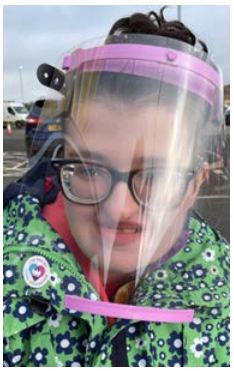
NHS
Derby and Derbyshire
Clinical Commissioning Group


NHS Derby and Derbyshire Clinical Commissioning Group Annual Report & Accounts 2020–2021



CONTENTS

FOREWORD 3

PERFORMANCE REPORT 4

Chief Executive Officer's Statement 5

Performance Overview 7

Performance Analysis 14

Finance Review 55

Our Duties 60

ACCOUNTABILITY REPORT 76

Corporate Governance Report 77

Members Report 78

Statement of Accountable Officer's Responsibilities 83

Governance Statement 85

Remuneration and Staff Report 118

Remuneration Report 118

Staff Report 125

Parliamentary Accountability and Audit Report 137

FINANCIAL STATEMENTS 138

Auditor's Report 168

APPENDICES 174

Appendix One: CCG Attendance at Meetings 2020/21 175

GLOSSARY 182

FOREWORD

The last 12 months have presented us all with an unprecedented challenge. Many people have lost their loved ones to the pandemic and we too have lost members of our NHS family in Derby and Derbyshire. I would like to take a moment to remember those who are sadly no longer with us and also those who continue to mourn their passing. We are indebted to the NHS colleagues we have lost to the virus for their contribution and selfless commitment to our patients. They will not be forgotten.

It has been a year of huge change for our health and care system at every level. In Secondary Care we have seen our resources stretched beyond their limits at times as we have fought to care for our sickest Covid-19 patients alongside a rising number of new infections, while also trying to look after our non-Covid-19 patients. Discharging patients safely has been a challenge throughout the pandemic and as we pass the one year mark since we went into lockdown and are now entering the 'roadmap out of lockdown' phase, Secondary Care is still under significant pressure.

Primary Care in our city and county experienced extreme pressure in different ways. We have constantly changed the way we work as increased Covid-19 infection rates and lockdowns have come and gone, but throughout the pandemic, Primary Care has done everything possible to make accessing services safe, offering face-to-face appointments when absolutely required.

Changing our ways of working has seen an increase in the use of digital technology; for example, consultations with our patients delivered virtually and remotely. Some services were temporarily stopped and adjustments made to others in order to release extra capacity and resilience where it was needed most. Keeping our patients and staff safe has been at the heart of our response to the pandemic throughout, with social distancing and personal protective equipment being constant themes for anyone visiting or working in our practices.

Other constant themes have been the unrelenting pressure and the tireless, brave and determined attitude of our staff across the system, which includes not only our frontline clinicians but our administrative staff, cleaners, drivers and all those who we depend on to keep our system moving. Every day our colleagues have put themselves on the line and every day we hear remarkable stories where people have gone much more than the extra mile to do all they can to care for and support our patients.

We see that determination to succeed as our system moves out of the latest lockdown and works hard to deliver the vaccination programme at a pace that has never been seen before. I can say with conviction that I have never been more proud to be a part of the Derbyshire health and care system. To our patients and public who have supported us in our endeavours, and to our staff who continue to care for us, thank you.

Dr Avi Bhatia
Clinical Chair
NHS Derby and Derbyshire Clinical Commissioning Group
25th May 2021

PERFORMANCE REPORT

Dr Chris Clayton

Accountable Officer

NHS Derby and Derbyshire CCG

25th May 2021

Chief Executive Officer's Statement

My reflection on the last year is difficult to put into words. At the beginning of the year the whole country was still coming to terms with the scale, speed of transmission and risk to life that Covid-19 presented. Scientists across the country and the world worked frantically to identify vaccines and treatments as the pandemic took hold. As the worldwide battle to understand the science and stem the tidal wave that Covid-19 rapidly became, colleagues across local health and care systems started their battle to save lives.

In Derbyshire, we saw our colleagues going out to fight the virus day after day, working long shifts to care for a rapidly increasing number of patients with extremely high levels of acuity. Tragically, patients and also members of our NHS family have succumbed to the virus over the last year. My heartfelt condolences go to the families of those we lost and my thoughts are with those who are still recovering. I cannot express the debt of gratitude we owe to our colleagues, who still continue this battle and thank you to all our system colleagues for your determination, selflessness and resilience during a horrendous year.

Looking back through the spring and summer of 2020 on a global level, the pandemic grew at incredible speed and we sadly saw loss of life alongside levels of acuity on an unprecedented scale. The Downing Street press conferences brought the scale of the challenge and the personal tragedies into our homes every day. We saw hope and optimism come and quickly fade away again, almost until the end of 2020 when the vaccination programme became a reality.

From a health and social care perspective, our local NHS and system partners responded to the challenge of vaccinating on an unprecedented scale immediately and with tremendous determination. Primary and Secondary Care colleagues worked in collaboration with other system partners at a relentless pace and this continues beyond the reporting year. Mutual aid has become a constant feature over the year as people have worked to share resources. The Local Resilience Forum is also continuing to play a vital coordinating role in bringing our partners across the system together with a common aim.

The wider joint effort has also been fantastic with volunteers from the wider community, returners to the NHS, our local politicians and many others responding to the Call To Arms campaign. We have seen staff from across the CCG working at vaccination sites in clinical support and administrative roles, volunteer drivers with 4x4 vehicles getting people safely home in the snow, and local farmers clearing car parks so that our patients can continue to receive their vaccinations despite challenging weather conditions. Our local media partners have played a vital role in helping us to promote vaccinations, testing and compliance as the key elements in the 'roadmap out of lockdown'.

The challenges of the pandemic have impacted our overall performance during 2020/21. Analysis of data illustrates that 9 of the 21 constitutional or mandated standards for our patients have been delivered during the year. Although a number of the standards have not been achieved, they compare favourably with nationally reported performance.

This joint working will stand us in tremendous stead as we progress through the next stages of the pandemic, on our journey towards becoming an Integrated Care System and also in the recovery and restoration of our services. I feel extremely proud and humbled to be part of a system that can mobilise and work together on such as scale, with a team spirit that is second to none. Thank you again to everyone who has played a part as we continue to work through one of the greatest challenges the NHS and our country has ever faced.

Dr Chris Clayton
MA MB BChir DRCOG PGCGPE MRCGP
Chief Executive Officer
NHS Derby and Derbyshire Clinical Commissioning Group
25th May 2021

Performance Overview

This overview provides a summary of the purpose and activities of NHS Derby and Derbyshire Clinical Commissioning Group (CCG) and how it performed during the year. It also provides the Chief Executive Officer's perspective on the performance of the CCG.

Purpose and Activities of the CCG

NHS Derby and Derbyshire CCG brings together local GP Practices and other NHS organisations to plan and help shape local health services for the people of Derby and Derbyshire. The CCG has representation from 112 GP Practices from the area and has a Governing Body, which is made up of local GPs, supported by Specialist Doctors and Nurses, Lay Members and experienced officers. More information on our Governing Body Members can be found at https://www.derbyandderbyshireccg.nhs.uk/about-us/who-we-are/governing-body/.

Our CCG area covers residents across Derbyshire, including the populations of Derby city, Chesterfield, Ilkeston and Long Eaton, Amber Valley, Derbyshire Dales, Bolsover District and High Peak. The CCG serves a population of more than 1,062,000 people.

Our mission and values

The CCG's vision is *'to continuously improve the health and wellbeing of the people of Derbyshire, using all resources as fairly as possible'*. The CCG is striving to achieve this by:

- providing local clinical leadership to the NHS, and working with everybody who can contribute to our aims;
- being open and accountable to our patients and communities, ensuring they are at the heart of everything we do;
- understanding our population and addressing inequalities so that services are in place to meet needs;
- planning services that best meet those needs now and in the future;
- aiming to secure the best quality, best value health and social care services we can afford; and
- using our resources fairly and effectively.

There are clear health inequalities within the CCG area. Working together with partner organisations is part of the whole system approach to tackling them, as articulated in our Derbyshire Sustainability and Transformation Plan. The latest update on developments can be found at https://joinedupcarederbyshire.co.uk/.

Key issues and risks that could affect the CCG delivering its objectives

The CCG's Governing Body uses an Assurance Framework to test our performance and capability. Part of this annual framework measures performance against what we say we need to deliver and whether these demonstrate improved outcomes for our patients, including how services and quality are delivered and improved. This includes measuring progress in how we delivered the requirements set by the Government in the NHS Mandate and the NHS Constitution.

The key issues and risks to the organisation achieving its objectives are described in the Governance Statement section of this report. The CCG's strategic risks identified during 2020/21 can be found here[1].

Adoption of the Going Concern Approach

The CCG has adopted a 'Going Concern' approach (where a body can show anticipated continuation of the provision of a service in the future) in preparing our annual financial statements. This follows the interpretation in the Government Accounting Manual of Going Concern in the public sector.

Our relationships

Patients in our area have access to services from a wide range of providers, including Derbyshire Healthcare NHS Foundation Trust (DHcFT), Derbyshire Community Health Services NHS Foundation Trust (DCHSFT) and East Midlands Ambulance Service NHS Trust (EMAS). Our largest contracts are with Chesterfield Royal Hospital NHS Foundation Trust (CRHFT) and University Hospitals of Derby and Burton NHS Foundation Trust (UHDBFT), and account for approximately 35% of our spending.

System Working and Collaboration

Our local Sustainability and Transformation Partnership, where health and social care partners work together to improve outcomes for local people, had expected the 2020/21 financial year to have been one of improving services following the extensive review on our five-year plan carried out in 2019. The priority need to respond to the Covid-19 pandemic halted much of this work. Due to a track record of extensive partnership working, enhanced through our engagement with local people on the plan review, we were in a better position to respond to the pandemic. In addition, the pandemic provided opportunities to speed up transformation work which had already been in progress, including the increased use of virtual approaches to outpatient appointments and the introduction of a mental health support telephone line.

The formation of teams from across organisations to look at issues such as the rapid development of Covid-19 testing centres across the city and county was not in anyone's transformation plan prior to February 2020. Our response led to many services being paused to enable staff to be redeployed into other priority areas. Overall, our staff performed magnificently to deliver in what has been an unprecedented and challenging period for the NHS and social care. We are hugely thankful to staff across health and social care for their commitment, sacrifices and flexibility during this time.

The health and care system learned lessons throughout the year as to how the speed of decision-making could be increased in times of crisis, and how this can be captured as a lesson for 'normal' times. The pandemic saw the establishment of emergency response structures through the Derbyshire Local Resilience Forum, including many elements which brought decision-making much closer to front line health and care services. The governance of Joined Up Care Derbyshire (JUCD) continued, but was adapted to enable a more agile approach, including Board and programme meetings. It was reflected that some of the changes helped increase 'real-time' decision-making, by those best placed to make such

[1] https://www.derbyandderbyshireccg.nhs.uk/about-us/public-involvement/risk-management/

decisions, with clinical and professional leaders working with managerial leaders at all levels of the system. We are determined to capture this in our future working.

Outside of the pandemic, JUCD appointed Dr Chris Clayton, Chief Executive Officer of the CCG, as its Interim Executive Lead during late summer 2020. JUCD was confirmed as being awarded Integrated Care System (ICS) status from the 1st January 2021. An ICS is a progression from a Sustainability and Transformation Partnership, being a closer form of collaboration in which NHS organisations and local authorities take on greater responsibility for collectively managing resources and performance and for changing the way care is delivered.

In November 2020, NHS England and NHS Improvement (NHSE&I) published its proposals for the future statutory role of ICSs from April 2022. This detailed the strategic commissioning role of a CCG being delivered through the ICS structure; the ongoing coordination of services at a 'Place' level; and the strengthening of alliances among healthcare service providers. This is all aimed at commissioning and providing services as close to patients' homes as possible in order to meet local needs, with the recognition that some specialist services benefit from being coordinated at a county, regional or national level. JUCD submitted its collective feedback to NHSE&I engagement exercise on the proposals, noting overall that the proposals were in line with local thinking and progress that has been made in recent years.

In February 2021, the Government published its White Paper on health and social care reform. The 2021/22 financial year will see us working through:

- how the reform will be implemented in Derby and Derbyshire;
- the ongoing delivery of our collective response to the Covid-19 pandemic alongside bringing back services paused during the pandemic response; and
- re-introducing some of the plans we have for service transformation in our original five-year plan.

The planning guidance for 2021/22 was also published in March 2021 and sets out the requirements of the system going forward, identifying the following key areas of focus for the first half of 2021/22:

- supporting the health and wellbeing of staff and taking action on recruitment and retention;
- delivering the NHS Covid-19 vaccination programme and continuing to meet the needs of patients with Covid-19;
- building on what has been learned during the pandemic to transform the delivery of services, accelerate the restoration of elective and cancer care, and manage the increasing demand on mental health services;
- expanding Primary Care capacity to improve access, local health outcomes and address health inequalities;
- transforming community, and urgent and emergency care to prevent inappropriate attendance at Emergency Departments (ED), improve timely admission to hospital for ED patients and reduce length of stay; and
- working collaboratively across systems to deliver on these priorities.

While we seek to restore and transform services in the future, it must be acknowledged that Covid-19 will likely be with us for some time, and we will have to deal with its legacy, such as the impact on tired staff, providing vaccinations, and dealing with Long Covid-19.

Place Development and Delivery

Place can be defined as *'empowering people to live a healthy life for as long as possible through joining up health, care and community support for people and local communities'*. Place-based working is key to the delivery of integrated health and social care in Derby and Derbyshire and is implemented through our eight Local Place Alliances:

- Amber Valley
- Bolsover and North East Derbyshire
- Chesterfield
- Derby City
- Derbyshire Dales
- Erewash
- High Peak
- South Derbyshire

Each Local Place Alliance has a diverse membership and brings together many groups including commissioners, community service providers, Local Authority, Public Health, voluntary sector, community stakeholders, public representation, Primary Care Networks, hospitals and emergency services.

Integrated Community Place Board

The individual Local Place Alliances are accountable to the Integrated Community Place Board. Formerly known as 'Place Board', the group changed its name in August 2020 to more accurately reflect the breadth of community services that fall within its remit, as well as its focus on developing integrated community services. Chaired by Dr Penny Blackwell, Governing Body GP Member, the Integrated Community Place Board reports into the JUCD Board.

Team Up Derbyshire

Team Up Derbyshire is our ambitious local programme to create one team across health and social care to see all housebound patients in a neighbourhood. The team covers urgent, planned and preventative care. It is not a new or 'add on' service, but a 'teaming up' of existing resources. This plan integrates general practice with community providers, mental healthcare providers, adult social care and the voluntary sector.

Despite the challenges of the pandemic we continued to develop the proposals, build a strong consensus about the changes needed and used national funding to expand services in parts of the county that are developing new approaches. The work this year puts us in a strong position to implement more significant changes in 2021/22.

Support to Care Homes

Local Place Alliance partners played an integral role in ensuring that Care Homes feel included and supported as key partners in the Derbyshire system.

They continue to support the implementation of the Enhanced Health in Care Homes Framework, which is an ambitious national plan to strengthen support for the people who live and work in Care Homes. It includes the development of teams of different professionals to provide health and care support to Care Homes, and every Care Home in Derby and Derbyshire now has a named lead for DCHSFT, Medicines Management and Primary Care. This means residents with complex conditions benefit from the knowledge and skills of a range of professionals, with some sites piloting mental health involvement in the team.

There are weekly check-in calls between Care Homes and Primary Care Networks, as well as ongoing work to ensure Care Homes have the appropriate skills and equipment for digital working. Partners have also been providing opportunities for networking and peer-to-peer support between Care Homes.

Primary Care Networks and Collaboration

GP Practices continued to work together and develop their Primary Care Network (PCN) infrastructure. Derbyshire has 15 PCNs, covering all 112 GP Practices and the whole population. PCNs are based on GP-registered lists, typically serving communities of around 30,000 to 50,000 people. This scale is small enough to provide personal care valued by both patients and GPs, but large enough to have significant impact and economies of scale through better collaboration between GP Practices and other service providers.

PCNs across Derby and Derbyshire started providing care in different ways to match different needs, including flexible access to advice and support for ‘healthier’ sections of the population, and joined up care for those with complex conditions. They focused on prevention and personalised care; supporting patients to make informed decisions about their care and look after their own health better. Through use of data and technology, they were able to understand their patients’ needs better and deliver ways of providing care at a scale bigger than just a single GP practice. The PCNs will continue to monitor how services perform and check on any differences in the quality of services across areas.

By making best use of collective resources across GP Practices and other local health and care providers, PCNs are able to ensure that the workload is managed amongst a larger range of professional groups.

PCNs have helped to form stronger relationships across GP Practices, and have Memorandums of Understanding in place for information sharing and supporting the CCG in use of data. Clinical Directors continue to meet regularly to discuss how PCNs are coping throughout the Covid-19 pandemic and resolve any development issues. PCN Operational Leads also meet regularly to share learning, protocols and best practice, and help recruit to new roles.

Expanding the workforce is the top priority for Primary Care. The Additional Roles Reimbursement Scheme enables each PCN to employ up to 12 additional roles within Primary Care. Recruitment to these roles required a large degree of planning and joint working across the wider system. It has been encouraging to see relationships develop

between PCNs and provider organisations, including the Voluntary Sector, EMAS and DHcFT, to help deploy roles that are new to Primary Care.

Health and Wellbeing Boards and Health Improvement Scrutiny Committee

In accordance with section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007, the CCG contributed greatly to the delivery of the Joint Health and Wellbeing Strategy and is fully engaged with the city and county Health and Wellbeing Boards. The Chief Executive Officer sits on both Health and Wellbeing Boards. A sub-group ensures that coordinated progress on integrated care is made, as well as jointly progressing the development of the Better Care Fund (which brings together funding for certain health and social care activities).

The CCG's five strategic objectives are closely linked to those of the Health and Wellbeing Boards, ensuring that the CCG is contributing to the delivery of the Health and Wellbeing Strategy. Out first objective is *'to reduce measurably our health inequalities and improve the physical health, mental health and wellbeing of our population'*. These objectives were developed with the Governing Body, which has representation from both Local Authority Directors of Public Health. The CCG reports on progress of the strategic objectives through its Governing Body Assurance Framework.

Derbyshire's Health and Wellbeing Strategy for 2018–23 sets out five priorities for improving health and wellbeing across Derbyshire, focusing on actions to address factors that can influence people's health. The Health and Wellbeing Strategy can be viewed here[2].

The five priorities are:

1. Enable people in Derbyshire to live healthy lives
2. Work to lower levels of air pollution
3. Build mental health and wellbeing across the life course
4. Support our vulnerable populations to live in well-planned and healthy homes
5. Strengthen opportunities for quality employment and lifelong learning

Addressing these priorities will help us work to achieve our overarching outcomes for Derbyshire:

- increased healthy life expectancy; and
- reduced differences in life expectancy and healthy life expectancy between communities.

Information on Derbyshire County Council's Health and Wellbeing Board can be found here[3] and information on Derby City Council's Health and Wellbeing Board can be found here[4].

In addition, representatives from the CCG Governing Body regularly attend the Derbyshire Health Improvement and Scrutiny Committee and the Derby City Protecting Vulnerable

[2] https://www.derbyshire.gov.uk/social-health/health-and-wellbeing/about-public-health/health-and-wellbeing-board/health-and-wellbeing-strategy/health-and-wellbeing-strategy.aspx
[3] https://www.derbyshire.gov.uk/social-health/health-and-wellbeing/about-public-health/health-and-wellbeing-board/health-and-wellbeing-board.aspx
[4] https://www.derby.gov.uk/health-and-social-care/public-health/hwb/

Adults Committee to update and present reports to Derby City Council and Derbyshire County Council Councillors.

Joint working with the Local Authority

The CCG is a key partner of the Joined Up Care Derbyshire Integrated Care System, which involves working closely with colleagues in Derbyshire's provider organisations and the two unitary authorities to develop health and care priorities for local people. This has strengthened links between the local Health and Wellbeing Board Strategies and the priorities emerging from the NHS Long Term Plan.

Performance Analysis

One of the key areas of focus outlined in the CCG's Commissioning Intentions is to make sure the resilience of the local health and care system is maintained, while meeting national standards. These standards are outlined in the NHS Constitution and include measures such as the time it takes to get treatment, ED waiting times and cancer waiting time standards.

How Performance is measured?

Performance against the NHS Constitution targets is monitored regularly in the CCG. We look at a range of data, at provider level, CCG level and by specialty where applicable. A large proportion of performance information is supplied via the North of England Commissioning Support Unit (NECS). The CCG produces regular internal reports which are discussed with Executive Directors and Lead Senior Managers. This makes best use of 'formal' and 'informal' intelligence and ensures performance management is continuous.

We have contracts in place with our providers, including a series of performance and quality indicators, to ensure that delivery against priorities can be measured and accounted for. Key performance indicators (KPIs) for our commissioning priorities are reported monthly to the Quality and Performance Committee through the Integrated Quality and Performance Report. This report highlights current performance, any known and emerging issues, performance trends, patient impacts and corrective action to manage current challenges. The Governing Body also receives reports at each of its meetings in public in order to provide assurance around performance and quality of services. A key data set is a set of performance metrics which can give an idea of progress against any targets.

The KPIs cover the NHS Constitution and how programmes are performing against the national and local priority standards. They also include KPIs for the acute hospitals, mental health and community trusts. Exception reports are produced for any indicators off track. Any issues or risks are captured in the Risk Register and Governing Body Assurance Framework.

The complexities of Covid-19 resulted in changes to the contractual relationships with our providers, and altered the approach to contract management. During the year, the CCG was not able to performance manage the standards as in previous years.

Impact of European Union Exit on Performance

The CCG worked closely with regional and national colleagues to 'horizon scan' and closely monitor potential impacts of the European Union (EU) Exit. This involved regular and comprehensive dialogue with the Derbyshire Local Resilience Forum, which includes members from local authorities, emergency services, other 'health' organisations and key regional stakeholders including NHSE&I.

To ensure that the main areas of potential impact were monitored, the CCG followed a national template and reported regularly on any areas of concern. This enabled the CCG to closely monitor key areas which were highlighted as likely to impact on the ability of NHS organisations to effectively deliver services.

These included;

- supply of medicines and pharmacy;
- supply of medical devices and clinical consumables;
- supply of non-clinical consumables;
- goods and services;
- supply of blood products;
- transplant organs and tissues;
- workforce, estates and facilities;
- clinical trials;
- data sharing, processing and access;
- reciprocal healthcare;
- cost recovery; and
- the readiness of partner organisations that are essential to the delivery of healthcare.

The information provided by the CCG was merged with other responses to enable a regional and subsequent national picture to inform decision making and future contingency planning.

Due to the extended period leading up to the transition, local mitigations were put in place through working closely with other key stakeholders and the Derbyshire Local Resilience Forum, which held frequent strategic and tactical meetings. Post EU Exit transition daily reporting was required by NHSE&I from the 1st January 2021 to the 31st March 2021. The CCG was 100% compliant with this requirement and no issues were escalated during this period.

Of the key areas NHS organisations were asked to monitor, neither the CCG nor its commissioned providers experienced any significant impact on departmental goals, strategic objectives and priority outcomes for 2020/21. The CCG holds a business continuity risk which includes the EU Exit transition and this risk is the responsibility of the Governance Committee, to which regular reports were submitted for assurance.

Covid-19 Pandemic Response

In response to the emergence of the Covid-19 virus at the beginning of 2020, the CCG initially established an internal Covid-19 Response Cell which formed part of the Local Resilience Forum Health sub-group. As matters rapidly escalated to national management and global pandemic status, the CCG established a System Escalation Cell in February comprising senior leaders from across the system and an internal Senior Leadership Team comprising of Executive and Functional Directors, who met daily to manage the response.

In line with national guidance, an Incident Control Centre was set up to manage all Covid-19 related communications. This ran between 8am and 8pm, seven days per week, and a staffing rota and Standard Operating Procedure were developed. As themes for support and additional work emerged, more ‘cells’ were established to manage the situation. The Incident Control Centre moved to a virtual operation in March 2020 when the CCG’s offices were closed and staff were required to work from home.

How the CCG has operated throughout the Covid-19 Pandemic

Significant programmes of work were delivered to support staff working from home, including digital support, health, safety and wellbeing perspectives. Digital support was also provided to GP Practices requiring off-site capability at short notice. Staff motivation, productivity and effectiveness remained high throughout the period.

In April 2020, the Governing Body approved a revised Business Continuity Plan to include information on when support would need to step up, along with functions that would need to be paused in order to be able to respond to the pandemic. Governance processes were regularly reviewed, including the frequency and content of Governing Body and Corporate Committee meetings, our Constitution and Standing Financial Instructions.

The CCG continued to adapt to the changing nature of the pandemic and collaborated with and supported the Derbyshire system to respond effectively. This included the development of a System Escalation Call Risk Register, a Covid-19 Risk Register and a Vaccination Operation Centre Risk Log. A specific CCG Covid-19 Risk Register was also compiled in early April 2020 which was later amalgamated with the Operational Risk Register and reviewed, updated and reported to Committees and Governing Body on a monthly basis.

A total of eight cells were set up to date as part of the CCG/system pandemic response. Their roles and activities are described in Table 1 below:

Cell	Dates (when in operation)	Immediate priorities at the beginning of the pandemic	Key activities during the pandemic
Vaccine Operations Cell	1 September 2020 to present	Coordinate and oversee the JUCD Covid-19 vaccination programme, operational seven days-a-week, 8am-8pm	• Senior leadership, lead provider, workstream leads appointed, team identified, with email inbox and dedicated phone • Standard Operating Procedure (SOP) developed to include full programme management support and leads assigned to specific areas for continuity • Estates – sites identified (NHS and non-NHS compliant to national requirements) to support vaccine delivery across Derbyshire • Cycle of meetings and briefings established with appropriate governance and project support to maintain good communication across the Derbyshire system relating to the vaccination programme
PPE Admin Cell	1 April 2020 to July 2020	Coordinate administration function for the PPE cell	• Meeting arrangements, planning, minuting, management and development of PPE email inbox • System point of contact for PPE • Information sharing across the system • Development of PPE standard operating procedure • Data collection
PPE Clinical Cell	1 April 2020 to July 2020	Ensure adequate provision of PPE across the system for safe delivery of patient care (staff and patients) Named system clinical senior responsible owner for PPE appointed	• Clinical advice and leadership to the cell • Seven days-a-week clinical cover for advice/support on delivery of PPE • Responded in timely way to urgent requests • Coordinated and advised on PPE for private care arrangements in conjunction with local authorities • Delivered PPE to Care Homes and practices • Assessed and validated clinical requests for PPE • Supported and coordinated sharing of PPE across the

Cell	Dates (when in operation)	Immediate priorities at the beginning of the pandemic	Key activities during the pandemic
			system • Shared national clinical guidance • Delivered training for infection prevention and control in respect of use of PPE for Care Homes and GP Practices • Delivered FIT test training
Staff Testing Cell	11 April 2020 to present	• Develop a coordinated Derbyshire process for testing public sector staff members or staff family members who may be displaying symptoms associated with Covid-19 • Implement a solution for satellite sites for testing symptomatic key workers • Develop and implement symptomatic testing following notification of an outbreak in Care Homes	• Regular Derbyshire System Testing Cell meetings to coordinate health and Local Authority testing for symptomatic staff • Development of a Derbyshire-wide SOP for key workers testing public sector staff members or staff family members • Daily coordination for receiving and booking all public sector referrals for symptomatic testing for Derbyshire organisations • Working closely with Derbyshire Health United to set up and run the two Derbyshire satellite testing sites • Supporting Public Health England with testing for symptomatic Care Home staff and residents • Siting of mobile testing units in Derbyshire to respond to symptomatic testing requirements • Working with health and social care partners in relation to lateral flow devices and anti-body testing

Cell	Dates (when in operation)	Immediate priorities at the beginning of the pandemic	Key activities during the pandemic
Care Homes Cell	April 2020 to present	To provide a multi-agency oversight of the Care Homes and provide support with respect to: • PPE • capacity tracker • nursing cover • communication of key messages • development of microsite • emotional support • testing • training • oversight of market, financial viability • digital support, NHS mail • vaccination • outbreaks Task and finish groups were set up to oversee the elements outlined above	• Microsite was set up to communicate key messages and provider guidance and support • Development of Care Home Support Team • Infection, Prevention and Control training set up weekly • Call to action rolled out – PPE/infection prevention and control/testing • Development of Outbreak Control Team meetings to monitor outbreaks, providing support and guidance where needed • Effective joint working across organisations • Prompt action to crisis such as staffing level challenges for homes with outbreaks • iPad and laptop roll-out to all homes • Financial support to sector from Infection, Prevention and Control grants and Local Authority support • Guidance and support on visiting arrangements
End of Life Cell	April 2020 to January 2021	To provide oversight of End of Life services and support to Care Homes with respect to: • communication of key messages • development of guidance and SOP • 24/7 helpline • emotional support • equipment such as consumables • out of hours support • monitoring admissions from Care Homes • services to react to the pandemic	• 24/7 Care Home Support Line • Support offers from services across Derbyshire for Care Homes • Wobble room and emotional support services provided for Care Home to access • Roaming service from Treetops

Cell	Dates (when in operation)	Immediate priorities at the beginning of the pandemic	Key activities during the pandemic
		and trial new ways of working From January 2021 processes were implemented to support people at the end of their lives to stay at home (or their Care Home) and avoid admission to hospital where possible/appropriate	
Discharge Cell	April 2020 to present	To provide oversight of the discharge process out of acute hospitals (including acute and community, mental health, Local Authorities and transport) during the Covid-19 pandemic by: • overseeing local delivery of the National Discharge Guidance • checking services available in the community and escalation/ resolution of discharge delays • commissioning of temporary designated capacity (Covid-19-positive isolation beds) • communication of key messages • emotional support to providers • oversight of market, financial viability • management of capacity due to outbreaks • acting as operational escalation route for all discharge to assess concerns • the setting up of sub-groups to	• More than 100 actions were put in place across providers to deliver the national discharge requirements to respond to Covid-19 (across acute hospitals, community health, social care, mental health trust, patient transport and voluntary sector) to ensure that good patient flow was maintained • Effective joint working across organisations • Development of: o Derbyshire Pathway Guidance o Derbyshire Service Operating Procedures o discharge to assess capacity data reporting o designated capacity monitoring • Support to people being discharged to nursing care homes • Prompt action to crisis, such as staffing level challenges for providers with outbreaks • Financial support to sector from National Hospital Discharge programme

Cell	Dates (when in operation)	Immediate priorities at the beginning of the pandemic	Key activities during the pandemic
		manage the above including: o The Derbyshire Pathway Group o Operational Group o Pathway Data Group	
Homeless Cell (external)	15 April 2020 to present (Vulnerable People's Sub Group continuing to report into Local Resilience Forum)	• Homeless residents in hotels to be supported to access primary healthcare • CCG Medicines Management Team to align planning with substance misuse commissioners • CCG to review existing Wilson Street Surgery homeless enhanced service so that it covers all city homelessness • CCG to work with district housing authorities to adopt similar model as city • As part of restoration and recovery, CCG to review the homeless service specification for Derby City and consider broader ongoing Primary Care support for homeless people across Derbyshire	• Red hub patient transport service expanded for use by city homeless people • Smartphones commissioned to city and county homeless accommodation to facilitate online GP consultations • All Derby and Derbyshire practices alerted of their requirement to temporarily register any homeless people in their area and offer a healthcare assessment • CCG offered guidance around Primary Care provision for people with no recourse to public funds • City Primary Care Covid-19 homeless service contract specification drafted • Support for the development of a rough sleepers' recovery plan with Derby Homes • CCG liaised with national colleagues to develop above planning for Derbyshire, adopting best practice

Table 1 – Roles and responsibilities of the CCG's Covid-19 pandemic response specialist cells

Performance Summary 2020/21

In 2019/20 the CCG reported meeting 9 of the constitutional or mandated standards. This year, our overall performance has shown that 9 of the 21 constitutional or mandated standards for our patients have been delivered during the year. Although a number of the standards were not achieved, they compared well with the nationally reported performance. Those standards that were not achieved are detailed by exception in the performance analysis section of this report.

Performance Analysis up to the end of Quarter 4

Indicator		Standard	DDCCG	NHSE
Referral to Treatment	18 weeks Referral to Treatment – Elective Surgery	92%	59.5%	62.1%
	18 weeks Referral to Treatment – 52+ week wait	0	8,261	–
Diagnostic waits	Diagnostic test waiting more than six weeks from referral	1%	38.57%	36.15%
A&E waits	A&E less than four hours	95%	86.1%	89.2%
Cancer waits less than 14 days	Urgent GP referral to first outpatient appointment	93%	89.1%	88.7%
	Urgent GP referral to first outpatient appointment (breast symptoms)	93%	80.2%	75.9%
Cancer waits less than 31 days	Diagnosis to first definitive treatment for all cancers	96%	94.1%	94.9%
	Subsequent surgery within 31 days of decision to treat	94%	81.4%	87.9%
	Subsequent drugs treatment within 31 days of decision to treat	98%	98.5%	99.1%
	Subsequent radiotherapy treatment within 31 days of decision to treat	94%	95.3%	96.6%
Cancer waits less than 62 days	Urgent GP referral to first definitive treatment for cancer	85%	71.6%	74.3%
	NHS screening service to first definitive treatment for all cancers	90%	69.7%	75.0%
	104+ days wait for first treatment	0	273	–
Mental Health	CPA seven days follow-up (Q3 data)	95%	96.1%	95.0%
	IAPT access	22%	26.34%	–
	IAPT recovery	50%	56.6%	50.8%
	IAPT waiting times (six weeks)	75%	92.7%	89.6%
	IAPT waiting times (18 weeks)	95%	98.6%	97.9%
	Early Intervention in Psychosis – completed	50%	86.6%	71.8%
	Early Intervention in Psychosis – wait <2weeks	50%	77.8%	26.1%
	Dementia diagnosis	67%	66.4%	62.8%

Table 2 – CCG performance against constitutional or mandated standards during 2020/21

2020/21 Performance Exceptions

Referral to Treatment Time (18 weeks)

In March 2020 all trusts were asked to cancel non-urgent planned surgery with a view to releasing capacity for the emerging Covid-19 pandemic. All patients had to be clinically prioritised for urgency of their procedure. The number of people awaiting treatment has risen sharply across Derby and Derbyshire as a result of the reduction in planned care at all trusts.

At the end of 2019/20, 89.7% of CCG patients on the incomplete pathways list had been waiting less than 18 weeks for their treatment. At Quarter 4 in 2020/21, performance had reduced to 59.5%.

During summer 2020, NHSE&I required all trusts and CCGs to submit a Phase 3 Recovery Plan by September, in which they were required to outline how they would increase planned care to the activity sustained during the same period in 2019/20. This related to both day case and planned activity.

Independent sector provision has been used across the county to provide more capacity in offering health services.

Patients waiting more than 52 weeks for treatment

At the end of March 2020 there were 27 breaches of the 52 week standard due to the Covid-19 pandemic and as a result of the cancellation of planned surgery. All these patients had accepted ‘to come in’ dates throughout March.

During the year the number of Derby and Derbyshire patients waiting more than 52 weeks for treatment increased substantially. At the end of March 2021 there were 8,261 Derby and Derbyshire patients waiting more than 52 weeks for their treatment. Of these, 6,684 were on the waiting lists at our two main providers, UHDBFT and CRHFT. The remaining 1,577 Derbyshire patients were on waiting lists at 55 other different trusts across the country.

Further increases in levels of infection during the pandemic throughout autumn and winter meant that this number continued to increase and it is uncertain when the majority of these patients will receive treatment.

Diagnostics

This standard has not been met throughout the year. Unfortunately, all non-urgent diagnostics were cancelled in March 2020 as a result of the pandemic. Once trusts were able to increase activity, this was not at the previous level due to social distancing restrictions. This meant that clinic sessions sometimes had half the number of appointments than in previous years.

In May 2020, 59.8% of patients had been waiting more than six weeks for their diagnostic procedure. The standard is less than 1% of patients should wait more than six weeks.

Although the performance over the year fluctuated it is now showing improvement and activity is increasing. Performance improved to 38.57% and is expected to continue. The number of Derby and Derbyshire patients on the waiting list for a diagnostic procedure at the end of March 2021 was 60% higher than the figure waiting at the end of March 2020.

Restoration of diagnostic activity is part of the 2021/22 Operational Plan and all trusts are required to recover their activity to the 2019/20 level of activity.

Accident and Emergency (A&E) Waiting Time – proportion with total time in A&E under four hours

The majority of Derby and Derbyshire patients attend UHDBFT and CRHFT. At the beginning of the Covid-19 pandemic there was a reluctance to attend the Emergency Departments, which led to the number of attendances dropping significantly and as a result performance improved. UHDBFT performance peaked at 90.9% in May 2020 when it had 29% fewer attendances than it did in May 2019; while CRHFT achieved the target in May and July 2020 when there were 33% fewer attendances than the previous year. However, since then the numbers have increased and performance at the end of the year was 86.1%.

Although numbers of attendances dropped, there were new infection control challenges that changed how the departments worked. The departments were divided into two areas – patients with potential Covid-19 symptoms were treated in one area while non-symptomatic patients were treated in the other. This increased safety but meant less flexibility in how the spaces could be used. In addition, departments needed increased physical space for social distancing and more intense cleaning of bays between patients, which resulted in a lower turnover of clinical space.

12 Hour Trolley Breaches

The NHS has a zero target for 12 hour trolley waits (12 hours from decision to admit to being moved to a bed). There were 35 breaches reported up to the end of March 2021 and all of these took place at Royal Derby Hospital.

All reported breaches are subject to an investigation which is shared with our Quality Team. The team reviews the information to identify if any harm has occurred as a result of extended stays in the Emergency Department. All reported breaches were investigated and the CCG are assured that no harm was caused by these delays. They were caused by two reasons:

- 29 breaches were due to patients awaiting a bed on the Medical Assessment Unit. This area had been extended and divided into two areas – one for patients testing positive for Covid-19 and the other for patients with negative results. This led to less flexibility in Medical Assessment Unit bed availability and transfers being delayed when Covid-19 test results were delayed; and
- six patients were awaiting a mental health bed elsewhere. At the Royal Derby Hospital these patients are cared for in a bedded area away from the Emergency Department, even though they are still kept on A&E systems.

Cancer

The CCG achieved two of the eight main cancer standards (31 days to subsequent surgery and 31 days to subsequent drug treatments). Despite not achieving the remaining six standards, performance has compared well against the nationally reported figures.

It has been a challenging year for cancer performance nationally as well as for our two main acute providers. Performance against most of the key cancer targets has been generally good compared with national performance, but there have been issues due to the pandemic.

During the pandemic we worked with our partners across Derby and Derbyshire to encourage the public to come forward to see their GP with any worrying symptoms that could be cancer. The public were offered reassurance that cancer services were being maintained throughout the pandemic, although some services may have been delivered in a slightly different way. We did this through the local media, social media, patient and public forums and text messaging.

Two-week wait (2WW) referrals for cancer treatment decreased by around 70% during April and May 2020, and although referrals increased during summer 2020, they again reduced during autumn and winter, but not down to the same levels as in April and May. The number of 2WW Derbyshire patients seen through autumn and winter exceeded the Phase 3 trajectories and continues to increase. There have also been significant increases in the volume of referrals and treatments.

Breast referrals, both 2WW and symptomatic, increased significantly during autumn 2020, and work has been undertaken to introduce specific breast pain clinics across our area. Diagnostics for cancer patients were prioritised throughout the year.

The 28-day Faster Diagnosis standard was due to be introduced during the year, but it was delayed to October due to the Covid-19 pandemic, and although we are able to report on the CCG position, the trusts' position is not being reported nationally until July 2021.

There continues to be a significant challenge to deliver the 85% performance for 62-day treatment, both locally and nationally. At the beginning of the pandemic, many patients were reluctant to attend hospital for outpatient appointments or diagnostic tests, which resulted in a large increase in the number of patients who had been waiting more than 62-days for their treatment. This improved during the summer and early autumn, however a number of patients were reluctant to attend until they had received their full vaccinations. Trusts are now reporting very little delays.

Radiotherapy and chemotherapy treatments continued during the year at the same levels as the previous year although there were some delays in surgery; however the numbers of surgical treatments were good in comparison to the previous year.

