

NHS DERBY AND DERBYSHIRE CCG

GOVERNING BODY – MEETING IN PUBLIC

Date & Time: Thursday 7th October 2021 – 9.30am to 11.00am

Via Microsoft Teams

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

Item	Subject	Paper	Presenter	Time
GBP/2122/142	Welcome, Apologies & Quoracy Apologies: Dean Wallace	Verbal	Dr Avi Bhatia	9.30
GBP/2122/143	Questions from members of the public	Verbal	Dr Avi Bhatia	
GBP/2122/144	Declarations of Interest <ul style="list-style-type: none"> • Register of Interests • Summary register for recording any conflicts of interests during meetings • Glossary 	Papers	Dr Avi Bhatia	
CHAIR AND CHIEF OFFICER REPORTS				
GBP/2122/145	Chair's Report – September 2021	Paper	Dr Avi Bhatia	9.35
GBP/2122/146	Chief Executive Officer's Report – September 2021	Paper	Dr Chris Clayton	
GBP/2122/147	Joined Up Care Derbyshire Board Update – September 2021	Paper	Dr Chris Clayton	
FOR DECISION				
GBP/2122/148	Derbyshire Anchor Charter	Paper	Dr Avi Bhatia	9.50
GBP/2122/149	DDCCG Corporate Committees' Updated Terms of Reference	Paper	Helen Dillistone	

FOR DISCUSSION				
GBP/2122/150	Developing the operating model for the ICS <ul style="list-style-type: none"> • Strategic Intent 	Presentation	Dr Chris Clayton / Zara Jones	
CORPORATE ASSURANCE				
GBP/2122/151	Finance Report – Month 5	Paper	Richard Chapman	10.15
GBP/2122/152	Finance Committee Assurance Report – September 2021	Verbal	Andrew Middleton	
GBP/2122/153	Audit Committee Assurance Report and Annual Report – September 2021	Papers	Ian Gibbard	
GBP/2122/154	Clinical and Lay Commissioning Committee Assurance Report – September 2021	Paper	Dr Ruth Cooper	
GBP/2122/155	Derbyshire Engagement Committee Assurance Report – September 2021	Paper	Martin Whittle	
GBP/2122/156	Governance Committee Assurance Report – September 2021	Paper	Jill Dentith	
GBP/2122/157	Primary Care Commissioning Committee Assurance Report – September 2021	Verbal	Professor Ian Shaw	
GBP/2122/158	Quality and Performance Committee Assurance Report – September 2021	Paper	Dr Buk Dhadda	
GBP/2122/159	CCG Risk Register – September 2021	Paper	Helen Dillistone	
GBP/2122/160	Governing Body Assurance Framework 2021/22 Quarter 2	Paper	Helen Dillistone	
FOR INFORMATION				
GBP/2122/161	Joined Up Care Derbyshire Board ratified minutes – 15.7.2021	Paper	Dr Chris Clayton	10.45
GBP/2122/162	Ratified Minutes of Corporate Committees: <ul style="list-style-type: none"> • Audit Committee – 25.5.2021 • Derbyshire Engagement Committee – 17.8.2021 • Governance Committee – 22.7.2021 • Primary Care Commissioning Committee – 25.8.2021 • Quality and Performance Committee – 26.8.2021 	Papers	Committee Chairs	

GBP/2122/ 163	South Yorkshire and Bassetlaw Integrated Care System CEO Report – September 2021	Paper	Dr Chris Clayton	
MINUTES AND MATTERS ARISING FROM PREVIOUS MEETING				
GBP/2122/ 164	Minutes of the Governing Body Meeting in Public held on 2nd September 2021	Paper	Dr Avi Bhatia	10.55
GBP/2122/ 165	Matters arising from the minutes not elsewhere on agenda: <ul style="list-style-type: none"> • Action Log – September 2021 	Paper	Dr Avi Bhatia	
GBP/2122/ 166	Forward Planner	Paper	Dr Avi Bhatia	
GBP/2122/ 167	Any Other Business	Verbal	All	

Date and time of next meeting: Thursday 4th November 2021 from 9.30am to 11am – via Microsoft Teams

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

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

Name	Job Title	Committee Member	Also a member of	Declared Interest (Including direct/ indirect interest)	Type of Interest			Date of Interest		Action taken to mitigate risk		
					Financial Interest	Non-Financial Professional Interest	Non-Financial Personal Interest	Indirect Interest	From		To	
Bhatia, Dr Avi	Clinical Chair	Governing Body	Erewash Place Alliance Group Derbyshire Primary Care Leadership Group Derbyshire Place Board Joined Up Care Derbyshire Long Term Conditions Workstream	GP Partner at Moir Medical Centre GP Partner at Erewash Health Partnership Spouse works for Nottingham University Hospitals in Gynaecology Part landlord/owner of premises at College Street Medical Practice, Long Eaton, Nottingham	✓ ✓ ✓			✓	2000 April 2018 Ongoing Ongoing	Ongoing Ongoing Ongoing Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair	
Blackwell, Dr Penny	Governing Body GP	Governing Body	Derbyshire Primary Care Leadership Group Gastro Delivery Group Derbyshire Place Board Dales Health & Wellbeing Partnership Dales Place Alliance Group Joined Up Care Derbyshire Long Term Conditions Workstream	Director of Flourish Derbyshire Dales CIC, which aims to provide creative arts and activity projects and to support others in this activity for the Derbyshire Dales GP partner at Hannage Brook Medical Centre, Wirksworth. Interests in Drug misuse GP lead for Shared Care Pathology, Derbyshire Pathology Clinical advisor to the board of Sinfonia Viva, a professional orchestra	✓ ✓ ✓	✓ ✓ ✓			Feb 2019 Oct 2010 2011 01/04/2021	Ongoing Ongoing Ongoing Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair	
Braithwaite, Bruce	Secondary Care Specialist	Governing Body	Audit Committee Clinical & Lay Commissioning Committee	Shareholder in BD Braithwaite Ltd, which provides clinical services to Independent Healthcare Group and provides private medical services in the East Midlands (including patients who are not eligible for NHS funded treatment according to CCG guidelines) Employed by Nottingham University Hospital NHS Trust which is commissioned by the CCG to provide services to NHS patients. Founder Member, Shareholder and Director of Clinical Services for Alliance Surgical plc which is a company that bids for NHS contracts. Fellow of the Royal College Of Surgeons of England and Member of the Vascular Society of Great Britain and Ireland. Advisor to NICE on an occasional basis. Honorary Associate Professor, University of Nottingham, involved in clinical research activity in the East Midlands. Medical Director of Independent Healthcare Group which provides local anaesthetic services to NHS patients in Leicestershire, Gloucestershire, Wiltshire and Somerset. Chief Medical Officer for Circle Harmony Health Limited which is part owned by Circle Health Group who run BMI and Circle Hospitals	✓ ✓ ✓ ✓ ✓ ✓		✓ ✓ ✓		Aug 2014 Aug 2000 July 2007 Aug 1992 Aug 2009 Oct 2020 Aug 2020	Ongoing Ongoing Ongoing Ongoing Ongoing Ongoing Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair Declare interest in relevant meetings Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair No action required No action required Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair	
Chapman, Richard	Chief Finance Officer	Governing Body	Clinical & Lay Commissioning Committee Finance Committee Primary Care Commissioning Committee	Nil								No action required
Clayton, Dr Chris	Chief Executive Officer	Governing Body	Clinical & Lay Commissioning Committee Primary Care Commissioning Committee	Spouse is a partner in PWC				✓	2019	Ongoing		Declare interest at relevant meetings
Cooper, Dr Ruth	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Finance Committee North East Derbyshire & Bolsover Place Alliance Group Derbyshire Primary Care Leadership Group CRHFT Clinical Quality Review Group GP Workforce Steering Group Conditions Specific Delivery Board	Locum GP at Staffa Health, Tibshelf Shareholder in North Eastern Derbyshire Healthcare Ltd Director of IS and RC Limited, providing medical services to Staffa Health and South Hardwick PCN, which includes the role of clinical lead for the Enhanced Health in Care Homes project Fundraising Activities through Staffa Health to support Ashgate Hospice and Blythe House	✓ ✓ ✓ ✓				Dec 2020 2015 03/02/2021 Ongoing	Ongoing Ongoing Ongoing Ongoing	Declare interests at relevant meetings and Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair	
Dentith, Jill	Lay Member for Governance	Governing Body	Audit Committee Governance Committee Primary Care Commissioning Committee Remuneration Committee System Transition Committee System People and Culture Group	Self-employed through own management consultancy business trading as Jill Dentith Consulting Providing part-time, short term corporate governance support to Rotherham NHS Foundation Trust Director of Jon Carr Structural Design Ltd Providing part-time, short term corporate governance support to Sheffield Teaching Hospitals NHS Foundation Trust	✓ ✓ ✓ ✓ ✓				2012 6 Oct 2020 6 Apr 2021 07.06.2021	Ongoing 8 April 2021 Ongoing End date tbc	Declare interests at relevant meetings	

Dewis, Dr Robyn	Director of Public Health, Derby City Council	Governing Body	Clinical & Lay Commissioning Committee Clinical Policy Advisory Group Joint Area Prescribing Committee Conditions Specific Delivery Board CVD Delivery Group Derbyshire Place Board Derby City Place Alliance Group Respiratory Delivery Group	Nil							No action required
Dhadra, Dr Bukhtawar S	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Finance Committee Quality & Performance Committee UHDB Clinical Quality Review Group Clinical Policy Advisory Group	GP Partner at Swadincote Surgery	✓				2015	Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Dillstone, Helen	Executive Director of Corporate Strategy & Delivery	Governing Body	Engagement Committee Governance Committee	Nil							No action required
Gibbard, Ian	Lay Member for Audit	Governing Body	Audit Committee Clinical & Lay Commissioning Committee Finance Committee Governance Committee Remuneration Committee Individual Funding Requests Panel	Nil							No action required
Jones, Zara	Executive Director of Commissioning & Operations	Governing Body	Clinical & Lay Commissioning Committee Quality & Performance Committee CRHT Contract Management Board	Nil							No action required
Lloyd, Dr Steven	Medical Director	Governing Body	CVD Delivery Group Clinical & Lay Commissioning Committee Conditions Specific Delivery Board CRHT Contract Management Board 999 Quality Assurance Group Derbyshire Prescribing Group Derbyshire System Flu Planning Cell Finance Committee Primary Care Commissioning Committee Quality & Performance Committee GP Information Governance Assurance Forum Primary & Community Collaborative Delivery Board	GP Partner at St. Lawrence Road Surgery Clinical sessions at St. Lawrence Road Surgery Shareholder in premises of Emmett Carr Surgery, Renishaw; and St. Lawrence Road Surgery, North Wingfield	✓ ✓ ✓				2012 2012 Ongoing	Ongoing Ongoing Ongoing	Declare interests at relevant meetings
McCandish, Simon	Lay Member for Patient and Public Involvement	Governing Body	Clinical & Lay Commissioning Committee Engagement Committee Primary Care Commissioning Committee Quality & Performance Committee Commissioning for Individuals Panel (Shared Chair)	Nil							No action required
Middleton, Andrew	Lay Member for Finance	Governing Body	Audit Committee Finance Committee Quality & Performance Committee Remuneration Committee Commissioning for Individuals Panel (Shared Chair) Derbyshire System Finance Oversight Group	Lay Vice Chair of East Riding of Yorkshire Clinical Commissioning Group Lay Chair of Performers List Decision Panels for NHS England Central Midlands Lay Chair of Appointment Advisory Committees at United Hospitals Leicester - chairing panels for appointing hospital consultants Independent Non-Executive Director for Finance and Governance for Barnsley Healthcare Federation	✓ ✓ ✓				Jan 2017 May 2013 Mar 2020 Aug 2021	Mar 2023 Ongoing Mar 2023 Jul 2022	Declare interests at relevant meetings Will not sit on any case which has knowledge of the GP or their practice, or a consultant at Leicester
Pizzey, Dr Emma	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Governance Committee Quality & Performance Committee Erewash Place Alliance Group	Partner at Littlewick Medical Centre Executive director Erewash Health Partnership	✓ ✓				2002 Apr 2018	Ongoing Ongoing	Declare interests at relevant meetings. The INR service interest is to be noted at Governance Committee due to the procurement highlight report, which refers to, for information only, the INR service re-procurement. No further action is necessary as no decisions will be
Shaw, Professor Ian	Lay Member for Primary Care Commissioning	Governing Body	Clinical & Lay Commissioning Committee Engagement Committee Primary Care Commissioning Committee Primary Care Enhanced Services Review Group	Professor at the University of Nottingham Subject Matter Expert and advisory panel member in relation to research and service development at the Department of Health and Social Care	✓	✓			1992 Jan 2020	Ongoing Jan 2021	Declare interests at relevant meetings
Stacey, Brigid	Chief Nurse Officer	Governing Body	Clinical & Lay Commissioning Committee Finance Committee Primary Care Commissioning Committee Quality & Performance Committee CRHT Contract Management Board CRHT 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 CRHT Clinical Quality Review Group	GP Partner at Killamarsh Medical Practice Member of North East Derbyshire Federation Adult and Children Safeguarding Lead at Killamarsh Medical Practice Member of North East Derbyshire Primary Care Network Director of Killamarsh Pharmacy LLP - I do not run the pharmacy business, but rent out the building to a pharmacist	✓ ✓ ✓	✓			2009 2016 2009 18.03.20 2015	Ongoing Ongoing Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair INR service interest is to be noted at Governance Committee due to the procurement highlight report, which refers to, for information only, the INR service reprocurement. No further action is necessary as no decisions will be made at this meeting and the information provided does not cause a conflict.
Wallace, Dean	Director of Public Health, Derbyshire County Council	Governing Body	Derbyshire Place Board	Nil							No action required
Watkins, Dr Merryl	Governing Body GP	Governing Body	Clinical & Lay Commissioning Committee Quality & Performance Committee	GP Partner at Vernon Street Medical Centre Husband is Anaesthetic and Chronic Pain Consultant at Royal Derby Hospital	✓				2008 1992	Ongoing Ongoing	Withdraw from all discussion and voting if organisation is potential provider unless otherwise agreed by the meeting chair
Whittle, Martin	Lay Member for Patient and Public Involvement	Governing Body	Engagement Committee Finance Committee Governance Committee Quality & Performance Committee Remuneration Committee	Nil							No action required

SUMMARY REGISTER FOR RECORDING ANY INTERESTS DURING MEETINGS

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

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

Abbreviations & Glossary of Terms

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

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

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

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

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

Governing Body Meeting in Public

7th October 2021

Item No: 145

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

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

Recommendations

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

Report Summary

One of my current lead roles is as the Chair of the System's Transition Assurance Committee (TAC). TAC meets monthly to oversee issues related to the transition of Joined Up Care Derbyshire (JUCD) to become a statutory Integrated Care System (ICS) in April 2022. This includes the establishment of a statutory ICS Body, as well as the safe closedown of the CCG.

JUCD has a track record of working in partnership through its Board. It's an important reminder that an ICS has only ever been a desirable place in which to think jointly about health and social care; it has never been set out in legislation as a statutory requirement on any single partner organisation. Colleagues in Derby and Derbyshire have worked very hard to make the most of these flexible and voluntary arrangements and have made strong progress in setting our strategic direction and priorities in recent years. Our governance has become focussed on 'system', with a JUCD performance committee, JUCD finance committee and JUCD engagement committee, among many other markers of a system forging its path towards a unified way of thinking. We have been successful in that, within the processes and levers available to us.

Since the Government set out its plans to create statutory ICSs, we have been keen to protect the progress we have already made and not have to take retrograde steps. The plethora of guidance that we are now frequently receiving from NHS England in guiding us in the set up on our ICS requires considerable time to review, process and reflect upon, to see how our Derby and Derbyshire system can retain its core of success, whilst building on the additional statutory duties that will be placed upon it. It is pleasing that the guidance to date has come with an air of flexibility. Of course, NHS England and the Department of Health and Social Care must have some minimum standards across all 42 integrated care systems, to enable the consistent enactment of national policy and the monitoring of standards and performance. We feel that so far, the guidance gives Derby and Derbyshire sufficient permission to

retain that solid core and add to it in a way that fits our local requirements.

There is a school of thought that asks whether now is the right time to be reforming the health and social care system. We continue to manage the Covid-19 pandemic, we are attempting to recover those services that have needed to be paused or slowed during the last 18 months and we are currently dealing with what continues to be unprecedented system pressure as we head into the traditionally busy winter period. I believe that if there was a time to reform the system, it is now. Rather than baking in post-pandemic reform, and potentially risking a reversion to traditional ways of working, we can take what we have learned from collaboration, streamlined governance and a collective will to quickly solve problems and take a stride forward towards true system working, with the statute books giving us a helpful steer on the governance.

Of course, the NHS can't direct colleagues in local authority, so while the NHS can focus on creating the new Integrated Care Board to start from April 2022, we must work with adult care, public health, district and borough councils, the voluntary sector and others to ensure that our Integrated Care Partnership (ICP) is truly a jointly hosted party, and not the NHS inviting local authorities and others to its event. Our maturity as a system stands us in good stead to achieve this and become one of the best performing partnerships in England. I expect we will use April 2022 as a staging post for the creation of the ICP, where we will meet the minimum statutory requirements with a view to taking further steps to truly establish our system approach during the year.

While I do believe the timing is right from a policy perspective, what mustn't be lost is the challenge to our leadership capacity in implementing this change at the same time as managing those other major priorities. Workforce is a significant pressure to the health and social care system nationally, and that applies equally and differently to our executive colleagues and officers as it does to our clinical colleagues working on the frontline. There is much work to be done and it is important that we seek to retain our best clinicians, leaders and managers through the times ahead.

Finally, as CCG Chair, and as a GP working in Erewash, I would like to take the opportunity to congratulate Maggie Throup, MP for Erewash, on her appointment as Parliamentary Under Secretary of State (Minister for Prevention, Public Health and Primary Care).

Dr Avi Bhatia
Clinical 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

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

Governing Body Meeting in Public

7th October 2021

Item No: 146

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

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

Recommendations

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

Report Summary

This month I am pleased to be able to report to the Governing Body some important milestones being achieved in protecting our population.

Derby and Derbyshire has once again been leading the way in the delivery of the Covid-19 vaccination programme, commencing vaccinations within the booster phase with health and social care staff on 20th September. Boosters will be made available to all adults aged 50 and over during the next few months, and the message is that people should wait to be contacted with the offer of a vaccine, as with the initial vaccination roll out.

In the same week we started our programme of vaccinations for 12-15 year olds, delivered in schools by the School Age Immunisation Service. Once again, Derbyshire's ability to collaborate and plan as a system can be held up as an exemplar and we are confident of rolling the two programmes out in efficiently to help protect our population.

We are also now seeing the start of the influenza vaccination programme. This is being delivered in the usual way by our GP practices, community pharmacies and to staff via employers. Some practices have started their campaign, and this will spread across all practices during October.

The vaccination programmes are an essential part of our plans to keep our staff and services resilient during winter. Pressure on the health and social care system has been well-documented, and it continues. All services continue to provide care at maximum capacity, and while we have seen some short periods of respite, the challenge isn't going away. Our winter surge plan already feels as though it is in full force, but our collaboration as a system has seen us able to highlight some additional steps we can take to try to protect activity in our operating theatres (which continue to work hard to reduce waiting lists that have risen during the pandemic) and ensure that we maintain the flow of patients through our hospitals to ensure we can continue to treat our most unwell patients. Helping people to avoid illness, through vaccination, is a key part of this and therefore everyone eligible for a vaccination for Covid-19 booster or influenza is encouraged to play their part. We

submitted our outline winter plan to NHS England/Improvement on the 30th of September.

Of equal importance to keeping people healthy is our ability to support our workforce. In recent times, an additional focus has been to ensure that staff are protected as far as possible from being over-stretched, and another has been to ensure they are protected from abuse and discrimination. Unfortunately, instances have been on the rise and we have heard of some difficult stories from colleagues in other systems. Derbyshire is committed to work as a system to protect our staff and are in the process of aligning our policies and training in this area to give our staff the tools to deal with such challenges, and to reinforce the steps we will take should they be subjected to any form of violence, aggression, abuse or discrimination.

We take the views of our staff very seriously and seek to act when they let us know that something is not right. This week sees the launch of the 2021 National Staff Survey, and we are encouraging all staff to find a few minutes to take part in the survey and let us know what they think of the CCG as a place to work. The results are published in February, and we have been very pleased with the feedback received from staff on the engagement that has been taking place during the pandemic on key matters. Our staff are starting to slowly test the water on working back in the office environment, without any pressure to do so, and we will continue to review how that is working. We've learned a lot from the views of our staff on home working on how things can be done differently and more efficiently, and we have tried to capture that in our new operating model.

Looking forward, October will be an important month for our system in thinking through the way in which Derbyshire's Integrated Care Board and Integrated Care Partnership will operate. We have many detailed and productive discussions about this through the Joined Up Care Derbyshire during the course of 2021, but the time is now upon us to put a stake in the ground and confirm our proposals to NHS England in November. I'm working with system colleagues to create an appropriate engagement environment with our statutory partner organisations to come to a mutual position. There is already a lot of consensus on what this may look like, so these further discussions will certainly be able to build from a solid foundation, which is a good position for Derbyshire to be in.

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

Chris Clayton
Accountable Officer and Chief Executive

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

Meeting and purpose	Attended by	Frequency
NHS England and Improvement (NHSE/I)	Senior teams	Weekly
ICS and STP leads	Leads	Frequency tbc
Local Resilience Forum Strategic Coordinating Group meetings	All system partner CEOs	Weekly
System CEO strategy meetings	NHS system CEOs	Fortnightly
JUCD Board meetings	NHS system CEOs	Monthly
System Review Meeting Derbyshire	NHSE/System/CCG	Monthly
Executive Team Meetings	CCG Executives	Weekly
Accelerating our System Transformation	CCG/System/KPMG	Ad Hoc
2021/22 Planning – Derbyshire System	CCG/System/NHSE	Monthly
LRF/Derbyshire MPs	Members and MPs	Monthly
Derbyshire Chief Executives	System/CCG	Bi Monthly
EMAS Strategic Delivery Board	EMAS/CCGs	Bi-Monthly
Joint Health and Wellbeing Board	DCC/System/CCG	Bi-Monthly
NHS Midlands Leadership Team Meeting	NHSE/System/CCG	Monthly
Joint Committee of CCG	CCGs	Monthly
Derbyshire Covid-19 SCG Meetings	CEOs or nominees	Weekly
Outbreak Engagement Board	CEOs or nominees	Fortnightly
Partnership Board	CEOs or nominees	Monthly
Clinical Services and Strategies workstream	System Partners	Ad Hoc
Collaborative Commissioning Forum	CCG/NHSE	Monthly
Urgent and emergency care programme	UDB & CCG	Ad Hoc
System Operational Pressures	CCG/System	Ad Hoc
Clinical & Professional Reference Group	CCG/System	Ad Hoc
Derbyshire MP Covid-19 Vaccination briefings	CCG/MPs	Fortnightly
Regional Covid Vaccination Update	CCG/System/NHSE	Weekly
Gold Command Vaccine Update	CG/DCHS	Ad Hoc
Integrated Commissioning Operating Model	CCG/System/NHSE	Ad Hoc

System Transition Assurance Sub-Committee	CCG/System	Monthly
East Midlands ICS Commissioning Board	Regional AOs/NHSE	Monthly
Team Talk	All staff	Weekly
JUCD Finance Sub Committee	NHS/System CEOs	Monthly
ICS Shared Services Workshop	Regional AOs/NHSE	Ad Hoc
Strategic Intent Executive Group	CCG/System	Monthly
Senior Leader's Forum: UHDB Leadership Conference	JUCD	Ad Hoc
Development of the ICS and Implications for HWB	CCG/DCC	Ad Hoc

3.0 National developments, research and reports

3.1 [NHS to get £5.4bn extra to deal with Covid backlog](#)

The NHS in England will get an extra £5.4bn over the next six months to respond to Covid-19 and tackle the backlog caused by the pandemic, the government has announced.

3.2 [Boris Johnson outlines new 1.25% health and social care levy to pay for reforms](#)

A new health and social care levy will be introduced across the UK to pay for reforms to the care sector and NHS funding in England.

3.3 [New NHS clinical leadership to support post-COVID challenges](#)

Leading clinicians from across the health service have been appointed to new national clinical roles to help lead action on post-COVID challenges facing patients and staff. The five new clinical leads – covering urgent and emergency care, elective care and long COVID – will provide expert advice to the NHS Medical Director, Professor Stephen Powis.

3.4 [Covid booster vaccine rollout](#)

From w/c 20 September, over 30m people will be offered a third dose of a COVID-19 vaccination, with the Pfizer-BioNTech vaccination recommended. Those eligible for a third 'booster' vaccination include:

- All adults aged 50 years or over
- Older adults living in a residential care home
- Frontline health and social care workers
- All those aged 16 to 49 years with underlying health conditions that put them at higher risk of severe COVID-19
- Adult household contacts of immunosuppressed individuals

The 'booster' vaccination programme is separate to the [recommendation of third doses for people with severely weakened immune systems](#) - something that is already being rolled out. As was the case when the vaccination programme first

began, the NHS will contact people directly to let them know when it is their turn to get their booster vaccine.

[3.5 Children aged 12 to 15 become eligible for a Covid vaccination](#)

From w/c 20 September all children aged 12 to 15 in England became eligible to receive one dose of the Pfizer-BioNTech vaccination. It follows advice from the UK's chief medical officers, who said the vaccination will help reduce disruption to education.

Vaccinations will be carried out in schools, although it will not start in all schools immediately. Specific arrangements will be made with each school to ensure the vaccine is delivered safely and effectively.

3.6 Health and Care Bill

The NHS Confederation has produced [an overview and analysis](#) of the health and care bill, including their view on the detail and what lies ahead. The Bill is currently in the Committee stage of its passage through the Houses of Parliament.

3.7 Chief Executive Recruitment for the 42 Integrated Care Systems in England

NHS England began the recruitment process to appoint Chief Executive Officers for each of the 42 Integrated Care Systems in England.

[3.8 NHS launches world first trial for new cancer test](#)

The NHS launches the world's largest trial of a revolutionary new blood test that can detect more than 50 types of cancer before symptoms appear.

[3.9 NHS cholesterol-busting jab to save thousands of lives](#)

A new drug to lower cholesterol will be made available to hundreds of thousands of NHS patients, thanks to a world-leading deal announced by NHS England. The revolutionary new treatment, Inclisiran, is delivered as an injection twice a year and can be used alongside statins, adding to the options available for patients.

[3.10 NHS to diagnose thousands of patients with rare diabetes](#)

Genetic testing on the NHS will spot a rare form of diabetes in thousands of people unaware they are living with the disease, alongside a new training scheme for staff. The test being rolled out across England can also spot whether people have passed the affected gene on to their children.

[3.11 Life-saving world-first NHS test for pregnant women](#)

A same-day life-saving test to rule out a potentially fatal disease in pregnant women is being rolled out across the NHS. Known as placental growth factor (PLGF) testing, the new blood test is the first of its kind in the world to rule out pre-eclampsia – a life-threatening condition for both pregnant women and their babies.

4.0 Local developments

4.1 Vaccination Site Changes

There have been some changes to the venues of our vaccination centres this month. This is largely due to the premises used so far in the programme needing to return to their usual state as public venues.

Chesterfield's Winding Wheel has now closed as a vaccination centre and clinics have restarted at Walton Hospital. Derby Arena's vaccination centre has now closed, and with no delay clinics started the following day at Midland House in the centre of Derby.

4.2 Vacancies for Patient and Public Partners

Joined Up Care Derbyshire is recruiting a number of patient and public partners across a range of delivery groups to be part of its collaborative approach to developing and implementing transformational projects. These are non-paid roles but out of pocket expenses will be reimbursed. For more information about each opportunity, please click the links below:

- [Cardiovascular delivery group](#)
- [Diabetes delivery group](#)
- [Respiratory delivery group](#)

4.3 [Tribute to Derbyshire’s coronavirus victims approved](#)

Proposals for a memorial park to remember and honour local people who died from Covid-19 have been given the go-ahead.

4.4 [UHDB research unit ‘leading the way for innovations in clinical trials’ alongside AstraZeneca](#)

The exceptional innovations made to advance clinical trials at UHDB during the pandemic have been recognised nationally.

4.5 [Derbyshire County Council has been highly commended in a national award for its outstanding response to the Covid-19 pandemic](#)

Derbyshire County Council were honoured in the MJ Local Government Achievement Awards ‘Public Health Improvement’ category for their county-wide response to the pandemic and influence on national decision making.

4.6 Latest vaccination statistics

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

4.7 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

7th October 2021

Item No: 147

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

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

Which committee has the subject matter been through? N/A

Recommendations

The Governing Body is requested to **NOTE** the update provided from the Joined Up Care Derbyshire Board meeting held on 16th September 2021.

Report Summary

New Chair – Derbyshire Healthcare NHS Foundation Trust

Selina Ullah, the recently appointed chair of Derbyshire Healthcare NHS Foundation Trust, was welcomed by colleagues to her first JUCD Board meeting. This appointment follows Caroline Maley's retirement from the post earlier this month.

Patient Story – Improving Autism Services in Derbyshire

A consistent theme in the research has been the need for organisations to put effective feedback mechanisms in place. Many NHS organisations told us that they struggle to analyse qualitative feedback such as stories and are more comfortable with quantitative analysis and data such as survey results. The emerging ICS have been asked to develop the culture and systems to act on feedback. Organisations who invest in feedback possess an 'improvement mind-set' and are committed to getting better. They understand that change is possible, and that things can be done differently:

- To shine a light and inform the Board on national changes in Autism.
- To give feedback on the longitudinal experience and impact of our services.
- To provide information on the New National Strategy.

The Board heard the story of Trevor, who had received a positive experience at the point of diagnosis and the positive impact understanding his condition had since had on his life and self-esteem but had found it challenging to link to post-diagnosis support in Derbyshire and had looked further afield. His experiences with his daughter had seen a more challenging process towards diagnosis, reporting a lack of joined up services and noting improvements that could be made to simple processes to ensure they could work more efficiently. It has also been challenging

for his daughter when reaching the age of 18, with CAMHS support ceasing and there being a lack of adult support, exacerbated during the isolation of the Covid-19 pandemic. The Board considered what this experience means for our plans as an anchor institution in supporting employees who are neuro-diverse, the context of a whole-system approach needed to tackle the challenges faced by people with neuro-diversity and how we can enhance system leadership of this agenda from people with lived experience.

Current System Position

Significant system wide operational pressures continue to challenge the ICS as a collective with high demand and activity across all partners. The system's level of operational resilience remains challenged with the ICS continuing to operate at the highest levels of escalation, with bed occupancy levels across general and acute and mental health in excess of 95%, where evidence shows that a figure below 90% is optimum. From a critical care perspective, the Royal Derby Hospital are supporting network partners (particularly Nottingham University Hospitals) and Chesterfield Royal Hospital operating at 125% of their normal critical care bedded capacity.

There are some specific services where operational resilience is of concern and impact on our ability to deliver comprehensive care including community nursing and therapy, care staff to support packages of care, theatre and medical assessment unit staffing. Given the pressures currently being faced by both our acute hospitals, this is a particular concern. Our System Operational Resilience Group continue to oversee the response and co-ordinate partner actions and collective actions to manage the current pressures. It has been and continues to be a considerable system effort in solving the challenges faced.

Our journey towards a statutory ICS

The pace of change was recognised by the Board, with guidance on progression towards the implementation of statutory ICS bodies being received and interpreted very regularly, and this at the time of a system under significant pressure in delivering 'business as usual' services and activities. Our capacity to implement these changes will be reviewed.

1. National ICS Guidance and Assurance

August 2021 has seen the publication of several key national guidance documents that will inform the work underway within JUCD. Each of the documents published has been reviewed by the ICS Transition Leadership Group. This series of guidance is primarily focused on supporting the legal establishment and operational readiness for April 2022 and includes materials such as the ICS Readiness to Operate Statement (ROS) and the ICS Establishment Guidance (Due Diligence). NHS England/Improvement has confirmed that the ICS ROS will be the primary mechanism for reporting and assuring progress towards ICS establishment.

NHS England/Improvement has provided feedback on System Development Plan and Transition Plan. These documents set out the steps we need to take to become a statutory ICS on 1st April 2022, including the closedown of NHS Derby and Derbyshire CCG, and to develop our system so that we can effectively deliver our ambitions for the people of Derby and Derbyshire. Feedback was very positive with

a recognition that our system plans are well developed with a clear direction of travel to evolve and mature our ways of working. Areas noted for further development included setting out the role of the ICB organisation and the ICP, and that of place and provider collaboratives at scale.

2. Developing the ICS Operating Model

There is a focus on the function of the statutory Integrated Care Board (which is the organisation coordinating and delivering NHS care) and the Integrated Care Partnership (a statutory committee of the ICB involving a broad range of NHS, local authority and other public sector partners). On Wednesday 15th September, NHS England/Improvement issued an engagement document' promoting discussions on the creation of ICPs, which supports discussions that have been ongoing by the JUCD Board over recent months.

This process is complex to ensure we maximise our opportunities for partnership working to improve local health and wellbeing and reduce health inequalities, build upon those structures and processes that already exist and should continue, and discharge the duties placed upon us by the forthcoming guidance. Understanding the roles and the relationship of and between the Integrated Care Partnership (ICP), the Integrated Care Board (ICB), our existing Health and Wellbeing Boards, the role and links with Place Partnerships and the way we include and consult other partners including the voluntary sector, education, our district and borough councils and anchor and other partners is crucial, and this remains an ongoing conversation through September, with further discussion at the October JUCD Board meeting.

3. Other transition items

The Transition Assurance Committee reviews delivery against the plan to establish the new ICB and ICP and provides assurance to the Board. Items currently in scope for review include the memorandum of understanding which sets out oversight agreements and ways of working between respective parties involved in the transition; the work to understand the transfer process related to the decision to include Glossop within the boundary of the Derbyshire ICS; the mapping of functions of the CCG and others which require consideration in the formation of the new bodies and; due diligence across a range of areas in line with the nationally-mandated checklist.

4. Board Appointments

Appointment of JUCD ICS Chair and CEO Designates Confirmation has been received from NHSEI of the appointment of John MacDonald as the JUCD ICS Chair and designate Chair of anticipated NHS Integrated Care Board. The recruitment process for the ICS CEO designate is progressing. It is anticipated that interviews will take place 13th October 2021 with confirmation of successful candidate by the end of October.

5. Midlands Region Approach to ICS Development

Regional workstreams are in place to support the 11 ICS systems across the region to develop. JUCD ICS has representation on each of the agreed regional workstreams:

Workstream	Focus
ICS Governance and Accountability	Support the development of ICSs in support of ICS functions including but not limited to the accountability and governance requirements of ICSs, informed by System Development Plans, and legislative requirements of ICSs.
Joint and Integrated Commissioning	Develop approaches to integrating commissioning functions including NHSEI Specialised and Direct Commissioning and pan system provider collaboratives
Place	Further support the development of Places across the Midlands including identification and spread of good practice
Provider Collaboratives	Support the development of provider collaboratives specifically providers working at scale, across multiple places, to achieve the benefits of collaborative working
Finance	Support the implementation of national guidance for ICSs including how money will flow to and through systems and how financial governance and accountability arrangements will operate.
Digital, Data and Intelligence	To focus on the digital and technology requirements to enable effective, joined up system working and how data and intelligence is made accessible and used to drive good decision to improve health outcomes and experiences of care
People and Culture	To ensure strong alignment between national policy and framework development, regional and system priorities and achievement of the shared vision for ICS development with regards to workforce and OD.

The collective purpose of the regional workstreams are to:

- Influence national ICS policy and approaches to implementation based on the experience of Midlands Systems
- Ensure that there is consistency in interpretation across Midlands Systems whilst recognising that there needs to be flexibility to adapt to the needs of local Systems and characteristics local populations
- Further support the development of ICSs (including Midlands Strategic Transformation and Recovery Board recommendations) and the implementation of transition to statutory ICSs (subject to legislation) Identify, agree and deliver regional support offers at scale to support progression including identification and sharing of good practice and learning from the experiences of others outside of the region
- Identify those areas of collaboration where a do once approach would be beneficial
- Identify implications for and influence the future NHSEI regional operating model
- System sponsorship, representation and engagement throughout

JUCD Derbyshire continues to learn from, and share intelligence and good practice, with ICS partners through the above regional workstreams. Additionally, the agreed buddying arrangement with Coventry and Warwickshire ICS continues to provide fruitful sharing of key ICS development documentation.

Establishing a system Programme Management Office

Work continues to progress at pace in establishing the transformational approach and programme management arrangements. The JUCD Senior Leadership Team has supported procurement of a digital PMO solution which provides the system with an opportunity to design and build an ICS tool that:

- Captures transformational aims and outcomes of the whole programme in a consistent way;
- Enables strategic confirm and challenge of the programme;
- Supports ownership of and accountability for change at delivery level;
- Standardises programme management processes and reduces duplication;

- Provides real time intelligence and oversight; and
- Standardises reporting and strengthens decision making.

System Financial Position

The Board had an in-depth conversation about the system's current financial status, including the ways we are addressing the underlying financial deficit within the NHS. Opening facts were that Derbyshire NHS currently allocates more money to its providers than it receives, resulting in an underlying financial deficit. Additionally, our provider organisations spend more than they are allocated. Finally, if we were to deliver all the care we are required to deliver, it would far exceed the allocations we currently receive. It is the job of the ICS to review these issues and to find solutions.

A strategic proposal in allocating and managing our finances is the value created by using our financial and other resources in new ways. Value in this context might be health outcome, quality of care, equity, user experience and resource consumption. All resources are finite, and this balance of allocating resources is not something we can move to quickly, but it will allow direct comparisons between opportunities to allocate resource to inform decision making and prioritisation.

We will take steps to align our transformation approach, with single calculations of investments and savings, reviewing our allocation and spend alongside each other. This needs to be allied to the work defined through our strategic intent and population health management priorities, with an understanding of how the financial flows work through our system through to our places, to ensure we can bring our system back to financial balance whilst also delivering the health and wellbeing improvements we desire across Derby and Derbyshire.

Place and Provider Collaboration

The Board heard updates on our work in developing our collaborative Place Partnerships, which have included the continued development of the operating model for place-based working, with involvement and support from all partners. This is benefitting from the receipt of ongoing national guidance and the progress with other building blocks within the Derby and Derbyshire system. Our approach to seeking the views of local citizens will be piloted in smaller areas, making use of the existing community engagement assets available to us in places, and benefitting from some of the system level engagement mechanisms we have been developing.

Our work to implement providers collaborating at scale is related to the place developments but requires a separate development journey to ensure we are in line with national guidance in this area. Consideration of the range of leadership models available has seen a recommendation for a Provider Leadership Board which brings together an alliance approach among providers. This is important for our governance processes, as we seek to promote decision-making as close to the patient as possible. The conversation continues, and we must have our model agreed by 31st March 2022.

System Leadership and Organisational Development

Through the discussion arising from many of the agenda items, a theme of collective leadership principles to help align the aspirations and common purpose of the

system. The People and Culture Strategic Oversight Group are building on the existing organisational development programme to further bind the shared work on the transition process, our approach towards a different financial regime, our workforce development and the clarity we can share on our main priorities as a system.

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

None as a result of this report.

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

Not applicable to this report.

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

Not applicable to this report.

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

Not applicable to this report.

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

Not applicable to this report.

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

Not applicable to this report.

Have any Conflicts of Interest been identified/ actions taken?

Not applicable to this report.

Governing Body Assurance Framework

To support the development of a sustainable health and care economy that operates within available resources, achieves statutory financial duties and meets NHS Constitutional standards.

Identification of Key Risks

Not applicable to this report.

Governing Body Meeting in Public

7th October 2021

Item No: 148

Report Title	Derbyshire Anchor Charter
Author(s)	Anchor Institutions
Sponsor (Director)	Dr Avi Bhatia, Clinical Chair

Paper for:	Decision	x	Assurance	Discussion	Information
Assurance Report Signed off by Chair			N/A		
Which committee has the subject matter been through?			N/A		
Recommendations					
The Governing Body is requested to AGREE the Derbyshire Anchor Charter.					
Report Summary					
<p>Working as a system alongside other local organisations, the Anchor Partnership has a significant responsibility to enable and facilitate Community Wealth Building. This means using the economic levers available to develop resilient, inclusive local economies within Derby/Derbyshire with more local spend and fair employment, as well as a larger and more diverse business base, ensuring that wealth is more locally owned and benefits all the residents of Derby/Derbyshire.</p> <p>The Derby/Derbyshire Anchor Partnership has therefore agreed to initially focus on two impact areas:</p> <ul style="list-style-type: none"> • Workforce and Access to Work • Procurement 					
Are there any Resource Implications (including Financial, Staffing etc)?					
Not applicable					
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?					
Not applicable					
Has a Quality Impact Assessment (QIA) been completed? What were the findings?					
Not applicable					
Has an Equality Impact Assessment (EIA) been completed? What were the findings?					
Not applicable					

Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
Not applicable
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Not applicable
Have any Conflicts of Interest been identified / actions taken?
Not applicable
Governing Body Assurance Framework
This paper supports the CCG in working with the Derbyshire system to maintain a strategic focus on overall health outcomes / health inequalities
Identification of Key Risks
BAF 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

Putting Derby/Derbyshire First & Keeping it Local

Anchor Charter

We are **Anchor Institutions** because we are rooted in Derby/Derbyshire by our vision, histories, land, assets, and vitally our established local relationships. As a group of Anchor Institutions working as a system, we have a significant responsibility to enable and facilitate **Community Wealth Building**. This means we use the economic levers available to us to develop resilient, inclusive local economies within Derby/Derbyshire with more local spend and fair employment, as well as a larger and more diverse business base, ensuring that wealth is more locally owned and benefits all the residents of Derby/Derbyshire.

Derby/Derbyshire Anchor Charter Mission Statement

To commit to long-term collaboration between Derby/Derbyshire Anchor Institutions, supporting shared Community Wealth Building goals to improve collective wellbeing and create a strong, resilient and inclusive Derby/Derbyshire economy.

We recognise as Anchor Institutions in Derby/Derbyshire we can have an impact in 5 key areas workforce/access to work, procurement, partnering in place, buildings and the environment.

As Partners we recognise significant work is already underway in these areas – our role is not to replicate but to add value and level up.

Keeping it local – Our Charter:

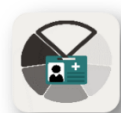
As Derby/Derbyshire's Anchor Organisations we agree

- ❖ We will recognise our role in being a local anchor and commit to working with partners in the Anchor Partnership to maximise the

collective influence we have in addressing socio-economic and environmental determinants

- ❖ We will embed this anchor Charter into our ethos through our organisational vision, values, culture, communications, behaviours, leadership, corporate planning and budgeting, we will seek to support inclusive, sustainable growth and the people and communities we are anchored within.
- ❖ We will use the Charter as an enabling/permission giving tool within our organisations and sectors that will act as a catalyst for change and a shared learning opportunity.
- ❖ Through the Charter, Partners will develop mutual mechanisms for accountability built on trust, shared aims and a joint understanding of our core aim
- ❖ We will listen to our diverse communities to ensure that our mission addresses what matters most to them and work with them through our partnerships to make sure our influence supports positive change
- ❖ We will work together through the Derby and Derbyshire Health and Wellbeing Boards and the Joined-Up Care Derbyshire ICS Board to seek and agree best practice, to measure impact and hold each other to account. We will share best practice and learning as an active Anchor Partnership within the system and with wider partners, focussing on our commonality and difference working from our points of strength as a partnership

As a Derby/Derbyshire Anchor Partnership, we have agreed to initially focus our combined influence and actions on the following two impact areas:



Workforce and Access to Work



Partnering in Place, Neighbourhoods and local communities



Procurement





Buildings



The Environment

Signatories to the Anchor Charter and members of Derbyshire's founding Anchor Partnership are:



Governing Body Meeting in Public

7th October 2021

	Item No: 149
Report Title	DDCCG Corporate Committees' Updated Terms of Reference
Author(s)	Suzanne Pickering, Head of Governance
Sponsor (Director)	Helen Dillistone, Executive Director of Corporate Strategy and Delivery

Paper for:	Decision	X	Assurance	Discussion	Information
Assurance Report Signed off by Chair			N/A		
Which committee has the subject matter been through?			Audit Committee – 16.9.2021 Clinical & Lay Commissioning Committee – 9.9.2021 Engagement Committee - 21.9.2021 Finance Committee - 30.9.2021 Governance Committee - 23.9.2021 Primary Care Commissioning Committee – 22.9.21 Quality & Performance Committee - 30.9.2021		
Recommendations					
The Governing Body is requested to APPROVE the Corporate Committee Terms of References.					
Report Summary					
<p>As part of the Governing Body's six-month review of all Committee Terms of Reference, the following Terms of Reference have been reviewed and agreed by their respective Committee, and any amendments are shown in red font within the document.</p> <p>The following Corporate Committee Terms of References are presented for approval:</p> <ul style="list-style-type: none"> • Audit Committee • Clinical and Lay Commissioning Committee; • Engagement Committee; • Finance Committee • Governance Committee; • Primary Care Commissioning Committee; and • Quality and Performance Committee. 					

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

NHS Derby and Derbyshire Clinical Commissioning Group

Committee Terms of Reference

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Audit Committee

Terms of Reference

1. PURPOSE

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

2. ROLES AND RESPONSIBILITIES

The Committee will incorporate the following duties:

2.1 Integrated governance, risk management and internal control

- 2.1.1 The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the CCG’s activities that support the achievement of the CCG’s objectives. Its work will dovetail with that of the Quality and Performance Committee which the CCG has established to seek assurance that robust clinical quality is in place.
- 2.1.2 In particular, the Committee will review the adequacy and effectiveness of:
 - all risk and control related disclosure statements (in particular the governance statement), together with any appropriate independent assurances, prior to endorsement by the CCG;
 - the underlying assurance processes that indicate the degree of achievement of the CCG’s objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
 - the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification; and
 - the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the NHS Counter Fraud and Security Management Service.

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

2.1.4 The Committee will oversee the transition of the committee and its assurance functions to the Integrated Care Board.

2.2 Internal Audit

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

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

2.3 External Audit

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

- consideration of the performance of the External Auditors, as far as the rules governing the appointment permit;
- discussion and agreement with the External Auditors, before the audit commences, on the nature and scope of the audit as set out in the annual plan, and ensuring coordination, as appropriate, with other external auditors in the local health economy;
- discussion with the External Auditors of their local evaluation of audit risks and assessment of the CCG and associated impact on the audit fee;

- review of all external audit reports, including the report to those charged with governance, agreement of the annual audit letter before submission to the CCG and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

2.4 Other assurance functions

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

2.5 Counter fraud

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

2.6 Management

- 2.6.1 The Committee shall request and review reports and positive assurances from directors and officers of the CCG on the overall arrangements for governance, risk management and internal control.
- 2.6.2 The Committee may also request specific reports from individual functions within the CCG as they may be appropriate to the overall arrangements.

2.7 Financial reporting

- 2.7.1 The Committee shall monitor the integrity of the financial statements of the CCG and any formal announcements relating to the CCG's financial performance.
- 2.7.2 The Committee shall ensure that the systems for financial reporting to the CCG, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the CCG.
- 2.7.3 The Committee shall review and approve the annual report and financial statements on behalf of the Governing Body and the CCG, focusing particularly on:
- the wording in the governance statement and other disclosures relevant to the terms of reference of the Committee;
 - changes in, and compliance with, accounting policies, practices and estimation techniques;
 - unadjusted mis-statements in the financial statements;
 - significant judgements in preparing of the financial statements;
 - significant adjustments resulting from the audit;

- letter of representation; and
- qualitative aspects of financial reporting.

2.8 Whistleblowing

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

2.9 Conflicts of Interest

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

3. CHAIR ARRANGEMENTS

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

4. MEMBERSHIP

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

4.2 Membership will comprise:

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

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

5. DECLARATIONS OF INTEREST, CONFLICTS AND POTENTIAL CONFLICTS

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

5.2 Where a member of the committee is aware of an interest, conflict or potential conflict of interest in relation to the scheduled or likely business of the meeting, they

¹ <https://www.england.nhs.uk/wp-content/uploads/2017/06/revised-ccg-conflict-of-interest-guidance-v7.pdf>

will bring this to the attention of the Chair of the meeting as soon as possible, and before the meeting where possible.

- 5.3 The Chair of the meeting will determine how this should be managed and inform the member of their decision. The Chair may require the individual to withdraw from the meeting or part of it. Where the Chair is aware that they themselves have such an interest, conflict or potential conflict of interests they will bring it to the attention of the Committee, and the Deputy Chair will act as Chair for the relevant part of the meeting.
- 5.4 Any declarations of interests, conflicts and potential conflicts, and arrangements to manage those agreed in any meeting of the Committee, will be recorded in the minutes.
- 5.5 Failure to disclose an interest, whether intentional or otherwise, will be treated in line with the Managing Conflicts of Interest: Revised Statutory Guidance and may result in suspension from the Committee.
- 5.6 All members of the Committee shall comply with, and are bound by, the requirements in the CCG's Constitution, Standards of Business Conduct and Managing Conflicts of Interest Policy, the Standards of Business Conduct for NHS staff (where applicable) and NHS Code of Conduct.

6. QUORACY

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

7. DECISION MAKING AND VOTING

- 7.1 The Committee will use its best endeavours to make decisions by consensus. Exceptionally, where this is not possible the Chair (or Deputy) may call a vote.
- 7.2 Only members of the Committee set out in section 4 have voting rights. Each voting member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.
- 7.3 If a decision is needed which cannot wait for the next scheduled meeting or it is not considered necessary to call a full meeting, the Committee may choose to convene a telephone conference or conduct its business on a 'virtual' basis through the use of email communication. Minutes will be recorded for telephone conference and virtual meetings in accordance with relevant sections of the Derby and Derbyshire CCG Governance Handbook.

8. ACCOUNTABILITY

The Committee is authorised by the Governing Body to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Committee. The Committee is authorised by the Governing Body to obtain outside

legal or other independent professional advice and secure the attendance of external personnel with relevant experience and expertise if it considers this necessary.

9. REPORTING ARRANGEMENTS

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

10. ATTENDANCE AT MEETINGS

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

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

- 10.5 any other officers of the CCG who have responsibility for specific areas (or similar) may be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director; and
- 10.6 the chair of the Governing Body may also be invited to attend one meeting each year in order to form a view on, and understanding of, the Audit Committee's operations.

11. FREQUENCY AND NOTICE OF MEETINGS

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

12. SUB-COMMITTEES

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

13. ADMINISTRATIVE SUPPORT

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

14. REVIEW OF TERMS OF REFERENCE

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

Reviewed by Audit Committee:

16th September 2021

Approved by Governing Body:

7th October 2021

Review Date:

Close of CCG on 31st March 2022

Primary Care Commissioning Committee

Terms of Reference

1. INTRODUCTION

- 1.1 In accordance with its statutory powers under section 13Z of the National Health Service Act 2006 (as amended); NHS England has delegated the exercise of the functions specified in Schedule 2 to these Terms of Reference to NHS Derby and Derbyshire CCG. Schedule 1 and 2 are specified in the NHS Derby and Derbyshire CCG Delegated Agreement.
- 1.2 The CCG has established the Primary Care Commissioning Committee (the “Committee”). The Committee will function as a corporate decision-making body for the management of the delegated functions and the exercise of the delegated powers.
- 1.3 It is a committee comprising representatives of the following organisations:
 - NHS Derby and Derbyshire Clinical Commissioning Group (the “CCG”).

2. STATUTORY FRAMEWORK

- 2.1 NHS England has delegated to the CCG authority to exercise the primary care commissioning functions set out in Schedule 2 in accordance with section 13Z of the National Health Service Act 2006 (as amended).
- 2.2 Arrangements made under section 13Z may be on such terms and conditions (including terms as to payment) as may be agreed between NHS England and the CCG.
- 2.3 Arrangements made under section 13Z do not affect the liability of NHS England for the exercise of any of its functions. However, the CCG acknowledges that in exercising its functions (including those delegated to it), it must comply with the statutory duties set out in Chapter A2 of the NHS Act and including:
 - 2.3.1 management of conflicts of interest (section 14O);
 - 2.3.2 duty to promote the NHS Constitution (section 14P);
 - 2.3.3 duty to exercise its functions effectively, efficiently and economically (section 14Q);
 - 2.3.4 duty as to improvement in quality of services (section 14R);
 - 2.3.5 duty in relation to quality of primary medical services (section 14S);
 - 2.3.6 duties as to reducing inequalities (section 14T);
 - 2.3.7 duty to promote the involvement of each patient (section 14U);

- 2.3.8 duty as to patient choice (section 14V);
- 2.3.9 duty as to promoting integration (section 14Z1);
- 2.3.10 public involvement and consultation (section 14Z2).
- 2.4 The CCG will also need to specifically, in respect of the delegated functions from NHS England, exercise those set out below:
 - duty to have regard to impact on services in certain areas (section 13O);
 - duty as respects variation in provision of health services (section 13P).
- 2.5 The Committee is established as a committee of the Governing Body in accordance with Schedule 1A of the National Health Service Act 2006 (NHS Act).
- 2.6 The members acknowledge that the Committee is subject to any directions made by NHS England or by the Secretary of State.

3. ROLE OF THE COMMITTEE

- 3.1 The Committee has been established in accordance with the above statutory provisions to enable the members to make collective decisions on the review, planning and procurement of primary care services in the CCG, under delegated authority from NHS England.
- 3.2 In performing its role the Committee will exercise its management of the functions in accordance with the agreement entered into between NHS England and the CCG, which will sit alongside the delegation and terms of reference.
- 3.3 The functions of the Committee are undertaken in the context of a desire to promote increased co-commissioning to increase quality, efficiency, productivity and value for money and to remove administrative barriers.
- 3.4 ~~The Committee have oversight of the CCG Recovery and Restoration work related to the Health and Care Pillar and will receive assurance regarding progress.~~
- 3.5 The role of the Committee shall be to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act. This includes the following decisions in relation to the commissioning, procurement and management of Primary Medical Services Contracts, including but not limited to the following activities:
 - 3.5.1 decisions in relation to Enhanced Services;
 - 3.5.2 decisions in relation to Local Incentive Schemes (including the design of such schemes);
 - 3.5.3 decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices;
 - 3.5.4 decisions about 'discretionary' payments;

- 3.5.5 decisions about commissioning urgent care (including home visits as required) for out of area registered patients;
 - 3.5.6 the approval of practice mergers;
 - 3.5.7 planning primary medical care services in the Area, including carrying out needs assessments;
 - 3.5.8 undertaking reviews of primary medical care services in the Area;
 - 3.5.9 decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list);
 - 3.5.10 management of the Delegated Funds in the Area;
 - 3.5.11 Premises Costs Directions Functions;
 - 3.5.12 co-ordinating a common approach to the commissioning of primary care services with other commissioners in the Area where appropriate; and
 - 3.5.13 such other ancillary activities that are necessary in order to exercise the Delegated Functions.
- 3.6 The CCG will also carry out the following activities to:
- 3.6.1 plan, including needs assessment, primary medical care services in the CCG's geographical area;
 - 3.6.2 undertake reviews of primary medical care services in the CCG's geographical area;
 - 3.6.3 co-ordinate a common approach to the commissioning of primary care services generally;
 - 3.6.4 manage the budget for commissioning of primary medical care services in the CCG's geographical area.
- 3.7 The Committee will also oversee the transition of the committee to the Integrated Care Board.

4. GEOGRAPHICAL COVERAGE

The Committee will comprise NHS Derby and Derbyshire CCG's geographical area.

5. MEMBERSHIP

- 5.1 The membership of the Committee is as follows:
- 3 x Governing Body Lay Members;
 - Chief Finance Officer or nominated Deputy;
 - Chief Nurse Officer or nominated Deputy;

- Medical Director or nominated Deputy.

5.2 Representatives shall attend the Committee as regular attendees as follows:

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

5.3 Officers of the CCG shall attend or nominate deputies appropriate to the items for discussion on the agenda. The Committee may also request attendance by appropriate individuals to present relevant reports and/ or advise the Committee.

5.4 The Chair of the Committee shall be the Governing Body Primary Care Commissioning Lay Member.

5.5 The Deputy Chair of the Committee shall be a Patient and Public Involvement Lay Member.

5.6 GP members of the Governing Body shall be invited to attend meetings to participate in strategic discussions on primary care issues, subject to adherence with the CCG's conflicts of interest requirements and the appropriate management of conflicts of interest. They will be required, for example, to withdraw from the meeting during the deliberations leading up to decisions and from the decision where there is an actual or potential conflict of interest.

6. MEETINGS AND VOTING

6.1 The Committee will operate in accordance with the CCG's Standing Orders. The Secretary to the Committee will be responsible for giving notice of the meetings. This will be accompanied by an agenda and supporting papers and sent to each member representative no later than five working days before the date of the meeting. When the Chair of the Committee deems it necessary in light of the urgent circumstances to call a meeting at short notice, the notice period shall be such as s/he shall specify.

6.2 Each member of the Committee shall have one vote. The Committee shall reach decisions by a simple majority of members present, but with the Chair having a second and deciding vote, if necessary. However, the aim of the Committee will be to achieve consensus decision-making wherever possible.

6.3 If a decision is needed which cannot wait for the next scheduled meeting or it is not considered necessary to call a full meeting, the Committee may choose to convene a telephone conference or conduct its business on a 'virtual' basis through the use of email/online communication platform. Minutes will be recorded for telephone conference and virtual meetings in accordance with the Derby and Derbyshire Corporate Governance Framework at Section 5.4.

6.4 Members are required to declare any interest relating to any matter to be considered at each meeting, in accordance with the CCG's constitution and the CCG Standards for Business Conduct and Managing Conflicts of Interest Policy. Members who have

declared an interest will be required to leave the meeting at the point at which a decision on such matter is being made. At the discretion of the Chair, they may be allowed to participate in the preceding discussion.

7. QUORUM

- 7.1 A quorum shall be four voting members, at least two of whom shall be Lay Members, to include the Chair or Deputy Chair. Deputies are invited to attend in the place of the regular members as required.
- 7.2 A duly convened meeting of the Committee at which quorum is present at the meeting, or are contactable by telephone conference call, is competent to exercise all or any of the authorities, powers and discretions vested in or exercisable by the Committee.
- 7.3 If a decision is needed which cannot wait for the next scheduled meeting or it is not considered necessary to call a full meeting, the Committee may choose to convene a telephone conference or conduct its business on a 'virtual' basis through the use of email/online communication platform. Minutes will be recorded for telephone conference and virtual meetings in accordance with relevant sections of the Derby and Derbyshire CCG Governance Handbook.

8. FREQUENCY AND NOTICE OF MEETINGS

- 8.1 The meetings to discuss items of a confidential nature will be held monthly and cancelled if necessary.
- 8.2 The meetings held in public session will take place at least quarterly with the option to be held more frequently. On the dates of the meetings held in public session the meetings will be divided into two sections; Public and Confidential. The Public session will commence at the start of the meeting and shall be held in public.
- 8.3 The Committee may resolve to exclude the public from a meeting that is open to the public (whether during the whole or part of the proceedings) whenever publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution and arising from the nature of that business or of the proceedings or for any other reason permitted by the Public Bodies (Admission to Meetings) Act 1960 as amended or succeeded from time to time.
- 8.4 Members of the Committee have a collective responsibility for the operation of the Committee. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.
- 8.5 The Committee may delegate tasks to such individuals, sub-committees or individual members as it shall see fit, provided that any such delegations are consistent with the parties' relevant governance arrangements, are recorded in a scheme of delegation, are governed by terms of reference as appropriate and reflect appropriate arrangements for the management of conflicts of interest.

- 8.6 The Committee may call additional experts to attend meetings on an ad hoc basis to inform discussions.
- 8.7 Members of the Committee shall respect confidentiality requirements as set out in the CCG's Standing Orders.
- 8.8 The Committee will present its public minutes to NHS England Midlands and the Governing Body of the CCG each quarter for information. Confidential minutes will be presented on a monthly basis.
- 8.9 The CCG will also comply with any reporting requirements set out in its constitution.
- 8.10 It is envisaged that these Terms of Reference will be reviewed from time to time, reflecting experience of the Committee in fulfilling its functions.

9. ACCOUNTABILITY OF COMMITTEE

The Committee will operate within the delegation detailed within the CCG Standing Orders, Schemes of Reservation and Delegation and Prime Financial Policies.

10. PROCUREMENT OF AGREED SERVICES

The detailed arrangements regarding procurement are set out in the delegation agreement².

11. SUB-COMMITTEES

- 11.1 The Committee delegates responsibility for specific aspects of its duties to the following sub-committees:
- Primary Care Quality and Performance Review Sub Committee
 - Estates Steering Group Sub Committee
 - GP Digital Sub Committee
 - Primary Care Workforce Steering Group Sub Committee
 - Primary Care Leadership Sub Committee
- 11.2 Each sub-committee will be required to submit a summary of key actions and minutes from each meeting to the subsequent meeting of the Committee.
- 11.3 Terms of Reference of the sub-committees will be reviewed annually by the Committee.

² NHS England Next Steps in primary care co-commissioning guidance
<https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2014/11/nxt-steps-pc-cocomms.pdf>

12. DECISIONS

12.1 Scheme of Delegation

- 12.1.1 The Committee will make decisions within the bounds of its remit.
- 12.1.2 The decisions of the Committee shall be binding on NHS England and the CCG.
- 12.1.3 The Committee will produce an executive summary report which will be presented to the Governing Body of the CCG each month for information.

12.2 CCG Allocations

- 12.2.1 The Committee shall make recommendations for CCG funding decisions to the Executive Team for additional and new allocations received in-year (please refer to section 2.10 within Annexure 1 of Appendix 4 – Standing Financial Instructions – Financial Limits for Delegated Authority).
- 12.2.2 The Committee are empowered to prioritise service investments and disinvestments within available resources. The Committee can review and recommend investment decisions based on which services should be commissioned or decommissioned, but cannot commit additional CCG financial resources, unless approved by the Executive Team.
- 12.2.3 Subject to 12.2.2, the Clinical and Lay Commissioning Committee shall make recommendations to the Primary Care Commissioning Committee on any changes in relation to the investment or disinvestment of Primary Care commissioned services.

13. REVIEW OF TERMS OF REFERENCE

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

Reviewed by Primary Care Commissioning Committee: 22nd September 2021

Approved by Governing Body: 7th October 2021

Review Date: Close of CCG on 31st March 2022

Clinical and Lay Commissioning Committee

Terms of Reference

1. PURPOSE

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

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

2. ROLES AND RESPONSIBILITIES

The Committee will incorporate the following duties:

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

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

3. CHAIR ARRANGEMENTS

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

4. MEMBERSHIP

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

- 4.2 The membership of the Committee will comprise of:
- At least 3 x GPs (to include GP Governing Body Members providing appropriate geographical coverage and the Chair);
 - 1 x Clinical representatives taken from clinical lead roles;
 - 1 x Secondary Care Doctor;
 - 3 x Lay Members;
 - 1 x Chief Nurse Officer;
 - 1 x Medical Director;
 - 1x Chief Finance Officer;
 - 1 x Public Health Representative; and
 - 1 x Executive Director of Commissioning Operations.
- 4.3 CCG Officer subject experts will be attendees at each meeting.
- 4.4 Committee members may nominate a suitable deputy when necessary and subject to the approval of the Chair of the Committee. All deputies should be fully briefed and the Committee secretariat informed of any agreement to deputise so that quoracy can be maintained.
- 4.5 The Committee may also request attendance by appropriate individuals to present relevant reports and/or advise the Committee.

