was to be submitted by 31<sup>st</sup> March 2022.

### **Integrated Care System Communications and Engagement Planning**

The Committee received an update on the current progress towards creating a statutory Integrated Care System and Integrated Care Board (ICB). The update included progress with the development of an integration index, outlined in the NHS Long Term Plan, which seeks to measure the way in which services join up to improve care. This work is being developed with The Kings Fund and is being piloted with the Team Up element of the Ageing Well programme. There is also a national pilot of the index which Derbyshire is also signing up to and work is underway to ensure the two approaches are complimentary.

The Committee was also updated on corporate communication developments relating to the establishment of ICS, including the new website provision, branding developments and the expected emergence of a national campaign to raise awareness of the work of ICSs, in part aimed at staff working across systems.

Part of the establishment process for the ICB includes submitting an Engagement Strategy. JUCD already has a live Communications and Engagement Strategy, and this is being refreshed in collaboration with local authority partners ahead of submission on 27<sup>th</sup> May.

<b>Exception Risk Report and Governing Body Board Assurance Framework</b>
The Committee agreed to reduce the score of the single risk currently being managed by the Engagement Committee at its meeting in January. This relates to a current 2x4=8 risk on the adherence to engagement legislation when undertaking service commissioning. Given the work to date on the engagement model and governance guide, in addition to the ongoing examples of engagement and communications taking place across the vaccination programme, the Committee felt able to agree a reduction of the score to 2x3=6. The risk will be closed in April 2022, with evidence to support the risk mitigation provided to the Audit Committee in due course.
<b>Are there any Resource Implications (including Financial, Staffing etc)?</b>
None identified
<b>Has a Privacy Impact Assessment (PIA) been completed? What were the findings?</b>
A PIA is not found applicable to this update. This report is for assurance and information
<b>Has a Quality Impact Assessment (QIA) been completed? What were the findings?</b>
A QIA is not found applicable to this update. This report is for assurance and information
<b>Has an Equality Impact Assessment (EIA) been completed? What were the findings?</b>
An EIA is not found applicable to this update. This report is for assurance and information
<b>Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below</b>
Not applicable to this update. This report is for assurance and information
<b>Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below</b>
Not applicable to this update. This report is for assurance and information but describes a range of patient, public communications and engagement activity across the breadth of CCG work
<b>Have any Conflicts of Interest been identified/ actions taken?</b>
None identified
<b>Governing Body Assurance Framework</b>
Risks assigned to the Engagement Committee are reviewed monthly and changes noted within this assurance report. The single risk currently allocated to the Committee is to close in April 2022 subject to Audit Committee assurance
<b>Identification of Key Risks</b>
Noted as above

## Governing Body Meeting in Public

7<sup>th</sup> April 2022

Item No: 013

<b>Report Title</b>	Primary Care Commissioning Committee Assurance Report – March 2022
<b>Author(s)</b>	Hannah Belcher, Assistant Director GP Commissioning Development
<b>Sponsor (Director)</b>	Clive Newman, Director GP Commissioning and Development

Paper for:	Decision	Assurance	x	Discussion	Information
<b>Assurance Report Signed off by Chair</b>		Professor Ian Shaw, Chair PCCC			
<b>Which committee has the subject matter been through?</b>		Primary Care Commissioning Committee – 23.3.2022			
<b>Recommendations</b>					
The Governing Body is requested to <b>RECEIVE</b> the decisions made by the Primary Care Commissioning Committee (PCCC) at the public meeting held on Wednesday 23 <sup>rd</sup> March 2022 for information and assurance.					
<b>Report Summary</b>					
The Primary Care Commissioning Committee Public meeting held on Wednesday 23 <sup>rd</sup> March 2022 formally APPROVED					
<ul style="list-style-type: none"> <li>The Feasibility Study for the Swadlincote area Executive Summary. The Committee noted the next stage post PID Options Appraisal (PPOA) / Outline Business Case (OBC). A PPOA can be usefully employed with the aim of arriving at a preferred option via a robust options appraisal process, in advance of completing a full OBC. Adopting a systematic approach provides DDCCG with an approval gateway/checkpoint, enabling all parties to reach agreement on the preferred option before proceeding through to the completion of the Business Case.</li> </ul> <p>The Committee noted that there will need to be further exploration of the short-term challenges and potential measures set out in Section 4 of the Feasibility Study to ensure the continuity of service delivery whilst a preferred long-term solution is identified and implemented in this area.</p> <p>The Committee also received the following reports for information and assurance:</p> <ul style="list-style-type: none"> <li>Update on the NHSE/I GP contract changes for 22/23 as set out in the letter dated 1<sup>st</sup> March 2022.</li> <li>M10 Finance Report</li> <li>Risk Register – no change to risk ratings this month</li> </ul>					

<b>Are there any Resource Implications (including Financial, Staffing etc)?</b>
Outlined specifically in each report considered by the Primary Care Commissioning Committee
<b>Has a Privacy Impact Assessment (PIA) been completed? What were the findings?</b>
Included as part of each report as required
<b>Has a Quality Impact Assessment (QIA) been completed? What were the findings?</b>
Included as part of each report as required
<b>Has an Equality Impact Assessment (EIA) been completed? What were the findings?</b>
Included as part of each report as required
<b>Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below</b>
Included as part of each report as required
<b>Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below</b>
Included as part of each report as required
<b>Have any Conflicts of Interest been identified / actions taken?</b>
Included as part of each report as required and highlighted where a conflict of interest applies for Governing Body members
<b>Governing Body Assurance Framework</b>
Considered for each agenda item
<b>Identification of Key Risks</b>
Considered for each agenda item

## Governing Body Meeting in Public

7<sup>th</sup> April 2022

Item No:014

<b>Report Title</b>	Quality and Performance Committee Assurance Report – March 2022
<b>Author(s)</b>	Jackie Carlile, Head of Performance and Assurance Helen Hipkiss, Director of Quality
<b>Sponsor (Director)</b>	Zara Jones, Executive Director for Commissioning Operations Brigid Stacey, Chief Nurse

<b>Paper for:</b>	<b>Decision</b>	<b>Assurance</b>	x	<b>Discussion</b>	<b>Information</b>
<b>Assurance Report Signed off by Chair</b>		Dr Buk Dhadda, Chair of Q&PC			
<b>Which committee has the subject matter been through?</b>		Q&PC – 31.3.2022			

### Recommendations

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

### Report Summary

#### Performance:

#### Urgent and Emergency Care:

- The A&E standard was not met at a Derbyshire level at 72.4% (YTD 77.2%). CRH did not achieve the standard, achieving 87.4% (YTD 90.7%). UHDB achieved 62.2% during February (YTD 68.9%).
- UHDB had 116 x 12-hour trolley breaches during February – 115 were due the availability of medical beds and 1 was due to the unavailability of a suitable mental health bed. CRH had 2 breaches, due to the availability of a mental health bed.
- EMAS were non-compliant for all their standards for Derbyshire during February, reflecting the continuing significant pressures being experienced by the trust.

#### Planned Care:

- 18 Week Referral to Treatment (RTT) for incomplete pathways continues to be non-compliant at a CCG level at 63.7% (YTD 65.9%). – a marginal decrease on last month's figure.
- CRHFT performance was 64.7%% (YTD 68.0%) and UHDB 60.6% (YTD 61.5%).
- Derbyshire had 5,488 breaches of the 52-week standard across all trusts – 56 more than the previous month.
- Diagnostics – The CCG performance was 40.55%, a deterioration from last month. Neither CRH (28.4%) or UHDB (43.72%) have achieved the standard, with performance deteriorating at both trusts.

#### Cancer:

During January 2022, Derbyshire was non-compliant in all the 9 cancer standards:

- 2-week Urgent GP Referral – 72.4% (93% standard) – Compliant for Stockport.

- 2 week Exhibited Breast Symptoms – 15.8% (93% standard) – Noncompliant for all trusts.
- 28-day Faster Diagnosis – 60.3% (75% standard) – Compliant for Chesterfield.
- 31 days from Diagnosis – 66.1% (96% standard) – Compliant for Stockport.
- 31-day Subsequent Surgery – 60.0% (94% standard) – Compliant at Stockport.
- 31-day Subsequent Drugs – 96.7% (98% standard) – Compliant for all Trusts except UHDB and Sheffield.
- 31-day Subsequent Radiotherapy – 89.0% (94% standard) – Compliant at Sheffield.
- 62-day Urgent GP Referral – 57.3% (85% standard) – Noncompliant for all trusts.
- 62-day Screening Referral – 53.1% (90% standard) – Noncompliant for all trusts.
- 104 days wait – 31 patients treated after 104 days.

## Quality

### Chesterfield Royal Hospital FT

**Mortality:** As reported at the last Quality and Performance Committee the Acute Cerebrovascular Disease (ACD) HSMR as of December 2021 (Hospital Standardised Mortality Rate) is reported as 122.7 which is classified as high. In terms of the actions being taken by the Trust, they are implementing the ABC-ICH Care Bundle. This is reported as a standing item in CQRG for updates and review of actions as part of assurance and oversight.

**Patient Safety Incident Framework (PSIRF):** There has been a brief pause on the Trusts PSIRP process due to capacity issues in the central team and the clinical areas; this is being kept under constant review by the Trust Quality Delivery Committee, with a review taking place the week commencing 21/03/22. The Trust continue to implement the SWARM methodology, in which staff hold a round table review of incidents which are moderate and above.

**Falls:** The Rate of low harm falls has increased as a result of the increased acuity of patients. This is due to a lack of registered nurses and a poor skill mix due to Covid sickness levels, therefore temporary staffing has been utilised to maintain safety. Risk assessments are being completed to ensure that wards are supported as appropriately as possible with the staffing resource available

### University Hospitals of Derby and Burton FT

**Patient Safety Incident Framework (PSIRF):** All thematic reviews are planned to be completed at the end of Quarter 4. UHDB continue to review immediate actions from Never events to ensure information and lessons learned are shared in a timely manner.

**Maternity:** The Homebirth service remains stood down due to continued workforce constraints and capacity. This is continually under review in line with staffing and remains under review at the Derbyshire Local Maternity and Neonatal System Quality and Safety forum, and Board.

### Derbyshire Community Health Services FT

**Staffing for Safe Care:** Absence due to either Covid or exposure to Covid has been a challenge. Most wards have at times worked on Level 2 Contingency Staffing (One RN per shift) due to vacancy and absence. The Matrons have continued to remain on a rostered On-Call to support deployment of staffing. Butterley ward at Ripley temporarily relocated to Ilkeston Hospital to support resilience and staffing across the two wards. The pilot of trialling the 12-hour shift pattern has continued but formal review has been delayed due to the

impact of absence. Predominately the feedback to date has been overall positive with some requests for amending the night-time shift times being the predominant feedback. Work is being undertaken now to address capacity by utilising staff to their best capabilities and to improve the talent pipeline for the future. This includes the E Roster programme and EJob Planning, optimising student placements, better use of apprenticeships, a fast-track recruitment process for recruiting graduate clinicians and working with the system to promote healthcare careers. Staffing Capacity and impact is monitored through CQRG.

### **Derbyshire Healthcare Foundation Trust**

**Falls on inpatient wards:** After an increase above the mean line in September and October, the number of falls in November has fallen, similar to previous months. The new Matron and Head of Nursing for the older adult areas have been working on reducing falls across the inpatient areas. The number of falls will be monitored at CQRG.

### **East Midlands Ambulance Trust**

**Serious Incidents:** Five Serious incidents were reported in January 2022. Two were prolonged waits, one was an incorrect coding which led to a prolonged wait and two were sub-optimal clinical care. A paper from the extraordinary CQRG held on the 16<sup>th</sup> December 2022 was presented to the System Delivery Board on the 25<sup>th</sup> January 2022 who agreed the issues with delayed response SI's were system problems which required a system response. In particular providing system forums where EMAS can raise and discuss issues with falls and respiratory pathways. SI themes and trends will continue to be monitored through CQRG.

### **Update from Quality and Performance Committee 31<sup>st</sup> March 2022**

The system is remains under significant pressure. The number of covid patients in the acute hospitals has significantly increased, they are mainly incidental positive cases. These patients have to be in separate areas following the IPC rules. There are also several beds closed across the sites due to outbreaks. Increasing care home outbreaks are leading to delayed discharges. A critical incidence was considered at SORG (silver group) on the 29<sup>th</sup> March 2022. A decision was taken on the 30<sup>th</sup> March 2022 not to have a gold call as the pressure had decreased slightly. NHSEI have been informed of the actions being taken. The situation is being monitored daily. It was asked that staff were thanked for the continued work in difficult situations.

The ambulance service serious incidents were discussed in terms of the level of reporting. GPs are seeing an increase in delays. Practices have been encouraged to log the serious incidents so they can be investigated. EMAS are reporting all patients they consider as coming to harm due to delays. It was noted that NHSEI has requested a review of the Category 2 delays. The return will be discussed at the next committee.

The support that GPs give to those waiting for treatment was noted. Routine referrals reporting does not cover GP advice and guidance. The operational planning is targeting increased advice and guidance, metrics are being put into place to ensure this activity is collected and recognised.

The seriousness of the system pressure was raised. The system is working at Business Continuity Level 4. Significant actions are being taken, with a risk assessment for all actions. A major fire at Lincoln A&E has added to the pressures this week, with ambulances diverted to our Trusts. All systems are raising concerns about the living with Covid Guidelines. Committee were assured that the system is working together in difficult circumstances.

The cancer consultation is underway, this was delayed because of the pandemic. The backlog of breast screening is showing an improvement. Current pathways are being reviewed to get the correct pathways and then right delivery. Two task and finish groups are in place to ensure stakeholder engagement. Extra clinics are being put on over Easter to further improve the referral times.

The Integrated report was approved by the Chair.

The activity report was noted. Elective delivery remains the biggest challenge. The draft planning submission was not compliant with the NHSEI targets. The delivery leads are determining how the targets can be met. JUCD current performance is middle of the pack for the region.

The Committee GBAFs were discussed, and the amendments made by the task and finish group were agreed. There are thirteen committee risks.

- Risk 27 - *Increase in the number of safeguarding referrals linked to self-neglect related to those who are not in touch with services. These initially increased immediately following COVID lockdown. The adult safeguarding processes and policy are able to respond to this type of enquiry once an adult at risk has been identified. Numbers are difficult to predict but are predicted to increase as COVID restrictions ease. This risk was proposed to reduce from 12 to 9 due to the mitigating actions being implemented. The Committee approved the reduction in risk score.*
- 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. to the risk was recommended to be closed due to the covid restrictions being lifted. The Committee approved the closure of the risk. The process for reviewing the closing position of Q&P committee risks and transferring those risks to the new ICB committee is in development.*

The SEND report as noted. The Glossop SEND transfer was discussed. Committee was assured that systems are in place to triangulate the data and a plan for delivery is being agreed. The committee was assured that all areas for the Glossop transfer are in hand.

The Cancer Harm Review was discussed. The regional cancer lead has stated they are reassured the JUCD have a good cancer plan. Individual patient reviews are underway, including patients who may wish to not engage. The recommendations were agreed.

The committee took assurance on the twelve-hour breaches reviewed.

The Ockendon report (Maternity) was published on the 30<sup>th</sup> March 2022. Committee noted and welcomed the publication. A report on progress against Ockendon initial 7 recommendations will be presented to the next Quality and Performance Committee and then to Governing Body in May 2022.

The committee agreed to return to monthly CQRGs, and the revised terms of reference were approved.

In March a further 5 EMAS serious incidents have been reported. These have been investigated, the key finding remains the increased demand. The harm review has shown no harm in category 2, the main issue is waits for people who have fallen. There is a definition of harm in the serious incident framework, EMAS use this for the harm reviews. Committee were assured by the report and noted the improvement in reporting.

The information items and the minutes of the sub-groups were noted. The minutes of the previous committee were approved. The assurance questions were fulfilled.
<b>Are there any Resource Implications (including Financial, Staffing etc)?</b>
No
<b>Has a Privacy Impact Assessment (PIA) been completed? What were the findings?</b>
N/A
<b>Has a Quality Impact Assessment (QIA) been completed? What were the findings?</b>
N/A
<b>Has an Equality Impact Assessment (EIA) been completed? What were the findings?</b>
N/A
<b>Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below</b>
N/A
<b>Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below</b>
N/A
<b>Have any Conflicts of Interest been identified/ actions taken?</b>
None
<b>Governing Body Assurance Framework</b>
The report covers all of the CCG objectives
<b>Identification of Key Risks</b>
The report covers GBAFs 1,2 and 6

# **Month 10 Quality & Performance Report 2021/22**

## **March 2022**

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## EXECUTIVE SUMMARY

<b>Key Messages</b>	<ul style="list-style-type: none"> <li>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.</li> </ul>
<b>Urgent &amp; Emergency Care</b>	<ul style="list-style-type: none"> <li>The A&amp;E standard was not met at a Derbyshire level at 72.4% (YTD 77.2%). CRH did not achieve the standard achieving 87.4% (YTD 90.7%). UHDB achieved 62.2% during February (YTD 68.9%).</li> <li>UHDB had 116 x 12 hour trolley breaches during February – 115 were due the availability of medical beds and 1 was due to the unavailability of a suitable mental health bed.</li> <li>EMAS were non-compliant for all of their standards for Derbyshire during February, reflecting the continuing significant pressures being experienced by the trust.</li> </ul>
<b>Planned Care</b>	<ul style="list-style-type: none"> <li>18 Week Referral to Treatment (RTT) for incomplete pathways continues to be non-compliant at a CCG level at 63.7% (YTD 65.9%). – a marginal decrease on last months figure.</li> <li>CRHFT performance was 64.7%% (YTD 68.0%) and UHDB 60.6% (YTD 61.5%).</li> <li>Derbyshire had 5,488 breaches of the 52 week standard across all trusts – 56 more than the previous month.</li> <li>Diagnostics – The CCG performance was 40.55%, a deterioration from last month. Neither CRH (28.4%) or UHDB (43.72%) have achieved the standard, with performance deteriorating at both trusts.</li> </ul>
<b>Cancer</b>	<p>During January 2022, Derbyshire was non compliant in all of the 9 cancer standards.</p> <p>2 week Urgent GP Referral – 72.4% (93% standard) – Compliant for Stockport.</p> <p>2 week Exhibited Breast Symptoms – 15.8% (93% standard) – Non compliant for all trusts.</p> <p>28 day Faster Diagnosis – 60.3% (75% standard) – Compliant for Chesterfield.</p> <p>31 day from Diagnosis – 66.1% (96% standard) – Compliant for Stockport.</p> <p>31 day Subsequent Surgery – 60.0% (94% standard) – Compliant at Stockport.</p> <p>31 day Subsequent Drugs – 96.7% (98% standard) – Compliant for all Trusts except UHDB and Sheffield.</p> <p>31 day Subsequent Radiotherapy – 89.0% (94% standard) – Compliant at Sheffield.</p> <p>62 day Urgent GP Referral – 57.3% (85% standard) – Non compliant for all trusts.</p> <p>62 day Screening Referral – 53.1% (90% standard) – Non compliant for all trusts.</p> <p>104 day wait – 31 patients treated after 104 days.</p>

Executive Summary

Trust	
<p>Chesterfield Royal Hospital FT</p>	<p><b>Mortality:</b> As reported at the last Quality and Performance Committee the Acute Cerebrovascular Disease (ACD) HSMR as of December 2021 (Hospital Standardised Mortality Rate) is reported as 122.7 which is classified as high. In terms of the actions being taken by the Trust, they are implementing the ABC-ICH Care Bundle. This is reported as a standing item in CQRG for updates and review of actions as part of assurance and oversight.</p> <p><b>Patient Safety Incident Framework (PSIRF):</b> There has been a brief pause on the Trusts PSIRP process due to capacity issues in the central team and the clinical areas; this is being kept under constant review by the Trust Quality Delivery Committee, with a review taking place the week commencing 21/03/22. The Trust continue to implement the SWARM methodology, in which staff hold a round table review of incidents which are moderate and above.</p> <p><b>Falls:</b> The Rate of low harm falls has increased as a result increased acuity of patients. This is due to a lack of registered nurses and a poor skill mix due to Covid sickness levels, therefore temporary staffing has been utilised to maintain safety. Risk assessments are being completed to ensure that wards are supported as appropriately as possible with the staffing resource available.</p>
<p>University Hospitals of Derby and Burton NHS FT</p>	<p><b>Patient Safety Incident Framework (PSIRF):</b> All thematic reviews are planned to be completed at the end of Quarter 4. UHDB continue to review immediate actions from Never events to ensure information and lessons learned are shared in a timely manner.</p> <p><b>Maternity:</b> The Homebirth service remains stood down due to continued workforce constraints and capacity. This is continually under review in line with staffing, and remains under review at the Derbyshire Local Maternity and Neonatal System Quality and Safety forum, and Board.</p>
<p>Derbyshire Community Health Services FT</p>	<p><b>Staffing for Safe Care:</b> Absence due to either Covid or exposure to Covid has been a challenge. Most wards have at times worked on Level 2 Contingency Staffing (One RN per shift) due to vacancy and absence. The Matrons have continued to remain on a rostered On-Call to support deployment of staffing. Butterley ward at Ripley temporarily relocated to Ilkeston Hospital to support resilience and staffing across the two wards. The pilot of trialling the 12 hour shift pattern has continued but formal review has been delayed due to the impact of absence. Predominately the feedback to date has been overall positive with some requests for amending the night time shift times being the predominant feedback. Work is being undertaken now to address capacity by utilising staff to their best capabilities and to improve the talent pipeline for the future. This includes, the E Roster programme and EJob Planning, optimising student placements, better use of apprenticeships, a fast track recruitment process for recruiting graduate clinicians and working with the system to promote healthcare careers. Staffing Capacity and impact is monitored through CQRG.</p>
<p>Derbyshire Healthcare Foundation Trust</p>	<p><b>Falls on inpatient wards:</b> After an increase above the mean line in September and October, the number of falls in November has fallen, similar to previous months. The new Matron and Head of Nursing for the older adult areas have been working on reducing falls across the inpatient areas. The number of falls will be monitored at CQRG</p>
<p>East Midlands Ambulance Trust</p>	<p><b>Serious Incidents:</b> Five Serious incidents were reported in January 2022. Two were prolonged waits, one was an incorrect coding which led to a prolonged wait and two were sub-optimal clinical care. A paper from the extraordinary CQRG held on the 16th of December 2022 was presented to the System Delivery Board on the 25th of January 2022 who agreed the issues with delayed response SI's were system problems which required a system response. In particular providing system forums where EMAS can raise and discuss issues with falls and respiratory pathways. SI themes and trends will continue to be monitored through CQRG.</p>

# PERFORMANCE OVERVIEW MONTH 11 – URGENT CARE

## NHS Derby & Derbyshire CCG Assurance Dashboard

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

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

### Part A - National and Local Requirements

#### CCG Dashboard for NHS Constitution Indicators

Urgent Care	Area	Indicator Name	Standard	Latest Period	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Chesterfield Royal Hospital FT			University Hospitals of Derby & Burton FT			NHS England		
									Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance
Urgent Care	Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	Feb-22	↑	72.4%	77.2%	77	87.4%	90.7%	6	62.2%	68.9%	77	75.7%	79.3%	77
		A&E 12 Hour Trolley Waits	0	Feb-22					0	16	0	116	788	19	16404	76193	77

## 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

Urgent Care	Area	Indicator Name	Standard	Latest Period	Direction of Travel	Current Month	YTD	consecutive months non-compliance	EMAS Performance (Whole Organisation)			EMAS Completed Quarterly Performance 2021/22				NHS England		
									Current Month	YTD	consecutive months non-compliance	Q1 2021/22	Q2 2021/22	Q3 2021/22	Q4 2021/22	Current Month	YTD	consecutive months non-compliance
Urgent Care	Ambulance System Indicators	Ambulance - Category 1 - Average Response Time	00:07:00	Feb-22	↓	00:08:44	00:08:39	20	00:08:56	00:08:44	19	00:07:54	00:09:05	00:09:17		00:08:51	00:08:30	10
		Ambulance - Category 1 - 90th Percentile Respose Time	00:15:00	Feb-22	↓	00:15:05	00:14:55	1	00:16:18	00:15:42	8	00:14:06	00:16:29	00:16:36		00:15:43	00:15:02	8
		Ambulance - Category 2 - Average Response Time	00:18:00	Feb-22	↓	00:41:41	00:39:10	19	00:48:26	00:45:59	20	00:33:40	00:49:29	00:56:39		00:42:07	00:39:32	19
		Ambulance - Category 2 - 90th Percentile Respose Time	00:40:00	Feb-22	↓	01:25:32	01:21:23	19	01:41:46	01:38:09	19	01:10:09	01:46:26	02:03:36		01:31:54	01:25:05	11
		Ambulance - Category 3 - 90th Percentile Respose Time	02:00:00	Feb-22	↓	06:03:19	05:49:13	19	06:27:20	06:35:18	19	04:30:11	07:17:52	08:24:08		05:30:21	05:27:49	11
		Ambulance - Category 4 - 90th Percentile Respose Time	03:00:00	Feb-22	↓	06:02:01	05:24:54	11	06:04:37	06:01:30	11	04:43:53	06:45:03	06:55:08		06:52:23	06:28:48	3

# PERFORMANCE OVERVIEW MONTH 10 – PLANNED CARE

## NHS Derby & Derbyshire CCG Assurance Dashboard

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

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

### Part A - National and Local Requirements

#### CCG Dashboard for NHS Constitution Indicators

Area	Indicator Name	Standard	Latest Period	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Chesterfield Royal Hospital FT			University Hospitals of Derby & Burton FT			NHS England			
								Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	
Planned Care	Referrals to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Jan-22	↓	63.7%	65.9%	48	64.7%	68.0%	33	60.6%	61.5%	49	62.8%	66.1%	71
		Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Jan-22	↓	5488	59877	24	1154	11388	22	5281	63495	23	311528	3154834	177
	Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Jan-22	↑	40.55%	33.26%	44	28.40%	18.73%	22	43.72%	37.10%	23	30.00%	25.50%	101
	2 Week Cancer Waits	All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	Jan-22	↓	70.6%	81.8%	17	Cancer 2 Week Wait Pilot Site - not currently reporting			62.3%	75.5%	17	75.0%	82.4%	20
		Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	Jan-22	↑	15.8%	51.7%	5	7.2%	48.6%	4	49.4%	65.3%	20			
	28 Day Faster Diagnosis	Diagnosis or Decision to Treat within 28 days of Urgent GP, Breast Symptom or Screening Referral	75%	Jan-22	↓	66.3%	73.6%	5	76.6%	77.2%	0	56.9%	70.9%	6	63.8%	71.7%	10
	31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	96%	Jan-22	↓	84.0%	90.9%	13	81.3%	91.8%	5	86.9%	91.4%	18	89.6%	93.5%	13
		Subsequent Surgery Within 31 Days Of Decision To Treat	94%	Jan-22	↓	63.7%	78.1%	26	78.6%	93.9%	1	70.2%	82.4%	8	N/A	85.2%	0
		Subsequent Drug Treatment Within 31 Days Of Decision To Treat	98%	Jan-22	↑	96.7%	98.4%	2	100.0%	100.0%	0	94.8%	98.1%	2	96.6%	98.8%	1
		Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	Jan-22	↓	89.0%	94.7%	1				75.3%	89.9%	4	91.5%	95.4%	1
	62 Days Cancer Waits	First Treatment Administered Within 62 Days Of Urgent GP Referral	85%	Jan-22	↓	57.3%	64.3%	35	66.9%	72.2%	30	51.1%	59.7%	45	61.8%	69.6%	73
		First Treatment Administered - 104+ Day Waits	0	Jan-22	↓	31	286	70	3	47	45	34	262	70	1362	10624	73
		First Treatment Administered Within 62 Days Of Screening Referral	90%	Jan-22	↓	53.1%	66.6%	33	37.8%	52.7%	33	64.0%	79.8%	14	65.4%	73.0%	46
		First Treatment Administered Within 62 Days Of Consultant Upgrade	N/A	Jan-22	↓	77.8%	80.7%		83.3%	84.6%		89.7%	86.9%		76.0%	80.0%	

# PERFORMANCE OVERVIEW MONTH 10 – PATIENT SAFETY

## NHS Derby & Derbyshire CCG Assurance Dashboard

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

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

### Part A - National and Local Requirements

#### CCG Dashboard for NHS Constitution Indicators

Area	Indicator Name	Standard	Latest Period	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Chesterfield Royal Hospital FT			University Hospitals of Derby & Burton FT			NHS England		
								Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance
Patient Safety	Healthcare Acquired Infection (HCAI) Measure: MRSA Infections	0	Jan-22	↔	0	1	0				0	1	0	63	558	34
	Healthcare Acquired Infection (HCAI) Measure: C-Diff Infections	Plan	Jan-22	↑		197					99					
		Actual				210	0			16	0		57	0		12095
	Healthcare Acquired Infection (HCAI) Measure: E-Coli	-	Jan-22	↓	82	721		31	228		45	496		82	721	
Healthcare Acquired Infection (HCAI) Measure: MSSA	-	Jan-22	↓	26	211		6	63		21	151		1039	10217		

# PERFORMANCE OVERVIEW MONTH 10 – MENTAL HEALTH

## CCG Dashboard for NHS Constitution Indicators

CCG Dashboard for NHS Constitution Indicators				Direction of Travel	Current Month	YTD	consecutive months of failure	Cancer 2 Week Wait Pilot Site - not currently reporting			Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure	
Mental Health	Area	Indicator Name	Standard	Latest Period	NHS Derby & Derbyshire CCG							NHS England								
	Early Intervention In Psychosis	Early Intervention In Psychosis - Admitted Patients Seen Within 2 Weeks Of Referral	60.0%	Jan-22	↓	40.0%	54.7%	3	50.0%	53.8%	3				70.2%	67.6%	0			
		Early Intervention In Psychosis - Patients on an Incomplete Pathway waiting less than 2 Weeks from Referral	60.0%	Jan-22	↑	40.0%	38.3%	7	40.0%	45.3%	7				28.9%	27.4%	33			
	Mental Health	Dementia Diagnosis Rate	67.0%	Jan-22	↓	63.3%	64.5%	19							61.6%	62.8%	22			
		CYPMH - Eating Disorder Waiting Time % urgent cases seen within 1 week		2021/22 Q3	↓	81.6%	74.6%													
		CYPMH - Eating Disorder Waiting Time % routine cases seen within 4 weeks		2021/22 Q3	↓	69.7%	83.9%													
		Perinatal - Increase access to community specialist perinatal MH services in secondary care	4.5%	2021/22 Q2	↑	3.5%	3.9%	7												
		Mental Health - Out Of Area Placements		Dec-21	↑	625	5050													
	Physical Health Checks for Patients with Severe Mental Illness	25%	2021/22 Q3	↑	28.4%	29.6%	0													
	Mental Health	Area	Indicator Name	Standard	Latest Period	NHS Derby & Derbyshire CCG				Talking Mental Health Derbyshire (D&DCCG only)			Trent PTS (D&DCCG only)			Insight Healthcare (D&DCCG only)			Vita Health (D&DCCG only)	
Improving Access to Psychological Therapies		IAPT - Number Entering Treatment As Proportion Of Estimated Need In The Population	Plan	Jan-22	↑	2.10%	21.00%													
			Actual			2.49%	26.05%	0												
Improving Access to Psychological Therapies		IAPT - Proportion Completing Treatment That Are Moving To Recovery	50%	Jan-22	↑	54.9%	52.8%	0	59.1%	55.1%	0	53.1%	52.3%	0	49.3%	46.9%	4	67.6%	57.6%	0
		IAPT Waiting Times - The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment	75%	Jan-22	↓	77.7%	91.2%	0	89.7%	89.1%	0	66.0%	90.4%	1	98.1%	98.1%	0	100.0%	98.3%	0
Improving Access to Psychological Therapies	IAPT Waiting Times - The proportion of people that wait 18 Weeks or less from referral to entering a course of IAPT treatment	95%	Jan-22	↔	100.0%	100.0%	0	100.0%	100.0%	0	100.0%	100.0%	0	100.0%	100.0%	0	100.0%	100.0%	0	
	Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Jan-22	↑	61.4%	75.0%	8												
Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways		0	Jan-22	↔	0	1	0													
Mental Health	Area	Indicator Name	Standard	Latest Period	Derbyshire Healthcare FT															
	Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Jan-22	↑	61.4%	75.0%	8												
Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways		0	Jan-22	↔	0	1	0													

# Quality Overview

## QUALITY OVERVIEW M10

Trust	Key Issues
Chesterfield Royal Hospital FT	<p><b>Mortality:</b> As reported at the last Quality and Performance Committee the Acute Cerebrovascular Disease (ACD) HSMR as of December 2021 (Hospital Standardised Mortality Rate) is reported as 122.7 which is classified as high. In terms of the actions being taken by the Trust, they are implementing the ABC-ICH Care Bundle, which consists of guideline-recommended interventions: Rapid Anticoagulant reversing; Intensive Blood pressure lowering; A Care pathway for prompt neurosurgical referral. The HSMR is being reported via the Trusts Mortality Group and being monitored closely. This is reported as a standing item in CQRG for updates and review of actions as part of assurance and oversight.</p> <p><b>Patient Safety Incident Framework (PSIRF):</b> There has been a brief pause on the Trusts PSIRP process due to capacity issues in the central team and the clinical areas; this is being kept under constant review by the Trust Quality Delivery Committee, with a review taking place the week commencing 21/03/22 . In terms of safety, the Trust continue to implement the SWARM methodology, in which staff hold a round table review of incidents which are moderate and above, which provides some assurance and allows for immediate lessons to be learned. The CCG will receive an updated position at the April 2021 Quality Meeting with the Trust.</p> <p><b>Falls :</b> The Rate of low harm falls has increased as a result increased acuity of patients. This is due to a lack of registered nurses on the rotas and a poor skill mix on the wards due to Covid sickness levels, therefore temporary staffing has been utilised to maintain safety. Risk assessments are being completed to ensure that wards are supported as appropriately as possible with the staffing resource available. This is supported by the “SafeCare” acuity assessment in Health roster – providing a Trust wide view.</p>
University Hospitals of Derby and Burton NHS FT	<p><b>CQC:</b> CQC engagement meetings have now reverted to face to face with the Trust with the first one held on the 22<sup>nd</sup> March 2022 – awaiting outcome. The Trust continue to progress well with the actions from the Imaging IRMER action plan and CQC have received a update progress report.</p> <p><b>Patient Safety Incident Framework: (PSIRF):</b> All thematic reviews are planned to be completed at the end of Quarter 4.UHDB continue to review immediate actions from Never events to ensure information and lessons learned are shared in a timely manner.</p> <p><b>Stroke:</b> Plans are being made in relation to a visit to Stroke Services by the Royal College of Physicians, the CCG are awaiting notification of timescales.</p> <p><b>Maternity:</b> The Homebirth service remains stood down due to continued workforce constraints and capacity. This is continually under review in line with staffing, and is being closely monitored by the Trust’s People And Culture Committee, and remains under review at the Derbyshire Local Maternity and Neonatal System Quality and Safety forum, and Board.</p>

## QUALITY OVERVIEW M10 continued

Trust	Key Issues
Derbyshire Community Health Services FT	<p><b>Vaccination:</b> The Staff flu vaccination programme is now complete and the trust internal review of data shows a 89% uptake. National verification data is currently unavailable and planning is underway for the 2022/23 programme (currently aligned to a national CQUIN). The trusts currently stands at 98.67% for front line COVID Vaccination Second Doses and 88.49% for COVID Boosters. Vaccination figures are monitored through CQRG. Lessons learnt from this years Flu vaccination programme will be discussed at the next CQRG meeting.</p> <p><b>Staffing for Safe Care:</b> Absence due to either Covid or exposure to Covid has been a challenge. Most wards have at times worked on Level 2 Contingency Staffing (One RN per shift) due to vacancy and absence. The Matrons have continued to remain on a rostered On-Call to support deployment of staffing. Butterley ward at Ripley temporarily relocated to Ilkeston Hospital to support resilience and staffing across the two wards. The pilot of trialling the 12 hour shift pattern has continued but formal review has been delayed due to the impact of absence. Predominately the feedback to date has been overall positive with some requests for amending the night time shift times being the predominant feedback. Work is being undertaken now to address capacity by utilising staff to their best capabilities and to improve the talent pipeline for the future. This includes, the E Roster programme and EJob Planning, optimising student placements, better use of apprenticeships, a fast track recruitment process for recruiting graduate clinicians and working with the system to promote healthcare careers. Staffing Capacity and impact is monitored through CQRG.</p>
Derbyshire Healthcare Foundation Trust	<p><b>COVID-19:</b> As at 01<sup>st</sup> March 2022 97% of patient facing staff have now received their first vaccination and 95% have received both vaccinations. Booster vaccinations are continuing. This will be monitored at CQRG.</p> <p><b>Delayed transfers of care:</b> Since the multi-agency discharge events (MADE) were held, numbers of delayed transfers of care have reduced and will continue to be monitored through CQRG.</p> <p><b>Falls on inpatient wards:</b> After an increase above the mean line in September and October, the number of falls in November has fallen, similar to previous months. The new Matron and Head of Nursing for the older adult areas have been working on reducing falls across the inpatient areas. The number of falls will be monitored at CQRG.</p> <p><b>Incidents of moderate to catastrophic actual harm:</b> The number of reported incidents of moderate to catastrophic harm have remained within common cause variation throughout the reporting period. This will continue to be monitored by the Heads of Nursing team on a quarterly basis and fed into the relevant Clinical Operational Assurance Team (COAT) meetings.</p>
East Midlands Ambulance Trust	<p><b>Performance:</b> Derbyshire achieved one of the six national standards during January: C1 90th centile. There was also an improvement across all of the standards when compared to the previous month. The deteriorating performance position continued to be seen across the country, with all ambulance services operating at REAP level 4. £55m of additional non-recurrent funding was made available across the ambulance sector in order to support improved performance. A performance improvement trajectory was developed along with an action plan detailing how the funding will be used in order to facilitate an improvement in performance. Performance will continue to be monitored at System Delivery Board.</p> <p><b>Serious Incidents:</b> Five Serious incidents were reported in January 2022. Two were prolonged waits, one was an incorrect coding which led to a prolonged wait and two were sub-optimal clinical care. A paper from the extraordinary CQRG held on the 16th of December 2022 was presented to the System Delivery Board on the 25th of January 2022 who agreed the issues with delayed response SI's were system problems which required a system response. In particular providing system forums where EMAS can raise and discuss issues with falls and respiratory pathways. SI themes and trends will continue to be monitored through CQRG.</p>

# QUALITY OVERVIEW M10

Derbyshire Wide Integrated Report

Part B: Provider Local Quality Indicators

Dashboard Key:

CCG assured by the evidence

Performance Improved From Previous Period

↑

CCG not assured by the evidence

Performance Maintained From Previous Period

↔

Performance Deteriorated From Previous Period

↓

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

Section	Area	Indicator Name	Standard	Chesterfield Royal Hospital FT				University Hospitals of Derby & Burton FT				Derbyshire Community Health Services				Derbyshire Healthcare FT			
				Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD
Ratings	CQC Ratings	Inspection Date	N/A	Aug-19				Mar-19				May-19				May-18			
		Outcome	N/A	Good				Good				Outstanding				Requires Improvement			
Adult	FFT	Staff 'Response' rates	15%	2019/20 Q2	↑	7.6%	8.6%	2019/20 Q2	↑	10.1%	10.1%	Dec-21	↑	90.7%	98.9%	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%	Dec-21	↔	72.0%	72.0%	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%	Dec-21	↓	N/A	97.7%	Jan-22	↑	93.4%	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%	Dec-21	↓	N/A	77.8%	Jan-22	↓	79.1%	80.3%	Jul-20	↓	N/A	99.3%				
	Complaints	Number of formal complaints received	N/A	Sep-21	↓	17	94	Jan-22	↑	35	530	Jan-22	↑	2	45	Jan-22	↑	17	174
		% of formal complaints responded to within agreed timescale	N/A	Jan-22	↓	65.0%		Jan-22	↓	56.8%	61.6%	Jan-22	↓	50.0%	83.6%	Jan-22	↔	100.0%	98.88%
		Number of complaints partially or fully upheld by ombudsman	N/A	Sep-21	↔	0	0	19-20 Q2	↔	1	2	Jan-22	↔	0	0	Jan-22	↔	0	0
	Pressure Ulcers	Category 2 - Number of pressure ulcers developed or deteriorated	N/A	Sep-21	↓	12	34	Jan-22	↑	58	499	Jan-22	↑	74	876	Jan-22	↔	0	3
		Category 3 - Number of pressure ulcers developed or deteriorated	N/A	Sep-21	↑	0	11	Jan-22	↑	17	171	Jan-22	↓	24	291	Jan-22	↑	0	2
		Category 4 - Number of pressure ulcers developed or deteriorated	N/A	Sep-21	↔	0	0	Oct-21	↔	0	0	Jan-22	↓	5	40	Jan-22	↔	0	0
		Deep Tissue Injuries(DTI) - numbers developed or deteriorated		Sep-21	↓	8	24	Sep-19	↑	16	94	Jan-22	↓	78	698	Jan-22	↔	0	0
		Medical Device pressure ulcers - numbers developed or deteriorated						Sep-19	↓	4	20	Jan-22	↔	11	122	Jan-22	↔	0	0
	Falls	Number of pressure ulcers which meet SI criteria	N/A	Sep-20	↑	0	3	Sep-19	↔	0	4	Jan-22	↑	0	6	Jan-22	↔	0	0
		Number of falls	N/A	Sep-21	↓	102	543	Data Not Provided in Required Format				Jan-22	↑	28	222	Jan-22	↓	32	294
	Medication	Number of falls resulting in SI criteria	N/A	Sep-20	↑	0	8	Sep-19	↑	0	19	Jan-22	↔	0	8	Jan-22	↔	0	0
		Total number of medication incidents	?	Sep-21	↓	70	457	Data Not Provided in Required Format				Jan-22	↔	0	1	Jan-22	↓	84	807
	Serious Incidents	Never Events	0	Jan-22	↔	0	0	Jan-22	↑	0	6	May-19	↔	0	0	Jan-22	↔	0	0
Number of SI's reported		0	Sep-20	↑	4	26	Sep-19	↑	7	115	Dec-20	↔	1	34	Jan-22	↔	0	7	
Number of SI reports overdue		0	Apr-21	↔	0	0	May-19	↓	19	28	May-19	↔	0	0					
Number of duty of candour breaches which meet threshold for regulation 20		0	Sep-20	↑	0	3	May-19	↔	0	0	Dec-20	↔	0	0					

# QUALITY OVERVIEW M10

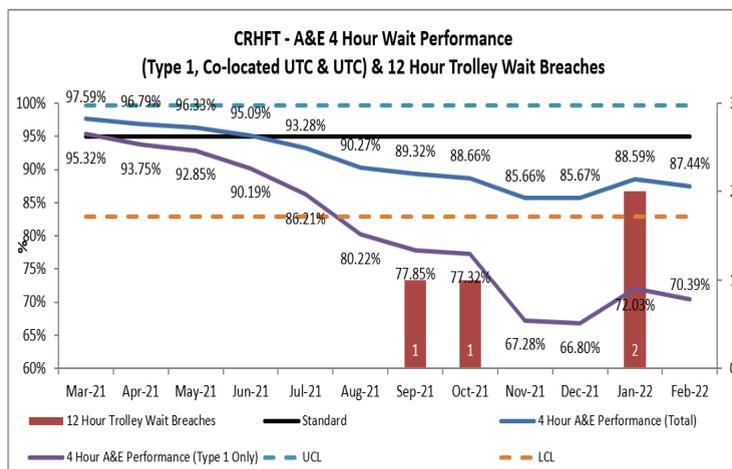
Part B: Acute & Non-Acute Provider Dashboard for Local Quality Indicators cont.				Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD	
Section	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					Jan-22	↔	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	Jan-22	↓	106		Nov-20	↔	107.4										
Summary Hospital-level Mortality Indicator (SHMI): Ratio of Observed vs. Expected			Oct-21	↓	0.990		Oct-21	↓	0.940											
Crude Mortality			Jan-22	↓	1.90%		Jan-22	↓	2.10%	1.60%										
Maternity	FFT	Antenatal service: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Jul-21	↑	98.3%	98.5%	Jun-21	↔	N/A	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?		Nov-21	↑	95.5%	98.9%	Jun-21	↓	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?		Nov-21	↔	100.0%	98.4%	Sep-21	↓	100.0%	98.0%									
		Postnatal community service: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Sep-21	↔	N/A	98.8%	Jun-21	↔	N/A	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													Jan-22	↔	0	0		
Workforce	Staff	Staff turnover (%)		Jan-22	↓	10.6%		Jan-22	↓	10.6%	9.8%	Jan-22	↔	9.4%	9.0%	Jan-22	↓	12.14%	11.18%	
		Staff sickness - % WTE lost through staff sickness		Jan-22	↓	5.1%		Jan-22	↑	5.7%	5.3%	Jan-22	↓	7.9%	5.7%	Jan-22	↓	8.23%	6.95%	
		Vacancy rate by Trust (%)		Jan-22	↓	0.4%		Data Not Provided in Required Format				Jan-22	↓	5.1%	3.7%	Jan-22	↑	10.1%	12.6%	
		Agency usage	Target														Jan-22	↑		
		Agency usage	Actual																0.76%	2.14%
		Agency nursing spend vs plan (000's)		Jan-22	↓		£2,045	Oct-18	↑	£723	£4,355	Jan-22	↓	£196	£1,026					
	Agency spend locum medical vs plan (000's)		Jan-22	↓		£7,208														
Training	% of Completed Appraisals	90%	Sep-21	↑	91.8%		Jan-22	↓	78.8%	81.3%	Jan-22	↓	83.8%	86.1%	Jan-22	↑	75.9%	75.9%		
	Mandatory Training - % attendance at mandatory training	90%	Jan-22	↓	81.5%		Jan-22	↓	86.2%	86.9%	Jan-22	↑	95.7%	95.8%	Jan-22	↓	85.2%	84.5%		
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 February 2022 the trust did not meet the 95% standard, achieving 87.4% and the Type 1 element achieving 70.4%, similar to the previous month. There were no 12 hour trolley breaches during February.



### What are the issues?

- Outbreaks at other providers either limited their capacity or needed temporary closure, reducing overall capacity in the system. CRH were particularly affected by outbreaks at Buxton UTC and DCHS community wards.
- Pressures in the South Yorkshire urgent care system have led to increased numbers of ambulances diverted to Chesterfield.
- The combined Type 1 & streamed attendances are close to pre-pandemic levels, with an average of 260 attendances per day.
- There were surges of Covid19 admissions & outbreaks in the beginning and middle of the month, with as many as 47 positive inpatients at one point and patients still in ICU. This added more pressure to a trust with an escalated critical care position.
- Staff sickness levels (due to the Omicron wave and other winter illnesses) across the trust have had a major impact on the performance in A&E. Staff sickness levels peaked at 7.8% during the month, with over half of these due to Covid19.
- There continued to be severely delayed discharges for patients requiring Packages Of Care, due to capacity for these in the county. These were exacerbated by covid outbreaks in Care Homes, meaning they couldn't admit patients discharged from acute trusts. This has led to the medical bed base being full (at times there have been enough Medically Fit For Discharge patients to fill whole inpatient wards), therefore reducing the beds available for those in A&E who need them.

### What are the next steps?

- The official Winter Plan will flex to increase or decrease bed capacity according to urgent care pressures.
- Creating a discharge lounge to improve flow through acute and elective care beds and ED/assessment units
- Broadening the Same Day Emergency Care (SDEC) pathway offer following a Perfect Week exercise, especially for surgical and Gynaecological conditions.
- Implementing further actions recommended by the Missed Opportunities Audit, including other pathway alterations, increased access to diagnostics and alternative streaming options

### What actions have been taken?

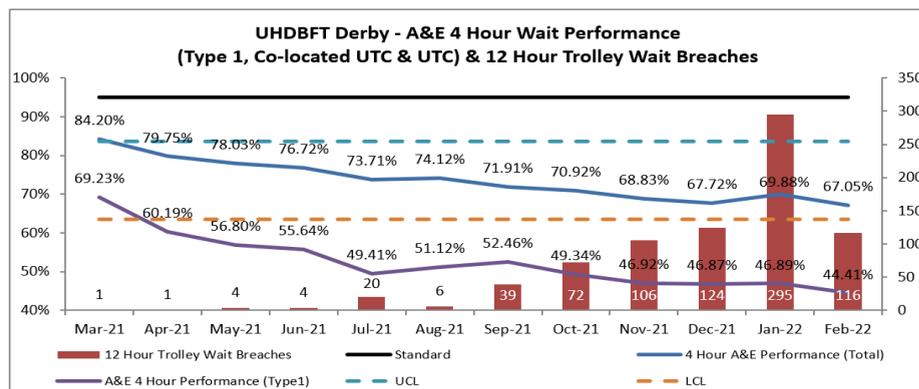
- The opening of surge beds in the community have increased emergency capacity in the system, enabling speedier discharge from base wards within the trust.
- The acute frailty service has based a geriatrician led team in ED, enabling more rapid assessment and treatment of frail elderly patients.
- The Community Rapid Intervention Service (CRIS) was implemented, preventing the need for patients to attend hospitals through collaborative working.
- System level meetings continued to be held regularly, with the System Organisational Resilience Group (SORG) meeting twice a week and System Escalation Calls (SEC) being held at times of high pressure. The membership includes acute trusts, community trusts and councils, solving problems collaboratively in addition to focussed meetings & communications to secure more capacity

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

### Performance Analysis

During February 2022, performance overall did not meet the 95% standard, achieving 67.1% (Network figure) and 44.4% for Type 1 attendances. These continue the deterioration since March 2021.

There were 116 x 12 hour breaches during February 2022 due to the availability of suitable Mental Health beds (1) and medical capacity issues (115).



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

### What are the next steps?

- Longer-term commissioning of the UTC to enable consistency in opening times and staffing.
- Improved back-up rotas have been devised to ensure unexpected absence, in anticipation of further staff sickness/isolation due to the Omicron wave.
- Developing an action plan following the MADE event of early December which focussed on flow of P1 patients.
- A further constructive peer review by Chris Morrow-Frost (NHSEI) to gain advice about further improvements now that the UTC has been established at his suggestion. Long-term contractual work to ensure consistent staffing is also taking place.

### What are the issues?

- Severe pressures in the Maternity Unit led to standard medical beds being temporarily used for Maternity, reducing general medical capacity.
- Pressures in the South Yorkshire urgent care system led to some Cardiac patients being diverted to Derby.
- The volume of attendances were very high, with an average of 461 attendances per day at Derby. These comprise both Type 1 and co-located Urgent Treatment Centre (UTC) numbers, as the UTC sees patients who would otherwise have been classed as minors.
- The acuity of the attendances was high, seeing an average of 13 Resuscitation patients & 189 Major patients per day.
- Staff sickness levels (due to the Omicron wave and other winter illnesses) across the site have had a major impact on the performance in A&E. Staff sickness levels peaked at 11.4% across the trust with 48% of these due to Covid19.
- Attendances at Children's ED continue to be high, with concerns about RSV and Bronchiolitis being major factors. Children's Type 1 attendances at Derby have averaged at 118 per day during February 2022.

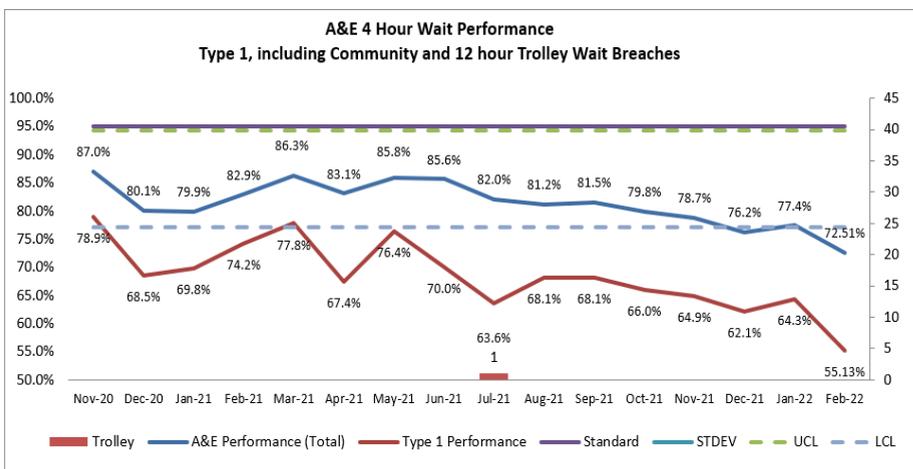
### What actions have been taken?

