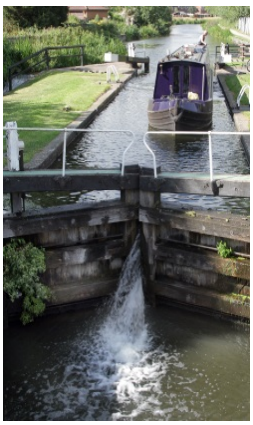
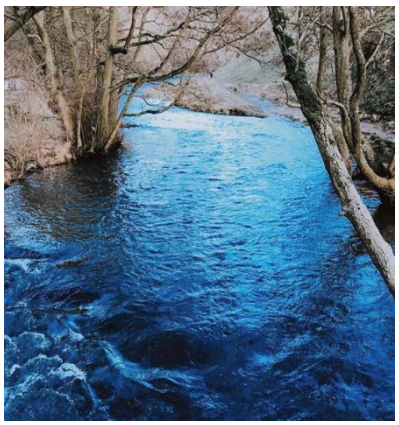
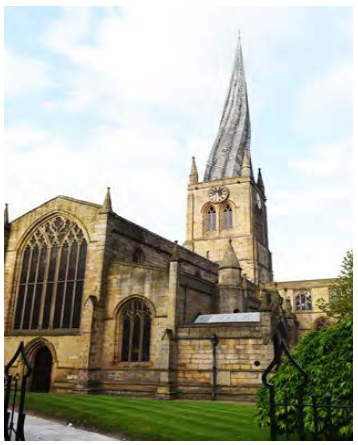
NHS
Derby and Derbyshire
Clinical Commissioning Group



NHS Derby and Derbyshire Clinical Commissioning Group Annual Report & Accounts 2019–2020



CONTENTS

FOREWORD

My name is Dr Avi Bhatia and I am Chair of NHS Derby and Derbyshire Clinical Commissioning Group (CCG) and also a General Practitioner (GP) at the Moir Medical Centre in Erewash. I am delighted to welcome you to our first annual report further to the merger of the four previous Derbyshire CCGs on the 1st April 2019. My first year as Chair has seen some significant challenges and also change at both CCG and system level which you will see described throughout this report. By 'system' I mean all the organisations involved in providing health and care to the people of Derby and Derbyshire.

From a Governing Body perspective we started the year with the following challenges, which we continually revisit to assess our progress against them:

- to continue to develop our strategy as a new CCG while at the same time developing the role and function for strategic commissioning;
- fulfilling our obligations and ambitions for quality of care and delivering better performance in a complex system; and
- to continue to transform services that deliver both better health outcomes for our people and demonstrate better value of the Derbyshire pound.

We are a proactive Governing Body, which is made up of Clinical, Lay, Public Health and Executive representation. One of our priorities is to ensure that we are directly engaged with both CCG and system priorities and performance. To help achieve this, clinical Governing Body members are a mix of Primary and Secondary Care Doctors who all have voting rights. This ensures that we have a powerful clinical voice, which is invaluable when making important and sometimes difficult decisions.

Clinical Members

Dr Avi Bhatia
Clinical Chair & Clinical Lead (Moir Medical Centre)

Dr Buk Dhadda
(Swadlincote Surgery)
Chair, Quality & Performance Committee

Dr Emma Pizzey
(Littlewick Medical Centre)

Dr Greg Strachan
(Killamarsh Medical Practice)

Dr Merryl Watkins
(The Lanes Medical Centre)

Dr Penny Blackwell
(Hannage Brook Medical Centre)
Chair, Derbyshire Place Board

Dr Ruth Cooper
(Staffa Health)
Chair, Clinical & Lay Commissioning Committee

Dr Bruce Braithwaite
(Secondary Care Consultant)

Chairing CCG Committees is an important route to ensuring direct Governing Body involvement, and each Lay Member is a committee Chair which links to their Governing Body lead role and their field of expertise. I would like to introduce our Lay Members, who all have voting rights, as follows:

Lay Members

Martin Whittle
Lay Member for Patient Participation and Involvement
Vice Governing Body Chair
Chair, Engagement Committee and Remuneration Committee

Gill Orwin
Lay Member for Patient Participation and Involvement
Vice Chair, Primary Care Commissioning Committee and Engagement Committee

Andrew Middleton
Lay Member for Finance
Chair, Finance Committee

Ian Gibbard
Lay Member for Audit and Conflicts of Interest Guardian
Chair, Audit Committee

Professor Ian Shaw
Lay Member for Primary Care Commissioning
Chair, Primary Care Commissioning Committee

Jill Dentith
Lay Member for Governance and Freedom to Speak Up Guardian
Chair, Governance Committee

Our Governing Body members representing Public Health bring yet another dimension and help to ensure that we have a tremendous range of experience and expertise representing a broad range of interests. Public Health representatives are non-voting members on our Governing Body.

Public Health Representatives

Dr Robyn Dewis
Derby City Council
Acting Director of Public Health

Dean Wallace
Derbyshire County Council
Director of Public Health

Our Executive Team provide collective executive leadership across the CCG and are held to account by the Governing Body for the development and implementation of commissioning and contracting strategy, organisational development, financial planning, improvements in clinical quality and the delivery of CCG statutory duties. The Executive Team are all voting members of the Governing Body, with the exception of the Executive Director of Commissioning Operations and the Executive Director of Corporate Strategy and Delivery, who both attend Governing Body meetings but do not have voting rights.

Executive Team

Dr Chris Clayton
Chief Executive Officer

Richard Chapman
Chief Finance Officer

Brigid Stacey
Chief Nurse Officer

Dr Steven Lloyd
Medical Director

Sandy Hogg
Executive Director of Turnaround

Zara Jones
Executive Director of Commissioning Operations

Helen Dillistone
Executive Director of Corporate Strategy and Delivery

We have moved rapidly into the next phase of the system partnership alongside our NHS and Local Authority partners over the course of the year. Clinical leadership has a vital role to play as we move our system forward and the Clinical and Professional Reference Group is the Joined Up Care Derbyshire vehicle for coordinating and representing our professional and clinical voice. The Terms of Reference for the Clinical and Professional Reference Group have recently been reviewed to strengthen its positioning within our Sustainability and Transformation Partnership and this is important as we move towards becoming an Integrated Care System (ICS).

The Chairs of each partner organisation have a clear role to play in moving our system forward at pace and in early 2020 fellow Chairs across the partnership started a programme of regular meetings to facilitate this. One of our main objectives is to work jointly to support our respective organisations to operate more effectively together on behalf of our patients, and also ensuring that we function more efficiently through reducing duplication. From a Chair's perspective we also want to create stronger links between our Governing Bodies and Boards and we will continue to meet regularly to take this forward.

As I close my foreword, the system connectivity I have mentioned above has become a vital element as part of our Derbyshire health and care system emergency response to the Coronavirus pandemic. At the time of writing, our system is working extremely cohesively and at tremendous pace to provide treatment and an ever increasing level of critical care for our sickest patients; whilst doing everything possible to protect all our patients, citizens and staff.

This unprecedented situation has seen the system work together in an unparalleled way, and from a CCG perspective our commissioning role has adapted at pace as we support the system to adopt significant changes promptly to facilitate the additional capacity and space that we need as part of our emergency response. Services are changing rapidly and one of our priorities is to ensure that our patients are kept informed and assured. As I see our clinicians and staff respond to challenges we have never seen before, I have never been more proud to be a part of our NHS. I want to pay tribute to those colleagues who continue to deliver in the face of such adversity and to those who themselves have faced illness and in some cases sadly succumbed to the Coronavirus.

At this point it is difficult to predict how 2020/21 will develop as it will depend on how quickly and effectively we are able to manage the Coronavirus pandemic both locally and at a national level. Whatever happens next I can assure you of our absolute commitment in continuing to transform the health and wellbeing of local people and subject to events, the next phase of our journey to becoming an ICS. Our objectives remain to bring care closer to home, help more people stay well and prevent ill health in the first place and 2020/21 will be a vitally important year for us and the wider health and care system in Derbyshire.

Dr Avi Bhatia
Clinical Chair
NHS Derby and Derbyshire Clinical Commissioning Group

PERFORMANCE REPORT

Dr Chris Clayton

Accountable Officer

NHS Derby and Derbyshire CCG

26 May 2020

Chief Executive Officer's Statement

Welcome to the first annual report for NHS Derby and Derbyshire Clinical Commissioning Group (CCG). This is our first year of operations since the successful merger of Southern Derbyshire, North Derbyshire, Erewash and Hardwick CCGs on the 1st April 2019. For the reporting year we had a budget of over £1.7bn and 114 GP Practices serving a population of over 1,055,000 people.

I am pleased to report that as one of the first counties to see a merger of its Clinical Commissioning Groups, Derbyshire has been seen as leading the field nationally in this area and senior colleagues have been requested to share our good practice on a number of national platforms. This includes leading and supporting information sessions about process and sharing our approach to engagement about the merger.

One of our earliest priorities following the merger was to consolidate our operations, ensuring that our staff would quickly settle into their roles to guarantee continuity of delivery; so we quickly introduced a programme of organisational development. Our first year has also seen us respond to some important priorities, with the financial challenge continuing to be one of our most significant strategic objectives. This year has seen us adapt our savings plan so that we can move from a transactional to a transformational approach, with the aim that we are continually improving the experiences of our patients whilst also improving efficiencies. We have delivered the control total we agreed with our NHS regulators for 2019/20, which ensures our entitlement to the Commissioner Sustainability Fund (CSF) of £29m. The year has also seen us move towards a system approach to the financial challenge, including the development of a System Savings Group as we continue to address the financial challenge of the future.

We continue to play a key role in the progress of the Derbyshire Sustainability and Transformation Partnership (Joined Up Care Derbyshire) as we progress towards becoming an ICS in 2021. This year has seen the concept of Place and Place Alliances become a reality in conjunction with the introduction of Primary Care Networks (PCNs) as part of the system transformation. The development of Integrated Care Partnerships (ICPs) for Derbyshire has moved at real pace since the planning started in earnest in September 2019. These partnerships will be made up of NHS, social care, voluntary sector organisations and other partners. There will be four ICPs for Derbyshire and they are ready to start operating in shadow form as we move into the new operational year on the 1st April 2020. These important developments are described in more detail in this report.

Throughout the year we have sought to strengthen the involvement of our patients and citizens in everything we do and particularly where we are looking to make changes. This builds upon the strong achievement of the four former CCGs for Derbyshire against the Patient and Community Engagement Indicator for 2018/19 where NHS England (NHSE) assessors judged our approach to engagement to be particularly strong and they recorded high levels of assurance.

In the last year we have introduced new channels of engagement to ensure that our approach is increasingly robust and incorporates more opportunities for 'confirm and challenge'. Developments include the Engagement Committee, which forms part of our governance structure and reports directly to our Governing Body; the Citizens Panel, which broadens the scope for engagement with a much greater volume of people; and the Lay Reference Group to seek opinion and challenge on proposed schemes and support for

Patient Participation Group networks to ensure that they have an active role in the emerging ICS.

This year has also seen us engage in new ways of working and on new agendas with our GP membership, and adopt a more proactive approach with regard to Local Authority scrutiny. It has been pleasing to see some particularly positive feedback on our approach to public consultation from both City and County Scrutiny Committees and the Engagement Committee. Involving our patients and putting citizens at the heart of all we do continues to be one of our highest priorities.

The 2019/20 year has seen us make some difficult commissioning decisions which are an inevitable part of our work to transform services to create the right environment for enhancing patient experience whilst maximising efficiency. Examples include changes to rehabilitation pathways in Ilkeston, new models of care for respite short breaks, and supporting GP Practices to consolidate operations, and in some cases to close branches in group GP Practices, to ensure the long term sustainability of vital services. The coming year will see us deliver a broader programme of transformation alongside system partners as we move towards becoming an ICS.

The Annual Report reflects not only the work of the CCG during 2019/20, but the impact on our financial position, performance data and staff absence at the end of 2019/20 following the unprecedented impact of the Coronavirus emergency mid-march. I would like to echo Dr Avi Bhatia's comments above in regards to the cohesive working across the system and thank the CCG staff and wider healthcare community for their flexibility and responsiveness to the Coronavirus emergency. For more information on how the CCG has been asked to respond to this crisis, please see Appendix One for a link to the letter received from Sir Simon Stevens, NHS Chief Executive, and Amanda Pritchard, NHS Chief Operating Officer on the 17th March 2020.

Overall we have made progress at pace in our first year as NHS Derby and Derbyshire CCG and our forward programme of work enables me to offer assurance that we will continue to deliver against our full range of priorities and objectives. 2020/21 is a critical year for the Derbyshire health and care system and I look forward with optimism to the emerging ICS and the developments and improvements it will bring to the way health and care is delivered in Derbyshire and our vital role in this.

Best wishes,

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

26 May 2020

Performance Overview

This overview provides a summary of the purpose and activities of NHS Derby and Derbyshire Clinical Commissioning Group (CCG) and how it has 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 Derbyshire. The CCG has representation from 114 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 officer staff.

Our CCG area covers the residents across Derbyshire, including the populations of Derby city, Chesterfield, Ilkeston and Long Eaton, as well as those living in Amber Valley, Derbyshire Dales, Bolsover District and the High Peak. The CCG serves a population of over 1,055,000 people.

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 tackle them, as articulated in our Derbyshire Sustainability and Transformation Plan. The latest update on developments can be found here.

We were allocated £1,678.7m of public money, split between £1,655.3m to spend on health services and £23.4m for running costs (administration). Running costs refer to the costs incurred for the organisation to exist; costs such as staff salaries, heating, lighting and rent. In 2019/20 the CCG used only £17.1m of the available running cost allocated, which amounts to 1.07% of our overall budget and £16.95 per head of population. This report will explain how this has been used to support your care and how this fits into the fourth year of a five-year plan to meet key priorities.

Patients in our area have access to services from a wide range of providers, including Derbyshire Healthcare NHS Foundation Trust, Derbyshire Community Health Services NHS Foundation Trust and East Midlands Ambulance Service NHS Trust. Our largest contracts are with Chesterfield Royal Hospital NHS Foundation Trust and University Hospitals of

Derby and Burton NHS Foundation Trust, and account for approximately 35% of our funding spend.

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 have delivered the requirements set out to us by the Government in the NHS Mandate and the NHS Constitution pledges.

Key Issues and Risks that could affect the CCG Delivering its Objectives

The key issues and risks to the organisation achieving its objectives are described in the Governance Statement section of this report. In summary, the key risks identified during 2019/20 were:

Risk 1	Ineffective commissioning may prevent the ability of the CCG to improve health and reduce health inequalities
Risk 2	Capacity and capability constraints may mean we will not deliver all of our strategic priorities
Risk 3	Insufficient workforce capacity in our providers may prevent the delivery of our strategic priorities and NHS Constitutional standards
Risk 4	Ineffective system working may hinder the creation of a sustainable health and care system by failing to deliver the scale of transformational change needed at the pace required
Risk 5	We do not commission services that meet the patients' greatest need
Risk 6A	The Derbyshire health system is unable to manage demand, reduce costs and deliver sufficient savings to enable the *CCG* to move to a sustainable financial position
Risk 6B	The Derbyshire health system is unable to manage demand, reduce costs and deliver sufficient savings to enable the *System* to move to a sustainable financial position

Adoption of the Going Concern Approach

The CCG has adopted a 'Going Concern' approach in the preparation of its annual financial statements. This follows the interpretation in the Government Accounting Manual of Going Concern in the public sector.

In summary, this interpretation provides that where a body can show anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that function in published documents (such as financial allocation plans), there is sufficient evidence of Going Concern. The only exception to this approach would be for public sector organisations, which are classed as trading bodies. CCGs being funded by direct allocation through NHSE are not trading bodies.

The adoption of a Going Concern approach by an NHS body can be called into doubt if that body is subject to a report under Section 30 of the Local Audit and Accountability Act 2014. These reports, from the auditor of NHS bodies to the Secretary of State, relate to issues of unlawful expenditure made or contemplated by the body. The CCG has confirmed with its Auditors, that the adoption of the Going Concern approach is appropriate for 2019/20.

Key Developments during 2019/20

Quality, Innovation, Prevention and Productivity Programme

Our Quality, Innovation, Prevention and Productivity programme exists to ensure that the organisation is focused on delivering the best possible outcomes for the population, from the highest quality services within the resources available. This is achieved through a regular review of the value and efficiency of commissioned care.

The four former Clinical Commissioning Groups for Derbyshire experienced significant financial challenge in 2017/18 and in response developed a Medium Term Financial Strategy with an enhanced focus on value and sustainability. Working jointly, the four CCGs developed a detailed efficiency programme in 2018/19 which delivered a £46m benefit through a range of transactional and transformational schemes. Transactional schemes are described as measures that can be implemented within a month that can control spend or activity (usually easy for a single organisation to implement). Transformational schemes are those that take six months or more to implement and require multi-partner input. With the single CCG for Derby and Derbyshire established on the 1st April 2019, the financial year 2019/20 represented the consolidation of the 2018/19 planning approach to value and financial recovery and a commitment to stretch the delivery of transformational change working with system partners.

The 2019/20 Efficiency Plan had at its core an ambitious Clinical Transformation Programme to ensure the improvement of outcomes for patients, population and staff. We began work on the development of the 2019/20 Quality, Innovation, Prevention and Productivity programme in September 2018, holding a number of focused workshops with staff from across the organisation. This programme was then tested and enhanced with input from Derbyshire system partners and patients. The publication of the Joined Up Care Derbyshire (JUCD) Plan and NHS Long Term Plan provided further framing. The following core programme areas have formed the central focus for transformation and improvement in 2019/20:

1. Planned Care
2. Urgent Care
3. Place-Based Integrated Care
4. Primary Care
5. Continuing Healthcare
6. Mental Health
7. Community Services
8. Medicines Management
9. Disease Management and Long Term Conditions
10. Organisational Efficiency

The CCG was forecast to deliver more than £50m of efficiencies in 2019/20 (based on the Month 12 position) with some significant success in key areas of the programme above:

- there has been ongoing work to ensure that Continuing Healthcare processes support the most vulnerable members of our community and work well for individual patients and families in order to help them access the right care at the right time. The Nursing and Quality Team have worked with system partners to ensure that clinicians are working in line with the national framework for Continuing Healthcare. This has ensured efficient processes at the times of greatest patient need;

- effective medicines management ensures that medicines are available when they are needed and patients receive better, safer and more convenient care. In 2019/20 the Medicines Management Team have continued to innovate, working with Primary Care and other providers to ensure the right access to medicines and the appropriate use of medicine prescriptions;
- the Long Term Plan supports the move from delivery of care requiring patients to travel to hospital, into convenient community settings. The Planned Care Teams in the CCG and partner organisations have worked together to look at ways to manage appropriate referrals into hospitals and support people closer to home where clinically appropriate. This has included new pathways for musculoskeletal, diagnostics, and ophthalmology for example, as well as looking at improving the model of care for hospital outpatients;
- internal efficiency and effectiveness has been a key focus for us and we have ensured that organisational management and support costs met national requirements a full year ahead of the national deadline.

The established approach to the Programme Management Office in 2018/19 has continued to provide the rigour and support required to offer assurance on all schemes and ensure the best chance of programme success. Central to this is making sure all the required programme documentation is in place and regularly monitoring progress against objectives.

This financial year has been focused on developing the approach to working as a single system to meet strategic objectives. Despite the determination of the Derbyshire system to improve efficiency and identify improvement opportunities to maximise how spend and cost is reduced, the mobilisation of system clinical transformation has been challenging and as a result the CCG has achieved £49.9m of savings in 2019/20.

This has been achieved by working more closely than ever with our system partners to develop new approaches to care and a vision for achieving financial sustainability as part of the emerging ICS. To support this we have established a single System Savings Group in Derbyshire to ensure that innovation is captured and translated into plans that truly drive value and deliver financial sustainability.

Delivering Urgent Care

It has been a busy year for Urgent Care in Derbyshire, with significant pressure across the health system. The volume of attendances at our Emergency Departments (ED) has been unprecedented; we have seen an increase in attendances of 7.3% relating to Derby and Derbyshire patients. The driver of growth between 2018/19 and 2019/20 is primarily related to ED attendances classified as ‘minor’.

A key focus for this year has been an engagement programme with patients, specifically targeting seldom heard groups and the protected characteristics, to understand the needs of our communities and how they use Urgent Care services. This engagement is ongoing and will support the development of our plans for 2020/21.

Our main achievements, aiming to improve access to and experience of Urgent Care services, are detailed below.

Operational support

The Derbyshire health and social care system worked together to produce a 12 month Operational Plan, which highlighted areas of increased pressure, such as the winter period. The plan evaluated system risks and mitigations to deal with these risks. The system worked well together during periods of escalation and effectively managed the delivery of services during times of pressure.

2019 saw the launch of a revised system of reporting pressure and escalation. The system is online and each provider states a daily red, amber or green rating with additional details relating to their current demand and capacity. The system is updated daily so all providers and stakeholders are aware of the current situation within the county at a glance. It also provides NHSE with the mandatory operational report by 11am each day, seven days a week; significantly reducing administration time for all providers.

Reducing unnecessary attendance and referrals into Emergency Departments

One of our biggest areas of work this year has been to achieve the new standard of <1% of outcomes of NHS 111 calls being advised to attend ED as a 'default' due to our Directory of Services not having a relevant service available for NHS 111 call handlers to refer to. Derbyshire are achieving this standard and the Directory of Services Team continues to monitor this percentage and work with Commissioning Teams to reduce this further.

From April 2019 onwards patients calling NHS 111, some of whom may have ordinarily been advised to go to ED, were subsequently offered a clinical consultation via telephone. The aim was to consult and complete the episode, and negate the need for patients to be referred to ED unnecessarily.

This has consequently shown a decrease in the number of patients who are making visits to ED when not clinically required. Furthermore, we have seen a reduction in the number of referrals to other parts of the urgent care system, demonstrating that not only are we improving outcomes for patients, but we are relieving the pressure on our urgent care system as a whole.

NHS 111 Online was introduced in 2018. It complements the existing national NHS 111 telephone service and can be accessed online or by mobile app 24 hours a day, 365 days a year. Patients answer a series of questions about an emerging health problem and receive health information or advice on where to go.

Since its introduction, the service has been developed further to enable patients to opt to receive a clinical call back depending on the outcome of their journey. The service aims to provide a personalised and responsive service to patients' urgent health needs regardless of whether using NHS 111 or NHS 111 Online.

Further work is being undertaken to determine how we can further harness the potential of the platform to introduce other services that suit the needs of our patients.

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 its patients' needs, with organisations and professionals behaving in a mutually supportive manner. The vision outlines three goals:

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 almost double (from 9%–15%) within 10 years; and
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.

These goals will both be supported by, and help us deliver, the national priorities as set out in NHSE's Long Term Plan; GP Forward View and GP Contract over the next five years.

Primary Care Networks

From the 1st July 2019, GP Practices began to work together in their local areas to form PCNs. Derbyshire has 15 PCNs, covering all 114 GP Practices and the whole population. PCNs are based on GP registered lists, typically serving natural communities of around 30,000 to 50,000. 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 others in the local health and social care system.

The core characteristics of a PCN are:

- GP Practices working together and with other local health and care providers, around natural local communities that geographically make sense, to provide coordinated care through integrated teams;
- 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;
- focus on prevention and personalised care, supporting patients to make informed decisions about their care and look after their own health, by connecting them with the full range of statutory and voluntary services;
- use of data and technology to assess population health needs and health inequalities;
- to inform, design and deliver care models that work at a GP Practice and population scale;
- support clinical decision making, and monitor performance and variation to inform continuous service improvement; and
- making best use of collective resources across GP Practices and other local health and care providers to allow greater resilience, a more sustainable workload and access to a larger range of professional groups.

PCNs have helped to form stronger relationships across GP Practices, and have Memorandum of Understandings in place for purposes of information sharing and supporting

the CCG in central data extraction. Clinical Directors meet regularly to discuss and resolve PCN development issues. PCN Operational Leads also meet regularly to share learning, protocols and best practice, which have proven to benefit PCNs in terms of standardisation and pace of delivery, e.g. recruitment plans.

All PCNs have actively been involved in the recruitment to new roles, i.e. Clinical Pharmacists and Social Prescribing Link Workers. At the time of writing there were 14 Clinical Pharmacists in post (13 Whole Time Equivalent) and 25 Social Prescribing Link Workers (22.8 Whole Time Equivalent). The additional roles have helped to enhance patient care and release GP time. Plans are in place for further recruitment in 2020/21 as set out in the PCN contract. More information on this can be seen in the next section.

Additional Roles Reimbursement Scheme

The Additional Roles Reimbursement Scheme is part of the GP contract agreement which enables PCNs to employ up to 12 additional roles within Primary Care.

Expanding the workforce is the top priority for Primary Care, as far more people are needed to boost capacity in order to:

- alleviate workload pressures on existing staff, and thereby ensure Primary Care is sustainable and can thrive;
- improve patient experience of access, cut waiting times and meet the Government's commitment to provide 50 million more GP Practice appointments; and
- improve the quality of care and implement the NHS Long Term Plan goals, including the integration of care.

The roles included in the Additional Roles Reimbursement Scheme are:

- Clinical Pharmacist
- Social Prescribing Link Worker
- First Contact Physiotherapist
- Physician Associate
- Pharmacy Technician
- Community Paramedic
- Occupational Therapist
- Dietician
- Chiropodist/Podiatrist
- Health and Wellbeing Coach
- Care Coordinator
- Mental Health Practitioner

Derbyshire General Practice Workforce

The total General Practice Workforce for Derbyshire is 3,407; a Full Time Equivalent (FTE) of 2,441.8; which is an overall participation rate (the average hours worked each week by each person) of 71%. This is higher than the national participation rate of 70%. Within the workforce there are four main staff groups. These are:

- General Practitioners – 654 headcount, 506.6 FTE;
- General Practice Nursing – 506 headcount, 363.8 FTE;

- direct patient care (those other than GPs and Nurses who provide care to patients) – 334 headcount, 225.7 FTE; and
- Administration and non-clinical – 1,913 headcount, 1,345.7 FTE.

Each quarter, GP Practices are required to submit their workforce figures into the National Workforce Reporting System. This data is then reviewed and verified by NHS Digital via a data quality exercise before being published in the public domain.

Throughout this year, we have worked closely with NHS Digital and all GP Practices to improve the quality of the information submitted to the National Workforce Reporting System, and we have seen a huge improvement in the accuracy of the figures. Figure 1 demonstrates a decline in the number of GPs working in Derbyshire, but increases in the number of Nurses and those working in direct patient care.

In Derbyshire we have an ageing workforce, with 23% of GPs and 24% of Practice Nurses over the age of 50. Whilst these percentages are high, we are below national average (England average of GPs over 55 is 18% and Nursing is 28%).Whilst this is less than the national average, we know that we need to do more to recruit staff fresh out of training to support the turnover of staff coming to retirement age. Compared to the Midlands region and the national picture, Derbyshire has a lower patient to GP ratio and is performing well in relation to the recruitment and retention of the Primary Care workforce. The introduction of a number of direct patient care staff via the new GP Contract will strengthen the workforce, provide better patient care and improve access.

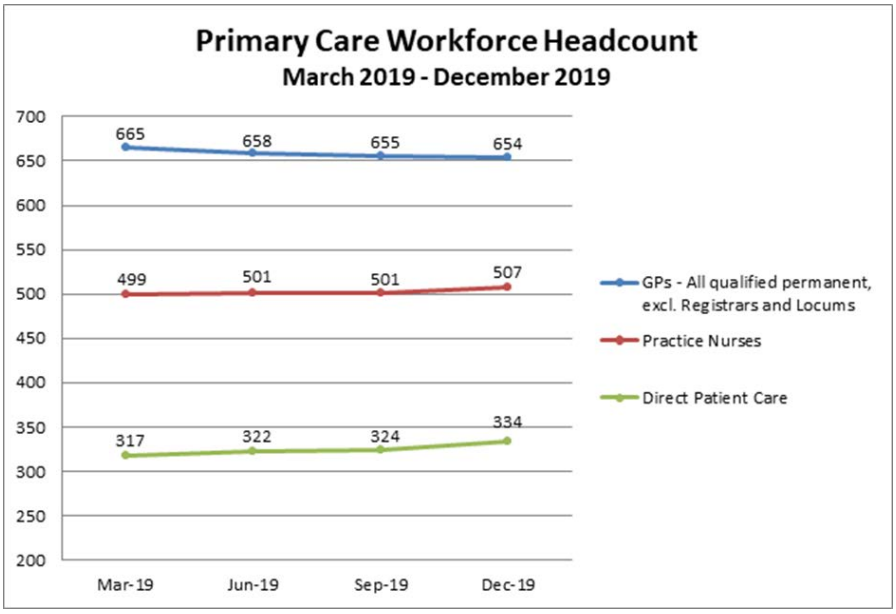


Figure 1: Primary Care Workforce Headcount (March 2019-December 2019[1]). Source: NHS Digital, National Workforce Reporting System

We have implemented a coordinated, structured and targeted approach to GP recruitment and retention via the GP Task Force and local training hub, Health Education Derbyshire, funded by NHS England and NHS Improvement (NHSE&I) and Health Education England. We have developed attractive packages for a portfolio career within at scale working;

[1] At the time of publication it was not possible to validate the January 2020–March 2020 data, however all Primary Care workforce data is published in the public domain on the NHS Digital website here.

Continuing Professional Development; mentoring; flexible working opportunities and funded fellowships schemes for both GPs and Nurses.

We have also worked with PCNs and Place Alliances to look at the current workforce and skill mix, and recruited Nurse Champions to work across PCNs to help us better understand our nursing development needs.

We have established a single Derbyshire Training Hub (Health Education Derbyshire), developing its infrastructure to coordinate future Primary Care training (pre and post-registration) and continued to work with local universities to fill trainee placements and retain trainees.

The Derby and Derbyshire Self-harm and Suicide Prevention Partnership Forum have delivered training courses to colleagues in Primary Care on the delivery of suicide awareness, managing suicidal conversations, and suicide awareness.

Extended Access

As part of our commitment to the General Practice Forward View, extended access for patients to Primary Care has been rolled out across all of Derbyshire and has significantly increased access to Primary Care since October 2018. 14 geographically-based hubs are operating additional appointments daily between 6.30pm–8pm, Saturday and Sunday mornings, including Bank Holidays. This equates to an additional 41,600 appointments per annum. Work is also ongoing to enable NHS 111 to directly book into the extended access appointments to ensure patients are seen in the right place, first time.

The Primary Care Team hold regular contract review meetings with all extended access hub leads to review performance against key national targets.

Monthly utilisation data for each hub is also collected and reported back to NHSE every quarter. All hubs are meeting the target of 75% of appointments utilised and all are working towards achieving 85% of appointments utilised by the 31st March 2020.

Primary Care Estates

The Primary Care Estates Team had three key objectives in 2019/20, which were to:

- establish good governance around estates decisions;
- deliver a Primary Care Estates Strategy with an implementation plan; and
- establish a centralised system to respond to planning authorities and manage the process for requesting developer contributions.

A Primary Care Estates Steering Group was established and is being embedded into the overall governance structure for Primary Care. The group is clear on its role and responsibilities, and meeting minutes are provided on a monthly basis to the Primary Care Commissioning Committee along with a quarterly report highlighting key recommendations for ratification.

The Primary Care Estates Strategy has been drafted; however, the steering group felt that while the document may have broadly met the criteria commissioned by the former Derbyshire CCGs, the format was not fit for purpose. As a result, the strategy is being reviewed and restructured, and will be presented to the Primary Care Commissioning

Committee in April 2020. The restructuring of the strategy has resulted in delayed delivery but it aims to provide a document that better supports estates transformation in Derbyshire.

A central estates mailbox has been established and we are reinforcing its use by planning authorities. Responses to planning applications are now consistent across most of the county and to ensure full coverage from April 2020 onwards a project is underway to establish better relationships with authorities who had not traditionally had a relationship with the NHS. In addition, a system for tracking agreed Section 106 developer contributions is being established to enable effective utilisation of capital. A further workstream with planning authorities and public health is looking at how we shape the process of developer contributions to reflect the changing health landscape and better incorporate the wider determinants of health i.e. considerations other than health, such as housing, air quality and working conditions.

Enhanced Services Review

Following the merger of the four former Derbyshire CCGs in April 2019, a review of enhanced services available for delivery by GP Practices took place. The aim of the review was to ensure consistency of approach in the provision of services available to patients registered with a GP Practice within the newly formed NHS Derby and Derbyshire Clinical Commissioning Group. A clinical review of service specifications took place to ensure services were clinically safe, effective and viable. Following this, a costing exercise took place which ensured the services being delivered were paid at a standard price and demonstrated value for money. A nationally recognised methodology (PSSRU[2]) was utilised for the costings. It took account of the time taken in each consultation or procedure by an individual staff group and also factored in associated costs such as administration.

A new contract will be issued from April 2020 featuring the services reviewed and will largely be commissioned on a cost per activity basis; previous arrangements were generally on a block-type of contract where GP Practices were paid a set fee for the number of patients (or population) on their registered list. Some services cross other work-streams within the CCG

[2] Personal Social Services Research Unit – Unit Cost of Health and Social Care volume

and are currently under review (such as anticoagulation and phlebotomy); as such these will be commissioned under existing arrangements for a period of 12 months to enable the service reviews to take place.

The Enhanced Services Review Group undertaking the review comprised lay representation, GPs, Practice Managers and Practice Nurses; along with Commissioning, Finance and Quality staff from the CCG. The group will continue to meet periodically to review existing specifications and to respond accordingly to an increased requirement for transfer of activity from other NHS providers into a Primary Care setting (as apparent during the review).

Quality

Supporting Quality Improvement Visit

The Supporting Quality Improvement Visit process has been rolled out across all 114 GP Practices in Derbyshire, with all of them receiving a clinically-led Supporting Quality Improvement Visit during the period October 2018–April 2020. Following completion of all the visits an evaluation of the themes, trends and outcomes will be undertaken and shared with all GP Practices. The next programme of visits will be planned and discussion is ongoing as to the frequency of the future visiting programme.

Clinical Governance Leads Meetings

Meetings of Clinical Governance Leads are now established across Derbyshire and are held on a quarterly basis as a mechanism for promoting patient safety and clinical effectiveness. To support clinical engagement for this agenda, reimbursement is included in the quality schedule for Primary Care.

National Screening and Immunisation Programmes

In order to increase the uptake of national screening and immunisation programmes, the team has established links and are working proactively with the screening and immunisation team at NHSE&I. All elements of the national screening and immunisation programmes have been incorporated into a CCG quality workstream. Targeted work has commenced with individual GP Practices and PCNs in relation to increasing uptake of cervical screening; influenza; and measles, mumps and rubella immunisations.

Primary Care Quality and Performance Sub-Committee

The Primary Care Quality and Performance Sub-Committee is a sub-committee of our Primary Care Commissioning Committee (PCCC) and it provides a report detailing the performance of GP Practices on a quarterly basis to PCCC. This year we have developed and implemented a quality matrix for Primary Care. The matrix is reviewed on a monthly basis at the Primary Care Hub meeting and is used as part of the triangulation/risk management of GP Practice related data and intelligence.

General Practice Nursing

This year we have established a steering group to manage the delivery of the 10-point action plan which aims to develop confidence, capability and capacity in General Practice Nursing. The steering group provides coordination, direction and support to those responsible for implementing the plan. The focus this year has been establishing contact and engaging with

all Practice Nurses, both individually and in teams across Derbyshire. Six Practice Nurse Champions were identified and are supporting this work programme.

Part of their remit is to share all relevant information and offer direct support to Practice Nurses. To support this they are establishing an email database for individual Nurses and also at a PCN footprint level. Furthermore, a quarterly General Practice Nurse (GPN) Bulletin is being produced electronically by the CCG, to provide a mechanism for disseminating relevant local and national news and updates. Articles and contributions are requested from GPNs and others working in Primary Care.

The CCG hosted two replica GPN Conferences in the north and south of the county to celebrate the work that had taken place and to discuss the expectations of the 10-point action plan going forward. These were well attended and received feedback that was overall positive. Presenters included national leads from NHSX Digital (a new unit driving forward the digital transformation of health and social care) and the lead for the Experience Led Care Programme.

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 1 identifies the ratings awarded to GP Practices by the CQC for the reporting period up to the 31st March 2020:

Rating	Total GP Practices
Outstanding	23
Good	88
Requires improvement	3
Inadequate	1

Table 1 – CQC ratings awarded to GP Practices up to 31st March 2020

From the 1st April 2019, the CQC changed the way in which they inspected GP Practices. Practices rated as 'good' or 'outstanding' (or 'good overall' with a breach) now have an Annual Regulatory Review (ARR). This is a telephone interview with the GP Practice to see if anything has changed since the previous inspection (either positive or negative) based on the questions detailed here. If any concerns arise from the interview, the CQC may carry out a full inspection. The ARR is announced four weeks in advance by telephone and the interview takes place at a mutually agreed time and date four weeks later. If the CQC decide to inspect after an ARR, this will be focused towards the effective and well-led domains, rather than all five. However, if there are concerns relating to any other domain(s), this will be added into the inspection.

If a GP Practice is rated as 'requires improvement' or 'inadequate', the annual regulatory review process and provider information collection call does not apply.

CQC will continue to inspect within:

- 6 months for a rating of ‘inadequate’; and
- 12 months for a rating of ‘requires improvement’.

Practices rated as ‘good’ or ‘outstanding’ will have a comprehensive inspection every five years, and this will be one of the criteria considered as part of the ARR. In addition, there will still be responsive inspections undertaken in response to any significant concerns which may be identified at any time.

Practices who receive a rating of ‘requires improvement’ are visited by the Primary Care Quality Team following the publishing of the CQC report to offer support. Ongoing support is then provided by the team in the form of quarterly meetings to review progress against an action plan for improvement.

The Primary Care Quality Team will arrange an immediate visit to any GP Practice rated as ‘inadequate’ to offer support however they can. Further support is also provided in the form of monthly meetings where progress towards improvement is monitored.

In addition, the Primary Care Quality Team provides regular updates on the progression of the GP Practice to the CQC.

From April 2020, GP Practices that have a change in partnership from a single handed GP Practice to a partnership will not be re-inspected if the registered manager stays the same. This is the same for GP Practices that become single handed from a partnership. If the GP Practice is rated as ‘requires improvement’ they will still be inspected as part of the CQC inspection programme.

The GP insight report is available on the CQC website. Full reports for each GP Practice can be reviewed here.

Community Services

2019/20 was a busy year for community commissioning, which involved working with our key partners in the NHS, wider health and social care sector, Local Authorities, and voluntary and community sector organisations to transform community services to meet the challenges set out in our JUCD Strategy and the NHS Long Term Plan. Going forwards, integrated, proactive and responsive community services will ensure that people can be cared for close to home, with local services tailored to meet the needs of local people.

Derbyshire Community Health Services NHS Foundation Trust

Derbyshire Community Health Services NHS Foundation Trust (DCHSFT) is our main provider of community health services across Derby city and Derbyshire. In May 2019, services provided by DCHSFT were inspected by the CQC, with the inspection findings published in September 2019. Overall, DCHSFT was rated as 'outstanding', with a rating of 'outstanding' also given to how caring the organisation is, and the quality of its leadership. DCHSFT's overall rating was an improvement from the 'good' rating it was given in 2016. This is a fantastic achievement, and is a testament to the leadership and continual efforts of the DCHSFT's 4,500 staff. This rating is also very positive for the people that they serve.

During 2019/20, the CCG worked collaboratively with DCHSFT to focus on some key areas for improvement and development, which are detailed over the next few pages.