Rapid Diagnostic Centres

We implemented rapid diagnostic centres in order to diagnose cancer patients more quickly and accurately. This helped us to make sure that patients diagnosed with cancer get onto the right pathway as soon as possible. It reduces the number of visits to the hospital for investigations and improves patient experience. We have a programme of work that focuses on services in lung cancer, gastro-intestinal cancers and non-site specific cancer services and we will continue to roll this process out to other cancer specialties.

Early Diagnosis of Cancer

There is a national ambition to diagnose 75% of cancers at an early stage by 2028 and to improve the number of patients who survive for longer following a cancer diagnosis. We have programmes in place to help us towards this ambition, one of which is supporting our GPs. We provided resources to support GP Practices improve the earlier diagnosis of cancer and to improve the uptake of national screening programmes.

Mixed Sex Accommodation

The mixed sex accommodation data has not been captured during the year due to the pandemic.

Planned Care

Outpatients

As a result of the pandemic and changes in clinical practice, the outpatients programme has been reviewed and redesigned to meet the changing needs of our population.

Referral management

Advice and guidance is currently provided across the Electronic Referral System and Consultant Connect Platforms through a variety of non-face-to-face methods including calls, messages and photos to support making the most clinically-appropriate referrals. It enhances the patient pathway and prevents the need for appointments. Digital communication channels allow clinicians (often in Primary Care) to seek advice from another (usually a specialist) prior to or instead of referral.

It is offered to ensure patients receive care locally whenever appropriate and reduces the number of hospital appointments required for patients. It allows clinicians to assess and treat patients who need specialist input and assists with reducing backlogs and waiting times for specialist services. Advice and guidance supports the NHS ambition of ensuring that patients receive the right care, in the right place at the right time.

We are undertaking a review of all advice and guidance in the Derbyshire system with a view to ensuring that this will be offered in all specialties (where clinically appropriate). CRHFT recently implemented a Referral Assessment Service and UHDBFT are developing local opportunities to support Referral/Clinical Assessment Services.

Tele-Dermatology

Throughout the pandemic, we were able to provide tele-dermatology services to support advice and guidance, sharing images of lesions/rashes (excluding suspected cancer). This service commenced in April 2020, and Consultants across Derby and Derbyshire offered rapid access to specialist guidance which led to more than 50% of requests being managed through Primary Care. The team were successful in receiving funding for equipment to enable the further development of this model through the use of dermatoscopes (devices that take a more detailed image of the lesion/rash to support diagnosis).

Clinical Specialties

We worked to establish and develop forums for the clinically-led review and redesign of 'end-to-end' clinical pathways. The use of digital communications and Microsoft Teams allowed a greater number of clinicians to contribute to these clinical forums. Dermatology, ophthalmology, cardiology, ear, nose and throat, gynaecology, urology and paediatrics are currently in place across Derbyshire and we are planning to develop this model further.

During the pandemic we worked to review patient risk on backlogs at our providers and completed referral reviews in cardiology, urology and dermatology in order to identify further opportunities to best support patient care.

Digital Solutions

We are working with providers to develop digital opportunities for patients to have more control over their care. This will be through self-help resources or digital resources that offer patient-initiated follow-ups, allowing patients to access clinical teams as and when their condition flares up.

Non face-to-face outpatients

Covid-19 saw the rapid development of telephone and video consultations. The team is working to review best practice in these consultations and to ensure that across Derbyshire we maintain this momentum (where clinically appropriate) to exceed the recently issued national targets of 25%. Feedback was received across Derbyshire as follows:

CRHFT	UHDBFT
97% would have another video appointment	89% (2,658/2,993) found it very easy or easy to join the video call
90% report their experience as very good or good	92% rated their overall experience as very good or good
78% saved up to 2 hours compared with a face-to-face appointment	87% felt able to communicate everything they wanted to the health care professional during the video/telephone call
75% saved up to £15 compared with a face-to-face appointment	88.5% found the video/phone consultation was helpful
Other key benefits were reported such as not having to take time off work or arrange childcare, and that patients prefer to have their appointment whilst being at home	82% were either very likely or somewhat likely to choose video/phone consultation again if was available

Ophthalmology

Hospital providers undertake telephone consultations for all patients not requiring face-to-face reviews/treatments in order to monitor patients' conditions. If at the point of a telephone consultation patients are identifying a change in their condition, the level of risk is assessed and, if appropriate, patients are asked to attend for a face-to-face appointment.

The Minor Eye Conditions Service (MECS) was launched in October 2019. The service enabled patients presenting to an Optician with a minor eye condition (such as red or dry

eyes) to be seen in Primary Care, reducing the need to be seen in hospital. Opticians are able to directly refer patients to Secondary Care if required.

Unfortunately, due to Covid-19, the service had to be halted after 23 weeks. It was replaced by a service called Covid-19 Urgent Eye Service, which CCGs were required to have in place during the pandemic. This new requirement aligned to the establishment aims of the MECS, enabling a swift transition. During the time that MECS was in operation, 395 patients (52%) completed feedback questionnaires. The results were extremely positive, with no negative comments; 90% of patients reported that they would be 'extremely likely to recommend the service to a friend or family member'.

Musculoskeletal Services

The Musculoskeletal (MSK) Clinical Assessment and Triage Service is a specialist service which triages all GP MSK referrals to Secondary Care (excluding red flag referrals). The service reviews the referral to identify if there is any conservative treatment that would be appropriate for the patient. Treatment options are discussed and agreed with the patient as part of a shared decision-making conversation. During the Covid-19 pandemic, the service launched virtual appointments where clinically appropriate, with those needing to be seen face-to-face triaged first. The service saw a drop of 39% in referrals during 2020.

For the virtual appointments that took place, two audits were undertaken to quickly evaluate virtual working and to identify any areas of concern or improvement. The survey undertaken by Physiotherapists at CRHFT demonstrated that:

- 92.5% felt the appointment was convenient;
- 92.5% felt confident that the physiotherapist identified and understood their problem;
- 95% understood the advice given;
- 90% were happy with the care; and
- 42.5% would have chosen this type of appointment if there was not a pandemic.

A separate 360 survey, which was carried out by DCHSFT, found that:

- 88% were satisfied with all remote consultations and 93% were satisfied with telephone consultations (video consultation was in its infancy when this review took place);
- the majority of referral and condition types were thought to be suitable for remote consultations and clinicians felt it worked well for screening of routine referrals, follow-up appointments and managing long term conditions;
- MSK clinicians advocated the permanent inclusion of virtual consultations; and
- remote consultations were more challenging where people had complex conditions and/or communication difficulties, therefore a face-to-face consultation was offered when this was identified. All patients are asked about their communication needs at their first point of contact with the service as part of diversity monitoring.

A set of educational videos were developed and shared with GPs, which support them managing patients with back conditions. The feedback from GPs was positive and further MSK videos are planned for 2021.

A review of the pain services available to support patients with MSK pain highlighted opportunities for improvement, but implementation is on hold due to the redeployment of clinical staff. UHDBFT were supported to develop a service to support and manage patients

with fibromyalgia in the community. This is due to be implemented as a pilot in 2021/22. Representatives on the MSK Delivery Board worked during the Covid-19 pandemic to support the review and backlog clearance of patients waiting for treatments where possible.

Physiotherapy

Work is underway on a system-wide MSK outpatient physiotherapy review. We completed an initial patient engagement review across Derby and Derbyshire and plan to further develop the physiotherapy model by working collaboratively with our providers and members of the public.

The CCG's Planned Care Team is working to understand how it can utilise some of the integrated physiotherapy capacity to support potential acute physiotherapy backlogs when clinical staff are being redeployed. Self-care digital options are also being explored for patients to self-care for a range of MSK conditions.

Urgent Care

Hospital capacity has had to be organised in new ways as a result of the pandemic in order to treat Covid-19 and non-Covid-19 patients separately and safely. This resulted in beds and staff being deployed differently from previous years, in both emergency and planned care settings within the hospital.

A key focus for this year has been to support the system during the pandemic including supporting NHS111 First, introducing virtual consultations at various Urgent Care services, and developing strong links between service providers. Our main achievements, which have improved access to and experience of Urgent Care services, are detailed below.

Transformation

When not at the height of the pandemic, meetings with service providers continued remotely to deliver the Urgent Care Transformation Programme. Both the Accident and Emergency Delivery Board and Urgent Care Transformation Board meetings also continued to be held virtually. However, the Covid-19 pandemic impacted the focus of our transformation work in adapting the way patients can access urgent and emergency care, ensuring patients are seen in the right place, first time, and changed capacity to meet infection protection and control requirements.

Virtual Consultations

Virtual consultations were successfully implemented by NHS111 and the five Urgent Treatment Centres. Virtual consultations are also being considered in our EDs to enable conversations between clinicians in different trusts.

Urgent and emergency care continuously explored introducing non-physical pathways where possible and moving to triage models while patients are still at home. Reductions were made to acute and community bed capacity to meet infection protection and control requirements.

Operational support

A System Operational Resilience Group, at silver command-level, was set up to quickly coordinate and deliver the actions necessary to respond to significant issues which were

affecting, or likely to affect, the health and social care system. The system worked well together during periods of significant pressure due to Covid-19, with mutual aid and redeployment of staff.

Demand Management

The system has been working together throughout 2020/21 to identify areas of opportunity for alternative ways of providing care, reducing pressure in EDs, and managing Covid-19 demand alongside the significant non-Covid-19 demand. Derbyshire Dialogue was established to inform the public of NHS111 First and urgent and emergency care programmes of work and services overall.

Below are the key areas of demand management work that have taken place 2020/21:

Urgent Treatment Centres (UTC)	Acute Hospitals	East Midlands Ambulance Service NHS Trust (EMAS)
Direct line for all UTCs to EMAS	Rapid implementation of co-located UTCs with both acute trusts	Work to reduce avoidable conveyance
Increase in ambulances taking 'minor' patients to the UTCs	Direct lines for advice and guidance for UTCs and the ambulance service	Ambulance service going direct to UTCs
Implementation of virtual consultants at the UTCs (phone and video)	Continued development of Same Day Emergency care at both acute trusts	Advice line for EMAS at UTCs and via Consultant Connect
	Work with the acute trusts to reduce ambulance handover waits	

NHS111 First

The NHS aims to continuously improve the patient experience and find new ways to see patients. During the Covid-19 pandemic this became more vital, keeping our patients and staff safe when coming into an ED. A national programme, NHS111 First, was launched during the pandemic, which we rolled out in Derbyshire in autumn 2020. As part of the evaluation process, data, patient and staff feedback across the system is currently being gathered and will be completed by the end of July/early August.

Primary Care

Derbyshire's vision for Primary Care

Our vision has been developed by GPs to provide high quality, patient-centred, General Practice-led care which has the freedom to innovate to meet patients' needs; with organisations and professionals behaving in a mutually supportive manner. The vision outlines three goals, which will be supported by, and help us deliver, the national priorities as set out in the NHS Long Term Plan; General Practice Forward View and GP Contract over the next five years.

1. All patients will have access to a General Practice-led multi-disciplinary team of community care professionals by 2024
2. In Derbyshire, the share of NHS resources spent on Primary Care should increase (from 9% to 15%) within 10 years
3. By 2024, no member of the General Practice Team will leave the profession as a consequence of an unsustainable workload and/or unreasonable working demands

Derbyshire General Practice Workforce

The total General Practice Workforce for Derbyshire is 3,460; a Full Time Equivalent (FTE) of 2,488; which is an overall participation rate (the average hours worked each week by each person) of 72%. This is higher than the national participation rate of 70%. Within the workforce there are four main staff groups; these are:

General Practitioners	698 headcount (524 FTE)
General Practice Nursing	505 headcount (361 FTE)
Direct Patient Care (those other than GPs and Nurses who provide care to patients e.g. Health Care Assistants, Physiotherapists, Pharmacists or Paramedics)	330 headcount (235 FTE)
Administration and Non-Clinical	1,927 headcount (1,368 FTE)

In Derbyshire, we saw a shift in the age profile within our workforce. While 25% of our Nursing workforce is over the age of 55, 24% are under the age of 39. We also have a similar picture in our GP workforce with 40% under the age of 39.

This is significantly better than the previous year, and although these percentages are favourable compared to national averages, we know we need to do more to recruit staff out of training to balance the turnover of staff nearing retirement.

Extended Access

The *General Practice Forward View*[5] helps general practice deliver more of its potential to improve the care available to patients. As part of our commitment to this, longer opening times (geographically-based hubs which operate additional appointments daily between

[5] https://www.england.nhs.uk/gp/gpfv/

6.30pm–8pm on week days, Saturday and Sunday mornings, including Bank Holidays) for patients in Primary Care were rolled out across Derby and Derbyshire and have significantly increased access to Primary Care since October 2018.

Throughout the pandemic, most hubs diverted capacity from within this service to support other areas where GP Practices in their Primary Care Networks were seeing patients in local hubs with suspected Covid-19, and more recently, delivering the vaccination programme. For those hubs which have continued to provide longer opening hours, appointments have been undertaken via telephone triage and treatment, virtual appointments and face-to-face for those who need it most.

Primary Care Estates

The Primary Care Estates Strategy was approved by the Primary Care Commissioning Committee in November 2020, providing a framework for the development of the Primary Care estate across Derbyshire to 2025. The strategy identified 20 next step activities and work has commenced on the four highest priority actions, which determine what is required for the estate. Feasibility studies have been undertaken in south east Derby, south west Derby and the Mickleover and Mackworth areas. A study in Swadlincote is expected to start before the end of 2020/21. The studies suggest options such as the refurbishment and extension of an existing building, or the development of a business case for the replacement of existing sites.

Quality

Supporting Quality Improvement Visit

Following the declaration of pandemic status of Covid-19 and Government guidance, it was agreed to postpone any future Supporting Quality Improvement (SQI) visits from March 2020. The CCG's commitment is to continuously improve the quality of healthcare for the population of Derby and Derbyshire. We have an established range of effective monitoring processes in place which are reported regularly to the Quality and Performance Committee; however a full evaluation of the SQI programme will take place to understand what will be required in the future to support practices.

National Screening and Immunisation Programmes

As a result of the Covid-19 pandemic, a decision was taken by NHSE&I in April 2020 to pause some of the National Screening Programmes, which included the:

- routine Diabetic Eye Screening programme – high risk and pregnant women were still called for appointments;
- routine Breast Cancer Screening programme – trusts were guided to ensure screening of high risk women continued;
- Bowel Cancer Screening programme; and
- Abdominal Aortic Aneurysm programme.

Patients presenting with any of the above symptoms were treated according to routine care and treatment.

The antenatal and newborn screening and Cervical Screening programmes continued as normal through colposcopy clinics, but at a reduced capacity, with high risk referrals seen as usual and low risk referrals contacted by the individual colposcopy clinics.

Since June 2020 screening providers implemented their recovery and restoration plans in order to clear any backlog caused by the first national lockdown. Practices and providers offered extra appointments to catch up on missed or delayed screens.

The routine National Childhood Immunisations Schedule was maintained throughout the year; initial reports suggesting that the impact on uptake of the vaccines was minimal.

The national influenza vaccination campaign for 2020/21, despite the difficulties experienced by General Practice, was the most successful year in the history of the programme with regards to uptake. Table 3 below shows the increase in uptake in each category:

Category	As of February 2020 (% uptake)	As of February 2021 (% uptake)	Increase in uptake (%)
Over 65 years	75.9	84.3	8.4
Under 65 'at risk' groups	46.1	57.7	11.6
Pregnant women	47.6	50.4	2.8
2 year olds	52.0	61.8	9.8
3 year olds	52.1	65.1	13

Table 3 – Increase in uptake (%) of flu immunisations between February 2020 and February 2021

General Practice Nursing

The *General Practice Nursing 10 Point Plan* is in the final year of delivery. The plan aims to:

- raise the profile of general practice nursing as a first destination career;
- improve access to training;
- increase the number of pre-registration nurse placements and enhance retention; and
- support return to work schemes for practice nurses and develop a career pathway for General Practice Nurses and Healthcare Support Workers.

The purpose of the plan is to provide support and equip General Practice Nurses to deliver safe, effective and quality care to patients. The focus this year has been on supporting practice nurses who are new to practice to undertake academic training to support the development of their role.

The outcomes enable GP practices to manage more people's health closer to home within the community rather than hospital-based care. It also builds General Practice Nurse capability to support improved and innovative approaches to delivering health and wellbeing and helps meet objectives of the NHS Long Term Plan. The full plan can be found here[6].

[6] https://www.england.nhs.uk/wp-content/uploads/2018/01/general-practice-nursing-ten-point-plan-v17.pdf

Health Education England has been commissioned to develop a Practice Nursing Strategy for Derby and Derbyshire, which will identify our system's strategic approach and vision for practice nursing and will consist of recruitment, retention and recovery. It will be a component of the wider Derbyshire system workforce planning work stream.

Care Quality Commission inspections of Primary Care

Delivering high quality services in Primary Care is an important part of managing the health of Derbyshire's population. Every Derbyshire GP Practice has been visited by the Care Quality Commission (CQC) and has received an inspection rating of either outstanding, good, requires improvement or inadequate. Table 4 identifies the ratings awarded to GP Practices by the CQC for the reporting period up to the 31st March 2021:

Rating	Total GP Practices
Outstanding	20
Good	87
Requires improvement	5
Inadequate	0

Table 4 – CQC ratings awarded to GP Practices up to 31st March 2021

During 2020, the CQC revised their approach. This focused on safety, how effectively a service is led and how easily people can access the service. These reports provide important assurance to the CCG of maintained service standards.

The Primary Care Quality Team continued to meet with the CQC on a quarterly basis during the pandemic, and action plans are in place to support GP Practices. Further information can be found at https://cqc.org.uk/.

Digital Development

The Digital Development Team supports the digitalisation of Primary Care and the Corporate information technology (IT) requirements of the CCG. The majority of this work is undertaken through the underlying GP IT and Corporate IT contracts with NECS, which the team manage on behalf of the CCG and Primary Care.

Our main goals

For 2020/21 our main goals included:

- completing the migration of all GP Practices onto the Health and Social Care Network and consolidating all sites onto the NECS infrastructure;
- completing the server virtualisation programme of work to replace local physical servers, thereby allowing secure access to GP Practice data remotely;
- delivering online consultation targets and telehealth; and
- supporting the digital delivery of Primary Care services into Care Homes.

Improved Infrastructure

The introduction of additional digital services and products to support patient care and the delivery of care services requires ongoing review of and investment in, an appropriate underlying IT infrastructure. Throughout 2020/21, we worked with NECS to complete the consolidation of the wider network, to improve resilience for our GP Practices in being able to work remotely whilst ensuring the security of our shared network.

The server virtualisation programme of work replaced physical servers previously held within GP Practices with virtual servers held centrally within a data centre. This allows colleagues within Primary Care to access documents and files as well as the clinical information system. This was especially useful during the Covid-19 response when working flexibly and remotely; and has been fundamental to the ways in which Primary Care delivers services.

Investments were also made in the network infrastructure to review usage and increase bandwidth where appropriate, taking into account the use of new high bandwidth services such as video consultation, which increased rapidly during the Covid-19 pandemic. Similarly, we responded to notifications from NHS Digital and NHSE&I regarding the increased risks from cyber-attacks during this period, investing in new hardware to support secure remote access for CCG and Primary Care colleagues; and investigating additional services which can provide an independent view of our cyber-security risks.

Working with fellow health and social care organisations within Derbyshire, we implemented a national wireless network standard to provide the ability for colleagues from all supported organisations to use a common network name to connect to the Internet or securely back to their own organisation's shared files and systems. This removes the need for duplicate wireless networks or reliance upon mobile data signals.

Digital Delivery of Primary Care Services

During the pandemic, the use of technology to remotely connect clinicians to GP Practices and patients to clinicians has grown rapidly. This year saw a marked increase in the use of video consultations between patients and clinicians, and allowed connectivity between the clinician and shielding patients and/or those within our Care Homes.

New systems delivered include further deployment of batch messaging capability to GP Practices to allow them to use SMS to contact patients for vaccinations or other means. The use of patient questionnaires to allow GP Practices to monitor patients within their communities has grown, alongside the capability for patients to submit photographs to clinicians during their remote consultations.

The CCG worked with Care Homes to provide them with access to a managed laptop to support the digital delivery of services. We supported the deployment of NHS Mail to social care services including Care Homes and domiciliary care providers. We continue to work with Primary Care colleagues and other health and social care organisations to identify other services which could be routed through this same equipment. The CCG has continued the rolling programme of replacing devices and equipment within GP Practices with the deployment of new laptops, additional monitors, web cams and headsets and supporting business continuity through the provision of remote access solutions.

Long Term Conditions

The 2020/21 planning and performance priorities focused on the Long Term Conditions (LTCs) of respiratory, cardio-vascular disease, stroke, gastroenterology and diabetes, which were aligned to NHS Long Term Plan objectives. In each of these conditions, outcomes are focused on improving the quality of care provision; addressing health inequalities; promoting local access to services; improving prevention support; and targeting differences in quality of clinical treatment and care.

The condition-specific priorities are agreed at the JUCD Long Term Conditions Board and are overseen by monthly delivery group meetings attended by system clinical leads, service providers, and third sector organisations.

During the Covid-19 pandemic, JUCD requested that all non-Covid-19 initiatives and meetings be stood down to free up the capacity of clinical staff, service managers and commissioners to support the Covid-19 response. Therefore, all work related to the 2020/21 plan was stood down and staff redeployed.

The Strategic Clinical Conditions and Pathways (SCCP) Team integrated both Primary and Secondary Care to support the recovery and restoration of services, and led on the development and implementation of Long Covid-19 services. This included:

Post-Covid-19 Syndrome Assessment Clinic Service	The service launched in December 2020 and was aligned to NHSE guidance. It provides patients with access to multi-professional advice all in one place, to ensure referral into appropriate services such as rehabilitation, psychological support, specialist investigation, or treatment.
Establishment of Red and Green Hubs in Primary Care	The team developed standard operating procedures for Primary Care Networks to ensure that patients who have Covid-19 symptoms can still access face-to-face appointments where required.
Prioritisation for LTC reviews in Derbyshire	Clinical leads developed Primary Care guidance to ensure that health reviews of high risk patients were prioritised during the pandemic.
Recovery of LTC services including diagnostics	Service providers were supported to develop alternative ways of delivering services and reducing patient backlogs.
Respiratory Covid-19 clinics	Aligned to national guidance, the SCCP Team supported acute providers to implement respiratory Covid-19 clinics for patients with on-going respiratory symptoms.

Although the priorities set out at the start of the year were impacted by the pandemic, the SCCP has still progressed objectives where capacity and clinical input has allowed. Highlights include:

Respiratory	
Home Oxygen Services	Pathway reviewed and new equipment contract appointed in October 2020, which introduced commissioner protocols and led to a reduction of patients inappropriately on home oxygen.
Pulmonary Rehabilitation	Providers worked together to develop and deliver new pulmonary rehabilitation services. Virtual programmes were developed due to the pandemic which are to be sustained to improve the patient experience.
Cardiovascular Disease	
Atrial Fibrillation identification	Through using portable ECG devices, the team worked with the East Midlands Academic Health Science Network to improve the number of identifications and diagnoses of Atrial Fibrillation patients in Primary Care.
Home BP Monitors	500 blood pressure monitors secured though NHSE funding to pilot their use in supporting extremely vulnerable patients with hypertension. Evidence from this pilot will support greater roll-out of the BP@Home programme.
Familial Hypercholesterolemia service	Working alongside NHSE&I to roll-out Nurse-led Familial Hypercholesterolemia genetic screening services across the East Midlands, offering patients identified at risk of Familial Hypercholesterolemia the ability to be diagnosed locally and receive treatment.
Gastroenterology	
Patient Knows Best Software	Utilised to review an appropriate cohort of Irritable Bowel Disease patients at UHDBFT in order to eliminate unnecessary annual reviews for patients on a 10-year colonoscopy list.
Diabetes	
Structured Education for Type 2 Diabetes	Development of a pilot triage system, offering different delivery and education packages to suit patients' needs with a single referral pathway.
Stroke	
Stroke Pathway Review	A new governance structure was established to support the ongoing review of services and to commence the development and implementation of an Integrated Derbyshire Stroke Pathway.

Integrated Community Care

Throughout 2020/21, the Joint and Community Commissioning Team continued to focus on working collaboratively with health and social care service providers and partners to develop strong integrated community services across Derbyshire. Transformation work has been targeted at projects which will enable the health and social care system to operate as effectively as possible in extremely challenging circumstances.

Immediate Covid-19 Support Projects

The projects below illustrate our response to the Covid-19 pandemic:

Care Homes Support	Coordinating support for Care Homes across Derby and Derbyshire throughout the pandemic to ensure they have access to training and support and providing opportunities for Care Home staff to access support to maintain healthy mental health.
Oximetry at Home Programme	Working closely with Derbyshire Health United to set up a programme to recognise when people with Covid-19 have low oxygen levels so that they can get rapid access to support that minimises complications, including reducing the number of deaths.
Local Resilience Forum Community Response and Recovery Cells	Contributing to a joint approach among partner organisations in mitigating the impact of the pandemic in communities.
Enhanced Support for Patients with Delirium and Dementia	An agreed priority as part of the immediate response to the Covid-19 pandemic was to ensure that, as far as possible, patients with delirium and dementia could be cared for away from hospital settings, either in their own home or in a Care Home.
Discharge to Assess	Enabling and supporting people to be discharged from our two Acute hospital trusts and community providers. Partner organisations have developed more than 70 temporary Covid-19 designated beds across residential and nursing settings and ensured that the commissioned services have been able to deliver even in the most difficult of circumstances.

Transformation Projects

We have focused on leading and supporting the projects and initiatives described below, which were identified as being most useful to the overall, longer-term response to the Covid-19 pandemic.

Outpatient Parenteral Antibiotic Therapy Services

Outpatient Parenteral Antibiotic Therapy services provide intravenous (IV) antibiotics to patients outside of the acute hospital inpatient setting. Patients can either be trained to self-administer IV antibiotics, or these can be administered by a healthcare professional in an inpatient or community setting.

Working across the healthcare system, we are developing a community IV service which offers the opportunity for improved efficiency and patient choice, while maintaining high quality of care. We developed a shared care model between acute Infectious Disease Consultants, Outpatient Parenteral Antibiotic Therapy Lead nurses, GPs and Pharmacists, to offer an IV antibiotics step-up service across Derby and Derbyshire.

Therapy Shift

There is strong agreement that patients should be discharged from a hospital setting as soon as they are medically optimised, and that longer-term planning should take place with the patient and their family/carers in the community, not in a busy hospital. To support this way of working, we worked with therapists, including Occupational Therapists and Physiotherapists, to look at how therapy support can be 'shifted' from hospitals into the community. Therapists from across JUCD (social care, mental health, community, acute and hospice) are actively reviewing the current process of patient flow. From this, four key outcomes have been defined:

- there is trust in the system between different providers of care;
- no patient 'falls through the gap' – all patients have a seamless positive experience of passing across organisations;
- no patient spends longer in a bed or pathway than they need to; and
- all clinicians are able to describe the 'patient offer' outside of their organisation, or know how to access this information.

The Emergency Care Improvement Support Team supported a workshop attended by more than 45 therapists from across JUCD in February 2021. This looked to develop two projects seeking to deliver the Discharge to Assess model, for those being admitted into and discharged from hospital. The outcomes of the workshop will inform how this project develops in the next few months.

Voluntary, Community and Social Enterprise Sector

There are a large number of voluntary and community sector organisations working across Derby and Derbyshire, alongside other system partners, to support the health and wellbeing of people in the county. The CCG is committed to engaging with the sector in the development of community-focused services and supporting nationally promoted initiatives such as development of Voluntary, Community and Social Enterprise Sector (VCSE leadership roles).

Our efforts for the wider sector are based on commissioning 12 VCSE infrastructure organisations to provide support to the sector. This support enables an effective, locally based voluntary and community sector, working to help maintain or improve the health and wellbeing of the people of Derby and Derbyshire by:

1. Supporting group development and sustainability
2. Increasing the amount of external funding being accessed by VCSE groups in Derbyshire
3. Supporting the delivery of a comprehensive volunteer brokerage service
4. Bringing the voice of the voluntary and community sector into the system and providing information to the people of Derby and Derbyshire about what the VCSE sector offers

During the last year, voluntary sector organisations played an essential part in the Covid-19 pandemic response, working together with the CCG and other partners to ensure that people receive local help. This included supporting the reduction of food poverty; providing emotional support to help reduce the likelihood of emerging mental health problems;

delivering prescriptions to people who are shielding and isolating; and supporting the NHS vaccine programme.

Social Prescribing

Social prescribing helps people to improve their health, wellbeing and social welfare by giving them time to consider and explore what is important to them and what they would like to achieve. This service is accessed through GP Practices and connects people to community services and activities that can help them to take steps towards their goals. For 2019/20, NHS England provided funding for a Social Prescribing Link Worker in each PCN. Since then, additional funding into PCNs, and greater flexibility with how this can be used, increased Social Prescribing Link Worker numbers in the county to more than 30, with a number of complimentary Health and Wellbeing Coaches coming on board. While these new roles are not commissioned by the CCG, we have taken an active involvement in supporting PCNs to make the most of the opportunities they present. We established the Social Prescribing Advisory Group, which brings the key stakeholders together on a regular basis, to facilitate a coordinated, joined-up approach.

From October to December 2020, the Social Prescribing Advisory Group oversaw a successful county/city-wide cross-sector bid securing £500k of Government funding to be one of seven areas in England chosen to be a Green Social Prescribing 'test and learn' site. Project delivery started in April 2021 and will run until March 2023.

Wound Care

Following on from the work undertaken in 2019/20 with DCHSFT and Primary Care, the work led by the Joint and Community Commissioning Team saw a clearer approach to managing wound care in the community. DCHSFT set up a number of clinics in 2020/21 and work is progressing to open up further clinics at London Road Hospital in Derby. While the impact of the pandemic delayed the opening of these clinics, DCHSFT continued to operate out of other community clinics or GP Practices and saw more patients with complex wounds as a result.

Unpaid Carers

Unpaid carers play a huge role in helping the health system to deliver care and support for people who need it. It is estimated that carers in Derbyshire contribute more than £998m to the local economy and collectively represent the largest provider of care and support.

Carers were particularly hard hit by the Covid-19 pandemic with much of their usual support being curtailed early on in the pandemic. The carers services, commissioned through Derbyshire Carers Association (DCA) and Citizens Advice Mid-Mercia (CAMM), worked tirelessly to minimise the impact of the pandemic and embraced alternative ways of delivering support to carers and the cared-for during the last 12 months. Training and support changed from face-to-face to online, and both DCA and CAMM quickly adapted what they do, including developing videos and setting up training and social groups virtually, so that carers can still keep in touch.

The CCG worked closely with DCA and CAMM, and the local authorities to keep them linked in with information and support for things such as Personal Protective Equipment (PPE) for carers and access to psychological support for staff.

Medicines, Prescribing and Pharmacy

The Derbyshire Medicines Management and Clinical Policies Team works with member practices and local providers to enable the best health outcomes through the best use of medicines. Working with stakeholders across the system, four key work themes were identified:

Health outcome	Key work theme
Improving experience of care	High quality and safe use of medicines
Improving the health of the population	Delivering effective interventions
Reducing the per capita cost of healthcare	Value use of medicines
Improving staff experience and resilience	Skilled and agile Pharmacy workforce

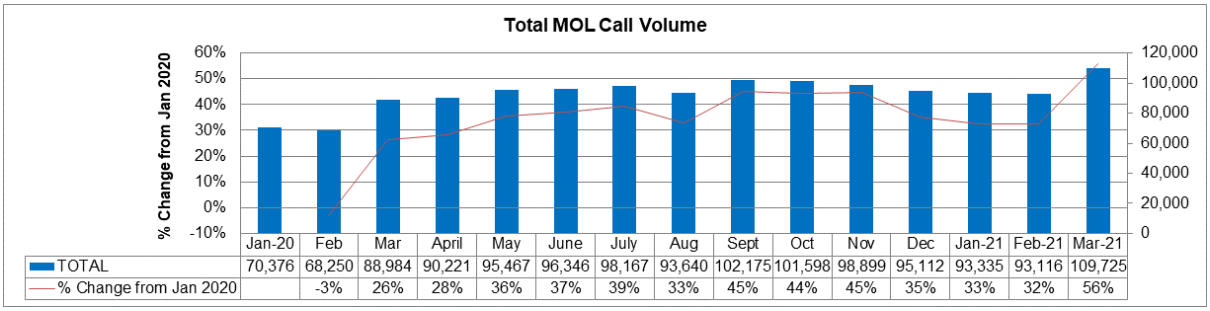
The Covid-19 pandemic had a significant impact on the planned work of the team during 2020/21. The team prioritised activity in line with the CCG business continuity levels in order to focus on statutory functions and Covid-19 pandemic support across the system. The Derbyshire Prescribing Group continued to meet routinely throughout the year to ensure that the work to support the Derbyshire system to improve the safety and quality of prescribing was delivered. Prescribing Leads forums were held periodically throughout the year to update practices on key work relating to medicines safety, quality and cost-effective prescribing.

A Pharmacy Cell was established and met regularly throughout the year to support the planning, implementation and mutual aid across all pharmacy systems. The cell agreed a priority work plan for 2020/21 and supported organisations with the impact of Covid-19 across providers and in care homes.

The national Covid-19 vaccination programme highlighted the importance of pharmacy within the NHS. The team undertook site visits and pharmacy sign-off visits for all of the Primary Care Network Local Vaccination Sites within Derbyshire. They worked closely with DCHSFT colleagues in order to ensure the pharmacy legal requirements of the vaccination centre at Derby Arena were met. Staff were redeployed to Derby Arena vaccination centre in the pharmacy room to ensure safe and secure handling of vaccines.

Medicines Order Line

At the onset of the pandemic there was a surge in demand for the Medicines Order Line (MOL), a dedicated phone line for patients to order their repeat medication, and many of the team were redeployed in order to increase capacity to this critical function. As shown in Figure 1, there was an initial significant increase in March 2020 activity (a 31% increase in calls compared to pre-Covid-19 levels). This was principally driven by wider use of the MOL by patients within existing practices served by the MOL, as well as a small increase in the number of practices covered by the MOL later in the year (a total of nine additional practices joined the MOL during 2020/21).



	Jan-20	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan-21	Feb-21	Mar-21
TOTAL	70,376	68,250	88,984	90,221	95,467	96,346	98,167	93,640	102,175	101,598	98,899	95,112	93,335	93,116	109,725
% Change from Jan 2020		-3%	26%	28%	36%	37%	39%	33%	45%	44%	45%	35%	33%	32%	56%

Figure 1 – Total Medicines Order Line Call Volume 2020/21

Significant work was undertaken to develop and share resources, as well as to support the national priority of increasing the uptake of electronic repeat dispensing. Other functions included supporting with medicines aspects of new Primary Care services such as Covid-19 assessment centres. Medication reviews and other prescribing support was provided to Care Homes, including development and implementation of proxy ordering to improve the safety and quality of prescribing. The CCG also has responsibility as the system incident lead for Covid-19 vaccinations to ensure learning is shared.

Statutory Functions

In addition to the Covid-19 response, the team continued to deliver statutory functions, which included:

Controlled Drugs

During 2020/21 the Controlled Drugs monitoring process was reviewed and updated to reflect the Public Health England Prescribed Medicines Review Report on prescription drug dependence.

Medicines Safety

The Derbyshire Medicines Safety Network, a system-wide group comprising Medicines Safety Officers from all Derbyshire providers, met virtually during the year with learning from local incidents shared and discussed.

Antimicrobial Stewardship

Antimicrobial stewardship is key to promoting and monitoring judicious use of antimicrobials to preserve their future effectiveness. Prescribing data was circulated to practices throughout the year to help us better understand volumes and variations in prescribing.

Clinical Policies

Due to the national lockdown from March 2020, and the CCG moving into business continuity level four, the Clinical Policies Team diverted resources towards supporting the Covid-19 vaccination programme.

Managing Individual Funding Requests

Managing Individual Funding Requests as a statutory function continued throughout the year, with reduced input from Public Health due to their skills needed for the Covid-19 response.

Clinical Policies Advisory Group

Due to the reduced capacity for non-essential activities, the Clinical Policies Team received assurances from the relevant specialists that it was clinically effective, relevant and safe to extend the review dates of clinical policies that were due to expire by a further six months.

Prior approvals

Prior approvals and cosmetic referrals have continued throughout the year, although since the pandemic, at a reduced rate.

Joint Area Prescribing Committee/Guideline Group

Due to increased pressure on clinical staff, the team agreed six month extensions to clinical guidelines with the relevant specialist, only where it was deemed clinically safe and effective to do so.

Ambulance and 111 Commissioning

For the year 2020/21, the CCG set out a number of commissioning intentions for urgent and emergency care.

Though there was nothing specific within the commissioning intentions for the NHS111 service, there were a number of programmes of work that depended on support from our NHS111 provider, Derbyshire Health United 111 (East Midlands) Community Interest Company (DHU111), in order to deliver or enhance them. For EMAS, there were three which are applicable to the regional urgent and emergency ambulance contract. The commissioning intentions relating to the two regional services are:

- to ensure delivery of all national ambulance performance standards on a quarterly basis in all counties covered by the contract, including Lincolnshire;
- to ensure that all national quality targets relating to ambulance handover are consistently delivered;
- to ensure there is a reduction of people conveyed to an ED which were avoidable;
- NHS111 direct booking into Primary Care appointments; and
- NHS111 clinical assessment service and clinical validation for callers who may need to attend the ED.

East Midlands Ambulance Service

Performance

A key enabler to delivering the commissioning intentions for EMAS is to ensure the resource requirements in the ambulance service are aligned to the agreed indicative activity plan, along with access to suitable alternative pathways such as same day emergency care, urgent treatment centres and clinical assessment services.

Ambulance performance is measured against six national performance standards within four response categories:

C1. For life-threatening illnesses or injuries, specifically cardiac arrest
C2. For emergency calls, such as stroke, burns or epilepsy
C3. For urgent calls, such as abdominal pains and non-severe burns
C4. Less urgent calls, such as diarrhoea, vomiting or back pain

Ambulance performance against the national performance standards for the region improved in all six categories since 2019/20 as shown in Table 5 below. The 90th centile measures the time in which 9 out of 10 patients received a response, with the mean measuring the average time in which patients receive a response.

EMAS	Category 1		Category 2		Category 3	Category 4
	Mean	90th centile	Mean	90th centile	90th centile	90th centile
	2020/21	2020/21	2020/21	2020/21	2020/21	2020/21
National Standard	**00:07:00**	**00:15:00**	**00:18:00**	**00:40:00**	**02:00:00**	**03:00:00**
Quarter 1	00:06:32	00:11:28	00:15:36	00:30:19	01:14:32	01:40:16
Quarter 2	00:07:17	00:12:56	00:23:11	00:47:36	02:38:27	03:28:21
Quarter 3	00:07:34	00:13:29	00:28:18	00:58:39	03:31:38	03:33:30
Quarter 4	00:07:21	00:12:57	00:25:56	00:53:12	03:06:45	02:59:42

Table 5 – quarterly national standards and actual response times

At a trust level, EMAS achieved all six national standards in Quarter 1 (Q1) 2020/21. This position was replicated in all counties with the exception of Lincolnshire, where four out of the six standards were achieved. The two standards that were not achieved for Lincolnshire in Q1 (Category 1 (C1) mean and Category 2 (C2) mean) were missed by just 15 seconds and 56 seconds respectively. Performance deteriorated in Quarter 2 (Q2) and Quarter 3 (Q3), with EMAS achieving only one of the six national performance standards (C1 90th) during both of these quarters at a trust level. The trust position was replicated in Derbyshire in both quarters, with achievement of one national standard (C1 90th). Leicestershire and Northamptonshire both achieved two of the standards in both Q2 and Q3 (C1 mean and C1 90th). Nottinghamshire achieved four of the standards in Q2 (C1 mean, C1 90th, C2 90th and C4 90th), but then deteriorated in Q3 only achieving two of the national standards (C1 mean and C1 90th). Lincolnshire failed to achieve any of the six national standards during Q2 or Q3.

There was a slight improvement in Quarter 4 (Q4), when EMAS achieved two of the six national performance standards (C1 90th and C4 90th) at a trust level. Derbyshire and Northamptonshire replicated the trust position of achieving both C1 90th and C4 90th. Leicestershire and Nottinghamshire also achieved two of the standards, but achieved C1 Mean and C1 90th. Lincolnshire achieved one of the national standards (C4 90th).

How Covid-19 affected the delivery of the service

As detailed in Table 6 below, EMAS did not see a reduction in activity as a result of Covid-19, with incidents (where a patient will receive a clinical assessment over the telephone or receive a face-to-face response) being above plan each month with the exception of December and February. It should be noted that the February actual position compared the 28-day month to a 29 day plan (due to the carryover of the 2019/20 plan as a result of the ongoing COVID-19 pandemic).