- Temporarily converting Urology Daycase and Gynaecology Daycase beds into emergency medical inpatient beds, with associated surgical cancellations.
- The opening Ward 5 and expanding Ward 2 at Florence Nightingale Community Hospital to treat Nursing Home and End Of Life patients in a more appropriate setting. This has also released capacity on base wards.
- The Community Rapid Intervention Service (CRIS) was implemented, preventing the need for patients to attend hospitals through collaborative working.
- The cancellation of some Priority 4 surgical procedures that needed inpatient beds on acute sites.
- The Same Day Emergency Care (SDEC) area now opens at weekends, treating 30% of non-electives.

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

### Performance Analysis

During February 2022, performance overall did not meet the 95% standard, achieving 55.4% for the Burton A&E and 72.5% including community hospitals. Performance has been deteriorating since Autumn. There were no 12 hour breaches during February 2022.



### What are the next steps?

- Developing workforce plans to increase the numbers working 'on the floor' in the department, to include the utilisation of more Allied Healthcare Professionals (AHPs).
- Improved back-up rotas have been devised to ensure unexpected absence, in anticipation of further staff sickness/isolation due to the Omicron wave.
- Relaunching the Acute Medicine Lead role, with a focus on escalation during times of pressure.
- Work with the surgical division to launch nurse-led A&E and Same Day Emergency Care (SDEC) pathways.
- Launch of a Professional Standards campaign to influence medical practice across the Trust and therefore improve patient flow.
- The acute frailty service will continue to operate over the winter – with a geriatrician led team located in ED.

### What were the issues?

- Pressures in the West Midlands and Staffordshire urgent care systems have led to increased numbers of ambulances diverted to Burton.
- Staff sickness levels (due to the Omicron wave and other winter illnesses) across the site have had a major impact on the performance in A&E. Staff sickness levels peaked at 11.4% across the trust with 48% of these due to Covid19.
- The opening of extra capacity on Philip Ward was further delayed.
- The department have experienced a high volume of activity with an average of 208 Type 1 attendances per day.
- The acuity of the attendances is high, with an average of 127 Resuscitation/Major patients per day (69% of Type 1s).

### What actions have been taken?

- The cancellation of some Priority 4 surgical procedures that needed inpatient beds on acute sites.
- Further recruitment of clinical staff including 1 middle-grade and 2 JCFs.
- Development of a revised Clinical Navigation Model with DHU.
- Opening an Acute Medical Unit Triage (AMUT) to assess patients away from ED as GPs refer directly into the unit or patients are 'pulled' there from the ED waiting room. An escalation plan has also been developed for this area.
- Every walk-in patient is now streamed by Clinical Navigators to ascertain whether ED is the most appropriate setting for their assessment or care.
- The Surgical Assessment Unit (SAU) now operates for 12 hours a day (9am-9pm) with 9 trolleys available for specialised assessment away from ED.
- Increased use of the Burton Treatment Centre to see elective patients and therefore release beds for emergency activity.
- The Discharge Team now have weekend cover, enabling speedier discharges for medically appropriate patients over the weekend and improving flow over the whole hospital.
- Further improvements to the discharge process to include earlier input to the discharge process and increased in-reach.
- Increased 'Every Day Counts' accreditation for wards to increase their focus on discharge planning to improve patient flow.

## DHU111 Performance Month 10 (January 2022)

### Performance Summary

- DHU111 achieved three of the five contractual Key Performance Indicators (KPIs) during January 2022. The following two KPIs were not achieved, however there was improvement compared to the previous month:
  - Abandonment rate which was 3.8% higher than the contractual KPI, at 8.8%.
  - The Average speed of answer was 2 minutes and 32 seconds above the contractual KPI, at 2 minutes and 59 seconds.

### Activity Summary

- During January, calls offered were 4.2% above the indicative activity plan (IAP) for Year 6 and clinical calls were 29.2% below the IAP. Please note that, as per the agreements made as part of the Year 6 contract, COVID activity is now included within the core activity lines. The coordinating commissioning team continue to work with DHU111 to understand why the variance to plan between the two activity lines is so different, we believe it is due to the complex arrangement in place around clinical calls and a detailed piece is due to be underway to look through these lines of activity.
- A total of 11,162 Category 3 validations were carried out during January 2022, this was an increase compared to the previous month where 10,719 validations took place.

Regional Performance Year Six - Key Performance Indicators (KPI's)							
		Quarter One (October – December)			Quarter Two (January – March 2022)		
Contractual KPI's	Standard	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Abandonment rate (%)	≤5%	7.00%	8.10%	16.00%	8.8%		
Average speed of answer (seconds)	≤27s	00:02:23	00:03:13	00:05:06	00:02:59		
Call Transfer to a Clinician	≥50%	69.20%	66.7%	66.60%	66.9%		
Self Care	≥17%	19.00%	18.8%	19.20%	18.5%		
Patient Experience	≥85%	This data is updated on a six monthly basis			This data is updated on a six monthly basis		
C3 Validation	≥50%	98.20%	97.9%	97.8%	98%		

## DHU111 Performance Month 10 (January 2022)

### What are the issues?

- DHU111 continue to experience high levels of activity, which is having a significant impact throughout the service.
- Despite the challenges being faced and non achievement of two KPIs, DHU111 have seen improvement this month and continue to perform well compared to other 111 providers across the country. Where DHU111 average speed of answer was 2 minutes and 59 seconds during January 2022, the national average figure was 6 minutes and 42 seconds.
- Dental related activity continues to be a concern across the region with January figures reaching a total of 12,116. Derbyshire's share of this activity was 3,304, with surges in dental demand being noted on Monday and Tuesday mornings.

### What actions have been taken?

- Recognising the pressures that 111 providers are under, national funding has been made available to support 111 providers over the winter period. DHU111 continue to do everything they can to recruit staff and presented a plan to January 2022 Contract Management Board (CMB) members, outlining how the funding would be utilised to support short term increases in staffing which included, Golden Hello and Retention, Overtime and Agency Costs, Desks and Homeworking.

### What are the next steps?

- It was agreed in the January CMB that the Senior Quality Assurance Manager for Ambulance and 111 Commissioning Team would liaise with the Dental Commissioning team in relation to the dental issues raised by DHU111, an update will be provided at the March 2022 CMB.
- DHU111 will provide CMB with a quarterly update in relation how the national funding is being utilised to support increased staffing and in turn improved performance.

		Year Six – Contract Year October 2021 – September 2022					
		Quarter One			Quarter Two		
Activity		Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Calls Offered	Actual	184,574	188,284	214,607	182,585		
	Plan	166,609	156,578	187,369	175,277		
	Variance	8.8%	20.2%	14.5%	4.2%		
Clinical Calls	Actual	30,000	24,775	27,933	27,116		
	Plan	37,187	35,263	42,520	38,293		
	Variance	19.30%	-29.7%	-34.3%	-29.2%		

*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 M10 (January 2022)

### What are the issues?

- The contractual standard is for the Derbyshire division to achieve national performance on a quarterly basis. For Quarter four to date, Derbyshire achieved one out of the six national standards, C1 90<sup>th</sup> Centile, in addition to this an improvement was seen in January 2022 on all standards when compared with December 2021. The variation to the national standard for the quarter four to date position was as follows:
  - C1 mean +1 minute and 32 seconds
  - C1 90<sup>th</sup> Centile 11 seconds below the national standard
  - C2 mean +16 minutes and 4 seconds
  - C2 90<sup>th</sup> Centile +30 minutes and 44 seconds
  - C3 90<sup>th</sup> Centile +2 hours, 39 minutes and 4 seconds
  - C4 90<sup>th</sup> Centile +1 hours, 21 minutes and 4 seconds
- There is a regional level trajectory for performance which is linked to the receipt of additional national funding. During January 2022, EMAS did not achieve any of the performance trajectories, however performance against the C1, C2 and C3 trajectories saw an improvement when compared to December 2021.
- Within Derbyshire demand from NHS111 remained the high at 29%.
- Whilst call activity remained high, the number of duplicate calls being seen saw a significant reduction across EMAS during January 2022, 18.5% compared to 21.6% in the previous month. For Derbyshire the percentage of calls being classed as a duplicate calls was 18.4%. This does however remain above the contractual threshold of 17.9%.
- Incident and on scene demand also saw further reduction across EMAS, now at -5.0% and -6.3% below plan respectively. January 2022 incidents in Derbyshire saw an decrease when compared to December 2021 (12,989 compared to 13,540).
- The acuity of patients is also reducing across the board, although remains much higher than assumed when introducing the Ambulance Response Programme (ARP).
- Average Pre hospital handover times during January 2022 continued to be above the 15 minute National Standard across Derbyshire at 24 minutes and 6 seconds which was a comparable to December 2021 performance (24 minutes and 42 seconds).
- Average Post handover times during January 2022 remained above the 15 minute national standard across Derbyshire with the exception of Macclesfield District (13 minutes and 8 seconds) and Stepping Hill (14 minutes and 43 seconds). Overall the post handover time in January 2022 was 20 minutes and 21 seconds which was a deterioration when compared to December 19 minutes and 35 seconds.
- Five Serious incidents were reported in January 2022. Two relating to prolonged waits, one was an incorrect coding which led to a prolonged wait, and two were sub-optimal clinical care.

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 – January	00:08:32	00:15:21	00:38:56	01:23:24	05:01:28	04:36:33
Derbyshire Actual – January	00:08:32	00:14:49	00:34:04	01:10:44	04:39:04	04:21:04
Derbyshire Actual – Quarter Four to date	00:08:32	00:14:49	00:34:04	01:10:44	04:39:04	04:21:04

January 2022	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	00:32:04	125:21:14	00:17:34	38:17:21	00:49:38	146:41:45
Chesterfield Royal	00:20:03	238:39:41	00:21:43	330:35:47	00:41:46	496:55:26
Macclesfield District General Hospital	00:24:11	7:27:23	00:13:08	1:58:06	00:37:19	7:37:52
Royal Derby	00:25:10	743:58:44	00:20:31	535:11:12	00:45:41	1135:30:01
Sheffield Northern General Hospital	00:37:36	28:05:51	00:17:45	8:09:58	00:55:22	32:23:21
Stepping Hill	00:25:16	70:07:56	00:14:43	21:09:09	00:39:59	77:10:26
Derbyshire TOTAL	00:24:06	1213:40:49	00:20:21	935:21:33	00:44:27	1896:18:51

## AMBULANCE – EMAS PERFORMANCE M10 (January 2022)

### What actions have been taken?

- All counties have continued to work on developing alternative pathways for ambulance services to access services such as same day emergency care, access to urgent treatment centres and clinical assessment services which is enabling patients to avoid the Emergency Department when safe and appropriate. Work has also taken place nationally to ensure the most commonly referred into pathways by Ambulance services are profiled and visible on the Urgent and Emergency Care Directory of Services so that ambulance crews can access these available alternatives consistently across the Country thus improving referrals to Non ED settings when safe appropriate.
- A proportion of the additional Mental Health funding received via NSHE/I as part of the NHS Mental Health Implementation plan is being allocated to EMAS to support additional mental health resource in the Emergency Operations Centre (EOC) through additional staff, training, and key project staff to support the project. The aim is to ensure patients with Mental Health illness are responded to by the most appropriate services in a more timely manner. This will enable Ambulance Trusts to increase the number of calls closed with clinical advice and reduce the number of on scene responses.
- The Derbyshire Rough Sleep Paramedic scheme has continued to successfully run during 2021/22. The initiative continues to prevent demand into EMAS through working directly with patients to improve any health conditions before the need to call an ambulance arises. As a result, commissioners have agreed additional funding to expand the scheme.
- In relation to serious incidents; a paper from the extraordinary CQRG held on the 16<sup>th</sup> of December 2022 was presented to the SDB on the 25<sup>th</sup> of January 2022 who agreed the issues with delayed response SI's were system problems which required a system response. In particular providing system forums where EMAS can raise and discuss issues with falls and respiratory pathways.

### What are the next steps

- EMAS have plans in place to recruit a further 40 call takers by the end of March 2022 which should further improve EOC capacity.
- The Coordinating Commissioning Team are waiting for the NHSE 2022/2023 Standard Contract Guidance Documents to be agreed, once received the final documents will be circulated in preparation for the 2022/2023 Contract Planning round.
- Following a successful pilot funding has now been agreed to appoint a permanent receptionist responsible for checking in patients arriving by ambulance at Chesterfield Royal Hospital, this role will facilitate faster handovers at the trust.

EMAS Activity - 2021 to 2022						
Derbyshire	October	November	December	Quarter Three	January	Quarter Four
Calls (Total)	22,150	20,588	21,327	42,738	19,214	19,214
Total Incidents	13,505	13,181	13,540	26,686	12,989	12,989
Total Responses	12,251	11,963	12,172	24,214	11,819	11,819
Duplicate Calls	4,842	4,262	4,482	9,104	3,533	3,533
Hear & Treat (Total)	5,057	4,363	4,673	9,420	3,862	3,862
See & Treat	4,405	4,343	4,468	8,748	4,201	4,201
See & Convey	7,846	7,620	7,704	15,466	7,618	7,618
Duplicates as % Calls	21.9%	20.7%	21.0%	21.3%	18.4%	18.4%
H&T ASI as % Incidents	9.3%	9.2%	10.1%	9.3%	9.0%	9.0%
S&T as % Incidents	32.6%	32.9%	33.0%	32.8%	32.3%	32.3%
S&C as % Incidents	58.1%	57.8%	56.9%	58.0%	58.6%	58.6%
S&C to ED as % of incidents	54.0%	53.5%	52.8%	53.7%	54.8%	54.8%

- Transformational work within Derbyshire will restart in March 2022 following a temporary pause due to system operational pressure. The areas of focus remain as SDEC, Frailty, CAS development and UTC development. SDEC workshops will be held between Acute Trusts, EMAS and NHSEI to maximise the referrals into this service. The Derbyshire Transformation Delivery Group is due to meet again in April and EMAS will be linked into this as appropriate.

# Planned Care

## DERBYSHIRE COMMISSIONER – INCOMPLETE PATHWAYS (92%)

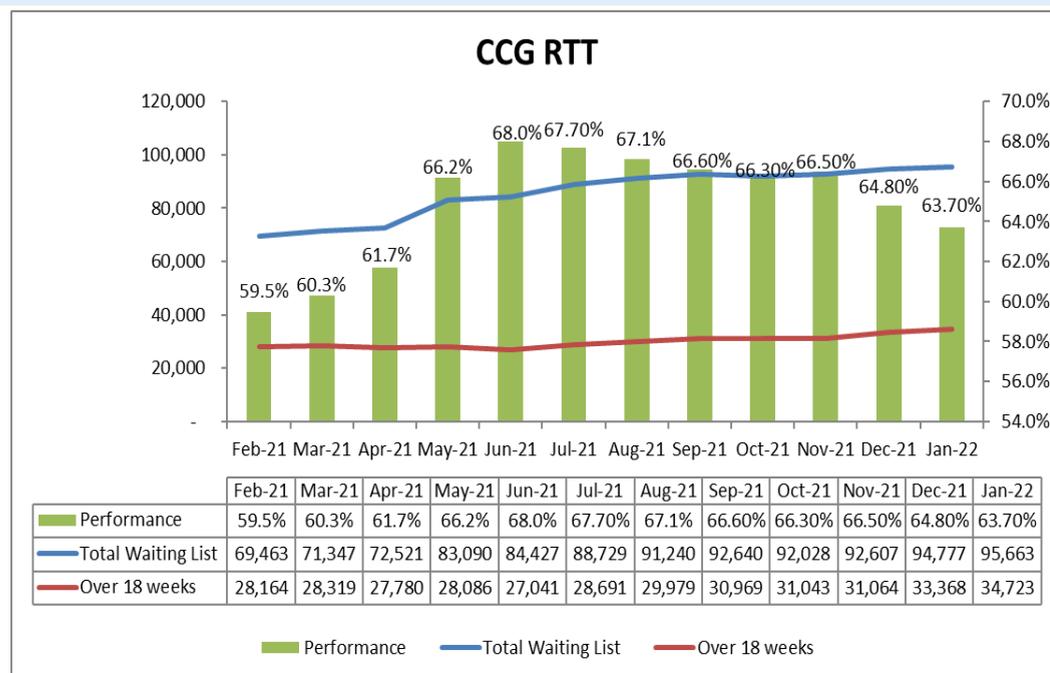
### Performance Analysis

Performance for January 2022 was 63.77%, a slight decrease on the 64.8% in December 2021.

The total incomplete waiting list for DDCCG was 95,663, an increase of 888 on the previous month.

The number of referrals across Derbyshire during January 2022 showed that there was an increase of 3% on the urgent referrals and a reduction of 37% of routine referrals when compared to the same month in 20120

Treatment Function	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Total 52 plus weeks
General Surgery Service	4,972	2,427	48.8%	815
Urology Service	4,222	2,901	68.7%	235
Trauma and Orthopaedic Service	14,053	7,383	52.5%	1,563
Ear Nose and Throat Service	6,883	4,511	65.5%	359
Ophthalmology Service	12,732	7,085	55.6%	841
Oral Surgery Service	5	5	100.0%	0
Neurosurgical Service	642	424	66.0%	23
Plastic Surgery Service	589	375	63.7%	51
Cardiothoracic Surgery Service	195	123	63.1%	23
General Internal Medicine Service	254	207	81.5%	1
Gastroenterology Service	4,516	3,344	74.0%	84
Cardiology Service	2,928	2,261	77.2%	37
Dermatology Service	7,075	4,474	63.2%	125
Respiratory Medicine Service	1,558	1,229	78.9%	5
Neurology Service	2,532	1,889	74.6%	15
Rheumatology Service	1,833	1,342	73.2%	7
Elderly Medicine Service	215	172	80.0%	2
Gynaecology Service	6,833	4,396	64.3%	362
Other - Medical Services	6,802	5,370	78.9%	85
Other - Mental Health Services	237	216	91.1%	0
Other - Paediatric Services	7,118	4,616	64.8%	258
Other - Surgical Services	8,439	5,389	63.9%	560
Other - Other Services	1,030	801	77.8%	37
<b>Total</b>	<b>95,663</b>	<b>60,940</b>	<b>63.7%</b>	<b>5,488</b>

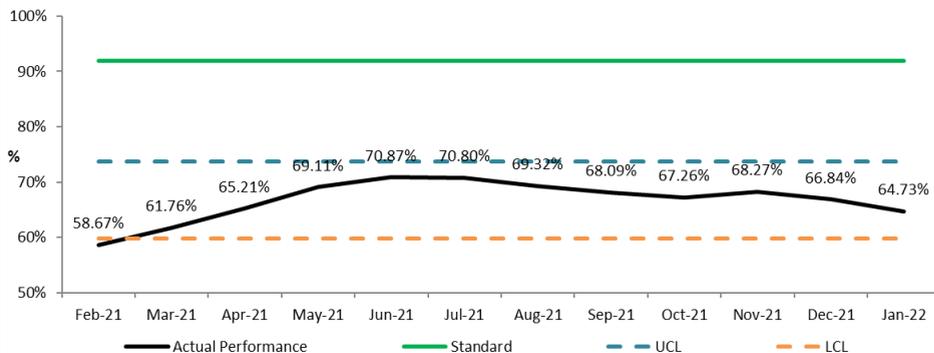


- The Derbyshire CCG position is representative of all of the patients registered within the CCG area attending any provider nationally.
- 70% of Derbyshire patients attend either CRHFT (25%) or UHDB (45%). The RTT position is measured at both CCG and provider level.
- The RTT standard of 92% was not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

## Referral to Treatment – Incomplete Pathways (92%).

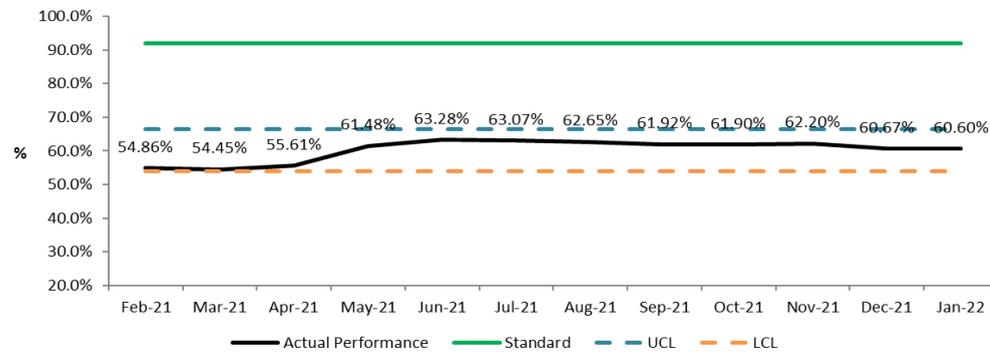
**CRH** – During January 2022 the trust achieved 64.7%, a slight decrease on the December figure of 66.8%. The incomplete waiting list at the end of January was 20,343 (December - 20,393)

CRHFT - 18 Weeks Incomplete RTT Performance



**UHDB** – During January the trust achieved 60.6%, a very slight decrease on the December figure of 60.7%. The incomplete waiting list at the end of January was 89,175. (December - 86,979).

UHDBFT - 18 Weeks Incomplete RTT Performance



Treatment Function	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Total 52 plus weeks
General Surgery Service	1,411	568	40.3%	290
Urology Service	1,127	839	74.4%	25
Trauma and Orthopaedic Service	2,195	1,127	51.3%	221
Ear Nose and Throat Service	1,903	1,331	69.9%	103
Ophthalmology Service	2,244	1,253	55.8%	154
Oral Surgery Service	1,304	696	53.4%	99
General Internal Medicine Service	220	176	80.0%	1
Gastroenterology Service	1,198	859	71.7%	9
Cardiology Service	575	447	77.7%	2
Dermatology Service	1,969	1,344	68.3%	1
Respiratory Medicine Service	558	369	66.1%	1
Rheumatology Service	360	297	82.5%	2
Gynaecology Service	1,462	984	67.3%	137
Other - Medical Services	856	703	82.1%	18
Other - Paediatric Services	1,090	825	75.7%	18
Other - Surgical Services	1,871	1,351	72.2%	73
<b>Total</b>	<b>20,343</b>	<b>13,169</b>	<b>64.7%</b>	<b>1,154</b>

Treatment Function	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Total 52 plus weeks
General Surgery Service	4,517	2,616	57.9%	471
Urology Service	3,504	2,275	64.9%	177
Trauma and Orthopaedic Service	14,187	7,395	52.1%	1,608
Ear Nose and Throat Service	7,175	4,352	60.7%	214
Ophthalmology Service	12,288	5,847	47.6%	1,052
Oral Surgery Service	2,845	1,525	53.6%	217
Neurosurgical Service	107	69	64.5%	2
Plastic Surgery Service	291	200	68.7%	11
Cardiothoracic Surgery Service	7	7	100.0%	0
General Internal Medicine Service	25	23	92.0%	0
Gastroenterology Service	3,459	2,735	79.1%	14
Cardiology Service	2,538	2,006	79.0%	10
Dermatology Service	6,600	3,612	54.7%	248
Respiratory Medicine Service	866	798	92.1%	0
Neurology Service	2,236	1,611	72.0%	15
Rheumatology Service	1,768	1,264	71.5%	7
Elderly Medicine Service	252	179	71.0%	4
Gynaecology Service	7,056	4,377	62.0%	316
Other - Medical Services	6,762	5,286	78.2%	72
Other - Mental Health Services	2	2	100.0%	0
Other - Paediatric Services	4,283	2,576	60.1%	210
Other - Surgical Services	7,259	4,454	61.4%	584
Other - Other Services	1,148	832	72.5%	49
<b>Total</b>	<b>89,175</b>	<b>54,041</b>	<b>60.6%</b>	<b>5,281</b>

## DERBYSHIRE COMMISSIONER – OVER 52 WEEK WAITS

### 52 Week Waits

At the end of January there were 5,488 Derbyshire patients waiting over 52 weeks for treatment in Derbyshire. This is an increase of 56 of those reported in December.

Of these, 4,197 were waiting for treatment at our two main providers UHDB and CRH, with the remaining 1,291 waiting at various trusts around the country as outlined in the table on the following slide.

CCG Patients – Trend – 52 weeks

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sept-21	Oct-21	Nov-21	Dec-21	Jan-22
<b>DDCCG</b>	2,658	3,388	4,245	5,903	7,554	8,261	7,490	6,859	6,199	5,897	5,627	5,781	5,705	5,399	5,432	<b>5,488</b>

### Main Providers:

In terms of Derbyshire the two main acute providers the 52ww monthly position up until January 2022 at UHDB and CRH is as follows:

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sept-21	Oct-21	Nov-21	Dec-21	Jan-22
<b>UHDB</b>	2,968	3,751	4,706	6,629	8,767	9,728	8,605	7,573	6,806	6,206	5,755	5,692	5,659	5,469	5,417	<b>5,281</b>
<b>CRH</b>	438	594	797	1,202	1,475	1,471	1,278	1,179	1,095	1,098	1,118	1,129	1,133	1,084	1,120	<b>1,154</b>

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

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

### Actions:

- System Planned Care Group are leading on the plans for restoration and recovery across the system.
- Patients are being treated in priority order and a number of patients currently waiting over 52 weeks are low priority.
- There is an increased focus by the National team at NHS England around the long waiters across Derbyshire. The CCG are working with the trusts reviewing those patients who have been waiting the longest time as there are a number over 104 weeks. Trusts will be expected to eliminate 104+ weeks patients by end of March 2022 (except for those identified as P5 or P6, which is due to patient choice).

## DERBYSHIRE COMMISSIONER – OVER 52 WEEK WAITERS

**Associate Providers** – Derbyshire Patients waiting over 52 weeks in January 2022 at associate providers were 1,291.

Provider	Total	Provider	Total
ASPEN - CLAREMONT HOSPITAL	9	SPIRE REGENCY HOSPITAL	6
BARTS HEALTH NHS TRUST	3	STOCKPORT NHS FOUNDATION TRUST	359
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	6	TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	4
BMI - THE ALEXANDRA HOSPITAL	10	THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST	1
BMI - THE PARK HOSPITAL	1	THE ONE HEALTH GROUP LTD	2
CALDERDALE AND HUDDERSFIELD NHS FOUNDATION TRUST	2	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	1
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	4	THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	4
CHELSEA AND WESTMINSTER HOSPITAL NHS FOUNDATION TRUST	1	THE ROTHERHAM NHS FOUNDATION TRUST	1
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	1	UNITED LINCOLNSHIRE HOSPITALS NHS TRUST	1
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	12	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	1
EAST CHESHIRE NHS TRUST	28	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	29
GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	1	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	2
HARROGATE AND DISTRICT NHS FOUNDATION TRUST	1	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	53
IMPERIAL COLLEGE HEALTHCARE NHS TRUST	1	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	7
LEEDS TEACHING HOSPITALS NHS TRUST	6	WOODTHORPE HOSPITAL	53
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	1	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	1
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	5	HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST	3
NORTH BRISTOL NHS TRUST	1	NUFFIELD HEALTH, YORK HOSPITAL	1
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	331	LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	4
NUFFIELD HEALTH, DERBY HOSPITAL	24	ROWLEY HALL HOSPITAL	7
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	1	SPAMEDICA DERBY	9
ROYAL BERKSHIRE NHS FOUNDATION TRUST	2	PRACTICE PLUS GROUP HOSPITAL - BARLBOROUGH	11
ROYAL FREE LONDON NHS FOUNDATION TRUST	7	SPAMEDICA MANCHESTER	1
SALISBURY NHS FOUNDATION TRUST	1	BEACON PARK HOSPITAL	4
SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	40	YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST	1
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	100	CIRCLE READING HOSPITAL	2
SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	94	NORTHERN CARE ALLIANCE NHS FOUNDATION TRUST	29
SPIRE NOTTINGHAM HOSPITAL	1	<b>Total</b>	<b>1291</b>

### Actions:

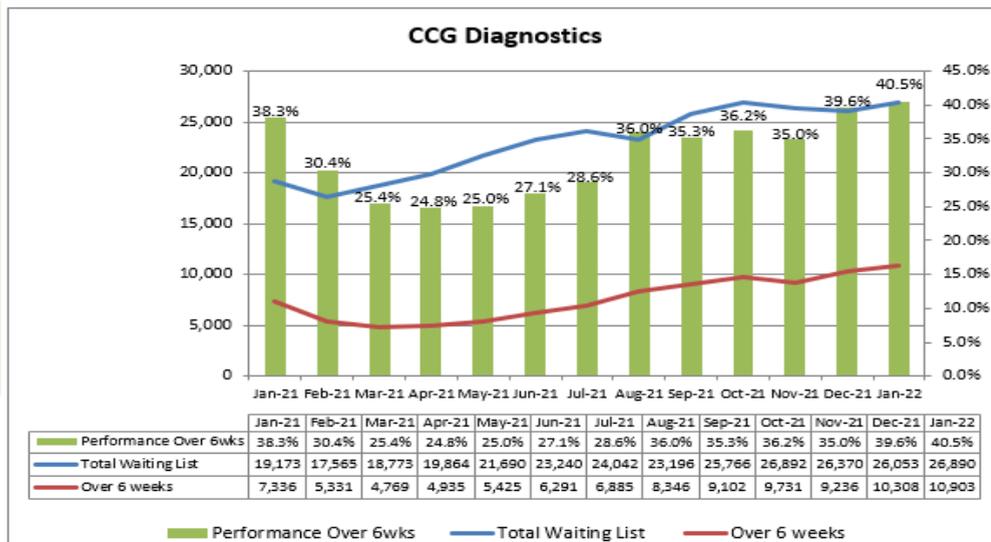
- The performance team make enquiries of the relevant CCGs and responses received back are that these patients are not clinically urgent but are being reviewed. We have not been informed of any TCI dates.

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

### Performance Analysis

Derbyshire CCG Diagnostic performance at the end of January was 40.5% waiting over six weeks, a deterioration on the 39.6% waiting at the end of December.

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



Diagnostic Test Name	University Hospitals of Derby & Burton	Chesterfield Royal Hospital	Stockport	Sheffield Teaching Hospitals	Sherwood Forest Hospitals	Nottingham University Hospitals	East Cheshire
Magnetic Resonance Imaging	48.6%	0.0%	21.5%	16.7%	5.0%	69.5%	27.7%
Computed Tomography	40.2%	3.9%	1.1%	19.1%	21.3%	20.8%	0.0%
Non-obstetric Ultrasound	50.8%	1.0%	1.7%	29.2%	37.7%	17.7%	0.0%
DEXA Scan	7.4%	0.0%	0.0%	19.7%	20.8%	60.1%	
Audiology Assessments	47.2%	64.5%	0.0%	5.8%	1.7%	18.0%	15.1%
Echocardiography	42.1%	71.5%	42.3%	22.1%	58.2%	52.9%	71.0%
Peripheral Neurophysiology	1.3%		0.0%	27.1%		1.1%	
Sleep Studies	25.4%		31.4%	31.8%	37.8%	49.5%	67.6%
Urodynamics - Pressures & Flows	70.1%	60.0%	8.3%	66.1%	25.0%	28.9%	
Colonoscopy	17.9%	17.0%	80.8%	46.4%	8.3%	53.5%	43.8%
Flexi Sigmoidoscopy	31.6%	32.0%	77.3%	58.3%	14.1%	59.6%	15.9%
Cystoscopy	20.3%	0.0%	0.0%	23.7%	46.7%	10.0%	18.2%
Gastroscopy	20.7%	20.5%	51.5%	49.3%	9.9%	61.7%	10.7%
<b>Total</b>	<b>43.7%</b>	<b>28.4%</b>	<b>34.4%</b>	<b>26.9%</b>	<b>33.1%</b>	<b>49.5%</b>	<b>33.1%</b>

Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Percentage waiting 6+ Weeks
Magnetic Resonance Imaging	5,729	2,451	983	42.8%
Computed Tomography	2,400	625	284	26.0%
Non-obstetric Ultrasound	8,917	3,351	965	37.6%
DEXA Scan	717	83	24	11.6%
Audiology Assessments	1,380	708	239	51.3%
Echocardiography	4,113	2,499	761	60.8%
Peripheral Neurophysiology	313	11	1	3.5%
Sleep Studies	242	87	22	36.0%
Urodynamics - Pressures & Flows	181	119	58	65.7%
Colonoscopy	1,077	378	193	35.1%
Flexi Sigmoidoscopy	464	201	69	43.3%
Cystoscopy	303	58	27	19.1%
Gastroscopy	1,054	332	124	31.5%
<b>Total</b>	<b>26,890</b>	<b>10,903</b>	<b>3,750</b>	<b>40.5%</b>

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

### Performance Analysis

Performance during January was 28.4%, a deterioration on the December figure of 25.9%.

The numbers on the waiting list have increased.

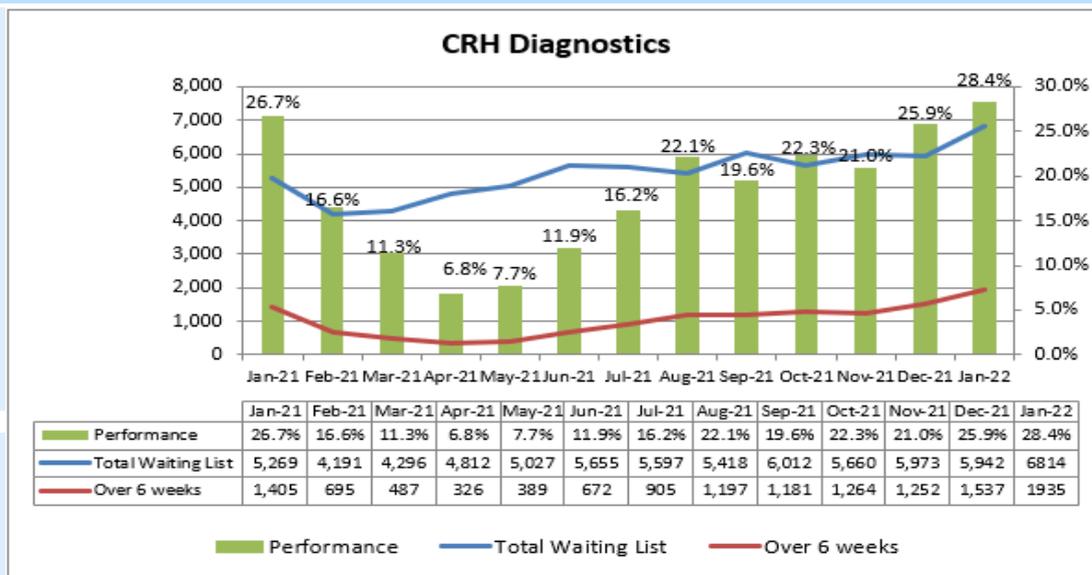
The number waiting over 6 weeks have increased but the number waiting over 13 weeks have decreased.

### Issues

- Staff sickness levels (due to the Omicron wave and other winter illnesses) across the trust have affected diagnostic capacity.
- The high demand due to higher outpatient referrals and increased non-elective activity continues.

### Actions

- Increased imaging capacity through the use of Mobile CT and Mobile MRI scanners.
- Immediate booking of Endoscopy dates to enable forward planning.
- The prioritisation of Imaging and Endoscopy activity for those patients on a cancer pathway.
- Further development of the clinical triage set and CAB.



Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Percentage waiting 6+ Weeks
Magnetic Resonance Imaging	732	0	0	0.0%
Computed Tomography	542	21	3	3.9%
Non-obstetric Ultrasound	2,108	21	2	1.0%
DEXA Scan	239	0	0	0.0%
Audiology Assessments	709	457	124	64.5%
Echocardiography	1,802	1,288	650	71.5%
Urodynamics - Pressures & Flows	45	27	11	60.0%
Colonoscopy	277	47	5	17.0%
Flexi Sigmoidoscopy	97	31	3	32.0%
Cystoscopy	53	0	0	0.0%
Gastroscopy	210	43	1	20.5%
<b>Total</b>	<b>6,814</b>	<b>1,935</b>	<b>799</b>	<b>28.4%</b>

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

### Performance Analysis

Performance during January was 43.7%, an deterioration on the December position of 43.1%.

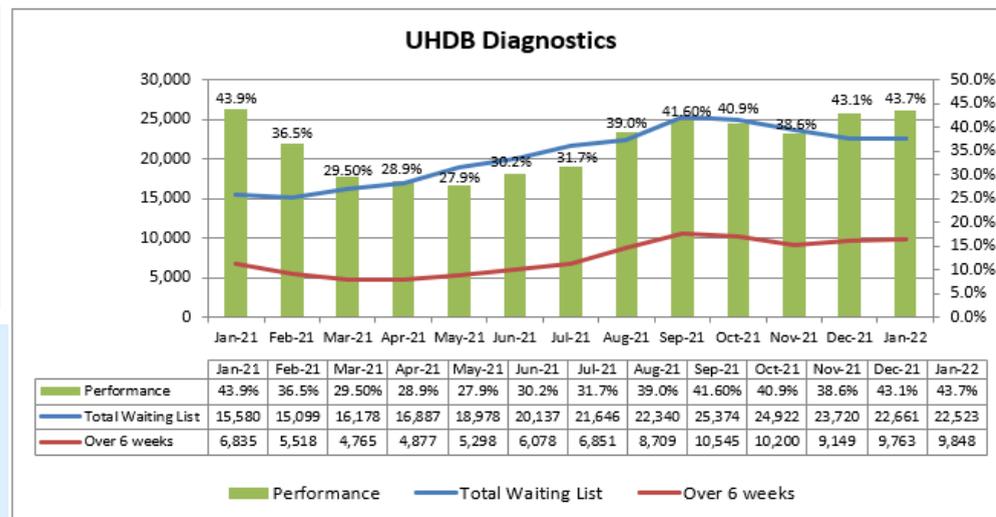
The overall numbers on the waiting list have decreased during January, with the numbers waiting over 6 weeks increasing but the numbers waiting over 13 weeks decreasing.

### Issues

- Staff sickness levels (due to the Omicron wave and other winter illnesses) across the trust have affected diagnostics, especially in Radiology.
- There has been limited ability to accommodate General Anaesthetic patients in Endoscopy, leading to higher waits for these patients.
- The high demand due to higher outpatient referrals and increased non-elective activity continues. The high emergency demand is particularly impacting Imaging service including Non Obstetric ultrasounds.

### Actions

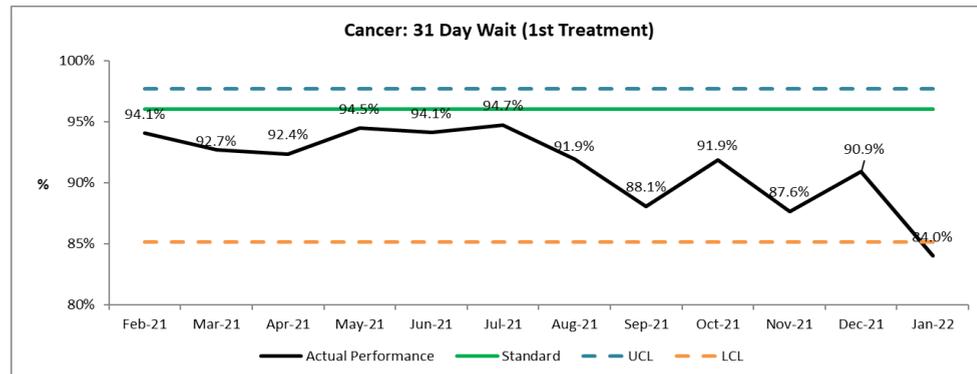
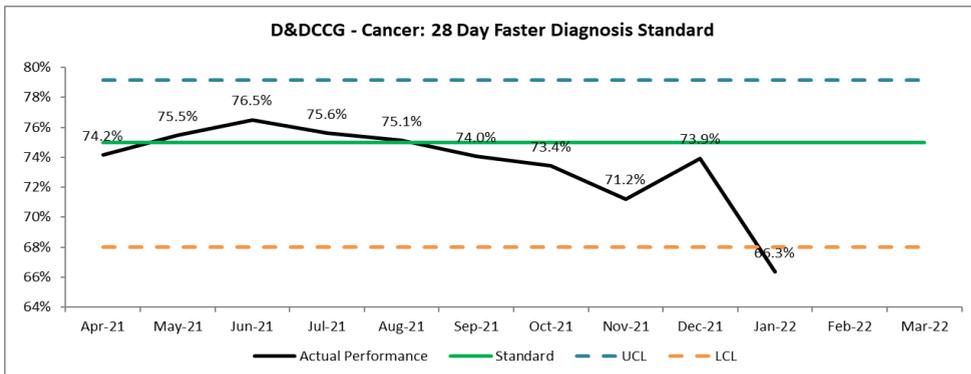
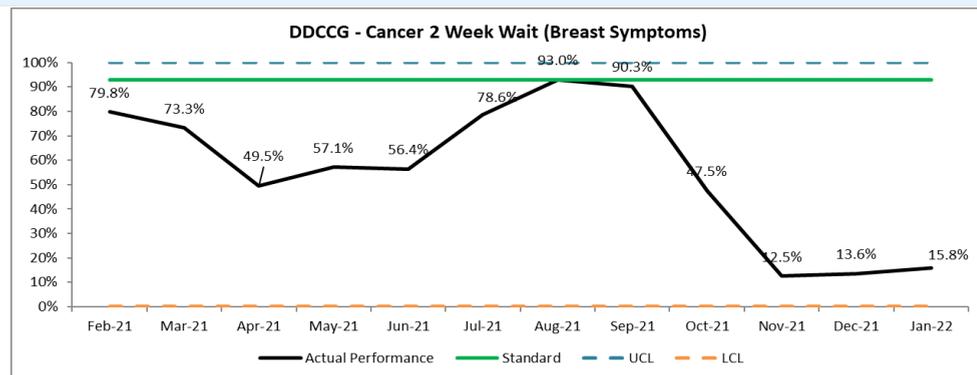
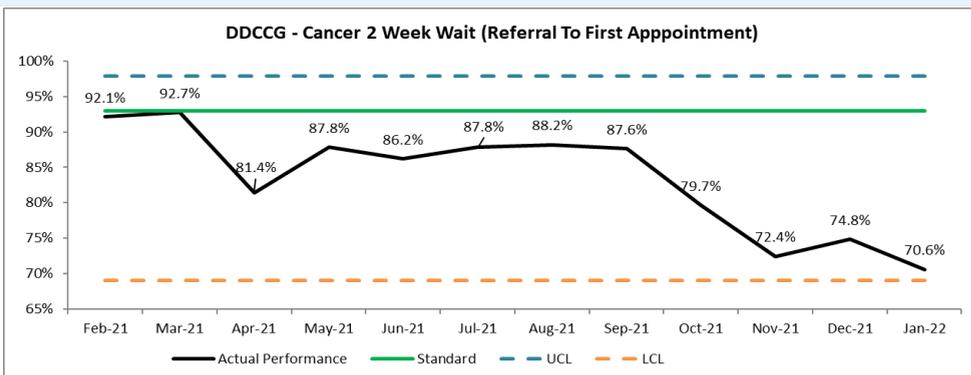
- Imaging have recruited 12 additional CT & MRI Radiographers from abroad, therefore not drawing away from other local labour pools.
- Agreement for the Alliance CT & MRI vans to remain operational at the RDH site for a further 6 months.
- Increased outsourcing of Echocardiography and Non-Obstetric Ultrasound activity.
- Infection Control have allowed turnaround times between patients have been relaxed by 5 minutes in some areas.
- The bid for a Rapid Diagnostics Site at the Trust was successful, which will enhance patient flow.
- Validation of the DM01 records identified approximately 800 patients who were incorrectly counted as exceeding the target.



Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Percentage waiting 6+ Weeks
Magnetic Resonance Imaging	5,190	2,523	886	48.6%
Computed Tomography	2,357	948	343	40.2%
Non-obstetric Ultrasound	8,471	4,303	1,317	50.8%
DEXA Scan	443	33	6	7.4%
Audiology Assessments	1,089	514	142	47.2%
Echocardiography	2,194	923	66	42.1%
Peripheral Neurophysiology	381	5	1	1.3%
Sleep Studies	272	69	2	25.4%
Urodynamics - Pressures & Flows	144	101	53	70.1%
Colonoscopy	654	117	12	17.9%
Flexi Sigmoidoscopy	345	109	11	31.6%
Cystoscopy	202	41	19	20.3%
Gastroscopy	781	162	26	20.7%
<b>Total</b>	<b>22,523</b>	<b>9,848</b>	<b>2,884</b>	<b>43.7%</b>

## DERBYSHIRE COMMISSIONER – CANCER WAITING TIMES

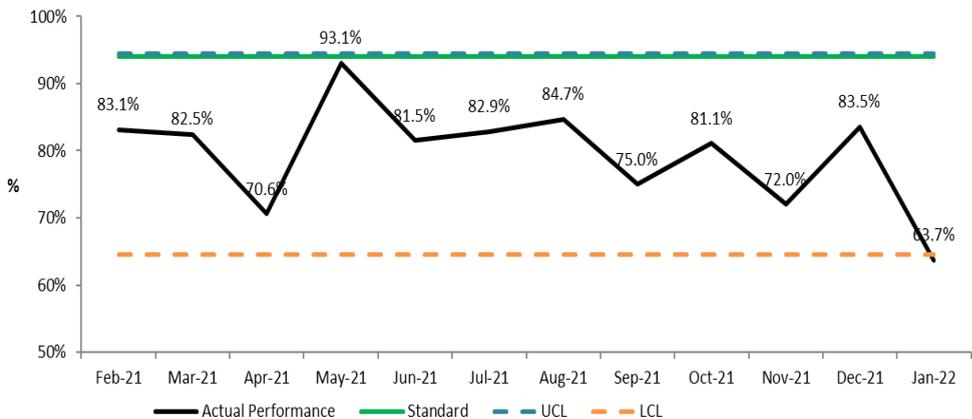
During January 2022, Derbyshire was non compliant in all of the 9 cancer standards.  
 2 week Urgent GP Referral – 72.4% (93% standard) – Compliant for Stockport.  
 2 week Exhibited Breast Symptoms – 15.8% (93% standard) – Non compliant for all trusts.  
 28 day Faster Diagnosis – 60.3% (75% standard) – Compliant for Chesterfield.  
 31 day from Diagnosis – 66.1% (96% standard) – Compliant for Stockport.  
 31 day Subsequent Surgery – 60.0% (94% standard) – Compliant at Stockport.  
 31 day Subsequent Drugs – 96.7% (98% standard) – Compliant for all Trusts except UHDB and Sheffield.  
 31 day Subsequent Radiotherapy – 89.0% (94% standard) – Compliant at Sheffield.  
 62 day Urgent GP Referral – 57.3% (85% standard) – Non compliant for all trusts.  
 62 day Screening Referral – 53.1% (90% standard) – Non compliant for all trusts.  
 104 day wait – 31 patients treated after 104 days.



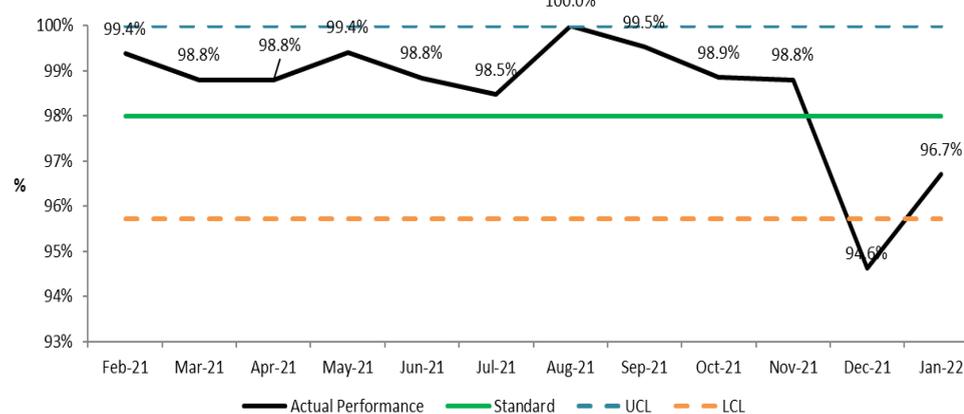
CCG performance data reflects the complete cancer pathway which for many Derbyshire patients will be completed in Sheffield and Nottingham.

# DERBYSHIRE COMMISSIONER – CANCER WAITING TIMES

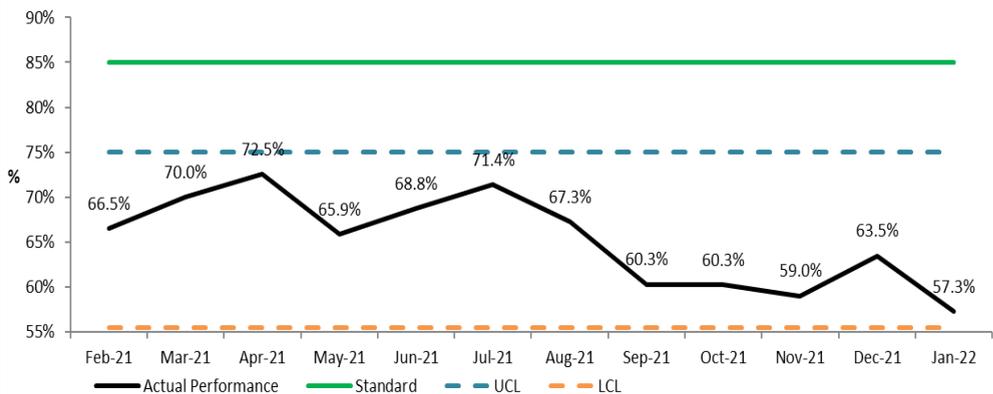
**Cancer: 31 Day Wait (Subsequent Surgery)**



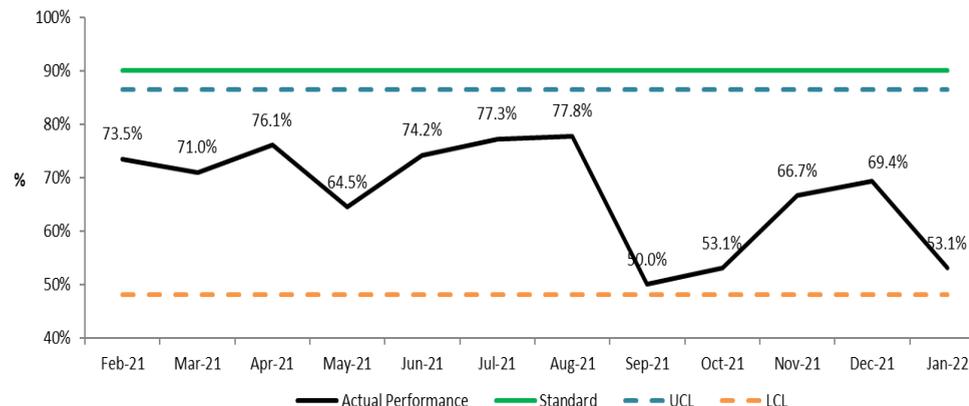
**Cancer: 31 Day Wait (Subsequent Drug Treatments)**



**Cancer: 62 Day Wait (Urgent Referral)**



**Cancer: 62 Day Wait (Screening Referral)**



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 January for first treatment within 62 days of urgent referral was 66.9% against the standard of 85%.

There were 87.5 accountable treatments with 58.5 of these within 62 days, with 29 breaches of the standard.

Of the 29 breaches, 10.5 were treated by day 76, with 15.5 between day 77 and 104, with 3 patients being treated after day 104.

The tumour sites reporting the breaches include Breast (9.5), Gynaecology (0.5), Haematology (3), Head & Neck (3), Lower GI (4), Lung (0.5) and Urology (8.5).

### Current Issues

- Issues currently going through tracking.
- Imaging reporting turnaround times.
- US reporting delays due to number of breast patients going through the pathway.
- Workforce issues – impacted upon by Covid and Isolation, particularly affecting Lower and Upper GI.
- PTL numbers over 62 day stabilising and are within H2 trajectory.