Community Nursing (District Nurses) Specification

The District Nursing Service is the largest of DCHSFT's services. It employs nearly 600 staff, including 400 qualified Nurses. The service provides both short and long term care for people either in their own homes, residential homes or in community-based clinics. It provides assessment and treatment such as pressure care and wound management, peripherally inserted central catheters and Hickman lines care, catheter care, bowel management and vaccinations. Throughout 2019/20, the CCG worked with clinicians, managers and stakeholders to review the District Nursing Service and develop a new service specification, making sure that the skills of this large group of staff are used in the most effective way, in line with evidence and national best practice. Patients will experience the same high level of clinical care from the service but with health and care services working more closely together in a more coordinated way.

Wound Care Service

During 2019/20, we worked with DCHSFT and colleagues in Primary Care to develop a new approach to wound care. The CCG's role was to facilitate an agreement between DCHSFT to care for essentially complex wounds; and the GP Practices to care for patients who are able to travel to a surgery with simple wounds. DCHSFT will continue to treat housebound patients in their own home whilst patients with more complex wounds who are able to travel will be seen in new wound care clinics, which have been established across Derby and Derbyshire. This is a more efficient and effective approach – the Nurses can see more patients each day in the clinic than they would if they visited everyone at home and the healing rate for patients is greatly improved. As this is a new approach to delivering the service, it will be monitored closely and kept under review in 2020/21.

Outpatient Parenteral Antibiotic Therapy (OPAT) services provide Intravenous (IV) Antibiotics to patients. Patients who are otherwise medically fit can avoid admission to hospital or be discharged sooner by receiving IV therapy either as an outpatient or within their own homes. A system-wide OPAT/IV steering group has been convened to establish a single model for OPAT/IV delivery in Derbyshire.

A pilot project, which aimed to maximise the number of patients who could self-administer their IV therapy commenced in October 2019 in North Derbyshire. This has released capacity within the OPAT team to treat more patients and the average number of monthly patient contacts for a full-time OPAT team clinician increased from 37 to 46. This is a promising sign that this approach can be rolled out across Derby and South Derbyshire.

Delivery of these improvements to OPAT provision will continue to be a priority for 2020/21.

Re-design of clinical pathways to support hospital discharge in Erewash

As part of our strategy to ensure that people can be cared for closer to home, the CCG led a project to make some changes to the support that is provided to Erewash residents when they are discharged from hospital. This work included:

- the opening of eight community support beds at Ladycross House Care Home;
- increasing the provision of community therapy/rehabilitation for patients within their own homes; and
- a reduction in beds at Ilkeston Community Hospital from 24 to 16.

The outcomes of this work have been that:

1. more Erewash patients are now seen in an out of hospital facility that meets their needs;
2. patient experience shows Erewash patients are happy with the care provided at Ladycross House Care Home; and
3. 80% of Erewash patients are achieving their personal outcome measures.

Derbyshire Wheelchair Service

The new Derbyshire Wheelchair Service provided by AJM Healthcare Ltd opened in January 2019. The CCG has worked with the new service throughout 2019/20 to ensure that it is fully mobilised and operating well. From July 2019, any patient who has an assessment with the service will have a ‘Personal Wheelchair Budget’, clarifying what the NHS offer is and giving them the choice to utilise the budget in a different way to meet their clinical needs. At the end of December 2019, 2,082 people had Personal Wheelchair Budgets.

The new service has also performed extremely well in dealing with a large backlog of referrals that had built up over the previous year. At the end of December 2018, there were 301 adults who had been waiting longer than 18 weeks from referral, with a further 18 who had been waiting for longer than 52 weeks. By the end of March 2020, this had reduced to 57 adults waiting for longer than 18 weeks. Patients are no longer waiting more than a year to receive their wheelchair. The most recent national performance figures for Quarter 4 of 2019/20 show that 95% of children and 89% of adults receive their wheelchair within 18 weeks of referral.

Voluntary and Community Sector

There are a large number of voluntary and community sector (VCS) organisations across Derby and Derbyshire that make a tremendous difference to people's health and wellbeing, and can offer early interventions that prevent the need for NHS services. The CCG is committed to working with these groups to ensure that they can operate as fully and effectively as possible. Historically, we have offered grant funding to groups to provide direct services, but following an efficiency review in 2018/19, we have refocused on commissioning both infrastructure support for VCS organisations, and signposting services (this is in addition to those VCS organisations to which we have awarded contracts to provide services following a competitive exercise).

In 2019/20, we commissioned 12 VCS organisations to provide infrastructure support, and 11 to provide signposting support. The planned outcomes for this work are:

- VCS organisations are supported to contribute towards the CCG's objectives of improving physical, mental and emotional health and wellbeing; and supporting people to be more independent and to self-care;
- an increase in the amount of funding being accessed by VCS groups to improve the health and wellbeing of the people of Derby and Derbyshire;
- an effective locally-based VCS working to help maintain or improve the health and wellbeing of the people of Derby and Derbyshire;
- a comprehensive volunteer brokerage service that enhances the contribution of health and wellbeing related groups and services to improve health outcomes for volunteers and service users;
- guaranteeing the voluntary, community and social enterprise has a strong voice and is actively engaged by the CCG in decision making processes; and
- ensuring individuals, groups and professionals have information about VCS services and are signposted to the services that they need.

Social Prescribing

Social prescribing involves helping patients to improve their health, wellbeing and social welfare by connecting them to community services, which might be run by the Council, a local charity or a person living in the local community. For example, signposting people who have been diagnosed with dementia to local dementia support groups. From July 2019, NHSE has funded a Social Prescribing Link Worker in every PCN. Whilst 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. This has included facilitating a strategic approach to social prescribing across a range of local organisations to ensure that different services enhance rather than duplicate each other, and working with the Local Medical Council to support General Practices.

We have established the Social Prescribing Advisory Group, which brings the key stakeholders together on a regular basis to ensure a coordinated and joined up approach. The Social Prescribing Advisory Group coordinates three subgroups who cover digital initiatives, engagement and evaluation processes. There are now 25 Social Prescribing Link Workers in post to help people find the support they need in their local communities.

Supporting Carers

Every year, more and more people take on a caring role. They play a huge role in delivering health and care outcomes for people across the country; the value of the support currently provided by carers is estimated to be in the region of £132bn across the UK and nearly £110bn in England. Carers are the experts-by-experience – turning treatment plans into reality can be an important influence towards the achievement of treatment success.

The CCG has continued to work closely with Derby City Council, Derbyshire County Council and Derbyshire Carers Association over the last year to provide carers' assessments, carers' breaks, telephone befriending, information and support, and personal budgets to support unpaid carers. Support is also available for those in carer crisis to minimise carer breakdown and reduce the need for the cared accessing statutory care services.

The CCG and Derby City Council have worked together to re-procure carers' services in the city with the provision being awarded to Citizens Advice Mid Mercia following a formal tendering process. This included extensive consultation and engagement with carers to ensure that the new service is fit for purpose and meets their needs. Citizens Advice Mid Mercia has taken over the reins from Derbyshire Carers Association from the 1st April 2020 and the CCG will work closely with Derby City Council to support the transition to the new provider. Derbyshire Carers Association will continue to provide carers' services for the county of Derbyshire.

Planned Care

Musculoskeletal Clinical and Treatment Service

The service was implemented across Derbyshire towards the end of 2018/19 where all referrals that would usually be sent directly to hospital for a musculoskeletal (MSK) related condition would be reviewed by a clinical MSK specialist to assess alternative therapies available.

During 2019/20 the service has improved, with input from the providers of the service, GPs referring in to the service and service users. The key changes include:

- altering the referral and management process to reduce timescales for patients so they are informed of the outcome of the triage assessment and advised of the next steps;
- introducing a service location in Swadlincote to reduce travel requirements and waiting times for patients in that area.

Between April 2019 and March 2020, 41,116 patients were referred to the MSK triage service.

The outcome for patients following triage was:

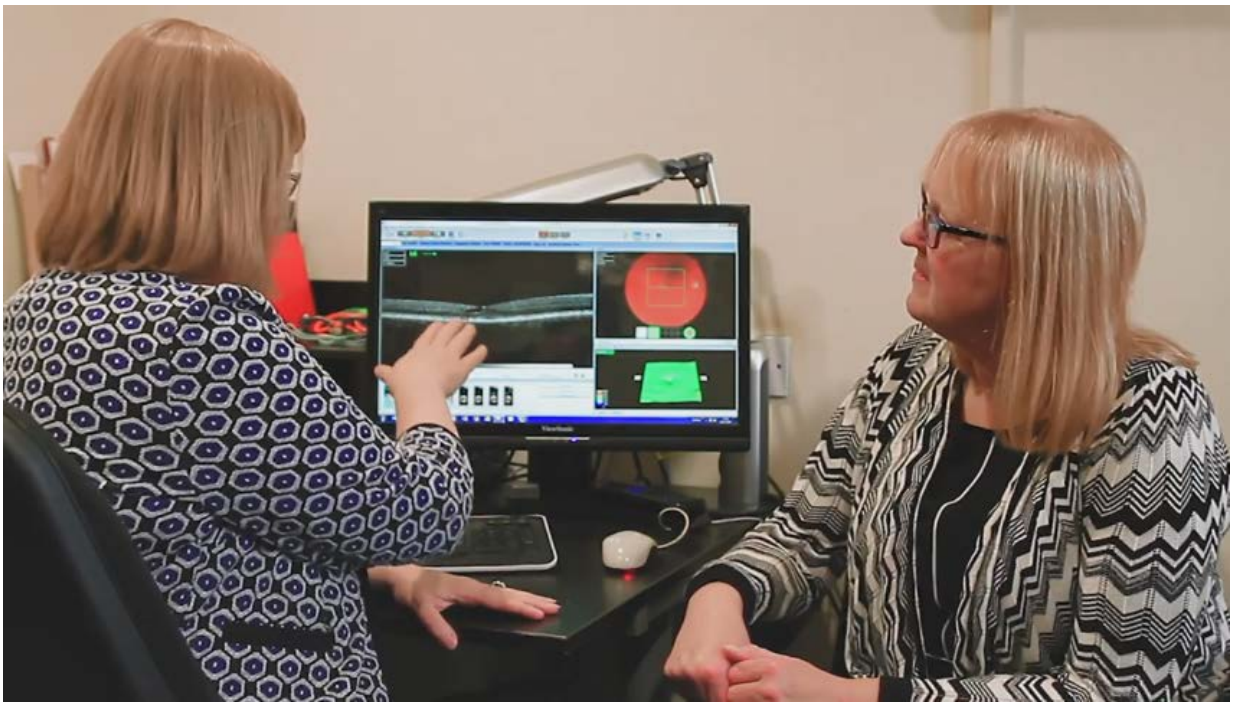
- 56% referred to Secondary Care;
- 19% referred for physiotherapy treatment; and
- 1% referred to podiatry.

The remainder of patients were either provided with advice and guidance to manage their condition or referred to other services, such as occupational therapy, lifestyle services and pain management education.

Following the introduction of the service, activity in Secondary Care has reduced. Comparing activity from April 2019–March 2020 to the same time period in 2018/19, a reduction in the following could be seen:

- 7% in all first outpatient attendances for Trauma and Orthopaedics (for routine referrals the reduction in activity is greater at 12% and where those routine appointments are referred by a GP it is 28%);
- 16% for procedures that are undertaken as a day case; and
- 10% for procedures that require the patient to stay in hospital.

The service ensures patients are aware of all the alternative options available to them and only referred to hospital when it is clinically appropriate.



Ophthalmology

Minor Eye Conditions Service

The Minor Eye Conditions Service is a ‘proof of concept’ service which was launched in October 2019 to operate for an 18 month period. The service enables patients who present to their Optician with a minor eye condition (such as red or dry eyes or those experiencing ‘flashers’ and ‘floaters’ for example) to be seen in Primary Care. This reduces the need for appointments in hospital and attendances at EDs/Eye Casualties. If it is found that a patient requires a referral to Secondary Care, Opticians are able to do this directly as opposed to the patient requiring an additional appointment with their GP for onward referral.

The service provides an improvement in quality for the patient as it reduces the need for additional trips to Secondary Care (unless clinically indicated), in a location they are familiar with (usually their own Optician) and as close to their home or place of choice as possible.

As of March 2020, there are 34 Optical Practices (out of 110 Ophthalmic Contractors) providing the service across the Derby and Derbyshire area.

Performance of the service between October 2019 and March 2020 is as follows:

- 772 patients have accessed the service; of these 419 (81%) were discharged or had a follow-up appointment with an Optician. These are split into 517 for Flashers & Floaters and 255 for other eye conditions, such as red, dry or sore eyes/eye lid problems; a higher number of follow ups here (2.3%) as Opticians need to check for improvement in the condition;
- urgent referrals into Hospital Eye Services (HES) represent 14.1% of activity; and
- around 2.5% of patients were routinely referred to their GP (for investigation into migraine for example) or HES.

Patient Experience

100 patient experience questionnaires have been completed with the following results:

- 89% were 'extremely likely to recommend the service' and 11% were 'likely to recommend the service'; and
- 36 patients reported they would have sought urgent care at Accident and Emergency (A&E) without the service and 32 would have visited their GP.

Redesigning ophthalmology services for better access for patients to be seen in the right setting, first time

The number of people with eye health conditions is projected to increase according to reports by NHSE and the innovation foundation Nesta (2019) and Royal College of Ophthalmologists (2016). This is due to an ageing population structure, increased prevalence in underlying risk factors (for eye conditions these include age, ethnicity, learning disability, obesity, diabetes, smoking, hypertension, stroke, dementia, and deprivation) and improvements in accuracy of diagnosis and recording.

Our 2018 Health Needs Assessment for eye health and ophthalmology predicts that, within Derby and Derbyshire, patients with serious eye conditions (glaucoma, wet age related macular degeneration, cataracts and diabetic retinopathy) will increase from 49,010 people in 2016 to 61,330 in 2030. This would put HES under significant pressure and so we, through our involvement with JUCD, are working alongside system partners to undertake a full review of ophthalmology services in Derbyshire. The aim is to develop a long term strategy for ophthalmology services and address the predicted demand by redesigning and better utilising current capacity where opportunities exist.

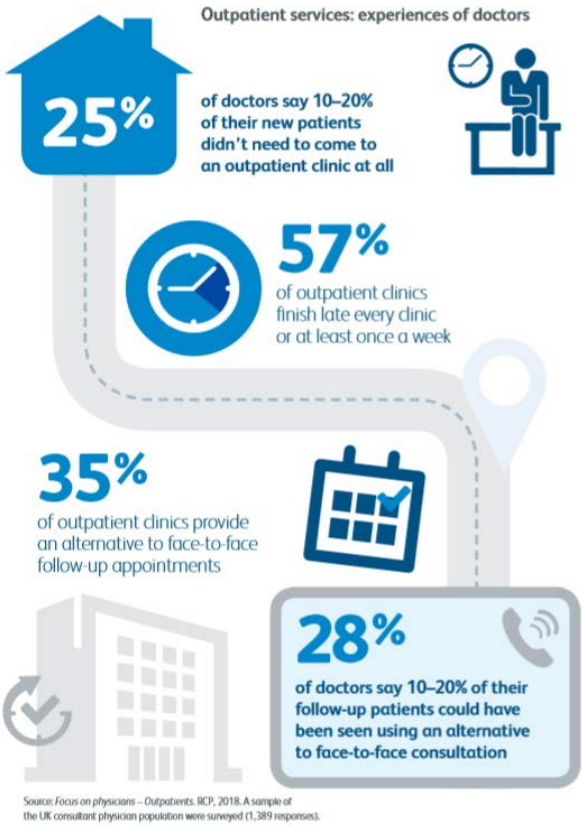
A wide range of stakeholders within the JUCD footprint have met in the last year to review the national and local context for ophthalmology, the services available currently and to discuss the way forward in tackling the increasing demand. Work to date includes the development and agreement of a future model for ophthalmology services which the group will work towards achieving, and the agreement of priority activities for 2020/21:

1. to develop and pilot a referral triage service for GP and Optician referrals across Derby and Derbyshire to ensure patients are treated in the right place, at the right time whilst also reducing the number of first outpatient appointments within HES;
2. to make better use of the skills and resources available in the Community and Optician Practices in Primary Care by shifting the treatment and monitoring of specific eye conditions to this group of clinicians. This will assist in reducing the demand within HES, thus supporting HES to treat patients with serious eye conditions that can only

be managed within a more specialist service. The work for 2020/21 will focus firstly on shifting the post-operative cataract service activity from HES to Opticians; and

3. in addition to point 2 above, work will commence on shifting the monitoring of patients with stable glaucoma from HES over to local Opticians qualified to undertake this activity. This will be carried out alongside introducing virtual first appointments for glaucoma at HES.

Joined Up Care Derbyshire Outpatient Modernisation Programme 2019/20



Within Derbyshire there is currently an estimated £119m spent on outpatient services, with a history of variable care pathways for patients across the county, often with different overarching approaches within the north and south. This has created difficulties for providers across Secondary Care, community and social care in navigating differing pathways, processes and policies. It is also complex to commission and both inconsistent and inefficient in the front line delivery of care.

In some hospitals, patients are already benefitting from the redesign of outpatient services; including better support to GPs to avoid the need for a hospital referral, online booking systems, appointments closer to home, and alternatives to traditional appointments (where appropriate including digital appointments, which avoids patients having to travel to unnecessary appointments). Changes like this support more productive use of consultant time, reduce carbon emissions, improve quality of care for patients and enables the capacity of outpatient clinics to be used more efficiently.

During 2019/20, the following three main areas of work were initiated:

Commissioning an enhanced model of specialist 'advice and guidance'

In September 2019, we commissioned a rapid telephone advice and guidance service that works alongside the existing e-Referral Service system providing written advice across Derbyshire. The service is for Primary Care and community physicians to access for non-urgent and/or non-procedurally based needs, across all service lines including a tele-dermatology service. It utilises local specialist consultants wherever possible and is backed up by a national network of NHS consultants.

As at the 31st March 2020 over 4,000 calls have been placed with the service in both acute and elective specialities; resulting in 45% of elective referrals and 17% of potential emergency admissions being treated out of hospital in acute specialities.

A survey of Derbyshire GPs conducted in February 2020 established that 85.82% found the experience of using the telephone service a positive one. Comments included:

"Excellent advice, very helpful and supportive"
"Very quick response"
"Very useful to be able to connect with a consultant for specialist advice which may have prevented an otherwise unnecessary referral"
"It's still the best system we've had for many years"

Developing a digitally enabled 'non-face-to-face' care model as the default means by which to follow-up non-urgent, non-procedural outpatient care

In line with the NHS Long Term Plan to reduce the number of face-to-face consultations by a third, a framework was developed and agreed by JUCD this year for the implementation of a digitally enabled plan over the next five years, through the following interventions:

- using patient initiated follow-ups to reduce routine follow-up appointments;
- target variation in clinical practice to reduce the volume of follow-up appointments;
- using telehealth and remote monitoring technology;
- using digital assessments; and
- video consultations.

During the COVID-19 pandemic, our acute partners are increasingly offering alternatives to face-to-face outpatient appointments, including clinical triage, telephone-based assessments, virtual appointments, virtual review of diagnostics and patient initiated follow-ups. This is, in effect, bringing forward our implementation of the JUCD Outpatients Modernisation Programme as outlined above.

Focus on Speciality Areas

During 2019/20 we conducted deep dives into patient pathways and processes, and identified opportunities for transformation. These were:

- Urology
- Dermatology
- Gynaecology
- Ears, Nose and Throat

A number of workshops have been held over the course of 2019/20 in each of the specialities previously listed, with representation from all JUCD partner organisations and patient representatives. These have resulted in areas of improvement, such as:

- a redesign of urinary tract infection pathways;
- the development of a Derbyshire wide tele-dermatology solution;
- a reduction of clinical variation in gynaecology services; and
- a review of ear syringing services.

Ambulance and 111 Commissioning

Regional Contracts – NHS 111 and Urgent and Emergency Ambulance Service

Each year more and more people are using NHS 111 and ambulance services. With increased demand of these services the Regional Contracts Team strive to ensure that the quality and service that these providers deliver is the best that it can be and that the patient continues to be at the centre of everything that they do.

One of the key challenges in 2019/20 has been enabling a smooth patient journey across the whole healthcare system so that each and every patient receives the right care in the right place at the right time.

With this focus in mind, NHS 111 and the ambulance service have looked at how the information on each patient can be improved. NHS 111 has improved the way it questions patients when completing a telephone assessment and the ambulance service have worked with the GPs of Derbyshire to enable access to their patient records to support clinical decision making.

Improved patient assessments when calling NHS 111

NHS 111 in Derbyshire have been working with NHS Pathways (the clinicians that write the questions to support the NHS 111 Advisor) to improve the questions that they are asking when doing a telephone assessment.

The aim of this project has been to ensure that the way assessment questions are worded and delivered means that all patients have the best understanding of what is being asked of them. This innovative work is studying the ‘cognitive load’ which is the memory needed to ask, understand and answer a question that the NHS 111 Advisor asks.

NHS 111 have a dedicated project team that have been attending national events and workshops and since October 2019 have been using their vast experience to review and provide detailed information of changes to the assessment questions.

The process of agreeing the questions has been challenging in the knowledge that we all receive information differently and can have a different understanding of what is being asked of us. However, the goal of achieving a low cognitive load on all the questions asked during the patient assessment means that patients have a smoother, shorter assessment and more focused advice for what action to take next.

This exciting work is being rolled out nationally so patients will be benefiting across the whole country.

Ambulance service having patient records on scene

East Midlands Ambulance Service NHS Trust (EMAS) now have access to GP patient records while in a patient’s home though an electronic tablet that the crews carry with them.

Through working closely with the GP Practices in Derbyshire since October 2019, EMAS now have the ability to see a summary of the patient’s medical history, any medication they are on and allergies they may have. This valuable information can help the ambulance crew

make a decision on how best to help the patient they are attending and where best to take them to give them the care that they need.

The process was a challenging one as all GP Practices in the area had to agree to share the records and then help the technical team set up the IT system; but through excellent partnership working most GP Practices were up and running at the beginning of 2020.

The ambulance crews are positive about the ability to access this information and say that being able to see this information when attending a patient means that they can give the best care and help to prevent unnecessary trips to hospital. At the end of January 2020, 90% of Derbyshire GPs were able to provide patient information to the ambulance crews, with crews in the East Midlands as a whole viewing 14,774 records in that month.

Community Pharmacist Consultation Service

In order to improve the experience for people calling NHS 111 who, after completing their assessment over the phone could be seen by a Pharmacist, we implemented a national scheme called the NHS Community Pharmacists Consultation Service (CPCS). The service enables patients to choose which Pharmacist is convenient to them, from a list of open Pharmacists.

The profiles for each NHS 111 pathway are set by the National Clinical Pathways Team and in October 2019 we were asked to review the CPCS pathways and, where clinically appropriate, change the local pathways to match the national CPCS pathway so that patients are offered the option of having a face-to-face consultation with a Pharmacist following an initial assessment by an NHS 111 call handler. The call handler can make a digital referral to a convenient Pharmacy, where the patient can attend to receive advice and treatment for a range of minor illnesses, or for an urgent supply of a previously prescribed medicine. Should the patient need to be escalated or referred to an alternative service, the Pharmacist can arrange this.

We worked with community pharmacy colleagues, NHS 111 colleagues, regional NHSE community pharmacy colleagues and the national Directory of Services Team to test that the changes were correct before we went live with the service. The challenge was to complete the changes so that NHS 111 had the updated process in place before we entered the winter period.

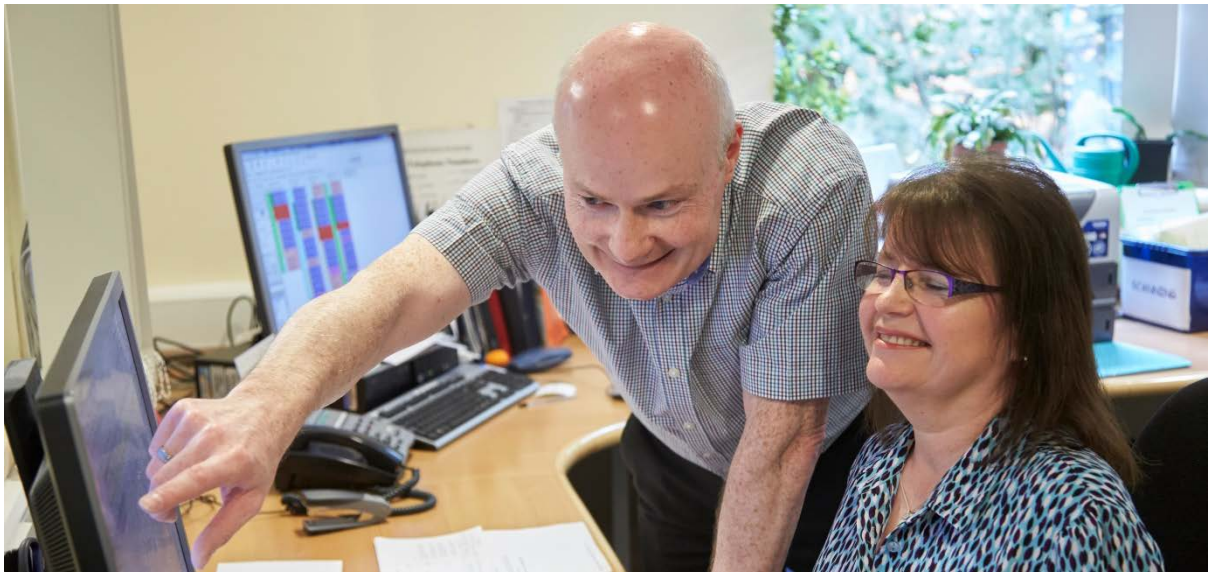
As at March 2020, 95% of all community pharmacies offer this service to patients. Approximately 37% of all callers to NHS 111 are now offered a referral to a community pharmacy, further supporting the ability for patients to get health advice outside of normal GP hours and closer to home.

Being available 24 hours a day, and harnessing the skills and medicines knowledge of Pharmacists, the CPCS is helping to alleviate pressure on GP appointments and EDs.

Mental Health

In line with our strategic objectives, reducing health inequalities and improving the quality of healthcare by working alongside local people and partners is central to our work across mental health commissioning for adults and children. Three key areas where these are illustrated are:

- our work to improve health outcomes for people with a Severe Mental Illness (SMI);
- increasing access to Improving Access to Psychological Therapies (IAPT); and
- our approach to supporting children and young people with mental health needs.



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Improving the physical health of people with a Severe Mental Illness

Significant partnership work has been undertaken to reduce the health inequalities that exist for people with a SMI. National evidence suggests that people with a SMI are known to have a reduced life expectancy by up to 20 years, largely based on an increased risk of cardiovascular disease. SMI physical health checks and follow-up support within Primary Care form a key part of our response to reducing avoidable health conditions. NHSE's target requires CCGs to achieve 60% attainment of SMI physical health checks across all health settings; Derby and Derbyshire's performance has remained at 30% for the last three quarters hence further work was required. Key achievements in 2019/20 include:

- a programme of engagement involving local people with an SMI/mental health condition, which has proved invaluable in helping to identify barriers faced (see figure 2 on the next page), and in informing and strengthening our local action plan. Outputs as at March 2020 include a co-produced patient invite letter for GP Practices to use, designed to support good communication and increase patient understanding;
- the initiation of a Local Enhanced Service to create a recognition payment for GP Practices undertaking SMI physical health checks. To date around 65% of all GP Practices across Derbyshire have signed up since January 2020;
- a wraparound support service designed by a Multi-Agency Project Group, which will commence in August 2020 and will be a patient-facing function to help people access SMI health checks and follow-up health interventions. It will also help address the

barriers to taking up the offer that were identified through the engagement mentioned above; and

- a Multi-Agency Strategic Partnership Group which is actively monitoring progress and risks; including issues such as Primary/Secondary Care data sharing, training and support needs, and identifying interfaces with related activity such as NHS Health Checks.

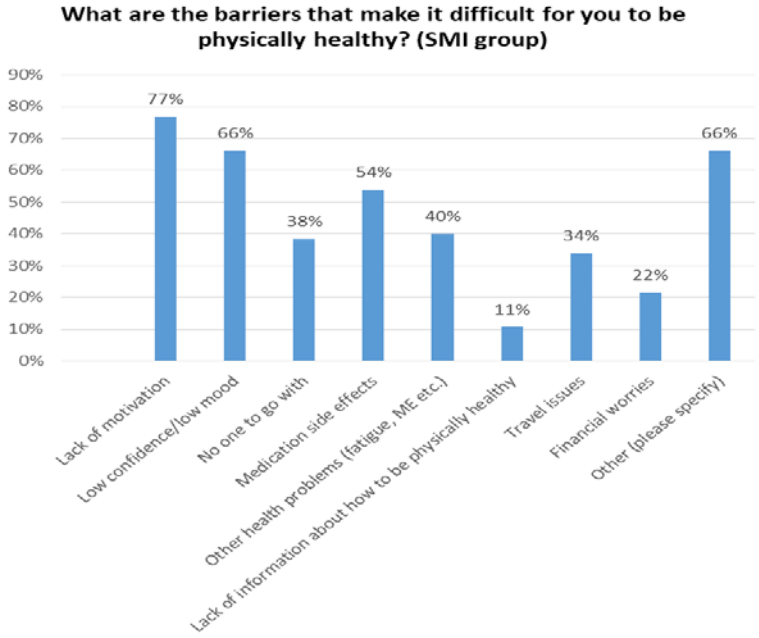

Figure 2 – Mental Health Together asked local people with an SMI "What are the barriers that make it difficult for you to be physically healthy?"

Improving Access to Psychological Therapies

Our performance in relation to the achievement of access rates, recovery and waiting time targets for IAPT is managed nationally. Please see Figure 3 for more information.

In Derbyshire, we are meeting the waiting times target of 75% of people referred entering treatment within six weeks. We also achieved the 2019/20 access target of 25% of the estimated local prevalence of Common Mental Health Disorders by the end of Quarter 1 and the CCG continues to see an increase.

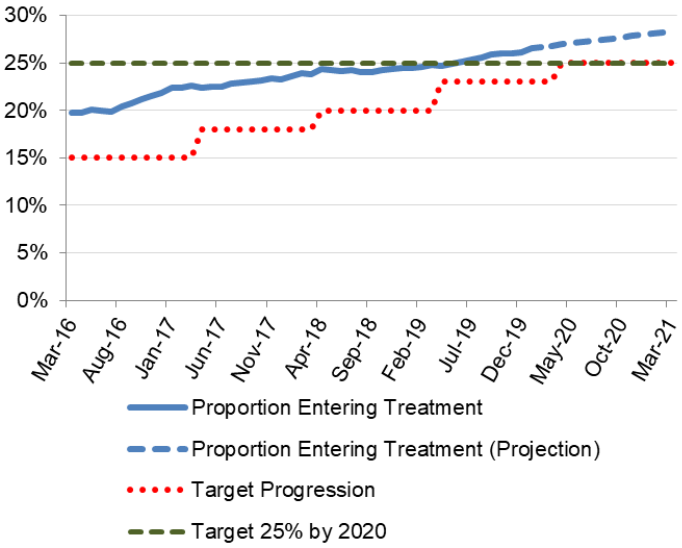

Figure 3 – Derby and Derbyshire IAPT access rates and projections

Estimated prevalence of Common Mental Health Disorders will increase by approximately 40% from 90,000 to 140,000 in April 2020. The figure of 90,000 has been used as the baseline prevalence since 2010 when the IAPT service started and is the figure we have been monitored nationally on. Prevalence rates have been updated to reflect population increase. As we are already exceeding the 2020 target, this puts us in a good place; early modelling has indicated that we will achieve the 2023 access target despite this increased prevalence. Recovery rates have consistently exceeded the 50% national target.

Prevalence	CCG	Year 1 2019/20	Year 2 2020/21	Year 3 2020/21	Year 4 2022/23	Year 5 2023/24
2000 APMS based	Prevalence	95,182	95, 707	96, 235	96, 766	97, 301
	Predicted Activity	25,328	26, 955	28, 688	30,530	32, 498
	Access Proj. %	26.60%	28.20%	29.80%	31.60%	33.40%
2014 APMS based	Prevalence	95,182	139,842	140, 516	141,193	141, 873
	Predicted Activity	25,328	26,955	28,688	30,530	32,498
	LTP Activity	**19,407**	**23, 393**	**27,149**	**30,387**	**33,182**
	Pred. Access Proj. %	26.60%	19.30%	20.40%	21.60%	22.90%
	LTP Access Proj.%	20.40%	16.70%	19.30%	21.50%	23.40%

Table 2 – Estimated prevalence of Common Mental Health Disorders

NHSE closely monitors these figures to ensure that there is sufficient workforce in the system to meet the activity requirements and that the workforce is IAPT compliant in terms of the range of the types of therapy delivered as part of the service specification. In 2019/20 we invested in a number of psychological wellbeing practitioner trainees through the Health Education England Programme.

During 2019/20 we completed the procurement process for the new IAPT Any Qualified Provider contract, which will be effective from April 2020. As part of the procurement process, we engaged with members of the public to ensure that the service was designed in a way that meets the needs of the local population.

The new IAPT service incorporates the long term conditions (LTC) pathway which aims to reduce the gap between Physical and Mental Health. The LTC pilot, which ended in December 2018, concluded that IAPT has been successful in helping people to manage their LTC and consequently reduced the number of non-elective admissions across Secondary Care and healthcare services in general. The contract incentivises older adult access and also has a focus on the discharge distribution between Step 2 and Step 3 therapies, which ensures individuals receive the least intensive intervention that is clinically appropriate and provides value for money for the CCG.

Specialist Community Advisers

The CCG has commissioned a team of Specialist Community Advisers to work in Place providing support and advice to Practitioners who are concerned about the mental and emotional wellbeing of a child or young person with whom they work; to enable the Practitioner to provide appropriate care and effective support to improve the mental and emotional wellbeing of the child or young person causing concern. The Specialist Community Advisers will be the first contact for GPs and will work closely with other

providers to ensure that children and young people receive the right community-based service in order to address their mental and emotional health needs.

Qwell and Kooth

In line with both the vision in NHSE's Long Term Plan and the CCG's Future in Mind Plan, we are now able to offer digital mental health and wellbeing support for children, young people, parents and carers following the procurement of services Qwell and Kooth. Both services, which require no referral, offer free, anonymous access to accredited counselling support both in and out-of-hours seven days a week.

As well as providing a service for children and young people, we felt it was important to be able to offer support to parents and carers whose mental health can have an impact upon their ability to support their child's development leading to the procurement of the Qwell service that commenced delivery in September 2019.

Since beginning in March 2019, the Kooth service has had nearly 2,500 registrations across Derbyshire, of which 281 were from people from a Black, Asian or Minority Ethnic background, and 13,500 logins – demonstrating the ability of a digital offer to reduce health inequalities.

MH:2K

In 2019/20 we funded MH:2K, partnering with the social enterprise 'Leaders Unlocked', Derby City Council and Derbyshire County Council to run a project to engage young people in conversations about mental health and emotional wellbeing. The project recruited over 30 citizen researchers aged 14–25 from a variety of backgrounds to engage with over 300 children and young people from across Derby and Derbyshire on the subject of mental health via a number of roadshows.

In line with ambitions outlined in NHSE's Long Term Plan, a focus of the project has been engaging with population groups who can often be unheard in service design and delivery. The citizen researchers facilitated roadshows at a wide variety of venues such as Chesterfield Football Club, at the 'Not in Education, Employment or Training' programme, and with special educational needs students at Burton and South Derbyshire College. The project was due to culminate with a showcase event to professionals from across Derby and Derbyshire at the end of March, however due to COVID-19 this was not able to take place. The main findings of the project will be captured in a report with a view to guiding future commissioning decisions.

Build Sound Minds

In 2019 Build Sound Minds, a targeted early intervention service provided by Action for Children and Derbyshire Federation for Mental Health became operational. The service provides a targeted early intervention service for children and young people aged 0–17 who are presenting with emotional and mental health difficulties but do not meet the thresholds for more specialist services such as child and adolescent mental health services. Interventions include focused group work for parents, young children and teenagers, direct 1-1 support to children and families, a digital offer and a schools programme. The majority of their work with children under eight is via support to parents and carers, rather than directly with children. Through early intervention, the service is able to build resilience and reduce

the development of more serious emotional and mental health issues, better preparing children and young people for the challenges of life. Moving forward there will be changes to the offer provided by Agenda for Change Action for Children to increase activity in schools through initiatives such as the Blues Programme, and a puppet-based intervention for younger children called 'Curious Beasts'.

Mental Health Support Teams: Changing Lives

We are currently trailblazing a national initiative to roll out mental health support teams within education settings. Following a successful expression of interest to NHSE, we have secured funding to deliver four mental health support teams, which has created 40 jobs and adds additional capacity within the system.

The Changing Lives Programme has four team clusters across Derby and Derbyshire which will act as centres of excellence. The mental health support teams will provide targeted early interventions to approximately 32,000 children and young people and will work across the educational settings within their cohort. Each mental health support team will provide evidence-based interventions to support children and young people with mild to moderate mental health needs. They will work as part of an integrated referral system with community services and support whole school approaches to the promotion of good mental health and wellbeing.

Trauma-Informed Service for children in care and other vulnerable children

We have been working with Derby City Council and Derbyshire County Council to secure a new Trauma-Informed Service for children in care, care leavers and other vulnerable children. All of these children will have experienced significant Adverse Childhood Experiences. 45% of children in care and 72% of those in residential care have a mental health disorder, compared to 1 in 8 of the general population, and care leavers are four to five times more likely to attempt suicide in adulthood. It is known that 50% of lifetime mental health (except dementia) begins by the age of 14 years and 75% by the age of 18.

Children in care, social workers, foster carers and residential carers have been engaged in the review and two market engagement sessions have taken place.

The new service will have three elements:

- direct support for children;
- direct support and consultancy for carers – foster or residential; and
- training for carers – foster or residential.

The key outcomes of this new service will be the improved mental and emotional health of children in care as they receive the right service, at the right time, in their own community. This will result in better outcomes in all aspects of their lives, including placement stability.

Workforce Development

During 2019/20, over 1,000 Practitioners have benefitted from training to enable them to have a trauma-informed approach to their work with children and young people. Many children experience some level of trauma which may include bereavement, domestic violence, family breakdown, bullying and/or abuse. If these children receive the right support using a trauma-informed approach, from the people who work with them, including those in

schools, most of these children will not need a specialist mental health service. Without this knowledgeable support there is a risk of deterioration in their mental health and wellbeing. We have also commissioned other workforce opportunities, including mental health awareness, work to understand the possible mental health needs of some young people self-determining as LGBTQI and/or gender fluid, and training regarding mental health and autism.

Medicines Management

The Derbyshire Medicines Management and Clinical Policies Team works with GP Practices and local providers to improve the safety and cost effectiveness of prescribing and are working to minimise harm from prescribing and maximise health improvement.

Our key priority in 2019/20 has been to deliver a significant savings programme against a back drop of organisational restructure, capacity gaps due to staff changes and recruitment while aligning ourselves to the priorities set out in the NHS Long Term Plan, including working closely with PCNs. Rising to this challenge, we planned a Medicines Savings Programme of £13.2m (net) and are expecting to meet this and exceed the plan with a predicted final position of £15.4m (based on month 11 data).