5. DECLARATIONS OF INTEREST, CONFLICTS AND POTENTIAL CONFLICTS

- 5.1 The provisions of Managing Conflicts of Interest: Statutory Guidance for CCGs³ or any successor document will apply at all times.
- 5.2 Where a member of the committee is aware of an interest, conflict or potential conflict of interest in relation to the scheduled or likely business of the meeting, they will bring this to the attention of the Chair of the meeting as soon as possible, and before the meeting where possible.
- 5.3 The Chair of the meeting will determine how this should be managed and inform the member of their decision. The Chair may require the individual to withdraw from the meeting or part of it. Where the Chair is aware that they themselves have such an interest, conflict or potential conflict of interests they will bring it to the attention of the Committee, and the Vice Chair will act as Chair for the relevant part of the meeting (or another non-conflicted member of the meeting if the Vice Chair is also conflicted).
- 5.4 The Chair of the meeting will determine how this should be managed and inform the member of their decision. The Chair may require the individual to withdraw from the meeting or part of it. Where the Chair is aware that they themselves have such an interest, conflict or potential conflict of interest they will bring it to the attention of the Committee, and the Vice Chair will act as Chair for the relevant part of the meeting (or another non-conflicted member of the meeting if the Vice Chair is also conflicted).

³ <https://www.england.nhs.uk/wp-content/uploads/2017/06/revised-ccg-conflict-of-interest-guidance-v7.pdf>

- 5.5 Any declarations of interest, conflicts and potential conflicts, and arrangements to manage those agreed in any meeting of the Committee, will be recorded in the minutes.
- 5.6 Failure to disclose an interest, whether intentional or otherwise, will be treated in line with the Managing Conflicts of Interest: Revised Statutory Guidance and may result in suspension from the Committee.
- 5.7 All members of the Committee shall comply with, and are bound by, the requirements in the CCG's Constitution, Standards of Business Conduct and Managing Conflicts of Interest Policy, the Standards of Business Conduct for NHS staff (where applicable) and NHS Code of Conduct.

6. QUORACY

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

7. DECISION MAKING AND VOTING

- 7.1 The Committee will use its best endeavours to make decisions by consensus. Exceptionally, where this is not possible the Chair (or Vice Chair) may call a vote. Any member where there is a conflict of interest will be excluded from voting for the proposal where there is a conflict.
- 7.2 Only members of the Committee set out at paragraph 4.2 have voting rights. Each voting member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.
- 7.3 If a decision is needed which cannot wait for the next scheduled meeting or it is not considered necessary to call a full meeting, the Committee may choose to convene a telephone conference or conduct its business on a 'virtual' basis through the use of email communication. Minutes will be recorded for telephone conference and virtual meetings in accordance with the CCG's Corporate Governance Framework at Section 5.4.

8. ACCOUNTABILITY

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

9. FREQUENCY AND NOTICE OF MEETINGS

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

10. REPORTING ARRANGEMENTS

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

11. SUB-COMMITTEES

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

12. ADMINISTRATIVE SUPPORT

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

13. REVIEW OF TERMS OF REFERENCE

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

Reviewed by Clinical and Lay Commissioning Committee: 9th September 2021

Approved by Governing Body: 7th October 2021

Review Date: Close of CCG on 31st March 2022

Finance Committee

Terms of Reference

1. PURPOSE

The purpose of the Finance Committee is to:

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

2. ROLES AND RESPONSIBILITIES

The Committee will incorporate the following duties:

- 2.1 oversee and recommend to the Governing Body the annual financial plan that reflects the prioritised commissioning plan for the CCG;
- 2.2 [oversee the transition of the committee to the Integrated Care Board;](#)
- 2.3 oversee and gain assurance on the delivery of the Financial Plan ensuring that it provides the desired strategic outcomes for the CCG in accordance with the short and long term recovery plans approved by NHS England;

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

3. CHAIR ARRANGEMENTS

The Chair of the Committee shall be the Finance Lay Member (not the Audit Chair), nominated by the Accountable Officer and endorsed by the CCG Chair. In the event

that the Chair is unavailable to attend, the Vice Chair, who shall be a Lay Member will deputise and Chair the meeting.

4. MEMBERSHIP

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

5. DECLARATIONS OF INTEREST, CONFLICTS AND POTENTIAL CONFLICTS

- 5.1 The provisions of Managing Conflicts of Interest: Statutory Guidance for CCGs⁴ or any successor document will apply at all times.
- 5.2 Where a member of the Committee is aware of an interest, conflict or potential conflict of interest in relation to the scheduled or likely business of the meeting, they will bring this to the attention of the Chair of the meeting as soon as possible, and before the meeting where possible.
- 5.3 The Chair of the meeting will determine how this should be managed and inform the member of their decision. The Chair may require the individual to withdraw from the meeting or part of it. Where the Chair is aware that they themselves have such an interest, conflict or potential conflict of interests they will bring it to the attention of the Committee, and the Vice Chair will act as Chair for the relevant part of the meeting (or another non-conflicted member of the meeting if the Vice Chair is also conflicted).

⁴ <https://www.england.nhs.uk/wp-content/uploads/2017/06/revised-ccg-conflict-of-interest-guidance-v7.pdf>

- 5.4 Any declarations of interest, conflicts and potential conflicts, and arrangements to manage those agreed in any meeting of the Committee, will be recorded in the minutes.
- 5.5 Failure to disclose an interest, whether intentional or otherwise, will be treated in line with the Managing Conflicts of Interest: Revised Statutory Guidance and may result in suspension from the Committee.
- 5.6 All members of the Committee shall comply with, and are bound by, the requirements in the CCG's Constitution, Standards of Business Conduct and Managing Conflicts of Interest Policy, the Standards of Business Conduct for NHS staff (where applicable) and NHS Code of Conduct.

6. QUORACY

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

7. DECISION MAKING AND VOTING

- 7.1 The Committee will use its best endeavours to make decisions by consensus. Exceptionally, where this is not possible the Chair (or Vice Chair) may call a vote. Any member where there is a conflict of interest will be excluded from voting for the proposal where there is a conflict.
- 7.2 Only members of the Committee set out at paragraph 4.2 have voting rights. Each voting member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.
- 7.3 If a decision is needed which cannot wait for the next scheduled meeting or it is not considered necessary to call a full meeting, the Committee may choose to convene a telephone conference or conduct its business on a 'virtual' basis through the use of email communication. Minutes will be recorded for telephone conference and virtual meetings in accordance with the CCG's Corporate Governance Framework at Section 5.4.

8. ACCOUNTABILITY

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

9. REPORTING ARRANGEMENTS

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

10. FREQUENCY AND NOTICE OF MEETINGS

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

11. SUB-COMMITTEES

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

12. ADMINISTRATIVE SUPPORT

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

13. REVIEW OF TERMS OF REFERENCE

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

Reviewed by Finance Committee: 30th September 2021

Approved by Governing Body: 7th October 2021

Review Date: Close of CCG on 31st March 2022

Governance Committee

Terms of Reference

1. PURPOSE

- 1.1 The purpose of the Committee is to ensure that NHS Derby and Derbyshire Clinical Commissioning Group (the “CCG”) complies with the principles of good governance whilst effectively delivering the statutory functions of the CCG.
- 1.2 The Committee has delegated authority to make decisions as set out in the CCG’s Prime Financial Policies and the Scheme of Reservation and Delegation.

2. ROLES AND RESPONSIBILITIES

- 2.1 The Committee will discharge the CCG’s responsibilities in respect of the following functions:

- Business Continuity;
- Corporate Governance;
- Complaints and PALS;
- Digital Development and ICT Assurance, including Cyber Security;
- Emergency Preparedness Resilience and Response;
- Equality, Human Rights and Inclusion;
- Estates;
- Health, Safety, Fire and Security;
- Human Resources;
- Information Governance;
- Organisational Development;
- Procurement;
- Research Governance; and
- Risk Management – oversight of the development and implementation of the risk management framework.

- 2.2 In order to discharge these duties, the Committee will:

- produce an annual work programme;
- ensure that suitable policies and procedures are in place to comply with relevant regulatory, legal and code of conduct requirements;
- review the adequacy and effectiveness of their responsible policies and procedures for ensuring compliance and related reporting;
- ensure that arrangements are in place to monitor compliance with statutory responsibilities;
- [oversee the transition of the committee and its assurance functions to the Integrated Care Board;](#)
- promote good risk management and ensure robust controls are in place in accordance with the CCG’s Risk Management Framework;

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

3. CHAIR ARRANGEMENTS

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

4. MEMBERSHIP

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

5. DECLARATIONS OF INTEREST, CONFLICTS AND POTENTIAL CONFLICTS

- 5.1 The provisions of Managing Conflicts of Interest: Statutory Guidance for CCGs⁵ or any successor document will apply at all times.
- 5.2 Where a member of the Committee is aware of an interest, conflict or potential conflict of interest in relation to the scheduled or likely business of the meeting, they will bring this to the attention of the Chair of the meeting as soon as possible, and before the meeting where possible.
- 5.3 The Chair of the meeting will determine how this should be managed and inform the member of their decision. The Chair may require the individual to withdraw from the meeting or part of it. Where the Chair is aware that they themselves have such an interest, conflict or potential conflict of interests they will bring it to the attention of the Committee, and the Vice Chair will act as Chair for the relevant part of the meeting (or another non-conflicted member of the meeting if the Vice Chair is also conflicted).
- 5.4 Any declarations of interest, conflicts and potential conflicts, and arrangements to manage those agreed in any meeting of the Committee, will be recorded in the minutes.
- 5.5 Failure to disclose an interest, whether intentional or otherwise, will be treated in line with the Managing Conflicts of Interest: Revised Statutory Guidance and may result in suspension from the Committee.
- 5.6 All members of the Committee shall comply with, and are bound by, the requirements in the CCG's Constitution, Standards of Business Conduct and Managing Conflicts of Interest Policy, the Standards of Business Conduct for NHS staff (where applicable) and NHS Code of Conduct.

6. QUORACY

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

7. DECISION MAKING AND VOTING

- 7.1 The Committee will use its best endeavours to make decisions by consensus. Exceptionally, where this is not possible the Chair (or Vice Chair) may call a vote. Any member where there is a conflict of interest will be excluded from voting for the proposal where there is a conflict.

⁵ <https://www.england.nhs.uk/wp-content/uploads/2017/06/revised-ccg-conflict-of-interest-guidance-v7.pdf>

- 7.2 Only voting members of the Committee set out at paragraph 4.2 have voting rights. Each voting member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.
- 7.3 If a decision is needed which cannot wait for the next scheduled meeting or it is not considered necessary to call a full meeting, the Committee may choose to convene a telephone conference or conduct its business on a 'virtual' basis through the use of email communication. Minutes will be recorded for telephone conference and virtual meetings in accordance with the CCG's Corporate Governance Framework at Section 5.4.

8. ACCOUNTABILITY

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

9. REPORTING ARRANGEMENTS

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

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

10. FREQUENCY AND NOTICE OF MEETINGS

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

11. SUB-COMMITTEES

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

12. ADMINISTRATIVE SUPPORT

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

13. REVIEW OF TERMS OF REFERENCE

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

Reviewed by Governance Committee: 23rd September 2021

Approved by Governing Body: 7th October 2021

Review Date: Close of CCG on 31st March 2022

Derbyshire Engagement Committee

Terms of Reference

1. PURPOSE

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

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

2. ROLES AND RESPONSIBILITIES

The Committee is asked to:

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

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

3. CHAIR ARRANGEMENTS

The Chair of the Committee shall be one of the Lay Members for Patient and Public Involvement (PPI), nominated by the CCG Accountable Officer and ratified by the

Derbyshire STP Director and Chair of the Joined Up Care Derbyshire Board. In the event that the Chair is unavailable to attend, the second CCG Governing Body Lay Member for PPI shall be the Vice Chair.

4. MEMBERSHIP

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

Voting Members

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

Non-voting Members

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

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

5. DECLARATIONS OF INTEREST, CONFLICTS AND POTENTIAL CONFLICTS

5.1 The provisions of Managing Conflicts of Interest: Statutory Guidance for CCGs⁶ or any successor document will apply at all times.

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

5.3 The Chair of the meeting will determine how this should be managed and inform the member of their decision. The Chair may require the individual to withdraw from the

⁶ <https://www.england.nhs.uk/wp-content/uploads/2017/06/revised-ccg-conflict-of-interest-guidance-v7.pdf>

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

- 5.4 Any declarations of interests, conflicts and potential conflicts, and arrangements to manage those agreed in any meeting of the Committee, will be recorded in the minutes.
- 5.5 Failure to disclose an interest, whether intentional or otherwise, will be treated in line with the Managing Conflicts of Interest: Revised Statutory Guidance and may result in suspension from the Committee.
- 5.6 All members of the Committee shall comply with, and are bound by, the requirements in the CCG's Constitution, Standards of Business Conduct and Managing Conflicts of Interest Policy, the Standards of Business Conduct for NHS staff (where applicable) and NHS Code of Conduct.

6. QUORACY

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

7. DECISION MAKING AND VOTING

- 7.1 The Committee will use its best endeavours to make decisions by consensus. Exceptionally, where this is not possible the Chair (or Vice Chair) may call a vote. Any member where there is a conflict of interest will be excluded from voting for the proposal where there is a conflict.
- 7.2 Only voting members of the Committee set out at paragraph 4.1 have voting rights. Each voting member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.
- 7.3 If a decision is needed which cannot wait for the next scheduled meeting or it is not considered necessary to call a full meeting, the Committee may choose to convene a telephone conference or conduct its business on a 'virtual' basis through the use of email communication. Minutes will be recorded for telephone conference and

virtual meetings in accordance with the CCG's Corporate Governance Framework at Section 5.4.

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

8. ACCOUNTABILITY

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

9. REPORTING ARRANGEMENTS

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

10. FREQUENCY AND NOTICE OF MEETINGS

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

11. SUB-COMMITTEES

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

12. ADMINISTRATIVE SUPPORT

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

13. REVIEW

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

Reviewed by Engagement Committee:

21st September 2021

Approved by Governing Body

7th October 2021

Review Date:

Close of CCG on 31st March 2022

Quality & Performance Committee

Terms of Reference

1. PURPOSE

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

2. ROLES AND RESPONSIBILITIES

2.1 Quality

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

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

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

- 2.1.19 Oversee the transition of the committee to the Integrated Care Board.
- 2.1.20 ~~Have oversight of the CCG Recovery and Restoration work related to the Health and Care and Statutory Requirement Pillars and will receive assurance regarding progress.~~

2.2 Performance

- 2.2.1 Monitor contract and operational performance across all commissioned services from key partners on an exception basis, assessing potential shortfalls and risk and to identify recommended actions. Review, challenge and scrutinise exception reports against delivery of targets or improved performance in accordance with agreed Recovery Action Plans (RAPs).
- 2.2.2 Monitor Key Performance Indicators (KPIs) relating to CCG performance, for example outlined in the CCG's Assurance Framework and the Public Health Outcomes Framework.
- 2.2.3 Review monthly reports detailing performance of commissioned services against contract standards, national and local targets and the CCG's Strategic Plans.
- 2.2.4 Review the risk register for its area of remit, considering the adequacy of the submissions and whether new risks need to be added or whether any risks require immediate escalation to the Governing Bodies.

3. CHAIR ARRANGEMENTS

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

4. MEMBERSHIP

- 4.1 Members of the Committee may be appointed from the CCG's Governing Body, Officers of the CCG or other external bodies as required to enable the Committee to fulfil its purpose.
- 4.2 The membership of the Committee will comprise:
 - 4 x GP Governing Body Members;
 - 3 x Lay Members;
 - 1 x Chief Nurse Officer or Deputy;
 - 1 x Medical Director;
 - 1 x Secondary Care Doctor;
 - 1 x Executive Director of Commissioning and Operations; and
 - 2 x Senior Healthwatch Representative (Derby City and Derbyshire County).
- 4.3 CCG Officer subject experts will be attendees at each meeting.

- 4.4 Committee members may nominate a suitable deputy when necessary and subject to the approval of the Chair of the Committee. All deputies should be fully briefed and the Committee secretariat informed of any agreement to deputise so that quoracy can be maintained.
- 4.5 The Committee may also request attendance by appropriate individuals to present relevant reports and/or advise the Committee.

5. DECLARATIONS OF INTEREST, CONFLICTS AND POTENTIAL CONFLICTS

- 5.1 The provisions of Managing Conflicts of Interest: Statutory Guidance for CCGs⁷ or any successor document will apply at all times.
- 5.2 Where a member of the committee is aware of an interest, conflict or potential conflict of interest in relation to the scheduled or likely business of the meeting, they will bring this to the attention of the Chair of the meeting as soon as possible, and before the meeting where possible.
- 5.3 The Chair of the meeting will determine how this should be managed and inform the member of their decision. The Chair may require the individual to withdraw from the meeting or part of it. Where the Chair is aware that they themselves have such an interest, conflict or potential conflict of interest they will bring it to the attention of the Committee, and the Vice Chair will act as Chair for the relevant part of the meeting (or another non-conflicted member of the meeting if the Vice Chair is also conflicted).
- 5.4 Any declarations of interests, conflicts and potential conflicts, and arrangements to manage those agreed in any meeting of the Committee, will be recorded in the minutes.
- 5.5 Failure to disclose an interest, whether intentional or otherwise, will be treated in line with the Managing Conflicts of Interest: Revised Statutory Guidance and may result in suspension from the Committee.
- 5.6 All members of the Committee shall comply with, and are bound by, the requirements in the CCG's Constitution, Standards of Business Conduct and Managing Conflicts of Interest Policy, the Standards of Business Conduct for NHS staff (where applicable) and NHS Code of Conduct.

6. QUORACY

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

⁷ <https://www.england.nhs.uk/wp-content/uploads/2017/06/revised-ccg-conflict-of-interest-guidance-v7.pdf>

all or any of the authorities, powers and discretions vested in or exercisable by the Committee.

7. DECISION MAKING AND VOTING

- 7.1 The Committee will use its best endeavours to make decisions by consensus. Exceptionally, where this is not possible the Chair (or Vice Chair) may call a vote. Any member where there is a conflict of interest will be excluded from voting for the proposal where there is a conflict.
- 7.2 Only members of the Committee set out at paragraph 4.2 have voting rights. Each voting member is allowed one vote and a majority will be conclusive on any matter. Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.
- 7.3 If a decision is needed which cannot wait for the next scheduled meeting or it is not considered necessary to call a full meeting, the Committee may choose to convene a telephone conference or conduct its business on a 'virtual' basis through the use of email communication. Minutes will be recorded for telephone conference and virtual meetings in accordance with the CCG's Corporate Governance Framework at Section 5.4.

8. ACCOUNTABILITY

- 8.1 The Committee is accountable to the CCG's Governing Body.
- 8.2 It shall maintain an annual work programme, ensuring that all matters for which it is responsible are addressed in a planned manner, with appropriate frequency across the year.
- 8.3 The Committee may investigate, monitor and review any activity within its terms of reference. It is authorised to seek any information it requires from any committee, group, clinician or employee (including interim and temporary members of staff), who are directed to co-operate with any request made by it.

9. REPORTING ARRANGEMENTS

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

10. FREQUENCY AND NOTICE OF MEETINGS

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

11. SUB-COMMITTEES

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

12. ADMINSTRATIVE SUPPORT

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

13. REVIEW

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

Reviewed by Quality and Performance Committee: 30th September 2021

Approved by Governing Body: 7th October 2021

Review Date: Close of CCG on 31st March 2022

Governing Body Meeting in Public

7th October 2021






Item No: 151

Report Title	Finance Report – Month 5
Author(s)	Georgina Mills, Senior Finance Manager
Sponsor (Director)	Richard Chapman, Chief Finance Officer

Paper for:	Decision	Assurance	x	Discussion	Information
Assurance Report Signed off by Chair	N/A				
Which committee has the subject matter been through?	Finance Committee – 30.9.2021				
Recommendations					
The Governing Body is requested to NOTE the following:					
<ul style="list-style-type: none"> • Allocations have been received for H1 at £1.036bn • The YTD reported underspend at month 5 is £0.128m • Retrospective allocations received for quarter 1 Covid spend on the Hospital Discharge Programme were £2.697m further expected funding is £1.569m relating to month 4 and 5. • The Elective Recovery Fund has been reimbursed £0.680m for April, May and 90% June. • H1 is forecast to conclude at a £0.199m underspend. 					
Report Summary					
The report describes the month 5 position. The key points are listed in the recommendations section above.					
Are there any Resource Implications (including Financial, Staffing etc)?					
N/A					
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?					
N/A					
Has a Quality Impact Assessment (QIA) been completed? What were the findings?					
N/A					

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

Financial Performance Summary
Month 5, August 2021

Statutory Duty/ Performance	Target	Result	Achieved	Key	Comments/Trends
Achievement of expenditure to plan	£850.55m	£851.991m		Green <1%, Amber 1-5% Red >5%	The expected reimbursement of £1.569m Covid results in a YTD favourable variance of £0.128m.
Remain within the Delegated Primary Care Co-Commissioning Allocation	£65.618m	£65.51m		Green <1%, Amber 1-5% Red >5%	£0.107m favourable variance. The YTD underspend is due to lower activity levels for enhanced services and reduced locum costs.
Remain within the Running Cost Allowance	£7.501m	£7.003m		Green <1%, Amber 1-5% Red >5%	Running costs are £0.498m underspent against plan and this is attributed to staff vacancies.
Remain within cash limit	Greatest of 1.25% of drawdown or £0.25m	0.85%		Green <1.25%, Amber 1.25-5% Red >5%	Closing cash balance of £1.342m against drawdown of £158.0m
Achieve BPPC (Better Payment Practice Code)	>95% across 8 areas	Pass 8/8		Green 8/8 Amber 7/8 Red <6/8	In month and YTD payments of over 95% for invoices categorised as NHS and non NHS assessed on value and volume

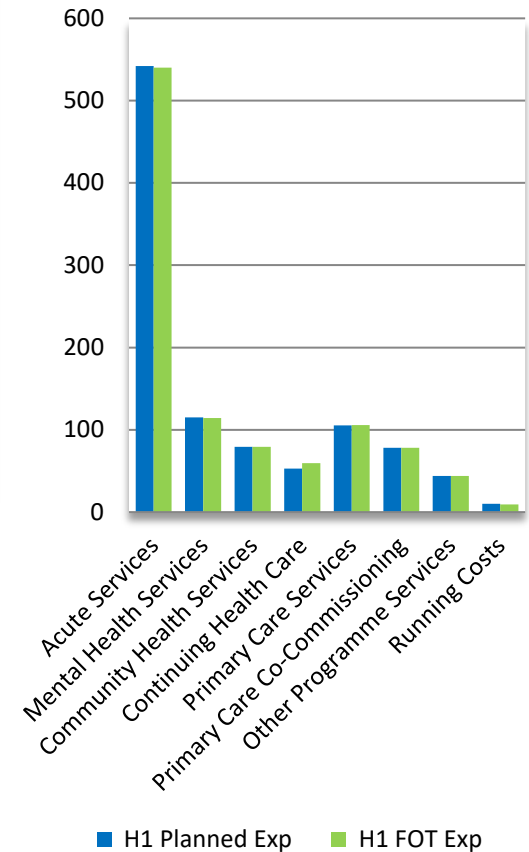
Operating Cost Statement For the H1 Period Ending: August 2021



Derby and Derbyshire Clinical Commissioning Group

	YTD Budget	YTD Actual	YTD Variance	YTD Variance as a % of YTD Budget	H1 Budget	H1 Forecast Outturn	Forecast Variance	FOT Variance as a % of Annual Budget
	£'000's	£'000's	£'000's	%	£'000's	£'000's	£'000's	%
Acute Services	451,684	449,999	1,685	0.37	542,004	540,213	1,791	0.33
Mental Health Services	94,746	94,478	268	0.28	114,888	114,336	552	0.48
Community Health Services	64,931	64,883	48	0.07	79,093	79,298	(205)	(0.26)
Continuing Health Care	44,430	48,202	(3,772)	(8.49)	52,832	59,290	(6,458)	(12.22)
Primary Care Services	86,995	87,256	(261)	(0.30)	105,465	105,579	(114)	(0.11)
Primary Care Co-Commissioning	65,618	65,510	107	0.16	78,166	78,042	124	0.16
Other Programme Services	34,588	34,658	(71)	(0.20)	43,795	43,947	(152)	(0.35)
Total Programme Resources	842,991	844,987	(1,996)	(0.24)	1,016,242	1,020,704	(4,462)	(0.44)
Running Costs	7,501	7,003	498	6.63	9,912	9,377	535	5.40
Total before Planned Deficit	850,492	851,991	(1,498)	(0.18)	1,026,154	1,030,081	(3,927)	(0.38)
In-Year Allocations	58	0	58	100.00	5,825	5,767	58	1.00
In-Year 0.5% Risk Contingency	0	0	0	0.00	4,244	4,244	0	0.00
Total Incl Covid Costs	850,550	851,991	(1,440)	(0.17)	1,036,223	1,040,092	(3,869)	(0.37)
Expected Covid Reimbursement in Future Months	2697	4,266	(1,569)		2,697	6,765	(4,068)	
Expected Elective Recovery Fund Allocation	680	680	0		680	680	0	
Total Including Reclaimable Covid Costs	847,173	847,045	128	0.02	1,032,846	1,032,647	199	0.02

H1 Planned v FOT Expenditure £'m



The reported position at month 5 is a underspend of £0.128m YTD and a favourable forecast of £0.199m.

This position includes £1.569m YTD and £4.068m FOT relating to Covid expenditure for the Hospital Discharge Programme which is expected to be reclaimed in full. An allocation of £2.697m for quarter 1 out of envelope covid expenditure was received in month 4, the quarter 2 funding is anticipated to be received in month 7.

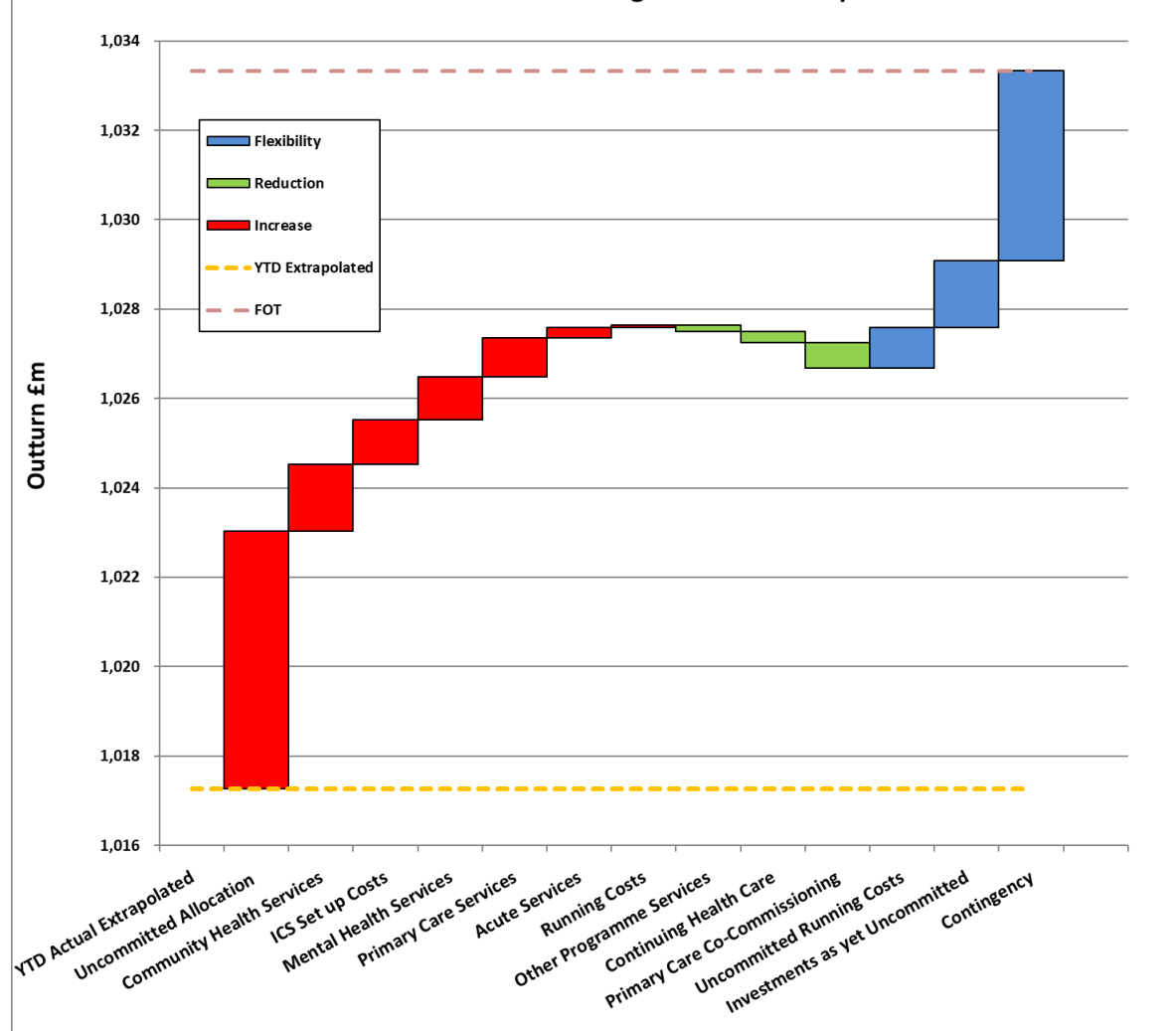
The Elective Recovery Fund (ERF) allocation retained by the CCG is £0.68m, it is not expected that any additional funding relating to CCG expenditure will be received.

The contingency of £1.356m YTD and £2.034m FOT required to breakeven the FOT at month 4 has not been required to facilitate the underspent position. (See slide 12 for a breakdown)

Run Rate based on H1 Expenditure

Derby and Derbyshire Clinical Commissioning Group

2021-22 Run Rate - Scenario excluding Outside Envelope Covid Costs



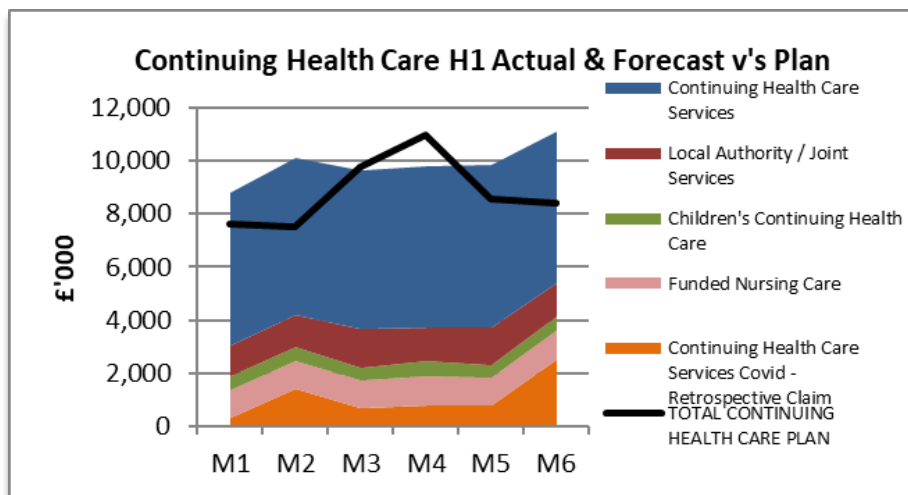
£16.057m variation between the H1 position to date continuing at its current rate and the H1 forecast.

- **Uncommitted Allocation** – Non-recurrent allocations received not yet distributed to areas, including £2.312m relating to Long Covid.
- **Community Health Services** – Ageing Well expenditure incurred later in period.
- **ICS Set up Costs** – One off expected expenditure.
- **Mental Health Services** – Service Development funding planned to be spent later in the period offset by LD income invoiced quarterly.
- **Primary Care Services** – Allocations with higher expenditure expected in later months.
- **Acute Services** – System ERF funds received in months 4 and 5 distributed to providers. Cancer Alliance allocations received not yet included in YTD amount.
- **Running Costs** – Small movement relating to differences on pay costs.
- **Other Programme Services** – NHS 111 First expenditure incurred in relation to allocation received for quarter 1.
- **Continuing Health Care** – Fast Track expenditure based on latest caseload information.
- **PC Co-Commissioning** – Movement relates to phasing of prescribing costs and payments commencing during period.
- **Uncommitted Running Costs** - £0.375m required for 3% in month 6 the remainder is expected to be utilised within patient care.
- **Uncommitted Investments** – Funding currently in reserves expected to be used by end of H1.
- **Contingency** – 0.5% H1 contingency of £4.244m.

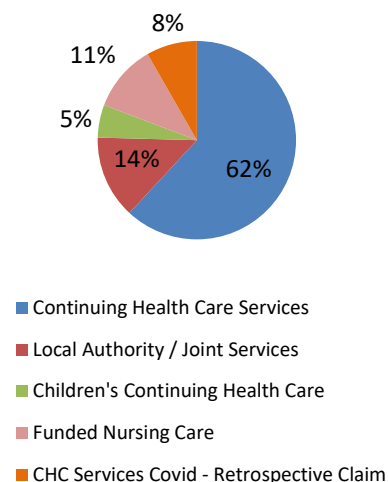
Continuing Health Care

Derby and Derbyshire Clinical Commissioning Group

	YTD Budget	YTD Actual	YTD Variance	H1 Budget	H1 Forecast Outturn	Forecast Variance
	£'000's	£'000's	£'000's	£'000's	£'000's	£'000's
Continuing Health Care						
Continuing Health Care Services	28,001	29,838	(1,837)	33,606	35,527	(1,920)
Local Authority / Joint Services	5,897	6,515	(618)	7,055	7,789	(734)
Children's Continuing Health Care	2,602	2,574	28	3,120	3,110	9
Funded Nursing Care	5,502	5,287	215	6,621	6,376	246
Continuing Health Care Services Covid - Retrospective Claim	2,429	3,989	(1,559)	2,429	6,488	(4,059)
	44,430	48,202	(3,772)	52,832	59,290	(6,458)



Continuing Health Care Year to Date Actual Expenditure

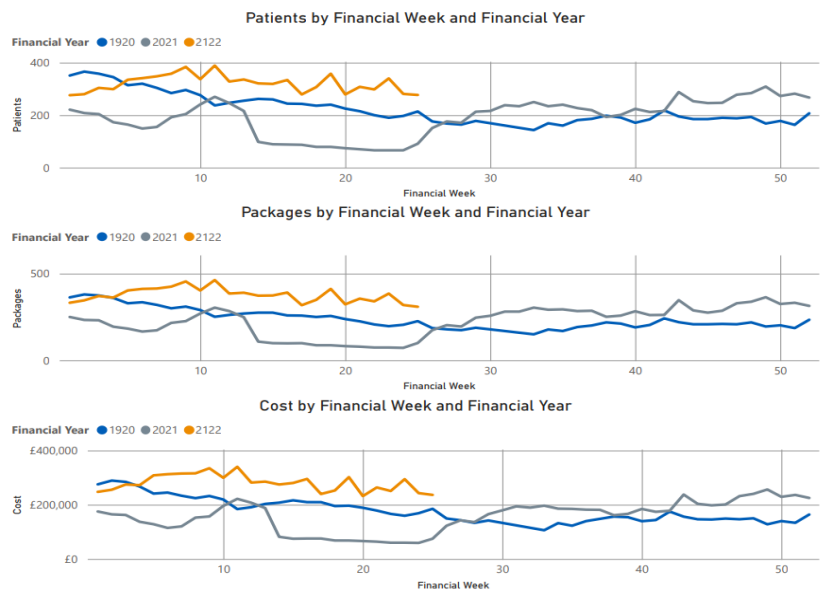


£1.559m YTD and £4.059m FOT of the reported overspend is due to Covid related costs for the Hospital Discharge Programme and these amounts are expected to be reclaimed in full. An allocation of £2.429m was received in month 4 to fund the quarter 1 expenditure. The FOT includes packages that will start before 30th September 2021 but will continue after this date due to the four week funding available.

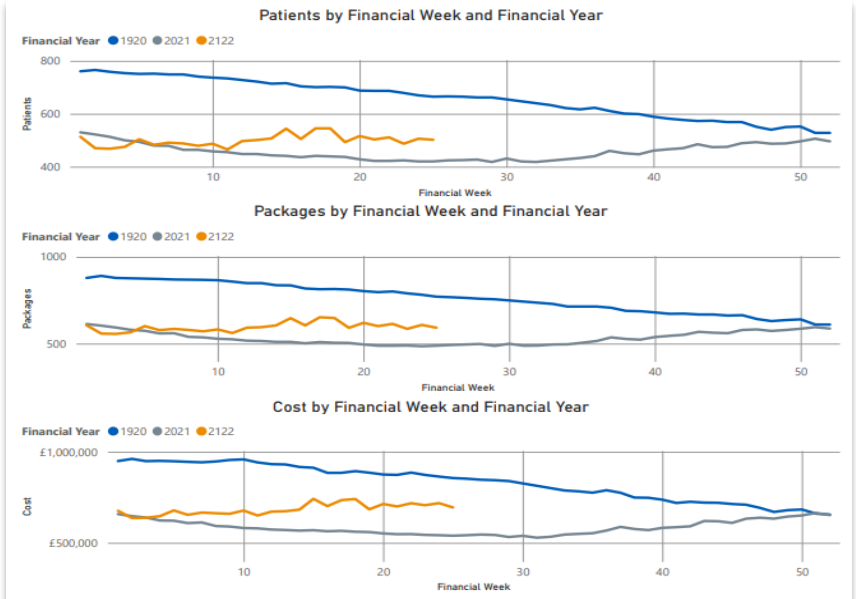
The main pressures relate to Fully Funded Adult CHC, Fast Track and Joint Funded CHC.

Continuing Health Care

Fast Track Packages and Cost



Fully Funded Packages and Cost



Fast track costs at M5 have reduced to a £0.384m overspend year to date with a forecast overspend of £0.182m. The latest data shows fluctuations upwards and downwards over the last 4 weeks although overall it is still on a downwards trajectory.

Fully Funded packages are reporting a £1.275m overspend and a £1.454m FOT above plan. This is expected due to the actions taken by colleagues in the Nursing and Quality team and the CSU to reduce the fast track packages, with a number of them converting to a more appropriate fully funded package of care. Data cleansing work is also ongoing between the finance, BI and CSU teams to ensure the quality of data in the CHC system is robust.

The arrangements put in place to reduce fast track packages continue including increased quality assurance, prioritisation of assessment and reviews. There is also ongoing communication from the Pathways Operations Group with the highest referring organisations supporting the correct utilisation of the fast track path way.

System Year to Date and Forecast Outturn

JUCD YTD and forecast by organisation

Month 05 Position Organisation	2021/22 H1					
	YTD Plan £m's	YTD Actual £m's	YTD Variance £m's	H1 Plan £m's	H1 Forecast £m's	Forecast Variance £m's
NHS Derby and Derbyshire CCG	0.0	0.1	0.1	0.0	0.2	0.2
Chesterfield Royal Hospital	0.2	0.9	0.7	0.0	0.0	0.0
Derbyshire Community Health Services	0.0	(0.1)	(0.1)	0.0	0.0	0.0
Derbyshire Healthcare	0.0	0.0	0.0	0.0	0.0	0.0
East Midlands Ambulance Service	0.0	(0.7)	(0.7)	0.0	(0.8)	(0.8)
University Hospitals Of Derby And Burton	1.8	5.0	3.2	0.0	2.8	2.8
Intra System Reconciliation	0.0	0.0	0.0	0.0	0.0	0.0
JUCD Total	2.0	5.2	3.2	0.0	2.2	2.2

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

Governing Body Meeting in Public

7th October 2021

Item No: 153.1

Report Title	Audit Committee Assurance Report – September 2021
Author(s)	Suzanne Pickering, Head of Governance
Sponsor (Director)	Ian Gibbard, Audit Lay Member and Audit Committee Chair

Paper for:	Decision	Assurance	x	Discussion	Information
Assurance Report Signed off by Chair				Ian Gibbard, Audit Committee Chair	
Which committee has the subject matter been through?				Audit Committee – 16.9.2021	

Recommendations

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

Report Summary

This report provides the Governing Body with highlights from the 16th September 2021 meeting of the Audit Committee. This report provides a brief summary of the items transacted for assurance.

For Approval

Terms of Reference

The Committee APPROVED the amendments to the Audit Committee Terms of Reference in relation to overseeing the Committee's assurance functions to the Integrated Care Board.

Audit Committee Annual Report

The Audit Committee NOTED and AGREED the contents of the Audit Committee Annual Report for 2020/21 and SUPPORTED the Chair's Annual Report conclusion.

External Audit

External Audit Technical Update – September 2021

The Audit Committee RECEIVED and NOTED the KPMG External Audit Technical Update for September 2021. The report highlighted the main risks facing the Health Sector in 2021/22.

Internal Audit

360 Assurance Progress Report

The Audit Committee RECEIVED the 360 Assurance Progress Report and NOTED that the following reports had been issued:

- Progress Report
- 2020/21JUCD Decision Making Report

- 2021/22 Contracting for Continuing Health Care (CHC)
- 2021/22 Conflicts of Interest
- 2021/21 Stage 1 Head of Internal Audit Opinion
- Counter Fraud 2020/21 Annual Report
- Counter Fraud Progress Report

The Audit Committee NOTED the substantial assurance of the Conflicts of Interest report; NOTED the significant assurance of the Contracting for Continuing Health Care report; NOTED that no recommendations were made in the Stage 1 Head of Internal Audit Opinion report and NOTED the ongoing work with JUCD on the Decision-Making report.

Finance

Finance Report

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

Finance Staff Journal Limits

The Committee NOTED the verbal update provided.

Losses and Special Payments Financial Policy and Procedure

Informal procedures for managing losses and special payments are in place, however, in order to ensure consistent application of policies and procedures by all Staff members, formal Financial Policies have been developed in line with constitution and HM Treasury requirements for Managing Public Money.

The Committee NOTED the contents of the Losses and Special Payments Financial Policy and Procedure.

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.

Single Tender Waivers

The Committee NOTED the Single Tender Waivers approved by the Chief Finance Officer from March to September 2021.

Contracts Oversight Report

The Audit Committee NOTED the report and the work in progress of the Contracts Oversight Group as follows:

- Sourcing of suitable software to maintain database.
- Agreement on regular monitoring and updating of database.
- Training of contract managers to facilitate an assessment of contracts under IFRS 16.
- An update was provided to the Governance Committee on the 22nd July 2021 who are fully sighted on the process, and the contracts database will be used as part of the Due Diligence process of the close down of the CCG.

Governance

Freedom to Speak Up Report

The Audit Committee NOTED the nil return of the report and GAINED ASSURANCE on the progress of recruiting CCG Freedom to Speak Up Ambassadors within the CCG.

Governing Body Assurance Framework 2021/22 Quarter 1

The Committee NOTED and GAINED ASSURANCE of the Quarter 1 Governing Body Assurance Framework

Risk Register

The Audit Committee RECEIVED and NOTED the CCG Risk Register Report for the period May to September 2021.

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
- Summary Register for Recording Any Interests During Meetings
- Gifts & Hospitality Register
- Procurement Register
- Breach Register – no further updates since last meeting

Forward Plan

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

Any Other Business

There were no items of any other business.

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

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

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

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

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

-

Governing Body Meeting in Public

7th October 2021

Item No: 153.2

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

Paper for:	Decision	Assurance	x	Discussion	Information
Assurance Report Signed off by Chair	Not applicable				
Which committee has the subject matter been through?	Audit Committee – 16.9.2021				
Recommendations					
The Governing Body is requested to NOTE the Audit Committee Annual Report for 2020/21 for assurance.					
Report Summary					
It is a requirement for Committees of the CCG to produce an Annual Report each financial year, as set out in the terms of reference. This report provides the Governing Body with a review of the work that the Audit Committee has completed during the period 1 st April 2020 to 31 st March 2021.					
Are there any Resource Implications (including Financial, Staffing etc)?					
Not applicable.					
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?					
Not applicable.					
Has a Quality Impact Assessment (QIA) been completed? What were the findings?					
Not applicable.					
Has an Equality Impact Assessment (EIA) been completed? What were the findings?					
Not applicable.					
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below					
Not applicable.					

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

Not applicable.

Have any Conflicts of Interest been identified / actions taken?

Not applicable.

Governing Body Assurance Framework

Not applicable.

Identification of Key Risks

Not applicable.

Audit Committee Annual Report 2020/21

AUDIT COMMITTEE ANNUAL REPORT 2020/21

1. INTRODUCTION AND BACKGROUND

- 1.1 This report reviews the work of the Audit Committee and covers the period from 1st April 2020 to 31st March 2021.
- 1.2 The report provides the Governing Body and Accountable Officer with evidence relevant to their responsibilities in relation to the Assurance Framework and Governance Statement. The production of an annual report is recommended good practice for all UK based audit committees and is included in the NHS Audit Committee Handbook.
- 1.3 The operation of an independent Audit Committee is a central means by which the CCG Governing Body ensures effective internal control arrangements are in place.

2. CONTEXT

- 2.1 The Audit Committee is accountable to the Governing Body and is constituted in line with the provisions of the NHS Audit Committee Handbook and the guidance issued by the UK Financial Reporting Council. It has overseen internal and external audit plans and the risk management and internal control processes (financial and quality), including control processes around counter fraud.
- 2.2 The work of the Audit Committee is driven by the priorities identified by the CCG, and the associated risks. It operates to a programme of business, agreed by the CCG, which is flexible to new and emerging priorities and risks. The Audit Committee also monitors the integrity of the financial and other disclosure statements of the CCG and any other formal reporting relating to the CCG's financial performance.

3. MEMBERSHIP

- 3.1 The Audit Committee was constituted in accordance with statute, and membership comprised the respective lay members of the CCG's Governing Body under their terms of reference. A benchmark of one meeting per quarter at appropriate times in the reporting and audit cycle is suggested. The Committee met six times in 2020/21. All meetings in 2020/21 were fully quorate. The quorum necessary for the transaction of business is two members. The full membership attendance can be found at Appendix One.
- 3.2 Additionally, the Audit Committee held a number of confidential meetings to discuss counter fraud and the procurement of External Audit services.

4. INTERNAL AUDIT SERVICE

- 4.1 360 Assurance carry out a range of activities in order to provide an independent and objective opinion to the Accountable Officer, the Governing Body, and the Audit Committee on the degree to which risk management, control and governance support the achievement of the organisation's objectives. The activities are conducted against a work plan and in accordance with the 360 Assurance contract.

All work was carried out within scheduled timescales and against a set of reported Key Performance Indicators. During the year the committee noted and agreed a number of changes to the scope of the Internal Audit plan proposed by 360 Assurance as part of its Covid-19 response.

- 4.2 Following the conclusion of its 2020/21 work programme, 360 Assurance issued a Head of Internal Audit Opinion of 'significant assurance'.

5 EXTERNAL AUDIT SERVICE

- 5.1 The statutory external audit service is provided to the CCG by KPMG. The service has included the preparation of various reports, including a value for money conclusion, and planning in preparation for the year-end audit of financial statements. The end of year audit delivered an unqualified opinion that the financial statements:

- 5.1.1 gave a true and fair view of the state of the CCG's affairs as at 31 March 2021 and of its income and expenditure for the year then ended; and

- 5.1.2 had been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State as being relevant to CCGs in England and included in the Department of Health and Social Care Group Accounting Manual 2020/21.

- 5.2 The Audit Committee considers that the service provided by KPMG represents good value for money but it will consider with the Chief Finance Officer opportunities for further efficiencies as part of a joint procurement of the external audit contract in tandem with system partners during 2021/22.

6. OUTPUTS OF THE AUDIT COMMITTEE

The main outputs of the Audit Committee are summarised below:

6.1 Financial Reporting

During the year the Audit Committee has overseen the preparation and planning for the 2020/2021 Annual Accounts audit in accordance with the published NHS timetable. The ISA260 report offered an unqualified opinion on the CCG's financial statements. The Annual Governance Statement was also reviewed and agreed by the committee.

6.2 Counter Fraud

- 6.2.1 During 2020/21 the CCG engaged with the Counter Fraud Specialist via 360 Assurance and used their input to ensure that appropriate policies and procedures were in place to mitigate the risks posed by Fraud, Bribery and Corruption.

- 6.2.2 The Accredited Counter Fraud Specialist regularly attended Audit Committee meetings and provided comprehensive updates on progress towards completion of the Annual Work Plan and compliance with the Standards for Commissioners.
- 6.2.5 Any instances of fraud have been reported to the committee throughout the year, and the Counter Fraud Specialist has continued to brief CCG staff on developments in fraud prevention.

6.3. Internal Controls

The following Audit Reports from the 2020/21 programme were considered by the Committee, together with the Head of Internal Audit Opinion:

Audit Assignment	Assurance Level
Governance Arrangement for Covid-19	N/A, through general positive conclusions
Conflicts of Interest	Significant
Integrity to the general ledger, financial reporting and budgetary control	Significant
Delegated primary medical care service	Substantial (NHSE opinion)
Policy Management Framework	Limited
Data Security and Protection Toolkit	Substantial

Any key risks which are highlighted within the reports were added to the CCG Assurance Framework. Actions flowing from the 'limited assurance' reports have subsequently been addressed by management.

6.4 Governance

The Audit Committee has had the opportunity to review many aspects of governance during 2020/21. Overall, the committee has been reassured by the professional and comprehensive response of the executive team to the many pressures and constraints introduced by the Covid-19 pandemic. Specific assurances have also been sought on the management of conflicts of interest, risk management and 'freedom to speak up'.

7. AUDIT COMMITTEE PERFORMANCE

- 7.1 The Audit Committee is committed to operating in a manner which is effective and efficient, continuing to provide best value return on time and resources invested in it. Specifically, its agenda has been designed to provide adequate consideration of the financial and other challenges to the achievement of the CCG's strategic objectives whilst acknowledging the monthly operational cycle of other Governing Body sub-committees.
- 7.2 The Audit Committee continues to monitor compliance with the requirements of the NHS Audit Committee Handbook and during the year it has reviewed its terms of reference within the constitution of the CCG and undertaken a Maturity Matrix Self-Assessment. The competence, commitment and challenge provided by individual members is a recognised strength of the committee.

8. ISSUES ARISING FROM THE COMMITTEE'S WORK

The end of year financial report preparation and audit certification was accomplished on time and the audit certification identified no issues of concern. Risks identified in the external audit plan have been satisfactorily mitigated. As part of its year end work the CCG received Independent Service Auditor Reports on the work of NHS business partners which delivered assurances below the level required. The committee did not receive reports on the work of the IT and business intelligence partner North of England Commissioning Support Unit (NECS), or Continuing Healthcare partner Midlands and Lancashire Commissioning Support Unit, as there was no contractual obligation to provide them. The CCG is currently working on rectifying this.

9. PLANS FOR 2021/22

- 9.1 The continued impact of Covid-19 on all aspects of the CCG's activities will require the committee to keep its workplan under review and to adopt a more flexible approach in testing the controls set out in the Assurance Framework. The health emergency introduced new risks into the CCG's operating environment and the Audit Committee will continue to test the scope and effectiveness of the organisational response. The potential disruption to the CCGs strategic priorities caused by the pandemic, together with mandated changes to local and national financial management arrangements, will provide a backdrop to that work and the level of assurance required will be reviewed with audit partners.
- 9.2 The planned handover of the CCG's functions as part of a transition to a new statutory body in April 2022 has generated new operational risks and a corresponding need for assurances in support of an effective close-down. The committee has agreed a provisional audit plan for 2021/22 which allocates resource to review system risks and to undertake system wide testing in collaboration with JUCD partners. The arrangements for conducting statutory audit of the year-end report and accounts have yet to be agreed.

10. CONCLUSION

The Audit Committee has previously confirmed to Governing Body, based on its work in 2020/21, that it considers the internal control framework to be appropriate and effective. The committee extends its appreciation to the Finance and Governance teams for their hard work and support to the committee's agenda.

Similarly, the committee has earlier noted and commended the achievement of the organisation's stretching financial targets, reflected also in the well-prepared set of annual report and accounts.

The continuing shift in risks and controls within the Assurance Framework, stemming from the many new demands being placed on the NHS, will be given further scrutiny in the coming year. The committee will continue to test and report to the Governing Body on these assurances on a regular basis.

Ian Gibbard
Chair of Audit Committee & Lay Member for Audit
August 2021

APPENDIX ONE

Audit Committee Attendance Record 2020/21

Audit Committee Member	29 Apr 2020	26 May 2020	17 Sep 2020	19 Nov 2020	21 Jan 2021	18 Mar 2021
Ian Gibbard <i>Chair, Lay Member for Audit and Conflicts of Interest Guardian</i>	✓	✓	✓	✓	✓	✓
Jill Dentith <i>Deputy Chair, Lay Member for Governance and Freedom to Speak Up Guardian</i>	✓	✓	X	✓	✓	✓
Andrew Middleton <i>Lay Member for Finance and Sustainability Champion</i>	✓	✓	✓	✓	✓	✓
Dr Bruce Braithwaite <i>Secondary Care Consultant⁺</i>	X	X	X	X	X	X

⁺ 'By invitation' in accordance with the Committee's workplan or where clinical input is required.

Governing Body Meeting in Public

7th October 2021

Item No: 154

Report Title	Clinical and Lay Commissioning Committee Assurance Report – September 2021
Author(s)	Zara Jones, Executive Director of Commissioning Operations
Sponsor (Director)	Zara Jones, Executive Director of Commissioning Operations

Paper for:	Decision	Assurance	x	Discussion		Information	x
Assurance Report Signed off by Chair		Dr Ruth Cooper, CLCC Chair					
Which committee has the subject matter been through?		CLCC – 9.9.2021					

Recommendations

The Governing Body is requested to **RATIFY** the decisions made by the Clinical and Lay Commissioning Committee (CLCC) on 9th September 2021.

Report Summary

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

CLC/2122/93 Clinical Policies

CLCC RATIFIED the following Policy and Position Statements:

- Fitting/Removal of Intra-uterine Contraceptive Devices and Levonorgestrel Intrauterine Systems in Secondary Care Policy
- Oraya Therapy for the Treatment of Wet Age-related Macular Degeneration (AMD) Position Statement

Areas for Service Development

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

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

Clinical Policy Advisory Group - EBI2 Interventions – updates for ratification and information

CLCC **NOTED** the following for information:

- 3a. Evidence Based Interventions (EBI2) Guidance

- 3b. Evidence-Based Interventions (EBI2) Guidance – review of Section 3 – pathways (part 2)

CLCC **NOTED** that the interventions included in section 3.2 required no further action by CPAG and were assured that providers are compliant and form part of a clinical pathway.

CLCC NOTED the CPAG Bulletin and Minutes for July 2021 and the CPAG Minutes.

CLC/2122/94 Adult ADHD Choice Referral Guidance

CLCC were asked to virtually:

- Approve as a clinical policy the ADHD Assessment Guidance noting the committees where it has been received
- Note the separate work underway with Regional CCGs and NHSE/I to look at the benefit of a possible Framework Contract and a Triage hub alongside a locally commissioned pathway to help manage the surge in demand and reassure referring clinicians on quality and price.

It was noted that the paper had been approved at the Senior Leadership Team on the 20th August

CLCC APPROVED the ADHD Guidance and NOTED the separate work underway. They requested that screening tools be made available on the website and for the guidance to be disseminated to GP's as soon as it is finalised.

CLC/2122/97 CLCC Terms of Reference

CLCC were asked to review the Terms of Reference as part of their mid-year review.

It was **NOTED** that there were two amendments to the document, which were highlighted in tracked changes:

- inclusion of paragraph 2.2 to Section 2 (Roles and Responsibilities), which details the role of CLCC in overseeing the transition of the committee to the Integrated Care Board; and
- the removal of paragraph 2.19, detailing the committee's responsibility for the Recovery and Restoration Plan, which has now been stood down.

CLCC NOTED the amended Terms of Reference and AGREED for their onward transmission to Governing Body for final approval.

CLC/2122/101 Governing Body Assurance Framework – Strategic Risk 3

**Governing Body Assurance Framework – Strategic Risk 3
Quarter 2 - September review (public facing paper)**

CLCC were asked to:

- **DISCUSS** and **REVIEW** the Quarter 2 (July to September) Governing Body Assurance Framework Strategic Risk 3 owned by CLCC
- **REVIEW** and **UPDATE** any further mitigating actions and assurances
- **REVIEW** and **UPDATE** the current risk score

CLCC DISCUSSED and REVIEWED Strategic Risk 3 and it was agreed that there needed to be an update relating to the strategic impact of Glossop CCG merging with DDCCG.

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

N/A

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

N/A

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

N/A

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

N/A

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

N/A

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

N/A

Have any Conflicts of Interest been identified/ actions taken?

N/A

Governing Body Assurance Framework

N/A

Identification of Key Risks

N/A

Governing Body Meeting in Public

7th October 2021

Item No: 155

Report Title	Derbyshire Engagement Committee Assurance Report – September 2021
Author(s)	Sean Thornton, Assistant Director Communications and Engagement
Sponsor (Director)	Martin Whittle, Vice Chair/Lay Member for PPI

Paper for:	Decision	Assurance	x	Discussion	Information
Assurance Report Signed off by Chair		Martin Whittle, Vice Chair/Lay Member for PPI			
Which committee has the subject matter been through?		Engagement Committee – 21.9.2021			

Recommendations

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

Report Summary

This report provides the Governing Body with highlights from the meeting of the Engagement Committee, held on 21st September 2021. This report provides a summary of the items transacted for assurance.

Insight into GP and Urgent Care Access

An update was provided on the recent period of insight collection by Britain Thinks. Having been formally presented to the Accident and Emergency Delivery Board, the report was due to be presented to the Primary and Community Care Delivery Board on 23rd September.

Headline findings from the report were that there was a variation in experience of accessing general practice across Derbyshire; that patients would not usually consider attending an A&E Department because of not being able to obtain an appointment with their GP; and that patients found that having accessed a service the care was of a high quality.

Discussions had already commenced on developing the resulting action plan which would include communications work on highlighting the delivery model within modern general practice and the multiple clinical roles that provide the overall service; work with practices to support clear and supportive messaging to patients around pressures; and alignment with the breadth of work already underway to support access in general practice within the Primary Care Development Team.

Winter Communications and Engagement Plan

Progress was underway to refresh the system's Communications and Engagement Plan to help with aligned key messages during the coming winter. With the blurring of the distinction between winter and ongoing general pressure, there has already been public communication on this topic, however the winter plan would also bring

in traditionally seasonal campaigns on influenza, norovirus, and the promotion of the range of services available during the period. The plan will see the system supporting all national campaigns, including NHS 111 First, pharmacy and self-care.

The plan itself will be a refreshed version of the 2020/21 plan, which had been developed as a collaborative effort across the Derbyshire health and care system and had been assured by NHS England. This year's assurance would be in the form of a monthly system return, setting out the specific actions taken against key targets, and the alignment with the system's operational winter plan, due to be submitted initially to NHS England on 30th September.

London Road Community Hospital Reconfiguration

Progress had been made in month on the engagement programme aimed at understanding the impact of the temporary changes made to provision of community hospital beds at the start of the Covid-19 pandemic. This work would help to support an informed decision on whether to make those changes permanent.

The details of the programme were due to be discussed at the Quality and Equality Impact Assessment (QEIA) Panel on 5th October, and subject to governance approvals, engagement over three months would commence in mid-November, with a final decision due in March 2022.

Engagement Model and Governance Guide

The Committee received a draft of the updated System Engagement Model, which had been refreshed in line of recent NHS England guidance on public and community engagement in the future ICS bodies. The model had previously been developed with the committee and the adjustments were approved. The model would now be used to further inform the Governance Guide on engagement and involvement, which would help system teams follow good practice and key processes fully involving citizens in service transformation. The guide would align with the transformation and PMO processes emerging across the system and would act as a key control in mitigating the risk of challenge in our service change programmes.

The Committee also formally received the recent guidance from NHS England on Working with people and communities and the Kings Fund paper on Understanding integration - How to listen to and learn from people and communities, both of which would form the bedrock of discussions in this area of work.

Place Engagement Approach

Allied with the updated Engagement Model has been a discussion about how to maximise community engagement in the work of place alliances. With the strong desire to engage in a way that 'feels different', a pilot approach will commence in Amber Valley aimed at putting the voice and lived experience of communities at the heart of place, promoting a culture of listening, learning and acting, founded in a continuous process of conversation, not simply a one-off conversation.

What has been clear from discussions is that the definition of Place, how it might work and what it might do, isn't important. What is important is:

- How people experience integrated care/joined up care or fragmentation of services and lack of co-ordination
- What matters most to people and communities in relation to health, care, and their wellbeing and what will make the most difference to people's lives?
- What factors have influenced their personal experiences, or those of friends and family the most?
- What influences people to participate in self-care or not, e.g., healthy behaviours?

Our work with the Kings Fund has identified that we can use 'concepts of integration' to prompt conversations with local people to see what works well. These might include:

- Services working together/coordination of services
- Receiving consistent/conflicting information
- Information sharing/having to repeat themselves to different professionals/services
- Being involved in what they want to gain from their care and treatment to assist with a better quality of life
- How services work together around a person's needs in a way that makes sense to them, i.e., being assessed as a whole person, signposting and partnership working.
- Being told about other services that may get involved and what their role will be
- Knowing what will happen next in their care and treatment/knowing who to contact.
- Getting support with self-care/knowing where to go to get support with self-care.
- Ways of promoting good health and preventing illness as an individual and within communities.

Convening conversation that will take place on a continuous basis over time, rather than as one-off discussions, we will start with those citizens who already have some element of interest in health and care. The aim is to 'go where the energy is' within mutual aid groups, local forums and networks and grow the discussion from there. We will need to collect the insight gathered and feed it into the place conversations. This will help with discussions around service improvement but will also enable us to find out more about what matters to people around integration of services, and how we can measure success.

Integrated Care System Governance Requirements

The Committee was updated on early thoughts around the position and remit of the Engagement Committee in the governance structures for the newly formed Integrated Care Board and Integrated Care Partnership. A small working group had formed to review and interpret the body of guidance received from NHS England and develop a proposal on the governance and assurance roles required on public engagement, for initial review by the Engagement Committee in October.

Update on Glossop Transition Communications and Engagement

The first meeting of the Glossop Transition Communications and Engagement Group would take place on Friday 1st October.

Exception Risk Report and Governing Body Board Assurance Framework
There were no changes to the scores of the single risk currently being managed by the Engagement Committee. This relates to a current 2x4=8 risk on the adherence to engagement legislation when undertaking service commissioning. The agenda item on the engagement model and governance guide provided assurance that progress continued towards achieving the target risk score of 2x3=6.
Are there any Resource Implications (including Financial, Staffing etc)?
None identified.
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?
A PIA is not found applicable to this update. This report is for assurance and information.
Has a Quality Impact Assessment (QIA) been completed? What were the findings?
A QIA is not found applicable to this update. This report is for assurance and information.
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
An EIA is not found applicable to this update. This report is for assurance and information.
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
Not applicable to this update. This report is for assurance and information.
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Not applicable to this update. This report is for assurance and information but describes a range of patient, public communications and engagement activity across the breadth of CCG work.
Have any Conflicts of Interest been identified/ actions taken?
None identified.
Governing Body Assurance Framework
Risks assigned to the Engagement Committee are reviewed monthly and changes noted within this assurance report.
Identification of Key Risks
Noted as above.