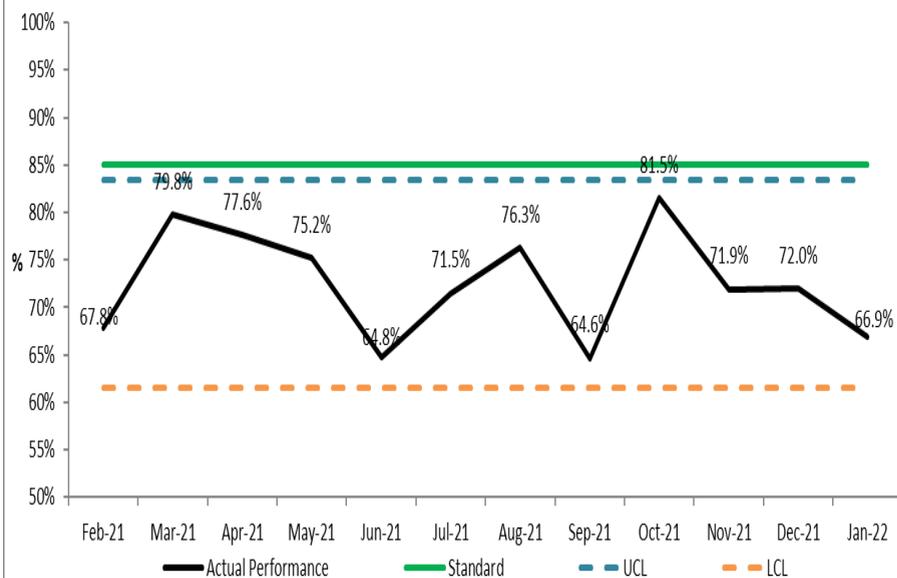
### Actions Being Taken

- Additional Breast Clinics, creating extra capacity.
- Monthly Tumour site Improvement meetings.
- Focus on reducing longest waits.

### What are the next steps

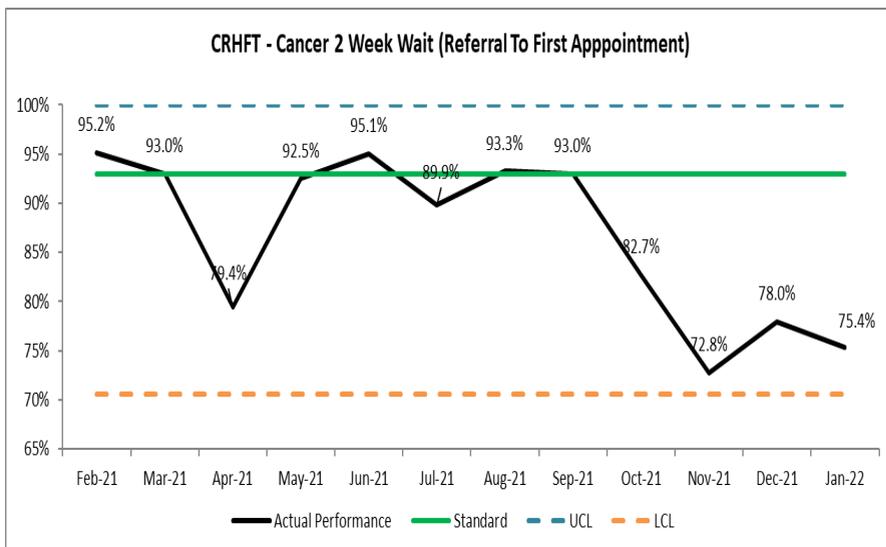
- Continued focus on those patients over 62 day and 104 day on the PTL.
- H2 Operational Plan for 21/22 requires the trust to reduce their PTL of patients waiting over 63 days for treatment to the February 2020 figure or lower as a system..

CRHFT - Cancer: 62 Day Wait (Urgent Referral)



Tumour Type	Total referrals seen	Seen Within 62 Days	Breaches	% Seen Within 62 Days
Breast	13	3.5	9.5	26.92%
Gynaecological	2	1.5	0.5	75.00%
Haematological (Excluding Acute Leukaemia)	4	1	3	25.00%
Head and Neck	5	2	3	40.00%
Lower Gastrointestinal	8.5	4.5	4	52.94%
Lung	5	4.5	0.5	90.00%
Other	1	1	0	100.00%
Sarcoma	1	1	0	100.00%
Skin	30	30	0	100.00%
Upper Gastrointestinal	1.5	1.5	0	100.00%
Urological (Excluding Testicular)	16.5	8	8.5	48.48%
Totals	87.5	58.5	29	66.86%

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



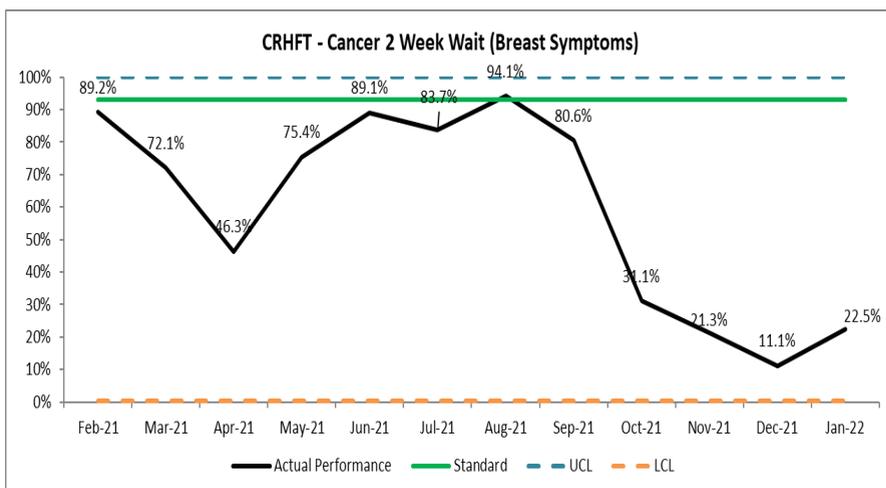
### Performance Analysis

January performance at CRH was 75.4%. The main challenges for 2ww performance this month has been associated with Breast which has continued to receive a high number of referrals and first appointments have been taking place outside the 14 day target.

Other than Breast, all other tumour sites were above 90% compliance with only Haematological Malignancies, Head & Neck, Other and Urology not meeting the standard.

There were a total of 959 patients seen this month, which is a decrease from December, and is above the trajectory submitted to NHSE as part of the H2 recovery plan. Of the 959 patients seen, 723 were seen within the 14 days resulting in 236 breaches with the large majority of these being Breast appointments.

## CRHFT - CANCER WAITING TIMES – Breast Symptomatic



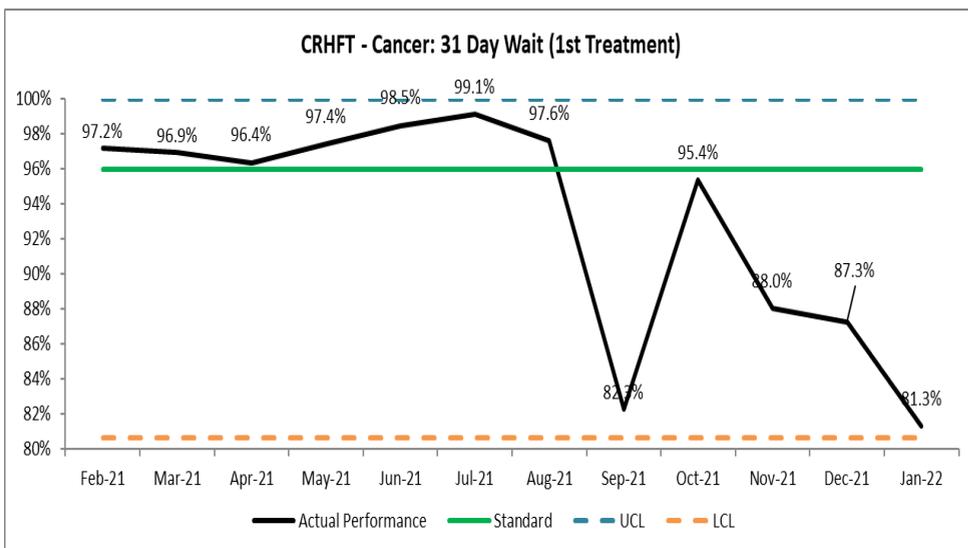
### Performance Analysis

Performance in January at CRH for the Breast Symptomatic standard has improved to 22.5%

There were 40 patients seen of which 31 were breaches. 22 of these patients were seen between 15 and 21 days with 9 being seen after day 21, again reflecting the outpatient availability.

**It is to be noted that CRH are not required to report 2WW and Breast performance nationally as they are a pilot site for the new 28 day to diagnosis standard.**

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



### Performance Analysis

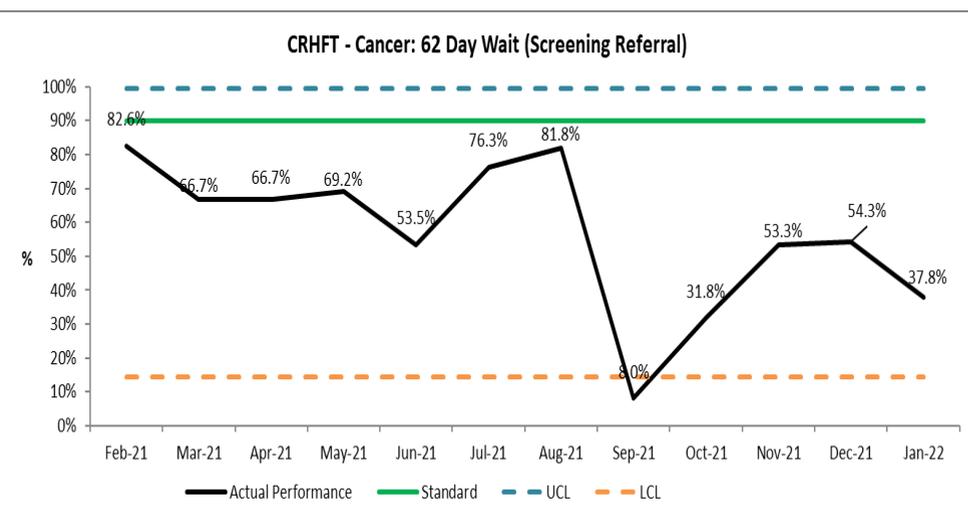
Performance in January at CRH for 31 day from diagnosis to first treatment was 81.3% against the standard of 96%.

There were a total number of 139 patients through this part of the pathway, with 113 of them treated within 31 days resulting in 26 breaches. The tumour sites reporting the breaches are Breast (20), Lower GI (2), Skin (1) and Urology (3).

Out of the 26 breaches, 17 were treated by day 48 with 9 patients treated by day 62.

The trust have again met the target submitted through H2 recovery plan.

## CRHFT - CANCER WAITING TIMES – 62 day Screening Referral



### Performance Analysis

Performance in January for the 62 day screening standard was 37.8% against the standard of 90%.

The number of patients treated via screening referral was 18.5 with 7 of these within 62 days, resulting in 11.5 breaches.

Of the 11.5 breaches, 10 were referred through breast screening.

5 patients were treated between day 63 and 76, 5.5 between day 77 and 104 days with 1 treated after day 104.

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

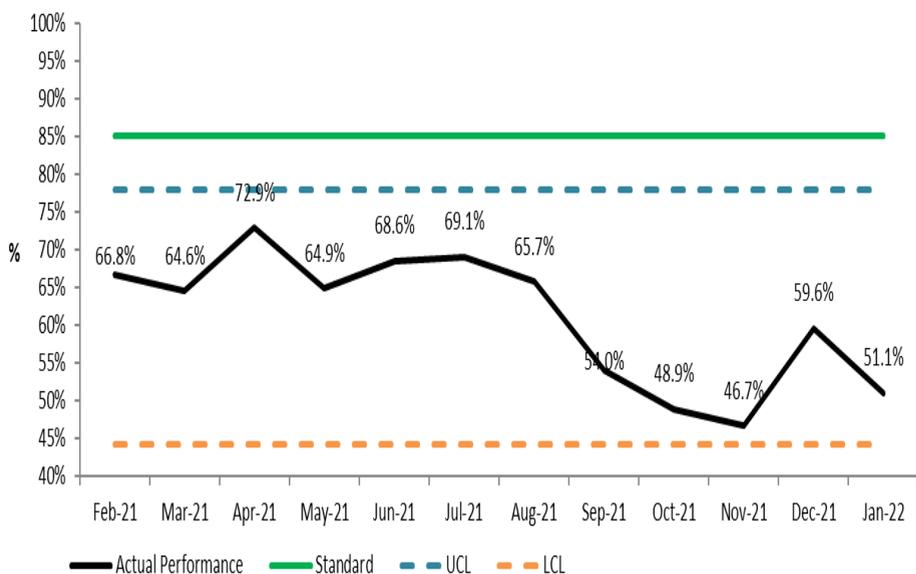
### Performance Analysis

UHDB performance during January was 51.1% against the standard of 85%.

There were a total of 210.5 patients treated along this pathway in January with 107.5 of those patients being treated within the 62 day standard resulting in 103 breaches.

Out of the 103 breaches there were 25.5 accountable treatments by day 76, 43.5 by day 104 with 34 patients being treated after day 104, with 20 of these within Urology.

UHDBFT - Cancer: 62 Day Wait (Urgent Referral)



### Current Issues

- Continued increase in referrals – Derbyshire currently receiving 125% more referrals than the same period in 2020 against a national average of 105-110%.
- Workforce issues – impacted upon by Covid and Isolation
- Limited workforce to schedule additional capacity.
- Capacity issues are particular high in lower GI

### Actions Being Taken

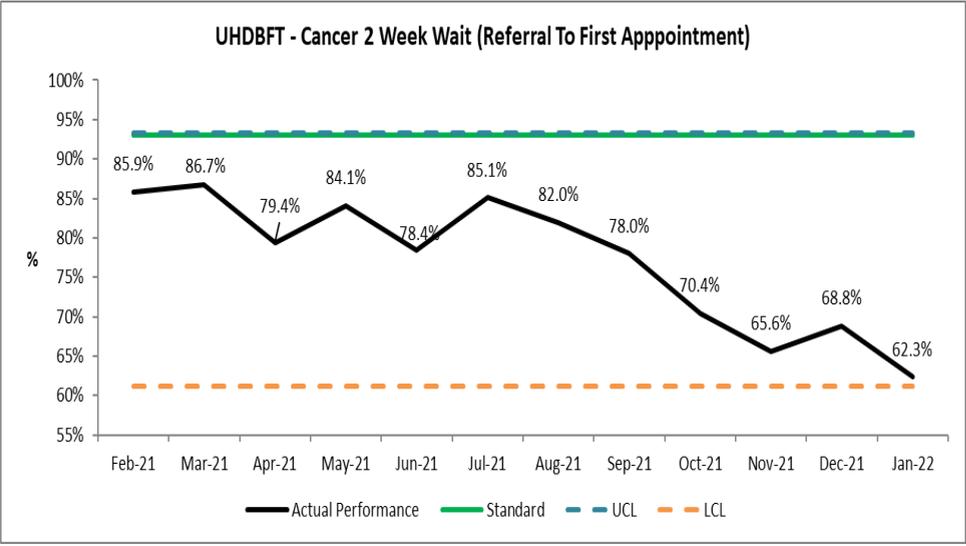
- Additional clinics where possible in particular to support increase in Breast and gynae referrals.
- Work with specific tumour sites and CCG where inappropriate referrals are received, pressure points and what actions we can take.

### What are the next steps

- Continued focus on those patients over 62 day and 104 day on the PTL.
- H2 Operational Plan for 21/22 requires the trust to reduce their PTL of patients waiting over 63 days for treatment to the February 2020 figure or lower.

Tumour Type	Total referrals seen	Seen Within 62 Days	Breaches	% Seen Within 62 Days
Breast	29.5	13	16.5	44.07%
Gynaecological	13	1	12	7.69%
Haematological (Excluding Acute Leukaemia)	12	5	7	41.67%
Head and Neck	12	10	2	83.33%
Lower Gastrointestinal	21	11	10	52.38%
Lung	10.5	10	0.5	95.24%
Sarcoma	2	0	2	0.00%
Skin	37	33	4	89.19%
Testicular	1	1	0	100.00%
Upper Gastrointestinal	20	7	13	35.00%
Urological (Excluding Testicular)	52.5	16.5	36	31.43%
<b>Totals</b>	<b>210.5</b>	<b>107.5</b>	<b>103</b>	<b>51.07%</b>

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



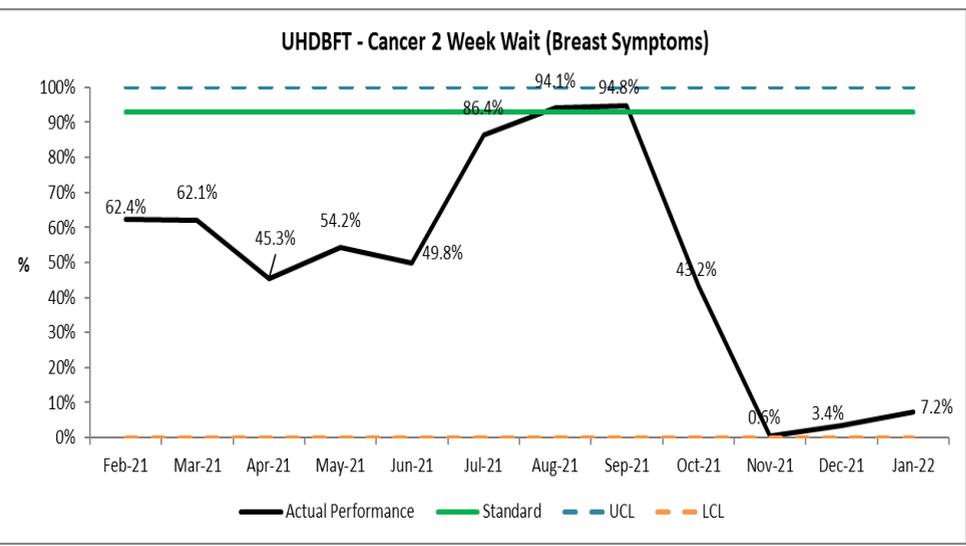
#### Performance Analysis

January at UHDB for 2 week wait was 62.3% against the standard of 93%.

The main challenges for 2ww performance has been associated with Breast, followed by Gynaecology as a result of continued increase in 2WW referrals.

There were a total of 2,798 patients seen in January which is above the number submitted as part of the H2 recovery trajectory.

### UHDB - CANCER WAITING TIMES – Breast Symptomatic



#### Performance Analysis

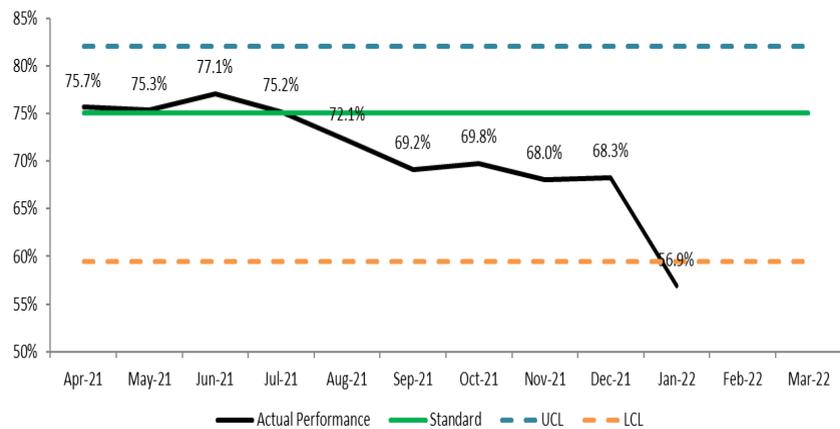
Although remaining below the 93% standard, performance in January at UHDB for the Breast Symptomatic standard has improved to 7.2% compared to the 3.4% reported in December.

There were 139 patients seen via the Breast Symptomatic pathway in January, a reduction of 10 compared to December.

It is to be noted that the polling range for breast appointments has been increased to 35 days to enable all referrals to have an appointment booked.

## UHDB - CANCER WAITING TIMES – 28 Day Wait Faster Diagnosis Standard

UHDBFT - Cancer: 28 Day Faster Diagnosis Standard



### Performance Analysis

Performance in January at UHDB for the 28 day Faster Diagnostic Standard was 56.9% against the 75% standard.

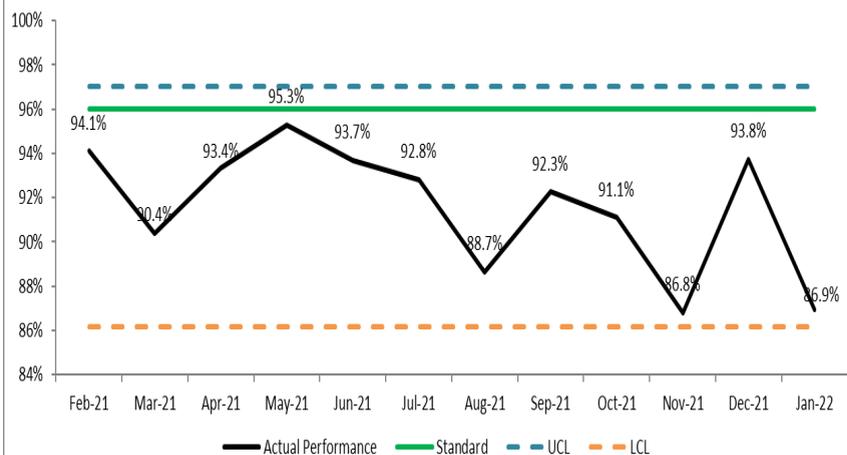
There were a total of 2,956 patients through this part of the pathway in January, a decrease on the 3,177 patients during December.

Of these, 1,681 patients were informed of a cancer diagnosis or told that they didn't have cancer during January, resulting in 1,275 breaches.

As there continues to be a high level of 2WW referrals, a number of patient are being seen after 2 weeks which then affects the ability of the teams to be able to diagnose or rule out a diagnosis of cancer within 28 days.

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

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



### Performance Analysis

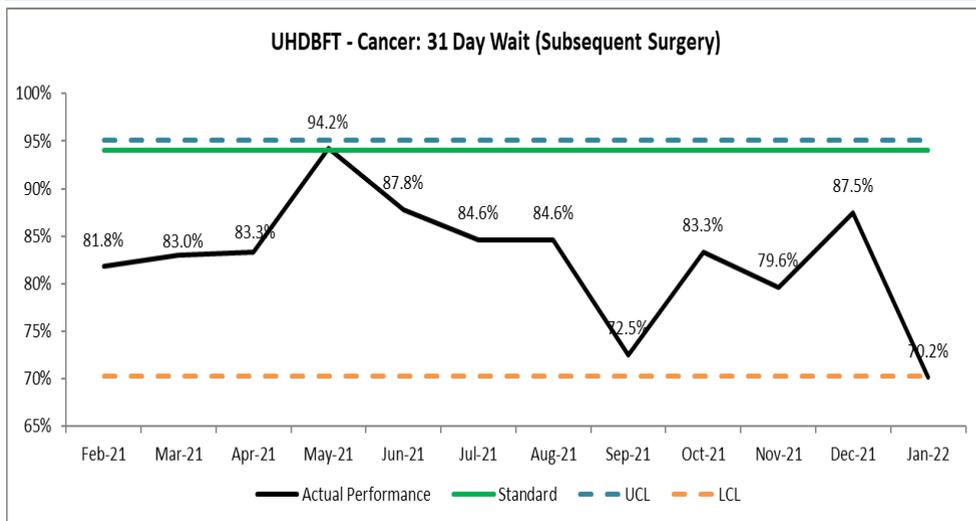
Performance in January at UHDB for 31 day from diagnosis to first treatment was 86.9% against the standard of 96%.

There were a total number of 383 patients treated in January along this pathway, remaining stable against the 384 patients seen during December, with 333 patients seen within the 31 day standard.

The tumour sites reporting the breaches include Breast (14), Lower GI (4), Other (10), Skin (9) and Urology (13).

The numbers seen during the month exceeds the trajectory submitted to NHSE as part of the H2 recovery plan.

## UHDB - CANCER WAITING TIMES – 31day to Subsequent Surgery



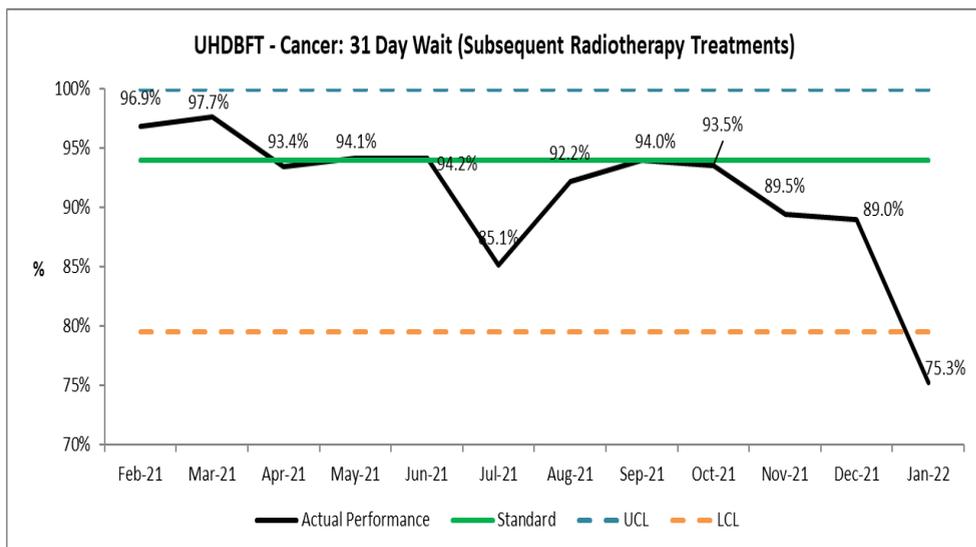
### Performance Analysis

January performance for 31 day to subsequent surgery was 70.2% against the standard of 94%.

There were a total number of 57 patients treated along the subsequent surgery pathway in January with 40 of those patients being treated within the 31 day standard, resulting in 17 breaches.

Of the 17 breaches, 7 patients were treated by day 38, 4 between days 39 to 48 and the remaining 6 after day 48.

## UHDB - CANCER WAITING TIMES – 31day Subsequent Radiotherapy Treatment



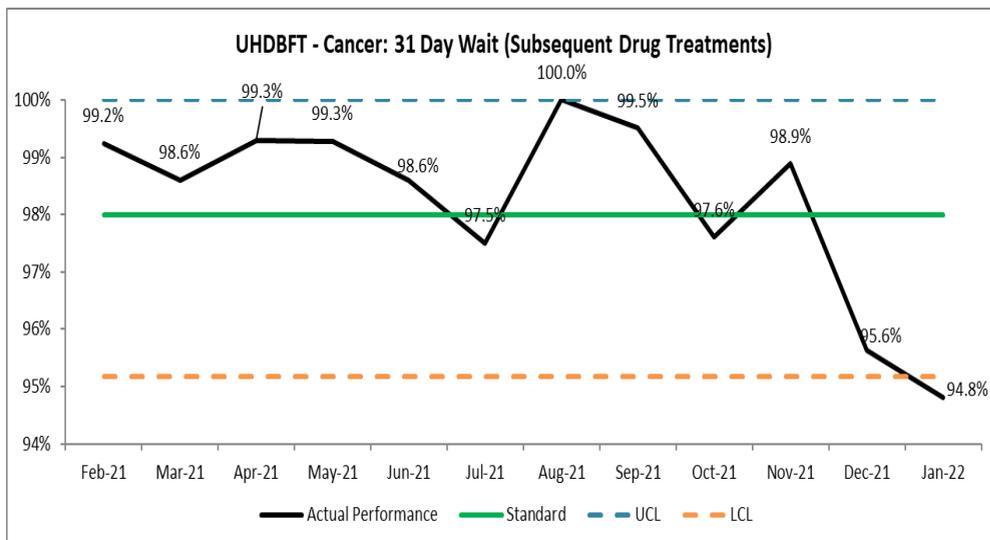
### Performance Analysis

January performance for subsequent radiotherapy was 75.3 against the standard of 94%.

There were a total of 97 patients treated during December, with 73 of these receiving treatment before day 31.

Of the 24 breaches, 9 received their radiotherapy treatment by day 38 with the remainder between 39 and 110 days – the longest waits were due to inadequate out-patient and capacity medical reasons.

## UHDB - CANCER WAITING TIMES – 31 day Subsequent Drugs treatment



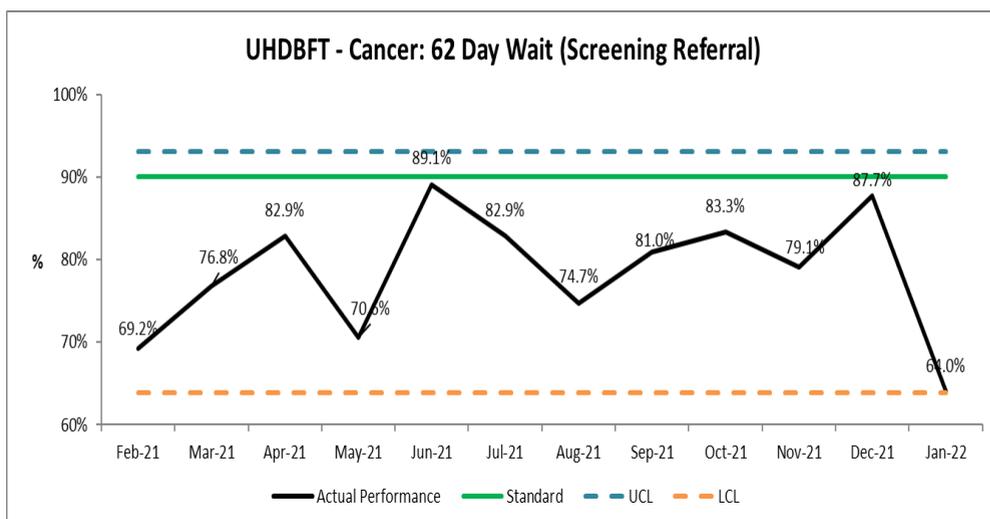
### Performance Analysis

January performance for subsequent drugs treatment was 94.8% against the 98% standard.

There were a total of 154 patients treated during December, with 146 of these receiving treatment before day 31.

Of the 8 breaches, 4 received their radiotherapy treatment by day 38, 3 received treatment between days 39 to 62, with the remaining 1 treated after day 62.

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



### Performance Analysis

Performance in January for screening referral was 64% against the 90% standard.

There were a total of 37.5 patients treated in January who were referred through via a screening referrals, with 24 being treated within 62 days (mostly breast screening referrals), resulting in 13.5 breaches relating to 14 patients.

The majority of breaches were in Breast with inadequate elective capacity identified as the most common reason for the breaches.

# Appendix

# PERFORMANCE OVERVIEW M10 – ASSOCIATE PROVIDER CONTRACTS

## Derbyshire Wide Provider 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

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				
					Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance	
Urgent Care	Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	Feb-22	↑	57.0%	61.7%	44	A&E pilot site - not currently reporting 4 hour breaches				↓	70.1%	72.9%	70	↑	84.4%	86.2%	16	↑	63.7%	68.3%	21	
		A&E 12 Hour Trolley Waits	0	Feb-22	↑	68	397	11	↓	535	2297	8	↑	2	58	12	↓	41	178	7	↑	9	77	7	
Planned Care	Referral to Treatment for non-urgent consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Jan-22	↓	62.9%	56.4%	53	↓	63.0%	66.7%	28	↓	74.0%	78.5%	24	↓	71.9%	70.0%	53	↓	51.7%	55.6%	48	
		Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Jan-22	↓	437	3770	25	↑	3681	34957	22	↑	1277	9370	22	↓	678	10312	22	↑	3783	38505	45	
	Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Jan-22	↑	33.11%	53.82%	23	↓	49.46%	43.82%	23	↑	26.90%	18.13%	23	↑	33.10%	23.45%	25	↑	34.35%	41.13%	31	
	2 Week Cancer Waits	All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	Jan-22	↑	80.5%	90.1%	5	↓	71.1%	84.1%	10	↑	82.8%	82.5%	10	↓	87.0%	90.8%	8	↓	97.1%	97.7%	0	
		Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	Jan-22	↑	66.1%	76.4%	11	↓	0.0%	71.4%	3	↑	6.7%	24.0%	10	↓	85.2%	93.3%	2	↔	N/A	N/A	0	
	28 Day Faster Diagnosis	Diagnosis or Decision to Treat within 28 days of Urgent GP, Breast Symptom or Screening Referral	75%	Jan-22	↓	60.3%	63.4%	10	↓	72.0%	79.6%	1	↓	61.8%	66.7%	10	↓	69.7%	76.4%	1	↓	59.3%	59.3%	10	
	31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	Subsequent Surgery Within 31 Days Of Decision To Treat	94%	Jan-22	↓	66.1%	92.1%	3	↓	81.7%	88.6%	34	↓	87.6%	90.9%	10	↓	83.5%	92.3%	8	↓	98.9%	98.0%	0
			Subsequent Drug Treatment Within 31 Days Of Decision To Treat	98%	Jan-22	↓	100.0%	100.0%	0	↓	98.3%	98.6%	0	↓	95.9%	99.0%	1	↔	100.0%	91.7%	0	↔	100.0%	100.0%	0
			Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	Jan-22					↓	91.2%	93.8%	1	↑	97.3%	96.6%	0								
			62 Days Cancer Waits	First Treatment Administered Within 62 Days Of Urgent GP Referral	85%	Jan-22	↓	31.0%	63.0%	28	↓	58.5%	66.6%	22	↓	54.9%	61.3%	77	↓	52.7%	65.7%	25	↓	65.1%	74.6%
62 Days Cancer Waits	First Treatment Administered - 104+ Day Waits	First Treatment Administered Within 62 Days Of Screening Referral	0	Jan-22	↑	5.5	32.0	17	↑	28.0	219.5	70	↓	10.5	184.0	70	↓	8.5	75.5	45	↑	5.5	26.0	33	
		First Treatment Administered Within 62 Days Of Consultant Upgrade	90%	Jan-22	↓	63.2%	75.8%	14	↓	69.0%	73.9%	14	↓	35.9%	65.3%	14	↓	44.4%	74.2%	8	↓	0%	35.3%	1	
		Healthcare Acquired Infection (HCAI) Measure: MRSA Infections	0	Jan-22	↔	0	2	0	↓	1	1	1	↔	0	0	0	↑	0	1	0	↔	0	1	0	
		Incidence of healthcare associated Infection	Healthcare Acquired Infection (HCAI) Measure: C-Diff Infections	Plan		Jan-22	↔		23		↑		100		↑		140		↓		67		↑		43
Actual				Jan-22	↔		6	0	↑		73	0	↑		109	0	↓		39	0	↑		39	2	
Patient Safety	Healthcare Acquired Infection (HCAI) Measure: E-Coli		-	Jan-22	↓	5	129		↓	58	575		↓	45	442		↓	28	278		↓	20	187		
		Healthcare Acquired Infection (HCAI) Measure: MSSA	-	Jan-22	↓	6	45		↑	16	214		↑	9	153		↓	9	75		↑	0	37		

## Governing Body Meeting in Public

7<sup>th</sup> April 2022

Item No: 015

<b>Report Title</b>	Governing Body Assurance Framework 2021/22 Quarter 4
<b>Author(s)</b>	Rosalie Whitehead, Risk Management & Legal Assurance Manager
<b>Sponsor (Director)</b>	Helen Dillistone, Executive Director of Corporate Strategy and Delivery

<b>Paper for:</b>	<b>Decision</b>	x	<b>Assurance</b>	x	<b>Discussion</b>		<b>Information</b>	
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### Recommendations

The Governing Body are requested to **AGREE** the 2021/22 Quarter 4 (January to March 2022) Governing Body Assurance Framework.

### Report Summary

The Governing Body Assurance Framework (GBAF) provides a structure and process that enables the organisation to focus on the strategic and principal risks that might compromise the CCG in achieving its corporate objectives. It also maps out both the key controls that should be in place to manage those objectives and associated strategic risks and confirms that the Governing Body has sufficient assurance about the effectiveness of the controls.

### Strategic Objectives 2021/22

On the 6<sup>th</sup> May 2021, the Governing Body reviewed and agreed the 2021/22 CCG Strategic Objectives. These are managed through the GBAF to support the delivery and management of organisational risk.

Further work was undertaken on the objective descriptions following feedback from Governing Body. The final 2021/22 strategic objectives are reflective of our final year of operation as a CCG and recognises the transition into the ICS and are as follows:

1. Safely and legally transition the statutory functions of the CCG into the ICS, and safely deliver the disestablishment of the CCG.
2. Deliver the commitments made in response to the Operating Plan, with a focus on reducing health inequalities and improving outcomes for the people of Derbyshire and continuing to support the system during transition to maintain a strategic focus on overall health outcomes / health inequalities.
3. Continue with the roll out of the Covid-19 vaccination programme and ensure a sustainable planning and operational model is in place.
4. Support the development of a recovering and sustainable health and care economy that operates within available resources, achieves statutory financial duties and meets NHS Constitutional standards.
5. Support our staff in the delivery of the above and transition into an ICS, through continued health and wellbeing programmes and effective communication and

engagement.

6. Continue to further develop and implement new and transformational ways of working that have been developed in response to Covid.
7. Work in partnership with stakeholders and engage with our population to achieve the above objectives where appropriate.

#### **Governing Body Assurance Framework Quarter 4**

The corporate committees proactively take the responsibility and ownership of their GBAF risks to scrutinise and develop them further. The Quality and Performance Committee GBAF Task and Finish Group meets monthly to review their GBAF risks thoroughly and is a dynamic group. The other committees are following a similar approach which is most appropriate for the Committee.

The corporate committees responsible for their assigned strategic risks have scrutinised and approved their GBAF Strategic Risks at their committee meetings held during January to March 2022.

The GBAF Quarter 4 can be found at appendix one to this report and updates to the strategic risk extract documents are detailed in red text.

There have been no changes in risk scores for the GBAF strategic risks during quarter 4 due to the position within the healthcare system relating to the impact and system pressures as a result the COVID pandemic.

The confirmation of several ICB Executive Director roles and the ICB Non-Executive Member posts has provided some stability and insight for continuity of Committees and their strategic risks. The Committees will review their risk scores for strategic risks in April once the appointments have been finalised and consider a reduction in risk score; and the preparation for the close down of the CCG Committees and transfer of business to the ICB Committees.

The strategic risks have been reviewed and specific timescales allocated for relevant actions.

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

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

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

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

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

Not required for this paper. Notwithstanding this, where any issues/risks that have been identified from a Quality Impact Assessment) appropriate actions will be taken to manage the associated risks.

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

An EIA is not found applicable to this update on the basis that the GBAF is not a decision making tool; however, addressing risks will impact positively across the organisation as a whole.

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

Due Regard is not found applicable to this update on the basis that the GBAF is not a decision making tool; however, addressing risks will impact positively across the organisation as a whole.

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

Not applicable to this update.

**Have any Conflicts of Interest been identified/ actions taken?**

Not applicable to this update.

**Governing Body Assurance Framework**

As detailed in appendix one, this paper provides Governing Body with assurance of the 2021/22 Quarter 4 GBAF for agreement.

**Identification of Key Risks**

The GBAF identifies the strategic/ principal risks which are linked to the corporate/ operational risks identified in the Corporate Risk Register.

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

**The 2021/22 Strategic Objectives of Derby and Derbyshire CCG are reflective of our final year of operation as a CCG and recognises the transition into the ICS:**

1. Safely and legally transition the statutory functions of the CCG into the ICS, and safely deliver the disestablishment of the CCG.
2. Deliver the commitments made in response to the Operating Plan, with a focus on reducing health inequalities and improving outcomes for the people of Derbyshire, and continuing to support the system during transition to maintain a strategic focus on overall health outcomes / health inequalities.
3. Continue with the roll out of the Covid-19 vaccination programme and ensure a sustainable planning and operational model is in place.
4. Support the development of a recovering and sustainable health and care economy that operates within available resources, achieves statutory financial duties and meets NHS Constitutional standards.
5. Support our staff in the delivery of the above and transition into an ICS, through continued health and wellbeing programmes and effective communication and engagement.
6. Continue to further develop and implement new and transformational ways of working that have been developed in response to Covid.
7. Work in partnership with stakeholders and engage with our population to achieve the above objectives where appropriate.

	<b>Strategic Risk(s)</b>	<b>Current Rating</b>	<b>Executive Lead</b>
<b>1</b>	Lack of timely data, insufficient system ownership and ineffective commissioning may prevent the ability of the CCG to improve health and reduce health inequalities. This is of particular concern during the COVID pandemic where some people may not be able to access usual services or alternatives.	<b>15</b>	Steve Lloyd
<b>2</b>	The CCG is unable to identify priorities for variation reduction and reduce or eliminate them.	<b>20</b>	Steve Lloyd
<b>3</b>	Ineffective system working may hinder the creation of a sustainable health and care system by failing to deliver the scale of transformational change needed at the pace required.	<b>12</b>	Zara Jones
<b>4A</b>	The Derbyshire health system is unable to manage demand, reduce costs and deliver sufficient savings to enable the CCG to move to a sustainable financial position.	<b>16</b>	Richard Chapman
<b>4B</b>	The Derbyshire health system is unable to manage demand, reduce costs and deliver sufficient savings to enable the system to move to a sustainable financial position.	<b>16</b>	Richard Chapman
<b>5</b>	The Derbyshire population is not sufficiently engaged to identify and jointly deliver the services that patients need.	<b>9</b>	Helen Dillistone

<b>6</b>	The CCG does not achieve the national requirements for the Covid-19 Vaccination Programme and have robust operational models in place for the continuous sustainable delivery of the Vaccination Programme	<b>20</b>	Steve Lloyd
<b>7</b>	CCG staff retention and morale during the transition will be adversely impacted due to uncertainty of process and implications of the transfer to the ICS, despite the NHSEI continuity of employment promise.	<b>12</b>	Helen Dillistone
<b>8</b>	If the CCG is not ready to transfer its functions or has failed to comprehensively and legally close down the organisation, or if the system is not ready to receive the functions of the CCG, the ICS operating model cannot be fully established.	<b>10</b>	Helen Dillistone

<p align="center"><b>Strategic Objective: 2</b></p> <p>Deliver the commitments made in response to the Operating Plan, with a focus on reducing health inequalities and improving outcomes for the people of Derbyshire and continuing to support the system during transition to maintain a strategic focus on overall health outcomes / health inequalities.</p>	<p align="center"><b>GBAF RISK 1</b></p>	<p align="center"><b>Executive Lead: Steve Lloyd</b> <b>Assigned to Committee: Quality and Performance</b></p>
<p align="center"><b>What would success look like and how would we measure it?</b></p> <ul style="list-style-type: none"> <li>• Agreement and commitment to agenda at JUCD Board with inequalities in the Terms of Reference.</li> <li>• New ICS governance structure to include addressing inequalities.</li> <li>• Strategic Long Term Conditions Programme Board to be established with a clear remit to reduce unwarranted variation in services.</li> <li>• Commissioning to focus on particular patient cohorts, with measures around services to be put in place to support reduction of inequalities.</li> <li>• Covid risk stratification work should cover health and social care inequality, as well as mental health not just physical health.</li> <li>• System Q&amp;P dashboard to include inequality measures</li> <li>• Patient experience and engagement feedback will be gathered at an early stage to inform all service change / development projects. This will be evidenced in business cases and project initiation documents.</li> <li>• Feedback about the experience of Derby and Derbyshire end of life care will be gathered and analysed to provide intelligence to support the development of services that are driven by those who use services.</li> <li>• A Quality and Equality Impact Assessment (QEIA) will be part of all service change / development projects and programmes. This will be a document that changes as benefits and risks along with mitigating actions are realised.</li> <li>• The QEIA will also include evidence to demonstrate compliance with legislative requirements in respect of public engagement.</li> <li>• Increase Patient Experience feedback and engagement.</li> </ul>		<p align="center"><b>Risk Description</b></p> <p><b>Lack of timely data, insufficient system ownership and ineffective commissioning and the impact of COVID-19 may prevent the ability of the CCG to improve health and reduce health inequalities. This is of particular concern during the COVID pandemic where some people may not be able to access usual services or alternatives.</b></p>

Risk rating	Likelihood	Consequence	Total
Initial	3	3	9
Current	5	3	15
Risk Appetite	Level	Category	Target Score
	Moderate	Commissioning and Contracting	8
	2	4	

### GBAF Risk 1

Month	Score
April	12
May	15
June	15
July	15
August	15
September	15
October	15
November	15
December	15
January	15
February	15
March	15

<b>Date reviewed</b>	March 2022
<b>Rationale for risk rating (and any change in score):</b>	
<ul style="list-style-type: none"> <li>The Derby and Derbyshire population are unable to access their usual service or an alternative due to the impact of the Covid pandemic,</li> <li>The CCG is unable to meet its strategic aim as above due to the impact of the Covid pandemic.</li> <li>Capacity in commissioning has improved.</li> <li>PLACE areas are now supported by a CCG Functional Director.</li> <li>QIA/EIA process in place.</li> <li>Recovery and Restoration plan and process in place.</li> </ul>	
<b>Link to Derby and Derbyshire Risk Register</b>	
1,2,3,4,5,6,7,9,12,14,17,19,21,22,24,25,26,27,28	

KEY CONTROLS TO MITIGATE RISK		SOURCES OF ASSURANCE	
Internal	External	Internal	External
<ul style="list-style-type: none"> <li>QIPP and Service Benefit Reviews challenge process.</li> <li>Prioritisation tool.</li> <li>Clinical &amp; Lay Commissioning Committee providing clinical oversight of commissioning and decommissioning decisions.</li> <li>Robust QIA process for commissioning/ decommissioning schemes and System QEIA now in place</li> <li>Clinical Quality Review Group (CQRG) measures built into all contracts</li> <li>Recovery and Restoration (R&amp;R) Action Plan</li> <li>R&amp;R progress and assurance reported monthly to Governing Body through the Quality &amp; Performance Assurance report</li> <li>2020/2021 Commissioning Intentions published and on website</li> <li>2020/2021 Contracting approach and objectives developed</li> <li>Chief Nurse of DDCCG is the Chair of the System Quality and Performance Group</li> <li>Quality and Performance Committee meetings reinstated from June 20. As a result of the COVID 19 pandemic.</li> <li>CCG Escalated to Business Continuity Level 4 in December 2020 due to Covid 19 pandemic.</li> <li>Corporate Committees and Governing Body Meetings have not been stood down and continue to meet monthly.</li> </ul>	<ul style="list-style-type: none"> <li>NHSE and NHSI assurance arrangements</li> <li>CQC inspections and associated commissioner and provider action plans</li> <li>Programme Boards</li> <li>STP Oversight</li> <li>Meetings with Local Authority to identify joint funding opportunities.</li> <li>System wide efficiency planning has commenced for 2020/2021 showing commitment to joint system working</li> <li>System Quality and Performance Group has been established and monthly meetings in place.</li> <li>System ownership of the health inequalities agenda.</li> <li>Daily System Escalation Cell (SEC) meetings established to support the management of COVID 19 across the Derbyshire System.</li> <li>Winter Planning Cell established.</li> <li>STP/ ICS Interim Accountable Officer appointed.</li> <li>Strategic Long Term Conditions Programme Board to be established or system to collate and triangulate data and agree actions.</li> <li>ICS guidance published November 2020.</li> <li>Derby and Derbyshire formally approved as an ICS.</li> <li>ICS White Paper was published in February 2021.</li> <li>JUCD system moved from Gold Command to Silver Command.</li> <li>SEC meetings were stood down in February 2021.</li> </ul>	<ul style="list-style-type: none"> <li>Quality &amp; Performance Committee</li> <li>Risk management controls and exception reports on clinical risks to Quality &amp; Performance Committee</li> <li>Performance reporting framework in place</li> <li>Lay representation within Governing Bodies and committee in common structures.</li> <li>System NHSE assurance meetings to provide assurance.</li> <li>Recovery and Restoration (R&amp;R) Action Plan and Highlight Report owned by Quality &amp; Performance Committee</li> <li>Joined Up Care 5 Year Strategy Delivery Plan 19/20 - 23/24</li> <li>STP Refresh Summary</li> <li>R&amp;R progress and assurance reported monthly to Governing Body through the Quality &amp; Performance Assurance report</li> <li>Measurement of performance targets</li> <li>System Quality and Performance Group minutes</li> <li>System Phase 3 Plan approved by Governing Body and Submitted to NHSE.</li> <li>Monthly Winter Plan Report provided to JUCD Board.</li> <li>SOC and SVOC update provided weekly to System Escalation Cell (SEC) until it was stood down in February. Now provided to SORG.</li> </ul>	<ul style="list-style-type: none"> <li>Quality Surveillance Group</li> <li>Recovery Action Plans</li> <li>Commissioning Boards</li> <li>Health and Well-being Boards</li> <li>Legal advice where appropriate</li> <li>NHSE System Assurance Letters</li> <li>System Quality and Performance Group minutes.</li> <li>Agreement and commitment to the Health Inequalities agenda at JUCD Board.</li> <li>SEC/SORG Agendas and Papers.</li> <li>SEC/SORG Action Logs.</li> <li>System Phase 3 Plan agreed and submitted to NHSE and is a work in progress plan.</li> <li>2021/22 JUCD Operational Plan</li> <li>ICS Transition Plan</li> <li>Transition Assurance Committee (TAC), agenda, papers and minutes</li> <li>NHSEI Net Zero Carbon Strategy</li> <li>NHS Midlands Greener NHS Board agenda and minutes</li> <li>Derbyshire ICS NHS Greener Delivery Group agenda and minutes</li> <li>Health &amp; Social Care Integration White Paper published on 9<sup>th</sup> February 2022.</li> <li>Health Inequalities Plan on a Page developed by the Anchor Institution.</li> </ul>

<ul style="list-style-type: none"> <li>• Functions continue to operate at BC level 3 and are reviewed regularly.</li> <li>• Winter Planning Cell established and in place to manage the impact of winter pressures and COVID-19.</li> <li>• System Operational Centre established and include the System Vaccination Operational Centre (SVOC)</li> <li>• JUCD system moved from Gold Command to Silver Command February 2021.</li> <li>• Covid-19 Vaccination Inequalities Group established and in place to support tackling vaccine hesitancy in high risk and transient communities. The first meeting was held in February 2021.</li> <li>• JUCD 2021/22 Operational Plan submitted to NHSE 14<sup>th</sup> May 2021.</li> <li>• Transition Assurance Committee (TAC) established and inaugural meeting took place end April and meeting monthly.</li> <li>• CCG GB Chair is the Transition Assurance Committee (TAC) Chair and ICS CCG Transition Working Group Chair.</li> <li>• CCG ICS Transition Working Group established and meets monthly. First meeting took place 6<sup>th</sup> May.</li> <li>• Dr Robyn Dewis, Director of Public Health Derby City is Chair of Health Inequalities Group across the System.</li> <li>• Helen Dillistone is SRO lead for NHS Greener/ Sustainability Programme for the Derbyshire ICS.</li> <li>• <b>CCG Committee Chairs to produce a Committee Annual Report and Risk Report to handover to ICB Committee Chairs.</b></li> </ul>	<p>and operational issues being fully managed by the System Operational Resilience Group (SORG)</p> <ul style="list-style-type: none"> <li>• Transition Assurance Committee (TAC) established and inaugural meeting took place end April and meeting monthly.</li> <li>• Health Inequalities is priority focus of JUCD Board and Strategic Intent.</li> <li>• Health inequalities programme of work will be supported by the strategic intent function of the ICS, the anchor institution and the future plans for data and digital management.</li> <li>• ICS Design Framework published 16<sup>th</sup> June 2021</li> <li>• Health and Care Bill ordered by The House of Commons 6<sup>th</sup> July 2021.</li> <li>• Further ICS/ ICB Guidance published August 2021</li> <li>• John MacDonald appointed as ICB Designate Chair.</li> <li>• Dr Chris Clayton appointed as Chief Executive Designate of NHS Derby and Derbyshire ICB</li> <li>• Greener NHS National Programme published Net Zero Carbon Strategy, cites multiple links between climate change, sustainable development, and health inequalities.</li> <li>• Improving health and patient care and reducing health inequalities is one of the top three priorities of the Greener NHS National Programme.</li> <li>• NHS Midlands Greener NHS Board</li> <li>• Derbyshire ICS NHS Greener Delivery Group</li> <li>• Joined Up Improvement Derbyshire Efficiency and Productivity PMO in place.</li> <li>• Craig Cook appointed as interim Chief Digital and Intelligence Officer.</li> <li>• <b>ICB transition deferred from 1<sup>st</sup> April 2022 to 1<sup>st</sup> July 2022.</b></li> <li>• <b>Confirmation of some Executive Officer positions have removed uncertainty of continuity and provides stability for the transition to ICB Committees.</b></li> <li>• <b>Glossop boundary change confirmed effective from 1<sup>st</sup> July 2022.</b></li> </ul>	<ul style="list-style-type: none"> <li>• Vaccine hesitancy updates reported to weekly Gold Call meetings</li> <li>• Plan on a page for each cohort.</li> <li>• Vaccination Inequalities Group Terms of Reference and Action Plan.</li> <li>• 2021/22 JUCD Operational Plan</li> <li>• ICS Transition Plan</li> <li>• Transition Assurance Committee (TAC), agenda, papers and minutes</li> <li>• CCG ICS Transition Working Group agenda, papers and minutes</li> <li>• <b>JUCD QEIA Panel reports to DDCCG Quality and Performance Committee and risks escalated from Q&amp;P to System Quality Group.</b></li> </ul>	
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GAPS IN CONTROL		GAPS IN ASSURANCE	
<p><b>Internal</b></p> <ul style="list-style-type: none"> <li>Commissioning the specific needs to meet the demands of the Covid Pandemic</li> <li>DDCCG patient experience function remains stood down with staff deployed to support pandemic response.</li> </ul>	<p><b>External</b></p> <ul style="list-style-type: none"> <li>CCG does not currently have an evidence-based strategy to address inequalities.</li> <li>Programme of work for appropriate interventions, informed by public health data and incorporating the wider determinants of health.</li> </ul>	<p><b>Internal</b></p> <ul style="list-style-type: none"> <li>DDCCG patient experience function remains stood down with staff deployed to support pandemic response.</li> </ul>	<p><b>External</b></p> <ul style="list-style-type: none"> <li>Understanding health data and implications of Covid including disparities of outcomes.</li> <li>Understanding direct impacts and long-term implications of Covid. Triangulating through system.</li> <li>Development of Derbyshire ICS NHS Greener Plan</li> <li>Development of ICS Health Inequalities Plan</li> </ul>
ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)			
<p><b>Internal</b></p> <ul style="list-style-type: none"> <li>Post COVID Syndrome Pathway meeting established in November and has been meeting fortnightly until w/c 15.03.21. Now meeting on a monthly basis, due to the launch of a monthly clinical forum.</li> <li>Addressing health inequalities is a key priority in the ICS System Development Plan currently being drafted for submission to NHSEI</li> <li>JUCD quality group is undertaking a review of the system quality strategies and a joint strategy will be developed in the next six months. Health inequalities will form part of that strategy.</li> </ul>	<p><b>Timeframe</b></p> <ul style="list-style-type: none"> <li>Monthly</li> <li>Monthly</li> <li>April 2022</li> </ul>	<p><b>External</b></p> <ul style="list-style-type: none"> <li>Long Term Conditions Strategy.</li> <li>Long Term Conditions Board to identify groups for focus (prioritisation work started)</li> <li>Derbyshire ICS NHS Greener Plan to be approved by ICB Board</li> <li>ICS Health Inequalities Plan to be approved by Shadow ICB Board April 2022</li> </ul>	<p><b>Timeframe</b></p> <ul style="list-style-type: none"> <li>May 2022</li> <li>May 2022</li> <li>April 2022</li> <li>April 2022</li> </ul>