EMAS		Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021
Incidents	Actual	61,622	61,881	61,112	63,685	65,193	64,554	67,883	66,165	68,731	69,721	61,914	68,000
	Plan	58,014	61,067	58,811	62,580	59,394	59,440	63,778	64,647	69,269	68,221	62,983	66,682
	Variance	6.2%	1.3%	3.9%	1.8%	9.8%	8.6%	6.4%	2.3%	-0.8%	2.2%	-1.7%	2.0%

Table 6 – incidents activity in 2020/21

EMAS crews had many challenges working in the community and entering patients' homes during the Covid-19 pandemic. The highly contagious nature of the virus meant that crews needed to be extra vigilant, ensuring they utilised PPE effectively which meant that each patient they visited could take longer. Where patients travelled in the ambulance that were known to have or suspected to have Covid-19, there was a requirement to deep clean the vehicle in-between patients, which led to increased post-hospital handover times. Table 7 below shows that not only did the post-hospital handover times remain above the 15-minute national standard; they were also higher than last year.

Average Post Hospital Handover Times	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021
2020/21	0:20:31	0:19:56	0:19:42	0:19:41	0:19:32	0:18:54	0:18:57	0:18:47	0:19:08	0:19:16	0:19:43	0:20:14
2019/20	0:17:36	0:18:19	0:18:34	0:18:17	0:18:25	0:18:11	0:17:34	0:17:17	0:16:58	0:17:33	0:17:53	0:18:49

Table 7 – average post-hospital handover times for 2020/21

EMAS recognised the importance of Infection, Prevention and Control needs and employed an Infection, Prevention and Control specialist whose role was to ensure that all guidelines are adhered to, cleaning is audited and staff are fully trained.

What has been achieved outside of Covid-19 this year?

All counties continue to work on developing alternative pathways such as same day emergency care, access to urgent treatment centres and clinical assessment services. In Derbyshire, there is now a dedicated Medical Same Day Emergency Care pathway and a 24/7 catheter care pathway at both acute hospital sites. This, in addition to increased access to urgent treatment services, is enabling patients to avoid ED when safe and appropriate.

There was significant work to enable higher 'hear and treat' rates, which included EMAS being one of three ambulance trusts taking part in a national pilot to clinically validate a selection of lower acuity incidents (e.g. non-life threatening or non-emergency complaints). They are also working with local clinical assessment services to enable them to provide further clinic triage when required. Phase 1 of the national Category 3/Category 4 pilot was evaluated by The University of Sheffield and the final report was published in February 2021. The evaluation identified that almost one third of validated calls required no ambulance response. There were also no serious incidents reported which could be attributed to call validation and re-contact rates for validated calls were extremely low, indicating the outcome of validation was clinically appropriate. Phase 2 of the national pilot is currently in place to extend the number of codes eligible for validation, with a final report due in May 2021. An unofficial Phase 3 of the pilot has commenced which will explore the use of video conferencing within the clinical assessment process to understand whether this helps to reduce the number of ambulances dispatched.

All system partners have worked together to help ensure that patients receive the most appropriate response in a timely and safe manner. EMAS and system partners ensured crews have access to patient records while on scene. They also provided dedicated clinical support for EMAS crews to access to enable increased 'see and treat' rates when safe and appropriate to do so. In Derbyshire, there is now a 24/7 mental health support line, which is accessible by both EMAS and the Police, to ensure that patients receive the most appropriate response. Within EMAS, there is a network of 'Alternative Pathway Ambassadors' who work with system partners to encourage further use of successful alternatives when safe and appropriate, and identify and improve any pathways that are not being routinely successful.

Although incident activity remains above the indicative activity plan, the work that has taken place has enabled a significant reduction in the number of patients conveyed to Emergency Department, reducing from 61% in 2019/20 to 52% in 2020/21. Figure 2 below shows the downward trend line from April 2019.

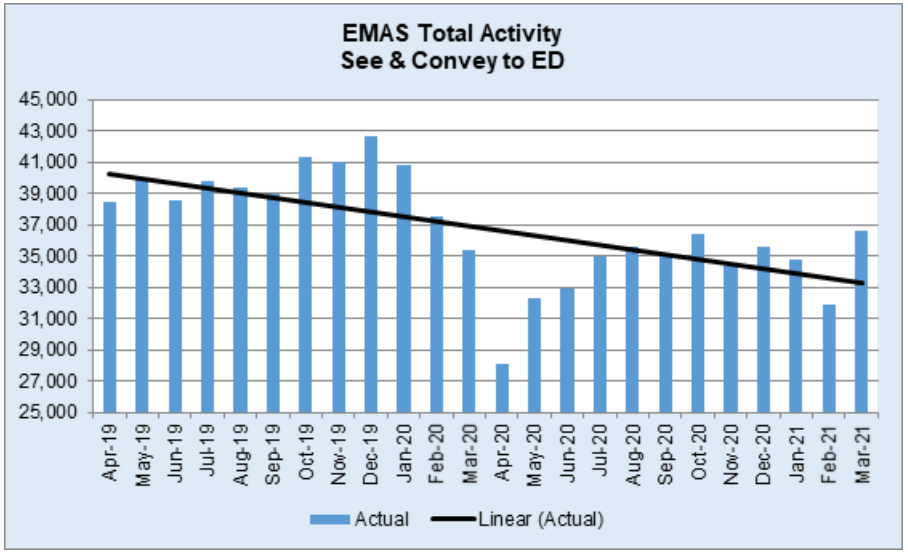


Figure 2 – EMAS Total Activity vs Plan See & Convey to ED 2019/20–2020/21

As a result of reduced conveyances, pre-hospital handover times (the time taken for ambulance crews to clinically handover the patient to the receiving hospital) also improved when compared to last year, although they do continue to be higher than the national standard of 15 minutes (see Table 8 below).

Average Pre Hospital Handover Times	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021
2020/21	0:20:21	0:18:44	0:18:22	0:18:35	0:19:48	0:21:33	0:21:54	0:23:33	0:23:53	0:23:58	0:21:25	0:21:08
2019/20	0:21:07	0:20:24	0:20:06	0:22:32	0:21:38	0:21:35	0:25:38	0:26:43	0:30:15	0:28:29	0:24:38	0:22:02

Table 8 – average pre-hospital handover times for 2020/21

Despite challenges with sickness and absence, EMAS were able to resource more hours to deliver activity, which contributed towards improved performance and therefore a more positive patient experience.

DHU111 (East Midlands) Community Interest Company

Performance

The NHS111 contract with DHU111 contains five Key Performance Indicators (KPIs) and a further KPI associated with the Category 3 (C3) Ambulance Validation Service. A summary of performance this year to date can be seen in Table 9 below. The months where performance was not met were months where the NHS111 service across the country was particularly impacted by the pandemic.

Calls Abandoned after 30 seconds	Apr 20	May 20	Jun 20	Jul 20	Aug 20	Sep 20	Oct 20	Nov 20	Dec 20	Jan 21	Feb 21	Mar 21
Actual	9.9%	0.9%	0.6%	0.4%	1.0%	4,4%	0.5%	0.1%	0.2%	0.2%	0.2%	0.2%
Target	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%	5%
Average call answer time	**Apr 20**	**May 20**	**Jun 20**	**Jul 20**	**Aug 20**	**Sep 20**	**Oct 20**	**Nov 20**	**Dec 20**	**Jan 21**	**Feb 21**	**Mar 21**
Actual	00:03:04	00:00:15	00:00:08	00:00:07	00:00:15	00:01:07	00:00:09	00:00:06	00:00:06	00:00:10	00:00:09	00:00:18
Target	00:00:27	00:00:27	00:00:27	00:00:27	00:00:27	00:00:27	00:00:27	00:00:27	00:00:27	00:00:27	00:00:27	00:00:27
Of calls triaged, proportion transferred to a clinician	**Apr 20**	**May 20**	**Jun 20**	**Jul 20**	**Aug 20**	**Sep 20**	**Oct 20**	**Nov 20**	**Dec 20**	**Jan 21**	**Feb 21**	**Mar 21**
Actual	68.9%	70.2%	70.7%	71.3%	73.7%	69.2%	66.0%	66.7%	69.6%	71.6%	70.4%	68.7%
Target	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%
Of calls triaged, proportion closed with self-care within 111	**Apr 20**	**May 20**	**Jun 20**	**Jul 20**	**Aug 20**	**Sep 20**	**Oct 20**	**Nov 20**	**Dec 20**	**Jan 21**	**Feb 21**	**Mar 21**
Actual	23.2%	21.0%	19.8%	21.7%	19.2%	27.2%	26.2%	23.6%	20.9%	20.6%	20.1%	20.4%
Target	17%	17%	17%	17%	17%	17%	17%	17%	17%	17%	17%	17%
Proportion of callers satisfied with their experience	**Apr 20**	**May 20**	**Jun 20**	**Jul 20**	**Aug 20**	**Sep 20**	**Oct 20**	**Nov 20**	**Dec 20**	**Jan 21**	**Feb 21**	**Mar 21**
Actual	87.8%*						*88.0%*					
Target	85%*						*85%*					

Table 9 – DHU111 performance summary for 2020/21
** Please note that due to the suspension of the patient experience survey during the Covid-19 peak from April–July 2020, performance for this time period is based on the August–September 2020 position.*

How Covid-19 affected the delivery of the service

The NHS111 telephone service was at the forefront of the response to the pandemic. The challenges and associated response changed throughout the year as the pandemic progressed and our understanding increased. At the start of the pandemic, call volumes into the service reached unprecedented levels as patients used the service to seek advice and clinical assessment. Many of these early calls were not necessarily clinical in nature but were generated by a lack of understanding of Covid-19 and associated concern across the population. Call volumes decreased over the summer but spiked again in September as children returned to their places of education.

Calls relating to Covid-19 remained high in the winter, however there were fewer calls associated with common winter illnesses, which was attributed to the social distancing measures in place. Calls into the NHS111 service in March 2021 saw a significant increase, which then impacted on performance; the main driving factor behind this increase was the concerns relating to Astra Zeneca Vaccination side effects.

What has been achieved outside of Covid-19 this year?

There has been an excellent performance against KPIs as shown above and operationally, DHU111 has had positive recruitment and training programmes over the year ensuring they have a robust workforce in order to deliver against performance standards.

NHS111 First

A key piece of work during the year was the national NHS111 First programme, the aim of which is to reduce the numbers of patients walking into an ED without having first undergone a clinical assessment.

This initiative means that when a patient has been assessed and needs treatment within ED, they can be booked into a time slot in the ED while on the phone to NHS111. Coupled with the introduction of new patient pathways, this means that only patients that are clinically appropriate to go to ED will be booked an appointment and all other patients will be managed appropriately elsewhere in the system.

Directory of Services

The Directory of Services is the tool used to identify the most appropriate service to manage patients' clinical needs. Significant efforts were made this year to improve and develop the Directory of Services so that patients consistently get to the right place, first time. This work was fundamental to the NHS111 First programme and the improvement to patient pathways within the NHS111 online service.

Direct Booking

This year saw the implementation of GP appointment booking by the NHS111 service. This meant that if a patient needed to have an urgent appointment with their GP a call-back could be booked at the time, negating the need for a patient to make a further phone call. As at the 31st March 2021, DHU111 was currently booking circa 1,900 patients every week into GP services across the East Midlands. This was an increase from circa 1,200 patients per week in Q3 as a result of more practices going live with direct booking, combined with the fact that more patients were using NHS111 to book appointments as per national communications.

Clinical Assessment Services and Emergency Department Validation

There has been an increase in patient pathways that receive clinical input, meaning that more patients receive the appropriate support without delay. This includes the clinical assessment of patients who may or may not need an ambulance, to review whether another service would be able to meet their needs more appropriately.

Category 3 Validations	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021
Patients Available for Validation	7,425	11,519	10,394	11,834	12,182	11,998	13,196	13,322	13,378	13,967	11,950	13,830
Total Clinically Validated	7,268	10,861	9,892	11,282	11,942	11,558	12,676	13,107	13,235	13,779	11,732	13,334
% Clinically Validated (Target 50%)	97.9%	94.3%	95.2%	95.3%	98.0%	96.3%	96.1%	98.4%	98.9%	98.7%	98.2%	96.4%

Table 10 – Category 3 validations for 2020/21

DHU111 has consistently been clinically assessing a high proportion of these calls within the 30-minute standard, as shown in Table 10 above. This means that fewer patients who are deemed to require an ambulance are referred to EMAS and patients are able to access the support they need in a clinically appropriate way.

Mental Health

The CCG has been working in partnership developing a whole system approach to the delivery of the Mental Health Long Term Plan. We have continued to meet our commitment to increase mental health spending in proportion with our income.

We adopted an all-age approach to transformation of services and pathways to reduce the gaps in age transition and between services. We developed a range of new services which increased access for Children and Young People (CYP) to mental health support. Improving access for CYP remains a national priority for the next three years.

Throughout the pandemic we supported the system to meet changing needs, which resulted in:

- bringing forward delivery of a 24 hour helpline;
- a revised emotional health and wellbeing website;
- an improved digital offer for CYP; and
- increased capacity for CYP counselling and introducing digital arrangements into most pathways.

Going forward, we will build on these and continue to improve access and efficiencies. Where safe to do so, more face-to-face support and services will be provided and social support networks will be expanded to rebuild resilience. We have five areas of all-age focus:

1	Our work to significantly transform locality-based community mental health services and improve health outcomes for people with mental health difficulties, including those with severe mental illness, is progressing in line with the Long Term Plan. This work commenced in High Peak and North Dales and is pioneering a new approach to integrated working, in preparation for a three-year roll-out across Derbyshire.
2	The Mental Health Urgent Care Programme is increasing timely support available for those people who need urgent mental health support. This is helping reduce admissions and lower out-of-Derbyshire bed use. We are developing our helpline offer to be better for all-ages disabilities. This will be backed by linked crisis response teams, developing safe havens and crisis cafés and our digital support offers.
3	We are further increasing access to psychological therapies, including developing support for the Long Covid-19 clinics and support to staff impacted through the pandemic.
4	We are supporting CYP with mental health needs, particularly improving access to targeted early interventions and reducing wait times. This work has expanded to include targeted and universal options. Additional help for higher risk schools and Looked after Children is also part of the delivery strategy.
5	We are beginning to join up health and social care approaches to help support the needs of people with autism who may also have mental health difficulties. This includes work to prevent inappropriate admission to hospitals but also how routine care in all mental health pathways can be improved, with better early help and low intensity support when it is needed.

Feedback on services

To demonstrate the impact of the new services introduced in 2020, we received the following comments from people who have used them:

Mental Health Helpline and Support Service

The Mental Health Helpline and Support Service is available 24-hours-a-day, for people of all ages and is a freephone number (telephone 0800 028 0077). Calls have averaged around 50–70 per day, and feedback has been very positive. 82% of callers were likely or very likely to recommend the helpline to family or friends *"…It was brilliant and I am now on the road to getting the support I needed"*.

Safe Haven

The Derby Safe Haven was established in November 2020 and is designed to provide short term support to people who may otherwise seek support at the ED for a mental health crisis. The service is based in the city and offers support to anyone in Derby and Derbyshire, therefore transport and telephone support is provided. We intend to develop a further Safe Haven in Chesterfield along with Crisis Café arrangements across Derbyshire. Referrals are made via the Mental Health Helpline and Support Service. People accessing the Safe Haven receive support in the form of de-escalation in a safe environment, safety planning and sign-posting.

Doreen contacted the helpline and as a result attended the Safe Haven and was referred for 12-weekly support sessions and additional peer-support groups: *"Everything went well. I was scared at first about asking for help, but now I'm more used to it. I'm a lot happier in myself now"*.

Individual Placement Scheme

The scheme prepares and helps people who have experienced significant mental health issues to gain the confidence and skills to get into employment. One participant said: *"Having an interview with an employer within three weeks, first time virtually too. Improved my confidence, I have a lot more belief in myself and a change in my own mind-set that I want to do something and work"*. A total of 36 people have now gained meaningful employment during lockdown.

Qwell and Kooth Digital Mental Health and Wellbeing Support

Kooth is for children and young people, and Qwell is for parents and carers. Both services provide access to text-based therapeutic supportive conversations with qualified professionals from 12pm until 10pm on weekdays, and 6pm until 10pm on weekends. 24/7 access to moderated online forums is also available, where concerns and relevant articles can be shared and discussed.

Between April and December 2020, Kooth had 2,328 new registrations and 21,062 logins. 8% of registrations were from people with an ethnic minority background, demonstrating the ability of a digital offer to reduce health inequalities. As it has proved valued, we fully intend to build on this approach in the near future.

Children and Young People Physical Healthcare, Neuro Development and Special Educational Needs and Disability

The Children and Young People Transformation Programme established by NHS England, includes:

- learning disability and autism;
- special educational needs and disability;
- end of life and palliative care; and
- health and justice.

The team has been involved in improving the experiences of CYP and their families/carers who have Special Educational Needs under the Derby Written Statement of Action. The autism diagnosis and early help pathway has been a focus for co-production and improvements with a wide range of organisation representatives across Derby and Derbyshire attending workshops. The work was led in conjunction with the JUCD CYP Board. We are ensuring that these intentions and learning gained are considered for all ages to improve the experience for adults too. Autism Spectrum Disorder is a key focus for work in the next few years and will reflect the national direction of travel for better experiences of mental health care for people with autism.

During 2020/21 we focused on rapidly changing our offer to supporting individual children to help ensure the risks of Covid-19, and associated issues that lockdown has brought within families, could be mitigated as far as possible.

Finance Review

Addressing Our Financial Challenge during 2020/21

The Covid-19 pandemic has affected all aspects of the NHS, including its financial regime. The CCG received notification of the expected allocations for 2020/21 in early 2020, however these were quickly changed as the impact of the pandemic was felt across the country. National contracting arrangements were established allowing the CCG little autonomy and the requirement for delivering financial efficiencies was suspended to ensure all available resources could be directed at delivering front line services.

These arrangements were initially put in place for the first four months of the financial year and new guidance was issued throughout this period; requiring the CCG to be flexible in its approach with providers, while maintaining the highest standards of financial governance. This initial four month period was extended by a further two months and a six month accounting period was established. It was agreed that all systems would be provided with sufficient resources to break even for that period. From October, a different financial regime was implemented whereby the CCG received an allocation for the final six months of the financial year, which included resources that had previously been directed straight to providers to cover the costs of their response to the pandemic. The CCG was required to work with providers on a Derbyshire system basis, to manage the resources and not exceed the amount allocated.

Through prudent financial management the CCG and the whole of the Derbyshire healthcare system were able to remain within the resources allocated, and still deliver the first class response to the pandemic described elsewhere in this report.

Financial Position

Total resources of £1,900.8m for the year were available, made up of income of £4.6m and £1,896.2m of allocations from the Department of Health and Social Care. The CCG committed expenditure totalling £1,900.5m, leaving the CCG with a surplus of £0.3m. Further details can be found in the Annual Accounts section of this report, which starts on page 138.

Considerable work was undertaken to understand the extent of the financial challenges being faced across the system as we head into 2021/22, and the ongoing impact of the pandemic, as well as the backlog of routine healthcare that has built up. National contracting and funding arrangements for the first half of 2021/22 will be similar to the final six months of 2020/21. It is then anticipated that the CCG will return to a more familiar NHS financial regime, although it is clear that ever-closer system cooperation on financial efficiencies will be required, in line with the white paper on the development of Integrated Care Systems[7].

[7] https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version

Gross Operating Costs 2020/21

Category of Expenditure	2020/21 Spend	2019/20 Spend
	£m	£m
Services from Foundation Trusts	1,062.0	972.8
Services from Other NHS trusts	107.9	101.8
Purchase of healthcare from Non-NHS bodies	243.4	256.0
Prescribing	161.6	148.7
Primary Care	173.6	162.6
Staff	23.4	22.1
Supplies and Services – General	3.1	4.5
Services from other CCGs and NHSE	9.1	7.9
Other	9.5	7.6
Covid-19	106.9	-
TOTAL	**1,900.5**	**1,684.0**

Table 11 – Gross Operating Costs 2020/21 and 2019/20

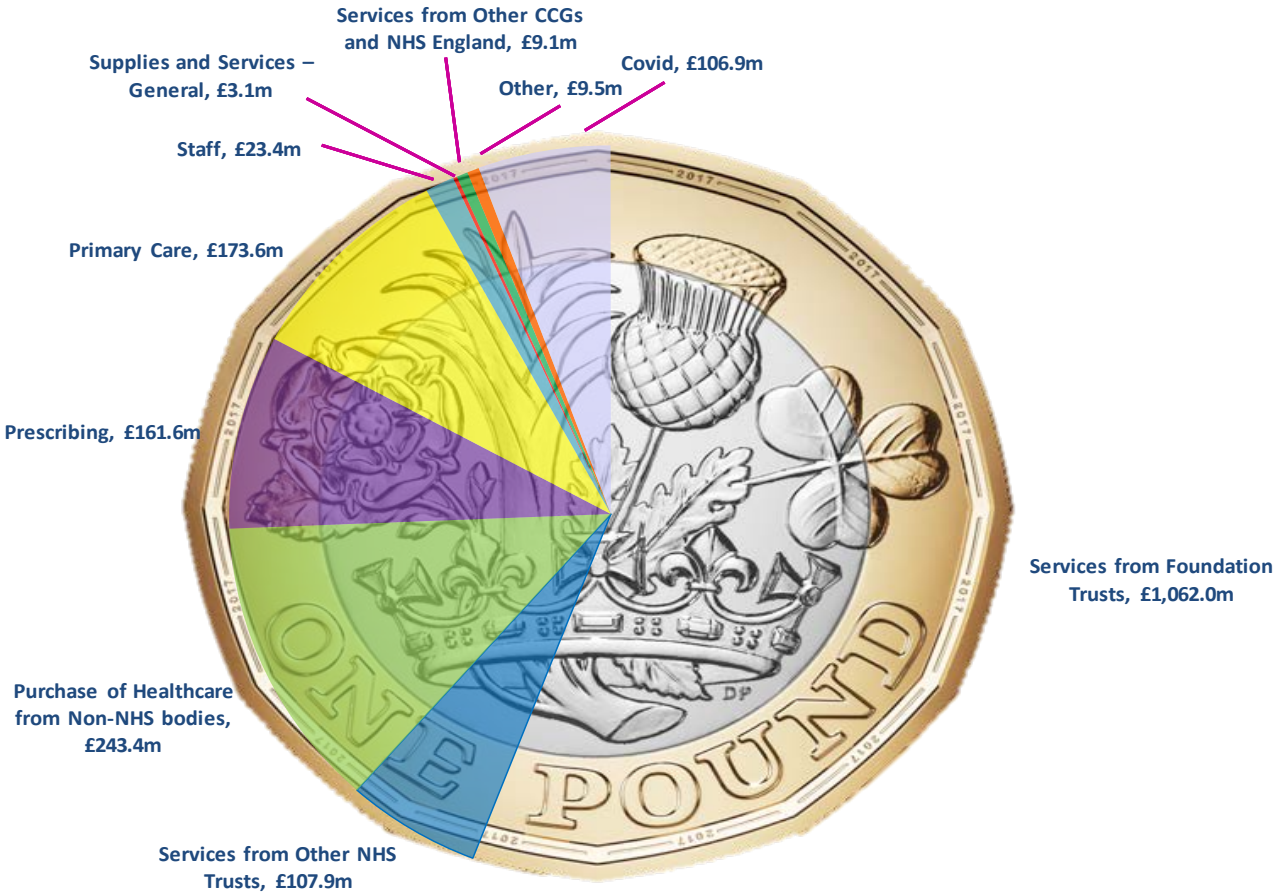


Figure 3 – Gross Operating Costs 2020/21 Derbyshire Pound

Covid-19 Expenditure

The CCG committed considerable expenditure in tackling the pandemic, much of this being funded from additional resources received from the Department of Health and Social Care. The funding received in the first half of the year was all reimbursed retrospectively, whereas in the second half of the year the CCG received resources for the whole of the Derbyshire health care system; and agreed with system partners how the resources would be utilised and shared. The CCG was also able retrospectively to claim reimbursement for elements that were not funded in the prospective Covid-19 system allocation.

In the first half of the financial year the CCG received £33.3m of funding retrospectively for the expenditure incurred in that period. At the beginning of the second half of the financial year the CCG received an allocation for the whole of the Derbyshire healthcare system of £54.8m for the remaining months of the year. This was committed with healthcare providers, the majority being with JUCD Providers. At the time of committing this expenditure there remained a high level of uncertainty and the CCG response to the pandemic continued to develop, as a result none of the allocated Covid-19 money remained unused at the end of the financial year. The CCG were also able to retrospectively claim for some Covid-19 expenditure in the second half of the year and this totalled £18.6m. Therefore in total the CCG spent £106.9m in response to the Covid-19 pandemic and Table 12 below shows how this was spent.

	Months 1–6	Months 7–12		2020/21 Total
	£'m	Reclaimable £'m	Allocated £'m	Total £'m
Covid-19 Allocations Received	**33.3**	**18.6**	**54.8**	**106.7**
Covid-19 Expenditure				
Derbyshire NHS Hospital Providers	–	–	43.2	43.2
Hospital Discharge Programme	21.2	18.6	–	39.8
Other Covid-19 Virus/Antibody Testing	3.2	–	2.1	5.3
Primary Care additional capacity	0.4	–	5.9	6.3
After care and support costs	2.1	–	1.3	3.4
Workforce	1.6	–	0.5	2.1
Consumables and PPE	1.2	–	0.8	2.0
Remote management of patients	1.8	–	0.1	1.9
Covid-19 related mental health services	1.2	–	0.6	1.8
Other	0.6	–	0.5	1.1
Total	**33.3**	**18.6**	**55.0**	**106.9**
Unused/(Overspent)	**0.0**	**0.0**	**(0.2)**	**(0.2)**

Table 12 – Covid-19 Expenditure 2020/21

Statement of Financial Position

Traditionally known as the Balance Sheet, this financial statement is generally accepted to be a helpful indication of financial health. The statement reviews the assets, liabilities and equity of an organisation.

For comparative purposes the 2019/20 statement is provided which shows a reduction in both the trade assets and liabilities in the 12 month period. This movement in trade assets and liabilities occurred as a result of the revised financial arrangement for NHS contacting and payments during the Covid-19 pandemic, which allowed NHS Providers certainty around their income. As a result of the emergency financial regime, the system saw a reduction in NHS invoicing, as well as release of previous year Statement of Financial Position opening balances into the financial position.

	31st March 2020 £'000	31st March 2021 £'000
Non-current assets		
Property, plant and equipment	442	355
Total non-current assets	**442**	**355**
Current assets		
Trade and other receivables	9,764	5,330
Cash and cash equivalents	40	110
Total current assets	**9,804**	**5,440**
Total assets	**10,246**	**5,795**
Current liabilities		
Trade and other payables	(102,118)	(96,343)
Provisions	(2,080)	(3,896)
Total current liabilities	**(104,198)**	**(100,239)**
Non-current assets plus/less Net current assets/liabilities	**(93,952)**	**(94,444)**
Non-current liabilities		
Provisions	(195)	(522)
Total non-current liabilities	**(195)**	**(522)**
Total assets less liabilities	**(94,147)**	**(94,966)**
Financed by Taxpayers' Equity		
General Fund	94,147	94,966
Total Taxpayers' Equity	**94,147**	**94,966**

Table 13 – Statement of Financial Position 2020/21

Financial Trend Data

It is considered best practice to include trend data presenting financial movements over several years to assist in the understanding of the information disclosed within this report. However, the CCG was established on the 1st April 2019 following the merger of the four predecessor CCGs across Derbyshire, and as such, comparable data is only available for the 2019/20 and 2020/21 financial years. This small amount of data is not considered sufficient to provide trend analysis. The 2020/21 financial information does demonstrate significant changes as the CCG has adapted its commissioning of healthcare in response to the pandemic; further detail of this is provided in this report.

EU Exit Expenditure

The CCG did not receive any specific funding in relation to the EU Exit and did not incur any expenditure as a result of the EU Exit.

Our Duties

Improvement in quality of services

The CCG has a statutory requirement to discharge its duties under Section 14R of the NHS Act 2006 (as amended) to improve the quality of services, as detailed in the CCG Constitution.

Patient Safety

The CCG has been working with NHSE&I to implement the Patient Safety Incident Response Framework (PSIRF). There are five providers within Derbyshire which have signed up to be early adopters of this framework. PSIRF is a key part of the NHS Patient Safety Strategy (published July 2019). It supports the strategy's aim to help the NHS improve its understanding of safety by drawing insight from patient safety incidents. The NHS published an introductory framework in March 2020 for implementation by nationally appointed early adopters. This testing phase will be used to inform the creation of a final PSIRF version prior to roll-out nationally.

During the last 12 months the early adopters worked hard to complete their own Patient Safety Incident Response Plans (PSIRPs), which focused on identified concerns/risks that they had within their organisation. Patient Safety Incident Investigations will be based on the system-wide learning that can be obtained from the particular incident. The individual PSIRPs from each organisation will have their own plans as to how they will manage their incidents. Derbyshire is the first area to go live, with all organisations having completed their PSIRPs. All five organisations have been working to the PSIRF principles from October–November 2020.

Pressure ulcers, falls, diagnostic and treatment delay incidents are the most common themes from all serious incidents. There is ongoing work to look at these themes across the system to ensure services learn from incidents and achieve the right care, first time. From October 2020 the numbers of incidents were far lower, due to the providers selected for the early adopters for PSIRF having commenced their PSIRPs and started to work under the new framework.

At the beginning of the pandemic, patient safety incidents continued to be reported, and in acceptable time frames. This is testament to the dedication of the patient safety teams.

Never Events

Never Events are serious incidents that are entirely preventable, with guidance or safety recommendations providing strong systemic protective barriers at a national level and which should be implemented by all healthcare providers. The option for commissioners to impose financial sanctions on trusts reporting Never Events has now been removed. This is to ensure that the true focus is on the learning from these events and to ensure the learning is embedded into practice.

There were two Never Events during 2020/21. The investigations were completed and learning was shared which will be followed up via the Trust Incident Learning Group. All Never Event action plans are followed up at the CCG Clinical Quality Review Group to

completion. All Never Events have been thoroughly investigated by the providers and signed off by our CCG Clinical Chair and Chief Nurse Officer.

Safeguarding Vulnerable Adults

The Adult Safeguarding Team worked in collaboration with key partner agencies to protect patients from abusive behaviour and practice. Joint working with Primary Care included the delivery of comprehensive training and the implementation of a safeguarding assurance programme. The CCG also actively supports the Safeguarding Adult Boards and their work streams.

Safeguarding Children and Looked after Children

The welfare of our population who come into contact with the services we commission, either directly or indirectly, is of paramount importance to the CCG.

We expect that all the services we commission deliver safe, good and effective care and that all staff have a responsibility to ensure that best practice is followed, including compliance with statutory requirements. We have robust arrangements in place to provide strong leadership in line with relevant legislation, statutory guidance and best practice guidelines. The CCG has clear lines of accountability and governance arrangements for safeguarding within the organisation and is a key and equal partner alongside the Police and Local Authority in the Derby and Derbyshire Safeguarding Children Partnership arrangement.

End of Life Services

Following approval of the JUCD End of Life Strategy in October 2019, the End of Life Operational Group, made up of health and social care organisations, was established to develop and implement key priorities from the strategy throughout 2020/21.

At the start of the Covid-19 pandemic, the Operational Group refocused its work on developing Care Home wraparound support with resource from Derbyshire's providers including End of Life Facilitation, direct access to NHS111 clinicians, 24/7 telephone support, individual and group counselling, and the development of a range of information and support tools.

Government funding provided additional resource into the system through the work of hospices for both adult and children's provision. This included delivering communication skills training, enhancing volunteer co-ordination, training new bereavement support workers and developing compassionate communities.

For people needing end of life care during out-of-hours, services were enhanced through the Roaming Service, the Palliative Care Car and access to Hospice at Home packages of care. For those that needed to be fast tracked into Continuing Health Care, the process of accessing this was made simpler. Work also continues on the implementation of the use of ReSPECT documentation and digital enablers such as Electronic Palliative Care Co-ordination Systems.

The priorities of the JUCD End of Life Strategy were revisited to include learning in light of work already undertaken or accelerated because of Covid-19.

Care Homes

At the start of the Covid-19 pandemic, a daily Care Home Cell was established with system partners to review the emerging situation in the sector and to provide system guidance and support. A Strategic Care Home Group was created to provide Senior Executive leadership and escalation for the emerging issues and risks. Separate cells were also set up specifically for PPE, testing and training to provide oversight and support in those areas.

During the early part of the pandemic, there was a huge amount of clinical and practical support that was quickly put into place for the sector including the establishment of a Covid-19 Care Home Virtual Support Team, provision of digital support including NHS mail, PPE training, emotional and counselling support and a helpline for End of Life care. A group, previously established pre-Covid-19 to implement the Enhanced Health in Care Home Framework, continued to oversee the onward development of this ongoing support.

During the year, Care Homes reported on the National Capacity tracker tool on a daily basis to record the number of Covid-19 outbreaks both for residents and staff, the level of PPE available, bed capacity and staffing levels. This gave both Derby City and Derbyshire County Local Authorities and the CCG valuable information to be able to respond to issues identified by the sector. The homes now provide information about flu and Covid-19 vaccine uptake, both in the staff groups and residents. Local Infection, Prevention and Control and Public Health teams support the Care Homes with clinical and practical advice. Outbreak Control Team meetings commenced during the year to oversee Care Homes with larger outbreaks. These continue to be held weekly and are led by Public Health to assess and manage the risk for individual services, putting in appropriate support where needed.

Occupancy levels continue to be monitored weekly to include comparisons with the position pre-Covid-19. The level of vacancies is unprecedented across Derby and Derbyshire. This causes concern for the financial viability of some providers. Help has been provided, where possible, and the ongoing situation continues to be closely monitored.

Care Home deaths continue to be closely monitored due to the high levels that occurred in the early part of the pandemic. As lockdown measures were put in place these levels reduced.

Testing in Care Homes was made available for symptomatic residents and staff in the early phase of the pandemic. It was then moved into a new phase where weekly testing of staff and monthly testing of residents was undertaken. This provided much needed reassurance as to the number of Covid-19 positive people who might be asymptomatic and who therefore needed to self-isolate to reduce the spread of the virus.

At the start of the pandemic, all agencies ceased face-to-face quality assurance and inspection regimes. The CQC made changes to the inspection process by undertaking instead a series of supportive phone calls as part of an Emergency Support Framework. Providers received a structured phone call to ascertain how they were managing in response to Covid-19 and were assessed as managing or not managing, prompting further support where required. As lockdown measures eased and in response to emerging risks, the CQC were able to physically visit providers where risk was deemed to be at a level where seeking assurance required visiting the Care Home.

The local multi-agency information sharing meetings continue weekly in order to monitor and respond to emerging risks. This includes the Local Authority, CCG, CQC and the Continuing

Care Team. In line with this, both the Local Authorities and the CCG are undertaking new joint quality assurance methods of monitoring Care Home providers to streamline processes, using both virtual and face-to-face methods.

Continuing Health Care

Due to the impact of the Covid-19 pandemic, the Continuing Health Care (CHC) Framework was stood down in March 2020 and reinstated from the 1st September 2020. During this time assessments were deferred and for any individuals requiring a new or increased care and support package, or new Care Home placement, the costs were met from a central Covid-19 fund. Since the re-introduction of the CHC Framework (from September 2020), there has been a requirement for CCGs to undertake assessments, for these deferred cases where CHC eligibility has been indicated.

The CCG was required to submit a trajectory for clearing the backlog of deferred assessments for individuals who were funded via the Covid-19 NHS Discharge funding arrangement in place from March to August 2020 and for whom it has been identified that an assessment for CHC eligibility is indicated. All deferred assessments were completed by the end of March 2021.

Learning Disability Mortality Review Programme

As part of the Learning Disability Mortality Review Programme, Derby and Derbyshire continued to meet targets set by NHSE&I in relation to completion of reviews. All reviews are allocated within three months of notification and the majority are completed within six months, which produces valuable learning. Throughout the year this learning was collated and used to acknowledge and share good practice, as well as make changes to improve health and social care experiences for individuals with a learning disability.

Transforming Care Partnership

The CCG continues to work with partners through the Transforming Care Partnership (TCP). The TCP consists of the CCG, two acute trusts (CRHFT and UHDB), a community trust (DCHSFT), a mental health trust (DHcFT), two Local Authorities (Derby City Council and Derbyshire County Council), patients and carers. The TCP is developing even closer ways of working to improve health and care services so that more people with learning disabilities can live in the community, with the right support closer to home.

Through earlier intervention, the aim is that fewer people will need to go into hospital for their care associated with their learning disability, autism and/or mental health needs. For those people who do need to go into hospital, a plan of care and treatment to support a robust and safe discharge will be developed in a multi-agency approach. This will ensure the length of stay in hospital is appropriate for the individuals' needs and not due to other social, environmental or housing factors.

The Transforming Care Partnership Team within the CCG's Nursing and Quality directorate strengthened partnership working through:

- implementation of a Dynamic Support Register which has impacted the reduction of admissions to acute mental health beds by ensuring that all agencies are aware of people at risk of crisis and able to intervene in a more timely fashion;

- the proactive use of enhanced multi-disciplinary team meetings, which include a CCG Transforming Care Partnership Commissioner, to explore support that can be offered in the community to avoid admissions into a hospital bed;
- the review of people in locked rehab hospital beds, focusing on the 12-stage plan with clear timescales and discharge plans;
- weekly procurement updates through multi-agency weekly meetings with providers, developing new services in Derbyshire led by the Local Authority;
- continued support and training from the NHSE Regional Team including more detailed reviews of complex cases and case reviews for Ministry of Justice cases;
- implementation of interim services to support autistic people, to enhance oversight for people admitted with an autism spectrum disorder diagnosis, including a trauma informed psychological support and crisis provision, not only for the individual but also their circle of support;
- an In-Reach Coordinator to work with acute mental health wards and acute treatment units, to ensure timely discharge for those in beds and to 'unblock' any barriers; and
- a Project Coordinator post recruited to work to support the Health Facilitation Team in their role to promote take-up of Annual Health Checks as part of the Learning Disabilities Annual Health Check Exemplar bid.

Throughout the Covid-19 restrictions, Care and Treatment Reviews and Local Area Emergency Protocols continued taking place virtually. Covid-19 has had an impact on the discharge plans of people with learning disabilities and/or autism, with transitions being disrupted by the restrictions. The CCG has worked closely with providers to use technology to maintain discharge transition pathways.

Reducing Health Inequality

The CCG has discharged its duties under Section 14T of the NHS Act 2006 (as amended), as detailed in the CCG Constitution, by agreeing strategic priorities which aim to contribute to increasing life expectancy. These are:

- Reducing mortality rates from preventable diseases
- Working with GP Practices to tackle practice and clinical variation
- Focusing on evidence-based and effective delivery
- Improving the integration of health and social care
- Improving integration of Primary and Secondary Care to improve care for the frail elderly and those with one or more long term conditions
- Working with partners to improve lifestyle choices of the Derbyshire population in relation to smoking, alcohol, diet and exercise

Place-based care strives to reduce health inequalities for patients living in specific geographical areas by bringing health and social care organisations together to work collaboratively.

The health of people in Derby and Derbyshire is varied compared to the England average. There are marked inequalities within the county. The gap in life expectancy between the least deprived areas of the county and the most deprived is 7.8 years for men and 7.1 years for women.

Around 15.3% (19,995) of Derbyshire's children live in low income households. A low income household is classified as living on less than 60% of the UK's median income (£17,640 in 2019). Growing up in a low income household can impact on physical and mental wellbeing and impacts on future life chances. For these children, levels of GCSE attainment are worse than the England average.

The rate of hospital admissions for alcohol-related harm is 755 per 100,000 which is worse than the England average. This represents 6,162 admissions per year in Derbyshire. Estimated levels of excess weight in adults are worse than the England average. The rates of statutory homelessness, hospital admissions for violence and the under-75 mortality rate for cardiovascular disease are all better than the England average.

Priorities for Derby and Derbyshire include working to reduce air pollution, improving mental health and wellbeing and supporting quality employment and lifelong learning.

Working together with a wider team means we are able to provide a more coordinated approach to patient care. It ensures that patients have access to the organisations that are the most appropriate to help and support them. The clinicians involved are able to provide the skills and mentorship for each other, to work together, freeing up more time for them to focus on their areas of expertise. Collaborative working across 'Places' means a pooled workforce should create flexibility in clinicians' roles.