Governing Body Meeting in Public

7th October 2021

Item No: 156

Report Title	Governance Committee Assurance Report – September 2021
Author(s)	Suzanne Pickering, Head of Governance
Sponsor (Director)	Jill Dentith, Governance Lay Member & Chair of Governance Committee

Paper for:	Decision	Assurance	x	Discussion	Information
Assurance Report Signed off by Chair		Jill Dentith, Governance Lay Member and Chair of Governance Committee			
Which committee has the subject matter been through?		Governance Committee – 23.9.2021			

Recommendations

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

Report Summary

This report provides the Governing Body with highlights from the 23rd September 2021 meeting of the Governance Committee. This report provides a brief summary of the items transacted for assurance.

Derby and Derbyshire CCG Procurement Highlight Report

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

Human Resources Policies & Procedures for Approval

Flexible Working Policy

The Governance Committee approved the Flexible Working Policy on the 11th March 2021. Following the implementation of the new Policy, the NHS Staff Council, on behalf of NHS trade unions and employers, jointly agreed revisions to Section 33 of NHS terms and conditions of service (TCS) handbook. The improvements are designed to support a cultural change towards ensuring flexible working is available to all NHS staff.

The contractual changes are effective from the 13th September 2021 in England, and will support the commitments made in the NHS People Promise around moving to flexibility by default. The Flexible Working Policy has been updated to reflect these new contractual requirements

The Governance Committee APPROVED the revised Flexible Working Policy.

Governance Committee Terms of Reference

The Governance Committee REVIEWED the updated Governance Committee Terms of Reference and agreed to RECOMMEND them to Governing Body for approval.

Contract Oversight Group Update

The Governance Committee NOTED the verbal update and the progress being made.

Human Resources Performance Report, Quarter 1 2021/22

The Committee NOTED the HR Performance Report, covering the period Quarter 1 2021/22, and RECEIVED an update in relation to vacancy levels, leavers, sickness absence across the CCG and equality data. The Committee also had a verbal update on the current vaccination levels for CCG staff which was very positive.

Mandatory Training

The Committee NOTED the CCG's completion figures for Mandatory Training as at the end of August 2021 and GAINED ASSURANCE that there are currently no concerns regarding compliance with training.

Business Continuity, Emergency Planning Resilience and Response

The Governance Committee held an Extraordinary confidential meeting on the 10th September 2021, to agree to the new operating model for the gradual return to offices as set out in the Amber status working environment. The new working model commenced on the 20th September 2021.

The Governance Committee NOTED the contents of the report for information and assurance.

Emergency Planning Resilience and Response (EPRR) National Core Standards 2021/22

It is an annual national requirement for NHS Organisations to complete a self-assessment of the EPRR National Core Standards. The Core Standards self-assessment were completed by the CCG and Derbyshire Provider organisations by the deadline for of the 31st August 2021.

The CCG submitted a self-assessment of fully compliant which reflects the assurance level of the CCG as in previous years. The Derbyshire Providers self-assessment compliancy levels were also provided to the Committee. The position for the Providers and the CCG has yet to be confirmed with NHSEI. Confirmation will take place in the form of "confirm and challenge" meetings with NHSEI.

The Governance Committee NOTED the content of the report for information and Assurance.

Health and Safety Report

The Governance Committee RECEIVED ASSURANCE that Derby and Derbyshire CCG is coordinating work to meet its health and safety obligations to remain compliant with health and safety legislation. The Committee also RECEIVED ASSURANCE that Derby and Derbyshire CCG is responding effectively and

appropriately to the changes in working practices as a consequence of the COVID-19 pandemic.

Violence Prevention and Reduction Standards

The Governance Committee NOTED the draft Violence, Prevention and Reductions Policy and Strategy for assurance and information. Comments made by the Committee will be built into the revised policy prior to final submission to the Committee for approval at its next meeting.

Information Governance Compliance Report

The Governance Committee APPROVED the items approved at the August Information Governance Assurance Forum meeting and RECEIVED an update regarding actions and compliance activities.

Digital Development & Cyber Security Report

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

Risk Register Report September 2021

The Governance Committee RECEIVED the Governance risks assigned to the Committee as at September 2021. The Committee APPROVED the decrease in risk score for risk 09 relating to 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.

Governance Committee Governing Body Assurance Framework Risks

Quarter 2

The Governance Committee DISCUSSED the Quarter 2 Governing Body Assurance Framework (GBAF) Strategic Risks 7 and 8 owned by the Governance Committee. The Committee AGREED that these should be included in the Quarter 2 GBAF presented to the Governing Body on the 7th October 2021.

Non-Clinical Adverse Incidents

No incidents were reported to the Committee.

Minutes of the Governance Committee 22nd July 2021

The minutes of the 22nd July 2021 were APPROVED as a true and accurate record.

Governance Committee forward planner

The forward plan was REVIEWED. It was AGREED that the future role of the Governance Committee and transition to the Integrated Care Board should be included on the forward planner.

Any Other Business

It was agreed that the minutes of the Extraordinary Governance Committee of the 10th September 2021 would be formally ratified at the Confidential Governance Committee on the 11th November 2021.

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

Governing Body Meeting in Public

7th October 2021

Item No: 158

Report Title	Quality and Performance Committee Assurance Report – September 2021
Author(s)	Jackie Carlile, Head of Performance and Assurance Alison Cargill, Assistant Director of Quality
Sponsor (Director)	Zara Jones, Executive Director for Commissioning Operations Brigid Stacey, Chief Nurse.

Paper for:	Decision	Assurance	x	Discussion	Information
Assurance Report Signed off by Chair				Dr Buk Dhadda, Chair of Quality and Performance Committee	
Which committee has the subject matter been through?				Q&PC – 30.9.2021	
Recommendations					
The Governing Body is requested to NOTE the paper for assurance purposes.					
Report Summary					
<p><u>Integrated Report</u> -The report was received by the Committee and agreed by the Chair. No issues were raised.</p> <p><u>Mental Health Update</u> - Overall, the Committee were assured in relation to Mental Health Services in Derbyshire. A number of queries were raised in relation to access for Children and Young People. The Chief Nurse agreed to arrange a meeting with GPs and the Mental Health Leadership Team to look at the concerns in more detail. It was agreed that a further update would be provided in three months.</p> <p><u>SEND</u> - The Committee received the first Annual Report from the Designated Clinical Officer. The Committee welcomed the report and were assured. It was noted that Derby City are to be inspected on the 4th to 6th October 2021, and a report on the outcome of the inspection was requested for the October Committee.</p> <p><u>Maternity</u> - The Committee were assured by the report. It was noted that, due to significant attention on Maternity Services due to national concerns, the Chair of the System Quality Group had written to the Chair of the Maternity Quality and Safety Forum to undertake a deep dive, including visits to both Providers. It was requested that the outcome of the deep dive be presented at the next meeting.</p> <p><u>CHC 360 Audit</u> - The Committee received the 360 external audit, which had been delayed due to the pandemic. The outcome of the audit resulted in significant assurance, with three minor issues, all of which have been addressed.</p>					
Are there any Resource Implications (including Financial, Staffing etc)?					
No					
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?					
N/A					

Has a Quality Impact Assessment (QIA) been completed? What were the findings?
N/A
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
N/A
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
N/A
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
N/A
Have any Conflicts of Interest been identified/ actions taken?
None
Governing Body Assurance Framework
The report covers all of the CCG objectives
Identification of Key Risks
The report covers GBAF risks 1, 2 and 6.

Month 04

Quality & Performance Report

2021/22

September 2021

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EXECUTIVE SUMMARY

Key Messages	<ul style="list-style-type: none"> The tables on slides 5-8 show the latest validated CCG data against the constitutional targets. A more detailed overview of performance against the specific targets and the associated actions to manage performance is included in the body of this report.
Urgent & Emergency Care	<ul style="list-style-type: none"> The A&E standard was not met at a Derbyshire level at 78.1% (YTD 80.9%). CRH did not achieve the standard achieving 90.3% (YTD 94.3%). UHDB achieved 70.4% during August (YTD 73.1%) which is a slight improvement. UHDB had 7 x 12 hour trolley breaches during July – 1 was due to the unavailability of a suitable mental health bed for an out of area patient and 6 were due to unavailable capacity in the trust. EMAS were non-compliant 5 of the 6 standards for Derbyshire during August 2021, slightly better than July despite continued increase in activity throughout the month.
Planned Care	<ul style="list-style-type: none"> 18 Week Referral to Treatment (RTT) for incomplete pathways continues to be non-compliant at a CCG level at 67.7% (YTD 66.1%). CRHFT performance was 70.8% (YTD 69.1%) and UHDB 63.1% (YTD 61.1%) Both our main provider improved slightly so the reduction in CCG performance is due to our associate providers. Derbyshire had 5,897 breaches of the 52 week standard across all trusts – the third consecutive month there has been a reduction. Diagnostics – The CCG performance was 28.64%, a deterioration from the previous month. Neither CRH (16.17%) or UHDB (31.65%) have achieved the standard.
Cancer	<p>During July 2021, Derbyshire was compliant in 3 of the 9 Cancer standards:</p> <ul style="list-style-type: none"> 28 day Faster Diagnosis – 75.6% (75% standard) – Compliant for Derby & Burton, Chesterfield, Nottingham & Sherwood Forest. 31 day Subsequent Drugs – 98.5% (98% standard) – Compliant all Trusts. 31 day Subsequent Radiotherapy – 96.2% (94% standard) – Non-Compliant at UHDB. <p>During July 2021, Derbyshire was non-compliant in 6 of the 9 Cancer standards:</p> <ul style="list-style-type: none"> 2 week Urgent GP Referral – 87.8% (93% standard) – Compliant for Stockport. 2 week Exhibited Breast Symptoms – 78.6% (93% standard) – Non compliant for all trusts. 31 day from Diagnosis – 82.9% (96% standard) – Compliant for Chesterfield and Stockport. 31 day Subsequent Surgery – 82.9% (94% standard) - Compliant for Chesterfield, East Cheshire, Sherwood Forest and Stockport. 62 day Urgent GP Referral – 71.4% (85% standard) – Non compliant for all trusts. 62 day Screening Referral – 77.3% (90% standard) – Non compliant for all trusts. 104 day wait – 19 CCG patients waited over 104 days for treatment.

Executive Summary

Trust	
Chesterfield Royal Hospital FT	Hip Fracture Mortality: CRH have been flagged as an outlier. Work is being undertaken to review the data and the pathway. Dependent on the outcome of this review CRH may ask for an external review by the British Orthopaedic Association. CRH will ensure the CCG are fully appraised of progress and plans prior this external invite. The CCG quality team will be kept appraised of plans.
University Hospitals of Derby and Burton NHS FT	12 hour Decision to Admit Breaches: There were 6 breaches in August at RDH which is an improvement on July's figures. One was due to mental health bed availability and five due to MAU capacity. Harm review process continues on each occasion. September's figures so far are significantly higher with 14 reported alone for the 11 th September.
Derbyshire Community Health Services FT	COVID-19: Staff vaccination continues, as of 10 th August 2021 1st vaccination was 96.3% and for both vaccinations 93.2%. The COVID absence rate (isolating & shielding) was 0.2% for the month of June, was 0.4% at 30th June. The Derby vaccination programme will extend into 2022 as there will be a booster programme and a plan for those aged 12 – 18 years. In response, a new flexible staffing model is in place. Vaccine centre has moved from Derby Arena to Midland House.
Derbyshire Healthcare Foundation Trust	Seclusion: The use of seclusion was within common cause variation, however, has increased in July. This appears to be a linked to a small number of patients who have been placed in seclusion on more than one occasion. This data will be monitored for patterns and further support needs for individual areas. Autistic spectrum disorder (ASD) assessments: Waiting list is slowly increasing with a steady number of referrals leading to a compounding month on month increase. The trust are continuing with their COVID-19 recovery plans and have identified locations, timings, protocols for safe COVID-19 face to face appointments. Patients placed out of area: There have been an additional 11 beds commissioned at Mill Lodge, Kegworth in order to increase capacity due to social distancing requirements resulting in closure of 10 adult acute beds These beds have been classified as "appropriate" out of area from April 2021 due to achieving continuity of care standards.
East Midlands Ambulance Trust	Performance: For the month of July, the Trust did not deliver any of the operational performance metrics. This level of performance was consistent across all our divisions with no division delivering any of the standards except Nottinghamshire who are delivering Category 1 Ninetieth Percentile. Performance against national standards improved in August compared to July, however the trust are still not delivering national standards. Serious Incidents: Eight Serious Incidents (SIs) were reported in July 2021 compared to one reported in July 2020. This brings the year to date total to 17 compared to 18 in the same period in the previous year.

PERFORMANCE OVERVIEW MONTH 5 – 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%	Aug-21	↑	78.1%	80.9%	71	90.3%	94.3%	2	70.4%	73.1%	71	79.1%	82.6%	71
		A&E 12 Hour Trolley Waits	0	Aug-21					0	7	0	7	36	13	2794	7515	71

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	Aug-21	→	00:08:29	00:08:14	14	00:08:38	00:08:16	13	00:07:54				00:08:28	00:07:52	4	
		Ambulance - Category 1 - 90th Percentile Respose Time	00:15:00	Aug-21	→	00:14:38	00:14:07	0	00:15:38	00:14:50	2	00:14:06				00:15:06	00:14:00	2	
		Ambulance - Category 2 - Average Response Time	00:18:00	Aug-21	→	00:38:55	00:34:33	13	00:43:37	00:39:10	14	00:33:40				00:38:39	00:31:03	13	
		Ambulance - Category 2 - 90th Percentile Respose Time	00:40:00	Aug-21	→	01:19:50	01:10:03	13	01:33:05	01:22:10	13	01:10:09				01:24:18	01:05:12	5	
		Ambulance - Category 3 - 90th Percentile Respose Time	02:00:00	Aug-21	→	06:12:26	05:03:23	13	06:26:07	05:33:35	13	04:30:11				05:28:34	04:24:36	5	
		Ambulance - Category 4 - 90th Percentile Respose Time	03:00:00	Aug-21	↓	06:26:46	04:53:24	5	05:00:57	05:07:20	5	04:43:53				05:57:27	05:34:54	5	

PERFORMANCE OVERVIEW MONTH 4 – PLANNED CARE

NHS Derby & Derbyshire CCG Assurance Dashboard

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

Part A - National and Local Requirements

CCG Dashboard for NHS Constitution Indicators

CCG Dashboard for NHS Constitution Indicators				Direction of Travel	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	
Urgent Care	Area	Indicator Name	Standard	Latest Period	NHS Derby & Derbyshire CCG			Chesterfield Royal Hospital FT			University Hospitals of Derby & Burton FT			NHS England			
					↑	78.1%	80.9%	71	90.3%	94.3%	2	70.4%	73.1%	71	79.1%	82.6%	71
Urgent Care	Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	Aug-21	↑	78.1%	80.9%	71	90.3%	94.3%	2	70.4%	73.1%	71	79.1%	82.6%	71
		A&E 12 Hour Trolley Waits	0	Aug-21					0	7	0	7	36	13	2794	7515	71
Planned Care	Referral to Treatment for planned consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Jul-21	↓	67.7%	66.1%	42	70.8%	69.1%	27	63.1%	61.1%	43	68.3%	67.3%	65
		Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Jul-21	↓	5897	26445	18	1098	4650	16	6206	30222	17	293102	1320128	171
Planned Care	Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Jul-21	↑	28.64%	26.49%	38	16.17%	10.87%	16	31.65%	29.75%	17	23.51%	23.05%	95
Planned Care	2 Week Cancer Waits	All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	Jul-21	↑	87.8%	85.9%	11	Cancer 2 Week Wait Pilot Site - not currently reporting			85.1%	81.7%	11	85.6%	85.8%	14
		Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	Jul-21	↑	78.6%	59.8%	9				86.4%	58.4%	8	74.7%	68.2%	14
Planned Care	28 Day Faster Diagnosis	Diagnosis or Decision to Treat within 28 days of Urgent GP, Breast Symptom or Screening Referral	75%	Jul-21	↓	75.6%	75.5%	0	78.3%	76.7%	0	75.2%	75.8%	0	73.9%	73.5%	4
Planned Care	31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	96%	Jul-21	↑	94.7%	93.9%	7	99.1%	97.8%	0	92.8%	93.8%	12	94.7%	94.7%	7
		Subsequent Surgery Within 31 Days Of Decision To Treat	94%	Jul-21	↑	82.9%	81.0%	20	100.0%	96.4%	0	84.6%	87.8%	2	87.2%	86.8%	36
		Subsequent Drug Treatment Within 31 Days Of Decision To Treat	98%	Jul-21	↓	98.5%	98.9%	0	100.0%	100.0%	0	97.5%	98.7%	1	99.2%	99.1%	0
		Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	Jul-21	↑	96.2%	96.0%	0				85.1%	92.0%	1	97.4%	97.1%	0
Planned Care	62 Days Cancer Waits	First Treatment Administered Within 62 Days Of Urgent GP Referral	85%	Jul-21	↑	71.4%	69.5%	29	71.5%	72.3%	24	69.1%	68.8%	39	72.1%	73.4%	67
		First Treatment Administered - 104+ Day Waits	0	Jul-21	↓	19	90	64	4	19	39	22	71	64	936	3536	67
		First Treatment Administered Within 62 Days Of Screening Referral	90%	Jul-21	↑	77.3%	73.8%	27	76.3%	65.7%	27	82.9%	82.7%	8	75.9%	74.5%	40
		First Treatment Administered Within 62 Days Of Consultant Upgrade	N/A	Jul-21	↓	79.5%	84.2%		100.0%	86.7%		89.5%	95.3%		81.7%	82.7%	

PERFORMANCE OVERVIEW MONTH 4 – 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

Urg	Area	Indicator Name	Standard	Latest Period	Direction of Travel	NHS Derby & Derbyshire CCG			Chesterfield Royal Hospital FT			University Hospitals of Derby & Burton FT			NHS England		
						Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance	Current Month	YTD	consecutive months non-compliance
Patient Safety	Incidence of healthcare associated Infection	Healthcare Acquired Infection (HCAI) Measure: MRSA Infections	0	Jul-21	↔	0	0	0	Cancer 2 Week Wait Pilot Site - not currently reporting	0	1	0	57	203	28		
		Healthcare Acquired Infection (HCAI) Measure: C-Diff Infections	Plan	Jul-21	↓	80					40			4796			
			Actual			74	1	4	0	20	0						
		Healthcare Acquired Infection (HCAI) Measure: E-Coli	-	Jul-21	↑	70	303		25	90		58	217	70	303		
Healthcare Acquired Infection (HCAI) Measure: MSSA	-	Jul-21	↓	22	91		6	24		14	66	1052	4048				

PERFORMANCE OVERVIEW MONTH 4 – MENTAL HEALTH

CCG Dashboard for NHS Constitution Indicators

CCG Dashboard for NHS Constitution Indicators				Direction of Travel	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure	Current Month	YTD	consecutive months of failure	
Mental Health	Area	Indicator Name	Standard	Latest Period	NHS Derby & Derbyshire CCG				Derbyshire Healthcare FT						NHS England					
	Early Intervention In Psychosis	Early Intervention In Psychosis - Admitted Patients Seen Within 2 Weeks Of Referral	60.0%	Jun-21	↑	87.5%	85.2%	0	77.8%	81.5%	0				65.2%	69.6%	0			
		Early Intervention In Psychosis - Patients on an Incomplete Pathway waiting less than 2 Weeks from Referral	60.0%	Jun-21	↔	100.0%	80.0%	0	100.0%	83.3%	0				28.1%	29.2%	26			
	Mental Health	Dementia Diagnosis Rate	67.0%	Jul-21	↓	64.9%	65.0%	13							62.1%	62.8%	16			
		CYPMH - Eating Disorder Waiting Time % urgent cases seen within 1 week		2021/22 Q1	↓	90.8%	74.6%													
		CYPMH - Eating Disorder Waiting Time % routine cases seen within 4 weeks		2021/22 Q1	↓	94.6%	83.9%													
		Perinatal - Increase access to community specialist perinatal MH services in secondary care	4.5%	2020/21 Q4	↓	2.6%	3.9%	5												
		Mental Health - Out Of Area Placements		Jun-21	↑	665	1960													
		Physical Health Checks for Patients with Severe Mental Illness	25%	2021/22 Q1	↑	22.2%	29.6%	5												
	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	Jul-21	↓	2.10%	8.40%													
			Actual			2.60%	10.79%	0												
Improving Access to Psychological Therapies		IAPT - Proportion Completing Treatment That Are Moving To Recovery	50%	Jul-21	↓	53.3%	53.7%	0	52.9%	54.7%	0	54.5%	54.2%	0	41.4%	46.7%	3	57.1%	58.1%	0
		IAPT Waiting Times - The proportion of people that wait 6 weeks or less from referral to entering a course of IAPT treatment	75%	Jul-21	↓	93.6%	96.6%	0	86.2%	93.2%	0	96.1%	97.8%	0	97.2%	97.9%	0	96.3%	97.8%	0
	IAPT Waiting Times - The proportion of people that wait 18 Weeks or less from referral to entering a course of IAPT treatment	95%	Jul-21	↔	100.0%	100.0%	0	100.0%	100.0%	0	100.0%	100.0%	0	100.0%	100.0%	0	100.0%	100.0%	0	
Referral to Treatment for planned consultant led treatment	Area	Indicator Name	Standard	Latest Period	Derbyshire Healthcare FT															
	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Jul-21	↓	82.4%	90.9%	2													
	Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Jul-21	↔	0	0	0													

Quality Overview

QUALITY OVERVIEW M3

Trust	Key Issues
Chesterfield Royal Hospital FT	<p><u>CQC</u> The Maternity Service Transitional Monitoring Approach (TMA) review is now complete and the verbal feedback indicated a judgment of low risk. There is no written CQC feedback to date as part of this process. CRH continue to review their service against the backdrop of pressures mirrored nationally.</p> <p><u>Hip Fracture Mortality data</u> CRH are an outlier and work is being undertaken to review the data and the pathway. Dependent on the outcome of this review CRH may ask for an external review by the British Orthopaedic Association. CRH will ensure the CCG are fully appraised of progress and plans prior this external invite. The CCG quality team will be kept appraised of plans.</p> <p><u>12 hour DTA breaches</u> 2 breaches for CRH in July related to medical capacity. We have continued to support the harm review process on each occasion.</p>
University Hospitals of Derby and Burton NHS FT	<p><u>CQC</u> The Maternity Service Transitional Monitoring Approach (TMA) review is near completion, with CQC feedback planned for the 20th September. The Trust are optimistic this will be positive.</p> <p><u>Staff wellbeing</u> Continued Trust focus on this. Real concerns around other non-COVID circulating viruses impacting on staffing. Flu season potentially will be 50% worse than previous years and planning includes impact of this on waiting list recovery.</p> <p><u>12 hour DTA breaches</u> For August there were 6 breaches in total, and all at Derby which is an improvement on Julys figures which were reported previously. 1 due to mental health bed availability and 5 due to MAU capacity. We have continued to support the harm review process on each occasion. Septembers figures so far are significantly higher with 14 reported alone for the 11th September.</p>

QUALITY OVERVIEW M3 continued

Trust	Key Issues
Derbyshire Community Health Services FT	<p>COVID-19 Vaccinations: As at 10th August 2021 for 1st vaccination was 96.3% and for both vaccinations 93.2%.</p> <p>COVID absence: The COVID absence rate (isolating & shielding) was 0.2% for the month of June, was 0.4% at 30th June.</p> <p>Derby Vaccination Programme: The programme will extend into 2022 as there will be a booster programme and a plan for those aged 12 – 18 years. So as to respond to this a new flexible staffing model is in place. Vaccine centre has moved from Derby Velodrome to Midland House. This will be monitored at CQRG.</p> <p>FFT: Score reduced from 92.7 (July) to 90.7 (August) / 95% target. This may be attributed to recovery of services and will be monitored at CQRG.</p>
Derbyshire Healthcare Foundation Trust	<p>Seclusion: The use of seclusion was within common cause variation, however, has increased in July. In further investigating this trend, there appears to be a linked to a small number of patients who have been placed in seclusion on more than one occasion. This data will be monitored for patterns and further support needs for individual areas.</p> <p>Vaccination status: 93% of people working for the Trust have now been vaccinated.</p> <p>Autistic spectrum disorder (ASD) assessment: Waiting list is slowly increasing. A steady number of referrals are leading to a compounding month on month increase. The trust are continuing with their COVID-19 recovery plans and have identified locations, timings, protocols for safe COVID-19 face to face appointments.</p> <p>Patients placed out of area – adult acute: The trust currently operate with 10 Trust adult acute beds closed in order to facilitate social distancing and cohorting. Whilst these beds are closed, 11 beds are commissioned at Mill Lodge, Kegworth. These beds were eventually classified as “appropriate” out of area from April 2021 due to achieving continuity of care standards.</p>
East Midlands Ambulance Trust	<p>Performance: For the month of July, the Trust did not deliver any of the operational performance metrics. This level of performance was consistent across all our divisions with no division delivering any of the standards except Nottinghamshire who are delivering Category 1 Ninetieth Percentile. Performance against national standards improved in August compared to July, however the trust are still not delivering national standards. This will be monitored at CQRG.</p> <p>Serious Incidents: Eight Serious Incidents (SIs) were reported in July 2021 compared to one reported in July 2020. This brings the year to date total to 17 compared to 18 in the same period in the previous year. Learning from Events sessions continue to be held to share learning from SIs and other sources, for example complaints, safeguarding investigations, compliments and audit findings.</p> <p>Covid-19 Outbreaks: As at 20 August 2021 the Trust had two active COVID-19 Outbreaks. It was 21 and 11 days respectively since the last positive case was identified in these areas, indicating that the mitigating actions put in place are being effective in managing the outbreaks.</p>

QUALITY OVERVIEW M4

Derbyshire Wide Integrated Report

Part B: Provider Local Quality Indicators

Dashboard Key:

CCG assured by the evidence

CCG not assured by the evidence

Performance Improved From Previous Period

Performance Maintained From Previous Period

Performance Deteriorated From Previous Period

↑

↔

↓

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

Section	Area	Indicator Name	Standard	Chesterfield Royal Hospital FT				University Hospitals of Derby & Burton FT				Derbyshire Community Health Services				Derbyshire Healthcare FT			
				Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD	Latest Period	Direction of travel	Current Period	YTD
Ratings	CQC Ratings	Inspection Date	N/A	Aug-19				Mar-19				May-19				May-18			
		Outcome	N/A	Good				Good				Outstanding				Requires Improvement			
Adult	FFT	Staff 'Response' rates	15%	2019/20 Q2	↑	7.6%	8.6%	2019/20 Q2	↑	10.1%	10.1%	2019/20 Q2	↑	2.7%	21.7%	2019/20 Q2	↑	3.2%	18.1%
		Staff results - % of staff who would recommend the organisation to friends and family as a place to work		2019/20 Q2	↑	56.0%	64.1%	2019/20 Q2	↑	70.2%	70.2%	2019/20 Q2	↑	50.4%	70.5%	2019/20 Q2	↑	57.3%	66.7%
		Inpatient results - % of patients who would recommend the organisation to friends and family as a place to receive care	90%	Jun-21	↓	N/A	97.7%	Jun-21	↑	93.1%	96.4%	Jul-20	↔	100.0%	98.6%				
		A&E results - % of patients who would recommend the organisation to friends and family as a place to receive care	90%	Jun-21	↓	N/A	77.8%	Jun-21	↑	85.4%	80.3%	Jul-20	↓	N/A	99.3%				
	Complaints	Number of formal complaints received	N/A	Jun-21	↑	15	47	May-21	↑	23	75	Jun-21	↔	3	11	Jun-21	↑	11	51
		% of formal complaints responded to within agreed timescale	N/A	Jun-21	↓	60.0%	75.3%	May-21	↓		69.2%	Jun-21	↑	100.0%	94.3%	Jun-21	↔	100.0%	97.92%
		Number of complaints partially or fully upheld by ombudsman	N/A	Jun-21	↔	0	0	19-20 Q2	↔	1	2	Jun-21	↔	0	0	Jun-21	↔	0	0
	Pressure Ulcers	Category 2 - Number of pressure ulcers developed or deteriorated	N/A	Jun-21	↓	7	10	May-21	↑	19	55	Jun-21	↓	86	255	Jun-21	↔	0	1
		Category 3 - Number of pressure ulcers developed or deteriorated	N/A	Jun-21	↓	4	7	May-21	↑	5	19	Jun-21	↑	24	97	Jun-21	↔	0	0
		Category 4 - Number of pressure ulcers developed or deteriorated	N/A	Jun-21	↔	0	0	May-21	↔	0	0	Jun-21	↓	6	14	Jun-21	↔	0	0
		Deep Tissue Injuries(DTI) - numbers developed or deteriorated		Jun-21	↓	3	8	Sep-19	↑	16	94	Jun-21	↑	54	203	Jun-21	↔	0	0
		Medical Device pressure ulcers - numbers developed or deteriorated						Sep-19	↓	4	20	Jun-21	↓	15	41	Jun-21	↔	0	0
	Falls	Number of pressure ulcers which meet SI criteria	N/A	Sep-20	↑	0	3	Sep-19	↔	0	4	Apr-21	↓	1	1	Jun-21	↔	0	0
		Number of falls	N/A	Jun-21	↑	85	262	Data Not Provided in Required Format				Jun-21	↑	18	58	Jun-21	↓	23	70
	Medication	Number of falls resulting in SI criteria	N/A	Sep-20	↑	0	8	Sep-19	↑	0	19	Jun-21	↑	0	1	Jun-21	↔	0	0
		Total number of medication incidents	?	Jun-21	↑	81	230	Data Not Provided in Required Format				Jun-21	↔	0	0	Jun-21	↓	80	230
	Serious Incidents	Never Events	0	Jun-21	↔	0	0	May-21	↓	2	2	May-19	↔	0	0	Jun-21	↔	0	0
Number of SI's reported		0	Sep-20	↑	4	26	Sep-19	↑	7	115	Dec-20	↔	1	34	Jun-21	↑	0	5	
Number of SI reports overdue		0	Apr-21	↔	0	0	May-19	↓	19	28	May-19	↔	0	0					
	Number of duty of candour breaches which meet threshold for regulation 20	0	Sep-20	↑	0	3	May-19	↔	0	0	Dec-20	↔	0	0					

QUALITY OVERVIEW M4

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					Jun-21	↔	0	0	
		% Risk Assessments of all inpatients	90%	2019/20 Q3	↓	96.9%	97.4%	2019/20 Q3	↓	95.9%	96.1%	2019/20 Q3	↓	99.5%	99.7%					
	Mortality	Hospital Standardised Mortality Ratio (HSMR)	Not Higher Than Expected	May-21	↓	109		Nov-20	↔	107.4										
		Summary Hospital-level Mortality Indicator (SHMI): Ratio of Observed vs. Expected		Mar-21	↓	0.961		Mar-21	↓	0.908										
		Crude Mortality		Jun-21	↑	1.25%	1.33%	May-21	↑	0.90%	1.10%									
Maternity	FFT	Antenatal service: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Jun-21	↔	N/A	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?		Jun-21	↓	N/A	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?		Jun-21	↓	N/A	98.4%	Jun-21	↓	98.4%	98.0%									
		Postnatal community service: How likely are you to recommend our service to friends and family if they needed similar care or treatment?		Jun-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													Jun-21	↔	0	0	
Workforce	Staff	Staff turnover (%)		Jun-21	↓	9.1%	8.6%	May-21	↓	10.2%	9.6%	Jun-21	↓	8.9%	8.8%	Jun-21	↓	10.72%	10.56%	
		Staff sickness - % WTE lost through staff sickness		Jun-21	↑	4.3%	4.2%	May-21	↓	5.6%	5.2%	Jun-21	↑	4.3%	4.3%	Jun-21	↓	6.55%	5.95%	
		Vacancy rate by Trust (%)		Sep-17	↓	1.9%	1.3%	Data Not Provided in Required Format				Jun-21	↓	2.8%	2.2%	Jun-21	↑	13.4%	13.8%	
		Agency usage	Target Actual														Jun-21	↑	2.43%	2.61%
		Agency nursing spend vs plan (000's)		Jun-21	↓	£167	£561	Oct-18	↑	£723	£4,355	Jun-21	↑	£48	£254					
		Agency spend locum medical vs plan (000's)		Jun-21	↓	£793	£2,281													
	Training	% of Completed Appraisals	90%	Jun-21	↑	68.9%	46.2%	May-21	↑		85.9%	Jun-21	↓	88.9%	89.0%	Jun-21	↓	74.7%	76.5%	
		Mandatory Training - % attendance at mandatory training	90%	Jun-21	↑	85.4%	85.1%	May-21	↑		87.9%	Jun-21	↓	96.0%	96.2%	Jun-21	↑	84.5%	83.4%	
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																	

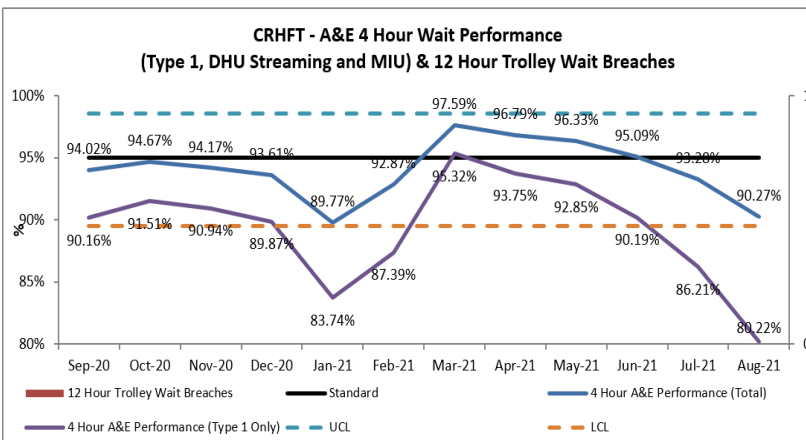
Urgent & Emergency Care

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

Performance Analysis

During August 2021 the trust did not meet the 95% standard, achieving 90.3% and the Type 1 element achieving 80.2%, a decline on last month's performance.

There were no 12 hour trolley breaches during August.



What are the next steps?

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

What are the issues?

- There have been severe delayed discharges for patients requiring Packages Of Care, due to capacity for these in the county. This has led to the medical bed base being full (at times there have been enough Medically Fit For Discharge patients to fill 2 wards), therefore reducing the beds available for those in A&E who need them.
- The volume of Type 1 attendances are approaching pre-pandemic levels, with an average of 183 attendances per day. However, August 2021 volumes were still around 94% of the August 2019 levels.
- Staff absence due to sickness is high, with around a quarter of sickness being due to Covid related sickness or isolation.
- Decreased bed capacity due to the high number of children attending the hospital with suspected RSV and Covid symptoms.
- The trust are still taking precautions against COVID-19 and still have these preventative measures in place to include streaming of patients at the physical front door and additional time between seeing patients to turnaround the physical space ensuring increased strict infection control.

What actions have been taken?

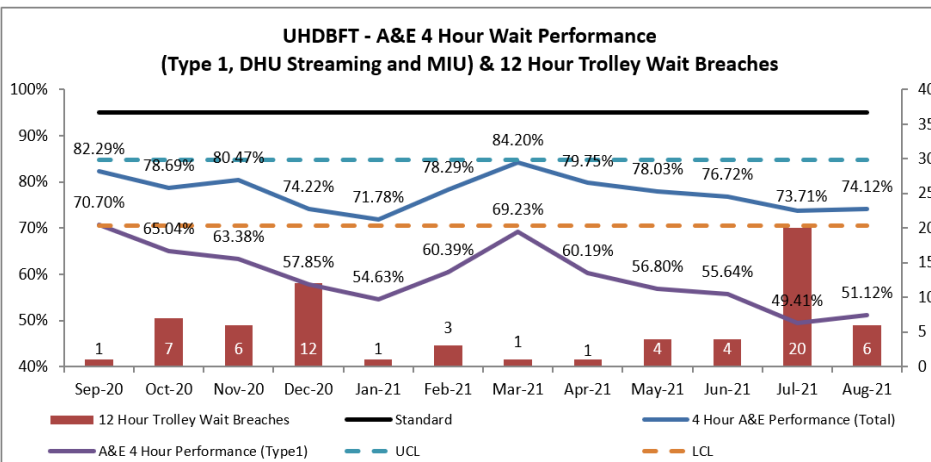
- Escalation of the Packages Of Care shortage to the System Organisational Resilience Group (SORG) which includes councils and community trusts, in addition to daily communications to secure more capacity.
- Streamlining of front door and booking-in processes to support more timely clinical review.
- AN NHSI critical friend visit was undertaken during June 2021, with a focus on urgent & emergency care. The Trust are awaiting written feedback.
- RSV Surge accommodation plans have been enacted to include increased oxygen provision across the site, equipment/consumables provision and detailed communications with relevant staff.
- Close working with EMAS to avoid unnecessary conveyances and to reduce Turnaround Times for those arriving this way.
- Established 24 hour access to the Assessment Units for relevant Medical, Surgical and Gynaecological patients.
- The implementation of the 111First project, whereby patients only access ED via 999 calls or booked appointments – to reduce unnecessary attendances.

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

Performance Analysis

During August 2021, performance overall did not meet the 95% standard, achieving 74.11% (Network figure) and 51.1% for Type 1 attendances. This was a slight improvement on the previous month.

There were 6 x 12 hour breaches during August 2021 due to the availability of suitable Mental Health beds (1) and medical capacity issues (5).



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

What are the next steps?

- Further embedding of the Urgent Treatment Centre, to reduce unnecessary ED attendances. 24/7 opening from September 2021 has been assured by system partners.
- A Data Quality Review to ensure that the recorded times (and other information) are accurate.
- The development of a Diagnostic Hub at Florence Nightingale Community Hospital, releasing capacity at the acute site.
- Developing Frailty pathways in the Discharge Assessment Unit and improving access to SystemOne for primary and community care.
- Improving the shared Pitstop area for patients arriving by ambulance.
- Increased public communications regarding 111First and Urgent Treatment Centres as alternatives to automatic A&E attendances.

What are the issues?

- The volume of Type 1 attendances is high, with an average of 495 attendances per day. As a Network the numbers of attendances are 35% higher than pre-pandemic levels (August 2021 compared to August 2019).
- Critical Care pressures have affected the whole region, with Derby taking transfers from Nottingham, which affects capacity as these patients tend not to be transferred back due to maintain safety & quality of care.
- Staff absence due to sickness is high, with around a quarter of sickness in the trust being due to Covid related sickness or isolation.
- The acuity of the attendances was high, seeing an average of 15 Resuscitation patients & 192 Major patients per day.
- Attendances at Children's ED have rapidly increased, with concerns about RSV and Broncheolitis being major factors. Children's Type 1 attendances at Derby have averaged at 108 per day during August 2021 (compared to 70 per day in August 2019).
- EMAS Patient Transport System (PTS) capacity has led to delayed discharges.
- ED and Assessment areas are still separated into red/green areas according to Covid19 symptoms to ensure infection control. This limits physical space and therefore flexibility of patient flow. The recent increase in the proportion of red capacity (to reflect greater need) was a large undertaking.

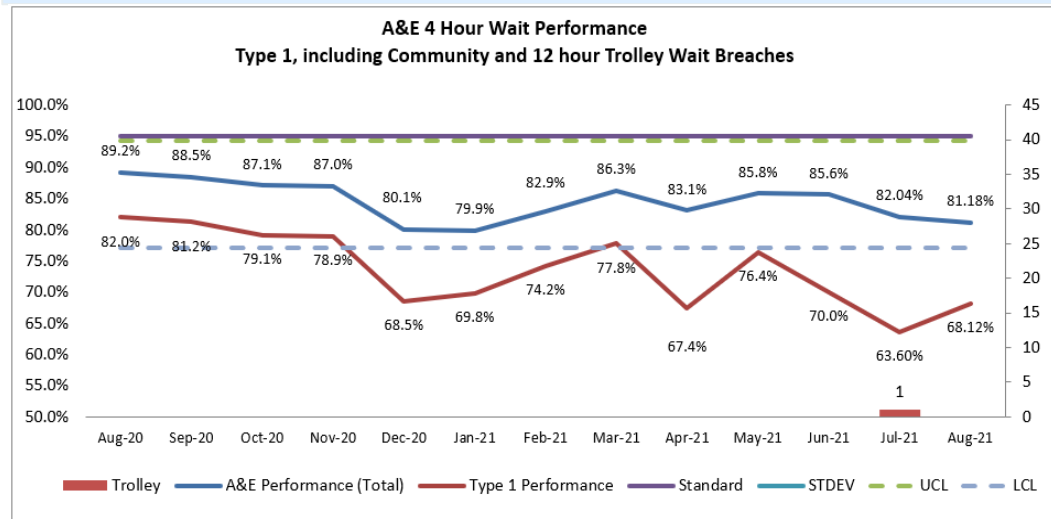
What actions have been taken?

- Improved consistency in Team Huddles (3x daily), with dashboards introduced and more defined roles within the department.
- Rotas have been improved to ensure that the skill mix matches the attendance profile, including the filling of medical gaps.
- An ED Team Building Programme to reflect & rebuild, listening to staff individually in 1:1s and acting on their feedback.
- Engaging clinicians throughout the Trust on the importance of ED flow, through internal Professional Standards Forums.
- Development of Same Day Emergency Care (SDEC) pathways. This includes extended access to imaging for Assessment Units, leading to more on-the-day scanning as part of the programme.
- Reconfiguration of the Lorenzo IT system, with training to ensure that patient flow isn't interrupted by slow recording of information.

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

Performance Analysis

During August 2021, performance overall did not meet the 95% standard, achieving 68.1% for the Burton A&E and 81.2% including community hospitals. Performance has been fluctuating since winter. There were no 12 hour breaches during August 2021.



What are the next steps?

- Devising an Action Plan following a departmental Critical Friend Review by Chris Morrow-Frost (NHSEI).
- A major capital programme to increase the number of Assessment Unit beds and increasing Majors bed capacity is continuing.
- The development of a Diagnostic Hub at Samuel Johnson Community Hospital, releasing capacity at the acute site.
- A Data Quality Review to ensure that the recorded times (and other information) are accurate.
- Continued development of the Every Day Counts programme, focussing on engagement and working behaviours.
- The development of a Community Hospitals Plan to enable improved patient flow processes.

What were the issues?

- The trust had been experiencing a decrease in attendances but now the attendances exceed the previous year by 47%, with an average of 175 Type 1 attendances per day.
- Critical Care pressures have affected the whole region, with Burton taking transfers from Birmingham & Stoke, which affects capacity as these patients tend not to be transferred back due to maintain safety & quality of care.
- Emergency estate works forced the closure of 8 beds and temporarily reduced capacity.
- The acuity of the attendances is high, with an average of 124 Resuscitation/Major patients per day (69% of total attendances).
- Staff absence due to sickness is high, with around a quarter of sickness in the trust being due to Covid related sickness or isolation.

What actions have been taken?

- The addition of a modular building to house GP Streaming services.
- The opening of a 2nd Ultrasound Room has increased availability of scanning capacity and increasing patient flow.
- Implemented a new working model which enables closer consultant working with ED doctors.
- The implementation of the Staffordshire 111First project, whereby patients only access ED via 999 calls or booked appointments – to reduce unnecessary attendances and improve capacity management for those who do attend.
- Improved data analysis support inform transformation.
- The implementation of revised Same Day Emergency Care (SDEC) pathways for Thunderclap Headaches, Dementia and Palliative Care.
- The GP Connect service now includes Frailty as a condition, whereby GPs can connect with UHDB Geriatricians before deciding whether a patient needs hospital support.

DHU111 Performance Month 4 (July 2021)

Performance Summary

- DHU achieved all six contractual Key Performance Indicators (KPIs) in July 2021, however there was a deterioration seen in the average speed of answer.
- Activity has been below plan throughout the contractual year (Year 5, October 2020 to date). This is due to a combination of factors; NHS111 First activity not materialising as anticipated, and a significant reduction in the usual winter illnesses as a result of social distancing measures in particular flu and respiratory illnesses.

Regional Performance Year Five - Key Performance Indicators (KPI's)														
KPI's		Standard	Quarter One (October – December)			Quarter Two (January – March)			Quarter Three (April - June)			Quarter Four (July-September)		
			Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21
Contract	Abandonment rate (%)	≤5%	0.5%	0.1%	0.2%	0.2%	0.2%	1.0%	1.0%	0.7%	0.9%	1.1%		
Contract	Average speed of answer (seconds)	≤27s	00:00:09	00:00:06	00:00:06	00:00:10	00:00:09	00:00:18	00:00:15	00:00:13	00:00:19	00:00:26		
Contract	Call Transfer to a Clinician	≥50%	66.0%	66.7%	69.6%	71.6%	70.4%	68.7%	66.5%	68.0%	66.5%	64.5%		
Contract	Self Care	≥17%	26.2%	23.6%	20.9%	20.6%	20.1%	20.4%	17.3%	17.1%	18.1%	19.0%		
Contract	Patient Experience	≥85%	88.0%	This data is updated on a six monthly basis					88.0%	This data is updated on a six monthly basis				
Contract	C3 Validation	≥50%	98.0%	98.9%	92.0%	98.9%	98.8%	98.4%	95.9%	98.7%	98.6%	98.2%		

Activity Summary

- Calls offered are 18.3% below plan year to date (October 2020 – July 2021). Due to the contractual $\pm 5\%$ threshold agreement in place, a credit at the end of quarter four is due to commissioners for £1,619,187*.
- Clinical Calls are also below plan for the year to date by 10.3%. Due to the contractual $\pm 5\%$ threshold agreement in place, a credit at the end of quarter four is due to commissioners for £328,485*.
- There were 13,467 Category 3 Ambulance Validations in July, with an associated cost of £242,810. This is an increase on June, when there were 13,047 validations with a cost of £235,237.
- The regional cost of COVID-19 activity for July was £103,742. COVID-19 calls have increased from 8,479 in June to 11,089 calls in July.

* The agreement reached between all associate commissioners in relation to transacting the underperformance position is as follows;

- Reconcile and transact the underactivity position at the end of Q3 within Leicester, Leicestershire and Rutland only
- Delay the reconciliation of funds for the remaining four counties until the end of Q4
- A year end reconciliation taking account of the full year position

DHU111 Performance Month 4 (July 2021)

What are the issues?

- Whilst calls offered are below plan, calls answered during July 2021 were 41.7% higher than July 2020. Analysis carried out by DHU111 has indicated that much of this activity is daytime activity, between the hours of 8.30am – 9pm
- One area in particular seeing an increase in demand is service access issues for dental related problems.
- The increase in overall demand is not unique to DHU111, nor the 111 service. Demand is up when compared with last year across the country.
- National Contingency also continues to be an issue. During July 2021, DHU111 only experienced 61 hours throughout the month where they were not picking up calls for other providers that had invoked national contingency. This has placed additional pressure on the provider since it is difficult to staff up for these unplanned surges in activity.
- DHU111 experienced a significant increase in Covid absence in July 2021, with an overall increase of 27.4% which equates to over 300 hours per day lost from the service. 33% of the overall absences are related to people being contacted via the NHS Track and Trace and instructed to self-isolate. However, since the changes in Government guidance 16th August, the provider have reported that this number is reducing.

What actions have been taken?

- Increased 111 demand is being discussed nationally and discussions in relation to Year 6 contract negotiations are currently underway. DHU111 and commissioners are working together to develop a realistic level of growth for the coming contract year.
- DHU111 have provided commissioners with a detailed plan of how any 111First monies could be used to increase staffing at short notice to cope with surges in demand, and also facilitate home working.

Activity		Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Year to date (Contract Year Oct 2020-Sep 2021)
Calls Offered	Actual	148,098	146,417	146,590	135,746	119,595	145,732	162,043	171,605	149,659	160,685	1,486,163
	Plan	152,299	153,848	203,460	199,210	177,571	188,612	188,704	186,048	177,330	192,078	1,819,160
	Variance	-2.80%	-4.80%	-28.00%	-31.90%	-32.6%	-22.70%	-14.10%	-7.80%	-15.6%	-16.3%	-18.3%
Clinical Calls	Actual	30,215	30,687	32,894	31,929	27,493	32,072	29,965	34,287	30,426	29,568	309,536
	Plan	29,898	30,333	39,528	36,350	31,639	35,140	36,518	35,809	34,529	35,256	345,002
	Variance	1.10%	1.20%	-16.80%	-12.20%	-13.10%	-8.70%	-18.00%	-4.30%	-11.9%	-16.1%	-10.3%

Covid-19 Activity – Actual	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
Non-Clinical	9,371	9,142	7,413	9,122	5,652	2,943	2,322	5,637	6,495	8,666
Clinical (total)	2,208	2,435	2,392	3,259	1,809	995	740	1,851	1,984	2,423

What are the next steps?

- The impact of national contingency on 111 providers is being raised nationally.
- Y6 negotiations will continue throughout August and into September, with formal sign off scheduled for the Contract Management Board meeting on 22nd September 2021.

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 M3 (July 2021)

What are the issues?

- The contractual standard is for the division to achieve national performance on a quarterly basis. For Quarter two to date (July), Derbyshire are not achieving any of the six national standards. C1 mean is not being achieved by 2 minutes, C1 90th Centile by 45 seconds, C2 mean by 27 minutes and 19 seconds, C2 90th Centile by 53 minutes and 33 seconds, C3 90th Centile by 4 hours, 58 minutes and 50 seconds, and C4 90th Centile by 1 hour and 36 minutes and 23 seconds.
- Average Pre hospital handover times during July 2021 remained above the 15 minute national standard across Derbyshire (25 minutes and 3 seconds) which was a deterioration compared to June 2021 (22 minutes).
- Average Post handover times during July 2021 remained above the 15 minute national standard across Derbyshire with the exception of Macclesfield District (10 minutes and 48 seconds). Overall the post handover time in July 2021 (18 minutes and 46 seconds) was comparable to June 2021 (18 minutes and 10 seconds).
- There has been a significant increase in demand across the East Midlands as a whole and the Derbyshire division, with C1 and C2 acuity in particular increasing.
- Due to the increase in C1 and C2 activity this is impacting on C3 and C4 response times which in turn is leading to higher levels of duplicate calls and non ASI H&T in particular calls being cancelled by the caller.
- Incidents in Derbyshire in July 2021 saw an increase when compared to June 2021 (14,155 compared to 13,905). The adverse variance against plan was highest in Derbyshire than any other county.
- Whilst on scene demand from 111 is down slightly from last month at 25% and 27% respectively, Derbyshire has the joint highest level of 111 on scene demand across the region with Leicestershire.
- There has been a significant increase in sickness during July in both substantive crews and private ambulance crews, which has contributed to the declining performance position.

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 – July	00:09:08	00:16:32	00:51:58	01:51:26	07:36:56	06:06:08
Derbyshire Actual - July	00:09:00	00:15:45	00:45:19	01:33:33	06:58:50	04:36:23
Derbyshire Actual - Quarter Two to date	00:09:00	00:15:45	00:45:19	01:33:33	06:58:50	04:36:23

July 2021	Pre Handovers		Post Handovers		Total Turnaround	
	Average Pre Handover Time	Lost Hours	Average Post Handover Time	Lost hours	Average Total Turnaround	Lost hours
Burton Queens	00:25:57	85:48:23	00:18:34	44:55:45	00:44:31	114:28:25
Chesterfield Royal	00:22:40	334:34:27	00:18:02	227:45:49	00:40:42	477:03:14
Macclesfield District General Hospital	00:30:44	16:39:26	00:10:48	0:41:32	00:41:32	13:50:57
Royal Derby	00:26:42	871:23:25	00:19:21	488:45:39	00:46:03	1209:55:59
Sheffield Northern General Hospital	00:30:08	35:01:45	00:18:37	15:04:26	00:48:45	43:06:36
Stepping Hill	00:17:59	32:09:42	00:18:09	36:36:51	00:36:08	56:16:48
Derbyshire TOTAL	00:25:03	1375:37:08	00:18:46	813:50:02	00:43:49	1914:41:59

AMBULANCE – EMAS PERFORMANCE M4 (July 2021)

What actions have been taken?

- The increase in demand is being seen across the country. NHSE/I have recognised there is a need for immediate and substantial action in order to ensure all patients are being reached as soon as possible and therefore £55m of additional non-recurrent funding has been made available across the ambulance sector in order to support improved performance. A performance trajectory was required from ambulance trusts along with an action plan and financial profile showing how they will utilise the additional funds (c.£3.7m for EMAS).
- GPs continue to work with care homes to support reduced avoidable demand into EMAS
- Work continues nationally to ensure the most commonly referred into pathways by Ambulance services are profiled on the DoS so that ambulance crews can access available alternatives consistently across the Country.
- The NHS England/NHS Improvement regional team have developed a set of professional standards which are designed to support a reduction in handover delays and expect processes to be in place to support a rapid handover of patients. These standards are now implemented but not fully enacted.
- One of the key national and regional priorities is the use of Same Day Emergency Care (SDEC) pathways by NHS111 services and ambulance services. EMAS Medical Director is working with SDEC leads and is auditing which SDEC pathways are open and available to Ambulance crews.

What are the next steps

- The performance trajectory begins in August and performance against that trajectory will be monitored
- EMAS have confirmed that the funding will be used to increase capacity across the Emergency Operations Centre (EOC), increase operational capacity on the front line and provide Hospital Ambulance Liaison Officers (HALO's) in Lincoln and Leicester. EMAS are on track to recruit frontline staff through September, October and November cohorts.
- It has been confirmed that from 1st September 2021, DHU111 will extend their C3 validation timeframe from 30 minutes to 60 minutes. Allowing more time for a DHU111 clinician to clinically validate C3 dispositions via 111. This pilot will run for up to three months and should hopefully reduce the number of C3 calls being passed through to EMAS. Whilst this could in turn increase the percentage of activity being categorised as C1 and C2 by EMAS, it should reduce overall incident numbers.
- In relation to handover delays, there is a survey taking place by NHSE/I in week commencing 23rd August to understand the position across every trust in the Midlands focussing on General and Acute beds, including how many patients are waiting longer than 24 hours for a P1 and P2 bed, and how the NEWS2 score could help identify those patients that don't need to be in hospital. The outputs from these surveys should be reported on 27th August.
- The fit to sit initiative is looking to be relaunched as it is not consistently implemented across the region. It is expected that only patients who have a clinical need will be taken into ED on a trolley. This should free space and improve processes within ED and therefore improve handover times.
- Sherwood Forest Hospital have been identified as an exemplar site and are sharing their learning across the region which includes understanding risk across the system and how decisions made in isolation can impact on patients.

Derbyshire	April	May	June	Quarter One 2021-2022	July	Quarter Two to date
Calls (Total)	17,643	20,461	21,110	59,214	23,342	23,342
Total Incidents	13,550	14,588	13,905	42,043	14,155	14,155
Total Responses	12,321	13,189	12,390	37,900	12,608	12,608
Duplicate Calls	2,936	4,129	4,776	11,841	5,500	5,500
Hear & Treat (Total)	2,386	3,143	3,944	9,473	5,234	5,234
See & Treat	4,134	4,433	4,392	12,959	4,617	4,617
See & Convey	8,187	8,756	7,998	24,941	7,991	7,991
Duplicates as % Calls	16.6%	20.2%	22.6%	20.0%	23.6%	23.6%
H&T ASI as % Incidents	9.4%	9.6%	10.9%	9.9%	10.9%	10.9%
S&T as % Incidents	31.9%	30.4%	31.6%	30.8%	32.6%	32.6%
S&C as % Incidents	58.7%	60.0%	57.5%	59.3%	56.5%	56.5%
S&C to ED as % of incidents	56.2%	55.5%	52.8%	54.8%	51.8%	51.8%

Planned Care

DERBYSHIRE COMMISSIONER – INCOMPLETE PATHWAYS (92%)

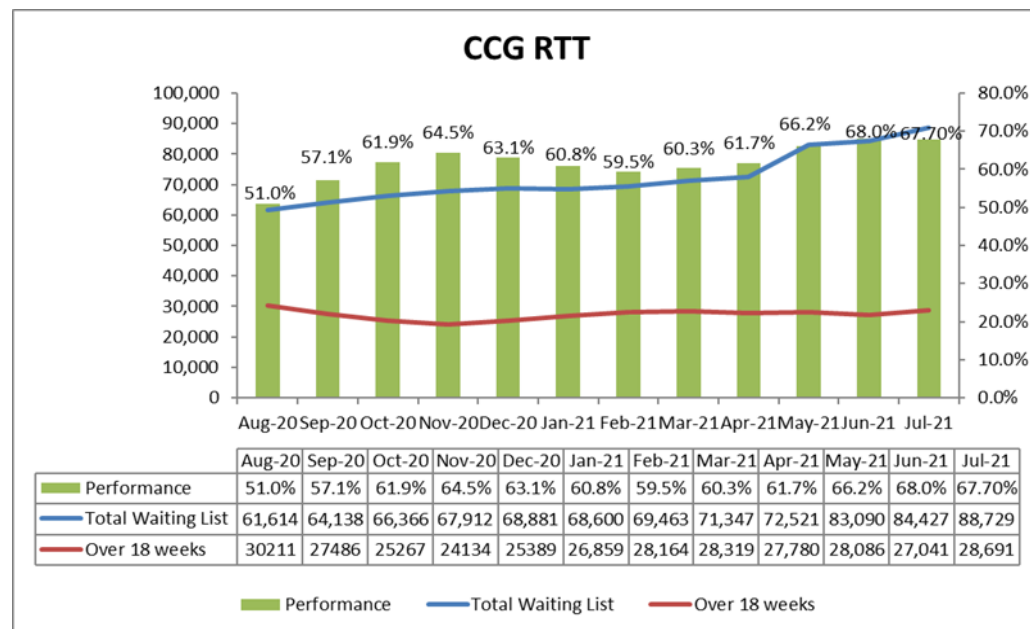
Performance Analysis

Performance for July 2021 was 67.7% a slide reduction on the figure of 68.0% for June.

The total incomplete waiting list for DDCCG was 88,729 an increase of 4,302 on the previous month. As mentioned previously those patients who are now on the ASI list at UHDB, awaiting an appointment, are now included in the overall figure.

The number of referrals across Derbyshire during July showed a slight decrease of 1% for urgent referrals and a reduction of 25% for routine referrals when compared with the average weekly referral of the previous 51 weeks. (Urgent referrals are 2% lower and the routine referrals 30% lower than the same month during 2019.)

Treatment Function	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Total 52 plus weeks
General Surgery Service	4,830	2,550	52.8%	808
Urology Service	3,883	2,854	73.5%	252
Trauma and Orthopaedic Services	13,019	6,832	52.5%	1,814
Ear Nose and Throat Services	6,317	3,928	62.2%	475
Ophthalmology Service	12,510	7,734	61.8%	808
Oral Surgery Service	9	7	77.8%	0
Neurosurgical Service	501	353	70.5%	26
Plastic Surgery Service	648	381	58.8%	73
Cardiothoracic Surgery Services	192	123	64.1%	12
General Internal Medicine Services	347	272	78.4%	0
Gastroenterology Service	4,528	3,599	79.5%	114
Cardiology Service	2,237	1,795	80.2%	37
Dermatology Service	6,369	4,722	74.1%	86
Respiratory Medicine Services	1,424	1,179	82.8%	2
Neurology Service	2,333	1,849	79.3%	8
Rheumatology Service	1,837	1,370	74.6%	10
Elderly Medicine Service	293	270	92.2%	3
Gynaecology Service	6,379	4,410	69.1%	279
Other - Medical Services	5,918	5,031	85.0%	55
Other - Mental Health Services	313	287	91.7%	0
Other - Paediatric Services	6,736	4,703	69.8%	439
Other - Surgical Services	7,126	4,966	69.7%	557
Other - Other Services	980	823	84.0%	39
Total	88,729	60,038	67.7%	5,897

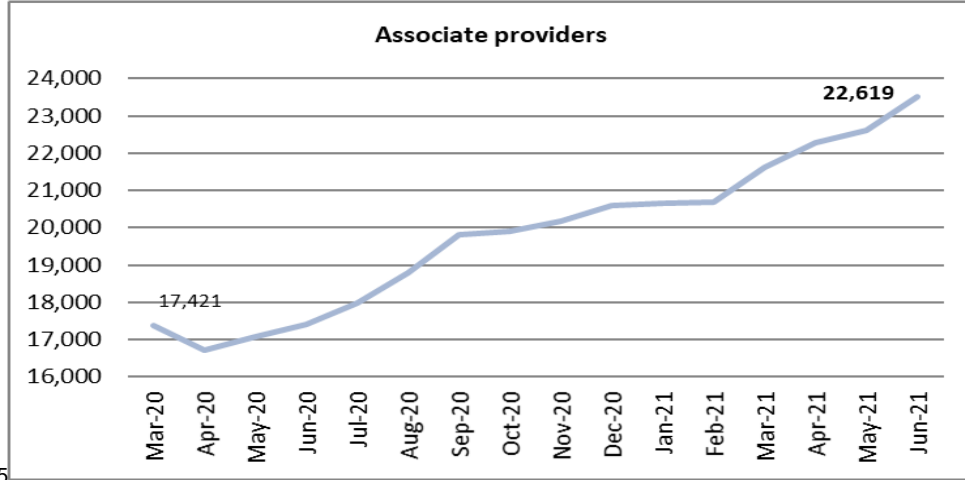
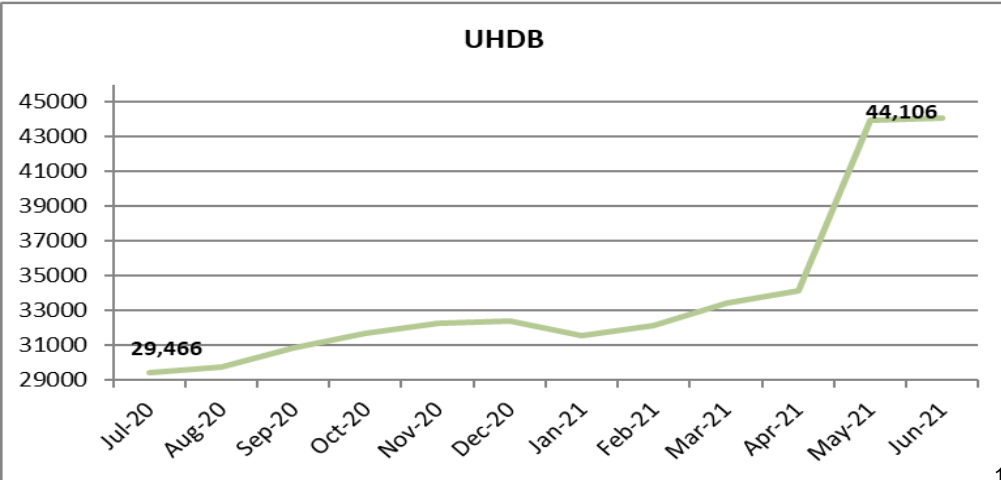
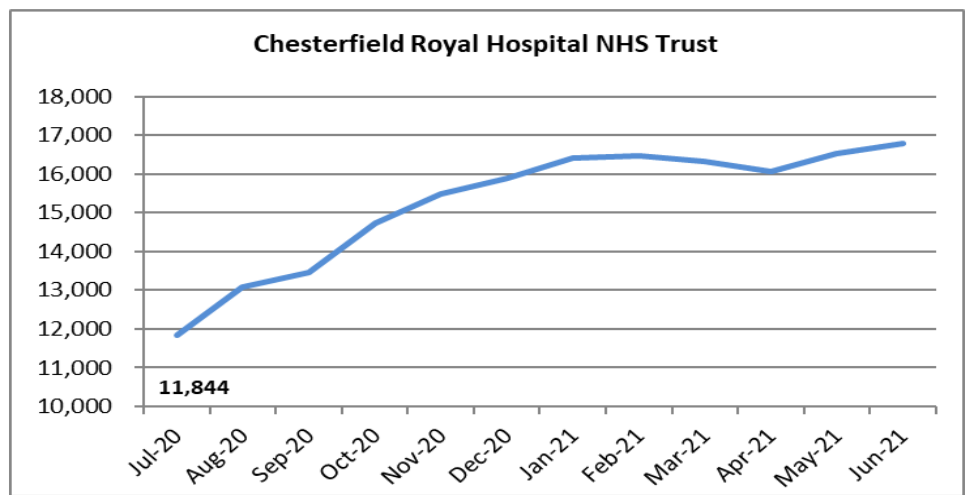
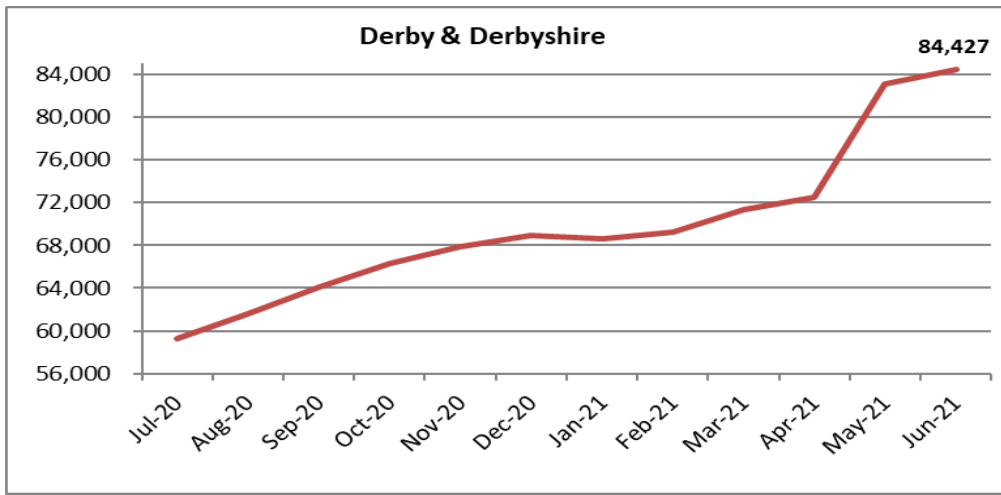


- The Derbyshire CCG position is representative of all of the patients registered within the CCG area attending any provider nationally.
- 70% of Derbyshire patients attend either CRHFT (25%) or UHDB (45%). The RTT position is measured at both CCG and provider level.
- The RTT standard of 92% was not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

ELECTIVE CARE – DDCCG Incomplete Pathways

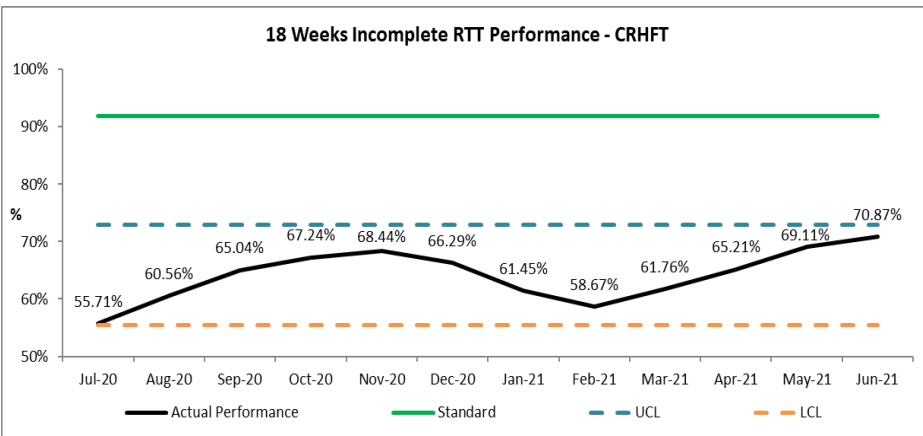
Derbyshire CCG incomplete waiting list at the end of July 2021 is 88,729, another increase on the previous month.