<p align="center"><b>Strategic Objective: 2</b></p> <p>Deliver the commitments made in response to the Operating Plan, with a focus on reducing health inequalities and improving outcomes for the people of Derbyshire and continuing to support the system during transition to maintain a strategic focus on overall health outcomes / health inequalities.</p>	<p align="center"><b>GBAF RISK 2</b></p>	<p align="center">Executive Lead: Steve Lloyd</p> <p align="center">Assigned to Committee: Quality and Performance</p>
<p align="center"><b>What would success look like and how would we measure it?</b></p> <ul style="list-style-type: none"> <li>• Agreement and commitment to agenda at JUCD Board with unwarranted variation in quality in the Terms of Reference.</li> <li>• JUCD to take a disease management approach to variation, rather than individual services.</li> <li>• New ICS governance structure to include addressing unwarranted variation in quality.</li> <li>• CCG to understand the variations in services across JUCD and if these are unwarranted.</li> <li>• Quality to work with commissioning teams to ensure contracts address the inequalities.</li> <li>• System Q&amp;P dashboard to used to identify the variations at system level.</li> <li>• System Q&amp;P to address the unwarranted variation identified from the dashboard, through the JUCD Programme Boards.</li> <li>• Improve Patient experience and engagement feedback and how it will be gathered to understand how varying of services is impacting on the people of Derbyshire.</li> </ul>		<p align="center"><b>Risk Description</b></p> <p align="center"><b>The CCG is unable to identify priorities for variation reduction and reduce or eliminate them.</b></p>

Risk rating	Likelihood	Consequence	Total	GBAF Risk 2												Date reviewed	March 2022
Initial	3	4	12													<b>Rationale for risk rating (and any change in score):</b> <ul style="list-style-type: none"> <li>CCG unable to identify priorities for variation reduction due to the impact of the Covid pandemic.</li> <li>Increase in risk score as a result in losing Clinical and Medical Staff to prioritise Covid patients.</li> <li>The STP Clinical leadership group is becoming established.</li> <li>The Systems saving group is bringing key partners together to deliver the financial priorities and has increased joint ownership of priorities.</li> <li>PLACE commissioning is developing.</li> </ul>	
Current	5	4	20													<b>Link to Derby and Derbyshire Risk Register</b> 1,2,3,4,5,6,7,9,12,14,17,21,22,23,24,25,26,27,28,29	
Risk Appetite	Level	Category	Target Score														
	Moderate	National Quality and Direction	8														
	2	4															
KEY CONTROLS TO MITIGATE RISK				SOURCES OF ASSURANCE													
<u>Internal</u> <ul style="list-style-type: none"> <li>Clinical &amp; Lay Commissioning Committee providing clinical oversight of commissioning and decommissioning decisions</li> <li>Robust QIA process for commissioning/ decommissioning schemes and new System QIA panel in place</li> <li>Clinical Quality Review Group (CQRG) measures built into all contracts</li> <li>Executive Team and Finance Committee oversight.</li> <li>Contract Management Board (CMB) oversight</li> <li>Quality &amp; Performance Committee</li> <li>Recovery and Recovery (R&amp;R) Plan</li> <li>R&amp;R progress and assurance reported monthly to Governing Body through the Quality &amp; Performance Assurance report</li> <li>Brigid Stacey, Chief Nurse of Derby and Derbyshire CCG is the Chair of the System Quality &amp; Performance Group</li> <li>Internal resource planning work led by HR</li> <li>Quality and Performance Committee meetings reinstated from June 20 as a result of the COVID 19 pandemic.</li> <li>Winter Planning Cell established and in place to manage the impact of winter pressures and COVID-19</li> <li>CCG Escalated to Business Continuity Level 4 in December 2020 due to Covid 19 pandemic.</li> </ul>		<u>External</u> <ul style="list-style-type: none"> <li>NHSE System assurance arrangements</li> <li>Provider Governance arrangements are clear and include any subcontracting responsibilities.</li> <li>CQC inspections and associated commissioner and provider action plans</li> <li>STP Oversight</li> <li>System Quality &amp; Performance Group established and meets on a monthly basis</li> <li>Winter Planning Cell established</li> <li>STP/ ICS Interim Accountable Officer appointed</li> <li>System Quality and Performance Group meetings stood down from March 2020 to July 2020 due to COVID 19 pandemic.</li> <li>ICS guidance published November 2020.</li> <li>Derby and Derbyshire formally approved as an ICS.</li> <li>System Quality and Performance Group meetings continue to meet and are not stood down at level 4</li> <li>ICS White Paper was published in February 2021.</li> <li>JUCD system moved from Gold Command to Silver Command.</li> <li>SEC meetings were stood down in February 2021, and operational issues being fully managed by the System Operational Resilience Group (SORG).</li> </ul>		<u>Internal</u> <ul style="list-style-type: none"> <li>Quality &amp; Performance Committee</li> <li>Risk management controls and exception reports on clinical risk to Quality &amp; Performance</li> <li>Performance reporting framework</li> <li>Lay and Council representation within Governing Bodies and committees structure.</li> <li>Clinical Committee established at Place,</li> <li>Quality assurance visits</li> <li>NHSE system assurance meetings to provide assurance.</li> <li>R&amp;R Plan and Highlight Report owned by Quality &amp; Performance Committee</li> <li>Joined Up Care 5 Year Strategy Delivery Plan 19/20 - 23/24</li> <li>STP Refresh Summary</li> <li>R&amp;R progress and assurance reported monthly to Governing Body through the Quality &amp; Performance Assurance report</li> <li>Brigid Stacey, Chief Nurse of Derby and Derbyshire CCG is the Chair of the System Quality &amp; Performance Group.</li> <li>Daily System Escalation Cell meetings established to support the management of COVID 19 across the Derbyshire System.</li> <li>System Phase 3 Plan approved by Governing Body and Submitted to NHSE.</li> <li>Monthly Winter Plan Report provided to</li> </ul>						<u>External</u> <ul style="list-style-type: none"> <li>Collaboration with Healthwatch</li> <li>Health and Well-being Boards</li> <li>NHSE/I assurance meetings</li> <li>CQC Inspections and action plans</li> <li>Quality Surveillance Group</li> <li>Minutes of System Quality &amp; Performance Group</li> <li>System Phase 3 Plan agreed and submitted to NHSE and is a work in progress plan</li> <li>2021/22 JUCD Operational Plan</li> <li>ICS Transition Plan</li> <li>Transition Assurance Committee (TAC), agenda, papers and minutes</li> <li>System Outcomes Based Accountability Steering Group has commenced work looking at health outcomes.</li> <li>NHSEI Net Zero Carbon Strategy</li> <li>NHS Midlands Greener NHS Board agenda and minutes</li> <li>Derbyshire ICS NHS Greener Delivery Group agenda and minutes</li> <li>Health &amp; Social Care Integration White Paper published on 9<sup>th</sup> February 2022.</li> <li>Health Inequalities Plan on a Page developed by the Anchor Institution.</li> </ul>							

<ul style="list-style-type: none"> <li>• Corporate Committees and Governing Body Meetings have not been stood down and continue to meet monthly.</li> <li>• Functions continue to operate at BC level 3 and are reviewed regularly.</li> <li>• JUCD system moved from Gold Command to Silver Command February 2021.</li> <li>• Covid-19 Vaccination Inequalities Group established and in place to support tackling vaccine hesitancy in high risk and transient communities.</li> <li>• JUCD 2021/22 Operational Plan submitted to NHSE 14<sup>th</sup> May 2021.</li> <li>• Transition Assurance Committee (TAC) established and inaugural meeting took place end April and meeting monthly.</li> <li>• CCG GB Chair is the Transition Assurance Committee (TAC) Chair and CCG ICS Transition Working Group Chair.</li> <li>• CCG ICS Transition Working Group established and meets monthly. First meeting took place 6<sup>th</sup> May.</li> <li>• Dr Robyn Dewis, Director of Public Health Derby City is Chair of Health Inequalities Group across the System.</li> <li>• Helen Dillistone is SRO lead for NHS Greener/ Sustainability Programme for the Derbyshire ICS</li> <li>• CCG Committee Chairs to produce a Committee Annual Report and Risk Report to handover to ICB Committee Chairs.</li> </ul>	<ul style="list-style-type: none"> <li>• Transition Assurance Committee (TAC) established and inaugural meeting took place end April and meeting monthly.</li> <li>• Health Inequalities is priority focus of JUCD Board and Strategic Intent.</li> <li>• Health inequalities programme of work will be supported by the strategic intent function of the ICS, the anchor institution and the future plans for data and digital management.</li> <li>• ICS Design Framework published 16<sup>th</sup> June 2021</li> <li>• Health and Care Bill ordered by The House of Commons 6<sup>th</sup> July 2021.</li> <li>• Health and Care Bill ordered by The House of Commons 6<sup>th</sup> July 2021.</li> <li>• Further ICS/ ICB Guidance published August 2021</li> <li>• John MacDonald appointed as ICB Designate Chair.</li> <li>• Dr Chris Clayton appointed as Chief Executive Designate of NHS Derby and Derbyshire ICB</li> <li>• Greener NHS National Programme published Net Zero Carbon Strategy, cites multiple links between climate change, sustainable development, and health inequalities.</li> <li>• Improving health and patient care and reducing health inequalities is one of the top three priorities of the Greener NHS National Programme.</li> <li>• NHS Midlands Greener NHS Board</li> <li>• Derbyshire ICS NHS Greener Delivery Group</li> <li>• Joined Up Improvement Derbyshire Efficiency and Productivity PMO in place.</li> <li>• Craig Cook appointed as interim Chief Digital and Intelligence Officer</li> <li>• ICB transition deferred from 1<sup>st</sup> April 2022 to 1<sup>st</sup> July 2022.</li> <li>• Confirmation of some Executive Officer positions have removed uncertainty of continuity and provides stability for the transition to ICB Committees.</li> <li>• Glossop boundary change confirmed effective from 1<sup>st</sup> July 2022.</li> </ul>	<p>JUCD Board.</p> <ul style="list-style-type: none"> <li>• Vaccine hesitancy updates reported to weekly Gold Call meetings</li> <li>• Plan on a page for each cohort.</li> <li>• Vaccination Inequalities Group Terms of Reference and Action Plan.</li> <li>• Decision making principles to be applied to each cohort to ensure consistent approach.</li> <li>• 2021/22 JUCD Operational Plan</li> <li>• ICS Transition Plan</li> <li>• Transition Assurance Committee (TAC), agenda, papers and minutes</li> <li>• CCG ICS Transition Working Group agenda, papers and minutes</li> </ul>	
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GAPS IN CONTROL		GAPS IN ASSURANCE	
<u>Internal</u> <ul style="list-style-type: none"> <li>CCG unable to identify priorities for variation reduction due to the impact of the Covid pandemic.</li> <li>CCG patient experience function stood down in response to COVID.</li> </ul>	<u>External</u> <ul style="list-style-type: none"> <li>Identify variation caused through system processes and work with system partners to eliminate or reduce.</li> <li>Priorities which carry the most significant at-scale benefits for early action.</li> </ul>	<u>Internal</u> <ul style="list-style-type: none"> <li>Development of STP planning and refresh.</li> <li>CCG patient experience function stood down in response to COVID.</li> </ul>	<u>External</u> <ul style="list-style-type: none"> <li>Differentiate which variation is appropriate for elimination and which is not; develop a prioritised plan for the former.</li> <li>Agree dataset to measure improvement in outcomes and patient experience.</li> <li>Development of Derbyshire ICS NHS Greener Plan</li> <li>Development of ICS Health Inequalities Plan</li> </ul>
ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)			
<u>Internal</u> <ul style="list-style-type: none"> <li>Establishment of Quality &amp; Performance Committee Task &amp; Finish Group to provide scrutiny and challenge.</li> <li>Addressing health inequalities is a key priority in the ICS System Development Plan currently being drafted for submission to NHSEI</li> <li>JUCD quality group is undertaking a review of the system quality strategies and a joint strategy will be developed in the next six months. Health inequalities will form part of that strategy.</li> </ul>	<u>Timeframe</u> <ul style="list-style-type: none"> <li>Monthly</li> <li>Monthly</li> <li>April 2022</li> </ul>	<u>External</u> <ul style="list-style-type: none"> <li>Increased system working with system partners to deliver transformation change.</li> <li>Refer issues to System Quality and Performance Group.</li> <li>Strategic Long Term Conditions Programme Board to address variation. (Working on risk stratification with BI / Board are reviewing priorities)</li> <li>Right Care Evidence and Data (awaiting updated data packs)</li> <li>Working with the LTC Board to agree Priorities at System Event.</li> <li>Working with the LTC Board to agree Strategic Long Term Conditions Programme Board to agree dataset measurement.</li> <li>Derbyshire ICS NHS Greener Plan to be approved by CCG Governing Body and ICB Board</li> <li>ICS Health Inequalities Plan to be approved by Shadow ICB Board</li> </ul>	<u>Timeframe</u> <ul style="list-style-type: none"> <li>Ongoing and Monthly</li> <li>Monthly System Quality &amp; Performance Group</li> <li>Monthly</li> <li>Monthly</li> <li>May 2022</li> <li>May 2022</li> <li>April/July2022</li> <li>May 2022</li> </ul>

<p align="center"><b>Strategic Objective: 6</b></p> <p>Continue to further develop and implement new and transformational ways of working that have been developed in response to Covid.</p>				<p><b>GBAF RISK 3</b></p>				<p>Executive Lead: Zara Jones</p> <p>Assigned to Committee: Clinical &amp; Lay Commissioning</p>			
<p align="center"><b>What would success look like and how would we measure it?</b></p> <p>Safe delivery of our Phase 3 and winter plan through effective system oversight of delivery and escalation and resolution of issues. Retaining the benefits of learning and transformation through wave 1 COVID-19. Improved / sustained relationships with system partners – increased collaboration and strengthened planning and delivery, less duplication and more shared accountability for delivery.</p>				<p align="center"><b>Risk Description</b></p> <p><b>Ineffective system working may hinder the creation of a sustainable health and care system by failing to deliver the scale of transformational change needed at the pace required.</b></p>							
Risk rating	Likelihood	Consequence	Total	<p align="center"><b>GBAF Risk 3</b></p> <p>The chart shows a horizontal line at a score of 12 across all months from April to March.</p>				Date reviewed	March 2022	<p><b>Rationale for risk rating (and any change in score):</b></p> <ul style="list-style-type: none"> <li>System working through the last few months remains at the same level in terms of collaboration and mutual support.</li> <li>Measures are not easily measurable making the score more subjective.</li> </ul>	
Initial	3	4	12					Current	3		
Risk Appetite	Level	Category	Target Score					Moderate	Collaborative working	2	4
<b>KEY CONTROLS TO MITIGATE RISK</b>					<b>SOURCES OF ASSURANCE</b>						
<b>Internal</b>			<b>External</b>		<b>Internal</b>			<b>External</b>			
<ul style="list-style-type: none"> <li>Senior members of staff are fully involved in STP/ ICS workstreams</li> <li>Link with STP</li> <li>Strong CEO lead and influence on STP</li> <li>Good clinical engagement i.e. Medical Director a key player in CPRG</li> <li>CPAG and new Clinical Pathways Forum</li> <li>Commissioning Intentions 20/21 finalised and agreed with Providers and published on website</li> <li>Clinical Leadership Framework in place</li> <li>Deep Dives on areas of poor performance involving provider partners e.g. Q&amp;P deep dives</li> <li>Lessons learned application to 20/21 planning and delivery through Finance Committee and shared with GB and system</li> <li>Clinical and Lay Commissioning Committee meetings reinstated June 2020 a result of the COVID 19 pandemic.</li> <li>Clinical Cell established to manage COVID 19 issues, Steve Lloyd Medical Director is the lead</li> </ul>			<ul style="list-style-type: none"> <li>Governance structure embedded</li> <li>Good CEO/DoF system engagement</li> <li>JUCD Board now fully functioning as a group of system leaders and meeting in public since January 2021.</li> <li>Systems Savings Group</li> <li>Future in Mind Plan agreed by the CCG, Derby City Council and Derbyshire County Council</li> <li>System Quality and Performance Group established to support in-year delivery strategically, linked to the transformation agenda</li> <li>System Planning leads oversight of contracting and planning for 20/21, linked to DoFs group to ensure we set the right framework for delivery of our transformation as a system.</li> <li>System Clinical and Professional Reference Group established and meets monthly.</li> <li>System intelligence – one version of the truth</li> <li>Winter Planning Cell established</li> <li>STP/ ICS Executive Lead appointed</li> <li>ICS guidance published November 2020.</li> <li>Derby and Derbyshire formally approved as an ICS.</li> </ul>		<ul style="list-style-type: none"> <li>Clinical &amp; Lay Commissioning Committee meetings</li> <li>Governing Body</li> <li>Executive Team</li> <li>Recovery and Restoration Action Plan</li> <li>Recovery and Restoration Plan Highlight Report owned by Clinical &amp; Lay Commissioning Committee</li> <li>Clinical &amp; Lay Commissioning Assurance Report provided to Governing Body.</li> <li>STP System Refresh</li> <li>Draft Joined Up Care 5 Year Delivery Plan 19/20 – 23/24</li> <li>Commissioning Intentions 20/21 published and available on the CCGs website.</li> <li>System Phase 3 Plan approved by Governing Body and Submitted to NHSE.</li> <li>Winter Planning Cell established and in place to manage the impact of winter pressures and COVID-19.</li> </ul>			<ul style="list-style-type: none"> <li>JUCD Board</li> <li>System Forums including delivery boards, planning leads</li> <li>CEO/DoF meetings</li> <li>CPRG meetings</li> <li>NHSE/I reviews</li> <li>Derby City Council</li> <li>Derbyshire County Council</li> <li>Future in Mind Plan published on Derby City Council website</li> <li>Future in Mind Plan published on Derbyshire County Council website</li> <li>STP refresh</li> <li>System Clinical and Professional Reference Group Minutes</li> <li>System Phase 3 Plan agreed and submitted to NHSE and is a work in progress plan.</li> </ul>			

<p>for the cell.</p> <ul style="list-style-type: none"> <li>• Zara Jones, Executive Director of Commissioning and Operations is the lead for the System Planning Cell.</li> <li>• Daily System Escalation Cell meetings established to support the management of COVID 19 across the Derbyshire System (currently stood down)</li> <li>• System Planning and Operations Cell established to manage and determine recovery plans and future planning.</li> <li>• Established intelligence and baseline data on finance, activity and workforce to enable scenario modelling to inform decision making.</li> <li>• CCG Escalated to Business Continuity Level 4 in December 2020 due to Covid 19 pandemic.</li> <li>• Corporate Committees and Governing Body Meetings have not been stood down and continue to meet monthly.</li> <li>• Functions continue to operate at BC level 3 and are reviewed regularly.</li> <li>• JUCD system moved from Gold Command to Silver Command February 2021</li> <li>• JUCD 2021/22 Operational Plan submitted to NHSE 14<sup>th</sup> May 2021.</li> <li>• System Transition Assurance Committee established and inaugural meeting took place end April and meeting monthly.</li> <li>• CCG GB Chair is the System Transition Assurance Committee Chair.</li> <li>• CCG Governing Body received Derbyshire ICS Boundary Update at their meeting in public 2<sup>nd</sup> September 2021.</li> <li>• Joint Derby Derbyshire CCG and Tameside and Glossop CCG Transition Steering Group established to lead four main workstreams.</li> <li>• Four workstreams comprising of specialist leads across both systems for Communications and Engagement, Finance IT and Contracting, Neighbourhood Development and Statutory Duties, Risks and People Impact Assessment.</li> <li>• <b>CCG Committee Chairs to produce a Committee Annual Report and Risk Report to handover to ICB Committee Chairs.</b></li> </ul>	<ul style="list-style-type: none"> <li>• ICS White Paper was published in February 2021.</li> <li>• JUCD system moved from Gold Command to Silver Command.</li> <li>• SEC meetings were stood down in February 2021, and operational issues being fully managed by the System Operational Resilience Group (SORG)</li> <li>• System Transition Assurance Committee established, and inaugural meeting took place end April and meeting monthly.</li> <li>• Secretary of State for Health and Social Care decision taken in August 2021 to amend the ICS boundary so that Glossop will move from the Greater Manchester ICS into the Derbyshire ICS</li> <li>• Dr Chris Clayton appointed as Chief Executive Designate of NHS Derby and Derbyshire ICB</li> <li>• John MacDonald appointed as ICB Designate Chair.</li> <li>• Joined Up Improvement Derbyshire Efficiency and Productivity PMO in place.</li> <li>• <b>ICB transition deferred from 1st April 2022 to 1st July 2022.</b></li> <li>• <b>Glossop boundary change confirmed effective from 1<sup>st</sup> July 2022.</b></li> <li>• <b>Confirmation of some Executive Officer positions have removed uncertainty of continuity and provides stability for the transition to ICB Committees.</b></li> </ul>	<ul style="list-style-type: none"> <li>• SOC and SVOC update provided weekly to System Escalation Cell (SEC) until it was stood down in February. Now provided to SORG.</li> <li>• 2021/22 JUCD Operational Plan</li> <li>• System Transition Assurance Committee, agenda, papers and minutes</li> <li>• CCG submitted its Engagement Report to NHSEI in June 2021.</li> <li>• Joint Transition Steering Group minutes and action log.</li> <li>• Derbyshire ICS Transition Plan</li> </ul>	<ul style="list-style-type: none"> <li>• SEC/SORG Agendas and Papers.</li> <li>• SEC/SORG Action Logs</li> <li>• 2021/22 JUCD Operational Plan</li> <li>• System Transition Assurance Committee, agenda, papers and minutes</li> <li>• Joint Transition Steering Group minutes and action log.</li> </ul>
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GAPS IN CONTROL		GAPS IN ASSURANCE	
<p style="text-align: center;"><b><u>Internal</u></b></p> <ul style="list-style-type: none"> <li>• Not able to influence decisions</li> <li>• Limited CCG capacity to contribute to all meetings Clinical and Lay Commissioning Committee meetings stood down from March 2020 to June 2020 due to CCG operating at level 4 Business Continuity Escalation as a result of the COVID 19 pandemic.</li> <li>• Withdrawal of Turnaround approach</li> <li>• Development of communications and engagement plan with stakeholders, patients and public.</li> <li>• Contracting and Commissioning implications on broader geography and population</li> <li>• Place/ PCN planning and Primary Care development to include Glossop</li> </ul>	<p style="text-align: center;"><b><u>External</u></b></p> <ul style="list-style-type: none"> <li>• National directives</li> <li>• 'Club v's country' i.e. organisational sovereignty over system</li> <li>• System Clinical and Professional Reference Group meetings stood down due to COVID 19 pandemic.</li> <li>• Workforce plans to be established across the system to provide the necessary competency and capacity to deliver healthcare, including contingency plans for staff reductions due to Covid-19.</li> <li>• Suspension of operational planning</li> <li>• Suspension of Systems Savings Group and PMO</li> <li>• Necessary delays in some transformation work</li> </ul>	<p style="text-align: center;"><b><u>Internal</u></b></p>	<p style="text-align: center;"><b><u>External</u></b></p> <ul style="list-style-type: none"> <li>• System Clinical and Professional Reference Group Minutes not available due to current Position.</li> <li>• Quantify residual health need resulting from Covid infection and factor into capacity and demand planning.</li> </ul>
ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)			
<p style="text-align: center;"><b><u>Internal</u></b></p> <ul style="list-style-type: none"> <li>• System savings work in place and ongoing</li> <li>• Joined Up Care Derbyshire Workstream Delivery Boards / Assurance</li> <li>• Strategic commissioner and ICS / ICP development</li> <li>• Virtual urgent decisions can be made by CLCC as per the Terms of Reference as required.</li> <li>• Weekly 30 minute Confidential GB Virtual Meetings established, with focused agenda have been established for urgent decision making and any urgent committee business.</li> <li>• Clinical Cell established to manage COVID 19 issues, Steve Lloyd Medical Director is the lead for the cell.</li> <li>• Zara Jones, Executive Director of Commissioning and Operations is the lead for the System Planning Cell.</li> <li>• Glossop transition Communications and Engagement Plan with stakeholders, patients and public.</li> <li>• Contracting and Commissioning Plan to include broader geography and population</li> <li>• Place/ Primary Care Network (PCN) Plan and Primary Care Plan to include Glossop</li> </ul>	<p style="text-align: center;"><b><u>Timeframe</u></b></p> <ul style="list-style-type: none"> <li>• Monthly review</li> <li>• Monthly</li> <li>• April 2022</li> <li>• As and when required</li> <li>• Weekly</li> <li>• Monthly</li> <li>• Since March 2020</li> <li>• December 2021 to June 2022</li> <li>• March to May 2022</li> <li>• March to May 2022</li> </ul>	<p style="text-align: center;"><b><u>External</u></b></p> <ul style="list-style-type: none"> <li>• Continued work with system partners to develop and deliver transformation plans</li> <li>• Development of Direct Enhanced Services during 2021/22 through PCCC.</li> <li>• System Escalation Cell/ SORG meetings established to support the management of COVID 19 across the Derbyshire System.</li> <li>• System Planning and Operations Cell established to manage and determine recovery plans and future planning.</li> </ul>	<p style="text-align: center;"><b><u>Timeframe</u></b></p> <ul style="list-style-type: none"> <li>• Monthly review</li> <li>• April 2022</li> <li>• Monthly</li> <li>• Monthly</li> </ul>

<p><b>Strategic Aim: 4</b> Support the development of a recovering and sustainable health and care economy that operates within available resources, achieves statutory financial duties and meets NHS Constitutional standards.</p>				<p><b>GBAF RISK 4A</b></p>				<p>Executive Lead: Richard Chapman Assigned to Committee: Finance Committee</p>				
<p><b>What would success look like and how would we measure it?</b></p> <ul style="list-style-type: none"> <li>Delivery of agreed 2021/22 financial position.</li> </ul>				<p><b>Risk Description</b></p> <p>The Derbyshire health system is unable to manage demand, reduce costs and deliver sufficient savings to enable the <u>CCG</u> to move to a sustainable financial position.</p>								
<p><b>Risk rating</b></p>		<p><b>Likelihood</b></p>	<p><b>Consequence</b></p>	<p><b>Total</b></p>					<p><b>Date reviewed</b></p>		<p>March 2022</p>	
<p>Initial</p>		<p>5</p>	<p>5</p>	<p>25</p>					<p><b>Rationale for risk rating (and any change in score):</b></p> <ul style="list-style-type: none"> <li>Identify underlying system position, current and forward-looking</li> <li>The risk score for GBAF risk 4A has been increased to a very high score of 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. The CCG is working with system partners to understand the recurrent underlying position and early work suggests there is a considerable system financial challenge moving into 2021/22.</li> <li>The Derbyshire NHS system has 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 to agree how these resources are used and what remaining financial risk there is, where this risk will be held and how it can be mitigated.</li> </ul>			
<p>Current</p>		<p>4</p>	<p>4</p>	<p>16</p>								
<p><b>Risk Appetite</b></p>		<p><b>Level</b></p>	<p><b>Category</b></p>	<p><b>Target Score</b></p>	<p><b>Link to Derby and Derbyshire Risk Register</b> 11,30</p>							
		<p>Low</p>	<p>Financial Statutory Duties</p>	<p>10</p>								
		<p>2</p>	<p>5</p>									
<p><b>KEY CONTROLS TO MITIGATE RISK</b></p>					<p><b>SOURCES OF ASSURANCE</b></p>							
<p><b>Internal</b></p> <ul style="list-style-type: none"> <li>Contract management incl. validation of contract information, coding and counting challenges etc.</li> <li>Internal management processes – monthly confirm and challenge by Executive Team &amp; Finance Committee.</li> <li>Recovery and Restoration (R&amp;R) Plan.</li> <li>R&amp;R progress and assurance reported monthly to Governing Body through the Finance Committee Assurance report.</li> <li>Finance Committee meetings reinstated from June 2020</li> <li>Temporary financial regime in place within the CCG for the 6 month period 1st April to 30th September 2020 as a result of COVID-19.</li> <li>NHSEI have provided guidance of a new financial for the period to March 2021. The allocations</li> </ul>			<p><b>External</b></p> <ul style="list-style-type: none"> <li>Standardised contract governance in line with national best practice.</li> <li>System Finance Oversight Group (SFOG) established.</li> <li>Daily System Escalation Cell meetings established to support the management of COVID 19 across the Derbyshire System</li> <li>System Savings Group established and in place</li> <li>System Finance Oversight Group in place and reinstated and continuing to meet at BC level 4.</li> <li>The Derbyshire NHS system has 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 to agree how these resources are used and what remaining financial risk there is, where</li> </ul>			<p><b>Internal</b></p> <ul style="list-style-type: none"> <li>Monthly reporting to NHSE/NHSI, Finance Recovery Group and Finance Committee.</li> <li>Internal Audit 20/21 Integrity of the general ledger, financial reporting and budgetary control Audit giving significant assurance.</li> <li>Recovery and Restoration Action Plan.</li> <li>R&amp;R progress and assurance reported monthly to Governing Body through the Finance Committee Assurance report</li> <li>Finance Committee Minutes</li> <li>Service Development Funding received end September 20.</li> <li>SOC and SVOC update provided weekly to System Escalation Cell (SEC) until it was stood down in February. Now provided to</li> </ul>			<p><b>External</b></p> <ul style="list-style-type: none"> <li>Regulator review and oversight of monthly financial submissions</li> <li>System Finance Oversight Group Minutes</li> <li>2021/22 JUCD Operational Plan</li> <li>ICS Transition Plan</li> <li>System Transition Assurance Committee, agenda, papers and minutes</li> </ul>			

<p>have been based on the first 6 months of the financial year and includes additional system allocations for COVID-19, Top-up and Growth.</p> <ul style="list-style-type: none"> <li>• CCG Escalated to Business Continuity Level 4 in December 2020 due to Covid 19 pandemic.</li> <li>• Corporate Committees and Governing Body Meetings have not been stood down and continue to meet monthly.</li> <li>• Functions continue to operate at BC level 3 and are reviewed regularly.</li> <li>• JUCD system moved from Gold Command to Silver Command February 2021.</li> <li>• JUCD 2021/22 Operational Plan submitted to NHSE 14<sup>th</sup> May 2021.</li> <li>• System Transition Assurance Committee established, and inaugural meeting took place end April and meeting monthly.</li> <li>• CCG GB Chair is the System Transition Assurance Committee Chair and ICS CCG Transition Working Group Chair.</li> <li>• CCG ICS Transition Working Group established and meets monthly. First meeting took place 6<sup>th</sup> May.</li> <li>• CCG Finance Committee integrated with System and Finance Estates Committee from January 2022.</li> <li>• CCG Committee Chairs to produce a Committee Annual Report and Risk Report to handover to ICB Committee Chairs.</li> </ul>	<p>this risk will be held and how it can be mitigated.</p> <ul style="list-style-type: none"> <li>• ICS guidance published November 2020.</li> <li>• Derby and Derbyshire formally approved as an ICS.</li> <li>• ICS White Paper was published in February 2021.</li> <li>• JUCD system moved from Gold Command to Silver Command.</li> <li>• SEC meetings were stood down in February 2021, and operational issues being fully managed by the System Operational Resilience Group (SORG)</li> <li>• System Transition Assurance Committee established and inaugural meeting took place end April and meeting monthly.</li> <li>• Dr Chris Clayton appointed as Chief Executive Designate of NHS Derby and Derbyshire ICB</li> <li>• John MacDonald appointed as ICB Designate Chair.</li> <li>• Joined Up Improvement Derbyshire Efficiency and Productivity PMO in place.</li> <li>• Glossop boundary change confirmed effective from 1<sup>st</sup> July 2022.</li> </ul>	<p>SORG.</p> <ul style="list-style-type: none"> <li>• 2021/22 JUCD Operational Plan</li> <li>• ICS Transition Plan</li> <li>• System Transition Assurance Committee, agenda, papers and minutes</li> <li>• CCG ICS Transition Working Group agenda, papers and minutes</li> </ul>	
<b>GAPS IN CONTROL</b>		<b>GAPS IN ASSURANCE</b>	
<p style="text-align: center;"><b><u>Internal</u></b></p> <ul style="list-style-type: none"> <li>• Consistent and regular reporting of timely, accurate and complete activity data with associated financial impact.</li> </ul>	<p style="text-align: center;"><b><u>External</u></b></p> <ul style="list-style-type: none"> <li>• Absence of integrated system reporting of the health financial position.</li> <li>• System Finance Oversight Group meetings to be reinstated September 2020.</li> <li>• Establish common system objective to deliver financial sustainability on a system-wide basis.</li> <li>• Identify underlying system position, current and forward-looking.</li> <li>• Establish system-wide monitoring, efficiency and transformational delivery process.</li> </ul>	<p style="text-align: center;"><b><u>Internal</u></b></p> <ul style="list-style-type: none"> <li>• Regularisation of integrated activity, finance and savings reporting incorporating activity trajectory matched to provider capacity to deliver and associated commissioner financial impact</li> </ul>	<p style="text-align: center;"><b><u>External</u></b></p> <ul style="list-style-type: none"> <li>• Absence of commitment to open-book reporting with clear risk identification.</li> <li>• System Finance Oversight Group Minutes</li> </ul>
<b>ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)</b>			
<p style="text-align: center;"><b><u>Internal</u></b></p> <ul style="list-style-type: none"> <li>• Strengthening of activity data reporting to ensure improved business intelligence to support decision making.</li> <li>• Integrated Activity Finance &amp; Savings report in place</li> </ul>	<p style="text-align: center;"><b><u>Timeframe</u></b></p> <ul style="list-style-type: none"> <li>• Monthly</li> <li>• Monthly</li> </ul>	<p style="text-align: center;"><b><u>External</u></b></p> <ul style="list-style-type: none"> <li>• Transparency of open book reporting through System Finance &amp; Estates Committee</li> </ul>	<p style="text-align: center;"><b><u>Timeframe</u></b></p> <ul style="list-style-type: none"> <li>• Monthly</li> </ul>

<p><b>Strategic Aim: 4</b> Support the development of a recovering and sustainable health and care economy that operates within available resources, achieves statutory financial duties and meets NHS Constitutional standards.</p>				<p><b>GBAF RISK 4B</b></p>				<p>Executive Lead: Richard Chapman Assigned to Committee: Finance Committee</p>		
<p><b>What would success look like and how would we measure it?</b></p> <ul style="list-style-type: none"> <li>Delivery of agreed 2021/22 financial position on a system basis.</li> </ul>				<p><b>Risk Description</b></p> <p>The Derbyshire health system is unable to manage demand, reduce costs and deliver sufficient savings to enable the <u>system</u> to move to a sustainable financial position.</p>						
<p><b>Risk rating</b></p>		<p><b>Likelihood</b></p>	<p><b>Consequence</b></p>	<p><b>Total</b></p>					<p><b>Date reviewed</b></p>	<p>March 2022</p>
<p>Initial</p>		<p>5</p>	<p>4</p>	<p>20</p>					<p><b>Rationale for risk rating (and any change in score):</b></p> <ul style="list-style-type: none"> <li>Identify underlying system position, current and forward-looking.</li> <li>The system does not currently have a functional efficiency programme or agreed structures to implement such a programme.</li> <li>The risk score for GBAF risk 4B has been increased to a very high score of 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. The CCG is working with system partners to understand the recurrent underlying position and early work suggests there is a considerable system financial challenge moving into 2021/22.</li> <li>The likelihood was increased based on initial assessment that the NHS system has a gap of c. £43m between expenditure assessed as required to meet delivery plans and notified available resource. Since this initial risk the CCG is working with system partners and we have, as a result of a much-improved CCG position, been able to report that the system are forecasting a break-even position, with the providers reporting a combined £5.0m surplus against the CCGs £5.0m deficit. Work remains ongoing to monitor and manage this position, particularly in relation to where the risks are and how these can be mitigated.</li> </ul>	
<p>Current</p>		<p>4</p>	<p>4</p>	<p>16</p>						
<p><b>Risk Appetite</b></p>		<p><b>Level</b></p>	<p><b>Category</b></p>	<p><b>Target Score</b></p>	<p><b>Link to Derby and Derbyshire Risk Register</b> 11,30</p>					
		<p>Low</p>	<p>Financial Statutory Duties</p>	<p>10</p>						
		<p>2</p>	<p>5</p>	<p>10</p>						

KEY CONTROLS TO MITIGATE RISK		SOURCES OF ASSURANCE	
Internal	External	Internal	External
<ul style="list-style-type: none"> <li>Internal management processes – monthly confirm and challenge by Executive Team and Finance Committee</li> <li>Integrated financial reporting incorporating I&amp;E and savings positions and risk</li> <li>Recovery and Restoration (R&amp;R) Plan.</li> <li>Clinical Leadership Framework in place across the system to support governance and clinical workstreams.</li> <li>R&amp;R Plan progress and assurance reported monthly to Governing Body through the Finance Committee Assurance report</li> <li>Finance Committee meetings reinstated from June 2020</li> <li>NHSEI have provided guidance of a new financial for the period to March 2021. The allocations have been based on the first 6 months of the financial year and includes additional system allocations for COVID-19, Top-up and Growth.</li> <li>CCG Escalated to Business Continuity Level 4 in December 2020 due to Covid 19 pandemic.</li> <li>Corporate Committees and Governing Body Meetings have not been stood down as continue to meet monthly.</li> <li>Functions continue to operate at BC level 3 and are reviewed regularly.</li> <li>JUCD system moved from Gold Command to Silver Command February 2021.</li> <li>JUCD 2021/22 Operational Plan submitted to NHSE 14<sup>th</sup> May 2021.</li> <li>System Transition Assurance Committee established and inaugural meeting took place end April and meeting monthly.</li> <li>CCG GB Chair is the System Transition Assurance Committee Chair and ICS CCG Transition Working Group Chair.</li> <li>CCG ICS Transition Working Group established and meets monthly. First meeting took place 6<sup>th</sup> May.</li> <li>CCG Finance Committee integrated with System and Finance Estates Committee from January 2022.</li> <li>CCG Committee Chairs to produce a Committee Annual Report and Risk Report to handover to ICB Committee Chairs.</li> </ul>	<ul style="list-style-type: none"> <li>Standardised contract governance in line with national best practice.</li> <li>System Finance Oversight Group (SFOG) established</li> <li>Requirement to agree a multi-year system recovery plan with regulator in order to mitigate impact score</li> <li>The Derbyshire NHS system has 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 to agree how these resources are used and what remaining financial risk there is, where this risk will be held and how it can be mitigated.</li> <li>ICS guidance published November 2020.</li> <li>Derby and Derbyshire formally approved as an ICS.</li> <li>SFOG continue to meet at BC Level 4, December</li> <li>ICS White Paper was published in February 2021.</li> <li>JUCD system moved from Gold Command to Silver Command.</li> <li>SEC meetings were stood down in February 2021, and operational issues being fully managed by the System Operational Resilience Group (SORG) 2020 onwards.</li> <li>System Transition Assurance Committee established and inaugural meeting took place end April and meeting monthly.</li> <li>Dr Chris Clayton appointed as Chief Executive Designate of NHS Derby and Derbyshire ICB</li> <li>John MacDonald appointed as ICB Designate Chair.</li> <li>Joined Up Improvement Derbyshire Efficiency and Productivity PMO in place.</li> <li>Glossop boundary change confirmed effective from 1<sup>st</sup> July 2022.</li> </ul>	<ul style="list-style-type: none"> <li>Monthly reporting to NHSE/NHSI, Executive Team and Finance Committee.</li> <li>Recovery and Restoration Plan.</li> <li>Clinical Leadership Framework in place across the system to support governance and clinical workstreams.</li> <li>Recovery and Restoration Programme progress and assurance reported monthly to Governing Body through the Finance Committee Assurance Report</li> <li>Finance Committee Minutes</li> <li>SOC and SVOC update provided weekly to System Escalation Cell (SEC) until it was stood down in February. Now provided to SORG.</li> <li>2021/22 JUCD Operational Plan.</li> <li>ICS Transition Plan.</li> <li>System Transition Assurance Committee, agenda, papers and minutes.</li> <li>CCG ICS Transition Working Group agenda, papers and minutes.</li> </ul>	<ul style="list-style-type: none"> <li>Regulator review and oversight of monthly financial submissions</li> <li>System Finance Oversight Group Minutes</li> <li>2021/22 JUCD Operational Plan</li> <li>ICS Transition Plan</li> <li>System Transition Assurance Committee, agenda, papers and minutes</li> </ul>

GAPS IN CONTROL		GAPS IN ASSURANCE	
<p><b>Internal</b></p> <ul style="list-style-type: none"> <li>Consistent and regular reporting of timely, accurate and complete activity data with associated financial impact.</li> </ul>	<p><b>External</b></p> <ul style="list-style-type: none"> <li>Absence of a single system view of activity data which is timely, accurate and complete.</li> <li>Absence of a system planning function on which partners place reliance.</li> <li>Absence of integrated system reporting of the health financial position.</li> <li>Regulatory and statutory financial duties mitigate against system collaboration and cooperation to reduce health cost.</li> <li>System Activity Finance &amp; Savings report</li> <li>System Savings Group established and in place</li> <li>System Finance Oversight Group in place</li> <li>System Finance Oversight Group reinstated September 20 and continues to meet at BC Level 4 from December 20,</li> <li>Establish common system objective to deliver financial sustainability on a system-wide basis.</li> <li>Identify underlying system position, current and forward-looking.</li> <li>Establish system-wide monitoring, efficiency and transformational delivery process.</li> </ul>	<p><b>Internal</b></p> <ul style="list-style-type: none"> <li>Regularisation of integrated activity, finance and savings reporting incorporating activity trajectory matched to provider capacity to deliver and associated commissioner financial impact</li> </ul>	<p><b>External</b></p> <ul style="list-style-type: none"> <li>Absence of commitment to open-book reporting with clear risk identification.</li> <li>Provider rules only allow reforecasting on a quarterly basis, unable to influence this</li> <li>Provider Sustainability Fund rules incentivise delay in risk recognition meaning forecasting may not be fully objective, unable to influence this</li> <li>System Finance Oversight Group minutes not available due to current position</li> </ul>
<b>ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)</b>			
<p><b>Internal</b></p> <ul style="list-style-type: none"> <li>System Activity Finance report</li> </ul>	<p><b>Timeframe</b></p> <ul style="list-style-type: none"> <li>Monthly</li> </ul>	<p><b>External</b></p> <ul style="list-style-type: none"> <li>Establish greater system working across finance teams</li> <li>Transparency of open book reporting through System Finance &amp; Estates Committee</li> <li>System Escalation Cell/ SORG meetings established to support the management of COVID 19 across the Derbyshire System</li> </ul>	<p><b>Timeframe</b></p> <ul style="list-style-type: none"> <li>Monthly</li> <li>Monthly</li> <li>Weekly</li> </ul>

<p><b>Strategic Aim: 7</b> Work in partnership with stakeholders and engage with our population to achieve the above objectives where appropriate.</p>				<p><b>GBAF RISK 5</b></p>				<p>Executive Lead: Helen Dillistone Assigned to Committee: Engagement Committee</p>								
<p><b>What would success look like and how would we measure it?</b> Output and delivery of comprehensive engagement programme, with % increase to Citizen's Panel membership and agreed % population engaged in planning in Yr1. Fully populated and network engagement structure, with permanent membership of Engagement Committee confirmed.</p>				<p><b>Risk Description</b> <b>The Derbyshire population is not sufficiently engaged to identify and jointly deliver the services that patients need.</b></p>												
<p><b>Risk rating</b></p>		<p><b>Likelihood</b></p>	<p><b>Consequence</b></p>	<p><b>Total</b></p>					<p><b>Date reviewed</b></p>		<p><b>March 2022</b></p>					
<p>Initial</p>		<p>4</p>	<p>3</p>	<p><b>12</b></p>					<p><b>Rationale for risk rating (and any change in score):</b></p> <ul style="list-style-type: none"> <li>The CCG recognises the risk of operating in a complex and financially challenged environment and the need to balance decision making with appropriate engagement and involvement.</li> <li>The risk likelihood was reduced from 4 to 3 in October to reflect the appetite and development to implement the Derbyshire Dialogue programme.</li> </ul>				<p><b>Link to Derby and Derbyshire Risk Register</b> 4,5,6,7,9,12,14,16,24,25,26,27,28</p>			
<p>Current</p>		<p>3</p>	<p>3</p>	<p><b>9</b></p>												
<p><b>Risk Appetite</b></p>		<p><b>Level</b></p>	<p><b>Category</b></p>	<p><b>Target Score</b></p>												
		<p>Low</p>	<p>Commissioning</p>	<p><b>6</b></p>												
		<p>2</p>	<p>3</p>													
<p><b>KEY CONTROLS TO MITIGATE RISK</b></p>					<p><b>SOURCES OF ASSURANCE</b></p>											
<p><b>Internal</b></p> <ul style="list-style-type: none"> <li>Clearly defined system strategy which identifies key health priorities and forward planning to ensure public engagement can be embedded.</li> <li>Engagement function with clearly defined roles and agreed priorities.</li> <li>Engagement Committee to provide challenge and internal scrutiny; the Committee has broad representation from provider Governors, members of the public, Local Government, Healthwatch and the Voluntary Sector.</li> <li>Alignment of CCG and JUCD communications and engagement agendas where necessary to provide streamlined and coherent approach.</li> <li>Identified involvement of communications and engagement lead involvement in all projects.</li> </ul>			<p><b>External</b></p> <ul style="list-style-type: none"> <li>Engagement Committee has dual responsibility for the alignment of JUCD and CCG communications and engagement agendas where necessary to provide streamlined and coherent approach.</li> <li>Relationship development with local parliamentary and council politicians.</li> <li>Structured approach to broader stakeholder engagement.</li> <li>Proactive formal and informal Engagement with Overview &amp; Scrutiny Committees, with clear business plan.</li> <li>Co-production approach to planning utilising existing local experts by experience (Lay Reference Groups)</li> <li>Joined Up Care Derbyshire Comms and Engagement collaboration and planning.</li> <li>Legal/Consultation Institute advice on challenging issues.</li> </ul>		<p><b>Internal</b></p> <ul style="list-style-type: none"> <li>Confirm and challenge and outputs for Engagement Committee providing assurance to GBs.</li> <li>Governing Body assurance of Engagement Committee evidence from training and development.</li> <li>Commissioning cycle to involve patient engagement.</li> <li>EIA and QIA process.</li> <li>QIA/EIA panel.</li> <li>Communications &amp; Engagement Team aligned to programme boards to maintain understanding of emerging work and implications</li> <li>Systematic completion of S14Z2 forms will provide standardised assurance against compliant decision making and recording of decisions at project level.</li> </ul>			<p><b>External</b></p> <ul style="list-style-type: none"> <li>Membership (and other stakeholder) feedback via annual 360 survey.</li> <li>Approval of commissioning strategy and associated decisions by the Clinical Lay Commissioning Committee.</li> <li>Approval of engagement and consultation processes from Overview and Scrutiny Committees.</li> <li>NHS England CCG Assurance Rating.</li> <li>INHS England Assurance on winter communications and engagement plan</li> <li>NHS England assurance on NHS 111 First communications and engagement plan</li> <li>2021/22 JUCD Operational Plan</li> <li>ICS Transition Plan</li> <li>System Transition Assurance Committee, agenda, papers and minutes</li> </ul>								