Narrowing of health inequalities

The equality of service delivery to different groups is endorsed throughout the CCG and addressing equality and health inequalities are at the heart of our strategic aims and objectives. They are embedded throughout our delivery of services and within our 2020/21 Commissioning Intentions which can be found here[8].

There are three elements to the CCG's commitment in narrowing health inequalities:

Reducing unwarranted clinical variation	Working with General Practice and system partners to develop a programme of work to support Practices to ensure that services are provided and referrals made to a high standard, with minimal unwarranted variation.
Commissioning of services equitably	The CCG commissions its services to ensure that all patients receive the same service regardless of their protected characteristic, or where they live in Derbyshire and general practices are funded at the same level, using weighted capitation to take into account deprivation.
Providing population health data and commissioning on outcomes	Working as part of JUCD, Primary Care is provided with data analytics for population segmentation and risk stratification to allow them to understand and act on their populations' health and care needs. JUCD is developing this information and approach through the national Population Health Management Leadership Programme sponsored by NHSE&I.

The CCG collects activity to measure its performance against equality of service delivery of KPI's and metrics, however this is not currently part of the standard performance monitoring process.

Equality Delivery System

The CCG has demonstrated a proactive approach to meeting the requirements of the Public Sector Equality Duty through the use of the NHS Equality Delivery System 2. The CCG's equality objectives can be found here[9].

Derby and Derbyshire's approach to Equality 2020/21

We are committed to designing and implementing policies and procedures and commissioning services that meet the diverse needs of our population and workforce, ensuring that none are placed at a disadvantage over others. We always consider current UK legislative requirements and best practice. These include the Equality Act 2010, Human Rights Act 1998, Gender Recognition Act 2004, the NHS Constitution, the Public Sector Equality Duty and guidelines on best practice from the Equality and Human Rights Commission and the Department of Health. We are committed to promoting Equality, Inclusion and Human Rights to ensure that our activities ensure no-one receives less

[8] https://www.derbyandderbyshireccg.nhs.uk/publications/
[9] https://www.derbyandderbyshireccg.nhs.uk/about-us/equality-inclusion-and-human-rights/

favorable treatment due to their personal circumstances. This includes, but is not limited to, the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity status.

The CCG is committed to meeting the Public Sector Equality Duty and we do this in a number of ways including:

- ensuring all staff understand their duties around equality – this is included in the job descriptions of all staff;
- reporting progress through the Equality Delivery System 2 template every year;
- developing equality objectives and reporting progress against delivery;
- ensuring that equality is considered at every committee through robust cover sheets with key considerations highlighted;
- ensuring due regard is taken in all decision-making through an Equality Impact Assessment (EIA);
- supporting staff to understand equality and how to complete an EIA through one-to-one and group discussion sessions;
- linking equality and quality impacts through a joint panel approval process;
- ensuring all decisions include a reasonable adjustment statement as there is an understanding that there are always exceptions; and
- ensuring that feedback from protected characteristic groups is actively sought and understood so that any inequalities can be highlighted and dealt with.

Equality considerations for corporate committees

All of our Corporate Committees have a cover sheet included in all papers that requires a statement of assurance from the senior project lead about the assessment of equality considerations before a decision will be made. There is either assurance that an EIA has been completed and/or that discussion has taken place at the Quality Impact Assessment Panel or, on occasion and where appropriate, a different process has been followed to challenge and confirm equality considerations.

Procurement

We continue to ensure that there are robust processes in place in the procurement of healthcare services. Each aspect of the procurement activity includes embedded equality considerations (where relevant) and includes comprehensive equality related tender questions in both the Pre-Qualifying Questionnaires and Invitation to Tender stages. These processes ensure that there is assurance that providers of healthcare services in Derby and Derbyshire understand our population and the important equality considerations that they should make. These include, but are not limited to, making reasonable adjustments to ensure that their services are accessible to all.

Equality Statement

An equality commitment statement is embedded in all CCG policy developments and implementations, while also providing a framework to support CCG decisions through equality analysis and due regard.

In carrying out its function, the CCG must have 'due regard' to the Public Sector Equality Duty. This applies to all activities for which the CCG is responsible, including policy development, review and implementation.

Equality Analysis and 'Due Regard'

The CCG adopts a robust model of Equality Analysis and 'due regard' which it has embedded within its decision-making process. This is evidenced in the design of policies, service specifications and contracts. Such evidence is reviewed as part of the decision-making process and summarised in all Governing Body and Corporate Committee cover-sheets.

The CCG has 'due regard' for the need to eliminate unlawful discrimination, promote equality of opportunity, and provide for good relations between people of diverse groups, in particular on the grounds of the characteristics protected by the Equality Act (2010). These are age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation, in addition to offending background, Trade Union membership or any other personal characteristic.

Workforce

NHS Workforce Race Equality Standard

With the publication of the NHS Workforce Race Equality Standard (WRES), the CCG reviewed the submissions by the main NHS providers in Derbyshire and identified both their compliance with the standard, their current position in terms of ethnic minority staff experience and the actions they intend to take. The CCG is required to demonstrate progress against a number of indicators of workforce equality as detailed in the WRES. The CCG reviewed the requirements of the WRES and has taken 'due regard' to them in its own activities, and reviews and monitors its WRES Action Plan.

The CCG introduced a Staff Diversity and Inclusion Network, which is inclusive of all staff/protected characteristics, including ethnic minority colleagues. The network is run by staff for staff and brings together people from across the CCG that identify with a particular protected characteristic. The network meets bi-weekly to discuss and consider issues that they feel need addressing/considering by the CCG and work with us to improve staff experience on specific issues, including race and religion.

In response to Black Lives Matters, the Chief Executive Officer (CEO) on the 12th June 2020 published a statement that we do not tolerate racism or hate crime in NHS Derby and Derbyshire CCG and we want all our staff to feel safe, protected and listened to.

The CEO made a personal commitment to inclusivity and understanding the lived experiences of our under-represented staff, including those of ethnic minority, and communicated this in the all-staff briefings and staff bulletin. The CEO along with the majority of the Senior Leadership Team are participating in reverse mentoring with junior

colleagues to better understand the lived experiences of our staff who are from a protected characteristic that is underrepresented within the CCG.

The following actions from the NHS People Plan to improve workforce equality and diversity are being progressed by the CCG:

- overhauling recruitment and promotion practices to make sure that staffing reflects the diversity of the community, and regional and national labour markets;
- discussing equality, diversity and inclusion as part of the health and wellbeing conversations.

NHS Workforce Disability Equality Standard

The Workforce Disability Equality Standard (WDES) is a set of 10 specific measures (metrics) which enables NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff. The WDES is important, because research shows that a motivated, included and valued workforce helps to deliver high quality patient care, increased patient satisfaction and improved patient safety.

The WDES also enables NHS organisations to better understand the experiences of their Disabled staff and supports positive change for all existing employees by creating a more inclusive environment for disabled people working and seeking employment in the NHS.

Completion of the WDES is mandatory for NHS trusts and the metrics data is used to develop and publish an action plan, which the CCG reviews and monitors. Although not compulsory for the CCG, we collate the metrics data for the WDES to help us better understand the experiences of our disabled staff and developed an action plan.

Public Involvement and Consultation

Engaging People and Communities

The CCG has discharged its duty under Section 14Z2 of the NHS Act 2006 (as amended) to involve the public in the delivery of commissioning activities. The Covid-19 pandemic has not only affected the way services have been delivered but also the way in which the CCG has engaged patients and the public. The immediate need was to communicate and engage about the way that NHS services were changing. A system-wide approach was taken to understand the essential changes and it was agreed that the JUCD website would be the place for public information about health. Following our assessment of local community needs, these resources include translated information which includes various languages and British Sign Language.

To ensure the population of Derby and Derbyshire was made aware of the available information, we developed and distributed postcards to every household in Derby and Derbyshire advising of the JUCD website. We have continued to use the JUCD website to provide information to patients and the public, as well as a call to arms for staff to undertake clinical roles where appropriate and for volunteers to support our vaccination centres.

The changing way of engaging

It was apparent that our usual engagement processes would need to change due to lockdown and social distancing restrictions. Early on in the pandemic, we set up clear

instructions and guidelines and started engaging through digital means, and were delighted with the engagement we have achieved. To date we have run Derbyshire Dialogue engagement sessions on mental health, Primary Care, urgent and emergency services, cancer, NHS111, Long Covid-19 and Ageing Well.

In addition we have engaged on service developments, examples include:

- Derbyshire Maternity and Neonatal Voices – development of new Maternity Voices Partnership;
- digital mental health support for children – development of service model; and
- a series of meetings for members of Derby and Derbyshire GP Practice Patient Participation Groups.

Experiences during the pandemic

The pandemic brought rapid change to everyday life and the way that services could be delivered. An insight group was formed with representation from local Healthwatch groups, the community and voluntary sector, and health care staff. As a result, JUCD commissioned Traverse to engage with the public to shape the debate around the experience of those who have accessed care and the barriers to accessing care during the pandemic. This feedback has also helped to form options for the outpatient transformation programme for Derbyshire which will be progressed 2021/22.

Linking with the seldom heard

Working in partnership with both the city and county councils, we strengthened links with local communities through leaders and people who are paid and who volunteer. In addition we developed a partnership with the Derbyshire Black, Asian and Minority Ethnic Forum and the Learning Disability Good Health Group.

Ensuring information reaches the community

There has been a wealth of information available about Covid-19 and the vaccination programme, and in Derbyshire there is a section on the JUCD website. However, there is recognition that not everyone is able to access the written information and therefore, through working with local community champions, a suite of more accessible information has been developed, including:

- videos from well-known community organisations on the importance of having a vaccination;
- video tour of the vaccination sites;
- printed vaccination journey information; and
- programme of engagement events for seldom heard communities to provide information and answer questions.

Patient Experience and Involvement in Our Services

The CCG gathers patient experience from many different sources and works in partnership with patients, carers and local partners to ensure that the services we commission are responsive to the needs of our population.

Our work

The way in which we are able to engage with service users, their carers and loved ones has been impacted by the Covid-19 pandemic. In response, the CCG has developed alternative methods of gathering patient experience feedback from those previously used, such as online interviews and focus groups, online surveys and in-depth telephone interviews where these are more appropriate or comfortable for people.

Examples of how we have gathered and used patient experience feedback over the last year include:

- understanding the experience of patients (and carers) who have used the three differing types of care available for those who need ongoing rehabilitation support when they are discharged from one of our main hospitals. This has helped the CCG to identify good practice, gaps in support and ideas for future provision. It will help enable people to move quickly and easily between settings and services while allowing us to make the best use of all available facilities;
- exploring what we already know about patient (and carer) experience of community crisis and reablement services (such as complaints, concerns, compliments and Healthwatch reviews) to inform plans for additional engagement and development of ongoing measures of patient experience as part of the Ageing Well programme. This will support services to build on the existing intermediate care provision to achieve the goal of delivering a community urgent response;
- working with partners from across Derby and Derbyshire to gather information about the experience of services provided to people at the end of their lives. This has assisted in identifying what is important to dying people, their carers and loved ones and is being used to inform the priorities of all aspects of the JUCD End of Life Delivery Plan; and
- developing a draft Patient Experience Plan in collaboration with a small group of patient leaders, identified through the East Midlands Academic Health Science Network's patient leadership programme for safety and improvement. This supports the CCG in meeting relevant national and local patient experience targets, provide guidance on how the CCG can best ensure that patient experience is firmly embedded in all of our commissioning activities and decisions, and drive quality improvements for our patients, service users and their carers.

Ongoing and Planned Work

Examples of our ongoing and planned work include:

Experience of using urgent and emergency services during the Covid-19 pandemic

This multi-agency project seeks to explore the experience of adults using 999 emergency ambulance services (including 'hear and treat' and 'see and treat'), EDs, Urgent Treatment Centres, NHS111 and Primary Care out-of-hours services and same day emergency care services (as they develop) during the pandemic.

It is looking particularly at how those experiences differ from those of people using services prior to changes made in response to the Covid-19 pandemic. This will inform service development and commissioning decisions.

Courtesy of The NHS Information Centre for health and social care. Full diagram available at: www.ic.nhs.uk/commissioning

Perinatal (the time immediately before and after giving birth) support for women from the ethnic minority community during Covid-19

Research shows significantly higher rates of maternal and perinatal mortality for ethnic minority women and their babies, than for white women. Evidence from Public Health England also shows a disproportionate rate of mortality from Covid-19 for this group. Work is underway to analyse ethnic minority Covid-19 patient experience data already gathered and held by providers of perinatal services and to develop a survey and in-depth interviews to further enhance understanding of women's experience during this time. Findings from this work will ensure that the evaluation of service user experience is built in as part of a continuous improvement approach to service commissioning and provision.

Collaborative working with partners

The CCG Patient Experience Team has established regular meetings with our commissioned providers and other key stakeholders such as Healthwatch Derbyshire and Healthwatch Derby. This ensures an ongoing two-way dialogue and allows for easy sharing of planned and ongoing work streams.

Sustainable Development

Our CCG has the following Sustainability Mission Statement within our Sustainable Development Management Plan:

> *"The aim of NHS Derby and Derbyshire CCG is to provide high quality sustainable health care in this region and it is committed to embedding sustainability into its operations and to encourage key partners and stakeholders to do the same".*

The CCG works in accordance with the Sustainable Development Unit's guidance for CCGs and has embedded the Sustainable Development Strategy for the NHS, public health and social care system into its programme development. The CCG is compliant with those elements of the Climate Change Act and adaptation reporting requirements, which are relevant to it as a commissioning organisation with no responsibility for estate/property assets. The CCG is also aware of its responsibilities as a socially responsible commissioner and includes this within procurement programmes. One of our Governing Body Lay Members is the CCG's Sustainability Champion.

The Social Value Act 2012 requires us to consider how to use our contracts to improve the economic, social and environmental wellbeing of our communities. The CCG is committed to the NHS Carbon Reduction Scheme and there is an ongoing focus to reduce our direct building-related greenhouse gas emissions, business travel and waste going to landfill.

Our key commitments to sustainability are as follows:

Leadership and Workforce Development

Sustainable and resilient services will only emerge from a culture that understands and values environmental and social resources alongside financial. This requires strong leadership from within the CCG coupled with raising awareness of staff and the profile of sustainability.

Carbon Hotspots

The CCG's health, and the health of the environment, are damaged by pollutants released and resources used in delivering care. To protect the wellbeing of the UK population the NHS has formally adopted two targets, for the:

NHS Carbon Footprint **(emissions under NHS direct control)**	Net zero by 2040, with an ambition for an interim 80% reduction by 2028-2032
NHS Carbon Footprint Plus **(includes wider supply chain)**	Net zero by 2045, with an ambition for an interim 80% reduction by 2036-2039

One in every 100 tonnes of domestic waste generated in the UK comes from the NHS, with the vast majority going to landfill. The New Economic Foundation calculates that recycling all the paper, cardboard, magazines and newspapers produced by the NHS in England and Wales could save up to 42,000 tonnes of carbon dioxide.

Travel by patients, staff and visitors, is a crucial part of the way the NHS delivers services. The NHS accounts for 5% of all road traffic in England and travel is responsible for 18% of

the NHS carbon footprint in England. This is an important area for reducing carbon impact, improving sustainability, convenience and safety, as well as saving time and money.

Table 14 below shows our energy consumption in 2020/21 and 2019/20 for our CCG headquarters at Cardinal Square, Derby:

	2020/21	2019/20
Electricity (kWh)	94,142	169,927
Gas (kWh)	64,690	230,929
Water (m^3)	589	1,177

Table 14 – CCG Headquarters' Energy Consumption for 2020/21 and 2019/20

Commissioning and Procurement

In England more than £212.1bn of public money is spent on health and care services. The commissioning of services and the procurement of products are powerful levers to influence the delivery of sustainable services. The CCG recognises that we can develop and use criteria to stimulate more ambitious and innovative approaches to delivering care that costs less, creates less environmental harm and reduces inequalities.

Creating Social Value

Actively designing and delivering social value is a core part of the transformation needed across public sector organisations and as such, this concept is now protected in legislation through the Public Services (Social Value) Act 2012. This Act places a clear expectation on public services to demonstrate how their work makes a difference and delivers greater social value. It highlights the importance of considering social value in advance of commencing any commissioning procurement processes. Such considerations should help inform and shape the purpose of the products needed, and perhaps more importantly, the design of the services required.

Sustainability and the impact of Covid-19

The CCG has continued to evidence securing emission reductions and improve sustainability in the following areas:

Energy	Reducing total consumption in CCG sites
Consumables	Working paperless and distributing committee agenda and paper packs electronically, and encouraging recycling
Travel	Reducing the carbon footprint through Sustainable Travel Plans and working remotely during the pandemic
Procurement	Taking account of the Procurement for Carbon Reduction Sustainable Procurement Tool

Further to the improvement in sustainability made in previous years, the impact of Covid-19 and the organisation working remotely for 12 months saw dramatic improvements in our sustainability, through increased staff efficiency (using Microsoft Teams for virtual meetings), and the removal of the need to travel to many meetings, thereby significantly reducing travel pollution. There was also an increase in attendance at our Corporate Committees, which has seen an 11% increase on average.

There was a major decrease in the use of consumables through digital working. The CCG is therefore exploring ways of maintaining gains in carbon reduction through the consideration of new ways of working as a result of the benefits experienced from remote working during the pandemic.

The CCG was able to demonstrate the following sustainable cost efficiencies during the year as a result of remote working:

- cost and carbon footprint reductions due to:
    - reduced travel between sites/home – the CCG annual spend on travel for 2019/20 was £314.5k or £26.2k per month (average). From April 2020 to March 2021, the total spend on travel was £37.9k, a 90% reduction, equating to a saving of £281.3k or £23k per month (average);
    - reduced building operational functions – the CCG saw a cost saving on energy consumption at its CCG headquarters in Derby of £25,716 for its 2020/21 annual spend compared to 2019/20; and
- as at the end of March 2021, there was a 1.02% reduction in sickness absence compared to March 2020, and a year-to-date cost saving of £190k.

ACCOUNTABILITY REPORT

Dr Chris Clayton

Accountable Officer

NHS Derby and Derbyshire CCG

25th May 2021

Accountability Report Overview

The Accountability Report is required to have three sections as detailed below:

Corporate Governance Report

The purpose of the corporate governance report is to explain the composition and organisation of the entity's governance structures, how these support the achievement of the entity's objectives and how they reflect the generally accepted principles of good governance as stated in the National Health Service Act 2006 (as amended).

Remuneration and Staff Report

The remuneration and staff report sets out the organisation's remuneration policy for directors and senior managers, reports on how that policy has been implemented and sets out the amounts awarded to directors and senior managers. In addition, the report provides details on remuneration and staff that users of the accounts see as key to accountability.

Parliamentary Accountability and Audit Report

Entities such as CCGs are not required to produce a Parliamentary Accountability and Audit Report.

Corporate Governance Report

Members Report

Member Practices

The CCG is comprised of 112[10] member GP Practices and a further 56 branch surgeries, which are detailed in Table 15 below:

Main Practice	Branch Surgery
Adam House Medical Centre	Hillside Surgery
Aitune Medical Practice	–
Alvaston Medical Centre	Aston Surgery
Appletree Medical Practice	Little Eaton Surgery
Arden House Medical Practice	–
Arthur Medical Centre	–
Ashbourne Medical Practice	–
Ashbourne Surgery	–
Ashover Medical Centre	–
Barlborough Medical Practice	Renishaw Surgery
Baslow Health Centre	–
Blackwell Medical Centre	–
Blue Dykes Surgery (DCHSFT Partnership)	Grassmoor Surgery
Brailsford Medical Centre	Hulland Ward Medical Centre
Brimington Surgery	–
Brook Medical Centre	–
Brooklyn Medical Practice	–
Buxton Medical Practice	–
Calow and Brimington Practice	Calow Surgery
Castle Street Medical Centre	–
Chapel Street Medical Centre	Mayfield Medical Centre
Chatsworth Road Medical Centre	–
Chellaston and Melbourne Medical Practice	Melbourne Medical Centre
Chesterfield Medical Partnership	Holme Hall Surgery Whittington Medical Centre
Clay Cross Medical Centre	Tupton Surgery
College Street Medical Practice	–
Crags Health Care	Whitwell Health Centre
Creswell Medical Centre	Langwith Medical Centre
Crich Medical Practice	Halloway Surgery South Winfield Surgery
Darley Dale Medical Centre (Credas Medical)	Winster Surgery Youlgreave Surgery

[10] Please note that at the beginning of the financial year, the CCG was comprised of 114 member practices and a further 55 branch surgeries, but this reduced in-year to 112 member practices, with 56 branch surgeries. Tideswell Surgery and Bakewell Medical Centre merged to become Peak and Dales Medical Partnership (Tideswell Surgery is now a branch surgery); and Oakwood Surgery is now a branch surgery of Park Medical Practice following a merger.

Main Practice	Branch Surgery
Derby Family Medical Centre	–
Derwent Medical Centre	–
Derwent Valley Medical Practice	Derwent Valley Medical Practice, Sitwell Street
Dr Purnell and Partners	–
Dr Webb and Partners	–
Dronfield Medical Practice	–
Eden Surgery	–
Elmwood Medical Centre	–
Emmett Carr Surgery	Eckington Health Centre
Evelyn Medical Centre	Heathersage Surgery
Eyam Surgery	Bradwell Surgery
Friar Gate Surgery	–
Friendly Family Surgery	–
Gladstone House Surgery	–
Golden Brook Practice	–
Goyt Valley Medical Practice	Chapel-en-le-Frith Surgery
Gresleydale Healthcare Centre	–
Hannage Brook Medical Centre	–
Hartington Surgery	–
Haven Medical Centre	Haven Medical Centre, Keldhome Lane
Heartwood Medical Practice	–
Hollybrook Medical Centre	Sinfin Surgery
Horizon Healthcare	Mackworth Surgery, Humbleton Drive Mackworth Surgery, Tufnell Gardens
Imperial Road Surgery	–
Inspire Health (formerly Avenue House and Hasland)	Hasland Medical Centre Hasland Surgery
Ivy Grove Surgery	–
Jessop Medical Practice	Church Farm Primary Care Centre
Kelvingrove Medical Centre	–
Killamarsh Medical Practice	–
Lime Grove Medical Centre	–
Limes Medical Centre	–
Lister House Chellaston Surgery	Coleman Health Centre
Lister House Surgery	Oakwood Medical Centre
Littlewick Medical Centre	The Dales Medical Centre
Macklin Street Surgery	Park Farm Surgery
Mickleover Medical Centre	–
Mickleover Surgery	–
Moir Medical Centre	Sawley Surgery Draycott Surgery
Newbold Surgery	–
Newhall Surgery	–
North Wingfield Medical Centre	–
Oakhill Medical Practice	–
Old Station Surgery	Cotmanhey Surgery Kirk Hallam Surgery

Main Practice	Branch Surgery
Osmaston Surgery	–
Overdale Medical Practice	Breaston Surgery
Park Farm Medical Centre	Vernon Street Surgery
Park Lane Surgery	–
Park Medical Practice	Borrowash Surgery University Surgery Oakwood Surgery
Park Surgery	–
Park View Medical Centre	–
Parkfields Surgery	–
Parkside Surgery	–
Peak and Dales Medical Partnership	Tideswell Surgery
Peartree Medical Centre	–
Ripley Medical Centre (DCHSFT partnership)	–
Riversdale	–
Royal Primary Care	Rectory Road Medical Centre Inkersall Family Health Centre
Sett Valley Medical Centre	The Old Bank Surgery, Market Street
Shires Healthcare	Shires Healthcare, Bishops Walk
Somercotes Medical Centre	–
Springs Health Centre	–
St. Lawrence Road Surgery	–
St. Thomas Road Surgery	–
Staffa Health	Stonebroom Surgery Pilsley Surgery Holmewood Surgery
Stewart Medical Centre	–
Stubley Medical Centre	–
Swadlincote Surgery	–
The Surgery at Wheatbridge	–
The Valleys Medical Partnership	Moss Valley Medical Practice
Thornbrook Surgery	Chinley Surgery
Vernon Street Medical Centre	The Lane Medical Centre
Village Surgery, Alfreton	–
Village Surgery, Derby	–
Welbeck Road Surgery	Glapwell Surgery
Wellbrook Medical Centre	–
West Hallam Medical Centre	–
Whitemoor Medical Centre	–
Whittington Moor Surgery	–
Willington Surgery	–
Wilson Street Surgery	Taddington Road Surgery
Wingerworth Medical Centre	–
Woodville Surgery	–

Table 15 – List of CCG GP Practices

Composition of Governing Body

The Governing Body members for the CCG are shown in Table 16 below.

Governing Body Member	Position
Voting	
Dr Avi Bhatia	Clinical Chair
Martin Whittle	Lay Member for Patient and Public Involvement and Vice Governing Body Chair
Dr Chris Clayton	Chief Executive Officer
Richard Chapman	Chief Finance Officer
Brigid Stacey	Chief Nurse Officer
Dr Steven Lloyd	Executive Medical Director
Helen Dillistone	Executive Director of Corporate Strategy and Delivery (voting member since September 2020)
Zara Jones	Executive Director of Commissioning Operations (voting member since September 2020)
Sandy Hogg	Executive Turnaround Director (until 31 July 2020)
Dr Penny Blackwell	GP Member
Dr Ruth Cooper	GP Member
Dr Bukhtawar Dhadda	GP Member
Dr Emma Pizzey	GP Member
Dr Greg Strachan	GP Member
Dr Merryl Watkins	GP Member
Jill Dentith	Lay Member for Governance and Freedom to Speak Up Guardian
Ian Gibbard	Lay Member for Audit and Conflicts of Interest Guardian
Andrew Middleton	Lay Member for Finance and Sustainability Champion
Simon McCandlish	Lay Member for Patient and Public Involvement (from 1 April 2020)
Professor Ian Shaw	Lay Member for Primary Care Commissioning
Dr Bruce Braithwaite	Secondary Care Consultant
Non-Voting	
Dr Robyn Dewis	Derby City Council Representative
Dean Wallace	Derbyshire County Council Representative

Table 16 – Members of the CCG's Governing Body in 2020/21

Audit Committee

The Audit Committee is accountable to the CCG Governing Body and provides them with an independent and objective view of the financial systems, financial information and compliance with laws, regulations and directions governing the CCG. The Governing Body approved and keeps under review the Terms of Reference for the Audit Committee, which includes the membership of the Audit Committee.

Full details of other sub-committees can be found in the Governance Statement on page 85.

Audit Committee Membership

The membership of the Audit Committee of the CCG is shown in Table 17 below.

Audit Committee Member	Position
Ian Gibbard	Chair – Lay Member for Audit and Conflicts of Interest Guardian
Jill Dentith	Deputy Chair – Lay Member for Governance and Freedom to Speak Up Guardian
Andrew Middleton	Lay Member for Finance and Sustainability Champion
Dr Bruce Braithwaite	Secondary Care Consultant ('by invitation' in accordance with the Committee's workplan or where clinical input is required)

Table 17 – Members of the CCG's Audit Committee in 2020/21

Register of Interests

The CCG holds a register of interests for all individuals who are engaged by the CCG. The registers are viewable at https://www.derbyandderbyshireccg.nhs.uk/about-us/conflict-of-interest/ and available on request at the CCG Headquarters.

Personal Data Related Incidents

There was one Information Governance incident during 2020/21 that met the criteria for reporting through the Data Protection and Security Toolkit (DPST) to the Information Commissioner's Office.

Statement of Disclosure to Auditors

In the case of each of the persons who are members at the time the report is approved:

- so far as the member is aware, there is no relevant audit information of which the NHS body's auditor is unaware; and
- has taken all the steps that they ought to have taken as a member in order to make themselves aware of any relevant audit information and to establish that the entity's auditor is aware of that information.

Modern Slavery Act

NHS Derby and Derbyshire CCG fully supports the Government's objectives to eradicate modern slavery and human trafficking. Our Slavery and Human Trafficking Statement for the financial year ending on the 31st March 2020 is published at https://www.derbyandderbyshireccg.nhs.uk/.

Statement of Accountable Officer's Responsibilities

The National Health Service Act 2006 (as amended) states that each CCG shall have an Accountable Officer and that Officer shall be appointed by the NHS Commissioning Board (NHS England). NHS England has appointed the Chief Executive Officer to be the Accountable Officer of NHS Derby and Derbyshire CCG.

The responsibilities of an Accountable Officer are set out under the National Health Service Act 2006 (as amended), Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- the propriety and regularity of the public finances for which the Accountable Officer is answerable;
- for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the CCG and enable them to ensure that the accounts comply with the requirements of the Accounts Direction);
- for safeguarding the CCG's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities);
- the relevant responsibilities of accounting officers under Managing Public Money;
- ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the National Health Service Act 2006 (as amended)) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the National Health Service Act 2006 (as amended));
- ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the National Health Service Act 2006 (as amended).

Under the National Health Service Act 2006 (as amended), NHS England has directed each CCG to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the CCG and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual and in particular to:

- observe the Accounts Direction issued by NHS England, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts;
- prepare the accounts on a going concern basis; and
- confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS Derby and

Derbyshire CCG's auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

I also confirm that as far as I am aware, there is no relevant audit information of which the CCG's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the CCG's auditors are aware of that information.

Dr Chris Clayton

Accountable Officer

NHS Derby and Derbyshire CCG

25th May 2021

Governance Statement

Introduction and Context

NHS Derby and Derbyshire Clinical Commissioning Group (CCG) is a body corporate established by NHSE on the 1st April 2019 under the National Health Service Act 2006 (as amended).

The CCG's statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG's general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

As at the 1st April 2020 the clinical commissioning group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006 (as amended).

The CCG brings together local GP Practices (General Practitioners) and other healthcare professionals to commission hospital and community NHS services for Derbyshire, comprising of 112 member GP Practices with a registered population of over 1,062,000.

The geographical footprint and eight areas known as 'Places' covered by the CCG are Amber Valley, Bolsover and North East Derbyshire, Chesterfield, Derby city, Derbyshire Dales, Erewash, High Peak and South Derbyshire. Our five year plan recognises that the health and social care needs of people varies significantly across Derby city and Derbyshire. Consequently, these eight Place Alliances across the Derbyshire Joined up Care Unit of Planning have been identified as a means to engage people in the development of services.

The CCG has a revenue income of circa £1.9bn for 2020/21 and has a workforce of around 500 employees.

Scope of Responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the CCG's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out under the National Health Service Act 2006 (as amended) and in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity. I also have responsibility for reviewing the effectiveness of the system of internal control within the CCG as set out in this governance statement.

Governance Arrangements and Effectiveness

The main function of the Governing Body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

The role of the Governing Body is corporate responsibility for the CCG's strategies, actions and finances. As a Governing Body of an NHS organisation, it is the custodian of a national asset, provides stewardship and remains publicly accountable.

Key Features of the CCG's Constitution in relation to Governance

The CCG is a clinically-led organisation and has 112 member GP Practices as detailed in the Constitution. In addition to our accountability to the public and patients we serve, the CCG is accountable to NHSE&I and to its Membership.

The CCG Governance Framework

The Governance Framework for the CCG is set out in its Constitution, which ensures that the CCG complies with section A of the UK Corporate Governance Code in all respects. The Constitution was last amended in January 2021.

Governing Body

The Governing Body is responsible for ensuring that the CCG exercises its functions effectively, efficiently and economically, and in accordance with sections 14L(2) and (3) of the National Health Service Act 2006 (as amended), as inserted by section 25 of the Health and Social Care Act 2012 and the Constitution of the CCG.

The Governing Body was appointed in accordance with section 14L of the National Health Service Act 2006 (as amended). The appointment process for Governing Body members varies according to the role they undertake and the appointment process specific to each role is therefore specified in detail within Appendix 3 (Standing Orders) to the Constitution. The CCG has therefore necessarily had to depart from sections B2 and B3 of the Code in that it is not in a position to have a Nomination Committee as set out in the Code. The Governing Body is supported by a Head of Governance and its composition is described in Table 18 below, each with a single non-transferable vote unless detailed otherwise.

Governing Body Member	Position
Voting	
Dr Avi Bhatia	Clinical Chair
Martin Whittle	Lay Member for Patient and Public Involvement and Vice Governing Body Chair
Dr Chris Clayton	Chief Executive Officer
Richard Chapman	Chief Finance Officer
Brigid Stacey	Chief Nurse Officer
Dr Steven Lloyd	Executive Medical Director
Helen Dillistone	Executive Director of Corporate Strategy and Delivery (voting member since September 2020)
Zara Jones	Executive Director of Commissioning Operations (voting member since September 2020)
Sandy Hogg	Executive Turnaround Director (until 31 July 2020)

Governing Body Member	Position
Dr Penny Blackwell	GP Member
Dr Ruth Cooper	GP Member
Dr Bukhtawar Dhadda	GP Member
Dr Emma Pizzey	GP Member
Dr Greg Strachan	GP Member
Dr Merryl Watkins	GP Member
Jill Dentith	Lay Member for Governance and Freedom to Speak Up Guardian
Ian Gibbard	Lay Member for Audit and Conflicts of Interest Guardian
Andrew Middleton	Lay Member for Finance and Sustainability Champion
Simon McCandlish	Lay Member for Patient and Public Involvement (from 1 April 2020)
Professor Ian Shaw	Lay Member for Primary Care Commissioning
Dr Bruce Braithwaite	Secondary Care Consultant
Non-Voting	
Dr Robyn Dewis	Derby City Council Representative
Dean Wallace	Derbyshire County Council Representative

Table 18 – Members of the CCG's Governing Body in 2020/21

At the confidential Governing Body meeting on the 2nd April 2020, the CCG formally escalated its business continuity level to level four, as a result of the Covid-19 pandemic. Consequently, the Governing Body meetings in public were stood down until July 2020 and the Corporate Committees of the Governing Body were stood down until June 2020, with the exception of the Audit Committee. The Governing Body agreed that they would conduct sub-committee business where required.

The Governing Body met a total of nine times confidentially while the CCG was operating at level four, and met in public nine times from July 2020. All meetings in 2020/21 were fully quorate. The quorum necessary for the transaction of business during the Covid-19 pandemic was:

- Clinical Chair, Vice Chair (Lay Member for Patient and Public Involvement), or Audit Committee Chair
- 1 x CCG Officer (Chief Executive Officer, Chief Finance Officer or Chief Nurse Officer) or Executive Director
- 2 x Lay Members
- 2 x voting clinicians (to include GP Members, Secondary Care doctor and/or Clinical Chair)

On the 6th August 2020, the original quoracy was reinstated, which was:

- Clinical Chair or Vice Chair (Lay Member for Patient and Public Involvement)
- 1 x CCG Officer (Chief Executive Officer, Chief Finance Officer or Chief Nurse Officer)
- 2 x Lay Members
- 4 x voting clinicians (to include GP Members and/or Secondary Care clinician)

At its September 2020 meeting, the Governing Body were asked to consider the balance of voting rights and a proposal was agreed to extend the Governing Body voting members to include the Executive Director of Commissioning and the Executive Director of Corporate Strategy and Delivery as additional voting members.

On the 14th January 2021, the Governing Body reverted back to the revised quoracy as a result of the CCG working at business continuity level four during the most recent increase in levels of infection due to Covid-19.

The membership and attendance record for the Governing Body and sub-committees can be found in Appendix One.

Governing Body Performance

The last time that the Governing Body met face-to-face was at its meeting in public on the 5th March 2020. High levels of attendance were maintained through virtual meetings and there has been no detriment to the quality and range of member contributions or the effectiveness of decision-making. The Governing Body meetings in pubic were stood down in April 2020; and at its confidential Governing Body virtual meeting, the CCG approved the formal escalation to business continuity level four, as a result of the CCG leading the response to the Covid-19 pandemic. Consequently, it was agreed to stand down Governing Body meetings in public until July 2020 and continue to meet virtually in confidential sessions on a weekly basis, with a shorter and specific agenda relating to Covid-19 and governance. The Corporate Committees were also stood down except for the Audit Committee; which was required in order to oversee and approve the Annual Report and Accounts process for 2019/20.

In May 2020, the Governing Body developed its approach for the recovery and restoration of services and established a Recovery and Restoration Plan. The Recovery and Restoration Plan, comprising the organisational pillars of recovery, was owned by the Corporate Committees and reported to the Governing Body monthly. Priority was given, in the short term, to restoring cancer services, urgent operations and mental health services in order to minimise the long term risks to patients. The longer term recovery plan considered the restoration of other NHS services.

On the 4th June 2020, the Governing Body approved the de-escalation from business continuity level four to level three, to enable oversight of the Restoration and Recovery Plan through the Corporate Committees. These meetings were reinstated with effect from June 2020.

On the 7th July 2020, the Governing Body returned to meeting in public virtually and continued to meet confidentially on a monthly basis. In September, the Governing Body reinstated its monthly Development Sessions.

Five Development Sessions took place during the year, which focused specifically on strategic development. These included:

- how the CCG operated within a system focus;
- the development of the Integrated Care System (ICS);
- the development of strategic intent for the ICS/JUCD;
- reviewing the CCG's strategic objectives and risks; and
- undertaking statutory mandatory training.

The Governing Body reviewed and agreed the CCG's strategic aims and objectives at its meeting in public on the 2nd July 2020. A draft opening 2020/21 Governing Body Assurance Framework (GBAF) defining the strategic risks was presented and agreed at the meeting in public on the 6th August 2020. During the year, the Corporate Committees have proactively taken the responsibility and ownership of their GBAF risks to scrutinise and develop them further. The Quality and Performance Committee established a GBAF Task and Finish Group which met monthly to review their GBAF risks thoroughly and this has proved to be dynamic group. The

other Committees are taking a similar approach. 360 Assurance, our Internal Auditors, published a benchmarking exercise report for the 2020/21 CCG GBAF. The report advised that 360 Assurance expect the GBAF to remain a dynamic document and that Covid-19 risks are to be integrated into the current risk management processes. It also illustrated that the CCG is mindful of the impact of Covid-19 on the GBAF strategic risks, which were reflected in the GBAF throughout 2020/21.

In October 2020, the CCG's Chief Executive Officer, Dr Chris Clayton, was appointed to the role of Interim Executive Lead for Joined Up Care Derbyshire; alongside his role for the CCG. The dual role will support the CCG's efforts in ensuring that the CCG continue to work closely and effectively as a system and do its very best for their patients and our population.

The CCG has continued to develop its transition to an ICS. In December 2020, NHS England published a paper designed to accelerate the move to integrated care. The document also described the options for giving ICSs a firmer footing in legislation, which will likely take affect from April 2022 (subject to Parliamentary decision). In December, JUCD was formally approved as the Derbyshire ICS and held its first meeting in public as a newly appointed ICS in January 2021.

On the 6th May 2021, the Governing Body reviewed and approved the 2021/22 Strategic Objectives for the final year of the CCG. These can be found here.

Corporate Committees of the Governing Body

To support the Governing Body in carrying out its duties effectively, Committees reporting to the Governing Body have been formally established. The remit and Terms of Reference of these Corporate Committees are reviewed every six months. Each committee receives regular reports, as outlined within their Terms of Reference and provides exception and highlight reports to the Governing Body.

The governance structure of the CCG comprises:

- Governing Body
- Committees of the Governing Body:
    - Audit Committee
    - Clinical and Lay Commissioning Committee
    - Engagement Committee
    - Finance Committee
    - Governance Committee
    - Primary Care Commissioning Committee
    - Quality and Performance Committee
    - Remuneration Committee

Ratified Corporate Committee minutes are formally recorded and submitted to the Governing Body in its meeting in public sessions, wherever possible, as soon as practicable after meetings have taken place.

As a final agenda item, the Committees are asked to review how effective the meeting was and to decide whether anything should be escalated to the Governing Body. The Governing Body then receives an assurance report following each Committee meeting, provided by the respective Chairs. This report outlines key assurances and/or risks, and allows for timely information to be provided prior to the submission of the ratified minutes.

Audit Committee

The Audit Committee is constituted in line with the provisions of the NHS Audit Committee Handbook and the 'Towards Excellence' guidance. 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.

The duties of the Audit Committee are 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 statements of the CCG and any other formal reporting relating to the CCG's financial performance.

Audit Committee Membership

The composition of the Audit Committee is shown in Table 19 below.