Of this number 64,623 Derbyshire patients are currently awaiting are at our two main acute providers CRH (17,221) and UHDB (47,402). The remaining 24,106 Derbyshire residents are on an incomplete pathways at other trusts out of Derbyshire. The graphs below show the current position and how this has changed over the last few months.



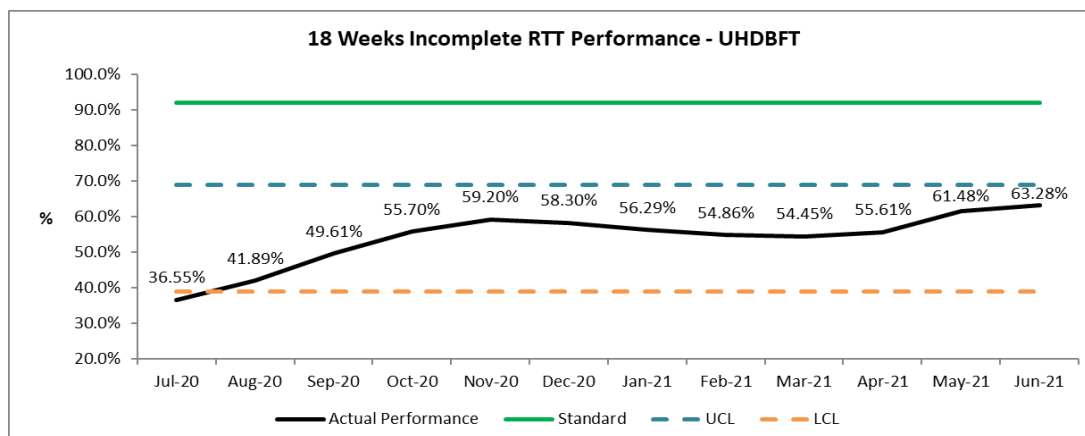
Referral to Treatment – Incomplete Pathways (92%).

CRH – During July 2021 the trust achieved 70.8% a similar standard to June. The waiting list at the end of July was 19,017.



UHDB

During July the trust achieved a standard of 63.1%, a similar figure to the previous month. The waiting list at the end of July was 84,407.



Treatment Function	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Total 52 plus weeks
General Surgery Service	1,184	551	46.5%	223
Urology Service	1,102	916	83.1%	14
Trauma and Orthopaedic Service	1,785	1,069	59.9%	139
Ear Nose and Throat Service	1,572	1,025	65.2%	112
Ophthalmology Service	2,276	1,449	63.7%	148
Oral Surgery Service	1,247	759	60.9%	111
General Internal Medicine Service	263	209	79.5%	0
Gastroenterology Service	1,143	885	77.4%	11
Cardiology Service	542	424	78.2%	0
Dermatology Service	1,703	1,516	89.0%	16
Respiratory Medicine Service	501	389	77.6%	1
Rheumatology Service	418	301	72.0%	4
Gynaecology Service	1,605	1,062	66.2%	158
Other - Medical Services	932	730	78.3%	14
Other - Paediatric Services	1,062	890	83.8%	21
Other - Surgical Services	1,682	1,289	76.6%	126
Total	19,017	13,464	70.8%	1,098

Treatment Function	Total number of incomplete pathways	Total within 18 weeks	% within 18 weeks	Total 52 plus weeks
General Surgery Service	4,583	2,658	58.0%	585
Urology Service	3,473	2,255	64.9%	348
Trauma and Orthopaedic Service	13,905	6,814	49.0%	2,114
Ear Nose and Throat Service	6,997	4,215	60.2%	346
Ophthalmology Service	11,074	5,769	52.1%	905
Oral Surgery Service	3,312	1,739	52.5%	386
Neurosurgical Service	133	81	60.9%	1
Plastic Surgery Service	418	258	61.7%	55
Cardiothoracic Surgery Service	9	6	66.7%	0
General Internal Medicine Service	356	259	72.8%	1
Gastroenterology Service	3,468	2,952	85.1%	5
Cardiology Service	1,682	1,562	92.9%	11
Dermatology Service	6,089	3,858	63.4%	84
Respiratory Medicine Service	618	585	94.7%	0
Neurology Service	2,128	1,618	76.0%	5
Rheumatology Service	1,712	1,317	76.9%	2
Elderly Medicine Service	373	309	82.8%	4
Gynaecology Service	6,405	4,188	65.4%	224
Other - Medical Services	6,180	5,294	85.7%	35
Other - Mental Health Services	4	4	100.0%	0
Other - Paediatric Services	4,440	2,703	60.9%	447
Other - Surgical Services	5,959	3,916	65.7%	599
Other - Other Services	1,089	875	80.3%	49
Total	84,407	53,235	63.1%	6,206

DERBYSHIRE COMMISSIONER – OVER 52 WEEK WAITERS

52 Week Waits

July figures show that there were 5,897 Derbyshire patients waiting over 52 weeks for treatment in Derbyshire. Of these 4,707 were waiting for treatment at our two main providers UHDB and CRH, the remaining 1,190 were waiting at various trusts around the country as outlined in the table on the following slide.

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

CCG Patients – Trend – 52 weeks

	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
DDCCG	934	1,519	2,107	2,658	3,388	4,245	5,903	7,554	8,261	7,490	6,859	6,199	5,897

Main Providers:

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

	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21
UHDB	1,011	1,667	2,367	2,968	3,751	4,706	6,629	8,767	9,728	8,605	7,573	6,806	6,206
CRH	117	212	308	438	594	797	1,202	1,475	1,471	1,278	1,179	1,095	1098

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

Main Provider Actions:

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

Actions:

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

DERBYSHIRE COMMISSIONER – OVER 52 WEEK WAITERS

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

Provider	Total	Provider	Total
AIREDALE NHS FOUNDATION TRUST	1	SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST	108
ASPEN - CLAREMONT HOSPITAL	33	SPIRE NOTTINGHAM HOSPITAL	1
BARTS HEALTH NHS TRUST	3	SPIRE REGENCY HOSPITAL	5
BIRMINGHAM WOMEN'S AND CHILDREN'S NHS FOUNDATION TRUST	4	STOCKPORT NHS FOUNDATION TRUST	390
BMI - THE ALEXANDRA HOSPITAL	7	TAMESIDE AND GLOSSOP INTEGRATED CARE NHS FOUNDATION TRUST	2
BMI - THE PARK HOSPITAL	1	THE ONE HEALTH GROUP LTD	1
CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	2	THE QUEEN ELIZABETH HOSPITAL, KING'S LYNN, NHS FOUNDATION TRUST	1
DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST	7	THE ROBERT JONES AND AGNES HUNT ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	4
EAST CHESHIRE NHS TRUST	20	THE ROYAL ORTHOPAEDIC HOSPITAL NHS FOUNDATION TRUST	1
EAST LANCASHIRE HOSPITALS NHS TRUST	1	THE ROYAL WOLVERHAMPTON NHS TRUST	1
LEEDS TEACHING HOSPITALS NHS TRUST	8	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	3
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	1	UNIVERSITY HOSPITALS BIRMINGHAM NHS FOUNDATION TRUST	22
LONDON NORTH WEST UNIVERSITY HEALTHCARE NHS TRUST	3	UNIVERSITY HOSPITALS COVENTRY AND WARWICKSHIRE NHS TRUST	2
MANCHESTER UNIVERSITY NHS FOUNDATION TRUST	16	UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST	57
NEWMEDICA COMMUNITY OPHTHALMOLOGY - BARLBOROUGH TREATMENT CENTRE	1	UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST	8
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	1	WEST SUFFOLK NHS FOUNDATION TRUST	1
NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST	260	WOODTHORPE HOSPITAL	5
NUFFIELD HEALTH, DERBY HOSPITAL	56	WRIGHTINGTON, WIGAN AND LEIGH NHS FOUNDATION TRUST	4
OXFORD UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	1	HULL UNIVERSITY TEACHING HOSPITALS NHS TRUST	8
PENNINE ACUTE HOSPITALS NHS TRUST	1	LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	7
QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	1	BEDFORDSHIRE HOSPITALS NHS FOUNDATION TRUST	1
ROYAL BERKSHIRE NHS FOUNDATION TRUST	1	PORTSMOUTH HOSPITALS UNIVERSITY NATIONAL HEALTH SERVICE TRUST	2
ROYAL FREE LONDON NHS FOUNDATION TRUST	3	PRACTICE PLUS GROUP HOSPITAL - BARLBOROUGH	15
SALFORD ROYAL NHS FOUNDATION TRUST	10	THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST	1
SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST	1	UNIVERSITY HOSPITALS SUSSEX NHS FOUNDATION TRUST	1
SHEFFIELD CHILDREN'S NHS FOUNDATION TRUST	46	YORK AND SCARBOROUGH TEACHING HOSPITALS NHS FOUNDATION TRUST	1
SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST	49	Total	1190

Actions:

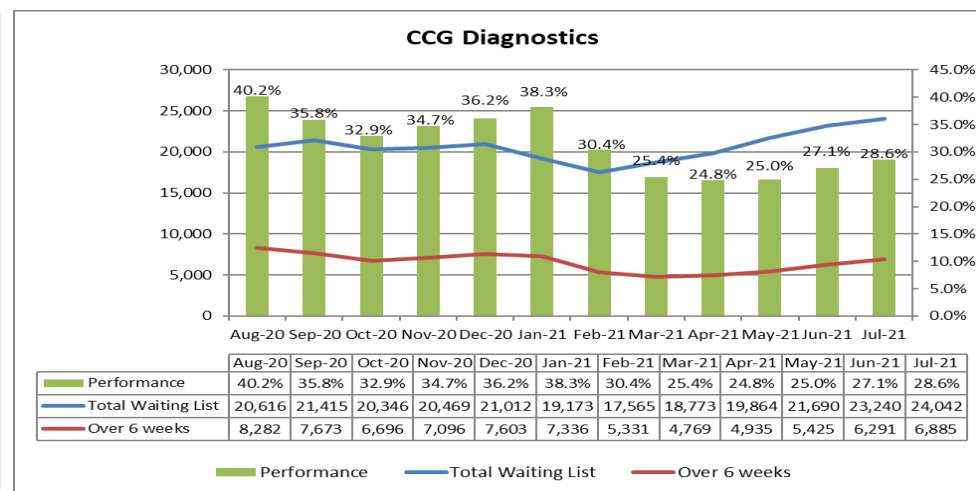
- The performance team make enquiries of the relevant CCGs and responses received back are that these patients are not clinically urgent but are being reviewed. We have not been informed of any TCI dates.

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

Performance Analysis

Derbyshire CCG Diagnostic performance at the end of July was 28.6% waiting over six weeks, another deterioration on the 27.1% waiting at the end of June.

The total number of Derbyshire patients waiting for diagnostic procedures increased again during July. The number of patients waiting over 6 weeks have increased but the number waiting over 13 weeks have decreased. All of our associates are showing non compliance for the diagnostic standard.



Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Percentage waiting 6+ Weeks
Magnetic Resonance Imaging	4,560	1,081	368	23.7%
Computed Tomography	2,800	586	187	20.9%
Non-obstetric Ultrasound	8,495	2,615	448	30.8%
Barium Enema	5	1	0	20.0%
DEXA Scan	798	136	44	17.0%
Audiology - Audiology Assessments	887	361	32	40.7%
Cardiology - Echocardiography	3,135	1,103	27	35.2%
Peripheral Neurophysiology	367	13	0	3.5%
Respiratory physiology - Sleep Studies	128	19	8	14.8%
Urodynamics - Pressures & Flows	122	55	20	45.1%
Colonoscopy	965	357	242	37.0%
Flexi Sigmoidoscopy	390	124	56	31.8%
Cystoscopy	271	60	28	22.1%
Gastroscopy	1,119	374	238	33.4%
Total	24,042	6,885	1,698	28.6%

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	27.3%	0%	13.5%	6.1%	2.4%	65.6%	0.0%
Computed Tomography	29.2%	0%	6.8%	6.8%	30.7%	12.8%	0.0%
Non-obstetric Ultrasound	44.1%	0%	4.7%	4.1%	6.4%	17.4%	0.0%
Barium Enema	5.7%						0.0%
DEXA Scan	14.9%	0%	69.9%	62.6%	7.6%	54.4%	
Audiology - Audiology Assessments	21.3%	62%	28.3%	51.8%	3.3%	18.1%	64.5%
Cardiology - Echocardiography	27.5%	39%	16.6%	38.6%	51.9%	0.0%	68.6%
Peripheral Neurophysiology	1.1%		0.0%	34.7%		0.0%	
Respiratory physiology - Sleep Studies	5.3%		7.9%	11.2%	8.0%	11.1%	10.0%
Urodynamics - Pressures & Flows	50.5%	52%	29.0%	74.6%	17.8%	24.3%	
Colonoscopy	7.5%	36%	83.3%	26.8%	27.8%	27.3%	23.5%
Flexi Sigmoidoscopy	10.7%	33%	80.2%	35.7%	37.0%	28.9%	15.3%
Cystoscopy	20.5%	0%	0.0%	7.8%	38.0%	8.5%	50.0%
Gastroscopy	6.6%	29%	79.6%	26.7%	43.3%	34.6%	20.4%
Total	31.7%	16%	42.7%	17.2%	21.8%	38.5%	28.5%

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

Performance Analysis

Performance during July was 16.2%, a further deterioration on the June figure of 11.9%.

The numbers on the waiting list have decreased overall. However, the number waiting over 6 weeks and 13 weeks have increased.

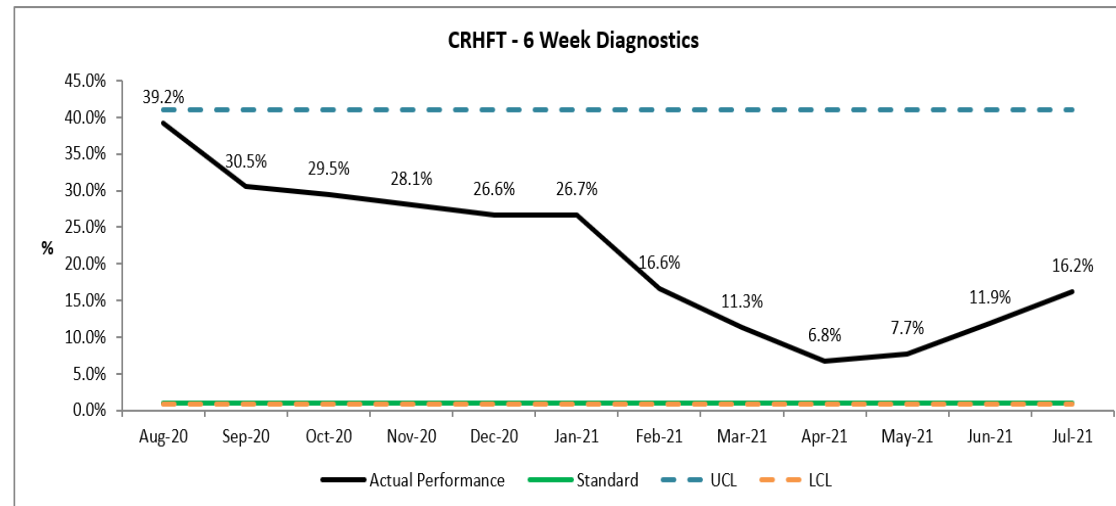
What are the issues?

Issues

- TRUSS and TP capacity is dependant on the number of patients that opt for a TP over TRUSS biopsy, affecting forward planning.
- Imaging reporting has been delayed by up to 7 days.
- Staff absence due to sickness is high, with around a third of sickness in the trust being due to Covid related sickness or isolation.
- The high demand due to higher outpatient referrals and increased non-elective activity continues.
- Radiology have reduced capacity due to staff shortages.

Actions

- Mobile CT and MRI has supported capacity throughout 2021.
- Endoscopy dates are now booked immediately to prevent recurrence of the booking issues.
- Imaging and Endoscopy activity for those patients on a cancer pathway is prioritised.
- Further development of the clinical triage set and CAB.
- Local diagnostic departments continue to validate waiting lists to ensure data quality.



Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Percentage waiting 6+ Weeks
Magnetic Resonance Imaging	691	0	0	0.0%
Computed Tomography	542	2	0	0.4%
Non-obstetric Ultrasound	1,901	3	0	0.2%
DEXA Scan	275	1	0	0.4%
Audiology - Audiology Assessments	417	258	17	61.9%
Cardiology - Echocardiography	1,081	417	1	38.6%
Urodynamics - Pressures & Flows	27	14	4	51.9%
Colonoscopy	295	107	49	36.3%
Flexi Sigmoidoscopy	103	34	13	33.0%
Cystoscopy	31	0	0	0.0%
Gastroscopy	234	69	35	29.5%
Total	5,597	905	119	16.2%

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

Performance Analysis

Performance during July was 31.7% a deterioration of the June position.

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

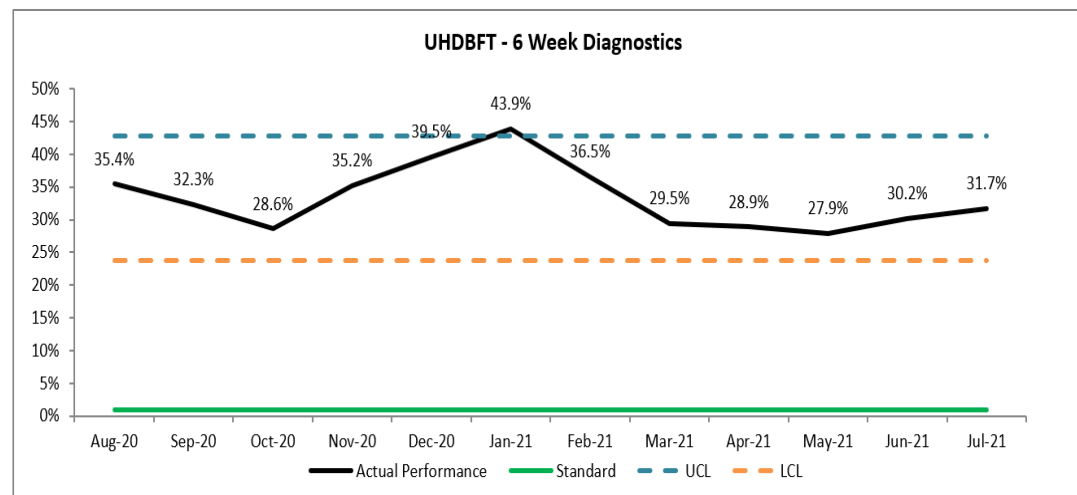
Non Obstetric ultrasounds and Urodynamics are experiencing the highest waits proportionally.

Issues

- TRUSS capacity has been reduced due to patient choice and staffing.
- Difficulty in covering the on call service for spinal MRI leading to a downturn in electives to protect the emergency capacity).
- Staff absence due to sickness is high, with around a third of sickness in the trust being due to Covid related sickness.
- The high demand due to higher outpatient referrals and increased non-elective activity continues.

Actions

- The bid for a Rapid Diagnostics Site at the Trust was successful, which will enhance patient flow.
- TRUSS patients are being offered a date at Burton with the Urologists to avoid delays.
- The use of bank staff to support Ultrasounds (uptake has been slow).
- Services have been ask to implement recording of priority of tests ordered (D1-D6) similar to surgical procedures.
- prioritisation.
- An additional 7 Sonographers have been recruited in order to increase capacity.
- Waiting list validation continues, to ensure that patients are not shown as waiting unnecessarily.



Diagnostic Test Name	Total Waiting List	Number waiting 6+ Weeks	Number waiting 13+ Weeks	Percentage waiting 6+ Weeks
Magnetic Resonance Imaging	4,256	1,160	147	27.3%
Computed Tomography	2,554	746	245	29.2%
Non-obstetric Ultrasound	8,773	3,866	764	44.1%
Barium Enema	35	2	0	5.7%
DEXA Scan	552	82	36	14.9%
Audiology - Audiology Assessments	839	179	23	21.3%
Cardiology - Echocardiography	2,128	586	11	27.5%
Peripheral Neurophysiology	476	5	1	1.1%
Respiratory physiology - Sleep Studies	188	10	0	5.3%
Urodynamics - Pressures & Flows	91	46	14	50.5%
Colonoscopy	573	43	11	7.5%
Flexi Sigmoidoscopy	261	28	1	10.7%
Cystoscopy	268	55	26	20.5%
Gastroscopy	652	43	12	6.6%
Total	21,646	6,851	1,291	31.7%

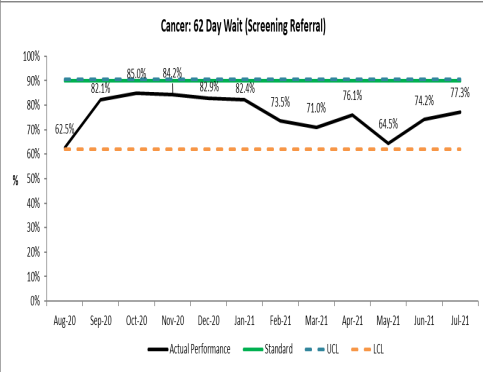
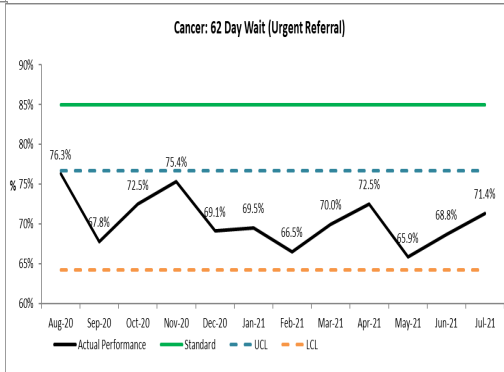
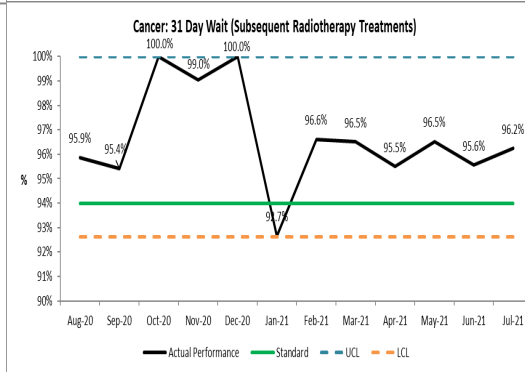
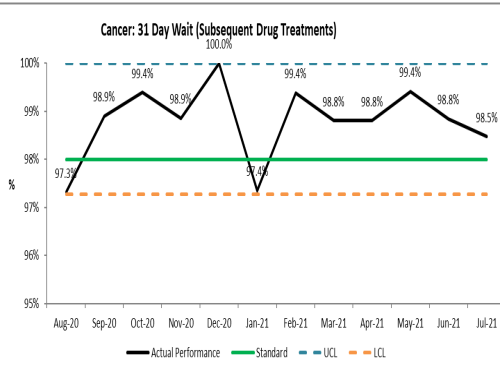
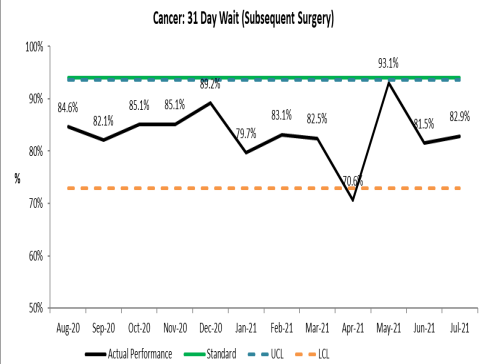
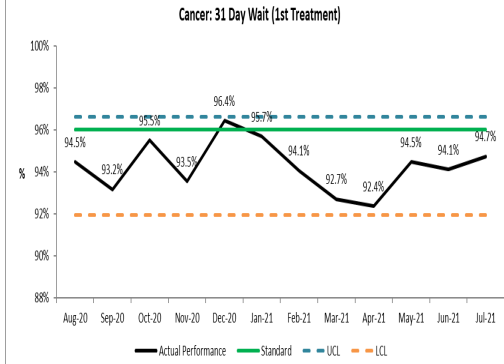
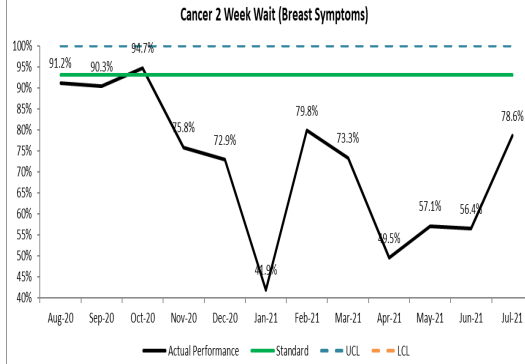
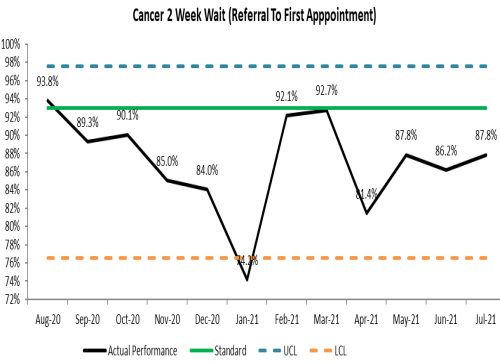
DERBYSHIRE COMMISSIONER – CANCER WAITING TIMES

During July 2021, Derbyshire was compliant in 3 of the 9 Cancer standards:

- **28 day Faster Diagnosis** – 75.6% (75% standard) – Compliant for Derby & Burton, Chesterfield, Nottingham & Sherwood Forest.
- **31 day Subsequent Drugs** – 98.5% (98% standard) – Compliant all Trusts.
- **31 day Subsequent Radiotherapy** – 96.2% (94% standard) – Non-Compliant at UHDB.

During July 2021, Derbyshire was non-compliant in 6 of the 9 Cancer standards:

- **2 week Urgent GP Referral** – 87.8% (93% standard) – Compliant for Stockport.
- **2 week Exhibited Breast Symptoms** – 78.6% (93% standard) – Non compliant for all trusts.
- **31 day from Diagnosis** – 82.9% (96% standard) – Compliant for Chesterfield and Stockport.
- **31 day Subsequent Surgery** – 82.9% (94% standard) - Compliant for Chesterfield, East Cheshire, Sherwood Forest and Stockport.
- **62 day Urgent GP Referral** – 71.4% (85% standard) – Non compliant for all trusts.
- **62 day Screening Referral** – 77.3% (90% standard) – Non compliant for all trusts.
- **104 day wait** – 19 CCG patients waited over 104 days for treatment.



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

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

Performance Analysis

CRH performance during July for first treatment within 62 days of urgent referral has improved to 71.5%, remaining non-compliant against the standard of 85%.

There were 75.5 patients treated along this pathway in July with 54 of those patients treated within the 62 day standard, resulting in 21.5 breaches.

Of the 21.5 breaches 7 patients were treated at 104days plus, 6 of these were within Urology and 1 in Lower GI. The reasons for the delay were Complex Diagnostics (some diagnostics impacted upon by Covid), Healthcare Initiated Treatment Plan and Medical Reasons.

Actions Being Taken

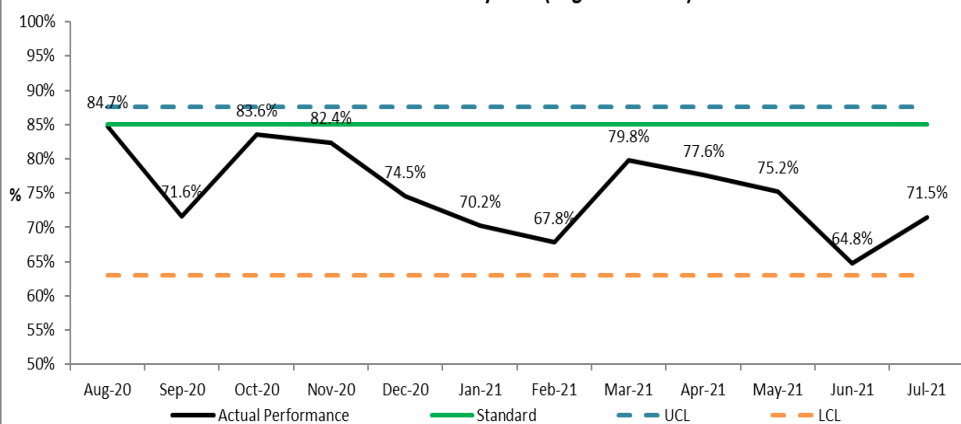
CRH

- Pathway reviews with a focus on delays at each tumour site.
- Monthly Tumour site Improvement meetings.
- Discussions in place to introduce template letters.
- Working with Lead Cancer GP and CCG to improve inappropriate referrals in Dermatology and Head & Neck.

What are the next steps

- Continued focus on those patients over 62 day and 104 day on the PTL. The H1 Operational Plan for 21/22 requires the trust to reduce their PTL of patients waiting over 63 days for treatment to the February 2020 figure or lower.

CRHFT - Cancer: 62 Day Wait (Urgent Referral)

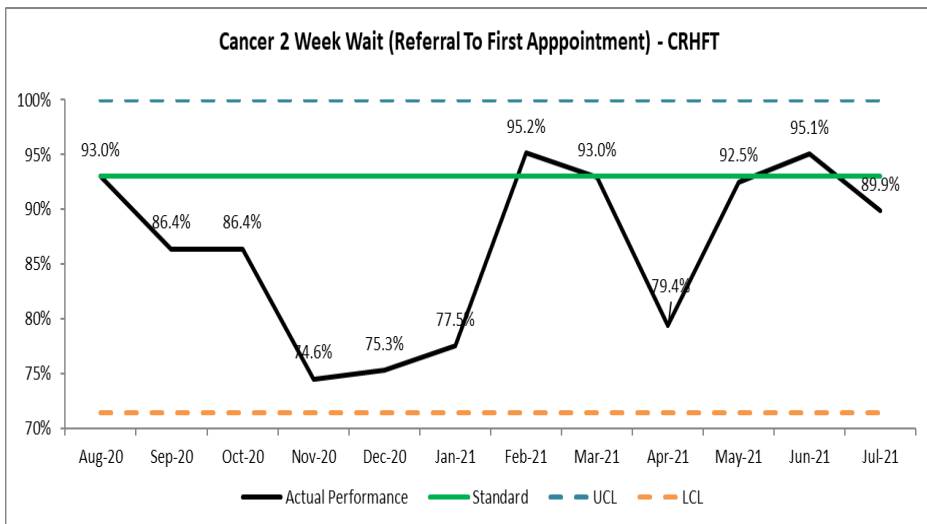


Current Issues

- Diagnostic capacity delays for TRUSS & TP biopsies
- Surgery capacity mainly in Breast and Lower GI
- Complex Pathways
- Patient Choice
- Outpatient capacity delays for first seen

Tumour Type	Total referrals seen during the period	Seen Within 62 Days	Breaches of 62 Day Standard	% Performance
Acute leukaemia	0	0	0	N/A
Brain/Central Nervous System	0	0	0	N/A
Breast	8.5	4.5	4	52.94%
Children's	0	0	0	N/A
Gynaecological	3.5	3.5	0	100.00%
Haematological (Excluding Acute Leukaemia)	4	4	0	100.00%
Head and Neck	2	1.5	0.5	75.00%
Lower Gastrointestinal	6.5	3.5	3	53.85%
Lung	4.5	2	2.5	44.44%
Other	2	1	1	50.00%
Sarcoma	0	0	0	N/A
Skin	18	17	1	94.44%
Testicular	1	1	0	100.00%
Upper Gastrointestinal	2	2	0	100.00%
Urological (Excluding Testicular)	23.5	14	9.5	59.57%
Totals	75.5	54	21.5	71.52%

CRHFT - CANCER WAITING TIMES – 2WW



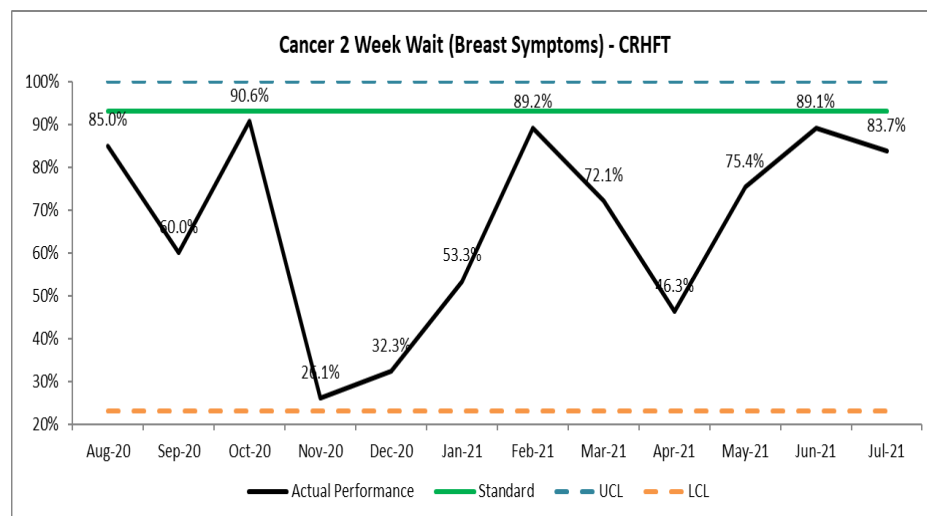
Performance Analysis

July 2 week wait performance at CRH has reduced to 89.9%, when compared to June which reported 95.1% being non-compliant against the standard of 93%.

The total number of patients seen under this standard during July was 1024, a decrease of 68 on the 1092 reported in June. Of the 1024 patients 920 were seen within the 14 day standard resulting in 104 breaches which is an increase when compared to the 54 reported in June.

The 104 breaches were due to Patient Choice(41), Outpatient Capacity(43) and Clinic Cancellation(20) and the wait days ranged between 15 and 35 days with one patient reporting at 78days which was due to Patient Choice.

CRHFT - CANCER WAITING TIMES – 2 Week Wait Breast Symptomatic



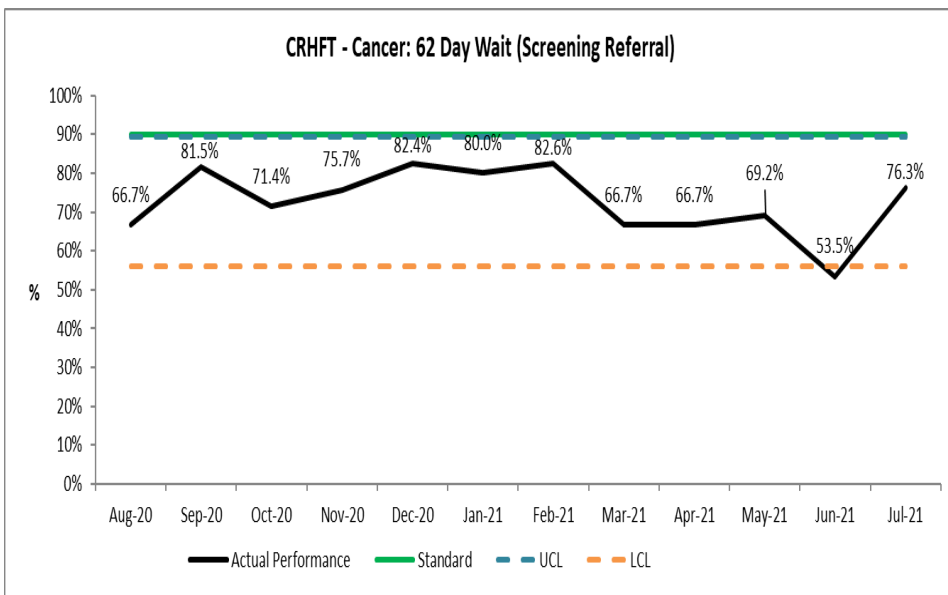
Performance Analysis

July performance at CRH for 2 Week Wait Breast Symptomatic has reduced slightly to 83.7% when compared to the 89.1% reported in June and continues to remain non-compliant against the standard of 93%. Breast referrals continue to increase which is a national issue.

The total number of patients seen under this standard during July was 43, a decrease on the 46 seen in June. Of the 43 patients 36 were seen within the 14 day standard resulting in 7 breaches. A slight increase to the 5 breaches reported in June.

Out of the 7 breaches 4 were due to clinic cancellation, 2 were due to Patient Choice and 1 being as a result of Outpatient Capacity. All patients were seen within 21days.

CRHFT - CANCER WAITING TIMES – 62day Screening Referral



Performance Analysis

Performance in July for the 62day screening standard has significantly improved to 76.3% when compared to the 53.5% reported in June, however, it continues to remain non-compliant against the standard of 90%.

The number of patients treated via referral through screening has reduced very slightly in July to 19, compared to 21.5 treated in June.

Of the 19 patients treated there were 14.5 treated within the 62 day screening standard resulting in 4.5 breaches (relating to 5 patients). The tumour sites include Breast(2) and Lower GI(3) with the waiting days ranging between 69 and 86 days.

The reasons were Elective Capacity(1), Healthcare Initiated Treatment Plan(1), Outpatient Capacity (1) and Medical Reasons(2).

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

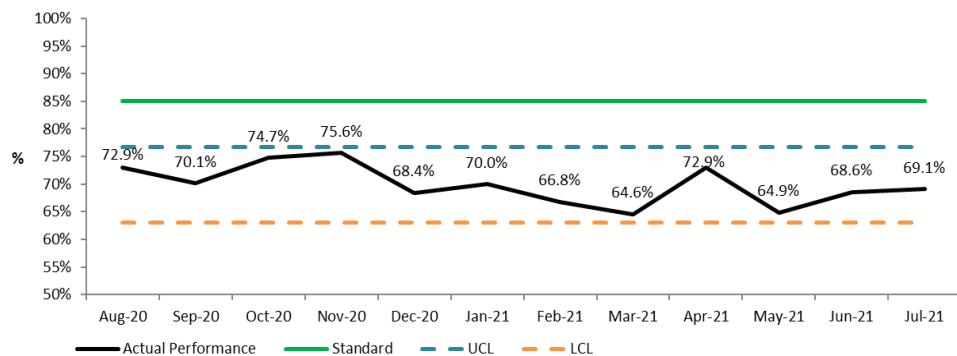
Performance Analysis

July Performance for first treatment within 62 days has improved slightly to 69.1%, remaining non-compliant against the standard of 85%.

There were a total of 173 patients treated along this pathway in July which is a reduction of the 203.5 treated in June. Of the 173 patients there were 119.5 who were treated within the 62 standard resulting in 53.5 breaches.

Out of the 53.5 breaches 22 patients were treated at 104plus days which were delayed due to Elective Capacity, Outpatient Capacity, Medical Reason, Complex Diagnostics and Patient Choice. The tumour sites reporting over 104 day include Gynaecology, Lower GI, Upper GI, Skin and Urology.

UHDBFT - Cancer: 62 Day Wait (Urgent Referral)



Current Issues

- Significant increase in 2 week wait referrals.
- Capacity for first appointment.
- A number of patients awaiting 28 day take off letters or appointments where cancer is excluded.
- Diagnostic capacity TRUS biopsies, PET scans, Bone scans, MRI, Endoscopy
- Surgery capacity
- Complex pathways
- Patient Choice

Actions Being Taken

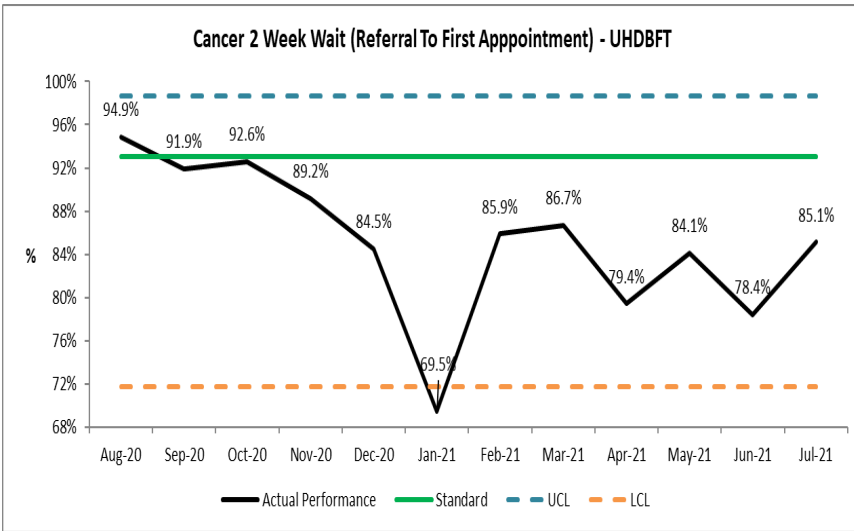
- More cross site appointments to accommodate patients earlier.
- 28 day template letters being rolled out.
- Introduction of local anaesthetic template biopsy in prostate this will speed up the pathway.
- Work with specific tumour sites and CCG where inappropriate referrals are received, pressure points 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. The H1 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 during the period	Seen Within 62 Days	Breaches of 62 Day Standard	% Performance
Acute leukaemia	0	0	0	N/A
Brain/Central Nervous System	0	0	0	N/A
Breast	32	27	5	84.38%
Children's	0	0	0	N/A
Gynaecological	11	4	7	36.36%
Haematological (Excluding Acute Leukaemia)	9	8	1	88.89%
Head and Neck	11	10	1	90.91%
Lower Gastrointestinal	18	8	10	44.44%
Lung	8	6.5	1.5	81.25%
Other	1	1	0	100.00%
Sarcoma	1	1	0	100.00%
Skin	41	37	4	90.24%
Testicular	2	2	0	100.00%
Upper Gastrointestinal	14	5	9	35.71%
Urological (Excluding Testicular)	25	10	15	40.00%
Totals	173.0	119.5	53.5	69.08%

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



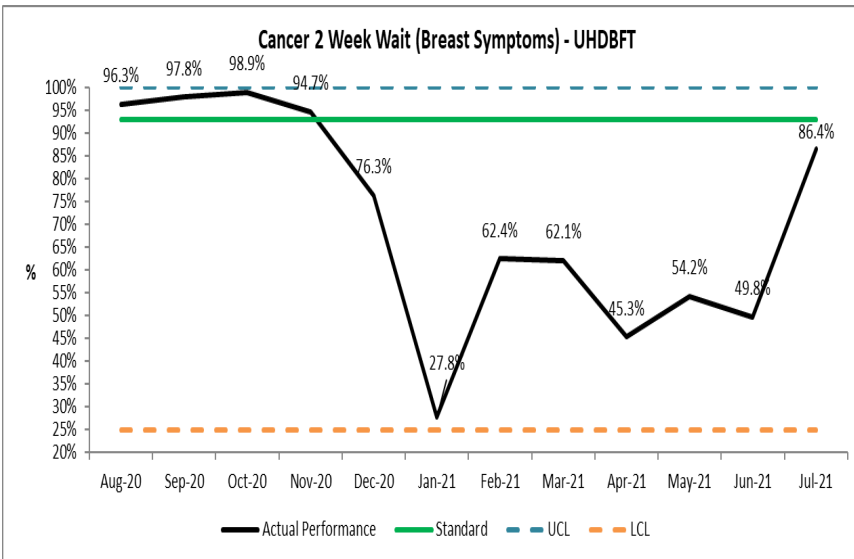
Performance Analysis

July performance at UHDB for 2 week wait has improved to 85.1%, however, it continues to remain non-compliant against the standard of 93%. The main challenges for 2ww performance have been associated with Breast, Lower GI and Skin.

There were a total number of 3236 patients seen in July by way of GP Urgent referral to first appointment which is a reduction on the 3481 reported in June. July also continued with nearly 60% of the referrals relating to Breast, Lower GI and Skin. Of the 3236 patients seen in July, 2755 of these patients were seen within the 2 week wait standard, resulting in 481 breaches which is a significant improvement on the 751 breaches reported in June.

The 481 breaches occurred in Breast (58), Children (2), Gynaecology (141), Haematology (5), Head and Neck (19), Lower GI (86), Lung (3), Skin(55), Testicular (2), Upper GI (82) and Urology (30). Nearly 93% of the breach reasons were due to Outpatient Capacity and Patient Choice, with a small few relating to Administrative delay.

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



Performance Analysis

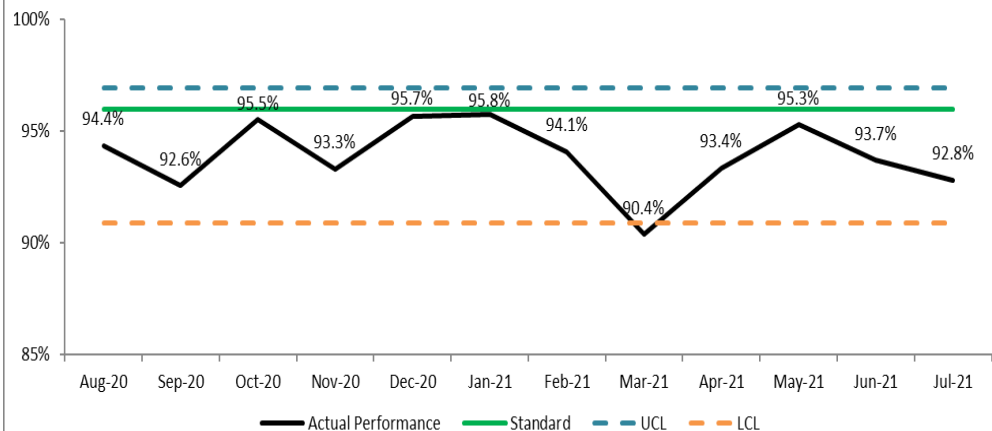
July performance at UHDB for 2 week wait Breast Symptomatic has significantly improved to 86.4% compared to the 49.8% reported in June. However, it continues to remain non-compliant against the standard of 96%.

Breast referrals polling range on Choose and Book, for both 2WW and symptomatic, was extended to more than 14 days to enable patients to book, even though the appointment would be after 14 days and although this has now stopped this has affected those patients seen in July.

The total number of patients seen this month by way of referral to Breast Symptomatic was 184 with 159 of those patients being seen within 2 weeks, resulting in 25 breaches which is a significant improvement to the 104 breaches reported in June. Of the 25 breaches 24 of the patients were seen within 21 days with just 1 patient waiting 24 days. The majority of the breach reasons were due to Outpatient Capacity(12) and Patient Choice(13).

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

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



Performance Analysis

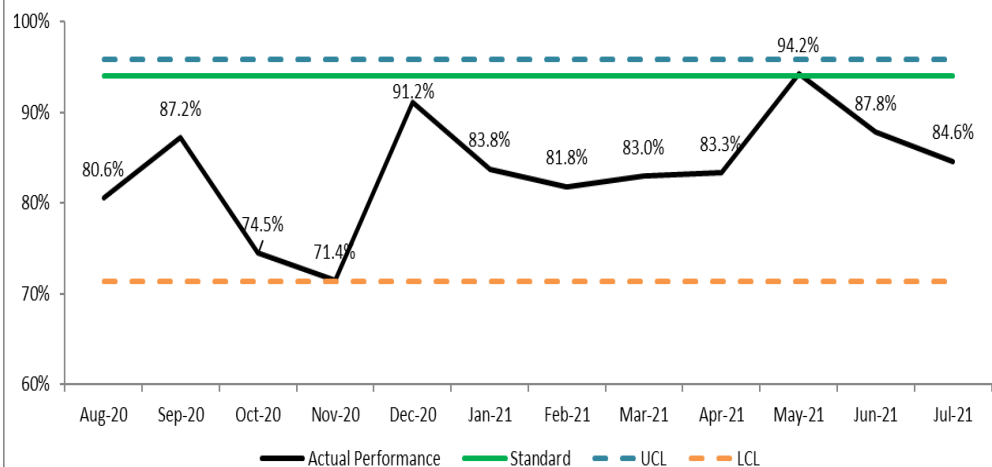
July performance at UHDB for 31 day from diagnosis to first treatment has reduced very slightly to 92.8%, remaining non-compliant against the standard of 96%.

There were a total number of 348 patients treated in July along this pathway, a reduction of the 397 treated in June. Of the 348 patients there were 323 patients treated within 31 days, resulting in 23 breaches (relating to 25 patients).

The 23 breaches occurred in Breast, Head and Neck, Lower GI, Skin and Urology. The majority of the breach reasons were due to Elective Capacity.

UHDB - CANCER WAITING TIMES – 31day to Subsequent Surgery

UHDBFT - Cancer: 31 Day Wait (Subsequent Surgery)



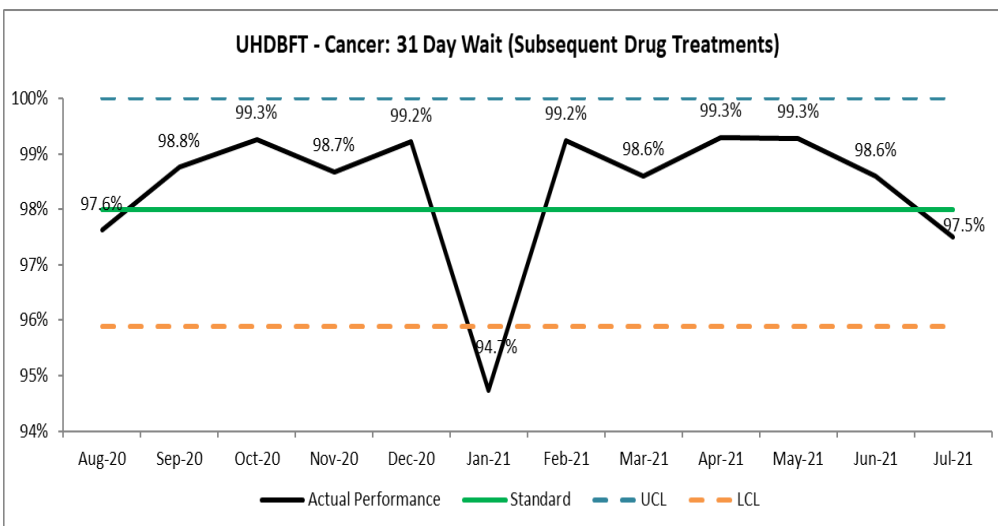
Performance Analysis

July performance at UHDB for 31 day to subsequent surgery has very slightly reduced to 84.6%, remaining non-compliant against the standard of 94%.

There were a total number of 39 patients treated along the subsequent surgery pathway in July. Of the 39 patients there were 33 patients who received surgery within 31 days, resulting in 6 breaches.

The 6 patients waiting for treatment were treated within a range of 33 - 56 days. The breaches that occurred were as a result of Elective Capacity(4), Medical Reasons(1) and Outpatient Capacity(1).

UHDB - CANCER WAITING TIMES – 31 Days to subsequent Drug treatment



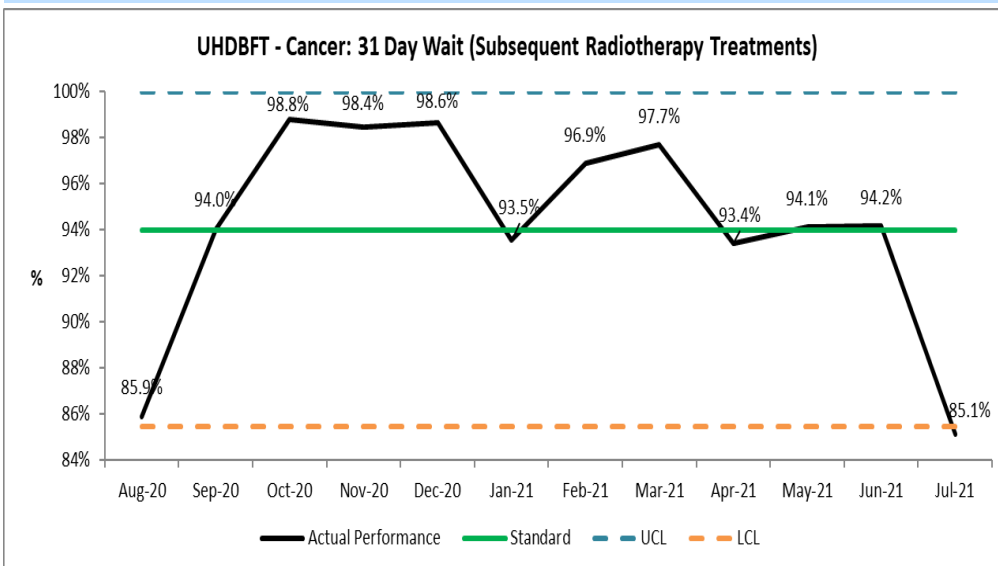
Performance Analysis

July performance at UHDB for 31 day to subsequent drug treatment has reduced slightly to 97.5%, being non-compliant against the standard of 98%.

There were a total number of 120 patients who received drug treatment in July. Of the 120 patients there were 117 patients who received the treatment within 31 days, resulting in 3 breaches.

All 3 breaches occurred as a result of Healthcare Initiated Treatment Plan.

UHDB - CANCER WAITING TIMES – 31days to subsequent radiotherapy treatment



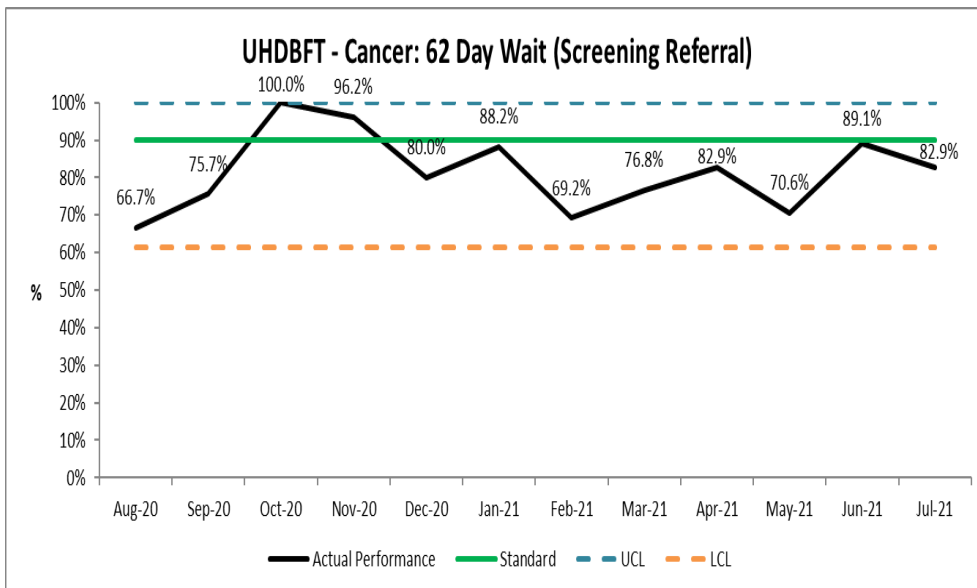
Performance Analysis

July performance at UHDB for 31 day to subsequent radiotherapy treatment has reduced to 85.1%, being non-compliant against the standard of 94%.

There were a total number of 74 patients who received radiotherapy treatment in July. Of the 74 patients there were 63 patients treated for radiotherapy within 31 days, resulting in 11 breaches.

The 11 patients waiting for treatment were treated within a range of 32 - 69 days. The breaches that occurred were as a result of Patient Choice(4), Healthcare Initiated Treatment Plan(5), Outpatient Capacity(1) and Medical Reasons(1).

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



Performance Analysis

Performance in July at UHDB has reduced slightly to 82.9%, remaining non-compliant against the standard of 90%. Had three more patients been treated the standard would have been achieved.

There were a total of 35 patients treated in July who were referred from a screening service with 29 of those patients being treated within 62 days, resulting in 6 breaches.

Of the 6 breaches, 1 occurred in in Gynaecology and 5 occurred in Lower GI. The breaches occurred as a result of Outpatient Capacity and Elective Capacity.

The number of days the patients breached ranged between 72 and 133 days, with one reporting at 210 days which was initially due to patient choice then complex diagnostics and currently outpatient capacity.