<ul style="list-style-type: none"> <li>Clearly defined offer and ownership of communications channels to support consistency of approach and clarity of message.</li> <li>QEIA panel now includes review of S14Z2 (engagement review) forms to provide early sighting on engagement requirements</li> <li>Simple engagement model now approved to support project flow through consistent process.</li> <li>Strengthening of CCG committee cover sheets to ensure committees making implementation decisions have full assurance that duties have been met.</li> <li>2020/21 Commissioning Intentions finalised and agreed with Providers.</li> <li>Population Health Management in development</li> <li>Recovery and Restoration Plan</li> <li>Governing Body</li> <li>Commissioning Intentions 2020/21 published and on website.</li> <li>Engagement Committee meetings reinstated from June 2020.</li> <li>Zara Jones, Executive Director of Commissioning and Operations is the lead for the System Planning Cell.</li> <li>Daily System Escalation Cell meetings established to support the management of COVID 19 across the Derbyshire System</li> <li>System Planning and Operations Cell established to manage and determine recovery plans and future planning</li> <li>Communications and Engagement Strategy-outline proposal of the strategy ready for January 2021 and final version in March 2021 asserting ambition for measuring success. CCG Escalated to Business Continuity Level 4 in December 2020 due to Covid 19 pandemic.</li> <li>Corporate Committees and Governing Body Meetings have not been stood down and Engagement Committee meets bi-monthly.</li> <li>Functions continue to operate at BC level 3 and are reviewed regularly.</li> <li>JUCD system moved from Gold Command to Silver Command February 2021</li> <li>JUCD 2021/22 Operational Plan submitted to NHSE 14<sup>th</sup> May 2021.</li> <li>System Transition Assurance Committee established and inaugural meeting took place end April and meeting monthly.</li> <li>CCG GB Chair is the System Transition Assurance Committee Chair and ICS CCG</li> </ul>	<ul style="list-style-type: none"> <li>Derbyshire Dialogue launched in September 2020 to begin process of continuous engagement with local people. Subjects covered to date include the pandemic response, primary care and mental health, with future sessions planned on UEC and cancer.</li> <li>Derby and Derbyshire formally approved as an ICS.</li> <li>ICS White Paper was published in February 2021.</li> <li>JUCD system moved from Gold Command to Silver Command.</li> <li>System Transition Assurance Committee established and inaugural meeting took place end April and meeting monthly.</li> <li>Health Inequalities is priority focus of JUCD Board during May and June 2021.</li> <li>Joined up Care Derbyshire Communications and Engagement Strategy approved at JUCD Board 15<sup>th</sup> July 2021.</li> <li>Further ICB guidance published in August 2021.</li> <li>Awaiting Health &amp; Social Care Bill to be passed in parliament.</li> <li>Dr Chris Clayton appointed as Chief Executive Designate of NHS Derby and Derbyshire ICB</li> <li>John MacDonald appointed as ICB Designate Chair.</li> <li>Glossop boundary change confirmed effective from 1<sup>st</sup> July 2022</li> </ul>	<ul style="list-style-type: none"> <li>Training for Engagement Committee membership to ensure robust understanding and application of guidance and statutory responsibility.</li> <li>2020/21 Commissioning Intentions finalised and agreed with Providers.</li> <li>Population Health Management supported by Public Health Directors and Governing Body.</li> <li>Establishment of Strategic Advisory Group.</li> <li>Governing Body developing CCG Strategy.</li> <li>Commissioning Intentions published and on website</li> <li>Significant community engagement programme in progress to support vaccine inequalities agenda.</li> <li>2021/22 JUCD Operational Plan</li> <li>ICS Transition Plan</li> <li>System Transition Assurance Committee, agenda, papers and minutes</li> <li>CCG ICS Transition Working Group agenda, papers and minutes</li> </ul>	
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<p>Transition Working Group Chair.</p> <ul style="list-style-type: none"> <li>• CCG ICS Transition Working Group established and meets monthly. First meeting took place 6<sup>th</sup> May.</li> <li>• Dr Robyn Dewis, Director of Public Health Derby City is Chair of Health Inequalities Group across the System.</li> <li>• <b>CCG Committee Chairs to produce a Committee Annual Report and Risk Report to handover to ICB Committee Chairs.</b></li> </ul>			
<b>GAPS IN CONTROL</b>		<b>GAPS IN ASSURANCE</b>	
<p style="text-align: center;"><u>Internal</u></p> <ul style="list-style-type: none"> <li>• A robust engagement programme that supports the health inequalities and commissioning agendas at the planning stage, with full population analysis to support reaching seldom heard groups.</li> <li>• Finalise construct of engagement mechanisms from PPG level, through PCN, Place, ICP to Engagement Committee level, subject to system structure agreement.</li> <li>• Embed clear and robust statements and processes relating to the desire to engage in CCG strategic policies.</li> <li>• Communication and Engagement not appropriately funded to ensure effectiveness in crowded public sector messaging space.</li> </ul>	<p style="text-align: center;"><u>External</u></p> <ul style="list-style-type: none"> <li>• Multiple public sector messages resulting in CCG cut through being a challenge</li> </ul>	<p style="text-align: center;"><u>Internal</u></p> <ul style="list-style-type: none"> <li>• Embed insight gathering processes into BAU for health service commissioning, with programme support identification of behaviours and issues that affect service commissioning and health inequalities</li> <li>• CCG Communications and Engagement Strategy requires refresh, including alignment with JUCD approach</li> </ul>	<p style="text-align: center;"><u>External</u></p> <ul style="list-style-type: none"> <li>• CCG Communications and Engagement Strategy requires refresh, including alignment with JUCD approach</li> </ul>
<b>ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)</b>			
<p style="text-align: center;"><u>Internal</u></p> <ul style="list-style-type: none"> <li>• Training support for project managers in development on commissioning cycle to standardise processes, building on recent project management training.</li> <li>• Fully populated and network engagement structure, with permanent membership of Engagement Committee confirmed.</li> <li>• Funding proposal developed to support implementation and ambition of Communications and Engagement Strategy</li> </ul>	<p style="text-align: center;"><u>Timeframe</u></p> <ul style="list-style-type: none"> <li>• Q4 2021/22 (paused during Level 4 Business Continuity arrangements)</li> <li>• Bi-monthly</li> <li>• Q4 2021/22 (in line with national and system financial planning processes for 21/22)</li> </ul>	<p style="text-align: center;"><u>External</u></p> <ul style="list-style-type: none"> <li>• Engagement Committee re-established bi-monthly.</li> <li>• Insight programme in progress but requires longer-term funding model</li> <li>• Funding proposal developed to support implementation and ambition of Communications and Engagement Strategy</li> </ul>	<p style="text-align: center;"><u>Timeframe</u></p> <ul style="list-style-type: none"> <li>• Bi-monthly 2021/22</li> <li>• Q4 2021/22</li> <li>• Q4 2021/22 (in line with national and system financial planning processes for 21/22)</li> </ul>

<p><b>Strategic Objective: 3</b></p> <p>Continue with the roll out of the Covid-19 vaccination programme and ensure a sustainable planning and operational model is in place.</p>				<p><b>GBAF RISK 6</b></p>				<p><b>Executive Lead: Steve Lloyd</b></p> <p><b>Assigned to Committee: Quality and Performance Committee</b></p>							
<p><b>What would success look like and how would we measure it?</b></p> <ul style="list-style-type: none"> <li>95% of the Derby and Derbyshire CCG population receive 1<sup>st</sup> and 2<sup>nd</sup> doses of a Covid-19 vaccination</li> <li>Phase 3 of Vaccination Programme is implemented from September 2021</li> </ul>				<p><b>Risk Description</b></p> <p><b>The CCG does not achieve the national requirements for the Covid-19 Vaccination Programme and have robust operational models in place for the continuous sustainable delivery of the Vaccination Programme.</b></p>											
<p><b>Risk rating</b></p>		<p><b>Likelihood</b></p>	<p><b>Consequence</b></p>	<p><b>Total</b></p>	<p><b>GBAF Risk 6</b></p> <p>The chart shows a constant score of 20 across all months from April to March. The y-axis ranges from 0 to 25 in increments of 5.</p>				<p><b>Date reviewed</b></p> <p>March 2022</p>		<p><b>Rationale for risk rating (and any change in score):</b></p> <p>Risk score remains at 20, new planning guidance issued for Spring/Summer/Autumn 2022 and work on-going to ensure coverage in JUCD Derbyshire. Requires Community Pharmacy, PCN and Vaccination Centre opt-in to ensure programmes continues.</p>				
<p>Initial</p>		<p>4</p>	<p>5</p>	<p>20</p>					<p>Current</p>				<p>4</p>	<p>5</p>	<p>20</p>
<p><b>Risk Appetite</b></p>		<p><b>Level</b></p>	<p><b>Category</b></p>	<p><b>Target Score</b></p>					<p>5</p>				<p>Clinical Quality &amp; Patient Safety</p>	<p>5</p>	<p><b>Link to System Wide Risk Register Risk 10</b></p>
<p><b>KEY CONTROLS TO MITIGATE RISK</b></p>					<p><b>SOURCES OF ASSURANCE</b></p>										
<p><b>Internal</b></p> <ul style="list-style-type: none"> <li>Vaccination Operations Cell (VOC) established and in place to coordinate and oversee the JUCD Covid-19 vaccination programme</li> <li><b>Permanent recruitment to vaccination programme underway as instructed by NHSEI</b></li> <li>Fully established VOC rota to manage and deliver the vaccination programme.</li> <li>Dr Steve Lloyd, Medical Director is the SRO for the Vaccination Programme.</li> <li>Senior Leadership, Lead Provider and Workstream leads managing the VOC and vaccination programme.</li> <li>Silver and Gold Command Operation Group</li> <li>JUCD 2021/22 Operational Plan submitted to NHSE 14<sup>th</sup> May 2021.</li> <li><b>Plan for Spring/Summer and Autumn 2022 in development.</b></li> </ul>			<p><b>External</b></p> <ul style="list-style-type: none"> <li>System Escalation Cell</li> <li>System Operational Resilience Group</li> <li>System Demand and Capacity Group</li> </ul>		<p><b>Internal</b></p> <ul style="list-style-type: none"> <li>VOC email inbox and dedicated phone line</li> <li>Standing Operating Procedure (SOP) for the VOC</li> <li>VOC draft structure developed</li> <li>Fully established Governance cycle of vaccination meeting to support delivery of the programme</li> <li>2021/22 JUCD Operational Plan</li> <li><b>Draft 2022/23 JUCD Operational Plan in development</b></li> <li>VOC Risk register</li> <li>Gold report being revised to include all elements of Phase 3 performance reporting to enable targeted uptake where necessary</li> <li><b>Integrated Performance Report in place covers Covid, Flu, Anti-virals and allergy. Overseas vaccination validation to be added.</b></li> </ul>			<p><b>External</b></p> <ul style="list-style-type: none"> <li>2021/22 JUCD Operational Plan</li> <li><b>Draft 2022/23 JUCD Operational Plan in development</b></li> <li>Weekly demand and capacity briefing</li> <li>NHSE regular returns for Health and Social Care Worker uptake across health and social care systems</li> <li>Weekly plan submitted to NHSE</li> <li>Weekly stocktakes submitted to NHSE</li> <li>Phase 3 planning return submitted monthly with revisions</li> <li><b>JUCD representation across all NHSEI Phase 3 planning meetings and next phase.</b></li> <li>JUCD representation at national level on children's programme</li> <li>National Maternity Board representation by Dr Steve Lloyd</li> </ul>							

<ul style="list-style-type: none"> <li>Public Health Inequalities Group across the System which also reviews hesitancy within groups of patients.</li> <li>Vaccination sites across Derby and Derbyshire to deliver vaccination programme</li> <li>Health Protection Board actions for early warning of delta variants and other VOC's.</li> <li>Modelling of further cohorts in Phase 3 for booster being undertaken, including vaccinating of 5-11 year olds to understand the impact on workforce and vaccine requirements.</li> <li>Vaccinating 5-11 year old at risk underway. Currently planning for 5-11 not at risk.</li> <li>Planning for phase 4 commenced to assess estate and workforce requirements.</li> <li>CCG Committee Chairs to produce a Committee Annual Report and Risk Report to handover to ICB Committee Chairs.</li> </ul>		<ul style="list-style-type: none"> <li>Health Protection Board</li> <li>Development of the vaccine programme as a strategic delivery board within the ICS structure, signed off by JUCD leadership.</li> <li>Weekly Phase 3 planning meeting now stood down as implemented. Fortnightly Flu cell remains for operational issues, reporting into Silver Operational Group.</li> <li>Weekly anti-viral meeting in place.</li> <li>Planning meetings now stood up for next phase in 2022 to support planning return by 14<sup>th</sup> March 2022.</li> <li>QEIA developed for Phase 3</li> <li>QEIA in development for next phase in 2022.</li> <li>DPH and LA engagement in schools programme, working closely with SAIS team.</li> <li>Ongoing meeting in place with Tameside &amp; Glossop with regards to Glossop Vaccination Programme transition for 2022.</li> </ul>	<ul style="list-style-type: none"> <li>JUCD SAIS representation at C &amp; YP NHSEI meetings</li> <li>Weekly separate Planning meetings also in place with NHSE.</li> </ul>
<b>GAPS IN CONTROL</b>		<b>GAPS IN ASSURANCE</b>	
<u>Internal</u>	<u>External</u>	<u>Internal</u>	<u>External</u>
<ul style="list-style-type: none"> <li>Influence and impact on system planning regarding restoration and recovery and co-delivery of the vaccination programme.</li> <li>Infrastructure to support new model to deliver suggested Phase 3 including Flu and sustainable delivery as a programme of work including operational delivery i.e. site leads.</li> <li>Any changes made in relation to phase 3 guidance giving very short notice affecting decisions/priorities and impact of opt-in/out of vaccine delivery.</li> <li>VOC Team diminishing as CCG staff return to their substantive roles. Key pieces of work subsequently paused.</li> </ul>	<ul style="list-style-type: none"> <li>Community Pharmacy contracting.</li> <li>National guidance including JCVI and Green Book publications.</li> <li>NHSEI financial model for vaccinations does not cover the costs incurred against low vaccine uptake, as an example SAIS.</li> <li>Capped vaccine supply still in operation.</li> </ul>	<ul style="list-style-type: none"> <li>Do not have access to booking information for local booking services.</li> </ul>	<ul style="list-style-type: none"> <li>Awaiting further guidance on 2022 approach i.e. Lead employer contracting, finance, enhanced services etc.</li> </ul>
<b>ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)</b>			
<u>Internal</u>	<u>Timeframe</u>	<u>External</u>	<u>Timeframe</u>
<ul style="list-style-type: none"> <li>Enhanced communications approach looking at new and innovative ways to reduce hesitancy within cohorts of patients not receiving first or second vaccinations.</li> <li>Surge planning being undertaken in areas with variants of concern (VOC) delta variant, in partnership with PH.</li> </ul>	<ul style="list-style-type: none"> <li>Daily/weekly push of communications using a variety of platforms e.g. Social media, postcards etc.</li> <li>Completed – New plan to be submitted by end Mar 22 as per recent guidance.</li> </ul>	<ul style="list-style-type: none"> <li>Escalating to NHSEI regional team regarding vaccine supply and surge planning issues with supply</li> <li>Escalation to NHSEI regional team regarding financial modelling for vaccinations against low vaccine uptake</li> </ul>	<ul style="list-style-type: none"> <li>Weekly and daily as required</li> <li>Weekly and daily as required</li> </ul>

<ul style="list-style-type: none"> <li>• Call to arms for staffing shortages.</li> <li>• Reviewing allocation at site level to make best use of Pfizer allocations to under achieving areas.</li> <li>• Phase 3 planning guidance published. Expressions of interest continue for Community Pharmacies to address any gaps in delivery.</li> <li>• Reviewing published PCN Enhanced Service guidance for Phase 3, providing JUCD system support to PCNs where required to support continuation of opt-in.</li> <li>• Gap analysis undertaken to ensure geographical coverage of vaccination sites.</li> <li>• Process established to understand system stock and forward bookings of patients. System email to all sites circulated to increase uptake of Moderna assured sites to cover off Pfizer supply issues.</li> </ul>	<ul style="list-style-type: none"> <li>• Completed – December 21</li> <li>• Completed – Weekly stocktake and delivery caps in place</li> <li>• Completed – December 21</li> <li>• Completed – December 21</li> <li>• Further review underway as per guidance published 23<sup>rd</sup> Feb 22 'Next Steps for the Vaccination Programme Planning and Delivery'</li> <li>• Completed – December 21.</li> </ul>		
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<p><b>Strategic Objective: 5</b> Support our staff in the delivery of the above and transition into an ICS, through continued health and wellbeing programmes and effective communication and engagement</p>				<p><b>GBAF RISK 7</b></p>				<p><b>Executive Lead: Helen Dillistone</b> <b>Assigned to Committee: Governance Committee</b></p>																												
<p><b>What would success look like and how would we measure it?</b></p> <ul style="list-style-type: none"> <li>The CCG workforce will transition over to the Integrated Care System (ICS).</li> <li>All employees to have effective communication on developments and structures within the ICS.</li> <li>Having robust health and well-being programmes in place to support staff.</li> </ul>				<p><b>Risk Description</b></p> <p><b>CCG staff retention and morale during the transition will be adversely impacted due to uncertainty of process and implications of the transfer to the ICS, despite the NHSEI continuity of employment promise.</b></p>																																
<p><b>Risk rating</b></p>		<p><b>Likelihood</b></p>	<p><b>Consequence</b></p>	<p><b>Total</b></p>	<p style="text-align: center;"><b>GBAF Risk 7</b></p> <table border="1"> <caption>GBAF Risk 7 Score History</caption> <thead> <tr> <th>Month</th> <th>Score</th> </tr> </thead> <tbody> <tr><td>April</td><td>8</td></tr> <tr><td>May</td><td>8</td></tr> <tr><td>June</td><td>8</td></tr> <tr><td>July</td><td>6</td></tr> <tr><td>August</td><td>6</td></tr> <tr><td>September</td><td>6</td></tr> <tr><td>October</td><td>6</td></tr> <tr><td>November</td><td>6</td></tr> <tr><td>December</td><td>12</td></tr> <tr><td>January</td><td>12</td></tr> <tr><td>February</td><td>12</td></tr> <tr><td>March</td><td>12</td></tr> </tbody> </table>				Month	Score	April	8	May	8	June	8	July	6	August	6	September	6	October	6	November	6	December	12	January	12	February	12	March	12	<p><b>Date reviewed</b></p> <p style="text-align: right; color: red;">March 2022</p>	
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<p>Initial</p>		<p>2</p>	<p>4</p>	<p>8</p>	<p><b>Rationale for risk rating (and any change in score):</b></p> <p>The CCG has concerns about losing staff and the impact of that is higher than the previous score of 2. The score then aligns the with the ICB Transition risk 1 within the register.</p>																															
<p>Current</p>		<p>3</p>	<p>4</p>	<p>12</p>																																
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<ul style="list-style-type: none"> <li>THRIVE Mental Health Provider providing briefing sessions to support CCG staff through the transition to ICB.</li> </ul>	<ul style="list-style-type: none"> <li>Non-Executive member roles appointed to from 1<sup>st</sup> March 2022.</li> <li>Confirmation of some Executive Officer positions have removed uncertainty of continuity and provides stability for the transition to ICB Committees.</li> <li>Glossop boundary change confirmed effective from 1<sup>st</sup> July 2022.</li> <li>ICB Draft Constitution submitted to NHS England December 2021 and February 2022. Positive feedback received.</li> <li>Quarter 4 Readiness to Operate statement evidence submitted to NHS England 31.03.22.</li> </ul>		
<b>GAPS IN CONTROL</b>		<b>GAPS IN ASSURANCE</b>	
<u>Internal</u>	<u>External</u>	<u>Internal</u>	<u>External</u>
<ul style="list-style-type: none"> <li>Further ICS Guidance to be published</li> </ul>	<ul style="list-style-type: none"> <li>Health and Care Bill still to be passed in Parliament</li> </ul>	<ul style="list-style-type: none"> <li>Communications content limited in detail while awaiting Bill.</li> </ul>	
<b>ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)</b>			
<u>Internal</u>	<u>Timeframe</u>	<u>External</u>	<u>Timeframe</u>
<ul style="list-style-type: none"> <li>Attendance at all national ICS communications briefings to keep track of timescales and emerging guidance.</li> </ul>	<ul style="list-style-type: none"> <li>Monthly</li> </ul>		

<p><b>Strategic Objective: 1</b> Safely and legally transition the statutory functions of the CCG into the ICS, and safely deliver the disestablishment of the CCG</p>				<p><b>GBAF RISK 8</b></p>				<p><b>Executive Lead: Helen Dillistone</b> <b>Assigned to Committee: Governance Committee</b></p>																																
<p><b>What would success look like and how would we measure it?</b> The CCG would meet all critical timescales as described in the programme plan in readiness for the ICS to launch as a statutory organisation in April 2022 and would receive the appropriate confirmation of a safe and legal transfer of duties and closure of the CCG from NHSEI.</p>				<p><b>Risk Description</b> <b>If the CCG is not ready to transfer its functions or has failed to comprehensively and legally close down the organisation, or if the system is not ready to receive the functions of the CCG, the ICS operating model cannot be fully established.</b></p>																																				
<p><b>Risk rating</b></p>		<p><b>Likelihood</b></p>	<p><b>Consequence</b></p>	<p><b>Total</b></p>	<div style="text-align: center;"> <p><b>GBAF Risk 8</b></p> <table border="1"> <caption>GBAF Risk 8 Score History</caption> <thead> <tr> <th>Month</th> <th>Score</th> </tr> </thead> <tbody> <tr><td>Closing..</td><td>20</td></tr> <tr><td>April</td><td>20</td></tr> <tr><td>May</td><td>20</td></tr> <tr><td>June</td><td>20</td></tr> <tr><td>July</td><td>15</td></tr> <tr><td>August</td><td>15</td></tr> <tr><td>September</td><td>15</td></tr> <tr><td>October</td><td>15</td></tr> <tr><td>November</td><td>15</td></tr> <tr><td>December</td><td>10</td></tr> <tr><td>January</td><td>10</td></tr> <tr><td>February</td><td>10</td></tr> <tr><td>March</td><td>10</td></tr> </tbody> </table> </div>				Month	Score	Closing..	20	April	20	May	20	June	20	July	15	August	15	September	15	October	15	November	15	December	10	January	10	February	10	March	10	<p><b>Date reviewed</b></p>		<p>March 2022</p>	
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<p>Initial</p>		<p>4</p>	<p>5</p>	<p>20</p>	<p><b>Rationale for risk rating (and any change in score):</b> Version 2 of Due Diligence update now received and being incorporated into project plans. 360 Audit have joined the CCG Transition Project Group which will provide assurance on the management of the project. Draft Due Diligence Checklist was presented to CCG Audit Committee on 17th December and subsequently submitted as part of the regional submission due by end December 21 and uploaded 20th December 21. The risk is now aligning with the score for risk 7 on the Transition Risk Register.</p>																																			
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<p><b>KEY CONTROLS TO MITIGATE RISK</b></p>					<p><b>SOURCES OF ASSURANCE</b></p>																																			
<p><b>Internal</b></p> <ul style="list-style-type: none"> <li>Chris Clayton CCG CEO is the interim Chief Executive of JUCD</li> <li>JUCD 2021/22 Operational Plan submitted to NHSE 14<sup>th</sup> May 2021.</li> <li>Transition Assurance Committee (TAC) established and inaugural meeting took place end April and meeting monthly. CCG represented.</li> <li>CCG GB Chair is the Transition Assurance Committee (TAC) Chair and ICS CCG Transition Working Group Chair.</li> <li>CCG ICS Transition Working Group established</li> </ul>			<p><b>External</b></p> <ul style="list-style-type: none"> <li>Transition Assurance Committee (TAC) established and inaugural meeting took place end April and meeting monthly.</li> <li>JUCD / ICS Governance Structure in Place</li> <li>JUCD Senior Leadership Team</li> <li>ICS Engine Room Team comprising of System Leaders</li> <li>JUCD Board meeting in public</li> <li>System Quality and Performance Committee in place</li> <li>System Finance and Estates Committee in place</li> </ul>		<p><b>Internal</b></p> <ul style="list-style-type: none"> <li>2021/22 JUCD Operational Plan</li> <li>ICS Transition Plan</li> <li>Transition Assurance Committee (TAC), agenda, papers and minutes</li> <li>CCG ICS Transition Working Group agenda, papers and minutes.</li> <li>Governing Body public and confidential minutes</li> <li>Governing Body ICS Development session notes</li> <li>ICS Programme Group minutes and meeting</li> </ul>			<p><b>External</b></p> <ul style="list-style-type: none"> <li>2021/22 JUCD Operational Plan</li> <li>ICS Transition Plan</li> <li>Transition Assurance Committee (TAC), agenda, papers and minutes</li> <li>JUCD Senior Leadership Team minutes</li> <li>Minutes of System Quality Committee</li> <li>Minutes of System Finance &amp; Estates Committee</li> <li>Minutes of System People and Culture Committee</li> </ul>																																

<p>and meets monthly. First meeting took place 6<sup>th</sup> May.</p> <ul style="list-style-type: none"> <li>ICS Project Group established to manage the operational ICS Transition Plan.</li> <li>Helen Dillistone, Executive Director of Corporate Strategy and Development is the CCG SRO for the ICS Transition.</li> <li>Governing Body supports the transition to ICS</li> <li>Governing Body ICS Development Sessions</li> <li>Executive Team</li> <li>Senior Leadership Team</li> <li>Programme Management Office support for management ICS Transition Plan</li> <li>Derbyshire Engagement Committee in place</li> <li>ICS Risk Register in place incorporating both CCG and system level risks, reviewed weekly by the Core Project Team and monthly by the CCG Transition Working Group and Transition Assurance Committee (TAC).</li> <li>Joint Derby Derbyshire CCG and Tameside and Glossop CCG Transition Steering Group established to lead four main workstreams.</li> <li>Four workstreams comprising of specialist leads across both systems for Communications and Engagement, Finance IT and Contracting, Neighbourhood Development and Statutory Duties, Risks and People Impact Assessment.</li> </ul>	<ul style="list-style-type: none"> <li>People and Culture Committee in place</li> <li>White Paper consultation published in November 2020</li> <li>ICS Design Framework published 16<sup>th</sup> June 2021</li> <li>Health and Care Bill ordered by The House of Commons 6<sup>th</sup> July 2021</li> <li>Final HR Framework published August</li> <li>Further ICS/ ICB Guidance published August 2021</li> <li>John MacDonald appointed as ICB Designate Chair.</li> <li>Dr Chris Clayton appointed as Chief Executive Designate of NHS Derby and Derbyshire ICB.</li> <li>Secretary of State for Health and Social Care decision taken in August 2021 to amend the ICS boundary so that Glossop will move from the Greater Manchester ICS into the Derbyshire ICS</li> <li>Draft ICB Constitution submitted to NHSEI 3<sup>rd</sup> December,</li> <li>Readiness to Operate Statement RAG rating and evidence submitted to NHSE by 31<sup>st</sup> December</li> <li>Due Diligence checklist approved by Audit Committee 17<sup>th</sup> December 2021 and submitted to NHSEI</li> <li>ICB transition deferred from 1<sup>st</sup> April 2022 to 1<sup>st</sup> July 2022.</li> <li>Non-Executive member roles appointed to from 1<sup>st</sup> March 2022.</li> <li>Confirmation of some Executive Officer positions have removed uncertainty of continuity and provides stability for the transition to ICB Committees.</li> <li>Glossop boundary change confirmed effective from 1<sup>st</sup> July 2022.</li> <li>ICB Draft Constitution submitted to NHS England December 2021 and February 2022. Positive feedback received.</li> <li>Quarter 4 Readiness to Operate statement evidence submitted to NHS England 31.03.22</li> </ul>	<p>papers</p> <ul style="list-style-type: none"> <li>ICS Risk Register</li> <li>Mapping of CCG Functions</li> <li>PMO system to support ICS Transition</li> <li>Derbyshire Engagement Committee Minutes</li> </ul>	
<b>GAPS IN CONTROL</b>		<b>GAPS IN ASSURANCE</b>	
<u>Internal</u>	<u>External</u>	<u>Internal</u>	<u>External</u>
<ul style="list-style-type: none"> <li>Potential planning gaps due to delays in passing the bill through Parliament and publication of guidance materials.</li> <li>Further ICS Guidance to be published</li> </ul>	<ul style="list-style-type: none"> <li>Health and Care Bill still to be passed in Parliament</li> </ul>		

ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)			
<u>Internal</u>	<u>Timeframe</u>	<u>External</u>	<u>Timeframe</u>
<ul style="list-style-type: none"> <li>Project Team will review guidance and HR framework to assess risks to delivery and ensure alignment to programme plan.</li> </ul>	<ul style="list-style-type: none"> <li>Monthly</li> </ul>		

## Governing Body Meeting in Public

7<sup>th</sup> April 2022

ITEM NO: 016

<b>Report Title</b>	CCG Risk Register Report at 31 <sup>st</sup> March 2022
<b>Author(s)</b>	Rosalie Whitehead, Risk Management & Legal Assurance Manager
<b>Sponsor (Director)</b>	Helen Dillistone, Executive Director of Corporate Strategy and Delivery

Paper for:	Decision	x	Assurance	x	Discussion		Information
<b>Assurance Report Signed off by Chair</b>				N/A			
<b>Which committee has the subject matter been through?</b>				Engagement Committee – 15.3.2022 Primary Care Commissioning Committee – 23.3.2022 Quality and Performance Committee – 31.3.2022 Finance Committee – 31.3.2022			
<b>Recommendations</b>							
<p>The Governing Body is requested to <b>RECEIVE</b> and <b>NOTE</b>:</p> <ul style="list-style-type: none"> <li>The Risk Register Report;</li> <li>The <b>DECREASE</b> in score for risk 27 relating to the number of safeguarding referrals;</li> <li>Appendix 1 as a reflection of the risks facing the organisation as at 31<sup>st</sup> March 2022;</li> <li>Appendix 2 which summarises the movement of all risks in March 2022.</li> </ul> <p><b>APPROVE:</b></p> <ul style="list-style-type: none"> <li>The <b>CLOSURE</b> of risk 24 relating to patients deferring seeking medical advice for non-COVID issues due to the belief that COVID takes precedence.</li> </ul>							
<b>Report Summary</b>							
<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 31<sup>st</sup> March 2022.</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>							

<b>Are there any Resource Implications (including Financial, Staffing etc.)?</b>
The Derby and Derbyshire CCG attaches great importance to the effective management of risks that may be faced by patients, members of the public, member practices and their partners and staff, CCG managers and staff, partners and other stakeholders, and by the CCG itself.  All members of staff are accountable for their own working practice and have a responsibility to co-operate with managers in order to achieve the objectives of the CCG.
<b>Has a Privacy Impact Assessment (PIA) been completed? What were the findings?</b>
Not applicable to this update
<b>Has a Quality Impact Assessment (QIA) been completed? What were the findings?</b>
Not applicable to this update
<b>Has an Equality Impact Assessment (EIA) been completed? What were the findings?</b>
Not applicable to this update; however, addressing risks will impact positively across the organisation as a whole
<b>Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below</b>
Not applicable to this update
<b>Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below</b>
Not applicable to this update
<b>Have any Conflicts of Interest been identified/ actions taken?</b>
Not applicable to this update
<b>Governing Body Assurance Framework</b>
The risks highlighted in this report are linked to the Derby and Derbyshire CCG Board Assurance Framework
<b>Identification of Key Risks</b>
The paper provides a summary of the very high scoring risks as at 31 <sup>st</sup> March 2022 detailed in Appendix 1

## **NHS DERBY AND DERBYSHIRE CCG GOVERNING BODY MEETING**

### **RISK REPORT AS AT 31<sup>ST</sup> MARCH 2022**

#### **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 purple within the Risk Register in Appendix 1.

#### **2. RISK PROFILE – MARCH 2022**

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

Risk Register as at 31<sup>st</sup> March 2022

<b>Risk Profile</b>	<b>Very High (15-25)</b>	<b>High (8-12)</b>	<b>Moderate (4-6)</b>	<b>Low (1-3)</b>	<b>Total</b>
Total number on Risk Register reported to GB for March 2022	7	12	5	0	24
New Risks	0	0	0	0	0
Increased Risks	0	0	0	0	0
Decreased Risks	0	1	0	0	1
Closed Risks	0	0	1	0	1

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

### 3. COMMITTEES – MARCH VERY HIGH RISKS OVERVIEW

#### 3.1 Quality & Performance Committee

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

1. Risk 01: *The Acute providers may breach thresholds in respect of the A&E operational standards.*

The current risk score is 20.

##### February performance:

- CRH reported 88.6% (YTD 90.&%) and UHDB reported 62.2% (YTD 68.9%).
  - At CRH the combined Type 1 & streamed attendances were high, with an average of 84 Type 1 attendances and 176 streamed attendances per day.
  - COVID 19 admissions and outbreaks remained high throughout the month, peaking at 47 positive inpatients. This added more pressure to a trust with an escalated critical care position.
  - At UHDB the volume of attendances is high, with an average of 461 attendances per day at Derby (Type 1 and co-located UTC) and 208 at Burton (Type 1 and Primary Care Streaming).
  - The acuity of the attendances was high, with Derby seeing an average of 13 Resuscitation patients and 189 Major patients per day and Burton seeing 127 Major/Resus patients per day.
  - Attendances at the Children's Emergency Department continue to be high, with concerns about RSV and Bronchiolitis being major factors. Children's Type 1 attendances at Derby have averaged at 108 per day during February 2022.
2. Risk 03: *TCP Unable to maintain and sustain performance, pace and change required to meet national TCP requirements. The Adult TCP is on recovery trajectory and rated amber with confidence whilst CYP TCP is rated Green, main risks to delivery are within market resource and development with workforce provision as the most significant risk for delivery.*

The current risk score is 20.

##### March update

##### Current bed position:

- CCG beds = 28 (Quarter 4 2021/22 target 19).
- Adult Specialised Commissioning = 16 (Q4 2021/22 target 14).

- Children and Young People (CYP) specialised commissioning = 5 (Quarter 4 2021/22 target 3).
- A time limited Task and Finish Group has been established to focus on ensuring the Dynamic Support Register (DSR) is evidence based and clinically led and that it focusses on enhanced wrap around provision in the community when appropriate, rather than admission avoidance.
- We are scoping the utilisation of the Cheshire and Wirral Dynamic Support Database and Clinical Tool. We are identifying ways in which to better utilise pre-commissioned community services such as the Intensive Support Team (IST) and Statutory Autism Team (SAT). This workstream is aligned with ASD Leads in NHSE/I.
- The provider Trust has funded the substantive appointment of a 1.0 wte Band 7 Commissioning Manager post to provide additional capacity to the TCP Team, this post holder commenced with the TCP team in March 2022. A substantive 1.0 wte admin post has been recruited to and also commenced during March 2022.
- The system will shift from a local approach to Care (Education) Treatment Reviews (C(E)TRs) and Local Area Emergency Protocols (LAEPs) to further align with the national Policy and Guidance. This will commence with an evaluation of the current approach with current C(E)TR Chairs during March 2022.
- In order to ensure timely and concise reporting to NHSE/I, mapping of the required reporting and associated timeframes has been undertaken.
- Clinical audit platform submissions continue to be completed in a timely manner on a monthly basis. A robust system is now in place to maintain compliance.
- Safe and wellbeing reviews (previously Five Eyes), Derby and Derbyshire have 31 of the regional 91 red RAG rated reviews. However as a system we have demonstrated most progress regionally in achieving completion of red RAG rated reviews.
- All CCG and Specialised Commissioning reviews have been completed. ICS scrutiny panels are now being facilitated weekly to identify themes and trends for local action, service delivery and/or improvement. We are focusing on the reviews that have identified concerns as our priority.

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:

- Terms of reference, including monthly reporting process are currently being revised to better capture the focus of the group.
- The monthly reporting is based on the minimum standards and will provide improved Provider positions.

### **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.

February/March update:

- Letter received from NHSE/I on 27th January 2022 requesting that for the period up until 31 March 2022 that they are asking that practices and Primary Care Networks (PCNs) focus on the following three key priority areas while continuing to use their professional judgement to clinically prioritise care:
    - Continued delivery of general practice services, which includes timely ongoing access for urgent care with clinical prioritisation, the ongoing management of long-term conditions, suspected cancer, routine vaccination and screening, annual health checks for vulnerable patients, and tackling the backlog of deferred care events.
    - Management of symptomatic COVID-19 patients in the community, as part of the local system approach, including supporting monitoring and access to therapeutics where clinically appropriate. COVID-19 treatments will continue to develop and evolve as we learn more about the virus. Primary care will continue to play an important role in supporting the delivery of these treatments while caring for patients with COVID and long-COVID.
    - Ongoing delivery of the COVID-19 vaccination programme. It remains important that PCN Groupings focus on reaching the most vulnerable people and minimise any inequalities in uptake working with CCG, local authority, and community partners.
  - The CCG provided an update to all practices to acknowledge that whilst the position in Derby and Derbyshire remains challenged with hospital flow and discharge, a persisting area of system focus, practices were requested to follow the guidance set out in the updated NHSEI letter.
2. ***Risk 04B: Quality: Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care. There are 112 GP practices in Derbyshire all with individual Independent Contracts GMS, PMS, APMS to provide Primary Medical Services to the population of Derbyshire. Six practices are managed by NHS Foundation Trusts and one by an Independent Health Care Provider. The majority of Derbyshire GP practices are small independent businesses which by nature can easily become destabilised if one or more core components of the business become critical or fails. Whilst it is possible to predict and mitigate some factors that may impact on the delivery of care the elements of the unknown and unexpected are key influencing dynamics that can affect quality and care outcomes.***

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

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

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

*\*Recruitment of GP Partners*

*\*Capacity and Demand*

*\*Access*

*\*Premises*

*\*New contractual arrangements*

*\*New Models of Care*

*\*Delivery of COVID vaccination programme*

*\*Restoration and Recovery*

*\*2021/22 Flu Programme*

*\*Becton Dickinson Blood Tube shortage*

The current risk score is 20.

March update:

- The Covid-19 vaccination programme continues and has been extended to the vaccination of healthy 5 to 11 year olds as well as the previous cohorts.
- Planning has been undertaken to meet the future demands of the Covid-19 vaccine programme including future boosters, if required and potential concomitant administration with other vaccines.

### **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.

March update

February position:

- The Derbyshire NHS system has a significant gap between expenditure assessed as required to meet delivery plans and notified available resource.

- The CCG is working with system partners to establish a sustainable long term financial position and deliver a balanced in-year position. As at Month 11 the CCG are not seeing any major financial pressures against planned expenditure and are reporting a year to date underspend of £0.142m against total anticipated resources available of £1,903.869m for the period covering April to January 2022.
- Against total anticipated resources available in 2021/22 of £2,082.892m the CCG is forecasting a surplus of £0.571m. However, while the in-year position now shows a surplus the underlying recurrent position for both the CCG and the wider system remains very challenging and we are some way from achieving a sustainable system financial position.
- The score remains the same as while the in-year position now shows a surplus, the underlying recurrent position for both the CCG and the wider system remains very challenging and we are some way from achieving a sustainable system financial position.

### 3.4 **Governance Committee – Very High Risks**

One Governance Committee risk is rated as very high.

1. *Risk 09: Sustainable digital performance for CCG and General Practice due to threat of cyber-attack, network outages and the impact of migration of NHS Mail onto the national shared tenancy. The CCG is not receiving the required metrics to provide assurance regarding compliance with the national Cyber Security Agenda, and is not able to challenge any actual or perceived gaps in assurance as a result of this.*

The current risk score is 16.

#### March update

- Engagement with the national team continues. Updates from national and local system providers are shared as required.
- As per previous updates, no instances or impact have been reported for Derby and Derbyshire. Reporting of progress will continue through Governance Committee.
- As we are unable to confirm the resolution of this issue at this point, the risk score remains the same with regard to the potential for impact locally. Links to the latest NHSD updates to show the potential attack surface is large and unknown.

### 4. **DECREASED RISKS**

One risk is recommended to be decreased in score:

1. *Risk 27: Increase in the number of safeguarding referrals linked to self-neglect related to those who are not in touch with services. These initially*

*increased immediately following COVID lockdown. The adult safeguarding processes and policy are able to respond to this type of enquiry once an adult at risk has been identified. Numbers are difficult to predict but are predicted to increase as COVID restrictions ease.*

This risk is proposed to be decreased in score from a high 12 (probability 4 x impact 3) to a high score of 9 (probability 3 x impact 3).

The reason for the decrease is:

- As COVID pressures ease and lockdown restrictions are lifted then work has been undertaken to assist those adults most at risk from harm. Self-neglect, hoarding, domestic abuse, and scamming remain the main areas of activity.
- Both the Safeguarding Adult Boards have received assurance that referrals are being actioned although concern remains about the sheer numbers and levels of operational activity.
- The CCG continues to seek assurance from NHS providers that they are meeting their statutory duties.
- Compliance levels are positive.
- CCG safeguarding activity is reported via the Quality & Performance Committee and the CCGs Safeguarding Committee.
- It is suggested that risks to the CCG have decreased in light of inter-agency working arrangements and the reduction in COVID mandates.

This decrease in risk score was approved at the Quality and Performance Committee on the 31<sup>st</sup> March 2022.

## **5. CLOSED RISKS**

One risk is recommended to be closed:

1. 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.*

This risk is currently scored at a moderate 6 (probability 2 x impact 3).

- The risk met the target risk rating several months ago and in light of the government announcement that all remaining COVID restrictions were lifted in England on 24<sup>th</sup> February 2022, it is advised to close and remove the risk and not to reintroduce the risk unless a variant of concern is identified, or the government reintroduces restrictions by law.

- It is acknowledged that a small percentage of patients may continue to defer receiving treatment. To mitigate this risk NHS patient and visitor guidance remains in place for now pending a review. This means that staff, patients and visitors will be expected to continue to follow social distancing rules when visiting any care setting as well as using masks or face coverings and other personal protection equipment.
- The government update states a continuation of free tests for symptomatic people in the oldest age groups and those who are most vulnerable. The additional booster dose to be offered to the over 75 age and most vulnerable over 12 age group in spring is also a positive development.

The closure of this risk was approved at the Quality and Performance Committee on the 31<sup>st</sup> March 2022.

## 6. **RECOMMENDATION**

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

- The Risk Register Report;
- The **DECREASE** in score for risk 27 relating to the number of safeguarding referrals;
- Appendix 1 as a reflection of the risks facing the organisation as at 31<sup>st</sup> March 2022;
- Appendix 2 which summarises the movement of all risks in March 2022.

### **APPROVE:**

- The **CLOSURE** of risk 24 relating to patients deferring seeking medical advice for non-COVID issues due to the belief that COVID takes precedence.



Risk Reference	Year	Risk Description	Initial Risk Rating	Mitigations (What is in place to prevent the risk from occurring?)	Actions required to treat risk (avoid, reduce, transfer or accept) and/or identify assurance(s)	Progress Update	Previous Rating			Current Rating			Target Rating			Task to be completed	Date Reviewed	Review Due Date	Executive Lead	Action Owner						
							Probability	Impact	Resilience	Probability	Impact	Resilience	Probability	Impact	Resilience											
09	2022	Sustainable digital performance for CCG and General Practice due to threat of cyber attack, network outages and the impact of migration of NHS Mail to the national shared tenancy. The CCG is not receiving the required metrics to provide assurance regarding compliance with the National Cyber Security Agency, and is not able to reliably and securely process data in the national as a result of this.	4	12	<ul style="list-style-type: none"> <li>CCG proposes to work closely with cyber awareness training Provider / Cyber Resilience Support team which may include identification and recommendations of other issues that may impact on cyber security, for example developing and implementing further strategies and policies - and identification of practical opportunities where necessary to support operational awareness.</li> <li>Development of local policies and working with the national team to devolve as much responsibility as possible to the local level thereby allowing us to have more control over the deployment, removal and changes to functionality within the Microsoft Teams and other environments linked to the NHS shared tenancy and Microsoft Office 365.</li> <li>Additionally, the migration of the CCG and colleagues within General Practice away from the previous NHS Mail system and onto the NHS national shared tenancy brings both benefits and risks. While there are economies of scale and additional functionality available, there is a lack of control over the launch of new functionality and removal of existing functionality. There are also configuration issues between settings at the national and local level, leading to a temporary pause in the deployment of Microsoft Office 365 within Derby &amp; Derbyshire until these are remedied.</li> <li>Visibility of the NECs responses and strategies to dealing with critical and high priority risks.</li> </ul>	<p>14.12.21 - At the time of writing the update there is currently a high severity CVECERT in place for a vulnerability within the Log4j component which is to be found in a number of different systems including Apple's iCloud and a number of systems in use across Derbyshire. This vulnerability can lead to remote agents taking control of a host system and as a result NECs has already identified internet facing systems which cause a potential threat and has taken steps to suspend these pending further investigation. There is currently no evidence to suggest any breaches of any NHS organisations within Derbyshire including the CCG or Primary Care. Mitigations also include local business recovery plans. However, given the severity of the vulnerability, the current status of not knowing all affected systems and the duration that this situation is likely to be ongoing, it seems prudent to raise the probability significantly to identify this increased risk.</p> <p>12.01.2022 - With regard to the Log4j vulnerability above, the CCG and other colleagues from NECs are engaged with the national response programme, delivered by NSEI, and are in receipt of the national validation and patch requirements. We are assured at this point that as much as possible will be delivered in a timely manner, and the national team are advising where attempts may have been made to exploit this. We have had no reported instances of impact from this across Derby and Derbyshire, and we remain vigilant.</p> <p>08.02.2022 - Connection to the national team with regard to the delivery of required actions for supplier assurance to address the Log4jShell vulnerability remain in place. No reported instances or impact for Derby and Derbyshire has been reported or identified. The risk score will remain at 15 until assurance activities are completed and assured with colleagues at the national level.</p> <p>15.03.2022 - Engagement with the national team continues. Updates from national and local system providers are shared as required. As per previous updates, no instances or impact have been reported for Derby and Derbyshire. Reporting of progress will continue through Governance Committee. As we are unable to confirm the resolution of this issue at this point, the risk score remains the same with regard to the potential for impact locally. Links to the latest NHS updates show the potential attack surfaces is large and unknown.</p>	4	4	10	4	10	4	10	4	4	4	4	4	4	4	4	4	4	4		
10	2022	If the CCG does not review and update existing business continuity contingency plans and processes, continuity in emergency progression 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 ineffective responses to local and national pressures.	4	4	<ul style="list-style-type: none"> <li>CCG active in Local Health Resilience Partnership (LHRP) and relevant sub-groups</li> <li>On-call staff are required to receive Met Office Weather Alerts. These will be cascaded to relevant teams who manage vulnerable groups</li> <li>Executive attendance at multi-agency exercises</li> <li>Internal Audits have evaluated Business Continuity preparedness</li> <li>Derbyshire-wide Incident Plan in existence</li> <li>Joint Emergency Services Interoperability Protocol (JESIP) training made available to on-call staff</li> <li>Staff member trained in Business Continuity and member of professional body</li> <li>Staff member competent to train Local Resilience Forum</li> <li>Derby and Derbyshire CCG represented on LHRP and LRF sub-groups including: HEPQG, Training and Exercising sub-group, Risk Assessment Working Group, LRF Tactical, Human Aspects and Derbyshire Health Protection Response Group</li> <li>On-call risks being reviewed to introduce two tier system with improved resilience</li> <li>Comprehensive training undertaken for On-call staff to National Standards</li> <li>Accountable Emergency Officer and Deputy AEO attend EU Exit conferences 17th September 2019</li> <li>On Call Forum has been established and has held productive meetings sharing knowledge and experience</li> <li>Table top exercise took place in December 2019 to test the robustness of the CCG response to IT and Telephony failure and to Fuel Shortage leading to improvements in processes and procedures</li> <li>CCG participating in local response to Coronavirus risks as part of the Derbyshire LHRP system following national guidance from PHE</li> <li>The Director of Corporate Delivery and the Business Resilience manager took part in a national seminar EU Exit End of Transition period workshop on 04 November 2020. This has resulted in key areas of work being identified and CCG Leads mobilised to provide a response</li> <li>Senior Responsible Officer for EU Exit designated for the CCG and contact details made available to NSEI</li> <li>EU Exit now a standing item on weekly SEC Meetings</li> </ul>	<ul style="list-style-type: none"> <li>Practices updating Business Continuity Plans to include consistent contact details for CCG in-hours and out of hours.</li> <li>Business Resilience Manager developed a single operational Business Continuity Plan. This will now be reviewed in the light of learning from the COVID pandemic.</li> <li>Conduct and challenge meetings with Providers and NSEI took place on 2nd October 2019 and agreement reached with Providers on first level of assessment against the core standards.</li> <li>CCG on call arrangements reviewed and CCG is operating a 2 tier on call system. Training has been provided to all on call staff from November to March 19.</li> <li>Accountable Emergency Officer and Deputy AEO attended EU Exit conference 17th September 2019, to gain assurance on EU Exit assurance.</li> <li>CCG took part in daily SIREP reporting to NSEI until stood down on 28 October 19.</li> <li>CCG provided exception reports on EU Exit through Local Resilience Forum</li> <li>Derbyshire System wide EU Exit Plan developed and distributed to Providers</li> <li>Two 'dry run' of preparing for EU Exit date risks the CCG in a stronger position</li> <li>Business Impact Assessments for each function within the CCG have been completed and approved the Governance Committee in March 2020</li> <li>Lessons learned from Toddbook Review will be incorporated into the Business Continuity plan when the EPRR review becomes available</li> <li>A review of the recent power outage situation at Cardinal Square is scheduled this month (November) and lessons learned incorporated into the Business Continuity Plan</li> <li>The On Call Forum has met regularly and has provided an opportunity to share experience and knowledge</li> <li>The CCG has fully participated in the response to the COVID pandemic and submitted evidence to NSEI as part of the 2020/21 EPRR National Core Standards</li> <li>Continued collaborative working with Provider organisations and other stakeholders including the LRF and NSEI Regional teams</li> </ul>	<p>March Update</p> <ul style="list-style-type: none"> <li>Derby &amp; Derbyshire CCG BC and EPRR key documents being reviewed and updated in preparation for ICB</li> <li>NSEI have set out a Roadmap for EPRR transition to ICB</li> <li>NSEI currently developing and soon to publish a revised EPRR Framework</li> <li>Regional / national workshops to be held to confirm EPRR expectations</li> <li>ICB will be designated as a Category 1 organisation</li> </ul> <p>The score has been reviewed and remains the same as there are additional demands on the system due to winter pressures and the effects of COVID</p>	2	4	6	2	4	6	2	4	6	2	4	2	4	2	4	2	4	2	4
11	2022	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	16	<ul style="list-style-type: none"> <li>Internal management processes - monthly confirm and challenge by Finance Committee</li> <li>Monthly reporting to NSEI</li> <li>Development of system I&amp;E reporting including underlying positions by organisation and for the system as a whole</li> </ul>	<p>The Derbyshire NHS system has a significant gap between expenditure assessed as required to meet delivery plans and notified available resource. The CCG is working with system partners to establish a sustainable a long term financial position and deliver a balanced in-Year position. As at M1 the CCG are not seeing any major financial pressures against planned expenditure and are reporting a year to date overdraft of £0.14bn against total anticipated resources available of £1,003.86bn for the period covering April to January 2022. Against total anticipated resources available in 2021/22 of £2,582.86bn the CCG is forecasting an surplus of £53.7bn. However, while the in-year position now shows a surplus the underlying recurrent position for both the CCG and the wider system remains very challenging and we are some way from achieving a sustainable system financial position. The score remains the same as while the in-year position now shows a surplus, the underlying recurrent position for both the CCG and the wider system remains very challenging and we are some way from achieving a sustainable system financial position.</p>	4	4	16	4	16	4	16	2	3	6	4	4	4	4	4	4				
12	2022	Inability to deliver current service provision due to impact of service review. The CCG has initiated a review of NHS provided Shared 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 the 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 recruit and recruit staff. There is an associated but yet unquantified risk of increased admissions - this picture will be informed by the review.	4	14	<ul style="list-style-type: none"> <li>Joint working in place with Derbyshire County Council to quantify the potential impact on current service users</li> <li>Joint working in place with Derbyshire Community Health Services NHS Trust to ensure business continuity plans in place and operational risks mitigated</li> <li>Communications and engagement teams are being involved throughout to manage consultation process and ensure information is shared within public domain to enable a balanced view</li> <li>Project team meeting weekly to monitor progress and review risks</li> <li>Task and finish group has been established with representation from local authority, CCG, DCHS and DHFT</li> <li>Action plan has been developed and sent to the BRS Delivery Group for comment</li> <li>Task and finish group will now take the action plan forward</li> <li>The crisis element of respite has been discussed in the wider system and agreement has been reached</li> <li>The original short break review - a position statement paper has been produced and will be discussed with Director to agree on next steps.</li> <li>Work to be carried out by the Strategic Commissioners</li> </ul>	<ul style="list-style-type: none"> <li>Covid-19 restrictions - impacting on discharge planning, inconsistent policies across different providers.</li> <li>Donard College maintained significant damage by a patient unable to be used at moment. This will not be repaired until 2021</li> <li>Ardenleigh - previously closed. Discussions have taken place to reopen to provide an urgent provision for transferring care patients. Discussions continue.</li> <li>The third unit remains closed as not currently fit for purpose.</li> </ul> <p>The crisis element of respite has been discussed in the wider system and agreement has been reached</p> <ul style="list-style-type: none"> <li>The expansion of BRT</li> <li>2. Commissioning of crisis accommodation</li> <li>3. Commissioning of crisis in reach</li> <li>4. Review of approach to respite</li> </ul> <p>February Update:</p> <ul style="list-style-type: none"> <li>Derbyshire County Council reviewing capacity to conduct reviews, including recruitment timetable for agency.</li> </ul> <p>March update:</p> <ul style="list-style-type: none"> <li>Funding agreed to support programme, small delivery group to be established.</li> <li>M, LD, A, AGC and CYP System Delivery Board approved the revised timetable for delivering the joint Health &amp; Social Care Review (July 2022).</li> <li>Proposal being drafted for an engagement and participation partner.</li> </ul>	3	3	9	3	9	3	9	2	3	6	3	3	3	3	3	3	3	3	3	
16	2022	Lack of standardised process in CCG commissioning arrangements. CCG and system may fail to meet statutory duties in S142Z of Health and Care Act 2012 and not sufficiently engage patients and the public in service planning and development, including restoration and recovery work arising from the COVID-19 pandemic.	4	14	<ul style="list-style-type: none"> <li>PMO processes are not being applied to restoration and recovery projects, therefore there are no checks and balances as projects proceed to ensure that they have completed either the S142Z or EA forms.</li> <li>An equality and engagement policy is being developed to address this gap in part, for proposed adoption by all JUCD partners.</li> <li>EIA/QIA process adopted by JUCD.</li> <li>Not all projects follow a systematic project management/commissioning/transformation process to ensure standardisation of process and application of legal duties.</li> <li>June update: Engagement Governance Guide and training being developed to support consistency of approach for officers involved with transformational change.</li> <li>Meeting with new ICS Director of Transformation to be arranged to ensure progress embedded in future project management approaches.</li> <li>September: Completion of Engagement Governance Guide in October and alignment with transformation/PMO processes.</li> </ul>	<p>Engagement Committee re-established in June 2020 following pause during peak of COVID-19 pandemic.</p> <p>Training for Engagement committee members on consultation law completed.</p> <p>Replacement lay members recruited to ensure sufficient lay voice on Engagement Committee following recent resignations.</p> <p>S142Z log reviewed regularly by Engagement Committee.</p> <p>CCG planning approach under review to identify potential annual commissioning business cycle, thus enabling rolling engagement programme in commissioning development and activity.</p> <p>December: Governance Guide verbal update given at November Committee - final amendments required prior to approval that could not be completed in time for the meeting due to team capacity challenge. To be reviewed at January 2022 Engagement Committee.</p> <p>January/February: Engagement Committee has reviewed the risk and ongoing work and determined that the score can be reduced to target 2x3-6. This reflects the breadth of engagement, infrastructure and delivery during 2021/22 that supports greater mitigation of this risk. The risk remains on the register for review for a further two months and if the position is the same, the risk will be reformed for closure.</p> <p>March: The committee agreed to the reduction in score for the engagement risk that was proposed at the last meeting and that this risk could be closed in May if there were no further issues.</p>	2	3	6	2	3	6	2	3	6	2	3	6	2	3	6	2	3	6		
17	2022	S117 package costs continue to be a source of high expenditure which could be potentially influenced with resource oversight. This growth across the system, if unchecked, will continue to outstrip available budget	4	13	<ul style="list-style-type: none"> <li>Although not overspent to budget at this time the rising cost of care under s117 is around 30m to the system. The CCG is investing in additional case managers, re-introducing S117 work stream under MHSDB when this is possible. It is anticipated that both of these measures will positively affect outturn at system level.</li> <li>17.09.20 The CCG have agreed to employ a number of case managers, which will cover s117 packages of care. This is being negotiated with the CSU to start in October. The reassessment for individuals given to be in place. This includes s117 cases.</li> <li>Although not overspent to budget at this time the rising cost of care under s117 is around 30m to the system. The CCG is investing in additional case managers, re-introducing S117 work stream under MHSDB when this is possible. It is anticipated that both of these measures will positively affect outturn at system level.</li> </ul>	<p>There is slippage in the introduction of case managers, so the savings have slipped from October 2020 to January 2021.</p> <p>Further re-design of specification now means delivery start date now Q1 21-22</p> <p>17.08.21 Risk remains unchanged pending case load review. CSU have not yet confirmed timeline.</p> <p>12.10.21 Discussed with MLCSU today, she confirms that reviews are now ongoing and that potential savings will be quantified over the next quarter. The risk remains high due to the ongoing issues that need resolving with system partners.</p> <p>17.11.21 Reviews remain on track as per previous report, potential savings quantified over next quarter.</p> <p>December/January/February 22: Reviews continuing as per previous updates, potential savings to be quantified in Q4</p> <p>11.03.22 MLCSU contacted to provide formal review feedback.</p>	3	3	9	3	9	2	4	3	6	3	6	3	6	3	6	3	6	3	6	
20	2022	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.	4	13	<ul style="list-style-type: none"> <li>Staff files from Scarsdale site are to be moved to a locked room at the TBH site. This is interim until the new space in Cardinal is available.</li> <li>There are all staff files at Scarsdale and Cardinal Square they are safely secured. Due to Covid-19 the work has been placed on hold as staff are all working from home.</li> <li>EAs/APAs at Cardinal Square have been contacted and a list is being pulled together of names and files (current or leavers) held ensuring that these are all securely saved in locked files</li> <li>Work is being completed at Cardinal Square by staff who do regularly attend site to compile the list and confirm who may be missing.</li> <li>Consider an electronic central document management system (DMS)</li> <li>This action remains once we are in a position to move the project forward.</li> </ul>	<ul style="list-style-type: none"> <li>A project team has been organised to work on the risks, ensuring that a standardised format and tick list is developed of the relevant paperwork to keep in HR files. This piece of work will take a significant amount of time before the CCG can even consider looking at a document management system</li> <li>Information Governance are currently working to secure a contract for archiving, this will ensure that staff leavers files are securely archived with the correct paperwork.</li> <li>Project team are obtaining guidance with other NHS organisations to consider a document management system.</li> </ul>	<p>10.12.21 - Project group met on 17.11.2021 - agreed that work can commence on current personal files as all the paperwork was agreed previously, with a front sheet added to everyone's HR folder. At this stage any that are required to be archived will remain in a separate filing cabinet closely marked with meta data. Files to be reviewed ahead of transition to ICS on 1 April 2022 Update 13.12.2021 - Governance advice to work from home wherever possible will temporarily pause project.</p> <p>11.02.22 - Governance advice to work from home wherever possible has temporarily paused project.</p> <p>11.02.22 - Project group to commence review of HR files. Although the requirement to work from home has been lifted, the restrictions have impacted on the ability of the CCG to review files.</p> <p>16.03.22 - Transition to the ICS now 1 July 2022. Due to turnover, there is a requirement to seek additional resources for the Project Group to enable the CCG to review files. The Derbyshire Healthcare system is working together to review digital solutions for HR, including an electronic HR document management system. The next meeting of the Derbyshire Digital Improvement Group is on 18 March 2022.</p>	3	3	9	3	9	1	2	2	3	6	3	6	3	6	3	6	3	6	
22	2022	The mental health CCG staff and delivery of CCG priorities could be affected by remote working and physical staff isolation from colleagues.	4	3	<ul style="list-style-type: none"> <li>Daily Team Meetings/catch up's held between Managers and their staff.</li> <li>Weekly All Staff virtual meeting held, led by Dr Chris Clayton, to update and inform CCG staff of developments etc.</li> <li>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.</li> <li>Twice daily COVID-19 Staff update emails issued outlining all progress, news and operational developments.</li> <li>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.</li> <li>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 page for leavers 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.</li> <li>17.04.20 continue to monitor and assess sickness returns for trends and patterns and review good practice for staff H&amp;WB e.g. NHS Employer, Social Partnership Forum etc.</li> <li>12.20.20 The CCG will develop and run briefings for management to support them in undertaking 1 to 1 wellbeing checks with their team to include wellness action plan, displaying screen equipment review and risk assessments for vulnerable staff.</li> <li>1 to 1 wellbeing checklist introduced for line managers to facilitate support for members of their team.</li> <li>Virtual tea breaks and initiatives to promote social connectivity introduced and ongoing.</li> </ul>	<p>08.04.20 A range of ideas to support the wellbeing of staff working from home will be launched shortly, with a toolkit to help staff all maintain a positive outlook and ensure interaction with colleagues 'off topic' to maintain spirits during the working week. Staff are encouraged that they should at all times remember that they are not 'working from home', but 'at home, during a crisis, trying to work'.</p> <p>17.01.22 - Continuation of wellbeing communication and initiatives for staff, including flexible working, social connectivity, exercise classes and maintaining good MSK. Staff working from home with exception of a few CCG staff for health &amp; wellbeing reasons.</p> <p>11.02.22 - As above. With the lifting of the restrictions, staff are again able to book a desk and work from a CCG base.</p> <p>18.03.22 - As above. Sessions taken have increased slightly compared to the previous 12 months (2.9% to 3.47%) but still much lower than pre-pandemic (3.2%). A Big Conversation is shortly to commence in the Midlands, which DCCCG will be part of, looking at wellbeing. Be Well Midlands is an online destination for staff to talk about wellbeing and will be able to share what works, what isn't working and what they think could be done to improve their wellbeing.</p>	2	3	6	2	3	6	1	3	3	2	3	2	3	2	3	2	3	2	3	
23	2022	CCG Staff capacity compromised due to illness in previous months. Increased number of CCG staff potentially unable to work due to COVID 19 symptoms / Self isolation.	4	14	<ul style="list-style-type: none"> <li>Staff asked to complete Skills Survey for redeployment. Detailed analysis of deployment within and outside of the CCG completed. Booking rota compiled for locked Centre (ICC).</li> <li>Majority of CCG staff working from home.</li> <li>Business Continuity Plan escalation level increased to 4 allows for pausing of functions within the CCG.</li> </ul>	<p>Running a mixed mode of remote/face work</p> <p>Possible shadowing of staff working in the ICC by backup rota staff.</p> <p>Identified capacity issues in covering staff shortages.</p> <p>Staff illness could compromise the operation of the ICC.</p> <p>Develop a resilient rota for the ICC, PPE and Testing Cells over 7 days</p>	<p>20.12.21 - Increasing number of redeployments away from the CCG, due to requirements to support the system with the COVID booster and vaccination programme. Risk probability score increased accordingly from 1 to 3. Permanent structure developed for VOC to support continuity &amp; deployment and submitted to Executive Team for consideration. Additional interim resources being brought in to boost capacity in the short-term (until 31 March 2021) from underpenned on both nursing and programme costs.</p> <p>17.01.22 - Increasing number of redeployments away from the CCG, due to need to increase surge capacity (clinical) and open wards plus ongoing requirements to support the system with the COVID booster and vaccination programme. Permanent structure developed for VOC to support continuity &amp; deployment to be further reviewed in 1 month.</p> <p>11.02.22 - Number of redeployments are starting to reduce with several Nursing &amp; Quality returning to undertake essential CCG work. Appointments to permanent VOC structure pending further review.</p> <p>11.03.22 - As above, the redeployment of CCG staff has reduced with colleagues returning to undertake essential CCG work. A revised VOC structure has been developed for consideration.</p>	3	4	13	3	4	12	1	3	3	3	4	3	3	3	3	3	3	3	