Audit Committee Member	Position
Ian Gibbard	Chair – Lay Member for Audit and Conflicts of Interest Guardian
Jill Dentith	Deputy Chair – Lay Member for Governance and Freedom to Speak Up Guardian
Andrew Middleton	Lay Member for Finance and Sustainability Champion
Dr Bruce Braithwaite	Secondary Care Consultant ('by invitation' in accordance with the Committee's workplan or where clinical input is required)

Table 19 – Members of the CCG's Audit Committee in 2020/21

The Audit Committee requests and reviews reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control. Significant items that were discussed and approved during 2020/21 are shown in Table 20 below.

Significant items approved/discussed by Audit Committee 2020/21	
Governance, Risk Management and Internal Control	
Aged Debt Report	Freedom to Speak Up Report
Annual Governance Statement	Governing Body Assurance Framework
Annual Report & Accounts 2019/20	Losses and Special Payments
Audit Committee Annual Report 2019/20	Review of Emergency Governance Arrangements in Response to Covid-19
Audit Committee Self-Assessment	Risk Register Exception Reports
Committee Meeting Business Log	Service Auditor Reports
Conflicts of Interest	Single Tender Waivers
Covid-19 Financial Updates	Write Off Reports
Internal Audit	
2019/20 Head of Internal Audit Opinion	Internal Audit Annual Report
2020/21 Head of Internal Audit Opinion Stage 1	Progress Reports
Audit Committee Maturity Matrix	Primary Medical Care Services Contract Oversight and Management Functions
Integrity of General Ledger & Key Financial Systems	

Significant items approved/discussed by Audit Committee 2020/21	
External Audit	
KPMG External Audit Plan for 2020-21	ISA 260 Report
KPMG Progress Report	
Counter Fraud	
Counter Fraud Functional Standard	2019/20 Counter Fraud Bribery and Corruption Annual Report
Counter Fraud Progress Report	

Table 20 – Significant items approved/discussed by Audit Committee in 2020/21

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 and also met twice confidentially.

All meetings in 2020/21 were fully quorate. The quorum necessary for the transaction of business is two members.

Primary Care Commissioning Committee

The role of the Primary Care Commissioning Committee is to carry out the functions relating to the commissioning of primary medical services under section 83 of the NHS Act 2006 (as amended). This enables the members, as detailed in Table 21 below, to make collective decisions on the review, planning and procurement of Primary Care services in the CCG, under delegated authority from NHSE. 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.

Primary Care Commissioning Committee Membership

Primary Care Commissioning Committee Member	Position
Professor Ian Shaw	Chair – Lay Member for Primary Care Commissioning
Simon McCandlish	Deputy Chair – Lay Member for Patient and Public Involvement (from 1 April 2020)
Jill Dentith	Lay Member for Governance and Freedom to Speak Up Guardian
Dr Chris Clayton	Chief Executive Officer (until 25 November 2020)[11]
Richard Chapman	Chief Finance Officer
Brigid Stacey	Chief Nurse Officer
Dr Steven Lloyd	Executive Medical Director
Sandy Hogg	Executive Turnaround Director (until 31 July 2020)

Table 21 – Members of the CCG's Primary Care Commissioning Committee in 2020/21

Significant items that were discussed and approved during 2020/21 are shown in Table 22 below.

Significant items approved/discussed by Primary Care Commissioning Committee 2020/21	
Ageing Well and Care Homes	Primary Care Commissioning Committee Annual Report 2019/20
Care Quality Commission Inspection Updates	Primary Care Estates Strategy
Community Hub Development	Primary Care Networks Estates Guidance
CQC Inspection Reports	Primary Care Quality & Performance

[11] Primary Care Commissioning Committee membership was amended in November 2020.

Significant items approved/discussed by Primary Care Commissioning Committee 2020/21	
	Assurance Reports
Feasibility Studies	Primary Medical Care Policy
Finance Update	Provision of GP Services Christmas 2020
General Practice Boundary Amendments	Recovery and Restoration
General Practice Development Proposals	Risk Management
General Practice Rent Reimbursements	St. Thomas Road Surgery Update
GP Forward View Programme	Sub-Committee Highlight Reports
Horizon Healthcare Branch Surgery Closures	Sub-Committee Terms of Reference
Pilsley Branch Surgery - Quarterly Progress Reports	

Table 22 – Significant items approved/discussed by Primary Care Commissioning Committee in 2020/21

The Committee met a total of 10 times during 2020/21 and all meetings were fully quorate. They also met nine times confidentially. The quorum necessary for the transaction of business is four members, at least two of whom are Lay Members and include the Chair or Deputy Chair.

Remuneration Committee

The Remuneration Committee is accountable to the Governing Body and makes recommendations to the Governing Body on determinations about the remuneration, fees and other allowances for employees and for people providing services to the CCG.

The Governing Body has approved and keeps under review the Terms of Reference for the Committee, which includes information on the membership. The Governing Body ensures that all members appointed remain independent. No decisions are made by Executive Officers.

The Governing Body has delegated specific functions and responsibilities, connected with the Governing Body's main function, remuneration, as specified in the Terms of Reference and the Group's Scheme of Reservation and Delegation. The work of the Remuneration Committee enables the CCG to declare compliance with Section D of the Corporate Governance Code of Conduct.

In order to avoid any conflict of interest, in respect of Lay Members who constitute the majority of the membership of the Remuneration Committee, their own remuneration is set directly by the Governing Body. The Lay Members who are conflicted are not part of the decision-making.

Remuneration Committee Membership

The composition of the Remuneration Committee is shown in Table 23 below.

Remuneration Committee Member	Position
Martin Whittle	Chair – Lay Member for Patient and Public Involvement and Vice Governing Body Chair
Ian Gibbard	Lay Member for Audit and Conflicts of Interest Guardian
Jill Dentith	Lay Member for Governance and Freedom to Speak Up Guardian
Andrew Middleton	Lay Member for Finance and Sustainability Champion

Table 23 – Members of the CCG's Remuneration Committee in 2020/21

Significant items that were discussed and approved during 2020/21 are shown in Table 24 below.

Significant items approved/discussed by Remuneration Committee 2020/21	
Approval of Redundancy Payment	Litigation Case
CCG approach to financial efficiency	Re-alignment of the Programme Management Office
Executive Remuneration	Very Senior Manager Finance Structure

Table 24 – Significant items approved/discussed by Remuneration Committee in 2020/21

The Committee meets as required but as a minimum annually. The Committee met four times during 2020/21. The quorum necessary for the transaction of business is two of the four members of the Remuneration Committee. The meetings were fully quorate and in accordance with its Terms of Reference.

Clinical and Lay Commissioning Committee

The purpose of the Clinical and Lay Commissioning Committee is to provide a clinical forum within which discussions can take place; recommendations are made on the clinical direction of the CCG; and it helps secure the continuous improvement of the quality of services. The membership detailed below in Table 25 has delegated authority to make financial recommendations as set out in the Standing Financial Instructions on disinvestment/ de-commissioning decisions.

Clinical and Lay Commissioning Committee Membership

Clinical and Lay Commissioning Committee Member	Position
Dr Ruth Cooper	Chair – Governing Body GP
Professor Ian Shaw	Deputy Chair – Lay Member for Primary Care Commissioning
Dr Bukhtawar Dhadda	Governing Body GP
Dr Emma Pizzey	Governing Body GP
Dr Greg Strachan	Governing Body GP
Dr Merryl Watkins	Governing Body GP
Dr Bruce Braithwaite	Secondary Care Consultant
Simon McCandlish	Lay Member for Patient and Public Involvement (from 1 April 2020)
Ian Gibbard	Lay Member for Audit and Conflicts of Interest Guardian
Brigid Stacey	Chief Nurse Officer
Dr Steven Lloyd	Executive Medical Director
Richard Chapman	Chief Finance Officer
Dr Robyn Dewis	Public Health Representative
Zara Jones	Executive Director of Commissioning Operations
Sandy Hogg	Executive Turnaround Director (until 31 July 2020)

Table 25 – Members of the CCG's Clinical and Lay Commissioning Committee in 2020/21

Significant items that were discussed and approved during 2020/21 are detailed below in Table 26.

Significant items approved/discussed by Clinical and Lay Commissioning Committee 2020/21	
Better Care Fund	Health Care Contracts
Business Cases	Hospices
Care Homes Market Position Update	Individual Funding Requests
Care of Children with Complex Needs	Interventional Procedures Guidance
Children and Young People Mental Health	Joint Area Prescribing Committee
Clinical Cell Decision Log	Medicines Order Line
Clinical Policies	Musculoskeletal
Clinical Policy Advisory Group	National Rehabilitation Centre – Public Consultation Response
Commissioning Intentions and Approach for 2021/22	Psychiatric Intensive Care Unit Beds
Contract Extensions	Phase 3 Recovery and Restoration – JUCD Plan Summary
Contractual Settlements	Policy statement for the Commissioning of Sensory Integration Therapy
Covid-19 Urgent Eye Service	Primary Care Out of Hours
Derby Integrated Community Equipment Service	Procurements
Directory of Services (DoS) Changes	Reflections and positive outcomes through Covid-19
Extension of Contracts	Risk Management
Future Commissioning priorities	Shared Care Pathology
Governing Board Assurance Framework	Voluntary and Community Sector Contracting Intentions 2021/22

Table 26 – Significant items approved/discussed by Clinical and Lay Commissioning Committee in 2020/21

The Committee met a total of 10 times during 2020/21 and in November the Committee reviewed the format of its meetings to enable them to provide transparency on their decision-making in relation to public-facing matters. The quorum necessary for the transaction of business is six members, to include four clinicians, one Lay Member and one Executive Lead. All meetings in 2020/21 were fully quorate.

Engagement Committee

The Engagement Committee meets with the purpose of assuring the Governing Body that the CCG is involving patients in its decisions about health services and that robust processes are in place to ensure that the CCG is fully compliant with their statutory obligations. Members are detailed in Table 27 and include representatives from the Governing Body, public representatives from communities, Foundation Trust Governors, Healthwatch and the voluntary sector. Staff from the CCG are invited to attend the Engagement Committee to update on the programme or scheme that they are working on, including an update on the communications and engagement strategy in place for that specific piece of work. This approach provides oversight and facilitates confirm and challenge opportunities for the Engagement Committee.

Engagement Committee Membership

Engagement Committee Member	Position
Voting Members	
Martin Whittle	Chair – Lay Member for Patient and Public Involvement and Vice Governing Body Chair
Simon McCandlish	Deputy Chair – Lay Member for Patient and Public Involvement (from 1 April 2020)
Professor Ian Shaw	Lay Member for Primary Care Commissioning
Maura Teager	Foundation Trust Governor – Secondary Care (from October 2020)
Denise Weremczuk	Foundation Trust Governor – Secondary Care (to December 2020)
Margaret Rotchell	Foundation Trust Governor – Secondary Care (from January 2021)
Bernard Thorpe	Foundation Trust Governor – Community (to December 2020)
Lynn Walshaw	Foundation Trust Governor – Community (from January 2021)
Kevin Richards	Foundation Trust Governor – Mental Health
Ram Paul	Derby City Council Representative
Jocelyn Street	Place Engagement Representative
Ruth Grice	Place Engagement Representative
Trevor Corney	Place Engagement Representative
Roger Cann	Place Engagement Representative (from July 2020)
Steve Bramley	Place Engagement Representative (from June 2020)
Tim Peacock	Place Engagement Representative (from June 2020)
Helen Dillistone	Executive Director of Corporate Strategy and Delivery
Non-Voting Members	
Beth Soraka	Healthwatch Derby Representative
Helen Henderson-Spoors	Healthwatch Derbyshire Representative
Kim Harper	Voluntary Sector City Representative
Sean Thornton	Assistant Director Communications and Engagement, CCG
Vikki Taylor	ICS Director, Joined Up Care Derbyshire
Karen Lloyd	Head of Engagement, Joined Up Care Derbyshire

Table 27 – Members of the CCG's Engagement Committee in 2020/21

Significant items that were discussed and approved during 2020/21 are detailed below in Table 28.

Significant items approved/discussed by Engagement Committee 2020/21	
Ageing Well Programme	Learning from Covid-19 Response
Baron Ward and Babington Hospital	London Road Wards 1 & 2 Consultation
Board Assurance Framework	Orthotics Engagement
CCG Recovery and Restoration	Patient and Public Expenses Policy

Significant items approved/discussed by Engagement Committee 2020/21	
Children's and young people's restoration and recovery	Restoration and Recovery Engagement Strategy
Communications and Engagement Strategy	Risk Management
Community Mental Health Framework	Service Change Legislation Guidance
Covid-19 Testing	Service Recovery and Restoration Assessment Process
Covid-19 Vaccination Communications	System Insight Group
Derbyshire Health Improvement and Scrutiny Committee	System Pressures Communications
Derbyshire Maternity and Neonatal Voices	Urgent Care
Engagement Committee Annual Report 2019/20	Waiting Time Risk Stratification
Insight Programme	Winter Communications Planning
Joined Up Care Derbyshire Board	

Table 28 – Significant items approved/discussed by Engagement Committee in 2020/21

The Committee met a total of seven times during 2020/21. The quorum necessary for the transaction of business is five members, to include two Lay Members for Patient and Public Involvement, two Place Engagement Representatives and one Executive Lead. All meetings in 2020/21 were quorate.

Finance Committee

The purpose of the Finance Committee is to review both the financial and service performance of the CCG against financial control targets and the annual commissioning plan. The Committee also identifies where remedial action is needed, ensuring that action plans are put in place and delivery is monitored.

Finance Committee Membership

The composition of the Finance Committee is detailed in Table 29 below.

Finance Committee Member	Position
Andrew Middleton	Chair – Lay Member for Finance and Sustainability Champion
Martin Whittle	Deputy Chair – Lay Member for Patient and Public Involvement and Vice Governing Body Chair
Ian Gibbard	Lay Member for Audit and Conflicts of Interest Guardian
Dr Ruth Cooper	Governing Body GP
Dr Bukhtawar Dhadda	Governing Body GP
Richard Chapman	Chief Finance Officer
Brigid Stacey	Chief Nurse Officer
Sandy Hogg	Executive Turnaround Director (until 31 July 2020)

Table 29 – Members of the CCG's Finance Committee in 2020/21

Significant items that were discussed and approved during 2020/21 are detailed in Table 30.

Significant items approved/discussed by Finance Committee 2020/21	
2020/21 Financial Regime	Operational Planning for Covid-19 Scenarios for 2020/21
CCG Constitution and Governance Handbook	Phase 3 System Financial Returns
CCG Recovery and Restoration	Primary Care Out of Hours
Committee Meeting Logs	Risk Management
Continuing Healthcare	System Financial Plans
Covid-19 Audit Report	System Income and Expenditure 2020/21
Finance Committee Annual Report 2019/20	Turnaround Programme Closure
Governing Body Assurance Framework	Value Focused Health Economy
Monthly Finance Reports	

Table 30 – Significant items approved/discussed by Finance Committee in 2020/21

The Committee met a total of 10 times during 2020/21. They also met four times confidentially and once extraordinarily to discuss the CCG and system financial plan for September 2020 to March 2021. The quorum necessary for the transaction of business is five members, to include one Executive Lead (Chief Finance Officer or Turnaround Director); at least one Clinical Representative and at least two Governing Body Lay Members. All meetings were quorate for 2020/21 apart from the meeting in June 2020, where no decisions were needed.

Governance Committee

The purpose of the Governance Committee is to ensure that the CCG complies with the principles of good governance whilst effectively delivering the statutory functions of the CCG. It also has delegated authority to make decisions as set out in the CCG's Prime Financial Policies and the Scheme of Reservation and Delegation.

Governance Committee Membership

The composition of the Governance Committee is detailed in Table 31 below.

Governance Committee Member	Position
Jill Dentith	Chair – Lay Member for Governance and Freedom to speak up Guardian
Ian Gibbard	Deputy Chair – Lay Member for Audit and Conflicts of Interest Guardian
Martin Whittle	Lay Member for Patient and Public Involvement and Vice Governing Body Chair
Dr Emma Pizzey	Governing Body GP
Dr Greg Strachan	Governing Body GP
Helen Dillistone	Executive Director of Corporate Strategy and Delivery

Table 31 – Members of the CCG's Governance Committee in 2020/21

Significant items that were discussed and approved during 2020/21 are detailed in Table 32.

Significant items approved/discussed by Governance Committee 2020/21	
Audit Committee Value for Money Conclusion	Information Governance compliance
Business Continuity	Mandatory Training
CCG Incident Control Centre	Maternity Voices Partnership
CCG Recovery and Restoration	Merger Benefits Realisation Report
Complaints Reports	Non-Clinical Adverse Incidents
Contract Oversight Report	'Our Big Conversation' – New Ways of Working
Cyber Operational Readiness Support Audit and Action Plan	Policies and Procedures
Digital Development	Policy Management Framework
Emergency Planning Resilience And Response	Procurement Highlights
Freedom of Information Reports	Risk Management
Freedom to Speak Up Guardian Role	Standards of Business Conduct and Managing Conflicts of Interest
Governance Committee Annual Report 2019/20	Workforce Disability Equality Standard
Guidance on the use of Microsoft Teams	Workforce Race Equality Standard
Health and Safety	

Table 32 – Significant items approved/discussed by Governance Committee in 2020/21

The Committee met a total of five times during 2020/21. They also met four times confidentially and twice extraordinarily to agree urgent business continuity escalation levels. The quorum necessary for the transaction of business is four members, to include two Governing Body Lay Members, one clinician and the Executive Lead (or nominated deputy). All meetings in 2020/21 were quorate.

Quality and Performance Committee

The purpose of the Quality and Performance Committee is to provide assurance to the CCG's Governing Body in relation to the quality, performance, safety, experience and outcomes of services commissioned by the CCG. It also ensures that the CCG discharges its statutory duties in relation to the achievement of continuous quality improvement and safeguarding of vulnerable children and adults.

Quality and Performance Committee Membership

The composition of the Quality and Performance Committee is detailed in Table 33 below.

Quality and Performance Committee Member	Position
Dr Bukhtawar Dhadda	Chair – Governing Body GP
Andrew Middleton	Deputy Chair – Lay Member for Finance and Sustainability Champion
Dr Emma Pizzey	Governing Body GP
Dr Greg Strachan	Governing Body GP
Dr Merryl Watkins	Governing Body GP

Quality and Performance Committee Member	Position
Simon McCandlish	Lay Member for Patient and Public Involvement (from 1 April 2020)
Martin Whittle	Lay Member for Patient and Public Involvement and Vice Governing Body Chair
Brigid Stacey	Chief Nurse Officer
Dr Steven Lloyd	Executive Medical Director
Dr Bruce Braithwaite	Secondary Care Consultant
Zara Jones	Executive Director of Commissioning Operations
Helen Henderson-Spoors	Health Watch Derbyshire County Representative

Table 33 – Members of the CCG's Quality and Performance Committee in 2020/21

Significant items that were discussed and approved during 2020/21 are detailed in Table 34.

Significant items approved/discussed by Quality and Performance Committee 2020/21	
Care Homes	Patient Experience Plans
Clinical Quality Reference Group	Patient Safety
Commissioning for Individuals Panel	Prioritisation of Services/Winter, Demand and Capacity
Continuing Healthcare	Quality & Performance Committee Annual Report 2019/20
Covid-19 Pandemic Response and Assurance	Quality Accounts
East Midlands Ambulance Service NHS Trust	Restoration and Recovery
Echo Wait Lists	Risk Management
Governing Body Assurance Framework	Risk Stratification
Independent Review Panel	Safeguarding Adults
Infection, Prevention and Control	Safeguarding Children
Integrated Report	Special Educational Needs and Disability
Integrating First Level Mental Health Into GP Practices	Statistical Process Control
Learning Disabilities Annual Report	Syringe Driver Project
Learning Disabilities Mortality Review	System Quality & Performance
Maternity	Transforming Care Partnership – Recovery Action Plan
National Guidance	Winter Plan 2020/21

Table 34 – Significant items approved/discussed by Quality and Performance Committee in 2020/21

The Committee met a total of 10 times during 2020/21. The quorum necessary for the transaction of business is five members, to include two clinicians, two Lay Members and one Executive Lead. All meetings in 2020/21 were quorate.

UK Corporate Governance Code

NHS bodies are not required to comply with the UK Corporate Governance Code. However, we have reported on our Corporate Governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG.

The Governance Statement is intended to demonstrate how the CCG has regard to the principles set out in the Code considered appropriate for CCG's for the financial year ended the 31st March 2021.

For the financial year ended the 31st March 2021, and up to the date of signing this statement, the CCG had regard to the provisions set out in the Code. All aspects that NHS Derby and Derbyshire CCG must reference within this statement are fully compliant.

Discharge of Statutory Functions

In light of recommendations of the 2013 Harris Review, the CCG has reviewed all of the statutory duties and powers conferred on it by the National Health Service Act 2006 (as amended) and other associated legislative and regulations. As a result, I can confirm that the CCG is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.

Responsibility for each duty and power has been clearly allocated to a lead Executive Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the CCG's statutory duties.

Risk Management Arrangements and Effectiveness

The CCG's integrated risk management system continued to be developed during the year in line with internal audit recommendations.

The CCG has a responsibility to ensure that the organisation is properly governed in accordance with best practice corporate, clinical and financial governance. Every activity that the CCG undertakes or commissions others to undertake on its behalf, brings with it some element of risk that has the potential to threaten or prevent the organisation achieving its objectives.

This integrated risk management system includes a risk management framework (strategy and procedural documents), Governing Body Assurance Framework, and the Corporate Risk Register. It enables the organisation to have a clear view of the risks and issues affecting each area of its activity; how those risks are being mitigated, the likelihood of occurrence and their potential impact on the successful achievement of the CCG objectives. This system has been developed further during the year to include a System Escalation Call Risk Register, a Covid-19 Risk Register and a Vaccination Operation Centre Risk Log.

The strategy applies to all employees of the CCG, the Governing Body, Executive Team and all senior managers to ensure that risk management is a fundamental part of the CCG's approach to the governance of the organisation and all its activities.

The organisation's strategic aims and objectives have been reviewed by the Governing Body during the year together with the strategic risks to integrate the impact of Covid-19.

The Risk Management Strategy was reviewed and approved by the Governance Committee in November 2020. It details the CCG's statement of intent in relation to risk management:

'Risk Management is not just the responsibility of one role or person within an organisation; it's everyone's responsibility'

Risk management is embedded in the activities of the organisation. Through its Corporate Committees and line management structures, the CCG is able to ensure accountability for risk at all levels of the organisation.

The CCG identifies, assesses, manages and governs risk in line with widely available standards and guidance, and specifically in line with ISO 31000:2009. In summary, the risk management system sets out:

- the context within which risk is to be managed is properly identified and understood. In this instance, the context is the entire range of activities carried out within the CCG, including all activities associated with commissioning patient care and treatment;
- how risks are identified;
- how risks are assessed in terms of their likelihood, or probability, and potential consequences or severity of impact, should they materialise;
- a clear and shared understanding of the CCG's 'appetite' for risk enables agreement on which risks can be accepted (tolerated) and which require management through action plans, so that they are either eliminated, transferred or properly controlled;
- assurance that there is proper communication and consultation with relevant stakeholders about all aspects of risk management; and
- that all aspects of the risk management system are regularly monitored and reviewed to ensure the system is working effectively.

Stakeholder involvement in managing risks

The Governing Body membership has always been made inclusive to ensure diverse public stakeholders and other stakeholders' voices help inform CCG decision-making and can assist in highlighting risks at Governing Body level. The Governing Body has a strong lay membership for Audit, Finance and Governance, and Public and Patient Engagement; other Governing Body members include our GP members, Executive Directors, Secondary Care and Public Health representation.

The CCG is passionate about involving people wherever opportunities to do things differently present themselves and we continue to collate a wealth of patient experience and feedback. In September 2020, we extended the opportunities for involvement further and launched the 'Derbyshire Dialogue', which was a virtual opportunity for anyone with an interest in health and care to join these sessions covering a range of health and care services. Membership included individuals from the public, Patient Participation Groups, Citizens Panel, and hospital employees. Governing Body colleagues share the passion with colleagues across the CCG to involve our public and patients at every opportunity and we were well represented at these sessions.

Stakeholder Forums continued to take place virtually throughout the year with the population and community groups. These provide the opportunity to engage with the public and highlight areas of risks.

Prevention and deterrence of risk

The CCG has strong processes in place to assist in the identification and mitigation of risks arising. All reports to the Governing Body and Corporate Committees have mandatory sections on the assessment of quality and equality impact, privacy impact and risk assessment. The Governing Body continually keeps up to date on matters of strategic risk and controls related to challenges within the local health economy and changes to national policy.

The CCG has a mature serious incident reporting system that is reviewed regularly. Staff are trained in carrying out systematic root cause analysis investigations in line with the National Patient Safety Agency guidance. Any serious incidents which have occurred are reported to NHSE&I and other appropriate bodies. Serious incidents are also reported through the Strategic Executive Information System. Any breaches of Information Governance which meet the level two criteria of the Information Commissioners Office (ICO) will be reported using the DPST to the ICO as appropriate. 360 Assurance (Internal Audit) provide specialist advice with regard to Counter Fraud.

The CCG continues to work closely with the Local Authorities, Local Health Resilience Partnership and other partnership groups, and it has an established relationship with NHSE&I in respect of Emergency Preparedness, Resilience and Response.

Each year the CCG is required to complete an annual self-assessment against the EPRR National Core Standards and submit to NHSE&I. In 2019/20 the CCG submitted a 'Full Compliance' self-assessment; however due to all NHS organisations responding to the Covid-19 pandemic and invoking their emergency response plans, the process for 2020/21 was modified. Rather than self-assess against the standards, organisations were required by NHSE&I to follow a revised process. The amended 2020/21 process focused on three main areas:

- progress made by organisations that were reporting as partially or non-compliant in the 2019/20 process;
- the process of capturing and embedding the learning from the Covid-19 pandemic; and
- progress and learning in winter planning preparation.

The CCG submitted a letter of assurance on the above process to NHSE&I on behalf of the CCG and Derbyshire providers.

Capacity to Handle Risk

The Governing Body has a duty to assure itself that the organisation has properly identified the risks it faces, processes and controls in place to mitigate those risks and the impact they have on the organisation and its stakeholders.

The accountabilities, roles and responsibilities for Risk Management are detailed within the CCG's Risk Management Framework, as follows:

Governing Body	Oversight and holding CCG management to account
Finance Committee	Development and implementation of risk management processes
Audit Committee	Reviewing the effectiveness of the GBAF and risk management systems
Governance Committee	Ensuring that the CCG complies with the principles of good governance whilst effectively delivering the statutory functions of the CCG
Accountable Officer	Ensuring the CCG has an effective risk management system in place for meeting all statutory requirements
Executive Team	Supporting the Accountable Officer and collectively and individually managing risk
Executive Director of Corporate Strategy and Delivery	Ensuring the delivery of risk management
Risk Group	Reviewing, monitoring and managing the risks on the CCG's Risk Register, and ensuring the risk management process is firmly embedded within the organisation. The group supports the Committees' understanding and parity in relation to risk, enabling them to provide assurance to Governing Body
Head of Governance	Development, implementation and maintenance of the risk management arrangements for the CCG
All Staff	Identifying, reporting and managing risks within their areas

The Governing Body Assurance Framework (GBAF) was presented quarterly to the Governing Body and the Audit Committee during 2020/21 for scrutiny and assurance. The Governing Body approved the 2020/21 opening GBAF on the 6th August 2020.

Risks to the CCG are reported, discussed and challenged at the monthly Governing Body and Corporate Committee meetings. Communication is two-way, with the Committees escalating concerns to the Governing Body and the Governing Body delegating actions to the responsible Committee where appropriate. Monthly Risk Reports are also scrutinised by the Governing Body and each Corporate Committee.

As Accountable Officer, I have ultimate responsibility for risk management within the CCG. Day to day responsibility for risk management is delegated to the Executives of the Governing Body with executive leadership being vested in the Chief Finance Officer and Executive Director of Corporate Strategy and Delivery.

In conjunction with these structures, all appropriate staff are provided with training in the principles of risk management and assessment in order for them to manage and treat appropriate levels of risk within their designated authority and day to day duties. Detailed procedures and guidelines are set out in the CCG's Risk Management Strategy and supporting Risk Management Framework which provides executives, managers and staff with the appropriate tools to identify, score and treat risk properly.

The Governing Body and Audit Committee fully support the Risk Management Framework within the CCG. There has been continuous improvement and refinement throughout the year, taking into account comments from members, resulting in processes and documents which are easy to read and readily accessible.

The CCG's Executive Director of Corporate Strategy and Delivery coordinates the risk management processes and systems of internal control, ensuring that all staff and committee members are fully aware of their responsibilities within the Risk Management Framework of the CCG.

Risk Assessment

Risk identification, assessment and monitoring is a continuous structured process in ensuring that the CCG works within the legal and regulatory framework, identifying and assessing possible risks facing the organisation, and planning to prevent and respond to these.

Risk management is embedded in the activity of the organisation through the above measures and also through assessments of specific risks e.g. information governance, equality impact assessment and business continuity. Control measures are in place to ensure that the CCG's obligations under equality, diversity and human rights legislation are complied with. The CCG operates a standard 5x5 matrix for assessing risk.

This financial year has been challenging in a number of areas for the CCG, particularly in relation to the Covid-19 pandemic, in turn this has had a major impact on the risk profile of the CCG.

Together with the CCG's operational risk register, a specific CCG Covid-19 Risk Register was compiled in early April 2020. In September, the Covid-19 Risk Register was amalgamated with the Operational Risk Register and reviewed, updated and reported to the Corporate Committees and Governing Body on a monthly basis.

Significant risks identified during 2020/21

In context, the most significant risks we faced during 2020/21 were:

- failure to meet the CCG's Constitutional standards and quality statutory duties in regard to Accident and Emergency;
- Transforming Care Plans are unable to maintain and sustain the performance, pace and change required to meet national Transforming Care Plan requirements;
- failure of GP Practices across Derbyshire results in failure to deliver quality Primary Care services, resulting in negative impact on patient care;
- patients deferring seeking medical advice for non-Covid-19 issues due to the belief that Covid-19 takes precedence. This may impact on health issues outside of Covid-19, long term conditions, cancer patients etc.;
- patients diagnosed with Covid-19 could suffer a deterioration of existing health conditions which could have repercussions on medium and long term health;

- 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; and
- an 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-19 lockdown. The adult safeguarding processes and policy are able to respond to this type of enquiry once an adult at risk has been identified. Numbers are difficult to predict but are expected to increase as Covid-19 restrictions ease.

Other Anticipated risks for 2021/22

- Failure to meet statutory financial duties in 2021/22
- There is a risk that the CCG does not have in place adequate arrangements to achieve financial sustainability in the medium term; due to the current underlying deficit at both the CCG and Integrated Care System (ICS) level
- Impact of Covid-19
- European Union Exit Transition

Sources of Assurance

Internal Control Framework

A system of internal control is the set of processes and procedures the CCG has in place to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise risks, evaluate the likelihood of those risks being realised and the impact should they be realised, and enables them to be managed efficiently, effectively and economically. The system of internal control also allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.

As Accountable Officer, I am responsible for the system of Internal Control within the CCG. Responsibility for specific elements of the Internal Control framework is delegated to individual members of the senior management team, who will establish the controls relevant to the key business functions, in line with the risks implicit in those functions. I receive assurance on the adequacy of those controls both in their design and their performance from the CCG's Internal and External Auditors. The Audit Committee is charged with receiving reports on the operation of key controls and ensuring that risks identified are appropriately mitigated and that actions are completed.

The CCG fulfils its duties in relation to the Equality Act 2010 and the Public Sector Equality Duty contained within that Act, through a robust equality analysis of all policies, procedures and decisions. This ensures that due regard is given to Equality, Inclusion and Human Rights with the aim of eliminating discrimination; harassment; victimisation; to advance equality of opportunity; and foster good relations. The CCG adopts the Derbyshire-wide Quality Schedule, which includes explicit reference to compliance with the Public Sector Equality Duty, enabling a robust and auditable process going forward. The process for EIAs and quality impact assessments has been strengthened and a robust system has been developed to support the Programme Management Office in the production of Project Initiation Documents which are thoroughly scrutinised by the Executive Team, Finance Committee and the Clinical and Lay Commissioning Committee.

The CCG is committed to maximising public involvement through the use of the Patient Reference Groups, Stakeholder Groups and Public Events. The CCG is committed to ensuring that patients and the public are fully involved at all levels of the CCG's activity and have a meaningful impact on commissioning decisions, as required by the public involvement duty in Section 14Z2 of the NHS Act 2006 (as amended).

The CCG engages the services of Counter Fraud Specialists via 360 Assurance and uses their input to ensure that appropriate policies and procedures are in place to mitigate the risks posed by Fraud, Bribery and Corruption. The CCG has also engaged a Local Security Management Specialist via 360 Assurance, to provide appropriate advice and support.

Annual Audit of Conflicts of Interest Management

The CCG is responsible for the stewardship of significant public resources when making decisions about the commissioning of health and social care services. In order to ensure and be able to evidence that these decisions secure the best possible services for the population it serves, the CCG must demonstrate accountability to relevant stakeholders (particularly the public), probity and transparency in the decision-making process.

A key element of this assurance involves the management of conflicts of interest with respect to any decisions made. Although such conflicts of interest are inevitable, having processes to appropriately identify and manage them is essential to maintain the integrity of the NHS commissioning system and protect the CCG, its Governing Body, its employees and associated GP Practices from allegations and perceptions of wrong-doing. A conflicts of interest report is presented at each Audit Committee meeting.

To further strengthen the scrutiny and transparency of the decision-making processes, the Lay Member for Audit is the CCG's Conflicts of Interest Guardian. The Conflicts of Interest Guardian provides support and advice to CCG employees, GP Practice staff, members of the public and healthcare professionals who have any concerns regarding conflicts of interest.

The CCG has managed its conflicts of interest by requesting declarations from all Governing Body and Committee members, decision makers and GP Practice staff with CCG involvement; all of which can be found at https://www.derbyandderbyshireccg.nhs.uk/about-us/conflict-of-interest/

The CCG also requests declarations from all staff and sub-committee members. These declarations are provided at CCG meetings in the form of a register to enable the decision-making processes to be transparent and managed effectively. Conflicts can also arise in the form of Gifts and Hospitality, and within the commissioning cycle from contracts and procurements. CCG employees are all requested to declare these when they arise and details of those declared within 2020/21 can also be found at the web link above.

The revised statutory guidance on managing conflicts of interest for CCG's (published June 2017) requires CCGs to undertake an annual internal audit of conflicts of interest management. To support CCGs to undertake this task, NHSE published a template audit framework. 360 Assurance carried out an audit of the CCG's management of conflicts of interest in September 2020. The objective of the audit was to evaluate the design of the arrangements that the CCG has in place to manage conflicts of interest and gifts and hospitality, and to ensure this complies with NHSE's guidance on managing conflicts of interest. The assurance opinion for this audit was 'significant assurance'.

During 2020/21, the CCG was required to produce a quarterly return to NHSE. This is approved by the Accountable Officer and Conflicts of Interest Guardian, and includes a self-assessment on the management of Declarations of Interests, Gifts and Hospitality, Procurement and Breaches.

All CCG staff were required to complete Managing Conflicts of Interest training in 2020/21, which is made up of three modules. By the 31st March 2021, 93% of staff had completed module one. This training is mandated and constructed by NHSE and NHS Clinical Commissioners.

Freedom to Speak Up Guardian

The CCG has a Raising Concerns at Work (Whistleblowing) Policy which supports employees in reporting genuine concerns about wrongdoing at work without any risk to themselves. The Freedom to Speak Up Guardian supports employees to speak up when they feel that they are unable to do so by any other means. The CCG's Lay Member for Governance is our Freedom to Speak Up Guardian, and they act as an independent and impartial source of advice to staff at any stage of raising a concern. The Raising Concerns at Work (Whistleblowing) Policy is the responsibility of the Governance Committee, and a Freedom to Speak Up Guardian report is presented at each Audit Committee meeting to update it of any concerns that have been raised. During 2020/21 the CCG has had no concerns raised through the whistleblowing process.

The CCG's whistleblowing arrangements act as a deterrent to unacceptable behaviour by encouraging openness and promoting transparency. It underpins the risk management systems and helps to protect the reputation of the CCG and senior management.

Data Quality

Data quality is crucial and the availability of complete, relevant, accurate and accessible and timely data is important in supporting patient care, clinical governance, management and service agreements for healthcare planning and accountability. We have a Data Quality Policy in place which sits alongside the regular monitoring of data standards which are a requirement of the NHS Data Security and Protection Toolkit (DSPT).

To provide the management of information necessary to manage commissioned activities, we commission our Business Intelligence Information Services from the NECS. CCG leads have worked with the team at NECS to develop the reports provided to the CCG to ensure that the information provided is fit for purpose. This has involved the delivery of a monthly Performance Report to the Governing Body, Finance Committee, and Quality and Performance Committee.

Information Governance

Compliance with Information Governance for NHS organisations is assured by annual completion of the DSPT, based on the 10 National Data Guardian Standards, which can be viewed here[12].

All organisations who handle confidential patient data are required to complete the DSPT, and are required to affirm that the standards are met. The privacy notice of the CCG can be found at https://www.derbyandderbyshireccg.nhs.uk/privacy/.

Information Governance policies were reviewed in-year and are supported by effective policy communication and implementation. Organisational oversight of delivery is provided through the Information Governance Assurance Forum. This forum is chaired by the Senior Information Risk Owner (SIRO), and attended by the Caldicott Guardian and Data Protection Officer; reporting to the Governance Committee as part of the overall CCG Governance structure. Included in the forum's annual forward plan are reviews of DSPT compliance activities and policies, access to information, cyber security updates, Information Governance incidents, training and staff communications. The forum met seven times during 2020/21. From the Information Governance Assurance Forum's minutes and papers, there is evidence of challenge, appropriate reporting and action being taken where required.

Information Asset Owners have reviewed all information flows in-year, and the CCG have in place a separate Covid-19 response flow mapping.

The CCG Caldicott Guardian, SIRO and Data Protection Officer receive professional support from the Information Governance Manager, with monthly assurance provided regarding Data Protection Impact Assessment processes, incident reporting and trends, information sharing agreements and managed Information Governance issues.

The CCG has had a single data security breach during 2020/21 which has been reported to the Information Commissioner's Office (ICO). Further work is ongoing with the ICO and is expected to conclude prior to the submission of the DSPT. The annual DSPT audit was undertaken by 360

[12] https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance

Assurance and the CCG received a ‘substantial assurance’ opinion. The CCG will submit a ‘standards met’ DSPT submission for 2020/21.

Business Critical Models

An appropriate framework and environment is in place to provide quality assurance of business critical models, in line with the recommendations in the MacPherson report.

Third party assurances

Table 35 shows the range of services which are provided by third party providers.

Service	Provider	Assurances
Prescribing Payment Processing	NHS Shared Business Services	Service Auditor Report
Dental Payment Processing	NHS Shared Business Services	Service Auditor Report
Finance and Accounting Services	NHS Shared Business Services	Service Auditor Report
HR and Payroll Management	Electronic Staff Record	Service Auditor Report
GP Payment Services	NHS Digital	Service Auditor Report
Primary Care Support	Capita	Service Auditor Report
Internal Audit	360 Assurance	Head of Internal Audit Opinion
External Audit	KPMG	Annual Audit Letter

Table 35 – services provided to the CCG by third party providers

The CCG keeps all contracts under review in order to ensure efficiency and value for money.

Control Issues

In the Month 9 Governance Statement return the following control issues were identified:

Quality and Performance - Mental Health and Dementia

Severe Mental Health and Physical Health

The JUCD STP saw a reduction of people being seen by GPs in Q1 and Q2, due to the Covid-19 pandemic. The plans to develop a patient-facing wraparound service to complement the Local Enhanced Service (LES) were paused due to Covid-19. A LES is in place for Primary Care. The STP is co-producing a patient-facing flyer to promote the checks and local support available. Supporting mental health and learning disabilities into vaccinations may become a significant issue.

Children and Young People

The JUCD STP has historically been below target however has seen month on month improvements. As of September 2020 data, the STP was at 35.1% (against a target of 35%). The STP has invested £330k in 2020/21 in the Voluntary, Community and Social Enterprise to

improve access. The Trauma Informed Service for Looked After Children commenced in September and the Community Triage Function commenced in October.

Perinatal Access

Derby and Derbyshire have historically been below target, and performance has been deteriorating since April 2020, largely impacted by the pandemic. Remote access software allowed delivery to continue, whilst face-to-face access was restricted. Financial investment was planned for 2020/21 in line with the Long Term Plan (LTP) submission and assumed no real term growth from the 2019/20 outturn. The STP has confirmed that future growth in the service is planned for later years in the Long Term Plan with a commitment to hit the access target in 2021/22.