Work in the following areas has contributed to our savings programme:

- High Cost Drugs – ensuring the uptake of Secondary Care biosimilars is in line with, and where possible, exceeding national targets;
- Medicines Optimisation – continued support to GP Practices to improve the quality, safety and cost effectiveness of prescribing. Review of patients with atrial fibrillation which has delivered considerable safety improvements for patients, including better monitoring. Review and implementing a change in formulary choice of blood glucose test strips;
- Reducing Waste in the Repeat Prescribing Process – continued development of the Medicines Order Line (MOL) with the support of Practice Medicines Coordinators to reduce prescribing waste. The scheme achieved in year net savings or £2,178,602. Having overcome a number of challenges (including delays in recruitment, training, IT and telephony challenges and securing future premises for the south MOL) by year-end we have achieved coverage of approximately 70% of the population of Derbyshire by the scheme. Due to COVID-19, the roll-out of the scheme to further practices has been paused, but will be reviewed as we embed a mixed model of remote and base working and are able to offer a consistent and sustainable service to a wider population. Similar schemes are in place around the country but Derbyshire MOL is considered the largest and has been recognised by other providers contacting us to request information about our service. We will continue to develop the service and deliver savings over the coming years;
- Use of Over the Counter Medicines as part of Self-Care Prescribing – continued implementation of this national priority area; promoting self-care for the management of minor, self-limiting ailments within Primary Care;
- Medicines Optimisation in Care Homes – commissioned the national scheme to improve use of medicines within care homes;
- Oral Nutritional Supplement – nutrition review and education through working with community-based dietician teams to improve use of oral nutritional supplements within Primary Care;

- Optimise Medicine Solution – use and management of a digital solution to influence medicine choice at the point of prescribing; and
- Syringe Driver Provision – delivering a change regarding the manufacture of syringe drivers from production in the Acute Trust to being made at the bedside, within the south of Derbyshire.

Implementing our new team structure has been a challenge from the beginning of the year. The team have been recruiting and training staff throughout the year which has taken a significant amount of time and resource. However, our excellent reputation has ensured that we have been able to recruit exceptional candidates. Work continues to ensure we are up to full capacity but we are in a good position for 2020/21.

In addition to the work described above, the team have been driving forward and making improvements in the following areas:

- managing the changing clinical leadership and membership as we moved to a single commissioner;
- ensuring our decision making processes for the Joint Area Prescribing Committee, Clinical Policies Assurance Group, Individual Funding Requests Panel and Derbyshire Prescribing Group are robust;
- managing and developing the Clinical Policies Work Plan and Group – this is now well represented with clear goals and outputs and is recognised within the CCG and system;
- project managing significant savings programmes and ensuring necessary assurance and governance processes are in place;
- developing, promoting and managing expectations for the NHS England Right Care Programme;
- managing and maintaining clinical engagement, particularly at a GP level, as we continue to implement increasingly difficult and challenging savings initiatives;
- Prescribing Lead Forum meetings have been established across Derbyshire to support discussion, share good practice, and create better engagement with GP Practices;
- the development of the Medicines Optimisation Delivery Team to function around the Places in an equitable way, with the challenge of team vacancies and competing demand on available resources;
- engaging with PCNs and GP Practice employed colleagues to develop and deliver education and training to GP Practices regarding updated prescribing guidelines and guidance consistently across the county; and
- implementing new data intelligence and digital solutions within GP Practices through offering Eclipse Live. The system supports and drives improvements in safety, cost and quality prescribing now and in future years.

Digital Services

The Digital Services Team deals with IT systems and equipment. Currently working within the Medical Directorate, we will transfer to the Corporate Strategy and Delivery Directorate on the 1st April 2020. We are responsible for managing the services provided by NHS North of England Commissioning Support Unit (NECS). This includes all IT services for corporate and Primary Care services.

Our three main goals

For 2019/20 our three main goals were to:

- develop new clinical digital services in Primary Care;
- improve and modernise IT infrastructure for GP Practices and corporate functions; and
- strengthen and improve cyber security and resilience, to protect confidential information and services.

New Clinical Digital Services

Modernising the clinical systems that our GPs use to provide the best care and help for patients in Derbyshire has been a key focus for us in 2019/20. While some of this is set by the national agenda, we are also in the process of developing our own local systems. These are designed and led by local GPs, ensuring that all our systems and services are responsive to local needs and conditions.

The main new systems that we have been working on this year include:

- deployment of the NHS App, which provides clinical assistance and information to Derbyshire patients. The app allows access to medical records, appointments (depending on the GP Practice) and the capability to make repeat prescription requests;
- a major programme of work to deliver online consultation (including 'web triage') systems to allow patients to access care in new and convenient ways; and
- developing a new local referral support system called Pathfinder, which enhances existing GP systems to allow patients who need access to specialist care to be directed quickly and efficiently to the most appropriate service.

IT Infrastructural Services

Keeping IT systems up to date is a constant process of renewal and improvement, as we work to achieve the best service that we can within the financial constraints that we work within. This year, over £442k of capital investment has been made in IT infrastructure at our main corporate sites and throughout the 114 GP Practices that we support.

This year, our focus has been on the following issues:

- completely replacing all existing data communication connections for the CCG and GP Practices. Super-fast broadband has been installed in all major premises, greatly improving the speed of new and existing IT systems. This has also improved the speed of Wi-Fi for staff and patients;
- continuing our programme of GP data server virtualisation, which essentially is improving the processing power and capabilities available to GP Practices. Although

this will be invisible to patients and staff, it is vital to ensure that we can continue to provide a fast, reliable service, at the lowest possible overhead; and

- upgrading PCs, laptops and other equipment to ensure compliance with latest standards and guidance. This is part of a five-year rolling programme of upgrades, aimed at ensuring all staff have the tools they need to undertake their duties. This has been particularly challenging this year, due to the late arrival of capital funding, and also supply chain problems related to INTEL chips and COVID-19.

Cyber Security and Resilience

As we continue to become more reliant on digital systems for clinical and business needs, ensuring that our IT systems are secure against accidental or deliberate damage is a vital responsibility of the CCG. Online threats are numerous and pervasive, requiring constant vigilance to protect our patients and staff from attack. During the year there have been a succession of high profile threats, which we have worked with national and specialist technical colleagues to keep our systems safe.

Our response to defending ourselves against cyber-crime and other forms of digital vulnerabilities are based around the following key approaches:

- ensuring all equipment and systems are up to date, with known vulnerabilities being promptly dealt with and appropriate software patches dealing with threats are downloaded within short deadlines. This also means the retirement of old, insecure equipment, as well as a programme of implementing firewalls and other security features in GP Practices;
- improving our governance processes by being the first CCG to participate in the NHS Digital cyber operational readiness support resilience process, which is examining every aspect of our organisational and technical capabilities; and
- continuing to emphasise the importance of cyber security training and awareness for all staff. The entire Executive Team has received Government Communications Headquarters accredited training, and regular annual training remains a high priority for the CCG.

System Working and Collaboration

The shape of the Derbyshire system

The first Derbyshire Sustainability and Transformation Plan (STP) was published in October 2016. Following the publication of the NHS Long Term Plan in January 2019, the refresh of the Derbyshire STP Strategy in 2019 (by now Sustainability and Transformation Plans had become Sustainability and Transformation Partnerships) identified relatively few changes to our five original priorities:

- **Place-Based Care:** accelerating the pace and scale of the work to 'join up' care to wrap care around a person and their family, tailoring services to different community requirements across our eight Places, and underpinned by PCNs;
- **Prevention and Self-Management:** preventing physical and mental ill health, intervening early to prevent exacerbation and supporting self-management, and to improve health and wellbeing;
- **Population Outcomes:** focus on improving the outcomes for the people of Derby and Derbyshire by better understanding available data to prioritise;
- **System Efficiency:** to ensure ongoing efficiency improvements across commissioners and providers; and
- **System Development:** we will come together to manage the Derbyshire system through an ICS, and develop ICPs and our strategic commissioning function through aligned leadership and governance.

JUCD is currently the STP for Derbyshire and will become the ICS for Derbyshire. There are already some ICSs across England in those areas where STPs have progressed further in certain areas of partnership or offered to work as pilots. All STPs are expected to become ICSs from April 2021.

Providers of care will continue to integrate services and delivery in defined communities. This will ensure that the desired health and wellbeing outcomes for the people of Derbyshire are achieved. These partnerships will be commissioned by the ICS and will be made up of NHS, social care, voluntary sector organisations and other partners, known as ICPs.

The JUCD Board has agreed that there will be four ICPs in Derbyshire. This follows deliberation over a number of options. The ICPs will cover the footprints of the existing eight Place Alliances in the following way to enable them to serve a larger population to achieve improved outcomes:

- Chesterfield, North East Derbyshire and Bolsover;
- Derby city;
- South Derbyshire, Amber Valley and Erewash; and
- Derbyshire Dales and High Peak.

ICPs are not new organisations, but partnerships of provider organisations (acute; community; Primary Care; Local Authority and third sector) working in a more integrated way with different contracts to deliver local health and care transformation. ICPs seek to understand our population and their health and social care needs by using intelligence gathered by Place Alliances. Running in shadow form from the 1st April 2020, our ICPs will:

- focus on care models, not clinical pathways in isolation;
- recognise that there needs to be service redesign, involving staff, patients and professionals;
- need to consider what is done at different levels within/across the system; and
- maintain and build on the added value of working together over the last few years, especially more latterly by Place Alliances and the Place Programme.

Place Development and Delivery

The merger of the four previous Clinical Commissioning Groups for Derbyshire into one commissioning body has further supported a coordinated approach to Place development with robust management and more effective decision making in 2019/20.

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 is key to the delivery of integrated health and social care in Derbyshire and is implemented through eight Place Alliances in Derbyshire:

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

Each Place Alliance has a diverse membership and typically brings together many groups including commissioners, community service providers, Local Authority, Public Health, voluntary sector, community stakeholders, public representation, PCNs, hospitals and emergency services. Place Alliances are also integrated into Health and Wellbeing Partnerships in some parts of the county, which enables joint ownership of priorities and responsibilities. The shared vision is to collaborate to meet the needs of their population. A successful programme of work in 2019/20 has been inter-organisation shadowing opportunities, which enables partners to truly understand the work of their colleagues in different host organisations.

The individual Place Alliances are accountable to the Place Board which reports into the JUCD Board for complete system integration. In April 2019, our Governing Body GP Member, Dr Penny Blackwell, was appointed as the Place Board Chair, having come from Derbyshire Dales Place and taking over from our Clinical Chair, Dr Avi Bhatia. Senior

Leadership was also established at each Place Alliance, with Place Chairs drawn from Primary Care, Public Health and the voluntary sector.

Place Alliances have established a strong foundation of partnership working across Derbyshire and are best placed to demonstrate and bring to life how this can be developed and built on in an emerging ICS. Place Alliances play a vital role in delivering the transformation as set out in the JUCD plan and will be central to the development of the four ICPs for Derbyshire in 2020/21.

Roles and Responsibilities of Place Alliances

Place Alliances are responsible for developing services and initiatives through collaboration to best meet the needs of their population within available resources. They will shift the focus of health and care services from a paternalistic approach to one where local populations take responsibility to maximise good health and wellbeing.

Place Alliances are being developed to support the following functions which span both commissioning and provision:

- understanding the Place population health and care needs;
- jointly reviewing local performance and outcomes, driving improvement in these where needed;
- ensuring equitable services for the Place population;
- using information and local knowledge to drive service change;
- understanding Place population resource usage and ensuring this is used as effectively as possible;
- developing robust links between services at a local level;
- the coordination and delivery of high quality care and support in the community and in people's homes, working across organisational boundaries;
- planned and case managed care for people at high risk of hospital and care home admission;
- providing targeted support for people with frailty and other long term conditions;
- helping people remain in good health through screening and provision of advice and other forms of support; and
- enabling people to die in the place of their choice.

Place Programme of Work

Place has an overarching programme of workstreams which can be seen in Figure 4. Each individual Place has also collaboratively defined key priorities specific to the local population or demographic.

Place Board Structure

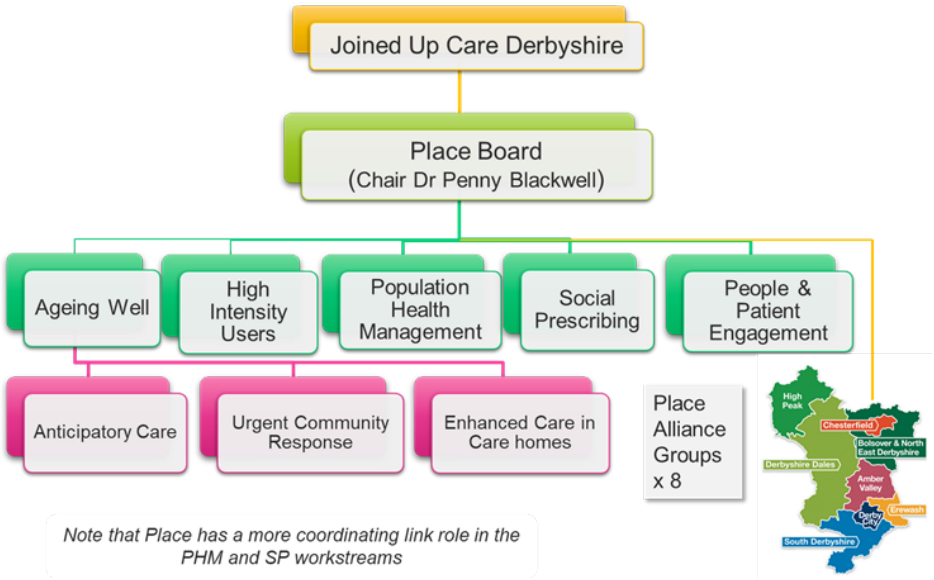

Figure 4 – Place Board Structure. Source: Joined Up Care Derbyshire

Place Achievements

Supporting frail and elderly people

In April 2019, Community Matrons and Care Coordinators from 11 GP Practices based in Derby city began a project to identify and support people with moderate frailty. Frailty is a common clinical syndrome, often in older adults, that carries an increased risk for poor health outcomes including falls, incident disability, hospitalisation and mortality. The project intended to test the theory that by providing preventative care and early intervention, people with moderate frailty could avoid deterioration of their condition and possible hospital admissions, for example due to a fall, or the flu. After the first six months, over 1,000 people had been identified in Derby city and almost 500 assessments had taken place.

Early feedback suggests that people have found the assessments beneficial. They valued the advice they received and the feeling of empowerment to support themselves in a better way. After six months, incidence of falls reduced by 76% across five GP Practices. A full evaluation will be completed after one year of the project. Dr Komal Raj, GP Lead for Derby city said: *"500 of the frailest patients in Derby city have had a comprehensive review! The service is working well with greater integration of Community Matrons in the Primary Care Team. We have de-prescribed a lot and identified patients at risk of falls and carried out interventions to help reduce their risk"*.

Chesterfield Place Alliance members were keen to set up local frailty teams following discussions at Place in 2018. The first team was set up in January 2019 with a part time community GP working alongside other community-based clinicians to provide care in people's homes and care homes, particularly for people with frailty who have an urgent need for care. The team respond quickly and ensure the link is made for delivery of more anticipatory and supportive care where needed. Team members work with service users and their families to discuss care and escalation planning and ensure relevant agencies are made aware of and have access to those plans. The team and its work is now providing information for wider delivery of the Ageing Well Programme across Derbyshire and

Chesterfield Place Alliance have plans to further roll this model out across the borough as national Ageing Well funding becomes available.

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Preventing Falls

Together with Derbyshire County Council, Public Health, local Acute and Community Trusts, Primary Care, and district and borough councils we have been developing an approach to falls that provides a consistent offer to the public across Derbyshire.

The approach looks at how we care for people who have fallen and explores how we could better identify people at higher risk of falling and work with them to reduce the risk. Examples of support could include the use of equipment or access to strength and balance classes to help mobility. Within Derbyshire, three Places have been identified as having a higher number of injuries from falls – Chesterfield, High Peak and South Derbyshire. These Places also have higher numbers of hip fractures recorded. There will be different levels of intervention for each community – with evaluation to determine effectiveness. Full support will see an awareness pack, falls 'champions', 'Strictly No Falling' classes, risk assessment and support from a Falls Prevention Coordinator.

To date the Chesterfield pilot has received positive feedback from service users, particularly around the length of time taken to speak to a clinician about issues such as hearing and sight problems. Onward referrals have been made into various services such as Strictly No Falling and the local Social Prescribing Scheme.

Enabling better care for people who visit emergency services regularly

Two pilot schemes were set up from October 2019 onwards to support people who regularly use medical services but may benefit more from a community approach. The multi-agency projects include acute care, voluntary and community services, emergency services, mental health, substance misuse, the Local Authorities and Primary Care. The pilot schemes have been commissioned for a 12-month period and operate around Chesterfield, North East Derbyshire, Bolsover and Derby city. The aim is that up to 100 people will get personal support to better manage their situation and reduce their reliance on emergency services. Initial data and feedback is indicating that this approach is making a positive difference.

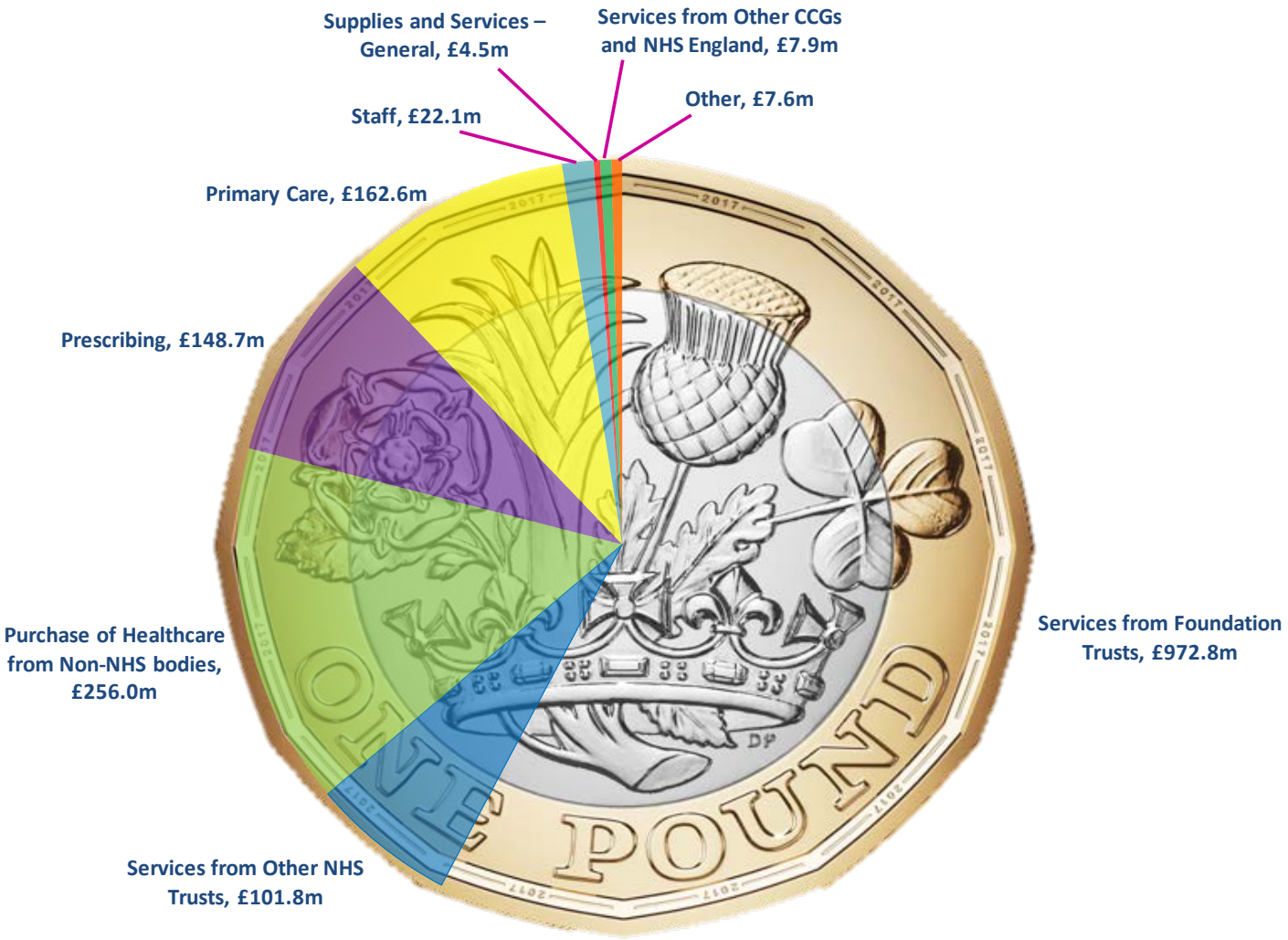
Engagement and Inclusion

Place Alliances undertook a countywide programme of engagement events in July 2019 as part of the STP refresh. Alliances consulted with professionals and members of the public to share updates and priorities whilst asking for feedback about what matters most to local populations. Some key themes arose countywide and plans are progressing to respond to the feedback.

Feedback	Action
Information shared in the engagement session needs to be shared more widely	The Place Team are working closely with the Communications Team to develop the JUCD and CCG website to share important information.
Health information (e.g. where to go for care, self-care information, access to support/ information groups) needs to be shared widely in as many settings and via as many mediums as possible Signposting of services needs to improve across all sectors (e.g. from GPs to social care/voluntary sector, inter-organisation)	Through a Place workstream and social prescribing, a digital platform is being considered which would make health, social care, voluntary and community sector information easier to access for the Derbyshire population. This is a large, complex project and in the interim other work is planned, for example a High Peak community event in May to share information about services with the whole community.
Prevention is considered to be fundamental but the funding does not seem to follow	Place Board has supported a recommendation to JUCD Board that an increased percentage of overall funds are ring-fenced for voluntary and community projects.
Mental Health needs to be a priority	Place Alliances are sharing more information with partners and the local population about the important work of specialist mental health commissioning and delivery teams.

It has been an exciting and busy year in Place and the partnership working has ensured strong multiagency relationships at a local level which has been vital in the response to the COVID-19 outbreak. Dr Penny Blackwell, Chair of Place Board, stated that *"there is now a strong foundation in Place of working and thinking differently about problems ensuring a coordinated approach to supporting the local population which will be built on as the system develops into an Integrated Care System"*.

Addressing our Financial Challenge during 2019/20



Gross Operating Costs 2019/20

Category of Expenditure	Total Spend
	£m
Services from Foundation Trusts	972.8
Services from Other NHS Trusts	101.8
Purchase of healthcare from Non-NHS bodies	256.0
Prescribing	148.7
Primary Care	162.6
Staff	22.1
Supplies and Services – General	4.5
Services from other CCGs and NHSE	7.9
Other	7.6
TOTAL	**1,684.1**

Table 3 and Figure 5 – Gross Operating Costs 2019/20

Financial Position

NHS Derby and Derbyshire CCG received two allocations for the financial year 2019/20 – the first for the commissioning of healthcare (programme) and the other for their running costs (administration). These allocations came in the form of Parliamentary Funding from NHSE and by March 2020 totalled £1,655.3m and £23.4m respectively. The CCG also received adhoc income of £5.4m.

In 2019/20 any CCG with an agreed deficit control total is eligible to access the CSF. This is available to CCGs on a quarterly basis if they remain on plan to deliver their deficit control total and by the end of the year the funding received will be equivalent to the deficit control total. The CCG had agreed a £29.0m deficit control total with NHSE for 2019/20 which it has delivered and therefore received £29.0m of CSF, allowing the CCG to report an in-year break even position.

The CCG has been able to manage cash effectively during the year, maintaining minimum balances at the end of each month and drawing funds from the treasury on a monthly basis. In doing so we have always been able to pay our staff and creditors on time and have complied with the requirements of the Better Payments Practice Code and Prompt Payment Code.

There have been no instances where circumstances outside the control of the CCG (such as interest rate changes) have impacted on the ability to deliver our financial obligations. Neither do we foresee circumstances where such events could impact in the future.

As the COVID-19 emergency developed in the early months of 2020, the CCG began to be affected by the emerging risks. The full impact of this was felt in March when there was a definite change in operating procedures that impacted the end of 2019/20 and the planning process for 2020/21.

The Government has made a clear commitment to meet the costs of the COVID-19 emergency and the emerging guidance in the last weeks of the financial year gave rise to a level of volatility and uncertainty never seen before. Set against this backdrop it is a considerable achievement for the CCG to have met the control total agreed with NHSE and report a break-even position for 2019/20.

Statement as to the 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.

Performance Analysis

One of the key areas of focus outlined in the CCG's Operational Plan for 2019/20 was to maintain system resilience and performance, whilst meeting all constitutional expectations. The constitutional expectations are those performance standards outlined in the NHS Constitution. These include measures such as Referral to Treatment Times, A&E waiting times and Cancer waiting time standards.

The CCG Governing Body receives a performance report against these measures on a monthly basis and monitors and gains more detailed assurance against the CCG's performance metrics. As part of the development of the STP, the CCG has developed an integrated performance report, which gives a system-wide view across Derbyshire for the CCG and providers, in addition to CCG level information.

How Performance is measured?

Performance against the NHS Constitution targets is monitored regularly in the CCG. We look at a range of data, validated and unvalidated, at provider level, CCG level and by specialty where applicable. A large proportion of performance information is supplied via NECS Commissioning Support Unit and the CCG produce regular internal reports which are discussed with Executive Directors and Lead Senior Managers; making best use of 'formal' and 'informal' intelligence and ensuring performance management is continuous, not periodical.

The national policy direction to reduce dependency on acute care continues and has been reinforced through the focus on the Derbyshire STP during the year. Ensuring good access to effective local Primary Care and community services remains a priority. The CCG has continued to support a successful transformation programme that began in 2015/16. The individual projects making up this transformation programme have all identified target measurements that show:

- **Improved Quality –** more care available locally to home;
- **Innovation –** working to a new model of care provision through Advanced Nurse Practitioners to complement GP services and ensuring access seven days a week ;
- **Prevention –** services are more accessible locally and to patients at risk of their condition worsening without that local support; and
- **Improved Productivity –** the local services developed need to show how they achieve more coverage for less money than the alternative available within the hospitals.

The effectiveness of these schemes is linked to the measurement of the number and type of A&E attendances, the number of Non-Elective (Emergency) Admissions to hospital and the number of referrals for outpatient appointments and follow-up outpatient appointments at hospital. Whilst the drivers affecting this demand are complex (for example a flu outbreak can increase demand on the health system overall and there is no agreed validated measure for tracking the number of urgent available GP appointments), analysis of the introduction and capacity within these transformation schemes is undertaken at GP Practice population level and time/day of attendance, which is linked back to acute hospital demand.

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) against our commissioning priorities are reported monthly to the Quality and Performance Committee through the Integrated Quality and Performance Report. This report provides assurance to the committee and highlights current performance, any known and emerging issues, performance trends, patient impacts and corrective action to manage current challenges. The Governing Body also receives a report at each of its meetings in order to provide assurance around performance and quality delivery. 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. Performance is reported via a monthly dashboard. Exception reports are produced for any indicators off track and material performance risks are captured in the Risk Register and Governing Body Assurance Framework (GBAF).

2019/20 Performance Summary

Our overall performance in 2019/20 has shown that 9 of the 24 constitutional or mandated standards for our patients have been delivered during the year.

Those standards that have not been achieved are detailed by exception in the performance analysis section of this report.

Performance Analysis

Table 4 shows how we have performed against the standards for 2019/20:

Indicator		Standard	CCG	NHSE
Referral to Treatment	18 weeks Referral to Treatment – elective surgery	92%	87.9%	84.4%
	18 weeks Referral to Treatment - 52+ week wait	0	39	17,305
Diagnostic waits	Diagnostic test waiting more than six weeks from referral	1%	5.2%	4.1%
A&E waits	A&E <4 hours (January 2020 data)	95%	81.8%	85.6%
Cancer waits - <14 days	Urgent GP referral to 1st outpatient appointment	93%	92.5%	90.0%
	Urgent GP referral to 1st outpatient appointment. (breast symptoms)	93%	77.9%	83.7%
Cancer waits - <31 days	Diagnosis to first definitive treatment for all cancers	96%	95.7%	96.0%
	Subsequent surgery within 31 days of decision to treat	94%	90.0%	91.3%
	Subsequent drugs treatment within 31 days of decision to treat	98%	99.1%	99.1%
	Subsequent radiotherapy treatment within 31 days of decision to treat	94%	93.3%	96.4%
Cancer waits - <62 days	Urgent GP referral to first definitive treatment for cancer	85%	75.4%	77.2%
	NHS screening service to first definitive treatment for all cancers	90%	78.7%	84.6%
	104+ day wait for first treatment	0	257	-

Indicator		Standard	CCG	NHSE
Mental Health	CPA 7 days follow-up	95%	96.2%	96.1%
	IAPT access (national data November 2019)	22%	27.5%	-
	IAPT recovery (national data November 2019)	50%	54.4%	52.1%
	IAPT waiting times (6 weeks)	75%	89.1%	89.4%
	IAPT waiting times (18 weeks)	95%	100%	99%
	Early intervention in psychosis – completed	50%	85.4%	74.5%
	Early intervention in psychosis – wait <2weeks	50%	83.2%	30.6%
	Dementia diagnosis	67%	71.7%	68.4%
Infection Control	CDI	235 FYO	255	13,174
	MRSA	0	7	813
Mixed Sex Accommodation	Mixed sex accommodation breaches	0	89	21,179

Table 4 – performance against standards for 2019/20

2019/20 Performance Exceptions

Referral to Treatment Time (18 weeks)

During 2019/20 the focus has been for Trusts to reduce their incomplete waiting lists. Extra validation is undertaken for patients waiting less than 18 weeks which has affected the Referral to Treatment Time performance. We have not met the standard during 2019/20.

We were able to hit our waiting list target at the end of March 2019 and we have worked with our two main acute providers throughout the year to ensure their waiting lists remain at the same figure in March 2020. The increase in referrals has made this challenging, particularly cancer referrals, which affects Referral to Treatment Time performance, as these cases are deemed more urgent. The figure is also influenced by waiting lists at our associate providers, mainly Nottingham University Hospitals NHS Trust (NUH) and Sheffield Teaching Hospitals NHS Foundation Trust (STHFT).

As a result of the COVID-19 pandemic all elective surgery was cancelled from the middle of March 2020 and as a result of this the CCG did not meet the waiting list target.

Patients waiting more than 52 weeks for treatment

Until February 2020, there had been six patients who waited for more than 52 weeks for their treatment during 2019/20. This equated to 12 breaches over the year as five of the patients breached more than once. Two of these patients were treated at UHDBFT with the remaining four under the care of associate providers. Chesterfield Royal Hospital NHS Foundation Trust (CRHFT) had no patients waiting over 52 weeks during the year, which marked a significant improvement over the previous year.

At the end of March 2020, there were 27 breaches of the 52 week standard as a result of the cancellation of elective surgery, due to the COVID-19 situation. All patients had accepted ‘to come in’ dates during March. During 2020/21, it is expected that the number of patients waiting over 52 weeks will increase during the first few months; until elective surgery is again at the pre-COVID-19 activity.

We receive weekly reports from the providers for those patients who have waited for more than 40 weeks for their treatment and breach reports are provided to ensure there is no harm to the patients.

Diagnostics

This standard was not met for the first 10 months of the year. This was mainly due to the performance of UHDBFT, particularly in relation to echocardiography which was an issue throughout the summer of 2019 due to the number of referrals received by UHDBFT. Performance was also affected by echocardiography performance at a number of our associate providers. The standard was met in February 2020 by the CCG and both our main acute providers. Unfortunately all non-urgent diagnostics were cancelled during March 2020, and as a result this standard was not met during March. There is no national reporting of diagnostics until the 1st July 2020, but the CCG are working with our main acute providers to fully understand the current activity and demand on the services.

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. Attendances have again increased from the previous year with a 8.7% increase (April 2019–February 2020). At UHDBFT, the growth in Type 1 demand is driven entirely by patients attending ED with minor injuries, which have increased by 45% on last year's volume. At CRHFT, the driver of the increase is primarily seen within the major injury pathway, where volume is up by 11.3%.

Our Quality Team were involved in a number of announced and unannounced visits to both Acute Trust provider EDs during 2019/20. Both CRHFT and UHDBFT have welcomed these visits which have been positive and seen positive engagement with staff and patients. Following the visit a full report is provided to the Director of Nursing at the relevant Trust and any actions or recommendations are followed up via the Clinical Quality Review Group.

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). Up to the end of Quarter 4, 117 breaches were reported, 81 of these took place at UHDBFT (46 at Royal Derby Hospital and 35 at Queen's Hospital Burton) and 36 at CRHFT.

All reported breaches are subject to a root cause analysis. We are assured that no harm has been caused by these delays. At Royal Derby Hospital, these patients are cared for in a bedded area away from the ED even though they are still kept on A&E systems. The breaches that occurred at Queen's Hospital Burton were caused when the available bed capacity was reduced due to infection control issues and the decision was made to keep people in ED rather than access beds in closed areas with confirmed norovirus.

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 the extended stay in the ED.

Investigation has shown that the breaches occur at CRHFT for a number of reasons; around 59% are due to capacity, 27% occur when patients require isolation due to influenza or

gastroenteritis and side room availability is at capacity, and approximately 14% are linked to availability of mental health beds, which is a known national issue.

Cancer

We achieved one of the nine national cancer standards during the year – the 31 day subsequent drugs treatment. .

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, although there have been significant increases in the volume of referrals and treatments. There continues to be a significant challenge to deliver the 85% performance for 62 day treatment, both locally and nationally.

Breast referrals, both two week wait referral (2WW) and symptomatic, increased significantly throughout the year which caused both our main providers to struggle to meet the breast 2WW and as a result also impacted on the overall 2WW standard.

A new 28 day faster diagnostic standard will be implemented from the 1st April 2020, but this has now been delayed until October 2020 due to the COVID-19 pandemic, which will eventually replace the current 2WW standard. The aim of this standard is that any one referred will know within 28 days whether or not they have cancer. It is envisaged that the 2WW standard will be phased out.

Both of our main acute providers have been capturing data during the year and working on the pathways since August 2019. CRHFT has been a national pilot site and since then they have not had to report their 2WW standards, although they have been collecting this data.

An initial standard of 75% compliance has been set and currently both of our main acute providers are meeting this standard. As this is not a national standard currently we do not know CCG performance.

There are a number of quality measures that relate to cancer that our Quality Team monitor. Both Trusts participate in the national cancer patient experience survey and also carry out a number of local patient experience surveys. Results and actions taken in response to findings are shared with the Quality Team. Both Trusts also have a programme of local and national cancer audits and share the findings with the Quality Team through an assurance process.

Mixed Sex Accommodation

Providers of NHS funded care are expected to have a zero-tolerance approach to mixed-sex accommodation, except where it is in the overall best interest of all patients affected.

A mixed sex breach refers to all patients in sleeping accommodation who have been admitted to hospital. In September 2019 revised guidance was published giving clarity regarding definitions of a breach and what is justifiable and unjustifiable. A number of unjustifiable breaches have been reported by both Trusts in 2019/20. These all occurred when there has been difficulty transferring patients out of critical care units into the

appropriate ward areas in a timely way. The Trusts provide our Quality Team with a report for the breaches detailing the circumstances and actions taken.

East Midlands Ambulance Service NHS Trust performance

The following data is for Quarter 1 to Quarter 4 in 2019/20 (April 2019–March 2020 inclusive).

Regional Position

Regional Response Times

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

- **Category 1 (C1):** life-threatening illnesses or injuries – specifically cardiac arrest;
- **Category 2 (C2):** emergency calls – stroke, burns or epilepsy;
- **Category 3 (C3):** urgent calls – abdominal pains and non-severe burns; and
- **Category 4 (C4):** less urgent calls – diarrhoea, vomiting and back pain.

In some instances C3 patients may be treated by ambulance staff in their own home, and C4 patients may be given advice over the telephone or referred to another service such as a GP or Pharmacist.

Ambulance performance against the national performance standards for the region can be seen in Table 5. The 90th centile measures the time in which nine out of 10 patients received a response, with the mean measuring the average time in which patients receive a response. Table 5 shows the national standard and the actual response times for each quarter. The times highlighted in green show which national standards were achieved; C1 90th centile in Quarter 1, Quarter 2, Quarter 3 and Quarter 4, and C4 90th centile in Quarter 1.

Performance EMAS Total	Category 1		Category 2		Category 3	Category 4
	Average	90th centile	Average	90th centile	90th centile	90th centile
National Standard	*00:07:00*	*00:15:00*	*00:18:00*	*00:40:00*	*02:00:00*	*03:00:00*
Quarter 1 (Apr 19–Jun 19)	00:07:25	00:13:12	00:26:37	00:55:25	02:40:50	02:37:27
Quarter 2 (Jul 19–Sep 19)	00:07:32	00:13:32	00:30:19	01:02:45	03:42:11	03:04:55
Quarter 3 (Oct 19–Dec 19)	00:08:00	00:14:27	00:37:05	01:17:32	04:35:54	04:16:40
Quarter 4 (Jan 20–Mar 20)	00:07:59	00:14:26	00:28:19	00:57:40	03:58:11	04:38:00

Table 5 – quarterly national standards and actual response times (regional)

Hospital Handover Times

There are two national measurements of handover times:

- the pre-hospital handover standard is 15 minutes and is a Hospital Trust standard; and
- the post-hospital handover standard is also 15 minutes and is an ambulance standard.

Tables 6 and 7 show the average times for pre and post-handovers for April 2019 to March 2020 compared to the previous year. Pre-hospital and post-hospital delays have both deteriorated between 2018/19 and 2019/20 and remain above the 15 minute national standards.

Average pre-handovers times EMAS Total	Apr	May	Jun	Jul	Aug	Sep
2019/20 pre-handovers	00:21:07	00:20:24	00:20:06	00:22:32	00:21:38	00:21:35
2018/19 pre-handovers	00:21:49	00:19:05	00:19:01	00:20:39	00:19:44	00:19:39
	Oct	Nov	Dec	Jan	Feb	Mar
2019/20 pre-handovers	00:25:38	00:26:43	00:30:15	00:28:29	00:24:38	00:22:02
2018/19 pre-handovers	00:19:47	00:20:59	00:21:45	00:23:53	00:23:01	00:20:59

Table 6 – 2018/19 and 2019/20 Apr–Mar average handover times for pre-handovers

Average post-handovers times EMAS Total	Apr	May	Jun	Jul	Aug	Sep
2019/20 post-handovers	00:17:36	00:18:19	00:18:34	00:18:17	00:18:25	00:18:11
2018/19 post-handovers	00:15:10	00:15:12	00:15:03	00:14:38	00:14:28	00:14:34
	Oct	Nov	Dec	Jan	Feb	Mar
2019/20 post-handovers	00:17:34	00:17:17	00:16:58	00:17:33	00:17:53	00:18:49
2018/19 post-handovers	00:14:07	00:13:55	00:13:41	00:13:16	00:14:44	00:16:35

Table 7 – 2018/19 and 2019/20 Apr–Mar average handover times for post-handovers

Incidents and responses

Incidents are where a patient will either receive a clinical assessment over the telephone or a face-to-face response; on-scene responses are where a patient receives a face-to-face response.

Both incidents and response activity has increased and are above the indicative activity plan as at the end of March 2020 (4.7% and 4.2% respectively), as shown in Table 8.