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				Revised/Current Risk				Target Risk Rating	Date Reviewed	Review Due Date	Executive Lead	Action Owner	
									Probability	Impact	Timing	Complexity	Probability	Impact	Timing	Complexity						
																						Rating
24	21/22	Patients deferring seeking medical advice for non COVID issues due to the belief that COVID tests procedure. This may impact on health issues outside of COVID 19, long term conditions, cancer patients etc.	Quality & Performance	Control	4	<p>National and local campaigns across all media platforms to promote access and availability of health services.</p> <p>Weekly performance brief to monitor patient attendance across providers (AE, 111, NEL, Elective Care, Cancer etc.)</p> <p>Primary Care agreed to prioritise LTC reviews for all priority (red) patients and have agreed to see all amber patients by 31st March 2021.</p> <p>Includes messages to voluntary sector to strengthen messages to patients.</p> <p>COVID vaccination roll out to commence in December, based on a prioritisation framework.</p>	<p>On-going public communication campaigns regarding service provision as we move across each phase.</p> <p>To support winter pressures, PCNs are developing contingency plans to support patients that display COVID/Flu symptoms. Learnings to be taken from the roll out.</p> <p>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.</p> <p>System Cell leading on the coordination of vaccine roll out, commencing in early December.</p>	<p>19/12/21: Concern over Omicron variant and national measures have been introduced to tackle the spread. Booster jab roll out for all 40+ commenced. Advice to keep the risk on the tracker due to forthcoming winter pressures and the spread of COVID variants.</p> <p>January: The spread of the Omicron COVID-19 variant across our communities has not yet resulted in the increased case of our intensive Care Services but general admissions to our hospitals with COVID-19 are increasing, together with an increase in care activity and requirements in our community-based services. With circa 200,000 confirmed cases each day nationally (7/1/22), it is inevitable that our staff will pick up the virus themselves. At present, this is the main challenge to service delivery, in both health and social care we have the estate and the facilities to meet most of the demand, but we are challenged in sustaining the staffing levels required to use it fully.</p> <p>Feb 22: Advise to keep the risk on the tracker due to winter pressures and the spread of COVID variants. Continued pressures in the system and impact on workforce/service delivery caused by COVID-19. COVID infections are now starting to reduce nationally and COVID restrictions are set to be lifted in Feb/March by the government.</p> <p>Mar 22: In light of the government announcement that all remaining COVID restrictions were lifted in England on 28th February it is advised to remove the risk and not to reintroduce the risk unless a variant of concern is identified or the government reintroduces restrictions by law. The risk met the target risk rating a couple of months ago. It is acknowledged that a small % of patients may not and/or guidance remains in place for now pending a review. This means that staff, patients and visitors will be expected to continue to follow social distancing rules when visiting any care setting as well as using masks or face coverings and other personal protection equipment.</p> <p>The government update states a continuation of free tests for symptomatic people in the oldest age groups and those who are most vulnerable. The additional booster dose to be offered to the over-75 and most vulnerable over-12s in spring is also a positive development.</p>	2	3	6	2	3	6	2	3	6	On-going	Mar-22	Apr-22	Dr Steve Lloyd, Medical Director	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster, Head of Strategic Clinical Conditions and Pathways
25	21/22	Patients diagnosed with COVID 19 could suffer a deterioration of existing health conditions which could have repercussions on medium and long term health.	Quality & Performance	Control	4	<p>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 re-configure and implement guidance.</p> <p>Primary Care agreed to prioritise LTC reviews for all priority (red) patients and have agreed to see all amber patients by 31st March 2021.</p> <p>NHSE has launched the 'Your COVID Recovery' service to provide advice and guidance (self-care) online, and a national COVID rehab service is in development.</p> <p>Post COVID rehab pathways for admitted and non-admitted patients being developed, and criteria for referral to secondary care if patients have ongoing needs.</p> <p>MDT's set up across the county in respiratory between Acute and Community Respiratory Teams. Working towards implementation with Acute and Primary Care.</p> <p>Post COVID Syndrome Assessment Clinic service implemented to support patients suffering with postlong COVID symptoms. MDT approach to provide physical and psychological assessments, to ensure patients access the required service and treatment.</p>	<p>Review COVID inpatient data to identify pre-existing LTCs to proactively support patients.</p> <p>Derbyshire-wide Condition Specific Boards to amend/develop pathways through embedding new guidance and good practice to allow effective follow-up of patients.</p> <p>Keep virtual consultations on-line support (empify).</p> <p>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.</p> <p>To support the roll out of the 'Your COVID Recovery Service' throughout Derbyshire as required. To include communications and implementation of rehab services.</p> <p>Review and scoping of pan-Derbyshire end to end rehab pathway.</p> <p>Develop and implement a Post COVID Assessment Clinic to ensure patients are referred to appropriate services.</p> <p>Post COVID integrate 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.</p>	<p>12/11/21: Agreed to develop two rehab centres at CRH and Florence Highgate. Recruitment to the workforce has commenced and system wide partners are dialogue to develop the patient pathway.</p> <p>19/12/21: Concern over waiting lists and recruitment at the Assessment Clinic. Funding being utilised to recruit additional clinician time to eradicate backlog by Dec 21.</p> <p>19/12/21: Ongoing development of the rehab service, and DCHS are implementing a revised plan to reduce the assessment clinic waiting list.</p> <p>January: The North and South Long COVID rehab centres have appointed case managers and assistant practitioners. Aiming for a March launch of both centres. To support the Post COVID Syndrome backlog, DCHS are triaging referrals and have recruited bank staff to eradicate the 230 patient backlog by March 22.</p> <p>Feb 22: No update. Still aiming to launch the rehab centres in March/April 22.</p> <p>Mar 22: The North and South Rehab hub are to undertake a soft launch in April 22. Majority of staff appointed appointed at both sites. Team currently working through referral process and developing communications for key stakeholders. The assessment clinic waiting list continues to reduce.</p>	3	3	9	3	3	9	3	3	9	On-going	Mar-22	Apr-22	Dr Steve Lloyd, Medical Director	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster, Head of Strategic Clinical Conditions and Pathways
26	21/22	New mental health issues and deterioration of existing mental health conditions for adults, young people and children due to isolation and social distancing measures implemented during COVID 19.	Quality & Performance	Control	3	<p>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 as a result of being exacerbated by Covid-19. Helpline is accessible via 111 warm transfer.</p> <p>a 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.</p> <p>a Working with Communications teams to ensure that information is disseminated effectively across all stakeholders and the system.</p> <p>a 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.</p> <p>a CYP services, targeted intervention predominantly online, CAMHS RAG rating and prioritising urgent cases. Digital offer Kooth and Qwell upwell continue until March 21. Ongoing CYP communications strategy with partners to send information out across the system.</p> <p>a MPT providers fully operational and accepting referrals</p> <p>a Attend Anywhere utilised across the trust for online consultations</p> <p>Mental Health System Delivery Board to provide Covid oversight recovery and planning</p>	<p>a To further recruit and upskill clinical triage &amp; assessment team staff responding to the helpline in CYP, LD &amp; Autism</p> <p>a Additional community based LD beds - there needs to be an agreed user of identified staff that can be called on this responsibility line with LA not CCG. Building needs to be furnished and cleared.</p> <p>a Re above - need to develop a training programme for staff working in the specialised unit- being actioned via LD delivery group.</p> <p>a Need to finalise the LD &amp; Mental Health All Age COVID Recovery Planning Group process to feed into LRF across providers.</p> <p>a 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</p> <p>a MPT providers are funded on AQP basis so there is no cap on activity</p> <p>a Frontline staff vaccinations will support increase in face to face capacity and engagement in care and improve resilience of staff capacity reducing absences</p>	<p>November 21 - Additional CYP crisis staff starting to come in to post i.e. in CAMHS Eating Disorder urgent care team. Continued pressures on paediatric units and in community. Working up / reviewing opportunities for CYP short term accommodation.</p> <p>December update - Continuing to recruit to Crisis, Liaison and Intensive Home treatment team. Ongoing pressures affecting low access in tier 4, paediatric units and community</p> <p>January update - Emergence of Omicron and impact on workforce capacity has resulted in reduced access to services. Continued focus on planning for additional investment in crisis response offers.</p> <p>February update - Work force capacity remains stretched, providers continuing to try to recruit to Crisis, Liaison and Intensive Home treatment team although some posts difficult to fill.</p> <p>March update - services across the pathway continue to report high levels of referrals and complexity of need. Planning focus on more integrated approaches / efficiency to get CYP to the right place, right time. School pathway toolkit launched to aid communication re offer.</p>	4	3	12	4	3	12	2	2	4	Apr-22	Apr-22	Zara Jones, Executive Director of Commissioning Operations	Tracy Lee, Head of Mental Health Clinical Lead Helen Van Rietall, TCP Programme Manager Jenn Bluffard, Head of Mental Health	
27	21/22	Increase in the number of safeguarding referrals linked to self neglect related to those who are not in touch with services. These initially increased immediately following COVID lockdown. The adult safeguarding processes and policy are able to respond to this type of enquiry once an adult at risk has been identified. Numbers are difficult to predict but are expected to increase as COVID restrictions ease.	Quality & Performance	Control	4	<p>Key statutory partners such as Health, Local Authority, Police and Voluntary Sector are working closely together to ascertain who are at enhanced risk. Safeguarding meetings and assessments are continuing to take place via virtual arrangements. Families and individuals are being signposted to relevant support services.</p> <p>During the COVID19 pandemic, the number of referrals to adult social care services has increased but not as yet at the rates envisaged and predicted at the outset of lockdown and enforced isolation.</p> <p>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. Plans are underpinning safe and well checked as appropriate and will use powers of enquiry if deemed necessary and proportionate.</p>	<p>Domestic Abuse is likely to increase as family groups are forced to be together for extended periods of time, children are at home on a full time basis. There are financial pressures due to restrictions upon employment, and adults at risk from abusive partners become socially isolated. It remains at an early stage. Referrals are expected to increase with another sharp spike in activity predicted when COVID restrictions are eased and victims feel safer in making disclosures</p> <p>Self Neglect: Individuals are finding it problematic to obtain aids to daily living and basic essentials. They do not have the motivation or ability to access sources to access or replenish essential items.</p> <p>Stammering: Individuals are targeted due to their physical or cognitive vulnerability and persuaded and coaxed to trust unscrupulous individuals.</p> <p>February: Both Derby &amp; Derbyshire Safeguarding Adult Boards (SABs) have development days thirteenth month and will review and revise the register accordingly.</p> <p>March: As Covid pressures ease and lockdown restrictions are lifted then work has been undertaken to assist those adults most at risk from harm. Self-neglect, hoarding, domestic abuse, and scamming remain the main areas of activity. Both the Safeguarding Adult Boards have received assurance that referrals are being actioned although concern remains about the sheer numbers and levels of operational activity. The CCG continues to seek assurance from NHS providers that they are meeting their statutory duties. Compliance levels are positive. CCG safeguarding activity reported via the G&amp;P committee and the CCG's Safeguarding Committee. I would suggest that risks to the CCG have decreased in light of inter agency working arrangements and the reduction in Covid mandates.</p> <p>December - No changes this month.</p> <p>January: This is currently under review. Update February/March.</p> <p>No change this month.</p>	<p>November - Safeguarding Adult referrals have increased by 16% over the last Quarter. This was anticipated due to an easing of lockdown restrictions began to take effect. These referral rates and types are monitored through the Safeguarding Adult Boards and also via case file audits. There should be little doubt that systems and resources are stretched and challenged but at the time of writing there are no particular areas of concern requiring escalation. Suggest that we continue with the risk levels as they currently stand until completing a roll and branch review during March 2022.</p>	4	3	12	3	9	3	9	Apr-22	Apr-22	Brigit Stacey, Chief Nursing Officer	Bill Nicol, Head of Adult Safeguarding			
33	21/22	There is a risk to patients on waiting lists as a result of their delays to treatment as a direct result of the COVID 19 pandemic. Provider waiting lists have increased in size and it is likely that it will take significant time to fully recover the position against these.	Quality & Performance	Control	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>An assurance group is in place to monitor actions being undertaken to support these patients which reports to PCOB 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 PCOB</p> <p>A minimum standard in relation to these patients is being considered by PCOB</p> <p>Work to control the addition of patients to the waiting is ongoing</p>	<p>Monthly groups are in place with all 4 providers represented</p> <p>Completion of assurance framework quarterly is undertaken by all providers and reports to PCOB quarterly, and to SOG</p> <p>Identified harm is reported on STES and all providers are monitoring this</p> <p>A risk stratification tool is being piloted by providers</p> <p>November: Nothing further to add this month.</p> <p>December: Provider Governance processes have been reviewed and strengthened regarding oversight.</p> <p>January/February: Focus on 104 day cancer waits with planned work to explore harm in more depth.</p> <p>March Update: Terms of reference, including monthly reporting process, currently being revised to better capture the focus of the group. The monthly reporting is based on the minimum standards and will provide improved Provider positions.</p>	4	4	16	4	16	3	2	6	Apr-22	Apr-22	Brigit Stacey, Chief Nursing Officer	Alison Cargill, Assistant Director of Quality		
37	21/22	The Royal College of Physicians identified that there is a risk to the sustainability of the Hyper Acute Stroke Unit at CRHPT and reviews to service provision for the population of North Derbyshire.	Quality & Performance	Control	5	<p>Short term work has been undertaken and assurance re the safety of services has been provided by the Medical and Nursing Director at CRHPT, 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, UHQB, and Stepping 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>Clinic Leadership support is being provided by Liverpool Consultant</p> <p>Trust to go out for advert to recruit new Stroke Lead consultant &amp; work being done to make advert attractive</p> <p>CCG, NHSE &amp; 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 safety staffing policy as required, including red flag acute reporting</p> <p>CRHPT and Integrated Stroke Delivery Network (ISDN) leads to develop service contingency plan to understand internal measures, mutual aid 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>12/11/21: Independent Panel is now due to meet virtually 13th December. The recommendations identified by the independent panel will be required to be presented to CCG, CRH and wider governance committees throughout Jan 2022.</p> <p>19/12/21 HASU workshop was delivered on 29/12/21 and all customer information has been written up in preparation for the Independent Panel on 13th December. For each service option the panel is required to provide recommendations as to whether the option will be shortlisted, discounted, or could proceed for further review subject to consult. The CRH Stroke has also been approached to undertake a desk top review of the process and output.</p> <p>14/1/22: Independent panel recruitment exploring the options of strengthening the HASU service by redesign. The working group will focus on the workforce challenges and consider of possible workforce models and good practice, taking learning from independent panel members. Support will also be sought from the East Midlands and South Yorkshire and Baseline Integrated Stroke Delivery Networks. The working group will be required to develop a plan and provide detail of the service redesign for option 2. The independent panel will then be requested to reconvene and assess the fully worked-up option before the commencement of the implementation phase in March 2022.</p> <p>Feb 22: Stakeholder workshop to be held in Feb/March to gain consensus on the agreed service redesign option. The service option is to be worked up by April 22 for consideration by relevant Boards before full scaled up model is presented in September 22.</p> <p>Mar 22: Working to be held end of March 2022. No further updates. Timescales for implementation of new redesign put back to March 2023 to allow partners to plan, develop and implement change.</p>	3	4	12	3	12	3	9	On-going	Mar-22	Apr-22	Dr Steve Lloyd, Medical Director	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster, Head of Strategic Clinical Conditions and Pathways		
40	21/22	In the period of transition from CCG to ICS, it is likely that a larger proportion of contracts will be extended on expiry rather than reprocured. The CCG is advised by Aron & GEM CCG on best practice for our procurement activity, but in some circumstances, the CCG may decide to proceed against best practice in order to get sufficient time for review of services within the framework of movement to an ICS. Proceeding against advice, carries a small risk of challenge from any providers who may have felt excluded from the process.	Governance	Control	4	<p>All healthcare contract extensions or renewals are reviewed via SLT, Execs, CLCC and then Governing Body for larger contracts. Any procurement issues and risks are highlighted as part of that process and the risk is accepted when agreement is given to proceed with the extension. Risks of challenge are small in most markets and the size of the risk will have been factored in to decision-making.</p> <p>Healthcare contracts expiring within 12 months are reviewed at Commissioning Ops Directorate SMT to ensure that timely action is taken before expiry.</p> <p>Where any challenge occurred from a provider, if the challenge were valid the risk could usually be mitigated by including the provider in future stages of procurement.</p> <p>Legislation is currently going through parliament to remove the requirement for NHS bodies to comply with the Public Sector Procurement Regulations for the procurement of healthcare services. This requirement will be replaced with a Provider Selection Regime which requires adherence to a decision-making framework but removes the right of legal challenge from providers except by judicial review.</p>	<p>A monthly meeting has been established between AGEM and the contracting team to review the procurement report and ensure that any issues around risk, progress or lack of engagement are escalated appropriately.</p> <p>The redesign of the procurement report has reduced the number of contracts of concern.</p>	<p>December: The CCG contracting team continues to monitor and manage all contracts due for expiry including plans to extend or reprocure. The risk score cannot be decreased until the Provider Selection Regime comes into force.</p> <p>January: The new provider selection regime has not yet come into force.</p> <p>February: Risk remains the same because the new procurement regulations are not yet in force and the mitigations are the same - contract expires regularly discussed through SLT.</p> <p>March: No change to this for March update.</p>	2	3	6	2	3	6	1	4	4	Apr-22	Apr-22	Helen Dillstone - Executive Director of Corporate Strategy and Delivery	Christy Tucker - Director of Corporate Delivery	
42	21/22	If the CCG does not prioritise the importance of climate change it will have a negative impact on its requirement to meet the NHS Net Zero Carbon 2030 targets and improve health and patient care and reducing health inequalities and build a resilient healthcare system that understands and responds to the direct and indirect threats posed by climate change.	Governance	Control	4	<p>Helen Dillstone, Net Zero Executive Lead for Derbyshire ICS</p> <p>NHSE Memorandum of Understanding in place</p> <p>NHSE Midlands Greener Board established and meets monthly</p> <p>Derbyshire ICS Greener Delivery Group established and meets bi monthly</p> <p>NHSE Midlands regional priorities identified</p> <p>Derbyshire Provider Trust Green Plans approved by individual Trust Boards and submitted to NHSE</p> <p>Derbyshire Provider Trust Green Plans approved by individual Trust Boards during March and approved by the CCG Governing Body on the 7th April 2022.</p>	<p>Helen Dillstone, Net Zero Executive Lead for Derbyshire ICS</p> <p>NHSE Memorandum of Understanding in place</p> <p>NHSE Midlands Greener Board established and meets monthly</p> <p>Derbyshire ICS Greener Delivery Group established and in place</p> <p>NHSE Midlands regional priorities identified</p> <p>Derbyshire Provider Trust Green Plans approved by individual Trust Boards and submitted to NHSE</p> <p>Derbyshire ICS final draft Green Plan will be approved through the Derbyshire Trust Boards during March and approved by the CCG Governing Body on the 7th April 2022.</p>	<p>Derbyshire Provider Trust Green plans ICS and NHS England February 2022</p> <p>Derbyshire ICS Green plan in development and will be approved April 2022</p> <p>NHSE Midlands Greener Delivery Board Terms of Reference</p> <p>NHSE Midlands Greener Delivery Board Agenda and Minutes</p> <p>Derbyshire ICS Greener Delivery Board Terms of Reference</p> <p>Derbyshire ICS Greener Delivery Board Agenda and Minutes</p> <p>Communications and Staff Engagement books published by NHSE</p> <p>NHSE Climate Medicine Toolkit published by NHSE</p> <p>Net Zero - One year on Staff Communication from Helen Dillstone, Net Zero Lead</p> <p>CCG Team Talk - staff engagement session on the Green NHS and Derbyshire arrangements in place - November 2021</p> <p>Derbyshire ICS Green Plan workshop 18th December 2021 and Derbyshire ICS Green Plan and action plan in development and will be approved by the CCG Governing Body on the 7th April and 12th Board July 2022</p> <p>Medicine Management Lead is a member of the Derbyshire ICS Delivery Group</p> <p>Climate Change National Audit Office best practice risk assessment presented to Audit Committee November 2021</p> <p>Risk score aimed to be reduced in April when the Green Plan is approved and in place.</p>	4	3	12	4	3	12	3	9	Apr-22	Apr-22	Helen Dillstone - Executive Director of Corporate Strategy and Delivery	Suzanne Pickering, Head of Governance		

Appendix 2 - Movement during March 2022

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
01	21/22	The Acute providers may breach thresholds in respect of the A&E operational standards of 95% to be seen, treated, admitted or discharged within 4 hours, resulting in the failure to meet the Derby and Derbyshire CCGs constitutional standards and quality statutory duties.	5	4	20	5	4	20	↔	The volume of attendances is high.	Zara Jones Executive Director of Commissioning Operations	Quality & Performance	Craig Cook Director of Contracting and Performance / Deputy Director of Commissioning Operations  Jackie Carille  Catherine Bainbridge, Head of Urgent Care  Dan Merrison Senior Performance & Assurance Manager
02	21/22	Changes to the interpretation of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) safeguards, results in greater likelihood of challenge from third parties, which will have an effect on clinical, financial and reputational risks of the CCG	3	4	12	3	4	12	↔	LPS readiness return submitted to NHSE/I as required.	Brigid Stacey - Chief Nursing Officer	Quality & Performance	Bill Nicol, Head of Adult Safeguarding
03	21/22	TCP unable to maintain and sustain performance, Pace and change required to meet national TCP requirements. The Adult TCP is on recovery trajectory and rated amber with confidence whilst CYP TCP is rated green, main risks to delivery are within market resource and development with workforce provision as the most significant risk for delivery.	5	4	20	5	4	20	↔	ICS scrutiny panels are now being facilitated weekly to identify themes and trends for local action.	Brigid Stacey - Chief Nursing Officer	Quality & Performance	Helen Hipkiss, Deputy Director of Quality / Phil Sugden, Assistant Director Quality, Community & Mental Health, DCHS
04A	21/22	<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	↔	Letter received from NHSE/I requesting that for the period up until 31 March 2022 they are asking that practices and Primary Care Networks (PCNs) focus on three key priority areas while continuing to use their professional judgement to clinically prioritise care.	Dr Steve Lloyd - Medical Director	Primary Care Commissioning	Hannah Belcher, Head of GP Commissioning and Development (Primary Care)
04B	21/22	<u>Quality:</u> Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care. There are 112 GP practices in Derbyshire all with individual Independent Contracts GMS, PMS, APMS to provide Primary Medical Services to the population of Derbyshire. Six practices are managed by NHS Foundation Trusts and one by an Independent Health Care Provider. The majority of Derbyshire GP practices are small independent businesses which by nature can easily become destabilised if one or more core components of the business become critical or fails. Whilst it is possible to predict and mitigate some factors that may impact on the delivery of care the elements of the unknown and unexpected are key influencing dynamics that can affect quality and care outcomes. Nationally General Practice is experiencing increased pressures which are multi faceted and include the following areas: *Workforce - recruitment and retention of all staff groups *COVID-19 potential practice closure due to outbreaks *Recruitment of GP Partners *Capacity and Demand *Access *Premises *New contractual arrangements *New Models of Care *Delivery of COVID vaccination programme *Restoration and Recovery +C30	4	5	20	4	5	20	↔	Planning has been undertaken to meet the future demands of the COVID 19 vaccine programme including future boosters, if required and potential concomitant administration with other vaccines.	Dr Steve Lloyd - Medical Director	Primary Care Commissioning	Judy Derricott, Head of Primary Care Quality

05	21/22	Wait times for psychological therapies for adults and for children are excessive. For children there are growing waits from assessment to psychological treatment. All services in third sector and in NHS are experiencing significantly higher demand in the context of 75% unmet need (right Care). COVID 19 restrictions in face to face treatment has worsened the position.	4	3	12	4	3	12	↔	CAMHS continue to deliver and prioritise urgent / crisis and essential services.	Zara Jones Executive Director of Commissioning Operations	Quality & Performance	Dave Gardner Assistant Director, Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning
06	21/22	Demand for Psychiatric intensive Care Unit beds (PICU) has grown substantially over the last five years. This has a significant impact financially with budget forecast overspend, in terms of poor patient experience, Quality and Governance arrangements for uncommissioned independent sector beds. The CCG cannot currently meet the KPI from the Five year forward view which require no out of area beds to be used from 2021.	2	3	6	2	3	6	↔	Regular mobilisation meetings in place with providers.	Zara Jones Executive Director of Commissioning Operations	Quality & Performance	Dave Gardner Assistant Director, Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning
09	21/22	Sustainable digital performance for CCG and General Practice due to threat of cyber attack and network outages. The CCG is not receiving the required metrics to provide assurance regarding compliance with the national Cyber Security Agenda, and is not able to challenge any actual or perceived gaps in assurance as a result of this.	4	4	16	4	4	16	↔	As we are unable to confirm the resolution of this issue at this point, the risk score remains the same with regard to the potential for impact locally.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Ged Connolly-Thompson - Head of Digital Development, Chrissy Tucker - Director of Corporate Delivery
10	21/22	If the CCG does not review and update existing business continuity contingency plans and processes, strengthen its emergency preparedness and engage with the wider health economy and other key stakeholders then this will impact on the known and unknown risks to the Derby and Derbyshire CCG, which may lead to an ineffective response to local and national pressures.	2	4	8	2	4	8	↔	NHSEI have set out a Roadmap for EPRR transition to ICB	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Chrissy Tucker - Director of Corporate Delivery / Richard Heaton, Business Resilience Manager
11	21/22	Risk of the Derbyshire health system being unable to manage demand, reduce costs and deliver sufficient savings to enable the CCG to move to a sustainable financial position.	4	4	16	4	4	16	↔	The score remains the same as while the in-year position now shows a surplus, the underlying recurrent position for both the CCG and the wider system remains very challenging.	Richard Chapman, Chief Finance Officer	Finance	Darran Green- Assistant Chief Finance Officer
12	21/22	Inability to deliver current service provision due to impact of service review. The CCG has initiated a review of NHS provided Short Breaks respite service for people with learning disabilities in the north of the county without recourse to eligibility criteria laid down in the Care Act. Depending on the subsequent actions taken by the CCG fewer people may have access to the same hours of respite, delivered in the same way as previously. There is a risk of significant distress that may be caused to individuals including carers, both during the process of engagement and afterwards depending on the subsequent commissioning decisions made in relation to this issue. There is a risk of organisational reputation damage and the process needs to be as thorough as possible. There is a risk of reduced service provision due to provider inability to retain and recruit staff. There is an associated but yet unquantified risk of increased admissions – this picture will be informed by the review.	3	3	9	3	3	9	↔	MH, LD & ASC and CYP System Delivery Board approved the revised timetable for delivering the joint Health & Social Care Reviews (July 2022).	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
16	21/22	Lack of standardised process in CCG commissioning arrangements. CCG and system may fail to meet statutory duties in S14Z2 of Health and Care Act 2012 and not sufficiently engage patients and the public in service planning and development, including restoration and recovery work arising from the COVID-19 pandemic.	2	3	6	2	3	6	↔	Engagement Committee agreed that this risk could be closed in May if there were no further issues.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Engagement	Sean Thornton Assistant Director Communications and Engagement
17	21/22	S117 package costs continue to be a source of high expenditure which could be positively influenced with resourced oversight, this growth across the system, if unchecked, will continue to outstrip available budget	3	3	9	3	3	9	↔	MLCSU contacted to provide formal review feedback.	Zara Jones, Executive Director of Commissioning Operations	Quality & Performance	Helen Hipkiss, Director of Quality / Dave Stevens, Head of Finance

20	21/22	Failure to hold accurate staff files securely may result in Information Governance breaches and inaccurate personal details. Following the merger to Derby and Derbyshire CCG this data is not held consistently across the sites.	3	3	9	3	3	9	↔	The Derbyshire Healthcare system is working together to review digital solutions for HR, including an electronic HR document management system.	Beverley Smith, Director of Corporate Strategy & Development	Governance	James Lunn, Head of People and Organisational Development
22	21/22	The mental health of CCG staff and delivery of CCG priorities could be affected by remote working and physical staff isolation from colleagues.	2	3	6	2	3	6	↔	Sickness levels have increased slightly compared to the previous 12 months (2.3% to 2.47%) but still much lower than pre-pandemic (3.2%).	Beverley Smith, Director of Corporate Strategy & Development	Governance	Beverley Smith, Director of Corporate Strategy & Development James Lunn, Head of People and Organisational Development
23	21/22	CCG Staff capacity compromised due to illness or other reasons. Increased numbers of CCG staff potentially unable to work due to COVID 19 symptoms / Self isolation.	3	4	12	3	4	12	↔	The redeployment of CCG staff has reduced with colleagues returning to undertake essential CCG work.	Beverley Smith, Director of Corporate Strategy & Development	Governance	Beverley Smith, Director of Corporate Strategy & Development James Lunn, Head of People and Organisational Development
24	21/22	Patients deferring seeking medical advice for non COVID issues due to the belief that COVID takes precedence. This may impact on health issues outside of COVID 19, long term conditions, cancer patients etc.	2	3	6	2	3	6		In light of the government announcement that all remaining COVID restrictions were lifted in England on 24th February it is advised to remove the risk.	Dr Steve Lloyd, Medical Director	Quality & Performance	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster Head of Strategic Clinical Conditions and Pathways
25	21/22	Patients diagnosed with COVID 19 could suffer a deterioration of existing health conditions which could have repercussions on medium and long term health.	3	3	9	3	3	9	↔	The North and South Rehab hub are to undertake a soft launch in April 22.	Dr Steve Lloyd, Medical Director	Quality & Performance	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster Head of Strategic Clinical Conditions and Pathways
26	21/22	New mental health issues and deterioration of existing mental health conditions for adults, young people and children due to isolation and social distancing measures implemented during COVID 19.	4	3	12	4	3	12	↔	Services across the pathway continue to report high levels of referrals and complexity of need.	Zara Jones, Executive Director of Commissioning Operations	Quality & Performance	Mick Burrows, Director of Commissioning for MH, LD, ASD, and CYP Helen O'Higgins, Head of All Age Mental Health Tracy Lee, Head of Mental Health Clinical Lead
27	21/22	Increase in the number of safeguarding referrals linked to self neglect related to those who are not in touch with services. These initially increased immediately following COVID lockdown. The adult safeguarding processes and policy are able to respond to this type of enquiry once an adult at risk has been identified. Numbers are difficult to predict but numbers are predicted to increase as COVID restrictions ease.	4	3	12	3	3	9	↓	Risks to the CCG have decreased in light of inter-agency working arrangements and the reduction in Covid mandates.	Brigid Stacey, Chief Nursing Officer	Quality & Performance	Bill Nicol, Head of Adult Safeguarding
33	21/22	There is a risk to patients on waiting lists as a result of their delays to treatment as a direct result of the COVID 19 pandemic. Provider waiting lists have increased in size and it is likely that it will take significant time to fully recover the position against these.	4	4	16	4	4	16	↔	Terms of reference, including monthly reporting process, currently being revised to better capture the focus of the group.	Brigid Stacey, Chief Nursing Officer	Quality & Performance	Alison Cargill, Assistant Director of Quality
37	21/22	The Royal College of Physicians identified that there is a risk to the sustainability of the Hyper Acute Stroke Unit at CRHFT and therefore to service provision for the population of North Derbyshire.	3	4	12	3	4	12	↔	Timescales for implementation of new redesign put back to March 2023 to allow partners to plan, develop and implement changes.	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

40	21/22	In the period of transition from CCG to ICS, it is likely that a larger proportion of contracts will be extended on expiry rather than reprocedured. The CCG is advised by Arden & GEM CSU on best practice for our procurement activity, but in some circumstances, the CCG may decide to proceed against best practice in order to give sufficient time for review of services within the framework of movement to an ICS. Proceeding against advice, carries a small risk of challenge from any providers who may have felt excluded from the process.	2	3	6	2	3	6		Risk remains the same because the new procurement regulations are not yet in force. The contract expires regularly discussed through SLT.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Chrissy Tucker - Director of Corporate Delivery
42	21/22	If the CCG does not prioritise the importance of climate change it will have a negative impact on its requirement to meet the NHS's Net Carbon Zero targets and improve health and patient care and reducing health inequalities and build a more resilient healthcare system that understands and responds to the direct and indirect threats posed by climate change.	4	3	12	4	3	12		Derbyshire ICS final draft Green Plan will be approved through the Derbyshire Trust Boards during March and approved by the CCG Governing Body on the 7th April 2022.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Suzanne Pickering - Head of Governance

**MINUTES** of a meeting of the **DERBYSHIRE HEALTH AND WELLBEING BOARD** held on 10 February 2022 at County Hall, Matlock, DE4 3AG.

**PRESENT**

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

C Cammiss	Derbyshire County Council
C Clayton	Derby & Derbyshire CCG
H Denness	Derbyshire County Council
H Henderson-Spoors	Healthwatch Derbyshire
N Hoy	Derbyshire County Council
H Jones	Derbyshire County Council
C Prowse	NHS Tameside And Glossop CCG
Clive Stanbrook	Derbyshire Fire and Rescue Service

Virtual attendance – H Bowen (Chesterfield Borough Council), L Pepper (North East Derbyshire District Council), S Scott (Erewash CVS), D Wallace (Derbyshire County Council), J Williams (Derbyshire County Council) and P Williams (Derbyshire County Council).

Also in attendance – A Appleton (Derbyshire County Council), A Kirkham (Derbyshire County Council), E Langton (Derbyshire County Council) and J Wagstaffe (Derbyshire County Council).

Apologies for absence were submitted on behalf of Councillor J Patten (Derbyshire County Council) and V Taylor (Joined Up Care Derbyshire).

**01/22**      **MINUTES RESOLVED** that the minutes of the meeting of the Board held on 30 September 2021 be confirmed as a correct record.

**02/22**      **HEALTH AND WELLBEING BOARD STRATEGY UPDATE**

The refreshed Derbyshire ‘Health and Wellbeing Strategy’ had been presented in draft format. The strategy continued to focus around 5 priority areas, outlined within the report.

The refreshed 2022 ‘Health and Wellbeing Strategy’ would be a live document and governance structures would continue to be updated to make sure it fully aligned with emerging Integrated Care System arrangements throughout 2022.

The strategy would be fully reviewed with an ambition to have a new strategy in place from the end of 2023 onwards. For this review officers would

fully engage with Board members and local residents to inform the development of new priorities and outline a longer vision which formalised arrangements between the Integrated Care System and the Health and Wellbeing Board once all governance was fully in place.

**RESOLVED** to (1) review and discuss the refreshed Health and Wellbeing Strategy; (2) provide comment and feedback on the draft strategy document by Thursday 10 March, so that a final version of the document could be approved at the Health and Wellbeing Board meeting on 31 March 2022; and (3) agree to have the 2022 refresh of the 'Health and Wellbeing Strategy' as a live document in preparation for the full strategy refresh in 2023.

### **03/22      PHYSICAL ACTIVITY IN DERBYSHIRE UPDATE**

Derbyshire County Council (DCC) had a long tradition of investing in physical activity and had worked with a range of partners including Active Derbyshire, Shift and the district and borough councils to deliver a range of interventions aimed at reducing inactivity levels.

The current physical activity system included a successful Jog Derbyshire programme delivered by Shift, an exercise by referral scheme that was delivered through district and borough councils and Walk Derbyshire. These programmes were funded through DCC Public Health Grants.

Derbyshire's new physical activity strategy, 'Making our Move', was launched in October 2021, and aimed to address inequalities and empower everyone to be active in a way that works for them. The strategy set out an approach that would help focus the efforts and resources to empower communities and unlock their potential.

The strategy outlined that most physical activity took place outdoor, within 20 minutes of people's homes, and that all population groups walk more than they do any other type of activity whether to keep fit, for leisure or for travel. There was an opportunity to further integrate the physical activity provision across the county and a new commissioning model was in development which would form part of the whole system approach to physical activity. This would ensure that commissioned services contributed to strategic objectives, namely increasing rates of physical activity and reducing rates of inactivity.

**RESOLVED** to (1) engage in the work of developing a whole system approach to physical activity; and (2) support the Walk Derbyshire programme and its implementation.

**04/22      HOMELESSNESS STRATEGY UPDATE**      A presentation had been given to provide the board with an update on Derbyshire's Homeless Strategy, aimed to be delivered in Spring 2022.

The plan was to build upon the positive partnership working that had emerged in response to the pandemic. To develop a regional approach to tackling homelessness across Derbyshire and therefore reduce and prevent homelessness across the County.

There was a need to understand system blockages such as drug and alcohol services where there may be limited, or lack of, flexibility around appointments and adapting to the particular needs of an individual service user. As well as mental health where there may be over-reliance on emergency health care services such as A&E by individuals experiencing multiple and complex needs.

The emerging priorities of the strategy had been outlined within the presentation. As well as how Health and Wellbeing partners could support the implementation of the strategy.

**05/22**      **UPDATE ON ICS**      HJ had provided HWB members with a verbal update on the Integrated Care System.

The instigation of ICS had been delayed until 01 July 2022. The work to build an integrated care partnership was being continued. Phase one would be held between January to September, this would determine the shape of the partnership and produce the strategy. Once passed there would be two strategy bodies and the roles and responsibilities of each were yet to be determined.

There had been a suggestion that the Health and Wellbeing Board would have a development session and that this could take place at the next scheduled meeting. This had been agreed and would take place on 31 March 2022.

**06/22**      **BETTER CARE FUND**      On 30 September 2021 the Department of Health and Social Care, Ministry of Housing, Communities and Local Government, and NHS England published the Better Care Fund (BCF) planning guidance for 2021-22. The details of allocations of funding for the BCF 2021-22 were made available in February 2021 as per the guidance and the planning template was submitted nationally on the 16 November 2021. Approval of the plan was granted from 9 January 2022 and the Section 75 agreement needed to be signed by 31 February 2022.

The Derbyshire 2021-22 BCF Plan was, in effect, a continuation of the 2020-21 plan. The overarching vision and aims of the plan remained the same as they did in 2015-16.

There was a continued focus on community services being funded through the plan to reflect the work of the Joined Up Care Derbyshire Place workstream. This included services such as Community Nursing, Therapy,

Matrons, Evening Nursing, Clinical Navigation, Intermediate Care Teams (North), Social Care support packages, Reablement, Hospital Social Work Teams etc.

The full 2021-22 expenditure plan was attached as an appendix to the report.

The Plan had been developed in conjunction with key partners through the Joint BCF Programme Board and its Monitoring and Finance Group. The final plan was approved by the Joint BCF Programme Board, a delegated sub-group of the Derbyshire Health and Wellbeing Board, at its meeting on 27 January 2022, the Section 75 agreement would be updated in February 2022.

**RESOLVED** to note (1) the summary of the 2021-22 Better Care Fund Planning Requirements; and (2) the 2021-22 Better Care Fund Plan for Derbyshire.

**08/22**      **HEALTH AND WELLBEING ROUND UP** HJ had provided HWB members with a written report containing a round-up of key progress in relation to Health and Wellbeing issues and projects not covered elsewhere on the agenda.