Appendix

APPENDIX 1: PERFORMANCE OVERVIEW M4 – ASSOCIATE PROVIDER CONTRACTS

Provider Dashboard for NHS Constitution Indicators					Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance	Direction of Travel	Current Month	YTD	consecutive months non-compliance
Urgent Care	Area	Indicator Name	Standard	Latest Period	East Cheshire Hospitals			Nottingham University Hospitals			Sheffield Teaching Hospitals FT			Sherwood Forest Hospitals FT			Stockport FT							
	Urgent Care	Accident & Emergency	A&E Waiting Time - Proportion With Total Time In A&E Under 4 Hours	95%	Aug-21	↑	58.1%	63.6%	38	A&E pilot site - not currently reporting 4 hour breaches			↓	74.3%	74.1%	64	↓	86.4%	89.1%	10	↓	76.5%	73.7%	15
A&E 12 Hour Trolley Waits			0	Aug-21	↓	13	33	5	↓	134	213	2	↔	2	11	6	↓	1	6	1	↓	1	3	1
Planned Care	Referral to Treatment for non urgent consultant led treatment	Referrals To Treatment Incomplete Pathways - % Within 18 Weeks	92%	Jul-21	↑	61.5%	56.4%	47	↓	70.0%	68.6%	22	↓	81.1%	81.8%	18	↑	69.6%	67.2%	47	↓	58.0%	58.1%	42
		Number of 52 Week+ Referral To Treatment Pathways - Incomplete Pathways	0	Jul-21	↓	386	3770	19	↓	3066	13456	16	↓	785	3456	16	↓	1096	5075	16	↓	3817	15924	39
	Diagnostics	Diagnostic Test Waiting Times - Proportion Over 6 Weeks	1%	Jul-21	↓	28.48%	53.82%	17	↓	38.54%	40.64%	17	↑	17.16%	14.18%	17	↑	21.76%	22.47%	19	↓	42.72%	45.02%	25
	2 Week Cancer Waits	All Cancer Two Week Wait - Proportion Seen Within Two Weeks Of Referral	93%	Jul-21	↑	74.5%	90.1%	5	↑	92.3%	87.6%	4	↓	79.8%	80.5%	4	↑	90.7%	92.6%	2	↓	97.1%	97.5%	0
		Exhibited (non-cancer) Breast Symptoms – Cancer not initially suspected - Proportion Seen Within Two Weeks Of Referral	93%	Jul-21	↑	44.2%	76.4%	5	↑	90.6%	68.6%	4	↑	15.9%	15.4%	4	↑	92.9%	93.8%	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%	Jul-21	↑	71.8%	68.9%	4	↓	78.7%	79.7%	0	↑	66.6%	64.0%	4	↓	75.9%	78.7%	0	↓	58.3%	58.9%	4
	31 Days Cancer Waits	First Treatment Administered Within 31 Days Of Diagnosis	96%	Jul-21	↑	95.0%	92.1%	7	↑	89.9%	89.2%	28	↓	90.0%	92.1%	4	↑	92.7%	94.4%	2	↓	97.8%	97.3%	0
		Subsequent Surgery Within 31 Days Of Decision To Treat	94%	Jul-21	↔	100.0%	92.3%	0	↑	73.3%	69.7%	39	↓	83.0%	84.0%	8	↔	100.0%	94.1%	0	↔	100.0%	94.4%	0
		Subsequent Drug Treatment Within 31 Days Of Decision To Treat	98%	Jul-21	↔	N/A	100.0%	0	↑	100.0%	98.9%	0	↑	99.5%	99.0%	0	↑	100.0%	87.5%	0	↔	N/A	100.0%	0
		Subsequent Radiotherapy Within 31 Days Of Decision To Treat	94%	Jul-21					↑	95.6%	94.2%	0	↓	97.3%	97.5%	0								
62 Days Cancer Waits	First Treatment Administered Within 62 Days Of Urgent GP Referral	85%	Jul-21	↑	70.9%	63.0%	22	↓	65.2%	70.3%	16	↓	58.9%	60.3%	71	↓	68.6%	70.9%	19	↑	80.0%	78.4%	27	
	First Treatment Administered - 104+ Day Waits	0	Jul-21	↑	2.0	32.0	11	↓	20.5	78.0	64	↑	24.0	91.0	64	↑	8.0	26.5	39	↑	2.0	8.5	27	
	First Treatment Administered Within 62 Days Of Screening Referral	90%	Jul-21	↑	85.2%	75.8%	8	↑	74.0%	69.0%	8	↓	48.7%	69.9%	8	↓	75.7%	79.8%	2	↔	50%	50.0%	2	
	First Treatment Administered Within 62 Days Of Consultant Upgrade	N/A	Jul-21	↓	62.2%	86.9%		↓	74.4%	76.4%		↑	83.8%	82.9%		↓	67.5%	76.1%		↓	70.0%	84.4%		
Patient Safety	Incidence of healthcare associated Infection	Healthcare Acquired Infection (HCAI) Measure: MRSA Infections	0	Jul-21	↔	0	2	0	↔	0	0	0	↔	0	0	0	↔	0	0	0	↔	0	0	0
		Healthcare Acquired Infection (HCAI) Measure: C-Diff Infections	Plan				11			40			56			28			19					
			Actual	↓		3	0	↓		25	1	↔		32	0	↓		12	0	↓		10	0	
		Healthcare Acquired Infection (HCAI) Measure: E-Coli	-	Jul-21	↑	8	123		↓	61	229		↓	45	164		↓	31	115		↓	25	87	
Healthcare Acquired Infection (HCAI) Measure: MSSA	-	Jul-21	↑	3	46		↓	25	84		↔	17	65		↔	8	34		↑	3	21			

Governing Body Meeting in Public

7th October 2021

ITEM NO: 159

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

Paper for:	Decision	x	Assurance	x	Discussion		Information
Assurance Report Signed off by Chair			N/A				
Which committee has the subject matter been through?			Engagement Committee – 21.09.21 Primary Care Commissioning Committee – 22.09.21 Governance Committee – 23.09.21 Quality and Performance Committee – 30.09.21 Finance Committee – 30.09.21				
Recommendations							
<p>The Governing Body is requested to RECEIVE and NOTE:</p> <ul style="list-style-type: none"> The Risk Register Report; Appendix 1 as a reflection of the risks facing the organisation as at 30th September 2021; Appendix 2 which summarises the movement of all risks in September 2021; The decrease in risk score for risk 09 relating to 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. <p>APPROVE:</p> <ul style="list-style-type: none"> The closure of risk 30 relating to fraud and cybercrime with this risk being transferred to the CCG Transition to Integrated Care Board (ICB) Risk Register. 							
Report Summary							
<p>This report presented to the Governing Body is to highlight the areas of organisational risk that are recorded in the Derby and Derbyshire CCG Corporate Risk Register (RR) as at 30th September 2021.</p> <p>The RR is a live management document which enables the organisation to understand its comprehensive risk profile, and brings an awareness of the wider risk environment. All risks in the Risk Register are allocated to a Committee who review new and existing risks each month and agree removal of fully mitigated risks.</p>							

Are there any Resource Implications (including Financial, Staffing etc.)?
The Derby and Derbyshire CCG attaches great importance to the effective management of risks that may be faced by patients, members of the public, member practices and their partners and staff, CCG managers and staff, partners and other stakeholders, and by the CCG itself. All members of staff are accountable for their own working practice and have a responsibility to co-operate with managers in order to achieve the objectives of the CCG.
Has a Privacy Impact Assessment (PIA) been completed? What were the findings?
Not applicable to this update.
Has a Quality Impact Assessment (QIA) been completed? What were the findings?
Not applicable to this update.
Has an Equality Impact Assessment (EIA) been completed? What were the findings?
Not applicable to this update; however, addressing risks will impact positively across the organisation as a whole.
Has the project been to the Quality and Equality Impact Assessment (QEIA) panel? Include risk rating and summary of findings below
Not applicable to this update.
Has there been involvement of Patients, Public and other key stakeholders? Include summary of findings below
Not applicable to this update.
Have any Conflicts of Interest been identified/ actions taken?
Not applicable to this update.
Governing Body Assurance Framework
The risks highlighted in this report are linked to the Derby and Derbyshire CCG Board Assurance Framework.
Identification of Key Risks
The paper provides a summary of the very high scoring risks as at 30 th September 2021 detailed in Appendix 1.

NHS DERBY AND DERBYSHIRE CCG GOVERNING BODY MEETING

RISK REPORT AS AT 30TH SEPTEMBER 2021

1. INTRODUCTION

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

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

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

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

2. RISK PROFILE – SEPTEMBER 2021

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

Risk Register as at 30th September 2021

Risk Profile	Very High (15-25)	High (8-12)	Moderate (4-6)	Low (1-3)	Total
Total number on Risk Register reported to GB for September 2021	6	16	5	0	27
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, the movement in score and the rationale for the movement.

3. COMMITTEES – SEPTEMBER VERY HIGH RISKS OVERVIEW

3.1 Quality & Performance Committee

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

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

The current risk score is 20.

August performance:

- CRH reported 90.3% (YTD 94.3%) and UHDB reported 70.4% (YTD 73.1%).
- CRH - The volume of Type 1 attendances are approaching pre-pandemic levels, with an average of 183 attendances per day. However, August 2021 volumes were still around 94% of the August 2019 levels.
- UHDB - Staff absence due to sickness is high, with around a third of sickness in the trust being due to COVID related sickness or isolation. This is also affected Derbyshire Health United (DHU), resulting in the Urgent Treatment Centre (UTC) being unable to operate 24 hours every day.
- The volume of Type 1 attendances is high, with an average of 495 attendances per day. As a network the numbers of attendances are 35% higher than pre-pandemic levels (August 2021 compared to August 2019).
- The acuity of the attendances was high, with Derby seeing an average of 15 Resuscitation patients & 192 Major patients per day and Burton seeing 124 Major/Resus patients per day.
- Attendances at Children's Emergency Department have rapidly increased, with concerns about RSV and Bronchiolitis being major factors. Children's Type 1 attendances at Derby have averaged at 108 per day during August 2021 (compared to 70 per day in August 2019) .
- SORG manages operational escalations and issues if required.
- Meeting frequency has been stepped up from weekly to twice per week.
- GP Connect roll out is complete enabling direct booking of GP appointments via 111.

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

The current risk score is 20.

September update

August position:

Current bed position:

- CCG beds = 33 (Q2 2021/22 target 25).
- Adult Specialised Commissioning = 19 (Q2 2021/22 target 17)
- Children and Young People (CYP) specialised commissioning = 2 (Q2 2021/22 target 3).
- The outcomes of the Derbyshire Learning Disability & Autism Programme Diagnostic review were presented at the August meeting of the Mental Health, Learning Disability & Autism Board.

Key findings & themes included:

- Further strengthening of strategic vision and priorities;
- Project & Programme Management Operating resource capacity;
- Recruitment and retention and engagement with Community Mental Health.

An Action Plan has been agreed in response and will report to the System Delivery Board.

- A weekly Derbyshire Transforming Care Partnership System Escalation meeting has been implemented with Health & Social Executives to facilitate timely and appropriate discharges in line with Estimated Discharge Dates.
- Derbyshire Health & Social Care Partners have been requested to nominate staff to implement 'virtual' TCP team to provide additional capacity.
- STOP moment conducted to review admission over the past six weeks to identify potential system gaps which could have prevented admission.

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.

September update:

- The CCG is working with provider partners to develop a digital model to assist with the appropriate prioritisation of patients.
- A Communications Plan has progressed regarding messages to the public.
- Other actions remain in place as previously.
- The risk score remains unchanged.

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.

September update:

- There continues to be increasing demand and pressure General Practice are facing. Appointment levels are already at least 10% higher than pre pandemic levels (additional 50,000 per month appointments across Derbyshire) as well as Primary Care continuing to deliver 75% of the COVID vaccination programme to date largely through the existing workforce.
 - The regular sitrep report is providing an accurate picture of the situation in General Practice that can be reported into the wider system meetings so partners have a clear understanding of what is happening in general practice and how it can be supported.
 - Planning for support for General Practice for the winter period is in progress to support requests for additional funding and resources in Primary Care to increase capacity in Primary Care to support the system. In addition, Primary care will also be starting the flu programme in September and therefore there are no changes recommended to the existing levels of risk this month.
2. Risk 04B: Quality: *Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care. There are 112 GP practices in Derbyshire all with individual Independent Contracts GMS, PMS, APMS to provide Primary Medical Services to the population of Derbyshire. Six practices are managed by NHS Foundation Trusts and one by an Independent Health Care Provider. The majority of Derbyshire GP practices are small independent businesses which by nature can easily become destabilised if one or more core components of the business become critical or fails. Whilst it is possible to predict and mitigate some factors that may impact on the delivery of care the elements of the unknown and unexpected are key influencing dynamics that can affect quality and care outcomes.*

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

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

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

**Recruitment of GP Partners*

**Capacity and Demand*

**Access*

**Premises*

**New contractual arrangements*

**New Models of Care*

**Delivery of COVID vaccination programme*

**Restoration and Recovery*

**2021/22 Flu Programme*

**Becton Dickinson Blood Tube shortage*

The current risk score is 20.

September update:

- There are delays in the delivery of flu vaccine to GP practices. Where flu clinics have already been organised, this is adding additional pressures.
- There is a shortage of Becton Dickinson blood tubes and this is being managed as a system. Updates and associated information is being issued to GP practices and there are only four instances where phlebotomy can be undertaken currently, due to the shortage. Therefore, phlebotomy undertaken within GP practices is severely restricted which will have a future impact on QOF prevention. It is expected that the situation will improve from 20.09.21 but pressures will still be felt. From 31.08.21 to 17.09.21 blood tests carried out in GP practices will be only in the four instances.
- Phase 3 COVID has been delayed until 22.09.21, planning is taking place.

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.

September update

August position:

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

- The CCG is working with system partners to establish a sustainable a long term financial position and deliver a balanced in-year position.
- As at month 5 the CCG are not seeing any major financial pressures against planned expenditure with the exception of CHC and we continue to work with Midlands & Lancs Commissioning Support Unit and providers to rectify this.
- We are reporting at month 5 a year to date surplus of £0.129m and have not used any of the 0.5% contingency.
- The forecast position is also a small surplus of £0.200m and again we have not used any of the 0.5% contingency.
- The year to date and forecast position assume a level of reimbursement of Retrospective Covid and Elective Recovery Fund.
- The CCG is continuing to work with system partners to understand the recurrent underlying position which is the true test of a sustainable financial position and this demonstrates there is a significant recurrent deficit.

4. SEPTEMBER OVERVIEW

4.1 Decreased risk since last month

One risk has decreased in score.

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.

This risk is proposed to be decreased in score from a high 8 (probability 2 x impact 4) to a moderate score of 6 (probability 2 x impact 3).

- The reduction relates to the impact level of the risk, as previously risk mitigation and responses to critical and high-level alerts were provided directly to NHS Digital for assurance with subsequent reporting to the CCG through operational contractual meetings.
- The revised approach means the CCG are both aware of all risks (not just critical and high-level) and receive more timely reports from NECS on how these are being actively managed. It also allows for the CCG to challenge responses where appropriate and to receive assurance that the risk has been addressed or where risks remain.
- Reviewing the available information would indicate risks are being appropriately managed and actioned and with the additional investment

made in our off-site storage and improvements to the firewall, the impact of the risk should be reduced given these additional mitigating actions.

4.2 Closed risk

One risk is proposed to be closed

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

The current risk score is a moderate 4 (probability 1 x impact 4).

- This risk is recommended to be closed and transferred to the CCG ICB Transition Risk Register due to potential risks of cyber-attack in transition to the ICB.
- Whilst confident that the CCG has done everything possible in terms of general cybercrime, there is a particular issue as the CCG transitions into an ICB.

Closure of this risk was approved at the Finance Committee on the 20th September 2021.

5. RECOMMENDATION

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

- The Risk Register Report;
- Appendix 1 as a reflection of the risks facing the organisation as at 30th September 2021;
- Appendix 2 which summarises the movement of all risks in September 2021;
- The decrease in risk score for risk 09 relating to 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.

APPROVE:

- The closure of risk 30 relating to fraud and cybercrime with this risk being transferred to the CCG Transition to Integrated Care Board (ICB) Risk Register.

Appendix 1 - Derby and Derbyshire CCG Risk Register - as at September 2021

Main Risk Register table with columns: Risk Reference, Year, Risk Description, Mitigations, Actions required to treat risk, Progress Update, Review Date, Executive Lead, Action Owner.

Risk Reference	Year	Risk Description	Type of Contract	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		Task to Board Assurance Framework	Date Reviewed	Review Due Date	Executive Lead	Action Owner				
								Probability	Impact	Probability	Impact	Probability	Impact									
								4	3	4	3	4	3									
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	4	16	<ul style="list-style-type: none"> A task and finish group is in place to monitor actions being undertaken to support these patients which reports to PCDB and SQP Providers are capturing and reporting any clinical harm identified as a result of waits as per their quality assurance processes An assurance framework has been developed and completed by all providers the results of which will be reported to PCDB A minimum standard in relation to these patients is being considered by PCDB Work to control the addition of patients to the waiting lists is ongoing Providers are contacting patients via letter 	<ul style="list-style-type: none"> Monthly reporting of progress against all work to control growth of waiting lists Two weekly task and finish groups with all 4 providers represented Completion of assurance framework has been undertaken by all providers and is being collated to go to PCDB for discussion Identified harm has been reported on STIES and all providers are monitoring this All providers have completed the assurance framework and this is being collated to go back to PCDB for discussion re further risk mitigations Work is ongoing around Consultant Connect, MSK and Ophthalmology <p>14.05.2021 update - Providers are all in the process of completing the assurance framework again to monitor progress. ToR now agreed and the next 3 meetings will focus on individual aspects of the minimum standard requirements to facilitate sharing and learning as all providers work to achieve this. Risk score to remain.</p> <p>24.06.2021 - Waiting lists remain a system issue and there continue to be significant numbers of patients on them, therefore the risk remains the same.</p> <p>12.07.21 update - PCDB and System Quality Group have been updated on the current position in relation to the assurance framework, there remains limited assurance overall regarding the ability to prevent harm due to the numbers of patients on the lists. A Derbyshire wide communications strategy is being worked up with Comms leads. Risk score to remain</p> <p>16.08.21 3 monthly assurance framework submissions continue and all providers are working to support increasing numbers of patients on the waiting lists. Twice weekly regional NIHEI meetings are in place. Comms strategy in progress. Risk remains the same</p> <p>07.09.21 Working with provider partners to develop a digital model to assist with the appropriate prioritisation of patients, comms plan has progressed regarding messages to the public, and other actions remain in place as above. Score remains unchanged.</p>	4	4	16	4	16	3	2	6	Feb-22	Sep-21	Oct-21	Brigid Staacy, Chief Nursing Officer	Laura Moore, Deputy Chief Nurse		
37	21/22	The Royal College of Physicians identified that there is a risk to the sustainability of the Hyper Acute Stroke Unit at CRHFT and therefore to service provision for the population of North Derbyshire.	Quality & Performance	4	5	<ul style="list-style-type: none"> Locum Consultant cover is in place Clinical Leadership support is being provided by Liverpool Consultant Trust to go out for advert to recruit new Stroke Lead consultant & work being done to make advert attractive CCG, NIHEI & System working with Trust Medical Director to contact other organisations and the Stroke Network for support Trust reviewing staff daily and escalating as per staff staffing policy as required, including red flag acute reporting CRHFT and Integrated Stroke Delivery Network (ISDN) leads to develop service contingency plan to understand internal measures, mutual aid options, and patient divert impact. SOP to operationalise the contingency plan. A task and finish group to commence a service review of the HASU, including options appraisal. All options to be reviewed with the aim of providing a sustainable service. 	<ul style="list-style-type: none"> June 21 - HASU service review is ongoing. The T&F group have agreed to review 4 options that include: Continuation of HASU with consultant workforce, conveyance and repatriation model, alternative workforce models or closure and conveyance to surrounding trust. Jo Keogh (CRH Divisional Director) is leading the review with support from CCG colleagues. July 21 - HASU service review update: 5 options have been identified by the group that include: 1. HASU provision continues as is delivered by the existing substantive Consultant, locum support and telemedicine. 2. The current HASU service is strengthened by redesign. 3. The Trust introduces a review and convey (rip and dip) model. 4. Decommission the CRH HASU element of the Stroke Service pathway, if workforce sustainability issues cannot be resolved, with either a single HASU provider or multiple providers. 5. Review of the CRH HASU as part of a wider East Midlands review to rationalise sites, continuing to provide the service 'as is' at CRH. To support the identification of the preferred option and to provide transparency on decision making, the task and finish group have requested that an outcome matrix and criteria is developed and is to be presented at the August meeting for review. August 21 - Workshop to be delivered in Sept 21, to allow all stakeholders to review the options and gain consensus on the preferred service delivery option. CRH are in discussion with Sheffield Teaching Hospitals to develop a joint staffing model for consultants to work across both sites. If agreed the proposal will be added to the consultation options. Sept 21 - Workshop has been rescheduled for Oct 21. The workshop will be utilised to enable stakeholders to work-up the options only. The decision on the future service option will be made by an Independent Panel appointed by the CCG. 	3	4	12	3	4	12	3	3	9	Nov-21	Sep-21	Oct-21	Dr Steve Lloyd, Medical Director	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster, Head of Strategic Clinical Conditions and Pathways	
38	21/22	The quality of care could be impacted by patients not receiving a care needs review in a timely way as a result of the COVID pandemic and the requirement for some of the Midland and Lancashire Commissioning Support Unit (MCSU) Individual Patient Activity (Continuing Health Care (CHC) services to redirect service delivery to support system wide pressures. This has had an impact on core CHC and Funded Nursing Care (FNC) service delivery in relation to care needs reviews.	Quality & Performance	4	2	<ul style="list-style-type: none"> A prioritisation matrix was put in place to ensure the most high risk/complex case reviews were prioritised. 	<ul style="list-style-type: none"> A service proposal has been presented and agreed by the CCG. MCSU will schedule and complete care reviews of all individuals who have a review that was due between 19th March 2020 and 31st March 2021. These will all be completed within 6 months 	<ul style="list-style-type: none"> May 2021 - 600 overdue reviews. Recovery action plan in place and review activity commenced. July 2021 - Trajectory in place to complete all 600 reviews by November 2021. Workforce in place and 220 reviews completed in June so on target. August 2021 - Remain on trajectory to complete the backlog by November. reduction in the number of reviews completed in July but still remain on target. September 2021 - No further additional narrative this month. 	4	2	8	4	2	8	3	2	6	Sep-21	Sep-21	Oct-21	Brigid Staacy, Chief Nursing Officer	Nicola MacPhail, Assistant Director of Quality
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 Avon & GEM CIG on best practice for our procurement activity, but in some circumstances, the CCG may decide to proceed against best practice in order to give sufficient time for review of services within the framework of movement to an ICS. Proceeding against advice, carries a small risk of challenge from any providers who may have felt excluded from the process.	Governance	4	16	<ul style="list-style-type: none"> 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. Healthcare contracts expiring within 12 months are reviewed at Commissioning Ops Directorate (SMF) to ensure that timely action is taken before expiry. Where any challenge occurred from a provider, if the challenge were valid the risk could usually be mitigated by including the provider in future stages of procurement. Legislation is currently going through parliament to remove the requirement for NIS 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. 	<ul style="list-style-type: none"> 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. August Update: The Governance Committee will provide the oversight to decision-making processes in relation to the Provider Selection for the 20 services to give assurance that procurement processes are being followed and Conflicts of Interests are appropriately managed. September update: The CCG contracting team is monitoring and managing all contracts due for expiry including plans to extend or reprocure and identifying the governance path for decision-making. This is refreshed regularly and presented to SLT every two weeks. 	3	4	12	3	4	12	4	2	8	Nov-22	Sep-21	Oct-21	Helen Dillstone - Executive Director of Corporate Strategy and Delivery	Christy Tucker - Director of Corporate Delivery	

Appendix 2 - Movement during September 2021

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
01	21/22	The Acute providers may breach thresholds in respect of the A&E operational standards of 95% to be seen, treated, admitted or discharged within 4 hours, resulting in the failure to meet the Derby and Derbyshire CCGs constitutional standards and quality statutory duties.	5	4	20	5	4	20	↔	SORG manages operational escalations and issues if required. Meeting frequency has been stepped up from weekly to twice per week.	Zara Jones Executive Director of Commissioning Operations	Quality & Performance	Craig Cook Director of Contracting and Performance / Deputy Director of Commissioning Operations Jackie Carille Claire Hinchley Dan Merrison Senior Performance & Assurance Manager
02	21/22	Changes to the interpretation of the Mental Capacity Act (MCA) and Deprivation of Liberty (DoLs) safeguards, results in greater likelihood of challenge from third parties, which will have an effect on clinical, financial and reputational risks of the CCG	3	4	12	3	4	12	↔	The CSU will take over the ReX applications to the COP on behalf of the CCG once the SOP has been approved.	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	↔	Derbyshire Health & Social Care Partners requested to nominate staff to implement 'virtual' TCP team to provide additional capacity.	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	↔	There continues to be increasing demand and pressure General Practice are facing	Dr Steve Lloyd - Medical Director	Primary Care Commissioning	Hannah Belcher, Head of GP Commissioning and Development (Primary Care)

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
04B	21/22	<p><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.</p> <p>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</p>	4	5	20	4	5	20	↔	Shortage of Becton Dickinson blood tubes is being managed as a system. It is expected that the situation will improve from 20.09.21 but pressures will still be felt.	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	↔	Target date amended to March 22 due to ongoing work required.	Zara Jones Executive Director of Commissioning Operations	Quality & Performance	Dave Gardner Assistant Director, Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning
06	21/22	Demand for Psychiatric intensive Care Unit beds (PICU) has grown substantially over the last five years. This has a significant impact financially with budget forecast overspend, in terms of poor patient experience, Quality and Governance arrangements for uncommissioned independent sector beds. The CCG cannot currently meet the KPI from the Five year forward view which require no out of area beds to be used from 2021.	3	4	12	3	4	12	↔	Use remains stable, searches underway for suitable providers. Risk level remains unchanged until suitable providers identified.	Zara Jones Executive Director of Commissioning Operations	Quality & Performance	Dave Gardner Assistant Director, Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning
09	21/22	Sustainable digital performance for CCG and General Practice due to threat of cyber attack and network outages. The CCG is not receiving the required metrics to provide assurance regarding compliance with the national Cyber Security Agenda, and is not able to challenge any actual or perceived gaps in assurance as a result of this.	2	4	8	2	3	6	↓	The revised approach means the CCG are both aware of all risks (not just critical and high-level) and receive more timely reports from NECS on how these are being actively managed	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	↔	EPRR Core Standards completed by CCG and submitted to NHSEI.	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 Derbyshire NHS system has a significant gap between expenditure assessed as required to meet delivery plans and notified available resource.	Richard Chapman, Chief Finance Officer	Finance	Darran Green-Assistant Chief Finance Officer

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
12	21/22	Inability to deliver current service provision due to impact of service review. The CCG has initiated a review of NHS provided Short Breaks respite service for people with learning disabilities in the north of the county without recourse to eligibility criteria laid down in the Care Act. Depending on the subsequent actions taken by the CCG fewer people may have access to the same hours of respite, delivered in the same way as previously. There is a risk of significant distress that may be caused to individuals including carers, both during the process of engagement and afterwards depending on the subsequent commissioning decisions made in relation to this issue. There is a risk of organisational reputation damage and the process needs to be as thorough as possible. There is a risk of reduced service provision due to provider inability to retain and recruit staff. There is a an associated but yet unquantified risk of increased admissions – this picture will be informed by the review.	3	3	9	3	3	9	↔	The System Delivery Board are reviewing and looking at prioritisation of work including the ATU review and Short Breaks regarding additional resources.	Brigid Stacey - Chief Nursing Officer	Quality & Performance	Mick Burrows Director for Learning Disabilities, Autism, Mental Health and Children and Young People Commissioning, Helen Hipkiss, Deputy Director of Quality /Phil Sugden, Assistant Director Quality, Community & Mental Health, DCHS
14	21/22	On-going non-compliance of completion of initial health assessments (IHAs) within statutory timescales for Children in Care due to the increasing numbers of children/young people entering the care system. This may have an impact on Children in Care not receiving their initial health assessment as per statutory framework.	4	3	12	4	3	12	↔	The risk to remain on the Risk Register at this time to evidence the substantial ongoing quality assurance work undertaken by the Designated CIC Professionals (Dr & Nurse) & by DDCCG Nursing and Quality Team.	Brigid Stacey - Chief Nursing Officer	Quality & Performance	Alison Robinson, Designated Nurse for Looked After Children
16	21/22	Lack of standardised process in CCG commissioning arrangements. CCG and system may fail to meet statutory duties in S14Z2 of Health and Care Act 2012 and not sufficiently engage patients and the public in service planning and development, including restoration and recovery work arising from the COVID-19 pandemic.	2	4	8	2	4	8	↔	Engagement Model refresh to September Engagement Committee, governance guide sits behind this as a resource for teams undertaking service change.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Engagement	Sean Thornton Assistant Director Communications and Engagement
17	21/22	S117 package costs continue to be a source of high expenditure which could be positively influenced with resourced oversight, this growth across the system, if unchecked, will continue to outstrip available budget	3	3	9	3	3	9	↔	Risk remains unchanged pending case load review, CSU have not yet confirmed timeline.	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	↔	Project group to recommence review of HR files with a view to scanning into an electronic filing system.	Beverley Smith, Director of Corporate Strategy & Development	Governance	Sam Robinson, Service Development Manager
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	↔	Briefing for all staff at Team Talk on 14.9.21 regarding the flexible model linked to virus transmission rates (red/amber/green) and an overview of the standard operating procedure.	Beverley Smith, Director of Corporate Strategy & Development	Governance	Beverley Smith, Director of Corporate Strategy & Development James Lunn, Head of People and Organisational Development

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
23	21/22	CCG Staff capacity compromised due to illness or other reasons. Increased numbers of CCG staff potentially unable to work due to COVID 19 symptoms / Self isolation.	1	4	4	1	4	4	↔	The number of CCG staff/ time commitment has reduced from 1 September 2021 with the move away from the mass vaccination centre. There is an ongoing review of existing redeployments and consideration of alternative solutions.	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	↔	System leaders are monitoring the live situation and will make changes to relieve capacity where possible and we're also asking the public to work with us by accessing the right NHS service.	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	↔	Currently working closely with multi-agency providers to develop the workforce model. Funding agreed to appoint a Long COVID Project Manager to lead the programme.	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	↔	Progressing recruitment to increase programme capacity.	Zara Jones, Executive Director of Commissioning Operations	Quality & Performance	Mick Burrows, Director of Commissioning for MH, LD, ASD, and CYP Helen O'Higgins, Head of All Age Mental Health Tracy Lee, Head of Mental Health Clinical Lead
27	21/22	Increase in the number of safeguarding referrals linked to self neglect related to those who are not in touch with services. These initially increased immediately following COVID lockdown. The adult safeguarding processes and policy are able to respond to this type of enquiry once an adult at risk has been identified. Numbers are difficult to predict but numbers are predicted to increase as COVID restrictions ease.	4	3	12	4	3	12	↔	The Safeguarding Adult Boards and their Quality and Performance Committees have taken a view that the risk of escalating adult safeguarding activity remains an unknown quantity.	Brigid Stacey, Chief Nursing Officer	Quality & Performance	Bill Nicol, Head of Adult Safeguarding
30	21/22	There is an ever present risk of fraud and cybercrime; the likelihood of which may increase during the COVID emergency response period.	1	4	4	1	4	4	↔	This risk is recommended to be closed and transferred to the CCG ICB Transition Risk Register due to potential risks of cyber-attack in transition to the ICB.	Richard Chapman, Chief Finance Officer	Finance	Darran Green- Assistant Chief Finance Officer / Ged Connolly-Thompson, Head of Digital Development

Risk Reference	Year	Risk Description	Previous Rating			Residual/ Current Risk			Movement	Reason	Executive Lead	Responsible Committee	Action Owner
			Probability	Impact	Rating	Probability	Impact	Rating					
32	21/22	Risk of exploitation by malevolent third parties If vulnerability is identified within any of the Microsoft Office 2010 applications after October 14th 2020 and not patched, due to support for Microsoft Office 2010 officially ending, after which point Microsoft will cease to issue updates and patches for vulnerabilities found within this suite of applications	3	4	12	3	4	12	↔	There remain around 300 devices yet to be migrated onto the latest version of Microsoft Office with around 4 of these still on older versions of Microsoft Windows 10.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Ged Connolly-Thompson - Head of Digital Development, Chrissy Tucker - Director of Corporate Delivery
33	21/22	There is a risk to patients on waiting lists as a result of their delays to treatment as a direct result of the COVID 19 pandemic. Provider waiting lists have increased in size and it is likely that it will take significant time to fully recover the position against these.	4	4	16	4	4	16	↔	Working with provider partners to develop a digital model to assist with the appropriate prioritisation of patients.	Brigid Stacey, Chief Nursing Officer	Quality & Performance	Laura Moore, Deputy Chief Nurse
37	21/22	The Royal College of Physicians identified that there is a risk to the sustainability of the Hyper Acute Stroke Unit at CRHFT and therefore to service provision for the population of North Derbyshire.	3	4	12	3	4	12	↔	Workshop has been rescheduled for Oct 21. The workshop will be utilised to enable stakeholders to work-up the options only. The decision on the future service option will be made by an Independent Panel appointed by the CCG.	Dr Steve Lloyd, Medical Director	Quality & Performance	Angela Deakin, Assistant Director for Strategic Clinical Conditions & Pathways / Scott Webster Head of Strategic Clinical Conditions and Pathways
38	21/22	The quality of care could be impacted by patients not receiving a care needs review in a timely way as a result of the COVID pandemic and the requirement for some of the Midland and Lancashire Commissioning Support Unit (MLCSU) Individual Patient Activity /Continuing Health Care (CHC) services to redirect service delivery to support system wide pressures. This has had an impact on core CHC and Funded Nursing Care (FNC) service delivery in relation to care needs reviews.	4	2	8	4	2	8	↔	Remain on trajectory to complete the backlog by November. Reduction in the number of reviews completed in July but still remain on target.	Brigid Stacey Chief Nursing Officer	Quality & Performance	Nicola MacPhail Assistant Director of Quality
40	21/22	In the period of transition from CCG to ICS, it is likely that a larger proportion of contracts will be extended on expiry rather than reprocured. The CCG is advised by Arden & GEM CSU on best practice for our procurement activity, but in some circumstances, the CCG may decide to proceed against best practice in order to give sufficient time for review of services within the framework of movement to an ICS. Proceeding against advice, carries a small risk of challenge from any providers who may have felt excluded from the process.	3	4	12	3	4	12	↔	The CCG contracting team is monitoring and managing all contracts due for expiry including plans to extend or reprocure and identifying the governance path for decision-making.	Helen Dillistone - Executive Director of Corporate Strategy and Delivery	Governance	Chrissy Tucker - Director of Corporate Delivery

Governing Body Meeting in Public

7th October 2021

Item No: 160

Report Title	Governing Body Assurance Framework 2021/22 Quarter 2
Author(s)	Rosalie Whitehead, Risk Management & Legal Assurance Manager Suzanne Pickering, Head of Governance
Sponsor (Director)	Helen Dillistone, Executive Director of Corporate Strategy and Delivery

Paper for:	Decision	x	Assurance	x	Discussion		Information	
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Recommendations

The Governing Body are requested to **AGREE** the 2021/22 Quarter 2 (July to September 2021) 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 6th 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 2

The following strategic risks have decreased in risk score during quarter 2, July to September 2021.

Strategic Risk 7: CCG staff retention and morale during the transition will be adversely impacted due to uncertainty of process and implications of the transfer to the ICS, despite the NHSEI continuity of employment promise. The responsible Committee is the Governance Committee. The risk score has decreased from a high 8 to a moderate 6. The reduction in score as a result of the HR Framework being published by NHSEI and the various HR Briefings and Health and Wellbeing sessions offered to all staff in the transition to the Integrated Care Board.

Strategic Risk 8: 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. The responsible Committee is the Governance Committee. The risk score has reduced from a very high 20 to a very high 16. The reduction in score is as result of various ICS documents being published to support the close down of CCGs and due diligence and readiness to operate as an Integrated Care Board.

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 July to September 2021.

The GBAF Quarter 2 can be found at appendix one to this report and updates to the strategic risk extract documents are detailed in red text.

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 2 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.

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

6	The CCG does not achieve the national requirements for the Covid-19 Vaccination Programme and have robust operational models in place for the continuous sustainable delivery of the Vaccination Programme	20	Steve Lloyd
7	CCG staff retention and morale during the transition will be adversely impacted due to uncertainty of process and implications of the transfer to the ICS, despite the NHSEI continuity of employment promise.	6	Helen Dillistone
8	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.	16	Helen Dillistone

<p align="center">Strategic Objective: 2</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">GBAF RISK 1</p>	<p align="center">Executive Lead: Steve Lloyd Assigned to Committee: Quality and Performance</p>
<p align="center">What would success look like and how would we measure it?</p> <ul style="list-style-type: none"> • Agreement and commitment to agenda at JUCD Board with inequalities in the Terms of Reference. • New ICS governance structure to include addressing inequalities. • Strategic Long Term Conditions Programme Board to be established with a clear remit to reduce unwarranted variation in services. • Commissioning to focus on particular patient cohorts, with measures around services to be put in place to support reduction of inequalities. • Covid risk stratification work should cover health and social care inequality, as well as mental health not just physical health. • System Q&P dashboard to include inequality measures • 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. • 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. • 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. • The QEIA will also include evidence to demonstrate compliance with legislative requirements in respect of public engagement. • Increase Patient Experience feedback and engagement. 		<p align="center">Risk Description</p> <p>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.</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

Date reviewed	September 2021
Rationale for risk rating (and any change in score):	
<ul style="list-style-type: none"> The Derby and Derbyshire population are unable to access their usual service or an alternative due to the impact of the Covid pandemic, The CCG is unable to meet its strategic aim as above due to the impact of the Covid pandemic. Capacity in commissioning has improved. PLACE areas are now supported by a CCG Functional Director. QIA/EIA process in place. Recovery and Restoration plan and process in place. 	
Link to Derby and Derbyshire Risk Register	
1,2,3,4,5,6,7,9,12,14,17,19,21,22,24,25,26,27,28	

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

<ul style="list-style-type: none"> • Functions continue to operate at BC level 3 and are reviewed regularly. • Winter Planning Cell established and in place to manage the impact of winter pressures and COVID-19. • System Operational Centre established and include the System Vaccination Operational Centre (SVOC) • JUCD system moved from Gold Command to Silver Command February 2021. • 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. • JUCD 2021/22 Operational Plan submitted to NHSE 14th May 2021. • Transition Assurance Committee (TAC) established and inaugural meeting took place end April and meeting monthly. • CCG GB Chair is the Transition Assurance Committee (TAC) Chair and ICS CCG Transition Working Group Chair. • CCG ICS Transition Working Group established and meets monthly. First meeting took place 6th May. • Dr Robyn Dewis, Director of Public Health Derby City is Chair of Health Inequalities Group across the System. 	<p>and operational issues being fully managed by the System Operational Resilience Group (SORG)</p> <ul style="list-style-type: none"> • Transition Assurance Committee (TAC) established and inaugural meeting took place end April and meeting monthly. • Health Inequalities is priority focus of JUCD Board and Strategic Intent. • 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. • ICS Design Framework published 16th June 2021 • Health and Care Bill ordered by The House of Commons 6th July 2021. • Further ICS/ ICB Guidance published August 2021 • John MacDonald appointed as ICB Designate Chair. 	<ul style="list-style-type: none"> • Vaccine hesitancy updates reported to weekly Gold Call meetings • Plan on a page for each cohort. • Vaccination Inequalities Group Terms of Reference and Action Plan. • 2021/22 JUCD Operational Plan • ICS Transition Plan • Transition Assurance Committee (TAC), agenda, papers and minutes • CCG ICS Transition Working Group agenda, papers and minutes 	
GAPS IN CONTROL		GAPS IN ASSURANCE	
<p style="text-align: center;"><u>Internal</u></p> <ul style="list-style-type: none"> • Commissioning the specific needs to meet the demands of the Covid Pandemic • CCG patient experience function stood down in response to COVID. 	<p style="text-align: center;"><u>External</u></p> <ul style="list-style-type: none"> • CCG does not currently have an evidence-based strategy to address inequalities. • Programme of work for appropriate interventions, informed by public health data and incorporating the wider determinants of health. 	<p style="text-align: center;"><u>Internal</u></p> <ul style="list-style-type: none"> • CCG patient experience function stood down in response to COVID. 	<p style="text-align: center;"><u>External</u></p> <ul style="list-style-type: none"> • Understanding health data and implications of Covid including disparities of outcomes. • Understanding direct impacts and long-term implications of Covid. Triangulating through system.
ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)			
<p style="text-align: center;"><u>Internal</u></p> <ul style="list-style-type: none"> • 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. • Addressing health inequalities is a key priority in the ICS System Development Plan currently being drafted for submission to NHSEI • 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. 	<p style="text-align: center;"><u>Timeframe</u></p> <ul style="list-style-type: none"> • Ongoing, monthly • Ongoing • November 2021 	<p style="text-align: center;"><u>External</u></p> <ul style="list-style-type: none"> • Long Term Conditions Strategy. • Long Term Conditions Board to identify groups for focus (prioritisation work started) 	<p style="text-align: center;"><u>Timeframe</u></p> <ul style="list-style-type: none"> • Ongoing • Ongoing

<p align="center">Strategic Objective: 2</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">GBAF RISK 2</p>	<p align="center">Executive Lead: Steve Lloyd</p> <p align="center">Assigned to Committee: Quality and Performance</p>
<p align="center">What would success look like and how would we measure it?</p> <ul style="list-style-type: none"> • Agreement and commitment to agenda at JUCD Board with unwarranted variation in quality in the Terms of Reference. • JUCD to take a disease management approach to variation, rather than individual services. • New ICS governance structure to include addressing unwarranted variation in quality. • CCG to understand the variations in services across JUCD and if these are unwarranted. • Quality to work with commissioning teams to ensure contracts address the inequalities. • System Q&P dashboard to used to identify the variations at system level. • System Q&P to address the unwarranted variation identified from the dashboard, through the JUCD Programme Boards. • 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. 	<p align="center">Risk Description</p> <p align="center">The CCG is unable to identify priorities for variation reduction and reduce or eliminate them.</p>	

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

<ul style="list-style-type: none"> • Corporate Committees and Governing Body Meetings have not been stood down and continue to meet monthly. • Functions continue to operate at BC level 3 and are reviewed regularly. • JUCD system moved from Gold Command to Silver Command February 2021. • Covid-19 Vaccination Inequalities Group established and in place to support tackling vaccine hesitancy in high risk and transient communities. • JUCD 2021/22 Operational Plan submitted to NHSE 14th May 2021. • Transition Assurance Committee (TAC) established and inaugural meeting took place end April and meeting monthly. • CCG GB Chair is the Transition Assurance Committee (TAC) Chair and CCG ICS Transition Working Group Chair. • CCG ICS Transition Working Group established and meets monthly. First meeting took place 6th May. • Dr Robyn Dewis, Director of Public Health Derby City is Chair of Health Inequalities Group across the System. 	<ul style="list-style-type: none"> • Transition Assurance Committee (TAC) established and inaugural meeting took place end April and meeting monthly. • Health Inequalities is priority focus of JUCD Board and Strategic Intent. • 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. • ICS Design Framework published 16th June 2021 • Health an Care Bill ordered by The House of Commons 6th July 2021. • Health and Care Bill ordered by The House of Commons 6th July 2021. • Further ICS/ ICB Guidance published August 2021 • John MacDonald appointed as ICB Designate Chair. 	<p>JUCD Board.</p> <ul style="list-style-type: none"> • Vaccine hesitancy updates reported to weekly Gold Call meetings • Plan on a page for each cohort. • Vaccination Inequalities Group Terms of Reference and Action Plan. • Decision making principles to be applied to each cohort to ensure consistent approach. • 2021/22 JUCD Operational Plan • ICS Transition Plan • Transition Assurance Committee (TAC), agenda, papers and minutes • CCG ICS Transition Working Group agenda, papers and minutes 	
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GAPS IN CONTROL		GAPS IN ASSURANCE	
<u>Internal</u> <ul style="list-style-type: none"> CCG unable to identify priorities for variation reduction due to the impact of the Covid pandemic. CCG patient experience function stood down in response to COVID. 	<u>External</u> <ul style="list-style-type: none"> Identify variation caused through system processes and work with system partners to eliminate or reduce. Priorities which carry the most significant at-scale benefits for early action. 	<u>Internal</u> <ul style="list-style-type: none"> Development of STP planning and refresh. CCG patient experience function stood down in response to COVID. 	<u>External</u> <ul style="list-style-type: none"> Differentiate which variation is appropriate for elimination and which is not; develop a prioritised plan for the former. Agree dataset to measure improvement in outcomes and patient experience.
ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)			
<u>Internal</u> <ul style="list-style-type: none"> Establishment of Quality & Performance Committee Task & Finish Group to provide scrutiny and challenge. Addressing health inequalities is a key priority in the ICS System Development Plan currently being drafted for submission to NHSEI 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. 	<u>Timeframe</u> <ul style="list-style-type: none"> Ongoing monthly Ongoing November 2021 	<u>External</u> <ul style="list-style-type: none"> Increased system working with system partners to deliver transformation change. Refer issues to System Quality and Performance Group. Strategic Long Term Conditions Programme Board to address variation. (working on risk stratification with BI / Board are reviewing priorities) Right Care Evidence and Data (awaiting updated data packs) Working with the LTC Board to agree Priorities at System Event. Working with the LTC Board to agree Strategic Long Term Conditions Programme Board to agree dataset measurement. 	<u>Timeframe</u> <ul style="list-style-type: none"> Ongoing Monthly System Quality & Performance Group Ongoing Ongoing TBC Ongoing

<p>Strategic Objective: 6 Continue to further develop and implement new and transformational ways of working that have been developed in response to Covid.</p>				<p>GBAF RISK 3</p>				<p>Executive Lead: Zara Jones Assigned to Committee: Clinical & Lay Commissioning</p>							
<p>What would success look like and how would we measure it? 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>Risk Description Ineffective system working may hinder the creation of a sustainable health and care system by failing to deliver the scale of transformational change needed at the pace required.</p>											
<p>Risk rating</p>		<p>Likelihood</p>	<p>Consequence</p>	<p>Total</p>					<p>Date reviewed</p>		<p>September 2021</p>				
<p>Initial</p>		<p>3</p>	<p>4</p>	<p>12</p>					<p>Rationale for risk rating (and any change in score):</p> <ul style="list-style-type: none"> • System working through the last few months remains at the same level in terms of collaboration and mutual support. • Measures are not easily measurable making the score more subjective. 						
<p>Current</p>		<p>3</p>	<p>4</p>	<p>12</p>											
<p>Risk Appetite</p>		<p>Level</p>	<p>Category</p>	<p>Target Score</p>	<p>Link to Derby and Derbyshire Risk Register 1,2,3,4,5,6,9,10,12,14,17,19,22,23,24,25,26,27,28,29</p>										
		<p>Moderate</p>	<p>Collaborative working</p>	<p>8</p>											
<p>Internal</p>		<p>External</p>						<p>Internal</p>							
<p>Internal</p> <ul style="list-style-type: none"> • Senior members of staff are fully involved in STP/ ICS workstreams • Link with STP • Strong CEO lead and influence on STP • Good clinical engagement i.e. Medical Director a key player in CPRG • CPAG and new Clinical Pathways Forum • Commissioning Intentions 20/21 finalised and agreed with Providers and published on website • Clinical Leadership Framework in place • Deep Dives on areas of poor performance involving provider partners e.g. Q&P deep dives • Lessons learned application to 20/21 planning and delivery through Finance Committee and shared with GB and system • Clinical and Lay Commissioning Committee meetings reinstated June 2020 a result of the COVID 19 pandemic. • Clinical Cell established to manage COVID 19 issues, Steve Lloyd Medical Director is the lead 		<p>External</p> <ul style="list-style-type: none"> • Governance structure embedded • Good CEO/DoF system engagement • JUCD Board now fully functioning as a group of system leaders and meeting in public since January 2021. • Systems Savings Group • Future in Mind Plan agreed by the CCG, Derby City Council and Derbyshire County Council • System Quality and Performance Group established to support in-year delivery strategically, linked to the transformation agenda • System Planning leads oversight of contracting and planning for 20/21, linked to DoFs group to ensure we set the right framework for delivery of our transformation as a system. • System Clinical and Professional Reference Group established and meets monthly. • System intelligence – one version of the truth • Winter Planning Cell established • STP/ ICS Executive Lead appointed • ICS guidance published November 2020. • Derby and Derbyshire formally approved as an ICS. 						<p>Internal</p> <ul style="list-style-type: none"> • Clinical & Lay Commissioning Committee meetings • Governing Body • Executive Team • Recovery and Restoration Action Plan • Recovery and Restoration Plan Highlight Report owned by Clinical & Lay Commissioning Committee • Clinical & Lay Commissioning Assurance Report provided to Governing Body. • STP System Refresh • Draft Joined Up Care 5 Year Delivery Plan 19/20 – 23/24 • Commissioning Intentions 20/21 published and available on the CCGs website. • System Phase 3 Plan approved by Governing Body and Submitted to NHSE. • Winter Planning Cell established and in place to manage the impact of winter pressures and COVID-19. 				<p>External</p> <ul style="list-style-type: none"> • JUCD Board • System Forums including delivery boards, planning leads • CEO/DoF meetings • CPRG meetings • NHSE/I reviews • Derby City Council • Derbyshire County Council • Future in Mind Plan published on Derby City Council website • Future in Mind Plan published on Derbyshire County Council website • STP refresh • System Clinical and Professional Reference Group Minutes • System Phase 3 Plan agreed and submitted to NHSE and is a work in progress plan. 			

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

<p>Strategic Aim: 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.</p>				<p>GBAF RISK 4A</p>				<p>Executive Lead: Richard Chapman Assigned to Committee: Finance Committee</p>				
<p>What would success look like and how would we measure it?</p> <ul style="list-style-type: none"> Delivery of agreed 2021/22 financial position. 				<p>Risk Description</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>Risk rating</p>		<p>Likelihood</p>	<p>Consequence</p>	<p>Total</p>					<p>Date reviewed</p>		<p>September 2021</p>	
<p>Initial</p>		<p>5</p>	<p>5</p>	<p>25</p>					<p>Rationale for risk rating (and any change in score):</p> <ul style="list-style-type: none"> Identify underlying system position, current and forward-looking 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. 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. 			
<p>Current</p>		<p>4</p>	<p>4</p>	<p>16</p>								
<p>Risk Appetite</p>		<p>Level</p>	<p>Category</p>	<p>Target Score</p>	<p>Link to Derby and Derbyshire Risk Register 11,30</p>							
		<p>Low</p>	<p>Financial Statutory Duties</p>	<p>10</p>								
		<p>2</p>	<p>5</p>									
<p>KEY CONTROLS TO MITIGATE RISK</p>					<p>SOURCES OF ASSURANCE</p>							
<p>Internal</p> <ul style="list-style-type: none"> Contract management incl. validation of contract information, coding and counting challenges etc. Internal management processes – monthly confirm and challenge by Executive Team & Finance Committee. Recovery and Restoration (R&R) Plan. R&R progress and assurance reported monthly to Governing Body through the Finance Committee Assurance report. Finance Committee meetings reinstated from June 2020 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. NHSEI have provided guidance of a new financial for the period to March 2021. The allocations 			<p>External</p> <ul style="list-style-type: none"> Standardised contract governance in line with national best practice. System Finance Oversight Group (SFOG) established. Daily System Escalation Cell meetings established to support the management of COVID 19 across the Derbyshire System System Savings Group established and in place System Finance Oversight Group in place and reinstated and continuing to meet at BC level 4. 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 			<p>Internal</p> <ul style="list-style-type: none"> Monthly reporting to NHSE/NHSI, Finance Recovery Group and Finance Committee. Internal Audit 20/21 Integrity of the general ledger, financial reporting and budgetary control Audit giving significant assurance. Recovery and Restoration Action Plan. R&R progress and assurance reported monthly to Governing Body through the Finance Committee Assurance report Finance Committee Minutes Service Development Funding received end September 20. SOC and SVOC update provided weekly to System Escalation Cell (SEC) until it was stood down in February. Now provided to 			<p>External</p> <ul style="list-style-type: none"> Regulator review and oversight of monthly financial submissions System Finance Oversight Group Minutes 2021/22 JUCD Operational Plan ICS Transition Plan System Transition Assurance Committee, agenda, papers and minutes 			

<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"> • CCG Escalated to Business Continuity Level 4 in December 2020 due to Covid 19 pandemic. • Corporate Committees and Governing Body Meetings have not been stood down and continue to meet monthly. • Functions continue to operate at BC level 3 and are reviewed regularly. • JUCD system moved from Gold Command to Silver Command February 2021. • JUCD 2021/22 Operational Plan submitted to NHSE 14th May 2021. • System Transition Assurance Committee established, and inaugural meeting took place end April and meeting monthly. • CCG GB Chair is the System Transition Assurance Committee Chair and ICS CCG Transition Working Group Chair. • CCG ICS Transition Working Group established and meets monthly. First meeting took place 6th May. 	<p>this risk will be held and how it can be mitigated.</p> <ul style="list-style-type: none"> • ICS guidance published November 2020. • Derby and Derbyshire formally approved as an ICS. • ICS White Paper was published in February 2021. • JUCD system moved from Gold Command to Silver Command. • SEC meetings were stood down in February 2021, and operational issues being fully managed by the System Operational Resilience Group (SORG) • System Transition Assurance Committee established and inaugural meeting took place end April and meeting monthly. 	<p>SORG.</p> <ul style="list-style-type: none"> • 2021/22 JUCD Operational Plan • ICS Transition Plan • System Transition Assurance Committee, agenda, papers and minutes • CCG ICS Transition Working Group agenda, papers and minutes 	
GAPS IN CONTROL		GAPS IN ASSURANCE	
<p style="text-align: center;"><u>Internal</u></p> <ul style="list-style-type: none"> • Consistent and regular reporting of timely, accurate and complete activity data with associated financial impact. 	<p style="text-align: center;"><u>External</u></p> <ul style="list-style-type: none"> • Absence of integrated system reporting of the health financial position. • System Finance Oversight Group meetings to be reinstated September 2020. • Establish common system objective to deliver financial sustainability on a system-wide basis. • Identify underlying system position, current and forward-looking. • Establish system-wide monitoring, efficiency and transformational delivery process. 	<p style="text-align: center;"><u>Internal</u></p> <ul style="list-style-type: none"> • Regularisation of integrated activity, finance and savings reporting incorporating activity trajectory matched to provider capacity to deliver and associated commissioner financial impact 	<p style="text-align: center;"><u>External</u></p> <ul style="list-style-type: none"> • Absence of commitment to open-book reporting with clear risk identification. • System Finance Oversight Group Minutes

ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)

<u>Internal</u>	<u>Timeframe</u>	<u>External</u>	<u>Timeframe</u>
<ul style="list-style-type: none"> • Strengthening of activity data reporting to ensure improved business intelligence to support decision making. • Development of an integrated Activity Finance & Savings report in place 	<ul style="list-style-type: none"> • Ongoing • Ongoing 	<ul style="list-style-type: none"> • Transparency of open book reporting through System Savings Group • Output from Demand & Capacity Workstream on waiting list growth (reduction) and consider in financial sustainability terms. 	<ul style="list-style-type: none"> • Ongoing • May 2021

<p>Strategic Aim: 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.</p>				<p>GBAF RISK 4B</p>				<p>Executive Lead: Richard Chapman Assigned to Committee: Finance Committee</p>		
<p>What would success look like and how would we measure it?</p> <ul style="list-style-type: none"> Delivery of agreed 2021/22 financial position on a system basis. 				<p>Risk Description</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>Risk rating</p>		<p>Likelihood</p>	<p>Consequence</p>	<p>Total</p>					<p>Date reviewed</p>	<p>September 2021</p>
<p>Initial</p>		<p>5</p>	<p>4</p>	<p>20</p>					<p>Rationale for risk rating (and any change in score):</p> <ul style="list-style-type: none"> Identify underlying system position, current and forward-looking. The system does not currently have a functional efficiency programme or agreed structures to implement such a programme. 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. 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. 	
<p>Current</p>		<p>4</p>	<p>4</p>	<p>16</p>						
<p>Risk Appetite</p>		<p>Level</p>	<p>Category</p>	<p>Target Score</p>	<p>Link to Derby and Derbyshire Risk Register 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"> Internal management processes – monthly confirm and challenge by Executive Team and Finance Committee Integrated financial reporting incorporating I&E and savings positions and risk Recovery and Restoration (R&R) Plan. Clinical Leadership Framework in place across the system to support governance and clinical workstreams. R&R Plan progress and assurance reported monthly to Governing Body through the Finance Committee Assurance report Finance Committee meetings reinstated from June 2020 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. CCG Escalated to Business Continuity Level 4 in December 2020 due to Covid 19 pandemic. Corporate Committees and Governing Body Meetings have not been stood down as continue to meet monthly. Functions continue to operate at BC level 3 and are reviewed regularly. JUCD system moved from Gold Command to Silver Command February 2021. JUCD 2021/22 Operational Plan submitted to NHSE 14th May 2021. System Transition Assurance Committee established and inaugural meeting took place end April and meeting monthly. CCG GB Chair is the System Transition Assurance Committee Chair and ICS CCG Transition Working Group Chair. CCG ICS Transition Working Group established and meets monthly. First meeting took place 6th May. 	<ul style="list-style-type: none"> Standardised contract governance in line with national best practice. System Finance Oversight Group (SFOG) established Requirement to agree a multi-year system recovery plan with regulator in order to mitigate impact score 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. ICS guidance published November 2020. Derby and Derbyshire formally approved as an ICS. SFOG continue to meet at BC Level 4, December ICS White Paper was published in February 2021. JUCD system moved from Gold Command to Silver Command. SEC meetings were stood down in February 2021, and operational issues being fully managed by the System Operational Resilience Group (SORG) 2020 onwards. System Transition Assurance Committee established and inaugural meeting took place end April and meeting monthly. 	<ul style="list-style-type: none"> Monthly reporting to NHSE/NHSI, Executive Team and Finance Committee. Recovery and Restoration Plan. Clinical Leadership Framework in place across the system to support governance and clinical workstreams. Recovery and Restoration Programme progress and assurance reported monthly to Governing Body through the Finance Committee Assurance Report Finance Committee Minutes SOC and SVOC update provided weekly to System Escalation Cell (SEC) until it was stood down in February. Now provided to SORG. 2021/22 JUCD Operational Plan. ICS Transition Plan. System Transition Assurance Committee, agenda, papers and minutes. CCG ICS Transition Working Group agenda, papers and minutes. 	<ul style="list-style-type: none"> Regulator review and oversight of monthly financial submissions System Finance Oversight Group Minutes 2021/22 JUCD Operational Plan ICS Transition Plan System Transition Assurance Committee, agenda, papers and minutes

GAPS IN CONTROL		GAPS IN ASSURANCE	
<p>Internal</p> <ul style="list-style-type: none"> Consistent and regular reporting of timely, accurate and complete activity data with associated financial impact. 	<p>External</p> <ul style="list-style-type: none"> Absence of a single system view of activity data which is timely, accurate and complete. Absence of a system planning function on which partners place reliance. Absence of integrated system reporting of the health financial position. Regulatory and statutory financial duties mitigate against system collaboration and cooperation to reduce health cost. System Activity Finance & Savings report System Savings Group established and in place System Finance Oversight Group in place System Finance Oversight Group reinstated September 20 and continues to meet at BC Level 4 from December 20, Establish common system objective to deliver financial sustainability on a system-wide basis. Identify underlying system position, current and forward-looking. Establish system-wide monitoring, efficiency and transformational delivery process. 	<p>Internal</p> <ul style="list-style-type: none"> Regularisation of integrated activity, finance and savings reporting incorporating activity trajectory matched to provider capacity to deliver and associated commissioner financial impact 	<p>External</p> <ul style="list-style-type: none"> Absence of commitment to open-book reporting with clear risk identification. Provider rules only allow reforecasting on a quarterly basis, unable to influence this Provider Sustainability Fund rules incentivise delay in risk recognition meaning forecasting may not be fully objective, unable to influence this System Finance Oversight Group minutes not available due to current position
ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)			
<p>Internal</p> <ul style="list-style-type: none"> Development of new System Activity Finance & Savings report 	<p>Timeframe</p> <ul style="list-style-type: none"> Ongoing 	<p>External</p> <ul style="list-style-type: none"> Establish greater system working across finance teams Transparency of open book reporting through System Savings Group System Escalation Cell/ SORG meetings established to support the management of COVID 19 across the Derbyshire System Output from Demand & Capacity Workstream on waiting list growth (reduction) and consider in financial sustainability terms. 	<p>Timeframe</p> <ul style="list-style-type: none"> Ongoing Ongoing Ongoing May 2021

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

<ul style="list-style-type: none"> Clearly defined offer and ownership of communications channels to support consistency of approach and clarity of message. QEIA panel now includes review of S14Z2 (engagement review) forms to provide early sighting on engagement requirements Simple engagement model now approved to support project flow through consistent process. Strengthening of CCG committee cover sheets to ensure committees making implementation decisions have full assurance that duties have been met. 2020/21 Commissioning Intentions finalised and agreed with Providers. Population Health Management in development Recovery and Restoration Plan Governing Body Commissioning Intentions 2020/21 published and on website. Engagement Committee meetings reinstated from June 2020. Zara Jones, Executive Director of Commissioning and Operations is the lead for the System Planning Cell. Daily System Escalation Cell meetings established to support the management of COVID 19 across the Derbyshire System System Planning and Operations Cell established to manage and determine recovery plans and future planning 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. Corporate Committees and Governing Body Meetings have not been stood down and Engagement Committee meets bi-monthly. Functions continue to operate at BC level 3 and are reviewed regularly. JUCD system moved from Gold Command to Silver Command February 2021 JUCD 2021/22 Operational Plan submitted to NHSE 14th May 2021. System Transition Assurance Committee established and inaugural meeting took place end April and meeting monthly. CCG GB Chair is the System Transition Assurance Committee Chair and ICS CCG 	<ul style="list-style-type: none"> 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. Derby and Derbyshire formally approved as an ICS. ICS White Paper was published in February 2021. JUCD system moved from Gold Command to Silver Command. System Transition Assurance Committee established and inaugural meeting took place end April and meeting monthly. Health Inequalities is priority focus of JUCD Board during May and June 2021. Joined up Care Derbyshire Communications and Engagement Strategy approved at JUCD Board 15th July 2021. Further ICB guidance published in August 2021. Awaiting Health & Social Care Bill to be passed in parliament. 	<ul style="list-style-type: none"> Training for Engagement Committee membership to ensure robust understanding and application of guidance and statutory responsibility. 2020/21 Commissioning Intentions finalised and agreed with Providers. Population Health Management supported by Public Health Directors and Governing Body. Establishment of Strategic Advisory Group. Governing Body developing CCG Strategy. Commissioning Intentions published and on website Significant community engagement programme in progress to support vaccine inequalities agenda. 2021/22 JUCD Operational Plan ICS Transition Plan System Transition Assurance Committee, agenda, papers and minutes CCG ICS Transition Working Group agenda, papers and minutes 	
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<p>Transition Working Group Chair.</p> <ul style="list-style-type: none"> • CCG ICS Transition Working Group established and meets monthly. First meeting took place 6th May. • Dr Robyn Dewis, Director of Public Health Derby City is Chair of Health Inequalities Group across the System. 			
GAPS IN CONTROL		GAPS IN ASSURANCE	
<p style="text-align: center;"><u>Internal</u></p> <ul style="list-style-type: none"> • A robust engagement programme that supports the health inequalities and commissioning agendas at the planning stage, with full population analysis to support reaching seldom heard groups. • Finalise construct of engagement mechanisms from PPG level, through PCN, Place, ICP to Engagement Committee level, subject to system structure agreement. • Embed clear and robust statements and processes relating to the desire to engage in CCG strategic policies. • Communication and Engagement not appropriately funded to ensure effectiveness in crowded public sector messaging space. 	<p style="text-align: center;"><u>External</u></p> <ul style="list-style-type: none"> • Multiple public sector messages resulting in CCG cut through being a challenge 	<p style="text-align: center;"><u>Internal</u></p> <ul style="list-style-type: none"> • Embed insight gathering processes into BAU for health service commissioning, with programme support identification of behaviours and issues that affect service commissioning and health inequalities • CCG Communications and Engagement Strategy requires refresh, including alignment with JUCD approach 	<p style="text-align: center;"><u>External</u></p> <ul style="list-style-type: none"> • CCG Communications and Engagement Strategy requires refresh, including alignment with JUCD approach
ACTIONS BEING TAKEN TO ADDRESS GAPS IN CONTROL/ASSURANCE (INCLUDE TIMESCALES)			
<p style="text-align: center;"><u>Internal</u></p> <ul style="list-style-type: none"> • Training support for project managers in development on commissioning cycle to standardise processes, building on recent project management training. • Fully populated and network engagement structure, with permanent membership of Engagement Committee confirmed. • Funding proposal developed to support implementation and ambition of Communications and Engagement Strategy 	<p style="text-align: center;"><u>Timeframe</u></p> <ul style="list-style-type: none"> • Q3 2021/22 (paused during Level 4 Business Continuity arrangements) • Ongoing • Q3 2021/22 (in line with national and system financial planning processes for 21/22) 	<p style="text-align: center;"><u>External</u></p> <ul style="list-style-type: none"> • Engagement Committee re-established bi-monthly. • Insight programme in progress but requires longer-term funding model • Funding proposal developed to support implementation and ambition of Communications and Engagement Strategy 	<p style="text-align: center;"><u>Timeframe</u></p> <ul style="list-style-type: none"> • Bi-monthly 2021/22 • Q2 2021/22 • Q3 2021/22 (in line with national and system financial planning processes for 21/22)