Activity EMAS Total	Apr	May	Jun	Jul	Aug	Sep
Incidents Plan	58,014	61,067	58,811	62,580	59,394	59,440
Incidents Actual	61,806	64,249	62,492	65,314	63,912	61,891
Variance	6.5%	5.2%	6.3%	4.4%	7.6%	4.1%
On Scene Responses Plan	54,125	56,852	54,703	57,850	55,190	55,158
On Scene Responses Actual	57,666	59,158	57,172	59,476	58,455	57,022
Variance	6.5%	4.1%	4.5%	2.8%	5.9%	3.4%

Activity EMAS Total	Oct	Nov	Dec	Jan	Feb	Mar	2019/20 Total
Incidents Plan	63,778	64,647	69,269	68,221	62,983	66,682	754,886
Incidents Actual	65,411	66,261	71,622	66,857	62,408	67,714	779,937
Variance	2.6%	2.5%	3.4%	-2.0%	-0.9%	1.5%	3.3%
On Scene Responses Plan	58,028	58,566	62,376	61,917	56,690	59,668	691,123
On Scene Responses Actual	60,194	60,708	64,686	60,971	56,671	60,694	712,873
Variance	3.7%	3.7%	3.7%	-1.5%	0.0%	1.7%	3.1%

Table 8 – year-to-date demand into EMAS (regional)

Derbyshire Position

Performance

The contractual agreement in place for 2019/20 was that national performance standards would be achieved from Quarter 2 onwards. Table 9 shows ambulance performance against the national performance standards for Derbyshire.

The Derbyshire division achieved the C1 90th centile in each quarter and achieved the C4 90th centile in Quarter 1 and Quarter 2. Performance across each standard deteriorated throughout the year and the division did not achieve national standards for C1 mean, C2 mean, C2 90th centile or C3 90th centile in any quarter.

Performance Derbyshire Division	Category 1		Category 2		Category 3	Category 4
	Average	90th centile	Average	90th centile	90th centile	90th centile
National Standard	*00:07:00*	*00:15:00*	*00:18:00*	*00:40:00*	*02:00:00*	*03:00:00*
Quarter 1 (Apr 19–Jun 19)	00:07:23	00:12:37	00:23:23	00:47:33	02:09:26	02:31:13
Quarter 2 (Jul 19–Sep 19)	00:07:28	00:13:12	00:27:07	00:55:02	03:08:56	02:43:45
Quarter 3 (Oct 19–Dec 19)	00:07:47	00:13:35	00:31:03	01:03:48	04:06:10	03:22:22
Quarter 4 (Jan 20–Mar 20)	00:07:36	00:13:22	00:26:26	00:54:01	03:33:57	03:01:40

Table 9 – quarterly national standard and actual response times (Derbyshire)

Hospital Handover Times

Tables 10 and 11 illustrate that hospital handovers in Derbyshire remain above the 15 minute standard for both pre and post-handovers, however this varies by hospital site. Although higher than the national standard, baseline averages were modelled for 2019/20.

Pre-Hospital Handover Time	Derbyshire Baseline	Derbyshire	Queens Hospital Burton	Chesterfield Royal Hospital	Macclesfield District General Hospital	Royal Derby Hospital	Sheffield Northern General Hospital	Stepping Hill Hospital
Quarter 1	00:20:27	00:19:34	00:20:25	00:19:11	00:23:00	00:19:17	00:24:32	00:22:01
Quarter 2	00:20:27	00:20:21	00:20:04	00:20:38	00:24:00	00:19:46	00:24:28	00:23:42
Quarter 3	00:21:16	00:22:31	00:24:24	00:21:49	00:28:25	00:21:57	00:26:01	00:28:47
Quarter 4	00:20:35	00:22:28	00:21:59	00:20:57	00:25:18	00:22:49	00:28:00	00:27:01

Table 10 – Derbyshire pre-hospital handovers

Post-Hospital Handover Time	Derbyshire Baseline	Derbyshire	Queens Hospital Burton	Chesterfield Royal Hospital	Macclesfield District General Hospital	Royal Derby Hospital	Sheffield Northern General Hospital	Stepping Hill Hospital
Quarter 1	00:13:34	00:17:45	00:15:10	00:18:15	00:11:13	00:18:18	00:15:37	00:13:30
Quarter 2	00:13:34	00:17:32	00:14:22	00:17:34	00:11:38	00:18:16	00:17:21	00:13:47
Quarter 3	00:14:03	00:16:24	00:14:05	00:16:29	00:10:12	00:16:59	00:15:54	00:13:29
Quarter 4	00:14:30	00:17:01	00:15:21	00:17:15	00:12:03	00:17:26	00:15:22	00:14:15

Table 11 – Derbyshire post-hospital handovers

Incidents and responses

Demand in Derbyshire for both incidents and responses are above the indicative activity plan as at the end of December (5.9% and 5.6% respectively), as shown in Table 12.

Activity Derbyshire Total	Apr	May	Jun	Jul	Aug	Sep
Incidents Plan	11,509	12,378	11,757	12,280	11,694	11,796
Incidents Actual	12,359	12,796	12,533	13,120	12,948	12,311
Variance	7.4%	3.4%	6.6%	6.8%	10.7%	4.4%
On Scene Responses Plan	10,836	11,628	11,049	11,504	11,004	11,081
On Scene Responses Actual	11,650	11,993	11,635	12,094	11,997	11,463
Variance	7.5%	3.1%	5.3%	5.1%	9.0%	3.4%
	Oct	Nov	Dec	Jan	Feb	Mar
Incidents Plan	12,501	12,768	13,707	13,269	12,465	12,987
Incidents Actual	13,084	13,334	14,427	13,402	12,390	13,658
Variance	4.7%	4.4%	5.3%	1.0%	-0.6%	5.2%
On Scene Responses Plan	11,537	11,730	12,529	12,273	11,452	11,887
On Scene Responses Actual	12,186	12,386	13,293	12,380	11,387	12,299
Variance	5.6%	5.6%	6.1%	0.9%	-0.6%	3.5%

Table 12 – year-to-date demand into EMAS (Derbyshire) NHS 111 Performance

The NHS 111 service across Derbyshire is provided by DHU 111 (East Midlands) CIC (DHU 111).

DHU 111 has performed extremely well during the 2019/20 financial year of the contract, achieving five out of the six contractual KPIs between April 2019 and January 2020:

- calls abandoned after 30 minutes;
- average answer time;
- calls transferred to a clinician;

- self-care; and
- C3 and C4 ambulance disposition revalidated.

In February 2020 KPI 2 (average answer time) saw a decline, and further deteriorations were also seen for KPI 1, KPI 2 and KPI 6 in March 2020. This was due to an unprecedented increase in calls as a result of the COVID-19 pandemic.

Patient experience data is collected via a NHS 111 service satisfaction questionnaire report which provides validated data on a biannual basis. For the first half of 2019/20 the report demonstrated that 82% of patients were very satisfied with the service provided by DHU 111.

		Year 3					
Contractual KPIs	**Standard**	**Apr 2019**	**May 2019**	**Jun 2019**	**Jul 2019**	**Aug 2019**	**Sep 2019**
1. Calls abandoned after 30 seconds	**≤5%**	0.9%	0.8%	0.9%	3%	2.2%	1.6%
2. Mean average answer time	**≤27 seconds**	00:00:08	00:00:07	00:00:08	00:00:24	00:00:16	00:00:15
3. Proportion of calls transferred to a clinician	**≥ 50%**	66.4%	65.7%	64.4%	62.6%	64.6%	66.3%
4. Proportion of calls not recommended to attend other service (self care)	**≥17%**	17.3%	17.7%	18.4%	20.3%	18.4%	18.0%
5. Proportion of callers satisfied with their experience of NHS 111	**≥85%**	**82% (reported six monthly)**					
6. Proportion of calls with an initial Category 3 ambulance disposition that are revalidated	**50%**	74.1%	70.2%	62.2%	63.4%	67.5%	72.3%
		Year 4					
	Standard	**Oct 2019**	**Nov 2019**	**Dec 2019**	**Jan 2020**	**Feb[3] 2020**	**Mar[2] 2020**
1. Calls abandoned after 30 seconds	**≤5%**	1.2%	1.9%	1.9%	0.7%	2.0%	29.2%
2. Mean average answer time	**≤27 seconds**	00:00:11	00:00:26	00:00:26	00:00:06	00:00:28	00:10:32
3. Proportion of calls transferred to a clinician	**≥ 50%**	67.6%	68.4%	61.2%	68.5%	68.8%	64.9%
4. Proportion of calls not recommended to attend other service (self care)	**≥17%**	18.6%	18.5%	18.0%	17.8%	19.8%	29.2%
5. Proportion of callers satisfied with their experience of NHS 111	**≥85%**	**Awaiting Results (expected June 2020)**					
6. Proportion of calls with an initial Category 3 ambulance disposition that are revalidated	**50%**	71.3%	72.4%	71.9%	81.4%	69.7%	40.1%

Table 13 – contractual KPIs for DHU 111

[3] The deterioration in February and March performance is due to the unprecedented increase in calls as a result of the COVID-19 pandemic.

Healthcare Acquired Infections

Methicillin-resistant Staphylococcus aureus

Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia are subject to a zero tolerance approach across all organisations.

Since April 2019, seven cases of MRSA bacteraemia have been reported relevant to the population of Derby and Derbyshire. All cases have been identified as community onset infections. In line with national guidance, all MRSA bacteraemia are subject to a post-infection review; with any identified learning being shared not only with those involved but with the wider health economy to support prevention of future cases. Nothing has been identified during a review of these community onset cases that would have prevented development of the infection.

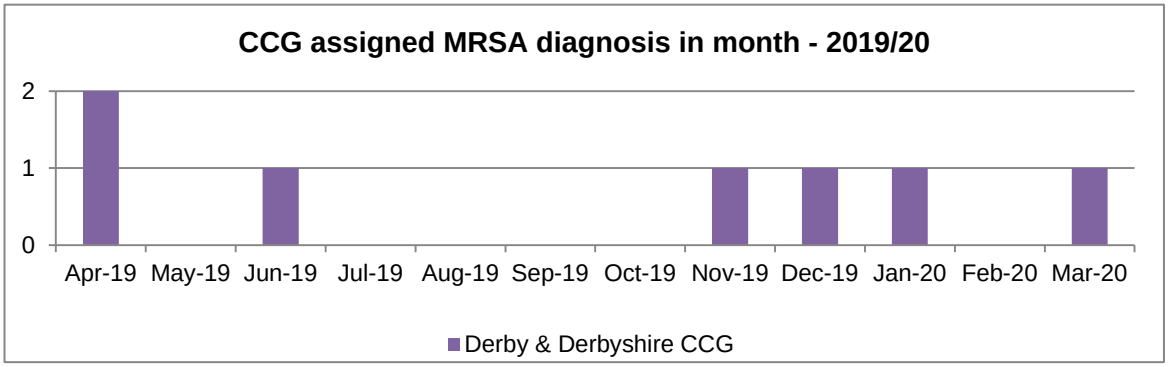


Figure 6 – CCG assigned MRSA diagnosis in month – 2019/20. Source: Public Health England HCAI Data Capture System

Methicillin sensitive Staphylococcus aureus

Methicillin sensitive Staphylococcus aureus (MSSA) blood stream infections have been subject to mandatory reporting since January 2011, though no organisational objectives are set.

During 2019/20, 259 MSSA blood stream infections were reported within Derby and Derbyshire. This reflects the epidemiology reported by Public Health England, which notes increasing numbers of MSSA being seen nationally, driven by an increase in community onset cases.

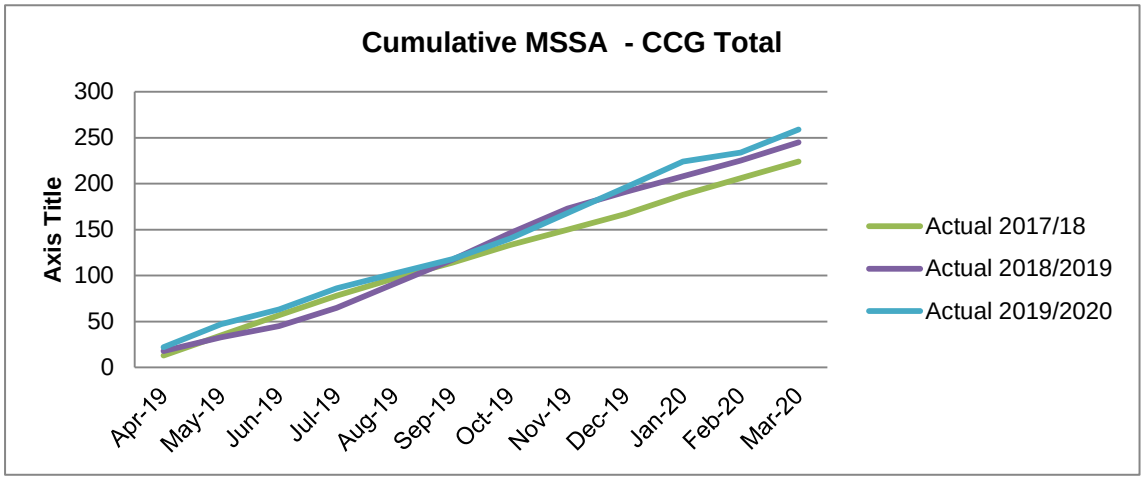


Figure 7 – Cumulative total of all MSSA cases. Source: Public Health England HCAI Data Capture System

Clostridium difficile Infection

Annual objectives for each organisation are set annually by NHS Improvement, with our objective being set at no more than 235 Clostridium difficile (CDI) cases (23.2 rate objective per 100,000 population) during 2019/20 compared to an objective of 279 cases during 2018/19.

During 2019/20 253 CDI cases have been reported across Derby and Derbyshire compared to 224 during 2018/19.

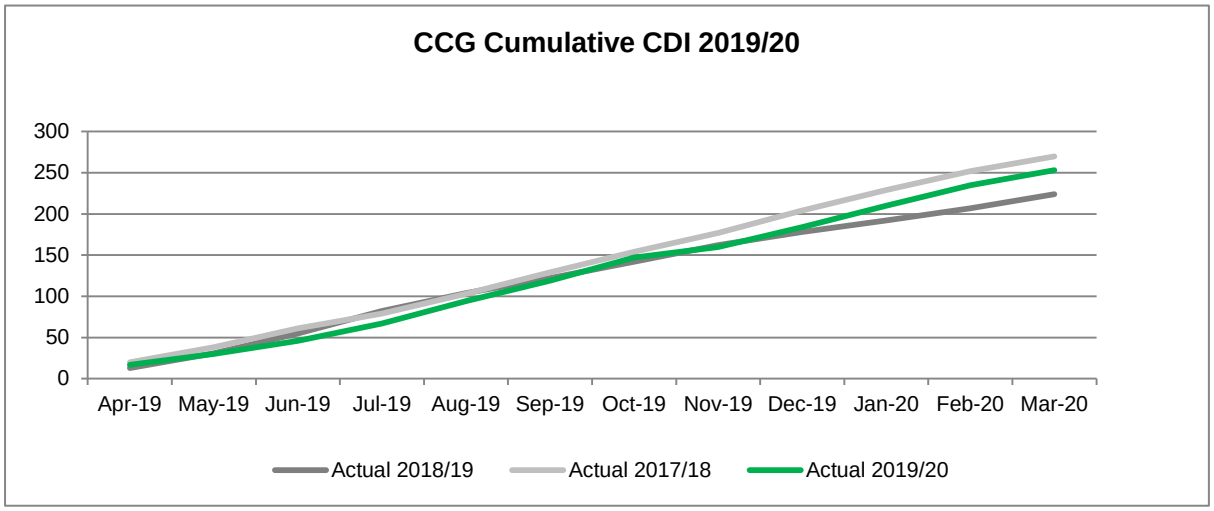


Figure 8 – Cumulative total of all CDI cases. Source: Public Health England HCAI Data Capture System

Acute provider organisations are also subject to an annual objective set by NHS Improvement. University Hospitals of Derby and Burton NHS Foundation Trust (UHDBFT) have remained under their objective of 117 cases during 2019/20 with a final count of 114 cases. CRHFT were over their objective of 34 cases with a total count of 41 cases.

Gram-negative blood stream infections

The Government had an initial ambition to reduce healthcare associated Gram-negative bloodstream infections by 50% by 2021, which previously resulted in targets being set for CCGs which focused on the reduction of Escherichia coli (E.coli) blood stream infections. The Government has since revised this ambition and now aims to halve healthcare associated Gram-negative blood stream infections by 2023/24. This also includes blood stream infections caused by Pseudomonas and Klebsiella species.

Escherichia coli

During 2019/20, 931 E.coli blood stream infections have been reported relevant to the population of Derby and Derbyshire in comparison to 1,018 during the same period of 2018/19. While a small reduction for all cases is noted for Derby and Derbyshire, this is not reflective of the national picture which continues to see an increase annually and appears to be driven by community cases.

Klebsiella

At the close of 2019/20 204 Klebsiella blood stream infections have been reported relevant to the population of Derby and Derbyshire in comparison to 229 during the same period of 2018/19. Klebsiella species are commonly found in the environment and in the human intestinal tract without causing harm though they can cause an assortment of healthcare-associated infections, including pneumonia, wound or surgical site infections and meningitis as well as blood stream infections. They can become resistant to a wide range of antibiotics. Nationally, Public Health England note a continued increase in the incidence of Klebsiella species blood stream infection in both hospital onset and community onset cases.

Pseudomonas aeruginosa

Pseudomonas aeruginosa was identified as the causative organism for 90 blood stream infections amongst the population of Derby and Derbyshire during 2019/20, compared to 91 in 2018/19. Pseudomonas is an opportunistic organism often found in soil and ground water and may cause a wide range of infections, including blood stream infections, in people who have weakened immune systems and may become resistant to many antibiotics.

Reducing Gram-negative bloodstream infections

We continue to work collaboratively across the health economy to support the reduction of Gram-negative bloodstream infections, including initiatives to reduce the number of patients having indwelling urethral catheters, the use of catheter passports and the promotion of campaigns to support hydration and early recognition of urinary tract infection. Work will continue with all aspects of health and social care provision to ensure antimicrobial stewardship is managed in line with the UK‘s five year plan to tackle antimicrobial resistance; as recognition is made that strong antimicrobial stewardship is a key factor in supporting the reduction ambitions of Gram-negative blood stream infections.

Patient Safety

The new national Patient Safety Strategy was published in July 2019. The strategy saw a shift from talking about harm to talking about safer systems that provide the right care, every time and learning from what actually works rather than just focusing on what does not work in isolation.

Following the merger of the four Derbyshire Clinical Commissioning Groups on the 1st April 2019 it has been important for us to move towards a more coordinated system approach to ensure that good working relationships are fostered with each organisation and that we all work together as effectively as possible to provide a safer system. Within patient safety this is crucial, especially when discussing shared learning from incidents across the health economy. It is key that all organisations can be open and transparent so individuals feel safe to discuss errors and learn from these to prevent reoccurrence and work continuously to maintain safety for the patients of Derbyshire health services.

Table 14 shows the numbers of serious incidents Derbyshire have reported in 2019/20. The reports have all been of a good standard and there has been a significant amount of learning that has taken place as a direct result of these. It is important that this learning is continuous and is embedded into practice in order to make that difference to the patients in our care.

	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020
UHDBFT	13	27	23	27	20	8	19	21	22	20	10	16
CRHFT	3	9	9	2	5	10	10	10	6	9	9	4
DHcFT	5	10	7	7	7	7	7	9	2	3	6	4
EMAS	0	0	2	7	5	8	4	4	7	6	6	0
DCHSFT	1	2	7	4	3	1	5	6	0	3	1	1
DHU	0	0	1	1	0	0	1	0	0	0	0	0
Cygnet Hospital	0	0	0	0	0	0	0	0	1	1	0	0
Insight Healthcare	0	0	0	0	0	0	0	0	0	0	0	1
Trent PTS	0	0	0	0	0	0	0	0	0	1	0	0
IAPT	0	0	0	0	0	0	0	1	0	0	0	0
Barlborough Treatment Centre	0	0	0	0	0	1	0	0	0	0	0	0
Derby and Derbyshire CCG Functions	0	0	1	0	0	0	0	0	0	0	0	0
Nuffield Hospitals	0	0	1	0	0	0	0	0	0	0	0	0
Aspire Health Care - Boden House	0	0	0	0	0	0	1	0	0	0	0	0
Air Liquide	0	0	0	0	0	0	1	0	0	0	0	0
Primary Care	0	0	0	0	0	0	1	0	0	0	0	0
Total	**22**	**48**	**51**	**48**	**40**	**35**	**49**	**51**	**38**	**44**	**32**	**26**

Table 14 – number of serious incidents reported in Derbyshire in 2019/20

Pressure ulcers, falls and diagnostic 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.

We are proud to have been selected to be early adopters of the new National Patient Safety Incident Response Framework which will replace the current Serious Incident Framework and will take a systems approach to safety investigation. A 'systems' approach to incidents considers all relevant factors and means our pursuit of safety focuses on strategies that maximise the frequency of things going right. There are five organisations in Derbyshire that will be part of this new process from April 2020. These are: DCHSFT, CRHFT, UHDBFT, DHU Health Care and Derbyshire Healthcare NHS Foundation Trust (DHcFT). We have been working collaboratively with these organisations and NHSE nationally to plan the implementation since October 2019.

© Alan Fletcher, A Shot in the Dark Photography

Never Events

Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been 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.

Table 15 shows that there have been 14 Never Events during 2019/20, across all providers. The main theme has been wrong site surgery, with the majority of the incidents taking place outside of the main theatre setting. We organised a whole health economy event to share the learning from these incidents and facilitate provider organisations to take the learning and adapt this to their own working environments to prevent further incidents.

	Apr 2019	May 2019	Jun 2019	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Total
CRHFT	0	0	3	0	0	0	1	0	0	1	1	0	**6**
UHDBFT	0	0	2	0	1	0	0	0	1	1	0	1	**6**
EMAS	0	0	0	0	0	0	0	0	0	0	1	0	**1**
DCHSFT	0	0	0	0	1	0	0	0	0	0	0	0	**1**
Total	**0**	**0**	**5**	**0**	**2**	**0**	**1**	**0**	**1**	**2**	**2**	**1**	**14**

Table 15 – number of Never Events in 2019/20

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

Friends and Family Test

The Friends and Family Test (FFT) is intended to provide users of health services with a quick and easy to use opportunity to give feedback on their experiences. This can then be used by providers to enhance the quality of patient experience. It is made up of a single mandatory default question followed by at least one open free-text question to allow people to feedback in their own words. Currently, the FFT asks people if they would recommend the services they have used and offers a range of responses.

Due to the flexibilities allowed within the FFT the numerical data is not comparable between organisations. Analysis of the FFT data can indicate improvement or decline in patient experience when triangulated with other sources of patient experience information such as that provided by national surveys and complaints and reports produced by the Patient Advice and Liaison Service.

FFT scores and patient opinions from the NHS website are assessed alongside local information in order to understand health services from a patient experience perspective.

FFT data is reported by NHS provider Trusts to NHSE on a monthly basis approximately two months in arrears i.e. data for January is reported in March. Figures 9, 10 and 11 show data for the first nine months of this financial year (April 2019–December 2019).

Chesterfield Royal Hospital NHS Foundation Trust

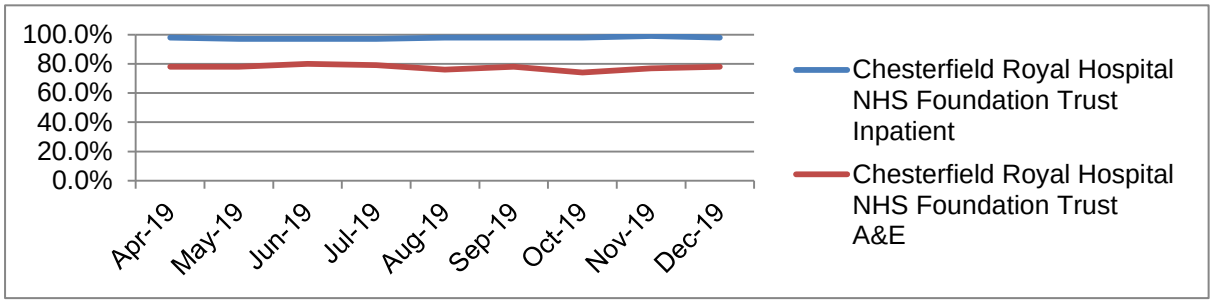


Figure 9 – inpatient and A&E Friends and Family data for Chesterfield Royal Hospital NHS Foundation Trust

University Hospitals of Derby and Burton NHS Foundation Trust

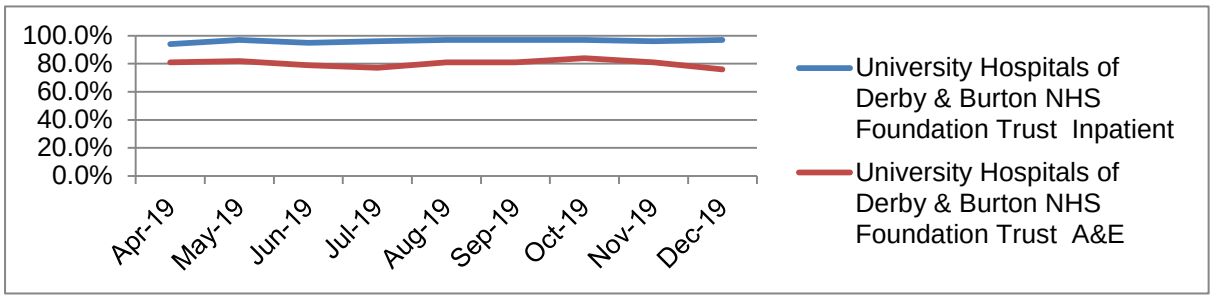


Figure 10 – inpatient and A&E Friends and Family data for University Hospitals of Derby and Burton NHS Foundation Trust

Derbyshire Community Health Services NHS Foundation Trust and Derbyshire Healthcare NHS Foundation Trust

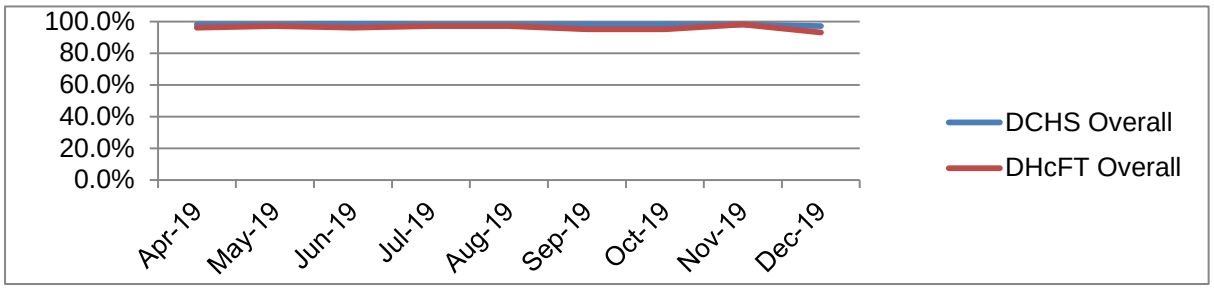


Figure 11 – Friends and Family data for Derbyshire Community Health Services NHS Foundation Trust and Derbyshire Healthcare NHS Foundation Trust

Patient Experience

We gather patient experience feedback from many different sources and work in partnership with patients, carers and local partners to ensure that the services we commission are responsive to the needs of our population.

Local people's experience and involvement are at the heart of transformational commissioning which approaches decisions from the perspective of patients, service users, carers, families and communities.

Our approach can be summarised in the three following points:

- to ensure that we use a variety of different mechanisms, methods and approaches to work with partners, patients, service users and their carers to understand their experiences of using services and how they feel these can be improved;
- to have systems, processes and infrastructure in place to ensure that the feedback we receive informs the design, delivery and implementation of services; and
- to work with partners, patients, service users and their carers to ensure that the providers of services that we commission collect and use patient experience feedback to enhance those services.

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

Examples of how we have gathered and used patient experience feedback over the last year are detailed on the following page.

Regular and routine monitoring and reporting of patient experience activity in our commissioned services

Our commissioned providers of health care report to us on a quarterly basis in respect of their activity relating to patient experience feedback. This includes, but is not limited to, how they look for themes and trends in the feedback they receive and what action they have taken to enhance services as a result of this, how they are gathering patient experience feedback in different ways and from the differing groups of people who use their services and how they are helping those with additional needs to give their feedback on services. This information is analysed by our Patient Experience Team and discussed with commissioned service providers at regular quality meetings.

The above quarterly reporting is triangulated with additional sources of information to provide our Governing Body (via its Quality and Performance Committee) with a clear picture of the performance of our commissioned services. These sources include: NHSE FFT data, Healthwatch data and reports, CQC reports and intelligence gathered from within the CCG through complaints, Patient Advice and Liaison Service contacts, enquiries and MP enquiries.

Musculoskeletal services

The MSK triage services were fully deployed across all GP Practices in Derbyshire from January 2019. These services involve all referrals being triaged by an appropriately trained clinician and referred for appropriate action. During this time the CCG carried out a number of activities to look at the experiences of patients, staff and referring GPs under the revised triage system. The results of the feedback gathered are being used to inform the development of the system including the way in which referrals are processed and managed, communication with patients around treatment options, and the way in which assessment takes place. This includes consideration of the particular challenges faced by people with long term health related problems and those living in rural locations.

Orthotics

The CCG has recently reviewed the experiences of people using Orthotic services in Derbyshire. This included a review and patient experience study carried out by Healthwatch Derbyshire earlier in the year. This enabled the CCG to look at what aspects of the service work well and those that people felt needed improvement. This information has been used to develop the service specification which went out for tender in December 2019. During the development of the specification, the evaluation of tenders and the moderation of the process, the Patient Experience Team ensured that the feedback gathered influenced decision making. In addition, a lay person was actively involved in the evaluation and moderation process to guarantee that the experience of patients is at the forefront of the outcomes expected.

Special educational needs and disability

Over the last 12 months, there has been a lot of work to develop the input of parents, children and young people with special educational needs and disability when planning and delivering health care. We have developed strong working relationships with two key carer groups across Derbyshire: Parent Carers Forum Derby City and Parent Carers Forum Derbyshire. Both have a very strong representative membership who are able to advise on

the needs of their membership group. For example, we used feedback from an 'In My Shoes' survey looking at experiences of using health, education and social care services to help improve services. Feedback was largely positive but it did provide some key learning around teams working more collaboratively and some specifics around the autism diagnosis pathway. Work is currently underway to utilise this information in the development of future care pathways including the neurodevelopment pathway assessment process which will improve the speed at which diagnosis and support is provided. Another key development has been the improvement in support provision available while parents and carers await a diagnosis.

Sustainable Development

NHS Derby and Derbyshire CCG has the following Sustainability Mission Statement located in our Sustainable Development Management Plan:

> *"The aim of NHS Derby and Derbyshire Clinical Commissioning Group 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".*

Sustainability has become increasingly important as the impact of people's lifestyles and business choices change the world in which we live. As an organisation that acknowledges its responsibility towards creating a sustainable future, we help to achieve that goal by running awareness campaigns that promote the benefits of sustainability to our staff and partners. One of our Governing Body Lay Members is the CCG's Sustainability Champion.

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.

The organisation has sought to secure emission reductions and improve sustainability in the following areas:

- **Energy:** by reducing total consumption;
- **Consumables:** by sending key meeting papers electronically instead of printed copies, and encouraging recycling;
- **Travel:** by reducing the carbon footprint through Sustainable Travel Plans; and
- **Procurement:** by taking account of the Procurement for Carbon Reduction Sustainable Procurement Tool.

As an alternative to travelling to meetings, the CCG is increasingly using teleconference and videoconferencing facilities. Significant reductions in travel pollution and lost staff time travelling are thus being achieved.

Business Continuity

During 2019/20 the CCG has managed various business continuity incidents. Of which, the most critical being the management and response to COVID-19; the Toddbrook Reservoir, Whaley Bridge incident; and the wider Derbyshire flooding.

Coronavirus Pandemic

Following the outbreak of COVID-19 in China and the spread of the virus outside that country, the virus spread worldwide. Work has increased for the CCG and the Derbyshire system in responding to national and political statements to support the management of priority and front line services to care for severely ill patients and help contain the spread of the virus.

On the 24th March 2020, the CCG formally moved to Level 3 of our Business Continuity Plan escalation, and it was deemed that we were in the situation where 'major pressures were being experienced in the CCG'; which meant that the CCG could no longer fully deliver its commissioning role as described in our Constitution.

The CCG established an Incident Control Centre to support and manage the responses nationally, and to the Derbyshire system and Primary Care. Daily System Escalation Group meetings and twice daily Senior Leadership Team meetings were also established to support and manage our response to COVID-19.

Mid-March saw the CCG transition towards remote working and the Chief Executive Officer communicates daily COVID-19 updates to all staff and the Governing Body. NHS Digital introduced Microsoft Teams for all NHSmail users, to support new ways of working during the COVID-19 response. Microsoft Teams is a secure communication tool to allow instant messaging and audio and video calling, with the ability to present documents. The CCG also worked directly with its own providers to ensure that we have sufficient capacity across our networks and independent providers have increased their capacity to ensure that we can continue to function and communicate as part of our day to day business.

Toddbrook Reservoir, Whaley Bridge

At the end of July/beginning of August 2019, the Toddbrook Reservoir at Whaley Bridge suffered structural damage following heavy rainfall. As a precautionary measure, residents living in the vicinity were evacuated and a multi-agency response was initiated to manage the incident, which included pumping out the reservoir to reduce the danger. The Derbyshire Local Resilience Forum, led by Derbyshire Constabulary and supported by the Emergency Planning Team hosted by Derbyshire County Council, held Strategic and Tactical Coordinating Groups to assist in managing the process. Representatives from the CCG and other health organisations were involved with some of those meetings.

Derbyshire Flooding

Derbyshire experienced sustained high levels of rainfall since the flooding that happened in November 2019; with two significant storms Dennis and Ciara happening in close succession in February 2020. Whilst the impact of both of these storms were felt more severely outside of Derbyshire; the already saturated ground and high river levels did impact on some Derbyshire residents. In response to the flooding the Local Resilience Forum, led by Derbyshire Constabulary and supported by the Emergency Planning Team, held strategic

and tactical meetings to manage the situation. The level of the River Derwent was anticipated to rise to unprecedented levels and whilst the Environment Agency were closely monitoring the situation there was still some uncertainty about the level of impact as the 'surge' moved down the River Derwent towards the centre of Derby and out towards the Shardlow area of Derby.

On the 10th November 2019, we were alerted that the CCG headquarters at Cardinal Square in Derby was without power and that subterranean electrical switching gear had been flooded by the rising water. This meant that the CCG and other organisations reliant on the building would need to make alternative arrangements until the power could be restored. The CCG's Business Continuity Plan was activated and staff were alerted by the CCG's Communications Team to work from home or from alternative sites if possible. The landlord of Cardinal Square made provisions to get six generators on site to ensure that there would be power to the building before a permanent repair could be made, which was predicted to be weeks rather than days. To minimise the risk of flood damage they were raised 750mm from the floor. Priority in finding fixed work areas was given to staff who could not access mobile working and other staff either worked from alternative sites, worked from home or, in the absence of any of those options, took Special Leave. The generators were up and running on the Thursday and the building was fully operational by Friday the 15th November 2019.

Improving Quality

Maternity

Better Births, a report of the National Maternity Review which was published in February 2016, set out a clear vision for Maternity Services across England to become safer, more personalised, kinder, professional, and more family friendly. It envisages an England where every woman has access to information to enable her to make decisions about her care and where she and her baby can access support that is centred on their individual needs and circumstances. The report also calls for all staff to be supported to deliver care which is women-centred; working in high performing teams in organisations which are well led and in cultures which promote innovation, continuous learning, and break down organisational and professional boundaries. The Derbyshire Maternity Transformation Programme Board provides direction and oversight in terms of delivering the aims of the programme, and there have been a number of successes during 2019/20:

- hundreds of staff including Midwives, Obstetricians, Anaesthetists, Health Care Assistants along with Trainees, Paramedics, Technicians and other frontline EMAS staff , have undertaken the Practical Obstetric Multi-Professional Training Programme. The programme combines lectures with hands on skills stations and simulation scenarios to replicate the clinical environment. The training aims to make practice safer and more efficient, with a reduction in morbidity and mortality;
- the launch of the Mother Hub 'choice offer' website;
- trialling a new personalised care plan document;
- piloting continuity of Carer Teams. The team offers continuity of the person caring for the woman antenatally, during the birth, and postnatally. Initial care models have been positively evaluated by women and plans are now being developed to expand the offer to more women;

- enhanced service models are being launched to support women with more complex needs and higher risk pregnancies, including joint clinics for diabetes, epilepsy and mental health, and additional support for women who smoke during pregnancy, including risk perception interventions. Trusts are now signed up to the East Midlands Smoke Free Pregnancy Pathway;
- the 'For You and Baby' social marketing campaign aimed at changing attitudes related to breastfeeding and smoking during pregnancy, was delivered over nine months. The campaign achieved significant digital engagement and reach, and achieved an Earned Media Value of £1,500,000 – 27 times more than the cost of the campaign. The Breastfeeding Welcome Here Award promoted through this campaign has been extended to Derby city, and new 'Breastfeeding Guardians' have been signed up outside of UNICEF accredited services; and
- as required by the national Maternity Transformation Programme, a local agreed improvement plan for postnatal care was finalised in March 2020 in line with agreed draft guidance as set out in *Implementing Better Births: Postnatal Care (October 2019)*.

Safeguarding Children

We have been instrumental in working collaboratively with the two Local Authorities (Derby City Council and Derbyshire County Council) and Derbyshire Police in developing and implementing the new joint Derby and Derbyshire Safeguarding Children Partnership. The purpose of the new arrangement is to achieve the best outcomes for children, young people and families. The new local safeguarding children arrangements are a shared responsibility between the three key partners who have an equal duty to make arrangements to safeguard and promote the welfare of children. The three safeguarding partners are required to agree on ways to coordinate their local safeguarding services, act as a strategic leadership group and implement local learning, including from serious child safeguarding incidents. Alongside our partners, we have embraced these new arrangements and continue to work with partners and key stakeholders in fulfilling the statutory requirements as set out in Working Together to Safeguard Children (2018). The new partnership set five key priorities. These have been agreed by the Chief Officers of the children partnership and are listed below:

Priority	Derby and Derbyshire Safeguarding Children Partnership priorities and key actions
1	Promote emotional health and wellbeing and reduce the impact of Adverse Childhood Experiences
2	Safeguard children at risk of exploitation, reflecting additional features such as contextual safeguarding and our understanding of emerging vulnerabilities
3	Reduce the adverse impact of parental substance misuse and parental mental health
4	Promote and obtain assurance of early help arrangements (including responding to neglect) and response to requests for services
5	Reduce the adverse impact of domestic abuse and family conflict

Alongside Derby and Derbyshire Public Health Services, we have developed and implemented the new local child death arrangements based on the Child Death Review: Statutory and Operational Guidance (2018). Together with Derby and Derbyshire Public Health Services we now have an equal responsibility and duty to ensure that all deaths of children normally resident in the local area are reviewed and if we consider it to be

appropriate any non-resident child who has died in the area. The aim is to analyse, gather and disseminate learning locally and nationally.

Safeguarding Adults

Our Adult Safeguarding Team has collaborated with key stakeholders and partners to respond effectively when allegations are made relating to the abuse or neglect of adults at risk. Evidence and assurance has been gathered by the team which consolidates the view that robust working practices are in place across the breadth of the NHS in Derbyshire to identify and eradicate abusive behaviour and practice. Our Adult Safeguarding Team plays an active role in determining, shaping, and implementing strategic safeguarding activities at a local, regional, and national level.