Out of Area Placements/Psychiatric Intensive Care Units

The system does not have any Psychiatric Intensive Care Units (PICU) beds in the Derbyshire area and we have seen increasing demand in PICU associated with lockdown. PICU pressure has reduced from May 2020's high point. A comprehensive plan, which includes alternatives to ED, has been in place for winter, with extra support measures at pre-admission. A procurement process for additional PICU capacity commenced in February 2021. Continuity of Care Principles (COCP) are currently difficult to achieve; however with additional acute beds and new PICU capacity this will ensure they are achieved.

Quality and Performance – Accident and Emergency

University Hospitals of Derby and Burton NHS Foundation Trust

The ED at the Royal Derby Hospital site has failed to deliver against the 4 hour national standard for 66 consecutive months; with current type 1 performance showing an improvement for March 2021 at 82.3%, as opposed to 78.4% in March 2020. The ED site/network performance for March 2021 (including at Derby Urgent Care Centre) was 69.3%, compared to 62.0% in March 2020, so this shows a further improvement.

Although the volume of patients had been lower through the pandemic, the numbers and acuity of patients remained high and returned to previous levels. To ensure infection control, the physical configuration was modified within ED. Assessment areas were separated into red/green areas according to Covid-19 symptoms. A major capital programme expanded physical ED capacity into an adjoining area to provide more physical capacity and to improve patient flow whilst ensuring infection control. The use of Ready Rooms, to create Covid-19-safe treatment areas and utilise the space more effectively, has improved patient flow. The NHS111First project has also been implemented, whereby patients only access ED via 999 calls or booked appointments, with the aim to reduce unnecessary attendances and improve capacity management for those who do attend.

<u>12 hour Trolley Breaches</u>

From the 1st April 2020 to the 31st March 2021 there were 35, 12 hour trolley breaches at UHDBFT. Of these, 29 were due to limited availability of medical beds, mainly in the assessment units which were divided into red/green areas according to Covid-19 symptoms. The remaining seven were attributable to unavailability of a mental health bed.

Chesterfield Royal Hospital NHS Foundation Trust

CRHFT achieved the 4-hour national standard in March 2021, with the type 1 performance reaching 97.6%. The standard was achieved in May and July 2020, but dipped below for other months. However, this was still a significant improvement from the performance of 85.9% in March 2020. The physical configuration therefore changed, with ED and Assessment areas separated into the red/green areas according to Covid-19 symptoms. The trust has also established a Surgical Assessment Unit and increased GP Streaming at the front door. Furthermore, as above, the NHS111First project has been implemented.

12 hour Trolley Breaches

From the 1st April 2020 to the 31st March 2021 there were no 12 hour breaches at CRHFT.

Diagnostics

Derbyshire failed to deliver against the national 1.0% standard in March 2021, as performance was at 25.4%. Although performance fluctuated towards the end of the year, the final months of 2020/21 demonstrated an improvement in performance, which is expected to continue into 2021/22.

Covid-19 has severely affected performance for all diagnostic tests, particularly due to the reduced capacity to deliver the same number of tests per session due to social distancing rules. UHDBFT and CRHFT both failed this standard during the year but the situation has improved. Other trusts treating Derbyshire patients are also failing this standard due to the impact of Covid-19.

Cancer

In line with the national picture, cancer 2WW demand reduced during the spring and early summer of 2020 due to the reluctance of some patients in visiting their GP due to the Covid-19 pandemic. Referral rates improved during the summer/early autumn, however demand slightly reduced again in November, although not to the same level as the spring of 2020. 2WW referrals during March 2021 have returned to near pre-Covid-19 levels.

CRHFT was meeting its targets for the number of patients seen from a 2WW referral, as directed in the Phase 3 Recovery Plan. Seven of the nine standards were non-compliant at a Derbyshire level in March 2021; however the 31-day subsequent drug and radiotherapy treatments were achieving.

Focus has also been placed on reducing the number of patients who have been waiting longer than 62 days for their treatment, and reducing the backlog at both CRHFT and UHDBFT. The data from March 2021 showed a reduction in numbers.

62 day Standard

The CCG has failed this standard for 25 consecutive months with 71.6% performance as at the 31st March 2021. This standard was not achieved, although both trusts are making improvements in their performance and activity for the number of patients during March increased for both trusts.

Both trusts are utilising independent sector support to deliver cancer (and elective procedures) where possible. Chemotherapy and radiotherapy have been less affected by the Covid-19 pandemic and have continued to undertake treatments throughout.

18 Week Referral to Treatment

18 week Referral to Treatment for incomplete pathways continues to be non-compliant at 60.3% for Derbyshire in March 2021. The performance worsened due to the Covid-19 pandemic, and all non-urgent elective surgery was cancelled in March, at the directive of NHSE. All patients were prioritised into four categories to highlight the urgency of whether the treatment would need surgery. Priority 1 was the most urgent (within 72 hours), which related to mostly cancer patients. This helped to identify those patients who could wait over 12 weeks for their surgery and had a detrimental effect on the number of patients who were waiting over 52 weeks, as highlighted below.

During the summer, GP referrals reduced due to the pandemic, particularly routine referrals, by as much as 78% in May. Although referrals increased, they were still below the number of referrals in the corresponding months during 2019. There is concern that once the pandemic has stabilised referrals will increase again and will be above previous levels.

52+ week waits

At the end of March 2021 there were 8,261 CCG patients who had been waiting over 52 weeks for treatment, with around 40% of these patients awaiting treatment by Trauma and Orthopaedics. This number decreased slightly over the last few weeks of 2020/21, but is expected to increase again and reflects the increase in referrals during last summer.

Learning Disabilities Transforming Care

The CCG is currently in regional escalation with NHSE&I due to the CCG bed position being over trajectory. On CCG funded beds, the actual is 29 against a target of 17. Adult Specialised Commissioning beds actual is 16 against a target of 14, and Children and Young People Specialised Commissioning beds are on target with an actual of seven against a target of seven.

The Covid-19 pandemic has had a huge impact on patients being discharged during 2020/21, and there was an increase in admissions to mental health acute beds specifically in relation to autism. The Learning Disability and Autism Delivery Group monitor implementation of the improvement plan and weekly reconciliation meetings with DHcFT are in place to ensure that admissions are appropriate with regards to confirmed diagnosis. Monthly NHSE&I regional escalation assurance meetings are also in place.

East Midlands Ambulance Service NHS Trust 2020/21

EMAS achieved all six national standards in Q1 2020/21. Performance deteriorated in Q2 and Q3, with EMAS achieving only one of the six national performance standards (C1 90th) during both of these quarters. There was a slight improvement in Q4, when EMAS achieved two of the six national performance standards (C1 90th and C4 90th).

During 2020/21, EMAS reduced the number of patients who were conveyed to an ED and work continues in each system to maintain this improvement, with a focus on access to alternative pathways and clinical advice. EMAS has introduced the advanced practitioner paramedic role which will further support the management of patients close to home and reduce avoidable

conveyance. Work continues to take place to support a reduction in handover delays with additional support from the Regional Urgent Care Team, though the position is an improvement on the levels experienced in 2019/20.

Data Breach reported to Information Commissioners Office

We reported to the ICO a possible data breach, related to the failure to remove access to systems following termination of employment. The investigation has now concluded and audit logs have shown that no access to data was undertaken. A report describing the investigation process and lessons learnt was received at the confidential Governance Committee on the 21st January 2021. This report will be provided to the ICO for review subsequent to this, and a closure report was presented to Audit Committee during May 2021. All closure documents have been provided to the ICO.

Review of economy, efficiency and effectiveness of the use of resources

The CCG is charged with ensuring that it achieves economy, efficiency and effectiveness in its use of resources.

The review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive directors and clinical leads within the CCG who have responsibility for the development and maintenance of the internal control framework. The recommendations from external auditors in their annual audit letter and other reports are also taken into consideration. Our external auditors raised a recommendation in their 2019/20 annual audit letter that upon the resumption of business as usual following the Covid-19 pandemic, the CCG should engage with system partners to develop arrangements to enable achievement of system-wide savings. This will be a priority for the CCG in 2021/22.

The CCG prepares an annual Finance Plan that sets out the financial resources available to the organisation and the means by which these will be used to deliver the CCG's objectives. Monthly financial performance is scrutinised by the Finance Committee and reported to the Governing Body. Internal and External Audit arrangements give assurance to the Governing Body on the delivery of the CCG's statutory financial responsibilities and the achievement of value for money. The CCG complies with the NHS Pension Scheme regulations. Through our Internal Auditors, the CCG's performance is benchmarked against similar organisations. It uses expert commissioning support to ensure the delivery of best value through procurement. It develops efficiency schemes that enable it to use its resources effectively and efficiently through improving patient pathways which make best use of available healthcare resources and reduce the use of expensive acute care where more convenient and better value local alternatives are available. In exceptional cases there may be instances where information is not reported as it is not accurate or reliable.

The CCG regularly reviews performance across its GP Practices, facilitates the comparison of relative performance in the use of resources as well as in health outcomes, and provides opportunities for GP Practices to share best practice and develop initiatives for wider roll-out. Performance reports are reviewed at the Governing Body, Quality and Performance Committee and Finance Committee.

The CCG also has a running cost allowance (typically 1% of total resource) within which it must operate, ensuring that as much resource as possible is concentrated on the commissioning and delivery of services to patients. In achieving this, the CCG uses commissioning support services to deliver economies of scale in the provision of some back-office and similar services.

Table 36 shows the CCG's running costs for the last two financial years and the plan for 2021/22.

	Allocation	Expenditure
	£'000	£'000
2019/20	23,431	17,864
2020/21	18,986	18,210
2021/22	19,824	19,824

Table 36 – CCG's running costs for 2019/20, 2020/21 and plan for 2021/22

Table 37 identifies how the CCG's running costs were used in 2020/21.

Breakdown of 2020/21 expenditure	
Expenditure	**£'000**
Pay costs	12,967
Travel expenses	-5
Premises costs	1,184
Charges from Commissioning Support Unit	1,266
Other non-pay costs	2,882
Commissioning income	-483

Table 37 – Breakdown of 2020/21 expenditure

The CCG's staff have worked from home during the 2020/21 financial year, which has resulted in minimal travel expenditure. This offset with an estimate of outstanding claims from 2019/20 has resulted in a negative expenditure result.

NHSE&I has a statutory duty to undertake an annual assessment of all CCGs. The CCG received a rating of 'good' for its 2019/20 annual assessment. The link to the NHSE publication is available here https://www.england.nhs.uk/publication/ccg-annual-assessment-2019-20/.

Delegation of Functions

The CCG keeps its governance structures under constant review with the aim of delegating decision-making responsibility where this enables the Governing Body to devote more time to strategy and optimises the use of clinical leadership. All such arrangements are set out in the CCG's Scheme of Delegation.

The CCG has two external delegation chains:

- delegated responsibility for Primary Medical Care from NHSE&I – this responsibility is led by the Primary Care Commissioning Committee under specific Terms of Reference common to all CCGs who have taken full delegated powers; and
- the Derbyshire Better Care Fund under the authority of the Health and Wellbeing Board.

Counter Fraud Arrangements

The CCG's Chief Executive Officer and Chief Finance Officer are jointly responsible for ensuring adherence to the NHS Protect Anti-Crime Strategy for countering fraud, bribery and corruption and the application of the related NHS Protect Standards for Commissioners. The Chief Finance Officer is also responsible for the completion of a Self-Assessment Review Toolkit in relation to these Standards which is submitted annually to NHS Protect.

In 2020/21 the CCG's Fraud, Corruption and Bribery Policy was reviewed by the CCG's Accredited Counter Fraud Specialist and made available to all staff. Counter fraud awareness has also taken place and regular updates including distribution of the publication 'Fraudulent Times' are made available. The Accredited Counter Fraud Specialist attends meetings of the Audit Committee and provides comprehensive updates on progress towards completion of the Annual Work Plan and compliance with the Standards for Commissioners.

During the year, the CCG has been acutely aware of increases in attempted fraud due to the pandemic; the Finance Committee identified a risk *'there is an ever present risk of fraud and cybercrime; the likelihood of which may increase during the COVID emergency response period'*. The risk is managed through the risk management processes monthly and is reported to the Governing Body, Finance Committee and Audit Committee.

Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the CCG, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's system of risk management, governance and internal control. The Head of Internal Audit concluded that:

> I am providing an opinion of **Significant Assurance** that there is a generally sound framework of governance, risk management and control designed to meet the CCG's objectives, and that controls are generally being applied consistently.

During the year, Internal Audit, 360 Assurance completed the following audit assignments, as detailed below in Table 38.

Audit Assignment	Assurance Level/Comments
Governance Arrangement for Covid-19	N/A, though 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[13]
Data Security and Protection Toolkit	Substantial

Table 38 – Internal Audit reports issued in 2020/21 by 360 Assurance

[13] Some follow-up work was undertaken in April 2021 to assess progress in implementing recommendations made in the Policy Management Framework report although due to the CCG's on-going response to the Covid-19 pandemic actual implementation target dates have been set as the end of June 2021. The follow-up work confirmed that of the 6 recommendations originally made, 5 had been fully implemented by the 31st of March 2021.

Review of the effectiveness of governance, risk management and internal control

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, executive managers and clinical leads within the CCG who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their annual audit letter and other reports.

Our assurance framework provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principles objectives has been reviewed.

I have been advised on the implications of the result of this review by the Governing Body, Audit Committee, Primary Care Commissioning Committee, Remuneration Committee, Finance Committee, Clinical and Lay Commissioning Committee, Governance Committee, Quality and Performance Committee and Engagement Committee; and have addressed any weaknesses during the year and ensure continuous improvement of the system is in place.

The effectiveness of the governance, risk management and internal control is reviewed by the Audit Committee which scrutinises and challenges the reports provided by the CCG. In addition, the reports in relation to the programme of work in the Internal Audit Plan are presented to the Audit Committee. A log of recommendations and electronic 'Pentana Tracker system' from the Internal Audit Reports is maintained and reported to each Audit Committee meeting.

My review is also informed via assurances provided by:

- Governing Body;
- Audit Committee;
- NHSE&I – NHS Oversight Framework and My NHS;
- 360 Assurance – Internal Audit reviews and Head of Internal Audit Opinion;
- KPMG – External Audit;
- NECS – via monthly contract monitoring meetings;
- Committees of the Governing Body; and
- the Executive Team.

Conclusion

No significant internal control weaknesses have been identified during the year. The CCG has received positive feedback from Internal Audit on the assurance framework and this, in conjunction with other sources of assurance, leads the CCG to conclude that it has a robust system of control.

Remuneration and Staff Report

Remuneration Report

Remuneration Committee

The CCG has an established Remuneration Committee. The committee makes recommendations on determinations about the remuneration, fees and other allowances for employees and for people/organisations providing services to the CCG. The Committee is chaired by a Lay Member. The composition of the Remuneration Committee is shown in Table 23 on page 92.

Policy on the remuneration of senior managers

For the purpose of this section the phrase 'senior managers' include all those individuals who have an influence in the decisions of the CCG, as listed in the remuneration tables later in this report. The Remuneration Committee is responsible for determining the remuneration of all individuals who are non-employees and engaged under the Contracts for Services. Remuneration for these positions is informed by local and national pay benchmarking. Their remuneration is reviewed periodically to ensure that it keeps pace with increasing demands on the time of the individuals in those positions. In order to avoid any conflict of interest, in respect of Lay Members who constitute the majority of the membership of the Remuneration Committee, their own remuneration is set directly by the Governing Body. The Lay Members who are conflicted are not part of the decision-making.

Remuneration of Very Senior Managers (subject to audit)

Employment terms for a Very Senior Manager (VSM) or member of the CCG's Executive Team are determined separately and where appropriate the principles of Agenda for Change are applied to these employees to ensure equity across the CCG. There is no national body to determine remuneration for VSM employees; therefore a robust process is in place within the CCG. The Remuneration Committee sets and approves the remuneration for all VSM employees. The Remuneration Committee comprises Lay Members from the Governing Body and their decisions are informed by independent, local and national benchmarking to ensure the best use of public funds and to help with recruitment and retention. Their decisions also take into consideration annual Agenda for Change pay circulars to ensure parity where appropriate.

The Chief Executive Officer and Chief Finance Officer are remunerated in line with the CCG Remuneration Guidance (updated) issued by the NHS Commissioning Board in late 2012 as adjusted to take account of the previous remuneration of the staff members concerned. All VSM salaries are reviewed by the Remuneration Committee and a recommendation is presented to Governing Body for their approval. The VSM pay review process includes a requirement for 100% compliance with mandatory training.

Senior Manager Remuneration (including salary and pension entitlements) (subject to audit)

Tables 39 and 40 show the Senior Manager total salary for 2020/21 and 2019/20.

Salaries and allowances 2020/21

Name	Title	Notes	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
			£000	£	£000	£000	£000	£000
Chris Clayton	Chief Executive Officer		160-165	0	0	0	37.5-40	195-199
Richard Chapman	Chief Finance Officer		135-140	0	0	0	50-52.5	185-190
Brigid Stacey	Chief Nurse Officer		120-125	0	0	0	10-12.5	130-135
Steven Lloyd	Executive Medical Director		110-115	0	0	0	5-7.5	115-120
Sandy Hogg	Executive Turnaround Director	To 31st Jul 2020	55-60	0	0	0	0	55-60
Helen Dillistone	Executive Director of Corporate Strategy and Delivery		115-120	0	0	0	20-22.5	135-140
Zara Jones	Executive Director of Commissioning Operations		115-120	0	0	0	20-22.5	135-140
Avi Bhatia	Clinical Chair		95-100	0	0	0	0	95-100
Penny Blackwell	GP Member		40-45	0	0	0	0	40-45
Ruth Cooper	GP Member		35-40	0	0	0	0	35-40
Bukhtawar Dhadda	GP Member		40-45	0	0	0	0	40-45
Emma Pizzey	GP Member		35-40	0	0	0	0	35-40
Greg Strachan	GP Member		35-40	0	0	0	0	35-40
Merryl Watkins	GP Member		35-40	0	0	0	0	35-40
Jill Dentith	Lay Member for Governance		10-15	0	0	0	0	10-15

Name	Title	Notes	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
			£000	£	£000	£000	£000	£000
Ian Gibbard	Lay Member for Audit		15-20	0	0	0	0	15-20
Andrew Middleton	Lay Member for Finance		10-15	0	0	0	0	10-15
Professor Ian Shaw	Lay Member for Primary Care Commissioning		10-15	0	0	0	0	10-15
Martin Whittle	Lay Member for Patient and Public Involvement and Vice Governing Body Chair		15-20	0	0	0	0	15-20
Bruce Braithwaite	Secondary Care Consultant		5-10	0	0	0	0	5-10
Simon McCandlish	Lay Member for Patient and Public Involvement		10-15	0	0	0	0	10-15
Robyn Dewis	Derby City Council Representative		0	0	0	0	0	0
Dean Wallace	Derbyshire County Council Representative		0	0	0	0	0	0

Table 39 – Senior Manager remuneration for 2020/21

Notes to Salaries and Allowance – 2020/21

1. 'All Pension related benefits' shows the increase in 'lifetime' pension which has arisen in 2020/21. The sum reported reflects the amount by which the annual pension received on retirement age has increased in 2020/21, multiplied by 20 (the average number of years a pension is paid to members of the NHS scheme following retirement), plus the lump sum increase in 2020/21. 'All pension related benefits' exclude employee contributions as directed in the Finance Act 2004.
2. No payments were made to Local Authority Representatives nor were recharges made by their employers.
3. Where a salary amount sits exactly on a pay boundary then the salary is reported at the lower band. For example if an employee had a salary of £50,000 they would be shown in the salary band (£'000) 45-50.
4. Sandy Hogg received £20,000 compensation for loss of office (see note 4.3 of the accounts for further details of the exit packages). These payments were calculated using the NHS redundancy terms and conditions and are included in the salaries reported above. At the point of loss of office, Sandy Hogg took early retirement; there were nil costs to the CCG associated with this.
5. The total remuneration disclosed in the table above for Dr Bukhtawar Dhadda and Dr Penny Blackwell includes clinical advisory services provided to the CCG unrelated to their roles as senior managers.
6. Chris Clayton's salary disclosed in the table above includes remuneration for his role as the Integrated Care System Lead.

Salaries and allowances 2019/20

Name	Title	Notes	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
			£000	£	£000	£000	£000	£000
Chris Clayton	Chief Executive Officer		150-155	0	0	0	30-32.5	180-185
Deborah Hayman	Interim Chief Finance Officer	Left 7th July 2019	45-50	0	0	0	87.5-90	130-135
Richard Chapman	Chief Finance Officer	From 1st July 2019	100-105	0	0	0	77.5-80	180-185
Brigid Stacey	Chief Nurse Officer		120-125	0	0	0	0-2.5	115-120
Steven Lloyd	Executive Medical Director		110-115	0	0	0	122.5-125	235-240
Sandy Hogg	Executive Turnaround Director		110-115	0	0	0	27.5-30	140-145
Helen Dillistone	Executive Director of Corporate Strategy and Delivery		110-115	0	0	0	32.5-35	145-150
Zara Jones	Executive Director of Commissioning Operations		110-115	0	0	0	25-27.5	140-145
Avi Bhatia	Clinical Chair		95-100	0	0	0	0	95-100
Penny Blackwell	GP Member		35-40	0	0	0	0	35-40
Ruth Cooper	GP Member		35-40	0	0	0	0	35-40
Bukhtawar Dhadda	GP Member		35-40	0	0	0	0	35-40
Emma Pizzey	GP Member		35-40	0	0	0	0	35-40
Greg Strachan	GP Member		35-40	0	0	0	0	35-40
Merryl Watkins	GP Member		35-40	0	0	0	0	35-40
Jill Dentith	Lay Member for Governance		10-15	0	0	0	0	10-15
Ian Gibbard	Lay Member for Audit		15-20	0	0	0	0	15-20
Andrew Middleton	Lay Member for Finance		10-15	0	0	0	0	10-15

Name	Title	Notes	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e) (bands of £5,000)
			£000	£	£000	£000	£000	£000
Gillian Orwin	Lay Member for Patient and Public Involvement	Left 31st March 2020	10-15	0	0	0	0	10-15
Professor Ian Shaw	Lay Member for Primary Care Commissioning		10-15	0	0	0	0	10-15
Martin Whittle	Lay Member for Patient and Public Involvement and Vice Governing Body Chair		15-20	0	0	0	0	15-20
Bruce Braithwaite	Secondary Care Consultant		0-5	0	0	0	0	0-5
Cate Edwynn	Derby City Council Representative	To December 2019	0	0	0	0	0	0
Robyn Dewis	Derby City Council Representative	From January 2020	0	0	0	0	0	0
Dean Wallace	Derbyshire County Council Representative		0	0	0	0	0	0

Table 40 – Senior Manager remuneration for 2019/20

Notes to Salaries and Allowance – 2019/20

1. 'All Pension related benefits' shows the increase in 'lifetime' pension which has arisen in 2019/20. The sum reported reflects the amount by which the annual pension received on retirement age has increased in 2019/20, multiplied by 20 (the average number of years a pension is paid to members of the NHS scheme following retirement). 'All pension related benefits' exclude employee contributions as directed in the Finance Act 2004.
2. No payments were made to the Healthwatch or Local Authority Representatives nor were recharges made by their employers.
3. Where a salary amount sits exactly on a pay boundary then the salary is reported at the lower band. For example if an employee had a salary of £50,000 they would be shown in the salary band (£'000) 45-50.
4. Where an employee has been in post for part of the year, their pay and pension amount is time apportioned to reflect time in post. Any start and end dates are shown in the 'Notes' column.

Pension Benefits as at 31st March 2021

Name	Title	Real Increase in Pension at pension age (bands of £2,500)	Real Increase in Pension Lump Sum at pension age (bands of £2,500)	Total Accrued Pension at pension age at 31 March 2020 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2020 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2019	Real Increase/ (Decrease) in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2020	Employers Contribution to Stakeholder Pension
		£000	£000	£000	£000	£000	£000	£000	£000
Chris Clayton	Chief Executive Officer	2.5-5	0	25-30	30-35	342	18	388	0
Richard Chapman	Chief Finance Officer	2.5-5	0-2.5	40-45	90-95	650	39	720	0
Brigid Stacey	Chief Nurse Officer	0-2.5	0	45-50	125-130	888	17	938	0
Steven Lloyd	Executive Medical Director	0-2.5	2.5-5	25-30	80-85	611	23	660	0
Sandy Hogg	Executive Turnaround Director	0	0	5-10	0-5	857	0	103	0
Helen Dillistone	Executive Director of Corporate Strategy and Delivery	0-2.5	0	30-35	55-60	477	14	515	0
Zara Jones	Executive Director of Commissioning Operations	0-2.5	0	25-30	45-50	342	7	371	0

Table 41 – pension benefits as at 31st March 2021

Notes
1. Pensions figures included in the above table are for Senior Managers that have pensions paid directly by the CCG and include all of their NHS Service not just pension payments that relate to 2020/21.
2. At the point of loss of office, Sandy Hogg took early retirement resulting in a large reduction in the cash equivalent transfer value.

Cash equivalent transfer values (subject to audit)

A cash equivalent transfer value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement).

Compensation on early retirement or for loss of office

Sandy Hogg, Turnaround Director received £20,000 compensation for loss of office (see note 4.3 of the accounts for further details of the exit packages). These payments were calculated using the NHS redundancy terms and conditions and are included in Table 39 on pages 119–120. At the point of loss of office, Sandy Hogg took early retirement; there were nil costs to the CCG associated with this.

Payments to past members (subject to audit)

No such payments have been proposed or paid during the year.

Fair Pay Disclosure (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid Director/Member in their organisation and the median remuneration of the organisation's workforce. For the pay multiples disclosure the CCG includes non-executive directors, agency staff and interim staff. This follows the guidance provided in the Hutton report.

The mid-point of the banded remuneration of the highest paid member in the CCG in the financial year 2020/21 was £197,500 (2019/20: £197,500). This was 4.83 times (2019/20: 5.09) the median remuneration of the workforce, which was £40,894 (2019/20: £38,765). There has been no significant change in the ratio over the last 12 months.

The calculation of the median remuneration of the workforce includes the remuneration of members of the Governing Body, but excludes the highest paid Member.

In 2020/21, nil employees received (2019/20: nil) remuneration in excess of the highest paid Member. Remuneration ranged from £17,500 to £197,500 (2019/20: £17,500 to £197,500) on a full-time equivalent basis.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Staff Report

Number of Senior Managers and Staff Composition

Table 42 shows the gender and pay band of VSMs and gender of the other CCG Employees for 2020/21.

	Male	Female	Total
Executive Members (including Functional Directors)	8	12	20
Band 8d	0	1	1
Band 8c	7	16	23
Band 8b	9	33	42
Band 8a	20	60	80
Other banded CCG employees	30	295	325
Total CCG employees	**74**	**417**	**491**
Other non-permanent engagements including non-executive directors and lay members	25	26	51
Total	**99**	**443**	**542**

Table 42 – number of senior managers and staff composition in 2020/21

Staff numbers and costs (subject to audit)

The staff costs for 2020/21 and 2019/20 are shown in Tables 43 and 44.

Employee Benefits 2020/21

Employee Benefits	2020/21		
	Permanent Employees	Other	Total
	£000	£000	**£000**
Salaries and wages	18,050	250	**18,300**
Social security costs	1,880	–	**1,880**
Employer Contributions to NHS Pension scheme	3,363	–	**3,363**
Other pension costs	2	–	**2**
Apprenticeship Levy	76	–	**76**
Other post-employment benefits	–	–	**–**
Other employment benefits	–	–	**–**
Termination benefits	20	–	**20**
Gross employee benefits expenditure	**23,391**	**250**	**23,641**
Less recoveries in respect of employee benefits	(105)	(0)	**(105)**
Total - Net admin employee benefits including capitalised costs	**23,286**	**250**	**23,536**
Less: Employee costs capitalised	–	–	–
Net employee benefits excluding capitalised costs	**23,286**	**250**	**23,536**

Table 43 – staff numbers and costs in 2020/21

Employee Benefits 2019/20

Employee Benefits	2019/20		
	Permanent Employees	Other	Total
	£000	£000	**£000**
Salaries and wages	16,342	816	**17,158**
Social security costs	1,715	–	**1,715**
Employer Contributions to NHS Pension scheme	3,128	–	**3,128**
Other pension costs	–	–	**–**
Apprenticeship Levy	72	–	**72**
Other post-employment benefits	–	–	**–**
Other employment benefits	–	–	**–**
Termination benefits	58	–	**58**
Gross employee benefits expenditure	**21,315**	**816**	**22,131**
Less recoveries in respect of employee benefits	–	–	**–**
Total - Net admin employee benefits including capitalised costs	**21,315**	**816**	**22,131**
Less: Employee costs capitalised	–	–	–
Net employee benefits excluding capitalised costs	**21,315**	**816**	**22,131**

Table 44 – staff numbers and costs in 2019/20

Average number of people employed

Table 45 shows the average number of staff employed by the CCG, excluding non-executive members and lay members.

	2020/21			2019/20		
	Permanently employed	Other	Total	Permanently employed	Other	Total
Total	423	4	**427**	392	10	**402**

Table 45 – average number of people employed by the CCG in 2020/21 compared to 2019/20

During 2020/21 the staff turnover for the CCG was 11.08%.

Sickness absence data

The average number of working days lost during 2020/21 is unavailable at present. Please refer to the NHS Digital website here[14] for the NHS Sickness Absence rates.

Supporting and Developing Our People

Support during the Pandemic

The CCG recognised that during the Covid-19 pandemic, social distancing, self-isolation and remote working impacted differently on colleagues and we adopted a health and wellbeing commitments *'Working differently. Our way'* that focuses on each individual's wellbeing needs.

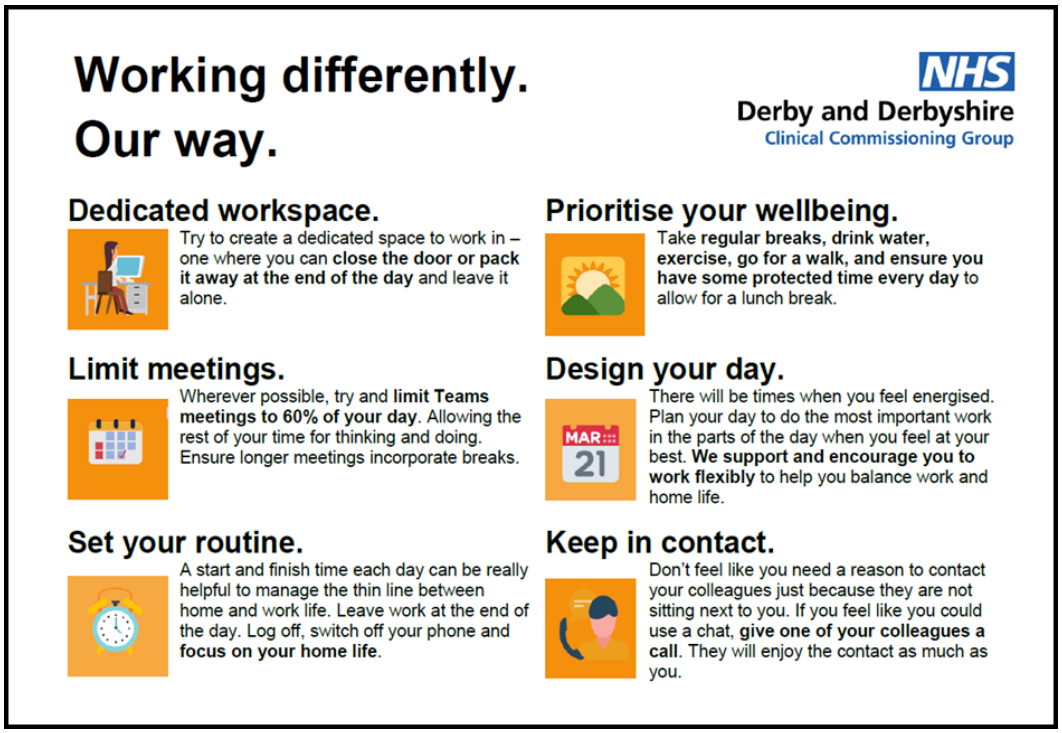


Figure 3 – Working Differently. Our Way

[14] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

In order to support the practical application of the commitments to staff, all managers have held 1 to 1 wellbeing conversations throughout the year with every team member, and risk assessments were implemented for all staff.

Disability Confident

The CCG is committed to employing, supporting and promoting disabled people in our workplace. In 2019/20 we received certification for another three years as a 'Disability Confident' employer. This means that we:

- have undertaken and successfully completed the Disability Confident self-assessment;
- are taking all the core actions to be a Disability Confident employer; and
- are offering at least one activity to get the right people for our business and at least one activity to keep and develop our people.

The CCG's commitment to action is to help staff understand various types of disabilities, including those which are hidden or invisible and offer work experience opportunities once normal service resume, that allows for a meaningful experience for an individual.

We actively look to attract and recruit disabled people by providing a fully inclusive and accessible recruitment process, as outlined in the CCG's Recruitment and Selection Policy.

Our recruitment process is fair, transparent and free from bias and our vacancies are accessible and available to the widest population possible.

Once appointed, and throughout an employee's employment, where necessary the CCG's Occupational Health service will be consulted to advise on any reasonable adjustments which need to be made. This may include changes to working patterns, adaptations to premises or equipment and provision of support packages to ensure disabled workers are not disadvantaged when applying for and doing their jobs. We are also happy to work in partnership with outside support agencies, such as Access to Work, where necessary.

We have also signed up to the Mindful Employer Charter to demonstrate our commitment to increasing the awareness of mental health, providing strong support networks and information, and making it healthier for our employees to talk about mental ill health without fear of rejection or prejudice.

Mental Health First Aiders

As part of our commitment to support the mental health of our staff, the CCG has nine trained Mental Health First Aiders working within the CCG. Mental Health First Aiders are trained by Mental Health First Aid England and act as a point of contact if an employee, or someone they are concerned about, is experiencing a mental health issue or emotional distress. They are not therapists or psychiatrists but they can provide initial support and signpost to appropriate help if required.

Human Resources Policies

We are committed to ensuring equal opportunities in employment and have appropriate Human Resources (HR) policies in place to ensure they are compliant with the relevant employment law as appropriate. Over the course of the year new policies have been introduced, including the Homeworking (during Covid-19) Policy and Grievance Policy, and other policies have been

reviewed and updated, including Raising Concerns at Work (Whistleblowing), Pay Protection, Close Personal Relationships, Disciplinary, and Maternity, Paternity, Shared Parental and Parental Leave.

The Governance Committee is responsible for approving the HR Policies and they are made available to staff on the CCG's Intranet. In November 2020 the CCG Governing Body demonstrated their focus and support to the importance of flexible working by approving, in accordance with the NHS People Plan, the processes for flexible working arrangements, recruitment, inductions and appraisals, and line management development.

All our HR policies are developed to ensure due regard to the Equality Act 2010 duties and include an Equality Commitment Statement which is designed to ensure that through the implementation of these policies no person is treated less favourably.

Where necessary, throughout an employee's employment our Occupational Health service is available to advise on any reasonable adjustments which need to be made to ensure the wellbeing of our staff. This may include changes to working patterns, adaptations to premises or equipment and provision of support packages to ensure disabled workers are not disadvantaged when applying for and doing their jobs. We are also happy to work in partnership with outside support agencies, such as Access to Work, where necessary.

The CCG has signed the Dying to Work Charter which is part of the Trades Union Congress's wider Dying to Work campaign. This helps members of staff who have a terminal diagnosis to receive support, protection and guidance to continue their employment as a therapeutic activity and help maintain dignity.

Joint Partnership Working Forum

We, alongside CCGs in Nottinghamshire, are part of a regional Joint Partnership Working Forum which represents the interests of all CCG employees from across the two counties. The forum meets every quarter and is used as a vehicle to discuss and consult on matters with the recognised trade union organisations and staff within each separate CCG. The established partnership agreement describes the way in which the CCGs and recognised trade unions work together. The Trade Union (Facility Time Publication Requirements) Regulations 2017 requires public sector organisations to report on trade union time in their organisation.

Staff Network

As a CCG we aim to address health inequalities and provide an inclusive working environment where everyone is treated fairly with dignity and respect. We are committed to creating a more diverse and inclusive organisation, where difference is embraced and people feel able to bring their whole self to work.

We have a staff diversity and inclusion network, which is an open forum run by staff and for staff to provide a safe and supportive environment in which to discuss issues relating to their protected characteristics to support equality and diversity by ensuring that the various protected characteristics have vision and impact.

The Network recognises that people have a number of identities and can face challenges associated with their gender, ethnicity, disability, religion and age alongside their sexual orientation. The Network has been set up to welcome people from a diversity of backgrounds.

The Network is run by people from protected characteristics that are under-represented within the CCG and is supported by Human Resources. The Network has a key role in making diversity and inclusion part of our DNA. Key initiatives have included:

- celebrating and promoting key dates in the inclusion calendar;
- introducing a programme of reverse mentoring with senior directors;
- raising awareness of the lived experiences of under-represented staff;
- learning and development: hidden disabilities, and unconscious bias; and
- informing the:

Workforce Race Equality Standard	Supporting and understanding the nature of the challenge of workforce race equality
	Focusing on enabling people to work comfortably with race equality
Workforce Disability Equality Standard	Enabling the CCG to better understand the experiences of their disabled staff
	Supporting positive change for all existing employees by creating a more inclusive environment for disabled people working and seeking employment in the NHS
Diversity and Inclusion action plans	Empowering the CCG to ensure that it is an inclusive organisation and an inclusive health service commissioner

Health and Safety

Our Health and Safety at work responsibilities are given equal priority along with our other statutory duties and objectives. To assist us in fulfilling our statutory obligations, expertise and advice is provided to the CCG by a private professional company called Peninsula, which is a specialist human resources, employment law and health and safety team. They provide us with a Health and Safety Policy, which is supported by a health and safety management system suite of procedures designed to ensure that we are compliant with relevant legislation.

Staff Engagement

Staff Survey

The 2020 NHS Staff Survey was open to all staff, and is the second year the CCG participated in the survey. The purpose of the survey is to collect staff views about working in the CCG. Data is used to improve local working conditions for staff, and ultimately to improve patient care. It also allows the CCG to compare the experiences of staff in similar organisations, and to compare the experiences of staff in the CCG with the national picture.

This year, our response rate was 83%, which is higher than the comparative average of 80% for similar organisations. Figure 4 provides a summary of the results of which the CCG has improved in all but one of the themed areas, which has remained at a score of 10.

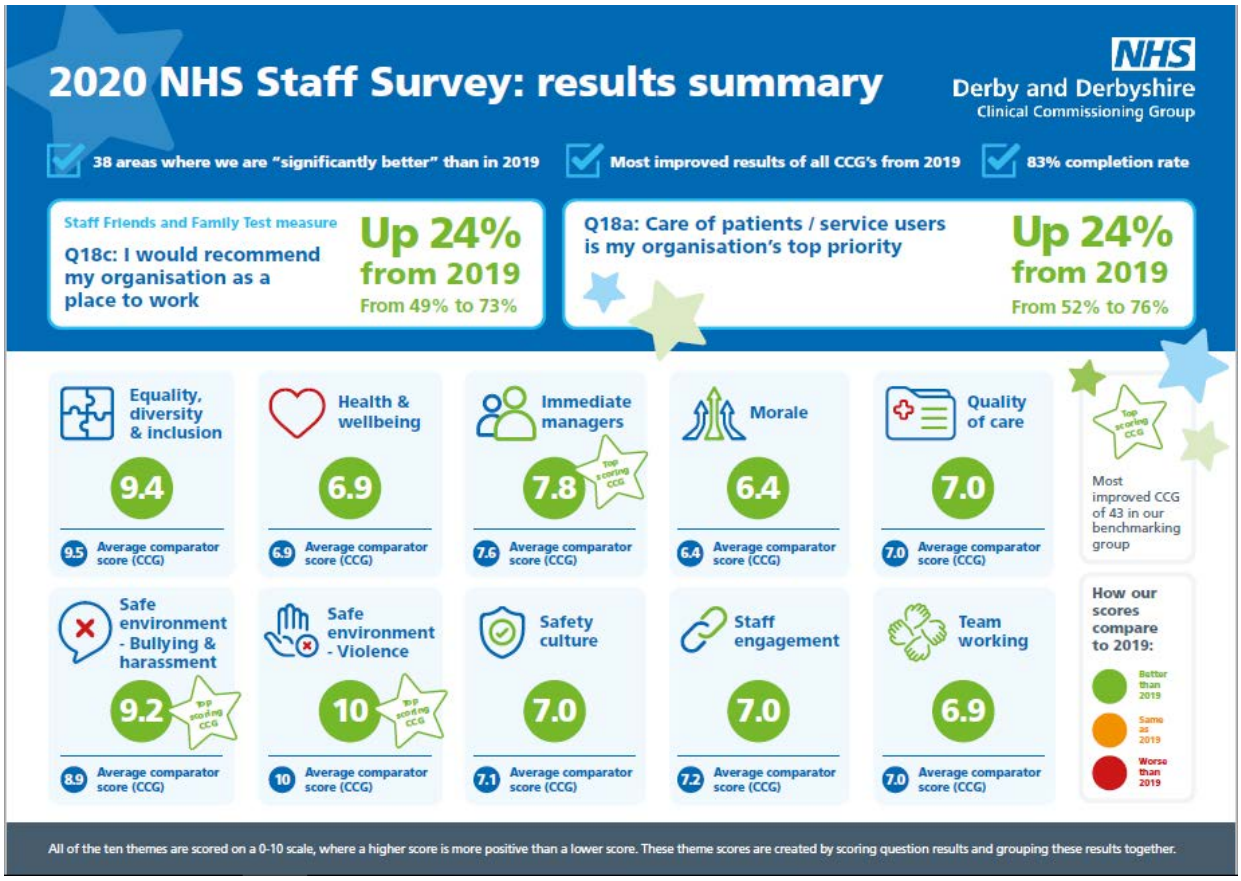


Figure 4 – 2020 NHS Staff Survey Results

Organisation Effectiveness and Improvement Group

In line with Government guidance and to help reduce the transmission of Covid-19 the large majority of CCG staff have been working remotely from home over the last 12 months. This has necessitated a change in how we engage with and involve our staff in shaping the work we deliver and the culture of the organisation.