<p>Strategic Objective: 3</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>GBAF RISK 6</p>				<p>Executive Lead: Steve Lloyd</p> <p>Assigned to Committee: Quality and Performance Committee</p>			
<p>What would success look like and how would we measure it?</p> <ul style="list-style-type: none"> 95% of the Derby and Derbyshire CCG population receive 1st and 2nd doses of a Covid-19 vaccination Phase 3 of Vaccination Programme is implemented from September 2021 				<p>Risk Description</p> <p>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.</p>							
Risk rating	Likelihood	Consequence	Total	<p>GBAF Risk 6</p>				Date reviewed	September 2021		
Initial	4	5	20					<p>Rationale for risk rating (and any change in score):</p> <p>VOC on the rise within Derbyshire requiring significant surge planning amidst workforce shortages and constrained vaccine supply.</p>			
Current	4	5	20								
Risk Appetite	Level	Category	Target Score								
	5	Clinical Quality & Patient Safety	5								
KEY CONTROLS TO MITIGATE RISK						SOURCES OF ASSURANCE					
<p>Internal</p> <ul style="list-style-type: none"> Vaccination Operations Cell (VOC) established and in place to coordinate and oversee the JUCD Covid-19 vaccination programme Fully established VOC rota to manage and deliver the vaccination programme. Dr Steve Lloyd, Medical Director is the SRO for the Vaccination Programme. Senior Leadership, Lead Provider and Workstream leads managing the VOC and vaccination programme. Silver and Gold Command Operation Group JUCD 2021/22 Operational Plan submitted to NHSE 14th May 2021. Linda Syson-Nibbs is Chair of Health Inequalities Group across the System which also reviews hesitancy within groups of patients Vaccination sites across Derby and Derbyshire to deliver vaccination programme Health Protection Board actions for early warning of delta variants and other VOC's. 			<p>External</p> <ul style="list-style-type: none"> System Escalation Cell System Operational Resilience Group System Demand and Capacity Group 			<p>Internal</p> <ul style="list-style-type: none"> VOC email inbox and dedicated phone line Standing Operating Procedure (SOP) for the VOC Fully established Governance cycle of vaccination meeting to support delivery of the programme 2021/22 JUCD Operational Plan VOC Risk register Gold report Health Protection Board Development of the vaccine programme as a strategic delivery board within the ICS structure, signed off by JUCD leadership Weekly Phase 3 planning meeting in addition to care homes cell, flu cel and workforce cell established as part of Phase 3 planning. QEIA in development for Phase 3 DPH and LA engagement in schools 			<p>External</p> <ul style="list-style-type: none"> 2021/22 JUCD Operational Plan Weekly demand and capacity briefing NHSE regular returns for Health and Social Care Worker uptake across health and social care systems Weekly plan submitted to NHSE Weekly stocktakes submitted to NHSE Phase 3 planning return submitted monthly with revisions JUCD representation across all NHSE! Phase 3 planning meetings JUCD representation at national level on children's programme National Maternity Board representation by Dr Steve Lloyd JUCD SAIS representation at C & YP NHSE! meetings Vaccine supply now on capped pull model 		

		programme, working closely with SAIS team	
GAPS IN CONTROL		GAPS IN ASSURANCE	
<u>Internal</u>	<u>External</u>	<u>Internal</u>	<u>External</u>
<ul style="list-style-type: none"> Influence and impact on system planning regarding restoration and recovery and co-delivery of the vaccination programme 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 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 	<ul style="list-style-type: none"> Community Pharmacy contracting National guidance including JCVI and Green Book publications NHSEI financial model for vaccinations does not cover the costs incurred against low vaccine uptake, as an example SAIS 	<ul style="list-style-type: none"> Do not have access to booking information for local booking services 	
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"> Enhanced communications approach looking at new and innovative ways to reduce hesitancy within cohorts of patients not receiving first or second vaccinations. Surge planning being undertaken in areas with variants of concern (VOC) delta variant, in partnership with PH. Call to arms for staffing shortages Reviewing allocation at site level to make best use of Pfizer allocations to under achieving areas Phase 3 planning guidance published. Expressions of interest continue for Community Pharmacies. Reviewing published PCN Enhanced Service guidance for Phase 3, providing JUCD system support to PCNs where required to support continuation of opt-in. Gap analysis undertaken to ensure geographical coverage of vaccination sites. 	<ul style="list-style-type: none"> Ongoing Immediate/ ongoing Ongoing Ongoing Ongoing Ongoing 	<ul style="list-style-type: none"> Escalating to NHSEI regional team regarding vaccine supply and surge planning issues with supply Escalation to NHSEI regional team regarding financial modelling for vaccinations against low vaccine uptake 	<ul style="list-style-type: none"> Weekly and daily as required Weekly and daily as required

<p>Strategic Objective: 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</p>				<p>GBAF RISK 7</p>				<p>Executive Lead: Helen Dillistone Assigned to Committee: Governance Committee</p>																												
<p>What would success look like and how would we measure it?</p> <ul style="list-style-type: none"> The CCG workforce will transition over to the Integrated Care System (ICS). All employees to have effective communication on developments and structures within the ICS. Having robust health and well-being programmes in place to support staff. 				<p>Risk Description</p> <p>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.</p>																																
<p>Risk rating</p>		<p>Likelihood</p>	<p>Consequence</p>	<p>Total</p>	<p style="text-align: center;">GBAF Risk 7</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>6</td></tr> <tr><td>January</td><td>6</td></tr> <tr><td>February</td><td>6</td></tr> <tr><td>March</td><td>6</td></tr> </tbody> </table>				Month	Score	April	8	May	8	June	8	July	6	August	6	September	6	October	6	November	6	December	6	January	6	February	6	March	6	<p>Date reviewed</p> <p style="text-align: right; color: red;">September 2021</p>	
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<p>Initial</p>		<p>2</p>	<p>4</p>	<p>8</p>	<p>Rationale for risk rating (and any change in score):</p> <p>The CCG has strong HR and communications processes, as reflected by the staff survey. Likelihood of this changing during transition is relatively low.</p>																															
<p>Current</p>		<p>2</p>	<p>3</p>	<p>6</p>																																
<p>Risk Appetite</p>		<p>Level</p>	<p>Category</p>	<p>Target Score</p>	<p>Link to Derby and Derbyshire Risk Register The ICS Transition Programme has a Risk Register managed at CCG and system level. Risk is a standing agenda item for the Transition Working Group who report up to the Governing Body each month</p>																															
		<p>Low</p>	<p>Statutory and mandatory compliance and governance</p>	<p>5</p>																																
<p>KEY CONTROLS TO MITIGATE RISK</p>					<p>SOURCES OF ASSURANCE</p>																															
<p>Internal</p> <ul style="list-style-type: none"> JUCD 2021/22 Operational Plan submitted to NHSE 14th May 2021. Transition Assurance Committee (TAC) established and inaugural meeting took place end April and meeting monthly. CCG GB Chair is the Transition Assurance Committee (TAC) Chair and ICS CCG Transition Working Group Chair. CCG ICS Transition Working Group established and meets monthly. First meeting took place 6th May. Governance Committee has oversight of the NHS People Plan and ICS transition. Comprehensive communications and engagement plan which places staff knowledge, information and ability to be involved at the heart of the transition. THRIVE Mental Health Provider providing briefing 			<p>External</p> <ul style="list-style-type: none"> Transition Assurance Committee (TAC) established and inaugural meeting took place end April and meeting monthly ICS Design Framework published 16th June 2021 Health and Care Bill ordered by The House of Commons 6th July 2021. Final HR Framework published August including commitment of employment guarantee. Further ICS/ ICB Guidance published August 2021 John MacDonald appointed as ICB Designate Chair. ICB Chief Executive Officer roles advertised nationally 			<p>Internal</p> <ul style="list-style-type: none"> 'People Matter' HR newsletter emailed to all CCG staff. 2021/22 JUCD Operational Plan ICS/CCG Transition Plan CCG ICS Transition Working Group agenda, papers and minutes CCG Team Talks CCG Staff Bulletins Bespoke communications activity in relation to the transition CCG Turnover and sickness absence statistics Health and Wellbeing information available on the CCG Intranet for all CCG Staff. 			<p>External</p> <ul style="list-style-type: none"> 2021/22 JUCD Operational Plan ICS Transition Plan Transition Assurance Committee (TAC), agenda, papers and minutes 																											

sessions to support CCG staff through the transition to ICB.			
GAPS IN CONTROL		GAPS IN ASSURANCE	
<u>Internal</u>	<u>External</u>	<u>Internal</u>	<u>External</u>
<ul style="list-style-type: none"> Further ICS Guidance to be published 	<ul style="list-style-type: none"> Health and Care Bill still to be passed in Parliament 	<ul style="list-style-type: none"> Communications content limited in detail while awaiting Bill. 	
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"> Communications and Engagement Plan to be finalised Attendance at all national ICS communications briefings to keep track of timescales and emerging guidance. 	<p>October 21</p> <p>Ongoing</p>		

<p>Strategic Objective: 1 Safely and legally transition the statutory functions of the CCG into the ICS, and safely deliver the disestablishment of the CCG</p>				<p>GBAF RISK 8</p>				<p>Executive Lead: Helen Dillistone Assigned to Committee: Governance Committee</p>																																
<p>What would success look like and how would we measure it? 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>Risk Description 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.</p>																																				
<p>Risk rating</p>		<p>Likelihood</p>	<p>Consequence</p>	<p>Total</p>	<p style="text-align: center;">GBAF Risk 8</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>16</td></tr> <tr><td>August</td><td>16</td></tr> <tr><td>September</td><td>16</td></tr> <tr><td>October</td><td>16</td></tr> <tr><td>November</td><td>16</td></tr> <tr><td>December</td><td>16</td></tr> <tr><td>January</td><td>16</td></tr> <tr><td>February</td><td>16</td></tr> <tr><td>March</td><td>16</td></tr> </tbody> </table>				Month	Score	Closing..	20	April	20	May	20	June	20	July	16	August	16	September	16	October	16	November	16	December	16	January	16	February	16	March	16	<p>Date reviewed</p>		<p>September 2021</p>	
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<p>Initial</p>		<p>4</p>	<p>5</p>	<p>20</p>	<p>Rationale for risk rating (and any change in score): The national guidance and HR framework has not yet been released and the White Paper has not yet been through parliament. The guidance is likely to include particular timescales which are not yet known, but it is anticipated at this stage they will be tight with the target for ICS establishment remaining as April 2022. The risk likelihood may reduce when the guidance is received and aligned to the programme plan.</p>																																			
<p>Current</p>		<p>4</p>	<p>4</p>	<p>16</p>	<p>Link to Derby and Derbyshire Risk Register The ICS Transition Programme has a Risk Register managed at CCG and system level. Risk is a standing agenda item for the Transition Working Group who report up to the Governing Body each month.</p>																																			
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<p>KEY CONTROLS TO MITIGATE RISK</p>					<p>SOURCES OF ASSURANCE</p>																																			
<p>Internal</p> <ul style="list-style-type: none"> Chris Clayton CCG CEO is the interim Chief Executive of JUCD JUCD 2021/22 Operational Plan submitted to NHSE 14th May 2021. Transition Assurance Committee (TAC) established and inaugural meeting took place end April and meeting monthly. CCG represented. CCG GB Chair is the Transition Assurance Committee (TAC) Chair and ICS CCG Transition Working Group Chair. CCG ICS Transition Working Group established and meets monthly. First meeting took place 6th May. 			<p>External</p> <ul style="list-style-type: none"> Transition Assurance Committee (TAC) established and inaugural meeting took place end April and meeting monthly. JUCD / ICS Governance Structure in Place JUCD Senior Leadership Team ICS Engine Room Team comprising of System Leaders JUCD Board meeting in public System Quality and Performance Committee in place System Finance and Estates Committee in place People and Culture Committee in place White Paper consultation published in November 2020 		<p>Internal</p> <ul style="list-style-type: none"> 2021/22 JUCD Operational Plan ICS Transition Plan Transition Assurance Committee (TAC), agenda, papers and minutes CCG ICS Transition Working Group agenda, papers and minutes. Governing Body public and confidential minutes Governing Body ICS Development session notes ICS Programme Group minutes and meeting papers ICS Risk Register 			<p>External</p> <ul style="list-style-type: none"> 2021/22 JUCD Operational Plan ICS Transition Plan Transition Assurance Committee (TAC), agenda, papers and minutes JUCD Senior Leadership Team minutes Minutes of System Quality Committee Minutes of System Finance & Estates Committee Minutes of System People and Culture Committee 																																

<ul style="list-style-type: none"> ICS Project Group established to manage the operational ICS Transition Plan. Helen Dillistone, Executive Director of Corporate Strategy and Development is the CCG SRO for the ICS Transition. Governing Body supports the transition to ICS Governing Body ICS Development Sessions Executive Team Senior Leadership Team Programme Management Office support for management ICS Transition Plan Derbyshire Engagement Committee in place 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). Joint Derby Derbyshire CCG and Tameside and Glossop CCG Transition Steering Group established to lead four main workstreams. 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. 	<ul style="list-style-type: none"> ICS Design Framework published 16th June 2021 Health and Care Bill ordered by The House of Commons 6th July 2021 Final HR Framework published August Further ICS/ ICB Guidance published August 2021 John MacDonald appointed as ICB Designate Chair. ICB Chief Executive Officer roles advertised nationally ICB Model Constitution published August 2021 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 	<ul style="list-style-type: none"> Mapping of CCG Functions PMO system to support ICS Transition Derbyshire Engagement Committee Minutes 	
GAPS IN CONTROL		GAPS IN ASSURANCE	
<u>Internal</u>	<u>External</u>	<u>Internal</u>	<u>External</u>
<ul style="list-style-type: none"> Potential planning gaps due to delays in passing the bill through Parliament and publication of guidance materials. Further ICS Guidance to be published 	<ul style="list-style-type: none"> Health and Care Bill still to be passed in Parliament 		
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"> Project Team will review guidance and HR framework to assess risks to delivery and ensure alignment to programme plan. 	<ul style="list-style-type: none"> Monthly, ongoing 		

Joined Up Care Derbyshire Board
Minutes of the Meeting held in PUBLIC on
Thursday 15 July 2021 (0900-1150 hours)
Via Microsoft Teams

CONFIRMED

Present:		Designation:	Organisation:	
Lee Outhwaite	LO	JUCD Finance Lead & Director of Finance	Chesterfield Royal Hospital NHSFT	
Helen Phillips	HP	Chair	Chesterfield Royal Hospital NHSFT	
Angie Smithson	ASm	Chief Executive	Chesterfield Royal Hospital NHSFT	
Avi Bhatia	AB	GP & Clinical Chair	Derby & Derbyshire CCG	
Chris Clayton	CC	Chief Executive & ICS Executive Lead	Derby & Derbyshire CCG	
Brigid Stacey	BS	Chief Nurse	Derby & Derbyshire CCG	
Sean Thornton	ST	Assistant Director Communications & Engagement	Derby & Derbyshire CCG JUCD	
Martin Whittle	MW	Chair of the System Engagement Committee	Derby & Derbyshire CCG	
Kath Markus	KM	Chief Executive	Derby & Derbyshire LMC	
Robyn Dewis	RD	Director of Public Health	Derby City Council	
Andy Smith	AS	Strategic Director of People Services	Derby City Council	
Roy Webb	RW	Councillor	Derby City Council	
Carol Hart	CH	Councillor & Cabinet Member for Health & Communities	Derbyshire County Council	
Helen Jones (part attendance)	HJ	Executive Director of Adult Social Care & Health	Derbyshire County Council	
Paddy Kinsella	PK	Exec of GP Alliance	Derbyshire GP Alliance	
Tracy Allen (late joining)	TA	Chief Executive	Derbyshire Community Health Services NHSFT	
Prem Singh	PS	Chair	Derbyshire Community Health Services NHSFT	
Ifti Majid	IM	Chief Executive	Derbyshire Healthcare NHSFT	
Caroline Maley	CM	Chair	Derbyshire Healthcare NHSFT	
Stephen Bateman	SB	Chief Executive	DHU Health Care	
Phil Cox	PC	Non-Executive Director	DHU Health Care	
Pauline Tagg	PT	Chair	EMAS NHSFT	
John MacDonald (Chair)	JM	ICS Chair	Joined Up Care Derbyshire	
Vikki Ashton Taylor	VT	ICS Director	Joined Up Care Derbyshire	
Gavin Boyle	GB	Chief Executive	University Hospitals Derby & Burton NHSFT	
Kathy Mclean	KMc	Chair	University Hospitals Derby & Burton NHSFT	
In Attendance:		Designation:	Organisation:	Deputy on behalf of/Item No:
Helen Dillistone	HD	Executive Director of Corporate Strategy and Delivery	Derby & Derbyshire CCG	CCG Exec Lead Rep
Zara Jones	ZJ	JUCD Planning Lead & Exec Director of Commissioning Operations	Derby & Derbyshire CCG	
Ellie Houlston	EH	Assistant Director Adult Social Care & Health (ASCH) Public Health	Derbyshire County Council	Deputy for Dean Wallace
Jim Austin	JA	Chief Information Officer & Transformation Officer & JUCD Digital Senior Responsible Officer	Derbyshire Community Health Services NHSFT	Item 10
Anna Bartram	ABa	Occupational Therapist	Early Supported Stroke Discharge Team DCHS	Patient Story
Michelle Bateman	MB	Chief Nurse	Derbyshire Community Health Services NHSFT	Patient Story

Sandra Hicken	SH	Quality Conversations Programme Lead	Derbyshire Community Health Services NHSFT	Patient Story
Natalie Spibey	NS	Stroke Nurse/Early Supported Discharge Nurse	Early Supported Stroke Discharge Team DCHS	Patient Story
Andrew Wall	AW	Technical Implementation Manager, Derbyshire ICS Digital Programme	Derbyshire Community Health Services NHSFT	Item 10
Harriet Brown	HB	Social Prescribing Development Worker	Derbyshire Dales CVS	Patient Story
Jackie Counsell	JC	ICS Executive Assistant	Joined Up Care Derbyshire	Note taking
Linda Garnett	LG	ICS Workforce & OD Lead	Joined Up Care Derbyshire	
Sarah Draper	SD	Assistant Director of Strategic Transformation, NHSE/I, North Midlands	NHS E/I – Midlands	Deputy for Fran Steele
Gino Distefano	GD	Director of Strategy	University Hospitals Derby & Burton NHSFT	
Members of the Public in Attendance:				
Lyndsey Bryant Marc Goddard Ian Mullan				
Apologies:		Designation:		Organisation:
Penny Blackwell	PB	Place Board Chair & Governing Body GP	Derby & Derbyshire CCG	
Dean Wallace	DW	Director of Public Health	Derbyshire County Council	
Riten Ruparelia	RR	GP Alliance Provider Representative	Derbyshire GP Alliance	
William Legge	WL	Director of Strategy & Transformation	EMAS NHSFT	
Rachel Gallyot	RG	Clinical Chair	East Staffordshire CCG	
Sukhi Mahil	SKM	ICS Assistant Director	Joined Up Care Derbyshire	
Fran Steele	FS	Director of Strategic Transformation, North Midlands	NHS E/I – Midlands	

150721/1	Welcome, Apologies and Minutes of Previous Meeting	Action
	<p><i>As per the Agenda, members were reminded that the meeting was being recorded purely for the purpose of minute accuracy.</i></p> <p>The Chair welcomed Board members to the meeting and apologies for absence were noted as reflected above; the meeting was confirmed as being quorate.</p> <p>The minutes of the last meeting held in public on 20th May 2021 and the extraordinary meeting on 27th May 2021 were noted to be an accurate record. Today's meeting was confirmed as being held in public.</p>	
150721/2	Action Log	
	VT advised that the one live action on the action log relating to work around the system financial framework was due to come back to the September Board.	
150721/3	Declarations of Interest	
	The Chair asked for any changes to the Declarations of Interest to be identified in the meeting. The purpose was to record any conflicts of interest and note any other conflicts in relation to the meeting agenda. No changes were noted.	
150721/4	Patient Story – What does a Quality Conversation feel like to our patients and clients? (MB, SH, HB, ABa, NS)	
	The Chair welcomed MB, SH and colleagues to the meeting. MB advised she was the senior responsible officer for the personalisation agenda across the system for Derby/Derbyshire. The personalisation agenda speaks to how we need to progress our conversations to engage our people in self-care and looking after themselves. Quality conversations (QC) is fundamental to help get people on side and encourage them in owning their healthcare to have a positive outcome. The team would go through their presentation (circulated in	

advance) outlining a couple of case studies to highlight the impact QC can have both for the practitioner/patients.

SH, programme lead advised how we listen and engage has an impact and gave a brief introduction to the Quality Conversation (QC) programme, which involved teaching enhanced listening/conversation skills to develop a health coaching approach, which considers the health inequalities of our citizens as well as being very strength focussed. It helps citizens see things from a new perspective/supports them to use their own resources to navigate themselves to self-identified health and wellbeing goals and evidence shows that in working in coproduction together towards shared goals improves engagement/outcomes. A whole system approach had been created with staff training from multiple organisations/roles, which facilitated shared learning, understanding of each other's roles, creates new networks and the techniques could be used in both work and personal life settings. The training/programme is not a one-off course there are several resources/support and over 50 peer coaches who champion the model/peer support developed to meet the needs of our busy staff in a flexible way. Support is given to teams to embed QC within their processes which gives an opportunity for real time reflection. The training covers staff across all health, social care and voluntary sectors in Derbyshire.

HB who was a Social Prescribing Development Worker, talked through 'Simon's story' and described how QC learning was used in terms of the GROW coaching method (a conversation framework to help an individual identify their goals, looking at what's happening in their life, what the options/barriers to meeting their goals in order to help identify a way forward). Other techniques used were asking open questions and checking unconscious bias, from which they were able to identify the main factor causing his anxiety. By asking him what he thought would help/what was important to him to tackle first, gave him control of the conversation and avoided overload, which he found a helpful/positive approach. It steers away from giving advice or going into the conversation with any preconceived ideas and was centred around his thoughts/feelings. Once the help had been received for the main cause of his anxiety, he then started engaging with the health support initially offered through his GP and was engaging with his local community (church/nature project) and had specialist support to set up his own small business.

ABa/NS were both representatives of Amber Valley & Erewash Early Supported Stroke Discharge Team and were part of a close-knit MDT providing a 6-week service to stroke patients. As a team they had been using QC for over 2 years/had all completed the training and found it had a really positive impact both on patients and the team. ABa/NS went through 'Dave's story' who was a young stroke survivor that had experienced two strokes. Active listening had been used to understand how he was feeling/what he wanted to achieve in the 6 weeks of therapy, using the Grow model and QC made him the centre of the problem solving/goal setting. QC helped him recognise the small improvements he was making which helped him strive further. Active listening skills and the GROW model was used to help him to identify long-term/achievable goals for the future, including investigating driving and supporting his daughter to learn golf.

To date nearly 600 staff members had been trained and if they incorporated QC techniques into 4 conversations each day over a 5-day week meant it could be helping over 10k people. Staff report they continue to use the techniques two months after training; are better able to engage with their patients/service users and can demonstrate the approach has improved patient outcomes, although covid has made it more difficult to measure. In terms of future direction there was a need to review how we can meet the needs of Derbyshire better; look if this approach resonates and fits with the service needed across Derbyshire; and if so, look at ways to grow it to reach/support even more individuals.

The following key summary discussion points were highlighted:

	<ul style="list-style-type: none"> • Informative presentation showing how working with people on what really matters to them using the application of a social model to practice, not purely a medical model. It had been found in social care that person centre approaches improved patient experience/outcomes and can in turn reduce the cost to the system as it can be preventative in nature. Valuable and chimes with the JUCD strategy/fully supportive, plus it had positive benefits for the workforce too (HJ). • Good reflective approach to Simon's story and consideration of unconscious bias (AS) • Really inspiring presentation, but what happens to those people being supported after they leave the health arena, are they passed on to the LA to continue to build resilience to prevent a revolving pattern back into the health service again (RW). • HB advised that working as a social prescriber they looked at root causes of issues and explored solutions which helped to prevent the revolving pattern back into the NHS. • Thanks were given to colleagues from DCHS/others for sharing the stories. It was suggested to adopt the GROW model as a concept of how culturally we do business in JUCD. In a clinical setting the whole idea is to increase efficacy/focus of patients to promote their own independence and self-care rather than to increase their dependence on health care services (PS). • Support to adopt this GROW model as an approach into our design principle (how we develop our services); organisational development work around our workforce; and governance/sub-committees, as it was more likely to lead to success (GB). • Great initiative. Support to adopt as a baseline for all we do. Need to review how we can garner more feedback to advertise/socialise it more widely across the system (MW). • ST would liaise with SH/team regarding holding Derbyshire Dialogue session to help socialise it further. • It was a hugely beneficial initiative and primary care should be included in training (PK). • It should be linked in with GP training/Medical Schools to embed within training (KM). • LG noted that we are in conversation with some of our feeder universities about this possibility. SH had made links with SHU and who are considering incorporating it into their undergrad and post grad Health and social care programmes. • The People and Culture workstream have supported/championed this approach from the beginning and are committed to making it part of our essential training. This Board's support is really helpful to have, and it would be great if you could reflect that back into your organisations (LG) • Really powerful stories. It was noted there had also been good conversations in Planned Care Board about how such conversations can support patients waiting longer than we want on NHS waiting lists/implications of that being much wider for individuals than on the health condition they are on the list for (ASm). • TA advised she had done the programme and can attest to it being energising, and incredibly useful for being in a leadership role. • MB noted that they had been approached by other areas looking at QC regarding our approach and thanked the Board for the opportunity to profile the programme. <p>The Chair thanked MB and colleagues on behalf of the Board for sharing their inspiring work, recognising there was a real desire to socialise this and roll it out further without making it too bureaucratic. ACTION: He suggested MB and the team have discussions outside the meeting with GB/PS to look at ways to encourage and adopt the approach more widely across services and to link into the service side as well as the staff side.</p>	<p>MB, GB, PS</p>
<p>150721/5</p>	<p>Chair and ICS Executive Lead Update (JM, CC)</p>	
	<p>The Chair noted the following in addition to the content in the Chair and Executive Lead Report (previously circulated):</p> <ul style="list-style-type: none"> • The ICS bill passed its second reading yesterday, it was noted that the legislation will now accelerate the pace of developments and there will be a huge amount of work to do over the next 3-4 months. A plethora of guidance was expected. • Advertisements for 3 ICS Chairs in the region were due to be advertised. This would be followed by advertisement/recruitment into executive lead positions. 	

	<p>CC highlighted the following salient points from Chair and Executive Lead Report:</p> <ul style="list-style-type: none"> • We are now experiencing the 3rd or 4th wave of covid, depending upon which part of the country we are looking at. Systems were under pressure from both covid and non covid disease, which needs constant monitoring/review/support. Covid incidence was increasing in communities and resulting in increased hospital admissions. Significant strides had been taken in JUCD and over 88% of adults had received their first dose vaccination and significant progress being made with second dose vaccinations. The push also continues to vaccinate the under 30s. CC asked Board members to use their networks to encourage/promote the vaccination programme. Overall JUCD continues to perform well. • Individual patient level conversations placed significant challenges in terms of planned care on the NHS side. The ambulance service is also under considerable pressure, which was a national challenge, with unprecedented activity levels. Regional conversations have been held with all systems regarding what we can do to support the position. <p>The JUCD Board NOTED the report.</p>	
150721/6	System Leadership Team Report (AS)	
	<p>AS advised the report gave a brief summary of the System Leadership Team (SLT) meeting held on 11th June 2021, where a number of items were discussed: the diagnostic work carried out by KPMG/relative benefits of taking that forward. Specifically, the outputs of the diagnostic work would inform our focus around future system development and support the development work underway within Place Partnerships and Provider Collaboratives at Scale.</p> <p>In addition, SLT received the JUCD ICS System Development Plan ahead of submission to NHSEI and the detailed mental health capital development bid to eradicate all dormitory-style inpatient accommodation for adult acute mental health, both of which have subsequently been received by the Board.</p> <p>The transformation programme as part of the Integrated Pharmacy and Medicines Optimisation (IPMO) Programme was supported prior to submission to NHS England/Improvement.</p> <p>The JUCD Board NOTED the report.</p>	
150721/7	JUCD ICS System Development: Transition Assurance Subcommittee Report (AB)	
	<p>AB updated the Board that the Transition Assurance Committee (TAC) continued to meet, there had been a couple of changes to membership as people moved organisations, however membership remained robust and varied across organisations. Discussions had focussed on reviewing progress against delivery milestones; the risk register and the system transition plan and crucially to stratify some of the CCG functions to see where they may sit going forward. An Executive Engine Room had been established to give assurance that nothing slipped between the cracks. Work had also been undertaken on what 'Good' looks like in terms of an ICS, noting the assurance committee were not there to design an ICS but were there to give assurance on an ICS. He noted that there is more national guidance due out and was fully cognisant that things may escalate at pace. TAC had looked at emerging guidance and the risk register was akin to a personal development plan for the ICS, which needed to be SMART and aspects of the GROW model could be applied, looking at how we measure and take ownership/accountability of those risks.</p> <p>VT/HD went through the presentation (previously circulated). In terms of key activities set out in the transition plan, it was noted that a number to be undertaken in quarter 1 had been completed, some actions were still in progress/ongoing for example those awaiting national guidance or decision i.e., confirmation of ICS boundaries and constituent organisations. In terms of the engagement programme including ensuring the public are aware of the changes, how the changes will benefit people/patients and how they can engage and influence, the recent Derbyshire dialogue session commenced this process and therefore the</p>	

outstanding action listed can be marked as completed. In terms of quarter 2, and further to the design framework publication and the 2nd reading of bill, the pace is likely to ramp up in terms of activities and guidance published. We need to ensure those staff affected by change are well supported/consulted with appropriately, which aligns well with our key commitment to support our people within JUCD.

The MOU covering oversight arrangements between NHSEI and ICS was due to be completed/signed off in June but had now been extended to the end of July. CC/VT had a meeting this afternoon with NHSEI to further progress discussions around this. The Executive Engine Room work was underway and they were in the process of trying to work through the alignment/overlap of the building blocks of the ICS, in terms of Place partnerships, Collaboration at Scale, Strategic Intent so we can better inform where the decision making will sit within the different tiers across the system. A key area of focus is on identifying where the statutory responsibilities of the CCG sit currently and where those need to transition in the future.

HD noted that extensive mapping had been undertaken of current health and care commissioning responsibilities and where they currently sit (i.e., NHSEI, CCG, LA) to be clear what the current statutory responsibilities/functions are i.e., Planning, agreeing and monitoring services; Financial; Governance; Cooperation, legal/general. HD advised that the slides shared highlighted the duties and powers within these areas. She added that we know functions will move into the ICS and part of the work is ensuring safe/legal transfer, it was not a simple lift and shift and there was a need to ensure functions/associated activities are described in different components of the ICS.

The following key summary discussion points were highlighted:

- We need to share information/consider how we learn from other systems and not reinvent the wheel. At an ICS Chairs meeting yesterday we were asked to share information/ findings and have peer reviews i.e., Coventry/Warwick appear well based systems (JM).
- Thanks were placed on record for the ongoing work. The sheer enormity of what must happen, i.e., transfer of functions, people, statutory responsibilities, etc we are not in competition with other ICSs, so must support learning/sharing of information with others. It was noted that it is hard to keep focus on how we do behaviours/relationships at the same time. We need to support the system to deliver on big ticket things, i.e., recovery/pushing forward on inequality aims. A very good paper on leadership behaviours for systems had been shared at the workshop with system/NHSEI, which may be worth sharing more widely (KMc). **ACTION:** Link to leadership behaviours paper to be circulated with minutes.
- It was noted that several Chairs were worried the relationship side was being squeezed out by formal governance/process. We need to focus on the very high level, what's the critical path/what needs to be done by April and thereafter (JM).
- VT advised that we are already partnering with Coventry/Warwickshire and sharing key documentation and exploring an appropriate timeline for a more formal peer review opportunity. To aid shared learning from broader partners, NHSEI have also put in place a supportive programme with a number of workstreams (i.e., Place, PC at Scale, statutory commissioning, comms and engagement etc) with representation across the 11 ICS in the Midlands systems for which JUCD has representatives on all groups across system. VT also met regularly with colleagues from across the Midlands region to share progress, learning and documentation on ICS development.
- Some of the other groups members were involved in, were noted: Midlands Place development forum; NHSE/NHS Confederation forums for system comms and engagement leads; National Group re Quality in ICS (as such all our Quality systems reflect the national ask as well as our local need); Several National Workforce forums (contributing to HR Guidance/framework) and Workforce Directors from Coventry/Warwick.

JC

- AB reiterated the TAC was not there to design the ICS and we may need to consider how much TAC should be driving the process. It was all iterative and we needed to work together.
- It would be useful for the Board to see a high-level critical path linked to major strategic risk and critical milestones.
- VT confirmed that the individuals nominated to join the NHSEI development groups are also the representatives on the key building block development groups so intelligence/ learning is being fed back to develop within those groups, to ensure a focussed approach to learn/share in system.
- AB thanked Board for the useful steer. As more guidance emerges there will be a huge amount of work to do, which is very complex, involving different organisations and difficult conversations will need to take place to get the balance right with governance.

The JUCD Board **NOTED** the assurance report, progress being made and the current CCG statutory functions.

150721/8 Developing ICS Operating Model: ICS Health & Care Partnership (CC)

CC went through the presentation (previously circulated) and advised the team would cover in 3 sections:

Section 1 – Strategic Intent

CC gave thanks to ZJ, RD and Steve Lloyd for their work on this. He highlighted that the operating model is a public health and care model. He recapped on discussions from the May/June Board meetings which set out the definition/purpose of Strategic Intent; the difference between Strategic Intent/Strategic Commissioning; the establishment of a Joint Commissioning Group between NHSEI/LA and noted the formal ask to Board to create a formal sub-committee for Strategic Intent and to stand up a formal shadow Strategic Intent Board from September 2021. He added that Strategic Intent will help to keep us grounded to get to our final destination and covered the 4 key functional areas: Strategic Commissioning; Health Protection; Population Health & Clinical Strategy; and Clinical Standards, Improvement & Innovation and Learning & Development. He noted that they had reviewed and consolidated the key functional areas from 8 to 4 where there was no longer a fit, however there are a couple of specific areas to test moving elsewhere in the ICS, i.e., Safeguarding and Comms & Engagement.

ZJ went through the slide covering Strategic Commissioning covering the scope/function and the interface between the 3 paths of commissioning coming together (NHS, LA, NHSEI). A joint commissioning working group had recently been established to work in parallel/scope out the core activity. She advised that through the pandemic the system had a planning co-ordination group, which had now branched out to support what Strategic Planning will look like at ICS level/what different types of planning will happen at the different levels at an operational/tactical level. It was noted that a group to support this part of the delivery would be needed to closely interact with the commissioning described. Monitoring of delivery (contractual process/functions), would have a monitoring delivery arm. Plus, an assurance function/escalation to ICS Strategic Intent Committee and making recommendations. There would be embedded support functions, e.g., covering finance/contracting – to look at how it works and where it is best placed in the ICS.

RD went through the Health Protection and Population Health & Clinical Strategy slides, covering the scope/function and key considerations/questions. She noted the Board fulfils the assurance function for LA and DsPH and raises visibility of Health Protection issues, which are so important in the system we don't want to put commissioning functions here, to ensure we maintain a scrutiny role. The Health Protection Strategy includes the need to assess and prevent health inequalities in clinical strategy. There are various strands we need to pull together and ensure we produce jointly across system. A key issue was much learning to be done, without the capacity in system to develop this.

In terms of Clinical Standards, Improvement & Innovation and Learning & Development - CC advised on scope and both old/new function. The draft operating model slide sets out the complex nature of Strategic Intent, which needs to support Place, Collaboratives at Scale, Anchor, NHS body and Integrated Care Partnership (ICP) and needs to be a robust vehicle. The ICS Strategic Intent Committee (ISIC) ToR membership would be supported through exec subgroups and the ISIC will need to make recommendations to the new Board in the autumn.

RD took the Board through a Test Case to consider Obesity, where they had looked at areas of work and where this responsibility may sit including looking at the wider determinants of health (i.e., Strategic Intent, Partnership Board/NHS Board, H&WB, People & Culture, Anchor Institution, Joint Commissioning Group, Long-Term Conditions, Place, Children and Young People (MH delivery Board)).

In terms of next steps – the Board was asked for agreement to the following:

- Subject to feedback on the work brought back in July and support of the JUCD Board, create a formal sub-committee for Strategic Intent; formally standing up the first meeting of a shadow ICS Strategic Intent Committee in September 2021.
- The first meeting of the ISIC (ICS Strategic Intent Committee) in September would set out to agree its ToR.

The following key summary discussion points were highlighted:

- The Obesity test case was a good example to illustrate what the ICS should be doing. However, questioned the need to set up yet another committee to do this and the role of the ICP which should be doing this kind of work anyway. Given the huge pressures on services, Execs and staff which are not going to go away anytime soon, there was concern about capacity to service all these committees, which was shared by other Board members. Might be creating something that's going to be akin to an ICP (PS).
- Agreement with PS' point above - aversion to lots of committees/groups. Can it be done in another way. As a Board we must trust people to go and do the work and bring back to us the high-level things and unless we trust people there was a danger of getting bogged down. It would be better to spend more time working on relationships and what matters to people (KMc).
- We need a stock take to ensure we are not going too 'governance heavy' (GB).
- The strategic intent function is critical and really helpfully elaborated. Agree the key leads for the function should progress, and report through Partnership for challenge, agreement and assurance. Not every important function needs a committee (TA)
- It's important to be reminded that we are good at managing statutory change, but the ICS provides an opportunity for much more than another re-organisation. It's the chance to reset relationships, mindsets/behaviours. We must create time/opportunity to do this work alongside managing the 'technical' business (TA).
- Creating the ICS and associated structures has to be an OD supported transformation rather than simply a reallocation of colleagues into a new model. Concern that if we don't set the tone and opportunity for different working up front, we will have same ways of working in a different structure (IM)
- We need to engage all staff in the new ways of working and culture of the ICS (BS)
- The obesity example is very helpful to bring to life the who does what around here in terms of the ICS and how the newer structures will enable and facilitate change; the "what" is good, the "where" is good too, the "how, precisely" is maybe where we continue to struggle a bit more (LO)
- CC confirmed that he would be guided by the Board in terms of if a Committee was required to do this. He considered there were pros/cons to both. This could be tested using the Executive function from September who can update the Board and keep it under review.

The Chair summarised JUCD Board **SUPPORT** for the Strategic Intent function. However, mindful we haven't got the ICP Board established yet and discussions at HWB will need to

significantly change over a period of time, so we do need to bring functions together. There was a strong preference to recognise as a function rather than establish another Committee, clarification around what level we mean by Strategic Intent. In addition, Strategic Intent includes allocation and clearly there are vested interests of different parties.

Section 2 – ICS Operating Model - Board Governance

CC highlighted the emergent changes to the Operating Model:

- Support inclusion of Performance within the Quality and Performance Committee
- Support oversight of safeguarding duties - to transfer to Quality and Performance Committee
- Support development of a Public Participation committee in the 'partnership space' of the operating model (to transfer from Strategic Intent)

Following the second reading of the Health and Care Bill yesterday. CC confirmed the 3 statutory bodies: Integrated Care Board (ICB); Integrated Care Partnership (ICP); and HWBBs. The ICB will create a 5-year plan in consultation with the HWBB;

The Board was asked to:

- Support the proposed changes to the operating model
- Acknowledge the proposed changes in legislation
- Reflect against the development to date for JUCD
- Consider the new guiding principles
- Consider the functional form suggestion for the ICP
- Review alongside additional national guidance through July & August

The Chair advised due to time constraints and an attempt to get the agenda/timings back on track, that Board members would have the opportunity over the next 2/3 weeks outside the meeting to have input and discuss this further. One opportunity was with himself at the Chairs meeting on 29th July and members could also contact CC directly. Therefore, he asked for comments with that opportunity in mind.

The following key summary discussion points were highlighted:

- Really supportive of bringing together Q&P, however, the mechanics will need to be worked through as currently the individual delivery boards have responsibility for overseeing performance within their respective areas. Also, SODB where delivery boards seek support/intervention from other parts of the system to enable delivery (VT).
- KMc noted the distinction that Q&P committee was about assurance. She pointed out that there was only 1 Board which is the NHS ICB, the ICP is not a Board, so this needed correcting in CC's slides. She added that the diagram on slide 24 looked hierarchical and we needed to ensure we were working in partnership and all voices are appropriately represented, concentrating on what is critical before April 2022.
- IM also advised that the sense of hierarchy on the diagram concerned him too. There was much information to take in and although we talk about avoiding duplication/doing things once, there is a worry that the ICP and HWBBs could potentially be a massive amount of duplication with the same people sitting in each group having similar conversations. In terms of the starter for 10 slide, are we meeting governance structure or development, or will it be representatives from delivery arms e.g. are we thinking representatives from PC at Scale or the leads actually doing the work who should attend, as with Place and Anchor. Is it new structures being represented?
- CC confirmed that there was no intention for the diagram to appear hierarchical, it was purely to try and show who was involved. He agreed there was only 1 Board (NHS ICB) and the slides would be corrected accordingly. He agreed to pick up further discussions around the ICP outside the meeting with IM.
- TA thanked CC for the helpful 'starters for 10', which she would appreciate more time to reflect on these approaches/proposals, understand different perspectives etc.

	<ul style="list-style-type: none"> MW advised that he was happy with Partnership "home" for Comms and Engagement. We needed to think through the assurance piece and how we preserve the clear blue water between the doing and the assurance to the NHS ICB if that retains a statutory role for engagement as we have now with the CCG. <p>The Chair summarised some good points had been made as a starter for the discussion and the Chairs and clinical leads would be engaged further over the next 2/3 weeks. ACTION: CC to bring back to the Board, a refined proposal around the ICS Operating Model - Board Governance, mindful of duplication and to consider what other systems are doing.</p> <p>Section 3 – Thoughts on the HWBB CC had been working with CH/RW on this, but due to overrunning/time constraints it was agreed this would come back to a future meeting.</p>	CC
150721/9	Anchor Institution (IM, AS)	
	<p>IM advised Anchor was an exciting piece of work led jointly by IM/AS working beyond traditional health and care boundaries. Good progress had been made and great engagement on 2 pieces of work thus far. At the last meeting on Monday as a partnership the final version of the Anchor Charter had been agreed with minor changes to the version included in the meeting papers (ACTION: <i>the final version to be circulated post meeting</i>). It was a recognition that our responsibilities as anchor organisations was to community wealth build while supporting/sustaining a vibrant economy and acted as a reminder of our role/duty. Also, it was the opportunity to focus/amplify the work we are already doing (and not stifling that). We are looking to embed these ways of working across all organisations, it was not piece of governance, but looked at ways we operate together honing/sharing best practice. An agreed focus was on access to work plus exploring the concept around procurement. The JUCD Board is now asked to take the final version of the Anchor Charter through their respective organisations to sign up to the ethos/promote/embed within each organisation.</p> <p>AS reported on the feedback and actions from the various survey responses. Each of the 9 Anchor organisations carried out a survey on employability and at the meeting on Monday it had been agreed to identify 2/3 areas to focus on, one was recruitment/employability space and looking at how anchor can focus on strategic ambition collectively. The first area recruitment would build on the good work already happening in the City/County councils and private sector companies, around identifying entry level jobs across the Anchor Estate and developing recruitment pipelines to try and source potential candidates from our communities for these roles. Channels across the Anchor organisations would be used to promote these entry level jobs and there was also potential funded training opportunities through working with our adult learning services across City/County. There was a need to ensure we are working with DWP although they are not currently part of the Anchor group, there was a role for DWP regarding access to the communities, so we needed to build on this and roll out across the wider system.</p> <p>The other agreed area of focus on was on the health and well-being space, which had the highest score on self-evaluation, but it was recognised that we can do more to promote health and well-being benefits across institutions and share in a more broader strategic sense. There was already a health and wellbeing collaborative which LG had been providing leadership to, largely JUCD organisations with input from LA, but this would be broadened to all anchor organisations to ensure consistent attendance at the right level and will mandate that group to extend the membership. For example, we could think of the Obesity example (used today) and discuss at Anchor focussing on the social value in procurement. Engagement was really powerful and to have Derby Community Trust, Rolls Royce and University of Derby as well as the more traditional anchors was really positive, and it will be interesting to see the impact from the priorities identified.</p> <p>The following key summary discussion points were highlighted:</p>	JC

	<ul style="list-style-type: none"> • IM noted that some of the work Rolls Royce are doing in the health and wellbeing space give opportunities for us to capitalise on. • Important/interesting and invigorating work. Happy that it is not set up as formal governance, but the Board needs to understand how the NHS is on board/participating/committing to priorities for all organisations (JM) • Really great work of the kind we should be doing in the integrated space. I'd commit as Chair of UHDB to take to Trust Board and ensure its known/understood in my organisation. We could make the biggest impact through this initiative. Hugely supportive and suggested a pledge to say leaders will take it through their organisations, ensuring its real and live (KMc). • PS concurred that he too was happy to do that. He suggested we forward plan a celebration event across the system in 6-8 months where stories/learning/achievements could be shared/celebrated. • It was noted that representatives from the LEP were at the Anchor Group when they considered the outcome of the skills audit so we could more fully understand what is going on in the system. The Vice-Chancellor of the University of Derby has also agreed to lead some further work on skills which will bring in the LEP further (AS) • A suggestion on how best to link into the 112 GP practices, could be through LMC (PK) • We have other mechanisms for holding organisations to account and we should do it through those mechanisms rather than setting up a structure to do it separately (TA) • CC advised there isn't a natural "home" for this in the H&WB space so would advise JUCD "holding" just for a bit longer whilst we establish bigger discussions with LA partners. • Some of the thinking around this compared to other systems is more ambitious which is really good, as it involves a wide range of people not just NHS/LA (JM) <p>The Chair summarised the actions below:</p> <p>ACTION: The final agreed Anchor Charter to be taken to individual organisational Boards to gain real commitment and ensure each organisation understands how they will link in and be an active participant.</p> <p>ACTION: IM/AS to plan a celebration event in 6-8 months' time to showcase stories/learning and achievements made in the Anchor Institution.</p>	<p><i>Chairs</i></p> <p><i>IM/AS</i></p>
150721/10	Data & Digital Strategy (TA, JA, AW)	
	<p>TA welcomed JA (SRO) and AW (from the ICS Digital team) to the meeting. She noted that the Board will be aware through the Digital and Data Board we had been developing the strategy over the last 4-5 months, about how we develop our capability capacity, the functions around digital transformation, technology/data, so that we can use information/technology to deliver better quality outcomes. The draft strategy has had extensive engagement from all partners to meet national requirements most importantly to support ICS ambitions/workstreams. The final strategy needs to be agreed by the Autumn, so work will continue over summer and the final strategy will be approved as part of the Development Plan.</p> <p>JA went through the presentation (previously circulated); highlighting the Context; Digital and Technical priorities; Data & Intelligence priorities; Governance; Impacts; Plan on a Page and Stakeholder engagement.</p> <p>The following key summary discussion points were highlighted:</p> <ul style="list-style-type: none"> • Really good and impressive work (JM) • DCHS Board had NHS providers attend to do session on what it means to be digitally tuned in and a digitally capable board. The session was highly recommended if of interest to others (PS) • JA advised that NHS providers were looking to do system level sessions with all boards. • Happy to support PH leadership of the population health management and knowledge development programme. DW is happy to stay as SRO. We need to collectively think about effective resourcing of PHM development, if we are serious about prioritising. (HJ). 	

- RD advised she was very happy to continue to support DW in the SRO role, noting capacity will hold us back if not tackled as a priority.
- The need to create some dedicated 'strategic intelligence' leadership/transformation capacity - under the leadership of DW (as SRO) is vital to take the data/intelligence work forward (TA)
- Strategic application of intelligence, innovation & transformation is a key building block of the ICS operating model, we do need to get behind this fully (CC)
- Joint Chief digital officer recruitment at CRH and UHDB would be a good example of collaboration on recruitment (HP)
- CC noted that any further recruitment for the ICS needed to be linked to the transition work that VT/HD were overseeing.
- Recognition that one of the important benefits is that it helps clinicians to take timely/better decisions with having more information available, so suggest strengthening the strategy with this point (JM).
- JA advised that Maria Riley, Transformation Director for the ICS PMO will sit as part of the Digital and Data Board and will work closely with LG/GB around workforce, digital upskilling and behaviours. The strategy will be strengthened to reflect both points.
- JM advised that the Board needs to focus on the outcomes and timelines and ensure we are seeing benefits coming through the system.
- TA placed on record thanks to all our CIOs, CCIOs and many other colleagues who really are working well together on this.

The JUCD Board was asked to:

- **Receive and approve the Digital and Data Strategy - draft strategy progressing to final state – September 2021**

The JUCD Board **APPROVED** the Digital and Data draft strategy progressing to final state.

- **Approve the strategic priorities and development of an operational delivery plan** (further detail in section 8 of the strategy):
 - Provide new digital services that improve the patient experience, transforms delivery models and reduces the overall cost of care.
 - Delivering and extending our Shared Care Record programme.
 - Develop our ecosystem of digital products and services.
 - Supporting/developing our citizens/workforce in the user/adoption of digital services.
 - Deliver a system-wide approach to the delivery of population health Intelligence.
 - We will implement system-wide health and care analytics function.
 - The democratisation of system-wide data products and intelligence.
 - Providing an active learning and development environment for future data scientists and continual development of our analytical workforce.
 - Develop a fit-for-purpose data architecture and reporting capability including integrated data sets that are accessible system-wide.

The JUCD Board **APPROVED** the strategic priorities and development of an operational delivery plan.

- **Approve the Digital and Data governance structure**
It is proposed that in 2021 the system-wide analytics, data, research and intelligence domains under the Digital Board will be formally aligned. The existing Digital Board will be renamed as the Derbyshire Digital and Data board to incorporate a greater role and dedicated workstream/strategy concerning the use of data, knowledge and intelligence across the ICS.
A new governance structure has been developed that aligns to the JUCD ICS governance structure and with the expansion of the remit of D3B the following sub-committees will be established:

- Design Authority
- Strategic Intelligence Group
- Digital Programme Delivery Group

The JUCD Board **APPROVED** the Digital and Data governance structure.

- **Approve the establishment of ICS Digital Office**

To deliver coordinated transformation across the JUCD system, there is a need to establish a central transformation, oversight and delivery capability for the strategy. The ICS digital office will take stewardship of the Digital Strategy, provide the mechanisms to harness the wide range of digital and technology skills, experience and knowledge across JUCD and utilise to provide effective cross-functional delivery teams. A recent example of the success of this approach has been the rapid procurement and initial implementation of the Derbyshire Shared Care Record. The ICS Digital Office will also look outwards and provide not only a link into wider system-level programme boards and committees but will proactively drive the exploration of digital opportunities as part of the system-level development plans

The JUCD Board **APPROVED** the establishment of ICS Digital Office.

150721/11 People & Culture Strategic Oversight Group (PS)

PS advised that the P&C SOG held its first meeting on 12th May and the minutes of the last Board meeting captured all the key points that were discussed. The next meeting was scheduled for 29th July. Attached to the report (Appendix 1) was a light touch ToR given the nuance for purpose/function of the committee/oversight group. It was important to be mindful of the plethora of national directive on people matters that was expected and the need to keep eye on this and create air cover for the system HRDs between national/local priorities.

The following key summary discussion points were highlighted:

- Need to take our people as seriously as our money. A Board level review of finance was planned for September and we should consider an equivalent on the people side given its importance and is our greatest asset/risk (CC).
- The Board had previously agreed to create more time for workshops than formal meetings, so perhaps we need to put together a programme of workshops from late Autumn and revisit i.e., digital, people, anchor; noting difficulties due to the amount of business the Board needed to get through (JM)
- Support/commend the short ToR and support a workshop type development session to work on this and think through the concept for one workforce. It will be the people who deliver, and we need to support/help them think transformational (KMc).
- There is a wealth of information about why transformation fails, and it is nearly all because of lack of buy in and engagement, and resistant behaviour, not because the change itself is not beneficial (LG)
- LG suggested the agenda for the next P&C SOG could be around reflections on the H&C Bill; one workforce and how as system we approach that; what information and how will SOG provide assurance about P&C/workforce across system. These discussions with SOG could then feedback into Board or form the basis of a workshop in the Autumn.
- PS/GB confirmed agreement to that Agenda suggestion for the next P&C SOG.

The JUCD Board **NOTED** the report.

150721/12 Finance & Estates Assurance Committee (CM)

CM noted the succinct coversheet report. She recognised the way the committee had worked was very good in terms of relationships and shows the benefits of having the committee established/up and running for some months now. In the last meeting on 1st July, the main decision had been to recommend a letter of support for the eradication of all dormitory-style inpatient accommodation for adult acute mental health. This had been actioned and the letter sent to NHSEI which would address this significant issue for Derbyshire for its Mental Health

	<p>Estate. The month 2 report was also discussed and due to covid income had exceeded expenditure but there was a need to describe a credible plan for underlying financial recovery of the gap between our expenditure/income, to recommence and reenergise our overall approach to efficiency as a system. There was great appetite, intent and ambition to get into how we start to solve the deficit with the long-term financial plan. We don't know what our funding for H2 will look like yet, nonetheless we will look to progress more on efficiency and long-term financial management at the next meeting (scheduled for the beginning of August). CM suggested taking DRAFT off the ToR as that was what we are currently working to with a review in 6 months' time.</p> <p>The following key summary discussion points were highlighted:</p> <ul style="list-style-type: none"> • In addition to the recovery focus, the financial focus will come back in the second half of the year (LO) • The Finance & Estates committee is a great example that we will need to work through as to whether it becomes a finance committee for the NHS ICB or remains as one for the whole system ICP - to date, it is predominated by NHS finance but that doesn't mean that LA partners couldn't be at the table if it remains an ICP function (CC) • HJ agreed we need to consider this further. • It would be good to grow the F&E committee into the ICP space to really understand broader impact/opportunities of Derbyshire health and care spend as/if possible (LO) • We do need to ensure that we get under the skin of the NHS funding as well as the wider financial envelope for the system as a whole (CM) <p>JUCD Board NOTED the report.</p>	
150721/13	<p>Quality Assurance Committee (KMc)</p>	
	<p>KMc advised that since writing the report the QAC had held its second meeting and had agreed the ToR and that Performance will be included as part of the Committee remit.</p> <p>In summary, the QAC were developing the approach to system quality and there were a number of system related issues coming forward to the next meeting, including System Approach to managing Complex Mental Health Children in our Acute Hospitals and Assurance on System process for reviewing potential harm for patients on waiting lists.</p> <p>The JUCD Board NOTED the report.</p>	
150721/14	<p>Clinical & Professional Leadership Group (AB)</p>	
	<p>AB advised that the report outlined recent activity in the ongoing transitioning from CPRG (a reference group) to CPLG (leadership group). It had good membership/buy in and had extended the membership to include dental and membership will continue to expand as required moving forwards. It was important to embed professional leadership in all areas, it's about engagement and developing a mandate across the system. We have taken steps to move from a reference group to a correctly mandated leadership group. A facilitated workshop was held and one of the priorities identified was the need to increase visibility of the group across the system. Some work around stratifying what clinical leadership is in different organisations across the system/linking in and not duplicating work had been undertaken and looking at how we liaise with clinical professional leadership across organisations and build on that with a formal road map. We need to decide whether it's an overview of clinical leadership and everything feeds into it to give the ICS a system view or whether it drives/directs the clinical and professional leadership.</p> <p>The following key summary discussion points were highlighted:</p> <ul style="list-style-type: none"> • JM advised that region were looking for good examples of more distributed clinical leadership style and he may suggest they speak to AB to explore JUCD's approach. • AB confirmed that some work had been done with neighbouring ICSs to benchmark. • To support AB's points LAs also have clinical leads - PH consultants and Principle Social workers (HJ) 	

	<ul style="list-style-type: none"> C&PL was another great example of how we are making progress thinking this through (CC) <p>The JUCD Board NOTED the report.</p> <p>The Chair summarised that the Assurance Committees seem to be getting well established and as such he did not consider the need to revisit the ToR again at this stage. Committees should run with the current ToR and when the ICS is formally established as a statutory organisation, we can review them at that time and amend if required. The Committee Chairs agreed.</p>	
	For Information	
	No Items.	
200521/15	Any Other Business	
	JM noted that today was the last public board meeting for CM and placed on record on behalf of the JUCD Board thanks for all the work she had done, her commitment, comments and observations, and acknowledged the huge input and contribution she had made.	
	<p>The Chair thanked the Board for the quality of the papers and meaningful discussion at today's meeting. He was grateful for Board members continued commitment.</p> <p>Key messages to be drafted following the meeting would cover:</p> <ul style="list-style-type: none"> Patient Story – Quality Conversations Our journey towards a statutory ICS including Legislation and Local Developments Data & Digital Strategy 	
200521/16	Questions from members of the public	
	No questions had been received from members of the public.	
150721/17	Date of Next Meeting	
	<p>The next formal JUCD Board meeting was scheduled to take place on Thursday 16 September 2021; to be held via MS Teams.</p> <p><i>NB, 19th August 2021 Development Session to be stood down due to the number of apologies.</i></p>	All to Note

**MINUTES OF DERBY AND DERBYSHIRE AUDIT COMMITTEE
HELD ON 25 MAY 2021**

VIA MS TEAMS AT 1.30AM

Present:

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

In Attendance:

Andrew Cardoza	Director, KPMG
Richard Chapman	Chief Finance Officer
Chris Clayton	Chief Executive Officer
Debbie Donaldson	EA to Chief Finance Officer (minute taker)
Darran Green	Associate Chief Finance Officer
Donna Johnson	Head of Finance
Frances Palmer	Corporate Governance Manager
Suzanne Pickering	Head of Governance
Richard Walton	Senior Manager, KPMG
Kevin Watkins	Business Associate, 360 Assurance

Apologies:

Helen Dillistone	Executive Director of Corporate Strategy and Delivery
Tim Thomas	Director, 360 Assurance
Chrissy Tucker	Director of Corporate Delivery

Item No	Item	Action
AC/2021/382	<p>Welcome and Apologies</p> <p>The Chair welcomed members to the Derby and Derbyshire Audit Committee.</p> <p>Apologies were received from Helen Dillistone, Tim Thomas and Chrissy Tucker.</p> <p>The Chair apologised for the delay in the sending out of some of the papers for today's meeting, due in part to the Annual Accounts timetable.</p>	
AC/2021/383	<p>Declarations of Interest</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>www.derbyandderbyshireccg.nhs.uk</p> <p><u>Declarations of interest from today's meeting</u></p> <p>There were no declarations of interest made.</p> <p>The Chair declared that the meeting was quorate.</p>	
<p>AC/2021/384</p>	<p>Losses and Special Payments</p> <p>Suzanne Pickering reported that this paper had come to Audit Committee to provide an update and to include the laptop equipment and overpayment of salary onto the Losses and Special Payments Register.</p> <p>It was noted that:</p> <ul style="list-style-type: none"> • During December the CCG was made aware of a data breach which had been reported to the Information Commissioners Office. • An investigation had taken place within the CCG; it involved a member of staff from the Medicines Order Line (MOL) leaving without serving notice and moving out of the country. • Various attempts were made to make contact with the individual; however, it became apparent that the individual had left the UK and had taken their CCG laptop with them. It was noted that this was the only way we had been able to make contact with the individual (via email). • Once a block had been placed on the laptop to ensure they were unable to access anything, we were unable to make contact with them. • Advice was taken through Counter Fraud and our local security management service, and our approach had been fully supported by 360 Assurance. • This incident had also been reported to the Police. • The Governance Committee had taken full responsibility in terms of the management of this incident and it had also been reported through to the Executive Team. • The value of the laptop was nil due its age (it was an older piece of equipment) and the overpayment of the salary and wages was £325.87. • It was noted that Governance Committee was handling all the learning from this incident. • Andrew Middleton asked whether the laptop had been de-activated by IT immediately. He then went on to ask whether lessons had been learned with regard to making it impossible for laptops to be used to access CCG records and systems 	

	<p>(whether on the last day of serving notice or on first day of realising individuals had gone and were not coming back)?</p> <ul style="list-style-type: none"> • Suzanne Pickering reported that as soon as the CCG were made aware of the incident, steps were taken to de-activate the laptop. In terms of the route cause analysis and closure report of the incident, full learning had been taken into consideration and implemented. • This learning had also been incorporated into the staff exit procedure within the CCG. Equipment was to be handed back on an individual's final day. • Darran Green reported that this write-off and entry into the Losses and Special Payments Register had gone into the 2020-21 year and formed part of the Annual Accounts and Report later on this Agenda. <p>Audit Committee APPROVED:</p> <ul style="list-style-type: none"> • The inclusion of the laptop in the CCG Losses and Special Payments register as the conclusion of the recommended actions for the CCG with regard to this incident. • The inclusion of the overpayment of wages in the CCG Losses and Special Payments register, given that the individual did not serve a notice period. 	
AC/2021/385	<p>Aged Debt Report</p> <p>Darran Green reported on a long standing issue with Birmingham and Solihull CCG, and highlighted the following:</p> <ul style="list-style-type: none"> • Members of this Committee had spoken previously of this issue. • The CCG had made an agreement to obtain half of the debt as the incorrect organisation had been billed; Birmingham and Solihull CCG was the lead commissioner, however the charge was the responsibility of NHS Sandwell & West Birmingham CCG. Therefore it was agreed that a credit note to Birmingham and Solihull CCG was to be issued for the full amount. • Sandwell and West Birmingham CCG accepted 50% of the costs associated with the overdue invoice; therefore DDCCG had raised an invoice for £158k and a credit note for £79k. The net amount, £79k, was subsequently paid by Sandwell & West Birmingham CCG in May 2021. • The 50% debt unpaid was not treated as a write off, nor reported as such in the Annual Accounts of DDCCG. This was due to NHSE guidance on Losses and Special Payments, which stated that NHS debts should not be derecognised but either paid or settled via the issue of a credit note. This guidance reflected the position of the NHS group on the basis that a body could not write off a debt with itself. 	

	<p>Audit Committee NOTED that the long term aged debt issue with NHS Birmingham & Solihull CCG was now resolved.</p>	
<p>AC/2021/386</p>	<p>2020/21 Annual Report, Accounts and Annual Governance Statement</p> <p>Richard Chapman asked Committee to approve the 2021 Annual Accounts, subsequent to the draft set of Accounts presented to Audit Committee on the 28th of April. Richard Chapman reported that the paper that Donna Johnson would take Committee members through outlined changes made to the draft Accounts following comments by Audit Committee members, further local management review and KPMG.</p> <p>It was noted that Audit recommendations/amendments did not impact on the financial performance, and reclassifications or additional disclosures and the fully audited set of Accounts, would be consolidated into the final Annual Report submission on the 15th of June.</p> <p>The Chair reported that this year's preparation of the Annual Report, Accounts and Annual Governance Statement had been a tremendous team effort and asked that this Committee's thanks be passed to those concerned.</p> <p>The Chief Executive Officer felt that the Annual Report, Accounts and Annual Governance Statement had been a really comprehensive document, which had been produced in the midst of a pandemic and he had been very pleased with the results.</p> <p>The following was highlighted:</p> <ul style="list-style-type: none"> • Andrew Middleton felt the document flowed well, one of the many improvements were the illustrations of how changes and investments had benefited patients particularly in the mental health section. He felt the sustainability section was starting to articulate the philosophy that we must drive into the future, and he was still pressing the question in the System Finance and Estates Committee (SFEC) as to where the sustainability issue lived in Committee governance terms; he was making a bid for SFEC to own it. • The Chair referred to page 128 of the pack which talked about third party assurances. He asked whether under those third party assurances, if Service Auditor Reports (SARs) had been received in relation to NECs and Arden and Gem CSU. He added that there was a report following this one which indicated that we may not have received SARs from those two particular suppliers. • Darran Green reported he was not aware that we had received them. He was however, aware that we had a process in place to have the requirement for a SAR to be put into contracts for those two organisations within the current financial year. 	