Our Head of Adult Safeguarding is Vice Chair of the Derbyshire and the Derby City Safeguarding Adult Boards, Chair of their respective Quality Assurance Committees, and led the audit of over 150 safeguarding case files. The wider team ensure we are represented at all of the city and county's safeguarding associated groups and committees. The Head of Adult Safeguarding also represents the East Midlands CCGs at the Midlands Board and is the East Midlands Representative at the National Group.

In 2019/20 we received a total of 2,300 adult safeguarding referrals – an increase of 17% on the previous 12 months – and participated in five Domestic Homicide Reviews and three Safeguarding Adult Reviews. The Head of Adult Safeguarding also led the review of the Vulnerable Adult Risk Management Operational Programme and secured partnership funding to employ a Vulnerable Adult Risk Management Coordinator.

We worked closely with Primary Care in 2019/20 and obtained adult safeguarding assurance from all GP Practices. We now also have an Adult Safeguarding Lead in every GP setting. Our Safeguarding Training Programme achieved a 95% compliance rate and we also successfully implemented a funding programme to assist those individuals who hoard and self-neglect. This has had some very successful outcomes for vulnerable people.

Our most recent Safeguarding Annual Report (2018/19) contains more detailed information about the work of the Adult Safeguarding Team and is available here.

End of Life Care

The need for a formal End of Life (EoL) Strategy for the STP was identified in July 2019 by the CCG, JUCD Board and Clinical and Professional Reference Group. The strategy would set out the clear aims and objectives for EoL care and the commissioning intentions to deliver those.

The EoL workstream was subsequently established with an associated EoL Programme Board chaired by the Chief Nurse Officer of the CCG. The Programme Board brings together system-wide clinicians, providers and commissioners to discuss and address EoL issues in Derby and Derbyshire.

The EoL Strategy was developed over the summer and approved in October 2019. The aim of the strategy and EoL Programme Board is to ensure collaborative, coordinated care from all providers of EoL care – maximising comfort and ensuring patients are enabled to die in their preferred place.

An EoL Operational Group has now been established to ‘operationalise’ the ambitions within the strategy, identify key priorities and make recommendations to the Programme Board in terms of areas for action. The Operational Group has built upon the work already undertaken across Derby and Derbyshire to map our baseline position against the ambitions for palliative care and the new NICE Guidance (2019) – EoL care for people with life limiting conditions. Key delivery areas have now been identified with delivery leads in place and a 2020/21 delivery plan has been developed to address the key priorities for the coming year.

System Quality and Performance

A JUCD System Quality and Performance Group has been developed to provide assurance to the JUCD Board in relation to the quality, performance, safety, experience and outcomes of services across Derbyshire. The need for a single shared quality and performance report that commissioners and provider organisations can use, has been agreed and work has commenced to deliver this in 2020. This report will demonstrate all of the key NHS Constitutional targets, be focused on the CQC domains and will seek to provide assurance to the JUCD Board on progress towards delivery of the mission and vision of JUCD.

Engaging People and Communities

Public Engagement and Consultation

We have discharged our public involvement duty by having arrangements in place for the public to be involved in:

- the planning of services;
- the development and consideration of proposals for changes which, if implemented, would have an impact on services; and
- decisions which, when implemented, would have an impact on services.

Increasing opportunities for public and patient involvement

We are committed to ensuring that opportunities for patient and public involvement are provided across the range of commissioning activities. NHS organisations have a duty under Section 14Z2 of the Health and Social Care Act 2012 and the NHS Act 2006 to 'make arrangements' to inform, involve and consult with the public where there is a potential service change. The intention is that every opportunity is sought to work with local people, service users and receivers as part of our commitment to ensure that our public and patients are at the heart of our decision making processes.

Our approach to involvement and engagement varies according to what we are engaging on and who we need to engage with. We use all the traditional routes which include the following:

- Events
- Surveys – both online and paper copies
- Face to face interviews
- Focus groups
- Co-production in service design and development
- Workshops
- Social media
- Direct contact and through our partner networks

Social Media

In order to access a wider range of participants we have expanded our use of social media through Facebook and Twitter. This expansion was particularly useful when targeting engagement to specific demographics such as our Maternity Services Engagement, and increasing our engagement reach during self-care campaigns, Diabetes Prevention Week and winter pressures. We have included some examples of this below. We have been developing our social media using scheduling tools to ensure our accounts are active seven days a week, including times we are not open, such as weekends and Bank Holidays.

Surveys

We ask a core set of demographic questions in every survey we undertake to allow us to understand who is completing the survey and if they meet the general demographics of the geographical or service area.

Questions asked relate to the nine protected characteristics:

1. Age
2. Disability
3. Gender reassignment
4. Pregnancy and maternity
5. Race
6. Religion or belief
7. Sex
8. Sexual orientation
9. Marriage or civil partnership

In addition we ask questions about:

- social economic status (approximation from the first four letters of the postcode);
- caring status; and
- long term conditions.

All of the information above is used to understand who has completed the survey and also allows for further analysis of information by group and response to see if there is more of an impact of suggested changes on certain groups of people.

Examples of recent surveys can be found in Table 16:

Survey	Date	Responses
Changing provision of Erewash beds pathway	June 2019	30 responses
Eating Disorder Service Review Children, Young People, Parents and Carers	June 2019	40 responses
Kids in their Environment (KITE) team service review, children's consumables	June 2019	17 responses
The Light House, children's residential short breaks	June 2019	19 responses

Survey	Date	Responses
Children and Young People Urgent, Emergency and Crisis Service Review	July 2019	63 responses
Mobile MRI Scanner Review Ilkeston	July 2019	26 responses
MSK Triage Service for Derbyshire	July 2019	57 responses

Table 16 – examples of recent surveys

Digital Campaigns

We promote opportunities to get involved by advertising on our public website, utilising our social media, advertising in the local newspapers, by holding drop in sessions at local marketplaces, attending/holding community events/campaigns and publicising through partner networks. Some of our digital campaigns can be seen further down in this report.

To further strengthen our involvement work in Derbyshire, we have introduced a range of new processes and opportunities in 2019 for involvement and engagement, which are detailed below.

Engagement Committee

The Engagement Committee, which reports to the Governing Body and the JUCD Board, held its inaugural meeting on the 1st May 2019, and meets monthly. Members include representatives from the Governing Body, public representatives from our communities, Foundation Trust Governors, Healthwatch and the voluntary sector. CCG staff 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 'confirm and challenge' opportunities for the Engagement Committee. Examples of the work of the Engagement Committee include:

- shaping the emerging engagement model (more detail can be found in the Priorities for 2020/21 section below);
- JUCD engagement programmes, including the STP refresh and publications;
- supporting the development of risk reporting and the GBAF;
- reviewing the consultation and engagement processes on key programmes such as The Light House and the Urgent Care Review;
- feedback on Commissioning Intentions; and
- deep dives on programmes and schemes including repeat prescribing and The Prescription Medicine Order Line.

You can find more information about the Engagement Committee on our website here.

Lay Reference Group

The work of the Engagement Committee is supplemented by a Lay Reference Group meeting, which is made up of a varied group of Lay Representatives, including members of Patient Participation Groups Networks. This group meets regularly as required, and is the engine room for the Engagement Committee to improve continuous engagement. It also provides confirm and challenge on a number of different project areas, helping to inform the potential approach to engagement at an early stage. This helps to ensure that potential schemes and associated service changes that have reached this stage are subject to rigorous scrutiny. There are approximately 30–40 Lay Representatives who have subscribed to this group and attendance varies according to the subject matter and agenda. Examples of agenda items and areas of work that the group has been involved in include:

- Terms of Reference for the Engagement Committee;
- shaping the emerging engagement model (more detail can be found in the Priorities for 2020/21 section below);
- Urgent Care review – testing and recommending engagement approaches;
- Continuing Health Care information presentation; and
- reviewing the draft Postnatal Care Improvement Plan for Derbyshire.

More information can be found on our website here.

Confirm and Challenge Sessions

In addition to the Lay Reference Group, we also convene confirm and challenge sessions to allow projects to be discussed at a very early stage. Project leads present their initial project ideas and use the session to understand generally if the proposals would work and also seek guidance on the approach to engagement.

Feedback from both Project Managers and those attending the sessions has been very positive as it allows for early and frank discussions where feedback is valued.

Section 14Z2 Planning and Assessment Form

NHS organisations have a duty under Section 14Z2 of the Health and Social Care Act 2012 and the NHS Act 2006 to ‘make arrangements’ to inform, involve and consult with the public. As part of its systematic Project Management Office arrangements, we have introduced a tool to capture the engagement requirements for any CCG project. This form, known as the Section 14Z2 form, was introduced in May 2019 and is a tool to help commissioners and providers identify whether there is a need for patient and public involvement in their activity and, if required, help them plan for a level of involvement which is ‘fair and proportionate’ to the circumstances. The form must be completed at the start of the planning process for any activity and before operational decisions are taken which may impact on the range of services and/or the way in which they are provided. Completed forms are used to ensure

that patients and the public are appropriately involved in the activity. No scheme can progress beyond the planning stage without having completed a Section 14Z2 form.

You can find more information on our website here.

Citizens' Panel

JUCD received funding from NHSE in February 2019 to pilot a Citizens' Panel. There are two parts to the panel:

- **Part one** was launched at the end of June 2019 with an aim to mirror the population of Derbyshire by age, gender, ethnicity and district. By December 2019 membership had grown to 1,366 and was recruited by the provider Membership Engagement Services at libraries, markets, supermarkets and events across Derbyshire.
- **Part two** was an invitation for existing Derbyshire system stakeholders to become members and this resulted in 300+ additional members opting to join the Citizens' Panel due to their interest in health and care. This includes not only people and patients, but frontline staff, voluntary and community sector organisations, clergyman and businesses. The only restriction to membership is that panel members need to be over 16 years old and live in Derbyshire.

These two aspects of the panel are kept separate, so that people self-selecting to join the panel do not introduce bias to the sample that the Membership Engagement Services recruited. This is important so it can be used for research purposes. Both sections of the panel receive the same communications and opportunities for involvement, but analysis of any survey results are separated out for research purposes.

The representative sample can be used to get a quick population 'temperature check' on a particular topic and check out insight from less rigorous methods, such as focus groups, to see if it is reflective of the population.

We strive to continually promote and improve on the diversity of the panel, which can be analysed in lots of different ways, including membership by PCN, Place Alliance, area of interest, and all the protected characteristics defined within the Equality Act 2010. The panel was showcased at the September 2019 NHS Health and Care Innovation Expo in Manchester and by February 2020 had over 1,600 members.

You can find more information on our website here.

Training and Development

To ensure that staff, Lay Representatives and members of the public understand the processes that the CCG has in place and the legal duties it must conform to, the following sessions have been offered:

- **Staff:** a number of development sessions on the completion of the Section 14Z2 and due regard have been held;
- **Lay Representatives:** development sessions for the Engagement Committee on the legal duties for patient and public involvement; and
- **Members of the public:** induction sessions for people registered with the Citizens' Panel are offered by JUCD. In addition a robust induction pack is provided to support people with engaging across the healthcare system.

Public involvement in Service Developments

Primary Care

Throughout the year we have worked with the people of Derby and Derbyshire on a wide range of issues and service areas. Some of this work has been contentious and more visible to our population. The engagement though is far more wide reaching than that which is immediately visible. We have highlighted below examples of the involvement activity to inform, engage and consult.

Bakewell Medical Centre and Tideswell Surgery: Peak and Dales Medical Partnership

Bakewell Medical Centre and Tideswell Surgery have worked closely together since April 2015 as the Peak and Dales Medical Partnership. During this time they have continued to run the two surgeries with separate patient lists. However, after careful consideration they felt the benefits to their patients of bringing the two GP Practices together would be very beneficial so they decided to formally merge on Wednesday the 1st April 2020, creating one patient list.

The merger improves access to services, protects the local GP Practices and enables patients to be seen at either site by a GP or member of the nursing staff. It also creates increased availability in terms of hours offered with both GP Practices offering extended opening hours in the evening and early mornings. The merger does not affect how patients contact the surgery; whether that is by telephone or face to face.

CCG Communications and Engagement Team staff provided support to GP Practices as they looked at ways in which they could inform their patients of the proposed merger and offer opportunities for patients to share their views. We worked with the Practices to shape communication materials for circulation to local newspapers and in Practice. This was one of the first opportunities to utilise the plasma screens placed in GP Practices to share information.

You can find more information on the Practice website here.

Staffa Health: Pilsley Practice

Staffa Health GP services work as one Practice from four sites and the Practices are at Tibshelf, Holmewood, Pilsley and Stonebroom. Staffa Health provides an integrated service for patients who have the option of attending any of these Practices. Staffa Health has been working closely with us over the last 12 months to look at options for effectively managing services across sites, noting that the four current sites had already moved to a reduction in hours to manage workforce issues.

Further to these discussions a decision was taken to commence a public consultation with patients and stakeholders around a proposal to permanently close the branch site at Pilsley. The rationale for this was partly due to a decrease in GP numbers and difficulty staffing four sites, but also because they believe that operating on fewer sites will allow for the positive redesign of some aspects of the service. This will allow the Practice to remain sustainable in the longer term and to continue to provide a quality service into the future. The formal consultation on the proposed closure of Pilsley Practice began on Monday the 24th June 2019 and took place over 60 days to understand the views of patients and stakeholders on

the proposal and understand more fully what the impacts of the potential change may be, if any.

Support through the Communications and Engagement Team included written narrative and support with questionnaires and other options for feeding back thoughts on the proposed closure. In preparation for a public consultation, a Quality Impact Assessment and an Equality Impact Assessment (EIA) were presented to the CCG's Quality Panel. The Consultation Report was also submitted to the CCG's Engagement Committee for discussion and assurance that a robust process was followed and that adequate opportunity was given for local residents to share their views.

On the 26th February 2020, the Primary Care Commissioning Committee made the decision that Staffa Health would postpone the final closure of the Pilsley Practice until the 1st April 2021; to allow them to improve patient access to services and transport, identify new ways of providing care, and streamline their services to ensure sustainability going forward. During 2020/21, the Committee will receive regular reports to monitor the progress being made and ensure implementation, particularly in regards to travel issues for vulnerable patients.

For further information on this consultation please see the Staffa Health website here.

Overseal Surgery, Swadlincote

Overseal Surgery is a small, single handed GP Practice and formally gave notice that it would be closing from the 31st January 2020. They had without success been trying to recruit a GP Partner for the Practice to ensure that they would be maintained for the local community. Despite their best efforts they were not able to do so and the current GP decided to retire. NHSE&I accepted the resignation and shared our commitment to ensuring all patients at the Practice would continue to have access to GP services in the future.

Support from the Communications and Engagement Team helped to ensure a smooth transition for patients during the Practice closure and that the messaging to patients and key stakeholders was presented in a timely fashion. Communication reached different parts of the population through press releases to general information sheets and included information on how to register with a different GP Practice. The GP Practice closed as planned on the 31st January 2020.

High Peak Practices – Breast Cancer Services

In September 2018, NHS Stepping Hill Foundation Trust in Manchester suspended Breast Cancer treatment services to High Peak patients due to workforce issues. Over the following months the suspension was lifted and then re-applied on two occasions culminating in the complete withdrawal of the service in summer 2019 and the transfer of patient lists to alternative providers across Manchester, South Yorkshire and Derbyshire.

Support from the Communications and Engagement Team included acting as a conduit for information around key issues such as alternative providers and access issues, including Patient Transport Services. We also worked with GP Practices and patients around some of these issues. Following the transfer of services we have been proactive in working to understand the impact of the transfer upon our High Peak patients. This included an invitation to share their experiences by email, telephone and through a feedback session which we hosted so that patients could respond directly with us. Key areas of interest and common themes were patient choice; the communications process regarding the transfer;

waiting times; travel and transport; and follow-up arrangements for their individual case. The patient feedback highlighted both challenges and positive experiences which we shared with colleagues at NHS Stockport CCG regarding both solutions to individual cases and on the more general patient experience points. This enabled us to jointly resolve the most immediate issues quickly and to develop and improve the service for our High Peak patients as we move forward. It is important to note that this is a continuing process.

Improving the health of our population

Helping people to better understand and manage their health is an important strand of work for us and the wider health and care system strategy. Key partners include Public Health England, our providers and network partners across the system. Effective partner engagement is essential if we are to deliver effective programmes and mini campaigns, particularly where resources and budgets are minimal.

Examples of Self-Care Campaigns 2019

Self-Care Week took place between the 18th–24th November and involved a launch event at Derby City Council where Self-Care Ambassadors from our Medicines Management Team, along with a Local Community Pharmacist, engaged with the public about self-care and highlighted resources they can access to treat minor conditions and ailments themselves .

More information about self-care and resources are available on our website here.

Diabetes Prevention Programme

Working alongside Livewell at Derby City Council we have worked hard to promote the NHS Diabetes Prevention Programme and more information on this can be found on our website here.

Our Communications and Engagement Team worked with Livewell Derby in the council house reception to offer staff and public free blood pressure checks and signposted them to other helpful information if required. The information provided was primarily around preventing type 2 diabetes and the prevention programme mentioned above, however Livewell also included advice on losing weight, quitting smoking and being more active.

In April 2019 we worked with Silver Star, a charity campaigning for diabetes awareness, to organise a number of roadshows to raise awareness about the risk of developing diabetes and the measures people can take to reduce their risk of developing it. More information about Silver Star is available here. The road shows were an opportunity for the public to:

- **Find out their risk:** using the Diabetes UK 'Know Your Risk Tool' to find out their risk of developing type 2 diabetes in just three minutes;
- **Get a free NHS health check:** people aged 40–74 years could check their risk of developing type 2 diabetes, cardiovascular disease and other conditions; and
- **Ask their GP/Practice Nurse to check if they are at risk:** people can then be referred to their local Healthier You.

Maternity

For You and Baby campaign and Mother Hub

For You and Baby is aimed at supporting Derbyshire families through pregnancy and the early years. The website focuses on myths and facts about breastfeeding and smoking during pregnancy, two of our local priorities. This website encourages lifestyle change for the whole family and not just the pregnant women. There are also useful links to local support services; healthy eating when pregnant advice; managing weight during pregnancy; and a helpful question and answer section.

For You and Baby also promotes the 250+ locations in Derby and Derbyshire that are in the 'Breastfeeding Welcome Here Award' scheme and encourages shops, cafés, outlets – in fact, any public facing premises – to sign up to become part of this scheme.

Families still feel the stigma of breastfeeding in public and this campaign aims to challenge negative perceptions of breastfeeding in a public space.

Unlike many other campaigns of a similar nature this campaign encourages families, not just mothers-to-be, to quit smoking; as research has shown that pregnant women find it hard to quit smoking when their partners and family members continue to smoke.

Mother Hub

Mother Hub has been developed to provide information for women and their families about the local offer for maternity services, birth and the early days of parenthood.

Within the website there is a section for partners called 'Parent Hub' which supports partners in knowing how to support the pregnancy and prepare for becoming a parent. Included within the site is an easy to use search via postcode to find children's centers, maternity units and breastfeeding groups in their local area. There is also the option for parents to share their story and their experiences with others. More information is available on the Mother Hub website here.

Service Transformation: Public Engagement and Consultations

The Light House: co-consultation with Derby City Council and co-designed with parents and carers of service users

The Light House is an integrated disabled children's service which is jointly funded by Derby City Council and the CCG. The Light House is a residential short breaks service that provides regular breaks for children with a wide range of disabilities from autism and/or challenging behaviour to complex physical health needs from 0–17 years. A paper submitted to the Engagement Committee in September 2019 described the service review process that was triggered by the local health provider giving notice, outlining interim arrangements and a request for support for a formal consultation on the long term model.

The public consultation period took place for 90 days from the 5th September 2019. Respondents included parents, carers and a range of relevant stakeholders, including health and social care professionals. Feedback and themes remained consistent from the start with the extensive pre-engagement phase which yielded invaluable intelligence and helped to shape the interim model. Some of the feedback to the consultation indicated *"nothing further to add"* due to the extensive opportunities to get involved in the pre-engagement stages and this is noted in the report. The combination of feedback from the pre-engagement and new or additional feedback from the consultation has provided robust feedback from those most closely involved with the service and this is reflected in the design of the proposed long term model. We worked in partnership with Derby City Council to consult with local people through various face to face channels. The feedback themes and responses to concerns raised are illustrated below. It was felt that the new service should offer:

- better continuity of care for all children;
- consistency of service provision with appropriate levels of staffing;
- a sustainable model which will help to ensure the continued operation of the residential short breaks service in the future; and
- a service that parents and carers are confident in and where they can be assured that care is safe.

Key issues from parents and carers were around the capacity to deliver respite allocations (which had to be reduced in the interim to maintain a safe service) and a positive experience for those accessing the service. The main feedback from those who were not parents and carers was around the importance of the right level of clinical support for children with the most complex health needs.

We were delighted that a spot check inspection by Ofsted in July 2019, when the service was under interim arrangements, awarded The Light House residential short breaks service a 'good' rating. During a combined Ofsted and CQC inspection of special educational needs and disability services in Derbyshire, The Light House pre-engagement programme and consultation plans were highlighted as examples of good practice following discussion and interviews with parents.

Table 17 outlines the changes in service since May 2019 and the proposed service model:

The Light House (Derby) Residential Short Breaks Services for Children and Young People with Disabilities, December 2019			
Date	**Staffing model for 48 children (current)**		**Outcomes for children**
Old (until the 31st May 2019)	Care and social needs met by care staff	Health needs met by Nurses	Multiple carers Restricted social experience Increasing service cancellation
Interim (1st June 2019 to 31st March 2020)	Care and social needs met by care staff	Health needs met by Nurses	Reduced service availability Increasing continuity of carer
	Training for care staff to meet some health needs with supervised practice		
Proposed model after consultation (from the 1st April 2020)	All care, social and health needs met by care staff trained in child-specific interventions trained and supervised by Nurses – 44 children	Bespoke packages of care for children with most complex needs – 4 children	Better continuity of carer Better quality of social experience Improved flexibility and increased availability of service

Table 17 – changes in The Lighthouse service since May 2019 and the proposed service model

The service transformation and consultation process was very well received by the Governing Body on the 6th February 2020. The proposed service model has been agreed and the minutes from the Governing Body meeting are available on our website here.

Further information on the consultation itself including access to the full report can be found on our website here.

Ilkeston Community Hospital

The Derbyshire STP, JUCD, has highlighted that the local system is overly reliant on bed-based care. Whilst we know that good care is provided in the individual settings, elderly patients sometimes spend too long in bed-based care; causing physical, psychological, cognitive and social deconditioning, often resulting in lost independence.

One of the STP's clear aspirations is to ensure that the '*right care is provided in the right setting by the right people'…that patients 'flow' effectively through their care pathway and are supported to stay at or near home wherever possible and return to safely living independently at home following a stay in hospital'.*

This view is acknowledged and jointly agreed by all statutory and non-statutory social, health, voluntary and independent organisations across the whole system. We want to ensure that we have the right services in place to meet the needs of people discharged from acute hospital care who are not able to go straight home without additional rehabilitation or support. Ensuring care is delivered in the right settings and with the right care according to patients' needs supports people to have the best health outcomes, keeps them safe and independent and care for them wherever possible, at home.

Engagement therefore took place around changing the provision of community rehabilitation in Erewash, and was delivered jointly with DCHSFT. The CCG launched a 60 day period of

engagement on the 27th June 2019 to enable people to share their views on our plans to change the model of community discharge and care in Erewash. The main aim was to help us to understand any unforeseen issues in implementing the planned changes.

Whilst there was general agreement with the changed model of care there was still concern from the public about whether the model presented would meet the needs of people in Erewash.

In September 2019, the Governing Body considered the feedback from the engagement and supported the proposed changes to the re-design of clinical pathways to support hospital discharge in Erewash. However it acknowledged that there was a lack of faith in the community about the model proposed and therefore about the robustness of the implementation and the care that this will provide.

In September 2019, the Governing Body considered the feedback from the consultation and supported the proposed changes to the re-design of clinical pathways to support hospital discharge in Erewash. Following the decision, the Governing Body requested an update in March 2020.

A report detailing the impact of the changes and a review of patient experience was provided to the CCG's Governing Body, and in summary it demonstrated that:

- more Erewash patients were now seen in a Pathway 2 facility than before the changes;
- the patient experience at Ladycross House Care Home has been very positive overall; and
- the number of beds available in Ilkeston Community Hospital has met patient demand.

Reducing Health Inequality

The CCG has discharged its duties under Section 14T of the NHS Act 2006, 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 Care and Secondary Care to improve care for the frail, elderly and those with one or more long term conditions; and
- 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. We aim for health and social care provision to be thought of in a wider context. Patients should have seamless care not restricted by organisational boundaries. It makes sense to work together with organisations that impact on health and wellbeing to 'co-produce' and manage patient care in a coherent and efficient way. Those organisations include, but are not limited to, community services, social care, mental health, Public Health and voluntary sector and community groups.

Working together with a wider team means we will be 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 that there will be a pooled workforce which should create flexibility in clinicians' roles.

This year has seen a great improvement in how the different organisations work together which has led to us being able to develop various 'pilot schemes' around Derbyshire that will help us identify what works best. This in turn will ensure that we can make the services match the need of the population, share the learning and provide services which meet local needs.

Health and Wellbeing in Derby and Derbyshire

The health of people in Derby city 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. 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 city and Derbyshire include working to reduce air pollution, improving mental health and wellbeing and supporting quality employment and lifelong learning.

Health and Wellbeing Boards and Health Improvement Scrutiny Committee

NHS Derby and Derbyshire CCG has contributed greatly to the delivery of the Joint Health and Wellbeing Strategy. The CCG is fully engaged, as were the previous four Derbyshire CCGs, with the city and county Health and Wellbeing Boards since early 2011 and the Chief Executive Officer sits on the Health and Wellbeing Board. A sub-group of this Board ensures that coordinated progress on integrated care is made, as well as jointly progressing the development of the Better Care Fund.

In addition, representatives from the CCG Governing Body regularly attend the Derbyshire Health Improvement and Scrutiny Committee and the Derby City Protecting Vulnerable Adults Committee to update, present reports and to develop a dialogue and partnership with Derby City Council and Derbyshire County Council Councillors.

Joint working with the Local Authority

The CCG is a key partner of the JUCD STP, which involves working closely with colleagues in Derbyshire's provider organisations and the two unitary authorities to develop health and care priorities for our local people. This has strengthened links between the local Health and Wellbeing Board Strategies and the priorities emerging from the NHS Long Term Plan. The CCG has been a key partner in developing the refresh of the JUCD STP in 2019/20. This was received by the CCG Governing Body in October 2019.

Health and Wellbeing Strategy

The CCG has been an active partner in the development and implementation of the Health and Wellbeing Strategies. The Strategies have been agreed by a partnership of health and social care and other public and voluntary sector organisations which has been led by Derby City and Derbyshire County Councils.

The CCG has five strategic objectives; the first objective is 'To reduce measurably our health inequalities and improve the physical health, mental health and wellbeing of our population'.

The strategic objectives were developed with the Governing Body, of which both Local Authority Directors of Public Health are active members of. They have helped to shape the objectives to ensure that they link with the wider system working and the CCG reports on progress of the strategic objectives through its GBAF.

Derbyshire's Health and Wellbeing Strategy for 2018–2023 sets out five priorities for improving health and wellbeing across Derbyshire, focusing on actions to address the wider determinants of health.

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; and
5. strengthen opportunities for quality employment and lifelong learning.

The Health and Wellbeing Strategy can be viewed here.

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.

The CCG Governing Body has been developing the CCG Strategy since August 2019; both the Directors of Public Health have led the development of the Strategy together with the Chief Executive Officer and Executive Team. Their focus has been on improving healthy life expectancy and the approach to prevention and population health management.

The CCG's 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.

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

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.

Derby and Derbyshire's approach to Equality 2019/20

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 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 decision making committee through robust cover sheets with key considerations highlighted;
- ensuring due regard is taken in all decision making through an 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 decision making committees

All of our decision making committees have a cover sheet that requires a statement of assurance from the senior project lead about the assessment of equality considerations before a decision will be made. There needs to be 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 Derbyshire understand the Derbyshire 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

The following equality commitment statement is embedded in all CCG policy developments and implementations, while also providing the framework to support CCG decisions through equality analysis and due regard:

> *The CCG aims to design and implement policy documents that meet the diverse needs of our services, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account current UK legislative requirements, including the Equality Act 2010 and the Human Rights Act 1998, and promotes equal opportunities for all. The document has been designed to ensure that no-one receives less favourable treatment due to their personal circumstances, i.e. the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual*

orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity. Appropriate consideration has also been given to socio-economic status, immigration status and the principles of the Human Rights Act.

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 has adopted 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 process and summarised in all Governing Body and Committee cover sheets.

Due Regard

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

With the publication of the NHS Workforce Race Equality Standard, the CCG has reviewed the submissions by the main NHS providers in Derbyshire and identified both their compliance with the standard, their current position in terms of BME staff experience and the actions they intend to take. The CCG has noted the requirements of the NHS Workforce Race Equality Standard and has taken 'due regard' to them in its own activities.

As a Disability Confident (Employer Level) holder, the CCG is passionate about supporting disabled members of staff to apply for jobs, be successful at interview and be supported through reasonable adjustments in post. The CCG has successfully supported various staff to remain in employment with support from the Occupational Health Team.

ACCOUNTABILITY REPORT

Dr Chris Clayton

Accountable Officer

NHS Derby and Derbyshire CCG

26 May 2020

Corporate Governance Report

Members Report

Member Practices

The CCG is comprised of 114[4] member GP Practices and a further 55 branch surgeries:

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	
Bakewell Medical Centre	
Barlborough Medical Practice	Emmett Car 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
Derby Family Medical Centre	
Derwent Medical Centre	
Derwent Valley Medical Practice	Derwent Valley Medical Practice, Sitwell Street

[4] Please note that at the beginning of the financial year, the CCG was comprised of 115 member practices and a further 55 branch surgeries, but this reduced in-year to 114 member practices following the closure of Overseal Surgery, Swadlincote as explained on page 80.

Main Practice	Branch Surgery
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	
Oakwood Surgery	
Old Station Surgery	Cotmanhey Surgery Kirk Hallam 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
Park Surgery	

Main Practice	Branch Surgery
Park View Medical Centre	
Parkfields Surgery	
Parkside 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
Tideswell 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	St. Lawrence Court Surgery
Woodville Surgery	

Table 18 – List of CCG GP Practices

Composition of Governing Body

The Governing Body members for the CCG are:

Governing Body Member	Position
Voting Members	
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
Deborah Hayman	Interim Chief Finance Officer (to 7 July 2019)
Richard Chapman	Chief Finance Officer (from 1 July 2019)
Brigid Stacey	Chief Nurse Officer
Dr Steven Lloyd	Executive Medical Director
Sandy Hogg	Executive Turnaround Director
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
Gillian Orwin	Lay Member for Patient and Public Involvement
Professor Ian Shaw	Lay Member for Primary Care Commissioning
Dr Bruce Braithwaite	Secondary Care Consultant
Non-Voting Members	
Helen Dillistone	Executive Director of Corporate Strategy and Delivery
Zara Jones	Executive Director of Commissioning Operations
Dr Cate Edwynn	Derby City Council Representative (to December 2019)
Dr Robyn Dewis	Derby City Council Representative (from January 2020)
Dean Wallace	Derbyshire County Council Representative

Table 19 – Members of the CCG's Governing Body in 2019/20

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 has approved and keeps under review the Terms of Reference for the Audit Committee, which includes membership of the Audit Committee.

Full details of other sub-committees can be found in the Governance Statement on page 99.

Audit Committee Membership

The membership of the Audit Committee of the CCG is as follows:

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
Dr Bruce Braithwaite	Secondary Care Consultant
Andrew Middleton	Lay Member for Finance

Table 20 – Members of the CCG's Audit Committee in 2019/20

Register of Interests

The CCG holds a register of interests for all individuals who are engaged by the CCG. The registers are viewable on the CCG's website here and available on request at the CCG Headquarters.

Personal Data Related Incidents

There have been no Information Governance incidents during 2019/20 that have met the criteria for reporting through the Data Protection and Security Toolkit (DPST) to the Information Commissioner's Office (ICO).

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 support 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 on our website here.

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

26 May 2020

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 2019, the CCG was not subject to any directions from NHSE issued under Section 14Z21 of the National Health Service Act 2006.

The CCG brings together local GP Practices (General Practitioners) and other healthcare professionals to commission hospital and community NHS services for Derbyshire, comprising of 114 member GP Practices with a registered population of over 1,055,000.

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.

NHS Derby and Derbyshire CCG has a revenue income of circa £1.7bn for 2019/20 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 114 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 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 February 2019.

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 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. 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 as follows, each with a single non-transferable vote unless detailed otherwise 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
Deborah Hayman	Interim Chief Finance Officer (to 7 July 2019)
Richard Chapman	Chief Finance Officer (from 1 July 2019)
Brigid Stacey	Chief Nurse Officer
Dr Steven Lloyd	Executive Medical Director
Sandy Hogg	Executive Turnaround Director
Dr Penny Blackwell	GP Member
Dr Ruth Cooper	GP Member

Governing Body Member	Position
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
Gillian Orwin	Lay Member for Patient and Public Involvement
Professor Ian Shaw	Lay Member for Primary Care Commissioning
Dr Bruce Braithwaite	Secondary Care Consultant
Non-Voting	
Helen Dillistone	Executive Director of Corporate Strategy and Delivery
Zara Jones	Executive Director of Commissioning Operations
Dr Cate Edwynn	Derby City Council Representative (to December 2019)
Dr Robyn Dewis	Derby City Council Representative (from January 2020)
Dean Wallace	Derbyshire County Council Representative

Table 21 – Members of the CCG's Governing Body in 2019/20

The Governing Body met a total of 12 times in public during 2019/20. All meetings in 2019/20 were fully quorate. The quorum necessary for the transaction of business is:

- 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)

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

Governing Body Performance

Following the authorisation and approval from NHSE of the formation of NHS Derby and Derbyshire CCG and the dissolution of the four Derbyshire CCGs, an introductory Governing Body meeting of the new CCG Governing Body members took place on the 28th March 2019. The session concentrated on introductions of the new members, working together as a new Governing Body, developing priorities and induction requirements, the formation of the CCG Governance Structures, Committees and Terms of References and an explanation of each of the Executive Directors' functions.

In preparation for the inaugural meeting of the Governing Body in April 2019, a Development Session was held on the 4th April 2019 for the new Governing Body to discuss the priorities and challenges for the new CCG, system working, 2019/20 finances, the approach to 2019/20 savings and the Medium Term Financial Plan. These two introductory meetings allowed the new Governing Body members to begin to build their relationship as a Governing Body and understand each other's strengths, specialisms and expertise.

The inaugural Public Governing Body meeting of NHS Derby and Derbyshire CCG took place on the 11th April 2019; at this meeting the Governing Body approved and formally adopted the CCG's Constitution, and the Committee Terms of References were approved. The Governing Body also approved the 2019/20 opening GBAF.

On the 2nd May 2019, a Development Session took place facilitated by our Internal Auditors 360 Assurance to review and agree the CCG's strategic objectives and strategic risks for the 2019/20 GBAF. The Governing Body agreed five strategic objectives and six strategic risks. The outcome of the session was very constructive and the Chief Executive Officer was assured that the CCG had established the correct strategic objectives and risks.

The strategic risks are reviewed and approved by the responsible Committees and are reported to Governing Body on a quarterly basis. A recommendation was made at the GBAF workshop and through an internal audit report on Governance and Risk Management completed in September 2019, that the CCG illustrate a stronger connection between the CCG strategic objectives and the GBAF strategic risks and evidence how we will measure the achievement of our strategic objectives.

In June 2019, the Governing Body established an Organisational Effectiveness and Improvement Programme Board. The purpose of the Board is to create opportunity to scope strategic direction and identify priorities for the CCG; provide oversight and direction for the development and delivery of the Organisational Effectiveness and Improvement Programme Plan (OEIPP); and coordinate the activities associated with each of the six workstreams within the OEIPP. Each Committee is responsible for the ownership of one of six workstreams with the OEIPP and receives a highlight report and updated action plan at each Committee meeting; each action has a measurement of success for the achievement of an action.

The Governing Body has thoroughly embraced the enactment of how the CCG measures its strategic objectives; at the December 2019 Governing Body meeting they reviewed the strategic objectives to amend the wording of the objectives to include the words 'measurably' where appropriate. The measurement of our objectives is demonstrated through the achievement of the NHS Constitutional performance targets and NHS Oversight Framework performance targets which are detailed in the Quality and Performance Committee Integrated Report and reported to the Governing Body each month. The Governing Body members provide constant challenge and scrutiny to the Governing Body and Executive Team, and hold them to account at each meeting.

Since August 2019, the Governing Body has been focused on working towards the development of the Clinical Commissioning Strategy during their development sessions and confidential meetings. On the 5th September 2019, a development session was led by the Chief Executive Officer and the two Derby City Council and Derbyshire County Council Directors of Public Health. The session concentrated on developing our strategic health needs and health outcomes for Derby and Derbyshire people.

The Governing Body has a statutory responsibility for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCG's principles of good governance. In October 2019, the CCG Chair and the Executive Director of Corporate Strategy and Delivery developed a Governing Body questionnaire to assist the CCG with ensuring that the Governing Body was self-assured and working as effectively as possible since its formation as a new Governing Body in April 2019.

The results of the survey were overall positive; a few of the comments from Governing Body members were as follows:

- the Executive Team have carefully considered the roles of Governing Body and have put together a very good team;
- committees are working well and following process and are open to challenge;
- Governing Body demonstrates a high level of commitment and a willingness to challenge;
- I think clinical members and Executives at the Governing Body work well as a team and I value them highly as colleagues;
- we have a strong team and I personally have confidence in it; and
- we are well supported by existing membership to understand the role.

The Governing Body embraced a Governing Body Questionnaire Outcome Report and supporting Action Plan, which was received at a confidential meeting in December 2019. As a result, some slight changes were made to the membership of two of the Committees.

Four Development Sessions took place in October, November, December 2019 and February 2020 which focused on mandatory training on Safeguarding Adults, Safeguarding Children, PREVENT and Data Security and Protection (Information Governance).

During the year, the Governing Body have led and supported the CCG in the rapid development of the STP, together with our System Partners, Local Authorities and JUCD as we move to an ICS. The Chairs of each partner organisation has a clear role to play in moving the system forwards. The CCG has developed robust governance arrangements and established a System Quality and Performance Group, System Savings Group and a System Clinical and Professional Reference Group. The CCG Executive Directors are the Chairs of these system working groups.

In November 2019, the Governing Body held an introductory meeting with John MacDonald, the newly appointed STP Chair. The meeting focused on building the system capacity and capability to deliver the STP Plan, the role of an ICS and the STP governance and effectiveness.

The Governing Body have also led the development of Place and Place Alliances together with the development of PCNs as part of the system transformation. Robust governance arrangements have been developed during 2019/20 with the establishment of the Derbyshire Place Board and the Joined Up Care Board, which meet monthly.