The purpose of the Organisation Effectiveness and Improvement Group (OEIG) is to give all staff the opportunity to contribute to and influence positive change in the CCG. It plays a vital role in helping to shape our organisational approaches, strategies and policies in different ways. OEIG have informed our approach to health and wellbeing, working differently and in helping make the CCG a better place for us all. Examples of the types of initiative that have already been instigated by OEIG are:

Social Connectivity	Maintaining social connections whilst working remotely, including social 'buddies', virtual interest groups, virtual coffee breaks
Think Green	Introducing various initiatives to make it easier to 'go green' and also raise awareness of the wider sustainability agenda in the NHS
Mental Health First Aiders	The CCG has nine qualified employees

The OEIG also helped to shape the CCG's organisational values, which are newly embedded into the CCG Annual Review Conversation (appraisal) process.

Figure 5 – Our Values and Behaviours

Our weekly 'Team Talks' have enabled the Chief Executive Officer and Executive Directors to share key messages and updates via Microsoft Teams and also provide staff with an opportunity to ask questions. Through 'Our Big Conversations' we are engaging with staff on issues that affect them at work and using the feedback to inform our approach and decision-making. There were a number of ways in which staff could offer feedback, including via email, a staff Facebook page, intranet discussion, Microsoft Teams discussion groups and manager briefings.

We have conducted a number of 'health and wellbeing' surveys to help us to understand how staff were feeling and also identify what further interventions, actions and support they would find most helpful. On the back of the survey, we have introduced a number of measures aimed at improving the physical and mental wellbeing of our staff whilst working remotely, including wellbeing checks, Covid-19 individual risk assessments and access to advice/support.

Staff Flu Immunisation

On the 5th August 2020, the Department for Health and Social Care and Public Health England communicated detail on the national flu immunisation programme 2020/21. The letter placed a requirement for the CCG to commission a service which made access easy to the vaccine for all frontline staff, encouraged staff to get vaccinated and monitored the delivery of their programmes.

The CCG adopted the best practice guidance provided in the letter and implemented a flu vaccination plan for CCG staff, which was made available to all employees, including those eligible for a free flu jab under the NHS programme. Employees were able to access the flu jab via clinics run by Occupational Health at CCG premises and also by arranging their own flu jab at a private provider and claiming back the expense.

As at the 31st March 2021, 72% of all CCG staff confirmed that they had received the flu jab. This was a significant improvement on last year's 50%. We have been advised by the NHSE&I Screening and Immunisation Team that the CCG was the highest performing CCG in the Midlands at 58.69% across all cohorts. Next year we will continue to promote the benefits of the flu vaccination to staff via the CCG weekly staff bulletin and Team Talk meetings, ensuring our Executive and Senior Leaders lead the messaging. We will also continue to offer staff a variety of options to access a flu jab.

Trade Union Facility Time Reporting Requirements

The Trade Union (Facility Time Publication Requirements) Regulations 2017 requires public sector organisations to report on trade union time in their organisation. The CCG does not have a Trade Union Official. The CCG is required to publish the following information on their website by the 31st July 2021.

Relevant Union Officials

What was the total number of your employees who were relevant union officials during the relevant period?	
Number of employees who were relevant union officials during the relevant period (full-time equivalent employee number)	0

Table 46 – relevant Union officials

Percentage of time spent on facility time

Relevant employed union officials who spent their working hours on facility time	
Percentage of time	**Number of employees**
0%	0
1%-50%	0
51%-99%	0
100%	0

Table 47 – percentage of time spent on facility time

Percentage of pay bill spent on facility time

Total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period	
Provide the total cost of facility time	0
Provide the total pay bill	0
Provide the percentage of the total pay bill spent on facility time	0

Table 48 – percentage of pay bill spent on facility time

Paid Trade Union Activities

Percentage of total paid facility time hours – the amount of hours spent by employees who were relevant union officials on paid trade union activities	
Time spent on paid trade union activities as a percentage of total paid facility time hours	0%

Table 49 – paid Trade Union activities

Expenditure on consultancy

The expenditure on consultancy for 2020/21 for the CCG was £29,672.98.

Business consultancy is used sparingly by the CCG and only for limited periods where there is demonstrable cost-effectiveness. Consultancy assignments are used where specialist skills and knowledge do not exist within the permanent staff team and are required to address urgent matters. Use of consultants is reviewed by the Audit Committee.

Off-payroll engagements

In line with HM Treasury guidance the CCG is required to disclose information about 'Off payroll Engagements'. These are reviewed by the Finance Committee and Audit Committee.

The information relating to the CCG is provided in the following tables:

Off-payroll engagements longer than six months

Table 50 shows all off-payroll engagements as at the 31st March 2021 for more than £245 per day and that last longer than six months.

	Number
Number of existing engagements as of the 31st March 2021	0
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between 2 and 3 years at the time of reporting	0
for between 3 and 4 years at the time of reporting	0
for 4 or more years at the time of reporting	0

Table 50 – off-payroll engagements longer than six months in 2020/21

New off-payroll engagements

Table 51 shows all new off-payroll engagements, or those that reached six months in duration, between the 1st April 2020 and the 31st March 2021, for more than £245 per day and that last for longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between the 1st April 2020 and 31st March 2021	0
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	0
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 51 – new off-payroll engagements 2020/21

Off-payroll engagements/senior official engagements

Table 52 shows any off-payroll engagements of Board members and/or senior officials with significant financial responsibility, between the 1st April 2020 and the 31st March 2021:

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year (1)	0
Total no. of individuals on payroll and off-payroll that have been deemed "board members, and/or, senior officials with significant financial responsibility", during the financial year. This figure should include both on payroll and off-payroll engagements (2)	23

Table 52 – off-payroll engagements/senior official engagements 2020/21

Exit packages, including special (non-contractual) payments (subject to audit)

Exit Packages

During the year, one exit package of £20,000 was agreed and paid. This package was subject to approval by the Remuneration Committee and under the NHS Redundancy Terms and Conditions. The exit package is identified in both the Remuneration Report and Table 4.3 of the accounts; the numbers disclosed are subject to audit. The payment is also part of the termination benefits disclosure identified in note 4.1 of the accounts.

Dr Chris Clayton

Accountable Officer

NHS Derby and Derbyshire CCG

25th May 2021

Parliamentary Accountability and Audit Report

NHS Derby and Derbyshire CCG is not required to produce a Parliamentary Accountability and Audit Report. Disclosures on remote contingent liabilities, losses and special payments, gifts, and fees and charges are included as notes in the Financial Statements of this report. An Audit Certificate and report is also included after the Financial Statements.

One complaint has been accepted for investigation by the Parliamentary Ombudsman during 2020/21. The complaint is currently under investigation and the outcome will be reported through the Governance Committee. The recommendations will be considered by the CCG at that point.

FINANCIAL STATEMENTS

Dr Chris Clayton

Accountable Officer

NHS Derby and Derbyshire CCG

25th May 2021

CONTENTS **Page Number**

The Primary Statements:

Statement of Comprehensive Net Expenditure for the year ended 31st March 2021 140
Statement of Financial Position as at 31st March 2021 141
Statement of Changes in Taxpayers' Equity for the year ended 31st March 2021 142
Statement of Cash Flows for the year ended 31st March 2021 143

Notes to the Accounts

1 Accounting policies 144
2 Other operating revenue 150
3 Income from sale of goods and services (contract) 150
4 Employee benefits and staff numbers 151
5 Operating expenses 154
6 Better payment practice code 155
7 Finance costs 155
8 Net gain/(loss) on transfer by absorption 156
9 Operating leases 156
10 Property, plant and equipment 157
11 Trade and other receivables 158
12 Cash and cash equivalents 159
13 Trade and other payables 159
14 Provisions 160
15 Contingencies 161
16 Commitments 161
17 Financial instruments 161
18 Operating segments 162
19 Joint arrangements - interests in joint operations 163
20 Related party transactions 166
21 Events after the end of the reporting period 167
22 Losses and special payments 167
23 Financial performance targets 167

Statement of Comprehensive Net Expenditure for the year ended 31 March 2021

	Note	2020-21 £'000	2019-20 £'000
Income from sale of goods and services	2	(4,489)	(4,212)
Other operating income	2	(117)	(1,139)
Total operating income		**(4,606)**	(5,351)
Staff costs	4	23,641	22,131
Purchase of goods and services	5	1,873,539	1,661,478
Depreciation and impairment charges	5	147	-
Provision expense	5	2,609	20
Other Operating Expenditure	5	524	446
Total operating expenditure		**1,900,460**	1,684,075
Net Operating Expenditure		**1,895,854**	1,678,724
Finance income		-	-
Finance expense	7	-	(8)
Net expenditure for the Year		**1,895,854**	1,678,716
Net (Gain)/Loss on Transfer by Absorption	8	-	90,754
Total Net Expenditure for the Financial Year		**1,895,854**	1,769,470
Other Comprehensive Expenditure			
Items which will not be reclassified to net operating costs			
Net (gain)/loss on revaluation of PPE		-	-
Net (gain)/loss on revaluation of Intangibles		-	-
Net (gain)/loss on revaluation of Financial Assets		-	-
Net (gain)/loss on assets held for sale		-	-
Actuarial (gain)/loss in pension schemes		-	-
Impairments and reversals taken to Revaluation Reserve		-	-
Items that may be reclassified to Net Operating Costs			
Net (gain)/loss on revaluation of other Financial Assets		-	-
Net gain/loss on revaluation of available for sale financial assets		-	-
Reclassification adjustment on disposal of available for sale financial assets		-	-
Sub total		**-**	-
Comprehensive Expenditure for the year		**1,895,854**	1,769,470

The notes on pages 144 to 167 form part of this statement.

Statement of Financial Position as at 31 March 2021

	Note	2020-21 £'000	2019-20 £'000
Non-current assets:			
Property, plant and equipment	10	355	442
Intangible assets		-	-
Investment property		-	-
Trade and other receivables		-	-
Other financial assets		-	-
Total non-current assets		**355**	442
Current assets:			
Inventories		-	-
Trade and other receivables	11	5,330	9,764
Other financial assets		-	-
Other current assets		-	-
Cash and cash equivalents	12	110	40
Total current assets		**5,440**	9,804
Non-current assets held for sale		-	-
Total current assets		**5,440**	9,804
Total assets		**5,795**	10,246
Current liabilities			
Trade and other payables	13	(96,343)	(102,118)
Other financial liabilities		-	-
Other liabilities		-	-
Borrowings		-	-
Provisions	14	(3,896)	(2,080)
Total current liabilities		**(100,239)**	(104,198)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(94,444)**	(93,952)
Non-current liabilities			
Trade and other payables	13	-	-
Other financial liabilities		-	-
Other liabilities		-	-
Borrowings		-	-
Provisions	14	(522)	(195)
Total non-current liabilities		**(522)**	(195)
Assets less Liabilities		**(94,966)**	(94,147)
Financed by Taxpayers' Equity			
General fund		(94,966)	(94,147)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(94,966)**	(94,147)

The notes on pages 144 to 167 form part of this statement.

The financial statements on pages 140-167 are subject to Audit Committee approval (as delegated by the Governing Body), on 25 May 2021 and will be signed on its behalf by:

Dr Chris Clayton
Accountable Officer

Statement of Changes In Taxpayers Equity for the year ended 31 March 2021

	General fund £'000	**Revaluation reserve £'000**	**Other reserves £'000**	**Total reserves £'000**
Changes in taxpayers' equity for 2020-21				
Balance at 01 April 2020	(94,147)	0	0	**(94,147)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted NHS Clinical Commissioning Group balance at 31 March 2020	**(94,147)**	**0**	**0**	**(94,147)**
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2020-21				
Net operating expenditure for the financial year	(1,895,854)			**(1,895,854)**
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	**0**
Net gain/(loss) on revaluation of intangible assets	0	0	0	**0**
Net gain/(loss) on revaluation of financial assets	0	0	0	**0**
Total revaluations against revaluation reserve	**0**	**0**	**0**	**0**
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	0	0	0	0
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial year	**(1,895,854)**	**0**	**0**	**(1,895,854)**
Net funding	1,895,035	0	0	**1,895,035**
Balance at 31 March 2021	**(94,966)**	**0**	**0**	**(94,966)**

	General fund £'000	Revaluation reserve £'000	Other reserves £'000	Total reserves £'000
Changes in taxpayers' equity for 2019-20				
Balance at 01 April 2019	0	0	0	0
Transfer of assets and liabilities from closed NHS bodies	0	0	0	0
Adjusted NHS Clinical Commissioning Group balance at 31 March 2020	0	0	0	0
Changes in NHS Clinical Commissioning Group taxpayers' equity for 2019-20	0	0	0	0
Net operating costs for the financial year	(1,678,716)	0	0	(1,678,716)
Net gain/(loss) on revaluation of property, plant and equipment	0	0	0	0
Net gain/(loss) on revaluation of intangible assets	0	0	0	0
Net gain/(loss) on revaluation of financial assets	0	0	0	0
Total revaluations against revaluation reserve	0	0	0	0
Net gain (loss) on available for sale financial assets	0	0	0	0
Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)	0	0	0	0
Net gain (loss) on revaluation of assets held for sale	0	0	0	0
Impairments and reversals	0	0	0	0
Net actuarial gain (loss) on pensions	0	0	0	0
Movements in other reserves	0	0	0	0
Transfers between reserves	0	0	0	0
Release of reserves to the Statement of Comprehensive Net Expenditure	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets	0	0	0	0
Transfers by absorption to (from) other bodies	(90,754)	0	0	(90,754)
Reserves eliminated on dissolution	0	0	0	0
Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year	(1,769,470)	0	0	(1,769,470)
Net funding	1,675,323	0	0	1,675,323
Balance at 31 March 2020	(94,147)	0	0	(94,147)

The notes on pages 144 to 167 form part of this statement.

Statement of Cash Flows for the year ended
31 March 2021

	Note	**2020-21 £'000**	2019-20 £'000
Cash Flows from Operating Activities			
Net operating expenditure for the financial year		(1,895,854)	(1,678,716)
Depreciation and amortisation	5	147	0
Impairments and reversals		0	0
Non-cash movements arising on application of new accounting standards		0	0
Movement due to transfer by Modified Absorption		0	0
Other gains (losses) on foreign exchange		0	0
Donated assets received credited to revenue but non-cash		0	0
Government granted assets received credited to revenue but non-cash		0	0
Interest paid		0	0
Release of PFI deferred credit		0	0
Other Gains & Losses		0	0
Finance Costs		0	0
Unwinding of Discounts	7.1	0	(9)
(Increase)/decrease in inventories		0	0
(Increase)/decrease in trade & other receivables	11	4,434	2,769
(Increase)/decrease in other current assets		0	0
Increase/(decrease) in trade & other payables	13	(5,766)	1,639
Increase/(decrease) in other current liabilities		0	0
Provisions utilised	14	(466)	(710)
Increase/(decrease) in provisions	14	2,609	20
Net Cash Inflow (Outflow) from Operating Activities		**(1,894,896)**	(1,675,007)
Cash Flows from Investing Activities			
Interest received		0	0
(Payments) for property, plant and equipment		(69)	(433)
(Payments) for intangible assets		0	0
(Payments) for investments with the Department of Health		0	0
(Payments) for other financial assets		0	0
(Payments) for financial assets (LIFT)		0	0
Proceeds from disposal of assets held for sale: property, plant and equipment		0	0
Proceeds from disposal of assets held for sale: intangible assets		0	0
Proceeds from disposal of investments with the Department of Health		0	0
Proceeds from disposal of other financial assets		0	0
Proceeds from disposal of financial assets (LIFT)		0	0
Non-cash movements arising on application of new accounting standards		0	0
Loans made in respect of LIFT		0	0
Loans repaid in respect of LIFT		0	0
Rental revenue		0	0
Net Cash Inflow (Outflow) from Investing Activities		**(69)**	(433)
Net Cash Inflow (Outflow) before Financing		**(1,894,965)**	(1,675,440)
Cash Flows from Financing Activities			
Grant in Aid Funding Received		1,895,035	1,675,323
Other loans received		0	0
Other loans repaid		0	0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0	0
Capital grants and other capital receipts		0	0
Capital receipts surrendered		0	0
Non-cash movements arising on application of new accounting standards		0	0
Net Cash Inflow (Outflow) from Financing Activities		**1,895,035**	1,675,323
Net Increase (Decrease) in Cash & Cash Equivalents	12	**70**	(117)
Cash & Cash Equivalents at the Beginning of the Financial Year		**40**	157
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0	0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**110**	40

The notes on pages 144 to 167 form part of this statement.

Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of Clinical Commissioning Groups shall meet the accounting requirements of the Group Accounting Manual issued by the Department of Health and Social Care. Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2020-21 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Clinical Commissioning Groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Clinical Commissioning Group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Clinical Commissioning Group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on a going concern basis.
Public sector bodies are assumed to be going concerns where the continuation of the provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents.

Where a Clinical Commissioning Group ceases to exist, it considers whether or not its services will continue to be provided (using the same assets, by another public sector entity) in determining whether to use the concept of going concern for the final set of financial statements. If services will continue to be provided the financial statements are prepared on the going concern basis.

1.2 Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.3 Movement of Assets within the Department of Health and Social Care Group

As Public Sector Bodies are deemed to operate under common control, business reconfigurations within the Department of Health and Social Care Group are outside the scope of IFRS 3 Business Combinations. Where functions transfer between two public sector bodies, the Department of Health and Social Care GAM requires the application of absorption accounting. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Department of Health and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Joint arrangements

Arrangements over which the Clinical Commissioning Group has joint control with one or more other entities are classified as joint arrangements. Joint control is the contractually agreed sharing of control of an arrangement. A joint arrangement is either a joint operation or a joint venture.

A joint operation exists where the parties that have joint control have rights to the assets and obligations for the liabilities relating to the arrangement. Where the Clinical Commissioning Group is a joint operator it recognises its share of, assets, liabilities, income and expenses in its own accounts.

The Clinical Commissioning Group's participation in Section 75 agreements (see note 1.5) are joint arrangements.

A joint venture is a joint arrangement whereby the parties that have joint control of the arrangement have rights to the net assets of the arrangement. Joint ventures are recognised as an investment and accounted for using the equity method.

1.5 Pooled Budgets

The Clinical Commissioning Group has entered into a pooled budget arrangement for better care with NHS Tameside & Glossop Clinical Commissioning Group and Derbyshire County Council; and separately with Derby City Council [both arrangements are in accordance with section 75 of the NHS Act 2006]. Under the arrangements, the two funds are separately pooled for the Derbyshire County "Better Care Fund", and Derby City "Better Care Fund", respectively. The Better Care funds aim to improve the provision of health and social care, with the overarching objective to support the integration of health and social care and align commissioning, as agreed between the partners.

Additionally the Clinical Commissioning Group is a partner of the "Children and Young People with Complex Needs" pooled budget with Derbyshire County Council. Under the arrangement, funds are pooled for children with a range of health and special educational needs that cannot collectively be addressed by local or ordinary services.

The Clinical Commissioning Group is also in a pooled arrangement with Derby City Council for the "Integrated Disabled Children's Centre and Services in Derby". This arrangement provides funds for the purchase and supply of equipment and technological aids for disabled children in Derby.

The Derbyshire County "Better Care Fund" and "Children and Young People with Complex Needs" pools are both hosted by Derbyshire County Council. The Derby City "Better Care Fund" and "Integrated Disabled Children's Centre and Services in Derby" pools are both hosted by Derby City Council.

The Clinical Commissioning Group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budgets, identified in accordance with the pooled budget agreements.

1.6 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the clinical commissioning group.

1.7 **Revenue**

In the application of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows;

• As per paragraph 121 of the Standard the Clinical Commissioning Group will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,
• The Clinical Commissioning Group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the Clinical Commissioning Group to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of funding for the Clinical Commissioning Group is from NHS England. This is drawn down and credited to the general fund. Funding is recognised in the period in which it is received.

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles. There are no significant terms.
The value of the benefit received when the Clinical Commissioning Group accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.8 **Employee Benefits**

1.8.1 **Short-term Employee Benefits**

Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

1.8.2 **Retirement Benefit Costs**

Past and present employees are covered by the provisions of the NHS Pensions Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the Clinical Commissioning Group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Clinical Commissioning Group commits itself to the retirement, regardless of the method of payment.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.9 **Other Expenses**

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.10 **Property, Plant & Equipment**

1.10.1 **Recognition**

Property, plant and equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes;
- It is probable that future economic benefits will flow to, or service potential will be supplied to the Clinical Commissioning Group;
- It is expected to be used for more than one financial year;
- The cost of the item can be measured reliably; and,
- The item has a cost of at least £5,000; or,
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or,
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

1.10.2 **Measurement**

All property, plant and equipment is measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting date.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use; and,
- Specialised buildings – depreciated replacement cost.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are re-valued and depreciation commences when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Net Expenditure.

1.10.3 **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.10.4 **Depreciation, Amortisation & Impairments**

Freehold land, properties under construction, and assets held for sale are not depreciated.
Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Clinical Commissioning Group expects to obtain economic benefits or service potential from the asset. This is specific to the Clinical Commissioning Group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over the shorter of the lease term and the estimated useful life.

At each reporting period end, the Clinical Commissioning Group checks whether there is any indication that any of its property, plant and equipment assets or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.11 **Leases**

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.11.1 **The Clinical Commissioning Group as Lessee**

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the Clinical Commissioning Group's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

1.12 **Cash & Cash Equivalents**

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Clinical Commissioning Group's cash management.

1.13 **Provisions**

Provisions are recognised when the Clinical Commissioning Group has a present legal or constructive obligation as a result of a past event, it is probable that the Clinical Commissioning Group will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate as follows:

All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

• A nominal short-term rate of -0.02% (2019-20: 0.51%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.
• A nominal medium-term rate of 0.18% (2019-20: 0.55%) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.
• A nominal long-term rate of 1.99% (2019-20: 1.99%) for inflation adjusted expected cash flows over 10 years and up to and including 40 years from the Statement of Financial Position date.
• A nominal very long-term rate of 1.99% (2019-20: 1.99%) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Clinical Commissioning Group has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with on-going activities of the entity.

1.14 **Clinical Negligence Costs**

NHS Resolution operates a risk pooling scheme under which the clinical commissioning group pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with clinical commissioning group.

1.15 **Non-clinical Risk Pooling**

The clinical commissioning group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group pays an annual contribution to the NHS Resolution and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.16 **Contingent liabilities and contingent assets**

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Clinical Commissioning Group, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the Clinical Commissioning Group. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingent liabilities and contingent assets are disclosed at their present value.

1.17 **Financial Assets**

Financial assets are recognised when the clinical commissioning group becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories:

· Financial assets at amortised cost;
· Financial assets at fair value through other comprehensive income and;
· Financial assets at fair value through profit and loss.

The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.17.1 **Financial Assets at Amortised cost**

Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.17.2 **Financial assets at fair value through other comprehensive income**

Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.17.3 **Financial assets at fair value through profit and loss**

Financial assets measure at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.17.4 **Impairment**

For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the Clinical Commissioning Group recognises a loss allowance representing the expected credit losses on the financial asset.

The Clinical Commissioning Group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation. The Clinical Commissioning Group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's lengths bodies and NHS bodies and the Clinical Commissioning Group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset's original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.18 **Financial Liabilities**

Financial liabilities are recognised on the statement of financial position when the clinical commissioning group becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.18.1 **Financial Guarantee Contract Liabilities**

Financial guarantee contract liabilities are subsequently measured at the higher of:

- The premium received (or imputed) for entering into the guarantee less cumulative amortisation; and,
- The amount of the obligation under the contract, as determined in accordance with IAS 37: Provisions, Contingent Liabilities and Contingent Assets.

1.18.2 **Financial Liabilities at Fair Value Through Profit and Loss**

Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Clinical Commissioning Group's surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

The Clinical Commissioning Group does not have any financial liabilities at fair value through profit and loss.

1.18.3 **Other Financial Liabilities**

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.19 **Value Added Tax**

Most of the activities of the clinical commissioning group are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.20 **Foreign Currencies**

The Clinical Commissioning Group's functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Clinical Commissioning Group's surplus/deficit in the period in which they arise.

1.21 **Third Party Assets**

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the clinical commissioning group has no beneficial interest in them.

1.22 **Losses & Special Payments**

legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

1.23 **Critical accounting judgements and key sources of estimation uncertainty**

In the application of the clinical commissioning group's accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.23.1 **Critical accounting judgements in applying accounting policies**

The following are the judgements, apart from those involving estimations, that management has made in the process of applying the clinical commissioning group's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

• The Clinical Commissioning Group has assessed the pooled element of the Better Care Fund as being a lead commissioning arrangement under IFRS 11 – Joint Arrangements. The Clinical Commissioning Group will report balances with the lead commissioner (local authority) only and not the providers with which the local authority contracts.

1.23.2 **Sources of estimation uncertainty**

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

• None.

1.24 **Gifts**

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.25 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**

The Department of Health and Social Care GAM does not require the following IFRS Standards and Interpretations to be applied in 2020-21. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 being for implementation in 2021-22, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

• IFRS 16 Leases – Due to the outbreak of COVID 19 pandemic, the standard which was due to be effective 1 April 2020 as adopted and interpreted by the FReM, has been deferred to 1 April 2022. The impact of the standard will be fully identified during 2021/22.

• IFRS 17 Insurance Contracts – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted. Adoption is expected from 1 April 2023.

2 Other Operating Revenue

	2020-21 Total £'000	2019-20 Total £'000
Income from sale of goods and services (contracts)		
Education, training and research	**24**	2
Non-patient care services to other bodies	**4,311**	4,097
Patient transport services	**-**	-
Prescription fees and charges	**3**	9
Dental fees and charges	**-**	-
Income generation	**-**	-
Other Contract income	**46**	104
Recoveries in respect of employee benefits	**105**	-
Total Income from sale of goods and services	**4,489**	**4,212**
Other operating income		
Rental revenue from finance leases	**-**	-
Rental revenue from operating leases	**-**	-
Charitable and other contributions to revenue expenditure: NHS	**-**	-
Charitable and other contributions to revenue expenditure: non-NHS	**17**	23
Receipt of donations (capital/cash)	**-**	-
Receipt of Government grants for capital acquisitions	**-**	-
Continuing Health Care risk pool contributions	**-**	-
Non cash apprenticeship training grants revenue	**47**	8
Other non contract revenue	**53**	1,108
Total Other operating income	**117**	**1,139**
Total Operating Income	**4,606**	**5,351**

3. Income from sale of goods and services (contracts)

3.1 Disaggregation of Income - Income from sale of goods and services (contracts)

	Education, training and research	Non-patient care services to other bodies	Prescription fees and charges	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000
Source of Revenue					
NHS	24	1,462	-	-	73
Non NHS	-	2,849	3	46	32
Total	**24**	**4,311**	**3**	**46**	**105**

	Education, training and research	Non-patient care services to other bodies	Prescription fees and charges	Other Contract income	Recoveries in respect of employee benefits
	£'000	£'000	£'000	£'000	£'000
Timing of Revenue					
Point in time	-	-	-	-	-
Over time	24	4,311	3	46	105
Total	**24**	**4,311**	**3**	**46**	**105**

3.2 Transaction price to remaining contract performance obligations

NHS Derby and Derbyshire Clinical Commisioning Group had no contract revenue expected to be recognised in future period, relating to contract performance obligations not yet completed at the reporting date.

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	2020-21		
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	18,050	250	18,300
Social security costs	1,880	-	1,880
Employer Contributions to NHS Pension scheme	3,363	-	3,363
Other pension costs	2	-	2
Apprenticeship Levy	76	-	76
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	20	-	20
Gross employee benefits expenditure	**23,391**	**250**	**23,641**
Less recoveries in respect of employee benefits (note 4.1.2)	(105)	-	(105)
Total - Net admin employee benefits including capitalised costs	**23,286**	**250**	**23,536**
Less: Employee costs capitalised	-	-	**-**
Net employee benefits excluding capitalised costs	**23,286**	**250**	**23,536**

	2019-20		
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits			
Salaries and wages	16,342	816	17,158
Social security costs	1,715	-	1,715
Employer Contributions to NHS Pension scheme	3,128	-	3,128
Other pension costs	-	-	-
Apprenticeship Levy	72	-	72
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	58	-	58
Gross employee benefits expenditure	**21,315**	**816**	**22,131**
Less recoveries in respect of employee benefits (note 4.1.2)	-	-	-
Total - Net admin employee benefits including capitalised costs	**21,315**	**816**	**22,131**
Less: Employee costs capitalised	-	-	-
Net employee benefits excluding capitalised costs	**21,315**	**816**	**22,131**

Termination Benefit costs consist of one (2019-20: two) exit package agreed in year (see note 4.3).

4.1.2 Recoveries in respect of employee benefits

	2020-21		
	Permanent Employees £'000	Other £'000	Total £'000
Employee Benefits - Revenue			
Salaries and wages	(84)	-	(84)
Social security costs	(10)	-	(10)
Employer contributions to the NHS Pension Scheme	(11)	-	(11)
Other pension costs	-	-	-
Other post-employment benefits	-	-	-
Other employment benefits	-	-	-
Termination benefits	-	-	-
Total recoveries in respect of employee benefits	**(105)**	**-**	**(105)**

4.2 Average number of people employed

	2020-21			2019-20		
	Permanently employed Number	**Other Number**	**Total Number**	Permanently employed Number	Other Number	Total Number
Total	**423**	**4**	**427**	392	10	402
Of the above:						
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	-	-	-

4.3 Exit packages agreed in the financial year

	2020-21 Compulsory redundancies		2020-21 Other agreed departures		2020-21 Total	
	Number	**£**	**Number**	**£**	**Number**	**£**
Less than £10,000	-	-	-	-	-	-
£10,001 to £25,000	1	20,000	-	-	1	20,000
£25,001 to £50,000	-	-	-	-	-	-
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**1**	**20,000**	**-**	**-**	**1**	**20,000**

	2019-20 Compulsory redundancies		2019-20 Other agreed departures		2019-20 Total	
	Number	£	Number	£	Number	£
Less than £10,000	1	767	-	-	1	767
£10,001 to £25,000	-	-	-	-	-	-
£25,001 to £50,000	1	48,314	-	-	1	48,314
£50,001 to £100,000	-	-	-	-	-	-
£100,001 to £150,000	-	-	-	-	-	-
£150,001 to £200,000	-	-	-	-	-	-
Over £200,001	-	-	-	-	-	-
Total	**2**	**49,081**	**-**	**-**	**2**	**49,081**

	2020-21 Departures where special payments have been made		2019-20 Departures where special payments have been made	
	Number	**£**	Number	£
Less than £10,000	-	-	-	-
£10,001 to £25,000	-	-	-	-
£25,001 to £50,000	-	-	-	-
£50,001 to £100,000	-	-	-	-
£100,001 to £150,000	-	-	-	-
£150,001 to £200,000	-	-	-	-
Over £200,001	-	-	-	-
Total	**-**	**-**	**-**	**-**

As a single exit package can be made up of several components each of which will be counted separately in this table, the total number will not necessarily match the total number in the table above, which will be the number of individuals.

These tables report the number and value of exit packages agreed in the financial year. The expense associated with these departures may have been recognised in part or in full in a previous period.

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Redundancy scheme. Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full in the year of departure.

Where entities have agreed early retirements, the additional costs are met by NHS Entities and not by the NHS Pension Scheme, and are included in the tables. NHS Derby and Derbyshire Clinical Commissioning Group agreed a single early retirement during 2020-21, however no associated costs were incurred. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

The Remuneration Report includes the disclosure of exit payments and early retirements relating to individuals named in that Report.

4.4 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The employer contribution rate for NHS Pensions increased from 14.3% to 20.6% from 1st April 2019. From 2019/20, NHS CCGs continued to pay over contributions at the former rate with the additional amount being paid by NHS England on CCGs behalf. The full cost and related funding has been recognised in these accounts.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

4.4.1 Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as 31 March 2020 updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.4.2 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

5. Operating expenses

	2020-21 Total £'000	2019-20 Total £'000
Purchase of goods and services		
Services from other CCGs and NHS England	10,078	7,898
Services from foundation trusts	1,098,756	972,815
Services from other NHS trusts	114,495	101,838
Provider Sustainability Fund	-	-
Services from Other WGA bodies	6	35
Purchase of healthcare from non-NHS bodies	249,044	209,932
Purchase of social care	50,404	47,845
General Dental services and personal dental services	-	-
Prescribing costs	161,614	148,730
Pharmaceutical services	79	261
General Ophthalmic services	485	382
GPMS/APMS and PCTMS	176,523	162,116
Supplies and services – clinical	-	-
Supplies and services – general	5,949	4,509
Consultancy services	30	287
Establishment	2,308	2,065
Transport	(1)	24
Premises	2,537	1,603
Audit fees	182	184
Other non statutory audit expenditure		
· Internal audit services	-	-
· Other services	10	14
Other professional fees	577	522
Legal fees	329	240
Education, training and conferences	86	170
Funding to group bodies	-	-
CHC Risk Pool contributions	-	-
Non cash apprenticeship training grants	48	8
Total Purchase of goods and services	**1,873,539**	**1,661,478**
Depreciation and impairment charges		
Depreciation	147	-
Amortisation	-	-
Impairments and reversals of property, plant and equipment	-	-
Impairments and reversals of intangible assets	-	-
Impairments and reversals of financial assets	-	-
· Assets carried at amortised cost	-	-
· Assets carried at cost	-	-
· Available for sale financial assets	-	-
Impairments and reversals of non-current assets held for sale	-	-
Impairments and reversals of investment properties	-	-
Total Depreciation and impairment charges	**147**	**-**
Provision expense		
Change in discount rate	-	-
Provisions	2,609	20
Total Provision expense	**2,609**	**20**
Other Operating Expenditure		
Chair and Non Executive Members	450	443
Grants to Other bodies	-	-
Clinical negligence	-	-
Research and development (excluding staff costs)	60	-
Expected credit loss on receivables	9	3
Expected credit loss on other financial assets (stage 1 and 2 only)	-	-
Other expenditure	5	-
Total Other Operating Expenditure	**524**	**446**
Total operating expenditure	**1,876,819**	**1,661,944**

Internal Audit Services are provided by 360 Assurance (Hosted by Leicestershire Partnership NHS Trust) and the associated expenditure is included within "Other Professional Fees".

The audit fees relating to the statutory external audit, provided by KPMG LLP (UK), include VAT.

The non-statutory audit of Mental Health Investment is disclosed as "Other non-statutory audit expenditure - Other service". The Clinical Commissioning Group is yet to commission this audit for 2020-21, therefore an accrual of the estimated expenditure has been made in-year.

6.1 Better Payment Practice Code

Measure of compliance	**2020-21 Number**	**2020-21 £'000**	2019-20 Number	2019-20 £'000
Non-NHS Payables				
Total Non-NHS Trade invoices paid in the Year	42,138	298,856	32,419	263,487
Total Non-NHS Trade Invoices paid within target	41,871	297,827	31,891	260,697
Percentage of Non-NHS Trade invoices paid within target	**99.37%**	**99.66%**	98.37%	98.94%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,636	1,241,869	7,845	1,088,952
Total NHS Trade Invoices Paid within target	2,628	1,241,769	7,739	1,088,190
Percentage of NHS Trade Invoices paid within target	**99.70%**	**99.99%**	98.65%	99.93%

The Better Payment Practice Code requires the Clinical Commissioning Group to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. The target is 95% across all indicators, which has been achieved.

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

NHS Derby and Derbyshire Clinical Commissioning Group incurred £nil during 2020-21 (2019-20: £153) relating to claims made under this legislation.

7.1 Finance costs

	2020-21 £'000	2019-20 £'000
Interest		
Interest on loans and overdrafts	-	-
Interest on obligations under finance leases	-	-
Interest on obligations under PFI contracts:		
· Main finance cost	-	-
· Contingent finance cost	-	-
Interest on obligations under LIFT contracts:		
· Main finance cost	-	-
· Contingent finance cost	-	-
Interest on late payment of commercial debt	-	-
Other interest expense	-	1
Total interest	**-**	**1**
Other finance costs	-	-
Provisions: unwinding of discount	-	(9)
Total finance costs	**-**	**(8)**

7.2 Finance Income

NHS Derby and Derbyshire Clinical Commisioning Group did not receive finance income during 2020-21 and 2019-20.

8. Net gain/(loss) on transfer by absorption

Transfers as part of a reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the Statement of Comprehensive Net Expenditure, and is disclosed separately from operating costs.

On 1 April 2019, NHS Derby and Derbyshire Clinical Commissioning Group received the balances from the four predecessor Clinical Commissioning Groups: NHS Erewash; NHS Hardwick; NHS North Derbyshire; and NHS Southern Derbyshire following a merger. No further transfers have taken place in 2020-21.

	2020-21 £'000	2019-20 £'000
Transfer of property plant and equipment	-	-
Transfer of intangibles	-	-
Transfer of cash and cash equivalents	-	157
Transfer of receivables	-	12,533
Transfer of payables	-	(100,470)
Transfer of provisions	-	(2,974)
Net loss on transfers by absorption	**-**	**(90,754)**

9. Operating Leases

9.1 As lessee

During the 2020-21 year, NHS Derby and Derbyshire Clinical Commissioning Group exited a lease with Erewash Borough Council, for the building, Toll Bar House, located in Ilkeston and used as office premises.

A lease for additional space in the Cardinal Square Office in Derby was agreed with Cardinal Square LLP on 2nd April 2020 until 31 March 2023.

As a result of the additional lease agreement, the Future minimum lease payments for buildings have increased by £239k.

Property rental charges are received from NHS Property Services Limited, for the office accommodation at Cardinal Square, Derby and Scarsdale, Chesterfield. Even though formal lease contracts are not in place, the transactions involved do convey the right to the Clinical Commissioning Group to use the Properties.

NHS Derby and Derbyshire Clinical Commissioning Group also have lease contracts in place for reprographic equipment with Ricoh and Grenke. During the 20-21 year, the CCG has exited all previous reprographic leases with Canon.

9.1.1 Payments recognised as an Expense

	2020-21			2019-20		
	Buildings £'000	**Other £'000**	**Total £'000**	Buildings £'000	Other £'000	Total £'000
Payments recognised as an expense						
Minimum lease payments	485	7	**492**	517	9	526
Contingent rents	-	-	**-**	-	-	-
Sub-lease payments	-	-	**-**	-	-	-
Total	**485**	**7**	**492**	517	9	526

9.1.2 Future minimum lease payments

	2020-21			2019-20		
	Buildings £'000	**Other £'000**	**Total £'000**	Buildings £'000	Other £'000	Total £'000
Payable:						
No later than one year	127	2	**129**	30	1	31
Between one and five years	142	4	**146**	-	-	-
After five years	-	-	**-**	-	-	-
Total	**269**	**6**	**275**	30	1	31

Although property arrangements with NHS Property Services Limited fall within the definition of operating leases, rental charges for future years have not yet been agreed. Consequently note 9.1.2 does not include future minimum lease payments for these arrangements.