**RESOLVED** to note the information contained in the round-up report.

**MINUTES OF DERBY AND DERBYSHIRE CCG AUDIT COMMITTEE  
HELD ON 20 JANUARY 2022**

**VIA MS TEAMS AT 9.30AM**

**Present:**

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

**In Attendance:**

Richard Chapman	Chief Finance Officer
Andrew Cardoza	Director, KPMG
Christopher Dean	Audit Manager, KPMG
Helen Dillistone	Executive Director of Corporate Strategy and Delivery
Debbie Donaldson	EA to Chief Finance Officer (minute taker)
Darran Green	Associate Chief Finance Officer
Frances Palmer	Corporate Governance Manager
Kevin Watkins	Business Associate, 360 Assurance

**Apologies:**

Suzanne Pickering	Head of Governance
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Item No	Item	Action
AC/2021/450	<p><b>Welcome and Apologies</b></p> <p>The Chair welcomed members to the Derby and Derbyshire Audit Committee.</p> <p>Apologies were received from Suzanne Pickering.</p>	
AC/2021/451	<p><b>Declarations of Interest</b></p> <p>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> <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><a href="http://www.derbyandderbyshireccg.nhs.uk">www.derbyandderbyshireccg.nhs.uk</a></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>	
<b>AC/2021/452</b>	<p><b>Minutes of the Derby and Derbyshire Audit Committee held on 18 November 2021 and Extraordinary Audit Committee held on 17 December 2021</b></p> <p>The Minutes of the Derby and Derbyshire Audit Committee held on 18 November 2021 and Extraordinary Audit Committee held on 17 December 2021 were presented.</p> <p>The Chair asked for an amendment to be made to the Minutes from 18 November 2021 on page 3, second bullet point be amended to read:</p> <p><i>"The government had agreed an overall financial settlement for the NHS for the second half of the year which provided £5.4bn funding (which included £1bn revenue and £500m capital to support the continued recovery for elective services)".</i></p> <p><b>The Minutes from the Derby and Derbyshire Audit Committee held on 18 November 2021 and Extraordinary Audit Committee held on 17 December 2021 were agreed and signed by the Chair.</b></p>	
<b>AC/2021/453</b>	<p><b>Matters Arising Matrix</b></p> <p>The Matters Arising Matrix was reviewed and updated.</p> <p>There were no further matters arising.</p>	
<b>AC/2021/454</b>	<p><b>KPMG - External Audit Plan 2021-22</b></p> <p>Christopher Dean presented KPMG's External Audit Plan for 2021-22 and highlighted the following:</p> <ul style="list-style-type: none"> <li>• Page 4 summary of the risks and areas of focus for the Audit this year.</li> <li>• Materiality thresholds had increased slightly from last year based on the way KPMG had calculated the benchmarks this year using both the allocations from H1 and H2 planning; it also included some uplift for the Covid spent.</li> <li>• KPMG would focus the Audit on the risks outlined on page 4 of the Audit Plan for 2021-22.</li> <li>• It was noted that with regard to the expenditure recognition risk, KPMG had considered the position of the system in determining this risk. Given this position, and with additional funding being available, there may be additional spend being recognised</li> </ul>	

	<p>around the end of the year. KPMG would continue to evaluate this, but this was how KPMG saw the risk at this time. If circumstances were to change then KPMG would look to update this risk.</p> <ul style="list-style-type: none"> <li>• Management Override Controls: this was a mandatory risk that Auditing Standards required KPMG to consider. KPMG did not consider there to be any specific risks to highlight; this was just factored into the audit approach.</li> <li>• Ongoing concern: this was to highlight to Committee that the CCG would cease to exist and would transfer into the Integrated Care Board. As a result, there would be additional disclosures required within the financial statements in respect of that and KPMG's audit report would highlight that.</li> <li>• Regularity work was highlighting KPMG's responsibility to determine regularity with parliamentary approvals.</li> <li>• Primary Care Commissioning: was highlighting the tests that KPMG do over primary care commissioning in light of the Service Auditor Reports and involvement over this area.</li> <li>• IFRS16: this was an area that was still under development but highlighted the procedures that KPMG would look to do should the CCG present some disclosures in its accounts regarding the impacts of IFRS16 coming in from next year.</li> <li>• VFM Reporting: was still ongoing at this time, as were risk assessments and would be reported to a later Committee. It was noted that nothing had changed in terms of the way that KPMG completed VFM reporting, given the changes that had come in last year.</li> </ul> <p>The following questions were raised:</p> <ul style="list-style-type: none"> <li>• Andrew Middleton asked whether KPMG had received any direction or instruction to look specifically at how the CCG had handled special Covid allocations, and whether the CCG had applied them in the way they were intended to be applied?</li> <li>• Christopher Dean reported that he had not seen anything specific in the group audit instructions. It was noted that the NAO had asked KMPG a question last year on this, and he suspected that they might do that again this year, but he had not seen anything yet. He went onto add that it would be covered in KPMG's expenditure recognition risk, as part of verifying that the spend had been used within the year and it had been correctly recorded within the year.</li> <li>• Jill Dentith referred to the 3-month delay in the start date for the ICB and asked whether this would impact on what KPMG were doing.</li> <li>• Christopher Dean reported that practically for this year, it would not change too much. The CCG was still a going concern and would transfer to the ICB on 1 July 2022; that event was still within 12 months of signing the Audit opinion. In terms of the months to July for the CCG, this was still to be decided by NHSE as to what they wanted Auditors to do for those 3 months; KPMG were awaiting guidance on this and would update Audit Committee at the future date.</li> </ul>	
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	<ul style="list-style-type: none"> <li>• Jill Dentith highlighted the proposed Glossop boundary changes, which would not impact the CCG up to 31<sup>st</sup> March, but asked whether we needed to take account of, or disclose anything as we move forward.</li> <li>• Christopher Dean reported that he was still consulting internally on the impact of the boundary changes. It was not known whether a disclosure regarding this was required in the current year.</li> <li>• Richard Chapman reported from conversations he had had with NHSEI that there would be a 3-month accounting period for the CCG, followed by a 9-month accounting period for the ICB. There would be a single audit to usual timescales for the whole of the 12-month period.</li> <li>• Christopher Dean reported that KPMG would be carrying out their audit at year end with a mixture of on site (if the Covid situation allowed) and remote working.</li> <li>• The Chair referred to issues regarding primary care commissioning spend and specifically the Capita input for several years, which was showing an increased risk, he asked what the assessment of this was, and had anything changed.</li> <li>• Christopher Dean reported that in terms of KPMG's approach nothing had changed; KPMG would perform standard testing themselves over the balance and do some sampling of that – the risk had not changed too much, it was more about the way KMPG were reporting it.</li> <li>• Richard Chapman reported that he had had a meeting with Christopher Dean to discuss any risks that we perceived might have changed or emerged during the year. The issue regarding Capita's calculation of deductions from practice payments, which were attributable to the LMC as their membership fee contribution, had been ongoing through the course of the year and was a known issue. It was believed that we now had the correct figures and that things were being worked through properly, but it took quite some effort to resolve it. From our perspective, he felt the Audit Plan highlighting that would give us some assurance on what was happening.</li> </ul> <p><b>Audit Committee NOTED the External Audit Plan 2021-22.</b></p>	
AC/2021/455	<p><b>360 Assurance</b></p> <p>Kevin Watkins presented 360 Assurance Progress report which highlighted work completed since the last Audit Committee:</p> <ul style="list-style-type: none"> <li>• Completed and reported on Stage 2 of their work supporting the Head of Internal Audit Opinion. Most of the core work had been completed, and there were no concerns to report.</li> <li>• Completed and reported on the Integrity of the General Ledger review, issuing a significant assurance in respect of the control environment examined.</li> <li>• Undertaken and reported on benchmarking of CHC, prescribing and Section 117 expenditure.</li> <li>• Undertaken fieldwork for two JUCD-wide exercises, examining arrangements for Transformation and Efficiency Planning and</li> </ul>	

	<p>providing a project assurance/support role for the JUCD Future People Services project. This work had been impacted with the local community being at Level 4 and responses had been delayed due to this. The JUCD Future People Services project had been briefly and temporarily placed on hold whilst the organisations within JUCD respond to the current operational changes that level 4 presented.</p> <ul style="list-style-type: none"> <li>• Continued to attend the CCG Transition Project Group and commenced the role of Project Assurance for the Finance Transition Project Board. The last meeting was cancelled due to Level 4. There were no major concerns for the close-down of the CCG and the establishment of the ICB. There was now an extra 3 months lead in time.</li> <li>• Undertaken follow-up work in response to updates provided by Management in respect of the implementation of actions.</li> <li>• Jill Dentith noted the email that Kevin Watkins had provided prior to Audit Committee regarding the Liberty Protection information.</li> <li>• Jill Dentith referred to the status of agreed actions. The implementation rate in 2021/22 was currently 100%. She felt that staff needed to be congratulated that they had been able to comply with the actions and within the timescales whilst being in Level 4.</li> <li>• The Chair referred to the financial governance decision making assignment – he had not seen Terms of Reference for this and asked whether he could have early sight of them. Kevin Watkins reported that the TOR for this had yet to be signed off, but as soon as they were, he would email them out.</li> <li>• Andrew Middleton (Finance Committee Chair) reported that the CCG's Finance Committee would be merging with System Finance and Estates Committee from January 2022. It was noted that he hoped to use this next 5 months to induct the SFEC leaders, Chairs and DoF's into understanding the areas of commissioning, which he suspected they had not focused on at all. He also felt they were not sighted on the extent and complexity of CHC spends, and Section 117. They also needed to embrace the wider agenda of tackling health inequalities, productivity, VfM, improving outcomes across the system and capital spend proposals.</li> <li>• Kevin Watkins reported that the Omicron variant wave of the Covid-19 pandemic and the subsequent escalation of the NHS response to a Level 4 national incident had had some impact on the delivery of their work. Notably, they had been requested to place the Personal Health Budgets review on hold and had experienced delays in the ability to progress development of the Terms of Reference for a potential review of Waiting List Coding. 360 Assurance hoped to progress these reviews when it was operationally possible to do so.</li> <li>• Kevin Watkins reported that they had completed the benchmarking of CHC, prescribing and Section 117 expenditure and provided the results to Management for analysis. Nationally available data was used for both CHC and prescribing expenditure, which enabled comparisons to be</li> </ul>	<p>KW</p>
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	<p>made with all other ICS's in the country. Key messages from the analysis of CHC spend were that the CCG's costs were broadly in line with the median in the Midlands region, particularly for non-fast track cases. It was slightly above the median fast track cases, although the overall trend since 2019 for fast-track expenditure was one of reducing costs, reflecting actions that had been taken to exert greater control on this area of spend.</p> <ul style="list-style-type: none"> <li>• Andrew Middleton reported that he was assured that there were no fundamental failures to follow procedures and protocols. However, PHBs, CHC and Section 117 were all on a rising trend of expenditure and we could not be benign about seeing expenditure going up by 10-15% when our resource allocation would at best go up by 2-3%. The other feature about them was they had a system dimension to them; they were interagency managed, multidisciplinary team managed etc. He went on to add that we well know that once you start crossing boundaries between organisations, that was where things fall through the cracks; this was where protocols did not necessarily get followed. Andrew Middleton would welcome Kevin Watkins thoughts about an internal audit investigation in these areas.</li> <li>• The Chair asked that Kevin Watkins put this into the draft plan for next year.</li> <li>• The Chair was also keen to see some benchmarking on prescribing.</li> <li>• Kevin Watkins reported that the analysis of prescribing costs offered the largest opportunity for benchmarking of the CCG's performance against other health communities. Data could be viewed by 'chapter' or by individual substance type, with the CCG's performance being displayed against all other ICS's in the country. Comparisons against the median cost for each chapter and substance were also provided, enabling rapid identification of specific substances where prescribing patterns were higher (and lower) than the national average.</li> <li>• Kevin Watkins added that there were sample graphs on prescribing contained within the report. The first graph gives an overall headline, which indicated that the CCG was slightly lower than the middle of the pack in terms of STP's across the country regarding overall spend per capita.</li> <li>• Kevin Watkins reported that the TOR had now been finalised regarding the ongoing process to ensure that the CCG transitioned into the ICB. It was noted that a section would be included in 360 Assurance's progress report going forwards on transition.</li> </ul> <p><b>The Audit Committee:</b></p> <ul style="list-style-type: none"> <li>• <b>Noted the key messages and progress made against the Internal Audit Plan since the last meeting.</b></li> <li>• <b>Approved the proposed adjustments to the 2021/22 Internal Audit Plan summarised within the progress report.</b></li> <li>• <b>Received the information and guidance papers produced by 360 Assurance.</b></li> </ul>	KW
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	<p><b>Integrity of the General Ledger &amp; Financial Reporting - Final Report:</b></p> <p>Kevin Watkins presented the final Integrity of the General Ledger and Financial Report and highlighted the following:</p> <ul style="list-style-type: none"> <li>• The overall objective of the review was to assess the adequacy of controls over the CCG's general ledger and its financial reporting arrangements.</li> <li>• The testing of the expected system controls was supplemented and informed by a short Finance Department staff survey and structured interviews with the Chairs of the Audit and Finance Committees.</li> <li>• There was one advisory recommendation that came out of the Finance Staff survey.</li> <li>• It was noted that the process for the maintenance of the general ledger was strong.</li> <li>• The Chair asked that Audit Committee's thanks be passed to the Finance team for their excellent work.</li> </ul> <p><b>Head of Internal Audit Opinion Stage 2 Report:</b></p> <p>Kevin Watkins presented Head of Internal Audit Opinion Stage 2 Report and highlighted the following:</p> <ul style="list-style-type: none"> <li>• It was noted that everything was going well and there were no concerns over the nature of the opinion that would be provided by 360 Assurance at the end of the year at this stage.</li> <li>• With regard to the GBAF, one low risk recommendation to further enhance controls in place had been made.</li> <li>• It was noted in the Finance survey that low numbers of staff had expressed concern about the resourcing of the Finance department and there had been an issue regarding training.</li> <li>• Richard Chapman had reflected on the survey results and reported that there had recently been some resourcing gaps due to staff leaving the CCG; those gaps were now being rapidly recruited to. The staff who had left the Finance team, had moved on to further develop their careers.</li> <li>• Richard Chapman reported that someone in the Finance team had reported a concern about journal protocols and processes and the importance of segregation of duties. This had been investigated by Darran Green and further processes had been put in place to address this concern. It was noted that there was now a nominated individual within the department to whom staff could raise any concerns that they had.</li> </ul> <p><b>Audit Committee NOTED:</b></p> <ul style="list-style-type: none"> <li>• <b>The Significant Assurance provided by Internal Audit on the General Ledger and Financial reporting.</b></li> <li>• <b>That there were no concerns for management in relation to the Stage 2 Head of Internal Audit Opinion.</b></li> </ul>	
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<p><b>AC/2021/456</b></p>	<p><b>Finance Report</b></p> <p>Richard Chapman gave a verbal Finance update highlighting the following:</p> <ul style="list-style-type: none"> <li>• As at M8 the CCG had met all its targets.</li> <li>• There were some underpinning assumptions; we were expecting £1.3m of Covid reimbursement and a small ERF reimbursement that would give a favourable YTD reported variance of £730k.</li> <li>• FOT as at M8 remains break-even having taken into the position £5.8m of additional roles for re-imburement in Primary Care Co-commissioning and having released into the YTD position £700k surplus £1.6m of H2 contingency, which was in line with the plan that was signed off by Governing Body.</li> <li>• We had carried out our usual analysis of run rate on the straight-line extrapolation compared to FOT. We had retained £2.5m of flexibility to deliver that position.</li> <li>• CHC pressures and our UDL prescribing pressure were still there. CHC was driven by increased discharges across the system, and prescribing driven by the volume rather than the price of prescriptions in Primary Care.</li> <li>• Richard Chapman was comfortable with the year-end position.</li> <li>• Richard Chapman had an early sight of M9, and a detailed report would be taken to the next Finance Committee.</li> <li>• The CCG was in receipt of several fairly material last-minute allocations from NHSE.</li> <li>• The System had received £5.5m for community diagnostics hubs late in the year (not all of which could be spent), together with £2m of cancer funding.</li> <li>• At M9 the CCG's and UHDB's position would move to surplus rather than break-even forecast FOT, simply as a result of those allocations being made very late in year and not being able to be spent. The allocations would therefore go to a bottom-line surplus.</li> </ul> <p><b>The Audit Committee NOTED the Finance Update given by Richard Chapman.</b></p>	
<p><b>AC/2021/457</b></p>	<p><b>Direct award NHS Standard Contracts for existing spot purchase placements</b></p> <p>Darran Green presented this report and asked for retrospective approval for the awards of these individual placement contracts.</p> <p>The following was highlighted from the report:</p> <ul style="list-style-type: none"> <li>• It was recognised that they should have had NHS Standard Contracts in place, together with the fact that they were not in place at the time Individual Placement Agreements (IPAs) were ordered.</li> <li>• It was best practice for these to get retrospective approval by Audit Committee, even though in normal circumstances they would not require that.</li> </ul>	

	<ul style="list-style-type: none"> <li>• This paper acknowledged that the contacts were not in place and had been presented to Audit Committee for retrospective approval.</li> <li>• To date contracting had identified that there were 87 patients with IPAs placed with 32 providers but with no NHS Standard Contract Particulars in place.</li> <li>• To address this the Contracting Team had drafted 32 NHS Standard Contract Particulars to support the IPAs that had been raised.</li> <li>• Additionally, in line with the CCG's governance requirements each of the direct awards would require a Single Tender Waiver (STW) to be completed (currently being progressed) in-order for the contracts to be issued, this would also provide a clear audit trail of all the retrospective agreements to fund the individual placements.</li> <li>• The Chair asked whether the private providers were accepting of the NHS standard conditions?</li> <li>• Darran Green reported that as far as he was aware, we had been able to put those terms and conditions in place and it was something that the whole NHS was now being encouraged to do with its private providers.</li> <li>• The Chair asked whether this report also needed to go to Governance Committee?</li> <li>• Richard Chapman reported that these private providers were providing IPAs to patients and were, in most cases, the best option for the provision of care to patients with very specific needs. The CCG would have gone through our standard frameworks, and not received any offers of provision on those frameworks. These providers were those which were able to meet the specific needs of those patients. The risk identified was that no formal contracts were in place, and therefore there was no means to formally hold those providers to account; they were bespoke contracts.</li> <li>• Retrospective approval was being sought because the provision was already happening. The patients were already placed with these providers. We had identified this risk and we were putting in place bespoke contracts to deal with this risk, as best as we were able, to mitigate it.</li> <li>• Jill Dentith felt the paper was very helpful in terms of describing the issues. However, she felt that Governance Committee should discuss/review the process being adopted. It was suggested that a report be presented to Governance Committee on a quarterly basis to ensure that the actions that were being proposed had been implemented. Jill Dentith reported that there also needed to be a discussion regarding Value for Money and duplicate payments; this may be something that needed to come back to Audit Committee at a future date.</li> <li>• The Chair reported that Audit Committee did endorse this approach, but would like to see further discussion about the process being followed up through Governance Committee rather than Audit Committee</li> <li>• Andrew Middleton would welcome a discussion at Governance Committee about this. He went on to add that he would also</li> </ul>	
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	<p>welcome a discussion with Midlands and Lancs CSU who do this work on behalf of the CCG, as he felt this clutch of retrospectives had probably highlighted a system control issue. He was concerned that we may not be following exactly the right procedure in terms of governance for approvals of IPAs.</p> <ul style="list-style-type: none"> <li>• Richard Chapman clarified that the report was not saying that there were any identified issues with clinical appropriateness and suitability of service. It was also not saying that there were any issues with procurement, and we had not stepped outside of standard procurement protocols. What the report was saying was that there were no formal contracts in place with these private providers, which had been appropriately sourced, and were clinically appropriate services, what the CCG wanted to do was put NHS Standard Contracts in place.</li> <li>• Darran Green agreed to contact the colleague who wrote this paper and ask them to provide a report to the Governance Committee for further discussion.</li> </ul> <p><b>The Audit Committee endorsed this approach but would like to see further discussion about the process being followed up through Governance Committee rather than Audit Committee.</b></p> <p><b>Audit Committee endorsed the direct awards for retrospective NHS Standard Contract Particulars being issued, to support Individual Placement Agreements being called off the overarching contract.</b></p>	DG
AC/2021/458	<p><b>Single Tender Waivers</b></p> <p>Darran Green reported that as per the DDCCG's Scheme of Delegation, the approval of Single Tender Waivers was to be monitored by the Audit Committee.</p> <p>This paper included a report for the STWs received and approved following those reported at the September Audit Committee and up to 4<sup>th</sup> January 2022.</p> <p>Darran Green reported that this paper in future, as requested by Audit Committee, would highlight the governance route that some of these decisions were being taken through.</p> <p><b>Audit Committee NOTED the report of Single Tender Waivers approved by the Chief Finance Officer.</b></p>	
AC/2021/459	<p><b>Aged Debt Report</b></p> <p>Darran Green presented the Aged Debt Report as at 31st December 2021; the report identified the total outstanding debt owed to the CCG in accounts receivables and payables.</p> <p>Darran Green highlighted the following:</p> <ul style="list-style-type: none"> <li>• A solution to the aged debt had been agreed with Chesterfield Royal Hospital.</li> </ul>	

	<ul style="list-style-type: none"> <li>• Accounts payable credit notes: Hill Care Services Ltd - Credit balance to be cleared against invoices paid in January 2021.</li> <li>• It was noted that there had been improvement on last year's report with the clearance of the outstanding debt with NHS Birmingham and Solihull CCG.</li> <li>• It was important that debts were cleared up before the end of the CCG on 30 June 2022; a real focus would be made in the lead up to end of June.</li> <li>• Andrew Middleton referred to non-NHS payable credit notes over 90 days and asked whether Audit Committee needed to know that we were in dispute over £12.98?</li> <li>• The Chair reported that we should not disregard anything that might point to a wider systemic problem.</li> </ul> <p><b>Audit Committee NOTED the report contents regarding the level of debt owed to the CCG and the number of days this has been outstanding.</b></p>	
AC/2021/460	<p><b>Accruals Report</b></p> <p>Darran Green explained that this report detailed the movement in accruals from M9 2020-21 and year-end 2020-21 with M9 2021-22 and explained the differences by exception.</p> <p>It was noted that the prepayments had been stripped out of the M9 2020-21 to 2021-22 comparison due to the unique situation where the block contracts were paid one month in advance during 2020-21 to ensure the NHS providers had enough cash to fight the pandemic.</p> <p>It was noted that Darran Green and Georgina Mills reviewed this monthly to ensure they both understood the movements, and as an audit trail. KPMG would be focusing on this area as part of their Audit.</p> <p><b>Audit Committee NOTED the accruals in the ledger in December 2020-21, March 2021-22 and December 2021-22.</b></p>	
AC/2021/461	<p><b>Freedom to Speak Up Report</b></p> <p>Jill Dentith presented the Freedom to Speak Up Report and highlighted the following:</p> <ul style="list-style-type: none"> <li>• The Ambassadors continued to meet monthly; although Jill Dentith was unable to attend the last meeting.</li> <li>• The Ambassadors were dealing with a number of cases, all of which seemed to be employee relations based.</li> <li>• Ambassadors were not there to resolve issues, but to signpost people and support them through a process rather than rectify situations.</li> <li>• There was positive feedback from the Ambassadors.</li> <li>• The team were hoping to implement an IT system to support this process, but there had been a few technical problems.</li> </ul>	

	<ul style="list-style-type: none"> <li>• There had been a few conversations within the HR system regarding the Ambassadors supporting staff through exit interviews, and how we could support the Ambassadors to do this. Audit Committee welcomed this suggestion and asked that this be taken as an action.</li> <li>• The Ambassadors who had stepped forward were doing a sterling job and were being supported by HR colleagues.</li> <li>• There had been a positive response from staff to the Ambassadors.</li> <li>• It was important to note that there were positives to remote working, but there were also some downsides with people feeling isolated working from home. Staff now had someone, closer to the work situation, that they could contact in order to voice concerns and seek help.</li> <li>• With the majority of staff transitioning into the ICB, a follow up in depth review of this service, Audit Committee felt sure, would be welcomed by the successor organisation.</li> </ul> <p><b>Audit Committee thanked Jill Dentith for her update.</b></p>	HD
AC/2021/462	<p><b>Annual Report and Annual Governance Update</b></p> <p>Frances Palmer gave an Annual Report and Annual Governance update and highlighted the following:</p> <ul style="list-style-type: none"> <li>• M9 Annual Governance Statement had been submitted this week and responsible Officers within the CCG had provided their responses regarding control issues at M9.</li> <li>• The final timetable for submission was received on 11<sup>th</sup> January 2022 and publication was as follows: <ul style="list-style-type: none"> <li>• by 18<sup>th</sup> January 2022 (5pm) – Submit Month 9 – Annual Governance Statement Control Issues certification to NHSE.</li> <li>• by 11<sup>th</sup> March 2022 (noon) – CCG to submit a draft copy of the Head of Internal Audit opinion.</li> <li>• by 26<sup>th</sup> April 2022 (noon) – CCG to submit draft Annual report (excluding accounts and staff).</li> <li>• 22<sup>nd</sup> June 2022 (9am) – full audited and signed annual report, as approved in accordance with the CCG scheme of delegation and signed and dated by the Accountable Officer and appointed auditors, as one composite document.</li> <li>• date TBC – CCG to publish Annual reports on their website; and</li> <li>• by 30<sup>th</sup> September 2022 – CCG to present Annual Report and Accounts to a public meeting.</li> </ul> </li> <li>• Future Audit Committee meeting dates had been aligned to suit the above deadlines.</li> <li>• It was noted that Suzanne Pickering and Frances Palmer were currently finalising a project plan narrative for the first draft of the report, with a view to bringing the draft and Governance Statement to Audit Committee’s meeting in March.</li> </ul>	

	<b>Audit Committee NOTED the 2021/22 update for the Annual Report and Annual Governance Statement.</b>	
<b>AC/2021/463</b>	<p><b>GBAF 2021/22 Quarter 3</b></p> <p>Frances Palmer presented Governance Body Assurance Framework 2021-22 Q3 and highlighted the following:</p> <p>The following strategic risks had changed in risk score during Q3, October to December 2021.</p> <p><b>Strategic Risk 7:</b> CCG staff retention and morale during the transition would be adversely impacted due to uncertainty of process and implications of the transfer to the ICS, despite the NHSEI continuity of employment promise.</p> <p>The responsible Committee was the Governance Committee.</p> <p>The risk score had <b>increased</b> from a moderate 6 to a high score of 12.</p> <p>The reason for the increase in score was:</p> <ul style="list-style-type: none"> <li>• The CCG had concerns about losing staff and the impact of that was higher than the current probability score of 2.</li> <li>• The risk score increase also aligns the with the ICB Transition risk 1 within the register.</li> </ul> <p><b>Strategic Risk 8:</b> If the CCG was not ready to transfer its functions or had failed to comprehensively and legally close down the organisation, or if the system was not ready to receive the functions of the CCG, the ICS operating model could not be fully established.</p> <p>The responsible Committee was the Governance Committee.</p> <p>The risk score had <b>reduced</b> from a very high 16 to a high score of 10.</p> <p>The reason for the reduction in score was:</p> <ul style="list-style-type: none"> <li>• Version 2 of the Due Diligence update was received and being incorporated into project plans.</li> <li>• 360 Audit had joined the CCG Transition Project Group which would provide assurance on the management of the project.</li> <li>• The Draft Due Diligence Checklist was presented to CCG Audit Committee on 17th December and subsequently submitted as part of the regional submission due by the end of December 21 and uploaded 20th December 21.</li> <li>• The GBAF risk was now aligning with the score for risk 7 on the Transition Risk Register.</li> <li>• The Chair reported that both these movements were noted by the Governing Body at its meeting in January.</li> <li>• The Chair asked why the assurances for the green and net zero carbon agenda sat against GBAF Risks 1 and 2. He felt</li> </ul>	

	<p>that it was important that we started to manage that green agenda through our formal assurances processes, but he was not aware where they sat on the GBAF.</p> <ul style="list-style-type: none"> <li>• Helen Dillistone reported that when we started to look at this important programme of work, we were looking at it purely through the lens of the structural and infrastructure within the NHS, eg how we use our buildings, where we travelled to, and underlying HR policy. When we started to get into some of the detail and priorities and identifying particularly around the use of medicines and the use of inhalers for example, we started to identify that there were some stark housing inequalities with particular communities and respiratory diseases and the management of some of those respiratory diseases. She was keen, after speaking with our Public Health teams, that we made those strategic connections and that we do not just see this work as something about buildings, processes and people working within the NHS healthcare setting, but also about the impact that the broader agenda had on people's health and wellbeing. We were starting to look at how we connect this with the support that sits within the Health and Wellbeing Board, to have a more strategic oversight to be able to drill down to very specific actions that the NHS could take.</li> <li>• Andrew Middleton reported that we all had to be mindful of our impact on the environment and on staff wellbeing, consumption of energy etc. He felt that there needed to be a prompt on the templates of Committee front cover sheets asking whether the green/workforce impact had been considered on all our reports.</li> </ul> <p><b>Audit Committee RECEIVED and NOTED the 2021/23 Quarter 3 (October to December 2021) Governing Body Assurance Framework.</b></p>	
AC/2021/464	<p><b>Risk Report</b></p> <p>Frances Palmer presented the Risk Report and highlighted the following:</p> <p>The decrease in risk score for:</p> <ul style="list-style-type: none"> <li>• <u>Risk 06</u> relating to the demand for Psychiatric intensive Care Unit beds (PICU).</li> <li>• <u>Risk 32</u> relating to the 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.</li> </ul> <p>The increase in risk score for:</p> <ul style="list-style-type: none"> <li>• <u>Risk 09</u> relating to sustainable digital performance.</li> <li>• <u>Risk 23</u> relating to CCG staff capacity compromised.</li> <li>• <u>New Risk 42</u> relating to climate change.</li> <li>• <u>Closure of Risk 38</u> relating to the quality of care potentially being impacted by patients not receiving a care needs review in a</li> </ul>	

	<p>timely way as a result of the Covid pandemic and the requirement for some of the Midlands and Lancashire Commissioning Support Unit (MLCSU) Individual Patient Activity /Continuing Health Care (CHC) services to redirect service delivery to support system wide pressures.</p> <p>It was noted that the CCG was still operating at Level 4, and there had been no notification to change that level. If the CCG received notification from the Centre to change the level of escalation it would be reported to Governing Body. It was noted that the vaccination programme, currently being rolled out, was a priority for the CCG.</p> <p><b>Audit Committee RECEIVED and NOTED:</b></p> <ul style="list-style-type: none"> <li>• <b>The Risk Register Report.</b></li> <li>• <b>Appendix 1 as a reflection of the risks facing the organisation as at 31<sup>st</sup> December 2021.</b></li> <li>• <b>Appendix 2 which summarised the movement of all risks in December 2021.</b></li> </ul>	
AC/2021/465	<p><b>Committee Meeting Business Log</b></p> <p>Frances Palmer presented the Committee Meeting Logs which summarised discussions and approved items at the following NHS Derby and Derbyshire CCG's committees, that had been formally ratified and not yet presented to the Audit Committee:</p> <ul style="list-style-type: none"> <li>• Clinical &amp; Lay Commissioning Committee</li> <li>• Engagement Committee</li> <li>• Finance Committee</li> <li>• Primary Care Commissioning Committee (Confidential &amp; Public)</li> <li>• Quality &amp; Performance Committee</li> </ul> <p>Following a request at the last Audit Committee, more detail had been added to the Primary Care Commissioning Committee logs.</p> <p>The Governance Committee log would be presented at the next Audit Committee meeting once the minutes from November 2021 had been ratified at the next Governance Committee meeting.</p> <p><b>Audit Committee NOTED the NHS Derby and Derbyshire CCG's Committee Meeting Logs.</b></p>	
AC/2021/466	<p><b>Conflicts of Interest Update</b></p> <p>Frances Palmer presented the Conflicts of Interest (COI) Update and highlighted the following:</p> <ul style="list-style-type: none"> <li>• NHSE had been notified of a COI breach on 10<sup>th</sup> December.</li> <li>• The finance team had been completing their biannual National Fraud Initiative exercise, and one of the elements of this</li> </ul>	

	<p>exercise was comparing payroll members to Companies House in order to highlight Directorships and therefore any COIs that we should be aware of.</p> <ul style="list-style-type: none"> <li>• Following further investigations, the team raised their concern with the corporate governance team that a PLACE Lead for the CCG, who was also a director of a private company, had not included this organisation on their declaration of interest form.</li> <li>• The company received an income from the CCG, and following this, Clive Newman, who was the Director of GP Development, had spoken to the individual and the individual had subsequently apologised and said it was an innocent oversight.</li> <li>• Invoices for the Company were approved by Dr Steve Lloyd and his Directorate and not the PLACE Lead, and it was agreed that the individual should complete a new declarations of interest form, so that we have it formally recorded.</li> <li>• The Chair asked that credit be passed to the Finance Team for doing very thorough checks; it did highlight what turned out to be an oversight, but clearly it was a potential indicator of fraud. The Chair was assured that this breach had been properly dealt with and addressed.</li> <li>• Jill Dentith was also assured, but asked whether the individual had any personal gain from the contract that was in place?</li> <li>• Frances Palmer reported that the individual had quite minimal employment duration with the organisation of 3 hours per week.</li> <li>• Jill Dentith was assured that the mechanism had worked but was keen that we shared learning from this; we needed to ensure that our clinical colleagues were clear on the rules and regulations of making COI declarations.</li> <li>• The Chair was content that the individual had not attempted to drive new business; the conflict was that they had just not fully declared their position.</li> <li>• Frances Palmer reported that NHSEI had reported that they were aiming to get some new COI guidance out soon.</li> </ul> <p><b>Audit Committee NOTED the Conflicts of Interest Update Report.</b></p>	
AC/2021/467	<p><b>Any Other Business</b></p> <p>There was no further business.</p>	
AC/2021/468	<p><b>Forward Planner</b></p> <p>Audit Committee NOTED the Forward Planner.</p>	
AC/2021/469	<p><b>Assurance Questions</b></p> <ol style="list-style-type: none"> <li>1. Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance processes?</li> </ol> <p>Yes.</p> <ol style="list-style-type: none"> <li>2. Were the papers presented to the Committee of an appropriate professional standard, did they incorporate a detailed report</li> </ol>	

	<p>with sufficient factual information and clear recommendations?</p> <p>Yes.</p> <p>3. Were papers that have already been reported on at another committee presented to you in a summary form?</p> <p>Some were.</p> <p>4. Was the content of the papers suitable and appropriate for the public domain?</p> <p>Not entirely.</p> <p>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?</p> <p>Yes.</p> <p>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?</p> <p>No.</p> <p>7. What recommendations does the Committee want to make to the Governing Body following the assurance process at today's Committee meeting?</p> <p>Governing Body would be supplied with a standard Assurance Report from the meeting today.</p>	IG
AC/2021/470	<p><b>Date of Next Meeting:</b> Thursday 17 March 2022 at 9.30am</p> <p><b>Future Meetings:</b></p> <p>Tuesday 26 April 2022 at 1.00pm</p> <p>Tuesday 24 May 2022 at 1.00pm</p>	

Signed: ..... Dated: .....  
(Chair)

**MINUTES OF DERBYSHIRE ENGAGEMENT COMMITTEE MEETING HELD ON  
18 January 2022 VIA MICROSOFT TEAMS  
11:15 - 13:15**

<b>Present:</b>		
Martin Whittle – Chair	MW	Governing Body Lay Member DDCCG
Helen Dillistone	HD	Executive Director Corporate Strategy and Delivery DDCCG
Maura Teager	MT	Lead Governor University Hospitals of Derby and Burton NHS Foundation Trust
Margaret Rotchell	MR	Public Governor CRH
Rebecca Johnson	RJ	Health Watch Derby
Simon McCandlish	SMc	Governing Body Lay Member DDCCG (Deputy Chair)
Chris Mitchell	CM	Governing Body Member Derbyshire Healthcare NHS Foundation Trust
Lynn Walshaw	LW	Deputy Lead Governor, Derbyshire Community Health Service
Beverley Smith	BSm	Director Corporate Strategy & Development DDCCG
Steven Bramley	SB	Lay Representative
Tim Peacock	TP	Lay Representative
Ian Shaw	IS	Lay Member for Primary Care Commissioning
Jocelyn Street	JS	Lay Representative
Vikki Taylor	VT	ICS Director Lead Joined Up Care Derbyshire
Sean Thornton	ST	Assistant Director Communications and Engagement DDCCG and Joined Up Care Derbyshire
Karen Lloyd	KL	Head of Engagement Joined Up Care Derbyshire
<b>In Attendance:</b>		
Lisa Walton	LWa	Personal Assistant DDCCG
Claire Haynes	CH	Engagement Manager DDCCG
Hannah Morton	HM	Engagement Specialist NHS Derby and Derbyshire Clinical Commissioning Group/Joined Up Care Derbyshire
Harriet Nichol	HN	Engagement Involvement Manager Healthwatch

<b>Item No.</b>	<b>Item</b>	<b>Action</b>
<b>EC/2122-126</b>	<b>WELCOME APOLOGIES AND QUORACY</b>  MW welcomed everyone to the meeting and agreed the meeting was quorate.	
<b>EC/2122-127</b>	<b>DECLARATIONS OF INTEREST</b>  MW reminded Committee members of their obligation to declare any interest they may have on any issues arising at Committee meetings which might conflict with the business of the CCG.  Declarations declared by members of the Engagement Committee are listed in the CCG's Register of Interests and included with the meeting papers. The Register is also available either via the corporate secretary to the Governing Body (GB) or the CCG website at the following link: <a href="http://www.derbyandderbyshireccg.nhs.uk">www.derbyandderbyshireccg.nhs.uk</a>  No declarations were made for this meeting.	

<p><b>EC/2122-128</b></p>	<p><b>ICB UPDATE</b></p> <p>VT informed the group that on 24 December 2021 national communications were issued which confirmed the statutory establishments of the Integrated care board would be delayed from 1 April 2022 for three months to 1 July 2022.</p> <p>We are awaiting a revised national timeline which will then be aligned with the local timeline and revise dates.</p> <p>HD noted there were pros and cons to the delay. The CCG will continue until 30 June and the ICB will run alongside parallel to the closedown of the CCG.</p> <p>The Governing Body has met to discuss the implications and will continue to meet until the end of June. All the committees will therefore also need to continue to meet until then.</p> <p>A key area of development to establish the ICB is to identify the committees the ICB will need. The ICB will have a number of statutory functions with about 80% of those which the CCG currently have assigned. One of the biggest changes will be how the system works together.</p> <p>The ICB will have more strategic ownership over the people agenda and specific requirements over how digital and data is used.</p> <p>HD gave an overview of the proposed committees for the ICB. There will be 7 committees, with a minimum of two statutory ones.</p> <ul style="list-style-type: none"> <li>• <b>Audit and Governance</b></li> <li>• <b>Remuneration</b></li> <li>• Finance and Estates</li> <li>• People Strategy and Culture</li> <li>• Quality and Performance</li> <li>• Strategic Population Health and commissioning</li> <li>• Public Partnerships</li> </ul> <p>The remaining committees will work alongside the wider system and not exclusively to the ICB.</p> <p>Public Partnerships is to understand the statutory nature of public engagement and will have a broader understanding of the system than the current format. HD noted the broader conversation needed with the ICP, to create a committee that services the ICB Board and also supports the broader system.</p> <p>ST informed the group that, as part of the delay it had been expected there would be an Engagement Strategy submitted in March, though that date may now change due to the delay.</p> <p>The new chair of the ICB John MacDonald is keen that the system committees are not just run by ICB Execs and non-execs, but that there is a true system ownership.</p> <p>MT raised concerns that, as a group to hold the non-execs to account for the organisation, and how they engage with the system, there will be issues with time commitments due to when they were recruited, it was for only one organisation.</p>	<p><b>HD</b></p>
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	<p>MT enquired if there had been any new risks identified due to the delay.</p> <p>HD responded with the issues, one is that with a protracted delay, there will be a protracted uncertainty.</p> <p>There are also concerns around 'double running' two organisations as one closes, and one opens and there will be costs involved to be mindful of.</p> <p>MW stated the CCG Finance committee has stopped meeting and has merged with the system finance committee.</p> <p>MW enquired when HD would be able to bring back to the committee an update and HD stated that this would be about April for more formal updates, but that it might be useful to keep it as a standing item until the completion of the transition.</p> <p>MW informed the group that any questions relating to the ICB should be directed to HD.</p> <p>The list of proposed committees will be shared with the next set of papers with the understanding that this is an ever-evolving project and may change.</p> <p><b>ACTION: LF to send HD's presentation with the minutes.</b></p> <p><b>The Engagement Committee NOTED the verbal update.</b></p>	<p>LF</p>
<p><b>EC/2122-129</b></p>	<p><b>STANDING ITEM: ICS' GOVERNANCE REQUIREMENTS AND FUTURE COMMITTEES</b></p> <p>This item was discussed under EC/2122-128.</p> <p><b>The Engagement Committee NOTED the verbal update.</b></p>	<p><b>HD</b></p>
<p><b>EC/2122-129b</b></p>	<p><b>STANDING ITEM: ICS COMMUNICATIONS AND ENGAGEMENT PLAN</b></p> <p>KL updated on mapping our Engagement approaches, methods, tools and techniques to the ICS Guidance on working with People and Communities.</p> <p>KL noted the ICS guidance which came out last year set out ten good practice principles to be working to. The guidance for that was to be done for around mid-March, however the ICB delay will affect that. KL is keen to work together with the Engagement Committee to ensure the principles are met.</p> <p>KL gave the Committee assurance that the principles are being upheld.</p> <p>KL informed the committee on work in the system with other experience and engagement leads which will enrich the collective information for all in the system. A learning network is being created to share knowledge.</p> <p>There is work ongoing for co-production framework. There are good examples within the system however they are not systematic across the board. The aim would be to embed co-production from the start of a project.</p>	<p><b>KL</b></p>

	<p>KL presented the ideas to the MH Board recently.</p> <p>The Glossop transition work is commencing some focus groups to ensure the population feel listened to.</p> <p>KL and ST will meet to discuss the approach to the Engagement strategy and how that will feed back to the Engagement Committee and will bring an update to the next meeting.</p> <p><b>ACTION: BF to the next meeting.</b></p>	
<p>EC/2122-130</p>	<p><b>UPDATE COMMS AND ENGAGEMENT RESPONSE TO SYSTEM PRESSURES AND VACCINATION PROGRAM</b></p> <p>ST Presented from the shared papers and informed the group of the vaccination programme and system pressures communications.</p> <p>ST informed the group of headlines for current work being undertaken.</p> <p><b>Vaccination programme</b></p> <ul style="list-style-type: none"> <li>• 12-month focus</li> <li>• Multi-faceted</li> <li>• Supporting services and system to achieve challenging targets</li> <li>• Treading new ground in our community approach to campaigns</li> <li>• Developing new relationships that can be utilised for other tasks</li> </ul> <p><b>System Pressures</b></p> <ul style="list-style-type: none"> <li>• Extension of winter communications and engagement plan</li> <li>• Shift from traditional service navigation/usage messages to more stark messaging e.g., to families</li> <li>• Aimed for broadcast media – and achieved</li> <li>• Convergence of pressure and vaccination – general practice</li> </ul> <p>ST noted that there had been 2.24m vaccinations delivered in Derbyshire since 08/12/20 and 839.4k first doses, 783.7k second doses and 617.9k boosters have been done. ST stated that as a result of this, there was significantly fewer hospital admissions.</p> <p>ST informed the committee that from 13 December 2020 the CCG was challenged by the Prime Minister to offer booster vaccinations to every adult by the end of December. This was a huge ask and 205,000 vaccinations were delivered between 13 December and 11 January. 83.1% of eligible people have now been vaccinated.</p> <p>ST gave a brief overview of how the communications for the Derbyshire population had been done to ensure everyone knew when where and how to receive their vaccinations, which included a BSL short video.</p> <p><a href="https://www.youtube.com/watch?v=pnl88B0gP_s&amp;t=223s">https://www.youtube.com/watch?v=pnl88B0gP_s&amp;t=223s</a></p> <p>ST shared the approach taken to help with inequalities which stretched the messaging from reaching out to everyone, to trying to target specific communities which were more vulnerable. There are now significant links with</p>	<p>ST</p>

	<p>existing community networks and figures as a result of this work and further work is ongoing to reach the remaining unvaccinated people.</p> <p>ST explained the winter plan objectives which involved two strands, prevention and operational.</p> <p>Priorities included encouragement of uptake of flu vaccinations and use of the NHS 111 online service.</p> <p>ST flagged in terms of pressures; a large issue has been about the flow through hospitals. Admissions have been relatively normal, however due to discharge packages not being available, people have been medically fit to be discharged, but not able to and this has increased the Length of Stay rates.</p> <p>Campaigns running in January include:</p> <ul style="list-style-type: none"> <li>• GP Access and pressure – urgent business only</li> <li>• NHS App</li> <li>• NHS 111</li> <li>• Flu – Public and staff</li> <li>• Winter week</li> <li>• Cleaning for Confidence</li> <li>• Keep antibiotics working</li> <li>• Health and care pressure guide</li> </ul> <p>TP noted the excellent work the communications team have undertaken and there was some interesting learning to be taken from the research.</p> <p><b>The Engagement Committee NOTED the verbal update.</b></p>	
<p><b>EC/2122-131</b></p>	<p><b>UPDATE ON URGENT TREATMENT CENTRES</b></p> <p>HM updated the committee on the pre-engagement work to learn and understand what people's perceptions of what urgent care services are, including why and how people use them.</p> <ul style="list-style-type: none"> <li>• What is most important when accessing centres</li> <li>• Understand patient flow</li> <li>• Whether used any other services before</li> </ul> <p>A survey was launched on 13 January which will run until the end of February and is open to all Derbyshire residents. Currently there are 198 responses.</p> <p>The second phase involves more focused targeted work. In February March there will be a number of focus groups launched. There are 68 people currently interested in attending with dates to be confirmed.</p> <p>The Urgent Care Team are conducting an equalities impact assessment to ensure the correct audiences are being reached.</p> <p>SB noted that the surveys being sent out are not always relevant to the area where there are no UTC's. HM will feed this back.</p> <p><b>Action: Bring forward to the next meeting.</b></p>	<p><b>HM</b></p>

	<b>The Engagement Committee NOTED the update received.</b>	
<b>EC/2122-132</b>	<p><b>ACCESSIBLE SERVICES FOR DEAF PEOPLE</b></p> <p>CH concerns from the deaf community with regard to mental health helpline about covid. Feedback was that it was not as accessible to them. This highlighted concerns about equitable access.</p> <p>This is a system wide issue and CH wanted the committee to understand the implications that may come from work CH proposes to undertake. CH requested the committee's approval to commission this work.</p> <p><b>The Engagement Committee APPROVED the request.</b></p>	<b>CH</b>
<b>EC/2122-133</b>	<p><b>MH MEMBERSHIP</b></p> <p>This item was removed from the agenda having been dealt with.</p>	
<b>EC/2122-134</b>	<p><b>S14Z2 LOG</b></p> <p>ST updated the committee on the current log situation.</p> <ul style="list-style-type: none"> <li>• <b>Erewash PCN - The</b> Local Vaccination Service provided through general practice would cease on the 17th December, patients will be able to access the service through local pharmacy and the Derby vaccination site (longer journey). Since the completion of the S14Z2 form, Erewash PCN has withdrawn notice and are now continuing with the vaccination programme.</li> <li>• <b>Derby PCN</b> The Local Vaccination Service provided through general practice will cease on the 17th December, patients will be able to access the service through local pharmacy and the Derby vaccination site (longer journey). Since the completion of the S14Z2 form, the Derby PCNs are now continuing with the vaccination programme.</li> <li>• <b>Sinfin health centre development</b> The proposal is to redevelop the Sinfin Health Centre as part of a national programme, the site will be one of six pioneer sites nationally, taking a collaborative and forward thinking approach to developing health buildings that are system owned, designed to meet the needs of the local population and provide the flexibility to enable services to change as the population need changes.</li> </ul> <p><b>The Engagement Committee Noted the ASSURANCE from the update.</b></p>	
<b>EC/2122-135</b>	<p><b>JUCD Board – Key messages (for information)</b></p> <p>(deferred – no JUCD Board meeting)</p>	<b>KL</b>

<p><b>EC/2122-136</b></p>	<p><b>DDCCG Exception Risk Report</b></p> <p>The Engagement Committee is asked to:</p> <p><b>RECEIVE and DISCUSS the Engagement Committee risk assigned to the committee as at January 2022 (Appendix 1).</b></p> <p>BS gave a brief update on the report. BS requested that the risk score be reduced due to now being in Q4, the risk hasn't changed and requested if the committee agreed to reduce the scores.</p> <p><b>ACTION: BS to reduce score for next meeting.</b></p> <p>The Engagement Committee received and discussed the risks presented.</p>	<p><b>BS</b></p>
<p><b>EC/2122-137</b></p>	<p><b>GBAF</b></p> <p>Discussed with previous item.</p>	<p><b>BS</b></p>
<p><b>EC/2122-138</b></p>	<p><b>MINUTES OF THE MEETING HELD ON: 16 November 2021</b></p> <p>The Engagement Committee <b>ACCEPTED</b> the Minutes of the previous meeting as a true and accurate record.</p>	
<p><b>EC/2122/139</b></p>	<p><b>MATTERS ARISING</b></p> <p>There were no matters arising.</p>	<p><b>MW</b></p>
<p><b>EC/2122-140</b></p>	<p><b>ACTION LOG FROM THE MEETING HELD ON: 21 SEPTEMBER 2021</b></p> <p>The Engagement Committee reviewed the action log and updated accordingly.</p>	<p><b>MW</b></p>
<p><b>EC/2122-141</b></p>	<p><b>ENGAGEMENT COMMITTEE FORWARD PLANNER 2021/22 FOR REVIEW AND AGREEMENT.</b></p> <p>The Engagement Committee <b>REVIEWED</b> and <b>AGREED</b> the Forward Planner.</p>	
<p><b>EC/2122-142</b></p>	<p><b>ANY OTHER BUSINESS</b></p> <p>It was agreed due to the rising issues in the system to have the meetings held bi-monthly with the next meeting being 15 March 2022.</p>	
<p><b>EC/2122-143</b></p>	<p><b>FUTURE MEETINGS IN 2021/22</b> <b>Time: 11:15 – 13:15</b></p> <p><b>Meetings will be held as virtual meetings until further notice.</b></p>	

<p><b>EC/2122-144</b></p>	<p><b>ASSURANCE QUESTIONS</b></p> <ol style="list-style-type: none"> <li>1. Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? <b>Yes</b></li> <li>2. Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? <b>Yes</b></li> <li>3. Were papers that have already been reported on at another committee presented to you in a summary form? <b>Yes</b></li> <li>4. Was the content of the papers suitable and appropriate for the public domain? <b>Yes</b></li> <li>5. Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? <b>No</b></li> <li>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? <b>No</b></li> <li>7. What recommendations do the Committee want to make to Governing Body following the assurance process at today's Committee meeting? <b>None, there was felt to be no specific recommendation at this stage.</b></li> </ol>	
<p><b>DATE AND TIME OF NEXT MEETING</b></p>		
<p><b>Date: Tuesday 15 March 2022</b></p>		
<p><b>Time: 11:15 – 13:15</b></p>		

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

**HELD ON**

**Wednesday 23<sup>rd</sup> February 2022**

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

**PRESENT**

Ian Shaw (Chair)	<b>IS</b>	Chair, Lay Member, DDCCG
Darran Green	<b>DG</b>	Associate Chief Finance Officer, DDCCG (for CFO)
Jill Dentith	<b>JeD</b>	Lay Member, DDCCG
Simon McCandlish	<b>SMc</b>	Deputy Chair, Lay Member, DDCCG
Marie Scouse	<b>MS</b>	AD of Nursing & Quality, DDCCG (for CNO)

**IN ATTENDANCE**

Hannah Belcher	<b>HB</b>	AD GP Commissioning & Development, DDCCG
Ged Connolly-Thompson	<b>GCT</b>	Head of Digital Development, DDCCG
Greg Crowley	<b>GC</b>	Derby & Derbyshire LMC
Judy Derricott	<b>JDe</b>	Head of Primary Care Quality, DDCCG
Jacqueline Gilmore	<b>JG</b>	Administrative Support – Corporate Directorate
Frances Palmer	<b>FP</b>	Corporate Governance Manager (transcribed minutes)

**APOLOGIES**

Richard Chapman	<b>RC</b>	Chief Finance Officer, DDCCG
Clive Newman	<b>CN</b>	Director of GP Development, DDCCG
Dr Peter Williams	<b>PW</b>	Derby & Derbyshire LMC
Dr Steve Lloyd	<b>SL</b>	Executive Medical Director, DDCCG

ITEM NO.	ITEM	ACTION
<b>PCCC/2122/176</b>	<p><b>WELCOME AND APOLOGIES</b></p> <p>The Chair, Ian Shaw (IS), welcomed Committee Members to the meeting, there were no members of the Public present at today's meeting. Apologies were received and noted as above.</p> <p>The Chair confirmed that the meeting was not quorate and it was agreed that the committee would begin with the items for information. Darran Green (DG) joined the meeting for Item 179.</p>	
<b>PCCC/2122/177</b>	<p><b>DECLARATIONS OF INTEREST</b></p> <p>The Chair informed members of the public of the committee members' obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG.</p> <p>Declarations declared by members of the Primary Care Commissioning Committee are listed in the CCG's Register of Interests and included within the meeting papers. The Register is also available either via the corporate secretary to the Governing Body or the CCG website at the following link:</p>	

[www.derbyandderbyshireccg.nhs.uk](http://www.derbyandderbyshireccg.nhs.uk)

**Declarations of interest from today's meeting**

No declarations of interest were raised.

Jill Dentith (JeD) made the committee aware that the register was not the current version, however this did not impact on any of the agenda items at the meeting today.

**FOR DECISION**

PCCC/2122/178

**LITTLEWICK MEDICAL PRACTICE AND DR PURNELL'S PRACTICE – FULL PRACTICE MERGER INCLUDING BRANCH CLOSURE**

Hannah Belcher (HB) presented the report, and highlighted the following:

- a letter has been sent to patients registered at the GP practices and their feedback was presented to the committee within the papers;
- the full practice merger will come into effect from 1 April 2022; and
- Dr Purnell's practice will close on 1 April 2022.

JeD made the committee aware that there will be a conflict of interest for Dr Emma Pizzey, Governing Body GP when the Primary Care Commissioning Committee assurance report is presented to the Governing Body.

JeD also highlighted the concerns raised by patients in regards to being able to contact the GP practice. It was noted that this was an IT issue, which has now been resolved. JeD requested assurance that this proposal enhances the provision of services rather than diminishing them. Marie Scouse (MS) provided assurance to the committee that the practice have acknowledged their issues with access and have submitted an action plan to the CCG.

HB has also received assurance that the Medicines Order Line will not be affected by any changes to the practice merger.

**The Primary Care Commissioning Committee:**

- **RECEIVED** the patient and stakeholder feedback and supporting documents, following approval in principle of the full practice merger and site closure at the Primary Care Commissioning Committee confidential meeting held on Wednesday 22<sup>nd</sup> December 2021;
- **RECEIVED** and **APPROVED IN PRINCIPLE** the request for both the full practice merger and to close the practice site in Ilkeston Health Centre with effect from April 2022;
- **NOTED** that all staff and primary care services will be provided solely at the Littlewick Medical Practice site with effect from April 2022; and
- **NOTED** that two confidential meetings have been held with the PPG in January who are supportive of the merger and were involved in commenting on the patient engagement letter.