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 committees are reviewed annually. 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
    - Remuneration Committee
    - Clinical and Lay Commissioning Committee
    - Engagement Committee
    - Finance Committee
    - Governance Committee
    - Primary Care Commissioning Committee
    - Quality and Performance Committee

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

Following a review of the effectiveness of our committees it was agreed that at each meeting, as a final agenda item, the committees would be asked to review how effective the meeting was and to decide whether anything should be escalated to Governing Body. The Governing Body then receive 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 as follows:

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
Dr Bruce Braithwaite	Secondary Care Consultant

Table 22 – Members of the CCG's Audit Committee in 2019/20

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 2019/20 were:

Significant items approved/discussed by Audit Committee 2019/20
Governance, Risk Management and Internal Control
Aged Debtor Balance Write Off
Aged Receivables and Payable Credit Notes
Annual Report and Account
Governing Body Assurance Framework and Risk Register
CCG Committee Meeting Logs
Financial Control Governance and Self-Assessment
Finance Reports
Freedom to Speak Up
Losses and Special Payments
Mental Health Investment Standard – Audit
Organisational Effectiveness and Improvement Plan
Scheme of Delegation
Service Auditor Reports
Standards of Business Conduct and Conflicts of Interest
Waivers of Standing Orders and Single Tenders
Internal Audit
Internal Audit Progress Reports
Head of Internal Audit Opinion
Internal Audit Plan 2019/20
External Audit
Annual Audit Letter
External Audit Plan 2019/20
Counter Fraud
Counter Fraud, Bribery and Corruption Risk Assessment and Work Plan 2019/20
Self-Assessment against Counter Fraud Commissioner Standards

Table 23 – Significant items approved/discussed by Audit Committee in 2019/20

A benchmark of one meeting per quarter at appropriate times in the reporting and audit cycle is suggested. The Committee met six times in 2019/20.

All meetings in 2019/20 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. This enables the members 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
Gillian Orwin	Deputy Chair – Lay Member for Patient and Public Involvement
Jill Dentith	Lay Member for Governance and Freedom to Speak Up Guardian
Dr Chris Clayton	Chief Executive Officer
Deborah Hayman	Interim Chief Finance Officer (to 7 July 2019)
Richard Chapman	Chief Finance Officer (from 1 July 2019)
Brigid Stacey	Chief Nurse Officer
Dr Steven Lloyd	Executive Medical Director
Sandy Hogg	Executive Turnaround Director

Table 24 – Members of the CCG's Primary Care Commissioning Committee in 2019/20

Significant items that were discussed and approved during 2019/20 were:

Significant items approved/discussed by Primary Care Commissioning Committee 2019/20
Boundary Change Applications
Derbyshire and Nottinghamshire Primary Care Hub Handbook
Finance Report
General Practice Provider Development Proposal
GP Commissioning and Development Work Plan and Governance Structure
Making Quality Referral Scheme
National Consultation on Digital-First Primary Care Policy
Practice Closures
Primary Care Networks
Primary Medical Care Policy Guidance Manual
Primary Care Quality and Performance Assurance Report
Primary Care Strategy
Quality, Innovation, Productivity and Prevention
Risk Register
Wilson Street Special Allocation Service

Table 25 – Significant items approved/discussed by Primary Care Commissioning Committee in 2019/20

The Committee met a total of 11 times during 2019/20 and all meetings were fully quorate. 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 as follows:

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

Table 26 – Members of the CCG's Remuneration Committee in 2019/20

Significant items that were discussed and approved during 2019/20 were:

Significant items approved/discussed by Remuneration Committee 2019/20
Accountable Officer Remuneration
Finance Structure
Redundancy claims and payments
Salary ranges
Settlement Agreement
Turnaround position
Very Senior Manager remuneration and pay progression

Table 27 – Significant items approved/discussed by Remuneration Committee in 2019/20

The Committee meets as required but as a minimum annually. The Committee met three times during 2019/20. 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 helps secure the continuous improvement of the quality of services. The Committee 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 Penny Blackwell	Governing Body GP (to December 2019)
Dr Bruce Braithwaite	Secondary Care Consultant
Gillian Orwin	Lay Member for Patient and Public Involvement
Ian Gibbard	Lay Member for Audit and Conflicts of Interest Guardian
Brigid Stacey	Chief Nurse Officer
Dr Steven Lloyd	Medical Director
Deborah Hayman	Interim Chief Finance Officer (to 7 July 2019)
Richard Chapman	Chief Finance Officer (from 1 July 2019)
Dr Robyn Dewis	Public Health Representative
Sandy Hogg	Executive Turnaround Director
Zara Jones	Executive Director of Commissioning Operations

Table 28 – Members of the CCG's Clinical and Lay Commissioning Committee in 2019/20

Significant items that were discussed and approved during 2019/20 were:

Significant items approved/discussed by Clinical and Lay Commissioning Committee 2019/20
Bolsover Out of Hours Service
Chesterfield Hospital Urgent Care Village Business Case
Children and Young People's Care
Clinical Policies
Commissioning Intentions 2020/21
Derbyshire Equipment Service Contract
Diabetes NHSE Low Calorie Diet project
Diabetes Work Programme and Diabetes Transformation Funding Plan 2019/20
Diagnosis and Management of Familial Hypercholesterolemia
District nursing specification

Significant items approved/discussed by Clinical and Lay Commissioning Committee 2019/20
DW553 Syringe Driver Provision
Early and Locally advanced breast cancer diagnosis and management
Follow-up appointments
Gastroenterology
Greater Manchester Improving Specialist Care Programme
Hospice at Home
Improving access to Psychological Therapies
NHS 111 re-procurement
Organisation Effectiveness Improvement Plan
Orthotics Service
Paediatric Ophthalmology
Prescribing Group Proposal
Primary Care Streaming
Prioritisation of Commissioning Spend
Quality, Innovation, Productivity and Prevention
Rapid Response Clinical Model and Service Model
Reducing waste in the repeat prescribing process
Retinopathy screening for patients taking hydroxychloroquine
Section 75 – Care for children with complex needs/Looked after Children
Strategic Shift Initiatives
The Lighthouse
Trauma informed services to address the mental and emotional health needs of children in care
Urgent Treatment Centre Designation
Wave 2 Mental Health Trailblazers

Table 29 – Significant items approved/discussed by Clinical and Lay Commissioning Committee in 2019/20

The Committee met a total of 11 times during 2019/20. 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 2019/20 were fully quorate.

Engagement Committee

The Engagement Committee, which reports jointly to the CCG's Governing Body and the JUCD Board, held its inaugural meeting on the 1st May 2019, and has met monthly since. The Engagement Committee meets with the purpose of assuring the Governing Body that the CCG is involving patients in decisions about health services and that robust processes are in place to ensure that the CCG is fully compliant with their statutory obligations. Members 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
Gillian Orwin	Deputy Chair – Lay Member for Patient and Public Involvement
Professor Ian Shaw	Lay Member for Primary Care Commissioning
Denise Weremczuk	Foundation Trust Governor – Secondary Care
Bernard Thorpe	Foundation Trust Governor – Community
John Morrissey	Foundation Trust Governor – Mental Health (to February 2020)
Kevin Richards	Foundation Trust Governor – Mental Health (from March 2020)
Ram Paul	Derby City Council Representative
Christine Coffey	Place Engagement Representative (to February 2020)
Colin Dorman	Place Engagement Representative (to August 2019)
Ian Mason	Place Engagement Representative
Jocelyn Street	Place Engagement Representative
Rosemary Brown	Place Engagement Representative (to August 2019)
Ruth Grice	Place Engagement Representative
Tracy Logan	Place Engagement Representative (to August 2019)
Trevor Corney	Place Engagement Representative
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
Karen Ritchie	Head of Engagement, Joined Up Care Derbyshire

Table 30 – Members of the CCG's Engagement Committee in 2019/20

Significant items that were discussed and approved during 2019/20 were:

Significant items approved/discussed by Engagement Committee 2019/20
360 Stakeholder Survey
Branch Closures
CCG Assessment Rating for Patient Engagement
Citizens' Panel
Commissioning Intentions
Committee Business Model
Community Rehabilitation in Erewash
Engagement Model and Strategy
Erewash Discharge Pathway
Friends and Family Test

Significant items approved/discussed by Engagement Committee 2019/20
Governing Body Assurance Framework and Risk Management
Joined Up Care Derbyshire Implementation Framework, and Refresh
Minor Eye Conditions Service
Organisation Effectiveness Improvement Plan
Patient and Public Involvement Payments Policy
Primary Care Strategy
Quality, Innovation, Productivity and Prevention
Repeat Prescribing
Sustainability Transformation Plans
The Lighthouse
Urgent Care Review
Wound Care

Table 31 – Significant items approved/discussed by Engagement Committee in 2019/20

The Committee met a total of 11 times during 2019/20. 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 2019/20 were fully 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 as follows:

Finance Committee Member	Position
Andrew Middleton	Chair – Lay Member for Finance
Martin Whittle	Deputy Chair – Lay Member for Patient and Public Involvement and Vice Governing Body Chair
Dr Penny Blackwell	Governing Body GP
Dr Ruth Cooper	Governing Body GP
Dr Bukhtawar Dhadda	Governing Body GP
Jill Dentith	Lay Member for Governance and Freedom to Speak Up Guardian (to December 2019)
Deborah Hayman	Interim Chief Finance Officer (to 7 July 2019)
Richard Chapman	Chief Finance Officer (from 1 July 2019)
Sandy Hogg	Executive Turnaround Director
Brigid Stacey	Chief Nurse Officer

Table 32 – Members of the CCG's Finance Committee in 2019/20

Significant items that were discussed and approved during 2019/20 were:

Significant items approved/discussed by Finance Committee 2019/20
Activity Planning Assumptions
Budgets 2019/20
Continuing Healthcare Right Sizing
Contract Reports
Final Accounts and End of Year Position
Finance Reports
Financial Governance Arrangements
Governing Body Assurance Framework and Risk Register
Joined Up Care Derbyshire Long Term Development Plan, and Systems Saving Plans
Organisation Effectiveness and Improvement Plan
Practice Prescribing Overspend
Psychiatric Intensive Care Unit
Quality, Innovation, Productivity and Prevention
Strategic Commissioning and System Efficiency Programme 2020/21

Table 33 – Significant items approved/discussed by Finance Committee in 2019/20

The Committee met a total of 12 times during 2019/20. 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 meeting were quorate on 2019/20 apart from one meeting, which did not require any decisions to be made.

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

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 34 – Members of the CCG's Governance Committee in 2019/20

Significant items that were discussed and approved during 2019/20 were:

Significant items approved/discussed by Governance Committee 2019/20
Business Continuity and Emergency Planning, Resilience and Response
Complaints
Corporate Policies
Cyber Security
Estates Update
European Union Exit
COVID-19
Freedom of Information
General Data Protection Regulation
Health and Safety
Human Resources Policies
Information Governance
Mandatory Training
Non-clinical Adverse Incidents
Organisational Effectiveness and Improvement Action Plan
Procurement Services
Quality and Equality Impact Panel
Risk Management Strategy
Risk Register
Workforce Reports

Table 35 – Significant items approved/discussed by Governance Committee in 2019/20

The Committee met a total of seven times during 2019/20. They also held one extraordinary meeting on the 26th March 2020. The quorum necessary for the transaction of business is four members, to include two Lay Members, one clinician and the Executive Lead (or nominated deputy). All meetings in 2019/20 were fully 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

Quality and Performance Committee Member	Position
Dr Bukhtawar Dhadda	Chair – Governing Body GP
Dr Emma Pizzey	Governing Body GP
Dr Greg Strachan	Governing Body GP
Dr Merryl Watkins	Governing Body GP
Andrew Middleton	Lay Member for Finance
Gillian Orwin	Lay Member for Patient and Public Involvement
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

Quality and Performance Committee Member	Position
Dr Bruce Braithwaite	Secondary Care Consultant
Zara Jones	Executive Director of Commissioning Operations
Helen Henderson-Spoors	Health Watch Derbyshire County Representative

Table 36 – Members of the CCG's Quality and Performance Committee in 2019/20

Significant items that were discussed and approved during 2019/20 were:

Significant items approved/discussed by Quality and Performance Committee 2019/20
2019/20 Operational Plan
Breast Service Provision for High Peak
Cancer
Care Homes
Care Quality Commission Inspections
Cavendish Muscular Skeletal
Children Services
Complaints
Continuing Healthcare
Court of Protection Deprivation of Liberty
Deep Dives on services
East Midlands Ambulance Service NHS Trust
End of Life
Friends and Family Test
Healthcare Acquired Infections
Hyper Acute Stroke Care
Improvement and Assessment Indicators
Integrated Reports
Maternity
Medicines Safety
Medicines Safety
National/Regional Guidance
Patient Experience
Patient Safety
Placement Of Patients With Mental Health, Learning Disabilities and Brain Injuries In Independent Hospitals
Quality Accounts
Quality and Equality Impact Assessment Policy
Quality Strategy
Quality, Innovation, Productivity and Prevention
Referral to Treatment Time Recovery Plan
Safeguarding Adults, and Children
Safeguarding Children
Stockport Breast Surgery
Urgent Care Strategy

Table 37 – Significant items approved/discussed by Quality and Performance Committee in 2019/20

The Committee met a total of 13 times during 2019/20. 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 2019/20 were fully 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 and best practice.

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 2020.

For the financial year ended the 31st March 2020, 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 Risk Management Strategy was reviewed and approved by the Governance Committee in July 2019. The strategy outlines the CCG's approach to risk and the manner in which it seeks to eliminate or control all significant risks. It is supplemented by a Risk Management Framework. Staff at all levels of the organisation are responsible for identifying and recording risk, with appropriate levels of staff trained to evaluate risks and treat them accordingly.

The Risk Management Strategy 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 main 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 process as it applies to the CCG is as follows:

- 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;
- risks are identified;
- 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;
- there is proper communication and consultation with relevant stakeholders about all aspects of risk management; and
- all aspects of the risk management system are regularly monitored and reviewed to ensure the system is working effectively.

By ensuring that all staff are aware of their responsibilities for managing risk, good progress has been made towards ensuring ownership of risk both by staff and by the wider membership of the Governing Body and its Committees. The Committees receive a Risk Register report and the risks that the Committee is responsible for at each meeting. The Governing Body receive an exception report with details of all 'very high' risks (scores of 15 and above) and any 'high' risks (scores of 8–12) that have been newly identified or for which the risk rating has increased during the month. The Executive Team also receive a monthly high level risk report.

The CCG has a well-established and functioning Risk Group. The Risk Group is established to review, monitor and manage the risks on the CCG's Risk Register, and ensures the risk management process is firmly embedded within the organisation. The Risk Group supports the Committees' understanding and parity in relation to risk, enabling them to provide assurance to Governing Body.

Staff are encouraged to identify and report risks arising from business cases, equality due regard, quality impact assessments, performance reports, contract meetings, incident reports and complaints registers, both within the CCG itself and its key providers.

A review of our Governance and Risk Management Arrangements took place in September 2019 by our Internal Auditors and concluded significant assurance for the risk management element of the audit; the report provided a limited assurance for governance. The CCG has made good progress on developing sound governance structures as a new CCG from the 1st April 2019; however our auditors identified some areas for further development. The CCG has progressed its arrangements to support and assess the delivery of its approved strategic objectives and these arrangements are now embedded. The auditors identified that performance metrics and a reporting programme to enable oversight of the delivery of the CCG's strategic objectives were not in place. The Organisational Effectiveness and Improvement Programme Board (OEIPB) began to report to the Governing Body in October 2019 on the performance of key workstreams designed to support delivery of organisational priorities. The CCG has progressed in the mapping of actions being taken within these workstreams to its strategic objectives and in the development of KPIs for measuring performance against strategic objectives. Action Plans for all six workstreams that have

been mapped to strategic objectives and which include measures of successes for each action. All Action Plans are updated with current progress before each meeting of the OEIPB and actions are 'RAG' rated in respect of their stage of completion.

The CCG is continuing to develop its arrangements for measuring progress in achieving its strategic objectives and is currently in the process of mapping performance targets that are reported to the Governing Body in the Quality and Performance Integrated Report to its strategic objectives.

Stakeholder involvement in managing risks

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 and Governance, and Public and Patient Engagement; other Governing Body members include Executive Directors and Public Health representation.

Public events including Stakeholder Forums have taken place throughout the year with population and community groups. These provide the opportunity to engage with the public and highlight areas of risks. There have also been specific engagement events including the Young People Forum, and listening events which actively engage with the public.

Prevention and deterrence of risk

The CCG has strong processes in place to assist in the prevention and detection of risks arising. All reports to the Governing Body and other Committees have mandatory risk assessment equality analysis and 'due regard' sections. 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 and this is continually being improved, and the Serious Incident Policy has been reviewed and strengthened during the year. 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 and other appropriate bodies. Serious incidents are also reported through the Strategic Executive Information System. Any breaches of Information Governance which meet the Level 2 criteria of the 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 other partnership groups and has an established relationship with NHSE in respect of Emergency Preparedness, Resilience and Response. NHS Derby and Derbyshire CCG received 'Full Compliance' for the 2019/20 Emergency Preparedness, Resilience and Response Core Standards Assessment from NHSE.

Capacity to Handle Risk

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

- Governing Body – oversight and holding management to account;
- Finance Committee – development and implementation of risk management processes;
- Audit Committee – reviews the effectiveness of the GBAF and risk management systems;
- Governance Committee – ensures that the CCG complies with the principles of good governance whilst effectively delivering the statutory functions of the CCG;
- Accountable Officer – responsible for having an effective risk management system in place and for meeting all statutory requirements;
- Executive Team – support the Accountable Officer and are collectively and individually responsible for the management of risk;
- Executive Director of Corporate Strategy and Delivery – responsible for the delivery of risk management;
- Risk Group – reviews, monitors and manages the risks on the CCG's Risk Register, and ensures 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 – responsible for the development, implementation and maintenance of the risk management arrangements for the CCG; and
- All Staff – responsible for identifying, reporting and managing risks within their areas.

The GBAF has been presented quarterly to the Governing Body and the Audit Committee during 2019/20 for scrutiny and assurance.

The Governing Body approved the 2019/20 opening GBAF at their inaugural meeting on the 11th April 2019. On the 2nd May 2019, a Development Session took place facilitated by our Internal Auditors, 360 Assurance, to review and agree the CCG's strategic objectives and strategic risks for the 2019/20 GBAF.

Risks to the CCG are reported and discussed and challenged at the monthly Governing Body and 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 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 providing executives, managers and staff with the appropriate tools to identify, score and treat risk properly.

The Governing Body and the 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.

Feedback from the Quarterly Assurance meetings with NHSE has been positive.

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

The 2019/20 financial year has been challenging in a number of areas for the CCG, particularly in relation to the financial position and savings plan, in turn this has had a major impact on the risk profile of the CCG and its reputation.

In context, the following details the most significant risks we have faced during 2019/20 and how we are managing them.

Significant risks identified during 2019/20

Failure to meet statutory financial duties in 2019/20

In 2019/20 the CCG agreed an Operational Plan with NHSE that had a deficit control total of £29.0m. This effectively meant that if the CCG stayed to this plan they would end the year with a £29.0m overspend, but by remaining to this plan and not exceeding this amount the CCG would be eligible to access £29.0m of CSF; allowing the CCG to report an in-year break even position.

This was an ambitious and challenging plan and required the CCG to transform the way it commissioned health care in Derbyshire, while continuing to, as a minimum, maintain the quality and safety of the care, and wherever possible improve. The CCG reported the position against this plan to NHSE on a monthly basis and each month remained on plan, eventually receiving the £29.0m of CSF.

The agreed Operational Plan included the requirement to deliver £69.5m of efficiency savings throughout the year. Working closely with NHS provider organisations in Derbyshire, the CCG achieved £49.9m of efficiency savings which is a considerable improvement on the level of savings delivered in previous years.

Financial pressures in acute hospital care and prescribing, along with the shortfall in delivering efficiency savings were off-set by contingencies set aside at the start of the financial year and some in year underspends that allowed the CCG to meet its statutory financial duties in 2019/20

Accident and Emergency – failure to meet the CCG's Constitutional standards and quality statutory duties

CRHFT continue to experience a high number of Type 1 attendees compared to 2018/19 with 2.1% more attendances during February 2020, with Operational Pressures Escalation

Level (OPEL) 3 status being declared during the month. The acuity of the attendances is increasing, with 28.3% of A&E attendances resulting in admission to either an assessment unit or a ward in February (27.6% for January). A minor chemical incident resulted in five High Dependency Unit beds being unavailable for two days and some discharges were delayed due to Pathway 1 Care Packages not being in place; or delays relating to the Patient Transport Service. COVID-19 preparations also had an effect on the system with increased pressure on NHS 111 services and EDs devoting physical capacity to isolation areas.

UHDBFT's volume of patients remains high, averaging at 277 adult patients and 93 child patients per day at Royal Derby Hospital. Attendances in the Derby network (i.e. including Type 1s, Minor Injury Units, Derby Urgent Care Centre and GP Streaming) averaged at 748 per day during February 2020.

The acuity of the conditions presented has also increased, with attendances classed as Major/Resus making up 68.2% of patients at Royal Derby Hospital. 28.3% of attendances result in admission to either an assessment unit or an inpatient ward. Staff shortages within the Mental Health Liaison Team have led to delays for some mental health patients.

Transforming Care Plans are unable to maintain and sustain the performance, pace and change required to meet national Transforming Care Plan requirements.

The CCG did not anticipate achievement of the trajectory at Quarter 4 2019/20; therefore a revised trajectory was submitted to NHSE&I on the 11th February 2020; along with a detailed letter providing assurance of the actions being taken to deliver performance.

New national monitoring arrangements were announced in September 2019, which included a CCG requirement to visit all Out Of Area placements every 6–8 weeks. A visit schedule is in place and being delivered.

A specialist supported living provider's development session was held during February 2020, and additional monies were received from NHSE&I to support accelerated discharges and admission avoidance.

New services have been commissioned to support 'transition to discharge' for two individuals receiving care in the Learning Disabilities Assessment and Treatment Unit.

Failure of GP Practices across Derbyshire results in failure to deliver quality Primary Care services, resulting in negative impact on patient care

<u>Early warning systems</u>

The CCG works with the Local Medical Committee and other partners to systematically identify and support GP Practices that may be in trouble, including: reviewing information on GP Practice performance via an internal cross directorate review of GP Practices looking at a range of data sources; linking with the Local Medical Committee to pool soft intelligence on GP Practice 'health' and to jointly support struggling GP Practices; and directly approaching GP Practices identified as at risk.

CCG support

The CCG commissions and funds a range of supportive measures designed to increase the resilience of General Practice, in line with the GP Forward View and GP Contract. Key working groups and committees have been established to support the delivery of the work programmes, these include:

- Primary Care Leadership Committee
- Primary Care Workforce Steering Group
- Primary Care Estates Steering Group
- General Practice Digital Steering Group

Peer support

PCNs provide a way that GP Practices can support each other in smaller groups. Over time this will provide a safe forum for GP Practices to seek help from peers and another route to help struggling GP Practices who are reluctant to approach the CCG directly.

Strategy

Implementation of the CCG's Primary Care Strategy will bring additional resources, capacity and support to General Practice, and develop its role at the centre of an integrated system, thus increasing resilience and mitigating against individual GP Practice failure. The CCG has financially supported the development of the GP Alliance, which have supported the development of Primary Care, and a reviewed of demand and capacity to understand access to Primary Care in Derbyshire.

Due to the increased pressures around workload, workforce and financial concerns, there is a risk to General Practice in providing quality Primary Care services to patients

Primary Care Quality Team

The Primary Care Quality Team provide monitoring of and support to GP Practices county wide. Communication pathways are established, which include the membership bulletin, Information Handbook, website development and a direct generic inbox.

Primary Care Quality and Performance Committee

The Committee oversees monitoring support and action plans for the delivery of Primary Medical Services, gains assurance regarding the quality and performance of the care provided by GP Practices, and identifies risks to quality at an early stage.

Primary cross-directorate internal review (hub) process

The Care Quality dashboard and matrix has been developed, and is discussed monthly at the hub meetings. It provides the opportunity to oversee multiple data sources and gain information from wider CCG teams in order to gain a collective view on the quality of care offered and to identify areas of best practice and areas of concern where support or intervention is needed. It also provides the opportunity to review and create action plans to support GP Practices that may be experiencing or demonstrating difficulty or signs of potential deficit in quality or unwarranted variation of care provision.

Supporting Quality Improvement visits

An 18 month rolling programme of GP Practice visits with a focus on quality and support is being delivered; this provides the opportunity of direct clinical face to face discussion between individual GP Practices and the CCG. It also provides a safe opportunity to discuss individual Practice quality metrics and for the Practices to raise any issues or concerns directly to the CCG.

Clinical Governance Leads meetings

These meetings were stablished and held quarterly across the Derbyshire PCN footprint; providing the interface between the CCG and individual Practices and the opportunity to share best practice, GP Practice concerns, learning and recommendations, and supports the implantation of GP Practice governance.

Quality Schedule

The Quality Schedule is being developed as part of the enhanced service review to provide a formal mechanism to contract for improved quality standards in areas such as sepsis and safeguarding. The Primary Care Quality Schedule has been included in the CCG's Commissioned Primary Care Contracts, to maintain and support the delivery of continuous quality improvement in Primary Care.

Increase in demand for Psychiatric Intensive Care Unit beds

Over the last five years, the demand for Psychiatric Intensive Care Unit (PICU) beds has increased. This had a significant impact financially with the CCG's budget forecast overspend in terms of poor patient experience, and quality and governance arrangements for uncommissioning independent sector beds. The CCG did not meet the KPI from the five year forward view, which requires no out of area beds to be used from 2021.

The risk was escalated due to continued high numbers in PICU which were causing a significant financial pressure. The CCG procured block and spot beds which helped to manage costs, and a CCG group was formed to address quality, finance and contracting issues. A Mental Health STP workstream group was also formed to look at PICU and out of area reductions, along with a business case regarding local bed capacity which aimed to bring people back into the area in a timely fashion.

From September 2019, the PICU bed use and placements began to reduce following substantial collaborative working across the Derbyshire healthcare system. This in turn provided a positive turnaround of the forecast overspend for the CCG so the risk score was reduced to a 'medium' risk. However, due to seasonal variation the PICU and out of area bed use increased between December and January, which resulted in a slight increase to the forecast overspend. DHcFT have established system estate plans as required by regulators to consider the shape of the local PICU picture and the CCG is monitoring the potential risk to its overspend for 2019/20.

Anticipated risks for 2020/21

Failure to meet statutory financial duties in 2020/21

The 2020/21 financial year would always have been a challenging one for the NHS, however the challenges it faces will be considerably different to the ones we expected to face a few months ago. The suspension of the regular operational planning arrangements and contract negotiations mean the CCG enters the year with an unprecedented level of financial risk and uncertainty. As a result of this, the CCG has been unable to produce a definitive financial plan for the 2020/21 financial year and the local healthcare system has agreed to suspend the efficiency processes for the period of the COVID-19 emergency.

Before the emergence of the COVID-19 emergency, initial allocations for the 2020/21 year were confirmed, totalling £1,662.3m for programme costs and £19.8m for running costs. Our financial target for the 2020/21 is an £11.4m deficit but the CCG will be able to report a break-even position after the receipt of £11.4m.

Undoubtedly the regulatory financial system will change and develop over the coming months and the CCG is well placed to adapt to these changes.

Impact of COVID-19

If the COVID-19 virus is not mitigated in Derby and Derbyshire, cases could rise to unmanageable levels. This would result in high levels of infection and staff absence, and the CCG would be unable to perform its statutory duties. This would negatively impact system work and transformation, patient care and the CCG and system financial positions. During the pandemic the CCG has established a Risk Register specific to COVID-19 risks.

European Union Exit Assurance

The CCG has in place an agreed European Union (EU) Exit Plan which has been used for our planning and preparation work. In addition, the CCG has in place a System Wide EU Exit Plan which has been shared with our provider colleagues. This document details the route for escalation of issues relating to the management of EU exit. In line with the EU exit operational readiness guidance, the CCG has received full assurance from the national EPRR team for compliance with the standards. The CCG can report minimal impact compared to other parts of the NHS in terms of its business continuity.

The CCG has identified a risk which relates to the supply of medicines and vaccines and this is regularly monitored through our corporate risk register.

Other Sources of Assurance

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the CCG to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise. The risks, to evaluate the likelihood of those risks being realised and the impact should they be realised; it is also to manage them efficiently, effectively and economically.

The system of internal control 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 Finance Committee, Financial Recovery Group 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 Act.

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 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 to protect the CCG, its Governing Body, its employees and associated GP Practices from allegations and perceptions of wrong-doing.

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 Practices; all of which are available on the CCG's website here. 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 with contracts and procurements. CCG employees are all requested to declare these when they arise and details of those declared within 2019/20 can also be found at the weblink 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 has published a template audit framework.

360 Assurance carried out an audit of the CCG's management of conflicts of interest in February 2020; the assurance opinion for this audit was 'significant' assurance.

During 2019/20 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.

During 2019/20 all CCG staff were required to complete Managing Conflicts of Interest training, made up of three modules. By the 31st March 2020, 93% of staff had completed module one. This training is mandated and constructed by NHSE and NHS Clinical Commissioners.

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 DPST.

Since the Health and Social Care Act 2012 was established on the 1st April 2013, the CCG has been unable to use Patient Confidential Information under section 251 for purposes other than direct care.

To provide the management of information necessary to manage commissioned activities, we commission our Business Intelligence Information Services from 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 significantly enhanced 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. For the CCG, this is a series of 106 standards where evidence is required of compliance with the 10 National Data Guardian Standards, which can be viewed here.

All organisations who handle confidential patient data are required to complete the DSPT, and are required to affirm that the standards are met.

The CCG have in place approved and implemented Information Governance policies, with organisational oversight of delivery 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 Structures. 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 has met seven times during 2019/20.

Public facing privacy information has been maintained, which was affirmed as compliant during 2019 by NHS Digital as part of the CCG Data Access Request Service application. The privacy notice of the CCG can be found here.

Information Asset Owners have been formally appointed across the functional directors' structure in support of the SIRO accountability for risk management of data processed (by the term 'processing' we mean data which is held, obtained, recorded, or used) within the CCG. The assessment and understanding of the information processing activities of the CCG have been completed with the delivery and approval of information flow mapping work during May to December 2019.

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.

During October 2019, 360 Assurance undertook stage one of their review of the CCG's delivery of the required DSPT actions with the following comment provided:

> *"We have considered your overall governance arrangements for developing and delivering a data security and protection culture. Whilst a new organisation in April 2019, the CCG is clearly developing a structured approach to managing Information Governance generally, including using the Data Security and Protection Toolkit to serve that purpose. Having brought a new Information Governance team into place to serve the new organisation, we confirmed the team is operating within the wider governance function. There are defined roles and responsibilities in place."*

From the Information Governance Assurance Forum's minutes and papers, there is evidence of challenge, appropriate reporting and action being taken where required.

The Stage two review undertaken in March 2020, has provided the following assurance:

Substantial Assurance	As a result of this audit engagement we have concluded that, in the areas examined, the risk management activities and controls are suitably designed, and were operating with sufficient effectiveness, to provide reasonable assurance that the control environment was effectively managed during the period under review. **Our opinion is limited to the controls examined and samples tested as part of this review.**

The CCG Information Governance Framework is reflected below:

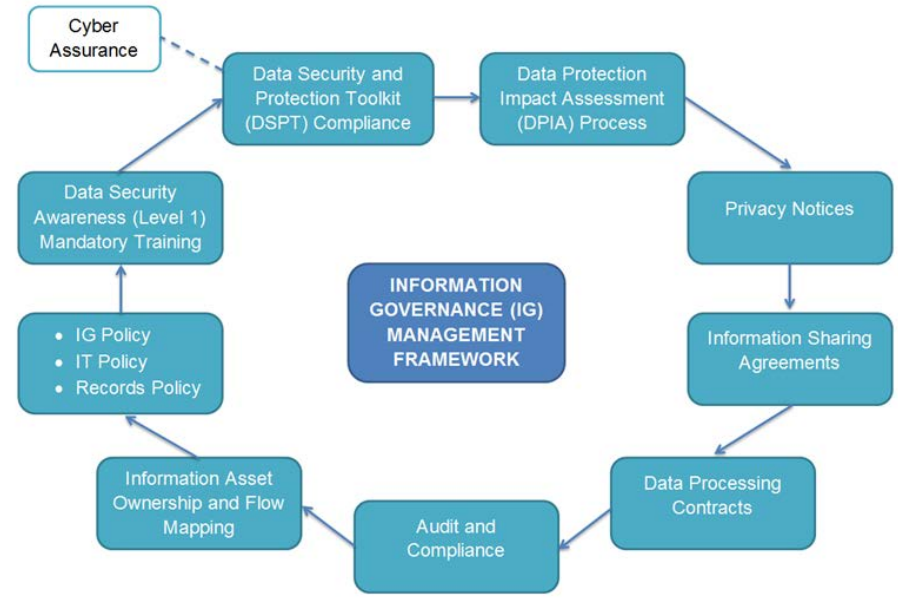


Figure 12 – CCG Information Governance Framework

In support of GP Practices, the CCG have purchased GP Information Governance Support via NECS, which is reported to the CCG and led by the NECS Contract Management Board.

The CCG has not had any data loss or data security breaches during 2019/20 which were found to be 'reportable' within the DSPT incident reporting tool to the ICO.

The CCG has met a 'standards met' DSPT submission for 2019/20.

Information Governance Newsletters

The Information Governance Team produce regular newsletters which are shared with CCG staff.

In 2019/20, seven newsletters were circulated via email to 'all staff' and the topics that have been covered within these newsletters include:

- Who we are (the Information Governance Team)
- CCG Incidents
- Recent fines by the ICO
- Data Security Awareness Level 1 face-to-face training dates
- Data Security Awareness Level 1 current compliance graphs
- Data Protection Impact Assessment Process
- National Data Standards
- Caldicott Principles
- Data Flow Mapping
- Information Asset Owner/Administrator Training
- Incident Reporting Process
- Best practice on the Management of Email
- Phishing
- Confidentiality Audit
- Information Governance Staff Awareness Survey – results analysis
- Information regarding secure shredding
- NHS Mail Use
- Password Guidance
- Importance of Information Governance training and how to access it (special edition in December)
- When the CCG can and cannot process Personal Identifiable Data
- A report on the clearance of Toll Bar House Basement
- Information Governance is the responsibility of everyone
- Confidentiality – talking about work at home
- Social Media

The Information Governance Team has received positive feedback from various members of staff about how interesting and professional the Information Governance newsletters are.

The newsletters have been shared with NHS Digital as good examples of Information Governance communication in a CCG.

Data Security

The CCG have affirmed their compliance with the Data Protection Act 2018, and the General Data Protection Regulations. The Data Protection by Design and Default principles are implemented via a robust Data Protection Impact Assessment process, overseen by the CCG Data Protection Officer.

Incidents which are reported are reviewed to understand whether these were caused by a known security vulnerability, and the CCG work closely with NECS as our Information and Communication Technology Service provider to ensure that any identified issues are resolved.

NECS support the CCG delivery of the DSPT, specifically around compliance with technical DSPT compliance.

Business Critical Models

In line with the best practice recommendations of the 2013 MacPherson review into the quality assurance of analytical models, the CCG does not use any models that it considers to be Business Critical. All models used are subject to full quality assurance processes.

Third Party Assurances

A range of services are provided by third party providers. These include:

Service	Provider	Assurances
Commissioning Support	– NECS – Arden Greater East Midlands Commissioning Support Unit – Midlands and Lancashire Commissioning Support Unit	Service Auditor Report
Payroll	Shared Business Services	Service Auditor Report
Internal Audit	360 Assurance	Head of Internal Audit Opinion
External Audit	KPMG	Annual Audit Letter
Primary Care transactions	NHSE	Service Auditor Report
Oracle Ledger	Shared Business Services	Service Auditor Report

Table 38 – 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:

Finance, Governance and Control – Other

At month 9 the CCG reported a Year to Date (YTD) overspend of £11.5m which is in line with plan. The CCG has received the second quarter of the CSF, which means the forecast outturn remains at £18.9m overspent which is again in line with the planned CSF adjusted Control Total. At month 9 the financial position remains in line with plan and the CCG remains eligible for £29m of CSF of which £10.2m has been received to date. If this happens the CCG will be able to report a breakeven position. Within this position the CCG has reported £4.5m of risk, which includes £3.2m related to acute provider activity and £0.8m on Practice Prescribing. This is being mitigated by contingencies, none of which is being used to support the YTD position.

Quality and Performance – Accident and Emergency

Derbyshire failed to deliver against the national 95% 4-hour standard during November (79.1%). Underperformance for the CCG is attributed predominantly to underperformance at UHDBFT and CRHFT.

University Hospitals of Derby and Burton NHS Foundations Trust

Emergency Department

The ED at Royal Derby Hospital has failed to deliver against the four hour national standard for 50 consecutive months, with current Type 1 performance for December at 56.23% (unvalidated), as opposed to 75.58% in December 2018. ED site/network performance for December (including the Derby Urgent Care Centre) was 76.77%, compared to 83.15% in December 2018. The underperformances are primarily due to volume of attendances, acuity of patients attending and patient flow issues due to the acuity of admissions. The Trust are looking at ways to improve patient reception from ambulances and improve ambulance handover times and at reinvigorating ‘fit to sit’ with EMAS.

Medical staffing issues are also being addressed with the introduction of a new workforce plan. GP streaming has been recently introduced at Queen’s Hospital Burton and trials are in place at Royal Derby Hospital to further increase the streaming from the existing service. GP streaming across UHDBFT is currently not meeting the 20% required and these actions will support achievement.

12 hour Trolley Breaches

From April 2019 to end of November 2019 there have been 24 x 12 hour trolley breaches at Royal Derby Hospital. Of these, 23 were attributable to the unavailability of a mental health bed. This cause is being monitored, with more detailed analysis, reporting and liaison with mental health services taking place.

Chesterfield Royal Hospital NHS Foundation Trust

Emergency Department

CRHFT has failed to deliver against the 4-hour national standard for 19 consecutive months, with current performance for December 2019 at 58.69% (unvalidated). The poor performance is attributed to a rise in both attendances and acuity of patients, causing an increased admission rate and patient flow issues. In response, CRHFT has opened additional medical beds and is establishing a Surgical Assessment Unit to improve patient flow. In August 2019, the Care Quality Commission (CQC) carried out an unannounced visit to the ED and raised concerns in relation to the storage of medicines, equipment, overcrowding and cleanliness. The CQC considered the risks they had identified were significantly reduced as a result of CRHFT's immediate actions and therefore they did not follow any enforcement action. The CCG attended two unannounced ED assurance visits with the CRHFT Director of Nursing shortly after the inspection. A detailed action plan has been developed by CRHFT in response to the CQC visits and is addressing the concerns raised.

12 hour Trolley Breaches

From April 2019 to the end of November 2019 there have been 18 x 12 hour trolley breaches. Of these, four were attributable to unavailability of a mental health bed, the remainder were due to medical or surgical capacity. The mental health breaches are being monitored in line with the breaches at UHDBFT.

The CCG chairs the Organisational Resilience Group which meets weekly to discuss urgent care at a system level with representation from all providers. Improvement projects currently being managed by the group include: capacity and demand analysis; direct booking of GP appointments via NHS 111; reduced ambulance conveyances; focusing on high intensity users and care home patients; increasing input from mental health services; and increasing capacity to administer intravenous antibiotics in the community. The Organisational Resilience Group reports to the Accident and Emergency Delivery Board.

Quality and Performance – Diagnostics

Diagnostics

Derbyshire failed to deliver against the national 1.0% standard during October (3.5%), with underperformance mainly being attributed to underperformance at UHDBFT reporting 3.98%. CRHFT have achieved the standard for five of the seven months since April 2019. Other Trusts treating Derbyshire patients who have failed are NUH and Stockport NHS Foundation Trust. Echocardiography has been a significant issue at UHDBFT, and during the summer performance that test worsened to 42% due to an increase in referrals and some capacity issues. A contract performance notice was issued to UHDBFT during May and the CCG have been monitoring the action plans. UHDBFT is now recovering, and unvalidated November data is showing at 13.67% for echocardiography. UHDBFT expects to recover their position for January 2020.