	<ul style="list-style-type: none"> • The Chair asked whether it was appropriate to take that reference out of the report as we were indicating a level of assurance on those two providers which we did not actually have. Darran Green agreed to review section. • The Chair highlighted page 137 of the pack where it referred to remuneration of very senior managers (subject to audit) and he asked whether this could now be taken off. He assumed this was pre-audit and we could remove that for approval by this Committee. • Richard Walton reported that unfortunately it would not be possible to remove that because that simple bracket takes out various other references that KPMG needed to put into their audit opinion; it was standard practice to show to the reader in terms of which bits of that whole report was subject to audit, and whether it was a piece of information that had been audited. He went onto add that the phrase was standard and allowed their audit opinion not to have a large amount of page references over it, which it would do otherwise. • Richard Chapman read this as audit outstanding, as in some audit activity still needed to take place on that remuneration. He went onto add that he felt it would be clearer to the reader if we used terminology such as 'assured by Audit'. • The Chair reported that he accepted KPMG colleagues' explanation, adding he felt as long as that did not stay in there when it was presented it in a public forum, then he was happy. Richard Walton stated it was still subject to final certification and was still a work in progress. • Jill Dentith reported that she had several minor changes she wished to make to the report, and agreed to email Suzanne Pickering with these after this meeting. • Suzanne Pickering reported that she would not be submitting the document until either 14/15 June so there was still opportunity to make the required minor changes. <p>Annual Accounts</p> <p>The Chair reported that there was a separate paper outlining the amendments made to the Annual Accounts that had been made during the Audit process on page 11 of the pack.</p> <ul style="list-style-type: none"> • Donna Johnson reported that the document had been presented to Committee on 28 April 2021 and adjustments had been made following comments made at that Committee and further management reviews and elements raised by KPMG. • The adjustments were minor changes to disclosures and correction of casting errors. There were no adjustments that had impacted the CCG's financial performance. 	<p>DG</p> <p>JDe</p>
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	<ul style="list-style-type: none"> • Donna Johnson highlighted that following the draft Accounts, we had received a directive from NHSE about our final resources for our running cost allocation admin resources, so as a result that figure had changed (Note 22 of the Accounts). It was noted that we still achieved that target, and the directive actually increased that resource. • There was also an amendment with regard to the disclosure of related party transactions with UHDB from £152k to £3k, and NHSE income from £2,698 to £239k. • Donna Johnson reported that when the Chief Executive Officer had reviewed the Annual Report he had questioned the disclosure of the consultancy fees. Donna reported that having looked at that, there were some of our own clinical leads in there, so these were taken out and reallocated within Note 5 of the operating expenditure. So that reclassified them to remove £161k from consultancy and reallocating to the General Medical Services and Supplies and Services. • Included within the paper was a section around agreement of balances, and the paper had an Appendix which detailed the mismatches over £300k, which KPMG considered significant. But these demonstrated only a few differences with other NHS organisations. • It was noted that the CCG holds documentary evidence supporting the CCG's opinion for those and that had also been shared with our Auditors. • Jill Dentith thanked Donna Johnson for the paper outlining the changes made to the draft accounts and commented that she had no further questions. • Andrew Middleton felt that it was very helpful to have the documented journey through the amendments. • The Chair thanked Donna Johnson and her team for their hard work in producing the Annual Accounts. <p>Annual Governance Statement (AGS)</p> <ul style="list-style-type: none"> • The Chair reported that it had been a year of challenge, and the AGS had given us a clear understanding of that. • Jill Dentith referred to the Terms of Reference for membership of PCCC, she felt sure that these were changed mid-year to take account of Sandy Hogg leaving and that the CEO had also been removed from the Membership. Suzanne Pickering agreed to check this and make any amendments required to the AGS and Appendix 1. • There were no further comments on the AGS. <p>The Audit Committee APPROVED the final Annual Report and Accounts 2020/21 with the very minor changes to be emailed by Jill Dentith to Suzanne Pickering after this meeting, and the</p>	SP
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	<p>amendments described to the PCCC membership, under the delegated authority given to Audit Committee.</p>	
<p>AC/2021/387</p>	<p>Service Auditor Reports</p> <p>Darran Green reported the following Service Auditor Reports for 2021/21 had been received:</p> <ul style="list-style-type: none"> • NHS Business Services Authority for Prescribing Payment Processing • NHS Business Services Authority for Dental payment processing • NHS Business Services Authority for Finance and Accounting Services • Electronic Staff Record for HR and Payroll Management • NHS Digital for GP Payment Services • Capita for Primary Care Support <p>It was noted that the full reports had been shared with the CCG External Auditors and members of the Audit Committee for assurance. However these reports had not formed part of the official papers for this Committee as there had been a restricted circulation placed on them.</p> <p>Darran Green reported that all 6 SARs provided assurance on the controls in place at the service organisations. All 6 SAR reports this year had given qualified opinions. We had received a number of controls that were tested and a number of controls that had not been met.</p> <p>Darran Green reported that the SARs had been quite generic and obviously applied to, in some instances, many CCG's across the country and whilst they were all qualified opinions, there was nothing specific in any of those reports that we could attach to our CCG.</p> <p>SARs were not provided by Midlands and Lancs CSU (who provided our CHC service) and NECs (who provided our IT service) as there was nothing in their current contracts or Service Level Agreements stating that there was a requirement to provide them. It was noted that there was an opportunity within the next 12 months to ask for the requirement of a SAR into those contracts and the CCG was currently working on what those requirements would look like.</p> <p>Andrew Middleton reported that it was slightly disturbing to a Lay Member to read qualified audit opinions, when none of them drew on evidence in Derbyshire. He asked whether there was a process that gave rise to those qualifications that we might want to adopt or learn lessons from. The second point he wanted to make was through the commissioning for individuals panels, he was very conscious of how big a spend went through Midlands and Lancs</p>	

	<p>CSU (eg £5k per patient per week sort of decisions). Therefore he felt the CCG should be sighted in some detail relevant to Derbyshire services in that CSU.</p> <p>Darran Green referred to Andrew Middleton's first point; many were related to primary care payments to primary care contractors. It was noted that whilst none of them were specific to Derbyshire, the CCG were reviewing to see if there was anything we could learn, and the CCG was working with NHSE colleagues to see what remedial action could be put in place. With regard to Andrew Middleton's second point, he was very conscious that whilst it was the finance team pushing for SARs, with regard to Midlands and Lancs CSU, we were involving colleagues in Bridget Stacey's team very closely in determining what controls and tests were required from Midlands and Lancs to ensure that their processes were appropriate for the CCG's needs.</p> <p>Richard Walton endorsed the comments that had been made about obtaining SARs from the CSU. As things progressed and an Audit becomes more formalised, he felt that SARs for any type of organisation that did a large amount of processing for the CCG was generally a good idea. A SAR helped formalise assurances and gave real clarity about how well those services were operating. Richard Walton encouraged the CCG to obtain SARs from the CSU and NECs.</p> <p>Richard Chapman referred to Andrew Middleton's comment about the high level of expenditure and therefore potential risk around commissioning for individuals and personal health budgets. Donna Johnson had been undertaking a piece of work on our own governance around sign off of those packages, which would become an increasingly large amount of our expenditure as we moved forward and therefore an increasing risk. That work was almost complete and ready to be considered internally by Officers prior to making decisions and what needs to happen going forwards.</p> <p>Donna Johnson reported this work also highlighted any governance issues that we potentially had, and options of how to take a pragmatic view to address those issues going forwards. Her paper was being prepared right now and it was hoped it would go to the SLT for consideration this week or early next.</p> <p>The Chair noted the receipt of six SARs as listed above, and noted the qualifications that they contained. It was also noted that the CCG wished to make some changes to the contractual arrangements for Midlands and Lancs CSU and NECs to ensure that SARs were available from them in the future.</p>	
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	<p>Audit Committee NOTED the Service Auditor Reports received for 2020/21.</p>	
<p>AC/2021/388</p>	<p>KPMG: Year End Report 2020/21 – ISA260</p> <p>Andrew Cardoza referred to the Year End Report 2020-21 ISA260 and highlighted the following:</p> <ul style="list-style-type: none"> • The Audit had gone well and had been done remotely with the help of Donna Johnson, Darran Green, Richard Chapman and the CCG’s accounting team. • It was noted that the CCG had produced a good set of accounts and that KPMG had a good working relationship with the CCG’s finance team. • Turning to the first page of the report, Andrew Cardoza reported that it was important to highlight what KPMG were intending to report. • The report had the usual Auditor caveats, in that KPMG still had to go through the final reviews and the final national moderation across KPMG’s NHS clients for the Value for Money conclusions. But that said Andrew Cardoza felt it was looking positive, and he did not have any particular concerns at this point in time. <p>Richard Walton presented the Year End Report 2020-21 ISA260 and highlighted the following:</p> <ul style="list-style-type: none"> • Page 4 of the report gave a status update in terms of things that at the time of writing were still underway. There were some elements of sample testing that were still being worked through, and some disclosure notes that were being tied back through to the individual working papers, which tended to be left until last, as these were least important in terms of the Audit work. • KPMG would definitely be able to sign off by the deadline of 15 June 2021. • In terms of the Value for Money, there were still a few moderation calls that were being done this week to compare notes and check that the company were all making similar decisions as it was a new process this year and KPMG did not want to be overly unfair or lenient towards the CCG. • KPMG had got past one level of moderation and would have the next one later this week. • Page 5 gave an overall headline messages. With regard to the work in terms of the main significant risk in expenditure recognition, KPMG had not found any concerns and did not have any amendments to make as a result of that testing. • Andrew Cardoza was not using any of his legal powers to write to the Secretary of State to make any kind of odd declarations. 	

	<ul style="list-style-type: none"> • There were no uncorrected Audit misstatements and there were very few Audit amendments that KPMG were required to report to the CCG that were material, and there had not been any changes in the numbers from KPMG's Audit. • There was one minor control deficiency control improvement point, which KPMG would come to later on, but nothing significant to impact their opinion work and the recommendations from the prior year had been implemented and KPMG had been happy to sign those off. • Page 8 gave a summary of the main work in terms of the risk. The risk was actually lower for the financial statements this year, because a lot of the risk came down to the judgmental nature and negotiation with providers that the CCG had contracts with. It was noted that because of the way the finance regimes had worked this year, there had been a lot less judgment within that, and so the Audit work had been more straightforward. • In terms of testing the bulk of the CCG's spend, normally there was only a small amount that KPMG could simply tick through, whereas this year there had been quite a lot, so that was important to point out within the financial statements, therefore there was less risk compared to a normal year • The next page was the standard risk that KPMG had in all Audit reports about management override of controls. It was confirmed that KPMG were not saying that they thought the CCG's management was particularly risky, this was a standard risk that they had in every plan and their Audit methodology had an inbuilt response and they had no concerns to raise. • Page 11 Other Matters, which had been a summary of all the other bits of work that KPMG had done. Looking at the annual report, KPMG did not think there was anything wrong with the CCG's draft Annual Report; KPMG agreed and endorsed the CCG's thoughts in terms of the way it was presented and in its content. • There had been some minor changes to the Remuneration Report, but nothing major. • KPMG also confirmed its independence as Auditors; it was important that they did this every year. • Page 12, Value for Money summary. At the last Audit Committee KPMG had raised one risk of a significant weakness. It was explained that it was a new world of Value for Money this year, so KPMG had not issued a Value for Money conclusion. • This year KPMG were only required to look for a significant weakness, if KPMG found a significant weakness, it would then be reported as such. If no significant weaknesses were found they would then just confirm that they had not found any. The big change this year was KPMG's commentary with regards to Value for Money, which was to be a public document this year. 	
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	<p>It was noted that KPMG would work with colleagues to get its wording confirmed and would make sure that Richard Chapman and the team had sight of what was being proposed in terms of public commentary.</p> <ul style="list-style-type: none"> • The Appendices contained explanations of the new Auditing and Accounting Standards. There was a summary of items that KPMG were required to report to the Audit Committee due to Audit Standards. KPMG confirmed that they did not have a concern under that particular bit of the Audit Standard. • Page 20 Recommendation – KPMG felt that it was best practice to make declarations every year; that allowed the finance team to then use that source to refresh it every single year, rather than relying on older information. It was noted that the rules had changed slightly in terms of what to declare with regard to spouses. KPMG would work with Donna Johnson to make sure the CCG had got an up-to-date form ready to go very soon; this had been a low risk recommendation. • The report at the end summarised two prior year recommendations which KPMG had signed off as being implemented. • It was noted that KPMG consulting colleagues were doing some work with Providers in Derbyshire. Initially this was thought to be a conflict of interest for the firm, but having consulted KPMG’s Risk Approval Panel, it was deemed that they were content for the team to continue as External Auditors for the CCG for this year. With regard to KPMG providing External Audit Services for next year, Audit Committee were told a decision would be made on Monday as to whether they could still provide those services and remain independent. • The Chair thanked KPMG for such a well prepared and very clear statement. • The Chief Executive Officer echoed the Chairs comments above. He went onto add that it had been a challenging time, and he asked that his thanks be passed to everybody concerned for a very clear statement. • Jill Dentith had no questions to ask and thanked the team on both sides, our Auditors and our own staff, who had done an incredible job. • The Chair asked Richard Walton, if at some point, he could let him know how the new Value for Money framework was operating and whether there were any pointers he could give the CCG in terms of preparing for the future. • Richard Walton reported that he hoped that by late summer KPMG could come back with any general best practice points for the CCG. 	
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	<ul style="list-style-type: none"> The draft letter of representation would be shared with the Chair in due course. It was noted that it had been emailed to Richard Chapman and Darran Green on 24 May 2021. <p>Audit Committee NOTED the ISA260 Audit Report for 2020-21 provided by KPMG.</p>	
AC/2021/389	<p>2020/21 Internal Audit Head of Internal Audit Opinion and Annual Report</p> <p>Kevin Watkins presented the Internal Audit Head of Internal Audit Opinion and Annual Report and highlighted the following:</p> <ul style="list-style-type: none"> Audit Committee had already received an interim Internal Audit Opinion at the April Audit Committee meeting. It was noted that the CCG had received a strong significant assurance, which had been a really positive outcome. This year had been significantly affected by Covid, it was noted that 360 Assurance had already taken some pieces of work out of the Plan in order to respond to the emergency. Other pieces of work were then subsequently deferred again, so essentially 360 Assurance had concentrated on all of the core audits, and this was what had constituted this opinion. The work that 360 Assurance had been doing for JUCD was now at an advanced state of completion. Kevin Watkins reported that third party assurances or SARs had very little impact on the Opinion. The key reason for that was that SARs did not tend to look at CCG specific transactions. 360 Assurance tended to focus more on specific pieces of work done for the CCG. Page 211 highlighted core Audits that were completed, one of which was the Policy Management Framework piece of work, which was the only report that 360 Assurance had issued in year with a limited assurance. 360 Assurance had agreed to do some follow up work and the outcome of this had been very briefly highlighted. In terms of the CCG's implementation dates, they were moved to the end of June because of the response to COVID-19. Nevertheless, by the end of March the CCG had cleared five out of the six. All of the medium risks within that were all cleared by the 31st of March, and it showed that the CCG had responded to that limited assurance. Turning to the Annual Report, 360 Assurance had briefly highlighted some aspects of that, including the fact that 360 Assurance had to obtain independent assessments which were contained on P213. 	

	<ul style="list-style-type: none"> • 360 Assurance were required, at least once every five years, to have an external assessment to make sure that they complied with the Internal Audit Standards; 360 Assurance had obtained 'generally conforms', which was the highest level of compliance. • The Chief Executive Officer gave thanks to Kevin Watkins and his colleagues for the work done on behalf of the CCG. • Jill Dentith felt the report was a really good reflection of the work that had been completed thus far. She was pleased that the follow up actions had been completed within the timescales which was testament to the team, as this year they had been working in very difficult circumstances. She was pleased that the CCG had continued to deliver on these targets, which were sometimes quite challenging. • The Chair turned to Kevin Watkins and referred to the survey that 360 Assurance had conducted across the patch that they served; this was on page 221. He reported that the colour coding had been very confusing. Kevin Watkins agreed and stated it was the way XLS had unfortunately selected the colours. • Andrew Middleton referred to the significant assurances received in this report; he would have preferred to see substantial assurances and asked what the CCG needed to do to obtain the highest marks. • Kevin Watkins reported that to get substantial assurance the CCG would need to have little or no recommendations. He added, to be fair, 360 Assurance did not often issue substantial assurances. <p>Audit Committee NOTED</p> <ul style="list-style-type: none"> • The outturn against the Internal Audit Plan for last year. • The achievement by 360 Assurance of the KPIs that we agreed. • The compliance that, as Kevin Watkins explained, was given by CIPFA as part of their standard review, • The survey results across the patch. 	
AC/2021/390	<p>Minutes of the Derby and Derbyshire Audit Committee held on 28 April 2021</p> <p>The Minutes of the Derby and Derbyshire Audit Committee held on 28 April 2021 were presented.</p> <p>Jill Dentith referred to P228 with regard to her declaration for related party transactions. On reflection after the meeting she found this statement to be incorrect, this had now been amended within the Annual Accounts by Donna Johnson on her behalf.</p> <p>The Chair asked that this section be redacted from the previous minutes. With that alteration Audit Committee were happy to support the Minutes as the approved minutes of the meeting.</p>	

AC/2021/395	<p>Risk Report</p> <p>Suzanne Pickering presented the Risk Report as at end of April 2021, which detailed the very high risks and gave an overview on the movement in risks during April and March 2021. It was noted that this had been agreed and approved through the CCG's Corporate Committees and also reported monthly to the Governing Body.</p> <p>Suzanne Pickering highlighted P291 of the pack, Section 4.1, during March there had been three risks that had decreased in score (Risks 24, 30 and 37) and during April a further decrease for Risk 1 in terms of the PICU beds.</p> <p>Audit Committee RECEIVED and NOTED:</p> <ul style="list-style-type: none"> • The Risk Register Report; • Appendix 1 as a reflection of the risks facing the organisation as at 30th April 2021; and • Appendix 2 which summarises the movement of all risks during March and April 2021. 	
AC/2021/396	<p>Conflicts of Interest Report (COI)</p> <p>Frances Palmer presented the Conflicts of Interest Report and highlighted the following work undertaken since the last meeting:</p> <ul style="list-style-type: none"> • Committee members and decision makers had all been asked to complete their COI forms for 2021-22 and to date all forms had been received back from Governing Body members, and there had been a good response from decision makers. • All other CCG employees would be asked to complete their COI forms from June 2021. • Audit Committee members were asked to note the two entries on the Confidential Register of Interests, these could be found at Appendix 4. The Chair, as Conflicts of Interest Guardian, had been made aware of these, and the resulting mitigating actions that had been put in place. • The Gifts and Hospitality Register had not any recent updates • The Procurement Register had had an abundance of updates recently, and Frances Palmer would be incorporating those into the register over the next week. • Frances Palmer would be reviewing the Conflict of Interest Policy as well as the Gifts and Hospitality and Procurement Policies, which would be presented to Governance Committee in July. • Jill Dentith thanked Frances Palmer for a comprehensive report. • Jill Dentith asked for a correction to be made in terms of her entry, her change was from April rather than August as stated on this document. Frances Palmer agreed to update this. • Jill Dentith referred to the mandatory training section of the report. At Governance Committee they had received various 	FP

	<p>reports about mandatory training, and the report presented today stated that we had got a really good rate of return on mandatory training, but in the report that had gone to Governance Committee, it suggested that perhaps some of the Governing Body Members were not quite as compliant as they might have been at levels 2 and 3. She asked whether we could tease that out and make sure that we were consistent in terms of our reporting.</p> <ul style="list-style-type: none"> • Frances Palmer responded that she had only reported on Module 1 for Governance Committee, as NHSE had suggested Modules 2 and 3 were something to be completed to help people understand their roles at that level, or as Commissioning Managers. Frances Palmer agreed to try to increase the uptake by Governing Body Members. • It was confirmed that level 1 was mandatory, but levels 2 and 3 were only desirable. Jill Dentith asked whether we needed to change the language in the Governance report, as it suggested that Modules 2 and 3 were mandatory as well. Frances Palmer agreed to review this. <p>Audit Committee NOTED the Conflicts of Interest Update Report.</p>	<p>FP</p> <p>FP</p>
<p>AC/2021/397</p>	<p>Any Other Business</p> <p>There was no further business.</p>	
<p>AC/2021/398</p>	<p>Forward Plan</p> <p>The Chair reported that two additional Audit Committee Meetings would be pencilled in for July and August 2021. It was noted that these additional meetings may not necessarily be full Committee meetings, and would be used to discuss procurement arrangements for External Audit services for the next financial year. It was noted that these meetings may be held in Confidential Session.</p> <p>Jill Dentith gave apologies for the next meeting of Audit Committee on 16 September 2021.</p> <p>Audit Committee NOTED the Forward Plan.</p>	
<p>AC/2021/399</p>	<p>Assurance Questions</p> <ol style="list-style-type: none"> 1. Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance processes? <p>Yes.</p> <ol style="list-style-type: none"> 2. Were the papers presented to the Committee of an appropriate professional standard, did they incorporate a detailed report with sufficient factual information and clear recommendations? <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>No, some of the Annual Report and Accounts documents were understandably sent out late.</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. Is the Committee assured on progress regarding actions assigned to it within the Recovery & Restoration plan?</p> <p>The Audit Chair assured members that the Recovery & Restoration Plan had now been completed.</p> <p>8. 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, and would also be informed of the receipt of the Annual Report and Accounts, and that Audit Committee had given them their approval under delegated authority.</p>	IG
AC/2021/400	<p>Date of Next Meeting: Two additional meetings were to be arranged for July and August 2021.</p> <p>Dates for future meetings: Thursday 16 September 2021, 9.30-12.30 Thursday 18 November 2021, 9.30-12.30 Thursday 20 January 2022, 9.30-12.30</p>	

Signed: Dated:
(Chair)

**RATIFIED MINUTES OF DERBYSHIRE ENGAGEMENT COMMITTEE MEETING HELD ON
17 August 2021 VIA MICROSOFT TEAMS
11:15 TO 13:15**

Present:		
Martin Whittle – Chair	MW	Governing Body Lay Member, DDCCG
Helen Dillistone	HD	Executive Director Corporate Strategy and Delivery, DDCCG
Lynn Walshaw	LW	Deputy Lead Governor, DCHS
Margaret Rotchell	MR	Public Governor, CRH
Sean Thornton	ST	Assistant Director Communications and Engagement DDCCG and JUCD
Beth Soraka	BSO	Health Watch Derby
Simon McCandlish	SMc	Governing Body Lay Member, DDCCG (Deputy Chair)
Steven Bramley	SB	Lay Representative
Tim Peacock	TP	Lay Representative
Karen Lloyd	KL	Head of Engagement, Joined Up Care Derbyshire
In Attendance:		
Lucinda Frearson	LF	Executive Assistant, DDCCG (Administration)
Anastasia Knox	AK	Associate Partner, BritainThinks
Loulwa Al Rasheed-Wright	LRW	Research Lead, BritainThinks
Louise Swain	LS	Assistant Director - Integrated Community Commissioning, DDCCG
Sukhi Mahil	SM	ICS Assistant Director Derbyshire Healthcare NHS Foundation Trust
Lee Mellor	LM	Comms and Involvement Specialist, Joined Up Care Derbyshire
Apologies:		
Vikki Taylor	VT	ICS Director Lead, Joined Up Care Derbyshire
Jocelyn Street	JS	Lay Representative
Maura Teager	MT	Lead Governor, University Hospitals of Derby and Burton NHS Foundation Trust
Kevin Richards	KR	Public Governor, Derbyshire Healthcare NHS Foundation Trust
Helen Henderson-Spoors	HHS	Chief Executive Officer, Healthwatch Derbyshire
Beverley Smith	BSm	Director Corporate Strategy & Development, DDCCG

Item No.	Item	Action
EC/21/22-49	<p>WELCOME APOLOGIES AND QUORACY</p> <p>MW welcomed all to the meeting, noting the apologies as above and declaring the meeting quorate.</p>	
EC/21/22-50	<p>DECLARATIONS OF INTEREST</p> <p>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.</p> <p>Declarations declared by members of the Engagement Committee are listed in the CCG's Register of Interests and included with the meeting papers. The Register is also available either via the corporate secretary to the Governing Body or the CCG website at the following link: www.derbyandderbyshireccg.nhs.uk</p> <p>DECLARATIONS OF INTEREST</p> <p>No further declarations were made.</p>	

EC/21/22-51

GP AND URGENT CARE ACCESS INSIGHT

The committee is asked to note progress to date for information and awareness at this stage.

An update of progress was given by Anastasia Knox (AK) and Loulwa Al Rasheed-Wright (LRW) from Britain Thinks who shared key specific points and outlined the objectives for the work being carried out explaining that they had been asked to explore drivers of patient behaviour and decision making, so looking at the types of issues for which patients accessing primary and urgent emergency care, also to look at the extent to which perceptions and lived experiences do or do not align and where the mismatch might be. And finally, to think about recommendations for communications, including potential interventions for the ICS to consider.

Key findings so far were: -

- Very strong support for the NHS and praise for the frontline staff in face of the pandemic. Aware NHS are facing challenges due to resources and under funding.
- Expectations were that GPs should be resuming work as normal and patients are becoming frustrated.
- How patients are accessing care – they are only accessing GP or urgent care when necessary and only seek help when symptoms develop and access urgent care only when necessary and quite severe.

Perceptions and real experiences: -

- GP access was difficult and when making appointments frustrations around having to justify why they need an appointment. Inconsistencies were found across the County.
- Gap between perceptions and what played out in reality. Sense quality of care has demised especially after the start of the pandemic. In real experiences the majority are saying quite happy with care received at appointment and care received.
- Emergency care, difficulty in getting appointments and access to care. A&E were what they were bearing in mind with long waits highlighted and issues around the types of environments ie; mental health.
- Quality of care in Urgent Treatment Centres (UTCs) was a good high standard and will be seen in those urgent scenarios and borne out in practice.

Recommendations, these were still in progress with a continual review but there was a role for comms in helping and giving reassurance and being open and honest: -

- Need to provide an explanation why services are struggling not just due to the pandemic.
- Opportunity to keep patients informed why trying to access care ie; A&E waiting times.
- Ways of providing information on how GPs are working whilst making appointments.
- Opportunity to educate patients, 111 seen as guide of call and UTC awareness is relatively low.
- Tone is important, comms need to strike a supportive tone and non-judgemental, no one is using unless necessary.
- The real challenge is to help patients feel they are being understood.

	<p>Communication alone will not improve and improvement in access especially GPs is required. The opportunity to share information across the County would be beneficial as some patients are getting seen more easily than others.</p> <p>SMc commented/asked: -</p> <ul style="list-style-type: none"> As well as perceptions of primary care, what were the drivers of these perceptions and where people get them from plus age wise. AK advised the most powerful drivers of perception is friends and family, almost a ripple effect and social media is the more powerful communicator for younger people. Social media is very complicated and there is element of distrust in there. If you have good experiences and use regularly in a care environment that is more positive, the less contact the more move towards negative. Did you get feedback from patients around what was considered serious enough? AK advised people only accessed care when necessary that is their perception. People have sense of knowing themselves but that definition around what is serious for one is different to another. GPs are a persistent issue, there seems to be a need for an initiative around public contact via receptions. <p>MW as Chair thanked AK and LAL for their presentation and contributions from other members of the Committee.</p> <p>Action: Update to be brought to the September meeting</p> <p>The Engagement Committee NOTED the verbal update and progress of the work undertaken.</p>	<p>ST</p>
<p>EC/21/22-52</p>	<p>FLORENCE SHIPLEY COMMUNITY HOSPITAL RECONFIGURATION</p> <p>The Engagement Committee is asked to: -</p> <ul style="list-style-type: none"> consider the updated position regarding the London Rd Community Hospital beds (wards 4, 5 and 6) Approve the engagement approach that aims to understand the impact of changing the D2A arrangements in the Derby City area through the changes to London Road Community Hospital re-configuration. To offer advice and guidance as to the methodology chosen and to highlight areas for improvement. <p>LS advised Wards 4, 5 and 6 which are run by University Hospitals Derby and Burton (UHDB), are providing a mixture of community beds. The paper presented focused on the P2b rehab beds, the pathway nursing provision that provides short term rehab provision to assist in the patient's return home as early as possible.</p> <p>In response to the Covid pandemic the mantra was 'home first' and the system agreed to temporarily repurpose Wards 4, 5 and 6 and relocate staff back into the acute site to prepare for the Covid surge. There were designated beds for Covid positive patients, physios were recruited and an EOL team established. Through this work a way to be more efficient and effective was found and a better understanding of the patients. This led to better outcomes for patients and more being supported at home. The 74 beds have not been replaced like</p>	

	<p>for like instead resources have been utilised better so more people are going home or being supported in lower level residential beds.</p> <p>The proposal is to engage with a full range of stakeholders to better understand the impact of the temporary changes to make an informed decision whether to make those changes permanent. Local Authorities agree in principle. Healthwatch have signed up to help with the engagement work and NHSEI have now agreed with the approach. The plan is to engage for 12 weeks collecting data.</p> <p>LW commented that public perception would be that this was not a true picture as being done around Covid and may be a challenge going forward. Highlighting some of the data around length of stay would be helpful as it shows not as many beds are required. Then there are the perceptions around primary care support when moving people home as speedy as possible, it is the assessing care once home and some patients may feel abandoned.</p> <p>SB had been involved in similar consultations in North Derbyshire and suggested using the figures from North Derbyshire to show how useful the service had been to service users and staff who had been terribly demotivated due to the changes at first.</p> <p>MW agreed that explaining why the wards were discharged due to Covid and what was being done now as a better model of care, giving examples from across the County, would be beneficial.</p> <p>Action: More detailed update to be presented at the September meeting.</p> <p><i>The Engagement Committee NOTED progress to gather feedback, APPROVED the engagement approach and was ASSURED of progress.</i></p>	<p>LS</p>
	<p><i>The meeting was adjourned for a comfort break.</i></p>	
<p>EC/21/22-53</p>	<p>PROPOSED SINFIN HEALTH CENTRE COMMUNICATIONS AND ENGAGEMENT PLAN</p> <p>KL had been asked to present the proposed communication and engagement plan advising this was not possible due to: -</p> <ol style="list-style-type: none"> 1) The project being overseen by NHSEI as a National Project and the go ahead to talk about the project had not been received. 2) The designated site was subject to a lease and it had not yet been agreed with the owner that the land could be used. If not agreed, then another site would have to be sought which would mean having to go to consultation. <p>Action: Update to be brought to Committee when available.</p> <p>The Engagement Committee NOTED the verbal update.</p>	<p>KL</p>
<p>EC/21/22-54</p>	<p>ICS COMMUNICATIONS AND ENGAGEMENT PLAN</p> <p>The committee is asked to note progress to date with the communications and engagement plan for the ICS development.</p> <p>KL gave an update to the Committee advising:</p>	

	<ul style="list-style-type: none"> • There were lots of explainer guides available, also one on the history of the ICS was to be published soon and another planned around the voluntary sector, building on the work done with the leadership programme. • Work was being done with Place partnerships, who were clear they wish to engage extensively with local communities around the purpose of the care partnership and it may be voluntary sector led. • New weekly stakeholder bulletin was being set up giving information on the ICS. • The Newsletter was to become bi-monthly rather than quarterly due to size. • Derbyshire Dialogue had over 250 people attend with another arranged for September regarding engagement in the ICS. • An online engagement platform was due to be launched and it was hoped to send out this week to Committee with a view to launch with the newsletter in December. <p>TP asked regarding the engagement platform and the many potential users whether there was any intention to use the platform for other organisations such a PPGs. KL advised there was a template to send out to anyone interested.</p> <p>The Engagement Committee NOTED the update and highlights given.</p>	
<p>EC/21/22-55</p>	<p>WINTER COMMUNICATIONS AND ENAGEMENT PLAN</p> <p>ST informed Committee that work was currently progressing regarding the winter and surge plan as part of communication and engagement at a high level, themes and topics will be similar but adapted.</p> <p>Action: Further update to be brought to the September meeting</p> <p><i>The Engagement Committee NOTED the verbal update.</i></p>	<p>ST</p>
<p>EC/21/22-56</p>	<p>ENGAGEMENT ON PATIENT RELUCTANCE TO ACCESS SERVICES</p> <p>ST verbally informed the Committee that a meeting had taken place which was the first step in understanding the data and who was in the bracket of those not coming forward. Advising of 4 cancer areas in which people are reluctant to come forward these were urology, lung and upper and lower gastrointestinal the locations targeted are Derby and an area in Bolsover where further work was needed to find out why people are reluctant to come forward.</p> <p>Action: Further update to be brought to the October meeting</p> <p>The Engagement Committee NOTED the verbal update.</p>	<p>ST</p>
<p>EC/21/22-57</p>	<p>S14Z2 LOG</p> <p>The Committee is asked to review the current S14Z2 log providing assurance that S14Z2 forms are being completed appropriately.</p> <p>Forms:</p> <ul style="list-style-type: none"> • London Road Wards 4,5,6 	

	<p>There was just one project which had been covered earlier in the meeting with a broader explanation of the project being given.</p> <p>TP commented that some explanation around the meaning of the short form headings on the log would be beneficial in helping to have a better understanding of the information given.</p> <p>Action: Log to be updated with explanation for each heading.</p> <p>The Engagement Committee NOTED the Log and were ASSURED they were being completed appropriately.</p>	ST
EC/21/22-58	<p>JUCD BOARD – KEY MESSAGES (For Information)</p> <p>The key messages had been omitted from the meeting pack and would therefore be circulated with the Minutes following the meeting.</p> <p>Action: Key messages to be circulated with Minutes.</p>	LF
EC/2122-59	<p>DDCCG EXCEPTION RISK REPORT</p> <p>The Committee is asked to RECEIVE and DISCUSS the risk assigned to the Committee as at August 21.</p> <p>ST advised the risk score would remain the same this month as continuing to seek to embed the processes within the organisation and ensure these are embedded into the ICS delivery too.</p> <p>An action was being undertaken to establish a governance guide to help set out programmes and the steps to take to ensure the following of rules regarding engagement and diversity.</p> <p>Action: Draft Governance Guide to be brought to the next meeting.</p> <p>The Engagement Committee RECEIVED and APPROVED and to be recorded accordingly.</p>	ST
EC/2122-59a	<p>GBAF</p> <p>The Engagement Committee are asked to discuss and review the quarter 2 (July to September) Governing Body Assurance Framework strategic risk owned by the Engagement Committee, review and update the mitigating actions and assurances and review and update the current risk score.</p> <p>The Engagement Committee gave APPROVAL to change, after reviewing the log the Committee were ASSURED it had been updated accordingly.</p>	
EC/2122-60	<p>MINUTES OF THE MEETING HELD ON: 20 July 2021</p> <p>Amendment to be made on the Minutes as TP's apologies had not been noted for the last meeting.</p> <p>The Engagement Committee ACCEPTED the Minutes of the previous meeting as a true and accurate record follow one amendment.</p>	

EC/2122-61	<p>MATTERS ARISING</p> <p>None received.</p>	
EC/2122-62	<p>ACTION LOG FROM THE MEETING HELD ON: 20 JULY 2021</p> <p>The Engagement Committee reviewed the action log and updated accordingly.</p>	
EC/2122-63	<p>ENGAGEMENT COMMITTEE FORWARD PLANNER 2021/22 FOR REVIEW AND AGREEMENT.</p> <p>Items to be included for October's meeting: -</p> <ul style="list-style-type: none"> • London Road Wards 4,5 & 6 • London Road Wards 1 & 2 • Governance Guide • Update re Glossop workstream – potential • Place engagement approach. • Winter Communication and Engagement Plan <p>The Engagement Committee REVIEWED and AGREED the Forward Planner.</p>	
EC/2122-64	<p>ANY OTHER BUSINESS</p> <p>MW highlighted coming out of the architecture for ICS's was future Committees and stakeholder name for Place Committee, there were no thoughts on the name, but the Committee would be the same as the Derbyshire Engagement Committee. A meeting was taking place on 23 September and MW wished to have some input from this Committee around how to develop the work of the Engagement Committee and any learnings moving forward suggesting HD and colleagues put together bullet points of ICS governance requirements to have some context.</p> <p>KL advised a number of the Boards and workstreams were approaching to recruit patient and public partners, as it may link into the work being done.</p>	HD
EC/2122-65	<p>FUTURE MEETINGS IN 2021/22</p> <p>Time: 11:15 – 13:15</p> <p>Meetings will be held as virtual meetings until further notice</p> <p>Tuesday 21 September 2021 Tuesday 19 October 2021 Tuesday 16 November 2021 Tuesday 21 December 2021 Tuesday 18 January 2022 Tuesday 15 February 2022 Tuesday 15 March 2022</p>	
EC/2122-66	<p>ASSURANCE QUESTIONS</p> <ol style="list-style-type: none"> 1. Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? Yes 2. Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? Yes 	

	<ol style="list-style-type: none"> 3. Were papers that have already been reported on at another committee presented to you in a summary form? Yes 4. Was the content of the papers suitable and appropriate for the public domain? Yes 5. Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? Yes 6. Is the Committee assured on progress regarding actions assigned to it within the Recovery & Restoration plan? Yes 7. Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? No 8. What recommendations do the Committee want to make to Governing Body following the assurance process at today's Committee meeting? <i>None, there was felt to be specific recommendation at this stage.</i> 	
DATE AND TIME OF NEXT MEETING		
Date: Tuesday 21 September 2021		
Time: 11:15 – 13:15		

DRAFT

**RATIFIED MINUTES OF GOVERNANCE COMMITTEE MEETING HELD ON
22 JULY 2021 AS A VIRTUAL MEETING VIA MICROSOFT TEAMS
AT 13:00 TO 15:00**

Present:		
Jill Dentith (Chair)	JED	Governing Body Lay Member – Governance, DDCCG
Dr Emma Pizzey	EP	Governing Body GP, DDCCG
Dr Greg Strachan	GS	Governing Body GP, DDCCG
Ian Gibbard	ICG	Governing Body Lay Member – Audit, DDCCG
Martin Whittle	MW	Governing Body Lay Member – Patient and Public Involvement, DDCCG
Chrissy Tucker	CT	Director of Corporate Delivery, DDCCG on behalf of Helen Dillistone
In Attendance:		
Ged Connolly-Thompson	GCT	Head of Digital Development, DDCCG
James Lunn	JL	Head of Human Resources and Organisational Development, DDCCG
Lisa Butler	LB	Complaints and PALS Manager, DDCCG (part meeting)
Lisa Innes	LI	Head of Procurement, NHS Arden and GEM CSU (part meeting)
Ruth Lloyd	RL	Information Governance Manager, DDCCG
Suzanne Pickering	SP	Head of Governance, DDCCG
Richard Heaton	RH	Business Resilience Manager, DDCCG
Frances Palmer	FP	Corporate Governance Manager, DDCCG
Lucinda Frearson (Admin)	LF	Executive Assistant, DDCCG
Apologies:		
Helen Dillistone	HD	Executive Director of Corporate Strategy and Delivery, DDCCG
Sean Thornton	ST	Assistant Director Communications and Engagement DDCCG and JUCD

Item	Subject	Action
GC/2122/27	<p>WELCOME, APOLOGIES & QUORACY</p> <p>JED welcomed members to the meeting and confirmed the meeting to be quorate.</p> <p>Apologies received: Helen Dillistone, Sean Thornton.</p> <p>JED noted the Committee's thanks to Maria Muttick for her assistance with the Committee's administration over the last few months.</p>	
GC/2122/28	<p>DECLARATIONS OF INTEREST</p> <p>JED reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG.</p> <p>Declarations made by members of the Governance Committee are listed in the CCG's Register of Interests and included with the meeting papers. The Register is also available either via the corporate secretary to the Governing Body or the CCG website at the following link:</p>	

	<p>www.derbyandderbyshireccg.nhs.uk</p> <p>LI declared an interest due to her role as Head of Procurement for Arden and GEM CSU.</p> <p>No further declarations were received.</p>	
<p>GC/2122/29</p>	<p>DERBY AND DERBYSHIRE CCG PROCUREMENT HIGHLIGHT REPORT</p> <p>LI presented the Procurement Highlight report taking the paper as read and advising of the proposal to change the format of the paper. The report now only includes notification of projects at high or medium risk to be presented. LI stated there were currently no high risks in services being delivered, only pipeline services.</p> <p>LI advised that the procurement team and contracting team would now be meeting monthly, this was to ensure risks were being progressed and escalated moving forward. LI stated there were no high-risk procurements currently that required escalating.</p> <p>JED asked if Covid issues were affecting capacity and if so, how were the issues were being worked through. LI informed the meeting that these were being progressed. Where there had been resource issues due to redeployment etc, some services had been temporarily suspended but these were now up and operational and an update would be given on the next report in terms of status. LI highlighted there were currently no major issues or risks to timelines.</p> <p>IG asked regarding the Lighthouse service, shown as red on the report, and whether the contract was to be extended. LI advised that the service had been recommissioned with a procurement exercise being undertaken but as the award outcome letter had not been published formally the service remained red on the report.</p> <p>The Governance Committee REVIEWED the Highlight report for Derby and Derbyshire CCG, NOTED status of projects, and NOTED the change in format proposed moving forward.</p>	
<p>GC/2122/30</p>	<p>CORPORATE POLICIES AND PROCEDURES</p> <p>FREEDOM OF INFORMATION POLICY:</p> <p>SP informed the Committee that this had been the first review of the FOI Policy since the merger of the four CCGs and minimal changes had taken place. Changes included an update of contact details, minor wording adjustments and an additional section 8.7 which detailed the approval process for drafting responses.</p> <p>The Committee APPROVED the NHS Derby and Derbyshire CCG's latest version of the Freedom of Information Policy.</p>	

	<p>STANDARDS OF BUSINESS CONDUCT AND MANAGING CONFLICTS OF INTEREST POLICY:</p> <p>FP advised a review of the policy had been carried out as part of the Policy's annual review. Amendments to the policy were minor and highlighted in red.</p> <p>The Committee APPROVED the NHS Derby and Derbyshire CCG's latest version of the Standards of Business Conduct and Managing Conflicts of Interest Policy.</p> <p>GIFTS AND HOSPITALITY POLICY:</p> <p>FP advised a review of the policy had been carried out as part of the Policy's annual review. Amendments to the policy were minor and highlighted in red.</p> <p>The Committee APPROVED the NHS Derby and Derbyshire CCG's latest version of the Gifts and Hospitality Policy.</p> <p>PROCUREMENT POLICY:</p> <p>FP and LI have undertaken a review of the Procurement Policy, FP advised this had been carried out as part of the policy's annual review. Amendments to the policy were highlighted in red.</p> <p>LI advised that once the ICS procurement guidance was released later in the year a further review would be carried out.</p> <p>The Committee APPROVED the NHS Derby and Derbyshire CCG's latest version of the Procurement Policy.</p> <p><i>NOTE - Item 38 was next discussed to enable LI to leave the meeting following this item.</i></p>	
<p>GC/2122/31</p>	<p>GOVERNANCE COMMITTEE ANNUAL REPORT</p> <p>JED presented the Governance Committee Annual Report which illustrates the work of the Committee during the year. The Report will be presented to the Governing Body on the 5th August.</p> <p>MW highlighted that he had been listed as not attending the January meeting. FP assured the meeting that the minutes were double checked but was happy to recheck.</p> <p>JED thanked everyone for their contributions to the meeting, both those that were members and those in attendance.</p> <p>The Governance Committee NOTED the contents of the report for information and assurance.</p>	<p>FP</p>

<p>GC/2122/32</p>	<p>CCG RECOVERY AND RESTORATION PLAN CLOSURE REPORT</p> <p>CT advised that at the last meeting a discussion had taken place around closing down the Recovery and Restoration plan, however there were actions which were still ongoing in relation to returning to offices. It had been agreed these actions would continue as business as usual and managed by other forums such as the Estates Group which reports into the Governance Committee.</p> <p>CT reported that this work had now been completed and the report identified the completed actions and how each had been managed. CT made a formal request to close down the process on behalf of the Governance Committee.</p> <p>An amended Terms of Reference was presented with the removal of the Recovery and Restoration plan from the Committee's responsibilities. JED requested that the changes were noted, and the Terms of Reference will be presented to Governing Body in September at the next six-month review</p> <p>The Governance Committee NOTED and APPROVED the contents of the report for information and assurance.</p>	
<p>GC/2122/33</p>	<p>HUMAN RESOURCES PERFORMANCE REPORT 2020/21 and STAFF SURVEY ACTION PLAN</p> <p>HUMAN RESOURCES PERFORMANCE REPORT</p> <p>JL presented the annual performance overview as the quarterly reports previously submitted through Governance Committee had been paused following the move to Level 4 Business Continuity.</p> <p>The report provides assurance of the continuation to track starters, leavers, and the filling of vacancies. The report covered the period April 2020 to March 2021. A summary noted a small reduction in the number of leavers over the period, a reduction in sickness levels and a slight increase in representation of Black Asian Minority and Ethnicity (BAME) colleagues. JL also advised that vacancy levels had slightly increased.</p> <p>IG asked if similar tracking was being carried out around the Covid vaccine uptake within the CCG staff group and if so where the information was being presented.</p> <p>JL informed members that the data was being gathered, managers have been asked to review individuals risk assessments in relation to government guidance and as part of that staff were being requested to confirm their vaccination status. This information is reported to NHSEI as part of the CCG's returns. The Committee believed the data to be important and requested JL to build into his reporting.</p> <p>Action: JL to report on CCG vaccination data at the next meeting.</p> <p>EP highlighted Table 7 and the BAME representation although it looked good there was nothing to compare to. JL stressed that unfortunately the census data within Derbyshire was from 2011 so was now out of date. The aim was to be representative of the community. The key point is moving forward into the ICS and looking at senior representation within the ICS Board and Committees</p>	<p>JL</p>

	<p>to have that representation at decision making level. Although it was noted that there may be limited opportunity to influence at this point.</p> <p>The Governance Committee NOTED the contents of the report for information and assurance.</p> <p>STAFF SURVEY ACTION PLAN:</p> <p>JL provided a progress update for information and assurance on the staff survey action plan following the last meeting. It outlined the progress made in relation to the actions completed and those still awaiting action. In summary, some good progress had been made against the actions. The action plan specifically focused on the experiences of the BAME staff group and work was ongoing with the Equality and Diversity Network focusing on those actions.</p> <p>The Governance Committee NOTED progress in relation to the Staff Survey Action Plan.</p>	
<p>GC/2122/34</p>	<p>WORKFORCE RACE EQUALITY STANDARD (WRES), WORKFORCE DISABILITY EQUALITY STANDARD (WDES) ACTION PLAN AND GENDER PAY GAP REPORT 2020/21</p> <p>JL presented the WDES and WRES action plans – advising they have been updated with actions mandated nationally in terms of national and regional Equality Diversity and Inclusion priorities.</p> <p>The actions from the staff survey had been incorporate into the relevant plans which had been presented for assurance and approval in terms of the draft action plans which had also been through the Diversity and Inclusion network.</p> <p>The gender pay gap is a new report, a statutory responsibility completed a year retrospectively and this was the first report since the four CCGs merged as previously, they had not met the threshold. The Committee noted the combined gender profile for the 454 CCG employees as 81% female and 19% male. Regarding the Governing Body, Executives Team and GP leaders in the CCG, there was a relatively even split between male and female. However, for all other employees of the CCG the percentages were 84% female and 16% male. The Committee noted that the CCG has a mean gender pay gap of 35.1% and a median gender pay gap of 20.6%. The report highlighted actions being taken to reduce this gap, including strengthening work around equality and promoting flexible working options.</p> <p>JED asked if the CCG are on target regarding BAME, equality and disability as the first quarters element had already been completed. JL advised that the CCG were on target and this work overlapped with the staff action plan. One key topic was around the fair and inclusive recruitment training; and in the next couple of weeks this would be presented to the Diversity and Inclusive Network with a hope to roll out in September.</p> <p>The Governance Committee NOTED and APPROVED the contents of the reports for information and assurance.</p>	

<p>GC/2122/35</p>	<p>2020/21 ANNUAL COMPLAINTS REPORT and QUARTER 1 2021/22 COMPLAINTS REPORT</p> <p>ANNUAL COMPLAINTS REPORT 2020/21</p> <p>LB presented the report and advised the report showed a look back at the previous year with a summary of the total complaints received and highlighting areas of concern. The main themes and trends were CHC and Medicines Management. Of note were the number of complaints being upheld and of the 14 complaints received against CHC last year, 13 were fully or partially upheld. Main themes had been poor communication and process. It was noted that lessons learned from this report would be built into processes going forwards.</p> <p>JED asked if the report was published formally. SP agreed to publish the report on the CCG website to demonstrate openness and transparency. RL stated it was a very positive report but did not reflect the breadth of responsibility of the Complaints team. LB advised the other part of their team's work related to Patient Liaison Advisory Service (PALS) which is reported through to the Patient Experience Group.</p> <p>LB highlighted the report was a statutory requirement which was being met by summarising the complaints and learning from them.</p> <p>The Governance Committee NOTED the contents of the report for information and assurance.</p> <p>QUARTER 1 2021/22 COMPLAINTS REPORT</p> <p>4 complaints had been received during quarter 1:</p> <ul style="list-style-type: none"> • 2 in relation to CHC; and • 2 in relation to Medicines Management policies. <p>All 4 were now closed with no complaints open at the end of the quarter. The CHC complaints had been due to process and communication. KPIs had now been put in place with the CSU responding to letters within 5 days and improvements were expected.</p> <p>The Governance Committee NOTED the contents of the report for information and assurance.</p>	
<p>GC/2122/36</p>	<p>QUARTER 1 FREEDOM OF INFORMATION REPORT</p> <p>SP presented the FOI Report for Quarter 1, April to June 2021. In terms of the volume of requests 45 had been received, a slight reduction of 5 compared to Quarter 4. Clarification was sought on one request, noting that no response was received and in line with process the request was closed after 30 days</p> <p>SP outlined most requests were unique with each having to be dealt with separately. The largest percentage of requests during this quarter had been regarding commissioning and procurement, with other popular topics being mental health and finance.</p> <p>In terms of response time, statutory duty had been met with no requests responded to outside of the 20-working day deadline.</p>	

	<p>The Governance Committee RECEIVED and Noted the FOI Quarterly report.</p>	
<p>GC/2122/37</p>	<p>CONTRACTS OVERSIGHT REPORT</p> <p>CT presented an update on the contracts oversight work brought to Committee previously. Contracts were being worked through and included onto a single database to give full control of contracts and knowledge of status. The Data Security and Protection Toolkit (DSPT) part of the contracts had now been completed with regularly meetings in place to ensure all contracts were listed, including details of current managers.</p> <p>Updates will be presented to SLT to enable them to monitor expiry dates and ensure a governance process is developed to ensure contracting decisions are made within the appropriate framework.</p> <p>A review of software was also underway to assess which would best meet the needs in maintaining the database, this work was still in progress.</p> <p>The Governance Committee NOTED the contents of the report for information and assurance.</p>	
<p>GC/2122/38</p>	<p>PROCUREMENT DECISIONS IN ICS TRANSITION</p> <p>CT presented the report advising a paper had been to the JUCD Senior Leadership Team as part of the conversations ongoing in relation to contract expiry dates approaching and the consideration to re-procure and transfer to the ICS. The decision made by the SLT was to involve Delivery Boards that had been formed as part of JUCD to have discussions around those services. There were around 20 services in the paper which requires a decision by those Delivery Boards. As the CCG are the statutory organisation, they would require a CCG committee to make the formal governance decision and oversee the process. CT informed the meeting that CLCC had discussed some services discussed at the A&E Delivery Board and Planned Care Board already.</p> <p>CT outlined the need to manage the Conflicts of Interest (COI) very carefully as some providers were members of the Delivery Boards. Appendix 2 showed a template CT proposed to bring through Governance Committee regularly which would detail the service to be procured, the Delivery Board that made the decision, the recommendation, how the COI were managed and the final decision of the CCG committee. This would give oversight of how and where decisions were being made. LI has been working with CT and HD in terms of contracting to give advice and guidance were necessary.</p> <p>EP commented around COI, highlighting many people on the Delivery Boards will be discussing the contracts and will be conflicted and asked if the process would be manageable and appropriately governed. CT explained that has been a major concern and provided an update for appendix 2 which CT agreed to circulate after the meeting showed how the first few discussions had been managed and how the providers were excluded from the conversation. IG suggested more granularity in terms of what the Committee would see was required due to providing oversight on the decision. CT advised that this would be included on the template.</p>	

	<p>Action: CT to circulate Appendix 2 following the meeting.</p> <p>JED questioned whether the oversight was the role of Governance Committee and was it included in Terms of Reference (TOR) and part of the Scheme of Delegation. CT reported the oversight of procurement process was within Governance Committee TORs and was about the process not the procurement. Guidance on the model Constitution for the ICS was expected imminently which may provide a framework for the ICS committee structure.</p> <p>The Governance Committee NOTED the contents of the report for information and assurance gave SUPPORT to the proposals.</p> <p><i>NOTE - This item was discussed earlier in the meeting, following items 28 and 29, to allow LI to leave the meeting prior to any further agenda discussions and possible COI in relation to her role as Arden and GEM Head of Procurement</i></p>	<p>CT</p>
<p>GC/2122/39</p>	<p>ESTATES UPDATE</p> <p>CT gave an update on work being carried out within the CCG. CT explained staff have been working from home for over 12 months and in preparation for the proposals to return to the office, work has begun to consider what the new ways of working model will look like.</p> <p>A staff survey has been completed with most staff supportive of a hybrid model. The Estates Group are working through a potential model, but this would need to reflect on current infection rates and where possible ensuring consistency with other NHS organisations where this was appropriate.</p> <p>A pilot scheme was initially proposed for September however due to the current high infection rates this is unlikely to be achieved, however, the work was still ongoing. CT gave assurance that health and safety obligations as part of the action plan were being addressed.</p> <p>CT advised the meeting that DCHS have been utilising some CCG offices on the ground floor south which the CCG have not formally moved into.</p> <p>The Governance Committee NOTED the contents of the report for information and assurance.</p>	
<p>GC/2122/40</p>	<p>BUSINESS CONTINUITY, EMERGENCY PLANNING RESILIENCE AND RESPONSE UPDATE</p> <p>RH advised the Committee that the national EPRR core standards could be issued within the next couple of weeks in a similar format to those that had been received previously.</p> <p>The Risk Assessment Working Group met for the first time and set a schedule of meetings over the next 6 months to review all the Derbyshire risks and ensure they correlate with the national risk register.</p> <p>RH also presented a paper on the CCG's lessons learnt on the EU Exit and its reflections, reporting the learning has been quite positive. Some systems and processes had already been put in place internally and system wide processes</p>	

	<p>continued during the pandemic, such as the setting up of specialist cells and reporting on system portals, which allowed a smooth transition into managing the Covid pandemic.</p> <p>The Governance Committee NOTED the contents of the report for information and assurance.</p>	
GC/2122/41	<p>HEALTH AND SAFETY REPORT</p> <p>RH highlighted the main item in the report was the new governance advice and work was underway with the estates team to review the transition back into using office space.</p> <p>RH clarified information on the health and safety audit of the sites were reported to that last meeting had been put in place and all recommendations were now fully compliant.</p> <p>MW commented on the checking of own personal equipment and how safe it was to ask staff to check their own equipment. CT advised that guidelines would be given on what to look for and would be a common sense check. Once we adopt a hybrid model and staff return into offices, PAT testing would be scheduled and undertaken professionally.</p> <p>The Governance Committee was ASSURED that Derby and Derbyshire CCG was coordinating work to meet its health and safety obligations to remain compliant with health and safety legislation and was ASSURED that Derby and Derbyshire CCG was responding effectively and appropriately to the changes in working practices as a consequence of the COVID-19 pandemic.</p>	
GC/2122/42	<p>VIOLENCE REDUCTION STANDARDS UPDATE</p> <p>RH advised that a detailed report and action plan was presented at the last committee. RH has since met with 360 Assurance to put together a schedule and key documents. It is the responsibility of 360 Assurance to provide these and they were expected to be available in draft form in time for the Committee, however, these have not yet been received.</p> <p>360 Assurance were also working with neighbouring CCGs on a master template for a policy and a strategy that each CCG can adopt and was hoped to be available for September.</p> <p>Action: SP to escalate concerns through 360 Assurance.</p> <p>The Governance Committee NOTED the contents of the report for information and assurance.</p>	SP
GC/2122/43	<p>INFORMATION GOVERNANCE & GDPR UPDATE REPORT</p> <p>RL presented the report giving a brief update issues that had occurred since the paper was published. The membership had now been confirmed for the GP Information Governance Assurance Forum, the first meeting would be during August and will focus on the Derbyshire Share Care Record to enable</p>	

	<p>DPIAs and information sharing agreements to be presented and then circulated to General Practice for review and agreement.</p> <p>The Data Security Protection Toolkit for next year has been published, timescales for submission are 30th June 2022; the CCG will plan to submit on 31st March which should align with the close down of the CCG and with annual reporting timescales.</p> <p>An EU adequacy decision had been provided, information flowing to and from the EU where required as part of national systems had been affirmed. Guidance to this was referenced at the end of the report but had not yet been published and will be shared through the usual IG newsletter channels once available</p> <p>The Governance Committee APPROVED and RECEIVED the update of actions and activities.</p>	
<p>GC/2122/44</p>	<p>DIGITAL DEVELOPMENT UPDATE</p> <p>GCT presented the update advising that work continues around the removal of unsupported applications on the network mainly around Office 365 and Windows 10. A process has been agreed with NECS regarding the outstanding GP practices to enable the deadline to be met with minimal disruption. Communication will go out to GPs prior to any configuration changes to ensure no data loss during the process or disruption during consultations. The communication will inform the GP that when they next turn on their PC the installation will take place.</p> <p>GCT is awaiting an update from NECS on the number of Windows 10 machines which are still unsupported. GCT expected then to be able to ask for the Cyber Essentials information to be informally reviewed by the auditor and assuming there are no issues, it will go to IGAF and ask for formal permission to submit to have Cyber Essentials re-accreditation.</p> <p>The GP IT operating model has been reviewed by PCN Clinical Directors and is going out to GP practices. The biggest issue with this is the connectivity of third-party devices on to the GP network, therefore we will be establishing a Change Advisory Board across the whole system.</p> <p>GCT reported a system performance issue that had taken place most of Wednesday 21st July 2021 which had affected corporate and GP practice sites. GCT gave assurance this had now been resolved and he was waiting the RCA from NECS to outline the cause and any remedial action required.</p> <p>ELECTRONIC EYE CARE REFERRAL SERVICE PID</p> <p>The detailed Project Initiation Document (PID) was included in the papers for the meeting. GCT advised they were currently in the process of appointing a Clinical Safety Officer to oversee the project. A meeting with NHSD was arranged to go through initial questions regarding timescales and to agree the final implementation.</p> <p>The Governance Committee NOTED the contents of the report for information and assurance.</p>	

<p>GC/2122/45</p>	<p>RISK REGISTER REPORT</p> <p>SP presented this report highlighting the approval of the closure of Risk 29 in relation to contract management arrangements which had been approved virtually by the Governance Committee and subsequently by Governing Body on 1st July 2021.</p> <p>The Governance Committee is responsible for 7 risks, one new risk was identified in the report, Risk 40. In the period of transition from CCG to ICS, it is likely that a larger proportion of contracts will be extended on expiry rather than re-procured. 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.</p> <p>This proposed new risk has been scored at a high 12 (probability 3 x impact 4).</p> <p>The Governance Committee RECEIVED the Governance risks assigned to the committee as at July 2021. The Committee NOTED the virtual approval received on 18th June 2021 from members for the closure of risk 29 relating to current contract management arrangements. The closure was also approved at Governing Body on 1st July 2021.</p> <p>The Committee APPROVED new risk 40 relating to extension of contracts in the period of transition from CCG to ICS.</p>	
<p>GC/2122/46</p>	<p>2021/22 QUARTER 1 GOVERNING BODY ASSURANCE FRAMEWORK</p> <p>SP presented the quarter 1 full GBAF for 21/22 report that had been presented to Governing Body on 1st July 2021. Updates were shown in red. As part of the Governing Body review of the CCG's strategy objectives in May, 2 additional objectives have been identified for the CCG which in turn have identified 3 new strategic risks for the GBAF. It was noted that as a result two new strategic risks had been identified for Governance Committee oversight: -</p> <ul style="list-style-type: none"> • GBAF Risk 7: CCG staff retention and morale during the transition will be adversely impacted due to uncertainty of process and implications of the transfer to the ICS, despite the NHSEI continuity of employment promise. • GBAF Risk 8: 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. <p>Moving forward the GBAF will be presented at every meeting with updated strategy risks. These will be reviewed virtually then brought to each Governance Committee for review and approval prior to Governing Body.</p> <p>MW commented that in terms of Risk 7 and 8 it was noted that the HR Performance report showed that the risk of people leaving due to uncertainty did not indicate this to be the case. In fact, figures are showing less staff have</p>	

	<p>left the CCG than previously and suggested that this should be reflected in the scores. He therefore suggested both risks are scored slightly high.</p> <p>CT advised regarding Risk 8, GBAF papers were prepared at a point in time and at that time it was unsure when the Bill was to go through parliament and this would possibly bring down the score for the next review as the Design Framework and HR Framework had both also been received. SP stated a review of the risks was due in July and suggested changes could be made at that point if the trends continued.</p> <p>The Governance Committee NOTED the Quarter 1 Governing Body Assurance Framework and RECEIVED GBAF Risks 7 and 8 which had been APPROVED virtually by Governance Committee on 18 June 2021. It was AGREEDA not to make any further changes to risks scores at the moment but NOTING comments made which will be considered at the next GBAF review.</p>	
GC/2122/47	<p>MINUTES OF THE MEETING HELD ON: 20 MAY 2021</p> <p>The Governance Committee APPROVED the Minutes of the meeting on 20 May 2021 as a true and accurate record of the meeting.</p>	
GC/2122/48	<p>MATTERS ARISING</p> <p>None.</p>	
GC/2122/49	<p>ACTION LOG FROM THE MEETING HELD ON: 20 MAY 2021</p> <p>The Governance Committee REVIEWED the action log. All actions were CLOSED.</p>	
GC/2122/50	<p>GOVERNANCE COMMITTEE FORWARD PLANNER 2021/22 (FOR DISCUSSION/AGREEMENT)</p> <p>The Governance Committee APPROVED the Forward Planner 2021/22</p>	
GC/2122/51	<p>ANY OTHER BUSINESS</p> <p>None received.</p>	
GC/2122/52	<p>FUTURE MEETINGS DATES Time: 13:00 – 15:00 <u><i>NB. The meetings will be held as virtual meetings until further notice.</i></u></p> <p>Thursday 23 September 2021 Papers due: Tuesday 14 September 2021</p> <p>Thursday 11 November 2021 Papers due: Tuesday 2 November 2021</p> <p>Thursday 10 February 22 Papers due: Tuesday 2 February 2022</p> <p>Thursday 24 March 2022 Papers due: Tuesday 15 March 2022</p>	