***Post-meeting note: Hannah Belcher received virtual confirmation from Darran Green that the finance directorate approved this item.***

**FOR ASSURANCE**

<p><b>PCCC/2122/179</b></p>	<p><b>FINANCE UPDATE</b></p> <p>The finance report for Month 9 was taken as read, and JeD highlighted that the report had been presented at the last Governing Body meeting.</p> <p><b>The Primary Care Commissioning Committee were requested to NOTE the Finance Report for Month 9.</b></p>	
<p><b>PCCC/2122/180</b></p>	<p><b>RISK REGISTER EXCEPTION REPORT</b></p> <p>HB presented the Risk Register exception report and made the committee aware that correspondence had been received from NHSEI with a change in focus to urgent care, as there are a decreasing number of GP practices who are reporting Covid-19 outbreaks.</p> <p>MS provided an update on the increase of GP practices presenting as vulnerable following the impact of the Covid-19 pandemic, particularly in relation to Care Quality Commission inspections. HB and MS recommended that the risk scores remain unchanged at this time.</p> <p><b>The Primary Care Commissioning Committee NOTED and RECEIVED the update on the two outstanding risks and:</b></p> <ul style="list-style-type: none"> <li>• <b>AGREED IN PRINCIPLE</b> that the scores remain unchanged for Risk 04A and Risk 04B</li> <li>• <b>were ASSURED</b> that the risk scores are reviewed on a regular basis.</li> </ul> <p><i>Post-meeting note: Hannah Belcher received virtual confirmation from Darran Green that the finance directorate agreed for the risk scores to remain unchanged.</i></p>	
<p><b>PCCC/2122/181</b></p>	<p><b>ST. THOMAS ROAD SURGERY UPDATE</b></p> <p>HB presented the St. Thomas Road Surgery procurement update, which has followed due process and has been managed by Arden GEM Commissioning Support Unit. The Invitation to Tender was published on 22<sup>nd</sup> December 2021 and will close on Friday 25<sup>th</sup> February 2022.</p> <p><b>The Primary Care Commissioning Committee:</b></p> <ol style="list-style-type: none"> <li>1. <b>NOTED</b> that the St Thomas Road Surgery (part of One Medical Group, Leeds) Alternative Provider Medical Services contract (APMS) was due to expire on 30 September 2021. In August 2020, Primary Care Commissioning Committee agreed to extend the current contract for 1 year to 30 September 2022 to enable feedback from patients and stakeholder engagement prior to the commencement of the procurement process.</li> <li>2. <b>RECEIVED</b> the paper providing an update of actions to date relating to patient and stakeholder engagement and feedback from the engagement process undertaken from 12 July 2021 to 17 September 2021 (Appendix 1);</li> <li>3. <b>RECEIVED</b> Appendix 2 – Procurement timeline, for information.</li> <li>4. <b>RECEIVED</b> the Invitation to Tender (ITT) list of documents (Appendix 3) and receive supporting appendices to support the approval of the ITT publication.</li> <li>5. <b>RECEIVED</b> the contract service specification (Appendix 4) for information; and</li> </ol>	

	<p>6. <b>RECEIVED the Market Engagement Event presentation (Appendix 5) held virtually on Wednesday, 1<sup>st</sup> December 2021 for assurance and information.</b></p> <p>7.</p>	
PCCC/2122/182	<p><b>QUARTER 3 PRIMARY CARE QUALITY AND PERFORMANCE ASSURANCE REPORT</b></p> <p>Judy Derricott (JDe) presented the report, which covered the period 1<sup>st</sup> October to 31<sup>st</sup> December 2021 (Quarter 3). The paper was taken as read.</p> <p><b>The Primary Care Commissioning Committee:</b></p> <ul style="list-style-type: none"> <li>• <b>ACCEPTED and NOTED the contents of this report; and</b></li> <li>• <b>to HIGHLIGHT any areas for future inclusion.</b></li> </ul>	
PCCC/2122/183	<p><b>CQC UPDATE – THE VILLAGE SURGERY</b></p> <p>JDe updated the committee on the Care Quality Commission's (CQC) announced inspection at The Village Surgery on the 10<sup>th</sup> and 13<sup>th</sup> December 2021. JDe made the committee aware that further inspection reports will be presented within the confidential meeting as part of the quarterly primary care assurance reports, and reported monthly through the primary care quality and performance review sub-committee – highlighting any escalations through this committee.</p> <p>The CQC carried out this inspection due to concerns shared with them, and the practice were given an overall rating of 'inadequate'. The Primary Care Quality Team meet with the practice on a fortnightly basis to review and discuss the practice action plan and support with the completion of these. There are a number of areas that relate to medicines management, therefore the CCG's medicines management team are working closely with the practice to address these. Peer support is also being provided by another GP practice who were in a similar position a few years ago. A meeting has been arranged for next week to review evidence, as this has not yet been provided.</p> <p>JeD queried what assurances have been obtained around the patient safety risks, and whether any significant risks are being captured on the CCG risk register. JDe confirmed that they are captured generically on the risk register and more information is provided on the risks within the confidential session. A confidential discussion will be had on how the committee can receive an assurance report on these risks within the public session, and to evidence that the CCG is supporting the practice to ensure they are adequately rated.</p> <p><b>The Primary Care Commissioning Committee NOTED the contents of the Village Surgery Care Quality Commission Inspection Outcome.</b></p>	
<b>FOR INFORMATION</b>		
	<b>There were no items for Information</b>	

## MINUTES AND MATTERS ARISING

<b>PCCC/2122/184</b>	<b>Minutes of the Primary Care Commissioning Committee meeting held on 26<sup>th</sup> January 2022</b>  The minutes from the meeting held on 26 <sup>th</sup> January 2022 were agreed to be an accurate record of the meeting.	
<b>PCCC/2122/185</b>	<b>MATTERS ARISING MATRIX</b>  There were no outstanding actions on the Action Matrix.	
<b>PCCC/2122/186</b>	<b>FORWARD PLANNER</b>  The committee requested for the forward planner to be extended for the period April to June 2022.	<b>HB</b>
<b>PCCC/2122/187</b>	<b>ANY OTHER BUSINESS</b>  There were no items raised.	
<b>PCCC/2122/188</b>	<b>ASSURANCE QUESTIONS</b>  1. Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? <b>No – there was no representation from finance colleagues.</b> 2. Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? <b>Yes</b> 3. Were papers that have already been reported on at another committee presented to you in a summary form? <b>Yes</b> 4. Was the content of the papers suitable and appropriate for the public domain? <b>Yes</b> 5. 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? <b>Yes</b> 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? <b>No</b> 7. What recommendations does the Committee want to make to Governing Body following the assurance process at today’s Committee meeting? <b>None</b>	
<b>DATE AND TIME OF NEXT MEETING</b>		
<b>Wednesday 23<sup>rd</sup> March 2022, 10:00-10:30am via Microsoft Teams Meeting</b>		

**MINUTES OF QUALITY AND PERFORMANCE COMMITTEE  
HELD ON 24<sup>th</sup> FEBRUARY 2022  
9AM TO 10.30AM  
MS TEAMS**

<b>Present:</b>		
Dr Buk Dhadda (Chair)	BD	Chair, Governing Body GP, DDCCG
Dr. Bruce Braithwaite	BB	Secondary Care Consultant
Alison Cargill	AC	Asst Director of Quality, DDCCG
Jackie Carlile	JC	Head of Performance and Assurance -DDCCG
Helen Hipkiss	HH	Director of Quality, DDCCG
Steve Hulme	SH	Asst Director – Medicines Management & ICS Pharmacy Lead
Andrew Middleton	AM	Lay Member, Finance
Simon McCalandish	SMcC	Lay Member, Patient Experience
Grace Mhora	GM	Senior Quality Assurance Manager
Bill Nicol	BN	Asst Director Safeguarding Adults
Dr Emma Pizzey	EP	GP South
Michelina Racioppi	MR	Asst Director of Safeguarding Children / Lead Designated Nurse for Safeguarding Children
Dr Greg Strachan	GS	Governing Body GP, DDCCG
Brigid Stacey	BS	Chief Nurse Officer, DDCCG
Martin Whittle	MW	Vice Chair and Governing Body Lay Member, Patient and Public Involvement, DDCCG
Helen Wilson	HW	Deputy Director Contracting and Performance - DDCCG
<b>In Attendance:</b>		
Jo Pearce (Minutes)	JP	Executive Assistant to Chief Nurse, DDCCG
<b>Apologies</b>		
Tracy Burton	TB	Deputy Chief Nurse, DDCCG
Dr Meryll Watkins	MWa	Governing Body GP, DDCCG
Suzanne Pickering	SP	Head of Governance- DDCCG
Dr Steve Lloyd	SL	Medical Director - DDCCG

Item No.	Item	Action
QP2122 /204	<p><b>WELCOME, APOLOGIES &amp; QUORACY</b></p> <p>Apologies were received as above. BD declared the meeting quorate.</p>	
QP2122 /205	<p><b>DECLARATIONS OF INTEREST</b></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: <a href="http://www.derbyandderbyshireccg.nhs.uk">www.derbyandderbyshireccg.nhs.uk</a></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. The questions are being collated for future reference if needed.</p>	
QP2122 /206	<p><b>INTEGRATED REPORT</b></p> <p>The report was taken as read.</p> <p>JC noted that 2WW referrals continue to increase with a 25% increase in December at both Trusts compared to December 2019. There has also been a system wide breast review meeting which was well attended and led by Christine Urquhart, Head of Cancer Commissioning. The purpose of the meeting is to examine the pathway and identify any issues. On Christine's retirement, Monica MacAlindon will take over as lead for this meeting.</p>	

	<p><b>ACTION</b> - BD asked for an update on the discussions and outcomes from the meeting to come to the quality and performance Committee in March 22.</p> <p>AM asked what actions are being taken to address the 12hr breaches at UHDBFT. JC replied to say that there are many different factors around the discharge of patients and offered to bring back a more detailed piece of information. AC confirmed that patients are receiving the appropriate levels of care and the CCG have Emergency Department visits planned for February so it can be monitored.</p> <p><b>ACTION</b> – JC will provide a paper to the next Quality and Performance Committee around the 12-hour breaches and give assurance that the patients are receiving the quality of care that is expected.</p> <p>BS explained the issues around flow through the system now that patients are more confident in attending acute settings. System work around discharges led by Helen Hipkiss has resulted in a large number of patients being discharged from hospital into an appropriate setting. Care homes are beginning to reopen, and staff are returning to work.</p> <p>MW referred to the high mortality rate for stroke at CRHFT and asked for an update on the HASU review. AC explained that there is a delay in the data reporting and the data within this report relates to January / February 2021. Work is ongoing and is being monitored through CQRG. A deep dive and review of case notes has been carried out and there is a higher acuity of patient, and they are being managed appropriately. BS further explained that the HASU review is ongoing, improvements have been made and they are now considering new workforce models, including roles such as Nurse Consultants. There is currently a Nurse leading the service. SNAPP data was originally reported CRHFT as a D and current SNAPP data is reporting a B which is an improved score. Steve LLOYD and Zara Jones are leading on the work around the reconfiguration of the HASU. Concerns were raised at the QAC this week that despite improvements being made reported mortality rates remained high due to the delay in available data. BS requested that AC obtain a detailed response from CRHFT into the actions being taken via CQRG meeting and a more detailed response to be included in the IRP report for March 22.</p> <p>BS confirmed that she will review the IRP and ensure that it is an accurate reflection of the current position and discussions that have taken place at this meeting.</p> <p>EP asked if conversion data is available for cancer 2WW so that figures can be compared. JC will ask if she can share figures from the recent Cancer Transformation Board with the Committee. Trusts are reporting the 2WW referrals have been appropriate and</p>	<p>JC</p> <p>JC</p>
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	<p>justified. HW noted the reported data from last year which showed higher conversion rates for specific tumour sites and explained that the data was from the same period that work was being done to stimulate patient referrals.</p> <p>EP asked if there was any data around increases in Urgent referrals and commented that she is not receiving communication from secondary care in terms of where patients are on waiting lists. HW explained that a referral would only be considered as urgent if a GP has re-referred. An App called "<i>My Planned Care</i>" is in development which will enable to patient to view statistics on likely waiting times without having to contact their GP or hospital trust. HW continued to note that in the 22/23 planning guidance trusts will be required to reduce 52 and 78 week waits and eliminate 104 week waits.</p> <p><b>Activity Report</b></p> <p>HW referred to A&amp;E activity and noted that it is not as high as 2019 despite feeling extremely busy in the Trusts due to continuing IPC measures and issues with discharge flow.</p> <p>Pending the review and any necessary amendments by BS, BD <b>APPROVED</b> the Integrated Report.</p>	
<p><b>QP2122</b> <b>/207</b></p>	<p><b>GBAF Q4</b></p> <p>The paper was taken as read.</p> <p>AM asked for assurance that the current risks listed within this report will be included in the system risk register and the risks will receive the appropriate level of scrutiny. BS confirmed that conversations have taken place around governance and the transfer off risks to the ICS. The Quality and Performance Committee need to actively look at reducing or closing these risks before the transition to the ICS. Any risks which are not closed will transfer over to the System Quality Group.</p> <p>The Committee noted the contents and approved the paper.</p>	
<p><b>QP212</b> <b>/208</b></p>	<p><b>RISK REGISTER</b></p> <p>The paper was taken as read.</p> <p>The Committee noted the contents and the approved the recommendations in the paper.</p>	

<p><b>QP2122</b> <b>/209</b></p>	<p><b>SAFEGUARDING ADULTS UPDATE</b></p> <p>The paper was taken as read.</p> <p>BN noted that there has been another Domestic homicide and the CCG will be undertaking a Domestic Homicide review on behalf of the GP practice.</p> <p>AM noted the increase in referrals over the last 10 years and asked for the reasons for the increase. BN replied to say that Derbyshire has been part of a peer review with Nottingham to look at the reasons behind the increase in referrals and the official outcome letter is still awaited. BN stated a number of reasons behind the increases which included people being more risk averse, CQC putting pressure on providers to refer inappropriately, a growing awareness around Safeguarding and improved training is making a difference.</p> <p>The Care Act has brought Domestic abuse into the Adult Safeguarding remit and police in Derbyshire are getting up to 70 calls a day around Domestic abuse concern.</p> <p>BD gave the Committee feedback from his GP colleagues around the quality of the Safeguarding training that is being delivered by the CCG.</p> <p>The Committee noted the contents and approved the paper.</p>	
<p><b>QP2122</b> <b>/210</b></p>	<p><b>SAFEGUARDING CHILDREN'S UPDATE AND LOOKED AFTER CHILDRENS REPORT.</b></p> <p>The paper was taken as read.</p> <p>MR explained that the Safeguarding Childrens partnership has set up a group called the Predicting Demand Group which analyses the number of contacts and referrals to Childrens Social Care as well as the cases that do not meet the threshold of intervention to help reduce the pressures on the front door of Childrens Social Care.</p> <p>AM referred to the number of Looked After Children that are placed within Derbyshire from other areas. MR explained that this is predominantly due to the number of private residential settings in Derbyshire. This has a knock-on effect for CCG providers as they are required to undertake the initial and review health assessments. The number of Looked After Children placed outside of Derbyshire is due to a lack of availability of Foster Carers in Derbyshire and there is a big drive to recruit additional foster carers to enable children to be kept in the county where possible.</p>	

	<p>MR highlighted a risk around capacity issues for the Designated Doctor role. Work is ongoing with the CCG Chief Nurse and Medical Director to try to recruit to the post and other areas have been approached to identify and interest. Nottinghamshire have been approached to look at mutual aid possibilities. MR confirmed that this is a national issue which has been raised with NHSE.</p> <p><b>ACTION</b> – MR will speak to BS around adding the capacity of the Designated Doctor onto the Risk Register.</p> <p>MR noted an increase in the number of unaccompanied asylum seekers which needs to be monitored considering the number of contingency hotels being opened in Derbyshire.</p> <p>The Committee noted the contents and approved the paper.</p>	<p><b>MR</b></p>
<p><b>QP2122</b> <b>/211</b></p>	<p><b>EMAS UPDATE</b></p> <p>The paper was taken as read.</p> <p>GM noted the key points</p> <ul style="list-style-type: none"> <li>• EMAS did not meet any of the six national standards in Q3 at a regional (East Midlands) and local (Derbyshire) level.</li> <li>• There continued to be a significant number of hours lost due to pre and post hand over delays.</li> <li>• There has been a correlation between not meeting performance targets and patient safety as has been evidenced by an increased number of serious incidents which have been reported under the category delayed responses when the national standards are not met. This is most evident when the Trust was in CSP4/CSP4A.</li> <li>• There have been twenty-two delayed response serious incidents reported in Q3 bringing the total number to thirty-one for 2021/2022.</li> <li>• It was agreed at the Extra-ordinary CQRG on the 16<sup>th</sup> of December 2021 that all were assured that EMAS were taking all the necessary actions and mitigations to provide as safe a service as possible. It was agreed the issues were system issues and systems were asked to support the EMAS Hospital Harm Prevention Tool as well as share what they had in place locally to address falls and respiratory pathways which were key themes in the delayed response serious incidents.</li> </ul> <p>BD asked how EMAS have achieved the improvement in meeting the C4 standard. GM replied to say there has been a slight decrease in demand in Q4 which is a contributing factor rather than internal changes being made.</p>	

	<p><b>ACTION</b> – GM will submit a paper to the Quality and Performance Committee meeting in March around an overview on the themes of the Serious Incidents.</p> <p>The Committee noted the contents and approved the paper.</p>	<b>GM</b>
<b>QP2122 /212</b>	<p><b>RISKS STRATIFICATION UPDATE</b></p> <p>The paper was taken as read.</p> <p>AC noted there has been an improvement in the minimum standards in particular around timely reviews and this is due to the prioritisation tools that are being used at both Trusts.</p> <p>A deep dive into lung cancer waits over 104 days is being carried out in terms of harm.</p> <p>BD highlighted the need for ongoing communication with GPs around patient waits. AC confirmed that she has raised this at the Planned Care Delivery Board and is now in contact with GP meetings where this can be discussed further.</p> <p>The Committee noted the contents and approved the paper.</p>	
<b>QP2122 /213</b>	<p><b>MEDICINES MANAGEMENT UPDATE</b></p> <p>The paper was taken as read and there were no additional questions raised by the Committee members.</p> <p>The Committee noted the contents and approved the paper</p>	
<b>QP2122 /214</b>	<p><b>CONTINUING HEALTHCARE UPDATE</b></p> <p>The paper was taken as read. There were no questions raised by the Committee members.</p> <p>The Committee noted the contents and approved the paper.</p>	
<b>QP2122 /215</b>	<p><b>IPC</b></p> <p>The paper was taken as read. There were no questions raised by the Committee members.</p> <p>The Committee noted the contents and approved the paper.</p>	

<p><b>QP2122</b> <b>/1216</b></p>	<p><b>CARE HOMES</b></p> <p>The paper was taken as read. There were no questions raised by the Committee members.</p> <p>The Committee noted the contents and approved the paper.</p>	
<p><b>QP2122</b> <b>/217</b></p>	<p><b>JUCD QEIA</b></p> <p>The paper was taken as read. There were no questions raised by the Committee members.</p> <p>The Committee noted the contents and approved the paper.</p>	
<p><b>QP2122</b> <b>/218</b></p>	<p><b>MINUTES FROM SUB COMMITTEES</b></p> <p>The Committee noted the minutes from the following sub-Committees:</p> <p>Updates from Trust CQRG meetings. UHDBFT CRHFT DCHS</p>	
<p><b>QP2122</b> <b>/219</b></p>	<p><b>MINUTES FROM THE MEETING HELD ON 27<sup>TH</sup> JANUARY 2022</b></p> <p>The minutes were approved as a true and accurate record.</p>	
<p><b>QP2122</b> <b>/220</b></p>	<p><b>MATTERS ARISING AND ACTION LOG</b></p> <p>The action log was reviewed and updated.</p>	
<p><b>QP2122</b> <b>/221</b></p>	<p><b>AOB</b></p> <p>There were no matters raised under AOB.</p>	
<p><b>QP2122</b> <b>/222</b></p>	<p><b>FORWARD PLANNER</b></p> <p>The Forward Planner was reviewed. No updates were made.</p>	
<p><b>QP2122</b> <b>/223</b></p>	<p><b>ANY SIGNIFICANT SAFETY CONCERNS TO NOTE</b></p> <p>None raised.</p>	

	<p><b>ASSURANCE QUESTIONS</b></p> <ul style="list-style-type: none"> <li>• Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? Yes</li> <li>• 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</li> <li>• Were papers that have already been reported on at another committee presented to you in a summary form? Yes</li> <li>• Was the content of the papers suitable and appropriate for the public domain? Yes</li> <li>• 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</li> <li>• 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</li> <li>• What recommendations do the Committee want to make to Governing Body following the assurance process at today's Committee meeting? None</li> </ul>	
<b>DATE AND TIME OF NEXT MEETING</b>		
<b>Date:</b> 31st March 2022		
<b>Time:</b> 9am to 10.30am		
<b>Venue:</b> MS Teams		

**Derby and Derbyshire CCG Governing Body Meeting in Public**  
**Held on**  
**3<sup>rd</sup> March 2022 via Microsoft Teams**

**UNCONFIRMED**

**Present:**

Dr Avi Bhatia	AB	Clinical Chair
Dr Penny Blackwell	PB	Governing Body GP
Richard Chapman	RCp	Chief Finance Officer
Dr Chris Clayton	CC	Chief Executive Officer
Dr Ruth Cooper	RC	Governing Body GP
Jill Dentith	JD	Lay Member for Governance
Dr 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
Simon McCandlish	SM	Lay Member for Patient and Public Involvement
Andrew Middleton	AM	Lay Member for Finance (part meeting)
Dr Emma Pizzey	EP	Governing Body GP
Professor Ian Shaw	IS	Lay Member for Primary Care Commissioning
Dr Greg Strachan	GS	Governing Body GP
Dr Merryl Watkins	MW	Governing Body GP
Martin Whittle	MWh	Lay Member for Patient and Public Involvement / Vice Chair

**Apologies:**

Dr Bruce Braithwaite	BB	Secondary Care Consultant
Dr Robyn Dewis	RD	Director of Public Health – Derby City Council
Dr Steven Lloyd	SL	Medical Director
Brigid Stacey	BS	Chief Nursing Officer
Dean Wallace	DW	Director of Public Health – Derbyshire County Council

**In attendance:**

Kate Brown	KB	Director of Joint Commissioning and Community Development (Item 262 only)
Tracy Burton	TB	Deputy Director of Quality and Associate Chief Nurse
Dawn Litchfield	DL	Executive Assistant to the Governing Body / Minute Taker
Kirsty McMillan	KM	Director – Integration & Direct Services – Derby City Council (Item 262 only)
Suzanne Pickering	SP	Head of Governance

Item No.	Item	Action
<b>GBP/2122/255</b>	<b>Welcome, Apologies &amp; Quoracy</b>  Dr Avi Bhatia (AB) welcomed members to the meeting.  Apologies were noted as above.  It was confirmed that the meeting was quorate.	
<b>GBP/2122/256</b>	<b>Questions received from members of the public</b>  No questions were received from members of the public.	

<p><b>GBP/2122/257</b></p>	<p><b>Declarations of Interest</b></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: <a href="http://www.derbyandderbysshireCCG.NHS.uk">www.derbyandderbysshireCCG.NHS.uk</a></p> <p><u>Item 267 – PCCC Assurance Report – February 2022</u> – Dr Emma Pizzey (EP) declared a conflict of interest in this item. The business case application for the full practice merger between Littlewick Medical Practice (where EP is a GP partner) and Dr Purnell's practice in Ilkeston was discussed at the PCCC meeting. As this is not a decision item it was agreed that EP would remain in the meeting but would not partake in any discussions that may arise in relation to this matter.</p> <p><u>Item 270 – Ratified minutes of corporate committees – PCCC – 26.1.2022</u> – Dr Penny Blackwell (PB) declared a conflict of interest in this item. PB is a GP Partner of the practice that has taken over the Hulland and Brailsford practice, which was discussed at the PCCC meeting in January. As this is not a decision item it was agreed that PB would remain in the meeting but would not partake in any discussions that may arise in relation to this matter.</p> <p>Jill Dentith (JD) advised that the dates for her commitments to STHFT have been updated; the register will be amended accordingly.</p> <p>No further declarations of interest were made, and no changes were requested to the Register of Interests.</p>	
<p><b>GBP/2122/258</b></p>	<p><b>Chair's Report – February 2022</b></p> <p>AB presented a report, a copy of which was circulated with the meeting papers; the report was taken as read and no questions were raised.</p> <p><b>The Governing Body NOTED the content of the report provided</b></p>	
<p><b>GBP/2122/259</b></p>	<p><b>Chief Executive Officer's Report – February 2022</b></p> <p>Dr Chris Clayton's (CC) presented a report, a copy of which was circulated with the meeting papers. The report was taken as read and the following points of note were made:</p> <ul style="list-style-type: none"> <li>• The COVID position has altered in line with the national position. Although public policy has changed in recent weeks, COVID remains active; the steady stream of patients being admitted into hospital with COVID are being managed.</li> <li>• The COVID Vaccination programme remains live and active.</li> <li>• The Non-Executive Member (NEM) appointments to the Integrated Care Board (ICB) were confirmed in the report.</li> <li>• Admiration was given to the Local Health Resilience Partnership for responding to and overcoming the challenges caused by the recent flooding across the county.</li> </ul>	

- Confirmation has been received that the boundary changes with Glossop will take place from 1<sup>st</sup> July 2022, with the creation of the ICB.
- The CCG remains committed in its support of the challenges faced by the System; there is still a high level of escalation in situ.
- The Elective Recovery Plan has now been published nationally, the response to which will be presented to the Governing Body and relevant sub-committees in due course. Derbyshire continues to have high waiting list numbers, with backlogs for elective care treatment which have exacerbated over the course of the pandemic.
- Section 2 provided details of the regular meetings attended by the CEO on behalf of the CCG and Derbyshire System.
- Sections 3 and 4 provided updates on Local and National developments.

The following questions were raised:

- Concern was expressed that Derby City seems to have gone back to normal with very little mask wearing being seen, apart from in healthcare settings; trying to persuade unvaccinated patients to have the vaccine is almost impossible, as they consider the pandemic to be over. Although there will be a new wave of vaccinations in April for the elderly and young children, there is a need to continue to push the vaccination message. CC welcomed this feedback on the challenges; it is important to promote the vaccination programme as it has made a huge difference in keeping people safe and continues to do so. The most seriously unwell people with COVID are more likely to be those that are unvaccinated. The targeted phase now is the hesitant / resistant group. It is important to keep the momentum going.
- The hospital consultants pension situation will limit the hours they are able to work without being penalised; this is creating issues when trying to obtain senior staff to undertake extra work to help recover the backlog. CC recognised this concern, which is a known national challenge, particularly in relation to the elective backlog and supporting clinicians to be able to do more work where they able to do so.
- It was queried whether the NHSE Delivery Plan relating to the elective backlog would have implications locally and, if so, whether there is any funding attached. CC advised that there will be implications for the CCG, and subsequently the ICB, both of whom will contribute to the national delivery. There is currently a significant challenge relating to the orthopaedic waiting list at UHDBFT. One of the biggest requests is to eliminate the 104-week wait position by Quarter 1 of 2022/23. Whilst the plans are clear, the System has been minded to, and planning for, this situation for some time; throughout the pandemic, one of the key objectives has been to maintain acute care for COVID and urgent non-COVID patients and prioritise elective work.

Zara Jones (ZJ) advised that the Annual Operating Plan for 2022/23 currently being compiled, will contain an element of elective care. The Plan is being worked through with System colleagues and there will also be ongoing work as the position develops.

Richard Chapman (RCp) advised that additional funding will be made available for the Elective Recovery Plan; however, it will have criteria attached to it. One of the key barriers to reducing the backlog is the availability of acute beds; the health and care System needs to ensure that it has available beds to support increased theatre capacity.

	<b>The Governing Body NOTED the content of the report provided</b>	
<b>GBP/2122/260</b>	<p><b>Section 75 Arrangements and Year End</b></p> <p>Richard Chapman (RCp) advised that, through joint system working, the H2 financial gap has been closed and the latest 2021/22 Risk Adjusted Forecast Outturn range is between £10m and £20m non-recurrent surplus, most of which sits with the CCG. If the CCG delivers a surplus, there is a risk that the benefit would be lost to the System. This has created an opportunity for flexibility at year end and a proposal has been developed to utilise it creatively, within the bounds of allowability. It is proposed to increase the CCG's contribution to the Better Care Fund (BCF), for services provided in the current financial year, by £10m; this would allow Derbyshire County Council (DCC) to carry forward an equivalent value in its reserves which could be utilised in the creation of a 'Community Future Fund' to accelerate transformation of Place under a new Section 75 Agreement in future years. These are CCG allocations which the Governing Body has discretion to commit. The fund will be jointly controlled by DCC, Derby City Council and the ICB. The fund will help to exacerbate transformation and alleviate the pressure on acute beds.</p> <p>NHSEI has been sighted on, and are comfortable with, the proposal. The External Auditors, KPMG, have been consulted and are assured that the payment is for services received in the current financial year; they are therefore comfortable with the arrangement. The fund will not be created using Derbyshire County taxpayers' money therefore can be used across both Derbyshire County and Derby City areas.</p> <p>Ian Gibbard (IG), as Chair of the Audit Committee, supported the proposal which was deemed to be a sensible way forward. It has also been considered by the CCG's and System's Finance Committees where it was supported.</p> <p><b>The Governing Body APPROVED a proposed non-recurrent increase in the NHS contribution to the Derbyshire County Better Care Fund for 2021/22, recognising that this action will free up £10m of Derbyshire County Council reserves, which will be utilised in future years to create a jointly controlled 'Community Future Fund' to accelerate the delivery of community transformation</b></p>	
<b>GBP/2122/261</b>	<p><b>Strategic update on the ICB arrangements and emerging policy and legislation</b></p> <p>AM joined the meeting at this point</p> <p>CC considered that the Governing Body would welcome an update on some of the recent policy developments in terms of the Government's White Papers, reforms, and Parliamentary Bills; this provides a chance to reflect on the important changes to be made, which mirror the strategic directions sought by the Governing Body around the integration agenda with health and social care.</p> <p>Helen Dillistone (HD) gave a presentation, a copy of which will be circulated post meeting. The following information was outlined:</p> <ul style="list-style-type: none"> <li>• Details of the timeline for the ICB creation were provided for information.</li> </ul>	

	<ul style="list-style-type: none"> <li>• Details of emerging legislation and policy were set out, including the White Papers on Integration, Levelling Up and Adult Social Care reform</li> </ul> <p>CC added that an important concept, which has been building for some time, is the importance of Place in the Health and Social Care White Paper and the concept of bringing accountability together around Health and Social Care budgets. Shared accountability and leadership with a single accountable person over a single health and social care budget is currently undergoing engagement and discussion; the outcome is awaited. Derbyshire has been taking this direction of travel for some time now in relation to Place and COVID-19 decisions across the whole health and social care system.</p> <p>The following questions were raised:</p> <ul style="list-style-type: none"> <li>• The target for implementation of the Shared Care Record is 2024; a comment was made that ICSs will be mandated to have something in situ this year - clarification was requested on this. HD advised that this will be an incremental development; the White Paper takes it further to build on the work already underway to formally bring everything together. It is a step towards what needs to be implemented over the next 12 months.</li> <li>• It was queried as to what the number of Places for Derbyshire will be - two has previously been quoted; it was enquired whether there has been any challenge to this number over such a large geographical area, particularly relating to the Glossop inclusion. Penny Blackwell (PB) confirmed that there will be two Places, Derby City and Derbyshire. Derby City will be able to go further faster as they are already working as a unit, whilst there is still work to do in Derbyshire on bringing together the seven Place Alliances. The thoughts already given to this align to the direction given in the White Paper. Whilst there is no doubt that it will be a challenge to create a Derbyshire Place entity, the desire is there to do it and the culture is already set up.</li> </ul> <p>Glossop will be an exciting addition; the High Peak Place Alliance is in a particularly good position in terms of its maturity. Glossop could not be working with a better Alliance. The seven Place Alliances are ready and willing to take on more decision making and become more accountable should they be requested to do so.</p> <p>The Executive Team will be guided by the Governing Body as to the level of detail required in future on important policy changes.</p> <p><b>The Governing Body NOTED the presentation provided</b></p>	
<p><b>GBP/2122/262</b></p>	<p><b>JUCD Community Transformation Plan – Team Up's Evolution</b></p> <p>Kirsty McMillan (KM), Director of Integration at Derby City Council and Kate Brown (KB), DDCCG's Director of Joint Commissioning and Community Development, gave a presentation on the JUCD Community Transformation Plan, Team Up's Evolution, a copy of which was circulated prior to the meeting. The refreshed Community Transformation Programme will be about improving the health and wellbeing, primarily of older people and other key cohorts, living in Derby and Derbyshire. Work has been undertaken to produce a range of improvement frameworks to provide an overarching version to guide planning and delivery in relation to improving the health and wellbeing of the older person. This will help to achieve three broad impacts to align the focus of all existing (and new) programmes of</p>	

work. The implementation of ten Sentinel outcome measures will provide an understanding as to whether the Community Transformation Programme is generating impacts for older people. These impacts are:

- Improved health and wellbeing
- Enhanced quality of care
- Value and sustainability

The following points were noted:

- There is ongoing work between System partners, to focus on coordinating and supporting individuals through the Ageing Well Agenda.
- The NHS has recently been exposed to the capacity challenges of non-NHS activity, particularly the social care workforce pressures; there is an increasing demand issue alongside a staffing supply shortage.
- There is need to change the current narrative and create an alternative community offer / model, as the scale of the challenge is too great to continue at the current pace. Building on the strengths and abilities of individuals to support themselves to find solutions that work best for them, will allow people to take re-control of their own lives.
- The NHS, nor the Local Authority, can manage demand on their own; they will have to pull together and include the private and voluntary sectors, both of which are huge deliverers of care.
- The Local Authority has progressed considerably with direct payments to help people have control of the resources they require.
- The existing planning submission and transformation programme has a number of components that could be used to monitor and measure the programme's outcomes. Pulling together existing areas of work will have the biggest impact on available scarce resources and help deliver the joined-up care agenda.
- This work will be routed in Place; the Integrated Place Executive will own this and drive it at Place level, moving it forward to engage partners, and build on what is already in existence. A focus on engagement will be required to achieve behavioural change.

KB added that, whilst we are trying to develop and build on the foundations of Place Alliances, and moving them into ICS Place partnerships, there is already a programme of work to galvanise efforts and shift the focus to individuals and communities, looking at the wider outcomes and inequalities rather than the acute activity focus previously undertaken.

The following questions were raised:

- It was enquired how the SMART objectives will be focused upon and how it will be demonstrated to the System that this is a better way to address the health and wellbeing of a population. Examples were requested. KB responded that part of this is about bringing together existing pieces of work that have sometimes not been joined up as well as they could be. Individual projects and programmes will be tracked, however a sense of the overall direction at a local Place level is required for them to own and drive the changes. Those issues that will have the biggest impact will be considered first; this will help to turn ambitions into measurables to know where to focus. The Population Health Management launch is taking place today, where conversations will be held around opportunities to reduce falls and addressing inequalities amongst other things. There are many active projects which will help to drive a cultural shift.

KM added that this is a potentially challenging, exciting, and rewarding approach; we cannot afford not to do things differently, as we cannot go through another winter with escalations and crises, being helpless in finding solutions due to demand outstripping the ability to support people. It will be a cultural change programme as well as a transformational programme. There are many examples where a different approach has produced a better outcome. Individuals need to be made aware of how small-scale interventions can make huge changes to their lives. Team Up's early interventions have led to individuals feeling more empowered and better able to cope. This alternative approach will allow more time for those people with complicated needs. KM confirmed that the existing resources will be used more wisely, as there will be no additional funding available for this programme.

- This is a very ambitious plan. There is no disputing the need for joint working between health and social care, as so much of a person's health is determined by their social situation; shared accountability and responsibility is paramount to this.
- Pressures are already being seen across the System particularly around Team Up not being able to provide a universal offer for all patients; there are areas that cannot be covered due to capacity issues. For this to work everyone needs to take responsibility for providing cover; it was enquired how this will be tackled. KM responded that this can only be done by collaboration, putting organisational objectives to one side, and thinking about the wider System and individuals' outcomes; this is what the White Paper is trying to achieve. It will be challenging and there may well be organisational change because of it; however, it will not be possible to level up resources without doing something radically different.
- It was asked how organisations will hold each other to account. KM advised that this has already been achieved in some areas. Getting buy-in around shared outcomes will be a necessity; if people sign up to the same outcomes, they will hold each other to account by demonstrating what is working well and if not address why. If the people required to deliver the change own it and lead on it, it will become more successful.
- There are already many social prescribers as part of the PCNs who do a lot of the work to ascertain what is available, for example social and exercise groups; it was enquired whether this has been factored in and utilised. KM confirmed that the plan is very much to build on social prescribing; the strength-based approach will engage, learn, and expand from this to be more of a default where appropriate.
- The home visiting service is fantastic in Derby City, it provides holistic care and makes a real difference to the patients; however, it falls down on capacity, as by 9.30am there is no availability therefore a GP or ANP has to visit to assess the individual problem, as opposed to providing holistic care. This is an opportunity missed. KM responded that social care and occupational therapy is gearing up to work with the PCN to broaden capacity as far as possible.
- It was suggested that, by making use of the tradesmen/women who have regular contact with vulnerable patients, any health and wellbeing concerns could be acted upon before medical or social problems develop. It was enquired whether there is a mechanism for these concerns to be raised. KM considered this to be a good point. During the pandemic people had a lot of contact with vulnerable individuals. There is a need to make every contact count. In the care sector, private providers deliver care, therefore the barriers are broken down to work closely with them to support people in communities. Providing the wider members of society, who are interacting with vulnerable people, with a single contact point could prove advantageous. An ambition could be set

	<p>to publicise how citizens could pass on genuine concerns; it was suggested that Care Coordinators could act as points of contact for these concerns.</p> <ul style="list-style-type: none"> <li>• This plan is something that has been worked towards for a long time now and is an opportunity to put the patient at the centre of what we do. When measuring outcomes, by looking at the numbers it is hard to demonstrate savings to the System in a short period of time. Some good services which were delivering outcomes, have not been taken forward due to them being unable to prove their viability. There is a need for everyone to have faith that this is the right direction of travel.</li> <li>• There are massive challenges with the workforce. The home visiting service is just one model which could be tweaked to provide better delivery.</li> </ul> <p><b>The Governing Body NOTED the presentation provided</b></p>	
<p><b>GBP/2122/263</b></p>	<p><b>Finance Report – Month 10</b></p> <p>RCp provided an update on the financial position as at Month 10 (H2). The following points of note were made:</p> <ul style="list-style-type: none"> <li>• All targets will have been met at M10.</li> <li>• The CCG is anticipating receipt of £3.057m COVID reimbursement, £248k Winter Access Funding and £235k Additional Roles Reimbursement; once received, the Year To Date (YTD) underspend at M10 will be £140k.</li> <li>• The forecast outturn has moved to a £468k surplus following receipt of material late allocations, a balance sheet review, and the commitment to make an additional non-recurrent payment to the Better Care Fund.</li> <li>• Running costs remain underspent YTD although commitments have been made in response to the pandemic, driven pressures, planning requirements and the development of the ICS, which will reduce the forecast outturn underspend to just under £1m against a YTD surplus of just over £2m.</li> <li>• £2.937m of the H2 contingency has been released into the YTD position in line with the agreed plan.</li> <li>• The bridge between the extrapolation of YTD expenditure and forecast outturn was noted. The largest elements of the variation are Additional Roles Reimbursement expenditure and Winter Access Funds in Primary Care Co-Commissioning. It also includes material sums yet to be committed for mental health, and hypothecated funds yet to be distributed for cancer recovery, ambulance services and discharge support.</li> <li>• There are some movements the other way which reduce the YTD run rate in acute, community and primary care services, where funding provided in H1 is not anticipated in H2.</li> </ul> <p><b>The Governing Body NOTED the following:</b></p> <ul style="list-style-type: none"> <li>• <b>Allocations have been received for the full year at £2.097bn</b></li> <li>• <b>The YTD reported underspend at month 10 is £0.140m</b></li> <li>• <b>Retrospective allocations received for Half 1 Covid spend on the Hospital Discharge Programme and vaccination inequalities were £5.498m; further funding is expected of £3.057m relating to month 7 to 10</b></li> </ul>	

	<ul style="list-style-type: none"> <li>• <b>Additional anticipated funding includes:</b> <ul style="list-style-type: none"> <li>• <b>Elective Recovery Fund reimbursed £0.713m for April to January with an additional £0.107m received for months 10-11; the expectation is this will be returned to NHSE as we do not anticipate the activity</b></li> <li>• <b>Winter Access fund £0.248m YTD and forecast to spend and reimbursed £2.471m</b></li> <li>• <b>Additional Roles Reimbursement Scheme £0.235m YTD and forecast to spend and receive £5.759m</b></li> </ul> </li> <li>• <b>The year-end position is forecast at £0.468m surplus</b></li> </ul>	
<b>GBP/2122/264</b>	<p><b>Finance Committee Assurance Report – February 2022</b></p> <p>Andrew Middleton (AM) provided a verbal update following the Finance Committee meeting held on 24<sup>th</sup> February 2022. The following points of note were made:</p> <ul style="list-style-type: none"> <li>• The February meeting was a CCG Finance Committee meeting only not a joint CCG Finance and System Finance and Estates Committee (SFEC) meeting. An SFEC meeting was held yesterday which most of the CCG Finance Committee members were able to attend.</li> <li>• The Committee discussed next year's financial allocations which are currently unprecise.</li> <li>• The Committee was pleased to vote £10m into the Community Transformation Fund; this coincided with the planning of a deep dive into the governance and structure of the Better Care Fund (BCF). This will be timely for demonstrating the value of the existing and additional money, totalling more than £100m, and has the potential to be a proactive change budget.</li> <li>• This was Niki Bridge's last Finance Committee meeting prior to her leaving the CCG.</li> <li>• It was suggested that it would be useful for the Governing Body to be updated on the work being undertaken by Craig Cook on the Central Intelligence Agency and Maria Riley on the Efficiencies Programme. This would enable constructive feedback to be provided.</li> <li>• Safe outcomes are anticipated for this financial year and the preparations for the ICS are going well.</li> </ul> <p><b>The Governing Body NOTED the verbal update provided for assurance purposes</b></p>	<b>AB/CC</b>
<b>GBP/2122/265</b>	<p><b>Clinical and Lay Commissioning Committee (CLCC) Assurance Report – February 2022</b></p> <p>Dr Ruth Cooper (RC) provided an update following the CLCC meeting held on 10<sup>th</sup> February 2022. The report was taken as read and no questions were raised.</p> <p>This was RC's last meeting as Chair of the CLCC; RC was thanked for being such an excellent Chair of the meetings over the past few years. RC was wished well for the future.</p> <p><b>The Governing Body NOTED the paper for assurance purposes and RATIFIED the decisions made by the CLCC</b></p>	

<p><b>GBP/2122/266</b></p>	<p><b>Governance Committee Assurance Report – February 2022</b></p> <p>Jill Dentith (JD) provided an update following the Governance Committee meeting held on 10<sup>th</sup> February 2022. The report was taken as read and the following points of note were made:</p> <ul style="list-style-type: none"> <li>• The Committee received and approved the updated Health and Safety policy.</li> <li>• A discussion was held around the estates position, the current amber status and how this is being communicated to staff. The opportunities provided in relation to the different working arrangements and how they will be played out in the longer term were also considered.</li> <li>• A report was received on Quarter 3 Freedom Of Information (FOI) requests. It was noted that 2 FOI requests exceeded the statutory deadline of 20 working days during the Christmas period of Quarter 3; however, assurance was provided that the position has been reviewed and the issue will not occur again as part of any cover arrangements.</li> <li>• Policy development for the ICB was discussed and consideration was given as to how the policies would be approved and ratified going forward; assurance was provided that this work is ongoing.</li> <li>• Risk 32 was initially decreased but subsequently closed through virtual consideration by the Committee.</li> </ul> <p><b>The Governing Body NOTED the paper for assurance purposes</b></p>	
<p><b>GBP/2122/267</b></p>	<p><b>Primary Care Commissioning Committee (PCCC) Assurance Report – February 2022</b></p> <p>EP declared a conflict of interest in relation to this item</p> <p>Professor Ian Shaw (IS) provided an update following the PCCC meeting held on 23<sup>rd</sup> February 2022. The following points of note were made:</p> <ul style="list-style-type: none"> <li>• The Committee approved the full merger of Littlewick Medical Centre and Dr Purnell's practice in Ilkeston with effect from April 2022. The closure of the premises situated at Ilkeston Health Centre, with effect from April 2022, was agreed following a patient and stakeholder engagement. All staff and services will be provided from Littlewick Medical Centre. There will be no change to the combined practice boundaries. The Committee was satisfied with the business case and accepted that the patient consultation was compliant.</li> <li>• The Month 9 Finance Report was received.</li> <li>• No changes were made to the risk ratings this month.</li> <li>• An update was provided on the St Thomas Road GP Practice – APMS contract procurement.</li> <li>• The Primary Care Quality and Performance Public Assurance Report for Quarter 3 was received.</li> <li>• It was noted that the Village Surgery Care Quality Commission Inspection Outcome was rated inadequate.</li> </ul> <p><b>The Governing Body NOTED the paper for assurance purposes</b></p>	

<p><b>GBP/2122/268</b></p>	<p><b>Quality and Performance Committee (Q&amp;PC) Assurance Report – February 2022</b></p> <p>Dr Buk Dhadda (BD) provided an update following the Q&amp;PC meeting held on 24<sup>th</sup> February 2022. The report was taken as read and the following points of note were made:</p> <ul style="list-style-type: none"> <li>• The Committee is acutely aware of the performance issues with the two-week breast symptoms clinic and are keeping a close eye on this. A System-wide review was undertaken of the service last month, the outcome of which will be received by the Committee in March; the Governing Body will be updated accordingly next month.</li> <li>• The Committee approved the reply to the Derbyshire County Council care homes consultation around residential care facilities being closed in Derbyshire due to modernisation. The response will be sent from the CCG Chair.</li> <li>• Christine Urquhart is retiring from the CCG at the end of February. Christine has done some fantastic work on cancer care across the whole of Derbyshire over many years. Thanks were conveyed to Christine who was wished a happy and healthy retirement.</li> </ul> <p><b>The Governing Body NOTED the paper for assurance purposes</b></p>	
<p><b>GBP/2122/269</b></p>	<p><b>CCG Risk Register – February 2022</b></p> <p>HD advised that this report highlights areas of organisational risk recorded in DDCCG’s Corporate Risk Register as at 28<sup>th</sup> February 2022. All risks in the Register are allocated to one of the CCG’s Corporate Committees which reviews them on a monthly basis to ascertain whether any amendments in risk score are required.</p> <p>No changes have been made to the risk scores since the last meeting.</p> <p>Work is ongoing behind the scenes to ensure that a closing and opening position of the risks is undertaken in preparation for April; this is slightly complicated by ICB timescales. The work will need to be undertaken in the first quarter of the next financial year; this will help to shape the work going into the ICB where it is appropriate to do so. Further discussions will be held within the Corporate Committee meetings over the next few months.</p> <p><b>The Governing Body RECEIVED and NOTED:</b></p> <ul style="list-style-type: none"> <li>• <b>The Risk Register Report</b></li> <li>• <b>Appendix 1 as a reflection of the risks facing the organisation as at 28<sup>th</sup> February 2022</b></li> <li>• <b>Appendix 2 which summarises the movement of all risks in February 2022</b></li> </ul>	
<p><b>GBP/2122/270</b></p>	<p><b>Ratified Minutes of DDCCG’s Corporate Committees:</b></p> <ul style="list-style-type: none"> <li>• Governance Committee – 11.11.2021</li> <li>• Primary Care Commissioning Committee – 26.1.2022 – PB declared a conflict of interest in relation to this paper</li> <li>• Quality and Performance Committee – 27.1.2022</li> </ul> <p><b>The Governing Body RECEIVED and NOTED these minutes</b></p>	

<b>GBP/2122/ 271</b>	<b>South Yorkshire and Bassetlaw – ICS CEO Report – February 2022</b>	
	<b>The Governing Body RECEIVED and NOTED to update provided</b>	
<b>GBP/2122/ 272</b>	<b>Minutes of the Governing Body meeting in public held on 3<sup>rd</sup> February 2022</b>	
	<b>The minutes of the above meeting were agreed as a true and accurate reflection of the discussions held</b>	
<b>GBP/2122/ 273</b>	<b>Matters Arising / Action Log</b>	
	<u>Action Log – February 2022</u> – No outstanding items	
<b>GBP/2122/ 274</b>	<b>Forward Planner</b>	
	<b>The Governing Body NOTED the Planner for information</b>	
<b>GBP/2122/ 275</b>	<b>Any Other Business</b>	
	As previously mentioned, RC is retiring from the CCG this month; therefore, it was her last Governing Body meeting today. RC was thanked for all her help over the years for every aspect of the work she has undertaken for the NHS.	
	RC thanked everyone for their kind words. It has been a pleasure and privilege to work with the CCG and to be given the opportunity to make a difference. Everyone has supported each other through the challenging times but worked through them and come out the other side. Particularly after this morning's presentations, RC feels that we can start to make a big difference and build upon the work undertaken over last 3 years as a CCG.	
<b>DATE AND TIME OF NEXT MEETING</b> – Thursday 7 <sup>th</sup> April 2022 at 9am via MST		

Signed by: .....  
(Chair)

Dated: .....

**GOVERNING BODY MEETING IN PUBLIC  
ACTION SHEET – February 2022**

Item No.	Item title	Lead	Action Required	Action Implemented	Due Date
<b>2021/22 Actions</b>					
<b>GBP/2122/264</b>	<u>Finance Committee Assurance Report – February 2022</u>	Dr Chris Clayton / Dr Avi Bhatia	It was suggested that it would be useful for the Governing Body to be updated on the work being undertaken by Craig Cook on the Central Intelligence Agency and Maria Riley on the Efficiencies Programme to enable constructive feedback to be provided.	CC and AB to give this consideration	<b>May 2022</b>

## Derby and Derbyshire CCG Governing Body Forward Planner (April to June 22)

	APR	MAY	JUNE
<b>AGENDA ITEM / ISSUE</b>			
<b>WELCOME/ APOLOGIES</b>			
Welcome/ Apologies and Quoracy	X	X	X
Questions from the Public	X	X	X
Declarations of Interest <ul style="list-style-type: none"> <li>• Register of Interest</li> <li>• Summary register of interest declared during the meeting</li> <li>• Glossary</li> </ul>	X	X	X
<b>CHAIR AND CHIEF OFFICERS REPORT</b>			
Chair's Report	X	X	X
Chief Executive Officer's Report	X	X	X
<b>FOR DECISION</b>			
Review of Committee Terms of References/ ICB Shadow Committee Terms of References	X		
<b>FOR DISCUSSION</b>			
360 Stakeholder Survey			
Mental Health Update			
<b>CORPORATE ASSURANCE</b>			
Finance Report	X	X	X
Joint CCG Finance and System Finance and Estates Committee Assurance report	X	X	X
Quality and Performance Committee Assurance Report <ul style="list-style-type: none"> <li>• Quality &amp; Performance Report</li> <li>• Serious Incidents</li> <li>• Never Events</li> </ul>	X	X	X
Governance Committee Assurance Report		X	

	APR	MAY	JUNE
<b>AGENDA ITEM / ISSUE</b>			
<ul style="list-style-type: none"> <li>• Business Continuity and EPRR core standards</li> <li>• Complaints</li> <li>• Conflicts of Interest</li> <li>• Freedom of Information</li> <li>• Health &amp; Safety</li> <li>• Human Resources</li> <li>• Information Governance</li> <li>• Procurement</li> </ul>			
Audit Committee Assurance Report	X	X	X
Derbyshire Engagement Committee Assurance Report	X	X	X
Clinical and Lay Commissioning Committee Assurance Report	X	X	X
Primary Care Commissioning Committee Assurance Report	X	X	X
Risk Register Exception Report	X	X	X
Governing Body Assurance Framework Quarter 4	X		
Strategic Risks and Strategic Objectives		X	
Annual Report and Accounts			X
AGM			
Corporate Committees' Annual Reports			
<b>FOR INFORMATION</b>			
Director of Public Health Annual Report			
<b>Minutes of Corporate Committees</b>			
Audit Committee	X	X	X
Clinical & Lay Commissioning Committee	X	X	X
Derbyshire Engagement Committee	X	X	X
Joint CCG Finance and System Finance and Estates Committee	X	X	X

	APR	MAY	JUNE
<b>AGENDA ITEM / ISSUE</b>			
Governance Committee		X	
Primary Care Commissioning Committee	X	X	X
Quality and Performance Committee	X	X	X
Minutes of Health and Wellbeing Board Derby City	X		X
Minutes of Health and Wellbeing Board Derbyshire County	X		X
Minutes of Joined Up Care Derbyshire Board	X		X
Minutes of the SY&B JCCCG meetings – public / private	X	X	X
<b>MINUTES AND MATTERS ARISING FROM PREVIOUS MEETINGS</b>			
Minutes of the Governing Body	X	X	X
Matters arising and Action log	X	X	X
Forward Plan	X	X	X
<b>ANY OTHER BUSINESS</b>			