Cancer

In line with the national picture, cancer demand has been increasing and the Trusts have struggled to increase capacity due to difficulties in recruiting specialists. Pathways are being reviewed in line with the national cancer pathways to ensure that they make the most effective use of available resource. Six of the nine standards were non-compliant at Derbyshire-level in October 2019, however all cancer 2WW targets were met at Derbyshire-level (95.4%). The 31 day diagnosis to treatment target was non-compliant at 95.2%, although UHDBFT were then compliant in November. 31 days subsequent surgery improved but was still non-compliant at 89.3%. This was due to non-compliance at CRHFT, UHDBFT, NUH and STHFT. The number of patients waiting over 104 days for treatment during October at both our main providers was 5 at CRHFT and 17.5 at UHDBFT. The Clinical Quality Team reviews all breach reports to ascertain if harm has occurred as a result of the breach.

62 day Standard

University Hospitals of Derby and Burton NHS Foundations Trust

UHDBFT have failed this standard for 18 consecutive months and are not expected to achieve during November 2019, with performance for October at 75.8% and YTD at 73.8%. 12% more 2WW referrals were received during the first two quarters of the year compared to the same period during 2017/18 and this has created significant pressure on specialties. Additional permanent clinics have been put in place in some specialties to recognise that increased demand is likely to remain. Oncology capacity has remained an issue this year and the Trust has had to rely on locum employment and is still trying to recruit substantively.

The CCG re-issued a Contract Performance Notice to UHDBFT in relation to the cancer performance this year and a new draft Remedial Action Plan has been developed by UHDBFT; focusing on outcomes and refining pathways. UHDBFT has put in place a new cancer governance structure which will control a number of cancer improvement workstreams. The workstream priorities and plans have been developed using lessons learned from other higher performing providers.

Chesterfield Royal Hospital NHS Foundation Trust

CRHFT did not achieve this standard during October with a performance of 67.3% (YTD 79.1%). There are issues with diagnostic capacity, particularly for breast patients and as a number of the pathways are shared with STHFT, CRHFT are dependent on capacity at that Trust. STHFT have been experiencing delays throughout the summer months with surgical capacity, although this is much improved. Oncology capacity continues to be an issue due to the numbers referred and shortage of Oncologists.

The CCG are working with both UHDBFT and CRHFT to introduce tumour site specific referral forms to ensure that the necessary information is available to enable more patients to have their first appointment as a diagnostic test, particularly in lower gastrointestinal.

Referral to Treatment/52-Week Wait

18 Week Referral to Treatment

Incomplete pathways continue to be non-compliant for Derbyshire at 88.6% (YTD 89.7%) and both main providers in Derbyshire (UHDBFT and CRHFT) failed to meet the 92% standard (90.5% and 87.5%). The performance has worsened due to elective cancellations as a result of urgent care pressures; both UHDBFT and CRHFT are experiencing unprecedented levels of urgent care demand. However, the time to treatment has not currently changed as both UHDBFT and CRHFT are now validating pathways below 18 weeks in an effort to reduce their waiting lists to bring them in line with their March 2019 position. CRHFT are still expecting to achieve their March 2019 waiting list outturn but UHDBFT have stated that they will be unable to recover their position and have asked for system agreement to increase their 2020 outturn position by 5,000. The CCG are reviewing this position and working on alternative solutions to the improvement of the waiting list position.

52+ Week Waits

At the end of October there had been nine CCG breaches which related to six patients:

- 2 at University Hospitals of Derby and Burton;
- 1 at Leeds Teaching Hospitals NHS Trust;
- 1 at Stockport NHS Foundation Trust;
- 1 at Nottingham University Hospitals NHS Trust; and
- 1 at Sheffield Children's NHS Foundation Trust.

Some of these breached for more than one month. CRHFT had no 52 week wait patients during this year and UHDBFT had 16 breaches of which two were CCG patients, year to date. The remainder were maxillofacial patients commissioned by NHSE. However, the CCG breaches all occurred earlier in the year with all providers at zero from September-December; so this position has improved due to provider action in managing, validating and prioritising patients waiting.

Discharge pathways

Demand continues to be high for non-elective admissions in acute beds across the Derbyshire footprint during the winter period; putting increased pressure on the system. Work is ongoing to ensure patients are discharged to the most appropriate pathway first time and to utilise all available community capacity as there is a mismatch between the escalation level of Acute Trusts and their lack of flow with community bed availability and utilisation.

The CCG are tracking community capacity and demand on a regular basis to ensure patients' clinical needs are met by the most appropriate level of support. CRHFT discharges are close to the aspirational target and work with UHDBFT is continuing to reach the target.

In addition we have set up a cross-sector system-wide improving flow workstream which includes specific input from commissioners and all providers including the two Local Authorities. It aims to deliver appropriate discharge to assess pathways to better meet patients' needs across the city and south of the county. The principles of the workstream are to create the right size of capacity in each of the Pathway 1 (short term reablement care packages), Pathway 2 (community support care home beds offering short term care, support

and rehabilitation to patients) and Pathway 3 (24/7 nursing care in a community hospital) in the city and south of the county with the explicit aim to enable as many people as possible to return back to their own homes. The work includes patient audits; data analysis; the alignment and update of standard operating procedures for each discharge pathway; and recommendations for further improvements to discharge planning. The workstream feeds into the Derbyshire Joined Up Care Board and regularly updates the Accident and Emergency Delivery Board. A report detailing recommendations from the workstream is due in April 2020.

Learning Disability Transforming Care

Although acute 'churn' and autism spectrum disorder remain an issue, the Transforming Care Plan has, over the years, succeeded in reducing the number of long stay (over five years) inpatients from over 30 to 16 and is forecast to be a possible nine by the end of the financial year. The current number of qualifying inpatients in all bed settings is 40 (December). There are currently 16 long stay patients (over five years; six CCG and 10 NHSE).There are seven long stay patients with a planned discharge date in 2019/20.

The anticipated position at the end of Quarter 3 in 2019/20 is 40 patients missing the combined target of 36. A Recovery Action Plan is with the regulators and system changes underway are significant.

Learning Disability Mortality Reviews

12 month rolling targets in Derbyshire have shown an increase of completed reviews from 34% in August 2019 to 43% in October 2019; this is equal to the England position and is improving with the additional investment. Child death reviews are already meeting the standard of 75% completed within timescales.

Quality and Performance – Mental Health and Dementia

Mental Health

The CCG has seen an improvement in the median length of stay for patients being sent out of area; from developing the actions behind the out of area bed use plan to eliminate inappropriate old age pensioners in mental health services for adults in acute inpatient care by 2020/22. The system is assured that our local data is accurate and patient flow management has been improved.

Children and Young People

34% of children and young people receive access to support in a timely way. There are some data issues which are required to be corrected (smaller providers cannot currently access the cloud, and children and young people in IAPT are not included). This means developing Place and school/college-based targeted support for mental health to help as early as possible, and more support for children and young people in or at the edge of 'Care'.

Perinatal

The rolling 12 month target measures have now been clarified. Our most recent performance is 3.4% against the 4.5% target. Actions are in place to establish what impact increased capacity would achieve within Quarter 4 given the 12 month rolling aspect.

Severe Mental Illness health checks

The approval to implement the Local Enhanced Service and financial commitment to support it has been secured and the Local Enhanced Service has been implemented from the 1st January 2020.

Quality and Performance – Ambulance Services

In Quarter 3, EMAS failed to deliver any of the quarterly performance standards with the exception of Category 1 90th centile. This is the same position as Quarter 1 and Quarter 2, with the exception of Quarter 1 when EMAS did deliver the Category 4 90th centile performance standard along with the C1 90th centile standard. As a result of non-delivery in Quarter 2, a Contract Performance Notice was issued. Analysis has identified four areas impacting on performance delivery: demand, pre-clinical handover delays, internal efficiencies and internal resourcing. At a Trust level the areas having the biggest impact are demand, handover delays and internal efficiencies. For Derbyshire the two areas having the greatest impact are demand and internal efficiencies. We are in the process of developing an Action Plan for each county to support improvement in performance and quality.

CQC Visit – East Midlands Ambulance Service NHS Trust

EMAS was subject to a routine inspection conducted by the CQC from the 2nd April to the 15th May 2019, with the inspection report published on the 17th July 2019. The CQC rated the Trust as 'good', which represents an improvement from their 2017 rating of 'requires improvement'. The CQC domains of safe, effective, responsive and well-led were rated 'good' and 'outstanding' was achieved for the domain of caring at this inspection.

All four of EMAS's core services, which are Emergency and Urgent Care, Patient Transport Services, Emergency Operations Centre (EOC) and Resilience Teams, including Hazardous Area Response Team, were inspected during this CQC inspection and were all rated as 'good'.

A number of minor breaches were identified in the inspection that the Trust was required to address. These did not justify regulatory action but were required to either prevent breaching a legal requirement or improve service quality. These were:

- ensuring a review of risk management processes and Trust board oversight of these;
- continuing to develop the accessible information standard for ambulances;
- strengthening clinical executive presence at sub-committees;
- auditing learning from incidents and complaints to ensure wider learning across the organisation;
- ensuring staff complete Mental Capacity Act training and mental health awareness training;
- risk assessing temperature of medication storage on vehicles and stores, and ensuring their Medications Governance Group monitor and review medications advice given by EOC staff.

The Trust has developed and implemented an action plan to address these 'should do' actions, which is in progress, and is monitored through their internal governance processes which commissioners are sighted on.

Quality and Performance – Regulators (including patient safety)

CQC Visit – Chesterfield Royal Hospital NHS Foundation Trust

An unannounced Care Quality Commission (CQC) visit to CRHFT was undertaken on the 19th August 2019 with a view to seeking assurance following a number of reported incidents.

A letter of intent was issued, which could have resulted in possible enforcement action.

The main areas of concern identified were: environment and equipment; infection, prevention and control; access and flow; and unsupervised mental health/dementia/children in the department.

CRHFT and the CCG carried out a follow-up visit on the 22nd August 2019, and immediate actions had been taken. An immediate action plan was submitted to the CQC on the 23rd August 2019, and no enforcement action was taken as a result due to the assurance being provided. Progress against the action plan is reviewed through the Clinical Quality Review Group.

NHS England and NHS Improvement Infection Prevention and Control Visit

An announced infection prevention and control visit was undertaken on the 11th December 2019. This was triggered by infection, prevention and control concerns from CQC, and CRHFT was rated 'Red'. Assurance was provided and CRHFT has now been rated 'Amber' as a result. CRHFT has responded to the proposed actions, and an action plan was shared with the CCG on the 10th January 2020.

CQC Visit – Derbyshire Healthcare NHS Foundation Trust

On the 26th November 2019, the CQC conducted a first visit of core services as part of their planned unannounced inspection. The outcome of this rated DHcFT as 'good' .

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 managers and clinical leads within the CCG who have responsibility for the development and maintenance of the internal control framework. The comments from external auditors in their annual audit letter and other reports are also taken into consideration.

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 reported to and scrutinised by 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.

The CCG has benchmarked its performance with similar organisations. It uses expert commissioning support to ensure the delivery of best value through procurement. It develops Quality, Innovation, Productivity and Prevention 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.

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 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 39 shows the CCGs running costs for the last two financial years and the plan for 2020/21.

	Allocation	Expenditure
	£'000	£'000
2018/19 legacy CCGs	22,470	18,834
2019/20	23,431	17,864
2020/21	20,824	19,775

Table 39 – CCG's running costs for 2018/19, 2019/20 and plan for 2020/21

The expenditure in 2019/20 is lower than the previous year due to the economies of scale delivered by the merger of the four previous CCGs for Derbyshire into NHS Derby and Derbyshire CCG and higher than expected levels of staff vacancies in the first six months of the year as the CCG restructured.

The expenditure in 2020/21 is comparatively higher due to increases in NHS pay scales, which has occurred in order to support lower paid employees. The CCG has also returned to an expected level of staff vacancies.

Table 40 identifies how the CCG's running costs were used in 2019/20:

Breakdown of 2019/20 expenditure	
Expenditure	**£'000**
Pay costs	12,960
Travel expenses	163
Premises costs	1227
Charges from Commissioning Support Units	1,179
Other non-pay	2,858
Commissioning income	-523

Table 40 – Breakdown of 2019/20 expenditure

The CCG's GBAF provides evidence that the effectiveness of the controls that manage risks to the CCG achieving its principle objectives have been reviewed. The Governing Body, Audit Committee and responsible Committees regularly review the GBAF, advising on the effectiveness of the system of internal control; plans to address weaknesses and ensuring continuous improvement of the system are in place.

The CCG's rating for the Improvement and Assessment Framework (IAF) has been replaced by the NHS Oversight Framework. MyNHS is a publicly accessible website which reports on all of the elements of the Oversight Framework and allows a user to compare the CCG position against other CCGs. It can be accessed here. NHSE is no longer required to provide a separate assessment of CCG performance in the six clinical priority areas of cancer, mental health, maternity, learning disabilities, diabetes, and dementia. The link to the NHS Oversight Framework can be found here.

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 – 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.

Although the CCG has taken on delegated powers for the commissioning of Primary Medical Care, the detailed financial transactions are processed by NHSE into the CCG's ledger from the Exeter/National Health Application and Infrastructure Services system. Capita was responsible for Primary Care support services at all NHS sites and the CCG were aware that the Capita Service Auditor Report did not give the required assurance over Primary Care services for 2019/20. As a result, the CCG worked closely with NHSE and external auditors

to obtain sufficient evidence to assure itself that primary medical care expenditure in the ledger is complete and accurate.

The CCG attends the Better Care Fund Finance and Performance Sub-Group and the Better Care Fund Programme Board. Through attendance at these monthly meetings the CCG is fully aware of the performance of the Better Care Fund and any associated risks.

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.

During 2019/20 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.

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 CCG's system of risk management, governance and internal control.

The Head of Internal Audit concluded that:

> This is my first Head of Internal Audit Opinion for the newly formed CCG. While I am directed to form an opinion on the Governance, Risk Management and Controls extant for 2019/20 I do recognise that significant work was required to develop and embed systems and processes during the year.
>
> In forming this opinion it is worth reflecting on the issues that directed me to provide a moderate opinion for the predecessor constituent organisations in 2018/19. The Governing Body Assurance Framework (GBAF) was very late being constructed and subsequently monitored, risk management processes were not sufficiently robust during the year and the profile of assignments lent towards limited assurance opinions, including core reviews of Data Security and Protection (IG Toolkit) and Risk Management. The follow-up position was, however, overall significant.
>
> The CCG invested significant resource to take forward the GBAF for the new organisation much earlier in the year. We recognised this in our Stage 1 Head of Internal Audit programme 'We acknowledge that the GBAF is further developed when compared to this time last year'. The profile of audit assignment opinions is improved, noting that the Data Security and Toolkit opinion has moved from limited to substantial. The Risk Management element of our Governance and Risk audit provided for significant assurance.

There is recognition at Audit Committee that providing assurance around system working and the impact partner organisations have on risks is an issue that needs constant consideration and we note that the CCG was an active participant in the Joined Up Care Derbyshire review undertaken by 360/KPMG across all Derbyshire healthcare organisations. This is a positive way forward and reflects well on the CCG and Derbyshire community.

In consideration of the above, I am providing a **Significant Assurance** – that there is a generally sound framework of governance, risk management and control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

For 2020/21 I would wish to see the following to sustain the significant assurance opinion:

- to implement and embed our recommended action within our Governance and Risk report for measuring progress in achieving Strategic Objectives including the mapping of performance targets. We note progress being made and we have continued to be provided with updates;
- continued participation in any STP/ICS programme of work recognising that my opinion is likely to place more emphasis on system working;
- sustained improvement in the follow-up position which is currently at 60%.

During the year, Internal Audit, 360 Assurance completed the following audit assignments

Audit Assignment	Assurance Level/Comments
Governance and Risk Management	Limited/ Significant Assurance
Merger of the Ledger Project	Advisory
Integrity of the general ledger, financial reporting and key financial systems	Significant Assurance
Data Security and Protection Toolkit (mandated)	Substantial Assurance
Policy Monitoring	Cancelled at CCG's request
Policy Management Framework	Deferred to 2020/21 at CCG's request
CCG's response to National Staff Survey	Deferred to 2020/21 at CCG's request
Client Wide Recruitment Review	Not applicable
Contract Management	Limited Assurance
Commissioning Strategy Development	Deferred to 2020/21 at the CCG's request
Quality, Innovation, Prevention and Productivity/Savings Report	Significant Assurance
Primary Medical Care (mandated)	Substantial Assurance (NHSE opinion rating)
Conflicts of Interest (mandated)	Significant Assurance
Joined Up Care Derbyshire (Operational Planning)	Advisory

Table 41 – Internal Audit reports issued in 2019/20 by 360 Assurance

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 have 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, 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 – IAF, 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;
- the Organisational Effectiveness and Improvement Board; and
- the Executive Team.

Conclusion

No significant internal control weaknesses have been identified during the year.

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 Group. The Committee is chaired by a Lay Member.

The Remuneration Committee is comprised of the following members:

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

Table 42 – Members of the CCG's Remuneration Committee in 2019/20

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 Very Senior Managers (VSM), or members 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 independent Remuneration Committee sets and approves the remuneration for all VSM employees. The Remuneration Committee comprises independent representatives 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.

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

Senior Manager total salary for 2019/20 is shown in the following table:

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	To 7 July	45-50	0	0	0	87.5-90	130-135
Richard Chapman	Chief Finance Officer	From 1 July	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 and Freedom to Speak Up Guardian		10-15	0	0	0	0	10-15
Ian Gibbard	Lay Member for Audit and Conflicts of Interest Guardian		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	To 31 Mar 2020	10-15	0	0	0	0	10-15
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 Dec 2019	0	0	0	0	0	0
Robyn Dewis	Derby City Council Representative	From Jan 2020	0	0	0	0	0	0
Dean Wallace	Derbyshire County Council Representative		0	0	0	0	0	0

Table 43 – 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 31 March 2020

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	0-2.5	25-30	30-35	301	12	342	0
Deborah Hayman	Interim Chief Finance Officer	2.5-5	10-12.5	50-55	155-160	823	93	1,170	0
Richard Chapman	Chief Finance Officer	2.5-5	5-7.5	35-40	85-90	537	60	650	0
Brigid Stacey	Chief Nurse Officer	0-2.5	0-2.5	40-45	125-130	845	5	888	0
Steven Lloyd	Executive Medical Director	5-7.5	17.5-20	25-30	75-80	440	145	611	0
Sandy Hogg	Executive Turnaround Director	0-2.5	0-2.5	40-45	105-110	788	34	857	0
Helen Dillistone	Executive Director of Corporate Strategy and Delivery	0-2.5	0-2.5	25-30	55-60	427	23	477	0
Zara Jones	Executive Director of Commissioning Operations	0-2.5	0-2.5	25-30	45-50	309	9	342	0

Table 44 – Pension Benefits as of 31 March 2020

Notes to Pension Benefits as at 31 March 2020

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 2019/20.*
2. *Where an employee has been in post for part of the year, their pension amount is time apportioned to reflect time in post. Deborah Hayman (left July 2019) and Richard Chapman (started July 2019) were in post for part of the year.*

Cash equivalent transfer values

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

No payments were made during the year in respect of early retirement or loss of office.

Payments to past members

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

Pay Multiples (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 Director/Member in NHS Derby and Derbyshire CCG in the financial year 2019/20 was £197,500. This was 5.09 times the median remuneration of the workforce, which was £38,765.

In 2019/20, nil employees received remuneration in excess of the highest-paid Director/Member. Remuneration ranged from £17,500 to £197,500.

The calculation of the median remuneration of the workforce includes the remuneration of the directors serving on the Governing Body but exclude the highest paid Director.

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 CETV of pensions. For part time staff, remuneration is calculated by grossing up the part time salary to FTE. The remuneration of the highest paid board member has been grossed up to FTE.

No prior year comparative information for 2018/19 is provided as the CCG was created on the 1st April 2019 and 2019/20 is the first year of operation.

Staff Report

Number of Senior Managers and Staff Composition

Table 45 shows the gender and pay band of VSMs and gender of the other CCG Employees for 2019/20.

	Male	Female	Total
Executive Members (including Functional Directors)	8	14	22
Band 8d	0	1	1
Band 8c	9	17	26
Band 8b	6	30	36
Band 8a	20	60	80
Other banded CCG employees	35	276	311
Total CCG employees	**78**	**398**	**476**
Other non-permanent engagements including non-executive directors and lay members	20	22	42
Total	**98**	**420**	**518**

Table 45 – number of senior managers and staff composition in 2019/20

Staff numbers and costs (subject to audit)

The staff costs for 2019/20 are shown in the following table:

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	-	-	**-**

Employee Benefits	2019/20		
	Permanent Employees	Other	Total
	£000	£000	**£000**
Termination benefits[5]	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 46 –staff numbers and costs in 2019/20

Average number of people employed

The average number of staff employed by the CCG, excluding non-executive members and lay members, is:

	2019/20		
	Permanently employed	**Other**	**Total**
Total	392	10	402

Table 46 – average number of people employed by the CCG in 2019/20

Sickness absence data

The average number of working days lost during 2019/20 is unavailable at present. Please refer to the NHS Digital website here for the NHS Sickness Absence rates.

Staff Policies

NHS Derby and Derbyshire CCG is committed to employing, supporting and promoting disabled people in our workplace, which is reflected in our 'Disability Confident' employer status. This means 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.

[5] Termination benefit costs include the exit packages agreed in year and some residual termination costs from exit packages agreed by the predecessor organisations in 2018/19.

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 we committed to training a number of Mental Health First Aiders and by July 2019 we had a total of 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.

Towards the end of 2019 our Mental Health First Aiders ran a number of sessions for staff to help raise awareness of mental health. These sessions were well received and there are plans to run sessions on a regular basis. Feedback from staff that have used the Mental Health First Aiders on an individual basis has also been positive.

Human Resources Policies

Since the merger of the four Derbyshire CCGs in April 2019 the Human Resources (HR) Team have been working on reviewing and developing its HR polices to ensure they are fit for purpose in the new organisation and to also comply with the relevant employment law as appropriate. Over the course of the year new policies have been introduced, including Pay Progression and Probationary Period, and others have been reviewed and updated, including Disciplinary; and Your Attendance Matters. The Governance Committee is responsible for approving the HR Policies and they are made available to staff on the CCG's Intranet.

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

We are committed to employing, supporting and promoting disabled people in our workplace and this is reflected in our continued 'Disability Confident' employer status. This means we actively look to attract and recruit disabled people by providing a fully inclusive and accessible recruitment process. This is outlined in more detail in our 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.

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.

In February 2020 our Governing Body agreed that the CCG should sign up to 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.

All staff are able to receive training on equality and diversity, and the duties in the equalities legislation. 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.

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

Organisation Effectiveness and Improvement Group

Over the last 12 months we have made many changes to improve the health and wellbeing of our staff and also in how we engage and involve our staff to help shape the work we deliver and the culture of the organisation.

Following the success of our first CCG staff event held on the 29th March 2019, we held our second on the 15th October 2019. While the first event was focused on helping our staff to understand how we would operate as one CCG following the merger of the four previous CCGs, the second sought to raise awareness of how the Governing Body and other decision-making committees operate and increase involvement from staff. Each Governing Body member spoke about their role on the Governing Body, and Staff from the Organisation Effectiveness and Improvement Group (OEIG) (a staff forum created in 2019/20) were invited to talk about the work they do and the changes that have been made in the organisation as a result.

The purpose of OEIG is to give all staff the opportunity to contribute to and influence positive change in the CCG. This group does not duplicate the role or responsibilities of recognised employee trade unions. All OEIG members have a collective responsibility to seek the views of all staff across directorates and feed back into the group, without bias.

The CCG has been working on an action plan to support all employees on matters relating to their health and wellbeing. It will build on the work from OEIG and should be approved in the early part of 2020/21. Examples of the types of initiative that have already been instigated by OEIG are:

- **Wellness at Work** – walking and running groups;
- **Dress Down Friday** – supporting staff to reflect their personality by relaxing the dress code on a Friday for all staff;
- **Think Green** – introducing various initiatives to make it easier to 'go green' and also raise awareness of the wider sustainability agenda in the NHS;
- **Diversity and Inclusion** – we have signed up to the 'Rainbow' scheme and have provided rainbow lanyards or pin badges to any staff who wish to wear them to show support to the LGBT+ community; and
- **Mental Health First Aiders** – the CCG has nine employees who are qualified as Mental Health First Aiders.

The OEIG has also helped to shape the CCG's organisational values this year, which are as follows:

Commitment to quality

- We demonstrate a commitment to quality of care
- We are responsive to the needs of patients carers and staff

Working together

- We show professionalism
- We take responsibility and be held accountable
- We collaborate and are responsive to people's needs

Respect and Dignity

- We are inclusive, we respect and value everyone

Integrity

- We behave with integrity
- We are open, honest and transparent in everything that we do
- We do what we believe is the right thing to do

Compassion

- We show consideration, kindness and care

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 2020.

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 47 – 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 48 – 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 49 – 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 50 – paid Trade Union activities

Expenditure on consultancy

The expenditure on consultancy for 2019/20 for the CCG was £0.287m.

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'.

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

Off-payroll engagements longer than six months

For all off-payroll engagements as at the 31st March 2020 for more than £245 per day and that last longer than six months:

	Number
Number of existing engagements as of 31 March 2020	1
for less than one year at the time of reporting	1
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 51 – off-payroll engagements longer than six months in 2019/20

New off-payroll engagements

Where the reformed public sector rules apply, entities must complete Table 52 for all new off-payroll engagements, or those that reached six months in duration, between the 1st April 2019 and the 31st March 2020, 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 1 April 2019 and 31 March 2020	4
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	4
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 52 – new off-payroll engagements 2019/20

Off-payroll engagements/senior official engagements

For any off-payroll engagements of Board members and/or senior officials with significant financial responsibility, between the 1st April 2019 and the 31st March 2020:

	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)	25

Table 53 – off-payroll engagements/senior official engagements 2019/20

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

Exit Packages

During the year, two exit packages totalling £49,081 were agreed and paid. These packages were subject to approval by the Remuneration Committee and under the NHS Redundancy Terms and Conditions. The exit packages are also identified in table 4.4 of the accounts and the numbers disclosed are subject to audit. The payments are also part of the termination benefits disclosure identified in note 4.1 of the accounts (these also include some residual termination costs from exit packages agreed by the predecessor organisations in 2018/19).

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.

FINANCIAL STATEMENTS

Dr Chris Clayton

Accountable Officer

NHS Derby and Derbyshire CCG

26 May 2020

CONTENTS

Statement of Comprehensive Net Expenditure for the year ended 31 March 2020

	Note	2019-20 £'000
Income from sale of goods and services	2	(4,212)
Other operating income	2	(1,139)
Total operating income		**(5,351)**
Staff costs	4	22,131
Purchase of goods and services	5	1,661,478
Depreciation and impairment charges	5	-
Provision expense	5	20
Other Operating Expenditure	5	446
Total operating expenditure		**1,684,075**
Net Operating Expenditure		**1,678,724**
Finance income		-
Finance expense	7.1	(8)
Net expenditure for the year		**1,678,716**
Net (Gain)/Loss on Transfer by Absorption	8	90,754
Total Net Expenditure for the Financial Year		**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		**1,769,470**

The notes on pages 163 to 187 form part of this statement.

Statement of Financial Position as at 31 March 2020

	Note	31 March 2020 £'000	01 April 2019 £'000
Non-current assets:			
Property, plant and equipment	10	442	-
Intangible assets		-	-
Investment property		-	-
Trade and other receivables		-	-
Other financial assets		-	-
Total non-current assets		442	-
Current assets:			
Inventories		-	-
Trade and other receivables	11	9,764	12,533
Other financial assets		-	-
Other current assets		-	-
Cash and cash equivalents	12	40	157
Total current assets		**9,804**	12,690
Non-current assets held for sale		-	-
Total current assets		**9,804**	12,690
Total assets		**10,246**	12,690
Current liabilities			
Trade and other payables	13	(102,118)	(100,470)
Other financial liabilities		-	-
Other liabilities		-	-
Borrowings		-	-
Provisions	14	(2,080)	(2,828)
Total current liabilities		**(104,198)**	(103,298)
Non-Current Assets plus/less Net Current Assets/Liabilities		**(93,952)**	(90,608)
Non-current liabilities			
Trade and other payables		-	-
Other financial liabilities		-	-
Other liabilities		-	-
Borrowings		-	-
Provisions	14	(195)	(146)
Total non-current liabilities		**(195)**	(146)
Assets less Liabilities		**(94,147)**	(90,754)
Financed by Taxpayers' Equity			
General fund		(94,147)	(90,754)
Revaluation reserve		-	-
Other reserves		-	-
Charitable Reserves		-	-
Total taxpayers' equity:		**(94,147)**	(90,754)

The notes on pages 163 to 187 form part of this statement.

The financial statements on pages 159 to 187 were approved by the Audit Committee (as delegated by the Governing Body), on 26 May 2020 and signed on its behalf by:

Dr Chris Clayton
Chief Executive Officer

Statement of Changes In Taxpayers Equity for the year ended 31 March 2020

	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 between reserves in respect of assets transferred from closed NHS bodies	0	0	0	**0**
Adjusted balance at 31 March 2019	**0**	**0**	**0**	**0**
Changes in taxpayers' equity for 2019-20				
Net operating expenditure for the financial year	(1,678,716)			**(1,678,716)**
Net gain/(loss) on revaluation of property, plant and equipment		0		**0**
Net gain/(loss) on revaluation of intangible assets		0		**0**
Net gain/(loss) on revaluation of financial assets		0		**0**
Total revaluations against revaluation reserve		**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
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 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 163 to 187 form part of this statement.

Statement of Cash Flows for the year ended 31 March 2020

	Note	2019-20 £'000
Cash Flows from Operating Activities		
Net operating expenditure for the financial year		(1,678,716)
Depreciation and amortisation		0
Impairments and reversals		0
Non-cash movements arising on application of new accounting standards		
Movement due to transfer by Modified Absorption		0
Other gains (losses) on foreign exchange		0
Donated assets received credited to revenue but non-cash		0
Government granted assets received credited to revenue but non-cash		0
Interest paid		0
Release of PFI deferred credit		0
Other Gains & Losses		0
Finance Costs		0
Unwinding of Discounts	7.1	(9)
(Increase)/decrease in inventories		0
(Increase)/decrease in trade & other receivables	11	2,769
(Increase)/decrease in other current assets		0
Increase/(decrease) in trade & other payables	13	1,639
Increase/(decrease) in other current liabilities		0
Provisions utilised	14	(710)
Increase/(decrease) in provisions	14	20
Net Cash Inflow (Outflow) from Operating Activities		**(1,675,007)**
Cash Flows from Investing Activities		
Interest received		0
(Payments) for property, plant and equipment		(433)
(Payments) for intangible assets		0
(Payments) for investments with the Department of Health		0
(Payments) for other financial assets		0
(Payments) for financial assets (LIFT)		0
Proceeds from disposal of assets held for sale: property, plant and equipment		0
Proceeds from disposal of assets held for sale: intangible assets		0
Proceeds from disposal of investments with the Department of Health		0
Proceeds from disposal of other financial assets		0
Proceeds from disposal of financial assets (LIFT)		0
Non-cash movements arising on application of new accounting standards		0
Loans made in respect of LIFT		0
Loans repaid in respect of LIFT		0
Rental revenue		0
Net Cash Inflow (Outflow) from Investing Activities		**(433)**
Net Cash Inflow (Outflow) before Financing		**(1,675,440)**
Cash Flows from Financing Activities		
Grant in Aid Funding Received		1,675,323
Other loans received		0
Other loans repaid		0
Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		0
Capital grants and other capital receipts		0
Capital receipts surrendered		0
Non-cash movements arising on application of new accounting standards		0
Net Cash Inflow (Outflow) from Financing Activities		**1,675,323**
Net Increase (Decrease) in Cash & Cash Equivalents	12	**(117)**
Cash & Cash Equivalents at the Beginning of the Financial Year		**157**
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		0
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**40**

The notes on pages 163 to 187 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 2019-20 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 of these pooled budget 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.

Notes to the financial statements

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 scheme 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 a 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 scheme 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.

Notes to the financial statements

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:

Early retirement provisions are discounted using HM Treasury's pension discount rate of negative 0.50% (2018-19: positive 0.29%) in real terms. 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 0.51% (2018-19: 0.76%) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 0.55% (2018-19:1.14%) 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% (2018-19: 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% (2018-19: 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 the 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 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.

Notes to the financial statements

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 derecognised 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.

Notes to the financial statements

1.22 **Losses & Special Payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed 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.

Losses and special payments are charged to the relevant functional headings in expenditure on an accrual's basis, including losses which would have been made good through insurance cover had the Clinical Commissioning Group not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

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 2019-20. 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 2021. The impact of the standard will be fully identified during 2020/21.

• IFRS 17 Insurance Contracts – This standard was due to be applied from 1 January 2021 but due to the outbreak of COVID-19 pandemic, has been deferred to accounting periods beginning on or after 1 January 2023 (awaiting adoption by the FReM).

2. Other Operating Revenue

	2019-20 Total £'000
Income from sale of goods and services (contracts)	
Education, training and research	**2**
Non-patient care services to other bodies	**4,097**
Patient transport services	**-**
Prescription fees and charges	**9**
Dental fees and charges	**-**
Income generation	**-**
Other Contract income	**104**
Recoveries in respect of employee benefits	**-**
Total Income from sale of goods and services	**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	**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	**8**
Other non contract revenue	**1,108**
Total Other operating income	**1,139**
Total Operating Income	**5,351**

“Other non contract revenue” comprises of expected resource to cover the increased costs of GP sickness and locum cover in 2019-20, resulting from the outbreak of the COVID-19 pandemic. The related expenditure is included in note 5 operating cost statement, "GPMS/APMS and PCTMS".

3. Income from sale of goods and services (contracts)

3.1 Disaggregation of Income - Income from sale of good and services (contracts)

	Education, training and research £'000	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Other Contract income £'000
Source of Revenue				
NHS	2	3,217	-	-
Non NHS	-	880	9	104
Total	**2**	**4,097**	**9**	**104**

	Education, training and research £'000	Non-patient care services to other bodies £'000	Prescription fees and charges £'000	Other Contract income £'000
Timing of Revenue				
Point in time	-	-	-	-
Over time	2	4,097	9	104
Total	**2**	**4,097**	**9**	**104**

3.2 Transaction price to remaining contract performance obligations

NHS Derby and Derbyshire Clinical Commissioning Group had no contract revenue expected to be recognised in future periods, relating to contract performance obligations not yet completed at the reporting date.

4. Employee benefits and staff numbers

4.1.1 Employee benefits

	2019-20		
	Permanent Employees	Other	Total
	£'000	£'000	£'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	**-**	**-**	**-**
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 include the two exit packages agreed in year (identified in note 4.4) and some residual termination costs from exit packages agreed by the predecessor organisations in 2018-19.

4.2 Average number of people employed

	2019-20		
	Permanently employed	Other	Total
	Number	Number	Number
Total	**392**	**10**	**402**
Of the above:			
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**

4.3 Staff sickness absence and ill health retirements

Details of sickness and ill health retirements are included in the remuneration report section of the annual report.

4.4 Exit packages agreed in the financial year

	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**

	2019-20 Departures where special payments have been made	
	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 no early retirements during 2019-20). Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the tables.

4.5 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. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They 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, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.
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:

a) 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 2020, is based on valuation data as 31 March 2019, updated to 31 March 2020 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.

b) 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%, and the Scheme Regulations were amended accordingly.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

5. Operating expenses

	2019-20 Total £'000
Purchase of goods and services	
Services from other CCGs and NHS England	7,898
Services from foundation trusts	972,815
Services from other NHS trusts	101,838
Provider Sustainability Fund	-
Services from Other WGA bodies	35
Purchase of healthcare from non-NHS bodies	209,932
Purchase of social care	47,845
General Dental services and personal dental services	-
Prescribing costs	148,730
Pharmaceutical services	261
General Ophthalmic services	382
GPMS/APMS and PCTMS	162,116
Supplies and services – clinical	-
Supplies and services – general	4,509
Consultancy services	287
Establishment	2,065
Transport	24
Premises	1,603
Audit fees	184
Other non statutory audit expenditure	
· Internal audit services	-
· Other services	14
Other professional fees	522
Legal fees	240
Education, training and conferences	170
Funding to group bodies	-
CHC Risk Pool contributions	-
Non cash apprenticeship training grants	8
Total Purchase of goods and services	**1,661,478**
Depreciation and impairment charges	
Depreciation	-
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	**-**
Provision expense	
Change in discount rate	-
Provisions	20
Total Provision expense	**20**
Other Operating Expenditure	
Chair and Non Executive Members	443
Grants to Other bodies	-
Clinical negligence	-
Research and development (excluding staff costs)	-
Expected credit loss on receivables	3
Expected credit loss on other financial assets (stage 1 and 2 only)	-
Inventories written down	-
Inventories consumed	-
Other expenditure	-
Total Other Operating Expenditure	**446**
Total operating expenditure	**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 total includes fees of £9,600 (including VAT), relating to additional work on the 2018-19 accounts.
NHS Derby and Derbyshire Clinical Commissioning Group has yet to commission the non-statutory audit of Mental Health Investment in 2019-20. As the audit relates to 2019-20, the estimated expenditure has been accrued in-year and is disclosed as "Other non-statutory audit expenditure – other services".

6.1 Better Payment Practice Code

Measure of compliance	2019-20 Number	2019-20 £'000
Non-NHS Payables		
Total Non-NHS Trade invoices paid in the Year	32,419	263,487
Total Non-NHS Trade Invoices paid within target	31,891	260,697
Percentage of Non-NHS Trade invoices paid within target	**98.37%**	**98.94%**
NHS Payables		
Total NHS Trade Invoices Paid in the Year	7,845	1,088,952
Total NHS Trade Invoices Paid within target	7,739	1,088,190
Percentage of NHS Trade Invoices paid within target	**98.65%**	**99.93%**

6.2 The Late Payment of Commercial Debts (Interest) Act 1998

NHS Derby and Derbyshire Clinical Commissioning Group incurred £153 relating to claims made under this legislation.

7.1 Finance costs

	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 Commissioning Group did not receive finance income during 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. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. 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, the Clinical Commissioning Groups of NHS Erewash; NHS Hardwick; NHS North Derbyshire; and NHS Southern Derbyshire ceased to exist and NHS Derby and Derbyshire Clinical Commissioning Group was established.

The figures shown below, are disclosed after adjusting for inter-trading balances between the four Clinical Commissioning Groups.

	2019-20				
	NHS Erewash CCG	NHS Hardwick CCG	NHS North Derbyshire CCG	NHS Southern Derbyshire CCG	Total
	£'000	£'000	£'000	£'000	£'000
Transfer of property plant and equipment	-	-	-	-	-
Transfer of intangibles	-	-	-	-	-
Transfer of cash and cash equivalents	72	7	70	8	157
Transfer of receivables	1,473	3,335	2,024	5,701	12,533
Transfer of payables	(9,332)	(10,369)	(30,216)	(50,553)	(100,470)
Transfer of provisions	(520)	(413)	(593)	(1,448)	(2,974)
Net loss on transfers by absorption	**(8,307)**	**(7,440)**	**(28,715)**	**(46,292)**	**(90,754)**

As NHS Derby and Derbyshire Clinical Commissioning Group is the recipient in the transfer of a function, it has recognised the assets and liabilities received as at the date of transfer. These balances are disclosed within the Statement of Financial Position and accompanying notes as at 1 April 2019. The corresponding net debit reflecting the loss is recognised within income and expenses as disclosed within the Statement of Comprehensive Net Expenditure, but outside of operating activities.