9.2 As lessor

NHS Derby and Derbyshire Clinical Commisioning Group is not party to any leasing arrangements where it acts in the capacity of a lessor.

10 Property, plant and equipment

2020-21	Information technology £'000	Total £'000
Cost or valuation at 01 April 2020	442	442
Addition of assets under construction and payments on account	-	-
Additions purchased	60	60
Additions donated	-	-
Additions government granted	-	-
Additions leased	-	-
Reclassifications	-	-
Reclassified as held for sale and reversals	-	-
Disposals other than by sale	-	-
Upward revaluation gains	-	-
Impairments charged	-	-
Reversal of impairments	-	-
Transfer (to)/from other public sector body	-	-
Cumulative depreciation adjustment following revaluation	-	-
Cost/Valuation at 31 March 2021	**502**	**502**
Depreciation 01 April 2020	-	-
Reclassifications	-	-
Reclassified as held for sale and reversals	-	-
Disposals other than by sale	-	-
Upward revaluation gains	-	-
Impairments charged	-	-
Reversal of impairments	-	-
Charged during the year	147	147
Transfer (to)/from other public sector body	-	-
Cumulative depreciation adjustment following revaluation	-	-
Depreciation at 31 March 2021	**147**	**147**
Net Book Value at 31 March 2021	**355**	**355**
Purchased	355	355
Donated	-	-
Government Granted	-	-
Total at 31 March 2021	**355**	**355**
Asset financing:		
Owned	355	355
Held on finance lease	-	-
On-SOFP Lift contracts	-	-
PFI residual: interests	-	-
Total at 31 March 2021	**355**	**355**

Revaluation Reserve Balance for Property, Plant & Equipment

	Information technology £'000	Total £'000
Balance at 01 April 2020	-	-
Revaluation gains	-	-
Impairments	-	-
Release to general fund	-	-
Other movements	-	-
Balance at 31 March 2021	**-**	**-**

The information technology equipment purchased during the year will be depreciated over 3 years, in line with existing equipment held, and with the accounting policies.

11 Trade and other receivables	**Current 2020-21 £'000**	**Non-current 2020-21 £'000**	Current 2019-20 £'000	Non-current 2019-20 £'000
NHS receivables: Revenue	1,229	-	860	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	1	-	3,890	-
NHS accrued income	-	-	-	-
NHS Contract Receivable not yet invoiced/non-invoice	1,645	-	471	-
NHS Non Contract trade receivable (i.e pass through funding)	-	-	-	-
NHS Contract Assets	-	-	-	-
Non-NHS and Other WGA receivables: Revenue	475	-	494	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	1,412	-	1,291	-
Non-NHS and Other WGA accrued income	-	-	-	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	6	-	2,306	-
Non-NHS and Other WGA Non Contract trade receivable (i.e pass through funding)	-	-	-	-
Non-NHS Contract Assets	-	-	-	-
Expected credit loss allowance-receivables	(3)	-	(4)	-
VAT	562	-	438	-
Private finance initiative and other public private partnership arrangement prepayments and accrued income	-	-	-	-
Interest receivables	-	-	-	-
Finance lease receivables	-	-	-	-
Operating lease receivables	-	-	-	-
Other receivables and accruals	3	-	18	-
Total Trade & other receivables	**5,330**	**-**	9,764	**-**
Total current and non current	**5,330**		9,764	

There are no prepaid pension contributions included in note 11.

11.1 Receivables past their due date but not impaired

	2020-21 DHSC Group Bodies £'000	**2020-21 Non DHSC Group Bodies £'000**	2019-20 DHSC Group Bodies £'000	2019-20 Non DHSC Group Bodies £'000
By up to three months	43	116	11	92
By three to six months	29	74	2	2
By more than six months	-	1	190	12
Total	**72**	**191**	203	106

11.2 Loss allowance on asset classes	**Trade and other receivables - Non DHSC Group Bodies £'000**	**Other financial assets £'000**	**Total £'000**
Balance at 01 April 2020	(4)	-	**(4)**
Lifetime expected credit loss on credit impaired financial assets	-	-	**-**
Lifetime expected credit losses on trade and other receivables-Stage 2	(3)	-	**(3)**
Lifetime expected credit losses on trade and other receivables-Stage 3	(11)	-	**(11)**
Credit losses recognised on purchase originated credit impaired financial assets	-	-	**-**
Amounts written off	11	-	**11**
Financial assets that have been derecognised	-	-	**-**
Changes due to modifications that did not result in derecognition	-	-	**-**
Other changes	4	-	**4**
Total	**(3)**	**-**	**(3)**

12 Cash and cash equivalents

	2020-21	2019-20
	£'000	£'000
Balance at 01 April 2020	40	157
Net change in year	70	(117)
Balance at 31 March 2021	**110**	40
Made up of:		
Cash with the Government Banking Service	110	40
Cash with Commercial banks	-	-
Cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in statement of financial position	**110**	40
Bank overdraft: Government Banking Service	-	-
Bank overdraft: Commercial banks	-	-
Total bank overdrafts	**-**	-
Balance at 31 March 2021	**110**	40

NHS Derby and Derbyshire Clinical Commisioning Group does not hold patients' money.

13 Trade and other payables	**Current 2020-21**	**Non-current 2020-21**	Current 2019-20	Non-current 2019-20
	£'000	**£'000**	£'000	£'000
Interest payable	-	-	-	-
NHS payables: Revenue	1,959	-	4,300	-
NHS payables: Capital	-	-	-	-
NHS accruals	3,070	-	21,764	-
NHS deferred income	-	-	1	-
NHS Contract Liabilities	-	-	-	-
Non-NHS and Other WGA payables: Revenue	8,613	-	3,951	-
Non-NHS and Other WGA payables: Capital	-	-	9	-
Non-NHS and Other WGA accruals	67,973	-	61,577	-
Non-NHS and Other WGA deferred income	-	-	-	-
Non-NHS Contract Liabilities	-	-	-	-
Social security costs	285	-	282	-
VAT	-	-	-	-
Tax	223	-	210	-
Payments received on account	13	-	-	-
Other payables and accruals	14,207	-	10,024	-
Total Trade & Other Payables	**96,343**	**-**	102,118	**-**
Total current and non-current	**96,343**		102,118	

NHS Derby and Derbyshire Clinical Commisioning Group does not have any liabilities included for arrangements to buy out the liability for early retirement over 5 years (£nil at 31 March 2020).

Other payables include £1.453m outstanding pension contributions at 31 March 2021 (2019-20: £1.381m). Other payables include GP pensions.

14 Provisions

	Current 2020-21 £'000	**Non-current 2020-21 £'000**	Current 2019-20 £'000	Non-current 2019-20 £'000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	-	-	-	-
Redundancy	-	-	-	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	3	-	8	-
Continuing care	646	-	229	-
Other	3,247	522	1,843	195
Total	**3,896**	**522**	2,080	195
Total current and non-current	**4,418**		2,275	

	Legal Claims £'000	**Continuing Care £'000**	**Other £'000**	**Total £'000**
Balance at 01 April 2020	**8**	**229**	**2,038**	**2,275**
Arising during the year	1	646	2,024	**2,671**
Utilised during the year	(6)	(229)	(231)	**(466)**
Reversed unused	-	-	(62)	**(62)**
Unwinding of discount	-	-	-	**-**
Change in discount rate	-	-	-	**-**
Transfer (to) from other public sector body	-	-	-	**-**
Transfer (to) from other public sector body under absorption	-	-	-	**-**
Balance at 31 March 2021	**3**	**646**	**3,769**	**4,418**
Expected timing of cash flows:				
Within one year	3	646	3,247	**3,896**
Between one and five years	-	-	522	**522**
After five years	-	-	-	**-**
Balance at 31 March 2021	**3**	**646**	**3,769**	**4,418**

Other Provisions

Legal claims are calculated from the number of claims currently lodged with NHS Resolution and the probabilities provided by them. Two such claims totalling £8k were provided for in 2019-20; one has been utilised following conclusion during 2020-21, the second has been further increased to £3k. The latter legal claim has been concluded after the accounting period and is detailed within note 21.

The continuing healthcare retrospective claims and disputes have been reviewed with £646k of new liability identified, and £229k being utilised during the year.

The Clinical Commissioning Group has "other" provisions, including that for the Cardinal Square and Scarsdale offices in Derby and Chesterfield respectively, known as 'dilapidation cost provision' (£522k) to cover the cost of putting the offices back to an expected condition, when the lease is terminated. During the year, the Clinical Commissioning Group exited Toll Bar House offices in Ilkeston, resulting in the utilisation of £75k of the previous dilapidation provision; releasing £62k as no longer required.

Other provisions include the following balances carried forward from 2019/20:

- Primary Care Network Roles, £0.52m brought forward. No amounts utilised in 2020/21.
- Primary Care Estates and Technology Transformation Fund, £0.55m brought forward. £0.05m utilised in 2020/21.
- Digital Transformation, £0.49m brought forward. £0.02m utilised in 2020/21.
- On-Line Consultation, £0.34m brought forward. £0.08m utilised in 2020/21.

Other provisions also include the following balances wholly arising in the 2020/21 year:

- Minor Surgeries Backlog, £1.06m
- Pension Shortfall, £0.29m
- Acute Service Improvement Post, £0.09m
- Corporate Education and Training, £0.06m

15. Contingencies

Currently one (2019-20: two) legal claim is pursued against NHS Derby and Derbyshire Clinical Commissioning Group as advised by NHS Resolution, the claim handler. A contingent liability of £nil (2019-20: £4,975) is disclosed due to the conclusion of the case shortly after the accounting period (see note 21).

16. Commitments

NHS Derby and Derbyshire Clinical Commissioning Group had £nil capital commitments or other financial commitments (2019-20: £nil).

17. Financial instruments

17.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities.

Because NHS clinical commissioning group is financed through parliamentary funding, it is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The clinical commissioning group has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the clinical commissioning group in undertaking its activities.

Treasury management operations are carried out by the finance department, within parameters defined formally within the NHS clinical commissioning group standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the NHS clinical commissioning group and internal auditors.

17.1.1 Currency risk

The NHS clinical commissioning group is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The NHS clinical commissioning group has no overseas operations. The NHS clinical commissioning group and therefore has low exposure to currency rate fluctuations.

17.1.2 Interest rate risk

The clinical commissioning group borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for 1 to 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The clinical commissioning group therefore has low exposure to interest rate fluctuations.

17.1.3 Credit risk

Because the majority of the NHS clinical commissioning group and revenue comes parliamentary funding, NHS clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

17.1.4 Liquidity risk

NHS clinical commissioning group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The NHS clinical commissioning group draws down cash to cover expenditure, as the need arises. The NHS clinical commissioning group is not, therefore, exposed to significant liquidity risks.

17.1.5 Financial Instruments

As the cash requirements of NHS England are met through the Estimate process, financial instruments play a more limited role in creating and managing risk than would apply to a non-public sector body. The majority of financial instruments relate to contracts to buy non-financial items in line with NHS England's expected purchase and usage requirements and NHS England is therefore exposed to little credit, liquidity or market risk.

17 Financial instruments cont'd

17.2 Financial assets

	Financial Assets measured at amortised cost 2020-21 £'000	Equity Instruments designated at FVOCI 2020-21 £'000	Total 2020-21 £'000
Equity investment in group bodies		-	-
Equity investment in external bodies		-	-
Loans receivable with group bodies	-		-
Loans receivable with external bodies	-		-
Trade and other receivables with NHSE bodies	1,011		1,011
Trade and other receivables with other DHSC group bodies	1,887		1,887
Trade and other receivables with external bodies	459		459
Other financial assets	-		-
Cash and cash equivalents	110		110
Total at 31 March 2021	**3,467**	**-**	**3,467**

17.3 Financial liabilities

	Financial Liabilities measured at amortised cost 2020-21 £'000	Other 2020-21 £'000	Total 2020-21 £'000
Loans with group bodies	-		**-**
Loans with external bodies	-		**-**
Trade and other payables with NHSE bodies	1,132		**1,132**
Trade and other payables with other DHSC group bodies	34,543		**34,543**
Trade and other payables with external bodies	60,147		**60,147**
Other financial liabilities	-		**-**
Private Finance Initiative and finance lease obligations	-		**-**
Total at 31 March 2021	**95,822**	**-**	**95,822**

18. Operating segments

NHS Derby and Derbyshire Clinical Commissioning Group considers that it has one operating segment, the commissioning of healthcare services.

19. Joint arrangements - interests in joint operations

The "Better Care Funds", "Children and Young People with Complex Needs" and "Integrated Disabled Children's Centre and Services in Derby", are pooled individually under the Section 75 arrangements of the NHS Act 2006. The total of the Clinical Commissioning Group's share of all pooled budgets are as follows:

	2020-21 £'000	2019-20 £'000
Income	(79,158)	(76,903)
Expenditure	78,992	76,826
	(166)	**(77)**

Better CareFund (BCF)

The Clinical Commissioning Group has two BCFs: The Derbyshire County BCF; and the Derby City BCF, which both became operational in 2015.

NHS Derby and Derbyshire Clinical Commissioning Group is a partner to the Derbyshire County BCF, along with NHS Tameside and Glossop Clinical Commissioning Group and Derbyshire County Council. NHS Derby and Derbyshire Clinical Commissioning Group is also a partner to the Derby City BCF, along with Derby City Council. The operation of the pools is ultimately managed by the Derbyshire Health and Wellbeing Board represented by members from each of the partners. The Funds operate as Section 75 pooled budgets.

Total agreed contributions to the Derbyshire County BCF pool are £103,982,942 including iBCF funding (2019-20: £101,476,251); £69,300,908 excluding iBCF (2019-20: £70,421,523). Total agreed contributions to the Derby City BCF pool are £32,840,601 including iBCF funding (2019-20: £31,654,818); £21,149,743 excluding iBCF (2019-20: £21,112,529).

The BCF aims to improve the provision of health and social care. All partners contribute to a pooled fund and the overarching objective of the fund is to support the integration of health and social care and align commissioning as agreed between the partners.

In April 2017 the Improved Better Care Fund (iBCF) commenced. This is a direct grant to local government, with a condition that it is pooled into the local BCF plan. In 2020-21 the Derbyshire County Council received additionally £34,682,034 (2019-20: £31,054,728); and Derby City Council additionally £11,690,858 (2019-20: £10,542,289) of funding direct from the Government with the aim of:

- Meeting adult social care needs
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready
- Ensuring that the local social care provider market is supported

Under the agreements, the two BCF pools are each split into 2 areas:

- Contributions to a pooled fund by all partners and commissioned by the local authority who are host and lead
- Commissioning of existing funded schemes directly by each partner

The memorandum account for the "Derbyshire County Better Care Fund" pooled budget is:

	2020-21	**2020-21 Pool Share**	2019-20	2019-20 Pool Share
	£'000	**%**	£'000	%
Income				
NHS Derby and Derbyshire CCG	(57,255)	55.06	(55,878)	55.07
NHS Tameside and Glossop CCG	(2,501)	2.41	(2,389)	2.35
Derbyshire County Council	(44,227)	42.53	(43,209)	42.58
Total Income	**(103,983)**	**100.00**	(101,476)	100.00

	2020-21	2019-20
Expenditure	**£'000**	£'000
CCG schemes aimed at reducing non elective activity	21,575	22,092
CCG schemes - wheelchairs	1,035	984
Derbyshire County Council schemes	7,898	6,961
ICES (Integrated Community Equipment Service)	5,770	5,499
Reablement	11,007	10,498
7 Day working	1,477	1,405
Administration, Performance and Information Sharing	538	512
Care Bill	2,259	2,149
Delayed Transfer of Care	7,606	7,169
Carers	2,154	2,048
Integrated Care	1,643	1,566
Workforce Development	2,820	2,695
Dementia Support	1,781	1,702
Autism and Mental Health	1,738	1,514
iBCF	31,055	31,055
Winter Pressures Grant	3,627	3,627
Total Expenditure	**103,983**	101,476
Net position for Pool	**0**	0

19. Joint arrangements - interests in joint operations, continued.

The memorandum account for the "Derby City Better Care Fund" pooled budget is:

	2020-21	**2020-21 Pool Share**	2019-20	2019-20 Pool Share
	£'000	**%**	£'000	%
Income				
NHS Derby and Derbyshire CCG	(18,557)	56.51	(17,647)	55.75
Derby City Council	(14,284)	43.49	(14,008)	44.25
Total Income	**(32,841)**	**100.00**	(31,655)	100.00

	2020-21	2019-20
Expenditure	**£'000**	£'000
CCG schemes aimed at reducing non elective activity	3,744	3,560
Derby City Council schemes	2,323	2,048
Community Health Services	5,935	5,657
Social Care	8,453	8,039
Mental Health	524	498
Accident & Emergency	171	162
iBCF	10,542	10,542
Winter Pressures Grant	1,149	1,149
Total Expenditure	**32,841**	31,655
Net position for Pool	**0**	0

NHS Derby and Derbyshire Clinical Commissioning Group is also a partner of the "Children and Young People with Complex Needs" pooled budget along with Derbyshire County Council. This pool is hosted by Derbyshire County Council.

The memorandum account for the "Children and Young People with Complex Needs" pooled budget is:

	2020-21	**2020-21 Pool Share**	2019-20	2019-20 Pool Share
	£'000	**%**	£'000	%
Income				
NHS Derby and Derbyshire CCG	(2,335)	33.00	(2,367)	33.00
Derbyshire County Council	(4,740)	67.00	(4,805)	67.00
Total Income	**(7,075)**	**100.00**	(7,172)	100.00

	2020-21	2019-20
Expenditure	**£'000**	£'000
Purchase of equipment and healthcare services	7,075	7,172
Total Expenditure	**7,075**	7,172
Net position for Pool	**0**	0

19. Joint arrangements - interests in joint operations, continued.

NHS Derby and Derbyshire Clinical Commissioning Group is also a partner of the "Integrated Disabled Children's Centre and Services in Derby" pooled budget, along with Derby City Council. This pool is hosted by Derby City Council.

The memorandum account for the "Integrated Disabled Children's Centre an Services in Derby" pooled budget is:

	2020-21	**2020-21 Pool Share**	2019-20	2019-20 Pool Share
	£'000	**%**	£'000	%
Income				
NHS Derby and Derbyshire CCG	(1,011)	43.62	(1,011)	44.28
Derby City Council	(1,307)	56.38	(1,272)	55.72
Total Income	**(2,318)**	**100.00**	(2,283)	100.00

	2020-21	2019-20
Expenditure	**£'000**	£'000
Residential Services	1,033	1,067
Community Service Team (Outreach Service)	276	301
Disability and Fieldwork Social Work Services	4	3
Management and Administration	797	789
Total Expenditure	**2,110**	2,160
Net position for Pool	**(208)**	(123)
Balance brought forward as at 1 April	(173)	(50)
Balance carried forward as at 31 March	**(381)**	(173)
NHS Derby and Derbyshire CCG share of surplus as at 31 March	**(166)**	(77)

The Integrated Disabled Chldren's Centre and Services in Derby pooled budget reported an underspend of £208k for the year (2019-20: £123k), with a total accumulated underspend of £381k at 31 March 2021 (2019-20: £173k).
NHS Derby and Derbyshire Clinical Commissioning Group's share of the accumulated underspend was £166k (2019-20: £77k). This amount has been carried forward in the pool.

20 Related party transactions

During the year none of the Governing Body Members or parties related to them have undertaken any material transactions with NHS Derby and Derbyshire Clinical Commissioning Group, other than those set out below (transactions identified were not with the member but between the Clinical Commissioning Group and the related party).

Details of related party transactions with individuals are as follows:

Body	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
College Street Medical	56	-	-	-
Derby City Council	30,346	(130)	3,309	(127)
Derbyshire County Council	73,858	(449)	7,766	(126)
Emmett Carr Surgery	696	-	-	-
Erewash Health Partnership	1,561	-	148	-
Hannage Brook Medical Centre	43	-	-	-
Killamarsh Medical Practice	1,103	-	-	-
Lakhani Jordan Bhatia & Partners	1,772	-	-	-
Lindop Williams Merrick & Partners	1,266	-	-	-
Littlewick Medical Centre	2,531	-	-	-
Moir Medical Centre	26	-	-	-
Natt And Miller	614	-	-	-
NHSE Central And Midlands	42	(239)	30	(2,033)
North Eastern Derbyshire Healthcare Ltd	1,075	-	-	-
Nottingham University Hospitals NHS Trust	43,505	-	-	-
Ramchandran & Partners	746	-	-	-
St Lawrence Road Surgery	22	-	-	-
Staffa Health	2,343	-	-	-
Swadlincote Surgery	1,751	-	-	-
The Rotherham Nhs Foundation Trust	233	(2)	3	-
University Hospitals Of Derby And Burton NHS Foundation Trust	499,822	(3)	75	(3)
University Hospitals Of Leicester NHS Trust	1,251	-	29	-
Vernon Street Medical Centre	1,118	-	-	-

All transactions have been at arm's length as part of NHS Derby and Derbyshire Clinical Commissioning Group's healthcare commissioning.

The Department of Health is regarded as a related party. During the year the Clinical Commissioning Group has had a significant number of material transactions with entities for which the Department is regarded as the parent Department. For example:

• NHS England including: NHS England Midlands; NHS Arden & GEM Commissioning Support Unit; NHS Midlands and Lancashire Commissioning Support Unit; NHS North of England Commissioning Support Unit
• NHS Foundation Trusts including: Chesterfield Royal Hospitals NHS Foundation Trust; Derbyshire Community Healthcare Services NHS Foundation Trust; Derbyshire Healthcare NHS Foundation Trust; and University Hospitals of Derby and Burton NHS Foundation Trust
• NHS Trusts including: East Midlands Ambulance Service NHS Trust; and Nottingham University Hospitals NHS Trust
• NHS Resolution; and,
• NHS Business Services Authority

NHS Derby and Derbyshire Clinical Commissioning Group also has material transactions with all the GP Practices within its locality and membership.

In addition, NHS Derby and Derbyshire Clinical Commissioning Group has had a number of material transactions with other Government departments and other central and local government bodies. Most of these transactions have been with Derby City Council; and Derbyshire County Council, in respect of joint enterprises.

During 2019/20 the following related party transactions were made with NHS Derby and Derbyshire Clinical Commissioning Group (transactions identified were not with the member but between the Clinical Commissioning Group and the related party):

Related Party	Payments to Related Party	Receipts from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£'000	£'000	£'000	£'000
College Street Medical	791	-	-	-
Derby City Council	18,980	(4)	1,191	(297)
Derbyshire County Council	72,505	(1,144)	115	(1,054)
Derbyshire Health United	20,141	-	148	-
Emmett Carr Surgery	618	-	-	-
Erewash Health Partnership	1,900	-	-	-
Hannage Brook Medical Centre	1,127	-	-	-
Killamarsh Medical Practice	1,079	-	-	-
Killamarsh Pharmacy LLP	1	-	-	-
Littlewick Medical Centre	2,399	-	-	-
Moir Medical Centre	1,746	-	-	-
NHS South West Lincolnshire CCG	1	(12)	-	(6)
North Eastern Derbyshire Healthcare Ltd	1,023	-	37	-
Nottingham University Hospitals NHS Trust	41,965	-	931	-
Sheffield Health & Social Care NHS Foundation Trust	658	-	-	(26)
St Lawrence Road Surgery	612	-	-	-
Staffa Health	2,553	-	-	-
Swadlincote Surgery	1,650	-	-	-
University Hospitals of Derby and Burton NHS Foundation Trust	402,684	(55)	5,566	(2,924)
University Hospitals of Leicester NHS Trust	1,285	-	152	-
University of Nottingham	-	(8)	-	(8)
Vernon Street Medical Centre	1,161	-	-	-

21 Events after the end of the reporting period

NHS Derby and Derbyshire Clinical Commissioning Group were notified on 19 April 2021 of an agreed settlement after the reporting period, resulting in a liability of £3,000. A provision of £2,250 had been recognised as at 31 March 2021, with a further £750 disclosed as a contingent liability. The notification was considered an adjusting event and as such, the full value of £3,000 is now recognised as a provision with no contingent liability disclosed.

22 Losses and special payments

22.1 Losses

The total number of NHS clinical commissioning group losses and special payments cases, and their total value, was as follows:

	Total Number of Cases 2020-21 Number	**Total Value of Cases 2020-21 £'000**	Total Number of Cases 2019-20 Number	Total Value of Cases 2019-20 £'000
Administrative write-offs	3	11	1	1
Fruitless payments	-	-	-	-
Store losses	-	-	-	-
Book Keeping Losses	-	-	-	-
Constructive loss	-	-	-	-
Cash losses	-	-	-	-
Claims abandoned	-	-	-	-
Total	**3**	**11**	**1**	**1**

A historical debt of £10,000 (2019/20:£1,285), owed to NHS Southern Derbyshire Clinical Commissioning Group was wriiten off. A further £681 of staff costs were written off , along with the loss of a laptop at nil cost to the Clinical Commissioning Group.

22.2 Special payments

	Total Number of Cases 2020-21 Number	**Total Value of Cases 2020-21 £'000**	Total Number of Cases 2019-20 Number	Total Value of Cases 2019-20 £'000
Compensation payments	1	10	-	-
Compensation payments Treasury Approved	-	-	-	-
Extra Contractual Payments	-	-	-	-
Extra Contractual Payments Treasury Approved	-	-	-	-
Ex Gratia Payments	-	-	-	-
Ex Gratia Payments Treasury Approved	-	-	-	-
Extra Statutory Extra Regulatory Payments	-	-	-	-
Extra Statutory Extra Regulatory Payments Treasury Approved	-	-	-	-
Special Severance Payments Treasury Approved	-	-	-	-
Total	**1**	**10**	**-**	**-**

During the year, a compensation settlement of £10,000 was agreed for an historic personal injury claim with NHS Erewash Clinical Commissioning Group.

23 Financial performance targets

NHS Clinical Commissioning Group have a number of financial duties under the NHS Act 2006 (as amended).
NHS Clinical Commissioning Group performance against those duties was as follows:

	2020-21 Target	**2020-21 Performance**	**Duty Achieved**	2019-20 Target	2019-20 Performance	Duty Achieved
Expenditure not to exceed income	1,900,759	1,900,461	Yes	1,684,086	1,684,067	Yes
Capital resource use does not exceed the amount specified in Directions	60	60	Yes	442	442	Yes
Revenue resource use does not exceed the amount specified in Directions	1,896,152	1,895,854	Yes	1,678,735	1,678,716	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	Yes	-	-	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	152,099	152,092	Yes	140,639	137,365	Yes
Revenue administration resource use does not exceed the amount specified in Directions	21,005	18,210	Yes	23,431	17,864	Yes

NHS Derby and Derbyshire Clinical Commissioning Group achieved an in-year surplus of £298k (2019/20: £19k).

The "Revenue resource use on specified matter(s)" relates to primary care co-commissioning, delegated to NHS Derby and Derbyshire Clinical Commissioning Group. Primary care co-commissioning resource and expenditure are also included in the financial performance targets: "Expenditure not to exceed income"; and "Revenue resource use does not exceed the amount specified in directions".

AUDITOR’S REPORT

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS DERBY AND DERBYSHIRE CLINICAL COMMISSIONING GROUP

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of NHS Derby and Derbyshire Clinical Commissioning Group ("the CCG") for the year ended 31 March 2021 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give 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
- have 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.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the CCG in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accountable Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accountable Officer's conclusions, we considered the inherent risks to the CCG's operating model and analysed how those risks might affect the CCG's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Accountable Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate;
- we have not identified, and concur with the Accountable Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the CCG's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the CCG will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the CCG's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the CCG's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported expenditure as a result of the need to achieve statutory targets delegated to the CCG by NHS England.
- Reading Governing Body and Audit Committee minutes.
- Using analytical procedures to identify any usual or unexpected relationships.
- Reviewing the CCG's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account possible pressures to meet delegated statutory resource limits, we performed procedures to address the risk of management override of controls, in particular the risk that CCG management may be in a position to make inappropriate accounting entries.

On this audit we did not identify a fraud risk related to revenue recognition because of the nature of funding provided to the CCG, which is transferred from NHS England and recognised through the Statement of Changes in Taxpayers' Equity. However, in line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we recognised a fraud risk related to expenditure recognition. We did not identify any additional fraud risks.

We performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included unexpected cash postings and seldom used accounts.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Inspecting transactions in the period following 31 March 2021 to verify expenditure had been recognised in the correct accounting period.

Identifying and responding to risks of material misstatement due to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors and other management (as required by auditing standards), and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

As the CCG is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The CCG is subject to laws and regulations that directly affect the financial statements including financial reporting legislation. Under the NHS Act 2006, as amended by paragraph 223I1 (3) of Section 27 of the Health and Social Care Act 2012, the CCG must ensure that its revenue resource allocation in any financial year does not exceed the amount specified by NHS England. Expenditure in excess of the amount specified is unlawful.

We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items and our work on the regularity of expenditure incurred by the CCG in the year of account.

Whilst the CCG is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2020/21. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2020/21.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 83, the Accountable Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the CCG's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Opinion on regularity

We are required to report on the following matters under Section 25(1) of the Local Audit and Accountability Act 2014.

In our opinion, in all material respects, the expenditure and income recorded in the financial statements have been applied to the purposes intended by Parliament and the financial transactions conform to the authorities which govern them.

Report on the CCG's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the CCG to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 83, the Accountable Officer is responsible for ensuring that the CCG exercises its functions effectively, efficiently and economically. We are required under section 21(1)(c) of the Local Audit and Accountability Act 2014 to be satisfied that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the CCG's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the CCG had proper arrangements in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if we refer a matter to the Secretary of State and NHS England under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the CCG, or an officer of the CCG, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in this respect.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Members of the Governing Body of NHS Derby and Derbyshire CCG, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Members of the Governing Body of the CCG, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Members of the Governing Body, as a body, for our audit work, for this report or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of NHS Derby and Derbyshire CCG for the year ended 31 March 2021 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Andrew Cardoza
for and on behalf of KPMG LLP
Chartered Accountants
1 Snow Hill Queensway
Birmingham
B4 6GH

14 June 2021

APPENDICES

Appendix One: CCG Attendance at Meetings 2020/21

Governing Body Attendance Record 2020/21

Governing Body Member	2 Apr 2020 (C)	16 Apr 2020 (C)	23 Apr 2020 (C)	30 Apr 2020 (C)	7 May 2020 (C)	14 May 2020 (C)	21 May 2020 (C)	4 Jun 2020 (C)	18 Jun 2020 (C)	2 Jul 2020	6 Aug 2020	3 Sep 2020	1 Oct 2020	5 Nov 2020	3 Dec 2020	14 Jan 2021	4 Feb 2021	4 Mar 2021
Dr Avi Bhatia *Clinical Chair*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Martin Whittle *Vice Chair, Lay Member for Patient and Public Involvement*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Chris Clayton *Chief Executive Officer*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Richard Chapman *Chief Finance Officer*	✓	✓	✓	✓	✓	X*	✓	✓	✓	✓	X*	✓	✓	✓	✓	✓	✓	✓
Brigid Stacey *Chief Nurse Officer*	✓	X	X	X	✓	✓	✓	✓	✓	✓	✓	X*	✓	✓	✓	✓	✓	✓
Dr Steven Lloyd *Executive Medical Director*	✓	X	X	X	X	✓	X	X	X	✓	✓	X*	✓	✓	✓	✓	X*	✓
Dr Penny Blackwell *GP Member*	X	✓	X	✓	✓	X	X	✓	X	✓	X	✓	X	✓	✓	X	✓	✓
Dr Ruth Cooper *GP Member*	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Bukhtawar Dhadda *GP Member*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	X	✓	✓	✓	X
Dr Emma Pizzey *GP Member*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X
Dr Greg Strachan *GP Member*	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Merryl Watkins *GP Member*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

(C) signifies the confidential meetings that were held while the CCG was operating at business continuity level four.
* Indicates where a member was deputised.

Governing Body Member	2 Apr 2020 (C)	16 Apr 2020 (C)	23 Apr 2020 (C)	30 Apr 2020 (C)	7 May 2020 (C)	14 May 2020 (C)	21 May 2020 (C)	4 Jun 2020 (C)	18 Jun 2020 (C)	2 Jul 2020	6 Aug 2020	3 Sep 2020	1 Oct 2020	5 Nov 2020	3 Dec 2020	14 Jan 2021	4 Feb 2021	4 Mar 2021
Jill Dentith *Lay Member for Governance and Freedom to Speak Up Guardian*	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ian Gibbard *Lay Member for Audit and Conflicts of Interest Guardian*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Andrew Middleton *Lay Member for Finance and Sustainability Champion*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Simon McCandlish *Lay Member for Patient and Public Involvement*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Professor Ian Shaw *Lay Member for Primary Care Commissioning*	✓	✓	✓	X	✓	✓	✓	✓	✓	X	X	✓	X	✓	✓	✓	✓	✓
Dr Bruce Braithwaite *Secondary Care Consultant*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	X
Helen Dillistone *Executive Director of Corporate Strategy and Delivery*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sandy Hogg *Executive Turnaround Director*	✓	X	X	X	X	X	X	X	✓	✓								
Zara Jones *Executive Director of Commissioning Operations*	✓	X	X	X	X	X	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Robyn Dewis *Derby City Council Representative*	X	X	X	X	X	X	✓	✓	✓	X	✓	X	✓	X	✓	X	X	X
Dean Wallace *Derbyshire County Council Representative*	X	X	✓	X	X	X	X	X	✓	✓	✓	✓	X	✓	X	X	✓	X

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 *Chair, Lay Member for Audit and Conflicts of Interest Guardian*	✓	✓	✓	✓	✓	✓
Jill Dentith *Deputy Chair, Lay Member for Governance and Freedom to Speak Up Guardian*	✓	✓	X	✓	✓	✓
Andrew Middleton *Lay Member for Finance and Sustainability Champion*	✓	✓	✓	✓	✓	✓
Dr Bruce Braithwaite *Secondary Care Consultant*[+]	X	X	X	X	X	X

Primary Care Commissioning Committee Attendance Record 2020/21

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

Remuneration Committee Attendance Record 2020/21

Remuneration Committee Member	30 June 2020	29 Sep 2020	17 Nov 2020	19 Jan 2021
Martin Whittle *Chair, Lay Member for Patient and Public Involvement*	✓	✓	✓	X
Ian Gibbard *Lay Member for Audit and Conflicts of Interest Guardian*	✓	✓	✓	✓
Jill Dentith *Lay Member for Governance and Freedom to Speak Up Guardian*	✓	✓	✓	X
Andrew Middleton	✓	✓	✓	✓

[+] 'By invitation' in accordance with the Committee's workplan or where clinical input is required.
[°] Primary Care Commissioning Committee membership was amended in November 2020.
* Indicates where a member was deputised.

Remuneration Committee Member	30 June 2020	29 Sep 2020	17 Nov 2020	19 Jan 2021
Lay Member for Finance and Sustainability Champion				

Clinical and Lay Commissioning Committee Attendance Record 2020/21

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

Engagement Committee Attendance Record 2020/21

Engagement Committee Member	17 Jun 2020	29 July 2020	16 Sep 2020	21 Oct 2020	18 Nov 2020	20 Jan 2021	16 Mar 2021
Martin Whittle *Chair, Lay Member for Patient and Public Involvement*	✓	✓	X	✓	✓	X	✓
Simon McCandlish *Deputy Chair, Lay Member for Patient and Public Involvement*	X	✓	✓	✓	✓	✓	✓
Professor Ian Shaw *Lay Member for Primary Care Commissioning*	✓	✓	✓	✓	✓	✓	✓

* Indicates where a member was deputised.

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

Finance Committee Attendance Record 2020/21

Finance Committee Member	25 June 2020	30 July 2020	27 Aug 2020	24 Sep 2020	21 Oct 2020	26 Nov 2020	17 Dec 2020	28 Jan 2021	25 Feb 2021	25 Mar 2021
Andrew Middleton *Chair, Lay Member for Finance and Sustainability Champion*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Martin Whittle *Lay Member for Patient and Public Involvement*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ian Gibbard	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

* Indicates where a member was deputised.

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

Governance Committee Attendance Record 2020/21

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

Quality and Performance Committee Attendance Record 2020/21

Quality and Performance Committee Member	25 June 2020	30 July 2020	27 Aug 2020	24 Sep 2020	29 Oct 2020	26 Nov 2020	18 Dec 2020	28 Jan 2021	25 Feb 2021	25 Mar 2021
Dr Bukhtawar Dhadda *Chair, GP Member*	✓	✓	X	✓	X	✓	✓	✓	✓	✓
Dr Emma Pizzey *GP Member*	✓	✓	✓	✓	✓	✓	X	✓	✓	✓
Dr Greg Strachan *GP Member*	✓	✓	✓	✓	✓	✓	✓	✓	✓	X
Dr Merryl Watkins *GP Member*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Andrew Middleton *Lay Member for Finance and Sustainability Champion*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Simon McCandlish *Lay Member for Patient and Public Involvement*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Martin Whittle *Lay Member for Patient and Public Involvement*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

* Indicates where a member was deputised.

Quality and Performance Committee Member	25 June 2020	30 July 2020	27 Aug 2020	24 Sep 2020	29 Oct 2020	26 Nov 2020	18 Dec 2020	28 Jan 2021	25 Feb 2021	25 Mar 2021
Brigid Stacey *Chief Nurse Officer*	✓	✓	X	✓	✓	✓	✓	✓	✓	X
Dr Steven Lloyd *Executive Medical Director*	X	✓	✓	✓	✓	X	X	X	X	X
Dr Bruce Braithwaite *Secondary Care Consultant*	X	X	✓	✓	✓	✓	X	X	✓	X
Zara Jones *Executive Director of Commissioning Operations*	X	✓	✓	✓	X*	X*	X*	X*	X*	X
Helen Henderson-Spoors *Healthwatch Derbyshire Representative*	X	X	X	X	X*	X*	X	X*	X*	X

GLOSSARY

Glossary

2WW	Two-week wait
A&E	Accident and Emergency
Bn	Billion
C1, C2, C3, C4	Category 1, Category 2, Category 3, Category 4
CAMM	Citizens Advice Mid-Mercia
CCG	Clinical Commissioning Group
CETV	Cash Equivalent Transfer Value
CPA	Care Programme Approach
CQC	Care Quality Commission
CRHFT	Chesterfield Royal Hospital NHS Foundation Trust
CYP	Children and Young People
DCA	Derbyshire Carers Association
DCHSFT	Derbyshire Community Health Services NHS Foundation Trust
DHcFT	Derbyshire Healthcare NHS Foundation Trust
DHU111	Derbyshire Health United 111 (East Midlands) Community Interest Company
DPST	NHS Data Security and Protection Toolkit
E.coli	Escherichia coli
ED	Emergency Department
EMAS	East Midlands Ambulance Service NHS Trust
EU	European Union
FTE	Full Time Equivalent
GBAF	Governing Body Assurance Framework
GP	General Practitioner
HR	Human Resources
IAPT	Improving Access to Psychological Therapies
ICS	Integrated Care System
IT	Information Technology
IV	Intravenous

JUCD	Joined Up Care Derbyshire
K	Thousand
KPI	Key Performance Indicator
LTC	Long Term Condition
m	Million
MECS	Minor Eye Conditions Service
MOL	Medicines Order Line
MSK	Musculoskeletal
NECS	North of England Commissioning Support
NHS	National Health Service
NHSE	NHS England
NHSE&I	NHS England and NHS Improvement
OEIG	Organisation Effectiveness and Improvement Group
PCCC	Primary Care Commissioning Committee
PCN	Primary Care Network
PPE	Personal Protective Equipment
PSC	Personal Services Company
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plans
SCCP	Strategic Clinical Conditions and Pathways
SOP	Standard Operating Procedure
SQI	Supporting Quality Improvement
TCP	Transforming Care Partnership
UHDBFT	University Hospitals of Derby and Burton NHS Foundation Trust
UTC	Urgent Treatment Centre
VCSE	Voluntary, Community and Social Enterprise Sector
VSM	Very Senior Manager
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard

About NHS Derby and Derbyshire Clinical Commissioning Group

NHS Derby and Derbyshire Clinical Commissioning Group brings together the combined expertise of 112 local GP Practices to commission health services on behalf of over 1,062,000 patients in Derby and Derbyshire. Our vision is to continuously improve the health and wellbeing of the people of Derby and Derbyshire, using all resources as fairly as possible.

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