	<p>ASSURANCE QUESTIONS</p> <ol style="list-style-type: none"> 1. Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? Yes 2. Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? Yes 3. Were papers that have already been reported on at another committee presented to you in a summary form? Yes 4. Was the content of the papers suitable and appropriate for the public domain? Yes, other than potentially some discussions around procurement which may have to be redacted when minutes presented in public. 5. Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? Yes 6. 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, however the review process as part of the ICS transition and Governance Committee's future role over the next 6-9 months will need additional work and should feature on the forward planner. 7. What recommendations do the Committee want to make to Governing Body following the assurance process at today's Committee meeting? The following will be highlighted in the assurance report to Governing Body: <ul style="list-style-type: none"> • Policies approved; • Procurement regarding transition to ICS; and • Proposed amendments to the TORs for the Committee as part of recovery and restoration changes. 	<p>SP</p>
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**MINUTES OF PRIMARY CARE COMMISSIONING COMMITTEE
PUBLIC MEETING**

HELD ON

Wednesday 25th August 2021

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

PRESENT

Ian Shaw (Chair)	IS	Lay Member Derby & Derbyshire CCG
Kath Bagshaw	KB	Deputy Medical Director (for Executive Medical Director)
Jill Dentith	JeD	Lay Member Derby & Derbyshire CCG
Simon McCandlish	SMc	Deputy Chair, Lay Member, Derby & Derbyshire CCG
Clive Newman	CN	Director of GP Development Derby & Derbyshire CCG
Jill Savoury	JS	Assistant Chief Finance Officer (For CFO)

IN ATTENDANCE

Hannah Belcher	HB	AD GP Commissioning & Development Derby DDCCG
Judy Derricott	JDe	Head of Primary Care Quality Derby & Derbyshire CCG
Kath Markus	KM	Chief Executive Derby & Derbyshire LMC
Abid Mumtaz	AM	Service Commissioning Manager Public Health, Derbyshire County Council
Jean Richards	JR	Senior GP Commissioning Manager DDCCG
Pauline Innes	PI	Executive Assistant to Dr Steven Lloyd DDCCG

APOLOGIES

Niki Bridge	NB	Deputy Chief Finance Officer, DDCCG (for CFO)
Steve Lloyd	SL	Executive Medical Director Derby & Derbyshire CCG
Adam Norris	AN	Service Commissioning Manager Public Health, Derbyshire County Council
Marie Scouse	MS	AD of Nursing & Quality Derby & Derbyshire CCG (for CNO)
Brigid Stacey	BS	Chief Nurse Derby & Derbyshire CCG

ITEM NO.	ITEM	ACTION
PCCC/2122/122	<p>WELCOME AND APOLOGIES</p> <p>The Chair (IS) welcomed Committee Members to the meeting. Apologies were received and noted as above.</p> <p>The Chair confirmed that the meeting was quorate.</p>	
PCCC/2122/123	<p>DECLARATIONS OF INTEREST</p> <p>The Chair informed members of the public of the committee members' obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG.</p> <p>Declarations declared by members of the Primary Care Commissioning</p>	

	<p>Committee are listed in the CCG's Register of Interests and included within the meeting papers. The Register is also available either via the corporate secretary to the Governing Body or the CCG website at the following link:</p> <p style="text-align: center;">www.derbyandderbyshireccg.nhs.uk</p> <p>There were no Declarations of Interest made.</p> <p>The Chair declared that the meeting was quorate.</p>	
FOR DECISION		
	No items for decision	
FOR DISCUSSION		
	No Items for discussion	
FOR ASSURANCE		
PCCC/2122/124	<p>FINANCE UPDATE</p> <p>Jill Savoury (JS) presented an update from the shared paper. The paper was taken as read and the following points of note were made.</p> <p>Key points of interest:</p> <ul style="list-style-type: none"> • The CCG have met all targets for Month 3. • The reported position as at Month 3 is a year-to-date underspend of £113k with a breakeven position to the end of Month 6. • This position includes £2.697m YTD and £4.624m FOT relating to Covid expenditure for Hospital Discharge Programme which is expected to be reclaimed in full. It also includes an estimated amount of £0.448m YTD and £1.579m FOT for Elective Recovery Fund which is also expected to be reimbursed but has not yet been validated. • Primary Care Co-commissioning budget is showing a forecast overspend of £136k at the end of Month 3, however mitigations are being considered to bring back in line by the end of Month 6. <p>The M4 financial position has not yet been reported to the Governing Body and so will be reported to the public session of the PCCC at the next 2021 meeting.</p> <p>The Primary Care Commissioning Committee NOTED and RECEIVED the update on the DDCCGs financial position for Month 3.</p>	
PCCC/2122/125	<p>RISK REGISTER EXCEPTION REPORT</p> <p>Hannah Belcher (HB) presented an update from the shared paper. The paper was taken as read and the following points of note were made.</p> <p>The Committee noted that there is an increase in demand, General Practice are seeing a 10 percent increase on the number of appointments prior to the pandemic in 2019 with 50k additional appointments every month is being seen in general practice at the moment. Concerns have been highlighted in terms of the number of staff being absent from work due to annual leave, COVID-19, self-isolating and general sickness.</p>	

	<p>HB reported that the weekly SITREP report has now been reinstated from practices. HB recommended to the Committee that the risk rating is not changed stating that in September this will be something that will need to be considered as the position potentially will get worse as winter approaches.</p> <p>Clive Newman (CN) reported that mitigations are in place with winter plans in place stressing to the Committee that the whole system is in a fragile position at the moment. CN supports HB comments stating that the position should remain the same as previous months.</p> <p><u>Risk 04A: Contracting:</u> Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care – Risk Score 16</p> <p><u>Risk 04B: Quality:</u> Failure of GP practices across Derbyshire results in failure to deliver quality Primary Care services resulting in negative impact on patient care. Risk Score 20</p> <p>Ian Shaw (IS) enquired if there was any further advice on the proposed booster programme which is due to commence in October 2021. CN explained that Primary Care Networks have been signed up to Phase 3 Booster programme with the enhanced service commencing on 6th September 2021 however no notification has been received of when the vaccines will arrive, stating that Primary Care are awaiting further detail from JCVI as to what the booster programme will look like. The Committee noted that 12- to 15-year-olds that have underlying vulnerabilities or living with people that are immunosuppressed are now being vaccinated however it is yet to be confirmed when vaccines will be offered to all 12-to-15-year olds.</p> <p>Kath Markus (KM) reported that JCVI need to take a decision so that planning can be undertaken stressing to the Committee that potentially very little notice will be given as to when the programme will commence.</p> <p>Kath Bagshaw (KB) stated that the Committee also need to be cognizant that the booster programme will also run alongside the flu programme which will further increase pressures for general practice.</p> <p>The Primary Care Commissioning Committee NOTED and RECEIVED the update on the two outstanding risks and AGREED that the scores remain unchanged and continue to be reviewed monthly.</p>	
PCCC/2122/126	<p>BRAILS福德 & HULLAND MEDICAL PRACTICE UPDATE</p> <p>Judy Derricott (JDe) presented an update from the shared paper. The paper was taken as read and the following points of note were made.</p> <ul style="list-style-type: none"> • CQC has placed Brailsford and Hulland Medical Practice in special measures. Services placed in special measures will be inspected again within six months. If insufficient improvements have been made such that there remains a rating of inadequate for any population group, key question or overall, CQC will take action in line with their enforcement procedures to begin the process of preventing the provider from operating the service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. • The service will be kept under review and if needed could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there 	

	<p>is not enough improvement CQC will move to close the service by adopting our proposal to remove this location or cancel the provider's registration.</p> <ul style="list-style-type: none"> • Special measures will give people who use the service the reassurance that the care they get should improve. • CQC found serious concerns about patient safety. The practice had to submit an action plan by 30 June 2021 to detail how the serious concerns that put patients at risk would be addressed. An action plan was submitted. Care taking arrangements were put in place on 25 June 2021 and the provider informed CQC that they would submit an application to cancel their registration with the Care Quality Commission. If these measures had not been put in place, we would have taken greater enforcement action. • The CCG has been working with this practice and local system partners since May to support the practice with short- and long-term resilience. The practice had been in discussions with South Dales Health and agreed a Memorandum of Understanding (MOU) to support short term resilience to enable the practice to continue to operate whilst merger discussions took place, the contract variation to enable the practice partnership arrangements to change became effective from the 1st August 2021. • South Dales Health, have met with staff and the patient participation group and have written a letter to be shared with all patients as way of update and assurance to the future of the practice and care of patients. <p>The Clinical Commissioning Group will continue to work with the practice to support the completion of actions in relation to the CQC Inspection report. This includes support from the Primary Care Quality Team, Contracting, Medicines management, Communications, and other directorates as appropriate.</p> <p>The Primary Care Commissioning Committee NOTED and RECEIVED the update and were ASSURED with the ongoing work and support provided to Brailsford & Hulland Medical Practice.</p>	
PCCC/2122/127	<p>PRIMARY CARE QUALITY & PERFORMANCE PUBLIC ASSURANCE REPORT – QUARTER 1</p> <p>Judy Derricott (JDe) presented an update from the shared paper. The paper was taken as read and the following points of note were made.</p> <ul style="list-style-type: none"> • The report covers the period 1st April to 30th June 2021 (Quarter 1) and is intended to provide the Primary Care Commissioning Committee with assurance that the Derby and Derbyshire Clinical Commissioning Group is fulfilling its statutory responsibility under delegated authority to monitor and support primary care quality and performance. • The PCQ&PRSC has further established a pre meeting (Hub) to review available quality and performance intelligence and data of member practices and Primary Care Networks (PCNs). The Hub will make recommendations to the PCQ&PRSC in respect of possible actions / interventions in relation to both individual practice and PCN performance. • The PCQ&PRSC and Hub Assurance meetings recommenced in May 2021. The interim Primary Care Quality & Performance Exception Assurance Group actions were transferred to the relevant meeting/committee for the appropriate action going forward. 	

	<ul style="list-style-type: none"> • The report covers the work undertaken or supported by the Primary Care Quality and Contracts/ Performance team and provides an overview of the areas monitored through the Primary Care Quality & Performance Exception Assurance Group where representatives from the related work areas attend if applicable. Monthly verbal escalation actions from this meeting are submitted to the Primary Care Commissioning Committee for information and assurance. • The Public Facing Dashboard included in this report details practice list size, CQC rating, QOF results, Patient Survey Experience Overall and Patient Online uptake. This has been included to develop an initial report which can be further developed to add additional areas as requested as new information becomes available which may be felt to reflect a quality summary of primary care more accurately. All these indicators have been agreed by the Patient Engagement Committee in 2019 which will be reviewed accordingly. <p>The Primary Care Commissioning Committee NOTED and RECEIVED the Primary Care Quality & Performance Public Assurance Report – QUARTER 1</p>	
FOR INFORMATION		
	There were no items of Information	
MINUTES AND MATTERS ARISING		
PCCC/2122/128	<p>Minutes of the Primary Care Commissioning Committee meeting held on 28th July 2021</p> <p>The minutes from the meeting held on 28th July 2021 were agreed to be an accurate record of the meeting.</p>	
PCCC/2122/129	<p>MATTERS ARISING MATRIX</p> <p>There are no outstanding actions on the Action Matrix.</p>	
PCCC/2122/130	<p>ANY OTHER BUSINESS</p> <p>There were no items of any other business</p>	
PCCC/2122/131	<p>ASSURANCE QUESTIONS</p> <p>Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? Yes</p> <p>Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? Yes</p> <p>Were papers that have already been reported on at another committee presented to you in a summary form? Yes</p> <p>Was the content of the papers suitable and appropriate for the public domain? Yes</p> <p>Were the papers sent to Committee members at least five working days in advance of the meeting to allow for the review of papers for assurance purposes? Yes</p> <p>Does the Committee wish to deep dive any area on the agenda, in more</p>	

	<p>detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? No</p> <p>What recommendations does the Committee want to make to Governing Body following the assurance process at today's Committee meeting? None</p>	
	DATE AND TIME OF NEXT MEETING	
<p>Wednesday 22nd September 2021, 10:00-10:30am via Microsoft Teams Meeting</p>		

**MINUTES OF QUALITY AND PERFORMANCE COMMITTEE
HELD ON 26th August 2021, 2021, 9AM TO 10.00AM
MS TEAMS**

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

Item No.	Item	Action
<p>QP2122 /079</p>	<p>WELCOME, APOLOGIES & QUORACY</p> <p>Apologies were received as above. BD declared the meeting quorate.</p>	
<p>QP2122 /080</p>	<p>DECLARATIONS OF INTEREST</p> <p>BD reminded committee members of their obligation to declare any interest they may have on any issues arising at committee meetings which might conflict with the business of the CCG.</p> <p>KB noted that she is a GP Partner at Littlewick Medical Centre, Ilkeston. ACTION JP will arrange an update to the DOI for Dr Kath Bagshaw.</p> <p>Declarations declared by members of the Quality and Performance Committee are listed in the CCG's Register of Interests and included with the meeting papers. The Register is also available either via the corporate secretary to the Governing Body or the CCG website at the following link: www.derbyandderbyshireccg.nhs.uk</p> <p><u>Declarations of interest from sub-committees</u> No declarations of interest were made.</p> <p><u>Declarations of interest from today's meeting</u> No declarations of interest were made.</p>	<p>JP</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>	
<p>QP2122 /081</p>	<p>Integrated Report</p> <p>The report was taken as read and the questions submitted, and responses provided prior to the meeting were noted.</p> <p>AM raised a question on variation between the 2 acute providers noting the requirement to address health inequalities. AM asked</p>	

	<p>how this issue would be addressed. HW confirmed the following points</p> <ul style="list-style-type: none"> ○ HW is involved in system waiting list work drilling down into key specialties to look at differences between the Trusts in terms of waits and clearance times. ○ Where Derby is an outlier, this relates to more complex surgeries that CRHFT do not cover on their caseload. ○ Where there are inequalities in electives the CCH is working with the Trusts on a series of initiatives to look at system waiting lists, system mutual aid and outsourcing to the independent sector where possible. ○ There are some specialties where there are currently no solutions, in particular bariatrics at UHDBFT and therefore it is likely that there will continue to be long waiters in that area. This is an issue nationally. Work is being undertaken at a national level with opportunities to apply for funding. ○ HW, CCo and JC are working with Maria Riley and Viki Taylor on constructing a new system performance framework, taking into consideration the ICS constitution, guidance, and governance. <p>BD stated that he would like any transitional work to come to Quality and Performance Committee so that by March 22 there can be a smooth handover. HH confirmed that in the new structure of the ICS Quality and Performance will be managed separately.</p> <p>AM referred to behavioural analysis at UTCs, HW confirmed that the CCG Insight Group were managing the data collected on patient behaviours, however during the Covid-19 pandemic there have been limits on how the data could be collected. HW suggested inviting someone from the Insight Group to a future Quality and Performance Committee to provide an update. SMacG informed the Committee of a new online engagement platform which is available for use by all partners across JUCD and is being led by Karen Lloyd.</p> <p>ACTION – HW will invite someone from the Insight Group to a future Quality and Performance Committee to provide an update around patient behaviours in UTCs.</p> <p>BD referred to the Breast Pain Pathway and asked Committee members for thoughts on how it has embedded. JC responded to say that once the data for July has been received, she will discuss with BD and BS and decide whether it will come back to a future Quality and Performance meeting.</p> <p>ACTION – JC will review the July data for the Breast Pain Pathway and decide with BD and BS whether an update is required to the Quality and Performance Committee meeting.</p> <p>BB asked what assurance the CCG has around theatres are being used efficiently and if theatre utilisation is at the recommended 80%. HW responded to say theatre utilisation work is being carried out with the Midlands Elective Recovery Programme which is</p>	<p>HW</p> <p>JC</p>
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	<p>reporting good utilisation of theatres and showing significant improvements have been made. The challenges are around the loss of staff from theatres into ICUs. ICU occupancy has once again increased which has impacted. During the pandemic theatre staff were put on rotation into the ICUs to support ICU staff, they are being kept on the rotations to maintain their skills should they be needed in the event of a resurgence.</p> <p>Staffing issues are also related to staff leaving and the "pingdemic". Staff morale is also a factor with a number of staff being off work due to their emotional wellbeing and burn out. This is a theme that is being seen across the board.</p> <p>HH noted the CAMHS waiting times continue to be a concern. HH is leading a group looking into a new Neurodevelopmental pathway for Children and Young People which will focus on the graduated support. A pilot is in development to support teachers around how they work with children who have Neurodevelopmental concerns.</p> <p>Activity Report</p> <p>The paper was taken as read. HW highlighted two points on A&E and ED attendances which continue to be high. There are still issues around bed capacity and discharges. Covid occupancy has increased and the complexity of covid patients being admitted is higher.</p> <p>Elective recovery programme targets were achieved YTD which released additional funding into the system to support elective recovery. Monthly reporting into the Midland region is showing that elective recovery targets are on trajectory despite the challenges.</p> <p>BD APPROVED the Integrated Report.</p>	
<p>QP2122 /082</p>	<p>GBAF Q2</p> <p>The paper was taken as read.</p> <p>The Committee noted the contents and approved the paper.</p>	
<p>QP2122 /083</p>	<p>RISK REGISTER</p> <p>The paper was taken as read.</p> <p>The Committee noted the contents and approved the paper.</p> <p>AM confirmed that the Quality and Performance GBAF Task and Finish Group reviewed the GBAF earlier in the week and agreed there would be no changes.</p>	

<p>QP2122 /084</p>	<p>RISK STRATIFICATION</p> <p>The paper was taken as read.</p> <p>The Committee noted the contents and approved the paper.</p>	
<p>QP2122 /085</p>	<p>SAFEGUARDING ADULTS</p> <p>The paper was taken as read.</p> <p>AM noted increased press reports on Domestic Abuse and asked about the situation for Derbyshire and if there are any concerns to note. BN replied to say that it was expected to see a national increase of 60% in referrals however this has not been the case. Currently the number of referrals in the first quarter of the year has increased by 50%; 13% of these have been domestic abuse. The Safeguarding team will be looking at Domestic Abuse in the older population as 2/3 of the referrals for older people are for Domestic Abuse. This could be linked to COVID pressures.</p> <p>The Committee noted the contents and approved the paper.</p>	
<p>QP2122 /086</p>	<p>SAFEGUARDING CHILDREN</p> <p>The paper was taken as read.</p> <p>The Committee noted the contents and approved the paper.</p>	
<p>QP2122 /087</p>	<p>EMAS QUARTERLY UPDATE</p> <p>The paper was taken as read.</p> <p>JJ noted some key areas of focus, demand, workforce and handover challenges.</p> <p>Demand – the acuity of patients is higher and causing significant challenges. 84% of the activity coming into EMAS is C1 or C2 which puts pressure on resources. BD asked if there are plans to validate these calls to ensure they are appropriate. JJ confirmed that EMAS is seeing an increase in patients that are deemed unconscious, JJ is working with EMAS to understand how many of these calls were genuine. In addition, for certain codes within the C2 category, an enhanced assessment will be carried out prior to dispatching a vehicle. It is believed that with this enhanced assessment some patients may be moved to a C3 response.</p> <p>Workforce – EMAS is running at a sickness level of 9% in the Emergency Operations Centre (EOC). In July there was upwards</p>	

	<p>of 300 patients waiting to be allocated a resource in any one day and staff were faced with the challenges of managing these numbers. Most of the staff sickness is stress related.</p> <p>Handovers – 60 minutes waits and over are running at between 4%-8% of all conveyances. Leicester and Lincolnshire hospitals remain challenging however these same challenges are being experienced by other trusts. The Midland region as a whole has the highest levels of patients being held in an ambulance outside and ED across the country.</p> <p>EMAS are looking at prolonged waits to ensure patients are safe, especially in the community. A deep dive into safeguarding referrals has been carried out following an increase. BD asked how appropriate the safeguarding referrals were reflecting on his own experience in general practice. JJ confirmed that Strategic Delivery Board members had raised concerns and BD suggested some triangulation work could be done to obtain a clearer picture.</p> <p>DHU are part of a 3-month pilot to increase the validation of C3 and C4 calls within 111 from 30 minutes to 60 minutes. It is hoped that this will create capacity to validate more C3 and C4 patients and reduce the number of patients transferring over to the ambulance service.</p> <p>The ambulance sector has been granted £55m to stabilise its current position in terms of performance. EMAS will receive £3.7m.</p> <p>A range of initiatives are being put into place for additional call handlers and clinical support within the EOC as well as hospital liaison officers in Leicestershire and Lincolnshire to help manage handover queues.</p> <p>EMAS have had excessive numbers of applications from newly paramedics than they have vacancies, therefore some of the £3.7m funding is being used to appoint additional newly qualified paramedics.</p> <p>MW referred to patients with Mental Health (MH) issues and asked how much of an impact they have on EMAS capacity. JJ noted it is hard to identify the level of demand in this area. There is a regional wide MH group looking at how the ambulance service can be supported in accessing alternative services and looking at how 111 can divert directly into MH crisis services. Challenges around this include the time it takes to find a location to convey to. MH Nurses have also been employed into the EOC to help raise awareness, support, and intervene if necessary.</p> <p>The Committee noted the contents and approved the paper.</p>	
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<p>QP2122 /088</p>	<p>TRANSFORMING CARE PARTNERSHIP PRESENTATION AND UPDATE</p> <p>The paper was taken as read.</p> <p>HH informed the Committee as of today there are 31 CCG patients, 17 Specialised Commissioning patients and 2 patients which are children. There are several high and medium confidence patients that predicted to be discharged by the end of Q2 and it is anticipated that targets will be met. The CCG is still the worst in the country for TCP but there are assurances in place to manage this. Executive calls take place every week to look at issues and actions that need to be taken.</p> <p>The Committee noted the contents and approved the paper.</p>	
<p>QP2122 /089</p>	<p>CONTINUING HEALTH CARE (CHC)</p> <p>The paper was taken as read.</p> <p>The Committee noted the contents of the report and there were no questions raised.</p>	
<p>QP2122 /090</p>	<p>INFECTION PREVENTION & CONTROL</p> <p>The paper was taken as read.</p> <p>The Committee noted the contents of the report and there were no questions raised.</p>	
<p>QP2122 /091</p>	<p>CARE HOMES</p> <p>The paper was taken as read.</p> <p>The Committee noted the contents of the report and there were no questions raised.</p>	
<p>QP2122 /092</p>	<p>CONTROLLED DRUGS ANNUAL REPORT</p> <p>The paper was taken as read.</p> <p>The Committee noted the contents of the report and there were no questions raised</p>	

<p>QP2122 /093</p>	<p>MINUTES FROM SUB COMMITTEES</p> <p>The Committee noted the minutes from the following sub-Committees.</p> <ul style="list-style-type: none"> ○ DPG – 1st July 2021 ○ Safeguarding Committee – 25.05.21 ○ Update reports from CQRG ○ UHDBFT ○ CRHFT ○ DCHS ○ DHCFT 	
<p>QP2122 /094</p>	<p>MINUTES FROM THE MEETING HELD ON 29th July 2021.</p> <p>The minutes were approved as a true and accurate record.</p>	
<p>QP2122 /095</p>	<p>MATTERS ARISING AND ACTION LOG</p> <p>The action log was reviewed and updated.</p>	
<p>QP2122 /096</p>	<p>AOB</p> <p>There were no matters raised under AOB.</p>	
<p>QP2122 /097</p>	<p>FORWARD PLANNER</p> <p>The Forward Planner was reviewed. No updates were made.</p>	
<p>QP2122 /098</p>	<p>ANY SIGNIFICANT SAFETY CONCERNS TO NOTE</p> <p>None raised.</p>	
	<p>ASSURANCE QUESTIONS</p> <ul style="list-style-type: none"> • Has the Committee been attended by all relevant Executive Directors and Senior Managers for assurance purposes? Yes • Were the papers presented to the Committee of an appropriate professional standard, did they incorporate detailed reports with sufficient factual information and clear recommendations? Yes • Were papers that have already been reported on at another committee presented to you in a summary form? Yes 	

	<ul style="list-style-type: none"> • Was the content of the papers suitable and appropriate for the public domain? Yes • Were the papers sent to Committee members at least 5 working days in advance of the meeting to allow for the review of papers for assurance purposes? Yes • Does the Committee wish to deep dive any area on the agenda, in more detail at the next meeting, or through a separate meeting with an Executive Director in advance of the next scheduled meeting? No • What recommendations do the Committee want to make to Governing Body following the assurance process at today's Committee meeting? None 	
DATE AND TIME OF NEXT MEETING		
Date: 30 th September 2021		
Time: 9am to 10.30am		
Venue: MS Teams		

Approved



Chief Executive Report

Health Executive Group

14th September 2021

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

Where has the paper already been discussed?

Sub groups reporting to the HEG:

- Quality Group

- Strategic Workforce Group

- Performance Group

- Finance and Activity Group

- Transformation and Delivery Group

System governance groups:

- Joint Committee CCGs

- Acute Federation

- Mental Health Alliance

- Place Partnership

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

N/A

Summary of key issues

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

Recommendations

The SYB ICS Health Executive Group (HEG) partners are asked to note the update and Chief Executives and Accountable Officers are asked to share the paper with their individual Boards, Governing Bodies and Committees.

Chief Executive Report

SOUTH YORKSHIRE AND BASSETLAW INTEGRATED CARE SYSTEM

Health Executive Group

14th September 2021

1. Purpose

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

2. Summary update for activity during August

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

Covid case rates in SYB remain at around 300-400 (per 100,000) which is due to increased levels of social mixing and large public events. There are also higher-than-expected rates among our vulnerable groups where case rates for the over-60's are at 250 per 100,000. This could translate into an increase in hospitalisations.

One of the main causes for concern among public health teams is that this appears to be a low figure and likely to rise in the coming weeks, especially now that schools have returned and subsequent Covid testing frequency will start to increase.

There also appears to be a natural slowing-down of vaccine uptake among our more vulnerable unvaccinated populations (over-50's) and the ongoing reluctance among those who remain unvaccinated, despite repeated offers, signalling uptake will not gather any further pace.

Our hospitals currently have 226 patients admitted for Covid-related illnesses (28 of those in intensive care beds) continue to find that the majority of their Covid patients are unvaccinated or have only had one vaccine dose (instead of two).

There are also preparations for a reassessment of workforce priorities if the Joint Committee on Vaccination and Immunisation (JCVI) changes its advice on eligible groups, especially in regards to 12-17 year-olds (currently only vaccinated in exceptional circumstances) and the proposed Covid vaccine booster campaign likely aimed at eligible cohorts identified as Clinically Extremely Vulnerable (not necessarily all).

These new vaccination commitments will have a knock-on effect on workforce demand, especially across our Primary Care Networks (PCNs), and so plans are being discussed on realigning workforce skills based on priority areas with the highest clinical need/capacity.

2.2 Regional update

2.2.1 Leaders meeting

The North East and Yorkshire (NEY) Regional ICS Leaders meet weekly with the NHS England and Improvement Regional Director. During August, discussions focused on urgent and emergency care and winter resilience, planning and recovery, the ongoing Covid response and

vaccination programme and ICS development (including feedback from the NEY transition oversight group).

2.3 National update

2.3.1 Social Care reform

A new health and social care tax will be introduced across the UK to pay for reforms to the care sector and NHS funding in England.

This new funding aims to generate £36bn for frontline services over the next three years and support the NHS' commitments to address the waiting list backlog exacerbated by the Covid-19 pandemic.

The tax will begin as a 1.25% rise in National Insurance (NI) from April 2022 and is paid by both employers and workers.

It will become a separate tax on earned income from 2023 (calculated in the same way as NI and appearing on an employee's payslip), paid by all working adults, including older workers.

You can [find out more](#) on the Government website.

2.3.2 Pride in the NHS Week and NHS Virtual Pride 2021 (#UnderTheRainbow)

The first ever national Pride in the NHS Week and NHS Virtual Pride finale will take place as an 'always-on' virtual festival.

Spanning 6th-10th September, this year's theme for 2021 is 'Elevate, Educate, Celebrate' to promote rest, relaxation and recovery for NHS colleagues from our LGBT+ communities.

The grand finale to Pride in the NHS Week will be the 'NHS Virtual Pride' returning for a second year on 10th September (4-6pm).

2.4 Integrated Care System update

2.4.1 System Development Plans

The new HR Framework to support the transition to Integrated Care Boards (ICBs) has now been published alongside a range of other guidance which can be found on the NHS England and NHS Improvement (NHS E/I) website:

- (1) [Interim guidance on the functions and governance of the integrated care board](#)
- (2) [HR Framework for developing Integrated Care Boards](#)
- (3) [Building strong integrated care systems everywhere: guidance on the ICS people function](#)

The guidance documents are intended to help NHS system leaders and their partners support the aforementioned 'one workforce' approach by delivering key outcome-based people functions from April 2022.

The HR Framework document provides a clear outline of the proposed changes relating to the Employer Commitment for colleagues within CCGs (and other NHS employers hosting ICS staff) that will move across during this transition to the SY ICB.

2.5 National award nominations for South Yorkshire and Bassetlaw

SYB has been successful in receiving nominations for two national awards.

A number of services were shortlisted for the 2021 [Health Service Journal \(HSJ\) Awards](#) with special recognition for the SYB ICS in the category of '*Integrated Care System of the Year*' based on our work in the transformation of the hyper acute stroke unit (HASU) pathway which has been firmly established by our [Integrated Stroke Delivery Network](#).

The following teams/services were also shortlisted:

- Primary Care Innovation of the Year: The South Yorkshire and Bassetlaw ICS Cancer Alliance: Nudge the Odds - Adopting behavioural science to increase early diagnosis of cancer
- Provider Collaboration of the Year: Sheffield Clinical Commissioning Group, Primary Care Sheffield, Sheffield Health and Social Care NHS Foundation Trust, Sheffield Mind, Sheffield City Council and Sheffield Primary Care Networks, Sheffield Mental Health Collaboration (Primary & Community Mental Health Transformation Programme)
- Environmental Sustainability Award: Sheffield Children's NHS Foundation Trust
- Primary Care Networks, GP or Community Provider of the Year: Barnsley Healthcare Federation, Covid-19 Response - Blue Clinic, Out of Hours, Extended Hours and PCN Vaccination Programme
- Digitising Patient Services Award: The Rotherham NHS Foundation Trust, Expanding Speech Therapy Services through synchronous and asynchronous digital care using Microsoft Teams
- Services and Information Award: Barnsley Hospital NHS Foundation Trust, Oxygen supply management during Covid-19 pandemic

SYB was also successful in the nomination process for this year's [Nursing Times Workforce Summit and Awards](#) (2021).

In the category of '*Preceptorship of the Year - Under 1,500 Nursing Staff*', SYB's Primary Care Workforce and Training Hub have been recognised for their work towards the primary care nurse pipeline project (nurse vocational training scheme).

NHS Professionals, International recruitment for South Yorkshire and Bassetlaw ICS also made the shortlist for the '*Best International Recruitment Experience*' category.

2.6 A new digital accelerator programme by Yorkshire & Humber AHSN

The Propel@YH scheme led by the Yorkshire & Humber Academic Health Science Network (AHSN) aims to find digital health solutions to strengthen our system priorities in the areas of reducing health inequalities, supporting our workforce and enabling patients to manage their long-term conditions.

With access to a six-month structured course of support and advice from experts in the field, this unique accelerator programme connects researchers, academia, local businesses and digital innovators to work together to implement new ideas to support SYB's five-year transformation plans (2019 - 2024). Applications close on 1st October 2021 ([see brochure](#)).

2.7 Media interest for SYB's green social prescribing schemes

Our [green social prescribing](#) initiatives were featured in WIRED magazine as an exemplary case study thanks to a direct approach to the SYB ICS from one of their journalists.

The article also includes patient perspectives and one of our GPs, Dr Ollie Hart (Clinical Director at Heeley Plus Primary Care Network and GP at Sloan Medical Centre, Sheffield).

In addition, BBC Radio Sheffield also hosted a live phone interview (8th September) with two project officers from the Sheffield and Rotherham Wildlife Trust to learn about our pre-work developments, the benefits of these social inclusion programmes to reduce non-medical interventions and an insight into a local walk – including an interview with a group participant.

Thank you to Karen Smith (Prevention Programme Manager at SYB ICS) for coordinating this and to Jenny King and Kieran Boden from the Wildlife Trust.

2.8 Better Health Sheff campaign helps smokers quit

Sheffield City Council has launched the 'Better Health Sheff' campaign to help raise awareness of the importance of quitting smoking, eating well and moving more.

The campaign is particularly focused on Black, Asian and Ethnic Minority communities aged over 40 who are likely to be at increased risk of Covid-19 due to poorer diet, lack of exercise and higher smoking rates. The campaign is inclusive and has been developed locally with the support of the BAME PH inequalities group.

This campaign aligns closely with SYB's recently launched QUIT programme, which provides patients (and those recently discharged) with specialist support from the relevant Trusts' own smoking cessation team, alongside as-needed clinical interventions such as nicotine replacement therapy.

Further [information](#) is available on the Sheffield Council website.

2.9 Developments for SYB's Health and Wellbeing 'emotional resilience' Hub

There have been further additions to raise the internal profile of staff support services which includes Vivup, the 24/7 helpline providing a potential gateway for staff counselling. SYB's wellbeing support also includes wellbeing webinars and self-help resources (videos/podcasts).

Developments include:

- A [new wrap-around website](#)
- 90-second promotional video filmed across multiple locations within SYB
 - Alternate formats include a [British Sign Language version of the video](#) and four additional non-English languages)
- A webinar 'launch' event with over 135 guests with talks by Professor Michael West, CBE (The King's Fund), Tracey Paxton (Vivup) and Dean Royles. You can now also [watch a recording of the event](#)

2.10 RDaSH Bee Gardens featured on BBC Radio 2

BBC Radio 2 broadcast their entire breakfast show (20th August) from the Doncaster site of Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH). The new Walled Garden and The Bee Garden, unveiled by Radio 2 DJ Zoe Ball and a host of other celebrities, is situated outside their new Children's and Young People's Mental Health unit. The interview also included a short interview with RDaSH's Christina Harrison (Children's Care Group Director) and a patient.

RDaSH were chosen to host the garden after a national children's competition to design it. The design was taken by Gardner's World presenter Adam Frost and turned into reality.

You can [watch a video](#) to see how the garden was transformed.

2.11 New Britain Thinks report – patient and public satisfaction of NHS services measured across the Covid pandemic

A new report '[Attitudes towards and experiences of the NHS during Covid-19: views from patients, professionals and the public](#)' by Britain Thinks and The Richmond Group of Charities provides an insight and useful benchmark to consider in our response to planning how health and care services will be delivered in the future.

3. Finance

At Month 4 the ICS has a surplus of £23.4m which is £20.8m better than plan. The forecast has improved from a surplus of £3.4m to a surplus of £20m as a result of a further review of forecast positions at Month 4. The key movements were an improved forecast position at STH of £16.8m and at SHSC £0.5m. These changes better align the year to date and forecast positions.

The forecast capital position is for an overspend of £13.2m which is made up of the £12.4m of additional costs that will be incurred at Doncaster Royal Infirmary as a result of the critical incident in the Women & Children's block an underspend at RDASH of £0.6m and an allowable overspend on accelerator capital of £1.4m. Work is ongoing to agree slippage of £12.4m to ensure that the ICS remains within its capital envelope for 21/22. This requires to be concluded by Month 5 reporting. A separate paper, on this issue, will be considered by HEG once agreed by provider Directors of Finance.

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

Date: 8th September 2021

Derby and Derbyshire CCG Governing Body Meeting in Public
Held on
2nd September 2021 via Microsoft Teams

UNCONFIRMED

Present:

Dr Avi Bhatia	AB	Clinical Chair
Dr Penny Blackwell	PB	Governing Body GP
Dr Bruce Braithwaite	BB	Secondary Care Consultant
Richard Chapman	RCp	Chief Finance Officer
Dr Chris Clayton	CC	Chief Executive Officer
Dr Ruth Cooper	RC	Governing Body GP
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
Dr Emma Pizzey	EP	Governing Body GP
Professor Ian Shaw	IS	Lay Member for Primary Care Commissioning
Brigid Stacey	BS	Chief Nursing Officer
Dr Greg Strachan	GS	Governing Body GP
Martin Whittle	MWh	Lay Member for Patient and Public Involvement

Apologies:

Jill Dentith	JD	Lay Member for Governance
Dr Robyn Dewis	RD	Director of Public Health - Derby City Council
Dr Steven Lloyd	SL	Medical Director
Dean Wallace	DW	Director of Public Health - Derbyshire County Council
Dr Merryl Watkins	MW	Governing Body GP

In attendance:

Dawn Litchfield	DL	Executive Assistant to the Governing Body/Minute Taker
Clive Newman	CN	Director of GP Commissioning and Development
Suzanne Pickering	SP	Head of Governance
Sean Thornton	ST	Deputy Director Communications and Engagement

Item No.	Item	Action
GBP/2122/120	Welcome, Apologies & Quoracy Dr Avi Bhatia (AB) welcomed members to the meeting. Apologies were received as above. It was confirmed that the meeting was quorate.	
GBP/2122/121	Questions received from members of the public No requested have been received from members of the public.	

<p>GBP/2122/122</p>	<p>Declarations of Interest</p> <p>AB reminded Committee members and visiting delegates of their obligation to declare any interests that they may have on any issues arising at Committee meetings which might conflict with the business of the CCG.</p> <p>Declarations declared by members of the Governing Body are listed in the CCG’s Register of Interests and included with the meeting papers. The Register is also available either via the Executive Assistant to the Governing Body or the CCG website at the following link: www.derbyandderbyshireCCG.NHS.uk</p> <p>No further declarations of interest were made, and no changes were requested to the Register of Interests.</p>	
<p>GBP/2122/123</p>	<p>Chair’s Report – August 2021</p> <p>AB provided a written report, a copy of which was circulated with the meeting papers; the report was taken as read. It was noted that the pressure within the System remains as it continues to work in a different manner in order to accommodate patients' needs. The following question was raised.</p> <ul style="list-style-type: none"> • The customer behaviour aspects of care are extremely important to the NHS. It was asked if there is a view on how public consultation could be shaped in order to provide better guidance; it is proving difficult to dispel from patients' perceptions that they cannot obtain GP appointments. It was queried if there is any guidance or communications, based on behavioural understanding, that could help to alleviate this challenge. Martin Whittle (MWh) advised that this is touched upon in the Britain Thinks work highlighted in the Engagement Report, the conclusions of which were taken to the A&E Delivery Board in August. Work is required to create a two-part process between a top-down message-giving service, delivered centrally, and Primary Care working to help educate the public as to what it is trying to achieve. When the Britain Thinks report has been fully analysed, a 360° System-wide engagement approach will be undertaken. <p>It was considered that there are two areas which warrant substantial analysis and exploration: the NHS cannot train staff fast enough to keep up with retirements and leavers, and the demand side of the equation is extremely complex. People feel they have an entitlement to the NHS. It is hoped that the System Engagement Committee will take this on as a major piece of work to try to better understand the nature of patient demand and the supply of services. MWh responded that if people do not understand the System, it is because it has not been explained properly and therefore thought needs to be given to this.</p> <p>General Practice (GP) is a hugely heterogenous group; however, the workforce issue is not only about GP numbers but what the workforce is actually doing and what levels they are working to.</p> <p>It was requested that the Britain Thinks report be presented to the Governing Body to consider the findings in full, and be disseminated across the System accordingly, as this will be an important part of the learning going forward.</p>	<p>MWh</p>

	<p>When patients are unwell, they tend to focus on themselves; understanding what is happening across the System is not relevant to them at that point in time. Although robust messaging from the CCG would be helpful for clinicians and GPs, the messages are sometimes better received by individual clinicians speaking directly to their patients. There needs to be robust leadership across the System and help to disseminate the messages across communities.</p> <p>The Governing Body NOTED the contents of the report provided</p>	
GBP/2122/124	<p>Chief Executive Officer's Report – August 2021</p> <p>Dr Chris Clayton (CC) provided a written report, a copy of which was circulated with the meeting papers. The report was taken as read and the following points of note were made:</p> <ul style="list-style-type: none"> • Section 1 set out some significant messages relating to the key developments in the NHS over the last month, both locally and nationally. Sir Simon Stevens has now stepped down and has been succeeded by Amanda Pritchard as Chief Executive Officer of NHS England. CC wished Amanda well in her new role. • Locally John MacDonald has been confirmed as Chair-Designate for the newly developed Derbyshire Integrated Care Board (ICB) which is the formal body that the CCG's functions will transfer into from April 2022. DDCCG is fully engaged in making the transition to an ICB a success. • Section 2 provided a flavour of the meetings attended by CC in the interest of partnership working and supporting the preparedness of the System for the challenges being faced. • Section 3 highlighted national developments, research and reports. This is currently a challenging time for everyone, both the public and those delivering care. It was challenging pre-pandemic in terms of demand and the capacity to meet it; however, the post-pandemic challenges have increased due to the displaced care needs that occurred during this period. CC's role in the System is to achieve a balance and understanding of what is going on in terms of care. • A national antibody surveillance programme has been rolled out to provide people with free access to antibody tests to help improve the understanding of immunity against COVID-19 from vaccination and infection. • Invitations have gone out to one million 16-17 year olds, and vulnerable 12-15 year olds, to take up the offer of a COVID vaccination. The Derbyshire vaccination programme remains strong, and important. • Section 4 provided details of local developments. CC expressed his gratitude to Derby City Council colleagues for supporting the success of the vaccination programme at the Derby Arena. The vaccination site is being relocated to the Midlands Education Centre in Derby City centre. • Planning is taking place well in advance of the winter period to ensure that adequate provision is implemented in order to manage demand. <p>The Governing Body NOTED the contents of the report provided</p>	
GBP/2122/125	<p>DDCCG Annual Report and Accounts 2020-21</p> <p>CC gave a message of thanks to all colleagues who have worked on producing the Annual Report and Accounts, particularly Suzanne Pickering and her team for coordinating the report. This year's report has a different</p>	

	<p>flavour to it due to the events of the past year. The report improves year on year in terms of the process and rigour of putting the material together, and its context and the messages it provides. The Governing Body was asked to receive the report in a positive manner and welcome what it says.</p> <p>When comparing this report to the previous year's reports, the difference is that this covered a full year of the pandemic, explaining how it has been managed. There was a difference in approach by the commissioner during this time, as it has been more about supporting the System in the demands placed upon it and the resilience and emergency preparedness response and vaccination programmes. It was also a year where there has been a significant change in the direction of travel around the future of the NHS, with the creation of Integrated Care Systems (ICS).</p> <p>Richard Chapman (RCp) outlined the financial statements contained within the Accounts. This year was a unique year, with the financial regime changing several times and clarity only being provided retrospectively. The CCG responded flexibly to these changes in order to deliver a final small surplus, resulting in a relatively strong balance sheet going into the new financial year. It has continued to develop financial relationships with partner organisations which will be essential in facing the challenges to come. Extended deadlines were made available to CCGs for the submission of the Accounts, however DDCCG managed to deliver them to the original deadlines and no issues were identified in the External Audit Report. DDCCG was congratulated on the quality of the papers submitted and thanked for making this happen on time.</p> <p>AB thanked CC for his valuable input over the past year. He also thanked those people who put the report together whilst working from home.</p> <p>The Governing Body RECEIVED NHS Derby and Derbyshire CCG's Annual Report and Accounts 2020/21 for information and assurance</p>	
<p>GBP/2122/126</p>	<p>South Yorkshire and Bassetlaw (SYB) ICS Joint Committee of CCGs (JCCCG) Transition Proposals</p> <p>CC advised that historically the long-standing relationship with SYB began through North Derbyshire and Hardwick CCGs and related to the patient flows in the North of the County. DDCCG has been formally engaged in the decision-making processes relating to Derbyshire patients. CC reflected that this has been a strong relationship and he has benefited greatly from attending the Committee over the last few years; there is a lot to learn about how to formally work across different boundaries. DDCCG is an affiliate member of the JCCCG, not a formal decision maker. The report relates to the development of the next steps; CC is comfortable with the decisions and recommendations included in the report. The good working relationship with SYB ICS JCCCG provides confidence that the views of Derbyshire are listened to and supported.</p> <p>DDCCG will remain a member of the SYB ICS JCCCG until it ceases on 31st March 2022. Going forward the committee's structure is altering. This report describes how the future ICS will prepare from a commissioning perspective; to this effect, a proposal was supported that a sub-committee to the JCCCG be created to take a forward view. DDCCG will not be a member of this sub-committee; CC will continue to attend the JCCCG until the end of March 2022 to provide support and guidance as appropriate. CC</p>	

	<p>is holding separate conversations with the JCCCG on how the ICSs could work together.</p> <p>It was queried if something similar is required for Glossop. CC responded that details of how the relationship with Glossop is progressing are included in the ICS Boundary Update paper provided for information later in the agenda. Relationships with Nottingham and Staffordshire are also important due to their care of Derbyshire patients. Guidance on what the future relationships will be between ICSs is still being formed. CC agreed to respond in writing to the JCCCG Chair confirming the Governing Body's approval to the recommendations made.</p> <p>The Governing Body REVIEWED the proposal, which seeks agreement from the CCG members of the Joint Committee to this approach and agreement for Schedule (3) enclosed to be added to the Joint Committee's CCG Manual Agreement/Terms of Reference (attached for reference), and specifically APPROVED the:</p> <ul style="list-style-type: none"> • proposed amendment to the delegation of the Joint Committee for the transition work, but the Joint Committee's Terms of Reference (enclosed for reference) are unchanged; and • establishment of the Joint Committee sub-committee – the Change and Transition Board – to take forward the transition work between September and March 2022 	CC
<p>GBP/2021/127</p>	<p>Finance Report – Month 4</p> <p>Richard Chapman (RCp) provided an update on the financial position as at Month 4. The following points of note were made:</p> <ul style="list-style-type: none"> • There is a favourable Year To Date (YTD) variance of £401k. This position includes £0.799m YTD relating to COVID expenditure for the Hospital Discharge Programme which is expected to be reclaimed in full. An allocation of £2.697m to fund Quarter 1 COVID expenditure was received in Month 4. The underspend also includes £0.093m YTD and FOT relating to the Elective Recovery Fund which is also expected to be reimbursed. An allocation of £0.289m was received in Month 4 to fund April and the majority of May's activity. • All financial targets have been met and DDCCG is confident that it will deliver a breakeven position. • Details of the current run rate extrapolation, based on H1 Expenditure with adjustments to forecast outturn, were provided for information. • The largest adverse movement in run rate was seen in Continuing Health Care (CHD) where the expenditure incurred is greater than plan. Although Fast Track costs have reduced, Fully Funded packages of care have increased and are reporting a £1.014m overspend above plan. • The movement in Primary Care Enhanced services relates to the phasing of prescribing costs. • Mental Health Services have a total overspend YTD of £0.389m and a H1 forecast of £1.106m. The ICS has set aside a reserve to cover this overspend with a non-recurrent allocation. • The JUCD system forecast outturn position has improved slightly from last month, by £100k; although there is still a deficit across the System, there is no cause for concern to the delivery of a breakeven position for H1. 	

	<p>The Governing Body NOTED the following:</p> <ul style="list-style-type: none"> • Allocations have been received for H1 at £1.029bn • The YTD reported underspend at month 3 is £0.401m • Retrospective allocations received for quarter 1 Covid spend on the Hospital Discharge Programme were £2.697m further expected funding is £0.799m relating to month 4 • The Elective Recovery Fund has been reimbursed £0.289m for April and 90% May a further YTD estimate and H1 forecast of £0.093m is expected to be reimbursed • H1 is forecast to conclude at a breakeven position 	
<p>GBP/2122/128</p>	<p>Finance Committee Assurance Report – August 2021</p> <p>Andrew Middleton (AM) provided a verbal update following the Finance Committee meeting held on 26th August 2021. The following points of note were made:</p> <ul style="list-style-type: none"> • AM was assured by RCp's Finance Report. • The comfort and assurance on the variables, each of which could have a significant impact, is that the Finance Team has a good grip on what is going on and other teams have a grip on their own worsening areas. CHC is a standing item on the Finance Committee agenda. It has experienced significant variations in case numbers which, along with increasing costs, have the potential to impact materially on the overall CCG budget; however, provision has been made for such pressures. • Section 117 is demonstrating increased costs. It is unsure how much is due to demand and how much is linked to the fact that it is difficult to source care packages at the right price. Aftercare for challenging Section 117 patients is specialist and complex, and the use of the private sector is required to meet these needs. The Mental Health Delivery Board is aware of this and in the medium term is enhancing the capacity of contracted providers to cope with patients of this nature. • Variances in Month 4 include expected one-off expenditure for ICS start-up costs which have been self-contained. • Despite predicting breakeven positions for H1 and H2, it is recognised that DDCCG is still in a special funding regime and the System Estates and Finance Committee has not lost sight of the underlying System resource challenge; a report from the System Finance Lead is expected at the September meeting on how this is going to be addressed. • The Committee is anxious to handover a “going-concern” position for financial scrutiny and reporting. As the months to 1st April 2022 reduce, the focus will increasingly be on systems and procedures to ensure the transfer of responsibilities is seamless and smooth. <p>The Governing Body NOTED the verbal update provided for assurance purposes</p>	
<p>GBP/2122/129</p>	<p>Clinical and Lay Commissioning Committee (CLCC) Assurance Report – August 2021</p> <p>Dr Ruth Cooper (RC) provided an update following the CLCC meeting held on 12th August 2021. The report was taken as read and the outcomes of discussions were noted.</p>	

	The Governing Body NOTED the contents of the report provided for assurance purposes	
GBP/2122/130	<p>Derbyshire Engagement Committee Assurance Report – August 2021</p> <p>Martin Whittle (MWh) provided an update following the Derbyshire Engagement Committee meeting held on 17th August 2021. The report was taken as read and the following points of note were made:</p> <ul style="list-style-type: none"> • An update was received on the recent insight collection by Britain Thinks, which was commissioned to obtain independent views from patients in Derbyshire about their perceptions of accessing GP and urgent care services in the area. • The Committee approved a 12-week engagement programme to commence in Derby to better understand the impact of the temporary changes made to the provision of community hospital beds at London Road Community Hospital at the start of the COVID-19 pandemic, and to support an informed decision on whether to make those changes permanent. Both Scrutiny Committees have agreed the proposals in principle. It was noted that this is consistent with occurrences in Belper, Bolsover and Buxton, from which good feedback has been received. • Following a discussion at the Quality and Performance Committee, insight will be collected from cancer patients to understand their views and behaviours in accessing services during the pandemic. The System is aware of fewer referrals being made during the pandemic and is keen to identify any messaging or service interventions that it may benefit from. This proposal will be discussed with Healthwatch Derby. <p>The following questions were raised in relation to the report:</p> <ul style="list-style-type: none"> • It was enquired whether there is any evidence which captures the fact that services have improved, and not deteriorated, despite changes being made to them. MWh agreed to share the evidence available. • The Government is making funds available to build 40 new hospitals. Care needs to be taken around the language used as the facility planned for Buxton is not a hospital but a health care facility, in line with the core strategy. Communications received by all Trusts from NHSE stipulate that any build counts as a new hospital in line with Government policy. It should not be about the building but about the services provided and expected from it. MWh assured that expectations will not be built up. <p>The Governing Body NOTED the contents of the report provided for assurance purposes</p>	MWh
GBP/2122/131	<p>Primary Care Commissioning Committee (PCCC) Assurance Report – August 2021</p> <p>Professor Ian Shaw (IS) provided a verbal update following the PCCC meeting held on 25th August 2021. The following point of note was made:</p> <ul style="list-style-type: none"> • An extensive discussion was held in relation to the two risks held by the PCCC. It was agreed that the risks would be kept under review however the scores would not be altered at this point in time. <p>The Governing Body NOTED the verbal update provided for assurance purposes</p>	

<p>GBP/2122/132</p>	<p>Quality and Performance Committee (Q&PC) Assurance Report – August 2021</p> <p>Dr Buk Dhadda (BD) provided an update following the Q&PC meeting held on 26th August 2021. The report was taken as read and the following points of note were made:</p> <ul style="list-style-type: none"> • Breast performance is to be reviewed by the Committee to understand if the new pathway is having an impact on performance; the August and September data will be used to establish any impact at next month's meeting. • The Committee is looking at how the new ICS performance structure is being constructed and it was agreed that the Committee would require oversight of the transition work. • There are emerging concerns, both locally and nationally, around NHS staff morale and sickness and how this might impact on the recovery and restoration of services and winter performance. Absence numbers and reasons are to be analysed to ascertain what the issues are and establish how performance is being sustained. <p>CC agreed that it is important that the Q&PC understands the challenge around the workforce to ascertain the impact on the quality and performance of services; however, it is not within its remit to fix the challenges. The People and Culture Board, created in the JUCD space, needs to think about the problem and available solutions. The newly formed ICB will have statutory accountability for the One Workforce Plan and individual provider organisations will have People Committees. The links from the CCG's Q&PC to the System Q&PC are crucial. Staff levels of absence are currently between 6 to 11%, with different challenges being faced by the community and acute settings. Although COVID has had a big impact on absence levels, the challenge relates to fatigue and staff maintaining their resilience and wellbeing.</p> <p>The Governing Body NOTED the paper for assurance purposes</p>	
<p>GBP/2122/133</p>	<p>CCG Risk Register – August 2021</p> <p>HD advised that this report highlights areas of organisational risk recorded in DDCCG's Corporate Risk Register as at 31st August 2021. All risks in the Register are allocated to one of the CCG's Corporate Committees which reviews them monthly. No changes have been reported since last month.</p> <p>The Governing Body RECEIVED and NOTED:</p> <ul style="list-style-type: none"> • The Risk Register Report • Appendix 1 as a reflection of the risks facing the organisation as at 31st August 2021 • Appendix 2 which summarises the movement of all risks in August 2021 	
<p>GBP/2122/134</p>	<p>Update on Derbyshire ICS Boundary</p> <p>CC advised that the decision has now been made by the Secretary of State to include Glossop CCG within the Derbyshire ICS Boundary. He thanked HD and her team for working up the conversations and becoming actively engaged in considering the implications of the decision. The paper set out</p>	

	<p>the process and timescales for completion; it is important now to take this forward as it will be of importance to the ICS.</p> <p>HD added that it is not believed that this decision will impact on patients' rights to use services outside of the Derbyshire ICS. All parties are committed to working positively together, as has been the case over the last few weeks throughout the discussions held on how to take this forward and incorporate it into the ICS transition. The CCGs will not be merging but will close down in the usual manner and services transferred into the new ICS from 1st April 2022. A Joint Transition Steering Group has been established, leading four main workstreams comprising of specialist leads from across both Systems:</p> <ul style="list-style-type: none"> • Communications and Engagement • Finance, IT and Contracting • Neighbourhood Development • Statutory Duties, Risks and People Impact <p>The first meeting of the Group is scheduled for mid-September and will focus on developing and overseeing a number of areas of key work. A report will subsequently be provided to the Governing Body, Transition Assurance Sub-Committee (TAC) and Transition Working Group (TWG) for oversight.</p> <p>It was queried where the PCCC will fit into this changing landscape, and whether it is something that needs to be merged separately. HD responded that the Glossop work inherited will need to form part of the Derbyshire System. There are ongoing conversations about direct commissioning. CC added that from April 2022, PCCCs will no longer be in existence; however, as the statutory responsibility will still exist, a joint conversation with Glossop was suggested in order to be sighted on any Primary Care developments between now and the end of March 2022.</p> <p>It was asked where such issues as list closures, GP premises extensions, mergers and premises closures will sit and where service user opinions would be articulated. CC responded that the statutory responsibility would sit with the ICB which will require a structure to support it, i.e., a commissioning sub-committee related to primary / hospital care., with the ability to hold discussions on individual issues where necessary. GPs need to be clear as to what they think is important to be undertaken at a practice level, Primary Care Network level and within Places for both Derbyshire and Derby City. The ICS will be supportive of the right movement for Derbyshire.</p> <p>The Governing Body NOTED the report for assurance purposes</p>	
<p>GBP/2122/135</p>	<p>Derbyshire County Council Health and Wellbeing Board meeting minutes – July 2021</p> <p>The Governing Body RECEIVED and NOTED the above minutes</p>	
<p>GBP/2122/136</p>	<p>Ratified Minutes of DDCCG's Corporate Committees:</p> <ul style="list-style-type: none"> • Derbyshire Engagement Committee – 20.7.2021 • Primary Care Commissioning Committee – 28.7.2021 • Quality and Performance Committee – 29.7.2021 <p>The Governing Body RECEIVED and NOTED these minutes</p>	

GBP/2122/137	South Yorkshire and Bassetlaw Integrated Care System (SYB ICS) CEO Report – August 2021 The Governing Body RECEIVED and NOTED the report	
GBP/2122/138	Minutes of the Governing Body meeting in public held on 5th August 2021 The minutes of the above meeting were agreed as a true and accurate reflection of the discussions held	
GBP/2122/139	Matters Arising / Action Log <u>Action Log – August 2021 – Item GBP/2122/099 – NHS People and Culture Development presentation</u> – Further information was requested on FTE numbers of Derbyshire NHS staff leaving and joining between April 2019 and March 2021. Data on the number of patients per FTE GP was also requested.	DL
GBP/2122/140	Forward Planner The Governing Body NOTED the Planner for information purposes	
GBP/2122/141	Any Other Business None raised	
DATE AND TIME OF NEXT MEETING – Thursday 7 th October 2021 – 9.30am to 11am via Microsoft Teams		

Signed by:
(Chair)

Dated:

**GOVERNING BODY MEETING IN PUBLIC
ACTION SHEET – September 2021**

Item No.	Item title	Lead	Action Required	Action Implemented	Due Date
2021/22 Actions					
GBP/2122/054	<u>Joined Up Care Derbyshire Board Update – May 2021</u>	Helen Dillistone	It was requested that a Governing Body Development / Transition Session be planned to ensure that Governing Body members are sufficiently sighted on the measures being taken to address the health inequalities in Derbyshire; Dr Robyn Dewis and Dean Wallace will be requested to provide input into this session.	To be scheduled in for the December Session	December 2021
GBP/2122/099	<u>Presentation – NHS People and Culture Development</u>	Linda Garnett	It was enquired how many additional nurses and doctors have been put in place in Derbyshire over the last 2 years, nett of retirement.	LG agreed to provide feedback on actual numbers – information circulated	Item Complete
GBP/2122/123	<u>Chair’s Report – August 2021</u>	Martin Whittle	It was requested that the Britain Thinks Report be presented to the Governing Body to consider the findings in full.	Discussion to be held at the November meeting on the findings of the Britain Thinks Report	November 2021
GBP/2122/126	<u>South Yorkshire and Bassetlaw (SYB) ICS Joint Committee of CCGs (JCCCG) Transition Proposals</u>	Dr Chris Clayton	CC agreed to respond in writing to the JCCCG Chair confirming the Governing Body’s approval to the recommendations made.	Letter sent to JCCCG Chair confirming approval of the recommendations made	Item Complete

GBP/2122/130	<u>Derbyshire Engagement Committee Assurance Report – August 2021</u>	Martin Whittle	It was enquired whether there is any evidence which captures the fact that services have improved, and not deteriorated, when changes being made to them.	The evidence available to demonstrate that more people are being discharged to the to the places that will best meet their needs is currently being collated	November 2021
GBP/2122/139	<u>Action Log – August 2021 – Item GBP/2122/099 – NHS People and Culture Development presentation</u>	Dawn Litchfield	Further information was requested on FTE numbers of Derbyshire NHS staff leaving and joining between April 2019 and March 2021. Data on the number of patients per FTE GP was also requested.	Information circulated to members	Item Complete

Derby and Derbyshire CCG Governing Body Forward Planner 2021/22

	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
AGENDA ITEM / ISSUE												
WELCOME/ APOLOGIES												
Welcome/ Apologies and Quoracy	X	X	X	X	X	X	X	X	X	X	X	X
Questions from the Public	X	X	X	X	X	X	X	X	X	X	X	X
Declarations of Interest <ul style="list-style-type: none"> Register of Interest Summary register of interest declared during the meeting Glossary 	X	X	X	X	X	X	X	X	X	X	X	X
CHAIR AND CHIEF OFFICERS REPORT												
Chair's Report	X	X	X	X	X	X	X	X	X	X	X	X
Chief Executive Officer's Report	X	X	X	X	X	X	X	X	X	X	X	X
FOR DECISION												
Review of Committee Terms of References		X					X					
FOR DISCUSSION												
360 Stakeholder Survey												X
Mental Health Update								X				
CORPORATE ASSURANCE												
Finance and Savings Report	X	X	X	X	X	X	X	X	X	X	X	X
Finance Committee Assurance report	X	X	X	X	X	X	X	X	X	X	X	X
Quality and Performance Committee Assurance Report <ul style="list-style-type: none"> Quality & Performance Report Serious Incidents Never Events 	X	X	X	X	X	X	X	X	X	X	X	X
Governance Committee Assurance Report <ul style="list-style-type: none"> Business Continuity and EPRR core standards Complaints 	X		X		X		X		X		X	

	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
AGENDA ITEM / ISSUE												
<ul style="list-style-type: none"> Conflicts of Interest Freedom of Information Health & Safety Human Resources Information Governance Procurement 												
Audit Committee Assurance Report	X	X	X				X		X		X	
Engagement Committee Assurance Report	X	X	X	X	X	X	X	X	X	X	X	X
Clinical and Lay Commissioning Committee Assurance Report	X	X	X	X	X	X	X	X	X	X	X	X
Primary Care Commissioning Committee Assurance Report	X	X	X	X	X	X	X	X	X	X	X	X
Risk Register Exception Report	X	X	X	X	X	X	X	X	X	X	X	X
Governing Body Assurance Framework	X	X		X		X		X			X	
Strategic Risks and Strategic Objectives		X		X	X							
Annual Report and Accounts			X			X						
AGM						X						
Corporate Committees' Annual Reports					X							
Joined Up Care Derbyshire Board Update	X		X		X		X		X		X	
FOR INFORMATION												
Director of Public Health Annual Report											X	
Minutes of Corporate Committees												
Audit Committee	X	X	X				X		X		X	
Clinical & Lay Commissioning Committee	X	X	X	X	X	X	X	X	X	X	X	X
Engagement Committee	X	X	X	X	X	X	X	X		X	X	X
Finance Committee	X	X	X	X	X	X	X	X	X	X	X	X
Governance Committee			X		X		X		X		X	
Primary Care Commissioning Committee	X	X	X	X	X	X	X	X	X	X	X	X
Quality and Performance Committee	X	X	X	X	X	X	X	X	X	X	X	X

	APR	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR
AGENDA ITEM / ISSUE												
Minutes of Health and Wellbeing Board Derby City	X		X		X				X		X	
Minutes of Health and Wellbeing Board Derbyshire County	X		X		X				X		X	
Minutes of Joined Up Care Derbyshire Board	X		X		X		X		X		X	
Minutes of the SY&B JCCCG meetings – public / private	X	X	X	X	X	X	X	X	X	X	X	X
MINUTES AND MATTERS ARISING FROM PREVIOUS MEETNGS												
Minutes of the Governing Body	X	X	X	X	X	X	X	X	X	X	X	X
Matters arising and Action log	X	X	X	X	X	X	X	X	X	X	X	X
Forward Plan	X	X	X	X	X	X	X	X	X	X	X	X
ANY OTHER BUSINESS												