9. Operating Leases

9.1 As lessee

NHS Derby and Derbyshire Clinical Commissioning Group has a lease with Erewash Borough Council, for the building, Toll Bar House, located in Ilkeston and used as office premises.
Additionally property rental charges are received from NHS Property Services Limited, for the office accommodation at Cardinal Square, Derby and Scarsdale, Chesterfield. Even though no formal lease contract is 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 Canon.

9.1.1 Payments recognised as an Expense

	2019-20			
	Land	Buildings	Other	Total
	£'000	£'000	£'000	£'000
Payments recognised as an expense				
Minimum lease payments	-	517	9	**526**
Contingent rents	-	-	-	**-**
Sub-lease payments	-	-	-	**-**
Total	**-**	**517**	**9**	**526**

9.1.2 Future minimum lease payments

	2019-20			
	Land	Buildings	Other	Total
	£'000	£'000	£'000	£'000
Payable:				
No later than one year	-	30	1	**31**
Between one and five years	-	-	-	**-**
After five years	-	-	-	**-**
Total	**-**	**30**	**1**	**31**

The property lease with Erewash Borough Council for the Toll Bar House accommodation was due to expire 29 April 2024 but due to the reorganisation of staff accommodation throughout Derbyshire, early notice was provided and the lease is now being terminated 5 August 2020.

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.

All reprographic equipment lease contracts are due for expiry and new contracts are being put in place during 2020-21 and hence no future minimum lease payments were agreed at 31 March 2020.

9.2 As lessor

NHS Derby and Derbyshire Clinical Commissioning Group is not a party to any leasing arrangements where it acts in the capacity of a lessor.

10. Property, plant and equipment
2019-20

	Information technology £'000	Total £'000
Cost or valuation at 01 April 2019	-	-
Addition of assets under construction and payments on account		-
Additions purchased	442	442
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 2020	**442**	**442**
Depreciation 01 April 2019	-	-
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	-	-
Transfer (to)/from other public sector body	-	-
Cumulative depreciation adjustment following revaluation	-	-
Depreciation at 31 March 2020	**-**	**-**
Net Book Value at 31 March 2020	**442**	**442**
Purchased	442	442
Donated	-	-
Government Granted	-	-
Total at 31 March 2020	**442**	**442**
Asset financing:		
Owned	442	442
Held on finance lease	-	-
On-SOFP Lift contracts	-	-
PFI residual: interests	-	-
Total at 31 March 2020	**442**	**442**

Revaluation Reserve Balance for Property, Plant & Equipment

	Information technology £'000	Total £'000
Balance at 01 April 2019	-	-
Revaluation gains	-	-
Impairments	-	-
Release to general fund	-	-
Other movements	-	-
Balance at 31 March 2020	**-**	**-**

The information technology equipment, comprising of laptops and videoconferencing equipment, will be depreciated in line with accounting policies.

11.1 Trade and other receivables

	Current 31 March 2020 £'000	**Non-current 31 March 2020 £'000**	Current 01 April 2019 £'000	Non-current 01 April 2019 £'000
NHS receivables: Revenue	860	-	2,343	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	3,890	-	4,889	-
NHS accrued income	-	-	153	-
NHS Contract Receivable not yet invoiced/non-invoice	471	-	2,206	-
NHS Non Contract trade receivable (i.e pass through funding)	-	-	-	-
NHS Contract Assets	-	-	-	-
Non-NHS and Other WGA receivables: Revenue	494	-	867	-
Non-NHS and Other WGA receivables: Capital	-	-	-	-
Non-NHS and Other WGA prepayments	1,291	-	1,458	-
Non-NHS and Other WGA accrued income	-	-	92	-
Non-NHS and Other WGA Contract Receivable not yet invoiced/non-invoice	2,306	-	11	-
Non-NHS and Other WGA Non Contract trade receivable (i.e. pass through funding)	-	-	-	-
Non-NHS Contract Assets	-	-	-	-
Expected credit loss allowance-receivables	(4)	-	(2)	-
VAT	438	-	513	-
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	18	-	3	-
Total Trade & other receivables	**9,764**	**-**	**12,533**	**-**
Total current and non current	**9,764**		**12,533**	

There are no prepaid pension contributions included in note 11.1.

11.2 Receivables past their due date but not impaired

	31 March 2020		01 April 2019	
	DHSC Group Bodies £'000	**Non DHSC Group Bodies £'000**	DHSC Group Bodies £'000	Non DHSC Group Bodies £'000
By up to three months	11	92	101	101
By three to six months	2	2	194	366
By more than six months	190	12	67	(6)
Total	**203**	**106**	362	461

11.3 Loss allowance on asset classes

	Trade and other receivables - Non DHSC Group Bodies	Other financial assets	Total
	£'000	£'000	£'000
Balance at 01 April 2019	(2)	-	**(2)**
Lifetime expected credit loss on credit impaired financial assets	-	-	**-**
Lifetime expected credit losses on trade and other receivables-Stage 2	(2)	-	**(2)**
Lifetime expected credit losses on trade and other receivables-Stage 3	-	-	**-**
Credit losses recognised on purchase originated credit impaired financial assets	-	-	**-**
Amounts written off	-	-	**-**
Financial assets that have been derecognised	-	-	**-**
Changes due to modifications that did not result in derecognition	-	-	**-**
Other changes	-	-	**-**
Total	**(4)**	**-**	**(4)**

12. Cash and cash equivalents

	2019-20 £'000
Balance at 01 April 2019	157
Net change in year	(117)
Balance at 31 March 2020	**40**
Made up of:	
Cash with the Government Banking Service	40
Cash with Commercial banks	-
Cash in hand	-
Current investments	-
Cash and cash equivalents as in statement of financial position	**40**
Bank overdraft: Government Banking Service	-
Bank overdraft: Commercial banks	-
Total bank overdrafts	**-**
Balance at 31 March 2020	**40**

NHS Derby and Derbyshire Clinical Commissioning Group does not hold patients' money.

13. Trade and other payables

	Current 31 March 2020 £'000	**Non-current 31 March 2020 £'000**	Current 01 April 2019 £'000	Non-current 01 April 2019 £'000
Interest payable	-	-	-	-
NHS payables: Revenue	4,300	-	9,692	-
NHS payables: Capital	-	-	-	-
NHS accruals	21,764	-	12,956	-
NHS deferred income	1	-	-	-
NHS Contract Liabilities	-	-	-	-
Non-NHS and Other WGA payables: Revenue	3,951	-	4,157	-
Non-NHS and Other WGA payables: Capital	9	-	-	-
Non-NHS and Other WGA accruals	61,577	-	60,836	-
Non-NHS and Other WGA deferred income	-	-	-	-
Non-NHS Contract Liabilities	-	-	-	-
Social security costs	282	-	216	-
VAT	-	-	-	-
Tax	210	-	260	-
Payments received on account	-	-	-	-
Other payables and accruals	10,024	-	12,353	-
Total Trade & Other Payables	**102,118**	**-**	**100,470**	**-**
Total current and non-current	**102,118**		**100,470**	

NHS Derby and Derbyshire Clinical Commissioning Group does not have any liabilities included above for arrangements to buy out the liability for early retirement over 5 years (£nil at 1 April 2019).
Other payables include £1.381m outstanding pension contributions at 31 March 2020 (£1.281m at 1 April 2019). Other payables include GP pensions.

14. Provisions

	Current 31 March 2020 £'000	**Non-current 31 March 2020 £'000**	Current 01 April 2019 £'000	Non-current 01 April 2019 £'000
Redundancy	-	-	125	-
Legal claims	8	-	-	-
Continuing care	229	-	1,847	-
Other	1,843	195	856	146
Total	**2,080**	**195**	**2,828**	**146**
Total current and non-current	**2,275**		**2,974**	

	Redundancy	**Legal Claims**	**Continuing Care**	**Other**	**Total**
	£'000	**£'000**	**£'000**	**£'000**	**£'000**
Balance at 01 April 2019	**-**	**-**	**-**	**-**	**-**
Transfer from other public sector body under absorption	**125**	**-**	**1,847**	**1,002**	**2,974**
Arising during the year	**-**	**8**	**-**	**1,347**	**1,355**
Utilised during the year	**(125)**	**-**	**(283)**	**(302)**	**(710)**
Reversed unused	**-**	**-**	**(1,335)**	**-**	**(1,335)**
Unwinding of discount	**-**	**-**	**-**	**(9)**	**(9)**
Change in discount rate	**-**	**-**	**-**	**-**	**-**
Transfer (to) from other public sector body	**-**	**-**	**-**	**-**	**-**
Balance at 31 March 2020	**-**	**8**	**229**	**2,038**	**2,275**
Expected timing of cash flows:					
Within one year	-	8	229	1,843	**2,080**
Between one and five years	-	-	-	195	**195**
After five years	-	-	-	-	**-**
Balance at 31 March 2020	**-**	**8**	**229**	**2,038**	**2,275**

The redundancy provision was fully utilised during 2019-20.
Legal claims are calculated from the number of claims currently lodged with NHS Resolution and the probabilities provided by them. NHS Derby and Derbyshire Clinical Commissioning Group has made an £8k provision for two legal claims, as advised by NHS Resolution.
The continuing healthcare retrospective claims and disputes have been reviewed with £0.283m utilised in year and £1.335m released as no longer required.
The Clinical Commissioning Group has "other" provisions, including that for the Toll Bar House offices in Ilkeston, known as 'dilapidation cost provision' (£137k), to cover the cost of putting the offices back to an expected condition, when the lease is terminated. The lease which was due to expire in 2024, has been terminated earlier for August 2020 and so the discount factor has been fully unwound in year, to cover the contractual obligation.
"Other" provisions include estates and technology transformation fund revenue costs, with £302k being utilised in year and a residual balance of £554k.
Additionally new short term provisions due within a year have arisen: £515k for primary care networks additional roles reimbursement; £147k for online consultation (and an additional £195k in more than one year); and notes digitisation transformation of £490k.

15. Contingencies
Currently two legal claims are being pursued against NHS Derby and Derbyshire Clinical Commissioning Group with a resultant contingent liability of £4,975, as advised by NHS Resolution, the claim handler. Additionally a provision relating to these claims has been identified (see note 14 provisions).

16. Commitments
As a result of the outbreak of the COVID-19 pandemic, NHS Derby and Derbyshire Clinical Commissioning Group will incur significant additional expenditure payable to many different suppliers and providers of health care and social care. It is not currently possible to assess the full impact but these costs are being monitored. It is expected that all the additional costs will be met from central Government, through increased resources during 2020-21, while the pandemic continues to be fought.

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 £'000	2019-20 Equity Instruments designated at FVOCI £'000	Total £'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	-		-
Trade and other receivables with other DHSC group bodies	520		520
Trade and other receivables with external bodies	810		810
Other financial assets	2,819		2,819
Cash and cash equivalents	-		-
Total at 31 March 2020	40		40
	4,189	**-**	**4,189**

17.3 Financial liabilities

	Financial Liabilities measured at amortised cost £'000	2019-20 Other £'000	Total £'000
Loans with group bodies	-		
Loans with external bodies	-		**-**
Trade and other payables with NHSE bodies	993		**993**
Trade and other payables with other DHSC group bodies	53,345		**53,345**
Trade and other payables with external bodies	47,287		**47,287**
Other financial liabilities	-		**-**
Private Finance Initiative and finance lease obligations	-		**-**
Total at 31 March 2020	**101,625**	**-**	**101,625**

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 all four pools are as follows:

	2019-20 £'000
Income	(76,903)
Expenditure	76,826
Net Position for pooled budgets	**(77)**

Better Care Fund (BCF)
The Clinical Commissioning Group has two BCFs: The Derbyshire County BCF; and the Derby City BCF, which both became operational in 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 £101,476,251 including iBCF funding (£70,421,523 excluding iBCF). Total agreed contributions to the Derby City BCF pool are £31,654,818 including iBCF funding (£21,112,529 excluding iBCF).
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 2019-20 the Derbyshire County Council received additionally £31,054,728; and Derby City Council additionally £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 commissioner
- Commissioning of existing funded schemes directly by each partner

The memorandum account for the "Derbyshire County Better Care Fund" pooled budget is:

	2019-20 £'000	2019-20 Pool Share %
Income		
NHS Derby and Derbyshire CCG	(55,878)	55.07
NHS Tameside and Glossop CCG	(2,389)	2.35
Derbyshire County Council	(43,209)	42.58
Total Income	**(101,476)**	**100.00**

	2019-20 £'000
Expenditure	
CCG schemes aimed at reducing non elective activity	22,092
CCG schemes - wheelchairs	984
Derbyshire County Council schemes	6,961
ICES (Integrated Community Equipment Service)	5,499
Reablement	10,498
7 Day working	1,405
Administration, Performance and Information Sharing	512
Care Bill	2,149
Delayed Transfer of Care	7,169
Carers	2,048
Integrated Care	1,566
Workforce Development	2,695
Dementia Support	1,702
Autism and Mental Health	1,514
iBCF	31,055
Winter Pressures Grant	3,627
Total Expenditure	**101,476**
Net position for Pool	**0**

19. Joint arrangements - interests in joint operations, continued

The memorandum account for the "Derby City Better Care Fund" pooled budget is:

	2019-20 £'000	2019-20 Pool Share %
Income		
NHS Derby and Derbyshire CCG	(17,647)	55.75
Derby City Council	(14,008)	44.25
Total Income	**(31,655)**	**100.00**

	2019-20 £'000
Expenditure	
CCG schemes aimed at reducing non elective activity	3,560
Derby City Council schemes	2,048
Community Health Services	5,657
Social Care	8,039
Mental Health	498
Accident & Emergency	162
iBCF	10,542
Winter Pressures Grant	1,149
Total Expenditure	**31,655**
Net position for Pool	**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:

	2019-20 £'000	2019-20 Pool Share %
Income		
NHS Derby and Derbyshire CCG	(2,367)	33.00
Derbyshire County Council	(4,805)	67.00
Total Income	**(7,172)**	**100.00**

	£'000
Expenditure	
Purchase of equipment and healthcare services	7,172
Total Expenditure	**7,172**
Net position for Pool	**0**

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.

19. Joint arrangements - interests in joint operations, continued

The memorandum account for the "Integrated Disabled Children's Centre an Services in Derby" pooled budget is:

		2019-20	2019-20 Pool Share
		£000	%
Funding provided to the pooled budget:			
Derby and Derbyshire CCG		(1,011)	44.28
Derby City Council		(1,272)	55.72
Total Income		**(2,283)**	**100.00**
Expenditure			
Residential Services		1,067	
Community Service Team (Outreach Service)		301	
Disability and Fieldwork Social Work Services		3	
Management and Administration		789	
Total Expenditure		**2,160**	
Net position for Pool		**(123)**	
Balance brought forward at 1 April		(50)	
Balance carried forward at 31 March	**0**	**(173)**	0
Derby and Derbyshire CCG share of surplus 31 March	**0**	**(77)**	

The Integrated Disabled Children's Centre and Services in Derby pooled budget reported an underspend of £123k for the year, with a total accumulated underspend of £173k at 31 March 2020.
NHS Derby and Derbyshire Clinical Commissioning Group's share of the accumulated underspend was £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:

Governing Body Member	Related Party	Payments to Related Party £'000	Receipts from Related Party £'000	Amounts owed to Related Party £'000	Amounts due from Related Party £'000
Avi Bhatia	College Street Medical	791	0	0	0
Robyn Dewis; and Cate Edwynn	Derby City Council	18,980	(4)	1,191	(297)
Dean Wallace	Derbyshire County Council	72,505	(1,144)	115	(1,054)
Ruth Cooper	Derbyshire Health United	20,141	0	148	0
Steve Lloyd	Emmett Carr Surgery	618	0	0	0
Avi Bhatia; and Emma Pizzey	Erewash Health Partnership	1,900	0	0	0
Penny Blackwell	Hannage Brook Medical Centre	1,127	0	0	0
Alexander Strachan	Killamarsh Medical Practice	1,079	0	0	0
Alexander Strachan	Killamarsh Pharmacy LLP	1	0	0	0
Emma Pizzey	Littlewick Medical Centre	2,399	0	0	0
Avi Bhatia	Moir Medical Centre	1,746	0	0	0
Andrew Middleton	NHS South West Lincolnshire CCG	1	(12)	0	(6)
Ruth Cooper	North Eastern Derbyshire Healthcare Ltd	1,023	0	37	0
Avi Bhatia; and Bruce Braithwaite	Nottingham University Hospitals NHS Trust	41,965	0	931	0
Jill Dentith	Sheffield Health & Social Care NHS Foundation Trust	658	0	0	(26)
Steve Lloyd	St Lawrence Road Surgery	612	0	0	0
Ruth Cooper	Staffa Health	2,553	0	0	0
Buk Dhadda	Swadlincote Surgery	1,650	0	0	0
Penny Blackwell; Merryl Watkins; and Brigid Stacey	University Hospitals of Derby and Burton NHS Foundation Trust	402,684	(55)	5,566	(2,924)
Andrew Middleton	University Hospitals of Leicester NHS Trust	1,285	0	152	0
Ian Shaw	University of Nottingham	0	(8)	0	(8)
Meryl Watkins	Vernon Street Medical Centre	1,161	0	0	0

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 North Midlands; NHS Arden & GEM Commissioning Support Unit; NHS Midlands and Lancashire Commissioning Support Unit; 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.

21. Events after the end of the reporting period

The outbreak of the COVID-19 pandemic has caused significant pressures on the health and social care sectors. The Government has pledged additional funds to meet the challenges being met. NHS Derby and Derbyshire Clinical Commissioning Group will monitor additional costs being incurred as it continues to work with its partners, in meeting the needs of its patients.

Following the end of the reporting period, the Department of Health and Social Care announced that there would be a revision to the Funded Nursing Care rate 2019-20. This cost increase is non-significant and will be charged to 2020-21.

22. Losses and special payments

The total number of losses and special payments cases, and their total value, was as follows:

22.1 Losses

	Total Number of Cases 2019-20 Number	Total Value of Cases 2019-20 £'000
Administrative write-offs	1	1
Fruitless payments	-	-
Store losses	-	-
Book Keeping Losses	-	-
Constructive loss	-	-
Cash losses	-	-
Claims abandoned	-	-
Total	**1**	**1**

A historical debt of £1,285, owed to NHS Southern Derbyshire Clinical Commissioning Group in 2017-18 was written off, as the debtor was owed more by the Clinical Commissioning Group.

22.2 Special Payments

NHS Derby and Derbyshire Clinical Commissioning Group made no special payments in the year.

23. Financial performance targets

NHS Derby and Derbyshire Clinical Commissioning Group has a number of financial duties under the NHS Act 2006 (as amended).
The Clinical Commissioning Group performance against those duties was as follows:

	Target £'000	2019-20 Performance £'000	Duty Achieved?
Expenditure not to exceed income	1,684,086	1,684,067	Yes
Capital resource use does not exceed the amount specified in Directions	442	442	Yes
Revenue resource use does not exceed the amount specified in Directions	1,678,735	1,678,716	Yes
Capital resource use on specified matter(s) does not exceed the amount specified in Directions	-	-	Yes
Revenue resource use on specified matter(s) does not exceed the amount specified in Directions	140,639	137,365	Information Only
Revenue administration resource use does not exceed the amount specified in Directions	23,431	17,864	Yes

NHS Derby and Derbyshire Clinical Commissioning Group received an allocation of £29m Commissioner Sustainability funding and achieved an in-year surplus of £19k.

The expenditure performance of £1,648.067m and revenue administration resource performance of £17.864m, are both net of an £8k finance cost credit. The finance cost credit is identified on the Statement of Comprehensive Net Expenditure for the year and relates solely to administration finance.

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 2020 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 2020 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the NHS Commissioning Board 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 2019/20.

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").

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least a year from the date of approval of the financial statements. In our evaluation of the Accountable Officer's conclusions we considered the inherent risks to the CCG's operations and analysed how these risks might affect the CCG's financial resources, or ability to continue its operations over the going concern period. We have nothing to report in these respects.

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.

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. 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 does not comply with guidance issued by the NHS Commissioning Board. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2019/20.

Accountable Officer's responsibilities

As explained more fully in the statement set out on page 97, 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 CCGs 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 to you if the CCG has not made proper arrangements for securing 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 97, 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 CCGs arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in December 2019 and updated in April 2020 as to whether the CCG had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. 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 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; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the CCG under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

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 2020 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Andrew Bostock
for and on behalf of KPMG LLP
Chartered Accountants
One Snowhill
Snowhill Queensway
Birmingham
B4 6GH

24 June 2020

APPENDICES

Appendix One: Next steps on NHS response to COVID-19: Letter from Sir Simon Stevens and Amanda Pritchard

The CCG received a letter from Sir Simon Stevens, NHS Chief Executive, and Amanda Pritchard, NHS Chief Operating Officer on 17 March 2020. The letter detailed the next steps on the NHS's response to COVID-19. The letter can be accessed on our website here.

Appendix Two: CCG Attendance at Meetings 2019/20

Governing Body Attendance Record 2019/20

Governing Body Member	11 Apr 2019	2 May 2019	6 June 2019	4 Jul 2019	1 Aug 2019	5 Sep 2019	4 Oct 2019	7 Nov 2019	5 Dec 2019	9 Jan 2020	7 Feb 2020	5 Mar 2020
Dr Avi Bhatia *Clinical Chair*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Martin Whittle *Vice Chair, Lay Member for Patient and Public Involvement*	✓	✓	✓	X	X	✓	✓	✓	✓	✓	✓	✓
Dr Chris Clayton *Chief Executive Officer*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Deborah Hayman *Interim Chief Finance Officer*	✓	✓	✓	X								
Richard Chapman *Chief Finance Officer*				✓	✓	✓	✓	✓	✓	✓	X	✓
Brigid Stacey *Chief Nurse Officer*	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓
Dr Steven Lloyd *Medical Director*	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	X
Dr Penny Blackwell *GP Member*	X	✓	✓	✓	X	X	✓	✓	✓	✓	✓	✓
Dr Ruth Cooper *GP Member*	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Bukhtawar Dhadda *GP Member*	✓	✓	✓	✓	✓	✓	✓	X	✓	X	✓	✓
Dr Emma Pizzey *GP Member*	X	✓	✓	✓	X	✓	✓	✓	✓	X	✓	✓
Dr Greg Strachan *GP Member*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Merryl Watkins *GP Member*	✓	✓	X	X	✓	X	✓	✓	X	✓	✓	✓
Jill Dentith *Lay Member for Governance and Freedom to Speak Up Guardian*	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓
Ian Gibbard *Lay Member for Audit and Conflicts of Interest Guardian*	✓	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	X
Andrew Middleton *Lay Member for Finance*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gillian Orwin *Lay Member for Patient and Public Involvement*	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	X

Governing Body Member	11 Apr 2019	2 May 2019	6 June 2019	4 Jul 2019	1 Aug 2019	5 Sep 2019	4 Oct 2019	7 Nov 2019	5 Dec 2019	9 Jan 2020	7 Feb 2020	5 Mar 2020
Professor Ian Shaw *Lay Member for Primary Care Commissioning*	X	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓
Dr Bruce Braithwaite *Secondary Care Consultant*	✓	X	X	✓	✓	X	✓	✓	✓	X	X	X
Helen Dillistone *Executive Director of Corporate Strategy and Delivery*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sandy Hogg *Executive Turnaround Director*	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓
Zara Jones *Executive Director of Commissioning Operations*	✓	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓
Dr Cate Edwynn *Derby City Council Representative*	✓	✓	X	X	✓	✓	✓	✓	X			
Dr Robyn Dewis *Derby City Council Representative*										✓	✓	✓
Dean Wallace *Derbyshire County Council Representative*	X	✓	X	✓	X	✓	X	✓	X	X	X	X

Audit Committee Attendance Record 2019/20

Audit Committee Member	25 Apr 2019	23 May 2019	23 Sep 2019	21 Nov 2019	16 Jan 2020	19 Mar 2020
Ian Gibbard *Chair, Lay Member for Audit and Conflicts of Interest Guardian*	✓	✓	X	✓	✓	✓
Jill Dentith *Deputy Chair, Lay Member for Governance and Freedom to Speak Up Guardian*	✓	✓	✓	✓	✓	✓
Dr Bruce Braithwaite *Secondary Care Consultant*	X	X	X	X	X	X
Andrew Middleton *Lay Member for Finance*	✓	X	✓	✓	✓	✓

Remuneration Committee Attendance Record 2019/20

Remuneration Committee Member	21 Jun 2019	10 Oct 2019	3 Mar 2020
Martin Whittle *Chair, Lay Member for Patient and Public Involvement*	✓	✓	✓
Ian Gibbard *Lay Member for Audit and Conflicts of Interest Guardian*	✓	X	X
Jill Dentith *Lay Member for Governance and Freedom to Speak Up Guardian*	✓	✓	✓
Andrew Middleton *Lay Member for Finance*	✓	✓	✓

Governance Committee Attendance Record 2019/20

Governance Committee Member	9 May 2019	11 Jul 2019	12 Sep 2019	14 Nov 2019	23 Jan 2020	12 Mar 2020	17 Mar 2020
Jill Dentith *Chair, Lay Member for Governance and Freedom to Speak Up Guardian*	✓	✓	X	✓	✓	✓	✓
Ian Gibbard *Lay Member for Audit and Conflicts of Interest Guardian*	✓	X	X*	✓	✓	✓	✓
Martin Whittle *Lay Member for Patient and Public Involvement*	✓	✓	✓	✓	✓	X	X
Dr Emma Pizzey *GP Member*	✓	X	✓	X	✓	✓	✓
Dr Greg Strachan *GP Member*	✓	✓	✓	✓	✓	✓	✓
Helen Dillistone *Executive Director of Corporate Strategy and Delivery*	✓	✓	✓	✓	✓	✓	X

*Indicates where a member was deputised

Primary Care Commissioning Committee Attendance Record 2019/20

Primary Care Commissioning Committee Member	22 May 2019	26 Jun 2019	24 July 2019	28 Aug 2019	25 Sep 2019	23 Oct 2019	27 Nov 2019	18 Dec 2019	22 Jan 2020	26 Feb 2020	25 Mar 2020
Professor Ian Shaw *Chair, Lay Member for Primary Care Commissioning*	✓	✓	X	✓	X	✓	✓	X	✓	X	X
Gillian Orwin *Deputy Chair, Lay Member for Patient and Public Involvement*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jill Dentith *Lay Member for Governance and Freedom to Speak Up Guardian*	✓	X	✓	X	✓	✓	✓	✓	✓	✓	✓
Dr Chris Clayton *Chief Executive Officer*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*	X*
Brigid Stacey *Chief Nurse Officer*	✓	✓	X*	X*	X	X	X*	X	X*	✓	X
Deborah Hayman *Interim Chief Finance Officer*	✓	X*									
Richard Chapman *Chief Finance Officer*			X*	X*	X*	X*	X*	X*	X*	X*	X*
Dr Steven Lloyd *Medical Director*	✓	✓	✓	X*	✓	X*	✓	✓	✓	✓	✓
Sandy Hogg *Executive Turnaround Director*	✓	X*	✓	X	X*	X*	X	X*	X*	X*	X

* Indicates where a member was deputised

Clinical and Lay Commissioning Committee Attendance Record 2019/20

Clinical and Lay Commissioning Committee Member	9 May 2019	13 Jun 2019	11 July 2019	8 Aug 2019	12 Sep 2019	10 Oct 2019	14 Nov 2019	12 Dec 2019	23 Jan 2020	13 Feb 2020	12 Mar 2020
Dr Ruth Cooper *Chair, GP Member*	✓	✓	X	✓	X	✓	✓	✓	✓	✓	✓
Professor Ian Shaw *Deputy Chair, Lay Member for Primary Care Commissioning*	✓	✓	X	X	✓	X	✓	X	✓	✓	✓
Dr Bukhtawar Dhadda *GP Member*	✓	✓	✓	X	✓	✓	✓	X	✓	✓	✓
Dr Emma Pizzey *GP Member*	✓	✓	✓	X	✓	✓	X	✓	✓	✓	✓
Dr Greg Strachan *GP Member*	✓	✓	X	✓	✓	✓	✓	X	✓	✓	✓
Dr Merryl Watkins *GP Member*	X	✓	X	✓	✓	✓	✓	✓	✓	✓	✓
Dr Penny Blackwell	✓	X	X	X	X	X	X	X			
Dr Bruce Braithwaite *Secondary Care Consultant*	X	X	X	✓	✓	✓	✓	X	X	X	X
Gillian Orwin *Lay Member for Patient and Public Involvement*	✓	✓	✓	X	✓	✓	X	✓	✓	✓	✓
Ian Gibbard *Lay Member for Audit and Conflicts of Interest Guardian*	X	✓	✓	✓	X	✓	✓	✓	✓	✓	✓
Brigid Stacey *Chief Nurse Officer*	✓	✓	X	X	✓	✓	X	✓	X*	✓	✓
Deborah Hayman *Interim Chief Finance Officer*	X	X									
Richard Chapman *Chief Finance Officer*			✓	✓	✓	X	X*	X*	X*	X*	X*
Dr Steven Lloyd *Medical Director*	X	X	✓	✓	X	✓	✓	✓	X	X	X
Dr Robyn Dewis *Public Health Representative*	✓	X	✓	✓	✓	✓	X	✓	✓	✓	✓
Sandy Hogg *Executive Turnaround Director*	✓	✓	✓	X	✓	X	✓	X	✓	✓	✓
Zara Jones *Executive Director of Commissioning Operations*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

* Indicates where a member was deputised

Engagement Committee Attendance Record 2019/20

Engagement Committee Member	1 May 2019	5 Jun 2019	3 July 2019	7 Aug 2019	4 Sep 2019	2 Oct 2019	6 Nov 2019	4 Dec 2019	8 Jan 2020	19 Feb 2020	18 Mar 2020
Martin Whittle *Chair, Lay Member for Patient and Public Involvement*	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gillian Orwin *Deputy Chair, Lay Member for Patient and Public Involvement*	✓	✓	✓	X	✓	✓	✓	✓	✓	✓	✓
Professor Ian Shaw *Lay Member for Primary Care Commissioning*	✓	✓	✓	X	✓	X	✓	✓	✓	X	X
Denise Weremczuk *Foundation Trust Governor – Secondary Care*	X	✓	X*	✓	X*	✓	X	X*	X	✓	X
Bernard Thorpe *Foundation Trust Governor – Community*	✓	X	✓	✓	✓	✓	✓	✓	X	✓	X*
John Morrissey *Foundation Trust Governor – Mental Health*	✓	✓	✓	✓	✓	✓	✓	✓	X		
Kevin Richards *Foundation Trust Governor – Mental Health*										✓	✓
Ram Paul *Derby City Council Representative*	X	✓	X	X	X	X	X	X	X	X	X
Christine Coffey *Place Representative*	✓	X	X	X	X	X	X	X	X		
Colin Dorman *Place Representative, Derby*	✓	✓	X	X							
Ian Mason *Place Representative, High Peak*	✓	✓	X	✓	✓	✓	✓	✓	✓	✓	X
Jocelyn Street *Place Representative, North Derbyshire*	X	✓	X	X	✓	✓	✓	✓	✓	✓	✓
Rosemary Brown *Place Representative*	✓	X	X	✓							
Ruth Grice *Place Representative*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X
Tracey Logan *Place Representative*	✓	X	X	X							
Trevor Corney *Place Representative*	X	✓	✓	✓	✓	✓	✓	✓	X	✓	X

* Indicates where a member was deputised

Engagement Committee Member	1 May 2019	5 Jun 2019	3 July 2019	7 Aug 2019	4 Sep 2019	2 Oct 2019	6 Nov 2019	4 Dec 2019	8 Jan 2020	19 Feb 2020	18 Mar 2020
Helen Dillistone *Executive Director of Corporate Strategy and Delivery*	✓	X*	✓	✓	✓	✓	✓	✓	X*	X*	✓
Non-Voting Members											
Beth Soraka *Healthwatch Derby Representative*	X	X	X	X	✓	✓	✓	✓	✓	✓	X
Helen Henderson-Spoors *Healthwatch Derbyshire Representative*	✓	X	X*	X	X	X	X	✓	X	X	X
Kim Harper *Community Action Derby*	X	X	✓	X	X	X	X	X	X	X	X
Sean Thornton *Assistant Director Communications and Engagement, CCG*	✓	✓	✓	X*	✓	✓	X*	✓	✓	✓	✓
Karen Ritchie *Head of Engagement, Joined Up Care Derbyshire*	✓	✓	X*	X*	X	✓	X*	X	X	X	✓

* Indicates where a member was deputised

Finance Committee Attendance Record 2019/20

Finance Committee Member	25 Apr 2019	30 May 2019	27 June 2019	25 Jul 2019	4 Sep 2019	26 Sep 2019	31 Oct 2019	28 Nov 2019	19 Dec 2019	30 Jan 2020	27 Feb 2020	26 Mar 2020
Andrew Middleton *Chair, Lay Member for Finance*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Jill Dentith *Lay Member for Governance and Freedom to Speak Up Guardian*	✓	✓	X	✓	✓	✓	✓	✓	X			
Martin Whittle *Lay Member for Patient and Public Involvement*	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	X	✓
Ian Gibbard *Lay Member for Audit and Conflicts of Interest Guardian*										✓	X	✓
Dr Penny Blackwell *GP Member*	✓	✓	X	X	X	X	X	X	X			
Dr Ruth Cooper *Chair, GP Member*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓
Dr Bukhtawar Dhadda *GP Member*	✓	X	✓	✓	X	✓	✓	✓	X	✓	✓	✓
Deborah Hayman *Interim Chief Finance Officer*	✓	✓	✓									
Richard Chapman *Chief Finance Officer*			✓	✓	✓	✓	✓	✓	✓	X*	X	✓
Sandy Hogg *Executive Turnaround Director*	X	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Brigid Stacey *Chief Nurse Officer*	✓	✓	✓	X*	X	✓	✓	X	X*	X	✓	X

* Indicates where a member was deputised

Quality and Performance Committee Attendance Record 2019/20

Quality and Performance Committee Member	5 Apr 2019	26 Apr 2019	31 May 2019	27 Jun 2019	25 Jul 2019	29 Aug 2019	26 Sep 2019	31 Oct 2019	28 Nov 2019	19 Dec 2019	30 Jan 2020	27 Feb 2020	26 Mar 2020
Dr Bukhtawar Dhadda *Chair, GP Member*	✓	X	X	✓	✓	X	✓	✓	✓	X	✓	✓	✓
Dr Emma Pizzey *GP Member*	✓	X	X	X	X	✓	✓	✓	✓	✓	X	✓	X
Dr Greg Strachan *GP Member*	✓	X	X	✓	✓	X	✓	X	✓	✓	✓	✓	✓
Dr Merryl Watkins *GP Member*	X	X	X	✓	✓	✓	✓	✓	X	X	X	✓	✓
Andrew Middleton *Lay Member for Finance*	✓	✓	✓	X	✓	X	✓	✓	✓	✓	✓	✓	✓
Gillian Orwin *Lay Member for Patient and Public Involvement*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Martin Whittle *Lay Member for Patient and Public Involvement*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	X	✓
Brigid Stacey *Chief Nurse Officer*	✓	✓	✓	✓	X	X	✓	✓	X*	✓	✓	✓	✓
Dr Steven Lloyd *Medical Director*	X	✓	✓	X	X*	✓	✓	X*	X	X	✓	X	X
Dr Bruce Braithwaite *Secondary Care Consultant*	X	X	X	X	X	X	X	X	X	X	X	X	X
Zara Jones *Executive Director of Commissioning Operations*	✓	✓	✓	✓	✓	X	✓	X*	✓	✓	✓	X	X*
Helen Henderson-Spoors *Healthwatch Derbyshire Representative*	X	X	X	X	X*	X*	X*	X	X*	X	X	X*	X

* Indicates where a member was deputised

GLOSSARY

Glossary

2WW	Two week wait
A&E	Accident and Emergency
APMS	Alternative Provider Medical Services
Bn	Billion
CCG	Clinical Commissioning Group
CDI	Clostridium Difficile
CETV	Cash Equivalent Transfer Value
CPA	Care Programme Approach
CPCS	Community Pharmacists Consultation Service
CQC	Care Quality Commission
CRHFT	Chesterfield Royal Hospital NHS Foundation Trust
CSF	Commissioner Sustainability Fund
DCHSFT	Derbyshire Community Health Services NHS Foundation Trust
DHcFT	Derbyshire Healthcare NHS Foundation Trust
DHU	Derbyshire Health United
DSPT	Data Security and Protection Toolkit
E.coli	Escherichia coli
ED	Emergency Department
EIA	Equality Impact Assessment
EMAS	East Midlands Ambulance Service NHS Trust
EOC	Emergency Operations Centre
EoL	End of Life
FFT	Friends and Family Test
FTE	Full Time Equivalent
GBAF	Governing Body Assurance Framework
GP	General Practitioner

GPN	General Practice Nurse
HES	Hospital Eye Services
HR	Human Resources
IAF	Improvement and Assessment Framework
IAPT	Improving Access to Psychological Therapies
ICO	Information Commissioner's Office
ICPs	Integrated Care Partnerships
ICS	Integrated Care System
ISO	International Organization for Standardization
IT	Information Technology
IV	Intravenous
JUCD	Joined Up Care Derbyshire
KPI	Key Performance Indicator
LGBTQI	Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex
LTC	Long Term Condition
m	Million
MOL	Medicines Order Line
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-resistant Staphylococcus aureus
MSK	Musculoskeletal
MSSA	Methicillin sensitive Staphylococcus aureus
NECS	North of England Commissioning Support
NHS	National Health Service
NHSE	NHS England
NHSE&I	NHS England and NHS Improvement
NUH	Nottingham University Hospitals NHS Trust
OEIG	Organisation Effectiveness and Improvement Group

OEIPP	Organisational Effectiveness and Improvement Programme Plan
OPAT	Outpatient Parenteral Antibiotic Therapy
OPEL	Operational Pressures Escalation Level
Pathway 1 Pathway 2 Pathway 3	Patients are discharged from hospital via three pathways for care and rehabilitation support for up to six weeks: • Pathway 1 – to Intermediate Care and Reablement Services provided in their own homes. • Pathway 2 – to Residential Care within the Independent and Community Sector • Pathway 3 – to Nursing Care in a community hospital
PCCC	Primary Care Commissioning Committee
PCN	Primary Care Network
PICU	Psychiatric Intensive Care Unit
PSC	Personal Services Company
PSSRU	Personal Social Services Research Unit
PTS	Psychological Therapies Service
SIRO	Senior Information Risk Owner
SMI	Severe Mental Illness
STHFT	Sheffield Teaching Hospitals NHS Foundation Trust
STP	Sustainability and Transformation Plan
UHDBFT	University Hospitals of Derby and Burton NHS Foundation Trust
UTC	Urgent Treatment Centre
VCS	Voluntary and Community Sector
VSM	Very Senior Managers
YTD	Year to Date

About NHS Derby and Derbyshire Clinical Commissioning Group

NHS Derby and Derbyshire Clinical Commissioning Group brings together the combined expertise of 114 local GP practices to commission health services on behalf of over 1,055,000 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.

The CCG would like to thank Maria Muttick, Sally Watkin and Alan Fletcher (A Shot in the Dark Photography) for providing some of the photography for this year's Annual Report.

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